THE

BULLETIN

OF

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VANCOUVER MEDICAL ASSOCIATION
PROGRAMME FOR THE FIFTY-THIRD ANNUAL SESSION

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REGULAR MONTHLY MEDICAL MEETINGS

First Tuesday—General Meeting—Vancouver Medical Association—T.B. Auditorium. Clinical Meetings, which members of the Vancouver Medical Association are invited to attend, will be held each month as follows:

Second Tuesday—Shaughnessy Hospital Staff Meeting.

Third Tuesday—St. Paul's Hospital Staff Meeting.

Fourth Tuesday—Vancouver General Hospital Staff Meeting.

Fifth Tuesday—(when one occurs)—Children's Hospital Staff Meeting.

Programme of General meetings will be circularized monthly by the Executive Office of the Vancouver Medical Association Programme of Clinical meetings will be displayed weekly on bulletin boards prepared for that purpose and placed in the Vancouver General, St. Paul's and Shaughnessy Hospitals.

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

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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.

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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.

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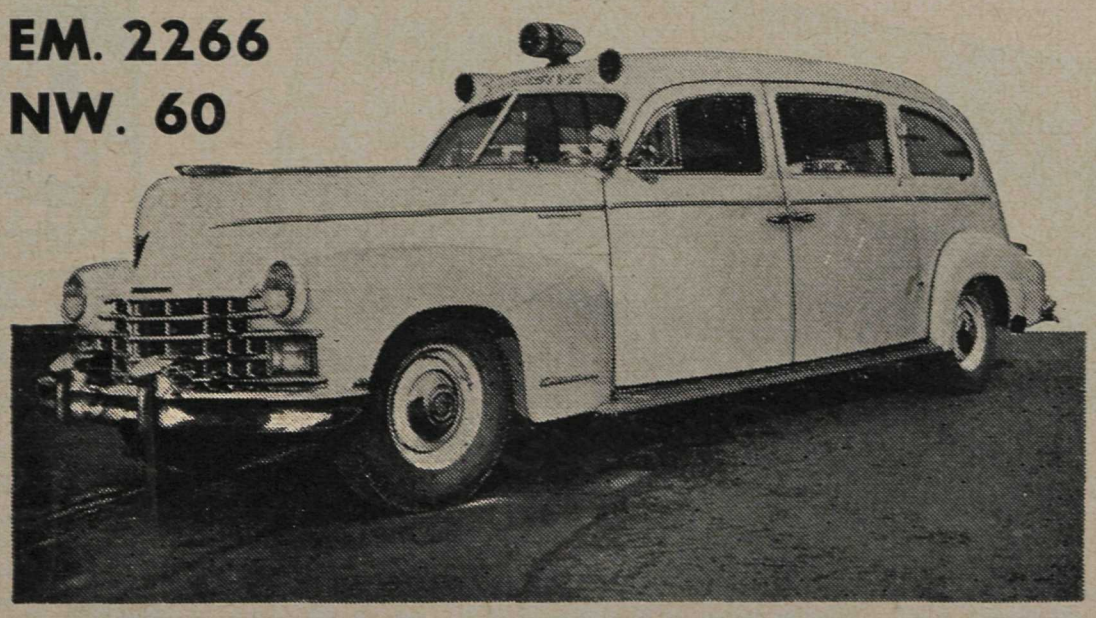

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1. *Tuft, L.: Clinical Allergy. Philadelphia, W. B. Saunders Co., 1947, pp. 335-336.*
2. *Hansel, F. K.: Allergy of the Nose and Paranasal Sinuses. St. Louis, C. V. Mosby Co., 1936, p. 769.*
3. *Kelley, S. F.: Choice of Sympathomimetic Amines. Cornell Conferences on Therapy, 11, 1947, p. 156.*

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VANCOUVER HEALTH DEPARTMENT
STATISTICS - JANUARY, 1952

Total population—census figure	340,272
Chinese population—census figure	7,117
Other—census figure	788

	January, 1952	
	Number	Rate per 100 pop.
Total deaths (by occurrence)	471	16.6
Chinese deaths	21	35.4
Deaths, residents only	427	15.0

Birth Registrations—residents and non-residents (includes late registrations)	January, 1952 Number	
Male	459	
Female	452	
	911	32.1

Infant Mortality—residents only

	January, 1952
Deaths under 1 year of age	28
Death rate per 1000 live births	41.9
Stillbirths (not included in above item)	5

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	January, 1952		January, 1951	
	Cases	Deaths	Cases	Deaths
Scarlet Fever	99	—	122	—
Diphtheria	—	—	—	—
Diptheria Carriers	—	—	—	—
Chicken Pox	196	—	—	—
Measles	367	—	12	—
Rubella	6	—	23	—
Mumps	58	—	58	—
Whooping Cough	—	—	—	—
Typhoid Fever	—	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	1	—	—	—
Tuberculosis	4	7	52	12
Erysipelas	—	—	2	—
Meningitis	3	2	1	—
Infectious Jaundice	—	—	—	—
Salmonellosis	2	—	4	—
Salmonellosis Carriers	—	—	—	—
Dysentery	2	—	3	—
Dysentery Carriers	—	—	—	—
Tetanus	—	—	—	—
Syphilis	15	—	14	2
Gonorrhoea	135	—	245	—
Cancer (Reportable Resident)	54	81	100	71

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The Editor's Page

From what we gather here from time to time, the newly re-organized B.C. Division of the Canadian Medical Association is working very hard: and doing its best to justify the confidence expressed in it by the profession at large. The Division has been able to secure the services of Dr. Gordon Ferguson, at present Registrar of the Saskatchewan College of Physicians and Surgeons, to be its Executive Secretary—and this is a great achievement in itself as Dr. Ferguson is well known as an able executive. He will be a tower of strength to the profession in British Columbia. Pending his arrival, Dr. E. C. McCoy is acting as Executive Secretary, and, as anyone who knows "Tim" would expect, has been doing some excellent work.

We are publishing in this issue some notes about the S.A.M.S., and the medical remuneration provided by the government for the payment of medical men. It is a difficult problem, and has puzzled the brains of all who have had to deal with it. The article will bear careful reading—and there is no simple formula for the settlement of this problem. For one thing, we must be careful not to forget that while it presents a problem along one line in the city, it presents an entirely different problem in the country: and in any solution offered or considered, we must be careful not to let mere size of medical population be the deciding factor by itself.

But what is said in these articles is very true—any settlement that we make will tend to establish precedents and set standards which will be of the greatest importance later on, and may lead us into some very difficult positions. But we feel that all these things are well known to our leaders, and will have the most careful thought from them.

We hear, too, that a new fee schedule or tariff is practically completed, and will soon be promulgated. This is a matter of the greatest importance—not only to us, but to everyone in the community—perhaps especially in the case of prepaid medical plans. If the Division has been successful in preparing a tariff which is fair and equitable to all concerned, it has done a tremendous job.

But all this means just one thing—we must *all* get behind the Division, and join it and pay our fees. We cannot, any of us, refuse our individual share of the burden. Each one of us will benefit by the work of the Division, and each one of us is bound, in common honesty, to pay his dues, which are so necessary, if the Division is to do its work thoroughly. Further, we shall be more or less bound by its decisions, and can only register *our opinions* by ourselves becoming members.

* * * * * * * * *

We note with regret the resignation by Dr. Murray Blair, from his post as Registrar of the College of Physicians and Surgeons. Of course, we know that Dr. Blair only took the job temporarily, on the lamented death of Dr. MacLachlan—and we know, too, that it has imposed a very heavy burden on him—but still we are sorry to see him go. Dr. Blair has a capacity for sympathy and understanding, and a native kindliness, that have helped all with whom he came in contact as Registrar. His wisdom and his integrity have made his work, in this capacity, outstanding.

Fortunately, we have in Dr. Lynn Gunn, who assumes the Registrarship, a worthy successor to Dr. Blair. Dr. Gunn has had rather a severe apprenticeship in his work as Executive Secretary—a position that he will continue to fill. He has had to work, not only for the College, which was his proper work, but for the B.C.M.A. for the past year or more, and it has left him no leisure and little rest. With the adjustments recently made his lot has been somewhat less hard—but not much. He has, we know, the confidence of Council and of the members of the College generally, and we wish him good luck.

New Library Hours:

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

As from Tuesday, April 1st, the Library of the Vancouver Medical Association will be open *every* evening until 9:30 p.m. from Monday to Friday, and until 1:00 p.m. on Saturdays. These hours will continue until the end of May when evening hours will be discontinued for the summer months.

Recent Accessions:

American Medical Association, Transactions of the Section on Ophthalmology, 1950-1951.

American Proctologic Society, Transactions, Fiftieth Annual Session, 1951.

American Urological Association, Transactions, Southeastern Section, 1951.

Darwin, Sir Francis (editor)—Charles Darwin's Autobiography, 1950. (In memory of the late Dr. W. M. Paton).

Duke-Elder, Sir W. S. and Goldsmith, A. J. B., Recent Advances in Ophthalmology, 1951. (In memory of the late Dr. E. H. Saunders).

Fulton, J. F., Physiology of the Nervous System, 3rd edition (revised), 1949.

Medical Clinics of North America—Symposium on Recent Advances in Cardiovascular Diseases, January, 1952.

Medical Research Council Report No. 274—Deficiency Diseases in Japanese Prison Camps, by Dean A. Smith and Michael F. A. Woodruff. London: H.M.S.O., 1951.

Medical Research Council Report No. 275—Studies of Undernutrition, Wuppertal, 1946-1949, by members of the Department of Experimental Medicine, Cambridge, and associated workers. London: H. M. S. O., 1951.

Medical Research Council—The Application of Scientific Methods to Industrial and Service Medicine (Proceedings of a Conference held from March 29th, to March 31st, 1950). London: H. M. S. O., 1951.

Mote, J. R. (editor), Procedings of the Second Clinical ACTH Conference—Volume I —Research; Volume II — Therapeutics. 1951 (Historical and Ultra-Scientific Fund).

Pratt, G. H., Surgical Management of Vascular Diseases, 1949.

Schwab, R. S., Electroencephalography in Clinical Practice, 1951.

The following is a letter of thanks and appreciation sent to Dr. Morton E. Hall for his recent gift to the Library:

Dear Doctor Hall:

May I, on behalf of the Library Committee, thank you most sincerely for your recent generous gift of the copies of the Annals of the Royal College of Surgeons of England from volume 1, 1947 to volume 7, 1950. The Committee feels that this gift is a most valuable one and they wish me to express to you their gratitude for your thoughtfulness in presenting this set of periodicals to the Library.

Yours sincerely,
J. L. PARNELL, M.D.,
Secretary, Library Committee.

ΤΟΥ ΜΕΓΑΛΟΥ

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This is the cut of the title page of the first volume of the Works of Hippocrates which Dr. I. Steiman presented to the Library recently. Members will recall a note on this gift and the Library Committee's letter of thanks and appreciation to Dr. Steiman in the last issue of the Bulletin.

BOOK REVIEW

MODERN PRACTICE IN DERMATOLOGY, edited by G. B. Mitchell-Heggs
London: Butterworth & Co. (Publishers) Ltd., 1950 pp. 836 illus.

This book is an encyclopedia of modern dermatologic thought and practice in the British Commonwealth. There are many illustrations. The printing is very legible on heavy glossy paper, making for very easy reading.

In this age of chemistry it is not unexpected to find that this text should place emphasis on the patient's reaction to his environment, and nicely illustrates how the skin mirrors bodily function in health as well as disease. It also points out the increasing role that the unconscious psychological problems play in dermatology in this age of stress and strain.

The authors are dermatologists of great experience both as teachers and practitioners and are representative of the British Commonwealth—i.e. England, Australia, Canada and Africa.

Canada is admirably represented by our own Dr. D. E. H. Cleveland's contribution —Chapters 37 and 38 on "Diseases Affecting the Mucous Membrane" and "Cancer of the Mucous Membrane" respectively.

Chapter 2 on "History and Examination of a Patient, with Notes on Diagnosis" is greatly recommended for the practitioner as well as specialist for the well illustrated clues aiding one in the diagnosis of every-day dermatological problems.

One senses an air of conservatism throughout the text, and the clinging to the old proven remedies, yet one wishes to deprecate the use of arsenic in syphilis and in chronic recurring diseases such as psoriasis and lichen planus and dermatitis herpetiformis because of their potential risks, as pointed out in the book. Similarly, sulfonamides topically are not looked upon with much favour on this continent.

Chapter 3 on "Principles of Treatment" particularly the subsection on Prevention of Skin Disease, merits careful scrutiny.

This reviewer was somewhat confused in Chapter 5 with the British use of the term "epithelioma" to designate specifically a squamous or prickle cell epithelioma, whereas in the American literature epithelioma is a generic term synonymous with carcinoma and subdivided into:

1. basal cell epithelioma (rodent ulcer).
2. prickle cell or squamous cell epithelioma, and
3. basosquamous cell epithelioma.

Chapter 8 on Industrial Dermatitis is very good, and makes special reference to prevention of recurrences and prognosis, and should be read along with the fine section on psychosomatic disorders—Chapter 28.

This fine text lays emphasis on the tried and proven remedies, and although no mention is made of the current wonder hormones, ACTH and Cortisone, one wishes to recommend it as a worthy addition to the Library and as a fine reference for student, practitioner and specialist alike.

B. K.

RECENT PUBLICATIONS BY MEMBERS OF THE VANCOUVER MEDICAL ASSOCIATION

Bagnall, A. W., Paradoxical Behaviour of the Erythrocyte Sedimentation Rate in Cortisone Therapy. Canad. Med. Assoc. Jl. 65:125-127, August, 1951.

Baird, M. M.; Holmes, C. B.; McIntosh, H. W.; Simpson, W. W.; Walsh, G. C.; and Whitelaw, D. M.; Cortisone in Nephrotic Syndrome occurring in Diabetes. Canad. Med. Assoc. Jl. 65:26-29, July, 1951.

Burke, Gerald L., On Congenital Dislocation of the Hip. Jl. Bone and Jt. Surg. 33B; 562-566, November, 1951.

Cleveland, D. E. H., Possible tuberculous skin infection from a swimming pool; report of four cases. Acta Dermato-Venereologica 31:147-152, 1951.

Dolman, C. E., et al. Two cases of Rate-bite Fever due to Streptobacillus Moniliformis. Can. Jl. Pub. Health 42:288-241, June, 1951.

Fratkin, L. B. and Jackes, H. L., The Treatment of Varicose Veins. Canad. Med. Assoc. Jl. 65:367-372, October, 1951.

Gundry, C. G., That Old Rascal Montaigne. Canad. Med. Assoc. Jl. 65:157-160, August, 1951.

Hebb, F., The Care of the Dying. Canad. Med. Assoc. Jl. 65:261-263, September, 1951.

Hobbs, F. S., Spontaneous Evisceration through Vagina. Canad. Med. Assoc. Jl. 66:68, January, 1952.

Hunt, C. L., Effectiveness of Modern Treatment for Gonorrhoea in Women. Canad. Med. Assoc. Jl. 65:351-352, October, 1952.

Kanee, B., Corticotrophin (ACTH) administered intravenously. Arch. Derm. and Syph. 65:95, January, 1952.

Kanee, B. and Hunt, C. L., Homosexuality as a source of Venereal Disease. Canad. Med. Assoc. Jl. 65:138-140, August, 1951.

Mallek, J., Kanee, B. and Zack, J., ACTH and Cortisone in Pemphigus Erythematosus. Canad. Med. Assoc. Jl. 65: 564-566, December, 1951.

McIntosh, H. W. and Holmes, C. B., Some Evidence suggesting the suppression of Adrenocortical Function by Cortisone. Lancet 2:1061-1064, December 8, 1951, also in Treatment Services Bulletin 6:539-546, December, 1951.

Parnell, J. L., Alexander, E. H. and Robertson, Rocke. An Interesting Case of Pharyngeal Tumor—case report. Treatment Services Bulletin 7:1-6, January, 1952.

Robertson, Ross and James, E. S., Congenital Lobar Emphysema. Pediatrics 8:795-804, December, 1951.

Skully, H. J., The Patient's Viewpoint. Canad. Med. Assoc. Jl. 65:64-65, July, 1951.

Strong, G. F., Wilson, Roger and Taylor, H. E., Rupture of Oesophagus. Canad. Med. Assoc. Jl. 65:455-462, November, 1951.

Williams, D. H., Management of Atopic Dermatitis in Children—Control of the Maternal Rejection Factor. Arch. Derm. and Syph. 63:545-560, May, 1951.

Wilson, Reginald and Rowe, Richard. Some special problems in the use of ACTH and Cortisone Therapy in Children—a report of three cases. Jl. Pediat. 4):164-171, February, 1952.

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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.

SOCIAL ASSISTANCE MEDICAL SERVICE

Negotiations that concern the S.A.M.S. contract are now proceeding between the Executive of the Board of Directors of the B.C.M.A. and the Honourable A. D. Turnbull, who represents the Provincial Government. The duty of the B.C.M.A. Executive Committee is clear. Guided by the mandate of last fall's vote they must negotiate to obtain a "satisfactory" increase in the *per capita* grant, or failing that objective, serve three months' notice of intent to cancel the contract.

Three years ago the whole plan was admittedly an experiment. It is fruitless now to concern ourselves with the genesis of the initial 14.50 *per capita* grant. That grant was accepted by the doctors, and it has continued to be the basis of payment until the present time. The 14.50 figure was not based on actual experience, because there was no experience of such a scheme in B.C. It was expected that 14.50 *per capita* would provide a sufficient fund to pay 70% of the medical accounts. Indeed, it did so when the first cheques were issued to the doctors—but never again. Why that estimate of 70% should have given us any feeling of security is far from clear in retrospect. Perhaps we were lulled by the promises of an annual revision of the *per capita* sum, which proved to be a false hope.

And now, in 1952, we have had three years of experience. The cost of medical service for this group is established. Good medical care has been provided. By and large the recipients of this care are satisfied. Utilization of medical services has in-

creased from 1 in 17 per month to 1 in 6 per month. (This latter compares with 1 in 8 of M.S.A. members). Increasing utilization without any increase in the basic per capita rate has produced the inevitable result. Gradually the percentage that is paid to the doctors for their services has been reduced until now it has reached 50%. And to make matters worse, the reduction in payment has occurred during three years of unprecedented increase of overhead expense for the doctor in practice.

Fees from well-to-do patients can no longer be expected to subsidize free work for the poor. Very few doctors in practice nowadays collect any fees from their private patients above the minimum schedule rate, from one year's end to the other. There is still a certain amount of free work in the practice of every doctor, that is given without hope or even thought of fee. But this free work has diminished and has to diminish, in the face of rising overhead costs. For medical care that is subsidized by the State, doctors should receive a proportion of the cost of their medical services that is equivalent to what is paid out by the Government for other services to indigents; e.g., hospitalization, drugs.

When we accept a deal that is, in reality, a 50% give-away, we receive neither thanks for our altruism, nor assurance of any better contract in the future. The fact that we have accepted such a standard is quoted to our disadvantage in other negotiations, and will be paraded before us, like a stage army, for years to come. Doubtless the doctors of other Provinces are lashed by the story of our S.A.M.S., as we suffer from the reports of some deals that they have made.

The problem needs to be regarded by the doctors in its true perspective. It concerns approximately one-twentieth of our population. We can ill afford to scramble after any sort of hand-out from the Government when the implications for all future negotiations are so serious.

Come what may, we will not neglect the future medical care of the indigent group. But that does not mean that we have to renew an intolerable contract with the Government on their behalf. The situation calls for firm action by our Committee.—F.T.

A REPORT OF THE ACTIVITIES OF THE COMMITTEE ON MEDICAL ECONOMICS OF THE B.C. DIVISION CANADIAN MEDICAL ASSOCIATION

R. A. Palmer, M.D., Chairman

The members of the committee were appointed by the board of directors of the division shortly after the annual meeting in September, 1951, and were chosen from the elected members of the assembly. It was felt therefore that the members would be reasonably representative of the profession as a whole. The members appointed were R. A. Palmer, Chairman; N. J. Blair, Peter Lehmann, F. P. Patterson, Ross Robertson, of Vancouver, and W. R. Brewster of New Westminster; John Tysoe of Victoria; H. F. P. Grafton, Kamloops and F. L. Wilson of Trail. Dr. F. L. Wilson was unable to serve. Ex-officio members of the committee are President of the Division, Dr. H. A. L. Mooney, and the Chairman of the General Assembly, Dr. F. A. Turnbull. Apart from some preliminary organization, the work of the committee did not begin until the 12th of January, 1952, when a joint meeting was held with the council of the college. At this time the president of the council announced that as a result of the plebiscite held in early December, 1951, the council felt that it must turn over all authority for the problems of medical economics to the representatives of the B.C. Division, and were prepared to do this as of the 11th of January, 1952.

At that time the work presented to the committee appeared to divide itself into two main groups: first those problems requiring immdiate or early action, such as the W.C.B. fee revision, the renewal of the S.A.M.S. contract, a revision of the tariff

schedule for medical fees, problems of prepaid medical plans, and the day-to-day problems of individual practitioners in the economic aspects of the practice of medicine; secondly, long-term problems, such as the various aspects of health insurance, provincial and dominion, studies of the basic costs of medical services of various types, and basic principles for the establishment of tariff schedules, studies of the patterns of practice, and changing methods of providing medical care to the community.

One other problem of considerable practical importance is the means of selection of future Committees on Medical Economics and its various sub-committees. This matter will undoubtedly be one of the early problems for the special session of the Assembly called for May, 1952, in order to insure that such committees, which may considerably influence the welfare and prosperity of the profession, are composed of men or women who are fully representative of the profession and enjoy the over-all confidence of the profession.

The committee began its work the 12th of January, 1952, and made preparations to cope with those existing problems requiring immediate or early attention. It soon became evident that a very considerable amount of work had already been done by the council of the college which prepared much of the groundwork for the handling of the various problems, and all this work was at once made available to your committee. The several main problems of Medical Economics were referred for study to separate sub-committees, which, with one exception, were set up under the chairmanship of a member of the main committee on medical economics, as follows:

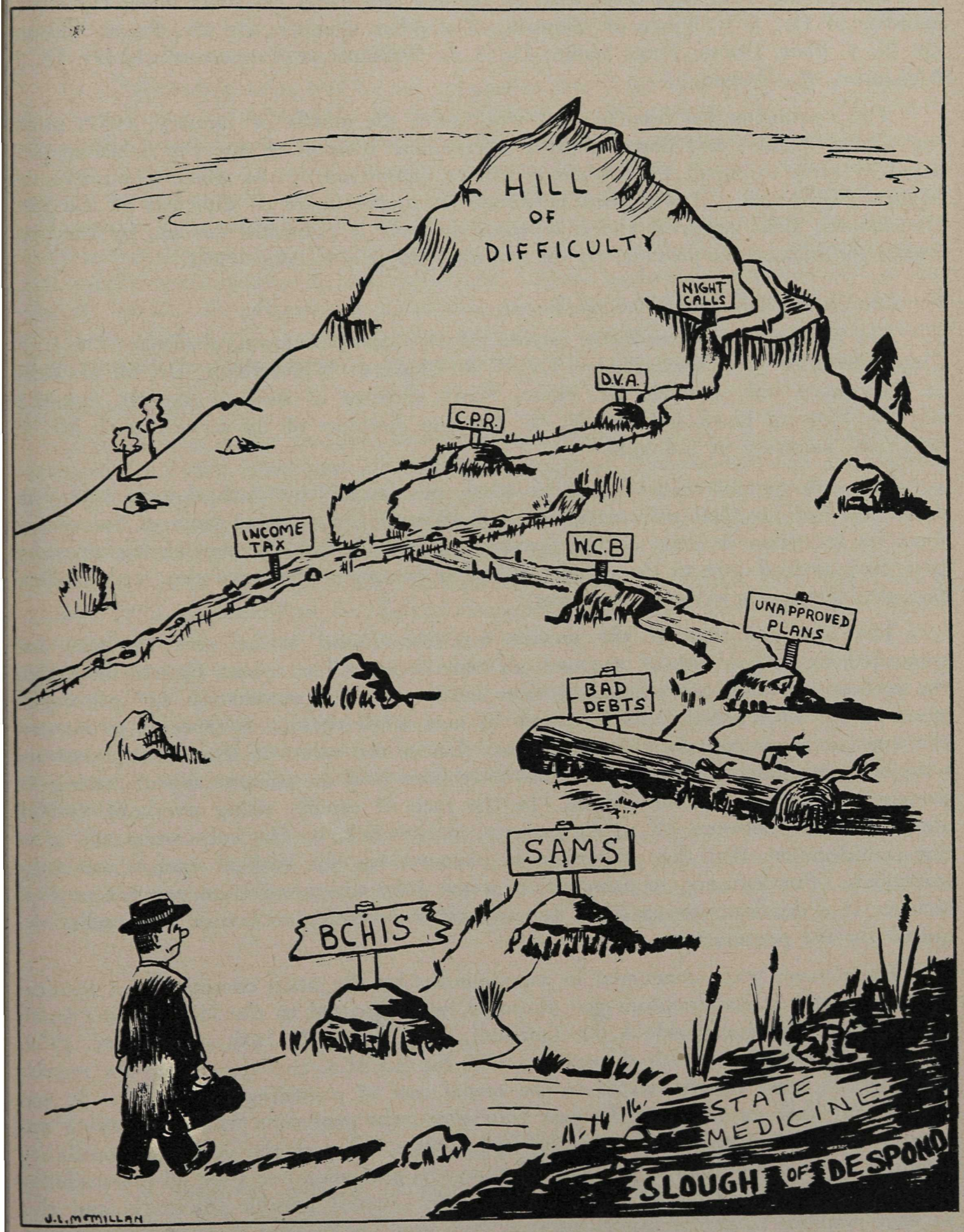
S.A.M.S. ..... Dr. Ross Robertson
Tariff ..... Dr. John Tysoe
Pre-Paid Plans ..... Dr. Peter Lehmann

The sub-committee set up by the council to negotiate with the Workmen's Compensation Board on revision of fees was at that time preparing to meet with the board. The members of that sub-committee were: Dr. Fred Sparling, New Westminster, Chairman; Dr. Roy Huggard, Vancouver, and Dr. G. A. McLaughlin of North Vancouver. These members were good enough to accept re-appointment for this work, as a sub-committee under the committee on medical economics of the B.C. Division, and began negotiations with the W.C. Board the 14th of January, 1952 as had been originally planned.

All of the above sub-committees have been regularly at work in the past two months and the present status of the various so-called immediate problems in Medical Economics may be summarized as follows:

1. *W.C.B. Fee Revision*

The members of our sub-committee under Dr. Fred Sparling held regular meetings with the representatives of the Medical Division of the Board until the end of February, 1952. These meetings were carried on in an atmosphere of harmony and goodwill, and attempt was made to consider the interests of all the parties concerned. Each item in the W.C. Board schedule was scrutinized, with a view to correcting any unsatisfactory situations and to secure conformity as far as possible with the existing tariff schedules of the medical profession. An obvious difficulty in proceeding with this work arose from the fact that revision of the 1948 schedule of the medical profession had not been completed or officially accepted, and was therefore not available as a guide to the sub-committee. However, the unapproved revision was used as a reference as far as it was appropriate to do so. The resulting recommended revised W. C. Board fee schedule has been reviewed by the main committee for Medical Economics and we believe that it represents a satisfactory revision of most items, though for obvious reasons it may not conform entirely to the 1952 tariff revision of the profession. Not only does our sub-committee under Dr. Fred Sparling deserve the thanks of the profession for very much time and effort devoted to this problem, but we also owe thanks to Dr. Giles Murphy of the Board and his medical officers, who



A PILL MAN'S PROGRESS

worked with our representatives in a sincere and courteous attempt to straighten out existing problems.

2. *Revision of the Minimum Schedule of Fees of the Medical Profession in B.C.*

This problem has been dealt with by the sub-committee on tariff under the chairmanship of Dr. J. F. Tysoe of Victoria. The other members are Dr. Roger Wilson, Dr. N. J. Blair, Doctor Peter Spohn, Dr. S. L. Williams of Vancouver and Dr. H. J. Alexander of Vernon.

This committee has been hard at work since the middle of January, 1952, meeting almost weekly, and hopes to have a complete revision of the Fee Schedule prepared by early in April, 1952 when it will be considered by the whole Committee on Medical Economics. It will then be passed on to the board of directors of the B.C. Division for final approval and it is hoped to have it published for use by the profession throughout the province by the end of April or early May, 1952.

3. *The Social Assistance Medical Services*

The appointed sub-committee consists of Dr. Ross Robertson, chairman; Dr. L. S. Chipperfield, of New Westminster; Dr. T. R. Blades of White Rock; Dr. M. M. Baird of Vancouver and ex-officio Dr. Henry Scott, director of medical services, S.A.M.S. and Dr. Howard Black and Dr. W. W. Simpson directors of the service, with Mr. E. Deighton, secretary of S.A.M.S.

This sub-committee examined the whole position of this medical service in some detail and had for their information records extending over three years of the service since its inception in 1948. It is generally accepted that the service has provided first class medical care to the recipients, and it compares very favorably with medical care available under any other auspices.

The administration of the service was also found to be very efficient, and amounted to 4.8 percent of the over-all expenditure. The recent figures show that the cost of provided professional services amounted to approximately $27 per capita based on the 1948 schedule of fees, and the new tariff revision is expected to increase this cost to approximately $29 per capita. Under the terms of the existing contract with the government the profession has only been paid an amount approximating 50 percent of the cost of the service. In the face of rapidly rising overhead (which annually varies between 30 to 65 percent) it was felt by the sub-committee, after due consideration, that this proportion of payment for our medical services was quite inadequate. Furthermore, in principle, it seems quite unreasonable to pay for medical services at a discount greater than for any other necessary service or commodity required for the pensioners.

These views were concurred in unanimously by the main committee on Medical Economics and a memorandum was prepared and presented to the Minister of Health and Welfare, the Honourable A. D. Turnbull, on Saturday the 16th of February, 1952, showing our experience with the operation of the S.A.M.S. and our reasons for requiring payment more closely related to the actual cost of providing the service. It was pointed out that, in effect in the past four years, the profession had been paying approximately 50 percent of the cost of the service, whereas the actual responsibility belonged to the community as a whole. The medical profession had a special responsibility in providing a high standard of service with the greatest possible efficiency; and this we were prepared to do if a reasonable agreement could be reached with the government. In lieu of certain costs assumed by the government, such as the collection of funds, your committee proposed to the Minister that we would be prepared to accept a discount of 10 percent of the estimated cost of the service which would raise the actual capitation fee to approximately $26 for 1952-53. Negotiations are still continuing, but to date Mr. Turnbull has given us little hope of a satisfactory settlement. It may be necessary

for the profession to terminate the contract and consideration is now being given to this eventuality.

It is the opinion of your committee that the position of the profession in this matter is basically a sound one as we know the actual cost of service to date, and can estimate the cost for the next year or two. At the same time it is quite unsound to expect the medical profession to continue to provide medical service under a contract so far below the actual cost of operation.

Mr. Turnbull pointed out to the committee two important problems which have been concerning his department in the operation of the services: Firstly, the rapidly rising utilization of drugs which has been due entirely to increase in the qualities used, and not to increase in price: Secondly, the steady increase in the utilization of all medical service by the pensioners. The minister requested the co-operation of the profession in attempting to find satisfactory measures of control of these factors. The minister was assured by the committee that we would give both these important problems careful consideration to determine how far the profession may usefully or may properly assist. At present the committee on pharmacy of the B.C. Division under Dr. D. M. Whitelaw is considering the problem of the utilization of medical services. It is expected that some useful recommendations will arise from these studies.

4. *Pre-Paid Plans*

This sub-committee has been under the chairmanship of Dr. P. O. Lehmann and includes Dr. Elmer Jones and Dr. Gordon Francis of Vancouver, with Dr. Gordon Grant of Victoria and Dr. Jack Sinclair of New Westminster. The sub-committee has had several meetings to consider the existing problems and it is anticipated that a joint committee meeting with the main committee will be held soon.

In summary, this report may indicate to the profession that since the 12th of January 1952 the committee on Medical Economics of the B.C. Division and its various sub-committees have been hard at work examining the various problems with some care and attempting to find some reasonable answer to them. Considerable progress has been made in several directions, and it is hoped to have more to report in the near future. It must be apparent that a number of the problems must necessarily be continuing, and lend themselves only to interim solution from time to time, and which are likely to require reconsideration in the future in the face of changing community conditions.

The terms for renewal of the S.A.M.S. contract have given your committee the greatest concern. Unless the government is prepared to offer more favourable terms it would seem necessary to terminate the contract. In doing so we must insure that the pensioners themselves will not be deprived of essential medical services.

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WANTED

A medical officer is required (preferably with radio-therapy experience) for the months of June, July, August, and September at the British Columbia Cancer Institute.

Application should be made to the Director of the British Columbia Cancer Institute, 685 West Eleventh Avenue, Vancouver 9, B.C.

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

Present Status of Chemotherapy in Tuberculosis

With the changing concepts in the use of these agents, the manner in which they are used in the Division of Tuberculosis Control was thought to be of interest.

Streptomycin—Toxic effects and the development of a drug-fast state have been the limiting factors in the use of this antibiotic. Investigations have gradually evolved a regime whereby these adverse affects have been minimized. By means of reducing the individual dose and prolonging the interval between doses, a marked reduction in the incidence of toxic manifestations and drug-fastness has occurred. This has been accomplished without appreciable loss of therapeutic effect and permits treatment to be carried on for longer periods. The regime used is, *administering 1 gm. of streptomycin dissolved in 3.5 cc of normal saline intramuscularly, twice weekly for a period of six months.*

P.A.S.—It is the policy to administer this agent always in conjunction with streptomycin. The effects of the two drugs are greater than either alone and the development of drug-fastness is diminished by their combination. P.A.S. is used in its sodium salt powdered form and only rarely has it been found that patients could not tolerate it. *P.A.S. is given by mouth in 3 gm. doses repeated three to four times daily so that a total of 9-12 gms. are given daily for a period of seven months.*

Dihydrostreptomycin—Utilization of the above regime has eliminated the original reason why this drug was advocated, namely avoiding the vestibular toxic effects of streptomycin. Subsequently, it has been found that to achieve effects comparable with streptomycin, the dose of dihydrostreptomycin must be doubled. Using this dosage, it has been found that dihydrostreptomycin produces as frequent neuritic effects as streptomycin, causing permanent auditory nerve damage with resultant deafness, whereas streptomycin affects the vesticular nerve and there is usually complete recovery within six to eight weeks. Dihydrosteptomycin is used only under special circumstances.

Indications—No fixed rules can be listed as to the use of streptomycin and P.A.S.: each case must be assessed individually. Several general principles can be stated, however:

(1) The entire plan of treatment should be outlined and then the use of the antibiotics so timed that their maximum effect will occur at the most advantageous period.

(2) Their immediate use is indicated in acute fulminating disease or pneumonic or miliary types of spread; in these latter cases the initial dose should be larger.

(3) When cavitation is present antibiotics should be withheld until they can be used in conjunction with collapse therapy.

(4) Minimal effects can be expected in fibro-caseous type of disease.

(5) The regime of 1 gm. of streptomycin twice weekly and 12 gms. of P.A.S. daily is advocated for all types of extra-pulmonary tuberculosis where antibiotic therapy is indicated.

(6) Rarely will the antibiotics alone control tuberculosis and therefore other forms of treatment and care must not be ignored or abandoned. These drugs only form an addition to the armamentarium used in combatting tuberculosis.

New Director for Division of Venereal Disease Control

Dr. John Nelson has been appointed as Director of the Venereal Disease Control Division. Dr. Nelson who was formerly physician in charge of Clinics with this division, has returned from a position as Venereal Disease Consultant with the New York State Department of Health, to accept this appointment.

Dr. Charles Hunt, who was full-time Director of the Division for two years and part-time director for the last year, has agreed to remain as Physician in Charge of Clinics on a part-time basis until a replacement can be obtained for this position. Following this he will act as a consultant to the division and continue his practice in Vancouver.

New Health Units

The municipalities of Surrey and Delta and School Districts Number 36 and 37 have consolidated their community and school health services in a Union Board of Health for administration through the Boundary Health Unit, with headquarters at Cloverdale.

Dr. H. K. Kennedy, former Director of the North Okanagan Health Unit, has transferred to accept the appointment as Director of the new Health Unit, and has been appointed Medical Health Officer and School Medical Inspector for this area.

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BRITISH COLUMBIA PROVINCIAL BIOPSY SERVICE

Pathological Tissue Label Form

Private physicians may obtain the above form from their local hospital.

The hospital should request additional supplies of this form from the Health Branch, Department of Health and Welfare, Victoria, B.C.

This form must accompany specimens submitted for examination free of charge under the Provincial Biopsy Service.

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LOCAL RECURRENCE FOLLOWING SUBTOTAL RESECTION FOR GASTRIC CARCINOMA

*Frank B. Thomson, M.D., and R. Edward Robins, M.D.**

The five-year survival rate following subtotal gastrectomy for carcinoma of the stomach is reported to be approximately 20 percent when radical local excision is carried out. In average surgical practice it is probable that only those cases of carcinoma *in situ* or low grade tumors, which might have survived five years anyway, are salvaged by the usual subtotal gastrectomy.

Why does subtotal gastrectomy fail? Is it because distant metastases, microscopic in size, have already occurred at the time of operation? While this may well be the case, to accept this thesis would mean that palliative resection should be the rule. In the absence of conclusive proof that this is so, surgeons are unwilling to adopt such a pessimistic attitude. Assuming therefore, that in a reasonable number of cases, distant metastases of a microscopic size have not occurred at the time of resection, a study of the incidence of local recurrence in gastric or duodenal stumps and immediate lymphatic drainage should help to reveal some of the shortcomings of this operative procedure.

From the Vancouver General and Shaughnessy Hospitals, we have obtained the records of 28 cases, each of which, after a previous subtotal gastrectomy for carcinoma of the stomach, had a post mortem examination. Following a study of these records, local recurrence in gastric stump, duodenal stump and gastric bed were tabulated. By the term gastric bed is meant the immediate perigastric tissues including the whole of the pancreas. In 6 cases, because of massive local recurrence, it was impossible to be sure whether the recurrence originated in gastric stump or gastric bed These have been listed as questionable.

* Presented at monthly staff meeting, Vancouver General Hospital, Nov. 27, 1952.

SITE OF RECURRENCE

	Gastric Stump	Duodenal Stump	Gastric Bed
Recurrence	5	3	13
Negative	17	25	9
Questionable	6	0	6
Total Cases	28	28	28

In these cases, the incidence of gastric stump recurrence is approximately one-half that in the gastric bed. In recent study of a similar nature, McNeer *et al*[1] reported their findings as follows:

SITE OF RECURRENCE

	Gastric Stump (all cases)	Duodenal Stump (alone)	Gastric Bed (alone)
Recurrence	46	9	19
Negative	46	78	44
Total Cases	92	87	63

These figures seem to indicate a much higher relative incidence of gastric stump as compared to gastric bed recurrence. However, in reporting all cases of gastric stump recurrences and only those cases of gastric bed recurrence in which the gastric stump was negative, they have assumed that in those cases in which both gastric stump and gastric bed are involved, the recurrence in the gastric bed arose subsequent to the gastrectomy and also as a secondary spread from the recurrence in the gastric stump. It is at least as probable that microscopic gastric bed secondaries were already present at the time of operation in these cases and to assume that they arose post-operatively is not justified. Also, if in these cases the gastric bed secondaries all arose as spread from the

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* Presented at monthly Staff Meeting, Vancouver General Hospital, November 27th, 1952.

gastric stump recurrence, then a study of these cases with gastric stump recurrence should reveal a higher incidence of gastric bed recurrence than in those cases with a negative gastric stump. In this regard, a study of McNeer's figures reveals the following:

	Total No. of cases	Gastric bed recurrence No. of cases	% cases
Gastric or duodenal stump recurrence	54	29	54
stump negative	38	19	40

In our own smaller series, the findings were as follows:

	Total No. of cases	Gastric bed recurrence No. of cases	% cases
Gastric or duodenal stump recurrence	7	4	59
Gastric or duodenal Stump negative	17	11	65

The percentages in both series are so close as to suggest that the gastric bed recurrence rate is independent of the presence or absence of gastric or duodenal stump involvement, and therefore that microscopic secondaries in the gastric bed are already present at the time of operation in the same percentage of cases subsequently developing gastric stump recurrence, as in those that do not. Therefore, all cases of gastric bed or duodenal stump recurrence should be included and not just those in which the gastric stump was negative. With this conclusion in mind, it is possible to present the incidence of gastric or duodenal stump and gastric bed recurrence in McNeer's series and to compare this with the smaller present series as follows:

	Site of Local Recurrence						Local Recurrence Present
	Gastric Stump		Duodenal Stump		Gastric Bed		
	#	%	#	%	#	%	%
McNeer *et al* 92 cases	46	50	14	15	48	53	80.5
Van. Gen. Hosp. and Shaughnessy Hospital 28 cases	5-11	18-40	3	11	13-19	46-68	93

It remains therefore to consider the incidence of local recurrence as tabulated above, and from this information attempt to determine why subtotal gastrectomy fails to prevent local recurrence of gastric carcinoma.

Gastric stump recurrence is sufficiently frequent to suggest that resections are too often done through involved gastric tissue. McNeer et al[1] report gastric recurrence in 50% of cases. The exact incidence in our series is confused by the presence of six cases in which it was not possible to be sure where the local recurrence originated. That a similar difficulty is not reported in McNeer's series is surprising. The classification of all such doubtful cases as gastric stump recurrence would, of course, markedly raise the apparent incidence of this complication in any series (from 18 percent to 40 percent in the present series). Coller and Kay[2] found carcinoma at the line of gastric section in 24.5% of surgical specimens examined. Zinninger and Collins[3] reported a similar finding in approximately 15% of surgical specimens. Lahey and Marshall[4] quote a personal communication from Shields Warren who found gastric stump recurrence in

19.6% of 122 cases coming to post mortem having had a previous subtotal gastrectomy for carcinoma. It would seem from the above reports and our own experience, that the line of gastric section is too low in roughly 30% of cases. Does this mean that total gastrectomy should be the rule for all carcinoma of the stomach? This has been advocated in recent reports by McNeer[1] and Lahey[4]. Wangensteen[5] in 1947 stated that it remained to be proven that total gastrectomy would materially improve the five-year survival rate. Longmire[6] in 1947 stated that the post-operative disability after total gastrectomy was such that it should not be a routine procedure for carcinoma of the stomach. Walters et al[7] in 1947 were not in favor of routine total gastrectomy unless it was obviously necessary if we could reasonably expect to remove all the cancerous tissue in the stomach. In their opinion, adequate local lymph gland removal is just as possible with subtotal as with total gastrectomy. While it may be too soon to judge, there has been no series in the surgical literature to date showing any significant improvement in the cure rate by routine total gastrectomy. The functional result is so much better after subtotal resection that a portion of the stomach should be left it at all possible. West[6], in discussing a series of total and subtotal resections, noted a much better nutritional status in the subtotal as compared to the total resection. How then are we to prevent the 30% gastric stump recurrence and still avoid the functional disability of routine total gastrectomy? Seventy percent of gastric carcinoma occurs in the prepyloric area and 30% in the body or cardia. Certainly subtotal resection should be adequate in those prepyloric tumors that show no gross evidence of extensive proximal intramural infiltration. Zinninger and Collins[3], from their study of surgical specimens, stated that the line of gastric section should be two inches above what one would consider to be safe, and beyond all gross evidence of infiltration. McNeer et al[9] take a circular quick section at the line of gastric division. Subtotal gastrectomy should be an adequate procedure in a significant number of cases if the line of gastric section were kept at least two inches proximal to all gross evidence of intramural infiltration in those cases of prepyloric carcinoma without extensive proximal infiltration. It should be noted that while total gastrectomy may be indicated in the widely infiltrated cases, the incidence of distance metastases at the time of operation in such cases is so high that total gastrectomy should nearly always be considered a palliative procedure.

The duodenal stump is also an important site of local recurrence. That pyloric carcinoma directly invades the first portion of the duodenum was clearly demonstrated when Coller and Kay[2] found duodenal involvement in 26% of surgical specimens. Zinninger and Collins[3] in a similar study reported 25% duodenal spread. McNeer[1] found recurrence in the duodenal stump in 15% of post mortems after partial gastrectomy. In our smaller series there were 3 cases (11%) of duodenal stump recurrence. Certainly the whole of the first portion of the duodenum must be resected in any partial gastrectomy for carcinoma of the pyloric end of the stomach if duodenal stump recurrence is to be prevented.

Local recurrence in the gastric bed is even more frequent than in gastric or duodenal stumps. Consideration of our own small series and McNeer *et al's* larger one suggests that slightly over 50% of cases recur in the local lymphatic drainage area. Also it seems likely, as mentioned above, that this area is already microscopically involved at the time of resection and not secondary to recurrence in gastric or duodenal stumps. The anatomical distribution and the frequency of recurrence in the various components of this lymphatic drainage were investigated by Coller and Kay[2]. They described the group of glands lying over the head of the pancreas and adjacent to the distal portion of the greater curvature and first and second portions of the duodenum as the inferior gastric group. This group drains the pylorus and the first portion of the duodenum, and was more frequently involved than any others (65% of cleared surgical specimens). Of those specimens with positive inferior gastric glands, the carcinoma extended to the line of section in this area in over 60%. Therefore, because the greater part of this group is technically inseparable from head of pancreas and

duodenum, residual carcinoma must have been left in this area in over 60% of their cases. They performed three autopsies after partial resection and in two cases found involved glands about the head of the pancreas and the duodenal stump. Coller and Kay[2] state that "residual carcinoma is frequently left in this area." The glands in the lesser omentum and along the course of the left gastric artery known as the superior gastric glands were involved in over 40% of their cases. These drain to the celiac glands lying at the superior border of the pancreas at the junction of body and tail. Of the cases in which this group was involved, there was carcinoma to the line of section and therefore residual carcinoma left in this area in 65%. The suprapyloric glands about the hepatic artery also drain into the celiac group and were positive in over 20% of specimens. Then pancreaticolienal glands along the proximal portion of the greater curvature and the superior border of the tail and body of the pancreas were involved in over 13% of specimens.

It should be evident from the studies of Coller and Kay[2] and from a knowledge of lymphatic anatomy that the lymphatic drainage of the stomach lies to a considerable extent in the peripancreatic tissues, and particularly about the head of the pancreas. A major portion of the infrapyloric glands and almost all of the celiac and pancreaticolienal glands are intimately associated with the pancreas. This major portion of the immediate lymphatic drainage of the stomach, lying as it does in the peripancreatic tissues and technically inseparable from the pancreas itself, is not removed during radical partial gastrectomy for carcinoma of the stomach as at present carried out. Because of this the highest incidence of local recurrence (over 50%) is found in this area. It would appear from this study that local recurrence in the immediate lymphatic drainage area of the stomach is extremely frequent and that from a pathological standpoint it could only be significantly reduced by the addition of total pancreaticoduodenectomy to the radical operative treatment of selected cases of carcinoma of the stomach. Whether such a radical approach is feasible could only be determined by experience.

CONCLUSIONS

1. In those cases of carcinoma of the stomach that develop recurrence in the immediate lymphatic drainage area (gastric bed) after partial gastrectomy, it is more likely that these glands were already the site of microscopic secondaries at the time of operation, than that they became involved because of secondary spread from subsequent recurrence in the gastric or duodenal stumps.

2. The gastric stump recurrence rate following partial gastrectomy for carcinoma of the stomach is approximately 30%.

3. The duodenal stump recurrence rate following partial gastrectomy for carcinoma of the stomach is 10 to 15%. This would be significantly reduced if the whole of the first portion of the duodenum were routinely resected in all operations for carcinoma of the stomach.

4. A significant portion of the immediate lymphatic drainage of the stomach lies in the peripancreatic tissues and is technically inseparable from the pancreas.

5. This commonly involved portion of the immediate lymphatic drainage is not removed in radical partial gastrectomy as at present carried out for gastric carcinoma. For this reason there is local recurrence in this area in over 50% of cases.

6. This peripancreatic portion of the immediate lymphatic drainage of the stomach could only be excised by adding total pancreaticoduodenectomy to the radical operative procedure in carcinoma of the stomach.

7. In pyloric carcinoma that remains reasonably located in the gross, subtotal gastrectomy plus radical excision of the immediate lymphatic drainage is more likely to improve the cure rate than is routine total gastrectomy.

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NOTES ON INCOME TAX

The following information was obtained by the committee on Legislation for the benefit of the members, particularly those on salary:

"A doctor who derives his professional income from the carrying on of a business is entitled to deduct annual membership fees paid to professional and scientific associations or societies. A doctor who derives his professional income from an office or employment is entitled to deduct only membership fees necessarily paid in order to maintain a professional status recognized by statute.

Expenses Incurred by an Individual Partner and not Deductible from the Partnership Income

The Income Tax Department now permits the deduction of such expenses if they are incurred for the purpose of earning income from the business, are not capital expenditures and are reasonable in the circumstances.

Travelling Expenses

A salaried doctor who is ordinarily required to carry on the duties of his employment away from his employer's place of business or in different places, and who under the contract of employment is required to pay the travelling expenses incurred by him in the performance of the duties of his office or employment may deduct the expenses so incurred.

Please see above remarks with reference to travelling expenses. If a doctor is entitled to claim automobile expenses he must file with his return a detailed record of such expenses prepared from records and vouchers available for inspection.

Office Expenses

A salaried doctor may deduct the cost of supplies that were consumed directly in the performance of the duties of his office or employment if he was required by the contract of employment to pay for such supplies. He may also deduct office rent, or salary to an assistant or substitute, the payment of which was required by the contract of employment.

SOME SURGICAL ASPECTS OF MELANOMA

*J. A. Elliot, M.D.**

Of all tumours of the skin the pigmented lesions are probably the most frequently misdiagnosed—the errors being in two directions—the benign nevi are often called malignant and the malignant melanomas are considered benign. There are two major theories of origin of the nevi—the neural and the epidermal—time will not permit a detailed discussion of the origin, other than to say that each theory is strongly supported by leading pathologists. The neurogenic theory is more widely accepted. Allen who is a real authority on melanoma supports the epidermal theory.

A classification of nevus—the benign lesion

1. Juncional nevus or epidermal nevus.
2. Common mole or intradermal nevus.
3. Compound nevus which is a combination of the first two.
4. Juvenile melanoma—generally speaking the term melanoma suggests malignancy, but prior to puberty these juvenile melanomas present a histological picture of a malignant tumour, but in spite of this they behave as benign lesions, in fact Pack states: "In our experience with more than 1050 verified cases of malignant melanoma we have never observed a single instance in which a melanoma of infancy or childhood metastasized to nodes or viscera, and we have never witnessed a fatal outcome."

The clinical features of juvenile melanoma are verrucous lesions with irregular margins—all are elevated—their colour varies from pink to red and brown to black. None are hairy. They occur anywhere on the body. There is usually a history of gradual increase in size and pigmentation but not a history of ulceration or bleeding.

Allen, of the Memorial Hospital, believes that all malignant melanomata arise from the junctional nevus. The lesion is smooth, hairless, light to dark brown, flat to slightly raised, and occurs on any part of the body. Pigmented lesions on the palmar surface of the hands, the plantar surface of the feet and the external genitalia, may be assumed to be junctional inasmuch as the common mole is rarely found in these sites. The junctional nevus may be present at birth or develop any time after birth. A junctional nevus begins in the basal layer of the epidermis at the junction of the epidermis and dermis, hence the name junctional.

The common mole or intradermal nevus is the ordinary nevus of which few people are completely free—it occurs in the skin of any part of the body, excepting for all practical purposes the external genitalia, the palms, the soles and the pulps of the fingers and toes. It is pink to various shades of brown—flat or papillary—may or may not contain hairs—if a pigmented nevus contains hair it is extremely likely to be a common mole.

Unfortunately there is nothing about the clinical appearance of a compound nevus to suggest that the common mole has been compounded with a junctional nevus—until the latter becomes active. Such activity is reflected in the increased depth of pigmentation as well as area of colouration for the junctional change spreads superficially along the epidermis.

A malignant melanoma is a pigmented spot, especially one that is hairless, and that enlarges, darkens in colour, bleeds and ulcerates or becomes nodular. What is the trigger mechanism that provokes a junctional nevus to become malignant? It may be assumed to be endocrine because of the rarity of malignant lesions prior to puberty and because of their rapid growth during pregnancy.

Trauma is generally assumed to make dormant junctional nevi flare up. Junctional nevi of the soles of the feet, the palms of the hand and bearded area of a man's face are repeatedly subjected to trauma.

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* Presented at regular Staff Clinical Meeting of V.G.H. September 25th, 1951.

From the foregoing description of the different types of benign nevi one can readily see how difficult it is to be sure of one's diagnosis except by biopsy.

In a review of 56 cases of melanoma, proven by biopsy, the following data were found.

Presenting symptoms in 56 cases

Increase in size	29
Bleeding	14
Increase in pigmentation	9
Raised lump on warty growth	8
Ulceration	6
Itchiness	5
Pain	5
Pimple which failed to heal	4
Enlarged gland	2
Callous formation	2
Infection under nail	3
Blister	2

The usual physical finding was a pigmented lesion varying in colour from a light brown to black, flat or raised; some had marked proliferation, giving the appearance of a pyogenic granuloma arising from a pigmented lesion. Other cases were ulcerated. A few, particularly on the foot, appeared as ulcers with little or no pigmentation to be seen. Most lesions were from 1-2 cm. across, others varied from a few mm. up to several cm. Some of the light brown lesions had scattered dark spots through them.

In table two one can readily see that the disease in this series of cases was rare before the age of 20 and that the age incidence in each decade over 20 was relatively equal, except in the 60-69 group.

Age Incidence

Under 19	1
20-29	7
30-39	5
40-49	7
50-59	7
60-69	17
70-79	7
80-	6

Table 3 shows the location of the primary tumour in this series of 56 cases. 37% of the total occurred on the head and neck, 21% on the feet and 7% on the hands. The incidence on the hands and feet is interesting in that the common mole is very rare on the feet, but not uncommon on the hands.

Location of primary tumour

Head and Neck		21
Face	15	
Neck	6	
Upper Limb		9
Arm	3	
Forearm	3	
Palm	2	
Back of Hand	1	
Subungal	1	
Trunk		11
Back	6	

Lower Limb	15
Thigh	2
Leg	3
Heel	2
Toe	4
Rest of Foot	4

Table 4 reveals the fate of 21 cases who had glandular involvement when first seen—17 died, 2 were not followed, one was only one month post operative following radical axillary glandular dissection and one had survived 4 years but this case is known to have visceral metastases. He was operated on one year ago for small bowel obstruction, which was due to intussception from a secondary melanoma in the jejunum.

21 *cases with Glands when first seen*

Site of Primary	*Age*	*Treatment to Glands*	*Dead Years after onset*	*Alive*
L Arm	20	Not radical		
Sole of Foot	20	Only inguinal		
Forearm	80	None—age	1	
Thigh	32	Inguinal and fem.	3 (cause not known)	
Mastoid	61	X-ray	Known secondaries	4
Neck	61	No, radical	No record since 1948	
Back	45	Yes, radical	2 (cause not known)	
Nose	80	X-ray	1 (cause not known)	
Heel	69	X-ray	½ (cause not known)	
Arm	42	Yes, radical		1 month
Back	55	Inguinal and fem.	1	
Cheek	68	Yes, radical	No record since 1949	
Face	69	X-ray—age	1	
Toe	87	X-ray	3	
Neck	30	X-ray	5	
Foot	83	X-ray	1 (cause not known)	
Head	30	X-ray	1	
Foot	52	No treatment	0	
Arm	53	X-ray	1	
Neck	65	X-ray	4	
Thumb	59	No treatment		

Table 5 reveals the treatment given to these 56 cases. The 4 cases who had amputations had such procedures carried out only on the toes.

Treatment

1. Local excision	15
2. Local and gland dissection	10
3. Local and radical dissection	5
4. Local and radiation	12
5. Radiation after biopsy	9
6. Hopeless	1
7. Amputation	3
8. Amputation and radical glds.	1

Table 6

5-year survival rate

No. of cases followed		21
No. of deaths		14
From melanoma	9	
Probably from melanoma	3	
Cause unknown	2	

Table 6 shows the 5-year survival rate as 33% in 21 cases who were seen 5 or more years ago. In the lower table are shown figures from other centres.

Author	*Treatment*	*No. of Cases*	*Successful Results* No.	%
Mohs	Chemosurgical	20	7	35
Scharnagel	Surgical & radiation	49	19	38.7
Cholnoky	Surgical	26	9	34.7
Adair	Surgical	125	35	28
Pack and associates	Surgical	852	?	17.7 & 15.6

In attempting to arrive at some conclusion as to the incidence of melanoma, I reviewed all the positive biopsies for primary melanomata in the Pathology Department of the Vancouver General Hospital for the periods 1948-51 inclusive. There were 38; this averages about 10 per year in a large hospital.

As the series is small and the types of treatment many, I did not attempt to determine the result from the different forms of therapy.

Treatment

The treatment for malignant melanoma of the skin is wide surgical excision. By and large these tumors are very radio-resistant. Pack states "we may state that we have never been able to cure a single patient of melanoma by radiation therapy alone." Radical surgical removal should effect a cure in those cases without metastases. Unfortunately these tumours are often removed under the incorrect assumption that a benign nevus is being excised; in such cases early local recurrence is the rule.

The removal of a liberal segment of skin containing the tumor with a wide dissection of subcutaneous tissues and deep fascia make it possible to close the wound without grafting, but it is the rule that all malignant melanoma distal to the knees and elbows and on the head and neck be removed with such wide sacrifice of skin that grafting becomes necessary.

In a melanoma situated adjacent to the lymph glands into which it may metastasize, one should employ the same principle as in radical mastectomy—the tumor, a wide area of skin, a wider area of subcutaneous tissues, deep fascia and lymphatic channels plus the regional lymph glands are removed *en masse*. The procedure in melanoma entails a wide sacrifice of skin surrounding the tumour and extension of this skin excision to include the skin overlying the regional lymph nodes: the skin flaps are dissected widely back, then the subcutaneous tissue with the deep fascia and lymphatics and the overlying ellipse of skin with the tumor are dissected to the lymph-bearing area where radical dissection is carried out. This procedure is not feasible where a long distance intervenes between the primary and regional lymph glands, as in a melanoma of the sole of the foot. In such a case one excises widely and if there are no glands the patient should be seen at frequent intervals and a search made for any evidence of dissemination of the melanoma.

If there is evidence of glandular involvement then one should do a hip-joint disarticulation with a deep iliac glandular dissection after x-ray of the chest and careful examination of the liver and other viscera.This may seem very radical but when one realizes that we are dealing with one of the most malignant of cancers it is a sacrifice that has to be made. The reasoning behind this operation is that it is asking too much for a cancer as highly malignant as a melanoma to spread all the way up through the myriads of lymphatics intervening between the foot and the groin without some of the melanoma cells becoming lodged in the minute lymph nodes intercalated in these pathways.

The radical operation is not done until one has microscopic evidence that metastases have occurred in the lymph nodes.

Conclusions

Malignant melanoma are rare.

All nevi of soles of feet, palms of hands and external genitalia should be excised and sent for biopsy because they are more likely to undergo malignant changes.

Any nevus that shows increase in size or pigmentation, ulceration, or bleeding, and any of the other symptoms I showed in Table I, should have a biopsy.

All malignant melanomas should be surgically treated as outlined.

X-ray has little to offer except in the very occasional case.

CO_2 snow and electrodesiccation are dangerous, except in the common mole, proven to be such by biopsy.

News and Notes

Dr. L. Maher is now practising in Quesnel.

Dr. H. H. Murphy of Victoria has retired.

Dr. J. E. Spankie of Vancouver has retired.

Dr. R. Farish is now practising in Vancouver.

Dr. T. R. Osler of Vancouver has received his fellowship in surgery.

Dr. M. K. Weare is now practising in Terrace, B.C.

Dr. K. S. Alstad of Scotland is now in West Vancouver.

Dr. F. J. Lishman of England is now with the Kamloops Health Unit.

Dr. Doreen Walton is now practising in Trail.

Dr. Wallace Wilson of Vancouver, has been elected president of the Community Chest and Council.

Dr. Max Word of Vancouver has opened new offices in the Burrard Medical District.

Dr. G. A. Bird of the D.V.A. in Vancouver has returned to California.

Dr. K. C. Boyce of Vancouver is now of the Hospital of Special Surgery in New York.

Dr. Don Williams of Vancouver is now in Europe for the World Health Organization.

Dr. D. J. Oakley of North Vancouver is now practising in Prince Rupert.

Dr. T. A. Johnston of Hollyburn has opened a new office in West Vancouver.

Dr. E. T. Felsted of Vancouver has received his certification in radiology.

Winter visitors to California have been *Drs. A. E. Trites, W. F. Bie, D. Tompsett, N. J. Blair,* all of Vancouver

Dr. John Nelson has returned from New York to become director of V.D. Control in B.C.

Dr. R. P. Kinsman has received a life membership in the Children's Aid Society in recognition of many years of devoted service.

Dr. Murray Blair has resigned as Registrar of the College after over a year of exceptionally able and conscientious work

The Exclusive Ambulance Telephone Number is now EM 2266.

BIRTHS

To Dr. and Mrs. *E. D. Herberts* of Vancouver, a son.

To Dr. and Mrs. *A. C. Waldie* of Vancouver, a daughter.

To Dr. and Mrs. *A. K. Mathisen* of Vancouver, a daughter.

To Dr. and Mrs. *Fred Downer* of Vancouver, a daughter.

To Dr. and Mrs. *A. W. Wallace* of Vancouver, a daughter.

To Dr. and Mrs. *E. C. McCoy* of Vancouver, a daughter.

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FIGHT CANCER — GIVE NOW!

April is Cancer Campaign month and this year the CONQUER CANCER CAMPAIGN is a joint appeal, sponsored by the British Columbia Division of the Canadian Cancer Society and the British Columbia Cancer Foundation.

The quota for the province is $250,000. Of this sum the Society needs $150,000 to maintain its programme of lay education, the promotion of research and the provision of welfare assistance for needy cancer sufferers.

The other $100,000 is required by the Foundation for the completion of the new building this year. At present the facilities at the British Columbia Cancer Institute are inadequate to meet the increased demands for treatment.

Last year the British Columbia Division of the Society spent over $77,000 on research and post-graduate training of doctors and nurses. The new British Columbia Medical Research Institute, situated in the grounds of the Vancouver General Hospital was established as a result of a grant from the Society for $75,000 and a further grant of $25,000 was made for equipping the isotope laboratory there.

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WORKMEN'S COMPENSATION BOARD

Applications will be received by the Workmen's Compensation Board of British Columbia for prospective vacancies in the following positions:

CHIEF MEDICAL OFFICER—duties, to supervise and direct all medical activities of the Board and to act as adviser to the Board on medical matters.

MEDICAL OFFICERS—duties, reviewing claims, attending to correspondence, checking on progress of injured workmen by examination and collaboration with the attending doctor.

DOCTORS FOR REHABILITATION DEPARTMENT with experience or training in physical medicine and/or traumatic surgery.

Applications should be addressed to the Chairman of the Board, 707 West 37th Avenue, Vancouver 13, B.C., stating age, qualifications, experience and salary terms.