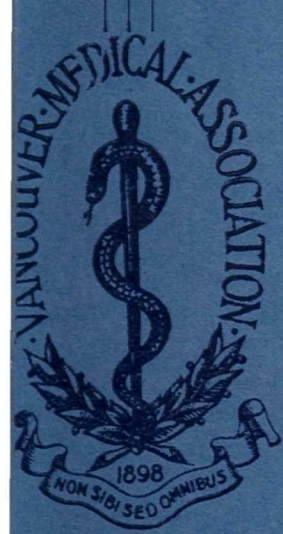

The BULLETIN

of the

VANCOUVER MEDICAL ASSOCIATION

UNIVERSITY OF BRITISH COLUMBIA
FEB 1940
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Vol. XVI. FEBRUARY, 1940 No. 5

With Which Is Incorporated
Transactions of the

Victoria Medical Society

the

Vancouver General Hospital

and

St. Paul's Hospital

In This Issue:

URETHRAL DISCHARGE
A FEW NOTES ON PEPTIC ULCER
NEWS AND NOTES

VANCOUVER MEDICAL ASSOCIATION
SUMMER SCHOOL, JUNE 25th TO 28th INCL., 1940

In the past a frequent complaint from mothers was the expense incurred when the large bottle of antiricketic was accidentally upset.

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Unbreakable

Mead's Vacap-Dropper will not break even when bottle is tipped over or dropped. No glass dropper to become rough or serrated.

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This unique device, after the patient becomes accustomed to using it, delivers drops of uniform size.

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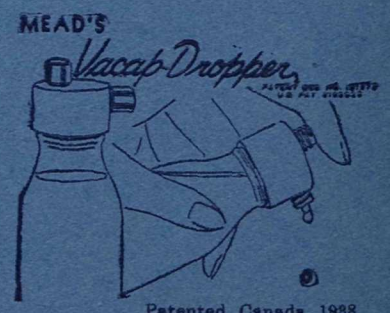

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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EDITORIAL BOARD:

DR. J. H. MACDERMOT

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

All communications to be addressed to the Editor at the above address.

VOL. XVI. FEBRUARY, 1940. No. 5

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20,000	International natural Vitamin A units
6,000	International natural Vitamin D units
150	International units of Vitamin B_1
190	gammas of Riboflavin
	Also rich in the antipellagric factor, the antidermatitis factor (B_6) and other components of the B-Complex.
1	gram dicalcium phosphate
0.66	gram liver extract (equivalent to 26.4 grams of fresh liver) together with the minerals contained in this substance and in malted wheat germ extract.

Navitol Malt Compound may be prescribed as a dietary supplement for growing children, pregnant and lactating women, patients on restricted diets or those convalescing from surgical operations. It is distributed in 1-lb. and 2-lb. wide-mouth jars.

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VANCOUVER HEALTH DEPARTMENT

STATISTICS, DECEMBER, 1939

Total population—estimated	263,974
Japanese population—estimated	8,891
Chinese population—estimated	7,728
Hindu population—estimated	389

	Number	Rate per 1,000 Population
Total deaths	242	10.8
Japanese deaths	3	4.0
Chinese deaths	13	19.8
Deaths—residents only	208	9.3
BIRTH REGISTRATIONS: Male, 168; Female, 158	326	14.5

INFANTILE MORTALITY:	December, 1939	December, 1938
Deaths under one year of age	10	17
Death Rate—per 1,000 births	30.7	48.7
Stillbirths (not included in above)	5	2

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	November, 1939		December, 1939		January 1st to 15th, 1940	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	31	0	18	0	5	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	134	0	123	0	78	0
Measles	2	0	9	1	7	0
Rubella	6	0	3	0	0	0
Mumps	7	0	5	0	10	0
Whooping Cough	14	0	11	0	19	0
Typhoid Fever	0	0	0	0	0	0
Undulant Fever	0	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	32	18	24	10	7	--
Erysipelas	3	0	5	0	4	0
Ep. Cerebrospinal Meningitis	0	0	0	0	0	0
Paratyphoid Fever			1	0	0	0

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	0	0	28	20	48
Gonorrhœa	0	0	0	0	71	13	84

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THE SCIENTIFIC HORMONE TREATMENT

Descriptive Literature on Request.

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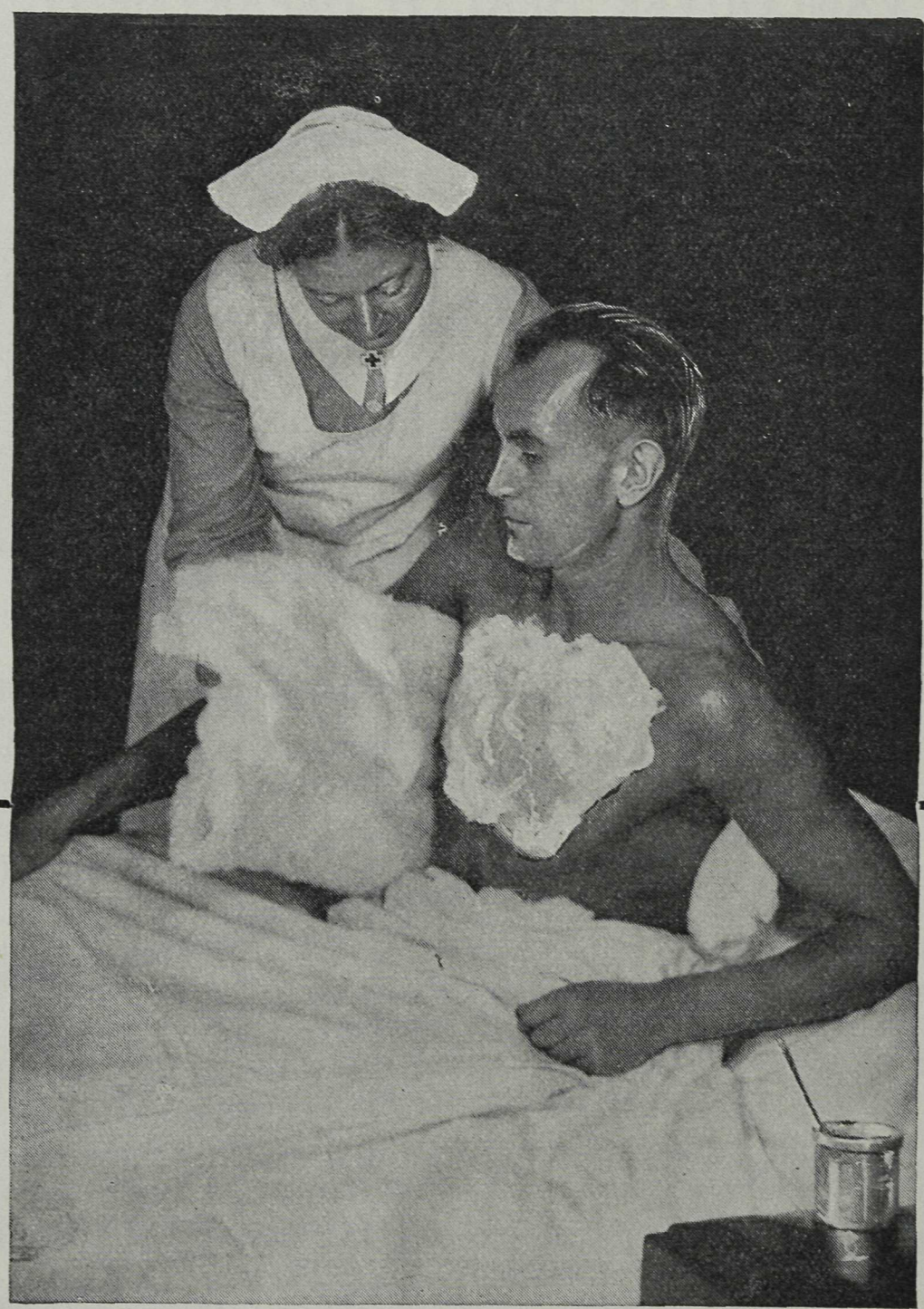

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GENERAL MEETINGS will be held on the first Tuesday of the month at 8:00 p.m.
CLINICAL MEETINGS will be held on the third Tuesday of the month at 8:00 p.m.
Place of meeting will appear on the Agenda.
General meetings will conform to the following order:
8:00 p.m.—Business as per Agenda.
9:00 p.m.—Paper of the evening.

1939. Programme of the 42nd Annual Session

October 3—General Meeting.
Dr. Howard Spohn: "Some observations on Pædiatric practice in Europe."
October 17—Clinical Meeting.
November 7—General Meeting.
Dr. W. A. Dobson: "Diagnosis of early Schizophrenia."
Dr. J. M. Jackson: "Treatment of early Schizophrenia."
November 21—Clinical Meeting.
December 5—General Meeting.
Dr. A. E. Trites: "Treatment of functional Menstrual Disorders."
December 19—Clinical Meeting.
1940
January 9—Dr. Earle Hall: "Urethral Discharge."
January 16—Clinical Meeting.
February 6—Dr. H. H. Pitts: "Symposium on Laboratory Methods."
February 20—Clinical Meeting.
March 5—Dr. D. D. Freeze: "Anæsthesia and Analgesia."
March 19—Clinical Meeting.
April 2—Dr. H. H. Boucher: "Low Back Pain."
April 16—Clinical Meeting.
April 23—Annual Meeting.

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When you recommend—or use—Kellogg's All-Bran, you are summoning the aid of three important benefits. This ready-to-eat cereal supplies these great helps in relieving common constipation: "bulk" and vitamin B1, the intestinal tonic vitamin. As an extra bonus, All-Bran gives a plentiful supply of iron. Made by Kellogg in London, Canada.

BULK
1 oz. of All-Bran contains as much "bulk" as 7¼ oz. of raw cabbage.

VITAMIN B_1
1 oz. of All-Bran contains more Vitamin B_1 than 2½ oz. of whole egg.

IRON
1 oz. of All-Bran contains as much iron as 6½ oz. of fresh spinach.

Each fluid ounce contains:

Heroin
Hydrochloride - 1-3 gr.
Ammonium
Chloride - - - 16 grs.
Chloroform - - - 2 min.
Acid Hydrocyanic
Dil. B.P. - - - 4 min.
Syrup Scillae - - - 90 min.
Syrup Tolu - - 120 min.

Dose: One to two fluid drachms repeated every four hours until relieved.

An Efficient Expectorant, Respiratory Sedative and Anodyne

NOTE: Scilexol with Codeine Phosphate 1 grain to the ounce also supplied.

Each tablet contains:

Ebsal, E.B.S. - - - 3 grs.
(Acetysalicylic Acid)
Phenacetine - - - 2 grs.
Caffeine Citrate - - ¼ gr.
Codeine
Phosphate - - - ¼ gr.

Dose: One to three tablets as required.

Analgesic Febrifuge Sedative

Each fluid ounce represents:

Ammonium
Carbonate - - - 8 grs.
Ammonium
Chloride - - - 16 grs.
Prunus Serotina - - 6 grs.
Senega - - - - - 8 grs.
Menthol - - - - ¼ gr.
Chloroform - - - 2 min.
Glycyrrhiza - - - q.s.
Honey - - - - - q.s.

Dose: One to two fluid drachms every three hours.

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EDITOR'S PAGE

It is with sincere regret that we note the resignation by Dr. S. Cameron MacEwen, of New Westminster, of his seat on the Council of the College of Physicians and Surgeons of British Columbia. Dr. MacEwen was the member for District No. 2, and has been an outstanding member of Council. Ill-health of a rather serious nature compelled him, a while ago, to give up activities of this nature, and the profession is the loser by his absence. Dr. MacEwen, in addition to his ordinary duties on the Council, had also filled the position of President of that body, and, perhaps more important still, had been the Chairman of the Committee on Economics appointed by the Council.

The Committee on Economics is possibly the most immediately important to our material welfare of any of the Committees of the Council. It has been an extremely busy Committee. It has nothing to do with the Health Insurance Committee, but is charged with the supervision and control of contracts, whether individual or collective, and with the vital matter of the study of medical economics in general. It has reviewed, and passed upon, such contracts as those made with the B. C. Telephone Co., the B. C. Electric Railway, the School Teachers' Association, and so on, and we do not think the average medical man has the slightest conception of the amount of sheer hard work done by this Committee. Suffice it to say that Dr. MacEwen for weeks, even months, on end, in addition to a very busy private practice in a city twelve to fifteen miles away, has been devoting an immense amount of time and energy, which he could ill afford, to his work on this Committee. He is unable to do so any more, and we cannot express adequately either our regret that it should be ill-health that causes this compulsory retirement, or our gratitude to him for the work he has done. It is men like Cameron MacEwen, quiet, unobtrusive and unselfish, who do the hard, often unacknowledged, work, day in and day out, which leads to greater security, more prosperity, and more progress for our profession at large, and, sad as the occasion is that prompts this tribute at this time, we are glad to pay it, and to pay it most sincerely, to aman who has served us most faithfully and well. We hope for Dr. MacEwen that he will have a speedy recovery, and be able to get back to active life soon.

There are those in our profession, a minority, we believe, who question the value of organisation in medicine, who decry the work done by the various medical associations or bodies, and who consider their duty to themselves, their colleagues and their community adequately done when they do their work adequately, and pay the taxes demanded of them. Yet these men accept, often as a matter of course, generally without thanks, sometimes even with a species of good-humoured contempt that men should so waste their time, the work and self-denial of men like Dr. MacEwen, and profit by their energy and work on the behalf of their profession. This work is essential from every point of view, and we should all give it our complete loyalty and support, for selfish reasons if for no other.

* * * *

The Council of the College of Physicians and Surgeons has made a wise choice in appointing Dr. W. A. Clarke of New Westminster to fill the vacancy created by Dr. MacEwen's resignation and to take the Chairmanship of the Committee on Economics.

Dr. Clarke is a very well known and familiar figure to us all. He was once a Vancouver physician, but found his permanent abiding place in New Westminster, and our loss is their gain. We have not, apparently, lost him either, as his work on the Council and the Committee brings him here very often. As Chairman of the Committee on Economics, no better choice could have been made. His long experience of practice, his sagacity, his unfailing courtesy and patience, make of him an ideal incumbent of this position.

* * * *

The BULLETIN would like to add its note of welcome to the new Medical Health Officer of British Columbia, Dr. G. F. Amyot, who succeeds the late Dr. H. E. Young in this office. Dr. Amyot is very well known in British Columbia, and we consider it a very fortunate thing that he should have been chosen to fill this most important position. He has been in close contact with the man in practice, and, we believe, understands and sympathises with his point of view. Dr. Amyot's keenness and enthusiasm in public health are well known, and his recent work has given him wide opportunities to study conditions all across the continent. We wish him every success in his new office.

NEWS AND NOTES

Dr. L. H. Leeson attended the Mid-Winter Course of the Research Study Club of Los Angeles, and also attended the three-day meeting of the American College of Surgeons.

* * * *

The Association offers its congratulations to Captain Fred Bonnell, R.C.A.M.C., who was married on January 19th to Miss Jean Stewart, of Vancouver. Captain Bonnell, formerly of the 12th Field Ambulance Corps, has left to join the No. 4 Casualty Clearing Station, R.C.A.M.C., being formed in Edmonton for overseas duty. We wish him Godspeed.

* * * *

Capt. E. E. Day, R.C.A.M.C., who has been specializing in Eye, Ear, Nose and Throat work in Vancouver, has given up his office and will go to Victoria as Principal Medical Officer of the Western Air Command.

* * * *

Major R. A. Hunter, R.C.A.M.C. (P.F.), who was formerly Principal Medical Officer of the Western Air Command in Victoria, has left for overseas duty.

* * * *

Dr. D. M. Meekison has been in the Eastern States, attending the Meeting of the American Academy of Orthopædic Surgeons at Boston.

* * * *

Dr. Otto DeMuth has left to attend the meeting of the American College of Surgeons at Los Angeles, and following that, to attend the meeting of the International College of Surgeons to be held at Venice, Florida, at which meeting he will read a paper on "Recent Developments in Biliary Surgery."

* * * *

Lieut. J. A. Ganshorn, R.C.A.M.C., who has been at York Island, has returned to Vancouver for three months.

* * * *

Major W. L. Boulter, R.C.A.M.C., will relieve Lieut. Ganshorn at York Island.

* * * *

At the annual meeting of the St. John Ambulance Society held recently, Dr. K. P. Groves was named to fill the position of Chairman, vacated by Mr. W. Brown. Dr. Groves is the youngest chairman in the history of the Society to fill this position. Other members of the Executive are Dr. H. R. Mustard, vice-president and Dr. W. J. Dorrance, Secretary-Treasurer.

* * * *

Dr. J. R. Naden will be away from the city until the end of February.

* * * *

Dr. C. W. Prowd and family have left for a vacation in the South. Dr. Prowd will attend the meeting of the American College of Surgeons in Los Angeles, and following that will drive to New Orleans.

* * * *

At a recent meeting of the Fraser Valley Medical Society in New Westminster, Dr. S. E. C. Turvey of Vancouver, spoke on "Diagnosis and Treatment of Asymptomatic Neurosyphilis."

* * * *

Dr. C. H. Hankinson of Prince Rupert, recently spent a few days in Smithers in his capacity of District Deputy Grand Master for the local Masonic Lodge.

* * * *

Dr. L. W. Kergin of Prince Rupert has his daughter, Miss Edith Kergin, R.N., home for a short visit previous to her departure as a lieutenant in the first Canadian overseas contingent.

We are pleased to report Lt.-Col. Gordon C. Kenning, R.C.A.M.C., of Victoria, is convalescent following his recent acute illness.

* * * *

Dr. Murray Meekison of Vancouver was the guest speaker at the last regular monthly meeting of the Victoria Medical Society. His subject was "Treatment of Common Fractures."

* * * *

Dr. G. E. L. MacKinnon of Cranbrook and family spent the Christmas holiday in Alexandria, Ont. They also visited Ottawa, Montreal and Toronto.

* * * *

Dr. and Mrs. W. F. Drysdale of Nanaimo left on an extended trip to visit their daughter in Carthage, Mo., and are expected to return in February. While away, Dr. Drysdale plans to attend the Mid-State Medical Convention.

* * * *

Major A. Llewelyn Jones, O.B.E., M.C., who has been in practice in Revelstoke, passed through Vancouver last week en route to Victoria, where he will take over an appointment with Headquarters in Military District No. 11.

* * * *

Dr. Osborne Morris was in Vancouver during the first week in January and attended the meetings of the Council of the College of Physicians and Surgeons on January 5th. He was accompanied by Mrs. Morris.

* * * *

Dr. and Mrs. F. W. Andrew of Summerland, were visiting their son in Vancouver at New Year.

* * * *

Lt.-Col. Thomas McPherson of Victoria attended the meeting of the Medical Council and while in Vancouver presided at a meeting of the Divisional Advisory Committee on military service.

* * * *

Dr. S. Cameron MacEwen is reported to be recovering rapidly his former good health.

* * * *

Owing to inability caused by ill-health, Dr. S. C. MacEwen has resigned from the Council of the College of Physicians and Surgeons.

* * * *

Dr. W. A. Clarke of New Westminster has been appointed by the Council of the College as member to replace Dr. MacEwen. Dr. Clarke will succeed Dr. MacEwen as Chairman of the Committee on Economics of the Council. He has been vice-chairman of the Committee on Economics.

* * * *

Dr. C. H. Ployart of Lillooet visited the office while in Vancouver.

* * * *

Dr. H. V. Gale of Copper Mountain, who is associated with Dr. R. J. Wride of Princeton, was married to Miss Zola Tee of Vancouver on January 13th. The profession offers congratulations.

* * * *

Dr. G. P. Dunne, who has been out of the city for some months, has recently returned to practice, after a post-graduate course in Southern California in Endocrinology.

* * * *

Dr. Karl Haig, who was on the sick list for a while, has happily recovered, and is back at work.

* * * *

The American College of Surgeons held its Western Sectional Meeting in Los Angeles, January 29, 30 and 31. Unfortunately, the notice reached the BULLETIN too late to be of much service, but we are quite sure the meeting will have been a great success. British Columbia joined with the eleven western states in this meeting, and Hawaii and Mexico were present by invitation. Several men from Vancouver attended, including Dr. R. E. McKechnie, a Regent of the College.

Dr. W. H. S. Stockton, who was an Interne at St. Paul's Hospital, has returned to Vancouver and is taking up practice in Pædiatrics.

* * * *

Dr. Gerald L. Burke was formerly an Interne at St. Paul's Hospital. He has been doing special work during three years in Orthopædics. He is now opening an office and will confine himself to that specialty.

* * * *

Dr. G. A. Lawson of Port Alice has recovered from the effects of his recent operation and called at the office to discuss the new and improved arrangements in Medical Services at Port Alice.

* * * *

Dr. J. P. Ellis of Lytton was relieved by Dr. Waldo B. Clarke during his recent visit in Vancouver.

* * * *

Dr. Neil Stewart of Whitehorse is going East for post-graduate study. During his absence Dr. R. S. Woodsworth will do locum tenens at that point.

* * * *

Dr. Stanley P. Findlay has returned to Vancouver after several years absence. Following his graduation from McGill he practised at Newfoundland and later in New York. He intends to take up practice in this province.

* * * *

Dr. J. H. Carson has returned to practice in Prince Rupert after a prolonged business trip to San Francisco.

* * * *

Dr. D. T. R. McColl has gone to Goldfields, Lake Athabasca, and will take over the medical services of the Consolidated Mines at that point.

* * * *

Dr. E. W. Boak of Victoria called at the office with New Year's greetings.

* * * *

Dr. Wilfrid Laishley of Nelson has returned from a trip to Ottawa and Montreal.

* * * *

Dr. F. M. Auld, of Nelson, President of the British Columbia Medical Association, recently visited Montreal.

* * * *

Dr. W. K. Blair, formerly of Nelson, has taken up practice at Wetaskiwin, Alta.

* * * *

Congratulations are extended to Dr. and Mrs. T. A. Johnston of West Vancouver on the birth of a daughter on January 3rd at the North Vancouver General Hospital.

* * * *

Dr. D. J. Sweeney of Vancouver has been visiting at the home of Dr. and Mrs. R. P. Borden of Penticton.

* * * *

Dr. R. R. Laird, Medical officer, R.M.S. *Empress of Russia,* visited his home in Oliver during January 7th week-end.

* * * *

The doctors of Nanaimo were entertained at a Christmas party at the Nurses' Home, Nanaimo General Hospital, as the guests of the Matron, Miss Helen Archer and the nursing staff. This proved to be a very enjoyable get-together.

* * * *

Dr. G. A. B. Hall of Nanaimo was in Vancouver at New Year, and called at the office. Dr. Hall has been travelling widely over the province in connection with his duties as Grand Master.

* * * *

Dr. R. W. Irving of Kamloops accompanied by his daughter, Miss Evelyn Irving, made a ten-day motor trip during the Christmas season, visiting Salt Lake City, Sacramento and Portland.

* * * *

Dr. S. A. Wallace of Kamloops spent New Year's Day at Harrison Hot Springs.

LIEUT. COLONEL A. L. JONES, O.B.E., M.C., R.C.A.M.C., D.M.O., M.D. No. 11

The profession in British Columbia accepts as a compliment to Provincial Medicine, the announcement of the appointment to the office of District Medical Officer of Military District No. 11, of Doctor A. Llewelyn Jones of Revelstoke.

Colonel Jones' promotion and the placing of him in his present position are popular in all parts of the province. The Divisional Advisory Committee of the British Columbia Medical Association (Canadian Medical Association, British Columbia Division) hope to find in him an official who will co-operate in so far as his office will allow in the matter of personnel. Colonel Jones, because of his long experience in practice and his broad understanding of its problems, will be able to interpret the needs of the Medical Services, Military and Civilian, in a very practical manner.

Our colleague had a long term of service during the last war, having left British Columbia for overseas in 1914 and, after serving in the forward area in France and Belgium with No. 1 Canadian Field Ambulance and as Medical Officer to various Battalions in the First Canadian Division, he became Deputy Assistant Director of Medical Services, a post which he filled with credit to the Medical Corps and himself. Colonel Jones received the Military Cross and later the Order of the British Empire was conferred upon him.

He was born in Mumbles, near Swansea in Wales, the son of the late Dr. A. Lloyd Jones of Mumbles, and a nephew of the late Dr. O. M. Jones of Victoria. He received his earlier medical training in London at St. Bartholomew's and came to Canada, graduating from McGill in 1914.

In 1919 he returned to British Columbia, practising in Victoria at first and then moving to Revelstoke, where he has become a prominent member of the profession in the Interior of this Province. He has been President of the District Medical Association and an active member of important committees in the Provincial organization.

Colonel Jones will carry to his new office the well wishes and confidence of his medical friends. By common consent it is agreed that he is the right man in the right place.

HISTORY OF SURGERY FOR MEDICO AND LAYMAN

The Story of Surgery, by HARVEY GRAHAM; Toronto: Doubleday; $4.

By JOHN E. WALKER.

It is a relief, after a rather too long series of semi-autobiographical and self-laudatory medical books, to find one in which the first person singular does not leap from every page. In this volume, Harvey Graham has covered the history of surgery and much in medicine that is not strictly surgical, from the dawn of civilization to our present day—and covered it very well. The style throughout is authoritative and at the same time very readable; it should be of interest to layman and medical man alike.

The average person of today takes the achievements of surgery very much as a matter of course. It should be of interest to him to know what was suffered under the knife during the centuries; what were the practises that governed pre-Listerian surgery; what manner of men they were who ministered to our long-suffering ancestors; through what struggles science finally triumphed over superstition; all these matters are answered through some 400 almost fiction-like pages.

MEDICINE'S ROLL OF HONOR.

The names that stand out in medical history are to most individuals almost unknown. In these pages, William Harvey, Ambroise Pare, John Hunter, Percival Pott, James Simpson, Joseph Lister and many others live again—their hopes, their fears, their struggles, their achievements—lives worthy of study and commemoration. In this age of prolific biography it is well to remember that war and politics are not the only spheres from which great characters can be drawn.

Accompanying a well-rounded chronicle are illustrations of more than usual interest.

SURGERY OF THE HAND

By John H. Couch, M.A., M.B., F.R.C.S., Edin.

The first sentence in this book gives the complete justification for its having been written: "The fate of an injured hand is often decided promptly and permanently by the doctor who renders first treatment."

Promptness, gentleness, thoroughness, meticulous attention to detail. These are the things required of those who would treat this member—the most essential and important to our welfare of all the members of the body. The early recognition of nerve injury, and the methods by which an exact localization may be done, are stressed, as are also the methods of testing and sorting out tendon injuries. Methods of repair, of course, are freely and fully given.

One thing attractive about this book is its conciseness and lack of padding. Each paragraph counts. The writer has a rather abrupt, unornamented style—but he is perfectly lucid, and can be followed all the more readily, since he does not waste words.

The economic cost of infection, both to the patient and to industry and the community at large, is well brought out. We tend sometimes to forget what Couch tells us, that infection increases the cost of recovery in a hand 500%, and that it is mostly preventable.

He has some tables of approximate periods of disability, which should be helpful to those who are called on to estimate the probable loss of time for injury.

Amputations, principles of treating infections, etc., are ably dealt with, and are followed by excellent chapters on paronchia, whitlow, etc.

Illustrations are few, but adequate, and easy to follow.

The writer, Dr. Couch, has an established position in regard to the surgery of the hand, which gives him adequate authority to speak about this subject, and we predict that many will find his little book very helpful. —J. H. M.

Vancouver Medical Association

SPECIAL NOTICE

Owing to the illness of the speaker, the Osler Dinner, which was to have been held on March 5th, has been postponed indefinitely.

At the regular General Meeting of the Association, to be held on February 6th, Dr. Pitts will conduct a "Symposium on Laboratory Methods." Included under this subject will be a paper by Dr. S. A. Creighton, "Statistical Review of Malignancies during the past ten years at the Vancouver General Hospital;" Dr. E. A. Geee will discuss "Ascheim-Zondek tests, Friedman modification, and resume of results at the Vancouver General Hospital Laboratory," and Dr. Pitts will speak on "A Few Recent Laboratory Procedures."

On March 5th, the General Meeting will be held in the Auditorium of the Medical Dental Building, and the speaker will be Dr. D. D. Freeze, who will speak on "Trends in Anæsthesia."

At the April Meeting of the Association, Dr. H. H. Boucher will give a paper on "Low Back Pain."

Dr. D. B. Collison of Vancouver, was elected a member of the Vancouver Medical Association and Dr. R. J. Wride of Princeton, was elected an Associate Member of the Association, at the regular Meeting held on January 9th.

URETHRAL DISCHARGE

Paper read by Dr. Earle Hall before the Vancouver Medical Association, Jan. 9, 1940

Urethral discharge, when observed in the male, usually causes great concern to the individual and in most instances the advice of his physician is eagerly sought. In many cases the patient fears the worst, especially where exposures have been readily admitted. Not a few of these cases, however, and where an acute Neisserian infection is the actual cause, will seek advice and treatment from the ever ready friend or from over the drug store counter and finally presents himself to his physician when the therapy has proven futile or complications have arisen. When a case presents himself for examination with an acute urethral discharge, purulent in nature, arising within the incubation period of Acute Gonorrhœal Urethritis, and exposure readily admitted, the diagnosis of gonorrhœa is quite easily made from a microscopic study of a stained smear. However, in practice, it is not uncommon to have a patient presenting all these factors, but a surprise resulting when the microscopic examination is entirely negative for evidence of gonococci.

A man having onset of discharge which is not accompanied by signs of an acute urethritis will usually seek reputable advice with an easier mind, but here again, in spite of the fact that it is definitely purulent discharge, a microscopic examination of a stained smear may show an entire absence of Gonococci.

It is usually found that the largest number of cases with negative findings for gonococci will have onset of discharge that is not profuse, does not increase in amount, and is more muco-purulent in appearance. It is usually present in the morning before the first urination, and occasionally seen at times during the day. Added to these findings, the history of exposure is remote, or, in the case of a married man, may be absolutely virtuous.

There are, at times, cases with urethral discharge very small in amount, who are very apprehensive on account of recent exposures. At the initial examination there may be no discharge found, or if any present it is not typically purulent and the external meatus does not show any inflammatory reaction. Added to this there is negative history for the presence of any burning with micturition. If a specimen of this small amount of discharge is obtained, or where at first there was non obvious but a small bead of discharge finally expressed, and stained smears examined, one may find polymorphs and a few diplococci which are usually extracellular. In short, the case presenting is a specific infection observed at its earliest development, so early, in fact, that any diplococci seen are all extracellular, and none in the typical grouping. If these cases are very apprehensive on account of recent exposures, they are usually recognized as a specific urethritis. If, however, exposuse is obscure or, as occurs in certain cases, appearing almost too remote, the physician perhaps being too busy to stain such a small amount of discharge, and at the same time a little too trusting as to the veracity of his patient's history, both patient and doctor may be surprised a few days later in finding a profuse discharge that is now typically purulent, the microscopic examination of which readily shows typical pus and gonococci.

Any case having a discharge appearing a few weeks after the eradication of a gonorrhœal infection naturally thinks it was not entirely cured. If the discharge appears several months or years after a specific urethritis, many then consider it to be the old infection coming back, or that it is the result of a so-called "strain."

When a patient presents himself with a urethral discharge it is absolutely essential that this be examined as a stained smear under the microscope, as one of the steps in the establishment of a diagnosis. This should be done regardless of the fact that it has all the appearance of a specific infection, in that it appeared a few days following exposure where no prophylaxis was used, and its presence is accompanied by irritation and burning with micturition. It is obvious that a history of the onset of a urethral discharge and any exposures should be determined at the first instance. If this and the clinical appearance point to gonorrhœa, then the stained smear should be examined. If this is positive, then it is a matter of instituting specific treatment. If, however—and as I have mentioned—a case had all these findings, with treatment instituted for gonorrhœa, without a microscopic examination to clinch the diagnosis, it may prove embarrassing later when the condition does not show definite or entire improvement, and where microscopic examinations now carried out do not show any gonococci present. In other words, this case was not one of

gonorrhœa, but was considered so and treated accordingly. With the passing of time, and the discharge still present perhaps in lesser, greater or unchanged amount, the individual becomes impatient and restless and will often seek advice elsewhere. With this occurrence, the physician not only loses a patient but may lose faith in his therapy, which would have been entirely adequate and satisfactory if the condition was one for which it had been intended. Of course, and I think everyone will agree, it is best to treat an acute discharge with accompanying history suggesting gonorrhœa as a specific infection until proven otherwise. When a number of negative smears are obtained, then it is best to suspend active treatment and extend the examination further in order to establish the cause of its presence. In this way, the diagnosis of the case is made and the necessary and suitable treatment can be carried out with more favourable results. At this point, I would like to stress the fact that any medical man not wishing to handle a case of urethral discharge, nor willing to examine one thoroughly, should not merely advise treatment, as it is obvious that in many instances dissatisfaction will result for all parties concerned.

I wish now to enlarge upon some common conditions found in the male, producing urethral discharge. Of course, one of the commonest is gonorrhœa, and the diagnosis of an acute infection is readily established and subsequent treatment falls in line. I do not propose to take up time in discussion of this type of urethral discharge.

A fairly common condition presenting for advice is a patient complaining of irritation at the external meatus, associated with discharge. Examination reveals a tight prepuce which has not been retracted from the glans for several years. Added to this, the external meatus is definitely inflamed, and there is considerable purulent discharge, some of which appears to be from the urethra. If there have been no exposures, it is usually found to be the result of non-hygienic measures. However, the possibility of an accompanying neoplastic growth must also be considered, especially if the prepuce cannot at once be readily rolled back from the glans penis for examination. If recent exposures are admitted and the patient is apprehensive, then smears must be studied. If exposure has occurred within the incubation period of a primary or hard chancre, then this must be looked for, especially where the glans is not readily accessible by retraction of a tight covering. When exposure is not a factor, or if so and smears are entirely negative, and neoplastic growths are not visible, then it is usually a mere question of local hygiene following a dorsal slit or circumcision. One of these procedures may be necessary to examine the involved area thoroughly. At this point I would like to emphasize the advantage of circumcision, as I am impressed repeatedly in genito-urinary practice of the great advantage to circumcised patients, not only in added comfort in acute infections, and again in later life for easier toleration of retention catheters, but in many instances on account of cleanliness itself.

Urethral strictures are commonly present as a causing factor in cases with urethral discharge. In this instance, the discharge is usually not profuse—often described as a "morning drop," which may not be seen every day, but if allowed to exist without attention, will usually increase so that an everyday appearance is noted. The discharge may not be definitely purulent—more muco-purulent, or at times fairly clear and colourless. Many of these cases have had a previous gonorrhœa and commonly are the ones who consider it as a recurrence and thus the cause of their present complaint and, as they describe it, "coming back upon them." This is especially so when there have been no recnet exposures. A careful history in many of these will reveal recent indiscretions in alcoholic intake, which factor appears to play an important part in the production of the urethral discharge. If, at the time of examination, there is not a satisfactory specimen of discharge present, it is well to give the patient some slides so that he may obtain smears first thing in the morning, and before he passes any urine. When smears have been examined and found negative a culture of the discharge, if possible, may serve to exhibit presence of micro-organisms not readily discernible in the stained smear. This is not absolutely necessary in ruling out a specific infection. If several negative results are obtained then it is good practice to give a urethral injection of silver nitrate, and have smears taken following. If there is a Neisserian infection present, the stained smears, after one or more silver injections, will readily show presence of gonococci if they are carefully examined.

If the case has had considerable discharge or varying amounts present for some time, it is well to use some local treatment in the form of urethral injections before attempting exploration of the urethra to show presence of strictures. Commonly used, among others, are Protagol, Argyrol, Neo Silvol, and Acriflavine. In this way, the infection may be kept at a minimum and we obtain a prophylaxis in the attempt to keep infection from being diverted to other channels as a result of the instrumentation, as it is not unknown to have fatal results following exploration of the urethra or a mere passing of an instrument.

In carrying out exploration of the urethra, diagnostic sounds will serve the best purpose and it is well to persist in the use of larger calibre instruments if there are at first no strictures apparent. In some instances where strictures are small, their presence is detected only by the larger instrumentation. The appearance of the external meatus will often give a clue to existing strictures involving the anterior urethra, as, when present in this region, the meatus often is more or less contracted or shows a persistent circular opening rather than the usual slit-like formation. In some cases with a naturally smaller opening than usual, it may be well to do a meatotomy so that the larger instruments may be inserted for adequate exploration of the urethra.

The following case serves to exemplify some of the points I have raised: Mr. A. D. H., age 47, single, consulted me recently with the complaint of urethral discharge. The onset was as follows: About three months previous he had onset of discharge appearing four weeks after last exposure. It was observed mostly in the mornings and was described as thick, yellow in appearance. This was also associated with burning at micturition. He had medical attention and a diagnosis of gonorrhœa was made. No smears were examined. He received treatment consisting of urethral injections and also stated that he took over 200 Prontylin tablets. He stated that the discharge was still present, last seen the day previous. At my initial examination, no urethral discharge was apparent, and a two glass urine test showed shreds and a few w.b.c. in the first glass, the second being negative. Following Silver Nitrate urethral injection, urethral smears were negative for any evidence of Gonococci. Following urethral injections of Acriflavine for a few days, exploration of the urethra was carried out, this disclosing several tight strictures in the mid and posterior urethra.

A word of caution may be in place, regarding instrumentation of the urethra. This is as delicate a part of the human anatomy as can be found, very easily injured and often with production of varying degrees of shock to the individual. Added to this it may be the site of infection which, while present within the urethra, does not produce much harm, but when suddenly thrown into the blood stream may cause grave results. Urethral dilation should never be too often, nor too large, but gradual in size and should never cause much bleeding.

The following case also illustrates some of these remarks: Mr. R. W. B., age 36, married, consulted me with the complaints of: (1) Urethral discharge (2) Occasional burning with urination. The onset was as follows: For the past year he had had urethral discharge which apparently came on for no apparent reason and was usually seen in the mornings. The discharge was purulent in character but not in profuse amount. Following some medication it disappeared and was absent until about three weeks ago when it reappeared and he was referred to me for examination. During the past three weeks he also had had occasional burning with urination, this being felt at the external meatus during the passing of the urine and also persisting for about ten minutes following. At my initial examination, some thin muco-purulent discharge was expressed from the urethra. Stained specimen showed presence of polymorphs, but no micro-organisms. Urine examinations were negative except for presence of a few w.b.c. Examination of the urethra showed tight strictures involving its mid and posterior portions. Following this examination he showed typical shock and developed an acute septicæmia from which he died a little more than twenty-four hours later.

Urethral discharge as a result of an existing prostatitis is a very common condition and in my experience is often the only complaint presented. The prostatitis is usually associated with a seminal vesiculitis and the result of infection by pyogenic organisms of a non-specific nature. The discharge is usually small in quantity and observed generally in the morning. It may, however, vary considerably in its amount and appearance, and with

increases, a history will often disclose alcoholic and sexual excesses as an accompanying factor. I have seen cases of prostatitis having a sudden onset of considerable purulent discharge following recent exposures and accompanied by irritation and buring with micturition. These always simulate an acute gonorrhea. The patient, if previously experienced with a Neisserian, infection, readily believes that he has contracted another. On the other hand, if exposures have been absent or remote, he is really puzzled as to the source and cause of his infection.

Following the disproval of a specific infection, and the finding of a negative urethra for presence of strictures, a rectal examination should be made to determine the condition of the prostate. Massage of the latter will show pus in the strippings. This, however, may not be disclosed at the first examination and negative prostatic examinations should only serve to stimulate repeated examinations. It is also quite common to find cases of prostatitis associated with urethral strictures.

A situation that may sometimes present, and one that I have been confronted with on several occasions during the past year, is the patient complaining of urethral discharge and the finding of numerous very tight strictures, with a urethra that is spongy and bleeds very easily. The blood Kahn in each instance was strongly positive. These cases do not show any appreciable response to local treatment directed against the urethral condition, until they have had some anti-luetic therapy as well. A blood Kahn is thus clearly indicated in all cases.

There are cases presenting urethral discharge, the cause being a urethritis of non-specific and pyogenic origin. These may be negative to all other examinations except for the presence of the discharge. Before these cases are finally diagnosed it may be necessary to carry out a cysto-urethroscopy. The origin of the infection is frequently the result of non-judicious treatment of previous gonorrhœa and from the careless or ignorant measures directed against disease and conception. Such cases have been repeated following intercourse with women having non-specific leukorrhea. An example of this is readily called to mind. I was consulted by a young man for impotency. Following some treatment and advice he reported that all was well and he had regained his lost libido. A few months later he again consulted me, complaining that his girl-friend was now pregnant. I gave my sympathy and advised him that the problem was beyond my field of endeavour. About two months later he again consulted me, at this time complaining of urethral discharge. Examination disclosed an acute urethritis and profuse discharge with a clinical appearance of gonorrhœa. Several examinations were entirely negative for any evidence of gonococci. Treatment was then instituted for non-specific urethritis and the condition rapidly returned to normal. At this time he also informed me that his friend had had an abortion a few weeks previously and exposures had been with no other party. About three weeks later he consulted me for return of the urethral discharge and examination again disclosed a non-specific but acute and purulent urethritis. Upon further questioning it was disclosed that his partner since the abortion had considerable vaginal discharge. I advised that she seek medical advice regarding this leukorrhea and then he would probably eradicate the source of his urethritis. This subsequently proved to be so.

There are other rarer types of urethral discharge also seen but generally never giving rise to a serious question of differentiation from acute gonorrhœa. Non-specific urethritis of a dietary or ingestive origin has been reported. Excessive alcoholic indulgence, purgative mineral waters, iodides, asparagus, cress, strawberries, etc., have all been accused of producing mild urethritis. In England, non-specific urethritis has been reported in persons of gouty and arthritic diathesis. In these cases, repeated examinations of smears are negative for the presence of the gonococcus, and under sedative therapy the condition is usually relieved.

A form of chronic non-gonorrheal urethritis (disease of Waelsch) is described in German literature. It is characterized by a relatively long incubation period (five to sixteen days) and a chronic course with few symptoms, signs, or complications. Rarely does the disease spread to the posterior urethra. Micro-organisms, except harmless Saprophytes are never found. Traumatic urethritis, occurs as a result of wounds of the urethra, injuries through the presence of foreign bodies such as a calculus, indwelling catheter, etc.

Rough or unclean instrumentation may produce urethritis with discharge. Over-treatment of gonorrhœal urethritis may produce traumatic or chemical urethritis.

Neoplasms of any type in the prethra may produce profuse discharge. Chancre and chancroid of intra-urethral type may produce urethral discharge not unlike that of gonorrhœal or non-specific origin.

Tuberculous urethritis, producing a urethral discharge, may occur as an extension from the bladder or the genital tract and may be mistaken for a gonorrhœal or non-specific urethritis.

It is now generally recognized that in some cases of non-specific urethritis the causing factor may be due to the presence of Trichomonas Vaginalis. The presence of this organism in the discharges of these cases should always be considered.

In conclusion, I merely wish to stress the importance of carefully examining all cases of urethral discharge, as they are caused by some underlying condition which, in not a few instances, will, if unchecked, produce some serious disorder to the patient. I think it is also the experience of nearly everyone that these cases are always very apprehensive when finally seeking medical advice and thus are most co-operative in their attempt to eradicate any disorder. A man may not pay attention to a "running nose" but will run post haste seeking advice for a "running urethra."

British Columbia Medical Association

(Canadian Medical Association, British Columbia Division)

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

Committee on Maternal Welfare.

Maternal Record Cards.

For the benefit of those members who were not present at the Annual Meeting, some explanation regarding the Maternal Record Cards to be distributed shortly by the Provincial Board of Health should be given.

While Maternal Care in British Columbia will compare favourably with that in other Provinces, it must be admitted that it can be improved, and it is with that object in view that the card has been prepared. It was suggested by and founded upon the Maternal Records used in the Manitoba Survey, but has been made as simple and concise as possible, without omitting any essential matters, for the practitioner's record of his case.

It is the hope of the Committee on Maternal Welfare that the medical men throughout the Province will give the few minutes of their time required to fill out the cards, and will send them to the Provincial Board of Health from time to time for abstracting, after which they will be returned for the doctor's files.

Brief Articles for Publication.

It is the intention of the Committee to publish short articles in the Bulletin which it is hoped will be useful. The Committee will also be glad to receive particulars of interesting or unusual cases and suggestions for the improvement of the Record Cards.

Service.

Members who have difficulties or unusual or problem cases are invited to write to the Committee for any help or advice.

DOMINION INCOME TAX
Memorandum Regarding Returns of Members of Medical Profession

Income

1. There should be maintained by the Doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

Expenses

2. Under the heading of expenses the following accounts should be maintained and records kept available for checking purposes in support of charges made:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and book-keeper; laundry and malpractice insurance premiums. (It is to be noted that the Income War Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fee:;

The names and addresses to whom fees are paid should be furnished. This information is to be given on or before the last day of February in each year on Income Tax Form known as Form T.4, obtainable from the Inspector of Income Tax. (Do not confuse with individual return of income, Form T.1, to be filed on or before 30th April in each year);

(e) Rentals paid;

The name and address of the owner (preferably) or agent of the rented premises should be furnished. (See (j));

(f) Postage and stationery;

(g) Depreciation on medical equipment;

The following rates will be allowed provided the total depreciation already charged off has not already extinguished the asset value—

Instruments—Instruments costing $50 or under may be taken as an expense and charged off in the year of purchase;

Instruments costing $50 are not to be charged off as an expense in the year of purchase but are to be capitalized and charged off rateably over the estimated life of the instruments at depreciation rates of 15 per cent to 25 per cent, as may be determined between the practitioner and the Division according to the character of the instrument, but whatever rate is determined upon will be consistently adhered to;

The residual value of instruments not heretofore fully depreciated will be depreciated along with instruments costing over $60 purchased subsequently;

The residual value of instruments not heretofore fully depreciated will be depreciated along with instruments costing over $60 purchased subsquently;

Office furniture and fixtures—10 per cent per annum;

Library—The residual value of library not heretofore fully depreciated will continue to be depreciated at 10 per cent per annum for the years 1932, 1933 and 1934 as well as charging off the actual cost of books purchased in those years. After 1934 only the cost of new books will be allowed as a charge.

Note:

Under date February 28th, 1933, the Department of National Revenue and the Canadian Medical Association jointly issued a memorandum re Income Tax for medical practitioners, from which the following is extracted:

(h) Depreciation on motor cars on cost:

Twenty per cent 1st year;
Twenty per cent 2nd year;
Twenty per cent 3rd year;
Twenty per cent 4th year;
Twenty per cent 5th year;

The allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

(i) Automobile Expense (one car):

This account will include cost of licence, oil, gasoline, grease, insurance, washing, garage charges and repairs;

(Alternative to (h) and (i)—In lieu of all the foregoing expenses, including depreciation, there may be allowed a charge of 10 cents a mile for mileage covered in the performance of professional duties.)

If chauffeur is employed so that in the result he is substantially used for business purposes (although incidentally used for personal or family use) the expense will be allowed.

(j) Proportional expenses of doctors practising from their residence—

(a) owned by the doctor;

(b) rented by the doctor.

(a) Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, depreciation and interest on mortgage (name and address of mortgagee to be stated);

(b) Rented premises—The rent only will be apportioned inasmuch as the owner of the premises takes care of all other expenses.

The above allowance will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(k) Sundry expenses (not otherwise classified)—

The expenses charged to this account should be capable of analysis and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10 per cent of the net income upon submission of receipts to the Inspector of Income Tax. (This is provided for in the Act.)

The annual dues paid to governing bodies under which authority to practise is issued and membership association fees not exceeding $100, to be recorded on the return, will be admitted as a charge.

The cost of attending post-graduate courses or medical conventions will not be allowed.

(l) Carrying charges:

The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(m) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Professional Men under Salary Contract

3. The salary of professional men will be taxed without any deduction therefrom except as hereunder provided, unless the individual is under contract which requires of

him, in order to maintain his contractual position, to operate a motor car of his own, in which case if the principal does not pay the upkeep, running expenses and depreciation, the individual will be allowed to reduce the salary by such expenses as the use of the car in the earning of his income may cost, on the same basis as above provided for, *i.e.*, expenses and depreciation or alternately 8 cents a mile for mileage covered in the performance of professional duties.

The annual dues paid to governing bodies under which authority to practise is issue, and membership association fees, not exceeding $100, to be recorded on the return, will be admitted.

The Department of National Revenue advises that, taking effect on January 1st, 1940, the mileage rate allowed will be reduced to 6 cents. INCOME TAX RETURNS MADE IN 1940, RELATING TO THE YEAR 1939, MAY BE SHOWN AT THE RATE OF 8 CENTS.

COLLEGE OF PHYSICIANS AND SURGEONS OF B. C.

INCOME TAX

Provincial returns from doctors must be filed on or before MARCH 31ST.

Dominion returns should be filed on or before APRIL 30TH.

Information regarding the preparation of Dominion returns is published below for your help.

No printed instructions are issued by the Provincial Offices. The following information may be helpful:

Depreciation—5% is allowed on Instruments and Office Equipment. If and when such equipment requires to be replaced, an appraisal at the full value less the depreciation already deducted will be accepted.

Automobile Depreciation—20% annually (Less 25% for private use = 15%).

It has been the practice of the Assessors to deduct 25% for private use.

Expenses—Cost of license, insurance, oil, gasoline, grease, tires, washing, garage and repairs.

In City practice: Where the cost of operating automobile exceeds $500.00 per year, a claim supported by proof of unusual wear and tear and heavy mileage would receive consideration.

In Country practice: Where Doctors are travelling on country roads, $600.00 per annum is allowed. Where expenses exceed this amount, as stated above, claim for greater allowance must be substantially supported by proof of cost of operation.

Members are urged to study the details of expenses in the Dominion memorandum so that all will be included.

COLLEGE OF PHYSICIANS AND SURGEONS OF B. C.

Please note that the Amendment to the "Administration Act" as set out below was admitted by Act of the Legislature to the Statutes of the Province at the last session. The Council has pressed for some preference in the matter of doctors' accounts against estates. Through the efforts of the members of the Legislative Committee (Lieut.-Colonels G. C. Kenning and Thomas McPherson), with strong support by Dr. J. W. Lennox of Victoria,

this Amendment was introduced by the Honourable the Attorney-General, Mr. Gordon Wismer.

BILL

No. 89 1939

AN ACT TO AMEND THE "ADMINISTRATION ACT."
R.S.B.C. 1936, c. 5.

HIS MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of British Columbia, enacts as follows:—

1. This Act may be cited as the "Administration Act Amendment Act, 1939."

2. The "Administration Act," being chapter 5 of the "Revised Statutes of British Columbia, 1936," is amended by adding the following as section 153A: "153A. (1) Claims for funeral expenses not exceeding one hundred dollars against estates of deceased persons shall be preferred as heretofore, and if there are two or more creditors having claims for funeral expenses each creditor shall be entitled to a pro rata share of the preference.

"(2) Claims for services rendered and medicine and goods supplied to the deceased during the last three months of his life by legally qualified medical practitioners, nurses and hospitals, shall rank equally with that of the claims for funeral expenses not preferred under subsection (1).

"(3) This section shall apply to estates of persons who die on or after the first day of December, 1939."

CANADIAN MEDICAL ASSOCIATION MEMBERSHIP

The method adopted whereby the reduced membership fee of $8.00 is collected by the Registrar with Annual Dues of the College has produced gratifying results.

There has been a very large response and a marked increase in the number of new members.

January 9, 1940.

Vancouver Medical Association,
The Bulletin of the Editorial Board,
203 Medical-Dental Bldg.,
Vancouver, B. C., Canada.

Dear Sirs:

Will you kindly publish in your BULLETIN the following announcement of our Course to be given in Portland, Oregon.

The annual course in Ophthalmology and Otolaryngology is to be given this year, April 1st to 6th, inclusive in Portland, Iregon. The guest speakers are two outstanding men in their respective fields, Dr. Meyer Weiner, professor of Ophthalmology in the Washington University School of Medicine, St. Louis, Mo., and Dr. Marvin Jones, professor of Otology in Columbia University Medical School, New York City. There will, also, be demonstrations of eye surgery and the usual demonstrations of surgery of the ear, nose and throat in the evenings. Preliminary programs will be out about March 1st, 1940.

Further information may be obtained from Guy L. Boyden, Secretary, 510 Stevens Bldg., Portland, Oregon.

Yours sincerely,
GUY L. BOYDEN.

Vancouver General Hospital

A REVIEW OF 316 CASES OF PEPTIC ULCER

By Dr. R. D. MacLaren

The object of this paper is to determine the efficacy of the treatment of peptic ulcers in the Outpatients' Department of the Vancouver General Hospital, and especially the value of the various antacids used. To complete the estimation, a review of the rêgime is first given.

At the time of admission to the Clinic in the afternoon, a history, physical examination, urinalysis and blood Kahn are taken. If ulcer is suspected the interne orders roentgen examination, examination of the stool for occult blood, gastric analysis, and, if indicated, complete blood count and an antacid or antispasmodic. McPhedran and Owen[8] suggest that it is inadvisable to attract the patient's attention at such an early date to the fact that he may have a peptic ulcer, until the diagnosis is confirmed.

After these investigations are complete, a physician on the visiting staff or senior interne confirms the diagnosis and orders treatment at the gastro-intestinal clinic. The patient is referred to the diet kitchen for advice concerning diet and budget if his income is low.

Diagnosis.

The following points are taken into consideration in establishing the diagnosis:

1. History.
2. Physical examination.
3. Gastro-intestinal X-ray with barium meal.
4. Occult blood in stool.
5. Gastric analysis.
6. Therapeutic tests.

1. *History* includes: First, pain, its location, character, time of onset, if relieved by food or alkalis; second, emesis, its time, frequency, the material and amount; third, presence of *tarry stools;* fourth, *weight* loss.

2. *Physical examinations*: Chiefly the presence of upper abdominal tenderness.

3. *X-ray*: This approaches 90% accuracy. In gastric ulcer the error is practically all on the side of missing an ulcer which is present, as "direct evidence" of the actual ulcer crate or deformity of the rugae is relied on completely. In examination for duodenal ulcer, spasm is frequently taken as the diagnostic evidence. Occasionally this is the source of error, as when the spasm is reflex.

4. The test for *occult blood* in the stool is done by the benzidine test. It is customary to repeat this at intervals, taking the usual precautions against error due to meat ingestion and bleeding from the gastro-intestinal tract other than peptic ulcer.

5. *Gastric analysis* is of some assistance. Fractional test meal after ingestion of four arrowroot biscuits and two cups of water is the method in use.

6. *Therapeutic tests* are also of some importance in cases where the diagnosis of benign or malignant gastric ulcer is in doubt.

Treatment.

The points considered are:

1. Diet.
2. Antacids.
3. Antispasmodics.
4. Bowel movements.
5. Sedation.
6. Hospitalization.
7. Surgery
8. Presence of infections.

1. *Diet*. This includes the food, number of feedings, reference to vitamin content, consideration of the use of alcohol and tobacco, and budgeting where necessary.

The two diets in use are the "Modified Sippy" and a modification or restriction of Meulengracht's Rêgime. These can be readily obtained from various books, etc.

Proper budgeting enables an adult male to purchase adequate food for from $2.02 to $2.35 a week, depending on the seasonal change in costs.

The vitamin content of the Sippy diet is lower than that of the Meulengracht, which is 10 to 15% higher than the average adult requirement.

Alcohol is prohibited entirely. It is similarly recommended that tobacco be discontinued, but failing this, patients are to use it only immediately after eating.

2. *Antacids.* Those used are outlined in Table III.

TABLE III.

Sippy A & B powders.

Pulvis Alkalinus——	Light mag. carb.	
	Preciptated Ca. Carb. aa	grs. XV
	Sod. Bic.	grs. X
	Oil pip.	m ¼

Tribasic magnesium phosphate
and
Tribasic calcium phosphate
Magnesium trisilicate†
Aluminium hydroxide colloidal gel‡.

† The simple powder—not a mixture with added medication.
‡ Marketed as "Amphojel."

Any of these are ordered either at regular intervals or P.R.N., and the amounts vary from one-half to two drachms. The regular intervals are after meals, or a half to one hour prior to the customary hour of onset of the pain, and at bedtime. The patient is also directed to keep either milk or antacid at his bedside if he is accustomed to waking before morning. As well, sodium citrate, two drachms to the pint of milk, is usually ordered.

A. *Antispasmodics.* Tincture of belladonna in doses of X-XV minims three times a day before meals is usual, but atropine grs. 1/100 may replace it although considered less desirable. Sixty patients received belladonna and seventeen received atropine.

4. *Bowel movements.* Considerable attention is paid to the regularity, as it is observed that poor therapeutic results usually follow persistence of the constipation which is so common. Aperients are frequently ordered, usually one of the following:

Liquid petrolatum;
Petrolagar (an emulsion of liquid petrolatum and agar, with or without cascara);
Magnolax (a mixture of liquid petrolatum and milk of magnesia).

Magnesium sulphate and pure cascara are not used because of the irritating effect on the ulcer.

5. *Sedation.* Occasionally phenobarbital is ordered as a bedtime medication, but it is not frequently used.

6. *Hospitalization.* Only those patients who are too ill to be ambulatory, or who do not respond to treatment, are admitted to the wards, and this because of scarcity of indoor accommodation.

7. *Surgery.* When deemed necessary, surgical consultation is obtained, and, if agreeable to the surgeon, the patient is transferred to his services.

8. *Presence of infections.* Once the rêgime is well under way the patient is examined for the presence of chronic infection, and is warned against contracting acute infections, particularly those of the respiratory tract.

TABLE IV.

Review of the cases admitted to the Outpatients' Department of the Vancouver General Hospital between January 1, 1937, and July 15, 1939.

		Percentage of Total†	Males %	Females %
No. of cases	316‡		82.2	17.8
Duodenal	219	75.0	81.3	18.7
Gastric	55	18.8	87.3	12.7
Both	18	6.2	77.8	22.2

† 24 cases were undifferentiated beyond "peptic ulcer." Hence the percentages are of 292 cases.
‡ This figure includes re-admissions as is done with all patients attending the Department over four years.

In Table IV it is seen that duodenal ulcers are present in 75% of the series and that males comprise over 80% of each gastric and duodenal types. Moynihan[2] in a series of 717 cases found 72.9% duodenal and 22.8% gastric, and males to comprise over 80% of the patients with a duodenal ulcer, but of the patients with a gastric ulcer only 50.6% were males and of the patients exhibiting more than one ulcer 45.5% were males. Hurst[6] and Tidy[10] agree with Moynihan's percentages for the frequency in England. Eusterman[3] found at the Mayo Clinic that in patients with gastric ulcer about 80% were males, showing a definite difference in incidence on this continent.

In assessing the results of treatment the patients have been divided into four groups, depending on their response.

GROUP I is comprised of patients whose symptoms, or symptoms and X-ray, cleared up under treatment and in whom no return of symptoms occurred after minor infractions of the rêgime. These were able to continue on a moderate diet and were discharged from the Clinic.

GROUP II is comprised of patients whose symptoms were absent as long as they adhered to the rêgime, but who would have minor flare-ups if they ignored their diet. Some in this group had to be placed back on antacids or antispasmodics periodically following the exacerbations.

GROUP III is comprised of patients who suffered periodical exacerbations even when adhering to their diet and who occasionally had to be hospitalized during these times.

GROUP IV is comprised of patients in whom medical treatment has been completely unsatisfactory while the patient is ambulatory and occasionally at any time.

Only those patients in Groups I and II were classed as "satisfactory" in the statistics.

TABLE V.

Antacid PrPescribed	Group				Total No. of	Satisfactory	Relative cost
	I*	II†	III	IV	Patients	Results: %	of Antacids
Sippy Powders	27	32	9	29	88	67.0	0.9
Pulvis Alkalinus	23	8	8	13	52	59.6	1.0
Trbiasic Phosphates	4	9	8	4	25	52.0	2.0
Magnesium Trisilicate	15	6	7	11	39	53.8	3.0
Aluminium Hydroxide	19	23	10	8	60	70.0	4.5
Diet alone	21‡	13§	3	1	38		

* Average length of treatment—11 months.
† Average length of treatment—18 months.
‡Includes 6 post-operative cases who had no complaints following operation.
§ Includes 2 post-operative cases who had occasional complaints following operation.

In Table V is seen the response of the patients while on the various antacids. The relative costs of the preparations were drawn up in an endeavour to find if the additional cost of some preparations is warranted. The antacids are not chosen with any regard to the case except when a patient fails to show improvement the medicine was frequently changed to aluminium hydroxide. It should be noted that preparations containing soda bicarbonate have given as much relief as the buffer antacids with the one exception of the aluminium hydroxide.

Further observations were carried out in an endeavour to judge how the patients responded to treatment under the various conditions listed:

1. The Gastric Acidity.
2. The Age of the Patient.
3. The Length of the Patient's History.
4. The Sex of the Patient.
5. The Diet the Patient Was Receiving.

1. *Gastric acidity* was estimated in 186 patients by means of the fractional test meal. If the free HCl reached 20 and did not go over 40 in any test it was considered normal. The cases were divided into four classes of hyperchlorhydria, normal HCl, hypochlorhydria, and absent HCl, as in Table VI.

TABLE VI.

	Response Group 1	2	3	4	Total No. of Cases	Satisfactory Results: %
Hyperchlorhydria	25	25	2	4	56	89.3
Normal free HCl	37	22	9	3	71	83.1
Hypochlorhydria	19	16	3	5	43	81.4
Absent free HCl	7	8	1	0	16	93.7
					186	

Beckman[1] states 40-50% of cases show hyperchlorhydria, while Brown[2] found nearly 50% with hyperchlorhydria, infrequently found hypochlorhydria and rarely was free HCl absent. Had histamine been used in the test, higher acidities might have been found.

2. Since the *Age of the Patient* is often a factor in prognosis, the patients were placed in three groups according to their age at the time they first received treatment. The classes were: (1) those under 30 years of age, (2) those 30 to 50 years of age, and (3) those over 50 years of age, as shown in Table VII.

TABLE VII.

Age	Group 1	2	3	4	Total No. of Cases	Satisfactory Results: %
Under 30 years	15	12	4	3	34	79.4
30 to 50 years	51	32	11	4	98	84.7
Over 50 years	42	39	5	4	90	90.0
					222	

Gaither[4] states the usual age for patients to appear for treatment is between 30 and 50 years. The better results found in the older age groups were attributed to the increased co-operation and diminished physical exertion.

3. *The length of the patient's history* at the time treatment was started was considered. Again the patients were divided into three groups: (1) those with a history lasting less than 1 year, (2) those with a history between 1 and 3 years, and (3) those with a history lasting over 3 years, as in Table VIII.

TABLE VIII.

Length of History:	Group 1	2	3	4	Total No. of Cases	Satisfactory Results: %
Under 1 year	49	33	8	5	95	86.3
1 to 3 years	18	22	3	4	47	85.1
Over 3 years	41	27	10	2	80	95.0
					222	

There has been an endeavour to ascertain the earliest date of the onset of the condition and these histories are taken to be moderately accurate, although Hunt[5] states it is uncommon for a patient to consult a doctor within two years of the first attack.

4. The results according to sex substantiated the fact that females are more co-operative than the males, as in Table IX.

TABLE IX.

Sex	Group 1	2	3	4	Total No. of Cases	Satisfactory Results: %
Males	87	70	18	9	184	85.3
Females	21	12	3	2	38	86.8
					222	

5. Considerable interest is taken in the relative efficacy of the two *Diets*. Table X shows the relative results but the differences in medicinal treatment are not taken into consideration.

TABLE X.

Diet	Group 1	2	3	4	Total No. of Cases	Satisfactory Results: %
Sippy	26	27	4	4	61	87.1
Meulengracht	75	46	13	13	147	82.3
					208	

The Meulengracht Diet is preferred in the Clinic at the present time, and this preference may be justified when it is seen that over 50% of the patients on this diet fall into Group 1.

Finally, an analysis of the patients treated and followed at the Clinic is shown in Table XI.

	Group 1	2	3	4	Satisfactory Results: %	Cases classed as very favourable results (Group 1): %
No. of patients with a follow-up: 222	108*	82†	21‡	11§	85.6	48.6

* Includes 14 post-operative cases.
† Includes 9 post-operative cases.
‡ Includes 1 post-operative case and 1 requiring operation.
§ Includes 3 post-operative cases and 4 requiring operation.

In addition 27 cases did not return to the Clinic after treatment was started. The remaining 67 cases were referred to the department for diagnosis and were given no treatment.

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St. Paul's Hospital

A FEW NOTES ON PEPTIC ULCER

A recent review of 1376 gastric X-ray examinations at the Peter Bent Brigham Hospital indicated 106 positive reports for gastric ulcer. (7.7%). The writer reviewed 1000 consecutive stomach examinations in the X-ray Department at St. Paul's Hospital and found 7.6% positive for gastric ulcer. Niches were present in 60 of the cases. In our series, 74 cases of carcinoma of the stomach were indicated and 170 were positive for duodenal ulcer. In order to ascertain if these figures approach the actual incidence of peptic ulcer, the obvious method of comparing X-ray with subsequent operative findings was not followed, but another approach was ventured which discloses different and perhaps greater possibilities of error than the fallibility of surgeons. It may be that this review, although it may lack logic, will illustrate some of the complexities of the disease.

One thousand autopsy records complete with clinical records were selected from consecutive material, except that an age group distribution similar to the X-ray material was aimed at. 54% were in the 30 to 60 age period, 25% in the 6th decade. Both groups represent general hospital material. In the former group, the focus is a little sharper on people with dyspepsia and the latter group are all dead.

Active gastric ulcers were found in 21 of the 1000 autopsies and active duodenal ulcers in 32. One case had both. In another, a single ulcer involved the pylorus and the duodenum. Peptic ulcer was the chief factor in 22 deaths, 10 gastric and 12 duodenal.

Healed gastric and duodenal ulcers were found post mortem in cases which had no clue in the history that they had ever suffered from peptic ulcer. The figures for healed ulcer in this series was considered to be far too low, as special search was not made for them. Instead, the figures of Lehman were used. In 1000 autopsies which he did personally with especial reference to healed ulcer, he found 202 cases (8% in both stomach and duodenum). In several cases in our series, active gastric or duodenal ulcers were found along with the healed scars of previous ulcers.

Considering first the group which died from other causes, six acute ulcers occurred in the series without any clinical suspicion of their presence. Five cases had more or less typical gastric symptoms. Of the acute group, eight were not X-rayed, two were reported positive and one was missed.

Chronic ulcer also occurred in this group without any history of pain or dyspepsia, six instances. In seven cases the clinical picture was suggestive but obscured by the symptoms of the terminal illness. In only four cases was there a typical history of ulcer. In the chronic group, eight were X-rayed, four reported positive, four indefinite. Nine were not examined.

In the ulcer deaths, exclusive of perforation and hæmorrhage, four were post operative, two after operation for gastro-jejunal ulcer, one after gastro-enterostomy (a penetrating posterior wall duodenal ulcer was not clearly identified at operation), and in a case of carcinoma of the ampulla of Vater, a well walled off perforated ulcer was uncovered at operation, the patient dying of general peritonitis.

Perforation occurred in twelve cases, six without any previous history. One occurred without warning during the terminal phase of pulmonary tuberculosis, another clinical picture was dominated by toxic cirrhosis, in still another instance, three days after a two-third resection for carcinoma of the stomach, a small ulcer perforated in the remaining stomach which had been overlooked by the surgeon and was not related in any way to the cancer. Nine of these cases were never X-rayed, three had been fluoroscoped in the past and reported positive.

Seven of the hæmorrhage cases occurred with previous ulcer symptoms noted in the history. One patient died of massive hæmorrhage which occurred entirely without warning and the scars of two healed ulcers were found at autopsy, although no history of pain or dyspepsia was obtained on careful search. Another case had cirrhosis with hæmorrhage from esophageal varices as well as active bleeding from a duodenal ulcer.

Eighteen of the active ulcers were multiple, a very high figure. Usual figures from surgical material, average 8 to 9%. One case in our series was associated with peptic ulcer of the esophagus.

In two young females, no satisfactory anatomical basis for death was found. They had no perforation, no severe hæmorrhage, no operation. Gastric ulcer was found in association with the common terminal infections of chronic deaths.

Associated conditions found in the cases not dying of ulcer or its complications, were as follows: Multiple pulmonary infarcts, carcinoma of the lung three, rheumatic heart disease two, carcinoma of the bladder and coronary thrombosis, carcinoma of the gall bladder, phlebitis and septicemia, toxic cirrhosis in various stages five, acute suppurative appendicitis, coronary thrombosis two, agranulocytosis, carcinoma of the bladder, carcinoma of the pancreas, pulmonary tuberculosis three, nephritis, carcinoma of the ampulla of Vater, myelogenous leukemia, pneumococcal peritonitis, idiopathic general paritonitis, arteriosclerotic gangrene and hypernephroma. Numerous instances of gastric erosions occurred in the series; they were found chiefly in terminal septic states without symptoms (except hematemesis). They have a different pathologic background and natural history and were not included in this series of peptic ulcer.

Carcinoma of the stomach was noted in combination with healed ulcer in several instances. In one case a gastro-enterostomy had been done many years before. All these patients had a previous ulcer history of 4 to 20 years duration. In no stomach was the carcinoma found to have any connection with the scar. Carcinoma was found in three

stomachs partially resected in the past for benign ulcer. In one case the operation had been done 12 years before—in another, 30 years previously. In the third case, the pathological report on a stomach resected two years before, was doubted. In three cases, carcinoma and ulcer were definitely associated; in two, the condition was interpreted as secondary ulceration of pre-existing carcinoma; in the other case, definite malignant change was noted in the marginal zone of a chronic but still active gastric ulcer. Carcinoma of the stoma occurred in one instance 23 years after a posterior gastro-enterostomy with interval relief of symptoms.

By far the largest number of fatal ulcers occurred in the 6th decade, the peak of incidence of the deaths from carcinoma of the stomach was reached in the 5th decade. This is in accord with the clinical impression that the complications of ulcer increase in severity in middle life and later. 43% of the active gastric ulcers were in females,, 19% of the duodenal ulcers. 65% of the gastric ulcers were on the lesser curvature or on the posterior wall, 60% of the carcinomas occurred at the pylorus. These figures agree in general with those from larger series of cases.

In the ulcer series, 54% were not X-rayed, of the rest, less than 6% were reported negative. Gastroscopy was negative in one case. In the entire series, 30% of the ulcers were not diagnosed.

If we allow 202 healed scars (Lehman) and add our 53 ulcers and look back at our 246 positive X-ray reports, are we justified in assuming that peptic ulcer is present or has been present in about 25% of people of this particular age distribution?

Many patients exhibit abnormal gastro-duodenal motility under the fluoroscope with or without symptoms, but no crater can be found. In this group, 31 cases have recently been studied, in which at re-examination after a considerable interval under the same conditions, crater was found. Remembering this and finding a combination of healed and active ulcers in some stomachs, it is permissible to suggest that ulcer may occur as an incident, in some cases a recurring incident in a more general disease. Vonderahe found organic changes in the dorsal nucleus of the vagus, the substantia grisea of the 3rd ventricle and the nucleus reuniens complex of the thalamus in 14 cases of peptic ulcer.

One may conceive of "ulcer disease" as a disturbance of gastric physiology probably iniated at certain areas of the subcortical level. This may occur entirely without symptoms but symptoms are more apt to be severe and "typical" in vagotonic individuals. In some cases the condition disappears. In others, however, particularly in certain constitutional types and under certain conditions, *e.g.*, when nervous strain is severe, when infections are common (spring and fall) and in the presence of focal infections, the condition goes on to actual ulceraiton. This also may occur and progress entirely without symptoms and the patient is liable for all the accidents and complications of ulcer, which are more serious after middle life.

The actual ulcer presents all variations in the time scale. It may heal rapidly in a matter of weeks or smoulder until autopsy 40 years later reveals it still active. In other people, several ulcers may come and go during this period. But all are subject to the accidents of perforation hæmorrhage and surgery.

Furthermore, the entire sequence of events, repeated ulceration with healing or continuous activity, may go on entirely without symptoms, and may be unsuspected during the lifetime of the individual.

C. G. Campbell, B.A., M.D.

DOCTOR AND PRIEST ARE ALIKE CONSCRIPTED IN THE BATTLE THAT IS LIFE

The letter of Dr. J. S. Cull, attached hereto, is self-explanatory. We take pleasure in reproducing this address, which is a thoughtful and stimulating one.

November 15, 1939.

The Editor, Vancouver Medical Association BULLETIN:

Dear Sir:—In the issue for Wednesday, October 25th, 1939, the *Huntingdon Gleaner*, which is published as a newspaper at Huntingdon, Quebec, carried an address by Dr. H. R. Clouston which was entitled "Doctor and Priest Are Alike Conscripted in the Battle That Is Life."

The late Dr. H. E. Young came across this article in his reading and brought it to my attention with favourable praise. I believe it was the original intention of Dr. Young to forward this article to you for your consideration and I am taking the liberty of enclosing a copy of same with this letter.

Yours very truly,

J. S. CULL, M.D., D.P.H.,
Acting Provincial Health Officer.

* * * *

Dr. H. R. Clouston, of Huntingdon, Delivers Interesting Address on the Relations Between Physician and Priest Before Members of St. George's Church, Montreal—Medico-Chirurgical Society Guests.

Speaking of the relation between physician and priest, Dr. H. R. Clouston, of Huntingdon, maintained that "the only cure for world's afflictions is the application of the prescription given by the Great Physician, who is also the 'Great High Priest'," at the Medical Sunday service in St. George's Church, Montreal, on Sunday morning.

On the Sunday nearest St. Luke's Day, October 18th, the Ven. Archdeacon A. P. Gower-Rees, M.D., D.C.L., M.C., rector of St. George's Church, invited the Montreal Medico-Chirurgical Society to take part in the service.

On this occasion members of the Society read the Lessons, gave the address and took up the collection.

Dr. Clouston's address, which is reproduced here, should interest one and all, and should be read by all who are interested in the past, present and future days of our existence.

The address is as follows:

Many years ago at McGill, Dr. Rudyard Kipling, who was the prophet of our youth, addressed us on "Values in Life." On that memorable occasion he tried to impress upon us that from time to time through life we should leave the heat of the game, draw breath, watch our fellows for a while and guide ourselves by our observations.

We are gathered today, according to our annual custom, to meditate on the institutes of religion, our relation thereto and to the world, and I would invite your attention especially to our peculiar relation to the priesthood.

For history has given Doctor and Priest a common origin; the frailties of mankind, a common task; and man's legitimate hopes and desires, a common aim. In all times and in all countries the Priest and Physician in the beginning were one, whether as Priest in the temples of Egypt or Medicine man in the wigwams of America. Sickness and all other calamities were attributed to evil spirits, and this profession became set apart to combat them and to accumulate wisdom for the preservation and perpetuation of the human race.

Our ancestors were unable to distinguish between the evil spirits which, according to them attacked the minds and those which diseased the bodies of men. We are able to differentiate between them, but we are learning again, the hard way, on the fields of Europe and on the seven seas, that the evil spirits which inhabit the minds of men can be quite as disastrous to flesh and blood as the ones which we see under the microscope.

It is probable that there has been some form of wound treatment ever since Adam trod on the first thorn outside the Garden of Eden, but the first premeditated human surgery recorded in Holy Writ was primarily of religious significance. It was a token between

Jehovah and Abraham, and the soul of the man child who was uncircumcised was to be cut off from his people.

The first mention of physicians in the Bible was when the body of Joseph's father was delivered to them for embalming. Now the Egyptians believed that somehow, some day, the spirit would return to the body, and this important preparation was really a religious one against the great day of the resurrection. However, this preservation of the body necessitated the removal of the brain and other internal organs of the body and required a period of forty days. One infers that the science of pathology is of considerable antiquity.

These autopsies perhaps explain advancement of medical science in Egypt, despite the fact that too often the organs of men and animals were supposed to foretell the future, rather than record the past. We read that one of the kings of Babylon "looked in the liver" to enable him to judge of the success of a projected campaign. Today the rulers of the modern Babylons have other means for guessing incorrectly, but there are still some of our farmers who forecast the length and strength of the winter, and whether it will be severe in the beginning or the middle or the end, according to the size and shape of a pig's spleen.

A good part of the laws of Moses concerned the duties of the priests as sanitary officers of the Board of Health; gave the differential diagnosis of certain contagious diseases such as leprosy; prescribed the number of days that the patients or contacts were unclean or contagious and gave instructions as to the cleansing of the person, clothes and utensils before the quarantine was lifted.

One of the deplorable results of the division of duties or the specialization of priest and physician was the loss, for a time, of the vision that religion was made for man as well as man for religion. The undue desire to mortify the flesh does not conduce to length of days in the land that is given to us. It is more than a little probable that many of the saints of the middle ages suffered from tuberculosis and bequeathed it to their followers. At the same time the clergy were sufficiently powerful to prevent the study of the human body. To do so was to peer into the secrets of the Almighty. Medical progress was delayed for centuries. Fortunately health and goodness are no longer considered incompatible.

It seems difficult for medical men and the clergy to restrict themselves to the fields which they have fenced off for themselves. Sometimes the priest takes the pulse, considers the respirations, and many offer a prognosis. Because of his experience in sick-rooms and at death-beds his opinion is often of value. [We question this.—Ed.]

Certain clergymen prescribe drug treatments, apparently "knowing by intuition everything that it has taken us years to learn."

Nor is this tendency confined to the lower clergy. Even His Grace the Archbishop of Canterbury has recently prescribed for the condition which is of more personal interest to members of our profession than any other ailment. High blood pressure with disease of the heart and blood vessels is the particular bane of physicians, so that it is often called "The Doctors' Disease." His Grace advocates religion for the prevention of this malady. And considering that His Grace's branch of our united professions has the longest "expectation of life" and that the medical branch has the shortest "expectation" of all the vocations, it may be that his treatment is a matter for controlled experimenation, that is, supposing that old age is in itself a state so desirable.

But who are we to complain of this invasion of our territory? We have taken the archiecture of the cathedrals for our colleges, hospitals and medical institutes. We have taken the gowns and hoods of the monks and nuns for our surgery and the bareness of the monastic cell for our operating rooms.

We have, for very many people, transferred the confessional box Sanctum. Some of those who confess their sins to us demand that we confer absolution on them and we presume to do so through the hollow of a needle.

Sometimes we meet emergencies at the bedside of a prospective mother who belongs to one of the great churches. When the Angel of Death hovers about the Gates of Birth, in the absence of the priest we do not hesitate to grasp the keys of St. Peter and confer one of the most precious Sacraments of the Church, that of Baptism. The Physician may be a heretic whose ancestors have protested against the doctrines of that Church, a Jew, a Freemason, or whatever is most condemned by that Church, yet he proceeds quite serenely

in the knowledge that if he intends to do what is done by baptism, and if he follows the prescribed form, the baptism is valid, and no priest of any rank may even rebaptize the child without the proviso that he does so in case that there has been an error in the technique of the previous ceremony.

It is not that we trespass on each other's ground without cause; the very nature of man's needs demands it. Some of mankind are branded as criminals who are only in need of medical treatment, and some come seeking drugs when a verse of Scripture tied about their necks, as has been done in some of the past ages, would be more efficacious.

According to the press there has been formed in Britain a National Council for Medical and Pastoral Co-operation, in which are interested the Medical Fraternity, Free Church leaders and the Archbishop of York's Committee of Clergy and Doctors. The aim of this body is the promotion of conferences of the clergy and doctors in the field of pastoral and medical psychology.

There are those who scoff that religion is simply an anodyne or painkiller, of, and for, certain classes. Poor things! they are in the unfortunate position of Balaam, who intended to curse, but was compelled to bless.

We know the place of anodynes: we know the need of anodynes: we are intensely proud of the armamentarum of modern medicine. We have the vaccines which have stopped plagues which once took millions of lives in single epidemics and disfigured the remainder of the population. A great beauty was a girl who had so far escaped smallpox. It was expected that everyone would have it.

We have serums like that against diphtheria, a disease which within the lifetime of some of us strangled four and five children in a single home. The stark hopelessness of the fight is hard to realize now. One man, just before the advent of diphtheria antitoxin, had to go to the village for a little coffin. The road was long and the snow was deep; so he brought back two little coffins, because another child had come down with the disease.

We have our organic extracts; our insulin, liver and others, to prolong the lives of millions who were formerly condemned.

We have more and more drugs which will kill organisms in the human body.

We have a rod to break the back of the serpent which formerly poisoned young mothers. We have a shield and buckler against the Captain of the Men of Death—viz., pneumonia.

It is only fair to remember that the first of the drugs of this type was quinine, and that it was not introduced to the world by medical men, but by Jesuit Priests who were missionaries in Peru (1632).

We have even drugs to restore sanity to some of those whom our fathers believed "afflicted of God" or "possessed by devils." Yet if we were restricted to the use of but one agent, most of us would keep the one which was named after the old Roman deity who was supposed to be possessed of that quality which has been esteemed most God-like in all religions: *i.e.*, the power to give his beloved sleep.

Our patients come to us not so much to be cured of their diseases as to obtain relief. They do not so much fear death as they do the manner of dying.

We value anodynes and we, more than most men, know the need of them. We, more than most men, see the miseries and inequalities of men; the distress caused by ignorance, poverty, disease, misfortune and war.

We see little babies born into conditions which you will not tolerate for cows if their milk is to be sold in your city. We may later see these babies suffering from a rash which does not correspond to that of any known infectious disease, and we are puzzled until we realize that it is caused by vermin.

There are poor little warped bodies, due to ignorance, heredity or parental disease. "When the parents have eaten forbidden fruit, the children's teeth are liable to be affected."

We see the man who has worked for a great company for a score of years destroyed by his occupation, and the company and the State refusing to assume any responsibility. A good worker is reduced to poverty, the mother trying to support the family by washing dishes to earn a few cents a day. Then everything is lost and the whole family is thrown onto the aged grandparents who are getting the Old Age Pension, and a whole group of bolshevists is created at one stroke.

When I was preparing this address I first included certain actual instances which I considered to be marked by mildness and understatement. I showed these to a colleague, who said, "Don't you think that you should leave those out? There may be some delicate people in the congregation." I agreed with him. But is there not something appalling in that very thought, that within a short walk of this place there exist conditions of disease and poverty too unspeakable for a Sunday morning audience? Should not someone tell you about these conditions? What sort of a citizen would you be if you saw a boulder on the railway and failed to report it? What sort of physicians would we be if we saw a malignant spot and did not advise the patient? Would not the old Prophet be justified in saying "Ye are all physicians of no value"? It is of enormous importance to the upper level to know what goes on below the tracks. Does it require much imagination to think of the thousands of points of contact of contagion? When the young person in your house breaks down on the verge of a promising career you cannot always think back to the splendid servant whose family was full of tuberculosis.

I know that you inspect this, and you examine that; you sterilize this and you pasteurize that; but if you think for one moment that your methods are perfect, that your systems never break down, that there are no leaks, I would urge you to examine the records of your schools and of your Board of Health. Instead of putting a fence around the top of the hill you are placing a part-time ambulance down in the valley. At the present time in this city there is a campaign to raise funds to deal with these conditions, and even if the objective is reached you will only be giving the workers a teaspoon for a job that they know requires a shovel.

And if there are conditions in our country which are so terrible that you cannot bear to hear about them, what about those who have to endure them? Let me suggest to you that if we do not deal adequately with these diseased places, along may come a witch doctor whose treatment will be a blood bath for "the aristocrats." And everyone who has a job and a dollar is classed as an aristocrat. When you are giving to the Charities, credit only a part to charity and the rest to self-defense.

But sorrow and unhappiness do not only dwell in empty purses. None knows better than the physician the troubles and heartaches of some of those whom the world would envy. We know where skeletons are carefully hidden and where the foxes are gnawing the vitals of those in high places. The wealthy, too, have painful experiences of mind and body.

And as if there was not enough misery in the world in a natural way, more is manufactured for us. We aid parents for years to bring up their children most carefully. We see that they get the proper food elements to build strong, beautiful bodies. We have worked with food formulas, the cod liver oil and the orange juice; we use various things to protect the children from all that might harm them. Then we are also called upon to select the most perfect of them to go into modern war at the lustful demand of some military or financial dictator.

We may well sigh and cry for all the abominations that are done in the midst of this world's activities. If there is any anodyne for the sufferers, any sedative for this crazy world's delirium, if there is any balm in Gilead, it will not be the medical profession which will mock at it.

But it is more and more borne in upon us that there is but one cure and only one cure for this world's afflictions; that all other suggested treatments are quack remedies or at best placebos; that there is but one specific, the practical application of the prescription given by the Great Physician, who is also the Great High Priest. That prescription has been advocated ten thousand times from ten thousand pulpits and too often rejected. But it must be taken before this world grows much older, or man, the so-called *Homo Sapiens,* will blast himself from the earth.

So long as we are content to have "Fifty years of Europe better than a cycle of Cathay"; so long as one man may work slavishly for a lifetime in one corner of our province for the sum that another man may spend in one evening in Montreal to entertain himself and his friends; just so long will we continue to sow the dragon's teeth which will bring forth a crop of national and international strife. Sooner or later we must provide a satisfactory answer to the age-old cry of Malachi: "Have we not all one father? Hath not one God

created us? Why do we deal treacherously every man against his brother?" We must answer correctly or perish.

This may sound like Communism. If it is, then make the best of it, for no less a one than His Majesty our King urged us, in an address in our own country on that visit which is so recent, yet seems so long past, that we should work for a better distribution of the good things of our civilization.

It is perhaps to dwell upon these things that we have this gathering. For we have a relation to them. We are busy men. We are occupied with overseeing matters of Life and Death. We are apt to act on the principle that the whole world is divided into only two classes, Doctors and Patients; that somehow we are set apart and aloof from the rest of mankind and that we are not subject to the laws that govern common men.

We are able to remove mountains and concentrate them into a small capsule which we call radium, to banish a blemish from a baby's back. We can prepare synthetically and crystallize in a test tube substances which are the cause of man's most intimate emotions.

If Job were alive today and should ask us, "Canst thou say to the lightnings, Go! and have them answer We are here?" we would say "Yes indeed." We confine the lightnings in various boxes to do our pleasure. With one we examine the heart of man. With another, which we call the X-ray, we, to use your own language, "make the flesh to consume away so that the bones stick out."

Because of these things we may consider ourselves scientists and materialists only. But the world will not deal with us on that basis. In spite of these things, perhaps because of these very miracles, they look to us to give them a lead in all other problems of life. They have been able to depend upon our predecessors in our profession in all cases of plague, famine, battle, murder or sudden death. They expect us in all the serious emergencies of life to remain calm and poised, to think clearly and give them directions.

Because of these things they still continue to invest us with the priestly functions of earlier times without either our permission or desire. Knowing ourselves as we know ourselves, we may be terrified by the implications and obligations of that status.

But I leave you with the solemn thought that, try to evade the responsibility as we may, in the battle which is life we are conscripted not only as physician but as priest, and "there is no discharge in that war."

We are glad to publish the following, at the request of The Society of the New York Hospital Lewis Cass Ledyard, Jr. Fellowship.

The Lewis Cass Ledyard, Jr. Fellowship was established in 1939 by a gift from Mrs. Ruth E. Ledyard, wife of the late Lewis Cass Ledyard, Jr., a Governor of The New York Hospital. The income, amounting to approximately $4,000.00 annually, will be awarded to an investigator in the fields of medicine and surgery, or in any closely related field. This amount will be applied as follows: $3,000.00 as a stipend and, approximately, $1,000.00 for supplies or expenses of the research. In making the award, preference will be given to younger applicants who are graduates in medicine, and who have demonstrated fitness to carry on original research of high order. The recipient of this Fellowship will be required to submit reports of his work under the Fellowship, either at stated intervals or at the end of the academic year; and when the result of his work is published he will be expected to give proper credit to the Lewis Cass Ledyard, Jr. Fellowship. The research work under this Fellowship is to be carried on at The New York Hospital and Cornell University Medical College. The Fellowship will be available on July 1st at the beginning of the academic year. Applications for the year 1940-41 should be in the hands of the Committee by the 15th of February. It is expected that the award will be made by April 1st, 1940.

Application for this Fellowship should be addressed to:

The Committee of the Lewis Cass Ledyard, Jr. Fellowship,
The Society of The New York Hospital,
525 East 68th Street,
New York, N. Y.

A sample application form can be seen at the Medical Library.

BOOK REVIEWS

Recent Additions to the Library

HYPERTENSION AND NEPHRITIS. Edited by A. M. Fishberg. 4th ed. 1939.

The fourth edition of this well-known book has been thoroughly revised. It remains one of the best books on the subject, both for the student, practitioner and specialist. Many of the chapters have been largely rewritten and a new chapter on asotæmia added. Recent developments on the surgical treatment of essential hypertension have been discussed. Among the additions and alterations to the new edition are: Prerenal azotæmia, the differentiation of glomerular and tubular elements in renal failure, clearance tests, the plasma proteins in the nephrotic syndrome, the Addis count, mercurial diuretics, Goldblatt's experimental production of hypertension, the pathogenesis and mechanism of hypertension, the treatment of œdema with acacia and concentrated blood serum, the Cushing syndrome, etc.

One of the commendable features of this book of immense detail and abundant references is the realization that the practitioner is called upon to treat the large majority of patients with hypertension and nephritis. For this reason the author has emphasized the clinical features and the simpler tests from which adequate information can be obtained. Treatment has been simplified to a great extent, particularly the phase dealing with dietetic measures. This is a book well deserving of the medical man's book-shelf.

—*Can. Med. Assn. Journal*, Jan., 1940.

PRACTICE OF ALLERGY. By Warren T. Vaughan. 1939.

An accurate, authoritative, well-written and complete presentation of our knowledge of allergy, and especially of its clinical aspects. Part I discusses history, theories of anaphylaxis and terminology. Part II deals with the General Characteristics of Clinical Allergy, and discusses functional pathology, incidence of allergy, climate, environment, social status and heredity. Part III is on the Physiology of Allergy. Part IV has chapters on discussion with the patient, skin testing, rests, physical allergy, vital capacity, etc. Part V is devoted to diagnosis and treatment of food allergy, and includes chapters on food groups, the food diary, trial and elimination diets. Part VI gives information on food allergens; Part VII takes up pollens. Part VIII is on bacterial allergy, vaccines and focal infection. Parts IX and XV deal with fungi in allergy, and use of drugs in the treatment of allergy. Part XVI has chapters devoted to asthma, hay fever, cardiovascular diseases and miscellaneous diseases. The numerous illustrations are excellent and well-selected. The result is the best textbook on allergy. —R. K.

TRAUMA AND INTERNAL DISEASE. A basis for medical and legal evaluation of the etiology, pathology, clinical processes following injury. By Frank W. Spicer. 1939.

Major topics are the effects of trauma on the brain, the spinal cord, the chest and respiratory system; trauma and tuberculosis; trauma and the heart, blood-vessels and abdomen; trauma and gastric and duodenum ulcers; trauma and tumours, and many other aspects of trauma in relation to internal diseases. There is an extensive bibliography and each section is summarized. The author has been a surgeon for thirty years and has ably marshalled his facts, has presented both sides in controversial matters, and has drawn his conclusions in a logacal and conservative manner. The result is a book that fills a real need in medical literature. It should prove valuable to surgeons, especially from the standpoint of diagnosis; to internists, especially because of valuable information on the late medical results of trauma, and to all physicians because of the obvious medico-legal implications.

—R. K. *Amer. Jour. Med. Sciences*, Dec., 1939.

PROBLEMS OF THE AGEING. Biological and medical aspects. Edited by C. V. Cowdry. 1939.

For the practitioner of medicine the book holds a supply of factual tabulated data that is easily accessible and is as essential to a consideration of the ageing patient as standard tables of height and weight are for those dealing with children.

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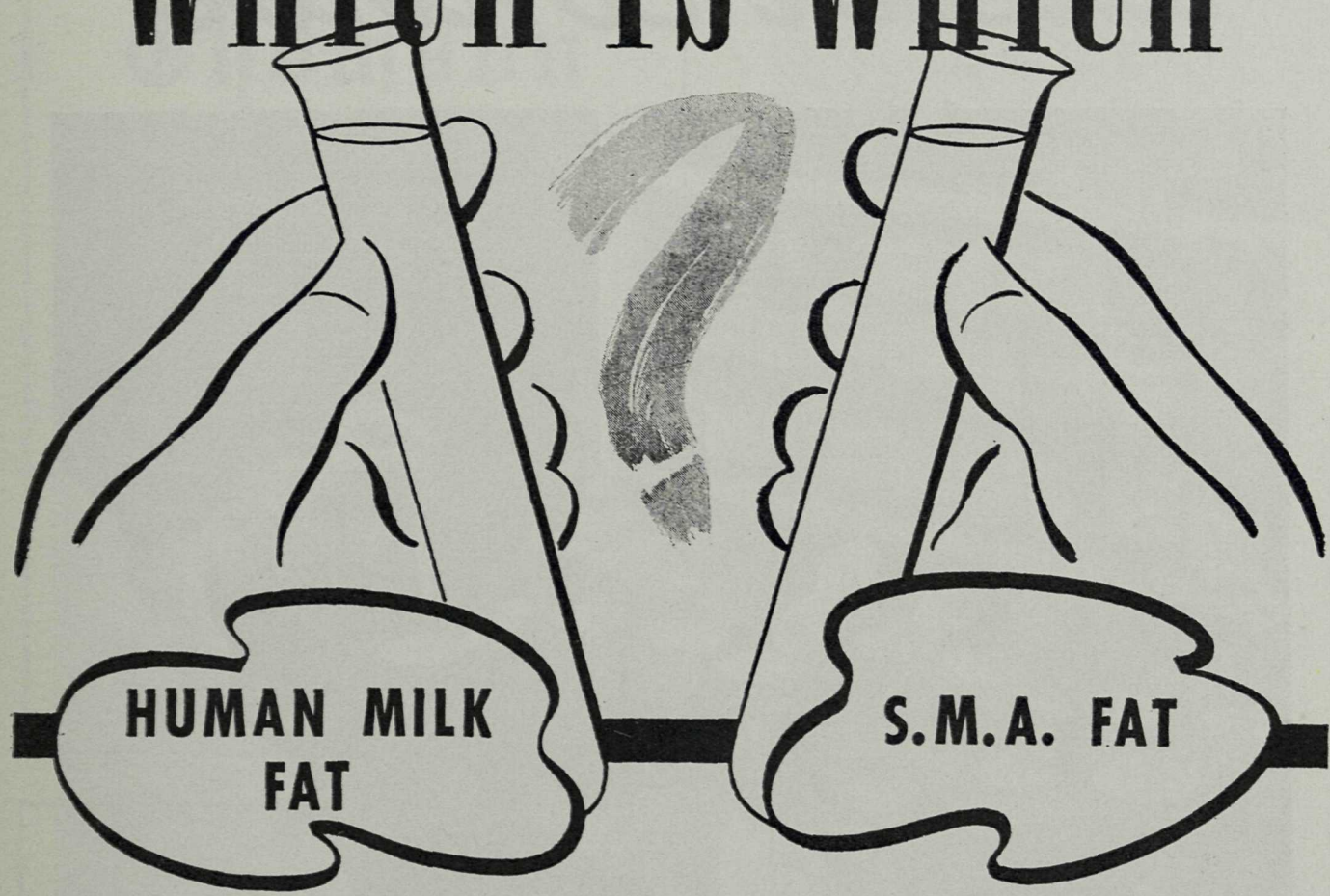

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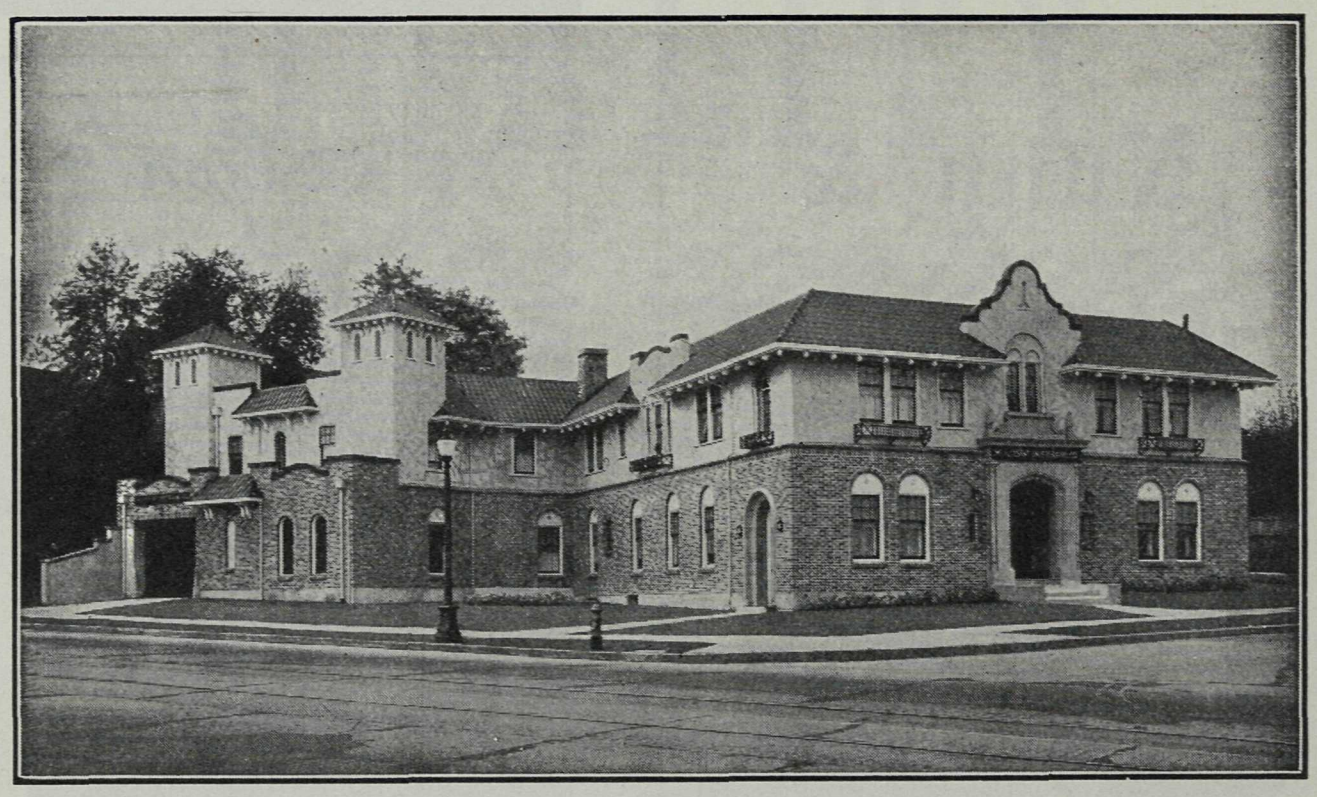

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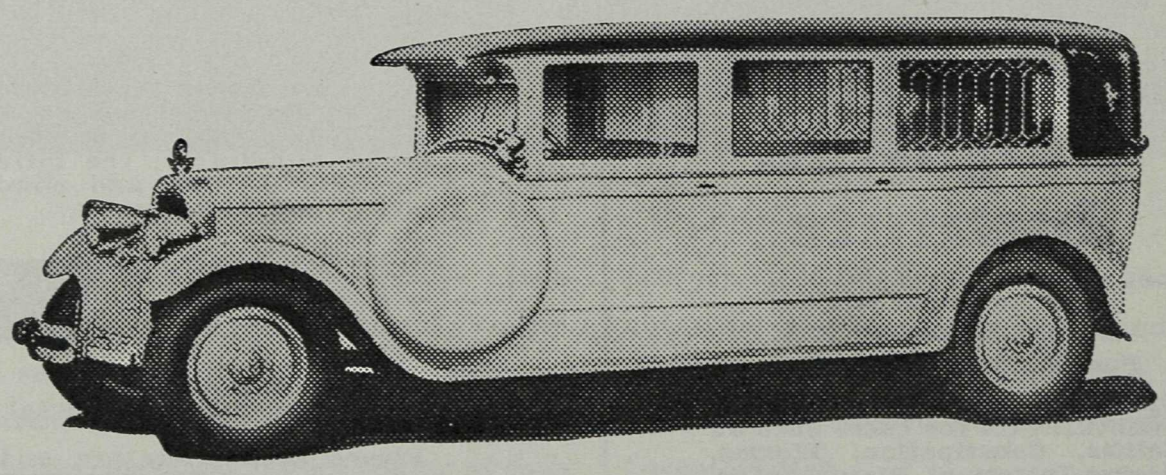

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(1) Dick, Geo. F.: The Yearbook of General Medicine 1939, p. 92. (The Yearbook Publishers Inc., Chicago).
(2) Kendrick, P., and Eldering, G.: Am. J. Hyg., Sect. B, **29**:133 (May) 1939.
(3) Sauer, R. W.: J.A.M.A. **112**:305 (Jan. 28) 1939.

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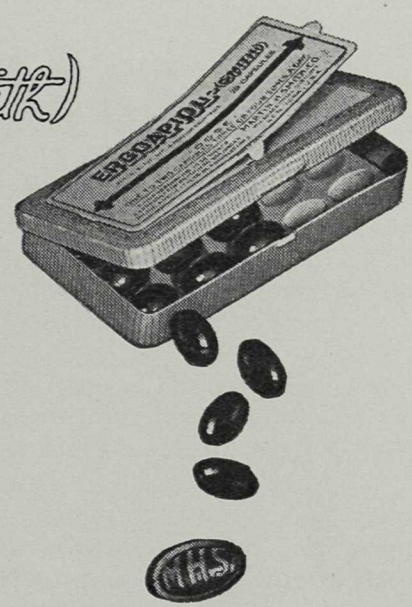

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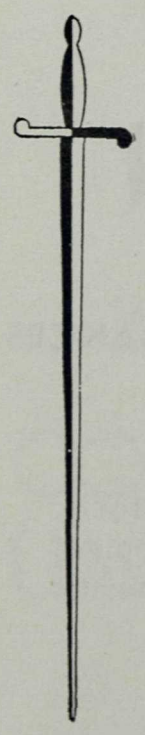

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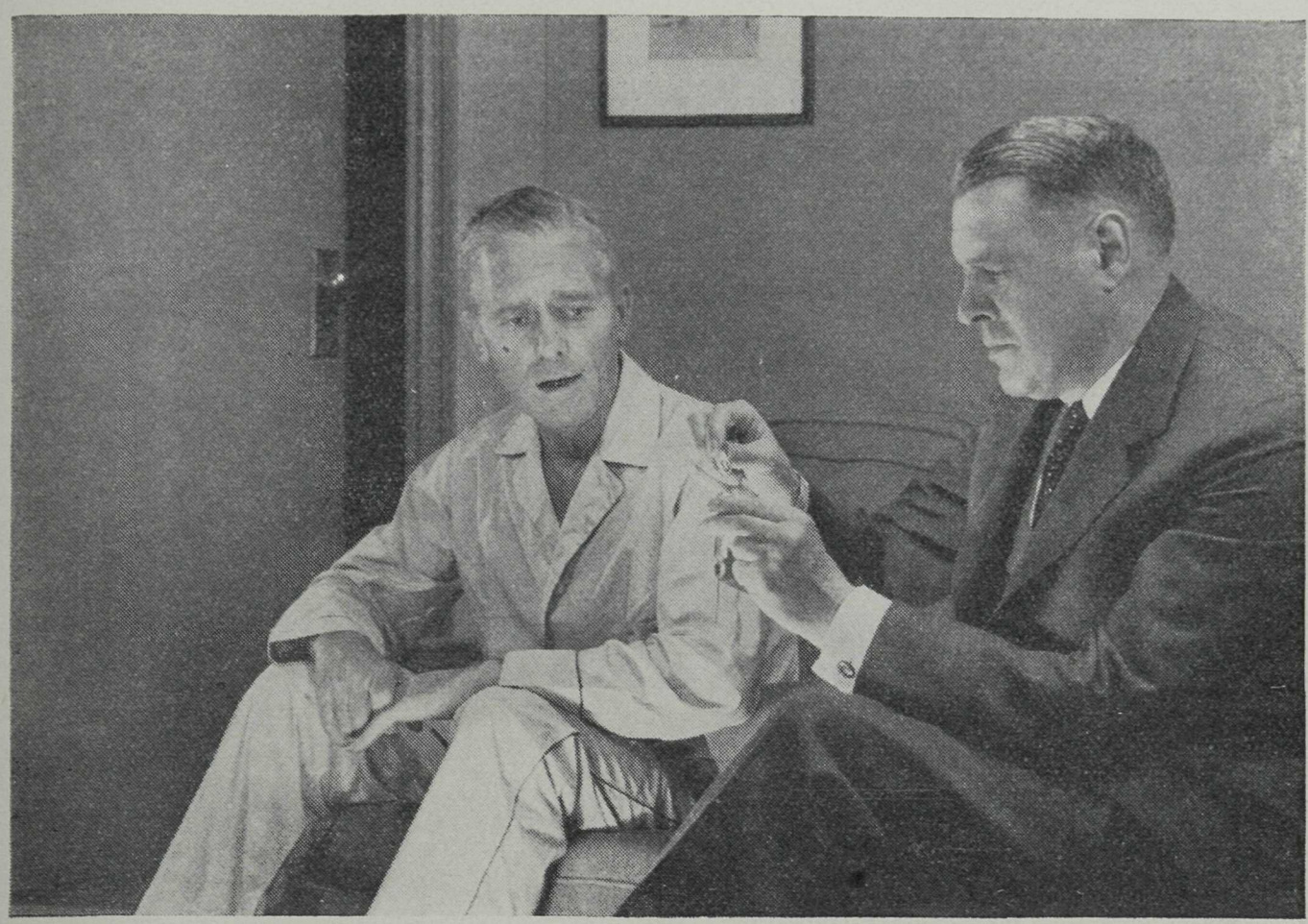

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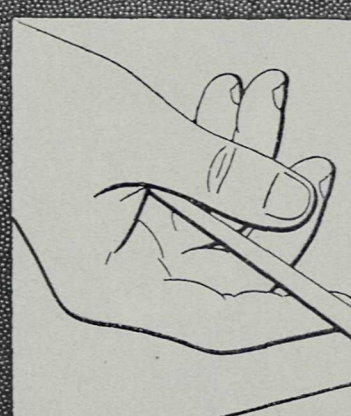

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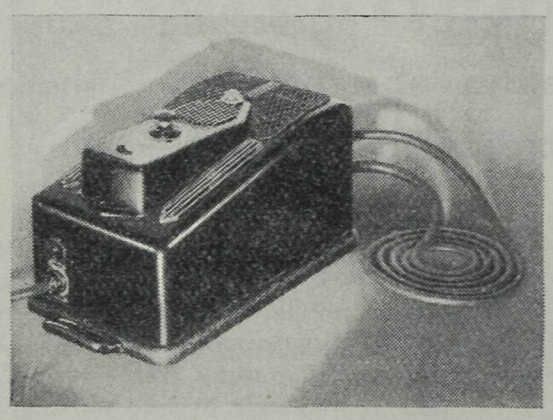

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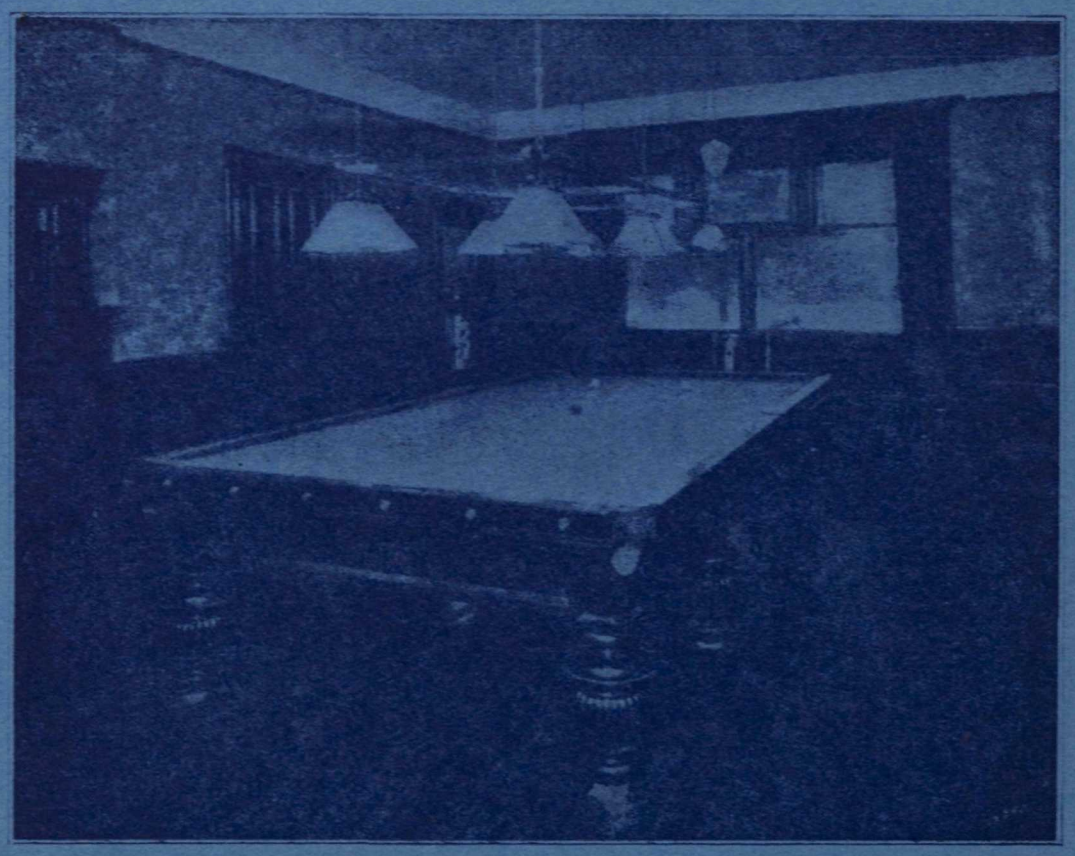

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