The BULLETIN

of the

VANCOUVER MEDICAL ASSOCIATION

Vol. 15 OCTOBER, 1938 No. 1

With Which Is Incorporated
Transactions of the

Victoria Medical Society

and the

Vancouver General Hospital

In This Issue:

EPILEPSY

B. C. MEDICAL ASSOCIATION ANNUAL MEETING

NEWS AND NOTES

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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VOL. XV. OCTOBER, 1938 No. 1

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Typhoid and Typhoid-Paratyphoid Vaccines

Although not epidemic in Canada, typhoid and paratyphoid infections remain a serious menace—particularly in rural and unorganized areas. This is borne out by the fact that during the years 1931-1935 there were reported, in the Dominion, 12,073 cases and 1,616 deaths due to these infections.

The preventive values of typhoid vaccine and typhoid-paratyphoid vaccine have been well established by military and civil experience. In order to ensure that these values be maximum, it is essential that the vaccines be prepared in accordance with the findings of recent laboratory studies concerning strains, cultural conditions and dosage. This essential is observed in production of the vaccines which are available from the Connaught Laboratories.

Residents of areas where danger of typhoid exists and any one planning vacations or travel should have their attention directed to the protection afforded by vaccination.

•

Information and prices relating to Typhoid Vaccine and to Typhoid-Paratyphoid Vaccine will be supplied gladly upon request.

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—AUGUST, 1938

Total Population—estimated	259,987
Japanese Population—estimated	8,685
Chinese Population—estimated	7,808
Hindu Population—estimated	335

	Number	Rate per 1,000 Population
Total deaths	239	10.8
Japanese deaths	6	8.1
Chinese deaths	12	18.1
Deaths—residents only	196	8.9
BIRTH REGISTRATIONS—		
Male, 191; Female, 166	357	16.17

INFANTILE MORTALITY—	August, 1938	August, 1937
Deaths under one year of age	9	10
Death rate—per 1,000 births	25.2	30.5
Stillbirths (not included in above)	10	7

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	July, 1938		August, 1938		Sept. 1st to 15th, 1938	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	26	0	14	0	7	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	23	0	4	0	11	0
Measles	2	0	3	0	0	0
Rubella	0	0	0	0	0	0
Mumps	1	0	1	0	4	0
Whooping Cough	15	0	44	0	17	0
Typhoid Fever	2	0	1	0	1	0
Undulant Fever	0	0	0	0	0	0
Poliomyelitis	2	0	3	1	1	0
Tuberculosis	44	12	37	9	17	-
Erysipelas	0	0	2	0	0	0
Ep. Cerebrospinal Meningitis	0	0	0	0	0	0

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

	Richmond	North Vancouver	Vancouver	Hospitals and private doctors	Totals
Syphilis	2	1	45	18	66
Gonorrhœa	0	0	98	26	124

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THE EDITOR'S PAGE

This number of THE BULLETIN is No. 1 of a new volume, the 15th. Our readers will notice changes, and it may be remembered that some months ago we mentioned the fact that negotiations were under way with the Victoria Medical Society and the Vancouver General Hospital to include their Transactions as regular features of THE BULLETIN.

In order to do this, it has been necessary to enlarge THE BULLETIN—and it is now a considerably bigger journal than before. The pages are larger and contain more words to the page; the type is, we consider, a distinct improvement, and altogether we feel that THE BULLETIN has taken another step forwards and upwards.

We must acknowledge here the ready co-operation of Dr. D. M. Baillie, Chairman of the Publications Committee of the Victoria Medical Society; Dr. B. J. Harrison, who fills the same position as regards the Staff of the Vancouver General Hospital, and perhaps especially the help given by Mr. Macdonald of the Roy Wrigley Publishing Company. Mr. Macdonald is our business manager and has done a very great deal to make these changes effective.

Our policy has been, and will continue to be, one of steady and gradual development, and we do not contemplate any radical changes, or any bold moves. For some time past we have felt, however, that the time was pretty near for expansion, and inclusion of more of the many things that are of interest to the medical men of British Columbia; for while this is THE BULLETIN of the Vancouver Medical Association, it is far more than a Vancouver journal. Our exchanges alone cover a very wide area, and THE BULLETIN reaches a long way. As an example of this, we may mention that when we began publication, our monthly issue was some two to three hundred copies. This first number of the new volume will print a thousand copies—and our publisher tells us he thinks we should print more, and seek for subscriptions outside the province. We receive letters from time to time, referring to articles, etc., published in THE BULLETIN: these come from all parts of the world: the United States, Canada, Great Britain; even South Africa and India have been heard from.

So no longer can we, or should we, be satisfied with purely parish-pump politics and local news. We should, the Publication Committee feels, be guided by circumstances and new possibilities, and as occasion offers, gradually include many new features, perhaps one at a time. One of the most important, and perhaps the nearest to hand, will be Public Health matters. For example, we hope to have some short articles by Dr. D. H. Williams, Director of the Division of Venereal Disease Control, Provincial Board of Health. These will be of great importance, as well as interest, to every medical man.

There is not enough, by a long chalk, of interchange between the two divisions of medicine—or rather, we should say, the two halves of medicine—the therapeutic half and the preventive half. No medical journal that we can think of at the moment caters to both sides at the same time. We have long felt that this is a great pity, and accentuates the natural tendency to dichotomy in this regard. THE BULLETIN feels that it has a great opportunity here to bring these twins together once again. They are like looking-glass twins—allelomorphs, to use a long word—pictures of each other, and should never have been separated as widely as they now are.

So we bespeak from our readers their interest and moral support. We would ask, too, that they remember that our one source of revenue comes from our advertisers. Advertisers are, and have to be, rigidly controlled, in their allotment of advertising, by the results obtained from that advertising. Our readers will notice that the great majority of our advertising is what is called "national" advertising, that is, by large firms doing nation-wide business here and in the United States. This, it may be said, is a proof, if any were needed, of the significance of THE BULLETIN as an advertising medium—but it would be greatly appreciated by your Publication Committee if all readers of this BULLETIN would make a point, wherever possible, of referring to this Journal as the source of their interest in any particular advertisement, and also of patronising these firms, who are all above reproach or suspicion. THE BULLETIN has always been very scrupulous about the character of the advertising it admits.

We hope that our new step will lead to wider horizons, more extensive fields, a clearer and a higher air. It has been a great joy to those of us associated with THE BULLETIN to

see it grow and expand and become more useful and valuable—but it is only at the beginning of its career yet, and we must never be satisfied with achievement. May we never arrive at the end of our journey of exploration—but travel hopefully, to do which, Stevenson tells us in an inspired phrase, is better than to arrive.

By the time this goes to press, the Vancouver Medical Association will have celebrated its fortieth anniversary at a dinner meeting. There may be more to say about this later, and Dr. Frank Turnbull's paper, read at that meeting, will appear in an early issue of THE BULLETIN. Meantime we record the meeting as a milestone in the history of our progress. In this regard, we wish to pay our respects to the *Vancouver News-Herald,* which is publishing an anniversary number dedicated to the Vancouver Medical Association. Our readers will no doubt find this a valuable and interesting document, and it will be preserved in the archives of the Vancouver Medical Association.

VANCOUVER MEDICAL ASSOCIATION ANNUAL DINNER

The Annual Dinner of the Association will be held on November 18th next. While definite arrangements are not yet completed, it is announced that the dinner will be held in the Oak Room of the Vancouver Hotel. Dr. D. E. H. Cleveland will have charge of the Programme and Dr. D. D. Freeze will manage business matters. KEEP THIS DATE IN MIND—FRIDAY, NOVEMBER 18TH, 1938.

VANCOUVER MEDICAL ASSOCIATION

Founded 1898 :: Incorporated 1906.

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 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.—Papers of the evening.

Programme of the 41st Annual Session

1938

October 4th—GENERAL MEETING.

DR. FRANK TURNBULL: "Pituitary and Para-pituitary Tumours."

October 18th—CLINICAL MEETING.

November 1st—GENERAL MEETING.

DR. J. ROSS DAVIDSON: "Some Aspects of Contract Practice."

November 15th—CLINICAL MEETING.

December 6th—GENERAL MEETING.

DR. KARL HAIG: Subject to be announced later.

December 20th—CLINICAL MEETING.

NEWS AND NOTES

The hearty congratulations of the Association will go to Dr. A. W. Bagnall, who was married on September 12th to Mrs. Gertrude Helen Taylor of this city. We offer our very best wishes to Dr. and Mrs. Bagnall.

* * * *

Dr. J. R. Naden has left for one month's well-earned vacation. He will motor south.

* * * *

Dr. D. E. Alcorn has opened offices in the Belmont Building in Victoria and will confine his practice to neurology and psychiatry.

* * * *

Dr. E. D. Emery of Nanaimo, the energetic Secretary of the Upper Island Medical Association, and Mrs. Emery have just returned from from a six weeks' vacation in Alberta.

* * * *

Dr. L. Giovando of Nanaimo returned from the Timberlands District with a large bag of birds.

* * * *

Dr. G. A. B. Hall of Nanaimo was prevented from attending the Victoria meeting by illness. We missed him at the Economic Conference. He has recovered and is back at the office.

* * * *

Dr. and Mrs. J. S. Henderson of Kelowna were holidaying at the Coast and are now preparing for the Annual Meeting of No. 4 District Medical Association, which is being held in Kelowna on October 2nd and 3rd.

* * * *

Dr. R. B. Shaw of Nelson is in Montreal doing postgraduate study.

* * * *

Dr. F. M. Auld of Nelson, the First Vice-President of the British Columbia Medical Association; Dr. Arnold Francis of New Denver; Drs. J. Bain Thom, member of Council, W. A. Coghlin and M. R. Basted of Trail represented the West Kootenay at Victoria.

* * * *

Dr. C. H. Hankinson of Prince Rupert, representative on the Board of Directors of the British Columbia Medical Association and member of the Committee on Economics of the College, travelled to Victoria by Union Stemaship to Campbell River, where he landed his automobile and motored down the Island to Victoria, arriving in time for the Breakfast Meeting of the Committee on Economics on Friday morning.

* * * *

Dr. S. Cameron MacEwen of New Westminster, a member of the Council and Chairman of the Committee on Economics, presided at the Breakfast Meeting on Friday, September 16th, at the Empress Hotel.

There were present: Doctors Anson C. Frost of Vancouver; G. W. C. Bissett of Duncan; C. H. Hankinson of Prince Rupert, C. C. Browne of Nanaimo (in the absence of Dr. G. A. B. Hall); E. J. Lyon of Prince George; Stewart A. Wallace of Kamloops; J. Bain Thom of Trail; E. W. Boak, W. H. Moore and D. M. Baillie of Victoria; J. H. MacDermot of Vancouver; T. C. Routley of the Canadian Medical Association, and M. W. Thomas.

Drs. G. A. B. Hall of Nanaimo and R. V. McCarley of North Vancouver were unavoidably absent.

* * * *

Dr. E. J. Lyon of Prince George and Dr. B. J. Hallowes of Alexis Creek added Cariboo colouring to the meeting in Victoria.

* * * *

Dr. John G. MacArthur of Prince George had an interesting trip by plane to Fort McLeod, Fort Grahame and Whitewater. One sees a lot of virgin territory when one flies.

* * * *

Dr. A. L. McQuarrie has finally proven the authenticity of his aeroplane experience. He was accompanied by Indian Agent Moore and Dr. Ross Stone of Vanderhoof. The

plane was taxiing up Stuart Lake at about 10 miles per hour and the pilot climbed out of his cabin to make some minor adjustment when he lost his foothold and slipped off into the lake. Dr. Stone quickly threw him a life-preserver, but—what next to do? The door to the cockpit was locked and the windows of the compartment were 12 by 16 inches. The three prisoners surveyed the scene and sized up their waistlines. Dr. McQuarrie was chosen to be thrust through the window with the aid of some skilful obstetrical manoeuvres by Dr. Stone. He then climbed into the driver's seat, and—what to do now? As he says, he looked at everything and fiddled about a bit and turned the plane about and returned to the floating pilot and then—to get it stopped. However, he did, and Dr. McQuarrie's friends still marvel at his ability as an acrobat and aviator. Dr. Stone appeared to have recovered from the experience sufficiently to laughingly verify the story.

* * * *

Dr. A. L. Jones of Revelstoke has had his son "Johnny" admitted to the Royal Military College in Kingston.

* * * *

Dr. and Mrs. R. Geddes Large of Prince Rupert are back after their two months' trip to Glasgow, Edinburg and London, returning on the record trip of the *Queen Mary*.

* * * *

Dr. J. M. McDiarmid, formerly of Abbotsford, has opened offices in Vancouver.

* * * *

Dr. R. J. Macdonald of Abbotsford has left for Toronto to do a "Public Health" course on the Fellowship of the Rockefeller Institute.

* * * *

Dr. H. E. Cannon, who has been associated with Dr. A. McBurney at Langley Prairie, has taken over the practice at Abbotsford.

* * * *

"Behind him he hears a buzzing sound that indicated that one of the hospital's new x-ray tubes has been brought to bear on his back."—*Victoria Daily Colonist*, Sept. 18, 1938. We could suggest other reasons for such sounds, if it was a pretty nurse.

* * * *

Word has been received that Dr. W. T. Kergin of Prince Rupert has undergone a successful operation recently at the Mayo Clinic, Rochester, Minn.

* * * *

Dr. J. H. Carson contemplates going to England in connection with North Pacific Halibut Liver Oils, which he so successfully manufactures in Prince Rupert, B. C.

LIBRARY NOTES

ALLAN B. KANAVEL, F.A.C.S.

Dr. Kanavel of Chicago, who died on May 27th after a motor accident in California, was one of those surgeons who influence practice every day in all parts of the world. Outside his own country he was known for his work on infections of the hand, which will long remain the basis of all study of these difficult and important conditions. His book on this subject, first published in 1912, has gone through six editions, and has even been translated into Chinese. It is founded on ten years of clinical observation and anatomical research; by the forcible injection of opaque material into tendon sheaths he was able to show the directions in which pus would spread in the hand, drawing attention to the thenar and middle palmar spaces not previously recognized by anatomists. Inestimable benefit has followed

the application of Kanavel's methods, and he himself became a master at restoring to function hands crippled by old infections. He wrote with authority, however, on a great variety of surgical subjects and was specially interested in the surgery of the central nervous system and in gynæcology.

At the time of his death Dr. Kanavel was professor of surgery at the Northwestern University medical school. He was a founder and life member of the American College of Surgeons, in which he had held many important offices, including those of regent and president. During the late war he served as colonel in the medical corps of the U. S. army, finally occupying the position of assistant to the chief consultant in surgery of the American Expeditionary Forces. Of recent years he had largely given up practice and had spent most of his time teaching and in editorial work. He was associated with *Surgery, Gynæcology and Obstetrics* from its inception in 1905 until 1935, when he became editor, and the July issue contains memoirs and a portrait. He was 63 years of age.—*Lancet,* July 16, 1938.

* * * *

BOOK REVIEW

Biological and Clinical Chemistry: M. Steel; Lea and Febiger, 1937.

"In the present text the author has attempted to blend theoretical and practical biochemistry and biophysics with chemical pathology and clinico-chemical methods." To this excerpt from the preface it may be added that the book covers the fields of both biochemistry and pathological chemistry, as known in several of our own universities, and includes instructions for laboratory work interspersed with the theoretical treatment of these subjects. The subject-matter of the book is extensive and supplemented with adequate references; the subject-form of the book is open to criticism. For example, vitamines and hormones are treated in both their academic and pathological aspects in Chapters 11 and 12, and nutrition and protein metabolism not till Chapters 18 and 21 respectively.

The dialectical relationship of theory and practice, of lectures and laboratory, is recognized by all teachers in the sciences, but is met in different ways. Through a keen desire, no doubt, to keep the experimental evidence before the too speculative mind, Professor Steel has attempted to include his practice with his theory. More strictly, he has given us a mixture of theory and theory of practice; for reading about an experiment can never be the same thing as doing it, or, conversely, the reading of textbooks is not a usual part of laboratory work. Detailed instructions for experiments are distracting to the mind on a definite train of thought. The incorporation of experimental evidence in the theoretical treatment of a subject is quite a different matter from the addition of details—often requiring quite a different theory—as to how that experimental evidence is attained. Thus, in the reviewer's opinion, this book would have been better without its experiments, although these appear to be well enough chosen and adequately described. The book contains much up-to-date and accurate information, and will be found useful by both students and medical practitioners.—*Canadian Medical Association Journal,* March, 1938.

* * * *

NEW BOOKS ADDED TO THE LIBRARY

Treatment in General Practice—H. Beckman. 3rd ed., 1938.
Radiation Therapy—Ira I. Kaplan. 1938.
Leukæmia and Allied Disorders—Claude E. Forkner. 1938.
Vitamin B and Its Uses in Medicine—T. R. Williams and T. D. Spies. 1938.
Approved Laboratory Technic—J. A. Kolmer and F. Boerner. 1938.
Diseases of the Skin—O. S. Ormsby, 1938.
Clinical Allergy—A. H. Rowe. 1938.
Primer for Diabetic Patients—R. M. Wilder. 6th ed., 1938.
Harvey Lectures—Series 33, 1937-38.

BRITISH COLUMBIA MEDICAL ASSOCIATION

COMMITTEE ON PUBLIC HEALTH

"MILK SITUATION"

There has been a considerable amount of discussion about the milk situation during the last year. There are some indications that the medical health authorities are considering a more general application of pasteurization, but unless some active steps are taken by both the Provincial authorities and the Municipal authorities, including the medical officers, no appreciable progress will be made. While the power rests with the Provincial and Municipal authorities, this does not excuse any laxity on the part of the medical profession, and we must persist in our efforts to educate and instruct the public. If in the past the medical profession throughout this Province had uniformly and persistently advocated pasteurization of milk, the public would probably be enjoying its benefits today. In the not far distant past we were able to demonstrate some of the advantages of a united front, and surely in matters pertaining to scientific methods we should present unanimity. In regard to medical advice concerning milk, this has unfortunately not been the case, and in some cases serious doubts have been left in the public mind because of a seeming divergence of opinion among medical men. As pasteurization has been universally accepted as the only scientific method available to produce a safe milk, could we not, as a profession, resolve to seize every opportunity to instruct the public properly about the kind of milk they should use. If every doctor took the time to advocate and explain pasteurization to his patients the public would soon be demanding universal pasteurization. The safety and convenience of canned milk is well appreciated by the dairyman, who is alive to the possibilities of an ever-increasing demand for safe canned milk.

Should there be any doubts among medical men, one cannot refer too often to a recent experiment in Toronto, the capital city of a province where pasteurization is general. Dr. Marguerite Price, in an investigation of non-pulmonary tuberculosis, examined 300 patients under 14 years of age and found 45 of them were infected with the bovine type of bacillus. All the patients infected had consumed raw milk and had come from *outside* Toronto. In Toronto itself not a single case of bovine tuberculosis was detected in this investigation. Examination of 100 samples of pooled raw milk before pasteurization revealed tubercle bacilli in 26. (The percentage of the presence of the tubercle bacillus in raw milk averages from 7 to 10% in all countries.) In Dr. Price's investigations, not a single sample of contaminated raw milk was found to contain tubercle bacilli after pasteurization.

One would like to think that Vancouver is as scientifically minded as Toronto. In England the cattle in attested herds must by law be fed milk from tuberculin-tested herds or the milk must be pasteurized. One can say, then, that in England attested herds are more safely protected by law against the dangers of raw milk than are the children of British Columbia.

This Province must of necessity spend each year very large sums of money on the *treatment* of tuberculosis. Does it not seem reasonable that the authorities should insist on the universal use of such a scientific protective agency as pasteurization to reduce the number of cases of tuberculosis? No nation is so decadent scientifically as the one that persistently refuses methods that have saved lives and lessened the ravages of disease.

Just at present the perennial stalemate in the milk question is at its peak. The Provincial Government has issued an excellent Bulletin endorsing pasteurization. The medical health officers in several large municipal districts, including Vancouver, have in the press endorsed the principle of pasteurization; several local and our Provincial and Canadian Medical Associations have strongly endorsed pasteurization. Much space has also been given in the press for the discussion of this question. Is it all to end, as in the past, in a multiplicity of words? Certainly the matter will never be adjusted by the Provincial and Municipal authorities continuing the milk football game of passing the question from one

seat of authority to the other. The medical profession at large has also a serious moral obligation to perform. Isn't it about time that all interested parties rid themselves of political and other astigmatisms and consider the question through the unbefogged glasses of impartial medical science?

A. HOWARD SPOHN, *Chairman.*

NEWS FROM THE TRAVELLING TEAM

Contributed by DR. M. W. THOMAS

The Lecture Team is still asleep at this early hour. On such a morning it seems to savour of sacrilege to sleep. Chilliwack is peaceful and still slumbers although the sun is rousing some of us and warming the chilled air as it casts its warm glow over the surrounding hills. From my window, as I read the *News-Herald* at 6:30 a.m., I see the blue hazes welcoming the light of another day.

I had a tired team on my hands last night. As I put them to bed and tucked them in I felt pleased and proud of my charges, for they had started out strongly on what I now presage to be a most promising tour. Last evening we dined with the newly-formed Chilliwack Medical Society at the Empress Hotel and we fraternized with the other visitors, Drs. H. E. Cannon of Abbotsford and Dr. J. A. Taylor, who has recently acquired his D.P.H. degree at Toronto and is now the Director of the Unit, with headquarters at Abbotsford. Dr. R. McCaffrey presided, and others present were: Dr. J. D. Moore, Vice-President; Dr. G. A. C. Roberts, Secretary; Drs. L. A. Patton, R. W. Patton, A. R. Wilson and W. E. Henderson.

Following an excellent dinner and informal chat about the proposed new hospital and happy reports on the value of the new organization of the local group, the President called upon Drs. Murray Baird and Roy Huggard, who dealt with "The Treatment of Medical Emergencies" and "Carcinoma of the Breast," and if the lively discussion of these papers reflects the interest shown and the quality of these presentations, I would predict that the meeting at Kelowna of the No. 4 District Medical Association (which includes doctors in that whole area from Bralorne and Pioneer, Lillooet, Lytton, Ashcroft, Revelstoke, Kamloops, Merritt and all the places down the Okanagan to Penticton and Oliver and including Princeton, Hedley and Blakeburn), and that at Trail of the West Kootenay Medical Association, which goes to Nakusp in the north, and then the meeting at Cranbrook, which comprises the whole area from Invermere to Creston, and including Michel, Fernie and Kimberley, would be eminently successful.

Both Drs. Huggard and Baird made a splendid contribution of well-prepared papers, presented in their own inimitable ways. I was, I say, pleased and proud of this exordial effort by my two star speakers.

They were both impressed by the fine spirit which pervades the profession and I may quote them: they feel that we have in British Columbia a something which is virile and vital—an organization that is both centrifugal and centripetal.

DR. W. D. BRYDONE-JACK

OBIIT AUG. 30, 1938. AET. 78.

The present writer has a very special memory of Dr. William D. Brydone-Jack, who was the first medical man he met on arriving in Vancouver some 32 years ago, almost to the day. At that time he was in partnership with Dr. A. S. Monro, with whom he remained associated till the death of the latter some years ago. The two men were about as different as two men could be—and so got along splendidly. Monro was quick, volcanic, and ready always to try new things, embark on new ventures, and plunge head-first into any scheme that appealed to him. Brydone-Jack seemed, in contrast with him, slow and reserved—quiet and courteous of speech, gentle of manner, but friendly and kindly in his treatment of a newcomer and stranger.

But this quiet reserve concealed a forceful and positive character, which has left its mark on our community life, and which found expression in the many public offices he filled and positions of trust that he occupied. It concealed, too, a depth of wisdom and practical common sense that has rarely been surpassed. Time and again one has seen him confronted with problems, important and urgent, but difficult of solution withal—and he rarely failed to find some practical, sane way out, fair to all concerned. That feature of his character is one that sticks in the writer's memory of our late colleague.

He had the gift of friendship, and was a welcome guest anywhere. He enjoyed good-fellowship and the companionship of his fellows, and contributed a full share to the entertainment.

As regard his work, it could hardly fail to be a success; he was a very busy man in his prime, and very popular with his patients. In later years, he devoted much of his time to his work as Coroner, and this position has never been more competently filled than it was by him.

His passing leaves a gap, both in public and professional life, and his host of friends will miss him sadly. But in the words of the old writer, "he has left a good name"—and that is success of the highest kind. May he rest in an honoured peace.

—J. H. M.

BRITISH COLUMBIA MEDICAL ASSOCIATION LECTURE TOURS

Dr. Murray McC. Baird and Dr. Roy Huggard will travel by automobile with Dr. M. W. Thomas to attend meetings in the Okanagan and East and West Kootenays.

Doctors Baird and Huggard will present papers to the Chilliwack Medical Society and at the Annual Meetings of No. 4 District Medical Association at Kelowna, the West Kootenay Medical Association at Trail, and the East Kootenay Medical Association at Cranbrook.

Doctor Huggard will address luncheon, dinner and evening meetings en route in support of the membership efforts of the various Units of the British Columbia Branch of the Canadian Society for the Control of Cancer. The Canadian Clubs in the various centres are co-operating in arranging these meetings. Doctors Baird and Thomas will support Dr. Huggard and, as it were, bask in the light of reflected glory as this fluent and forceful speaker carries a convincing message to these lay audiences.

CHILLIWACK

The first stop, on Friday, September 30th, will find the eight doctors of Chilliwack at dinner at the Empress Hotel with the doctors from Abbotsford and Mission. Both Doctors Baird and Huggard will present post-prandial papers to this augmented Chilliwack Medical Society.

LYTTON

On Saturday, October 1st, Dr. J. P. Ellis has arranged a public meeting after dinner at Lytton, when Dr. Huggard will speak on "Cancer."

On Sunday, October 2nd, the party will visit Dr. Drummond at Ashcroft, the doctors in Kamloops, then on to Salmon Arm, Enderby, Armstrong and Vernon, where Dr. Huggard will address a public meeting.

KELOWNA

On Monday, October 3rd, the lecture team will participate in the Annual Meeting of No. 4 District Medical Association. A full programme has been prepared, commencing with golf on October 2nd, and a visit to the fruit packers and canners, and then on to the winery.

After luncheon the lectures will include: Dr. Murray Baird on "Treatment of Medical Emergencies" and "Some Remarks on Rheumatic Diseases"; Dr. Roy Huggard: "Carcinoma of Breast" and "Radical versus Conservative Treatment in Acute Cholecystitis."

Dr. G. Allan Mail, Dominion Entomologist at the Government Station, Kamloops, will speak on "Tick and the Resultant Diseases."

The dinner of this Association is an outstanding feature and is followed by the Annual Business Session, election of officers and the selection of the venue for the next Annual Meeting. Dr. J. S. Henderson is the President and Dr. Reba E. Willits is the Honorary Secretary-Treasurer.

TUESDAY, OCTOBER 4th

This will be a busy day for Dr. Huggard. The party will visit Peachland, Summerland, West Summerland, and at

PENTICTON

Doctors R. B. White and H. McGregor will arrange a luncheon at which "Cancer" will be the topic.

GRAND FORKS

The party will visit Oliver and Greenwood, and after dinner a meeting at Grand Forks has been arranged by Dr. Windsor Truax, when Dr. Huggard will speak.

TRAIL

On Wednesday, October 5th, the West Kootenay Medical Association convenes in its Annual Meeting. Doctors Huggard and Baird will present papers, and Mr. Mail of Kamloops will deal with "Diseases Caused by Ticks."

There will be clinical features presented by local men. After dinner the Annual Business Meeting will be held. Dr. M. R. Basted is the President and Dr. Wilfrid Laishley of Nelson is the Honorary Secretary-Treasurer.

NELSON

Leaving Trail on Thursday, October 6th, en route to Nelson, the party will visit Dr. Goresky at Castlegar. Dr. F. M. Auld of Nelson is arranging a luncheon to hear Dr. Huggard.

CRESTON

Creston will be reached for dinner on October 6th, and after Dr. Huggard talks on "Cancer" the party will proceed to Cranbrook.

CRANBROOK

On Friday, October 7th, the members of the East Kootenay Medical Association will meet in Annual Session. Doctors Baird and Huggard will present four papers following luncheon at the Cranbrook Hotel. Dr. F. E. Coy of Invermere will preside and Dr. J. F. Haszard of Kimberley is the acting Honorary Secretary-Treasurer. The lecture programme will be held in the Training School of St. Eugene Hospital.

At this point the party will lose Dr. Murray Baird, who will have left his mark on the two Kootenays and intervening points. Dr. Baird will travel by train to Rochester to visit the Mayos.

However, Doctors Huggard and Thomas will still continue the journey and more places will be visited, and Doctor Huggard will be just as busy spreading his pep in the projection of the British Columbia Branch of the Canadian Society for the Control of Cancer.

COWICHAN RIVER

If all the doctors will come to the Cowichan River, Doctor Thomas will have a few days' fishing—perhaps.

BRITISH COLUMBIA MEDICAL ASSOCIATION ANNUAL MEETING, SEPTEMBER, 1938

THE BULLETIN desires to extend its heartiest congratulations to the British Columbia Medical Association on the very great success of its Annual Meeting, held at Victoria, September 15 to 17. We feel particularly good about it, since we urged our readers to attend in force, and promised them all sorts of good things, and our advice, for once (or as usual), has turned out to be thoroughly sound, and our promises were all more than implemented, as the saying is. Besides, we went ourselves, chiefly on our own recommendation, and we felt that it showed our sincerity and honesty when we took our own advice.

Well, there is no doubt that it was good advice. The meeting, from first to last, admirably fulfilled its purposes. These were chiefly, we take it, to strengthen and tighten the bonds of union between us as members of this Association; to provide the latest educational and scientific material for our professional betterment, and to provide for growth and progress in the work of the medical profession. Incidentally, there was an entertainment radical somewhere in the gigantic molecule of unsatisfied affinities—and this entertainment radical, which contained a great deal of carbon dioxide and an alcohol ester of one kind or another, probably did as much to satisfy these affinities as anything else. The carbon dioxide was, of course, provided by the trees on golf courses and the like.

The scientific part of the programme was excellent, and we owe much gratitude to the speakers who gave so liberally from the "bonded storehouse of their knowledge," as Jorrocks would say. All the speakers were good, and the loud-speaker arrangement ensured that nobody missed a word—except when our good friend Dr. Cleveland, acting as chairman, kept moving it out of the way of the speaker; perhaps he was afraid they would speak into it.

The attendance was very good indeed, and we are sure our hosts at Victoria must have felt gratified, as every good host must do, to see so many partaking of the good things they had provided. Half the Vancouver medical profession seems to have gone, either for part or all of the time, and we saw a great many men from all parts of the province.

Victoria, as we prophesied, proved to be one of the very best of hosts. The weather was superb, the golf courses in excellent shape (rather excessively bunkered, on cannot help feeling), and there was ample entertainment for everybody. Garden parties, teas, dances, dinners, for men and women alike, were thoroughly enjoyed, and left us all with a delightful feeling of having had a thoroughly good time. There was no effort and no strain, and everything moved so easily and as if on oiled bearings, that one forgot that there had been a good deal of hard work and organisation necessary before this meeting could function as it did.

For there was this preparation and effort, unsparingly contributed by those in charge of the meeting. Dr. M. W. Thomas, our Executive Secretary, has been perhaps the busiest man in the Western Hemisphere for some weeks, and this rose to a climax during these three days, as he had to be everywhere at the same time, and keep all the pots boiling, without allowing any to burn, or go out, or boil over. Quite an assignment—but it was in good hands, and by the time dinner came on the table everything was just right. We add our most sincere congratulations and thanks to the many that he has already received.

Speaking of dinners, we were very glad to have with us the Hon. T. D. Pattullo, the Premier of British Columbia, and the Hon. G. M. Weir, Provincial Secretary, at the Annual Dinner. Mr. Pattullo was our guest speaker, and we hope he enjoyed being with us as much as we enjoyed having him. His speech was short and to the point, and showed a great deal of friendly understanding of our points of view.

A great deal of praise, and our sincere thanks, are due to the officers of the Association, notably Dr. Gordon Kenning, the President, who was admirably at home in conducting the proceedings, and made an excellent chairman at the Dinner.

* * * *

We propose to publish in the form of a Supplement the papers read at this meeting. They are, to some extent, presented as read. In other cases, our stenographer took notes, and these are given. We feel that in this form they will be of most value to the members of the Association.

VICTORIA MEDICAL SOCIETY

Duncan, V.I., Sept. 23rd, 1938.

Dear Dr. MacDermot:

Dr. Baillie has written me saying that you are bringing out the next BULLETIN in its enlarged form and indicates that a short statement from me in my capacity as President of the Victoria Medical Society would be acceptable for inclusion.

Personally, and also in my official capacity, I consider this the major accomplishment of one year: a true stepping-stone forward.

I should like to say that the Victoria members will be gratified to have their transactions and papers included in THE BULLETIN. We feel that much of value has been lost to ourselves and the profession elsewhere in the province through our lack of publishing facilities. We further feel that this budding graft onto THE BULLETIN will be received with general acclaim as a very tangible piece of evidence of the growing unity within the profession.

I wish to take this opportunity to thank you personally for your own efforts, which I feel have played a large part in making this good thing possible.

Yours sincerely,
G. W. BISSETT.

* * * *

Victoria, B. C., Sept. 29t9h, 1938.

Dear Dr. MacDermot:

May I say, on behalf of the Publicity Committee of the Victoria Medical Society, how pleased and grateful we are for the hospitality of THE BULLETIN's columns.

We feel that this new development is of great significance to our profession in the Province and particularly to the Victoria Medical Society. We hope that it will lead to the organization in the near future of a British Columbia Medical Journal.

Yours sincerely,
DAVID M. BAILLIE.

FROM THE CANADIAN MEDICAL ASSOCIATION

TO THE PROFESSION:

The Authorship Committee appointed by the Department of Cancer Control of the Canadian Medical Association has undertaken as its initial effort the production of a handbook on cancer, for the Medical Profession.

The manuscripts for this handbook were submitted for criticism, through the Deans of the nine Medical Schools in Canada, to the leaders in our profession interested in cancer, as well as to the Cancer Committee of each of the nine Provinces. The final text is an attempt to express the combined opinion of these collaborators.

Cancer of the various anatomical sites is discussed from the standpoint of pathology, diagnosis, treatment and prognosis. The book will be off the press this summer.

If you feel that such a book would be of value to you in your work, the Canadian Medical Association will be glad to mail you a copy with its compliments, if you will write your request (using your professional stationery) to the Department of Cancer Control of the Canadian Medical Association, 184 College Street, Toronto.

Yours faithfully,
T. C. ROUTLEY, *General Secretary.*

CANADIAN MEDICAL ASSOCIATION DEPARTMENT OF CANCER CONTROL

For the Medical Man

The education of the doctor in the latest known scientific facts about cancer, by means of books, pamphlets, lectures and films.

The establishment of Tumour Clinics in Hospitals—making biopsies available.

The encouragement of Cancer Study Groups in Medical Societies.

All this tending to make the Doctor "Cancer Conscious" and ready to co-operate with the layman in his desire for a complete examination leading to early recognition of disease and prepared to advise the layman as to the proper lire of treatment to be adopted.

The provision of standard records for clinical and statistical purposes.

CANADIAN SOCIETY FOR THE CONTROL OF CANCER

For the Lay Man

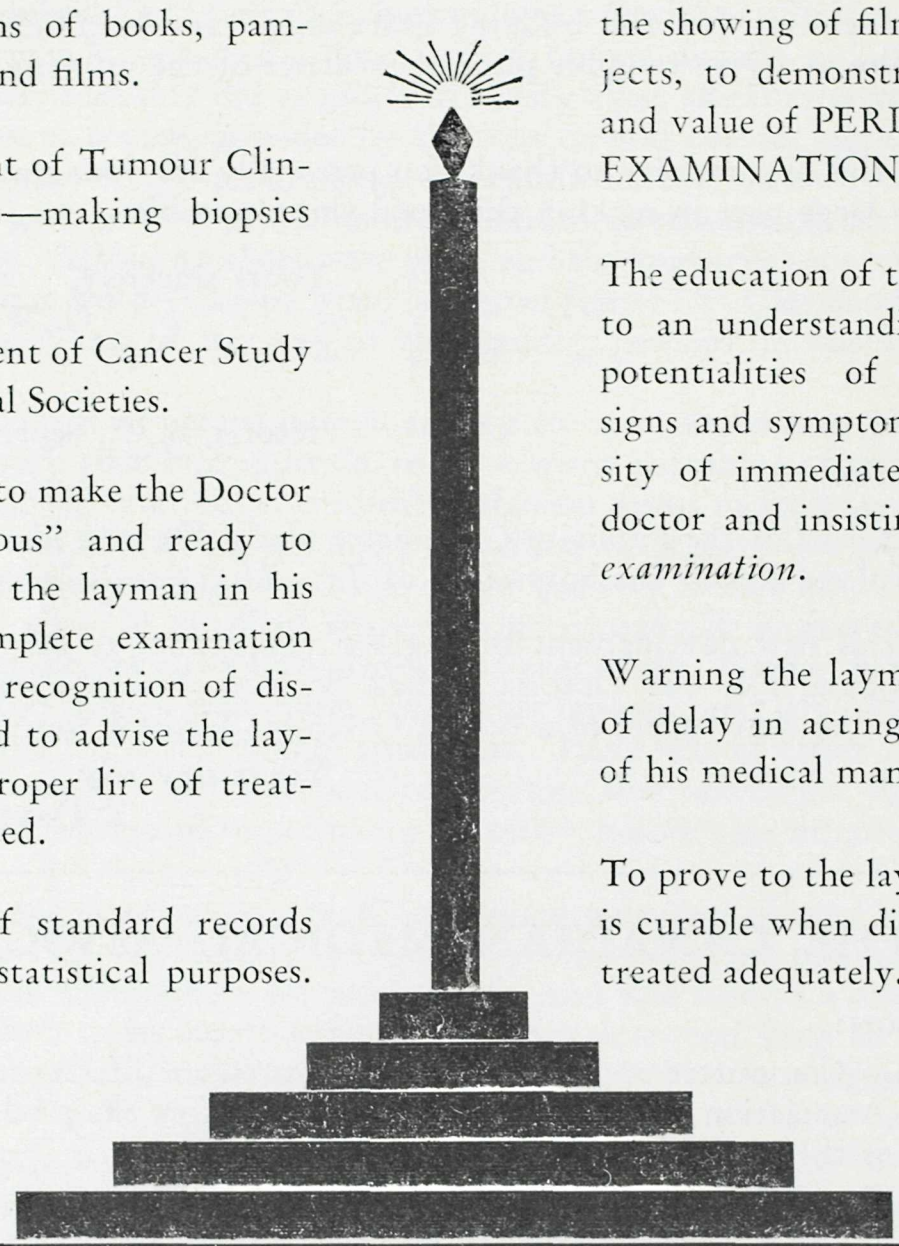
OBJECTS

The education of the layman by means of pamphlets, lectures and the showing of films on cancer subjects, to demonstrate the necessity and value of PERIODIC HEALTH EXAMINATIONS.

The education of the layman leading to an understanding of the grave potentialities of certain definite signs and symptoms and the necessity of immediately consulting his doctor and insisting on a *complete examination*.

Warning the layman of the danger of delay in acting upon the advice of his medical man.

To prove to the layman that Cancer is curable when diagnosed early and treated adequately.



In general to do everything possible to lower the mortality and morbidity statistics of cancer in the Province of British Columbia: to help in every way towards a solution of the cancer problem in the Dominion: to support all humanitarian efforts to alleviate the sufferings of patients with cancer: to this end to enlist the sympathetic support and financial aid of the general public by building up membership in the

CANADIAN SOCIETY FOR THE CONTROL OF CANCER

THE CANADIAN SOCIETY *for the* CONTROL OF CANCER

BRITISH COLUMBIA BRANCH

Objective — 50,000 Members

UNIT:

An Executive of five, consisting of: Chairman, Secretary, Treasurer, two elected members.

Executive of Five and ..... members.

150 Units in British Columbia, each with an Executive of five. Endless chain method of obtaining members. Each unit sending two elected representatives to their District Council—one lay and one medical.

DISTRICT COUNCIL:

Approximately 36 members—sending two elected representatives to the Provincial Council—one lay and one medical.

9 District Councils in British Columbia, each receiving two representatives from each unit in their District. The number of members of each District Council varies with the number of units in their district.

PROVINCIAL COUNCIL:

Forty members, which include two representatives from each District Council plus 22 members at large, 11 medical and 11 lay. Now in process of organization by a Provisional Board of Directors under the chairmanship of Dr. A. Y. McNair.

The Provincial Council of British Columbia receiving two representatives from each of the nine District Councils.

DOMINION GRAND COUNCIL:

Eighteen members—two from each Provincial Council. Now in process of organization by a Provisional Board of Directors under the chairmanship of Dr. J. S. McEachern, assisted by three laymen and three medical men.

Head Office: Toronto, Ont.

Department of Cancer Control of the Canadian Medical Association with a Board of 18 members.

THE CANADIAN MEDICAL ASSOCIATION

THE TRUSTEES OF THE KING GEORGE V SILVER JUBILEE FUND.

EPILEPSY

Discussion of the Surgical and Non-Surgical Treatment

By R. Glen Spurling, M.D.,
Louisville, Ky.

Read before the Summer School of the Vancouver Medical Association, June 21-24, 1938.

There is perhaps no single group of chronic sufferers who are so utterly miserable as those composing the epileptic group. They do not ordinarily die of the disease; many of them must await some intercurrent ailment to relieve them of what has been a horrible existence. Many of them are thwarted in their attempts to make something useful of their lives. Most of them are denied the pleasures of marriage and children because of the hereditary feature of the disease. What may be more pathetic is the social stigma which descends upon the immediate family of the victim. For centuries the sufferers of fits have been spoken of in hushed tones and with lifted eyebrows. They and their families are forced by social customs to be secretive at best and social outcasts as a rule.

That the source of the disease has not been eradicated and its treatment more efficient is not due to lack of interest among clinical and laboratory investigators; scores of brilliant men have devoted their lives to the study of the problem. *Much has been accomplished* and I believe if these accomplishments were better known to the profession, the plight of the epileptic as far as treatment is concerned would be tremendously improved.

I shall attempt to discuss today the practical rather than the theoretical aspects of the problem. I shall tell you the methods we use in the study and treatment of the various types of epileptics.

When the patient enters the hospital—and every case should be hospitalized during the investigation—he is subjected to a complete clinical study. Since convulsive seizures occur as a manifestation of general systemic disease, notably cardiorenal disorders, hyperinsulism, febrile illness of childhood, parasites, arteriosclerosis and chemical poisoning, these causes are eliminated in the beginning. If a primary disease of the central nervous system is present, such as a cerebral tumour, a cerebral abscess, cerebral birth paralysis, or a traumatic lesion of the brain, a painstaking neurological examination should ordinarily disclose it. However, it is rather striking how frequently one of these cerebral lesions has been missed clinically in our series of over four hundred epileptic patients, and their presence finally disclosed by air studies—a subject I shall discuss at some length a bit later in the paper.

Perhaps the most important part of the clinical investigation is an accurate history of the attacks. This should always be obtained from the patient and some person who has observed him repeatedly. What was the first symptom noted at the beginning of an attack? What did the patient do? How did he act? What was the sequence of events after the onset of the attack? To which side did the head turn? In which direction were the eyes rotated? Did one arm and leg behave differently to the corresponding member? These and many more similar questions and their answers often lead the investigator into an accurate localizing diagnosis. It is often desirable for the physician to observe personally the pattern of a seizure. In most epileptics a convulsion can be induced by hyperventilation (hyperpnœa) or by hydration. When an accurate account cannot be obtained, then I feel justified in deliberately inducing a seizure.

The most frequent localizing sign is elevation of the eyes and turning of the head to the side opposite the hemisphere involved. Seizures which have their origin in the frontal lobe are usually characterized by loss of consciousness (without aura) and turning of the eyes, head and body to the opposite side. This is followed by a nearly simultaneous convulsion of the opposite extremities, falling, and generalization of the attack. In seizures which arise from lesions just anterior or posterior to the Rolandic fissue, unconsciousness does not ensue until later. A tingling sensation may follow a jacksonian march, just as movement follows in seizures arising in the frontal lobe. In fact, consciousness is apt to be lost late in seizures arising anywhere behind the central sulcus. Such seizures are ushered in by aurae. It must be remembered, however, that a major attack may leave retrograde

amnesia, so that the aura is forgotten. In such circumstances, the aura may be remembered only in slight seizures which do not progress to generalization. Seizures originating in the occipital pole or in the supramarginal gyrus are characterized by "trembling" or "flashing" of lights, seen in the contralateral field. An aura of epigastric distress or pain is frequently experienced with lesions of the sensory cerebral cortex usually of the postcentral convolution. "Buzzing sounds" and dizziness are characteristic of unilateral temporal lobe lesions. Uncinate attacks, those queer hallucinations of smell, are always pathognomonic of a lesion involving one or both temporal lobes.

With the introduction by Dandy in 1919 of pneumoencephalography, the study of organic cerebral disorders received a tremendous impetus. This important diagnostic procedure has revolutionized the localization of obscure brain lesions and has opened up, because of the additional information obtained, new avenues of treatment heretofore unknown. No epileptic has been completely studied until he has been subjected to air studies. Whether air is injected directly into the ventricular system (ventriculography) or into the spinal subarachnoid space (encephalography) is a matter of individual preference. I prefer the latter procedure in those cases without marked increased intracranial pressure. By replacing the entire volume of cerebrospinal fluid with air, or oxygen, it is possible by means of carefully taken x-ray films to study not only the interior of the brain by visualization of the ventricular system but the exterior of the brain as well by visualization of the cerebral subarachnoid spaces and basal cisternae. Pneumoencephalography stands in the same relative importance to neurological diagnosis as do pyelography to urology and cholecystography to abdominal surgery. Curiously enough, the injection of air into the subarachnoid space has a beneficial effect upon the number and severity of the convulsive attacks. Patients have been known to be free of seizures for many months following this procedure when no other therapy has been employed. However, it is not because of the possible therapeutic benefits that we advise encephalography in every epileptic patient, but because the information obtained provides us with data which may be indispensable for the proper management of the case.

With our knowledge of treatment of epilepsy in its present state, the patients may be divided roughly into two groups: (1) The surgical; (2) the nonsurgical.

The Surgical.

The operative treatment of epilepsy has been the perennial vogue in various clinics for the past forty years. Simple decompression operations, implantation of foreign bodies upon the surface of the brain, various types of cervical sympathectomy, drainage of arachnoidal lakes of fluid, surgical alterations of venous drainage—all of these and many more, such as colectomy, have been employed from time to time with the hopes of bringing relief to the epileptic patient. Needless to say that most of these have been lacking in rationale and, consequently, have been discarded. Today it is generally conceded that there is no approved or accepted surgical procedure for cases of idiopathic epilepsy. On the other hand, there are two types of epilepsy in which surgery offers very satisfactory end-results: (1) Traumatic epilepsy with localized cortical scars, and (2) jacksonian epilepsy with a sharply defined trigger point with or without scar formation.

The principles laid down by Föerster, Penfield and their pupils[4] form the basis for all modern treatment of traumatic epilepsy. Penfield summarizes the situation perfectly in these words: "If the patient's history, the encephalogram, the pattern of the seizures and perhaps the neurological examination all incriminate the same area of the brain, then electrical exploration is justified. If this exploration is in accordance with the rest of the evidence, complete radical excision of the focal lesion is the rational method of treatment, a treatment which has been justified by its practical results."

In order to carry out satisfactorily an electrical exploration of the brain, it is necessary that the operation be done under local anæsthesia or perhaps local supplemented by a light basal anæsthesia. If stimulation of the suspected area with a weak faradic current produces a convulsion with the same pattern as observed during the investigation, whether there be gross evidence of disease or not, then that area should be excised with the electrosurgical knife so widely that further stimulation fails to reproduce the muscular responses

already noted. If there be bony defects overlying cortical scars, these are always repaired with either a bone graft or a celluloid plate. We have used the latter method exclusively for the past four or five years with better results and with considerably less work than when massive bone grafts were attempted.

While much has been written about the repair of cortical scars in traumatic epilepsy, little has been said about their prevention. In most cases of acute head injury resulting eventually in a localized cortical cicatrix there has been a depressed fracture of the skull with an area of local contusion and laceration to the brain and meninges. It has been a too common practice, if any operation is done at all, simply to elevate or remove the skull fragment and disregard the devitalized brain tissue. In the process of healing, all such tissue is replaced by an astroglial network, which often becomes thoroughly fixed to the meninges and tissues of the scalp. Such a scar exerts a pull over a widespread area of the brain. If at the time of the acute injury all devitalized cerebral tissue is clearly removed, the resulting gliosis is reduced to a minimum and the cavity thus created becomes filled with cerebrospinal fluid. The likelihood of an extensive scalp-meningo-cerebral scar is thus greatly diminished. A thorough débridement of the entire traumatized area at the time of the acute injury would certainly reduce the incidence of traumatic epilepsy to the minimum.

The Nonsurgical.

By far the largest number of epileptic patients (perhaps 80 per cent) fall into the nonsurgical group. They are the ones most difficult to treat chiefly because the etiology is so frequently obscure. After the air studies are completed and the possibility of a surgical lesion has been ruled out, the patient is then started on a routine which in my experience brings some measure of relief to all cases and has enabled others to remain free of seizures over a period of years.

I shall discuss the nonsurgical treatment under four headings: (1) General hygiene; (2) drug therapy; (3) ketogenic diet; (4) dehydration.

General Hygiene.—It is most important that the patient subject to convulsive seizures should lead a carefully regulated life as free as possible from emotional stress, mental and physical fatigue. A moderate amount of daily exercise in the open air is advisable. Alcohol and all stimulants should be eliminated from the diet. If the patient's occupation is such that attacks endanger himself or co-workers, it should be changed. Likewise, he should not be allowed to operate a motor vehicle or engage in any recreations where, should he have an attack, his own life of that of others would be endangered.

Proper elimination is an essential feature of the routine.

Because of the stigmata associated with the term "epilepsy" in the minds of the laity, physicians are reluctant at times to tell the family or patient the true condition. This point of view is wrong. If it has once been established that the patient is suffering from epilepsy, the responsible member of the family should be told. This not only promotes better co-operation from the standpoint of treatment but avoids having the patient or his family discover the true nature of the malady from sources other than their medical advisors.

Drug Therapy.—For the control of the seizures, drug therapy is by far the simplest method. The bromides have for years been the generally accepted medication for the epileptic. With the introduction in 1912 of phenobarbital (luminal) as a nerve sedative, this drug has practically replaced the bromides in popular favor. These two drugs, given singly or in combination, do control in a fairly satisfactory manner the number and severity of the seizures. These beneficial effects are in the majority of instances only temporary, as a tolerance is developed rapidly. There will always be a group of patients in whom, for one reason or another, more exact and desirable methods cannot be instituted. Drug therapy in this group will be the only method available. Phenobarbital is perhaps the most satisfactory drug to use. It should be given in doses sufficiently large to control the convulsions. In many cases, four and a half to six grains daily will be required. This drug should never be prescribed unless the patient returns to the physician for frequent observation, so that the dose may be properly regulated. The maintenance should be as low as possible to control the seizures.

Ketogenic diet.—Dietary treatment has been perhaps the greatest single advance in the treatment of epilepsy. It has been known for centuries that fasting will stop convulsive seizures temporarily. While fasting as a means of treatment has been discredited by most investigators because it does not give permanent results, yet the chemical changes observed in the body as a result of fasting form the basis for all modern dietary treatment of the condition. Careful investigation has shown that when a patient becomes free of seizures from fasting, the sugar content of the blood is low and acetone bodies, *i.e.*, acetone and diacetic acid, are present in increasing quantities in the blood. Also, the carbon dioxid combining power of the blood is diminished and the hydrogen ion concentration is slightly reduced. Wilder[9] and later Peterman[7] first suggested that the improvement associated with fasting is not attributable to the starvation itself but to the ketosis with which starvation is naturally associated. Acting upon this assumption, they placed their epileptic patients on a diet which was calculated to produce a constant ketosis. Many authors, notably Talbot[8], Helmholz[5] and others, have experimented along the same lines and their efforts have been crowned with considerable success. In many instances there has been a complete cessation of the attacks over a period of years, and in others a decrease in the number and severity of seizures has occurred. Furthermore, it has been demonstrated beyond doubt that a patient may remain on this diet indefinitely without detrimental effects to the general health. In fact, normal growth and development take place even in the young. Some authors believe that patients maintained on a ketogenic diet are freer from intercurrent illnesses than on a normal diet. This is true particularly in the case of the common cold.

In our experience, it is futile to attempt the diet unless the patient and some other responsible person have been instructed thoroughly in the practical side of dietetics. Hospitalization for a week or ten days is essential. First, encephalographic studies are made and following this procedure the patient is placed in charge of the dietitian for instructions into the theory and practice of the diet. He is taken to the diet kitchen and taught to prepare his meals under supervision. He learns to test daily his state of ketosis by analysis of his urine for diacetic acid. When he is sufficiently conversant with all the details, he is discharged from the hospital and is instructed to report to the physician or the dietitian when any change is to be made in the diet, or when the diet fails to produce the desired ketonuria.

It is possible for patients in any walk of life to learn this diet and adhere to it rigidly. We have records of labourers who have learned the diet and who have carried it out over a period of years. Young children offer the most difficult problem, because in many instances it is impossible to make them understand the importance of rigid adherence to the routine. Many of them will steal candy or sweets and, of course, spoil the state of ketosis. Other children learn very early the importance of rigid adherence. One of my colleagues in Lexington, Kentucky, tells a most illuminating story of one of his little patients who had been on the diet for several months. This boy came into a corner drug store with three of his playmates. The playmates each bought an ice cream cone, and this little fellow showed no inclination to obtain one. A travelling salesman standing in the store noticed that the boy did not have a cone and feeling sorry for the youngster he suggested that he would be glad to buy one for the child. The boy looked up at him and said: "Thanks, Mister, but I wouldn't eat one of them things for fifty dollars. I would be sure to have a fit tonight if I did."

Dehydration.—The possible relationship of hydration and dehydration to epileptic seizures has attracted the attention of many investigators. Sinc the days of Hippocrates a moist brain has been thought to be associated with epilepsy. McQuarrie[6] in 1929 showed that there was a tendency for the epileptic to store water during the active stage of the disease in amounts that were harmful. He also showed that convulsions tend to occur when a water balance above a certain magnitude is established, and that after dehydration occurred, convulsions, in many instances, were prevented. He found that it was possible by a sudden increase in the water intake to throw the severe epileptic patient into convulsions, and by dehydrating him to relieve the convulsive manifestations. Temple Fay[3] has been the chief proponent and advocate of this method of treatment. On the basis

VANCOUVER GENERAL HOSPITAL SECTION

FOREWORD

It is with a great deal of satisfaction that I write this introductory paragraph on the occasion of the first issue of THE BULLETIN to which the Vancouver General Hospital contributes a part. There is a wealth of clinical material passing through the institution from which can be drawn a great deal of valuable information for the medical profession. The Outpatient Department work warrants study that will add to our experience and knowledge in the practice of Medicine. The various special clinics can broaden the scope of this endeavour. In the Pathological Department last year there were over 600 autopsies, and this work is now forming the basis for the Wednesday Pathological Conferences. Many very unusual pathological conditions are being found which perhaps would not be so unusual if autopsies were done on all cases of death. The various clinical ward rounds can and should be extended to cover all departments or specialties in Medicine. Thus, you can see that this hospital has facilities that can be major factors in the contributions to medical knowledge and the extension of postgraduate experience for the local medical profession.

To the Medical Profession is extended a cordial and ready welcome to avail themselves of this opportunity.

A. K. HAYWOOD, M.D., *General Superintendent.*

EPILEPSY *(Continued from preceding page)*

of his own experience, he finds this method has given relief to patients when other methods have failed.

Dehydration automatically occurs in patients upon the ketogenic diet. Barbour[1] experimentally demonstrated that dogs on a high-fat, low-carbohydrate diet take voluntarily approximately 50 per cent less water than animals under similar environmental conditions will take on a normal mixed diet. From our experience, we find that patients on a high ketogenic ratio do not desire water in large quantities. We have for several years limited the fluid intake of epileptic patients in connection with the ketogenic diet and have found that they remain comfortable on a fluid intake as low as 600 cc. per 24 hours. It is our belief that the combination of ketosis plus dehydration is the method of choice in the treatment of the epileptic.

In closing, let me say that for one to appreciate fully the change that has occurred in the attitude toward the treatment of epilepsy, he must read the literature of a decade ago and compare it with that of recent date. More exact information has taken the place of surmises, conjectures and pseudo-knowledge. I do not mean to imply that the problem is solved; it is far from that state, but I have attempted to show that sufficient scientific advances have been made to justify our substituting a spirit of hope and expectancy for that of utter despair when dealing with the epileptic patient.

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EDUCATIONAL FACILITIES OF THE OUTPATIENTS' DEPARTMENT

E. CHRISTOPHERSON

The morning clinics, beginning at 10 o'clock, are open to all medical men, who will be welcomed by the attending staff. The afternoons are given over to admission of new patients, who are examined by internes and required laboratory work ordered, on the completion of which they are referred to the proper clinics. If treatment is urgent it is commenced that same day. We are desirous of having all our new patients in the afternoons between 1 and 2 o'clock except Saturday.

The schedule of Clinics is as follows:

Medical and Surgical—Monday, Wednesday and Friday, 9 a.m.

Ear, Nose and Throat—Monday and Thursday, 9 a.m.

Eye—Tuesday and Friday, 9 a.m.
Skin—Tuesday, 9 a.m.
Dental—Every day but Friday, 9 a.m.
Neurology—Tuesday, 9 a.m.
Psychiatry—Wednesday, 9 a.m.
Proctology—Wednesday, 9 a.m.
Tumour—Thursday, 10 a.m.
Diabetic—Thursday, 9 a.m.
Genito-Urinary—Friday, 9 a.m.
Varicose Veins—Friday, 9 a.m.
Orthopædics—Saturday, 9 a.m.
Medical Arthritic—Saturday, 9 a.m.
Pædiatrics—Saturday, 9 a.m.
Fracture—Thursday, 1:30 p.m.

It will be noted that there are no general medical clinics, which is unfortunate, as there are many patients who do not belong to any particular clinic.

It has been my duty to direct the distribution and disposal of patients. The former is easy but the latter is more difficult. Many patients require regular attendance on account of a chronic disease or their social status. Others in the lower income group or on City Relief are referred back to their own doctors with a report on the findings after investigation and the line of treatment as recommended by the attending staff.

MEDICAL RECORDS

From the Perspective of the Vancouver General Hospital.

"How long, how long in infinite pursuit
Of this and that endeavour and dispute."
—OMAR KHAYYAM.

While medical records have been more widely discussed in the past twenty years, they are by no means a subject of recent origin. Hippocrates reputedly made his bedside notes, but doubtless deplored his isolation, so that it is only reasonable to expect that in another hundred years from now sighs will be heard because of the inadequacy of medical records as a whole.

Of their value no doubt exists—patient, doctor and hospital are equal beneficiaries, and their aid in legal matters, public health and medical research is undisputed. Proofs of this are forthcoming daily. The patient's viewpoint may be instances in various ways, and, while the following may have its humour, one detects a note of anxiety:—

"Genl Hosp
Vancr

Will you kindly let me know hows that pig. I beleave they give him some of my T B germs the dr said he'd tell me if he dies or not hope to here from you in the near future thank you."

Instances of the dependence upon good records of domestic peace range all the way from the mother keeping her "Baby's record" who, having failed to remember her child's birth weight, telephones the Records Department, to the man whose son, failing to sustain himself in the country to the south of us and endeavouring to return, was refused permission to cross the border until he could furnish proof of Canadian birth; the father, being communicated with, came to us, admitted his boy's birth was unregistered, and asked our aid. Sex consciousness 25 years ago was not so acute as now, but although we could only

give him a certificate showing that Mrs. ——— "gave birth to a baby," he came in a month later to say his boy was home again.

The 1937 survey of hospitals by the American College of Surgeons revealed, according to the report, that the greatest weakness is a lack of adequate medical records. Those who have essayed reviews of Vancouver General Hospital records in the past few years should be competent judges, but while their verdict still awaits definite pronouncement, expressions of disappointment are not wanting.

The situation today is that while By-laws No. 102 and 103 of the Vancouver General Hospital demand from the attending and visiting staffs a history within 48 hours of admission of a patient, the work devolves upon an interne staff whose inhibitions, as well as their activities in other directions, all too often preclude this instruction being rigidly observed.

Often a conscientious but harassed interne is left to his own devices to obtain a case history from a patient who he feels is the subject of a "twice-told tale." In this connection, what excellent use could be made of the much-vaunted standardized medical form, an original for the doctor's office and a duplicate for the hospital.

The fluctuation in interne staffs—never so marked in the past seven years as in this present year of grace—can also be charged with being a factor in the lack of adequate histories. We commenced this interne year with a staff of approximately 40, but have descended to as low as 26, with even two seniors failing to complete their year of seniority. Is it not obvious that adequate histories are an impossibility in such circumstances? Small blame to the interne before whose eyes is dangled the alluring prospect of the comparative wealth of private practice as against his honorarium as an interne, but until interneships are at a premium, or until completion of at least one year plays a definite part in the issue of a license to practise, this aspect of the situation will remain unchanged.

The medical value of the individual record applies equally to patient and doctor. Patients' memories are frequently quite vague on even vital matters, and the doctor being consulted is at a disadvantage without reference to the written word. "Patients forget: records remember."

In 1937, for medical, legal and research reasons, 5545 charts were extracted from the records, of which some 250 dated back anywhere from 4 to 30 years ago; 1020 were taken to wards for review upon readmission of patients, and 1107 were perused in the department by doctors to discover the nature of previous illness of current patients. The year's correspondence included 18 requests from out-of-town doctors and hospitals for medical information on former V. G. H. patients. Essondale sought details of 12 and Shaughnessy 20 cases. This surely speaks volumes for the necessity of continued effort to secure good records. Of the satisfaction gained from their perusal it is not the prerogative of this writer to make any estimate, but it being the duty of the Records Department to secure a history on every case, it can at least be said that this objective is not altogether easy of achievement.

FREDK. J. FISH, *Director of Medical Records.*

MEDICAL WARD ROUNDS

The Ward Rounds of the Medical Staff of the Vancouver General Hospital are held every Thursday morning at nine o'clock. Instead of the older method of a large group of physicians standing at the bedside of a sick patient in a public ward, the physicians meet in one room to which the patient is wheeled on his bed, and chairs, a blackboard, and x-ray view-boxes are provided.

Four to six patients from the medical service are shown each morning, and these are of two types: (1) Interesting or rare syndromes; (2) puzzling, undiagnosed cases. Not infrequently, patients from the Outpatient Department are shown also.

The interne reads the history; a member of the x-ray department is present to interpret x-rays; a pathologist is present to interpret tests and biopsies; and the discussion is led by the Chairman. The diagnosis and ultimate disposal of patients previously shown are also reported.

The ward rounds are attended by fifteen to twenty physicians and have been improving steadily. All physicians are invited to attend and to join in the discussions.

CASE REPORTS

Postmortem Finding: Hyperthyroidism with Large Thymus in Adult.

The following case is reported with a short history and a résumé of the highlights of the autopsy findings, as it was thought that it might be of some interest:

Miss J. K.; 24 years.—Dr. Hodgins.

Admitted, May 16th, 1938; died, May 28th, 1938.

This patient was admitted giving a history of palpitation, profuse perspiration, voracious appetite and nervousness and tremor for the past three or four months. The onset of her illness had been gradual and slowly progressive. Patient stated that she had been worried for some time, due to unemployment of her father, and also there was a history of emotional upset over a boy friend. There had been no bouts of diarrhœa or vomiting. Menstrual history, normal.

Physical examination.—Patient was flushed and obviously very nervous; exophthalmos, moderate, was present; also lid lag. Thyroid was uniformly enlarged, quite firm, and bruit was heard over both lobes. Heart, normal; blood pressure, 148/74; B.M.R., plus 50. No anæmia.

May 19th—Presented at medical ward rounds, where it was decided that deep x-ray should be given to the gland, preliminary to operation, provided this opinion was concurred in by surgical consultant. Received x-ray treatment on three occasions.

May 23rd—Patient was upset; speech was slurred and at times incoherent; pulse rapid.

May 26th—Very toxic; pulse rapid and thin; flushed; confused and incoherent; pulse continued to rise from 140 on admission, and patient finally died, May 28th.

Treatment.—In addition to x-ray therapy, patient was given a high carbohydrate diet and sedation. During the last two days she was given intravenous glucose three times a day, containing sod. iod. grns. 15.

The highlights of the autopsy findings are as follows:

The body is that of a well developed but only fairly well nourished white female, 24 years of age. There is nothing particularly noteworthy on external examination. The lungs are quite congested, and in the left lower lobe there are fairly extensive bronchopneumonic areas. A well defined purulent bronchitis is also present. The heart is moderately enlarged and the musculature shows the so-called "thrush breast" type of appearance, denoting a well-marked degenerative process. The liver shows a moderate degree of fatty infiltration; the kidneys show evidence of parenchymatous degeneration, but the spleen, uterus and adnexa and adrenals show nothing particularly noteworthy.

One of the most interesting findings is a very markedly enlarged thymus gland. This gland weighed 53 grms. According to the tables given by Hammar, the thymus, between the ages of 21 and 25 years, weighs at the maximum 25 grms., so that here we have a thymus that is more than twice the maximum weight at this age period.

The thyroid is somewhat slightly enlarged, weighing 40 grms., and is very firm and beefy, presenting on section a compact greyish-brown color, very definitely and markedly hyperplastic in appearance. Microscopically, in general it gives the impression of a markedly hyperplastic thyroid gland.

Microscopic examination confirms the presence of the bronchopneumonic process, and also the fatty infiltration of liver, the parenchymatous degenerative changes in the kidneys and in the heart.

The main and interesting features in this case are the very marked hypertrophy and hyperplasia of the thymus gland. It is a well-known fact that hyperplasia of the thymus and practically all lymphoid tissue is a fairly consistent finding in hyperthyroidism, but enlargement to such a marked degree in the thymus is not usually seen.

The handling of these thyrotoxic cases is also a very controversial subject; whether prolonged rest with Lugols' iodine before attempting any surgical intervention, or whether prolonged rest with sedation or the ligation of the superior thyroid arteries with an interval of three or four days between ligations and then followed, after two or three months' rest period, by thyroidectomy or possibly one lobectomy.

Apparently the general consensus of opinion is that they are extremely difficult cases to handle and that the mortality, with practically any mode of treatment, is very high.

* * * *

Fibrosarcoma of Small Intestine Causing Obstruction of Bowel.

Mr. Fred Ganski, age 30, Polish labourer, was admitted to the Emergency Ward of the Vancouver General Hospital on May 13, 1938, at 5:50 a.m. Past admissions—none. Common complaint—cramp pain in abdomen, 24 hours; vomiting 10 hours. Admitted to Ward "J", May 13th 1938, at 7:00 a.m.

Present information.—This man was apparently in good health until 1 p.m. yesterday when he was suddenly seized with an acute spasmodic pain about the umbilicus. Following the pain he vomited and the pain seemed to be temporarily relieved. Later in the day, however, he had several attacks and called his doctor, who administered morphia. With persistent pain, patient was admitted to hospital.

There was no history of any chronic complaint, debilitating conditions or familial diseases.

Functional enquiry.—No headache or dizziness. No cough, sputum, or loss of weight. No dyspnœa or swelling of feet and ankles. Has had some belching of gas, but no food intolerance. Occasional periods of constipation. No genito-urinary symptoms.

Physical examination.—A well developed, well nourished adult, male, at present lying quietly in bed, having a moderate amount of abdominal discomfort. Head, neck and eyes normal. Mouth dry, but clean. Teeth in good condition. No cervical adenopathy. Chest expansion poor, but equal. No adventitious sounds. Heart, no enlargement or irregularities. Blood pressure, 130/80. Abdomen, normal contour; "Maximum point of tenderness just to the right of the umbilicus." No rigidity. No abnormal masses. Genitalia normal. Extremities negative.

Laboratory report.—Urinalysis negative; white blood count 11,200.

Differential diagnosis—(1) Ruptured gastric ulcer; (2) acute appendicitis; (3) intestinal obstruction.

Operative report.—Surgeon, Dr. S. A. McFetridge: Pre-operative diagnosis—Intestinal obstruction; post-operative diagnosis—Intestinal obstruction. Operation performed—End-to-end anastomosis and enterostomy:

The abdomen was opened by a paramedian incision. A loop of small bowel found to be greatly dilated to the size of the stomach adherent into the pelvis. This was freed and obstruction found to be a mass the size of a walnut in the mesentery of the small bowel and a ringlike constricture involving the lumen of the small bowel. This loop was resected 6 inches distal to the growth and about 3 feet above where we could find semi-normal bowel. An end-to-end anastomosis was done and an enterostomy above as a safety-valve, and catheter brought out through the wound.

The abdomen was closed in layers.

Pathological Report (Dr. H. H. Pitts)

Macroscopic examination.—Specimen consists of 24 cms. of small intestine superficially pale and smooth but extremely thick-walled, as though it had been chronically obstructed. The distal extremity of this portion of the intestine is definitely constricted, and the intestine beyond this point, laid open, measures only 4.5 cms.; at the point of constriction, a firm mass is palpable, a smooth superficial area of thickening being noted in the serosa extending into the attached mesentery. On section through this area, the lumen of the gut laid open in this point measures only 2.2 cms. and in situ this would probably amount to complete obstruction, as a ridge-like area projects into the lumen. This is covered by smooth, intact mucosa over most of its surface, but centrally is superficially ulcerated. On section, the musculature at this site is seen to be tremendously hypertrophied, measuring on the average about 1 cm. in thickness. The muscle coat can be traced throughout the entire area, but superficially it appears extremely pale, greyish-white in colour, as though partially replaced by a fibrous process, and from this surface fibrous bands of similar con-

sistency extend into the adjacent mesenteric fat. This does not altogether suggest a carcinomatous process although it may be a neoplastic one, but rather suggests a chronic inflammatory process. Numerous sections were taken through this area to include practically the entire thickened portion. The remainder of the mucosa is intact and there is no evidence of a neoplastic or inflammatory process in it.

Microscopic examination.—A great many sections were taken through the firm fibrotic mass mentioned above and this is seen to consist of a moderately cellular structure, apparently arising in the subserosa and consisting of very pleomorphic and polymorphic cells, in some instances arranged in somewhat whorl-like aggregations. The cells vary greatly in size and shape, with many almost giant-like forms, with reduplication of nuclei and, in some instances, these cells are aggregated to form almost pearl-like formations, although not in the same sense as epithelial pearls. The cells apparently are fibroblastic in origin, the majority quite plump, fairly deeply staining, and yet there is a quite abundant, rather wavy fibrous intercellular substance. There is very extensive inflammatory reaction as well, some edematous imbibition and the tumour tissue is well vascularized throughout. In some of the sections infiltration throughout the muscularis and into the submucosa is noted, but the mucosa itself appears quite well preserved. There is also a very marked hypertrophy of the muscularis. I believe that this is probably a fibrosarcoma, arising in the subserosa, and does not appear markedly malignant.

Dignosis: Fibrosarcoma of small intestine causing obstruction of bowel.

May 24, 1938—Enterostomy tube removed. Well-formed stools with enemata. Passes gas per bowel freely. Soft diet well retained. Still some discharge from wound. No severe complaints. Progress satisfactory.

May 30, 1938—Up and around ward daily. Incision clean. Discharged.

June 8, 1938—Seen in Outpatients' Department. Bowels moving with enemata, free from pain or discomfort.

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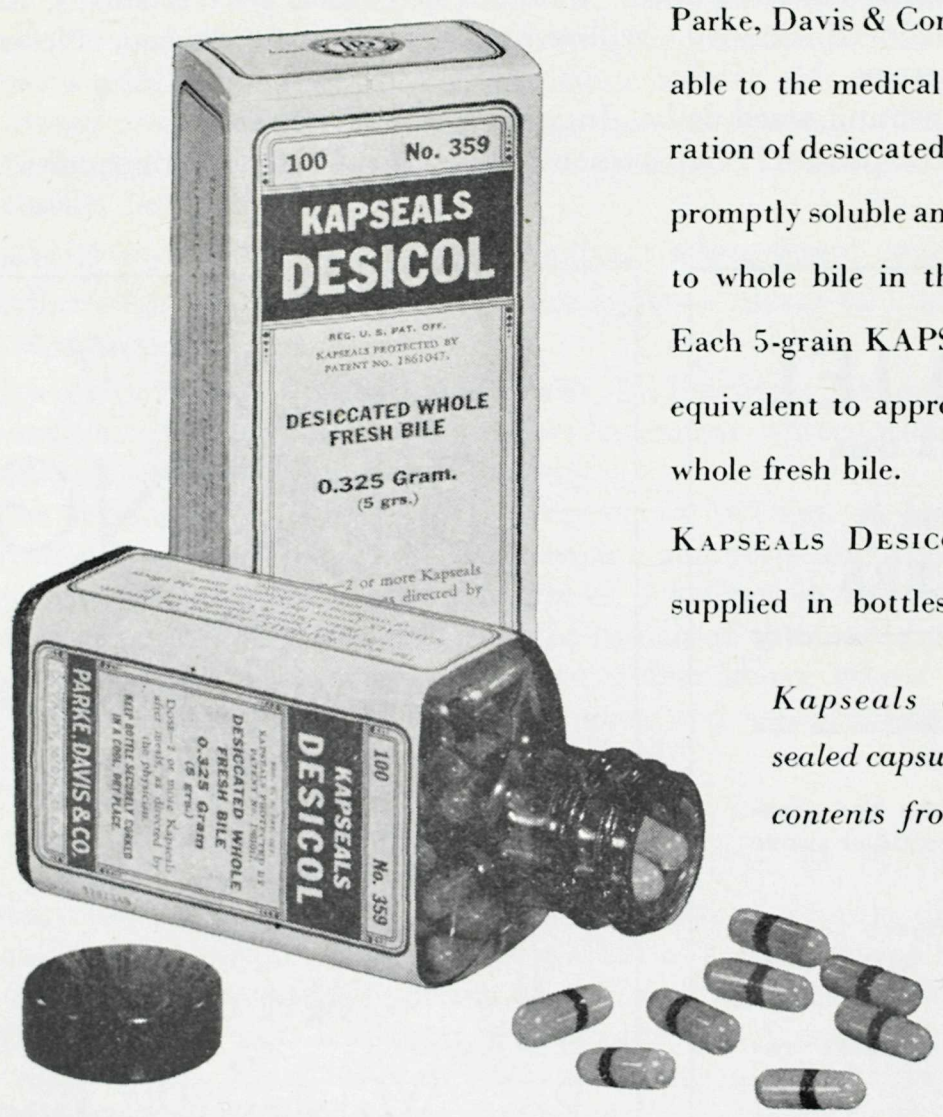

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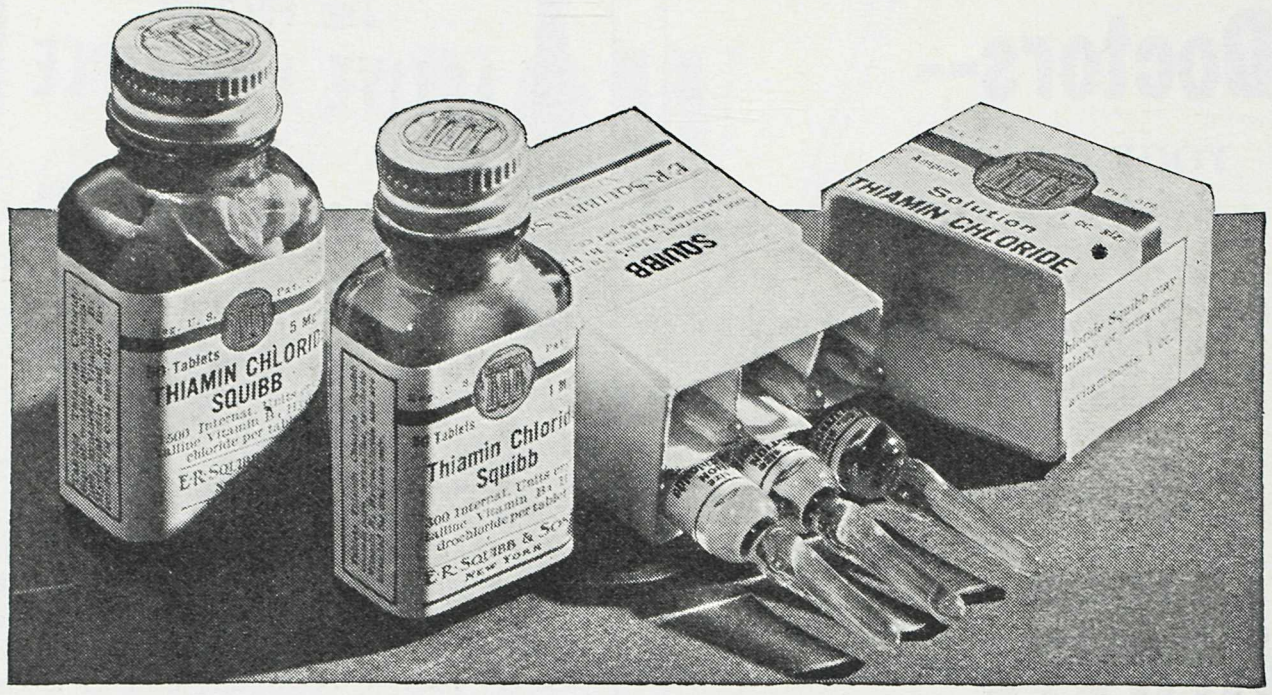

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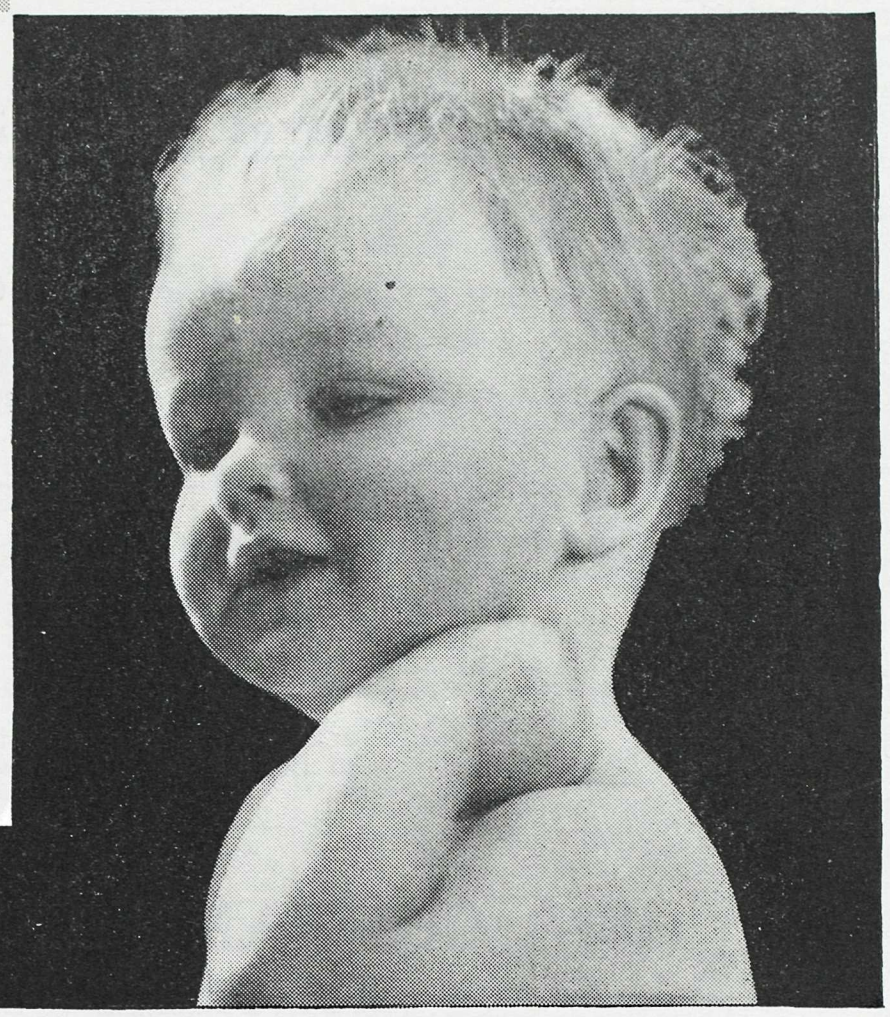
HILL, LEE FOREST; J. Lancet, p. 180, May 1937.



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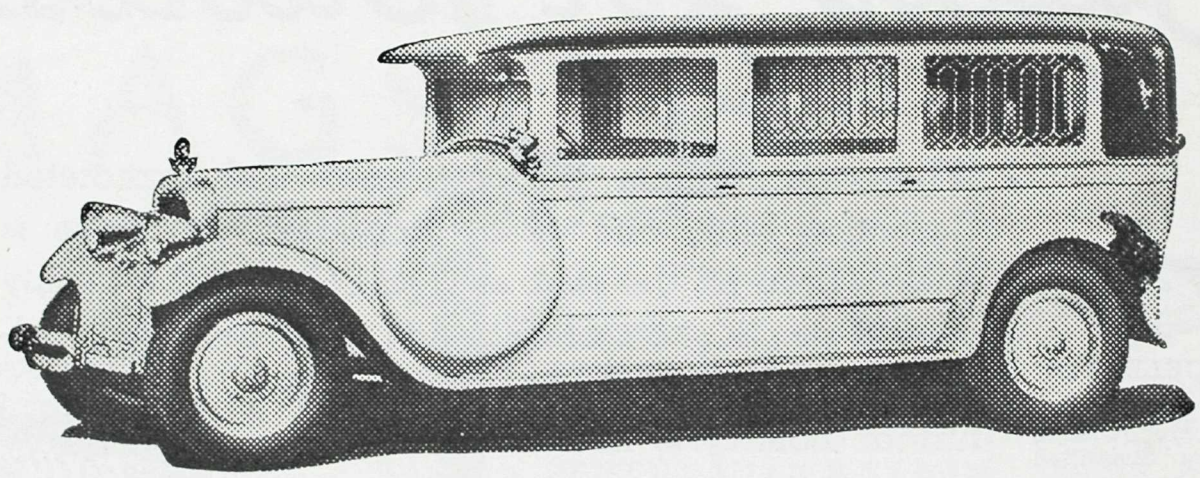

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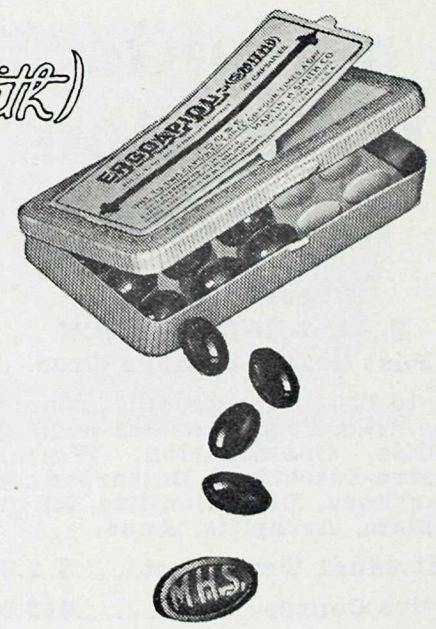

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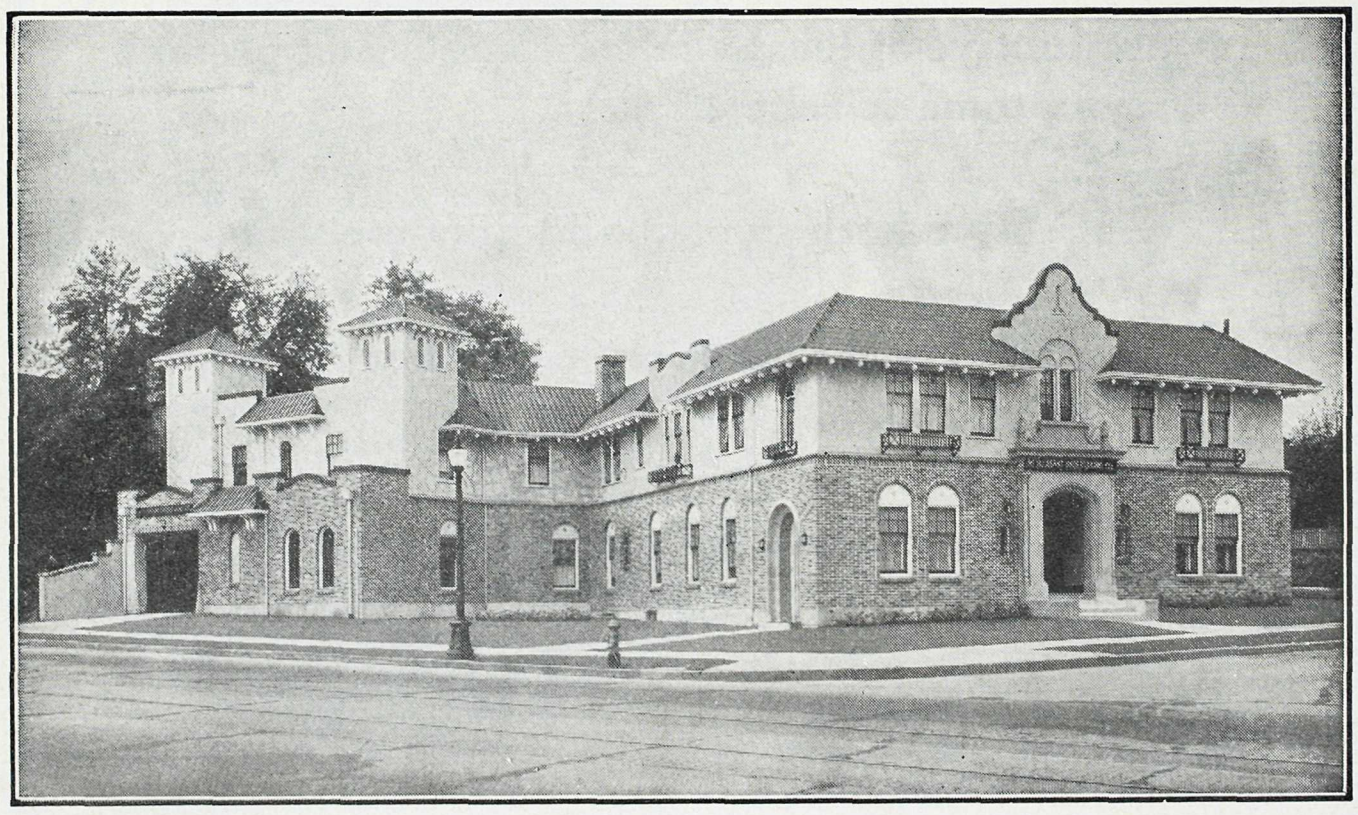

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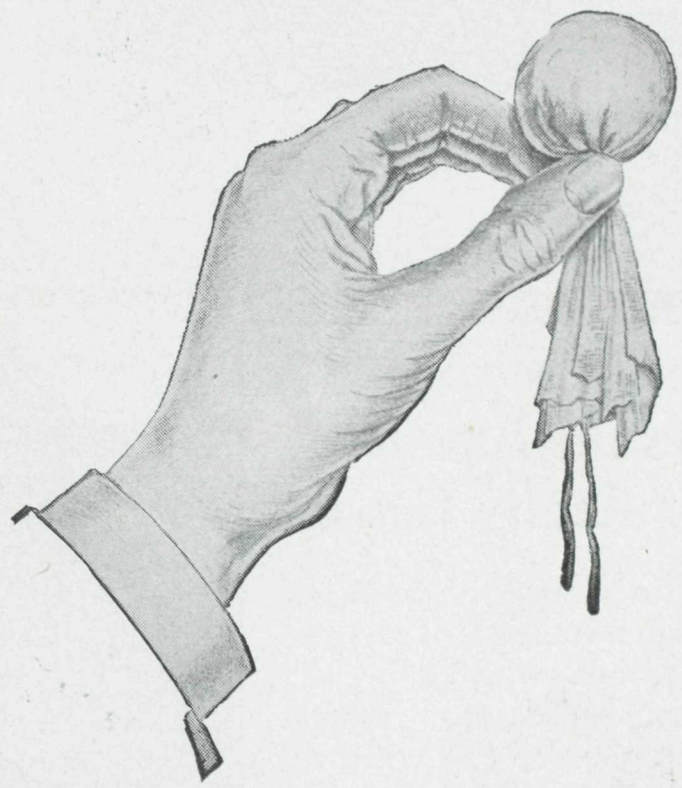

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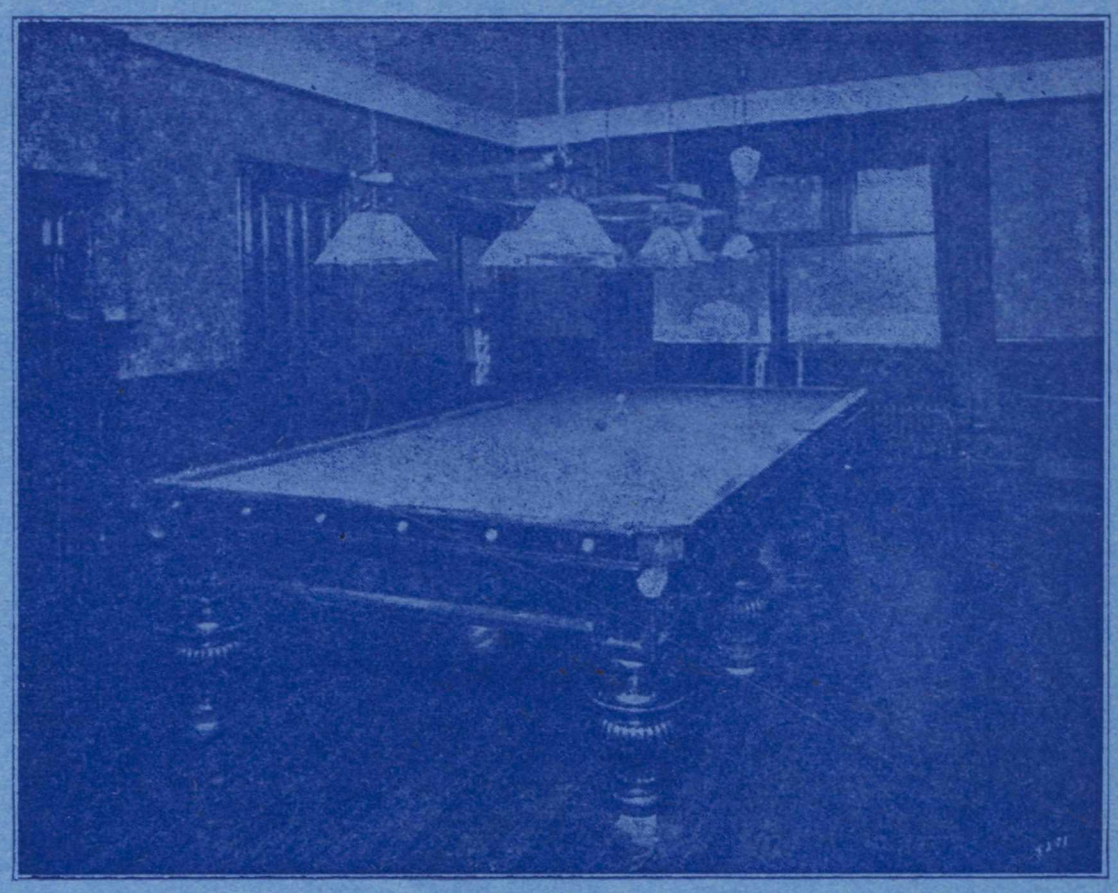

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