THE BULLETIN

OF

The Vancouver Medical Association

EDITOR

DR. J. H. MACDERMOT

EDITORIAL BOARD

DR. D. E. H. CLEVELAND — DR. J. H. B. GRANT
DR. H. A. DESBRISAY — DR. J. L. MCMILLAN

Publisher and Advertising Manager

W. E. G. MACDONALD

VOLUME XXVIII. JULY, 1952 NUMBER 10

OFFICERS 1952-53

DR. E. C. MCCOY, *President* — DR. D. S. MUNROE, *Vice-President* — DR. J. C. GRIMSON, *Past President*

DR. GEORGE LANGLEY, *Hon. Treasurer* — DR. J. H. BLACK, *Hon. Secretary*

Additional Members of Executive:
DR. G. R. F. ELLIOT — DR. F. S. HOBBS

TRUSTEES

DR. G. H. CLEMENT — DR. A. C. FROST — DR. MURRAY BLAIR

Auditors: MESSRS. PLOMMER, WHITING & CO.

SECTIONS

Eye, Ear, Nose and Throat

DR. B. W. TANTON ..... Chairman — DR. JOHN A. IRVING ..... Secretary

Paediatric

DR. PETER SPOHN ..... Chairman — DR. JOHN W. WHITELAW Secretary

Orthopaedic and Traumatic Surgery

DR. A. S. MCCONKEY ..... Chairman — DR. W. H. FAHRNI ..... Secretary

Neurology and Psychiatry

DR. R. WHITMAN ..... Chairman — DR. B. BRYSON ..... Secretary

Radiology

DR. R. G. MOFFAT ..... Chairman — DR. H. BROOKE ..... Secretary

STANDING COMMITTEES

Library

DR. J. L. PARNELL, Chairman; DR. D. W. MOFFAT, Secretary; DR. A. F. HARDYMENT; DR. W. F. BIE; DR. R. J. COWAN; DR. C. E. G. GOULD

Co-ordination of Medical Meetings Committee

DR. J. W. FROST ..... Chairman — DR. W. M. G. WILSON ..... Secretary

Summer School

DR. J. H. BLACK, Chairman; DR. J. A. IRVING, Secretary; DR. B. T. H. MARTEINSSON; DR. PETER SPOHN; DR. S. L. WILLIAMS; DR. J. A. ELLIOTT

Medical Economics

DR. E. A. JONES, Chairman; DR. G. H. CLEMENT, DR. W. FOWLER, DR. F. W. HURLBURT, DR. R. LANGSTON, DR. ROBERT STANLEY, DR. F. B. THOMSON

Credentials

DR. W. J. DORRANCE, DR. HENRY SCOTT, DR. J. C. GRIMSON

V.O.N. Advisory Committee

DR. ISABEL DAY, DR. D. M. WHITELAW, DR. R. WHITMAN

Representative to the Vancouver Board of Trade: DR. D. S. MUNROE

Representative to the Greater Vancouver Health League: DR. W. H. COCKCROFT

Published monthly at Vancouver, Canada. Authorized as second class mail, Post Office Department, Ottawa, Ont.

A tradition in infant feeding for 20 years

the quality and dependability of PABLUM *cereals*

A MULTI-GRAIN cereal and three single-grain cereals share the Pablum* heritage of quality.

Uniform texture and maximum digestibility as well as high nutritional values are assured by careful Pablum processing.

Vitamins and minerals from natural sources are incorporated in Pablum Mixed Cereal, Pablum Oatmeal and Pablum Barley Cereal. Pablum Rice Cereal, with crystalline vitamins, has special advantages of hypoallergenicity.

Recent improvements in Mead's exclusive manufacturing process bring out more than ever the rich, full grain flavors of all the Pablum cereals.

Older children as well as infants will like these 4 cereals and welcome the variety they provide.

You may prescribe Pablum cereals with *confidence*.

The Pablum packages, designed for superior protection and convenience, have the exclusive "Handy-Pour" spout.

MEAD'S

MEAD JOHNSON & CO.
OF CANADA, LTD., BELLEVILLE, ONT.

*Registered Trademark

LOCAL REPRESENTATIVE: RONALD TURNER, THE BRANCHES, CALEDONIA AVENUE, DEEP COVE 2261

VANCOUVER MEDICAL ASSOCIATION
PROGRAMME FOR THE FIFTY-THIRD ANNUAL SESSION

Founded 1898; Incorporated 1906

The Regular Monthly Meetings of the Vancouver Medical Association are discontinued for the summer months, but will be resumed in October.

VANCOUVER GENERAL HOSPITAL

Regular Weekly Fixtures in the Lecture Hall

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)

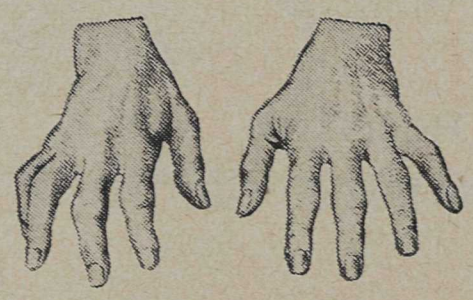
Alternate Fridays—8 a.m.—Surgical Conference

Friday—9 a.m.—Dr. Appleby's Surgery Clinic

Friday—11 a.m.—Interesting Films Shown in X-ray Department

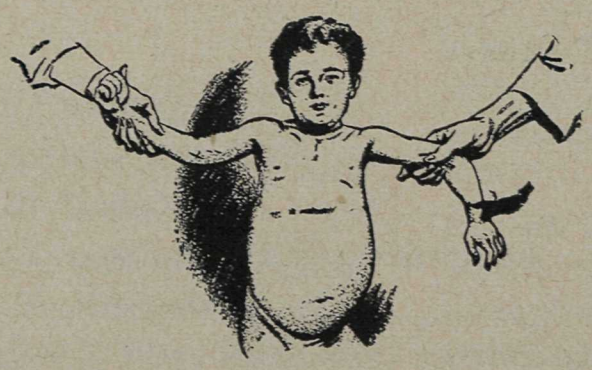
NEW *5-mg. Tablets of* Cortone*

For accurate adjustment of Maintenance Dosage and for therapy in conditions responding to Low Dosage



RHEUMATOID ARTHRITIS

ADDISON'S DISEASE



ADRENOGENITAL SYNDROME

FOLLOWING BILATERAL ADRENALECTOMY

Advantages of 5-mg. Tablets

FLEXIBILITY—

Used alone or in conjunction with the 25-mg. tablets, the new 5-mg. tablets afford greater flexibility in adjusting dosage to the individual patient's requirements. Fluctuations in the natural course of rheumatoid arthritis may be better controlled.

ACCURACY—

Permit more accurate establishment of minimum maintenance doses, thus controlling symptoms more closely and further minimizing the incidence of undesirable physiologic effects.

ECONOMY—

Prevent waste of CORTONE by more exact correlation between requirement and dosage.

Literature on Request

Cortone*

ACETATE

(CORTISONE ACETATE, MERCK)

---

*CORTONE *is the registered trade-mark of Merck & Co. Limited for its brand of cortisone. This substance was first made available to the world by Merck research and production.*

MERCK & CO. LIMITED

Manufacturing Chemists

MONTREAL · TORONTO · VANCOUVER · VALLEYFIELD

SHAUGHNESSY HOSPITAL

Regular Weekly Fixtures

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

BRITISH COLUMBIA CANCER INSTITUTE

685 West Eleventh Avenue,
Vancouver 9, B.C.

SCHEDULE OF WEEKLY CLINICAL MEETINGS

Monday—9 a.m. - 10 a.m.—Ear, Nose and Throat Clinic
Tuesday—9 a.m. - 10 a.m.—Weekly Clinical Meeting of Attending Medical Staff
Tuesday—10:30 a.m. - 11:30 a.m.—Lymphoma Clinic
Daily—11:45 a.m. - 12:15 p.m.—Therapy Conference

B.C. SURGICAL SOCIETY

Spring meeting—April 25th, 26th, 1952.

VANCOUVER HEALTH DEPARTMENT
STATISTICS — MAY, 1952

Total population—census figure (final) 344,833
Chinese population 7,117

	May, 1952	
	Number	Rate per 1000 pop.
Total deaths (by occurrence)	357	12.4
Chinese deaths	15	25.3
Deaths, residents only	319	11.1

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

	May, 1952	
Male	505	
Female	439	
	944	32.9

Infant Mortality—residents only

	May, 1952
Deaths under 1 year of age	9
Deathe rate per 1000 live births	13.6
Stillbirths (not included in above item)	11

CASES OF COMMUNICABLE DISEASES REPORTED IN CITY

	May, 1952		May, 1951	
	Cases	Deaths	Cases	Deaths
Scarlet Fever	90	—	95	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Chicken Pox	194	—	195	—
Measles	147	—	155	—
Rubella	21	—	99	—
Mumps	89	—	39	—
Whooping Cough	1	—	18	—
Typhoid Fever	—	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	3	1	—	—
Tuberculosis	47	7	38	8
Erysipelas	1	—	—	—
Meningitis	—	—	—	—
Infectious Jaundice	—	—	—	—
Salmonellosis	—	—	8	—
Salmonellosis Carriers	—	—	—	—
Dysentery	—	—	1	—
Dysentery Carriers	—	—	—	—
Tetanus	—	—	—	—
Syphilis	11	3	12	1
Gonorrhoea	149	—	147	—
Cancer (Reportable Resident)	82	62	80	42

CONNAUGHT

LIVER EXTRACT INJECTABLE

(20 MICROGRAMS OF VITAMIN B_{12} PER CC.)

Liver Extract Injectable is prepared specifically for the treatment of pernicious anaemia. The potency of this product is expressed in micrograms of vitamin B_{12} as determined by the Lactobacillus leichmanii test. Liver Extract Injectable as prepared in the Connaught Medical Research Laboratories

—contains 20 micrograms of vitamin B_{12} per cc. derived directly from liver.

—is carefully tested for potency.

—is low in total solids and light in colour.

—is very highly purified and therefore can usually be administered without occurrence of discomfort or local reactions.

Liver Extract Injectable (20 micrograms of vitamin B_{12} per cc.) is supplied in packages containing *single* 5-cc. vials, in multiple packages containing *five* 5-cc. vials, and in 10-cc. vials.

Dry Liver Extra for Oral Use is supplied in packages containing ten vials; each vial contains extract derived from approximately one-half pound of liver.

\+ \+ \+

CONNAUGHT MEDICAL RESEARCH LABORATORIES
University of Toronto **Toronto, Canada**

Established in 1914 for Public Service through Medical Research and the development of Products for Prevention or Treatment of Disease.

DEPOT FOR BRITISH COLUMBIA

MACDONALD'S PRESCRIPTIONS LIMITED

MEDICAL-DENTAL BUILDING, VANCOUVER, B.C.

The Editor's Page

We read with interest the recent announcements in the Press of a report by Premier Johnson, in which he announced that the B.C. Hospital Insurance Scheme, during the past year had accumulated a surplus of three million dollars. This is a very satisfactory state of affairs, and reflects a great deal of credit on those who have had the very difficult, and often unpleasant, task of administering the Scheme. It will make the case for hospital insurance in the Province a great deal stronger, and will justify to a great extent the measures taken to make it function efficiently.

It gave Premier Johnson too a chance to pat co-insurance on the back, as a very good thing. He is reported to have said that it saved money by cutting down days' stay. We doubt this very much, as far as the saving of money goes—since the moment a patient goes out, in most of our hospitals, another immediately goes in. Perhaps it helps that way—by giving more people a chance to get hospital beds.

But we should like to see the actual figures about days' stay. We seem to have seen cases where it worked the other way—since once the ten days' co-insurance was paid, the patient was in no hurry to leave. He felt he had some time coming to him. We have often wondered whether it would not be a more effective deterrent to apply co-insurance only after, say a week or ten days of hospital stay. Then it would be easier to persuade people that they were well enough to go home. It would not, of course, be as easy to apply it that way.

Our new rulers have stated that they intend to abolish the compulsory clause, and make hospital insurance voluntary. One speaker said more people would join if it was voluntary. Unless the vote in June, 1952, means a very fundamental change in human nature in British Columbia, we do not think this will turn out to be the case. If hospital insurance is put on a voluntary basis, we feel that two things will happen, at least. One is that it will have to go up very greatly in price. The only reason hospital insurance could be offered at the ridiculously low rate charged (low as compared with any type of voluntary insurance) was that it took in everybody—good risks, bad risks and all. If it is left on a voluntary basis, with no compulsion, many people will simply wait till they see trouble ahead, and then take it out. This would overload and swamp any scheme at all.

Another thing we see in the crystal ball is utter chaos for the unfortunate hospitals—which, under the B.C.H.I.S., have been just beginning to get into clearer water. Now they won't know where they are and will have more bad debts than ever.

We think, for what our opinion is worth, that B.C.H.I.S. is and has been a magnificent piece of work in many ways: the principles on which it was founded are the right principles. There have been many mistakes in its application; the price was set too low at first; not enough advice was sought from those who knew—and there was often a lack of frankness, and a disregard of the public feeling. But these things can all be remedied, and the scheme has been of enormous value to the people of British Columbia, and must be perpetuated, with what improvements and modifications are necessary. We do not, frankly, believe it can be done on a voluntary basis—but time will show, and we must give our new government all the help and support we can, as long as they deserve it.

Meantime, we feel that B.C.H.I.S. will be a monument to the late Coalition Government of B.C., which, with all its faults and mistakes, yet has given British Columbia some magnificent social legislation. The new government has some very fine foundations to build on: let us hope they will build worthily and well.

Library Hours During the Summer Months:

Monday to Friday ..... 9:00 a.m. - 5:00 p.m.
Saturday ..... 9:00 a.m. - 1:00 p.m.

Recent Accessions

Brock, R. C., The Life and Work of Astley Cooper, 1952 (Nicholson Collection).

Eastman, N. J., Williams' Obstetrics, 10th edition, 1950.

Maxcy, K. F. (editor)—Rosenau's Preventive Medicine and Hygiene, 7th edition, 1951.

Medical Clinics of North America—Symposium on Endocrine and Metabolic Disorders, New York Number, May, 1952.

Ophthalmological Society of the United Kingdom, Transactions, 1951.

Peham, H. V. and Amreich, J., Operative Gynecology translated by L. Kraeer Ferguson, 2 vols., 1934 (gift).

Pugh, D. G., Roentgenologic Diagnosis of Diseases of Bones, 1950.

Wolff, H. G., and Wolf, S. G. jr., Pain, 1951.

World Health Organization, Pharmacopoea Internationalis, Vol. 1, 1951.

An interesting new precedent has been set by a local doctor donating to the Library a gift in appreciation of medical treatment given to his family by a confrere.

Those of our readers who prepare bibliographies for their papers may be interested in the following which appeared in "The Lancet" for June 21, 1952, in the column "In England Now".

It is a big step forward for the young medical author (and a welcome one for his editors) when he appreciates the niceties of bibliographical abbreviation as laid down in the *World List of Scientific Periodicals*. This will show him how to avoid such betises as *B. M. J.* and *J. A. M. A.* and works of supererogation such as *J. Pharmacol. & exp. Ther. or Proc. Staff Meet. Mayo Clinic.* After a couple of days with the World List at his elbow he will be clearing such hurdles as *J. Lab. clin. Med.* and *Proc. Soc. exp. Biol., N.Y.*, with never a stop or capital misplaced or a superfluous syllable. He will enjoy the very special thrill of pruning oversize titles like *Bollettino della Malattie dell' Orecchio, della Gola, Della Naso, di Tracheo-Bronco-Esofagoscopia e di Fonetica* to the laconic *Bol. Mal. Orecch.*

Foreign publishers are apt to follow a code of abbreviations of their own, and this morning, when running through a Belgian abstract journal, we were shaken to find a paper on the aetiology of peptic ulcer credited to *Wikliwo* 62, 674, 1950. This raffish-looking title suggested one of those Continental weeklies, filled with risque cartoons, which one finds in the better Harley Street waiting-rooms. With bitter memories of instigating library searches for the current volumes of *Ibid.*, we appealed to a learned colleague, schooled in military terminology, who identified it in a few seconds as the journal known in our chaster code as *Wien. klin. Wschr.* NATO, SHAEF, NATSOPA, ROSPA, and now WIKLIWO; only a little farther down the slippery slope and we shall find ourself figuring as a case-history in the *J. ment. Sci* (or will it be JOMESCI?).

BOOK REVIEW

THE DIAGNOSIS AND TREATMENT OF ADRENAL INSUFFICIENCY

By G. W. Thorn, 2nd edition, 1951, pp. 182 illus.

It is now about 100 years since Thomas Addison laid the foundation to the understanding of adrenal physiology correlating the clinical picture of the disease bearing his name and destruction of the adrenal cortex. His study was shortly followed up by the intrepid Brown-Sequard who observed that the demise of a variety of animals subjected to bilateral adrenalectomy, was similar in many respects to that of patients suffering from Addison's disease. In the subsequent 100 years, there has been a tremendous volume of work published on the subject of adrenal function, and in the past fifteen years the work of Selye on the Adaption Syndrome and the more recent discovery of the therapeutic potentialities of ACTH and Cortisone, have acted as potent stimuli in directing attention to the adrenal cortex.

The name of George Thorn has, for some time, been closely associated with studies on this gland. It is not surprising that his book "Diagnosis and Treatment of Adrenal Insufficiency" has, in the space of two short years, run to a second edition. The book itself gives a fairly complete account of the physiology, the symptoms, signs and treatment of adrenal insufficiency. There is a useful chapter in which the activity and potency of different adrenal cortical preparations is discussed. This is the only place that I know where this information is collated. However, considering Professor Thorn's extensive experience, there are some disappointments. There is no consideration given to the intravenous use of ACTH in testing for adrenal insufficiency. This is of importance because it has become recognized in the past few years that there is considerable inactivation of the hormone when given by the intramuscular route. There is little said regarding the use of Cortisone and it would appear that the oral use of this material is perhaps one of the most satisfactory ways of controlling Addison's disease. There is little information with regard to the twilight state of adrenal insufficiency without the full-blown picture of Addison's disease.

There is, though, much useful information in the book and it is to be hoped that subsequent editions will remedy these failings.

H. W. M.

● ● ● ●

MEDICAL EDITORS' MEETING

Following the Sixth General Assembly of The World Medical Association in Athens, Greece, October 12-16, 1952, there will be a meeting of the Medical Editors of the World, Friday, October 17, 1952.

The meeting held in Stockholm in connection with the Fifth General Assembly was so successful that it was decided to hold a similar meeting this year.

The tentative program for the Conference is attached hereto.

PROPOSED PROGRAM FOR IIIrd ANNUAL MEETING
of the
MEDICAL EDITORS OF THE WORLD
Athens Greece
October 17th, 1952

I—PAPERS

1. Medical-Political Editorials.
2. Control of Advertising in Medical Publications.
3. The Extension of Medical Information through Abstract Services.
4. Medical Publications in Latin America.

II—ROUND TABLE DISCUSSION

Subject: Practical Matters of Medical Publications. (To include Authors reprints, exchanges, etc.).

Vancouver Medical Association

President	Dr. E. C. McCoy
Vice-President	Dr. D. S. Munroe
Honorary Treasurer	Dr. G. E. Langley
Honorary Secretary	Dr. J. H. Black
Editor	Dr. J. H. MacDermot

Editor, Vancouver Medical Association Bulletin.
Dear Doctor MacDermot:

I am enclosing a copy of the programme for the Refresher Course on Malignant Disease which will take place during the week of October 6-10. The chief speakers are: Sir Stanford Cade, and Professor B. W. Windeyer of London, England. Other visiting guest speakers are: Dr. S. T. Cantril and Dr. Franz Buschke of the Tumour Institute of the Swedish Hospital, Seattle, Wash.; Dr. O. H. Warwick of the National Cancer Institute of Canada; Dr. H. M. Parker of Richland, Wash. and Dr. B. V. Low-Beer of the University of California Hospital, San Francisco.

Yours sincerely,
A. M. EVANS, M.D.,
Medical Director

Course is open to everyone. There will be no charge—but anyone wishing to attend is asked to write to above when a ticket of admission will be issued. This is necessary to find out the size of accommodation needed. Apply now.

Ed. Note.

BRITISH COLUMBIA CANCER INSTITUTE
TENTATIVE PROGRAMME FOR
REFRESHER COURSE — MALIGNANT DISEASE
OCTOBER 6-10, 1952

Morning Session: MONDAY, OCTOBER 6

8:30 A.M. Registration.
9:00 A.M. Introduction by Dean M. M. Weaver.
Chairman: Dr. A. M. Evans—Cancer of the Breast.
9:15 A.M. 1. Surgical Management—Sir Stanford Cade.
10:00 A.M. 2. The Role of Radiotherapy—Professor B. W. Windeyer.
10:45 A.M. 3. The Role of Hormones—Dr. L. G. Ellison.
11:15 A.M. 4. Discussion Period.
12:15 P.M. Surgical Ward Rounds, Vancouver General Hospital.

Afternoon Session:
Chairman: Dr. F. P. Patterson.
The Treatment of Bone Tumours.
2:00 P.M. Sir Stanford Cade.
2:30 P.M. Professor B. W. Windeyer.
3:00 P.M. Dr. Franz Buschke.
3:30 P.M. The Treatment of Cancer of the Lip—Dr. A. M. Evans.
4:00 P.M. The Treatment of Cancer of the Skin—Dr. S. T. Cantril.

Evening Session:
Chairman: Dr. G. F. Strong.
8:15 P.M. Official Opening Ceremonies in the Ballroom, Hotel Vancouver.
The Rt. Hon. Paul Martin, Minister of National Health & Welfare.

TUESDAY, OCTOBER 7

Morning Session:

Chairman: Dr. A. Taylor Henry.

9:00 A.M. Clinical Meeting. Presentation of new cases of malignant diseases.

10:15 A.M. The Treatment of Cancer of the Tongue by Radiotherapy and by Surgery. Sir Stanford Cade.

11:00 A.M. The Treatment of Cancer of the Maxillary Antrum. Professor B. W. Windeyer.

11:30 A.M. Demonstration of Treated Cases—Lip, Tongue, Tonsil, Skin and Breast.

Afternoon Session:

Chairman: Dr. A. B. Nash.

2:00 P.M. The Treatment of Cancer of the Cerxix Uteri—Dr. S. T. Cantril.

2:45 P.M. British Columbia Cancer Institute results—Dr. Margaret Hardie.

3:00 P.M. The Treatment of Cancer of the Ovary.
1. Surgery—Dr. J. E. Harrison.
2. Radiotherapy—Dr. Margaret Hardie.

3:40 P.M. The Treatment of Cancer of the Corpus Uteri—Dr. Ethlyn Trapp.

Evening Session:

Vancouver Medical Association.

9:00 P.M. "The Changes in the Treatment of Cancer"—Sir Stanford Cade.

WEDNESDAY, OCTOBER 8

Morning Session:

9:00 A.M. Clinico-Pathological Conference at Vancouver General Hospital. Chairman: Dr. J. Balfour.

10:15 A.M. The Treatment of Cancer of the Bladder—Professor B. W. Windeyer.

11:00 A.M. The Treatment of Cancer of the Kidney—Dr. R. D. Nash.

11:30 A.M. Recent Advances in Surgery—Sir Stanford Cade.

Afternoon Session:

Chairman: Dr. R. B. Kerr.

The Management of the Lymphomas.

2:00 P.M. Professor B. W. Windeyer.

2:45 P.M. "Experience in the Treatment by Chemotherapy of One Hundred Cases of Leukaemia and Allied Diseases"—Dr. O. H. Warwick.

3:15 P.M. The Practice at the Britsih Columbia Cancer Institute. Dr. D. M. Whitelaw, Dr. R. G. Moffat.

4:00 P.M. Discussion Period—Dr. Franz Buschke, Dr. H. H. Perry, Dr. H. K. Fidler.

THURSDAY, OCTOBER 9

Morning Session:

9:00 A.M. Medical Ward Rounds, Vancouver General Hospital. Chairman: Dr. H. Rocke Robertson.

10:15 A.M. The Role of Radiotherapy in the Treatment of Tumours of the Brain and Spinal Cord—Professor B. W. Windeyer.

11:00 A.M. The Treatment of Pain in Malignant Disease—Dr. Frank Turnbull.

11:30 A.M. Surgery and Radiotherapy in the Treatment of Cancer of the Oesophagus. Dr. Franz Buschke.

Afternoon Session:

2:00 P.M. Conferring of Honorary Degrees at the University of British Columbia. Sir Stanford Cade—Professor B. W. Windeyer.

4:00 P.M. Open House at the British Columbia Cancer Institute. Tea by the Women's Auxiliary.

FRIDAY, OCTOBER 10

Morning Session:

Chairman: Dr. L. H. Leeson.

9:00 A.M. "Diagnosis, Choice of Method of Treatment and Surgery in Cancer of the Larynx"—Sir Stanford Cade.

9:45 A.M. "The Radiotherapeutic Treatment of Cancer of the Larynx". Professor B. W. Windeyer.

10:30 A.M. The Treatment of Cancer of the Nasopharynx—Dr. S. T. Cantril.

11:15 A.M. The Spread of Tumours—Dr. William Boyd.

Afternoon Session:

Chairman: Dr. William Boyd.

2:00 P.M. "The Role of the Physicist in the Treatment of Cancer". Dr. H. M. Parker.

2:30 P.M. The Use of Radioactive Isotopes—Dr. E. T. Feldsted.

3:00 P.M. Cobalt 60 Beam Therapy—Dr. H. F. Batho.

3:30 P.M. Clinical Experience in the Use of Radioactive Isotopes. Dr. B. V. Low-Beer.

4:00 P.M. Diagnostic Uses of Radioactive Iodine—Dr. H. W. McIntosh.

● ● ● ●

THE HUMAN FOOT

By DR. J. H. MacDERMOT

The human foot is to a great extent an unexplored area in medicine. The medical student receives full training in the anatomy of the foot, and its relation to the function of the body generally, but the dynamics of the foot, its relation to general diseases of the body, its capacity for developing diseases and disorders of its own, are not adequately taught. There are several excellent monographs on the foot available to the medical practitioner; e.g., Lewin's "The Foot and Ankle", and Lake's "The Foot", but these are not in general use for the medical student.

One can search through the leading systems of orthopaedics, surgery, paediatrics, obstetrics and gynaecology, and find no reference to the foot as an entity. There is no reference to diseases of the foot in the aged, nor to the prevention of the ills which emanate from foot disorders. Morton, the well-known medical authority on diseases of the foot, after whom "Morton's Disease" is named, says "The foot is the only part of the body for which prevailing ideas of care and treatment have remained practically unchanged for forty years."

However, we are beginning to realize more and more the importance of the foot as a cause of human disability and suffering, and as a cause of very great economic loss. Industry finds that foot ailments are the cause of much loss of time, poor work, and accidents. Workmen's Compensation Boards are interesting themselves in the prevention of crippling through injuries of the foot. The armed forces, in the last War, found a tremendous amount of incapacity developing during service as a result of unstable and weak feet, and conducted surveys which have been of great value.

Orthopaedists, paediatricians, and internists are becoming increasingly conscious of the need for foot care. However, the great majority of people go first to their family doctor and the training of these men, which is so complete in other lines, is not such as to give them the necessary knowledge and skill either to prevent or to treat foot disorders adequately.

Surveys indicate that modern life bears hardly on the foot. Women have gone into many activities, in factories, in hospitals, in stores and restaurants, where the increased strain on their feet is apt to be productive of much trouble. Pregnancy and childbirth, with the shifting of the centre of gravity and increase in weight, are a serious

threat to the foot. Girls' feet appear, from surveys made, to be more liable to disorders than boys'. Lake, of Charing Cross Hospital, says in his book, "The Foot", that "not more than 10% of adult women have normal feet."

Men, too, in industry especially, have trouble referable to their feet. Sore feet in industry, we are told, are a cause of absenteeism to the degree that one man in ten is absent from two to seven days a month. In the auto industry, says one authority, foot ailments are present in 50% of the men employed. Sore feet, says another authority, are a frequent cause of accidents.

Such opinions have aroused the concern of employers of large groups of men and women. Henry Kaiser, the automobile manufacturer, the Endicott-Johnson Shoe Company, Sears and Roebuck, and other similar companies in the United States, provide chiropody clinics and foot care for their employees.

The Metropolitan Life Insurance Co., Aetna Life Insurance, Zurich Insurance Co., U.S. Fidelity and Guaranty Co., are conducting studies on the relation of foot health to accident prevention.

The records of the disabilities found in men in the United States who were being examined with a view to military service, show that 14.5% of the men examined, supposedly young, healthy men, showed foot defects. A great many of these conditions could have been detected, and probably remedied, in childhood but had, with the passing years, become irreversible, and made the man unfit for enlistment.

In the aged, too, a vast amount of suffering and disability is caused by bad feet as a result of disabilities which could presumably have been corrected in earlier life. In the later years, peripheral vascular disease, arterior-sclerosis, diabetes, produce consequences in the feet which can be very serious. Dr. J. H. Sheldon, in "The Social Medicine of Old Age"—a report made to the Nuffield Foundation in England—says "Pain in the feet is a most important cause of disability in old people, affecting nearly 40% . . . There is little doubt that the two measures which would give the greatest relief to old people are adequate provision for chiropody and the supply of suitable spectacles."

A report made in Great Britain by representatives of the Society of Medical Officers of Health says that some 80% of old people need chiropody. Many of these, the report adds, could probably be restored to earning capacity by suitable care.

All these statements, however, deal with actually existing foot disabilities. As in other departments of medicine, the most important and most productive kind of medical care is prevention. And this brings us to consider foot diseases in children, where most of adult foot disability originates, and where alone it can be prevented by suitable early care.

A survey made in New York by the National Association of Chiropodists, and under the supervision of the educational and school medical authorities, showed that of 15,000 boys and girls in school, 63% showed foot disorders, some of which needed only advice and general care. A larger number needed actual professional care—this proportion being higher with the older students. Girls showed a 10% higher incidence than boys. A good many of the conditions present could have been prevented by proper shoe fitting. This question of shoes in childhood is perhaps the most important single factor in the prevention of foot disorders. It is of interest that at the present time a study is being instituted in Vancouver under the joint control of Professor J. F. McCreary, Head of the Paediatric Department of the University of British Columbia, and Doctor Frank Patterson, Head of the Department of Orthopaedic Surgery at the Vancouver General Hospital, into the development of children's feet. In this study, the active advice and participation of chiropodists has been solicited. It is intended to follow a series of infants and children with routine radiological and photographic examinations to determine when arches develop.

Very briefly we have indicated the increasing realization of the need for research into the prevention and treatment of foot disease in three main groups—children, adults,

especially women, and the aged. A great deal more could be said to expand this theme, but one or two things stand out in summary.

We have in the modern community a great deal of foot disability at all ages—disability which causes a large economic loss and human suffering. A great deal of this probably originates in childhood—most of it is recognizable in childhood, and may be preventable or remediable in childhood. Little or no provision exists at present for systematic surveys of children's feet at home, in schools or elsewhere. Such surveys would uncover actual or potential trouble, and so allow preventive and curative measures to be taken. These surveys could be undertaken in school medical systems, in children's hospitals and clinics, in post-natal and infant welfare work. Negotiations are now on foot between the School Medical authorities of Greater Vancouver and the B.C. Chiropodists' Association, with a view to finding if some way cannot be worked out of holding foot clinics in the schools, as dental clinics are held. The chiropodists assure us that this could be the means of detecting much trouble in the early and curable stages, instead of allowing minor disabilities to become fixed and develop into more serious conditions later. It seems a logical way of attacking the preventive side of the problem, and should be a constructive contribution to public health.

It is very doubtful if this work can be done by the medical profession itself. It must be done with their help and support. The actual detailed care of foot disabilities, either in children or adults, calls for an intensive application of specially acquired skills and a knowledge of shoes that few, if any, medical men possess. Moreover, the man in medical practice has not the time, if he had the skill, to do this type of work. Success in the care of foot disabilities requires detailed, meticulous, often daily care, which can be best given by one who devotes himself entirely to this work. It requires training in shoe-fitting, in supportive measures, that can only be given in special curricula.

For example, in regard to flat-foot in children Lewin says—"Diagnosis is important —treatment requires one year (Whitman) for a cure, but shoes need attention indefinitely. The indications for treatment are to teach proper walking, to increase the power of the supporting structures, to support the weakened structure, to increase the local circulation and to correct associated pathological conditions. Methods are . . . prescribing proper shoes, exercising, massage, contact foot baths, felt pads, plaster casts and operations." Except for operations, most of this is beyond the scope of the average medical man to carry out alone. It needs, in addition, the services of men who have been trained in this sort of detailed work—in short, chiropodists.

The present state of affairs is somewhat analogous to that which existed in the old days when there were few dentists, and those not very highly skilled. Every doctor had a more or less complete set of dental forceps. If a patient had a toothache, he did his best to pull the tooth for him, or as much as he could before the patient felt he had had enough. Otherwise, since he knew nothing about teeth, he could do nothing for such things as dental caries, dental obliquities, buried molars and so on. But the dentists faced the problem, improved their methods and standards of education and practice, developed methods of research and study, and went deeply into the preventive aspects of dentistry. So they became the fine, scientific profession that they are today. The result, in improved health, especially for children, in the prevention of adult dental disorders, in the generally improved well-being of the community, is great.

My thesis is that we have to do the same thing about feet as we did about teeth; recognize the foot, its disorders and diseases, its need for maintenance as a strong and healthy supporting organ. The prevention of foot ill-health must be the subject of special study and training, by men who will specialize in this limited field, as the dentists have done in theirs, and devote themselves entirely to it. These men must, of course, be trained along general medical lines, as are the dentists. They must be sufficiently trained in general medicine and its cognate subjects; and in the basic sciences—anatomy, chemistry, physiology, pathology and the rest—so that they have a comprehensive knowledge of the body as a whole; and they must further have devoted sufficient time to the detailed study of the foot, its care and treatment, and the prevention of disease.

The medical profession has come to recognize dentistry as an integral part of the

medical structure, and accepts the claim of the dentist to complete professional standing. His training is along medical lines, and his training in the basic sciences is adequate. Medicine, in this country at least, has been slower to recognize chiropody in the same way. This is due to several things. First, there is the natural reluctance of the profession to endorse any new thing till it has justified its claims thoroughly, and this is a good habit of mind.

The second reason, I think, is that modern chiropody is a very recent thing. To many of us, in the older age levels of medical practice, the word chiropodist brings to us a memory of the "corn doctor" of thirty or so years or so ago—whose training was of the sketchiest, and who could lay no claim to an adequate professional standing.

In the last twenty or twenty-five years, however, the picture has changed very radically. Chiropody has gone a long way in that time. It has steadily raised its standards of education, both academic and pre-academic, till now the Canadian and American chiropodist undergoes a four-year course of training, preceded by a general education. To obtain a license, for example in British Columbia, the candidate must show a standard of preliminary education which must be at least equal to the end of the first year in Arts in the U.B.C., or other recognized Canadian universities. His training at College is along medical lines—in that he has to pass examinations in the basic sciences, anatomy, physiology, histology, chemistry, pathology, and so on. The teaching in these subjects is given along general lines, and not limited to the foot. In most of the colleges, these subjects are taught by medical men. He has some 4200 hours of lectures, clinics, demonstrations and the rest, and as one who has spent some time inspecting one of their colleges, I can testify to the fact that their course is a pretty stiff one.

The chiropodist of today is a trained professional man, with professional and ethical standards like our own, and based upon rigid training. Like the dentist, he specializes in a limited field of the body, outside of which he never ventures. Apart from his basic training, he is given courses in general medicine, surgery, dermatology, pathology and so on, which make him a safe and reliable practitioner.

In the forty-eight States of the Union, chiropodists are recognized as an integral part of the medical structure of the country. They are recognized by the American Medical Association as a medical auxiliary profession. As a general rule, in each State, they are subordinate to the State Medical Board, with whom they work in harmony. In a considerable number of the States, their final examinations are set by the State Medical Board, as in California—in others there is a Joint Examining Board of doctors and chiropodists, in others the Chiropodists conduct their own examinations.

There are six main schools of Chiropody in the U.S.A.

Two of these are associated directly with universities.

Within the past year, all these schools have been recognized as institutions of higher learning by the Department of Education, Federal Security Agency, Washington, D.C.

In Great Britain, the chiropodist is similarly recognized as a medical auxiliary, and the Offices of the British Chiropody Society are housed in the British Medical Association Building in London.

Some time ago the B.C. Chiropodists Society, through their President, Dr. J. I. Gorosh, of Vancouver, approached the Vancouver General Hospital, and offered to install and equip at their own expense a Chiropody Clinic in connection with the Outpatient Department of the Hospital, under the control of the Department. They presented a Brief to the Medical Board of the Hospital, based on an enquiry made of some 250 American hospitals in which these questions were asked:

Is there a Chiropody Clinic in connection with your hospital?

What is your opinion of its value?

Are the relations between the medical men and the chiropodists harmonious or otherwise?

The answers were classified, and these facts emerged. A great many of the largest hospitals in the States have chiropody clinics, and make extensive use of them. Joslin,

the noted authority on diabetes, in his big clinic in Boston, employs ten or more of them continuously, and says that nobody can treat diabetes adequately without access to and employment of the chiropodist's services. The Mayo Clinic, the Philadelphia General Hospital, Massachusetts General Hospital, Mount Sinai Hospital in New York, and many other large hospitals have clinics. These were all enthusiastic about their clinics, and there were numbers of comments about their absolute necessity, especially as regards diabetes and peripheral vascular disease. One hospital stated that before they had the clinic, the incidence of amputations in diabetics had been about 19%, whereas, with proper chiropodial care, this had been reduced to about 4%.

Almost without exception, the answer came that the relations between doctors and chiropodists were most harmonious and friendly, and that there was no encroachment whatever on the part of the latter upon fields that were not legitimately their own.

As a result of all this, the V.G.H. agreed to the establishment of a Chiropody Clinic. In some three years this clinic has given some 8000 treatments (two days a week), and is constantly some seven or eight weeks behind with its bookings. The Clinicians of the O.P.D. value and respect this clinic—in fact most of the cases treated are referred by other clinics in the Department. In the words of several of the heads of departments, it is "indispensable", and it is one of the busiest and most popular of all the clinics.

St. Paul's Hospital has recently installed a similar clinic, again equipped and paid for by the chiropodists themselves, and it is rapidly repeating the history of the V.G.H. clinic. In view of the fact that there are only some 38 chiropodists in B.C., that the men in Vancouver give their time in rotation at the Clinic without charge, one cannot but applaud the sincerity and public spirit of these men.

An interesting series of findings and recommendations is to be found in the Report of "The Committees on Medical Auxiliaries" made to His Majesty by the Minister of Health for Great Britain. This is known as the Cope Report and is issued under the Chairmanship of V. Zachary Cope, M.D., M.S., F.R.C.S.

It deals with a great many subjects—diet, physiotherapy, radiotherapy, etc., and has a section of some length on chiropody. Some extracts are given here:

"More could be done by Local Education Authorities in giving attention to children's feet".

"Representatives of the British Orthopaedic Association told us that chiropody should be available for the treatment of both in-patients and out-patients referred by the hospital medical authorities".

"Representatives of the London County Council and the Society of Medical Officers of Health told us that the chiropody service given by local Authorities was extremely popular, and agreed that it was capable of great extension".

"In hospitals of the National Health Service in England and Wales there were 313 chiropodists, in Scotland 75, some full-time, but most part-time".

The conclusions at the end of the Report were:

"(a) There is evidence to support the view that there should be a chiropodist available in every general hospital. Where departments exist for the treatment of Diabetic, Orthopaedic, Dermatological and Rheumatic patients, the services of chiropodists are particularly required.

(b) There appears to be considerable demand for chiropody through the Local Authority Clinics.

(c) If there is an extension in geriatric work, as seems likely, there will undoubtedly be an increase in the demand for the services of chiropodists in connection with these units".

The medical profession, I feel, has much to gain, and nothing to lose by making recognition of this group of men as part of the medical structure, limiting their work to a certain field, the foot. They are rigidly controlled by their Chiropody Acts in each Province, and could not infringe in any way on medical practice, if they wanted to. They have high standards of practice and ethics, and are constantly striving to make

these even higher. By recognizing them, by consulting with them, by utilizing their special skill and knowledge, we shall be increasing our capacity for useful service to our patients, and helping to improve public health conditions. As it is, there is a growing tendency, among orthopaedists, paediatricians, internists and others to refer their patients with foot conditions requiring expert care, to chiropodists who can help them greatly in their work. They are taught in their schools to keep in close touch with the attending medical man, and at all times to regard him as the responsible authority in charge of the case.

At the Annual National Convention of Chiropodists in Great Britain this year, Sir John Stopford, M.D., F.R.S., Vice-Chancellor of the Victoria University of Manchester, was their guest speaker. In part, he said "During the first World War, I did come much closer to your work because for a number of years I was in charge of nerve injuries, and . . . associated with orthopaedic hospitals. I learned that no orthopaedic service can be complete without having some connection with your profession.

"We must have the right relation with the medical profession . . . we must both still realize that each of us has a very distinctive part to play. Each of us must realize that there is room and need for both of us and that we are interdependent and often complimentary.

"Another important point is that chiropody and medicine cannot remain static . . . The direction taken will depend upon the individual members of the profession, what they are contributing. May I ask you to be research-minded. The preventive aspects are very apt to be neglected in medicine and the fields of mdical auxiliaries, and yet I am sure you will agree with me that (by preventive medicine) it is attaching the subject at the right end.

"Just to summarize. First, let us insist on a high educational standard . . . Secondly, let us do everything in our power to secure full and happy co-operation between the two professions. Let us demand the highest ethical standards. Thirdly, let us try to advance our subject and perfect our methods of treatment, and see that preventive measures receive a full measure of consideration."

Dr. Charles A. Mayo gave an address in Des Moines, before a State Convention of Chiropodists. He said, *inter alia*:

"Chiropody, unfortunately, does not receive the attention it merits in our medical schools . . . I am convinced that doctors of medicine, myself included, have paid too little attention to the feet in their relationship to the condition of a patient. The doctor of medicine should be capable of recognizing foot ailments, and when treatment and care of such conditions are necessary should refer the patient to those accredited and skilled in that specialty."

Lastly, I should like to quote from an article in the "Practitioner" written by a leading English chiropodist. This number of the "Practitioner"—February, 1946—contained a symposium on "Disorders of the Feet". It is a most interesting number and contains the following articles:

The Problem of Footwear—by Lake of Charing Cross Hospital, London.

Congenital Abnormalities of the Foot—by Mercer.

Minor Surgery of the Foot—by Moore of London.

Skin Diseases of the Foot—by Dowling of St. Thomas' Hospital.

Lastly, comes "Indications for Chiropody", by John H. Hanby, F.Ch.S., Consulting Chiropodist at Guy's Hospital and the London Foot Hospital. He is also President of the Society of Chiropodists which, I understand, has its head office in the British Medical Association building in London. He deals with the modern outlook of chiropody, the technique of treatment, foot ailments and their treatment, and closes with these words:

"The chiropodist's work, if intelligently applied, is closely connected with that of the orthopaedic surgeon and the dermatologist. Yet, the link is an harmonious one. The chiropodist recognizes his limitations, but he feels that he has a noteworthy contribution to make towards the relief of suffering, and he is ready to take his rightful place in the health services of the country. There is a close co-operation between many con-

sultants and chiropodists. Among the major body of medical practitioners, however, there is a lack of appreciation of the basic and scientific training which is now undertaken at responsible schools of chiropody. It is in the interest of the general public, and particularly children, that there should be a closer co-operation between the general practitioner and the chiropodist, which must be to the mutual benefit of all concerned in maintaining a healthy and fit nation."

● ● ● ●

OFFICE PRACTICE IN OTO-RHINOLARYNGOLOGY*

LELAND G. HUNNICUTT, M.D.
Associate Clinical Professor of Surgery (Oto Rhino-Laryngology)
University of Southern California
Los Angeles, California

Office practice in oto-rhinolaryngology varies as to the method of handling of the patient as much as in any other specialty. The method of handling reflects the training you received in medical school as well as reflecting the make up of the physician. There is no such thing as the correct way because several different methods arrive at the same end result which is the curing of the patient as well as having a satisfied patient. My method is to see as many different patients as possible and to avoid useless visits to the office.

I would like to discuss my treatment for different kinds of cases that come into the office. It will help clarify our thinking as a new patient presents himself. I have found it is efficient to be well organized ahead of time as to treatment for each separate condition.

An adult comes into the office with a fresh runny nose cold and the nose is very stuffy. I know right away there is nothing I can do to cure the cold but there are definite things to do for symptomatic treatment and to prevent complications. He has no general toxic symptoms and no fever, and all of the symptoms are confined to the nose. I ask the nurse to give him the following medicine to drink. Twenty drops in a little water of equal parts of Tr. aconite, Tr. Belladonna and Tr. Opium. Before he leaves the office the nose is quite dry and there is a sense of well being. To open the nose temporarily, a flexible wire applicator with a little cotton on it and a drop of saturated cocaine is passed along the floor of the nose from front to back. This is done quickly and causes the minimum of discomfort. The patient is left for about five minutes and upon my return, as a rule the nose is open. If not then a similar applicator is passed along the middle meatus from front to back and in another two or three minutes the patient can breathe well and, symptomatically, is free from complaints. I explain that this is only temporary, then write down several things for him to do at home. Every six hours, if the nose continues to run he takes twenty drops of the three tinctures. He is told not to blow the nose under any circumstances and to take one or two aspirin tablets every three to four hours. If he is fortunate, the cold will not go into the suppurative stage and will remain open most of the time. As a final bit of advice, I explain that most so called colds come on following an accumulative fatigue, so in the future he is to try to avoid such a state. I do not give penicillin or any other antibiotic for this condition.

A patient comes in with a cold that has been present for several days and there are symptoms of the sinuses being blocked. The runny nose stage is past and there is some purulent material that is being blown out and dripping into the throat. Depending on the severity of the symptoms and the financial status of the patient, x-rays of the sinuses may be ordered. The nose is sprayed with a vasoconstrictor and it makes little difference which one is used. The flexible wire applicator with a small amount of saturated cocaine solution is passed along the middle meatus on each side and around the opening of the sphenoid sinuses. The patient is left for a few minutes, then is given advice as to home treatment. This includes steaming compresses to the face,

* Read before the Vancouver Medical Association Summer School, 1952.

warning the patient not to let the steaming towel contact the tip of the nose as it blisters quite easily. He is told to avoid blowing the nose. Hot throat irrigations, using water without salt or soda may be ordered to be used two or three times a day for the purpose of heating up the circulation in the throat and nasopharynx. Either neosynephrin or propadrine capsules are prescribed about every three to six hours to help in the vasconstriction. The dosage varies from the small 1 mg. neosynephrin to the 25 mg. size and the propadrine varies from 3/8 to 3/4 grain, depending on the type and size of the patient. If there is a very marked blocking of the sinuses, the patient is told to fill one side of the nostril in the head low position (Parkinson), using 1/4% ephedrine in normal salt solution once a day for three days. If there is no relief by the third day or if it becomes worse with this treatment an x-ray, P.A. position is taken and the treatment is then directed toward the involved sinuses. Again I put off the use of penicillin or similar drugs until the results of the treatment are noted. Depending on the financial status of the patient a culture may be taken at the time of the first visit, then the proper antibiotic prescribed later if necessary. However, after three days, if the sinus involvement is not relieved and the patient gives no history of sensitivity to antibiotics then shots of penicillin are started. At times a smear is taken first to see if the bacteria are gram positive or gram negative. This, of course, helps determine which of the antibiotics may be of value.

A patient comes in with blocked Eustachian tubes which may be from a cold or from a change in altitude while flying. The treatment is the same. At the first visit the tube may be inflated, but the character of the infection, if present, may make it seem unsafe to open the tube. If there is little or no infection then inflation of the Eustachian tubes followed by massage of the drum is done. Then the patient is instructed to avoid blowing the nose, take the neosynephrine or propadrine capsules as already described, take a mild saline cathartic every morning before breakfast for dehydration purposes and to get extra rest. He will report by phone in three or four days and if there is no improvement he returns to the office for another inflation and a further check on the adjacent sinuses which may be keeping up the congestion.

Another patient comes in with a marked vasomotor rhinitis with a chronically congested nose. I am giving a complete lecture on that subject so will no more than mention that it represents one of our most common complaints in Southern California and certainly one of the most challenging conditions to treat. I would like to make one statement, that the patient as a rule is one who does lots of nose blowing and uses a lot of vasoconstrictors.

We are troubled with dry mucous membrane in our locality and the patient coming in with a dry crusty nose is a difficult one to handle. In looking in the nose we see dry exudate with minute bleeding points, each of which represents a break in the continuity of the epithelium with granulations trying to heal the injury. The nose may be open, with good breathing space at the moment, but later with nature's effort to shut off the dry air, one side will swell shut for one-half hour or longer and no air can pass through. There is then the tendency to blow hard with the resulting further injury to the membrane as the scab is torn loose. The treatment is done entirely at home and an outline is presented to the patient. Three times a day for a fifteen to thirty minute period he is instructed to put a light plug of cotton in one nostril and at the end of such time, the cotton is removed. During this period the mucous membrane is recoated with mucus and dry spots are given a chance to heal. At no time is the patient permitted to blow the nose. Twice a day, usually morning and evening, he uses steam compresses over the face for two purposes, to add a little moisture and to stimulate circulation. There may be a low grade infection on the septum which keeps up the crusting and bleeding, so it may be necessary to use a mild antiseptic. I very often prescribe some 2% aqueous mercurochrome on a light plug of cotton, and, in order to make good contact with the septum the patient presses on the side of the nostril. The cotton is removed at once and the mercurochrome has had a chance to have its effects, one, a mild antiseptic and two, it has a mild protein precipitation

effect and tends to 'toughen' the tissues. If there appears to be considerable scar tissue from recurrent small ulcerated points, then iodine by mouth, usually in the form of Lugol's solution, is used for a number of weeks. It improves circulation and stimulates thin lubricating secretions.

A patient comes in with a so called scratchy throat. Examination shows the lateral walls of the pharynx to have streaks of red and there is a lot of postnasal discharge. The usual history is that the patient was fatigued when this condition came on. To give immediate relief from symptoms I paint a streak on either side of the pharynx, using carbofung, which is a combination of fuchsin, acqueous phenol, boric acid, acetone and resorcinol. It is sometimes known as Castellani's solution. It anesthetizes almost instantly and the patient tells me I have 'hit the spot' and the throat feels better almost at once. I explain that this is not a cure but merely a booster. He is instructed how to irrigate the throat and advised to get extra rest. For discomfort he can take one or two aspirin tablets. Again I give no antibiotic. Very often in the office I will spray some Besredka bacterial filtrate in the throat to stimulate local antibody reaction. This seems to work very well in a number of cases. We used to be able to buy the Besredka filtrate before the war but it has not been made since then, so we have it made at the hospital, obtaining cultures from a number of patients, growing the culture for several weeks until the bacteria tend to die out. The broth is then run through a Berkefeld filter and the filtrate used on the patient.

Acute tonsillitis as a rule does not come into the office but is seen as a sick patient in the home, usually by the general practitioner or pediatrician. Besides the use of antibiotics, local treatment can give much comfort. If the patient is an adult, a dehydrating hot gargle of almost saturated magnesium sulphate will give much comfort. A tablespoonful of the magnesium sulphate to one-half glass hot water is used as a gargle aid. At first the patient will not like it but after one or two times will notice that the throat has a clean astringent feeling. Hot throat irrigations are also used, using hot water without salt or soda and followed by about one-half can of cold water this is of much value in improving the circulation and washing away the exudate. Either hot or cold compresses to the throat may help. The patient is instructed to try first one and then the other and use the one which gives the greater relief. A small turkish towel is wrung out of hot water and placed on the neck. This is covered with a piece of plastic cloth, (which most people have in their home in the form of a kitchen apron or something similar) then a dry cloth placed over this and the compress left on for ten minutes. The cold compress can be used in the same way and the plastic cloth will protect the clothing from moisture as well as hold in the heat or cold.

Stomatitis, whether it be from a drug reaction or non-specific, may last long enough so that the patient's general health is impaired. Improper nutrition along with the misery of a very sore mouth contribute to the general poor condition of the patient. In some of the most severe cases the use of insulin, (7½ units Lilleton) before meals will improve the general metabolism and resistance to the point where the stomatitis will rapidly recede. The patient is, of course, instructed as to the proper intake of food.

For recurrent stomatitis, especially with ulcers, Dr. Jud Scholtz, one of our excellent dermatologists, has instructed me to give the following treatment. First, a regular multiple-pressure vaccination. Second, one week later, or depending on the intensity and duration of initial reaction, give increasing doses of vaccine solution, at 7 to10-day intervals. Draw the contents of a single capillary tube of vaccinia virus into 0.5 cc of normal saline in a tuberculin syringe, and give in the following manner:

0.5 cc.
0.1
0.15
0.2
0.3
0.4
0.5

This is entirely an arbitrary schedule.

Injections are given intradermally and subcutaneously for the larger volume.

I stay away from strong antiseptics, cauterizing agents and mouth washes. To promote eating, the patient uses a ¼% Pontocaine spray on the sensitive areas.

Postnasal drip and clearing of the throat is another of the most common complaints and one of the most difficult to treat. Allergy must always be suspected and a smear to check for eosinophiles is usually done. We use French Hansel's stain and if it is proven to be allergy, then antihistamines are tried first. Later, if necessary, the usual skin tests and desensitization are done. If the smear shows mostly polys, then the post-nasal drip is treated as an infection. If the patient has bad nose habits such as blowing and the use of vasoconstrictors, these are stopped. Usually I prescribe bacterial filtrate twice a week for two weeks to help stimulate resistance to the low grade infection. Throat irrigations are of much value as described before. To stimulate thin lubricating secretions I prescribe iodine or ammonium chloride depending on the appearance of the mucous membrane. It is important to avoid fatigue and over smoking and drinking. As a final bit of advice I encourage the patient to stop clearing the throat, literally to talk through the 'frog' in the throat and avoid the excessive clearing of the throat. He will report by telephone about once a week.

The pediatrician calls up about a problem child he is sending in. A little girl of six arrives in the office presenting herself as a rather thin, slightly under nourished and unhappy appearing youngster. The mother gives the appearance of being at the end of her rope and she tells the following story. Most of the winter has been spent at home rather than in school because of recurrent colds and persistent low grade fever. There is little or no appetite yet she has been filled up on vitamins and iron tonics. There is rarely a happy moment in her life. The tonsils and adenoids are still present and an x-ray of the sinuses shows a little congestion in the maxillary. X-ray treatments have been given with no benefit. Examination shows a moderately congested nose, slightly enlarged tonsils, moderately granular red pharynx and slightly enlarged cervical lymph nodes throughout. The pediatrician and the mother wanted to know if the child should have a tonsillectomy and if it is going to cure the child. I explain that in my opinion the removal of tonsils and adenoids is not going to cure her of all the complaints but it may be necessary to have it done later. In the meantime I want her to follow the so-called 'rest regime' at home. I then dictate an outline of this to my nurse and present the mother with a typewritten card telling of the home routine. Every evening for one week or longer the child is to go to bed one hour before supper. If the feet are cold, a heating pad or hot water bottle is placed at the feet. She may sit up in bed and do interesting things but be sure and have a good light for the activities. Supper is served in bed. Radio is permissible but I have found that television is not good during this rest period. Lights are turned out at the regular bed time. It requires one week of this regime to be rehabilitated and back to a normal feeling of being rested. In the future whenever the first signs of fatigue are noted, the week of extra rest is to be repeated. The signs of fatigue are irritability, loss of appetite, loss of sparkle in the eyes and often a slightly congested running nose. If this regime is followed out the inevitable so-called cold that will come on after a period of fatigue usually can be avoided.

These examples are given to let you know of one method of carrying on an office practice. The general philosophy is to try on the first visit to establish a diagnosis and outline treatment that will work toward a cure without repeated visits to the office. The patient reports by phone instead of coming to the office to report. By doing this the office is not cluttered up with a lot of useless visits and there is more time for new patients with perhaps more interesting problems. I find, in the long run, the patients like it much better and it is certainly a much more interesting way to practice oto-rhino-laryngology.

THE CHRONICALLY CONGESTED NOSE

By LELAND G. HUNNICUTT, M.D.

The chronically congested nose is one of the most common complaints in ear, nose and throat office practice and it is one of the most unsatisfactory conditions to treat. This type of patient can either be a permanent visitor in the office or can be directed as to home treatment and only occasionally have to come to the office. When relief is given, seldom is there a more grateful patient.

There are many things that can be done for relief of the chronically congested nose and it is some of these that are to be presented. One of the most important services that can be rendered to a patient is to teach him how to take care of his nose so that normal or nearly normal physiology is present. It is often the ill-advised patient who develops a chronically congested nose. The normal nose should be one that serves its purpose without producing symptoms.

First, let us discuss what a normal nose is like. Rarely does the normal nose require blowing. At certain times of the day there is an excess of lubricating secretion and it normally is directed posteriorly where it may cause postnasal drip. If one side of the nose becomes a little too dry the inferior turbinate will enlarge in an effort to narrow the space and prevent further drying as well as to increase the secretion and lubrication of the cilia. These two normal conditions should be explained to the patient so that he will not treat them as symptoms of disease.

The causes of a congested nose are many. In the adult one of the most common is from excessive nose blowing and excessive use of vasoconstrictors. The patient comes in with the statement that for the past three months his nose has been congested. He had had to blow the nose a great deal and the only way he can get relief is to use vasoconstrictors. There is also a great deal of postnasal discharge. It originally followed a cold which seemed to hang on. The doctor gave him a vasoconstrictor and told him to return if the cold did not improve. Instead of returning he had the prescription refilled several times. He was never really sick and finally his wife could stand it no longer so made him come in to the office. He reports that the discharge is almost always clear, although at times there is some purulent or bloody material in the rather tenacious mucus. After shrinking the nose, the findings are quite negative. Transillumination of the sinuses is clear. The conclusion is that the correcting of the physiology will probably cure the patient. He is then taught what I like to call 'nasal hygiene' and told to report by phone at the end of four to five days. The advice given is no blowing of the nose, no nasal medication, propadrine or neo-synephrin capsules if the nose is too congested and if the nose is too uncomfortable at bed time, he is to take two aspirin tablets. If one side persists in being congested a light plug of cotton is put in the nostril and is left in for 15-20 minutes, two or three times a day, to prevent drying from the inspired air. Some patients receive considerable relief from hot compresses over the entire face, and the technique is described. Care is taken not to contact the tip of the nose with the hot compress or blistering will occur.

At this point it is well to discuss a similar condition in children. The treatment varies somewhat in that fatigue often is the basis for continuation of the congested nose following a cold weeks or months before. I explain to the mother that if fatigue is allowed to continue, a cold will usually develop. To get rid of fatigue a typewritten paper with instructions is given the mother. If the child is old enough, I like to describe to the child exactly what he is to do, and let the child know that mother is often so busy with the household affairs that she is apt to forget. The first signs of fatigue are loss of appetite, poor disposition, loss of sparkle in the eyes along with the nose symptoms. The rest regime is outlined as follows: At the first signs of fatigue the child is to go to bed one hour before supper and have supper served in bed. If the feet are cold, heat is placed at them. If there is restlessness, an aspirin tablet will relax. Amusement is furnished the younger children and older children are encouraged to do their studying in bed. Experience has proven that television does not relax, while radio seems

to do no harm. This regime has been worked out by the chest clinics over the United States and has been used for the past twenty-five years. They have found nothing that is its equal in building up resistance and getting rid of fatigue.

Inherited vasomotor rhinitis is treated as described above, but good results are not as easily obtained. Often there are emotional factors which keep up the congested nose. It is then necessary to go into the background of the individual and it often requires careful detective work to determine what the basic condition is. It may be an inadequate personality, unpleasant home surroundings, inability to keep up in school work and many other conditions that tend to upset the emotional balance. Glandular conditions may enter into the picture. Nasal allergy presents so many facets that a simple discussion is impossible. Our method of handling is first to eliminate local conditions such as sinus infection, mechanical obstruction, or infected adenoid. Again the emotional life may be of utmost importance. Fatigue is often related to the start of a severe attack. The allergy life of the individual is studied. If it seems to be beyond our ability to solve the allergy investigation or if the parent wishes to have an allergy specialist, we encourage this inestigation and treatment by such a specialist. Antihistamines are of great value in some and of no value in others. The tendency to out-grow the nasal allergy is what both the doctor and the parents hope for.

Systemic conditions such as hypothyroidism and blood dyscrasias may be overlooked by the internist where the first manifestation may be noted in the ear, nose and throat examination. These should be cared for by the proper physician.

Air borne irritants are important in our area. We refer to them as smog and in some it causes marked nasal congestion which clears when the patient goes to the mountains, desert or seashore.

The mechanical obstruction is cared for surgically. This includes deviated septum, chronic turbinitis in which the turbinate is incapable of shrinking, or an enlarged turbinate, especially the middle, in which there is a turbinate cell.

I would like to discuss local treatment for the chronically congested nose and I believe these treatments can best be brought out by describing several different kinds of patients that come into the office. A man of forty years complained of a congested nose of about twenty years standing. He had used vasoconstrictors about six times a day for twenty years. He had been told twenty years before that he should use a vasoconstrictor about every four hours. He played golf every afternoon when the weather permitted and he stated that at the end of the ninth hole he would use the drops, then use them again at the end of the eighteenth hole. He awakened once in the night to use the drops, then slept until morning, and used them again on arising. When I saw him the inferior turbinates were completely blocking the airway and he had not used the drops for three or four hours. I used a small amount of saturated cocaine on a flexible wire applicator passing it along the floor from front to back. In a few minutes the inferior turbinate had receded to the point that there was a good airway and no disease could be found. X-rays were taken and found to be essentially negative. I placed him on the nasal hygiene regime. I saw him again in four days and his nose was clear. He then confessed to me that he had an appointment the next day with a doctor in another city for a trans-antralethmosphenoidectomy. This, of course, was cancelled. My final advice was that he follow the nasal hygiene regime and to stay away from ear, nose and throat doctors unless it was a dire emergency. This case represents the typical over-medication type of congested nose and is easily cured by stopping all medication.

A man of about forty comes into the office occasionally because of chronically congested nose, apparently based purely on vasomotor rhinitis. There is a very marked emotional factor which he feels is the cause in that the nose congests only when his business causes him to be under considerable strain and stress. After trying a number of things unsuccessfully we finally decided to use the electric needle. I have found the Hyfrecator with an insulated needle to work very well. I have used it on him occasionally for the past two years and do not find any ill effect. Prior to the electric needle

I tried painting a strip of pure phenol from front to back and even a weak zinc ionization of the inferior turbinates.

Stasis of the secretions is illustrated in the case of a college girl who, for about a year, had had a very congested nose. There was thick mucopus lying in the floor of the nose and the inferior turbinates were swollen. Aspiration brought out congealed pus, apparently having been there for a long period of time. After several such aspirations the cilia began functioning again and normal secretions formed resulting in a normal nose.

In summary, the chronically congested nose can result from bad nose habits, the over use of vasoconstrictors, emotional states, mechanical conditions in the nose, airborne irritants and systemic conditions. Usually the nasal symptoms can be eliminated by instructing the patient as to proper nasal hygiene.

● ● ● ●

News and Notes

Dr. Dick Beck has returned to become a teaching fellow at the Vancouver General Hospital after a year at the Royal Victoria Hospital.

Dr. E. A. Boxall has opened a practice in internal medicine in Vancouver.

Dr. Gerry Smith of Vancouver has begun a year in surgery at Shaughnessy Hospital.

Drs. V. O. Hertzman and *A. K. Mathisen* of Vancouver have returned from the American Internists Conference in Cleveland.

Dr. C. A. Cawker has opened a practise in New Westminster in referred urology.

Dr. Vaughan Ewart of Vancouver is now studying in New Rochelle, N.Y.

Dr. T. C. Johnston has opened a practice in Hastings East, Vancouver.

Dr. R. R. Laird of Tranquille has retired.

Dr. B. D. Prosterman of Vancouver is continuing her surgical studies in New York.

Dr. W. L. Valens has opened a practice in Victoria, B.C.

Dr. K. D. Varnum has opened an office in Vancouver.

Dr. M. Turko is now practising in obstetrics in Vancouver.

Dr. J. M. Coles is now practising general practice on Lulu Island.

Dr. A. D. McDougall is now practising at Williams Lake.

Dr. Carl Simpson has entered general practice in Vancouver-Cambie District.

Dr. P. Yates is now practising on Vancouver Island.

Dr. Mel Shaw of Vancouver is now resident in cardiology at the Vancouver General Hospital.

Dr. Frank Hebb is now full time physician for University Health Services, University of British Columbia.

CANADIAN MEDICAL ASSOCIATION—B. C. DIVISION

October, 1951 — September, 1952

OFFICERS

President	Dr. H. A. L. Mooney, Courtenay, B.C.
President-Elect	Dr. J. A. Ganshorn, Vancouver, B.C.
Vice-President	Dr. R. G. Large, Prince Rupert, B.C.
Honorary Secretary-Treasurer	Dr. W. R. Brewster, New Westminster, B.C.
Chairman, General Assembly	Dr. F. A. Turnbull, Vancouver, B.C.

STANDING COMMITTEES	CHAIRMEN
Constitution and By-Laws	Dr. R. A. Stanley, Vancouver, B.C.
Finance	Dr. W. R. Brewster, New Westminster, B.C.
Legislation	Dr. J. C. Thomas, Vancouver, B.C.
Medical Economics	Dr. R. A. Palmer, Vancouver, B.C.
Medical Education	Dr. G. O. Matthews, Vancouver, B.C.
Nominations	Dr. H. A. L. Mooney, Courtenay, B.C.
Programme and Arrangements	Dr. R. C. Newby, Victoria, B.C.
Public Health	Dr. G. F. Kincade, Vancouver, B.C.

SPECIAL COMMITTEES	CHAIRMEN
Arthritis and Rheumatism	Dr. A. W. Bagnall, Vancouver, B.C.
Cancer	Dr. A. M. Evans, Vancouver, B.C.
Civil Defence	Dr. L. H. A. R. Huggard, Vancouver, B.C.
Emergent Epidemics	Dr. G. F. Amyot, Victoria, B.C.
Hospital Service	Dr. J. C. Moscovich, Vancouver, B.C.
Industrial Medicine	Dr. E. W. Boak, Victoria, B.C.
Maternal Welfare	Dr. A. M. Agnew, Vancouver, B.C.
Membership	Dr. L. H. Leeson, Vancouver, B.C.
Pharmacy	Dr. D. M. Whitelaw, Vancouver, B.C.

Editorial

Many will have read the issue of MacLean's dated June 15th, 1952, concerning the high cost of medical care. If any have not seen this issue, they should get it and study it, for it clearly portrays 'The Doctors Dilemma' of the present era.

Whether we agree with it or not, or whether we think it presents us in a fair light or not, are questions of minor importance at the moment, and nothing is to be gained by brushing it aside as a matter of little consequence. On the contrary, we must recognize:

1. That the problems raised are of such magnitude that our leading national magazine saw fit to delegate one of its top men to make a five month unbiased study of the situation and to devote most of one issue to report the results.

2. That this is what a large section of the Canadian people rightly or wrongly, think of us.

3. That this summary of our profession went completely unanswered. Since it was a national publication it should have been answered at a national level. Possibly there is no answer, but it would seem that a prompt, thoughtful and unpredjudiced reply could at least have improved the impression left by the aforementioned study. Our silence can only be interpreted as acquiescence or indifference or both.

4. That we must recognize the obvious fact that a large section of our citizens want sickness and old age security and they want hospitalization and medical care, etc., etc., but they would like someone else to pay for it, and they are willing to sacrifice a large portion of their freedom and independence to have it so.

Pensions For M.P.'s

It is interesting to note that our federal members of parliament who now receive a yearly indemnity of $6,000 of which $2,000 is free of income tax, have arranged a pension for themselves. Anyone who is elected three time may apply. By the simple process of paying 6% of the above remuneration (income tax free) which the government will match from the copious purse of a grateful public, they can have $58 a week for life, at an age as young as 35. This bill was so popular in the House of Commons, that it passed almost unanimously, which shows that the economic theories of the various parties are very similar after all. What seems so paradoxical is that the same philanthropic government flatly refused to allow the medical profession in Canada to lay aside any portion of its revenue (although unmatched from public coffers) for the purpose of retirement, unless it first paid every cent of its income tax on such monies. Maybe we are public enemy No. 1?

Are *You* Doing Your Share?

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

CONSULTATIVE CANCER CLINICS

In order to assist in the diagnosis of cancer and to make recommendations regarding the treatment of patients referred by the physicians in the area, the British Columbia Cancer Foundation has established Consultative Cancer Clinics throughout the province. The clinics are conducted by radiotherapists from the staff of the British Columbia Cancer Institute, Vancouver, who visit the various areas at intervals, the frequency of visits depending upon the volume of work and demand of the local physicians. The private physician is asked to attend the clinic, and detailed reports are, of course, returned to him. Clinics are held in the following cities: Penticton, Kelowna, Vernon, Kamloops, Nelson, Trail, Cranbrook, Prince George and Prince Rupert.

Close co-operation is maintained with the director of the local health unit, from further information may be obtained. Expenses of these clinics are met through funds provided by Federal and Provincial grants.

PEARSON TUBERCULOSIS HOSPITAL

On May 14, 1952, the Pearson Tuberculosis Hospital containing 264 beds was opened in Vancouver. This new hospital provides complete treatment facilities for tuberculosis. Future plans call for a duplication of the present beds making an overall total of 528 beds.

HEALTH UNIT DIRECTORS TRAINED

Two health unit directors who have completed the course for their D.P.H. are returning to their former positions in June. Dr. A. A. Larsen returns to Mission as Director of the North Fraser Valley Health Unit, and Dr. H. M. Brown is returning to Prince George as Director of the Cariboo Health Unit.

Dr. H. T. Lowe, who has filled Dr. Brown's position during his absence, is joining the staff of the Tranquille Sanatorium for three months before proceeding to Toronto in September to take his Diploma in Public Health.

PROVINCIAL MENTAL HEALTH SERVICES
VISIT OF DR. MacDONALD CRITCHLEY

The Provincial Mental Health Services recently brought Dr. MacDonald Critchley, Dean of the Institute of Neurology, National Hospital for Nervous Diseases, Queen Square, London, to Vancouver for a series of lectures and conferences with the medical staff of the Mental Health Services. While in B.C., Dr. Critchley also addressed the summer school of the Vancouver Medical Association.

STAFF NOTES

Dr. A. M. Gee attended the annual meeting of the American Psychiatric Association in Atlantic City in May and while there, participated in a round table discussion on the Psychiatrist as a Mental Hospital Administrator.

Dr. F. E. McNair attended the annual meeting of the Canadian Medical Association at Banff and read a paper on "Psychosis Occurring Post Partum".

HEALTH BRANCH
DEPARTMENT OF HEALTH AND WELFARE

ISONICOTINIC ACID HYDRAZIDE (ISONYAZID)

Although large scale studies have been set up to investigate the place of isonicotinic acid hydrazide in the treatment of tuberculosis, discussions of this problem at the annual meeting of the National Tuberculosis Association and the Canadian Tuberculosis Association indicated that it will be some time yet before it can be determined how it should be used and how it compares in effectiveness with other antibacterial agents now in use.

However, preliminary investigations have shown that the early reports from the lay press were unduly optimistic. Although it appears that isonicotinic acid hydrazide will prove very useful in the treatment of tuberculosis, there is, as yet, no indication that it is superior to the established treatment by combined streptomycin and para-amino salicylic acid therapy and therefore should not be used unless treatment by this method has failed. Isonicotinic acid hydrazide has not been proven to be bacteriocidal, but it has been shown that as a result of its use resistant strains of the tubercle bacillus develop in a relatively short time and in a higher proportion of patients than in the case of streptomycin when it was used alone before the advent of the combined therapy.

It was urged by the Council on Chemotherapy of the National Tuberculosis Association that the use of isonicotinic acid hydrazide by continued on an investigational basis until its true value is determined and until some method is developed to control the emergence of resistant strains. It is anticipated that this can be controlled as in the case of streptomycin by using isonicotinic acid hydrazide in combination with other substances.

The continuous course of streptomycin in combination with PAS for six to twelve months or longer is still the treatment of choice in active tuberculosis. The streptomycin is given in doses of one gram intramuscularly twice a week and the PAS twelve grams daily. To prevent the emergence of resistant strains PAS should always be used in combination with streptomycin and if PAS is not tolerated, serious consideration should be given to the discontinuance of the streptomycin therapy.

FEDERAL HEALTH GRANTS

It is interesting to note that since 1948, under the Professional Training Grant of the Federal Health Grant, some 60 physicians have completed post graduate training; 21 of these physicians have had at least a full academic year of training and 29 have partaken in short term post graduate education. The fields covered in these courses have been Psychiatry, Tuberculosis, Public Health, Venereal Diseases, Cancer, Industrial Hygiene, Rehabilitation Services and Hospital Administration. In each instance the physician to whom assistance has been granted has agreed to remain in the employ of the sponsoring agency for a certain period of time dependent on the length of post graduate training.

STAFF NOTES

Dr. A. J. Nelson, Director, Division of V.D. Control, read a paper entitled "Some Important Considerations in the Public Health Control of Gonorrhoea" at the recent annual meeting of the Canadian Public Health Association held in Winnipeg.

Attending the annual meeting of the Canadian Tuberculosis Association in Regina were Dr. Elliott Harrison, Consultant in Chest Surgery, Division of T.B. Control, and Dr. K. Severin Alstad, Medical Director, Victoria Unit, Division of T.B. Control, who presented papers entitled "Experience in Pulmonary Resection for Tuberculosis" and "A Follow-up Study of Preventorium Care". Dr. Gordon Kincade, Dr. F. O. R. Garner, and Dr. W. H. Hatfield also attended the proceedings of this annual meeting.