THE

BULLETIN

OF

The Vancouver Medical Association

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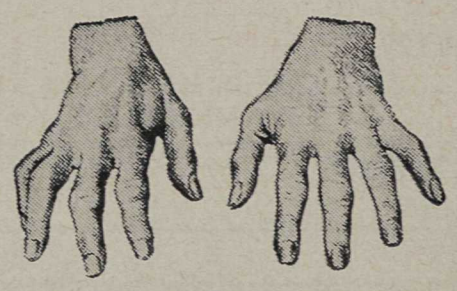

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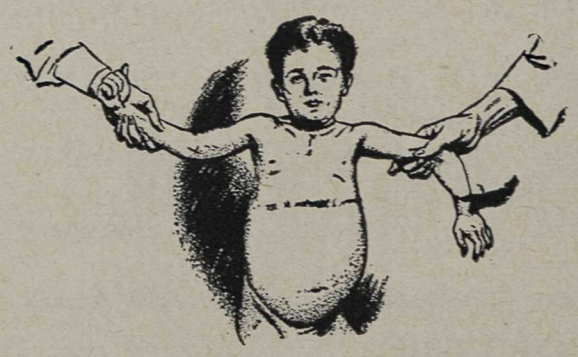

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Monday, 8:00 a.m.—Orthopaedic Clinic.
Monday, 12:15 p.m.—Surgical Clinic.
Tuesday—9:00 a.m.—Obstetrics and Gynaecology Conference.
Wednesday, 9:00 a.m.—Clinicopathological Conference.
Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.
Friday, 9:00 a.m.—Paediatric Clinic.
Saturday, 9:00 a.m.—Neurosurgery Clinic.

ST. PAUL'S HOSPITAL
Regular Weekly Fixtures

2nd Monday of each month—2 p.m. ..... Tumour Clinic
Tuesday—9-10 a.m. ..... Paediatric Conference
Wednesday—9-10 a.m. ..... Medical Clinic
Wednesday—11-12 a.m. ..... Obstetrics and Gynaecology Clinic
Alternate Wednesdays—12 noon ..... Orthopaedic Clinic
Alernate Thursdays—11 a.m. ..... Pathological Conference (Specimens and Discussion)
Friday—8 a.m. ..... Clinico-Pathological Conference (Alternating with Surgery)
Alternate Fridays—8 a.m. ..... Surgical Conference
Friday—9 a.m. ..... Dr. Appleby's Surgery Clinic
Friday—11 a.m. ..... Interesting Films Shown in X-ray Department

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Tuesday, 8:30 a.m.—Dermatology.
Wednesday, 10:45 a.m.—General Medicine.
Wednesday, 12:30 p.m.—Pathology.
Monday, 11:00 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

BRITISH COLUMBIA CANCER INSTITUTE
2656 Heather Street
Vancouver, British Columbia

SCHEDULE OF CLINICS AND MEETINGS—1953

Every Monday—9:00 a.m.-10:00 a.m. ..... Ear, Nose and Throat Clinic
11:45-12:45 p.m. ..... Therapy Conference
Every Tuesday—11:00 a.m.-12:00 p.m. ..... Clinical Meeting
12:00 noon-1:00 p.m. ..... Therapy Conference
Every Wednesday—11:45 a.m.-12:45 p.m. ..... Therapy Conference
Every Thursday—11:45 a.m.-12:45 p.m. ..... Therapy Conference
Every Friday—9:00 a.m.-10:00 a.m. ..... Lymphoma Clinic (during February)
10:15 a.m.-11:15 a.m. (as of March 6) ..... Lymphoma Clinic
11:45 a.m.-12:45 p.m. ..... Therapy Conference

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Niacinamide	6 mg.
Pyridoxine HCl.	1 mg.
Ascorbic acid	30 mg.
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Sodium iodide	0.04 mg.

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Vitamin D	1000 I.U.
Thiamine HCl.	1 mg.
*Niacinamide	2.5 mg.
Ascorbic acid	30 mg.
Sodium iodide	0.04 mg.

*Not declared on label

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VANCOUVER HEALTH DEPARTMENT

STATISTICS — DECEMBER, 1952

Total population (census)	344,833
Chinese population	7,117

	December, 1952	
	Number	Rate per 1000 pop.
Total deaths (by occurrence)	370	12.9
Chinese deaths	20	33.7
Deaths, residents only	339	11.8

Birth Registrations—residents and non-residents (includes late registrations)

	December, 1952	
Male	371	
Female	347	
	718	24.9

Infant Mortality—residents only

	December, 1952
Deaths under 1 year of age	15
Death rate per 1000 live births	27.6
Stillbirths (not included in above item)	9

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	December, 1952		December, 1951	
	Cases	Deaths	Cases	Deaths
Scarlet Fever	34	—	135	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Chicken Pox	115	—	142	—
Measles	39	—	390	—
Rubella	4	—	15	—
Mumps	204	—	54	—
Whooping Cough	16	—	11	—
Typhoid Fever	1	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	2	—	—	—
Tuberculosis	35	3	28	8
Erysipelas	1	—	3	—
Meningitis (meningococcic	2	—	—	—
Infectious Jaundice	22	—	—	—
Salmonellosis	3	—	2	—
Salmonellosis Carriers	—	—	—	—
Dysentery	13	—	6	—
Dysentery Carriers	—	—	—	—
Tetanus	—	—	—	—
Syphilis	6	2	19	—
Gonorrhoea	135	—	159	—
Cancer (reportable resident)	100	57	97	52

HEPARIN

Clinical experience in the use of Heparin as a blood anticoagulant has extended over many years. The product has been administered intravenously in very dilute solution.

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1,000 International Units per cc.
10,000 International Units per cc.

Heparin (Amorphous Sodium Salt)—Dispensed in 100-mg. and 1-gm. phials as a dry powder, containing 100 International Units per mg., for the preparation of solutions for laboratory use.

Recent References:

Stats, D., and Neuhof, H.: Am. J. Med. Sci., 1947, 214: 159.

Walker, J.: Surgery, 1945, 17: 54.

Cosgriff, S. W., Cross, R. J., and Habif, D. V.: Surgical Clinics of North America, 1948, 324.

De Takats, G.: J.A.M.A., 1950, 142: 527.

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The Editor's Page

We should like to take this opportunity of congratulating the B.C. Division of the C.M.A. on the attainment of its first anniversary since its recognition. Nor are our congratulations based merely on the fact that it has survived the first year of life, always a very dangerous year—nor that it has gained an adequate amount of weight, as represented by a surprisingly large membership (though there is room for improvement here). We feel, rather, that our chief reason for congratulation, and may we say admiration, is the amazing vitality of the young Division. For it started its life in circumstances which were not altogether favourable, and in an amosphere of tension and urgency which is not the happiest environment for a growing infant. A year ago, there were not a few who shook their heads rather gravely over the newcomer's crib, and the prognosis was not unanimously hopeful.

But happily, all this is past—and there must be few of us now who would fail to predict a long and lusty life for the B.C. Division. For it had good parents. The men who , in the face of discouragement, and mountains of work, and grave problems, gave of their time and energy and devotion, so unselfishly and so unstintedly, have been abundantly justified of their effort by the results which they have achieved. They faced a very difficult task. First of all they had to secure a membership whose size and enthusiasm would make the B.C. Division a practical success. Then they had to meet and solve a great many difficult economic problems. How well they have succeeded in this part of their work, we can all see today. A new, and on the whole, an excellent schedule of fees has been promulgated—relations with the government over S.A.M.S. cases have been improved—as also with the Workmen's Compensation Board; and this has benefited the whole profession. All these things have meant an appalling amount of work—how much work, most of us will never know. But they did the work, and we owe them a very great debt of gratitude. These architects of the B.C. Division have done a job of which they may well be proud.

Their next job, and one of the biggest they had to tackle, was the improvement of public relations, and relations with the press: an undertaking long overdue, and one calculated to daunt any people less determined to succeed. And they have done, and are doing, a very good job in this respect. Our relations with the press have, we believe, been very greatly improved, and through radio broadcasts and by other means, our relations with the public are gradually becoming much franker and more cordial.

Because of its obvious sincerity and honesty of purpose, the Division is coming to be regarded as a genuine, and approachable, spokesman for the medical profession as a whole. And we believe it is fully to be trusted in this capacity. Our new Executive Secretary is a tower of strength in this regard, and he has back of him an Executive on which he can thoroughly rely. As a result of their joint efforts, this new Division, the youngest in Canada, is also one of the strongest and most efficient—and in many ways, we feel, is an example of what the Divisions of the Canadian Medical Association should be, and its work is an example of what they should all be doing.

And in congratulating the officers of the Division and their Secretary, we congratulate ourselves—we feel pride in their work and their accomplishments—and if we have any sense at all, we shall all join the Division as members (preferably paying Founders' fees, too) and give them our enthusiastic support in their endeavours.

Vancouver Medical Association

President ..... Dr. E. C. McCoy
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SUMMER SCHOOL

June 1st to 5th, 1953

The 31st Annual Summer School of the Vancouver Medical Association will be held in Salon A of the Hotel Vancouver this year on the above dates.

The Summer School was first instituted in 1921, and has been held yearly since then, except for one year during the Second World War. It has become an important fixture in the annual programme of medical meetings in British Columbia, and a constant succession of notable speakers has been secured from year to year, thanks to the hard work and devotion of the various Summer School Committees.

The programme arranged for this year is in every way up to the high standards of past years, and medical men throughout the province will do well to arrange their timetables so as to take in this year's School. As will be seen from the list of speakers published below, this programme will have a great deal to offer to every medical man, especially to the general practitioner, for whom these Schools are, of course, specially designed.

The speakers are as follows:

Orthopaedic Surgery — Dr. Joel Baker, Mason Clinic, Seattle, Wash., U.S.A.

Surgery — Dr. Howard Stearns, Clin. Professor of Obstetrics and Gynaecology, University of Oregon, Portland, U.S.A.

Obstetrics and — Dr. Martin M. Hoffman, Professor of Medicine, Dalhousie University Dept. of Metabolism, Halifax, N.S.

Gynaecology — Dr. R. Graham Huckell—Professor of Orthopaedic Sugery, University of Alberta, Edmonton, Alta.

Medicine

Dr. Carl Aberhart of Toronto has also been invited to give a paper or papers on Urology, but his acceptance has not yet been definitely received.

Summer School Chairmen for 1953

Dr. S. L. Williams, *Chairman*
Dr. John A. Elliot, *Secretary*
Dr. J. A. Irving
Dr. Max Frost
Dr. France E. Word
Dr. Elmer Jones

More details will be given in subsequent announcements in the Bulletin.

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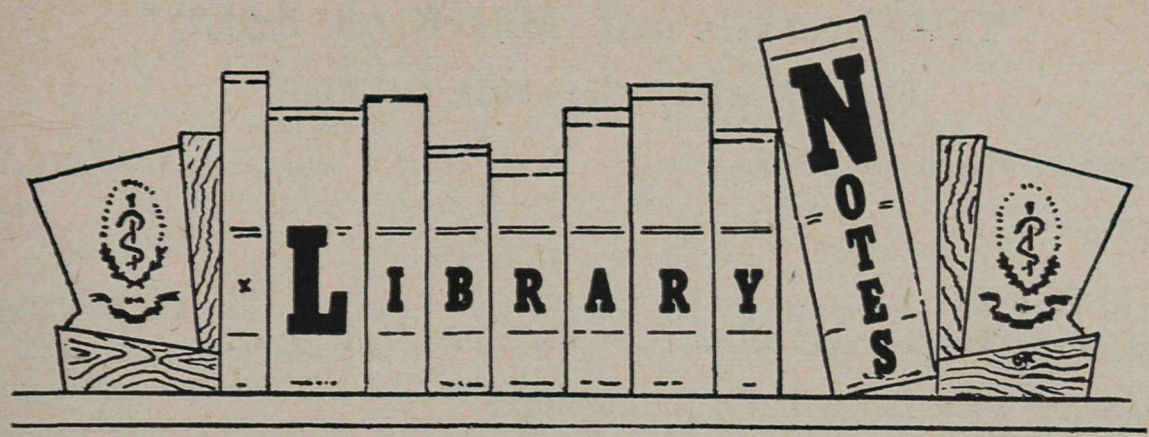

Library Hours:

Monday to Friday ..... 9:00 a.m. - 9:30 p.m.
Saturday ..... 9:00 a.m. - 1:00 p.m.

Recent Accessions:

Surgical Clinics of North America, Symposium on Safeguards in Surgical Diagnosis. December, 1952. The Queen Charlotte Textbook of Obstetrics edited by S. G. Clayton, 1952.

Cowdrey's Problems of Ageing edited by A. Lansing. 1952 Year Book of Drug Therapy, 1952, edited by H. Backman. Transactions of the Association of American Physicians, 1952.

Medical Clinics of North America, Symposium on Gastro-Intestinal Diseases. January, 1953.

The following volume has been presented to the Library by Dr. D. B. Collison:
The Principles and Practice of Medicine by Sir William Osler. Sixth Edition, 1906.

The journals listed below are those received in the Library in the surgical field:
American Journal of Surgery.
Annals of the Royal College of Surgeons of England.
Archives of Surgery.
Australian and New Zealand Journal of Surgery.
British Journal of Surgery.
Bulletin of the American College of Surgeons.
Journal of Bone and Joint Surgery.
Journal of the International College of Surgeons.
Journal of Neurosurgery.
Journal of Thoracic Surgery.
Surgery.
Surgery, Gynecology and Obstetrics: International Abstracts of Surgery.
Western Journal of Surgery, Obstetrics and Gynecology.

"Paradise Enow"

"When I die," said dear and whimsical old Doctor Pycroft, "I shall have a bell hung on my head-stone, with an inscription asking the compassionate passer-by to ring it long and loud. And I shan't get up.

REGINALD L. HINE,
Confessions of an Uncommon Attorney."

FOR SALE

Doctors Office equipment. Apply Doctors Millar and Millar, 2232 West 41st Avenue. KErr. 0409.

THIRD ANNUAL MEDICAL BALL

PLEASE NOTE CHANGE OF TIME

Date: Thursday, March 26, 1953.

Time: 9:30 p.m.

Supper at 11:00 p.m.
To be held in the Banquet and Ballroom of the Hotel Vancouver.

For reservations: Write to Medical Ball Committee,
c/o Medical School Office,
University of British Columbia.
Phone KErr. 1357 between 6 p.m. and 7:30 p.m.

Tickets: Send requests to:
Chairman, Medical Ball Committee,
Medical School Office,
enclosing $9.50 for each couple ticket required.

Tickets on Sale in some of the larger hospitals the week previous.

Report on Past and Present Medical Balls and Future Prospects

A. *First Two Medical Balls*

1. Attendance (a) 1st Ball—300
   (b) 2nd Ball—500
2. Results (a) 1st Ball—Two $100 bursaries
   (b) 2nd Ball—Two $100 bursaries

The money from the Balls goes into a Medical Bursary Fund administered by the Administration. These bursaries are, of course, for medical students only.

B. *Third Medical Ball*

1. Place—Hotel Vancouver
2. Price—$9.50 per couple
3. Date—March 26, 1953
4. Expected attendance—600
5. Plans

This year the Medical Ball Committee has decided to pay more attention to the Interior and Northern British Columbia medical men. They realise, of course, that they must of necessity concentrate on the doctors living on the Island and Lower Mainland. Those in the Interior who are not able to attend are being encouraged to support the bursaries directly be contributing to the fund. Direct contributions may be made through the Alumnae Development Fund.

C. *Future Prospects*

1. Attendance—As many doctors in the province who can possibly attend
2. Prospects
   (a) We hope to make this Ball "*the*" annual event for the Medical profession in the province.
   (b) We hope to have enough money for bursaries so that aid can be extended to all who require it.

EARLY RECOGNITION OF CANCER OF THE FEMALE GENITAL ORGANS*

WILLIAM F. FINN, M.D. AND R. GORDON DOUGLAS, M.D.
(From the Department of Obstetrics and Gynecology of the New York Hospital and Cornell University Medical College.)

INTRODUCTION

Two-thirds of all cancers of the female genital tract are detected in advanced stages. This results in the existent poor outcomes because a direct correlation exists between the stage of the cancer when treatment is begun and the survival rate. Cancer of the breast, which accounts for twenty-five per cent of all cancers in women, is the commonest cancer of the female body. Female genital tract cancer comprises another 25 per cent of these cancers. The breakdown by organ is as follows:

Cervix	13 per cent
Endometrium	5 per cent
Ovary	5 per cent
Vulva, Vagina, Tube	2 per cent

The remaining 50 per cent are composed chiefly of intestinal and skin cancers.

The survival rate will not increase until we find more cancers in earlier stages. To accomplish this we must educate both the patient and the doctor. Instruction of the patient should be directed toword two aims, 1) the prophylactic physical examination, and 2) appreciation of early symptoms. Routine physical examination performed on apparently well persons in the course of insurance applications, industrial examinations, induction into the armed forces, and at cancer detection centres reveal a high incidence of unsuspected disease other than cancer, averaging about 50 per cent, and reveals about 1 per cent unsuspected cancer. Fortunately many of the cancers in which we are interested are readily accessible and can be detected by inspection of the cervix and palpation of the uterus and adnexa. Besides stressing the value of physical examination on the well patient, the patient should learn the importance of early symptoms of cancer and should be impressed with the need of prompt medical consultation supplemented by cytological smear, diagnostic biopsy and curettage as indicated.

Education of the physician is also necessary. The Philadelphia Committee for the Study of Pelvic Cancer[1] found that the physician was responsible for one-third to one-half of all delay in the diagnosis and treatment of cancer. The physician is more concerned in the diagnosis and treatment of existing diseases than in the detection of asymptomatic diseases in incipient stages. He has not as yet fully accepted the need for prophylactic physical examinations. However, success in cancer treatment can result only from diagnosis in increasingly earlier stages so that the existing modes of therapy will be effective. Another professional failing is the tendency to minimize early symptoms and the failure to recommend and to perform indicated diagnostic tests. Smear, cervical punch biopsy and curettage are the indispensible cornerstones of diagnosis. They must be applied to more patients, especially to patients with slight symptoms which at first questioning may appear to be of slight consequence. Another professional error is the habit of treatment before all diagnostic tests have been used. A busy practitioner is tempted to treat the symptom without thorough diagnosis. But progress in cancer can result only when the emphasis is on detection in early stages, for then every cancer patient can begin treatment while the cancer is still confined to a curable stage.

CANCER OF THE CERVIX

These general principles will be applied in turn to the various genital organs. We shall start with the commonest cancer—cancer of the cervix.

*Read before the Summer School of the Vancouver Medical Association, May 26-30, 1952.

Two out of every three patients who develop cancer of the cervix die within five years. These high mortality figures are disturbing since cervical cancer constitutes about 15 per cent of all cancers in women and about half of the cancers of the female genital tract. Foote and Li[2] state, "Dr. Morton L. Levin, of the New York State Division of Cancer Control, and Mrs. Ruth Salt of the Department of Statistics, Memorial Hospital, independently estimated that in the female population at large one would expect approximately one case of carcinoma of the cervix per firteen hundred women over the age of 35." The New York State Department of Health[3] estimates that the probability of a woman developing cancer of the cervix from birth to death is 2.2 per cent. This high incidence of cancer in an accessible part of the body emphasises the need for prompt diagnosis. The analysis of survival according to the stage in which treatment was instituted show that the current high mortality rate could be reduced immeasurably, if cancer of the cervix was detected in earlier stages. (Table 1)[4] Several startling facts emerge from these data. First, only 15 per cent of the cervical cancers were detected while still confined to the cervix. i.e. Stage 1. Second, the overall cure rate of cervical cancer is only half of the cure rate of stage 1 and only one-third of the cure rate of stage 0 which approximates 100 per cent. Further review of previous annual reports show that the overall cure rate has risen only slightly in the past decade—from 26.3 per cent in 1938 to the present rate of 32.6. These data show the imperative need for the recognition of cervical cancer in early treatable stages. What is "early cervical cancer?" Opinions vary. Some believe that a stage 1 cervical cancer is early, but when we reflect that 20 per cent of the so-called "stage 1" lesions already have positive pelvic lymph nodes as shown by Meigs[5], and when we reflect further that the five-year survival rate of patients with stage 1 cervical cancer is only 58 per cent, we realize that the detection of stage 1 cancer is already too late and that we must discover cervical cancer in still earlier stages, to wit, stage 0. Douglas and Studdiford[6] aptly summarize the situation: "In short, should we continue to regard stage 1 cancers as the earliest manifestation of the disease, there seems to be little chance of improving our therapeutic results—whether by radiation or by radical or ultraradical surgery."

LIFE HISTORY OF CERVICAL CANCER

Investigations suggest that the last and obvious stages of cervical cancer constitute but a short period in the total life history of the disease. This concept of a long latent period during which progression to clinically obvious cancer may, but does not necessarily, occur was first proposed by Schiller[7]. Schauenstein[8] in 1907, and Pronai[9] in 1908 described anaplastic changes in cervical epithelium. Schottlander and Kermauner[10] in 1912 described such anaplastic changes in the surface epithelium near invasive cancer. It remained for Schiller[7] in 1928 to state that these changes were early cervical cancers. This concept met with determined opposition from those to whom cancer connotes invasion. Now, however, the work of Smith and Pemberton[11], Younge and Hertig[12], TeLinde, Galvin and Jones[13-14-15], to name only a few of the many writers on this subject, make it evident that the cytological changes in surface cancer and invasive cancer are identical and that surface cancer has been observed to progress to invasive cancer. Many fascinating speculations arise in this connection.

1. Does intraepithelial cancer inevitably progress to invasive cancer?

No! Many cancers have been observed to remain in an intraepithelial location for many years. Wespi[16] has reported follow-up for as long as eight years without evidence of invasion. Kottmeier[17] has observed 42 patients with intraepithelial cancer; only three of these have developed evidence of invasion during one to nine years of observation.

2. What is the longest time interval so far recorded in the progression to invasion?

Jones, Galvin and TeLinde[14] have observed this progression to occur over a period of 17 years.

3. How many intraepithelial cancers have become invasive?

The latest tabulation by Galvin et al[15] lists 30 such cases.

4. How many cervical cancers are preceded by intraepithelial lesions?

Galvin et al[15] report that in a group of patients with cervical cancer 11 of the 13 patients who had had previous cervical biopsies, and 2 of 8 patients who had had previous curettages have shown evidences of intraepithelial lesions prior to development of invasive cancer.

This entire subject is best summarized by a direct quotation from Galvin, Jones and TeLinde[15]: "1. Carcinoma *in situ* is potentially invasive, and, if untreated, may progress to clinically evident cervical cancer. 2. As this study is retrospective, it does not indicate that carcinoma *in situ* always becomes invasive. It does, however, indicate that clinical cervical cancer is preceded by carcinoma *in situ* in too large a proportion of cases to be coincidental. 3. The clinical course of cervical cancer represents only a small segment of its life history and the greater part of its existence is spent in the preinvasive stage."

DETECTION OF CERVICAL CANCER

GENERAL METHODS

Routine mass screening is not feasible except under special circumstances such as a study in industry or the Armed Forces. Selective screening is more practicable and should be directed toward the patient with a high probability of developing cervical cancer. Such cancer-potential patients, as shown by Lombard[18] are those who have married young, have given birth while still young, have had cervical lacerations or have had syphilis. The incidence of cervical cancer, conversely, is low in Catholic nuns as shown by Gagnon[19], and about one-ninth as common in the Jewish woman as in the Gentile, as shown by Rothman, Rapaport and Davidson[20], and Kaplan and Rosh[21], Selective screening directed toward cancer-prone groups would result in significantly higher percentages of cancer detection than indiscriminate sampling of the entire population. This is suggested by Day's[22] recent study at the Kips Bay Health Centre in which three intraepithelial cervical cancers, 0.23 per cent, were detected in 1300 apparently healthy women, while routine smear examinations of patients applying at a gynecological clinic or admitted on a gynecological service show a higher incidence of latent cervical cancer, 1 to 2 per cent.

SPECIFIC METHODS

This examination should consist of history, pelvic examination, speculum visualization of the cervix, cystological smear, and biopsy of the cervix.

1. *History.* History can help only when symptoms have occurred. We should question regarding contact bleeding, e.g. after a pelvic examination, after a douche or after coitus. We should further query regarding leukorrhea. But since our goal is the detection of asymptomatic cancer, history is of little avail.

2. *Pelvic examination.* The detection of cervical cancer by the palpation of a crater or of parametrial thickening is now outdated. To attain the best results cancer must be detected in a stage when little or no physical evidence exists but when the diagnosis is exclusively based on miscroscopic findings.

3. *Speculum visualization.* This aids us in distinguishing the various non-malignant lesions, i.e. unrepaired laceration, erosion, eversion, cervicitis, polyps, hyperkeratosis, which might cause confusion. It permits selection of a biopsy site and aids in obtaining endocervical smears. Since inspection alone is unreliable, confirmation must be obtained by biopsy and smear. Colposcopy, so ardently advocated by Hinselman[23] never became popular in this country because it was inconclusive and furthermore needless, since biopsy confirmation was still necessary.

4. *Cytological Smear.* The introduction of a cellular diagnostic method by Papanicolaou and Traut[24] in 1943 constituted a major advance in the earlier diagnosis

of cervical cancer. It permits the diagnosis of asymptomatic latent cancer which in many cases is still confined to the surface epithelium. Direction in this intraepithelial stage, where cure rate approaches 100 per cent, is our goal.

Patients should be cautioned not to douche for 48 hours prior to the taking of smears. No lubricant should be employed in the vagina immediately prior to the obtaining of smears. Smears may be taken directly from the vagina by inserting an applicator or a cannula into the vagina. Smears which are especially abundant in cells may be obtained from the material on a dependent blade of the speculum. Smears may be taken from the endocervical canal by aspiration, by a cotton applicator, or by scraping with a tongue blade or a spatula as recommended by Ayre[25]. Contact smears may be obtained directly from the surface of the lesion or by a Gelfoam sponge, as advocated by Gladstone[26]. All smears must be properly spread and fixed immediately in a solution of equal parts of ether and 50 per cent alcohol.

Smears are of especial value in the detection of the early lesion. This is amply attested by many writers, including L'Esperance[27] who writes that observations at the Strang Clinics showed that 62 per cent of the cancers of the cervix, both the preinvasive type and the early infiltrating carcinomas, were first recognized by the smear before there was any evidence of a gross lesion of the cervix or before the onset of the earliest symptoms. The smear has the further advantage that it is easily done, does not hurt the patient and may be repeated frequently.

Its disadvantages are false negative reports which occur in 2 to 5 per cent of all examinations. These may be due to improper collection or fixation of the specimen, or to errors in interpretations. Such negative reports lull the clinician into a false sense of security. False positive interpretations may also occur. Pund[28] states that these are chiefly due to healing ulcerations and to imperfect metaplasia. While smears are invaluable as a screening technique and in detecting asymptomatic cancer, the above mentioned errors make the performance of a biopsy mandatory before the institution of treatment.

5. *Biopsy.* The cervical biopsy is the decisive diagnostic test in the detection of cervical cancer. The punch biopsy is the commonest type. The obtaining of a cervical biopsy should mean not a single sample of tissue, but the obtaining of many particles from the lesion and the surrounding borders, or if no lesion is obvious, from the vicinity of the external os. Pain, which is slight, can be reduced, if the biopsy forceps is not pulled but twisted gently in a clockwise fashion until the tissue is removed. Bleeding is rarely of consequence and can be readily checked by the application of a cauterizing agent. Biopsies may also be obtained by scraping with a Novak[29] spoon, by a ring incision with an Ayre[30] knife, by cutting wedges from the cervix and by a Gusberg[31] coning curette. Routine punch biopsies with the occasional use of curettage of the endocervix or wedge or ring excision of the endocervix have served our needs.

We have not applied Lugol's solution to the cervix prior to biopsy, but have relied on extensive biopsies about the external os rather than on staining reactions. We always take multiple biopsies, agreeing with Foote and Stewart[32] that most cervical cancers arise in a critical zone about the external os. Previously biopsy was employed only when there was an obvious cervical lesion, but if we are to detect the early intraepithelial cancer which has not produced a change on the surface of the cervix, we must condition ourselves to taking biopsies from the normal appearing cervix. Routine cervical biopsies in this fashion by Cox, Buhler and Mixson[33] detected two invasive cervical cancers and three intraepithelial cancers in 110 patients. Lock[34] has advocated obtaining a cervical biopsy at every curettage. Biopsies thus obtained will detect treatable, confined intraepithelial lesions before progression to an unconfined extraepithelial state occurs.

6. *Curettage.* Curettage of the endocervix is essential in the detection and/or confirmation of high endocervical lesions which are beyond the reach of biopsy clamp. A by-product of curettage for another indication may be hitherto unsuspected cervical

cancer. This method is particularly valuable in the detection of adenocarcinoma of the endocervix.

7. *Amputation of Cervix or Hysterectomy.* One per cent of the total hysterectomies performed at The New York Hospital between 1947 and 1951 resulted in the detection of previously undetected cervical cancers as shown by Finn[35]. These were very early cancers, were usually in the endocervical canal, and most cases were overshadowed by myomas or prolapse which appeared to provide adequate explanation for the symptoms.

The application of the above methods will result in increased detection of extremely early cervical cancer and thereby increase the survival rate of patients with cervical cancer.

CANCER OF THE ENDOMETRIUM

Cancer of the endometrium is becoming more important because it is on the increase. This increase is not merely due to better reporting of cancer, but is due to the increasing age of our population. More women are living to attain the age of 55 to 60 when cancer of the endometrium is most common. It has been estimated that 35 out of every 1,000 women who attain the age of 40 will develop cancer of the endometrium.

Certain women are more prone to develop endometrial cancer. A composite picture of such a woman would be—middle-aged, single or, if married, with either none or only a few children, a story of late menopause, obese, more likely well-to-do and a private patient, who may have diabetes, who might have had radium insertion or excessive estrogens in the past, and who may have had hyperplasia of the endometrium previously. These are some of the antecedents and concomitants of the endometrium. Routine screening techniques to obtain maximum yield should be directed toward such groups of women.

The peak incidence occurs in a middle-aged woman of about 55, but the disease occurs in younger women as shown by Hertig[36], Speert[37] and others. Dockerty, M.B.[38] et al record that two per cent of the endometrial cancers observed at the Mayo Clinic occur in women under 40. Hirst[39] has recorded the youngest patient, a girl of 16. Hence youth is no guarantee that endometrial cancer is not present. The patient, with endometrial cancer, is frequently a spinster. If married, she may have reduced fertility. Corscaden and Gusberg[40] report a sterility incidence of 38.6 per cent, Randall[41] reported 28.2 per cent, while Taylor and Becker[43] recorded 31.5 per cent. It is interesting to speculate whether the factors which resulted in infertility ultimately caused cancer. A corollary is that subsequent follow-up of patients in an infertility clinic may yield a higher incidence of endometrial cancer than in the general population. A number of patients with endometrial cancer have excessive bleeding at the time of menopause and continue to bleed longer than those women who do not develop endometrial cancer. Corscaden and Gusberg[40] estimate that the average age at menopause of patients with endometrial cancer is 52-54, several years later than the average. Crossen and Hobbs[43] have stated that late menopause, i.e. after 50 years, is four times as common when endometrial cancer is present. Randall[41] has estimated that 35 per cent of the women with endometrial cancer have continued to menstruate after 50 years of age as opposed to eight per cent of those who have not developed cancer during a 15-year period after menopause. Obesity accompanies endometrial cancer. Palmer et al[44] observed that 75 per cent of their patients with endometrial cancer were overweight. This is approximately twice the incidence in a control group of the same age. Diabetes has been reported by Palmer and his co-workers to be anywhere from 3 to 16 times as prevalent. Radiun appears to have a carcinogenic effect as observed by Smith [45] and others. Speert[46] and Peightal reported that eight per cent of the patients with endometrial cancer at Roosevelt Hospital had been irradiated prior to the development of endometrial cancer as opposed to a 0.3 per cent incidence in the group of patients with carcinoma of the cervix. Hyperplasia is a common precursor of endometrial cancer. Hertig[36-47-48] in his development of the concept of *in situ* endometrial cancer states that hyperplasia

and polyps commonly occur 6 to 13 years prior to the appearance of endometrial cancer and that adenomatous hyperplasia and anaplasia are commonly observed during the 3-to-5-year period prior to the discovery of fully developed endometrial cancer. This naturally leads to the consideration of the role of estrogens in the development of endometrial cancer. Fremont-Smith[49] and his co-workers, Vass[50] and others, have described the appearance of endometrial cancer after the administration of large doses of estrogen. It has been estimated by Ingram and Novak[51] that 15-27 per cent of the patients with feminizing tumors develop endometrial cancer. Endometrial cancer is 100 times as common as the expected incidence when a feminizing tumor, particularly a thecoma, exists. The co-existence of mammary and endometrial cancers is 24 times as great in the presence of a feminizing tumor as would be expected from chance alone. Such evidences, while not conclusive, suggest that estrogens may cause endometrial cancer. The concept of the woman who is prone to endometrial cancer has been developed at length, because earlier detection of endometrial cancer will be achieved if we direct our energies toward such cancer-prone individuals.

Approximately two-thirds of all patients who develop endometrial cancer have passed the menopause. Their presenting symptom is post-menopausal bleeding. This is frequently neglected by the patient who feels that she is rejuvenated or by the doctor who may attribute it to some superficial cause such as atrophic vaginitis. Post-menopausal bleeding cannot be overlooked. Fifty per cent is due to cancer. It must be promptly investigated. The patient who has the dramatic reappearance of bleeding after the menopause is fortunate compared with the younger woman who has irregular bleeding while still menstruating. Such bleeding may be ascribed to "change of life" without further investigation. The most grievous delays are incurred in this younger group. A current problem is withdrawal bleeding a few days after the cessation of estrogens. If it occurs in orderly fashion at the customary time, it may be attributed to withdrawal but any variations from an orderly pattern warrant investigation.

Diagnosis is all important. It seems platitudinous to insist that diagnosis be made prior to the institution of treatment but the press of events in modern life frequently encourage the easier approach of treatment first to see what will happen. Our diagnostic armamentarium consists of smear, endometrial biopsy and curettage. Smears are desirable in screening procedures, but their accuracy is only 70 to 85 per cent in the detection of endometrial cancer. Scheffey[52] and Fremont-Smith[53] have reported 30 per cent failures with smears, while Cuyler[54] et al have observed a 16 per cent incidence of false negative reports. The location from which smears are obtained is most important. Smears obtained by aspiration from the endometrial cavity are more accurate than samples of the entire vaginal detritus. A positive smear needs confirmation while a negative smear has a 16 to 30 per cent chance of error. Hence smears which are most desirable in the detection of cancer of the cervix do not achieve that degree of accuracy in the detection of endometrial carcinoma.

Endometrial biopsy may be used. Its simplicity, the fact that it may be done in an office without anesthesia, and its cheapness recommend it. But when we consider how much of the endometrium still remains in the uterus even after the most thorough of curettages performed under anesthesia, the inadequacies of the biopsy which at best can onlp sample the endometrium, are evident.

The indispensable means of diagnosis is curettage. Curettage is mandatory in all cases of irregular excessive menstruation. Thoroughly performed curettage will yield the diagnosis in almost all cases, but errors in diagnosis may occur as outlined elsewhere by Finn[55] (1) The uterus may be perforated, (2) The internal os may not be dilated, hence only endocervix is curetted, (3) the cancer may be in an inaccessible part of the uterus such as a cornu, (4) a polyp or submucous myoma may protect the cancer from the curette, (5) hematometra may simply be drained without curettage, and (6) discovery of an obvious cause of bleeding may lead to the deferment of thorough investigation.

Hysterography has been advocated, chiefly by European authors. We have had little experience with this technique and doubt that it will replace a thorough curettage. Similarly hysteroscopy has been suggested by Norment[56]. This is still an experimental stage and will not supplant the curettage. Curettage will remain the indispensable means of diagnosis for cancer of the endometrium.

SARCOMA OF THE ENDOMETRIUM

Sarcoma of the endometrium is the only sarcoma of the female genital tract which is common enough to warrant mention. When located in the endometrium, its chief symptom is excessive menstruation or post-menopausal bleeding. When located in a myoma or in the myometrium, the myoma is observed to grow or a mass develops or pain appears. These symptoms indicate the need for curettage and hysterectomy. Since radiation is of little value, our sole hope of improving the survival of patients with sarcoma is to detect them so early that the sarcoma is still confined to the uterus and hence can be eradicated by hysterectomy. Surgical tours de force for more extensive sarcomas do not improve the results.

CANCER OF THE OVARY

Ovarian cancer is hardly ever detected in an early stage. It is usually in a metastatic phase before symptoms ocur. Frequently delays in diagnosis occur even after symptoms appear. Diddle[57] in collating the statistics of Dallas, Texas, observed eight months between the onset of symptoms and the establishment of the true diagnosis.

Frequent routine pelvic examinations with careful palpation of the adnexal masses will help to detect incipient asymptomatic ovarian cancers. It would be well to perform a pelvic examination as part of the general physical examination in every woman, particularly after an arbitrary age, perhaps of 30. The discovery of any adnexal mass should then lead to thorough examination under anesthesia. The adnexal organs should be investigated at every laparotomy, even though no symptoms have been present in the pelvic area. For practical purposes, the only ovarian cancers which are detected early are ovarian cancers which are unexpectedly found during the course of a laparotomy for another indication. Developing this vein further, routine prophylactic oophorectomy has been recommended when hysterectomy is performed at or after the age of 45. The sudden appearance of ascites in a woman renders paracentesis mandatory. Bloody ascitic fluid or fluid of high specific gravity is suggestive of ovarian cancer. A careful pelvic examination immediately after paracentesis may lead to the discovery of ovarian tumors which had been hitherto obscured by the presence of fluid. Cytological smears of the fluid clinch the diagnosis. Peritoneoscopy and culdoscopy have not been helpful in our hands. We prefer an adequate abdominal incision which permits inspection, palpation and the obtaining of copious biopsies from the original tumor as well as from metastatic locations such as the omentum.

CANCER OF THE TUBE

The prospects of early diagnosis of cancer of the fallopian tube are equally dismal. Only two tube cancers in the group of about 500 have been diagnosed preoperatively. Tubal cancer is rarely recognized in the operating room or at gross pathological examination and is usually first diagnosed on microscopic examination. The adnexal organs should be carefully palpated during every routine physical examination, at each annual check, and at the time of pelvic examination under anesthesia. They should be inspected or palpated during the course of every laparotomy. Vaginal and cervical smears have contained anaplastic cells from the tube as reported by Finn and Javert[58] and others. Hysterosalpingography has been suggested as a means of diagnosis, but seems to us a fallible and potentially dangerous procedure. One problem encountered in our review of the tube[58] cancer was the occurrence of repeatedly negative curettages in the presence of post-menopausal bleeding. Two of our patients with cancer of the tube exhibited this. Subsequent laparotomy revealed a tubal cancer as the source of the bleeding. The

problem of early diagnosis of cancer of the ovary and tube is one of the most discouraging in the entire field of gynecology.

CANCER OF THE VULVA

A more encouraging outlook is present in cancer of the vulva, where we are dealing with an exposed surface of the body. Here prophylactic gynecology can be influential in the prevention of cancer since about one third of all vulvar cancers have an antecedent leukoplakia. The treatment of leukoplakia is unsatisfactory, but simple excision deserves consideration since it achieves the additional result of removing a potential site of cancer development.

Early cancer of the vulva can be detected by inspection, palpation and biopsies. All but the most rapidly developing vulvar cancers should be detectable in a premetastatic stage. Cancer may develop in Bartholin's gland, but the biopsy of the ulcer or the mass permits rapid diagnosis. Cancer may also develop in the urethra. Hematuria and dysuria occur early, so that smear and biopsy facilitate ready recognition.

CANCER OF THE VAGINA

Cancer of the vagina may be asymptomatic, but more commonly manifests itself by vaginal discharge which may be blood stained or by bleeding. This discharge or bleeding may be intermittent. Inspection, palpation, vaginal smear and biopsy are the steps in diagnosis. It is perhaps well to regard every vaginal cancer as metastatic until primary lesions have been excluded elsewhere.

CHORIONEPITHELIOMA

An unique cancer arises in the female genital tract—chorionepithelioma. This cancer represents malignant change in the cells of the chorion of the placenta. It usually follows a hydatidiform mole, but may occur after an abortion or after a term delivery. Three indicators alert us to the possibility of a chorionepithelioma: (1) the persistence or re-occurrence of bleeding after a mole, an abortion or a delivery, (2) subinvolution of the puerperal uterus, and (3) persistently positive gonadotrophic titres or the reappearance or an increase in gonadotrophin titres. Chroionepithelioma is rarely detected in a premetastatic stage. Its rarity and the reluctance of the doctor to perform hysterectomy in the young woman usually delay the diagnosis until after metastates to liver, lungs and brain preclude any hope of cure. Curettage is of dubious value in diagnosis since chorionepithelioma is a myometrial lesion which frequently cannot be detected by curettage. The history of bleeding, the feeling of subinvolution and the reappearance or increase in gonadotrophin titres are more important than a negative curettage. More recently hysterotomy and biopsy as tried by Javert[59] shows promise and deserves further trial.

Metastatic Lesions of the Genital Tract

Such lesions can be diagnosed by the appropriate means of diagnosis for the organ in which the metastasis lodges. Investigation of the bladder or rectum may be necessary to detect a primary site in these locations. A gastro-intestinal series will be helpful in the diagnosis of a primary stomach cancer which spreads to both ovaries. Hypernephroma has a predilection for the vagina as shown by Martzloff[60]. Hence, our examinations should be thorough and the commonness of primary lesions of the genital tract should not blind us to the possibility of metastases.

SUMMARY

Our desideratum is to detect cancer in so early a stage that the survival rate will approximate 100 per cent. There is little hope of this at the present time with respect to cancers of the ovary and of the tube, chorionepitheliomas or metastatic lesions from other organ systems. But cancer of the cervix, of the endometrium, of the vulva and of the vagina can be detected in earlier stages. This involves the acceptance of the in situ concept of cancer with a dormant asymptomatic period during which it can be

diagnosed while still confined to the surface epithelium. It requires frequent prophylactic physical examinations. It demands the use of the smear and biopsy in a routine screening fashion. To be practical it forces us to concentrate our efforts on groups of women who are more prone to cancer than are the general population. Our hope of detecting genital cancer in treatable premetastatic stages lies in both the prompt use of the existing diagnostic tests when symptoms are present and in their routine use as screening techniques when symptoms are not present.

TABLE I (Hayman[4])

Annual Report—Cancer of Uterine Cervix Vol. VII, 1952

Stages Apparent	Number of Patients Treated	Per cent by Stages	Five-year Survival with no Evidence of Disease	Relative Recovery Rate %
1	10,582	16.5	6,214	58.7
2	23,190	36.1	9,268	40.0
3	22,911	35.7	5,000	21.8
4	7,529	11.7	478	6.3
Unclassified	24	-------	3	-------
Total	64,236	-------	20,963	32.6

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LADIES OF THE ORDER OF THE EASTERN STAR FREE CANCER DRESSINGS

The supply of free cancer dressings for those for whom the cost of dressings may be a difficult burden has been a major humanitarian project of the Order of the Eastern Star for several years.

At present there are 36 stations throughout the Province working to make and supply these dressings. In some cases, although sufferers could pay for dressings without being unduly burdened, special dressings are required, such as could not be purchased in the ordinary way. In these cases special dressings will be made and supplied to meet special requirements, as advised by the medical and nursing attendance.

For these special dressings, and also for ordinary dressings, it must be clearly understood that no payment will be accepted. On occasion patients may wish to show their gratitude in some tangible form, and a donation to further this work of the Order of the Eastern Star will not be refused. It hardly needs repeating that this service is rendered to all cancer patients without regard to Colour, Race or Creed.

This notice is being published because although the medical profession has in the past been circularized with full information, it has been observed that many cancer patients and their doctors are as yet unaware of this valuable and humanitarian service, which is at the disposal of them all.

Dressings may be applied for by doctors, V.O.N. or Public Health Nurses or other authorized medical attendants at the local Dressings Station or the Headquarters at 2586 Heather Street, Vancouver.

We would call special attention to this notice, which will be a help to many medical men, and above all will mean a great saving in expense to cancer patients who require dressings. The work of these ladies is most worthy of our appreciation and the best way we can show this is by using the service they so generously supply. ED.

NOTICE

A panel discussion of the subject "Is Home Care a Solution to the Hospital Bed Shortage?" is to be held on February 26, at 8:00 p.m., at the T.B. Seal Auditorium. Dr. Stewart Murray, City Health Officer; Dr. Myron Weaver, Dean of the Faculty of Medicine; Mrs. Rex Eaton, O.B.E., President of the Provincial Council of Women; A. H. J. Swencisky, President of the B.C. Hospital Association, and Tom Alsbury, President of the Vancouver Trades and Labour Council, will take part in the discussion.

The annual meeting of the Victoria Order of Nurses will take place following the panel discussion.

British Columbia Division
Canadian Medical Association

1807 West 10th Ave., Vancouver, B.C. Dr. G. Gordon Ferguson, Exec. Secy

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VANCOUVER—POST GRADUATE CENTRE

In considering post graduate courses, I have recently been impressed by the excellent opportunities in this regard, offered by our city. Let us consider them a moment, I am sure they will give you a sense of achievement.

Any week at all, there are many activities going on. Look at the third page of this journal and you will see regular weekly fixtures at different hospitals. In addition to these, there are the Out Patient Clinics at the Vancouver General, St. Paul's, and Children's Hospitals, five days a week, at which any visiting doctor is welcome to go and observe or even take part. In this way it means that any week one could visit Vancouver and arrange a very full and satisfying period of instruction. It is these basic week by week activities that make a centre really important.

Of course all medical centres have "specials", and Vancouver is no exception in this regard. Let us look at a few: The Vancouver General Hospital puts on frequent refresher courses of different categories—if you are not now receiving their notices I suggest you might contact them, for you will find these excellent concentrated features along some important points of the various subjects undertaken. The V.M.A. has an interesting medical conference every Tuesday evening at the various hospitals. Then of course there is their highlight, the annual summer school, which is certainly one of the best short courses available anywhere. You will be finding further information on this subject in the Bulletin each month. Your provincial association also has an annual meeting every fall, with excellent clinical material. Again note the dates on the cover of this Bulletin. All these are most excellent opportunities for study or refresher training.

However, in addition to this, there are the activities of each section—for example, the B.C. Surgical Society is having a two day meeting on the 25th and 26th of April. The B.C. Society of Internal Medicine is having an all day meeting on the 28th of March, while each other section has meetings and the clinical portions of all of these are open to you.

While most of these Specialist Societies, whether provincial or extending beyond, are open only to those qualified in the particular field, there has recently been formed an international group to which any doctor may belong. This was formed in 1950, with members from Northern California, Oregon, Washington, Idaho, and British Columbia. It is essentially for the dissemination and integration of medical knowledge in the north west. The medical schools in Seattle, Portland, and Vancouver supply the impetus and papers, but the greatest number of members are those who come to listen and learn. There has been one meeting in each of the university centres, with a second this year in Seattle. Next year the meeting will be in Vancouver. The subjects considered at these meetings cover all of medicine and the speakers have included professors of medicine at each of the universities, professors of pathology, radiology, surgery, obstetrics and gynecology, plus departmental heads in almost all branches. Dr. E. Christopherson is the president this year and is in charge of arranging the meeting in Vancouver next spring. Here is your chance to join an international organization—the North West Society for Clinical Research.

F. L. SKINNER, Editor.

RADIO BROADCASTS—Your Public Relations committee feels that you may not all be able to hear all the programmes so we are reproducing a sample. You will see here that our object is to try to make it interesting to the public by giving them authentic information on purely medical subjects, and intersperse these programmes with others which we feel are more important to us as a profession. Our announcer in all these is Mr. Dorwin Baird of CJOR.

DOCTORS' VIEWPOINT

Tuesday, January 20, 1953—"HEALTH INSURANCE"

BAIRD—This is, the Doctors' Viewpoint. Each week at this time your doctor, through the British Columbia Division of the Canadian Medical Association, presents a program giving the doctors' viewpoint on various medical matters. Tonight the subject of our discussion will be Health Insurance, and our speaker will be Dr. John A. Ganshorn, president of the B.C. Division. Many Canadians have recently been asked to sign a petition being circulated throughout the nation, which calls for *state* health insurance. Tonight, and in other broadcasts in future weeks, your doctor will discuss health insurance. Perhaps Dr. Ganshorn, you could give us the doctors' viewpoint on this question from a policy point of view—and then we can go into details.

DOCTOR—The Canadian Medical Association, as long ago as 1942 approved the adoption of the principle of health insurance. We are not in favor of state health

insurance however, because politics and health don't mix, and because government with its bureaucracy would cause deterioration in the standard of medical care. Health insurance, to our way of thinking, is a cooperative effort to pool resources and utilize all our medical facilities to the utmost, and to assure that the relationship between patient and doctor is one that will foster even greater development of the service and make certain that medical advance will not be stifled.

BAIRD—Since you do not favor a government plan, have you an alternative?

DOCTOR—We have done, and are doing, a great deal about health insurance plans. We have inaugurated local or provincial plans along the lines which we believe can be the answer to the very reasonable demand for coverage for all people. A plan of this sort would be sponsored by the doctors, just as M.S.A. in B.C. was first sponsored by the doctors, but in the same way, the plan would not necessarily be run by the doctors.

BAIRD—What are the more important points of your plan?

DOCTOR—There are four of them I should mention here. One—the patient must have a free choice of doctor. Second, there must be no interference in the patient-doctor relationship. Third, it should be a contributory type of insurance, and fourth, the fee for service basis of payment to the physician should be used.

BAIRD—Your points, I gather, leave an important element of private enterprise and personal initiative in the picture.

DOCTOR—Definitely, and they leave the individual with responsibilities with regard to his own health.

The free choice of doctor, and the payment of a fee for each service, continues to encourage better doctors. It also encourages the steady development in medicine that we have had in the past half century. Physicians naturally vary in their capacity to work, as well as in their professional abilities. Fee for service in the only way to allow different compensation for these personal characteristics. Each doctor is paid in proportion to his effort. We believe this to be the only reasonable method.

BAIRD—I can see where the free choice of a doctor benefits the patient too.

DOCTOR—It certainly does. A patient must have faith in his doctor, and the foundation of that faith is the fact that he selected the doctor in the first place. Your faith might well be shattered now and then if you had to apply to a board or a government department for a family doctor selected by them. Certainly, the mutual confidence that is so necessary between doctor and patient might not always be there. Both the patient and doctor would be free under this system. The patient would be free to choose, and change doctors, and the doctor would be free to develop. He would not be a salaried civil servant.

BAIRD—You are, I understand, in favor of the regional plan idea rather than any national super-plan.

DOCTOR—We do feel that each province should have a plan, developed to suit its particular needs. Basic standards could be nation-wide. It's just that in the actual running of the plan we feel the government should keep hands off. A health scheme should never become a political football. It should be above politics. We believe that administration should be a joint effort by those rendering and those receving the services —and as far as policy is concerned in actual medical care, this should be the responsibility of the doctors.

BAIRD—There are those who say that a government health plan will almost automatically lead to a healthier nation.

DOCTOR—This just isn't true. We are becoming a healthier nation by leaps and bounds—and this is because of all the developments of the past few decades which have come about because of the system we now have. The medical profession has encouraged research, and health education—and both have been responsible for our progress to date. The road to a completely healthy nation is a long one. We are moving faster along that road today than at any other time in the history of mankind. We feel that the institution of any government health plan would slow down our

progress, not speed it up. As long as we have doctors with initiative, push and ambition, the standard of care and the health of the nation will continue to rise. Of those qualifications, initiative is the most important, for it has been the doctors of initiative who have given us our greatest medical advances. We feel that under a bureauocracy, initiative would be stifled, and the standards would deterioriate.

BAIRD—In this discussion, is there anything to be learned from the experience of medical men in the armed forces?

DOCTOR—Yes. In the armed forces treatment of the individual was not always personal because administrative demands sometimes dictated the treatment. In such a highly organized effort, the supply and inegration of an army, together with evacuation demands interfered with the individual. In civilian life this is not necessary and our plan can avoid these administrative and bureaucratic requirements.

BAIRD—What do you feel are the points in the health insurance petition mentioned earlier, with which you disagree?

DOCTOR—Two of the points in the petition, we feel, are far wide of the mark. In the first place, by advocating financing by general taxation, the proposal ignores the very important factor of personal responsibility. And second, I believe that we have discussed the disadvantages of *state* plans sufficiently tonight to answer that part of the petition.

BAIRD—I know that this field of health insurance is too broad for one broadcast, but could you give us a summary of the position that you have outlined tonight?

DOCTOR—Once again, the main point is that there are so many advances in medicine today that only by planning can the new things be made universally available at reasonable cost to the individual. We are therefore in favor of spreading this cost through health insurance. We are *not* in favor of state health insurance because we fear for the standards of medical care under such a political system of control. We do have a plan of our own, and the plan receives its strength by maintaining the present relationship between patient and doctor. We also keep the free choice of a doctor, and free choice of patient, and we advocate the payment of doctors on a fee for service basis. The fourth important point is that the individual can do so much to keep his mind and body in a healthy state that he must be left with considerable responsibility himself. Our interest today, as always, lies in seeing the standard of care continue to improve—and in this way our interests are the interests of every Canadian. An insurance plan is an ideal thing for Canada, but your doctor feels very strongly that a state plan, without responsibility by the individual, would fall far short of doing the job. In future broadcasts, other doctors will elaborate on this viewpoint, in order that it may be fully understood.

BAIRD—Tonight, the Doctors' Viewpoint has brought you a discussion on health insurance, with Dr. John A. Ganshorn, president of the B.C. Division of the Canadian Medical Association—sponsor of these weekly talks. Your doctor invites you to send in your comments on these broadcasts, and to be with us again next Tuesday evening, when the Doctors' Viewpoint will discuss various aspects of cancer, and its control in Canada. Listen again next week then, for another broadcast of The Doctors' Viewpoint.

DOCTORS' VIEWPOINT

Tuesday, January 27, 1953—"CANCER"

BAIRD—This is, the Doctors' Viewpoint. Each week at this time, your doctor, through the British Columbia Division of the Canadian Medical Association, presents a broadcast of discussion of medical matters in the news. From time to time on this series, we have discussed various diseases which themselves frequently become headline news. Tonight Dr. A. Maxwell Evans speaks for the doctors, on the subject of cancer. Perhaps the best way to start, Doctor, would be to get some definition of cancer.

DOCTOR—I suppose the best definition would be to say that cancer was a new growth or mass of tissue growing from normal cells which are altered by some unknown

process. The growth has no useful function. It continues to grow, and if it is not treated, it is fatal.

BAIRD—Is this one of the diseases recently discovered since the advances of medical science in this century . . . or is it older?

DOCTOR—We have evidence that cancer was known to the ancients. Our modern methods of diagnosis mean that we have more cases today than ever before, but that is largely because we have better ways of spotting cases. One other matter of interest right here, and that is that cancer is not selective. It affects every race . . . class . . . colour and age group. Indeed, we find it in plants and animals, too.

BAIRD—In plants? That seems strange.

DOCTOR—I'm sure you've seen trees with strange growths on them that seem to have no relationship to the tree itself. But don't get the idea that you can get the disease from plants or animals. Cancer most definitely is not infectious.

BAIRD—Does that mean you cannot induce cancer experimentally?

DOCTOR—No. Tumors have been produced experimentally. Two Japanese doctors did it back in 1914, dealing with rabbits. It has been produced in other instances too, but so far that has not led us very close to the knowledge of what cancer is. I think our present situation can be summed up by saying that we are learning more and more ways to discover cancer, and to either cure or treat it—but that our knowledge of the cause is still pretty sketchy. Doctors all over the world are trying very hard to get at the causes of the disease, but it is entirely possible that some day we will find a complete cure, without ever knowing everything there is to know about cancer itself.

BAIRD—In that case, I guess our best bet is to discuss some of those treatments now in general use.

DOCTOR—Yes—but first I should say that the secret of successful treatment is early discovery of the disease. If every person would realize the importance of going to their medical practitioner when they felt that something was wrong, we'd be able to start treatment earlier, and have just that much more chance of success.

BAIRD—You say . . . "when something is wrong." Do you mean, when pain is experienced?

DOCTOR—Not necessarily. Pain usually encourages an early visit to the family doctor, but pain does not always turn up as a symptom of cancer. In some cases, a tumour may reach a large size without any discomfort to the patient. What I mean is that a great many people notice lumps that have no explanation, or cracks or sores that do not heal, or other unusual things happening to their bodies that are not always painful. Sometimes people with these conditions may suspect cancer, but for some reason a certain kind of person will hesitate to go to his doctor. I think perhaps these people have a fear of cancer. By this fear they put off diagnosis and treatment until the condition is advanced. We doctors suggest that since the odds are against it being cancer, that the best thing to do is allow your doctor to examine you and either set your mind at rest, or if cancer is present, start a treatment that will arrest the tumour in its early stages. Your doctor has a wide range of tests available to him now. He has the means, in other words, to spot the early development of most types of cancer. That is why I believe that a person with any reason to believe that something is wrong with him should see his doctor. It might not be cancer. Chances are it isn't . . . but it still might be another condition that should be checked and treated.

BAIRD—Is this possibility of early diagnosis a pretty general rule?

DOCTOR—Yes, although there are exceptions. There are also exceptions to the rule that we can arrest cancer when we find it soon enough. It's that kind of a disease. Our fight against it has made tremendous strides, but there is a great deal yet to be learned. We can say though, that the majority of cases respond to early treatment . . . the earlier the better.

BAIRD—Which brings us to the subject of treatment itself.

DOCTOR—This falls into two fields, surgery and radiation. Surgery can be very effective in many cases. Removal of the tumour is naturally a very efficient way of

getting rid of it, provided of course that vital parts of the body do not have to be removed too. In the past twenty-five years surgery has advanced a long way, due to better methods of anaesthesia, the discovery of antibiotics, the availability of blood, and so on. Along with this general advance in surgery has gone an advance in surgery for cancer conditions . . . but as I said, there are some limitations.

BAIRD—In mentioning radiation, I presume you mean X-rays, radium treatment, and radioactive isotopes such as the Cobalt Bomb?

DOCTOR—The X-rays, discovered by Roentgen in 1895, were in use a few years later. About that time, the Curies discovered Radium, and we stayed at that stage until the discovery of the Radioactive Isotopes, which now could be said to be a by-product of the atom bomb. Personally I feel the curative uses of these by-products are far more vital to the future of Man than any other aspect of atom-smashing.

BAIRD—What is the basis of radiation treatment, Dr. Evans?

DOCTOR—It is based on one very important fact—the ability of these radiations to destroy cancer cells without destroying normal tissue. This is important, because you can very easily appreciate what would happen if both cancer and everything else in the path of the ray were to be destroyed. It is also important to point out that some tumours are only partially sensitive to radiaion, while some others do not react at all. The Cobalt Bomb has given us what might be called a powerful source of radiation but it is still new enough that we do not know all of its capabilities, nor have we yet discovered all of its limitations. We do know enough about it to say that Canada deserves to be proud that this instrument was devised in this country.

BAIRD—Considering all the various treatments now in use, and the research work now being done in the cancer field, have you any special remarks regarding the future of Cancer control?

DOCTOR—A complete solution to the problem of cancer seems at the moment to be an extremely complex one. As we have pointed out, a great deal of research is now going on. Perhaps the eventual solution may be found to be quite simple—as has been the case in other diseases we have brought under control. However, the present day picture is considerably brighter than that of a quarter century ago. The disease can be cured and controlled in a large measure, with the fullest use of present day methods. We are looking forward to the day when it can be completely controlled, and we have every reason to believe that day is coming. In the meantime, may I urge once again that all persons give themselves a break by reporting to their doctors when any suspicious developments occur that could possibly be cancer, or any other disease.

BAIRD—Thank you, Dr. Evans. Tonight the Doctors' Viewpoint has presented a discussion of some aspects of Cancer, with Dr. A. Maxwell Evans as our guest. These broadcasts are presented by your doctor, through the B.C. Division of the Canadian Medical Association. Your doctor invites you to be with us again next Tuesday evening for another broadcast of The Doctors' Viewpoint.

NOTICE

Proposed Section of Physicians in Public Service of the Canadian Medical Association, B.C. Division.

On April 9th at 8:15 P.M. in the Christmas Seal Auditorium at Tenth and Willow, a meeting will be held to discuss the formation of such a Section. The Canadian Medical Association, B.C. Division, has signified its approval of such a step.

All Physicians and Surgeons employed full or part time in an institution or with a government department are urged to attend.

THE CANADIAN MEDICAL ASSOCIATION

135 St. Clair Avenue West
Toronto 5.

January 30, 1953.

TO THE SECRETARIES OF THE DIVISIONS

RE: NEW IMMIGRANTS

Our attention has been drawn to the fact that a number of immigrants coming to Canada have been found shortly after their arrival to be physically and mentally unfit.

The question has been asked of this office, "Do the medical examiners abroad carry out their task as thoroughly as they should?"

It will be appreciated if you will let me know of any instances which came to your attention in your own province which would suggest a tightening-up policy healthwise in respect to Canadian immigration, especially from European countries.

Yours sincerely,

T. G. ROUTLEY,
General Secretary.

Since no comments in this regard have been heard by the secretary, the letter is published in the hope that any practising physician in British Columbia who has encountered any evidence of sick immigrants being admitted to Canada, will advise the office of C.M.A., B.C. Division, of their experience.

NOTICE

The special committee on Arthritis and Rheumatism wishes to announce that two pamphlets will be distributed shortly to the doctors of British Columbia. These have been published by the Canadian Arthritis and Rheumatism Society as a service to you and your patients, this initial free distribution being made possible by a grant from the B.C. Department of Health under the Federal Health Grant programme.

The pamphlet, "What You Should Know About Arthritis," contains general information about rteumatic diseases for laymen.

The pamphlet, "Rheumatoid Arthritis — A Handbook for Patients", is designed to assist patients suffering from Rheumatoid Arthritis and Spondylitis to gain a better understanding of their disease and thus be better equipped to follow the general principles of treatment.

A small charge of ten and twenty cents respectively will be necessary for further pamphlets and, if more are desired, they may be obtained by your patients by writing to the Canadian Arthritis and Rheumatism Society, B.C. Division, 1093 West Broadway, Vancouver 9, B.C.

F. W. B. HURLBURT,
Chairman, Special Committee on
Arthritis and Rheumatism.

PUBLIC HEALTH AND MENTAL HEALTH NEWS

G. F. AMYOT, M.D., D.P.H.,
Deputy Minister of Health, Province of British Columbia

A. M. GEE, M.D.,
Director, Mental Health Services, Province of British Columbia

CYTOLOGICAL DIAGNOSTIC LABORATORY

A free cancer diagnostic and screening service is available at the Cytological Diagnostic Laboratory located at the B.C. Cancer Institute, Vancouver. This laboratory was originally set up in August, 1949, under a research grant from the Canadian Cancer Society, B.C. Division. Experience indicated that cytology service should be regularly available, and from November, 1950, therefore, this laboratory has been financed by the National Health Grant for Cancer Control and matching Provincial funds. The laboratory is under the direction of the Director of Pathology, Vancouver General Hospital.

At the time of its inception, this plan of having free cytological examinations available at only one centre in the province was the logical step in the early planning of this program. During the past year detailed consideration was again given to the question of whether or not this service should be absorbed into the biopsy service, that is, available at any general hospital where there is a certified pathologist, and it was decided that there should be no change. The British Columbia Association of Pathologists supported this decision by resolution at their annual meeting in September, 1952. However, it was also decided that this resolution would not prevent those pathologists interested in cytology from giving similar services in their hospital, if so desired.

The steady growth of the services given by the Cytological Diagnostic Laboratory is indicated by the following table:

Number and Result of Examinations
Three Years ended September, 1952

	Total	Positive	Suspicious	Negative
Year ended September, 1950	1,644	141	63	1,440
Year ended September, 1951	2,737	236	151	2,350
Year ended September, 1952	5,765	301	168	5,296

Of the 5,765 examinations done during the 12 months ended September, 1952, the anatomical source was cervical in 76 per cent of the examinations, pulmonary in 15 per cent, exudates 5 per cent and miscellaneous 4 per cent.

A follow-up program has been developed. During the past year 2,026 patients with negative cytological reports have been followed for one year and 1740 have been followed for two years. Owing to pressure of work only first year follow-up of patients with negative reports has been done since August, 1952. In addition, 387 patients with suspicious or positive reports have been followed at two monthly intervals until confirmatory information or otherwise is located, and then copies of all pertinent pathological, autopsy or x-ray reports are acquired together with tissue slides. As the follow-up records of the 1951 cases were not closed until January, 1953, information on the results of the follow-up is not yet available.

STAFF NOTES

Dr. Stephen Carr has been appointed Director of the Skeena Health Unit with headquarters at Prince Rupert.

Dr. Duncan McC. Black has been appointed Director of the North Okanagan Health Unit with headquarters at Vernon effective February 1. Dr. Black was formerly Director of the Skeena Health Unit.

CIVIL DEFENCE

Attending the Second Western Regional Conference of Civil Defence Health Services at Edmonton, January 26, 27 and 28, 1953, were the following physicians from this Province:

Dr. A. D. McKenzie, Asst. Professor, Surgery, University of British Columbia, who participated in a Panel Discussion on First Aid.

Dr. John Sturdy, representing the B.C. Division, Canadian Medical Association.

Dr. T. H. Patterson, Chairman, Civil Defence Health Services Advisory Committee, British Columbia.

Dr. J. L. Gayton, Medical Health Officer, Victoria-Esquimalt Board of Health.

Dr. S. S. Murray, Senior Medical Health Officer, Metropolitan Health Committee of Greater Vancouver.

Dr. G. R. F. Elliot, Assistant Provincial Health Officer.

News and Notes

IMPORTANT NOTICE

The General Practitioners Section of the C.M.A., B.C. Division will hold a scientific session at Harrison, March 20th and 21st. Speakers will be Doctors J. F. McCreery, R. B. Kerr, Dean Myron Weaver, in addition to a guest speaker from Seattle. Details may be had from Dr. Howard Black, 925 West Georgia Street in Vancouver.

Dr. Samuel Bogoch is now doing post-graduate work at Harvard Medical School.

Dr. D. H. T. Lee is now studying radiology at Sunnybrook Hospital in Toronto.

Dr. J. C. Kovach of Vancouver is now in surgery at Bellevue Hospital in New York. *Dr. Murray Enkin* is also in Obstetrics there.

Dr. Elizabeth Mahaffy is now working on her M.P.H. degree at the University of California in Berkely.

Dr. A. J. Venables is now in residence in pathology at the Tacoma General Hospital.

Dr. A. J. Kergin is now in general surgery in New Westminster.

Dr. A. McMurchy is now in the department of Anesthesiology at the Vancouver General Hospital.

Dr. J. G. McPhee is now radiologist at the Royal Columbian Hospital in New Westminster.

Dr. W. L. Sharp is now practising internal medicine in West Vancouver.

Dr. J. L. Danto is now practising in South Granville, Vancouver, B.C.

Dr. A. C. McKenna from Ireland has joined the staff of the Victoria Tuberculosis Division.

Dr. and Mrs. S. Janowsky of Victoria have returned from a trip through California and Mexico.

Dr. and Mrs. S. Avren of Victoria have returned from a motor trip through the West Coast and Mexico.

Dr. R. E. Burns of Victoria attended the annual meeting of the American Academy of Dermatology in Chicago last month.

Dr. J. K. Clokie, formerly of the Vancouver General Hospital, is now practising in Vancouver Cambie district.

Dr. B. R. Mooney is now practising on West Broadway in Vancouver.

Dr. M. Murray is now pathologist at St. Joseph's Hospital in Victoria.

Dr. H. A. Ort is now practising in North Vancouver.

Dr. R. C. Pronger is now in association, in otolaryngology, with *Dr. R. S. Grimmett* of Vancouver.

Dr. T. K. Stevenson, former surgical resident at the Vancouver General Hispital, is now practising in New Westminster.

Dr. J. W. Hunt is now associated with *Dr. J. G. Patterson* of Victoria.

Dr. R. D. R. Sargent is now practising at Port Renfrew.

BIRTHS

To *Dr. and Mrs. John Roe* of Victoria, a daughter.

To *Dr. and Mrs. D. A. Hewitt* of Victoria, a daughter.

To *Dr. and Mrs. T. K. Stevenson* of Vancouver, a daughter.

To *Dr. and Mrs. G. R. Barrett* of Nelson, a daughter.

To Dr. and Mrs. S. Kaplin, of Vancouver, a son.

To Dr. and Mrs. L. E. Ranta, of Vancouver, a daughter.

To Dr. and Mrs. Ken Boyce, of Vancouver, a daughter.

To Dr. and Mrs. M. K. Allen, of Vancouver, a son.

ENGAGEMENTS

Dr. W. D. Panton of Vancouver to Miss Mabel Robinson of Alert Bay.

FOR SALE

Four room outside office suite in the Medical Dental Building. Built in fixtures. Modern furniture. Dictating unit, adding machine, Allison table, filing cabinets, typewriter, sterilizers, surgical instruments, scales, large centrifuge. Terms if desired. Selling with view to retirement. Apply 1022-925 Georgia Street West, Vancouver, or Telephone MArine 7848.

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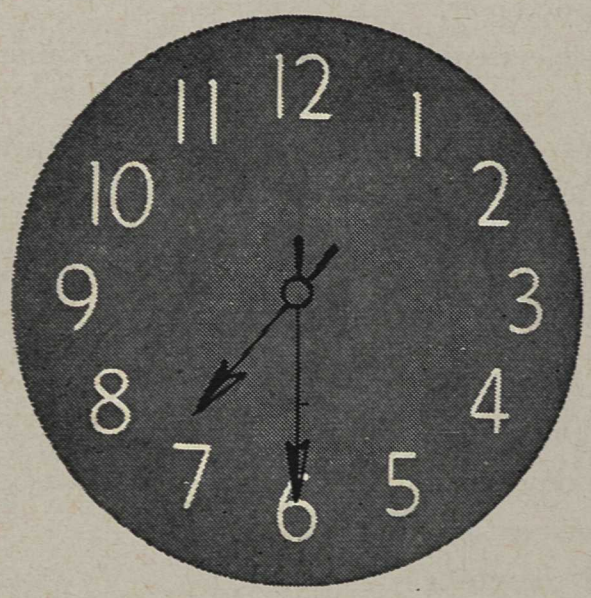

habit time

- Habit Time of Bowel Movement—not merely relief of constipation—is secured by proper use of Petrolagar.

  Petrolagar promotes development of normally hydrated, comfortable and easily passed stools.

  Once achieved, the normal bowel habit may often maintain itself even though the dosage of this adjuvant is slowly tapered off.

PETROLAGAR

PETROLAGAR PLAIN, PETROLAGAR WITH PHENOLPHTHALEIN, PETROLAGAR WITH MILK OF MAGNESIA AND PETROLAGAR WITH CASCARA

Supplied in bottles of 16 fl. ozs.

Wyeth

Registered Trade Mark