THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Published monthly at Vancouver, B. C.

Convention Number

AUGUST, 1925

Published by
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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Published Monthly under the Auspices of the Vancouver Medical Association in the Interests of the Medical Profession.

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VOL. I. AUG. 1st, 1925 No. 11

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VANCOUVER MEDICAL ASSOCIATION.

Founded 1898. Incorporated 1906.

28th Annual Session

GENERAL MEETINGS will be held on the first Tuesday of the month at 8 p.m.

CLINICAL MEETINGS will be held on the third Tuesday of the month at 8 p.m.
Place of meeting will appear on Agenda.

GENERAL MEETINGS will conform to the following order:
8 p.m.—Business as per Agenda.
9 p.m.—Paper of Evening.

The regular work of this Session will commence on Tuesday, Oct. 6, 1925. Programmes to be announced later.

* * * *

HEALTH DEPARTMENT STATISTICS.
JUNE, 1925.

Total Population (estimated)		126,747
Asiatic Population (estimated)		9,960
		Rate per 1000 of Pop. per Annum
Total Deaths	106	10.2
Asiatic Deaths	18	22.0
Deaths—Residents only	86	8.3
Total Births—Male, 143 Female, 133	276	26.5
Stillbirths—not included in above	10	
Infantile Mortality—		
Deaths under 1 year of age	11	
Death rate per 1000 births	39.9	

CASES OF CONTAGIOUS DISEASES REPORTED.

	May.		*June.*		*July 1st to 15th.*	
	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Smallpox	10	0	10	0	3	0
Scarlet Fever	49	0	24	0	5	0
Diphtheria	9	0	11	1	4	0
Chicken-pox	42	0	12	0	5	0
Measles	0	0	3	0	0	0
Mumps	21	0	21	0	0	0
Erysipelas	4	0	1	0	4	1
Tuberculosis	34	11	2	8	3	0
Whooping Cough	25	0	28	1	14	1
Typhoid Fever	1	0	3	0	1	0
(Cases from outside City included in above.)						
Diphtheria	1	0	3	1	3	0
Smallpox	1	0	0	0	0	0
Scarlet Fever	7	0	3	0	0	0

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EDITOR'S PAGE.

We are frequently reminded by those who regretfully regard the past, that the golden age of clinical acumen is slipping away. No longer, we are told, does the modern medical man cultivate properly his powers of observation at the bedside or appreciate fully the advantages of the *tactus eruditus* in the pursuit of diagnoses. On the contrary he neglects these things, rushing after the so-called instruments of precision and laboratory methods, with the consequence that the ways by which the fathers of the craft enriched the book of knowledge are falling into undeserved disuetude.

It may be so. In this world of mutations the old order of things constantly changeth, if it does not pass away. Men have used the natural means at their command, but these were used not on account of their superiority but because they were the only ones at hand. With the advent of experimental methods and especially with the development in other arts and sciences which may be laid under tribute by the medical profession, quicker and more generally accurate means of diagnosis are now often available. It is true that with this alteration something of romance is passing away and more rarely now has the experienced observer or bold guesser such opportunities of exercising his powers of divination. What, we may ask, has the world lost by the discovery and perfecting of the Widal reaction as a detector of typhoid infection, or of the Wassermann reaction of the presence of syphilis? Or by the incursion of the radiographer to many dark regions of the human form? We confess ourselves wholly on the side of the "instruments of precision" party. If the X-ray can detect early tuberculosis of the lung for the multitudes when that opportunity was formerly the province of the few naturally gifted or as the result of long and arduous apprenticeship, the advantage is surely greater than the loss.

Nor is it any answer to point to the practitioner in remoter districts and ask where are his X-ray plants and laboratories. These things will follow and are following him. It does not need a prophet to foresee the time when in some centre these will be available to everyone.

However, the use of these instruments of precision may work both ways, and one use of familiarity with their workings in certain instances is the increased ability to recognize by natural or clinical methods the very manifestations of disease which these instruments have unmasked. This is notably the case in the use of the electro-cardiograph, familiarity with which in time enables the cardiologist to recognize conditions which this instrument has in the first instance revealed. Likewise by the frequent use of the basal metabolism recorder many men have acquired facility in detecting at all events the grosser departures from the normal standard without resort to its use. But to the infrequent student of these conditions these instruments remain invaluable, and he may and will resort to their use with increasing confidence.

We have passed through the period when the experienced clinician claimed to have estimated a patient's temperature by means of a hand on the forehead. Or later to estimate blood pressure by a finger upon the pulse. The clinical thermometer and the blood pressure machine have passed into daily and habitual use, nobody now regretting their advent. In like manner we may hope to see the increasing perfection of a large number of similar aids to diagnosis, each of which in its turn will ultimately take its place in halping the inerun-- development of our art.

* * * *

The Life of Sir William Osler. By Dr. Harvy Cushing. In two volumes. Oxford University Press. 1925. 37s. 6d.

Dr. Cushing has provided us with a fascinating book, every page of which is of interest. Osler touched life at many points and warmed both his hands with an enviable gusto. The development of this book has been internal rather than external, and Dr. Cushing has said in his preface that "Little pretence is made to do much more than let his story, so far as possible, tell itself through what he puts on paper." Fortunately for the world, Osler put a great deal on paper, most of it very well worth while, and most fortunately, almost from his early days, the recipients of many of his personal communications appear, with admirable and almost uncanny foresight, to have carefully filed these away for our present delectation. The work of connecting up and amplifying these written statements has been excellently done, and if we may say so, Dr. Cushing seems to have caught up some of Osler's whimsical spirit into his own work.

Volume I. opens with the customary ancestral account which in this case is more than perfunctory in that Osler's forbears were of unusually vigorous and distinctive stock. His early teachers, whose names are carried in the dedication of his text book in medicine, receive careful and sympathetic handling. Tracing his career through youth and early manhood, it is not long before we find Osler established at Montreal as Professor of Medicine at McGill. In 1884 he is called to Philadelphia and his cosmopolitan career is fairly begun. Five years later we find him at the newly established medical school of Johns Hopkins. In 1904, Osler was appointed Regius Professor of Medicine at the University of Oxford, and here, after a lively account of the strenuous leave-taking ceremonies on this side of the Atlantic, the first volume leaves him.

Says the New York *Evening Post* at the close of its review: "How does it happen that this man . . . . was able to do so much for his day and generation? The answer is so simple it will scarcely be grasped by a rising generation of wise men. . . . . From

his beginning Willie Osler had to work and work hard for everything he got."

To which we say "Amen," the mere reading of his strenuous activity leaving us somewhat breathless.

The second volume of Dr. Harvey Cushing's work carries us with the Osler family—father, mother and son Revere—to Osler's third transplantation, that of Oxford. As Regius Professor of Medicine in that ancient seat of learning, he enters into the medical life of the three Kingdoms.

To a far-off observer at that time one felt that Dr. Osler's removal to Oxford seemed to mean a retirement from the actualities of medicine, that it would give him time for meditation, for assembling all his observations which he had stored away and which fugitive time had not permitted him to gather into a useful form. Also one felt sensitive as to whether in his new sphere, Dr. Osler would have the opportunity of making a personal impress on medicine within the British Isles. However, Dr. Harvey Cushing soon shows us that a change of location does not alter a man's character. Soon we find Dr. Osler leading a more active life than ever. Clinics are instituted at the Radcliffe Infirmary for graduates as well as undergraduates. He immediately took a live interest in Oxford's remarkable library—Bodley—and he allowed his hobby for collecting rare old medical works to have full play. For Osler believed in and taught all his students to have a hobby.

For giving addresses to medical students on special occasions, Osler seemed to be ever on call. He threw all his energies into getting anti-tuberculosis work in England and Ireland on a new footing.

He also took a leading part in helping Sir J. W. G. Macalister to unite the medical profession of London and to bring to that great medical centre its proper position for postgraduate study.

New duties and new interests seemed to be thrust upon him almost daily. Then the war came. Here our author shows what a noble part Sir Wm. Osler played, in keeping the amenities of British, Canadian, and American medicine on a happy footing. The migration to Oxford did not rob him of that great gift he possessed to a rare degree—the knack of getting in touch with young people; young children were his particular joy, and young students felt the friendliness of a kindred spirit, that met them on terms of mental equality. None of these students left his contact with Osler without feeling that he also could make something tell for righteousness in his life's work.

We of the Vancouver Medical Association have a special interest in the second volume of Dr. Cushing's work, since portions of two letters written by Sir William to our Society are included. His interest in our library and the practical encouragement he gave us by a donation of $100.00, will be cherished always.

Dr. Harvey Cushing has performed a great and loving task

in giving to the profession and to the world such an intimate retrospect of the life of his great friend, William Osler. The task has been a huge one, for Osler's idle moments were rare, and to crowd even into two volumes anything that would adequately represent the activities of Dr. Osler is a memorable feat.

* * * *

B. C. MEDICAL ASSOCIATION NEWS FOR "BULLETIN."

The Annual Meeting of the B. C. Medical Association was held in the lecture room of the Wesley Church, Vancouver, on Friday, July 3rd, 1925.

Dr. Vrooman, president, in the chair. There was a good attendance, with a large number of out-of-town members.

It was decided, unanimously, that the honorary membership of the Association should be extended to Dr. G. L. Milne, of Victoria, in recognition of the fact that he has been in practice in the province for fifty years, and has performed eminent services to the medical profession.

The auditor's report for last year was read and adopted. The finances of the Association are in sound condition, and the reduction of the fee has been justified by results.

The report of the secretary-treasurer gave an account of the activities of the Association during the past year. A gratifying increase in paid-up membership over this date last year was reported. The work of the Association shows steady growth in bulk and importance, and the methods in which it serves the individual medical man as well as the profession at large, were described at some length by the secretary-treasurer.

Discussion of the report elicited some questions as to the operating expenses of the Association. This was taken up later by the executive, which appointed a small committee to investigate the comparative costs of our Association and those in other provinces, and to report at an early date, as a first step to a complete enquiry into the subject. As an outcome of the discussion it was decided that steps should be taken to hold a conference between the B. C. Medical Association, the B. C. Medical Council and the Vancouver Medical Association, with a view to discovering methods of economy both in money and time, and increased efficiency of work.

Reports were read as follows:—

Legislative Committee.
Industrial Service Committee.
Publicity and Educational Committee.
Constitution and Credentials Committee.
Ethics and Discipline Committee.
Health Insurance Committee.

A dinner was held at the Ambassador Cafe, in the evening, at which Sir Henry M. W. Gray, of McGill University; Dr. Hugh Cabot, of Boston; and Dr. Carr, of Chicago, were the guests of honour. Each of these gentlemen spoke after dinner, and a delightful evening was spent, until it was time to return to the Summer School meetings at the Wesley Church. At the close of the dinner the officers for the coming year were elected as follows:—

Dr. W. B. Burnett, Vancouver, President-elect.
Dr. W. A. Clarke, New Westminster, Vice-President.
Dr. J. H. MacDermot, Vancouver, Secretary-Treasurer.
Dr. M. G. Archibald, Kamloops; Dr. F. W. Andrew, Summerland; Dr. T. A. Briggs, Courtenay, Members at Large of Executive Committee.

The following letter is self-explanatory:—

The British Columbia Medical Association.
927 Vancouver Block,
Vancouver, B. C.,
July 10th, 1925.

Open Letter to the Past President of the Vancouver Medical Association.

DR. H. H. MILBURN,
1190 Granville Street,
Vancouver, B. C.

Dear Dr. Milburn:

In the course of discussion at the recent Annual Meeting of the B. C. Medical Association, I made certain remarks, which I learn since, have been interpreted by yourself and by others who were present, as a reflection on the work of the Executive of the Vancouver Medical Association, of which you were President last year.

I wish to express my sincere regret to you for having made these remarks, which I can now see now were capable of this interpretation, though I assure you that I did not mean to make any personal reflection on you, or any of the members of your Executive, who all worked hard and loyally for the good of the Association, as shown by the year's record and the good work accomplished. I am sure that any suggestions that you made at any time were made for the good of both Associations and of the profession as a whole.

I would ask you to accept this as a retraction of anything I may have said of a disparaging nature.

I remain,

Yours sincerely,

W. B. BURNETT.

The Thirteenth Annual Meeting of the Pacific Coast Oto Ophthalmological Society was held in Vancouver, June 18th, 19th and 20th, under the Presidency of Dr. H. M. Cunningham. There was a large attendance and many excellent papers were presented.

After welcoming the visitors, Dr. Cunningham touched briefly on the many unsolved problems in Eye, Ear, Nose and Throat

work, referring particularly to the etiology of glaucoma, trachoma and cataract. He reported a case of congenital atresia of the post nasal choanae with complete obstruction in which the sinuses were fully developed. He considered a case of this kind absolutely disproved the pneumatic pressure theory of development of the sinuses. Dr. Cunningham also dealt with recent advances in the study of cardiospasm, referring to the work of Plummer of the Mayo Clinic, Jackson of Philadelphia, and Mosher of Boston. He mentioned some work he was doing on this subject in conjunction with Dr. H. H. McIntosh of the Vancouver General Hospital, on which he had hoped to make a preliminary report, but they had decided it would be premature to do so at the present time.

It had been confidently anticipated that Dr. George Piness, in his paper on "Allergies of the Upper Respiratory Tract," would give results of the work carried on by him during the past few years, but Dr. Piness, beyond stating that they had cases relieved over a period of seven years, would not make any statement as to final results. He outlined the symptomatology and methods of diagnosis of these conditions. Most allergies of the upper respiratory tract gave a history of onset early in life. Every case of eczema and allergic coryza in infancy and childhood must be considered a potential asthma. All asthmas must be classed as chronic except those due to the introduction of a foreign protein. Angioneurotic oedema is an allergic condition similar to the disease produced in a patient who eats foods to which he knows he has an idiosyncrasy, but who does not react when tested against such foods. Another type of oedema definitely allergic is that accompanied by an urticaria. Methods of diagnosis include a complete physical examination—X-ray, blood, urine and sputum examinations — and studies against proteins, also in certain cases personal surveys of the environment and botanic surveys. He advised the cutaneous method of testing. The interpretation of reactions is important. Reactions may occur that are not true, but pseudo or skin reactions. The true reaction is the one with a wheal with pseudopodia and an erythema regardless of size. An analysis of reactions is the final criterion for determination of treatment. With regard to surgery in allergies of the upper respiratory tract, Dr. Piness said that out of a series of 854 cases not one had been cured by operative measures. No man should promise an allergic individual relief by surgery. Obstructive interference should be removed regardless of the allergy. He was firm in his belief that Dr. Sluder's work on Meckel's ganglion was absolutely wrong, and he urged upon the members present to be more conservative in their treatment of the allergic individual by surgical measures.

Dr. Gordon B. New, of the Mayo Clinic, gave three lantern slide demonstrations, the first dealing with advances in the treatment of congenital and acquired deformities of the face and neck, particularly saddleback and luetic noses and rhinophyma. He advocated the use of full thickness skin grafts rather than Thiersch grafts in the plastic repair of these cases, bringing the flap down

from the forehead. In cleft palate and hare lip operations he recommended the two stage operation with the use of lead plates to prevent post operative flaring of the nasal alae. In his second lecture on "Malignant Tumours of the Nose and Throat," Dr. New drew special attention to nasopharyngeal tumours, the most commonly overlooked of all growths of the head and neck; 25% to 30% of these cases have neurological symptoms only; forty cent. come primarily to the Internist, only a very small percentage come primarily to the Laryngologist. The results of treatment are not good, as patients are seen so late in the disease. He discussed the relative merits of radium, diathermy and surgery in treatment of these tumours. In his third lecture on "Unusual Lesions Seen First by the Laryngologist," Dr. New drew attention to cases of acute and chronic leukaemia which were easily mistaken for malignant conditions, and in which very close co-operation is necessary between pathologist and laryngologist. He referred to the value of the differential blood count in diagnosis of these conditions. Other unusual lesions seen by the Laryngologist are pemphigus, thrush and actinomycosis. In 107 cases of the last named condition examined at the clinic, only seven had been correctly diagnosed beforehand.

Dr. Harry Wurdemann, discussing Dr. H. G. Merrill's paper on "The Light Sense" and its test by means of Percival's rotating discs, referred to it as one of the most important papers presented. Aviation was making rapid strides in the industrial world, and it would be their duty as ophthalmologists to decide what men could safely fly. The test was simple, easily and quickly made, and should be done as a routine test by all ophthalmologists.

The value of the blood count as an aid in early diagnosis and deciding for or against operative interference, was emphasized by Dr. L. Klemptner in his paper on "Bezold's Mastoiditis." He agreed, however, that a leucocytosis was not certain evidence of acute mastoiditis, and the number of his cases was as yet too small to draw definite conclusions. The X-ray had proved a disappointment, as plates very often showed no visible bone destruction, yet on operation very considerable destruction was found.

Dr. Colin Graham, of Vancouver, in the discussion on Dr. G. F. Chase's interesting paper on "Thrombosis of the Sigmoid Sinus and Blood Stream Infection," mentioned several cases in which he had used exsanguination transfusion with success. One of these was a double mastoid with a temperature of 106 per rectum at time of operation. He thought exsanguination transfusion a valuable procedure in these cases, as it helped to wash out the infection.

Dr. Edward Jackson, in describing the eye as "the laboratory and clinic of the living body," said that from observations made in this laboratory were coming some of the great advances in modern medicine. The eye is peculiarly favourable for exact observation. It may be termed the bulletin board for diseases of the brain and spinal cord. As the observer on the mountain top gives

fire protection to thousands of miles of forest, so the ophthalmologist, by interpreting the signals given by the eye, has command of a great territory of disease. The study of the living eye with the ophthalmoscope has bridged the gap between the studies of the dead house and the laboratory. The ophthalmoscope has doubled the clinical value of Harvey's great discovery, and training in its use by the general practitioner should, in the very near future, play as important a part in the observation of general disease as feeling the pulse did 70 years ago.

Dr. Martin D. Icove, speaking on "Intra Orbital Anaesthesia in Ophthalmic Operations," said the reason so many men were disappointed in its results was because they did not allow sufficient time to elapse after induction before commencing to operate. They should wait at least half an hour. Dr. A. S. Green said the dangers were practically nil. The method had been in use in Paris for six years with no ill effects. He considered it the anaesthetic of choice in all cases where the eye had to be pulled upon or cut.

Dr. F. P. Hyde reported a case of ligation of the external carotid with recovery in a case of simple uncomplicated epistaxis. He thought this treatment should be included in the text books as an emergency operation of great value in severe idiopathic nasal haemorrhage.

Dr. Ira E. Gaston's paper on "Milk Injections in Ophthalmic Diseases" led to a spirited discussion as to whether better reactions were obtained by whole milk than by the use of preparations, such as aolin, kaseosan, etc., and whether any therapeutic results could be attributed to the injections. Dr. Wurdemann thought if any good was accomplished it was by the reaction of the system to the bacterial products, and the general opinion appeared to be that the more contaminated the milk the better the results obtained.

Dr. A. C. Jones said the fulminating character of the acute ethmoiditis which breaks through into the Orbit led him to believe that there may be a chemical action produced by the bacterial growth which leads to the formation of carbon dioxide under great pressure, and that the etiology is not always a defect in the osseous boundaries. The theory of the formation of carbon dioxide under pressure is the probable explanation of the bulging eye and meningeal complications in this type of ethmoiditis.

Other interesting papers were "Sinus Infection in Children," by Dr. F. M. Shook; "Mucocele of the Frontal Sinus," by Dr. Mearle C. Fox; "Central Retinal Haemorrhage Synchronous with Onset of Menstruation," by Dr. E. Nelson Neulin; "Fibroma of the Larynx in a Child of Three, with Operation and Recovery," by Dr. Chester Bowers; and "The Value of the Ultra Violet Ray in Eye, Ear, Nose and Throat Field," by Dr. H. F. McBeth.

On Friday morning Dr. A. S. Green gave a clinic at the Vancouver General Hospital when he operated on five cases of cataract by the Barraquer method. Demonstrations by Dr. Lewis of his test for differentiation between Stapes Fixation and Obstructive

Deafness; by Dr. Pischel of a test for localization of foreign bodies in the eye by means of markers in the conjunctiva; and presentation of a case of "Jaw Winking" in a little girl, by Dr. Spencer Howe, concluded the scientific programme.

At the business meeting held on Friday, the 19th, Dr. Kasper Pischel was elected President, and San Francisco was chosen as the place of meeting in 1926.

THE PACIFIC NORTHWEST MEDICAL MEETING AT PORTLAND.

The meeting of the Pacific Northwest Medical Association, held in Portland, June 29th, 30th, and July 1st, was well attended and was enjoyed by all present, among whom were eight Vancouver medical men.

Sir Henry M. Gray was present and gave three interesting papers which he later presented at the Vancouver Medical Association Summer School. These are abstracted in the account of that meeting.

Dr. Geo. N. Stewart, of Cleveland, presented three papers, respectively on the "Physiology of the Suprarenal Glands," "The Thyroid," and "The Islands of Langerhans." In speaking of the suprarenals he pointed out that we are dealing with two separate and distinct glands, the cortex and the medulla. Most is known about the medulla, whose secretion—epinephrin—is entirely under the influence of the nerves and can be detected in the blood qualitatively and quantitatively, being present in a dilution of 1-100,000,000, although even to a strength of 1 in 1 to 5 million in the blood of the adrenal vein. He estimates that a good sized man daily produces the equivalent of one P. D. & Co. one-ounce bottle of adrenalin. Dr. Stewart found that the medulla experimentally is not indispensable to rabbits, rats and dogs, and the blood pressure is not affected by removal, either together or at different times. We do not know what the cortex produces, but when it is removed (with the unimportant medulla) certain definite things happen, although 50% of white rats live indefinitely and have bred young after such complete removal. Deprival of vitamins and other nutritional deficiencies also make the operative results less good. Dogs, however, live from six to seven, or even sixteen days, without any treatment and are apparently well, but they all die, and probably suddenly, after one, two or three days of anorexia, with sometimes nervous symptoms and spasms, "but asthenia is *not* the prominent symptom, if at all." Coupled with the anorexia is a well marked condition of the alimentary canal —congestion—present from the cardiac end of the stomach to the anus, with bloody stools and even vomit, reverse peristalsis, with bile also, and concurrently a highly congested pancreas. Dogs can be kept alive four or five times as long by injections of Ringer's solution containing some sugar, beginning preferably 24 hours after operation, lessening the general concentration, which is also shown by considerable increase of the red blood cells.

Dr. W. McKim Marriott, of St. Louis, gave an instructive paper on "Some Newer Viewpoints Concerning the Nature and Treatment of Nephritis." He described the tubular type (nephrosis) and the glomerular or haemorrhagic type. In the tubular variety (nephrosis) there is a gradually decreased secretion of urine with small amount of blood, if any, but large amount of albumen and casts; no acidosis or increase in blood pressure; N. P. N. not increased and no true uraemia; also the eye grounds and skin capillaries are normal. There is, however, marked general oedema and anaemia, and the patient's nutrition is such that resistance is poor and death not infrequently follows infection. Post mortem the kidneys are found to be large and white, the tubules being filled with degenerated cells. However, the majority recover completely. Nephrosis in childhood is most frequently due to a staphyloccocus infection of nasal sinuses, the successful treatment of which clears up the kidney condition. Blood cultures are mostly negative, but the general condition seems due to a toxaemia. Phthalein tests do not show lack of kidney function, but the tissues retain salts and water. The protein of the blood serum is lowered and oedema increases as this occurs. This is apparently coincident with lowering of the surface tension of the serum, which can be measured by weighing a drop of serum. The smaller the drop the lower is the surface tension. In cardiac oedema or that due to glomerular nephritis, the surface tension of the serum is not lowered. In these cases there is apparently a substance in the blood which changes the permeability of animal membrane and acting on the kidney epithelium causes the latter to pass albumen freely. This substance has been isolated from urine of these cases by Clausen and experimentally has produced albuminuria.

Treatment.—Examine nose and throat carefully, remove enlarged tonsils and adenoids to improve drainage, and prevent reinfection. Treat sinus infection if present. Diet is important, due to large loss of albumen. They need a high protein diet (2 to 4 grms. per kilo of weight per day), milk, eggs and meat, also green vegetables and those containing protein. Salt and water need not be limited. Sweating is of no value. Intravenous injections of blood are useful. Theobromine occasionally produces marked diuresis and may increase the surface tension, thus lessening oedema. Heliotherapy also may aid patient.

In contrast to preceding variety is acute glomerular or haemorrhagic nephritis, coming on acutely with diminution or suppression of urine, which is of a smoky colour from contained blood. Microscopically large numbers of red blood cells and some white blood cells are seen. A moderate amount of albumen is present and casts may be seen at first. Here a definite inflammatory condition of the glomeruli exists which may cause permanent fibrosis, but in most cases also the damage is not too extensive and recovery may occur. The kidney function is much altered. Non-protein nitrogen, urea and chlorides are all retained. Acidosis is present and phthalein excretion is diminished. The serum protein is not

reduced and the surface tension of the blood is not diminished, therefore oedema is rarely marked. The capillaries are definitely narrowed and beaded and blood pressure increased. Dr. Marriott stated that by simply examining the capillaries at the base of the nail with a microscope it is possible to diagnose this form of nephritis. True uraemia may occur, and, if late, is grave. These cases are also due to an infection, probably of a haemolytic streptoccus, most frequently following a sore throat or tonsillitis, but may be from elsewhere. There is no definite evidence of septicaemia, but the capillaries in general are damaged and the result in the severer cases may be chronic nephritis with high blood pressure.

The Treatment.—Removal of focus of infection, as operation on acute mastoid, may clear up case. Do not remove acutely inflamed tonsils. Keep in bed for some time after subsidence of acute condition. On account of possibility of uraemia a low protein diet is necessary—1 gram per kilo of weight or less in older children or adults. Milk protein is the best, but one must give sufficient calories with the milk to maintain nutrition by using fats, cream and carbohydrates, especially arrowroot. Salt-free food is indicated. Curds and eggs may be given in the more chronic stages, and meat may be given after the blood has disappeared from the urine. If the blood persists, or is marked, put on free sugar diet, giving 10 grams of sugar per pound of body weight, give in water. A large intake of water is useful. Diuretics, especially diuretin, are contra-indicated in this form. Alkalies may cause alkalosis and tetany. Acidosis, if present, is due in these cases to retention of acid sodium phosphate, and is best treated by calcium lactate in large doses by mouth—even 15 to 30 grains every four hours. Sweating is contra-indicated. Hypertonic solution of glucose, 20%, is good—1 oz. of solution per kilo given intravenously.

Dr. Nathaniel Allison, of Boston, gave two addresses which were of great interest. He dwelt mostly upon the pathology of arthritis, stressing the fact that the disease may originate in either the synovial membrane or in the bone contiguous to the joint, and spread to it. In the former the structures become swollen, opalescent and loaded with exudation products. Granulation tissue spreads out over the cartilage, which loses its natural bluish white and polished surface and becomes dull, yellowish and opaque. Pits form which coalesce and completely destroy portions of cartilage, which are thrown off into the joint. Or the disease begins in inflammatory foci in the bone beneath the cartilage. As these become larger, they coalesce and approach the cartilage, which is raised from its source of blood supply, becomes necrosed and cast loose. In similar manner all the structures about the joint are invaded with granulation tissue and disorganized.

Dr. Hugh Cabot gave two papers on "The Management of Small Stones in the Kidney and Ureter" and on "Renal Tuberculosis," which were enjoyed by everyone present.

Dr. L. F. Barker gave papers on "The Medical Aspects of

Gastric Ulcer," "Psychic Factors in General Medicine," and on "The Present Status and Future Prospects of Endocrinology."

Dr. Henry Woltman, of the Rochester Clinic, gave two comprehensive lectures on "The Syndrome of Compression of the Spinal Cord" and "The Significance of Pain as a Symptom in Diagnosis of Diseases of the Nervous System."

Dr. Jas. B. Herrick, of Chicago, read three papers of interest on "Angina Pectoris," "Diseases of the Coronary Arteries," and on "Syphilis of Heart and Aorta."

Dr. Reginald Fitz, of Harvard, gave two papers on "The Action of Insulin" and "The Importance of a Routine Wassermann Test in Private Practice."

Dr. R. L. Benson, of Portland, lectured on "The Pathology of Coronary Artery Sclerosis."

Dr. R. W. Te Linde, of Johns Hopkins, gave two papers on the "Present Status of Adenomyoma and Endometrial Growths" and on "Diseases of the Endometrium." In his second paper he gave some interesting results of recent research in the physiology of the endometrium before and during menstruation.

The Pacific Northwest Urological Society and the North Pacific Paediatric Society met during the same time. At the latter meeting Drs. H. A. Spohn and R. E. Coleman, of Vancouver, read a paper on "Some Metabolic Observations in Cases of Herter's Disease," which was very favorably received and commented on by those at the meeting.

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LIBRARY NOTES.

(*The Library is situated in* 529-531, *Birks Building, Granville Street, Vancouver. Librarian*: *Miss Firmin. Hours*: 10 *to* 1, 2 *to* 6.)

Dr. Alan U. Drury, from the Medical Research Council of England, gave four interesting and instructive papers. In his paper on "Clinical Signs in Cardiological Practice," he began with method of examination. Has the patient cardiac failure of the congestive type or not? If present, rest over long period is necessary. Cases with ascites, oedema and small urinary output are easy of diagnosis, but we should get them sooner. In the borderline cases there is a reliable and certain sign—first the right side of the heart is engorged, then the veins become engorged—in a normal person the veins of the neck are flat when in the upright position, but if his neck veins are full the heart is failing; similarly the liver becomes enlarged and rales are heard at base of the lungs.

No enlarged heart is healthy, and not all normally sized hearts are healthy. The maximal impulse marks the border of the heart.

This maximal impulse is small and definite and pushes the finger out and holds it. It may or may not be surrounded by a diffuse impulse. Sustained and forcible movement of the ribs indicate an enlarged heart. Gross cardiac displacement must be excluded. Percussion of the left border will give ventricular enlargement, but does not say which ventricle. If this sign does not agree with maximal impulse, then take the latter. The right border is more difficult. Heart sounds alone are not taken as evidence of heart trouble unless this fits in with other symptoms. Gallop rhythm can occur in effort syndrome.

Valves—If affected it is most likely that heart muscle also has been injured by the same process.

Cardiorespiratory systolic murmur — best heard during inspiration—is probably only a broken up breath sound, but this is not certain; it is not important.

Systolic murmur over pulmonary is of no prognostic significance, but if there is a thrill present it may be pulmonary stenoses, when cyanosis either transient or permanent will be present.

There may be a long systolic with a thrill from a patent Ductus arteriosus.

Aortic systolic murmurs with thrill are not necessarily stenosis, unless with evidence of regurgitation also, which is probably always present, and one finds a slow-rising flat topped pulse.

Apical systolic murmurs may be:

(*a*) Position murmurs—heard only in certain positions.
(*b*) Inconstant murmurs.
(*c*) Constant murmurs, mitral regurgitation, it must be decided whether it is from diseased valve or relaxed ring.

Tricuspid murmurs may be unimportant, as this ring dilates easily under stress.

Aortic regurgitation: A diastolic murmur at base, heard best at left of sterinum, is a reliable sign in early stages. Later there is the water hammer pistol shot pulse with throbbing.

Mitral Stenoses: There is almost always a diastolic rumble (occasionally a thrill only), an accentuated first sound or increased secondary pulmonary sound alone are not sufficient evidence. Raise the rate of the heart-beat and place patient on the left side, when you can get the diastolic rumble necessary for diagnosis.

Rhythm.—There may be no enlargement or murmur, but a disturbed rhythm, which may have significance; e. g., if bradycardia is present it may be:

(a) Physiological; or (b) due to heart block.

There is a good clinical sign which indicates heart block—when the auricle and ventricle go off together (synchronize) there is a definite increase in the heart sound at that time.

Auricular fibrillation may occur in the normal, but usually in a damaged heart—as also is the case in extra systole. If the heart rate is raised by amyl nitrite or exercise to, say, 120 and the irregularity persists, it is fibrillation; but if irregularity ceases it is due to extra systole.

Tachycardia.—(a) Physiological; (b) Paroxysmal, which may occur in a healthy or damaged heart and is not affected by exercise; (c) Flutter, which occurs in a damaged heart, the rate is about 160, which is not affected by mild exercise, but violent exercise may even double the rate and the patient faint.

Speaking of the use of the galvanometer, Dr. Drury insisted that to-day this instrument could give diagnostic information beyond that procurable by clinical examination in only from 5 to 10% of cases. It will disclose:

(a) Mild heart block, which cannot be diagnosed clinically with certainty.

(b) Arborization block or some disorder of conduction in the ventricle, splitting of the R. or widening of the Q. R. S. wave.

The T-wave, whether up or down, has at present no known significance.

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THE SUMMER SCHOOL OF THE VANCOUVER MEDICAL ASSOCIATION, JULY 2-4, 1925.

In beautiful weather, with the city decorated and *en fete* for the Dominion Day celebrations, the Annual Summer School of the Vancouver Medical Association opened on July 2, under brilliant auspices, which the progress of the meeting did not belie. The committee in charge is to be congratulated upon the smooth working arrangements it had perfected. It is quite safe to say that, despite the many successful meetings which have been held, none has exceeded, if indeed any has reached, quite the perfection of the one which has just closed.

We hope that the registration of attendance measures up to the deserts of the programme. If it has not, it should have done so, for nobody could afford to miss so comprehensive and sound a series of lectures, so well presented and so full of information.

The meetings for the first time were held down town, and the change in venue was, we think, amply justified and a pronounced success.

The proceedings were opened by a short address of welcome from Dr. W. D. Keith, acting president of the committee during the regretable illness of Dr. Alison Cumming. Dr. Hugh Cabot, Professor of Surgery, University of Michigan, gave the first address on the subject of "Non-tuberculous Infections of the Kidney." These infections were in general of two types, those pro-

duced by the colon-typhoid group of organisms which do not readily produce suppuration, and those produced by the pus producing cocci. Dr. Cabot discussed in an amusing and instructive manner the supposed methods of infection, but thought the only probable one was by way of the blood stream. He referred to the lesions produced and considered that the pyelitis generally present was really a pyelonephritis. A large proportion of these cases was produced by organisms of the b. coli type. Coccal infections, on the other hand, tended more to lodge in the kidney substance, producing cortical abscesses, the rupture of which was probably responsible for the occurrence of perinephritic abscess.

The next paper was presented by Dr. Alan Brown, Professor of Paediatrics, University of Toronto, whom the audience recognized as an old acquaintance. Dr. Brown devoted this lecture and the one delivered on the evening of the same day, to a consideration of the nutritional disturbances of infancy and childhood. These disturbances he regarded as those of quantity and those of quality. Considering the various food stuffs, Dr. Brown said that children absorbed 85% of the fats. Calcium soaps were an end product of their digestion and were present in large amounts when fat was in excess. By virtue of this calcium soap the tendency of fats was to constipate rather than produce diarrhoea. The digestion of carbohydrates took place by way of acids of fermentation, such as lactic and succinic, with the formation of CO 2. It is the carbohydrates which are largely responsible for the diarrhoea and the CO 2 "gas" which so often produces colicky pains. In cases of artificially fed babies on patent foods, the excess carbohydrate is stored in the liver and tissues as glycogen. Each molecule of glycogen requires two molecules of water and leads to the production of the over-fat "water-logged" baby. The protein of the diet rarely causes any nutritional disturbances except the occasional cases of anaphyl actic sensitization. The lecturer considered that all (even certified) milk should be boiled before being fed. Boiling for the short period necessary in no way interferes with the digestibility and renders the liability to infection of tubercular nature much more remote. He said that practically all the milk in Toronto was pasteurized and that in eleven years out of 60,000 cases not a single instance of abdominal tuberculosis had occurred in the Sick Children's Hospital. Nutritional disturbances were by no means limited to artificially fed babies. Breast fed babies were not exempt. In these, disturbances might be due to mechanical defects, such as hare lip, cleft palate or adenoids, or the babies might be weak or indolent or awkward nursers. Again, overfeeding was at times a factor, whether due to parenteral disturbance or to the constitutional peculiarities of the baby. Finally there might be underfeeding, which might be detected by careful weighing before and after feeding. Dr. Brown distributed various formulae and instructions as used in the Sick Children's Hospital, Toronto, for the preparation of foods, their care and administration. Lactic acid milk was found to be a very acceptable article of diet in a great many instances, and both the

natural and artificial methods of preparation were described. Butter soup (which no doubt tastes better than it sounds) was useful when a high, easily assimilable fat diet was required.

The concluding paper of the first session was presented by Dr. J. G. Carr, Associate Professor of Medicine, Northwestern University, Chicago. Dr. Carr was invited on the recommendation of Dr. M. T. McEachern, and the audience evidently heartily endorsed that recommendation. The condition of auricular fibrillation, though apparently first recognized in 1835, was more fully described by Cushing in 1899 without attracting much attention. In 1907 another paper by the same author firmly established it as a clinical entity. At one time it was presumed that fibrillation once having occurred was permanent, but to-day the existence of paroxysmal auricular fibrillation is well recognized. Among diagnostic features the usually rapid and always irregular cardiac rhythm was important, while "pulse deficit" was characteristic. The lecturer referred at some length to the use of Quinidine which had been used on about 100 cases at the Cook County Hospital, Chicago. The opinion there was favourable to its use and no untoward results had been experienced. Abolition of the irregular rhythm had been maintained in selected instances for as long as two years.

After the lunch interval, during which Dr. Cabot was entertained by and spoke at the Kiwanis luncheon, Dr. A. J. Pacini lectured on "Diathermy and the Violet Ray." Dr. Pacini, who had attended the meeting of the Canadian Medical Association in Regina, had already addressed a large meeting of the Vancouver Society on Monday, June 29. At this lecture he took as his subject "The Relation of Light to the Growth and Development of Animal Life Upon the Earth," reviewing in an interesting way the work of Moore and Bailey on irradiation of inert material and the production of synthetic sugar substances in that manner.

The next paper of the busy afternoon session was by Dr. Roscoe Graham, of the Surgical Department of the University of Toronto. Referring to the question of simple colloid goitre, Dr. Graham said that in view of the possibility of later toxaemia the question of removal should be placed before the patient, the mortality of operation in this variety being about 0.25%. The average length of time that an adenoma was present before being brought to the attention of the surgeon is 16 years, the patients as a rule being much older than those with diffuse hyperplasia. In toxic cases the blood pressure reading showed a fairly high systolic with a diastolic remaining unchanged, while the metabolic rate might be high or low and was only of value in connection with clinical symptoms. In diffuse hyperplasia the blood pressure runs in cycles: (1) a high systolic with a normal diastolic which in a few weeks may fall to (2) a low systolic with diastolic unchanged. This again to be followed by (3) a high systolic and a rising diastolic which if it reached 100 m.m. or more indicated a dangerous risk. They had had unsatisfactory results with X-ray therapy,

and preferred surgical measures with or without the use of iodine.

Dr. Hugh Cabot took as the subject of his afternoon lecture the very practical one of the so-called "Catheter Cystitis." This annoying complication was one which particularly dogged the footsteps of the gynaecologist and the obstetrician. Usually when after an interval of hours the patient had not urinated and distension was becoming obvious, the catheter was passed—by some one else. When and if cystitis later developed, the catheter and its manipulator were blamed for the occurrence. Dr. Cabot reviewed experimental work which showed the extreme difficulty of infecting a normal bladder in animals, with or without trauma in addition. Practically it could not be done. Something additional was required, and that something was overdistension. Given overdistension, infection was easy to produce. Instructions in his clinic were that when an amount of urine was present, estimated at ten ounces, the catheter was passed regardless of the time which had elapsed.

The first lecture of the evening session was given by Sir Henry Gray, Surgeon in Chief to the Royal Victoria Hospital, Montreal, on "Developmental Abnormalities Affecting the Colon." This paper, which was illustrated by lantern slides, dealt in a very thorough manner with the whole question of the development of the intestinal canal and the manner in which it came to occupy its final position. The work of Arbuthnot Lane was considered and the affect of the various bands and kinks in the production of symptoms. Sir Henry detailed his methods of examination in these cases and gave the steps of the operation he used for the fixation of the ascending colon and caecum.

Dr. Alan Brown's continued paper on "Nutritional Disturbances," which has already been referred to, brought to a close the first interesting, albeit strenuous day of the School.

On Friday, July 3, the meeting was called to order at 9 a.m. and Sir Henry Gray delivered his second lecture, taking as his subject the important one of "Cancer of the Breast." He showed by means of lantern slides the various ways in which cancer might spread from this area. While lymphatic fermention as demonstrated by Handley might account for local dissemination, blood or lymph migration must be called for to explain more distant metasasis. Generally regarded as a disease of later life, of 311 cases 27.3% were under 40 years of age. He referred to the large statistical material of 24,800 cases gathered from all parts by Dr. Janet Lane Claypon, and read from an article published as long ago as 1867 in which the modern operation is very closely detailed.

The second paper of the morning session was by Dr. Alan Brown, on "Eczema." This, as the lecturer explained, was really a discussion of the exudative diathesis, which is a very definite thing. These children may be restless, irritable and excitable, may suffer from itching, intertrigo, eczema and subcutaneous

abscess. They vomit easily and frequently. Catarrhal infections are frequent, and later asthma may develop. There is a tendency to general hyperplasia of the lymph glands. A high fat diet is a sort of function test of the exudative diathesis and may produce any or all of these reactions. There is also a susceptibility to certain foreign proteins and some of the profounder reactions produced by the injections of sera occur in children of this type. In the treatment of eczema the immediate causes had to be considered. These were excess fat or sugar in the diet or the use of some unsuitable form of protein. No irritating clothing should be allowed next to the skin. Water should not be used for cleansing purposes, oil being substituted. The urine should be kept alkaline, Sod. Bicarb. grs. 30 to 40 daily being used. Scratching should be eliminated if necessary by means of jacket and mitts. For the acute weeping type of eczema affecting chiefly the face, apply crude coal tar as obtained from the gas works. May need to be used on three or four successive days. Later, bismuth paste was applied; this is a mixture of bismuth subcarb., lime water and lanoline. For the acute intertrigenous form exposure to the air in a warm room was recommended and the use of 4% resorcin ointment in the seborrhoca type.

Following the conclusion of Dr. Brown's lecture, Dr. James G. Carr took up the subject of the "Intrathoracic Complications of Pneumonia." It is to be remembered that in the large majority of cases which hang over, there is no such thing as unresolved pneumonia, which is a diagnosis that should never be made in the early stages of a complication, and also that in a large proportion there is pus in the chest. In cases of empyema following pneumonia the pneumonia may not have disappeared and the alteration of the breath sounds consequent upon this may be transmitted through the pus. Tactile fremitus is invariably absent and is, the lecturer considered, the best sign of the presence of fluid. We must continue to look for pus in every patient with pneumonia who does not do well. Lung abscess was found to be less common in lobar pneumonia than in the broncho-pneumonic variety, most of the cases he saw being post-operative. Treatment of these acute abscesses was often disappointing.

The afternoon proceedings were opened by Sir Henry Gray with a paper on "Acute Osteomyelitis." Sudden attacks of pain in bone should always make one think of osteomyelitis. The disease may affect a joint by direct spread, and this secondary suppurative arthritis was as dangerous as the primary variety. Multiple lesions are common. As to diagnosis it is important to remember that the X-ray will very rarely show changes in the early stages; it is not until two or three weeks have elapsed that alteration in bony structures takes place. The question is often asked as to whether if the periosteum be left at operation the formation of new bone can be looked for. In children it can, but not in adults. The disease may be cut short by drilling or by gouging the bone so as to give vent to the pus. Several lantern slides were shown illustrating the conditions and the means for its relief.

The next lecture was that of Dr. Alan Brown, on "Deficiency Diseases." Out of the number of diseases which have been shown to be of this variety, the lecturer confined his remarks chiefly to rickets. Interest in this subject had been re-awakened by Mellanby of Sheffield, in 1918. It was very widespread and was probably present in some degree in every artifically fed baby, while even breast fed babies were by no means immune if the mother's diet was not well balanced. Rickets was produced by defects in diet, by lack of radiant energy, and by undue confinement. In the diet it is the lack of phosphorus rather than the absence of calcium which, together with the absence of the anti-rachitic factor, produces the disease. Symptoms are restlessness, excessive perspiration, cranio tabes, beading of the ribs with flaring out of the lower ribs, enlargement of the ends of bones, etc. Numerous lantern slides were here shown illustrative of the experimental variety of rickets in animals and of the natural variety in children, radiographs showing the mushroom-like appearance of the ends of the bones, with micro-photographs showing the process of healing under the administration of cod liver oil or by means of ultra violet radiation. Of all cod liver oils Dr. Brown considered that the Newfoundland oil as prepared by Mead, Johnson & Co. was the best.

The rest of the afternoon was given up to the annual meeting of the B. C. Medical Association. An account of the proceedings will be found on another page of this issue. This meeting was followed by a dinner under the auspices of the same Society at the Ambassador Cafe, at which Sir Henry Gray and other guests spoke.

The evening session of July 3rd was opened by Dr. Carr with a paper on the "Treatment of the Anaemias." Referring especially to pernicious anaemia, the speaker considered that nothing was so likely to produce improvement as prolonged rest in bed. Arsenic in some form should be used, usually as Fowler's solution or sodium cacodylate. Forced feeding with a diet high in protein was important. As to removal of foci, while he considered that any gross or evident foci should be removed, he did not think that the results had come up to what was hoped for. Transfusions were useful, but pernicious anaemia was not cured by these proceedings. The results after splenectomy were not very encouraging, though there was considerable difference of opinion on this point. Dr. Carr thought that the blood picture of a pernicious anaemia might be simulated by a severe secondary anaemia following cancer, syphilis, tuberculosis or nephritis.

The final paper of the day was presented by Dr. Hugh Cabot, who had selected "Ulcer of the Stomach and Duodenum" for his subject. Regarding etiology Dr. Cabot reminded his hearers that this was the day of "foci," but while he thought they were of some importance that importance had been greatly over-rated. As to hyperacidity he was at a loss to know whether the acidity produced the ulcer or the ulcer the acidity. In diagnosis he considered that history was of great value, though at times the disease

was very closely simulated by appendicitis or by disease of the gall bladder or ducts. The X-ray was important, though these useful members of the profession—the radiographers—came in for a good deal of good humoured criticism by the lecturer. Treatment, Dr. Cabot considered, should be combined medical and surgical. The economic factor had to be carefully considered. For ulcers of the duodenum gastro enterostomy was the most useful procedure, while for ulcers of the stomach he was coming more and more to rely on the operation of partial gastrectomy.

Nothing daunted by the strenuous work of the last two days and nights, lecturer and audience turned out betimes on Saturday morning for the final session of the School.

Dr. Carr, who had previously held a clinic at St. Paul's Hospital, opened at 9 a.m. with a lecture on "Coronary Sclerosis," which we hope to reproduce in full in a later number of the BULLETIN. Dr. Carr said that arterio sclerotic hearts showed diminished reserve and a lack of recuperative power. One of the common occurrences in these hearts was anginal pain, due, according to one theory, to disease of the coronary vessels; according to another theory, to disease of the aorta. Coronary thrombosis was often overlooked and but rarely was the diagnosis made. A description of the symptoms of this complication was given.

For his final address Dr. Hugh Cabot spoke on "Disease of the Gall Bladder." For the diagnosis of gall bladder conditions it was difficult to get assistance from any instruments of precision. Clinical methods had to be used, and it was safe to say that a correct diagnosis could be arrived at in this way in some 80% of cases, and in stone even higher. Recently, however, there had come to our aid a new method in which substances were introduced into the blood which were absorbed by the liver and secreted into the bile. They passed into the gall bladder and there produced a shadow under the X-ray. It seemed possible that an estimate of the density of this shadow might be of value in determining the absorptive properties of the mucous membrane of the gall bladder, and therefore its condition as affected by disease processes. Removal of a gall bladder has certain outstanding objections, and there seems to be at present a reaction against its removal in many cases. There are borderline cases when it is very difficult to know what is best. Drainage may tend to increase inflammation. In some instances when stones have been removed and the wall of the gall bladder has seemed reasonably good, Dr. Cabot has sewn it up without drainage.

At the close of his lecture Dr. Cabot received an ovation. His various lectures deeply interested the large audiences present.

Sir Henry Gray, with his final address on "Acute Intestinal Obstruction," brought the session to a close. This address has been left with the Committee, and will be published in another issue.

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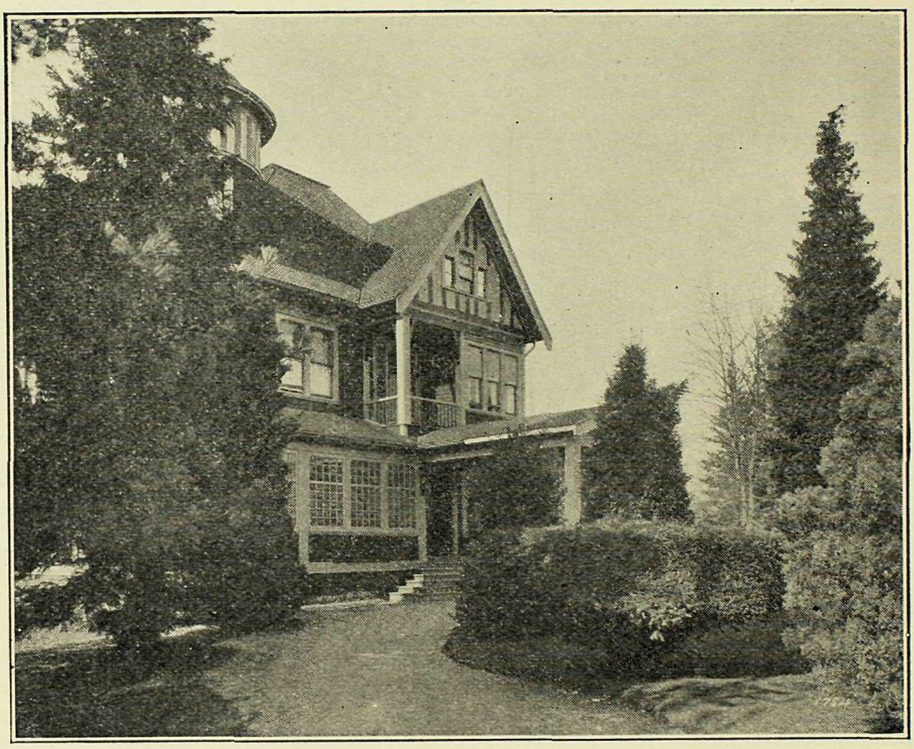

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