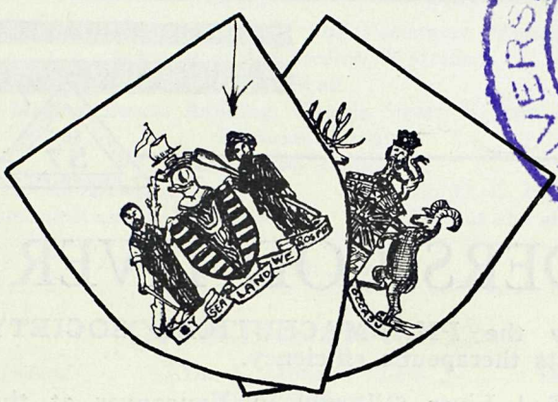
THE BULLETIN



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OF THE
VANCOUVER MEDICAL ASSOCIATION

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Vol. VIII. APRIL, 1932 No. 7

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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. VIII. APRIL, 1932 No. 7

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VANCOUVER HEALTH DEPARTMENT

STATISTICS, FEBRUARY, 1932

Total Population (Census, 1931)		246,593
Asiatic Population (Estimated)		15,000
	Rate per 1,000	Population
Total Deaths	226	11.5
Asiatic Deaths	14	18.4
Deaths—Residents only	203	10.4
Birth Registrations	301	15.4
Male 164		
Female 137		
INFANTILE MORTALITY—		
Deaths under one year of age	13	
Death Rate—per 1,000 births	43.2	
Stillbirths (not included in above)	3	

CASES OF CONTAGIOUS DISEASEIS REPORTED IN CITY

	January, 1932		February, 1932		March 1st to 15th, 1932	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	13	2	23	10	8	1
Scarlet Fever	9	0	5	0	9	0
Diphtheria	8	0	6	1	3	0
Chicken-pox	60	0	45	0	18	0
Measles	2222	1	1059	3	178	0
Mumps	80	0	62	0	47	0
Whooping-cough	23	1	25	3	18	0
Typhoid Fever	2	0	1	0	1	0
Paratyphoid	0	0	0	0	0	0
Tuberculosis	57	11	35	12	24	—
Poliomyelitis	0	0	0	0	0	0
Meningitis (Epidemic)	1	1	0	0	0	0
Erysipelas	4	0	5	1	0	0
Encephalitis Lethargica	0	0	0	0	0	0

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Studies in Scotland

A recent comparison of the effect of raw and pasteurized milk was carried out by the Department of Health for Scotland. In this study there was provided a supply of tuberculin tested raw milk with fat content of 3.5% and a maximum bacterial count of 200,000 per cubic centimeter. This supply was blended and half of it pasteurized at 145 degrees for thirty minutes. Three-quarters of an Imperial pint was furnished daily to each of 10,000 school children, one-half of them receiving the raw milk and the other half the pasteurized milk.

This test was continued for four months. The height, weight and general condition of the children was noted carefully by physicians and nurses at the beginning and at the end of the test. As a control of these results similar measurements were made of 10,000 comparable children who did not receive the daily allowance of milk.

For our present purposes we will quote only two conclusions as they appear in this very interesting report:

"1. *The influence of the addition of milk to the diet of school children is reflected in a definite increase in the rate of growth both in height and weight.*

2. *Insofar as the conditions of this investigation are concerned, the effects of raw and of pasteurized milk on growth in weight and height are, so far as we can judge, equal.*"

Both the carefully controlled experiments and the experience of more than twenty years on a large scale agree in indicating that *pasteurization does not have any appreciable harmful influence upon the desirability of milk as a food, and at the same time adds very materially to the safety of the food substance.*

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IN VANCOUVER SINCE 1913

VANCOUVER MEDICAL ASSOCIATION

Founded 1898 Incorporated 1906

PROGRAMME OF THE 34th 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 meetings will appear on Agenda.

General Meetings will conform to the following order:
8:00 p.m.—Business as per Agenda.
9:00 p.m.—Paper of Evening.

1931.

November 3rd—GENERAL MEETING.
Papers:
Dr. H. A. DesBrisay: "Syphilis in Medical Practice."
Dr. W. T. Lockhart: "Treatment of Syphilis."
D. A. L. CREASE of Essondale will discuss the treatment of Degenerative Types of Neurosyphilis.
Discussion: Dr. J. E. Campbell; Dr. W. L. C. Middleton.

November 17th—CLINICAL MEETING.

December 1st—GENERAL MEETING.
Papers:
Symposium on Fractures to be arranged by Dr. A. B. Schinbein and Dr. D. M. Meekison.
Discussion: Dr. F. P. Patterson; Dr. J. A. West.

December 15th—CLINICAL MEETING.

1932.

January 5th—GENERAL MEETING.
Papers:
Dr. C. S. McKee: "The Interpretation of Blood Pictures."
Dr. Murray McC. Baird: "The Clinical Aspect of Some Blood Diseases."
Discussion: Dr. W. H. Hatfield; Dr. A. Y. McNair.

January 19th—CLINICAL MEETING.

February 2nd—GENERAL MEETING.
Papers:
Dr. H. Dyer: "Tracheotomy in Children."
Dr. C. Graham: "Inflammation of the Accessory Nasal Sinuses in Children."
Dr. E. E. Day: "Indications for Endoscopy."
Discussion: Dr. J. A. Smith; Dr. H. R. Mustard.

February 16th—CLINICAL MEETING.

March 1st—GENERAL MEETING.
The Osler Lecture: Dr. F. P. Patterson.

March 15th—CLINICAL MEETING.

April 5th—GENERAL MEETING
Papers:
Dr. J. W. Thomson: "Emergencies in Abdominal Surgery."
Dr. A. W. Hunter: "Diagnosis and Treatment of Some Urological Emergencies."
Discussion: Dr. G. E. Gillies; Dr. Lee Smith.

April 19th—CLINICAL MEETING.

April 26th—ANNUAL MEETING.

EDITOR'S PAGE

We wonder if Dr. Coleman's contribution to last month's Bulletin has affected many of our readers as it has ourselves.

It is probably true that the real value of any speech, sermon, lecture, or written article, lies not in its contents *per se.*, no matter how full it be of matter, nor how pregnant with meaning; but in its power to make the hearer or reader think for himself, to make him use his imagination, to enlarge his vision, to force him to see, in short, to educate him, in the true sense of the word "educate." If any such utterance have in it a phrase which lingers in the mind and memory, and, sticking like a burr, teases and irritates one into action, it has earned its keep.

Dr. Coleman's article contained two ideas at least which merit our most earnest and thoughtful consideration, and they are constructive. We cannot say all we should like about either of them, but we feel that they should be emphasized.

The first, is his reference to the sterility of the doctor's life, in so many of the things that make life full and happy, as opposed to those that merely make it busy.

These are the days of service clubs, and associations, and committees, and activities of every sort, most of them designed to increase communal activity, and to ensure a thorough mixing of the elements of society. One sometimes wonders if the best work is done this way: if working in a crowd, *en masse,* is conducive to the development of one's individual ability. The Babbitry of modern life is rather dreadful really. We belong to so many things, but never to ourselves. We have no time for hobbies, for pictures, for writing or talking, or music, or any of the things that make life beautiful.

We have no leisure. Rabindranth Tagore that wise old poet, said in one of his addresses in Vancouver, "We should never forget that if time is money, leisure is wealth"—and it has been said even more beautifully, "What shall it profit a man, if he gain the whole world, and lose his own soul?" What, indeed?

We live in an age of speed and ever-increasing speed—why we are in such a hurry, and where we are in such a hurry to arrive, and what we shall do after we get there, are not so apparent. We speed along the road in a motor-car and a cloud of gasoline fumes and miss all the wayside flowers and little trees and lanes. If Mr. Jones' budget, with its increased gasoline tax, puts some of us afoot again, we shall have reason, some day, to bless Mr. Jones.

It is a pity: there must be more in the world, even for those of us who must work hard to make a living, than merely work and food and sleep, more even than success and fame. Dr. Coleman is to be thanked for reminding us of it.

The other idea that has stuck in our mind, and moves us to comment, is his remark that if reforms are to be effected in our economic status as a profession, it must be done by the younger men. We hope the younger men have taken note of this: it would be well for them to think it out. Not but what the older men are ready and glad to help

with their advice and personal effort, but they have been through their time of struggle, and their point of view is conservative, rather than aggressive. Moreover, the younger men are even more vitally concerned, though we are all in the same boat to some extent: but they have the strength and the freshness of energy as well as the greater incentive, and it is for them to man the oars and battle with the waves. There is rough water ahead, and it is going to need a long pull, a strong pull, and a pull all together. The experience and seamanship of the older hands will be of great value no doubt, but it is the younger and stronger men who must do the heavy work.

We shall need unity and strength and unselfishness of purpose and devotion to the common good, in the days to come, and we should begin *now* to organize our forces.

* * *

OSLER DINNER

The Annual Osler Dinner was held at the Hotel Vancouver on March 1st. This is the twelfth Osler Dinner since Dr. F. Brodie, then President of the Vancouver Medical Association, first suggested that an annual dinner be held in honour of the late Sir William Osler. Dr. C. W. Prowd, this year's president, in his short introductory speech took occasion to point out that the number of members present at this dinner was exactly twice the number present at the first dinner, thus showing growth of the Vancouver Medical Association and perhaps growing interest in the Osler Dinner.

The dinner was held in the Oval room of the hotel and there were 117 present besides several who came in later in the evening. The head table was graced by many past presidents and Osler lecturers.

Dr. F. P. Patterson was the speaker of the evening and his paper will be reported in full in a later number of the Bulletin. We feel perhaps that the large turnout was mainly a tribute to Dr. Patterson himself, who commands the earnest attention of any audience he may address on any subject connected with his specialty. This lecture was no exception, and though the subject he chose was a difficult one, not of immediate interest to the practitioner, the rapt attention with which his audience followed him through two hours of close and careful speaking shows the ability with which the speaker handled his topic. We cannot but feel that it is far the best course for an Osler lecturer to pursue, to aim high in his choice of subject and treatment of that subject, as Dr. Patterson did. Lesser subjects may be kept for ordinary occasions, but the standard of Osler lectures has on the whole, been very high, and it is unnecessary to say that Dr. Patterson maintained that standard at its highest. His address was illustrated by lantern slides which will unfortunately be missing in the published article.

A short business meeting was held before the actual address and on the motion of Dr. A. Y. McNair, the Cancer Investigation Committee was organized into a regular section of the Vancouver Medical Association, to be known as the Cancer Section.

No other business was transacted and the meeting adjourned at 10:30 p.m.

NEWS AND NOTES

We extend our sympathy to Dr. James T. Wall, upon the loss of his father, Mr. W. H. Wall, who died on February 21st. Mr. Wall was a genuine British Columbia pioneer who came to the Colony sixty-eight years ago, rounding the Horn in a sailing ship.

* * *

In the death of Mr. Richard Hall in Vancouver recently, British Columbia lost its oldest McGill graduate. He was the father of Dr. W. K. Hall, to whom we offer our condolences in his bereavement.

* * *

We are sorry to record the death of another whose son is numbered among our colleagues. The death occurred recently at Penticton of Mr. A. DesBrisay. We sympathize deeply with Dr. H. A. DesBrisay in the loss of his father.

* * *

Among the distinguished personages from Vancouver who attended the opening of the Provincial Legislature was Dr. R. E. McKechnie. We understand that the Honourable Dr. Josiah Hinchcliffe did not insist upon his being vaccinated before landing at Victoria.

* * *

The marriage took place at High River, Alberta, on February 13th, of Miss Dorothy Young of High River, to Dr. C. D. Moffatt of Vancouver. Dr. Moffatt and Mrs. Moffatt are both well-known in Vancouver, the doctor having practised here for some years, while Mrs. Moffatt is a former member of the Vancouver General Hospital staff.

* * *

Drs. G. F. Strong and H. H. Pitts are guest speakers at the Sixteenth Annual Clinical Session of the American College of Physicians in San Francisco, on April 5th. Their subject is "Further Observations on Primary Carcinoma of the Liver in Chinese."

* * *

Overheard in the Medical Dental elevator.

"Hello, Lena, are you going to see a doctor here?"

"Oh, yaw; last week ay bane see one frash faller, and he yust tall me ay bane eat too much. Now ay bane go see new doctor; he bane good Swede faller, his name Dr. Neilson.

* * *

Losh man, there wis a muckle din at the Forum on Thursday February 18th. The Laird o' Fintry, or one gey like—or it micht ha' been that chield Bilodeau, lately known as Houghmaghandi—wi' a wheen o' they doctor-bodies were a' takin' a fling o' the stanes. Och ay! Sic a skirlin' an' a loupin' an' bletherin' o' "Soop her up " ye never did hear the like. They ca'd it a Medicinal Bonspiel, or sae it wis announced by Roy Pedlow wha got it up an' did a' the wark. An' did ye no see the bonny picturs forbye that was stickit up i' the hospitals? 'Twas Miss Bernie Wilson, the wee niecie o' Neil MacDougal wha pentit them, and the doctors thank her kindly. She showed Dunnie Meekison, bunnet an' a', wi' sax rid hairs on the ane knee an' fower black yins on t'ither tae the life. Scotty McNair wis there, an' wee Geordie Clement forbye

lukin' braw in kilt an' plaidies. Anson Frost, E. H. Saunders and Chairlie Walsh got prizes, but Scotty Conklin fair surpassed himsel in walkin' awa wi' a prize. The canny auld veteran 38 years oot o' th' game wis for dingin' oot the stanes o' sic young buckies as Boucher an' a'. Jock McCrae, the bagman frae Frosst (Tootootoo) brocht up prizes for a' the winners, and votit a guid and leal freend o' th' profession. Had he bin gien yin for the bonniest-lukin curler it shairly wud ha' gane to that canny body wha minds th' bawbees, Lockhart himsel, wi' his tammie an' reefer, skelpin' th' ice an' flingin' his stanes wi' th' best o' them. Taylor Henry brocht a load o' new broomies, but it grieves me sairly to relate that he's still lookin' for some feckless loons wha hadna th' siller at hand for them.

A'thegither there wis mair nor 80 braw curlers makin' merry, sic an aggregation as wad dae ye guid to tak' a blink o' them. An' gin ye dinna ken the taste o' a wee drappie when the stanes are ringin' doon the ice, come an' tak a scunner wi' th' lads th' neist time.

Hoot man, awa wi' ye an' yer pickle haverin'; gin ye come hame tae yer guidwife a wee bit daft-like, she'll ken na deeference an' pit it doon tae yer vaccination!

* * *

Congratulations to Dr. R. de L. Harwood. Lady Luck dropped a handful of green-backs on his front door-step on March 15th. Dr. Harwood is *not* interested in news about the new oil-well developments, silver stocks or other holes-in-the-ground.

* * *

Dr. "Bill" Gunn admits that he may not know his groceries, but he does know a milk-wagon when he sees it, even in the pre-dawn hours. And he knows just where to hit to get the biggest splash.

* * *

The Bulletin feels that due acknowledgement should be made to Dr. C. A. Ryan for the trouble and time he has spent on the picture gallery which now appears on the Library walls, comprising the Past-Presidents of the Association. Dr. Ryan has spent many hours on this and has done a remarkably neat piece of work. The lettering is his own, and each photograph is neatly inscribed with the name of the President that appears thereon, with his date of office.

* * *

INDICATIONS FOR ENDOSCOPY

By Dr. E. E. Day

The purpose in presenting this subject tonight is to direct your attention to some of the advantages of endoscopy and to foster a spirit of co-operation between those who are interested in this subject and the other departments of medicine.

The writer will not be quoting his own experiences and impressions, rather the views of men, well qualified by education and experience in this field, will be given.

Killan in 1897 was the first to employ a rigid metal tube, introduced through the mouth, to remove a bone from the right bronchus

Read before Vancouver Medical Association, February, 1932.

of a man, 64 years of age. In the early days endoscopy was a difficult and formidable feat. Today, thanks to the efforts of such pioneers as, Chevalier Jackson Sr., Mosher, Ingals, Johnson, Friedberg, Coolige Arrowsmith, Yankauer, Lynah, Imperatorii and others, it has become a relatively simple procedure.

Bronchoscopy and eosophagoscopy can no longer be looked upon as emergency measures of last resort and to him who still believes that such terms are to be associated with only the foreign body case, together with all the old time dread of complications, this is to be said. In Jackson's clinics in Philadelphia, foreign body work represents only 2% of the total number of cases examined and operated upon, and furthermore the mortality rate is as low as 1%, including all cases treated by Jackson and his associates.

A complete list of the indication for laryngoscopy, bronchoscopy and oesophagoscopy is long. Any list that mathematically states indications often arouses doubt of value, and to one not familiar with the scope of the work may seem to approach exaggeration. Rather clinical acumen will recognize conditions as they present themselves and in consequence determine whether endoscopy is necessary for diagnosis, treatment, or both. From a narrow field, which a few years ago was restricted to emergency foreign body operations, the list of indications for endoscopy in exploration for diagnosis and treatment of conditions to be found in the larynx, bronchial tree, pleural cavity, pharynx, oesophagus and stomach, has so lengthened that at the present time it is possible for an endoscopist to render invaluable assistance to both internist and surgeon.

The larynx shall be considered first because it is so accessible to examination, either by the indirect or direct method.

Hoarseness, voice change or discomfort call for laryngeal examination for diagnostic purposes. Hoarseness is the most common pathological laryngeal symptom and is due to some interference with the proper vibration and approximation of the vocal cords. It is a symptom common to vocal nodules, papilloma, laryngeal inflammations or malignancy. Hoarseness as a symptom offers no variation in type diagnostic of the particular condition present.

To quote the late J. A. MacKenty. "Persistent, progressive hoarseness, in or after middle life may and often does mean that laryngeal cancer is present. In no other situation in the body does cancer give such early or such easily recognizable warning of its presence." He further states, "that only by early examination and with biopsy of early and suggestive lesions, an early diagnosis and cure can be obtained as the only hope in this dire disease is radical removal, to eradicate to a large extent the unspeakable misery attendant on uncontrollable laryngeal cancer. "According to Gabriel Tucker, "the average length of time between the onset of symptoms of carcinoma and the time of diagnosis is eleven and one half months." It may be interesting to know that laryngeal cancer comprises 5% of all cancer.

Bronchoscopy

It is well known that bronchoscopy is indicated in the presence of a foreign body in the lower air passages. However, there are other condi-

tions in which obscure signs may be rendered more clear and very often treatment efficaciously administered.

Foreign Body

Choking, coughing and wheezing coming on suddenly in a healthy individual should make one think of foreign body. X-ray plates must be made before bronchoscopy is attempted, for from these, if the foreign body is opaque, information as to its size, shape and position can be ascertained. It is advisable to have a plate taken immediately prior to operation as foreign bodies often migrate. If the foreign body is non-opaque there are usually radiographic evidences of partial or complete obstruction in the lungs. McCrea has pointed out that one can find some diminished expansion and fine rales even in cases of small non obstructive foreign body. Even if foreign body is suspected and there are no discernible physical or radiographic signs it is safer to do a bronchoscopy, for often they are overlooked.

Jackson has on record over two hundred (200) cases of opaque foreign bodies which were overlooked for periods varying from six (6) months to forty (40) years. This writer's postulate that every ailing child should have a roentgen-ray examination from occiput to ischia to exclude foreign body merits some consideration when on considers that more than 50% of all foreign bodies removed have been from children under two years of age. Failure to diagnose, locate and remove a foreign body from the lungs usually results in permanent destruction of lung tissue which may cause the patient to become a chronic invalid and frequently leads to untimely termination.

Pulmonary Suppuration

The bronchoscope is a valuable aid in the diagnosis and localization of pulmonary suppuration. It is frequently the best therapeutic method available.

There are two types of lung suppurations. First the lesion characterized by dilatation of the bronchial elements, termed bronchiectasis, and secondly the lesion in which the lung parenchyma is primarily involved with formation of localized abscess and cavitation. Both of these conditions are primarily the result of bronchial obstruction and secondarily of infection. According to Van Allen, "Bronchial obstruction is essential to the production of abscess irrespective of the organism introduced." Early lung suppurations should be considered primarily as a medical disease and as such should be handled by the internist. Chronic pulmonary suppuration calls for surgery.

Spontaneous cure results in 50 to 60% of cases but it cannot be predicted which will recover spontaneously. Fulminating cases usually terminate fatally regardless of treatment.

By means of bronchoscopy in these cases the suppurative area can be attacked through its communicating bronchial connection. Localized abscess and suppurative bronchiectasis can be differentiated and the presence of foreign body or neoplasm can be excluded. In chronic cases strictures can be dilated and granulations removed. The exudate can be

aspirated, irrigation carried out when indicated and medicaments directly applied.

Centrally located lung abscess can be cured by these means but bronchiectasis is not so encouraging, but here the symptoms of bronchitis and asthma can be relieved.

Atelectasis and Pheumonia

Massive collapse of the lung, especially post operative, is due to bronchial obstruction, usually by mucus plugs and direct aspiration of the mucus by means of the bronchoscope is indicated. Post operative pneumonia is a type of obstructive atelectasis of the lung. According to the experimental work of Coryllos and Birnbaum, post operative atelectasis and post operative pneumonia represent two phases of the same pathological process, the prominent factor being bronchial obstruction and the result depends upon the infective organism in the obstructing mucus. They cite one case of pneumonia in which bronchoscopic aspiration led to a hastening of the crisis and ultimate recovery. Similarly by aspiration and lavage unresolved pneumonia can be benefited.

Neoplasm

For diagnosis of neoplasm of the lung there is one procedure as valuable as bronchoscopy. The vast majority of pulmonary tumours are of bronchogenic origin. The radiologist may diagnose an opacity and by inference neoplasm, but a definite diagnosis is only possible by biopsy.

A non productive cough gradually increasing in severity, with breath sounds suggestive of asthma, or haemoptysis with no evidence of lung suppuration or tuberculosis, should be investigated bronchoscopically with the prospect of finding an early carcinoma. Yankauer states, "that in cases presenting symptoms of pulmonary suppuration after 40 years of age, 50% have malignant growths." Benign tumours are occasionally met with such as haemangioma, papilloma and fibroma. Carcinoma of the bronchus is not an extremely uncommon disease. Bronchoscopy offers the best means of early diagnosis. Patients with obscure chest conditions should have a bronchoscopic examination in conjunction with the other methods of examination.

Asthma

Bronchoscopy is positively indicated in cases of asthma when all other means of investigation have failed to establish a correct diagnosis and when relief of symptoms cannot be obtained by the usual measures, as often the underlying cause is neoplasm, compression stenosis or foreign body. Jackson's dictum "that all is not asthma that wheezes" has been only too often proved. Again by means of the bronchoscope uncontaminated secretion can be obtained from deep in the lungs for the purpose of preparing vaccines. Bronchoscopic treatment by aspiration and instillation of bland medication relieves a great number of these cases of asthma—why this relieves is not known.

Tuberculosis

Clerf in a recent article states that, "the value of bronchoscopy in pulmonary tuberculosis is limited largely to diagnosis. It is rarely indicated in uncomplicated pulmonary tuberculosis. The chief value in tuberculosis is to aid in diagnosis of unexplained signs and symptoms

and in cases presenting obscure pulmonary symptoms in which tuberculosis may be suspected but cannot be proved, for in these cases the tubercle bacillus can often be discovered in secretion aspirated from a lesion deep in the lungs, where the usual methods fail."

Stenosis

Clinical data are seldom sufficient and adequate to determine the aetiology and type of stenosis, whether it be intra-bronchial or compression from without as, for example, by enlarged bronchial glands or a dilatation of the aorta. Only by bronchoscopy can the diagnosis of the cause of the stenosis be arrived at.

Yankauer goes so far as to say, "that no diagnosis of an intra-thoracic lesion is complete without a bronchoscopic examination and further that in general no operation upon an intra-thoracic condition is justifiable without including the endoscopic findings in the indications for operation."

Oesophagoscopy

Dysphagia is the one symptom common to practically all oesophageal conditions. This symptom is present whether there is foreign body, stricture, mild or ulcerative oesophagitis, diverticulum, mediastinal pressure, carcinoma or the so called cardiospasm, in varying degree from a slight discomfort to severe pain. Dysphagia is not pathognomonic of any one of these conditions. It is an early symptom and often the only one of beginning oesophageal malignancy. Pain, regurgitation and haemorrhage are advanced symptoms while cachexia and loss of weight are toxic or nutritional symptoms due to obstruction.

Often we witness the removal of a normal or slightly inflamed appendix to avoid more serious conditions. Yet is one not even more justified in performing a diagnostic oesophagoscopy, so that direct inspection and removal of tissue for microscopic examination may offer at least an early opportunity to avoid more serious conditions?

Granted that at the present time, malignancy of the oesophagus is 100% hopeless. Nevertheless only by early diagnosis can any degree of hope be held out for this distressing condition, as is the case with carcinoma elsewhere.

Jackson reports cases of angioneurotic oedema, urticaria, serum disease and herpes involving the oesophageal mucosa, and that the only means of arriving at a diagnosis in these cases is by direct inspection of the lesions. Peptic ulcer of the oesophagus in patients complaining of pain back of the sternum, gastric haematemesis and regurgitation should be considered and perhaps would be found to be less rare if a direct examination were made.

A few words concerning the swallowing of foreign bodies reaching the stomach and intestines are in order.

Myerson, commenting on this accident, feels that there is no great cause for alarm if a foreign body is swallowed into the stomach. In a series of thirty-nine (39) such accidents, thirty-six (36) of the foreign bodies passed through without incidence, even though 82% of these were pointed. This indicates that the patient should be watched fluoroscopically and that surgical measures need not be resorted to unless positive

indications of obstruction or perforation arise. Nor is it necessary to prescribe special diets or feed absorbent cotton to entangle the foreign body. The last mentioned item may so increase the bulk that obstruction is inevitable. Although the giving of cathartics is contraindicated, yet in most cases seen, this remedy has already been tried before medical advice is sought and no untoward results have occurred.

Contra Indications

Contraindications to endoscopy are few and limitations of the procedure from the patient's standpoint are governed by the physiological reaction, age, intended co-operation, part to be examined, anaesthesia to be employed, anatomical or pathological obstacles to be encountered, such as advanced arterioselerosis with aortic aneurysm or kyphosis of the cervical vertebrae. Also in cases of pulmonary tuberculosis where pneumothorax, marked haemoptysis, extensive pulmonary involvement or laryngeal involvement are present.

Chevalier Jackson has repeatedly emphasized the value of endoscopy as a therepeutic and diagnostic aid. Yet he recognizes that this procedure is subject to definite limitations and should be more or less restricted to selected cases, and therefore subject to the combined opinion of a team, made up of internist, roentgenologist, pathologist, thoracic surgeon and endoscopist. Each one indispensable, no one always final and in combination making up a co-ordinated team that is capable of giving a finely drawn diagnosis and directing a most rational treatment.

* * *

THE CHALLENGE OF STATUS LYMPHATICUS

W. N. Kemp, B.A., M.D., *Vancouver, B. C.*

On Friday, August 28th, 1931, Baby F., aged 19 months and apparently a normal child, developed a nasal discharge that was unaccompanied by a cough. On Saturday he was listless and refused his milk (modified cow's milk with dextri-maltose). He gradually became more listless and by evening he did not appear to notice anything in his environment. Occasionally he would give utterance to a shrill cry. At 5:00 a.m., Sunday, the 30th, he had a convulsion. His eyes were fixed and staring and his respirations were laboured and noisy. At 9:50 a.m. he was admitted to the Infants' Hospital. At this time he was comatose and his lungs seemed to be "filled with secretion." His colour was waxy white with his lips and finger nails a "pallid blue." His chest was full of coarse moist rales and respiration was laboured. His extremities were cold and clammy and flaccid. The little patient's condition became steadily worse in spite of all the usual supportive treatment and he died at 12 noon as preparations were being made to perform a diagnostic lumbar puncture, (post-morten tap showed a normal spinal fluid).

Exactly seven hours later on the same day, Sunday, August 30th, Baby R., aged 6 months, was carried into the Admitting Room of the same hospital. He was cyanosed and in a state of shock. He died fifty minutes after admission in spite of the heroic efforts of the attending interne. There was nothing of significance in his previous history. He had been attending the outpatient clinic regularly and was gaining and

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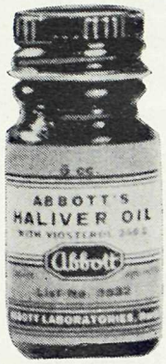

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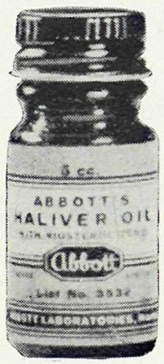

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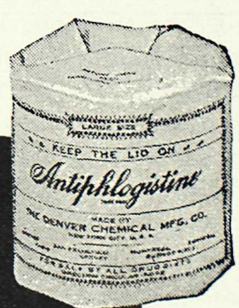

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progressing normally. The only abnormality previously noted was a history of loose stools for 24 hours preceeding death. Four other children of these parents were alive and well.

Post mortem examination was conducted by Dr. H. H. Pitts, Pathologist of the Vancouver General Hospital on August 31st. The autopsy findings were remarkably similar in each case. In the first child no signs of pneumonia or meningitis were found. After a careful and thorough search nothing of abnormal significance was found except many hyperplastic mesenteric lymphatic glands and a thymus gland weighing 33½ grams. In the second infant (Baby P.) the only fiindings of note were the presence of numerous enlarged mesenteric lymphatic glands, a thymus that weighed 30 grams and an oedematous condition of the brain (but no meningeal exudate).

In one day, within eight hours two children have died rather suddenly from the same underlying constitutional deficiency which, for want of a better term, we call status lymphaticus. Every practitioner of medicine in Vancouver knows that many, even more sudden and tragic, fatalities occur among the infants and children of this city. The presence of this constitutional anomaly in such a comparatively large proportion of our children is a definite challenge to our powers of clinical investigation and our scientific training. Status lymphaticus is essentially a clinical problem which is particularly prominent in the Pacific North-west. Surely, by availing ourselves of recent animal experimental results, by examining definite cases from every angle and by pooling our results and comparing theories and facts, we can arrive at a working solution of this tragic condition. *This is the challenge of status lymphaticus.*

As a start in this hoped-for research the writer has made a review of the history and present opinions in regard to status lymphaticus. These and a new theory of its aetiology will be briefly indicated here in the hope that more interest will be aroused in this, our own problem, and that a sound theory or explanation of its aetiology will be established on a clinical basis.

It would appear that the overwhelming emphasis that has been placed upon the presence or absence of enlargement of the thymus gland has greatly clouded the issue and hidden the real cause of status lymphaticus for many decades. The thymus enlargement, (there is usually some slight enlargement) is only incidental to the real deficiency, which is elsewhere. The really most constant and diagnostically significant of the postmortem findings in status lymphaticus are enlargement of the mesenteric lymph glands and Peyer's patches. The thymus may, or may not, be enlarged, depending upon the nutrition of the child. There is also a sad lack of knowledge concerning the real normal weight of the thymus. It would appear that this normal thymic weight varies in different geographical localities and the only sound way of arriving at a *true* normal weight is by the autopsy of every child dying suddenly from *trauma*. Seven to eight per cent. of these children will show some of the signs of status lymphaticus and should be excluded in computing the normal weight. It is only by first arriving at a true value of the normal thymic weight that we can rationally discuss any particular case of

sudden death from the point of view of thymic enlargement and the inferences thereof.

The recent activities and results obtained by workers in various physiological laboratories in "researching" suprarenal cortical insufficiency are of great interest and importance to any student of status lymphaticus. Briefly stated, it has been shown by many laboratory animal experiments that the adrenal cortex is essential to life. When deprived of its cortex, the animal dies in a short time and the manner of his death resembles that of the unfortunate babies discussed in the early part of this paper. On postmortem, every animal (in Banting's series of 37) had marked enlargement of the mesenteric, retroperitoneal and mediastinal lymphatic glands and an enlargement of the thymus in every case.

More interesting still, are the results of partial cortical adrenalectomy in dogs. It has been found that dogs can survive and live an apparently average dog's life if only one eighth of their adrenal cortex is left in situ. Such dogs are more subject to infection than normal dogs, but otherwise they pass as normal dogs. If they are killed (and it takes much less than an average dose of poison to kill them) a most significant set of postmortem findings meets the autopsist.

For basis of comparison the following autopsy report in a case of accidental death is recorded at this point:

"The post-mortem findings are:

(1) A large vascular thymus measuring 14 x 6 x 2.5 cms.
(2) Large mesenteric, retro, peritoneal and mediastinal lymph glands.
(3) The lymph follicles in the lower portions of the small intestine are large and prominent.
(4) The spleen is slightly larger than normal.
(5) The tonsils are much larger than normal."

The above findings are typical and are those commonly seen by competent pathologists in cases of sudden and unexplained death in children. However, the above described autopsy was made by Crowe and Wislocki, *on a dog,* aged 18 months. in whom a partial adrenal cortical insufficiency had been operatively produced 4½ months before his death in a street accident.

If the condition that we call status lymphaticus in children is due to an adrenal cortical insufficiency, how is such insufficiency incurred? The answer to this question entails a brief review of the best opinion regarding the prenatal and immediately postnatal state and function of the adrenal cortex. In foetal life the adrenal cortex, having important morphogenetic functions, is relatively many times larger than in adult life or even in the first year of life. When these morphogenetic functions have been largely discharged at about the fifth month of foetal life, the adrenal cortex gradually undergoes involution. *After birth, the most important change is the degeneration of the inner cortical layers (foetal reticulata and fasiculata) to make room for the rapidly developing medulla, the cortex regenerating from the glomerulosa to form the permanent cortex of the gland.*

Although Nature's ways are wonderful and perfect in 99 per cent. of individuals, yet it is quite within reason and common sense to assume that the degeneration and subsequent regeneration of the adrenal cortex before and after birth are not perfectly timed and accurately controlled in every individual "born of woman." When the degeneration is too rapid or the regeneration is too tardy in its inception, a period will occur when the infant many be temporarily without the cortical secretion that we know is absolutely essential to life. It is at such a period that the baby's hold on life is a very precarious one. He may die suddenly in bed or in his mother's arms. Or he may succumb to a slight infection or a mild physical shock that would have little or no effect upon a child with average cortical function. At autopsy, all that is found is a thymus gland that is usually larger than the *true* normal gland and enlargement of the mesenteric lymphatic glands with prominence of Peyer's patches in the intestine. For want of a better term the coroner's physician makes a post-mortem diagnosis of *status lymphaticus*.

EDITOR'S NOTE—The above paper warrants, we think, the serious consideration of our readers. Two recent deaths in children, one under an anaesthetic, the other at home in bed, give added point to the question that Dr. Kemp puts to us in his article, "Have we got to the bottom of status lymphaticus? Do we know the real cause of it?"

The thymus gland has held the centre of the stage so far, as the villain of the piece. But we all know that the role the thymus plays is not clearly understood. Dr. E. D. Carder, in a paper read some years ago on the thymus gland, and its relation to sudden deaths, stated that while the thymus would appear to have some connection with the condition that causes these, we are not at all clear as to what the connection really is.

Dr. Kemp suggests that we must go further back, to a deficiency in the adrenal cortex, a deficiency that may be temporary, and coincident with certain stages of growth in the child, or that may be permanent. He has spent much time and labour in his study, and many of his points are too striking to be ignored. The whole question of calcium in the organism, a question that is so prominent nowadays in the minds of all who deal with children, is involved.

We congratulate Dr. Kemp on his work. He himself does not consider it final, but feels that it is worth following up. Perhaps a committee might be formed which would study the question, and either prove or disprove the theories put forward by Dr. Kemp. We cannot have too much of this sort of thing, it benefits those who do it, and may lead to results which will be of value to humanity.

MEDICAL ECONOMICS (2)

Minimal Fees

By R. E. Coleman, M.B.

The first paper on this subject was designed to establish the reality of a medical economic problem right here in Vancouver. The intention was to follow with a series of discussions of the various phases with the

object of ultimately developing a range of fees which would be more scientific in character. For this purpose a second paper was prepared and presented to several physicians for criticism. The result was almost complete condemnation on the grounds that the paper was too technical, too far from the main point and that proof of the points discussed was unnecessary. As a matter of fact these criticisms were unsound in that any attempt at complete proof must be of necessity highly technical. Further numerous conversations with physicians concerning problems of medical conomics has shown that in actual practice they constantly make economic decisions on extremely far-fetched points. Lastly, one of the physicians who was most insistent that proof was unnecessary would not admit a practical consequence until the connection was pointed out and the proof adduced. There was, however, another criticism which could not be met. It was pointed out that a detailed analysis of this character would lack the general interest so vital to the problem. As one physician said "Much more interest would be shown and more rapid progress made if a "hat" were thrown into the ring, with a challenge for anyone to kick it, the owner of the hat then undertaking to iron out the dents." The following is the "hat":

As I am the owner of this "hat", it will be described in the first person singular. Also since I wish you to give it plenty of kicks I will promise not to put any bricks in it, though of course I cannot prevent others slipping in a brick or two, nor can I be responsible for your aim.

When I entered the University I had absorbed the usual lay impression that medicine was a noble altruistic profession with the surgeon on top. To-day I am not so pleased with the mechanism by which altruism is developed in the individual nor with the mechanism which has placed the surgeon where he is. Economically I thought that medicine offered anything from a good living up. Today I know that here in Vancouver this is in error. At the University I absorbed another idea, to the effect that no physician could maintain his own self respect unless he exhausted every effort in the diagnosis and treatment of every patient he saw. It was the logical development of this last that finally forced me, much against my will, to accept the fact that the patient, the practitioner, the community and the advancement of science were financially inseparably interdependent. Soon after I entered the clinical laboratory I accepted the general statement of the visiting physicians that laboratory aids to diagnosis and treatment were too costly. I did not know in those days that each branch of medicine thought this of every other branch nor that it was simply the general attitude of the consumer to the producer. So for thirteen years I studied ways and means of reducing the cost to the patient of clinical laboratory examinations. I invented shortcuts and trained technicians but absolutely no progress was made toward lowering the charges. I made abortive attempts to find what individual tests cost, which were profitable and which were done at a loss, but it was not until Dr. H. W. Hill became director that any progress was made. It then took us six months to collect the first set of data. About three years later we were able to incorporate our results in the work. It had previously become obvious that the clinical laboratory had earned a profit from the very beginning, though it had always been and was still shown in red ink in the hospital books. I saw then that the clinical laboratory

profits were always diverted into other channels, and my goal of lower prices would always be unattainable under such conditions.

I then turned to private practice with the idea that the profits of the clinical laboratory would thus be available for improvements and reduction of costs within its own field. Appreciating the value to the clinical laboratory of the cost-accounting that Dr. Hill and I had done, I began to study the costs of other phases of medical practice. This double experience, of personal private practice and numerous very personal conversations with physicians regarding their own costs and selling price, led to a real surprise, and a complete change of front on the whole question of medical economics. In short I definitely decided that medical fees were too low. Today I am convinced that the patient, the practitioner, the community and the advancement of medical science will all profit, when more money finds its way into medical activities. It is quite true that there are many economies that should be effected, but when these are made we should not repeat the mistakes of the past. Such savings must not be passed on immediately to the consumer, but rather used to build up a solid well balanced financial structure first. This, in the last analysis, is in the interests of the consumer. In my opinion there is a *real* medical fee which is independent of the observer. That is a fee which is more or less independent of any prejudices on the part of the patient or physician. It is about this *real* fee that fluctuations occur. Modern medical fees are below this real fee. My objective is to find the *general range of this real fee* for different classes of medical activities.

To make a start I will produce a "hat" in the statement that any work done by a recent graduate here in Vancouver should be charged for at the rate of over $6.00 per hour if it is a private patient, and at least $3.80 if on a salary basis. Any smaller charge than this is quite equivalent to giving away the same amount of cash. (I can see the physicians looking over their biggest boots so that they will be sure to kick the hat right out of the ring the first kick, in spite of my friend who says that my statements will be accepted.) As a matter of fact I expect to raise this figure before I am satisfied, but then, after all, personal economics is a matter of personal satisfaction. There are many ways of calculating this basic figure and they all yield different results. Here is one way.

A postal clerk might have started here in Vancouver on a salary of $1,080.00 per annum. There are many reasons why I chose a postal clerk, but this is not the place to give them, so I am told. He enters by examination and advances by examination at a rate of $100.00 per annum to a maximum of $1,700.00 per annum. Now the average age at graduation at one of our Canadian Universities for the year 1930 was 27 years. That is, for 9 years these students sacrificed a steady income which represents $14,520.00. I allow 5 per cent, compound interest making the amount $18,183.00. In this particular class the expenditures, exclusive of living and amusements, was $1,640.00 and at 5 per cent this becomes $1,812.00. In this particular class there was also a wastage due to failures and repeating, which, at 5 per cent. becomes $263.00. Thus at graduation each student represented a capital investment of $20,258.00. That is, a graduate of 1930, commencing practice in Vancouver, should receive the equivalent of a postal clerk's salary plus compensation for

his investments. I would allow him 5 per cent. on $20,258.33 (his invested capital) which is $1,012.91. I would also allow him 5 per cent. for his sinking fund so that when his machine (himself) was worn out he would have his money back. That is, I would allow him $2,025.83 per annum to carry his investment. From a questionnaire that I collected I know that the professional costs of a practice of this size in Vancouver would be at least $2,400.00 per annum. The total yearly income would therefore be the postal clerk's salary of $1,700.00 plus investment dues $2,025.83, plus running expenses $2,400.00. This makes a total of $6,125.00. I am also convinced that he can not do justice either to himself or his patients and show more than 1,000 income producing hours in the year. He should therefore receive $6.12 per income producing hour.

To return to our "hat". I maintain that here in Vancouver the minimum fee charged to the patient should be over $6.00 per hour. I am also prepared to maintain that this is in the interests of the patient, the practitioner, the community and the advancement of medical science. I furher maintain that since the production, distribution and financing of a product is of necessity in the hands of the producer, it is the duty of the medical profession to arrange the financing and to sell their price as well as their product. Finally, since the present situation is the result of group opinion and as group opinion is but the sum of individual opinions our problem is to alter a sufficient number of individual opinions to alter the group opinion.

B. C. MEDICAL ASSOCIATION NOTES

We are able to publish this month a certain amount of advance information regarding accommodation and proposed entertainment which is being prepared for the members of the B. C. Medical Association, who will attend the Annual Meeting in June, at Kelowna, B. C., May 26, 27 and 28.

Hotels

The Royal Anne will be able to make reservations for fifty. Most of the rooms have private baths.

The Mayfair Hotel also can make about fifty reservations. There are no private baths, but the hotel is comfortable and attractive.

The Willow Inn can take twenty-five reservations with or without private baths as desired.

The Eldorado Arms is four and one-half miles from Kelowna, on the lake-point. This is a well-known establishment and ideal for family parties, especially if there are children. Its accommodations, for about thirty-five, will all be held open for B.C. Medical reservations.

The local management of the C.P.R., will keep the steamer Sicamous tied at the wharf and can furnish accommodation for one hundred. Both railroads will keep a sleeping-car on the siding, provided a party from the coast fills either of them. A porter will be in charge and the charge will be based on a daily rental per berth.

It is important that everyone intending to be present shall write *at once* to Dr. Underhill, the local secretary at Kelowna, asking for

reservations, in order that each one may be accommodated as he wishes. This will also make it possible to decide whether the steamer and either or both sleeping-cars will be needed.

The Golf Tournament will be a major event, and takes place on Saturday afternoon. At the same time many of the beautiful gardens of Kelowna will be the scene of afternoon teas. Numerous auto trips through the valley have been arranged, and can be taken at any time without any cost. The orchards should be in their gayest robes of blossom and leaf, and saturating the whole atmsophere with their fragrance.

Two dances will be given, one of them at least at the Aquatic Pavilion, so well-known to coast people who have attended the regattas there.

Another item that is attractive will be an excursion by the steamer Sicamous up the lake to visit Captain Dunwater's ranch at Finty.

The annual banquet will be held at the Royal Anne Hotel.

It hardly seems necessary to add after considering the list of entertaining features, that apart from the many advantages arising from the meeting of the doctors from all corners of the Province to discuss the affairs of their profession, and the scientific programme under preparation, a visit to Kelowna in the early summer will be a most delightful way of taking a holiday. A change is as good as a rest, and going into the highlands of the interior for a few days will offer all the elements to provide a change, that can be found.

Change of altitude, change of atmosphere, change of scenery, change from sea to lake, change from our daily grind to physical relaxation and mental stimulation. Come to Kelowna!

THE STRUGGLE TO MAINTAIN THE EDUCATIONAL STANDARDS OF THE COUNTRY IN THE TREATMENT OF THE SICK

By Dr. A. P. Procter

In the Province of British Columbia there has been concluded an inquiry into Chiropractic and Drugless Healing, presided over by the Honourable Mr. Justice Murphy of the Supreme Court of British Columbia, who has just issued his report. A history of the struggle in this Province of the profession to maintain the educational standards of those who seek to treat the sick may be of some interest to the profession throughout the Dominion.

About the time of the Great War, and perhaps just before it, chiropractors began to come in to British Columbia from the United States, as they doubtless did in every Province in the Dominion. Their primary and secondary educational qualifications were practically nil. They based their claims as they do now for the right to be entrusted with the treatment of the sick on the amazing theory that all disease is the result of a misplaced vertebra, which impinges on the nerve passing through the intervertebral foramen resulting in the disease, whatever it may be. The cure is, of course, to reduce the so-called subluxation

and Nature does the rest. Even infectious diseases, we are gravely told by these people, will not occur in those whose spines are in proper alignment. In the Commission just held it was stated that the sublaxation for infectious disease may not always occur in the same region. This, briefly, is the Chiropractic theory, as stated by their representatives in evidence to the Commissioner. Nothing else in the way of education, apparently, or very little, is considered necessary. When one of these gentlemen was asked in a recent inquiry in this Province what preliminary education he had received, he replied with apparent self-satisfaction that he had got into the third reader twice. It was only natural, then, that the profession here, as elsewhere, viewed with alarm the granting of the right to treat the sick, with all that that responsibility means, to men whose educational qualifications were a joke.

In 1921 and 1922, the chiropractors of British Columbia brought Bills before the legislature for their legal recognition. The principle upon which the profession took its stand was that no one should be allowed the right to treat the sick unless he or she possessed a fundamental knowledge of certain standard subjects. In other words, when these people showed knowledge and competency, the profession had no desire to interfere with the particular line of treatment they desired to adopt, but the knowledge of the human body and the ability to recognize disease, were held to be essential, and no one without these qualifications should be granted legal recognition. With these views, in 1921 and 1922, special committees appointed by the legislature to inquire into this question, agreed, and a special section was placed in the Medical Act providing for an examination in these subjects for chiropractors, and later on, drugless healers, who also became insistent for recognition. An examining Board was also provided for, composed of three doctors and two Chiropractors, or three doctors and two Drugless Healers, and it is interesting to note, from that date, not a single chiropractor or drugless healer has ever presented himself or herself for examination. The reason, of course, is obvious. They have little or no knowledge whatever of these subjects, and doubtless felt there was no possibility of passing an examination before anybody competent to examine them. The agitation, however, has continued, one demand being for an Examining Board of their own members—the blind examining the blind—their statement being that they refused to be examined by medical men who do not understand the chiropractic standpoint, whatever that might be, although it is a little difficult to understand how there can be one kind of anatomy, physiology, or pathology for chiropractors, and another for the medical profession. The human body is the same for us all, however much the mental processes may differ. However, since 1922 the agitation and demand for recognition has gone on and an enormous amount of energy and money has been expended and a great deal of time, both of the profession and the legislature, wasted, so that a year ago when further bills in the interests of chiropractors and drugless healers were brought before the legislature, in order to take this question out of politics and put an end to the ceaseless agitation, the profession requested the Government to refer the whole matter to a Commissioner, preferably a judge of the Supreme Court, upon whose report the legislature might act. To this the Government finally agreed, and

the understanding was that the claims of these cults for legal recognition would be referred to a Commission and a report presented at the next session of the legislature, which it was hoped would dispose of the matter. With this the profession was well content and awaited the appointment of a Commissioner.

What the profession had every right to expect, was that a commission would be issued which would enable the Commissioner to go into all questions necessary to enable him to come to a conclusion on the matters involved, regarding Chiropractic and Drugless Healing. In due course, the Honourable Mr. Justice Murphy was appointed as Commissioner, and I should like to take this opportunity of saying that no better appointment could have been made. Mr. Justice Murphy holds the respect and confidence, not only of the medical profession, but that of all shades of opinion in the Province. A few days after this, the Commission was issued, and to the amazement of the profession, it was found that it was divided into two parts—one for chiropractors, which was so restricted as to make the inquiry a farce—and one for drugless healers, which was left fairly wide open. In the inquiry into chiropractic, as will be seen from Mr. Justice Murphy's report, he was absolutely prevented from going into the one question that really mattered, and of paramount importance, that is, *whether the qualifications these people possessed rendered them safe in the public interest.* His report in opening the commission reads as follows:

"Questions of the efficacy of chiropractic or of its relative merit as compared with medicine, were not open to be considered. In particular, no inquiry was to be made as to the adequacy or otherwise, from the standpoint of protection of the public, of the accepted chiropractic training for the diagnosis of disease, nor for the accepted chiropractic method of treating human ailments."

Mr. Justice Murphy went to some pains in his report to drive this fact home, and later on in the report, he reiterates in order to make the limitations that had been forced upon him quite clear. "Once more (he says) to guard against misapprehension, your Commissioner repeats that the terms of the commission preclude him from making any investigation as to whether or not the Chiropractic standard in reference to the proposed subjects for examination, does adequately protect the public." In other words, Mr. Justice Murphy has gone to some pains to point out in his report that he was quite unable to bring out the one fact that ought to have mattered to the legislature of this Province, or any other Province, as to whether the qualifications of the members of this cult were of such a kind as to adequately protect the public. It may be wondered, that with this question unsolved, because under the terms of the commission the Commissioner was effectively muzzled, how any legislature can point to this report in order to justify the granting of legal recognition to these people to treat the sick.

It naturally occurs to anybody interested enough to consider the matter, as to why any government would appoint a Commissioner and then under the terms of the commission effectively prevent his being able to bring out any salient facts from which he could present a real report.

The painful fact is that under our present political system, whenever it is considered that a sufficient number of people with a sufficient number of votes, desire a thing, it would appear to be extremely difficult to prevent it, even though it is recognized to be all wrong. It may well be asked, why in this country where we are spending hundreds of thousands of dollars on higher education, and where, if our boys or girls desire to study medicine, they have to spend from seven to ten years before being considered safe to be entrusted with the great responsibility of treating the sick, our legislature, from motives of political expediency, should be found apparently ready and willing to break down the educational standards of the country and grant legal recognition to those whose educational qualifications they know to be largely non existent in any real sense.

The profession in this Province during the past ten or fifteen years has done everything in its power to induce the legislature to confine the granting of legal recognition to treat the sick to those whose qualifications adequately protect the public. It now feels that the responsibility for legalizing those who do not possess these qualifications should be left squarely on the shoulders of the legislature where it properly belongs.

Mr. Justice Murphy's report is not long, and is so interesting that is may be found possible to print it for the information of the profession, and will be found to bear out everything that has been written above.

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VIOSTEROL SAFE IN PREGNANCY

USE OF VIOSTEROL DURING PREGNANCY

To the Editor:—Please advise me whether administration of irradiated ergosterol to pregnant women could cause a premature calcification of the fetal head, resulting in dystocia, with possibly damage later to the child.

M.D., Waco, Texas.

J.A.M.A., *Dec. 19, 1931*, *p. 1914*

ANSWER.—There is no danger to mother or child from therapeutic doses of viosterol (irradiated ergosterol) given during pregnancy. In fact, such medication probably would be of advantage, owing to the excessive drain of calcium and phosphorus that takes place during this period. This medication is especially indicated in cases in which the intake of calcium compounds has been insufficient.

MEAD'S VIOSTEROL IN OIL 250 D, because of its well-known effect upon calcium absorption, is attracting increased interest among obstetricians for use during pregnancy, especially in connection with foods rich in calcium, such as Mead's Cereal (220 mgm. Calcium per oz.). Aside from its mineral nutritional aspect, Mead's Viosterol in Oil 250 D has a marked effect in lowering blood coagulation time. Samples and literature on request. Mead Johnson & Company of Canada, Ltd., Belleville, Ontario. Pioneers in Vitamin Research.

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★ *Answers to Questions* ★

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WITH VIOSTEROL—250 D

QUESTION:

What is Parke-Davis Haliver Oil?

ANSWER:

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QUESTION:

Does Haliver Oil represent vitamin A in its most concentrated form?

ANSWER:

Yes. It enables the physician to prescribe in terms of drops or minims instead of teaspoonfuls. One minim equals a teaspoonful of cod-liver oil.

QUESTION:

Is halibut liver oil rich in vitamin D as well as vitamin A?

ANSWER:

Yes. It is the richest natural source of both these vitamins. While especially rich in vitamin A, halibut liver oil also contains from 20 to 25 times as much vitamin D as cod-liver oil, which potency is increased to 250 D in the finished product.

QUESTION:

Why has not halibut liver oil been available to the medical profession before?

ANSWER:

Because the oil from the liver of the halibut cannot be extracted by the methods commonly used for removing oil from the liver of the cod. The method for extracting halibut liver oil has but recently been perfected.

QUESTION:

Is this new product indicated wherever either cod-liver oil or Viosterol has been used in the past?

ANSWER:

It is. It successfully meets these indications, because it provides *both* vitamins A and D in highly concentrated form.

QUESTION:

What dosage is recommended?

ANSWER:

The average dose is 3 minims (10 drops) or one capsule, *once* a day. Larger doses when specifically indicated.

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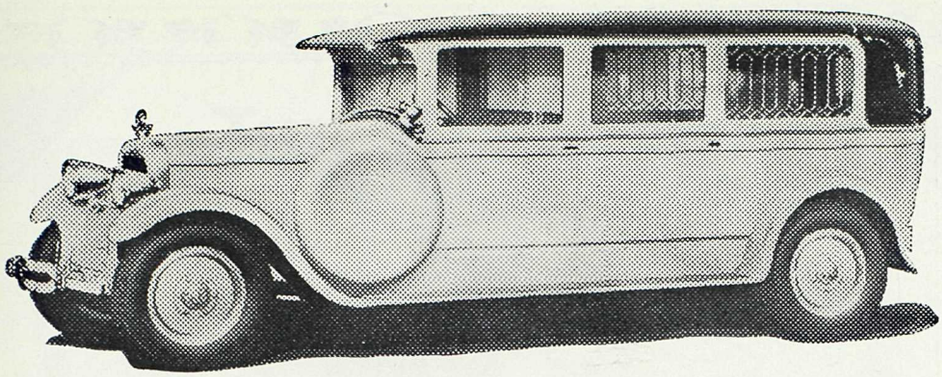

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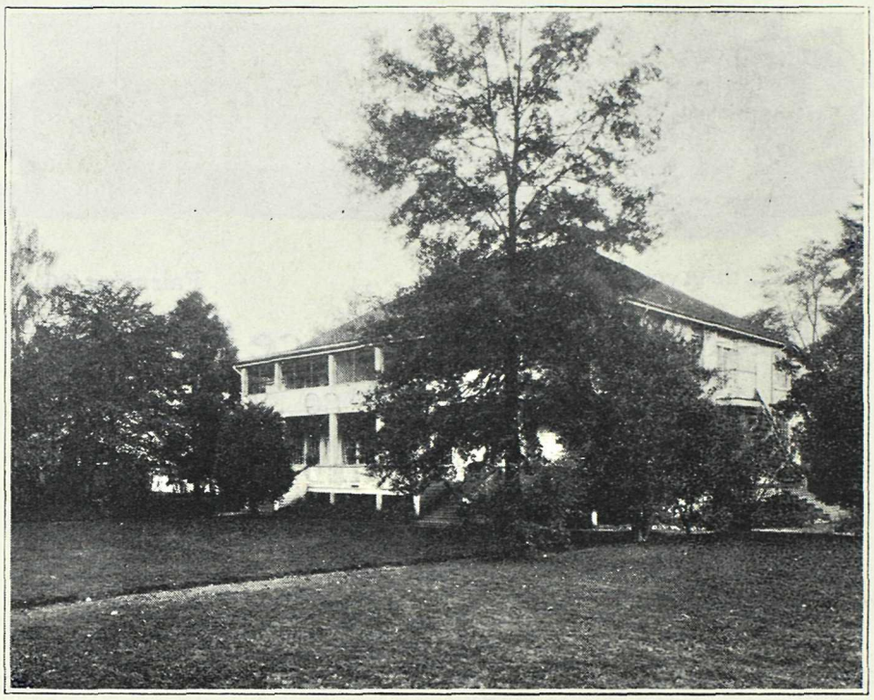

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