THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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

Offices: 203 Medical-Dental Building, Georgia Street, Vancouver, B.C.

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VOL. XXII. SEPTEMBER, 1946 No. 12

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... *Intramuscular injection* of Mercuhydrin Sodium Solution provides an absorption site from which the medication is released to the circulation slowly. This measure spares conduction centers of the heart from the shock of relatively massive drug concentrations which follow intravenous administration of mercurial diuretics.

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Vancouver, B. C.

VANCOUVER MEDICAL ASSOCIATION

Founded 1898 : : Incorporated 1906

PROGRAMME OF THE 49th ANNUAL SESSION

GENERAL MEETINGS will be held on the first Tuesday of each month at 8:00 p.m.

CLINICAL MEETINGS will be held on the third Tuesday of each month at 8:00 p.m.

October 1 GENERAL MEETING—Symposium—"Recent Advances in P
Doctors E. J. Curtis, E. S. James, W. H. S. Stockton and Reg. Wilson.

October 15 CLINICAL MEETING—Vancouver General Hospital.

November 5 GENERAL MEETING.
Doctors A. R. Anthony, L. H. Leeson and J. A. McLean.

November 19 CLINICAL MEETING—St. Paul's Hospital.

December 3 GENERAL MEETING. Symposium on Gynecology.
Doctors Leigh Hunt and Gardiner Frost.

December 10 CLINICAL MEETING—Shaughnessy Hospital.

Ergoapiol-(Smith)

Breaks the vicious circle of perverted menstrual function in cases of amenorrhea, tardy periods (non-physiological) and dysmenorrhea. Affords remarkable symptomatic relief by stimulating the innervation of the uterus and stabilizing the tone of its musculature. Controls the utero-ovarian circulation and thereby encourages a normal menstrual cycle.

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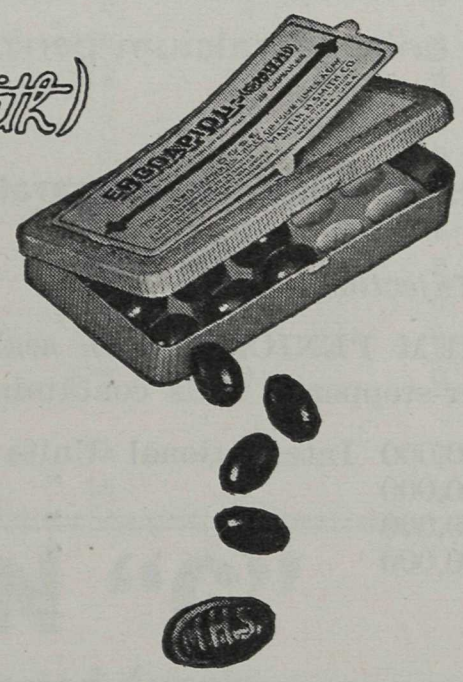

Dosage: 1 to 2 capsules 3 or 4 times daily. Supplied in packages of 20.

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Full formula and descriptive literature on request

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Since the first publication by Romansky of the satisfactory blood levels of penicillin obtained and maintained for a period of eighteen hours following the intramuscular injection of 300,000 units of calcium penicillin in beeswax and peanut oil, both laboratory investigations and collaborative clinical studies in the treatment of gonorrhea and pneumonia have been made by the Connaught Medical Research Laboratories. It has been widely confirmed that penicillin prepared according to the Romansky formula maintains the blood levels which are required in the treatment of gonorrhea and certain other conditions, and permits of one injection every twelve to twenty-four hours.

The Connaught Medical Research Laboratories have prepared a suitable product which can be readily administered with the use of a disposable plastic syringe provided in each package. This syringe, with sterile, built-in needle, is ready for immediate use with a special cartridge containing 300,000 units of calcium penicillin in 1 cc. of beeswax and peanut oil.

Other Penicillin Preparations Available from these Laboratories

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SODIUM PENICILLIN in sealed rubber-stoppered vials containing:

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200,000 " "
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VANCOUVER HEALTH DEPARTMENT

STATISTICS—JULY, 1946.

Total population—estimated	323,850
Chinese Population—estimated	6,566
Hindu Population—estimated	361

	Number	Rate per 1,000 Population
Total deaths	294	10.7
Chinese deaths	18	32.3
Deaths, residents only	248	9.0
BIRTH REGISTRATIONS:		
Male	408	
Female	416	
	824	30.0
INFANT MORTALITY:	July, 1946	July, 1945
Deaths under 1 year of age	26	13
Death rate—per 1000 live births	31.6	20.8
Stillbirths (not included above)	11	10

CASES OF COMMUNICABLE DISEASE REPORTED IN THE CITY

	May, 1946		June, 1946		July 1-15, 1946	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	21	0	10	0	7	0
Diphtheria	2	0	2	0	1	1
Diphtheria Carrier	0	0	2	0	0	0
Chicken Pox	233	0	99	0	7	0
Measles	9	0	4	0	2	0
Rubella	6	0	0	0	1	0
Mumps	351	0	248	0	32	0
Whooping Cough	0	0	1	0	2	0
Typhoid Fever	1	0	2	1	0	0
Typhoid Fever Carrier	0	0	0	0	0	0
Undulent Fever	0	0	0	0	2	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	93	22	115	23	0	0
Erysipelas	1	0	3	0	0	0
Meninboccus Meningitis	3	0	3	0	0	0
Infectious Jaundice	0	0	1	0	0	0
Salmonellosis	2	0	6	1	6	0
Salmonellosis (Carrier)	22	0	1	0	2	0
Dysentery	0	0	0	0	0	0
Syphillis	176	0	129	2	0	0
Gonorrhoea	301	0	278	0	0	0
Cancer (Reportable)						
Resident	62	0	92	0	0	0
Non-Resident	41	0	46	0	0	0

BIOGLAN "C"

Prepared separately for *male* and *female*.

Composition: Anti-thyroid principles of the pancreas, duodenum, embryonin, suprarenal cortex, tests (or ovary). Each 1 c.c. ampoule contains the equivalent of approximately 29 grams of fresh substance.
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Descriptive Literature on Request

THE SCIENTIFIC HORMONE TREATMENT

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

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EDITOR'S PAGE

From time to time this Journal, like every other medical publication, receives printed material from firms which manufacture pharmaceutical preparations or other things of which we may make use in our daily practice. With these enclosures comes a request or a suggestion that we run the material in our columns—as the information contained therein may be of interest or value to our readers.

We have always made it a rule, in the BULLETIN, to decline to do this—as we regard it as advertising, pure and simple, no matter how innocent it often looks. We believe that this is more or less the rule with most of our contemporaries, though occasionally we find that some medical journal has opened tis columns to this material. This is, of course, entirely their own business, and we have no criticism to offer, but a recent experience has made us more sure than ever that it is wiser to resist the lure so temptingly set.

In a recent issue of the BULLETIN, we published a report by Dr. K. D. Panton, of Vancouver, on some results he had had from the use of Absor-Vite and Ray-Vite products in his practice. These results he had found surprisingly good. He had gone further, and submitted the material in question to the Department of Chemistry at the University of B. C. Here very careful analyses had been made, which Dr. Panton set forth. He referred, also, to the effect of these earths in agricultural work—in fact, he went to a great deal of trouble to ensure that every effort should be made to prove the worth of these preparations, before he wrote the article. We, in turn, knowing Dr. Panton as we do, and knowing that his good faith was beyond any question at all, gladly published his report for what it was—a personal report of his own experiences. It goes without saying, that in doing this, there was no endorsement, on the part of the BULLETIN, and much less on the part of the Vancouver Medical Association, which publishes the BULLETIN, of any of these preparations, any more than in the case of any other medical journal, which publishes similar case reports.

To the dismay of ourselves and of Dr. Panton, the publication of this issue was followed by reports in one or two of the Vancouver newspapers, and later in a Victoria daily, to the effect that the Vancouver Medical Association had endorsed this miracle-working drug, which these puffs declared was also endorsed by the B. C. Medical Association, in at least one paper. Nothing, of course, could be further from the truth, and Dr. Panton at once got in touch with the manager of the firm making these preparations, and received, as we understand, from him, assurances that this would not recur, and that it had been done without the manager's knowledge or consent. We accepted, of course, these assurances. Believing that this would end the matter, we took no further steps hoping that we had seen the last of this misleading type of publicity. As, however, a runner appeared in a Victoria paper, some two weeks ago, we wrote to the Editor of that paper, and he was good enough to publish our letter in full.

Advertising is a perfectly legitimate thing, and any maker of a reputable product has a perfect right to do all that he honourably can to promote public knowledge of the goods he has to offer. But we question very strongly the ethics of such a proceeding as we have described. We are very glad to have the assurance from the head of the firm that it will not happen again. Meantime, we feel that some explanation is due to the readers of the BULLETIN, since many medical men must have seen the advertising referred to, and must have wondered what underlay it. We have written a letter to the manager of this firm, setting forth our position, and have impressed on him that we do not intend to let any such misstatements go unanswered in the future. As in most advertising of this kind, there is a tendency to make claims of a somewhat extravagant nature—and we cannot prevent that. But when the manufacturer makes these claims, or allows them to be made, on the totally unjustified grounds that publication of this kind of report constitutes a blanket endorsement by the medical profession, it is time to call a halt. Our readers may rest assured that we shall leave nothing undone to prevent such a thing happening again.

THE LIBRARY

LIBRARY HOURS:

Commencing Wednesday, October 2nd, evening hours will be resumed and the library will then be open—

Monday, Wednesday and Friday: 9:00 a.m. to 9:30 p.m.
Tuesday and Thursday: 9:00 a.m. to 5:00 p.m.
Saturday: 9:00 a.m. to 1:00 p.m.

RECENT ACCESSIONS TO THE LIBRARY:

Recent Advances in Neurology and Neuropsychiatry, by W. Russell Brain and E. B. Strauss, 5th ed., 1946.

Medical Clinics of North America, Symposium on Splenomegaly, Mayo Clinic Number, July, 1946.

Supplements to Acta Medica Scandinavica:

No. 175—Haemodynamic factors and retinal changes in hypertensive diseases.
No. 176—The normal plasma protein values and their relative variations.

NARCOTICS REGULATIONS

Effective September 1, retail druggists will no longer be required to keep under lock and key the codeine preparations detaild in section 8 of the Opium and Narcotic Drug Act, the Hon. Dr. J. J. McCann, acting minister of National Health and Welfare, announces.

Other changes in the Act are the consolidation into a single list of the narcotics named in the schedule of the Act and a provision that certain codeine preparations, when combined with suitable medicinal ingredients, may be sold by retail druggists without a prescription, providing such items are properly labelled. These preparations include all items containing one-eighth grain codeine when in solid form, or one-third grain codeine per fluid ounce when in liquid form, providing such drug is combined with other suitable medicinal ingredients.

N.B.—*The wartime regulations allowing druggists to accept over the telephone and fill emergency prescriptions for codeine have been cancelled.* K. C. Hossick, chief of the narcotic division, pointed out that removal of this privilege has, however, been offset by the fact that prescriptions are no longer required for codeine preparations mentioned in section 8 of the Act.

Section 8 of the Act is as follows: "(a) any retail druggist may have in possession or may sell or distribute preparations containing one-eighth grain or less of codeine per tablet or other solid form, or liquid preparations containing one-third grain or less of codeine per fluid ounce, when such preparations are combined with other medicinal ingredients and the maximum dose prescribed for the preparation contains (i) one such ingredient not less in quantity than the amount prescribed by the British Pharmacopoeia as a minimum dose for such ingredient; (ii) two such ingredients having a similar action, each not less in quantity than one-half the amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively; or (iii) three such ingredients having a similar action each not less in quantity than one-third the amount prescribed by the British Pharmacopoeia as a minimum dose for each such ingredient respectively.

NOTICE

Members of the Profession are reminded that under the provisions of the Narcotic Act, prescriptions must be DATED as well as signed in their own handwriting.

Vancouver Medical Association

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Vice-President ..... Dr. G. A. Davidson
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SUMMER SCHOOL

The 24th annual Summer School was held later than usual because of the Canadian Medical Association Convention at Banff in June.

The attedance at the sessions reached a peace-time high of 404 registrations with a goodly number of doctors from Washington and Oregon again enrolled.

The calibre of the lectures and clinics were pronounced on all sides as extremely good and certainly the speakers were more than usually interesting and instructive. The round table on Thrombophlebitis, an innovation this year, was so well received that similar discussions will likely prove permanent fixtures at future Summer Schools. Our lecturers, one and all, proved to be outstanding men both personally and professionally and we cherish the hope that they will remember us as long as we do them.

The speaker at the opening luncheon was Dr. Elmer Belt, just back from "Operation Crossroads," and his talk was most timely as well as most terrifying by its implications of the havoc that any future war would bring.

At the final banquet Dr. E. L. Turner, Dean of Medicine at the University of Washington, spoke on the requirements for the proper functioning of a modern medical school. He emphasized the proper integration of preclinical and clinical teaching, the need for a coordinated teaching of medicine, sociology and economics to meet present day problems in our profession. He also staggered us with estimates of the probable cost of such projects.

The Golf Tournament was held again at Capilano Golf and Country Club and a large number of those registered turned out despite the threat of inclement weather. The successful prize winners are as follows:

First Low Gross:
S. Durkin—83.
Second Low Gross:
Geo. Langley—84.
First Low Net:
Fred Sinclair—90-20—70.
Second Low Net:
John Balfour—95-24—71.

Long Drive:
Gerald Burke.
Hidden Hole:
R. DeBoyrie—3 on the 7th.
Nearest the Pin:
M. R. Caverhill.
High Gross:
C. H. Ployart—132.

Trophy Winners

Joe Bilodeau Memorial Trophy—Low gross in the third game of the season—
George Langley—84.

Worthington Cup—Donated annually by Dr. George Worthington—low net in the third game of the season—
Fred Sinclair, Cloverdale, B.C.—70.

Ram's Horn Trophy—Donated by Dr. Dan McLellan—best low gross in two of the three games of the season—George Clement—141. George Langley also had 141 for two of three games played.

Macdonald Trophy—Donated by Austin & Vans Macdonald—for the low gross in two of three games of the season for annual competition—

The winner this year received a handsome silver tray—W. Morton, 170.

Lockhart Trophy—To be donated by Angus Matheson of Wyeths for the best net in any one of three games played in one season by a player with a handicap over 18—

The best score was 66 turned in by Dr. George Clement but by reversion goes to a tie:

L. W. McNutt—94-23—71; Douglas Milne—91-20—71.

This trophy will be available as soon as a suitable one can be secured.

The Seniors' Trophy to be donated by Mr. T. O. Turner for the golfer over 55 years of age making the lowest gross score in any one of three games played in the season.

The nature of this award has not been settled but it is hoped to have a cup in the near future.

The first winner is Tom Nelles with 89 in the first game of the season.

A number of exhibitors showed their products during the sessions and their financial help was much appreciated.

The full list of registrations follows:

Dr. A. M. Agnew ..... Vancouver
Dr. E. H. Alexander ..... Vancouver
Dr. J. D. Alexander ..... Vancouver
Dr. J. A. Alton ..... Lamont, Alta.
Dr. R. N. Anderson ..... Ladner
Dr. W. F. Anderson ..... Kelowna
Dr. L. H. Appleby ..... Vancouver
Dr. W. S. Archibald ..... Kamloops
Dr. T. F. H. Armitage ..... Vancouver
Dr. F. M. Auld ..... Nelson
Dr. W. E. Austin ..... Vancouver
Dr. F. R. Atridge ..... Vancouver
Dr. T. W. Arbuckle ..... Vancouver
Dr. H. J. Alexander ..... Vancouver
Dr. Blackwelder ..... Vancouver
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Dr. A. W. Bagnall ..... Vancouver
F/L. P. J. Bailey ..... Vancouver
Dr. John Balfour ..... Vancouver
Dr. H. G. Baker ..... Vancouver
Dr. Harry Baker ..... Vancouver
Dr. H. A. Barner ..... Bremerton, Wn.
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Dr. C. E. Battle ..... Vancouver
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Dr. D. Berman ..... Victoria
Dr. J. C. Becher ..... Vancouver
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Dr. W. F. Bie ..... Vancouver
Dr. J. H. Black ..... Vancouver
Dr. D. Black ..... Vancouver
Dr. J. H. Blair ..... Vancouver
Dr. A. Bogoch ..... Vancouver
Dr. F. H. Bonnell ..... Vancouver
Dr. W. L. Boulter ..... Vancouver
Dr. H. H. Boucher ..... Vancouver
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Dr. R. W. Boyd ..... Vancouver
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Dr. John Brown ..... Vancouver
Dr. C. E. Brown ..... Vancouver
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Dr. F. M. Bryant ..... Victoria
Dr. B. F. Bryson ..... Essondale
Dr. H. L. Burris ..... Kemloops
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Dr. R. B. Burroughs ..... Vancouver
Dr. Gerald Burke ..... Vancouver
Dr. Douglas Bush ..... Spokane, Wn.
Dr. D. F. Busteed ..... Vancouver
Dr. V. P. Byrne ..... Essondale
Dr. W. J. Blakeney ..... Vancouver
Dr. A. W. Bowles ..... New Westminster
Dr. M. Baird ..... Vancouver
Dr. S. T. Baldwin ..... Vancouver
Dr. C. E. Benwell ..... Essondale
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Dr. R. M. Campbell ..... Vancouver
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VANCOUVER GENERAL HOSPITAL

THE PATHOLOGY OF CHRONIC THYROIDITIS

J. Sturdy, M.D.

In the differential diagnosis of affections of the thyroid there is, perhaps, no more confusing combination of symptoms encountered by the surgeon than that of the condition to which the ill-considered generic term "chronic thyroiditis" has been applied. Its importance from a practical viewpoint is its differentiation from malignant disease of the thyroid, for which it is all too frequently mistaken. The recorded cases of so-called inoperable carcinoma of the thyroid, who are alive and well many years after the establishment of that diagnosis clinically, are legion, and most of them indubitably fall into this hitherto obscure group of thyroid strumae. The condition has a further significance to the surgeon as a disease entity in its own right, one which is unquestionably much more common than was heretofore thought to be the case, and one which presents a symptom-complex of an order recognizable with moderate facility in the wards and in the operating theatre. It is in receipt currently, in the larger centres, of an increasing amount of attention, both experimental and clinical, with the result that one is now able to discuss its pathogenesis and symptomatology much more categorically than was possible a few years ago.

It would be inconsistent with the accepted behaviour of tissues elsewhere to assume that the anatomical juxtaposition of the thyroid gland and such sources of acute and chronic infection as the nasopharynx, the tonsils and the teeth, this considered in association with its extremely rich blood supply, would not lay the organ constantly open to bacterial and toxic invasion, and there is indeed abundant evidence that infection is common. It is on account, however, of that same rich blood supply, that the acute suppurative lesions of acute thyroiditis rarely develop, but having done so, cultures from the infected gland have yielded, according to the literature, such organisms as the staphylococcus, streptococcus, bacillus coli, bacillus typhosus and pneumococcus, all of which lends support to the clinicopathological assumption that the gland is frequently inoculated. As a result of recent animal experimentation, it has been ascertained that the thyroid, because of its abundant blood supply, tends to become sterile shortly after its bacterial contamination via the blood stream or lymphatics. It is undoubtedly the case, however, that transitory inflammatory processes in the thyroid almost invariably leave a local aftermath in the form of bacterial exotoxins, which in turn leave their marks in most instances upon the acinar epithelium. The circulating toxins in such systemic conditions as scarlet fever, typhoid fever, diphtheria and septicæmia likewise leave their issue. The result is the sequence of inflammation elsewhere, namely, tissue damage and replacement fibrosis of the damaged areas. The partially fibrosed condition of the thyroid in a large series of necropsies on an older age group, led Joll many years

ago, to the conclusion that transitory infections are frequent during a life-time. The appearance of chills and fever in these mild attacks of non-specific thyroiditis, depend of course upon the virulence of the organism concerned, the resistance of the tissue involved, and the amount of foreign protein, including inactivated thyroglobulin, released.. The resistance of the tissue is doubtless accentuated in older persons with general arterial dysfunction. The course of repair and reabsorption of damaged epithelial elements may be long or short, and should the fibrosis progress to clinical recognition with signs of enlargement and pressure, the result is the lesion known as Riedel's struma, or synonymously "lignous" or "woody" thyroiditis, or perhaps even better, the term Struma Fibrosa. Pathologically, upon occasion in the operating room, and rarely clinically, a variant of Riedel's struma known as the giant-cell variant of deQuervain is now recognized. Its pathogenesis is presumed inflammatory, as is Riedel's struma fibrosa, the presence of foreign-body giant cells being as yet considered an unexplained tissue response to bacterial infection, and not a disease *sui generis*.

Included in the term "chronic thyroiditis" is the more obscure, almost equally common, struma of Hashimoto, or better (since Hashimoto was not the first to describe it) one must consider the term Struma Lymphomatosa more acceptable, and certainly more descriptive. This lesion is of doubtful etiology, but experimental evidence would indicate that its initiating process is degenerative rather than inflammatory. There is strong experimental support to the theory that its pathogenesis may be concerned with dysfunction of the pituitary gland, in much the same way that an endocrine imbalance is associated with such conditions as mazoplasia, and endometrial hyperplasia, the thyrotropic hormone in this instance being the offender. That this is a precursor of Riedel's struma fibrosa has no less an advocate than Ewing but there has been amassed such a quantity of evidence to the contrary that it is now generally accepted as a disease entity quite distinct from Riedel's struma.

In the November issue of *Surgery, Gynaecology & Obstetrics,* an article by J. A. Schilling of Rochester, N.Y., describes eleven cases of Struma Lymphomatosa, Struma Fibrosa, and its giant-cell variant of de Quervain, from the Strong Memorial Hospital. A search of the records of The Vancouver General Hospital over the seven-year period rom 1939 to 1946 yielded, to our surprise, a comparable number of cases, which on thorough investigation presented similar characteristics to those of Schilling's series. With your permission, I would like to refer to these briefly, summarizing the essential qualities of each. It might be pointed out that in only one instance was the diagnosis recorded preoperatively.

The first four cases are examples of Struma Lymphomatosa.

Case Histories

1. *Miss B.*: A seventeen-year-old white female with a history of increasing pressure in the thyroid area of a fairly rapidly growing nature for eleven months. The swelling was diffuse and bilateral. There was noticeable gain in weight since the onset. She tired easily and complained of inability to concentrate. There were no signs of thyrotoxicity. She was operated on the day following admission, and was discharged twelve days later. The swelling recurred in one year's time and subsided of its own accord one month later. There are present at the time of writing definite signs of myxedema being controlled by minimal doses of thyroid extract.

2. *Mrs. D.*: A forty-nine-year-old female presented with definite pressure symptoms of one year's duration—both dysphagia and difficult inspiration. She had periodical gastro-intestinal upsets with frequent bouts of palpitation and subjective asthenia for the same length of time. Both lobes were removed surgically three days after admission, and fiv days later, after an uneventful convalescence, she was discharged. A follow-up one year after discharge revealed no definite signs of myxedema.

3. *Miss Y.*: A ninteen-year-old girl with a two-month history of recent enlargement of a previous thyroid swelling for two years and at the time of admission causing pressure symptoms. An interesting feature was the history of menstrual disorders be-

ginning at the same time as the onset of the struma. She was lugolized although there were no signs of thyrotoxicity and was operated on eight days after admission. The post-operative period was uneventful. The follow-up done twenty months later revealed the patient taking thyroid extract for dry skin and hair. One year after discharge she was found to be suffering from pulmonary tuberculosis, which may account for the very mild myxedematous symptoms.

4. *Mrs. F.*: The last case of struma lymphomatosa was a twenty-one-year-old woman admitted with a four to six year history of swelling in the neck, emotional upsets, weakness, night sweats and tremors. She had, further, additional pressure symptoms. She was lugolized for a nine-day period, the struma being removed surgically. Convalescence was uneventful.

The following six cases, presented briefly, are of Riedel's struma fibrosa.

5. *Mrs. B.*: The first is a fifty-eight-year-old woman with symptoms predominately of pressure, notably dysphagia and dyspnœa and stridor for six months, the struma being present for one year. The follow-up four and one-half years later revealed no post-operative complications.

6. *Mrs. S.*: The second case of woody thyroiditis was a sixty-year-old woman admitted with an eighteen-month-old thyroid tumour exerting pressure upon adjacent cervical structures. The post-operative period was uneventful, and according to a surviving sister, there were no myxedema or voice changes in the two-year period following operation and preceding her death.

7. *Miss S.*: The third case was a twenty-one-year-old girl with an eight month history of swelling in the neck, and a one month history of pain therein. There were vague pressure symptoms. Her pre-operative basal metabolic rate was plus 27. A follow-up six years later revealed the patient to be definitely myxedematous and to exhibit definite signs of laryngeal involvement. She is at present taking both thyroid extract and parathormone.

The last three cases are more classical.

8. *Mrs. M.*: Presented with a definite myxedematous facies, had signs of embarrassing pressure upon the trachea and oesophagus for seven months, and the painless bilateral goitre made its subjective appearance two months after the onset for the first symptoms. She was forty-nine years old when operated on and twenty months later the follow-up showed her suffering minimal myxedema symptoms with laryngeal nerve involvement.

9. *Mrs. C.*: This sixty-three-year-old woman complained of a rapidly growing right-sided struma with few signs of pressure. Her pre-operative basal metabolic rate was minus 9. The post-operative period was stormy, and her subsequent history reveals her suffering from myxedema controlled by moderate doses of thyroid extract.

10. *Mrs. B.*: The last case of struma fibrosa is in a forty-five-year-old American woman with a four month old painful struma exerting recent pressure upon the oesophagus and laryngeal nerves. The pre-operative basal metabolic rate was plus 1. Follow-up a year later showed no laryngeal nerve involvement but a very definite myxedema which appeared to respond to minimal doses of thyroxin.

11. *Mrs. D. B.*: The only available case in the hospital records of the giant-cell variant of Riedel's struma was operated on by Dr. Lennie only last month. She is fifty-one years of age, and was admitted with symptoms of acute respiratory embarrassment due to pressure of a seven-week-old right-sided enlargement of the thyroid gland. The struma was painful and typical of this variety; the pain radiated to the back of the head, the homolateral ear, and to the shoulder area. Her convalescence was uneventful and follow-up to this early date shows no evidenc of myxedema, laryngeal involvement or tetany.

TABLE I.

	STRUMA LYMPHOMATOSA		STRUMA FIBROSA		GIANT CELL VARIANT	
	Schilling	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*
AGE	40 - 60	17 - 39 (3 in 2nd, 3rd decades)	20 - 40	20 - 63	20 - 40	Single case age 51.
Sex—% Female	Almost 100	100	60 - 80	100	60 - 80	Female.
Predominant Symptons	Presence of Goitre— Vague Pressure signs.	Goitre, mild. Pressure signs with occasional symptoms of hypothyroid.	Predominant pressure symptoms.	Pressure symptoms and occasionally signs of myxedema, some pain.	Mod. pressure signs, pains in shoulder, neck, ear.	Marked Dysphagia, Dyspnoea, Pain radiated to shoulder and occiput.
Duration of Symptoms	Usually years. Recent Acceleration.	1 to 6 years	1 to 2 yeras.	3 months to 18 months.	1 to 12 months.	7 weeks.
Presence of Goitre	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.
Duration of Goitre	Usually years.	1 to 6 years.	1 to 2 years.	3 months to 18 months.	1 to 12 months.	7 weeks.
Amt. Thyroid Involved	Always diffuse.	Bilateral.	30% Unilateral.	1 in 6 Unilateral	30% Unilateral.	Unilateral.
Response X-ray	Excellent.	Not tried.	None.	Not tried.	Unknown.	Unknown.
Post-operative	Uneventful	Uneventful.	Often stormy.	2/6 stormy.	Uneventful.	Uneventful.
Follow-up	Myxedema and general metabolic disorders.	2/4 myxedema, No trace 3rd 4th—general metabolic disorders.	No myxedema, Sometimes no relief pressure symptoms. Laryngeal paralysis and tetany.	4/6 myxedema, 1 recurrence, 3/6 laryngeal paralysis, 1 on Parathormone. No follow-up on two.	Usually prompt remission symptoms— No recurrence.	In hospital at time of writing.

AGE: To recapitulate the symptom-complex in its presently accepted form, first considering age, the tendency for struma lymphomatosa to occur in the fourth and fifth decades is noted. Struma fibrosa and its giant-cell variant usually occur in the third and fourth decades. It was our experience that there is considerable overlapping, and considerable variation in these ascribed limits, so that age is a most unreliable criterion.

SEX: With regard to sex incidence, it is remarked that whereas the ratio in thyroid disease generally of female to male is 5 or 6 to 1, the proportion in struma fibrosa is about 4 to 1. Our cases were all female. In struma lymphomatosa there are only six strictly authnticated cases of the condition reported in males.

HISTORY AND SYMPTOMS

Struma lymphomatosa is frequently of longer standing than struma fibrosa and its variant and is usually attended by a history of recent enlargement in a previously hypertrophied gland.

The usual presenting symptom in struma lymphomatosa is a diffuse and bilateral enlargement of the thyroid with such pressure symptoms (often vague) as dyspnœa, dysphagia, hoarseness of voice, cough, or subjective sensations of constriction. An early or well advanced myxedema may be present, and such symptoms as tremor, palpitation, nervousness and dizziness which are in fact symptoms rather referable to the sympathetic and central nervous systems than to hyperthyroidism, not infrequently lead to the mistaken impression that the latter co-exists. There may be a well defined history of gain in weight.

In struma fibrosa and the de Quervain variant, pressure symptoms almost invariably predominate. The commonest signs are dyspnœa and dysphagia, the former upon occasion giving rise to a sensation of imminent asphyxia. Schilling makes the remark that the anxiety state so produced may render a basal metabolic rate grossly inaccurate.

PAIN: In all three conditions, pain is inconstant. It is rarely present in struma lymphomatosa, frequently present in struma fibrosa, and almost always severe in the giant-cell variety of de Quervain, where it tends to radiate to the occipital and prietal regions and to the back of the neck and shoulders.

Tenderness is common to all three conditions but may not be present.

BRUIT: There is no bruit heard in the region of the struma.

CLINICAL PALPATION: Clinically, the gland is always diffusely and bilaterally enlarged in struma lymphomatosa. It is firm to the touch and rarely possesses the bone-hard consistency of Diedel's struma fibrosa. A further differentiating eature is the occasional unilateral growth of the latter and its giant-cell variant.

TABLE II.

SURGICAL CHARACTERISTICS

	STRUMA LYMPHOMATOSA		STRUMA FIBROSA		GIANT CELL VARIANT	
	Schilling	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*
Surgical Appearance	Pseudo-loculated Yellow.	Compact, gray-pink to yellow.	White smooth.	Finely lobulated, fibrous.	Gray-white smooth.	Gray-white smooth.
Bleeding Tendency	Variable.	Increased.	Decreased.	Not mentioned.	Usually decreased.	Not marked.
Adjacent Adhesions	Pretracheal only.	Pretracheal sometimes lateral.	Invariable Dense.	Very dense, Diffuse.	Variable, Usually none.	Marked in involved lobe.
Extent Involved	100% diffuse.	100% diffuse.	1/3 Unilateral.	1/5 Unilateral.	1/3 Unilateral.	Single case Unilateral.
Consistency	Firm.	Firm, 1 of 4 soft.	Bone-like.	Very hard.	Hard.	Hard.
Presence of Adenomas	None.	Small adenoma in 1.	Occasional.	None.	Occasional.	None.

Surgical differentiation is upon occasion difficult. The bleeding tendency is variable instruma lymphomatosa and usually decreased in Riedel's disease. Admissions are inevitable in all three forms. Struma fibrosa and its giant-cell variant are of inflammatory origin, and as one might therefore reasonably expect, are invariably associated with adhesions, upon occasion indeed being densely adherent to almost every adjacent structure. It is for this reason that post-operative complications are rarely avoidable. Struma Lymphomatosa on the other hand, being degenerative in origin, is not markedly adherent to the periglandular tissues, but is requently found to be strongly attached to the pretracheal fascia. The tumour therefore sometimes moves with deglution.

GROSS APPEARANCE

The exterior of the gland in struma lymphomatosa presents a smooth pinkish, finely lobulated appearance. The cut surface is faintly yellowish. Struma fibrosa presents a white, glistening, smoothly enlarged, very hard, fibrous appearance and on the cut surface may be discerned fine fibrous trabeculae. The giant-cell form of de Quervain is said to be somewhat more gray than its unembellished affiliate.

Microscopically the distinction is more pronounced. In struma lymphomatosa there is a predominance of lymphoid tissue, a scanty stroma, hyperplastic germinal follicles and scanty colloid. In struma fibrosa, there is complete fibrous tissue replacement of

TABLE III.

MICROSCOPICALLY

	STRUMA LYMPHOMATOSA		STRUMA FIBROSA		GIANT CELL VARIANT	
	Schilling	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*	*Schilling*	*V.G.H. Cases*
Acinar Epithelium	Degenerate, Low and Cuboidal.	Degenerate, Low and Cuboidal.	Compressed, Absent in Involved Areas.	Compressed, Absent in Involved Areas.	Ac. Degeneration in Involved Areas.	Compressed, Degenerate in Involved Areas.
Colloid Presence	Scanty to Absent.	Scanty.	Normal in Uninvolved Areas.	Very Scanty.	Intercellular in Involved Areas	Intercellular in Involved Areas.
Stroma	Slight Increase in Fine C.T.	Slight increase in Fine C.T.	Fibrosis and Hyalinization.	Broad bands Fibrous Tissue.	Perilobular whorls of Dense C.T.	Perilobular whorls of Dense C.T.
Cellular Infiltrate	Lymphocytic with Lymph Follicles.	Lymphocytic with Lymph Follicles.	Moderate Lymphocytic and Polys. in Fibrous C.T.	Somtimes Massive Lymphocytic and Polys.	Dense Lymph Plasma and Histiocytes Giant Cells.	Dense Lymph Plasma and Histiocytes Giant Cells.
Blood Vessels	Uninvolved.	Not noteworthy.	Thick Intima and Media	Thick Medial Coat.	Peri-art. Fibrosis.	Peri-art. Fibrosis.

the normal acini, with compression and atrophy of the residual thyroid elements. The picture is frequently conused by a well-marked infiltration by lymphocytes and inflammatory cells. In the de Quervain variant there is both a true and a pseudo-giant-cell reaction superimposed upon the usual picture of struma fibrosa propria. The true giant cells are of foreign body type, the pseudo-giant cells are often undistinguishable and appear to be of colloid-monocyte genesis.

POST-OPERATIVE COURSE

The post-operative course in thyroiditis is usually more stormy in Riedel's than in the other forms. A severe bout of pyrexia may attend convalescence following surgical extirpation. Myxedema is an almost inevitable post-operative consequence of struma lymphomatosa, and according to Graham (and our own experience) may accompany removal of a Riedel's struma. Owing to the dense adhesions found in struma fibrosa, laryngeal paralysis or tetany are grave and sometimes unavoidable consequences of surgical interference.

DIFFERENTIAL DIAGNOSIS

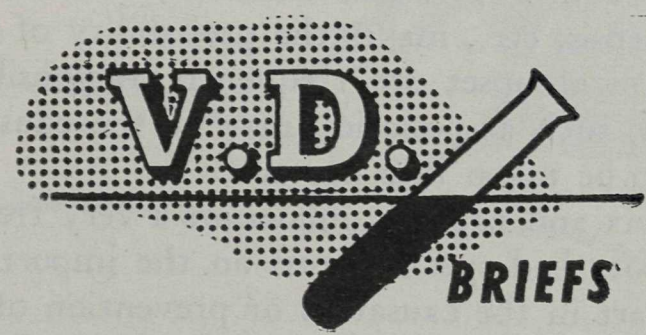
In malignant disease of the thyroid from which these conditions must be differentiated both by reason of the firm, adherent gland and the usual occurrence in the so-called "cancer-age" group, it is as well to bear in mind that carcinoma rarely occurs in a previously normal thyroid. A history of nodular thyroid tumor is frequent and it has in fact been estimated that 80 to 85 percent of carcinomata arise in adenomata associated with thyrotoxicosis.

Cancer is characterized by a relatively rapid increase in size and hardness in a soft goitre. Pressure signs are common; pain is not uncommon. There may be considerable concomitant cardiovascular disturbance. Metastases are common, especially in the lungs and bones. Differentiation is most usually confirmed at operation, and its confirmation by rush diagnosis should be an inflexible rule. The opinion offered at rush diagnosis should affect the course of the operation radically. Complete as possible surgical resection of a carcinomatous thyroid, followed by intensive radiotherapy, is the procedure of established custom. On the other hand, should the case prove to be struma fibrosa, complete removal is unjustifiable owing to the consistent prevalence of post-operative

complications. Only sufficient tissue therefore should be removed to ensure relief of pressure symptoms.

In the instance of struma lymphomatosa it has been ascertained that the lesion responds in remarkable fashion to radiotherapy, and it is thus highly recommended that x-ray therapy beaccepted method of choice in the case of struma lymphomatosa, after initial biopsy to finally rule out the question of malignancy.

In conclusion it is suggested that chronic thyroiditis is a much commoner clinical entity than has in the past been recognized, and that further studies may both serve to elaborate its treatment and to assist in its all-important differentiation from malignant disease of the thyroid.



Over a thousand more cases of venereal disease were reported in Canada in the second quarter of this year than in the same period of 1945, the Hon. Dr. J. J. McCann, acting minister of National Health and Welfare, announced at Ottawa recently.

"Authough the most recent reports show a decline in new cases, venereal diseases continue among the top-ranking problems facing Canada today," Dr. McCann said. "Venereal disease can be eradicated. This year the federal government has set aside over $270,000 ot combat the V.D. menace, but legislation, money and medical skill are not enough. To eliminate this scourge requires an enlightened community and wholehearted co-operation, not only on the health front but equally on the moral, welfare and legal sectors.

In the first six months of this year 21,933 cases of syphilis and gonorrhœa were reported. Of these 8,283 were syphilis and the remainder gonorrhœa.

The total number of cases in the April-June quarter was 10,235 as against 11,698 in the first three months of the year. For the April-June period of 1945 total new cases of all types of V.D. were 9,188.

Dr. B. D. B. Layton, chief of the venereal disease control division, Department of National Health and Welfare, explained that these statistics are provided by provincial health departments and compiled by the Dominion Bureau of Statistics. The laeest figures are "encouraging," he said, but would not in any way modify the all-out effort to eradicate these infections.

The rate of syphilis for Canada has fallen from 147 per 100,000 population during the first quarter of 1946 to 125 per 100,000 in the April-June period. The rate of gonorrhœa per 100,000 has declined 11 per cent., from 236.8 to 210.8 per 100,000 population.

ACUTE PELVIC PERITONITIS

(Given at V.M.A. Summer School)

By Dr. Philpott

Dr. Philpott considers "acute pelvic inflammation" a better term. This pelvic inflammation includes upper and lower tract inflammations, and is not limited to the peritoneum, besides the condition is not merely one of peritonitis, even as regards its abdominal manifestations. Along with peritoneal involvement we have parametritis, and salpingitis, and these last two are inseparable from the peritonitis present. So that pelvic peritonitis as a separate clinical or pathological entity does not exist.

There are two types of inflammation of the pelvis—

1. *Upper tract inflammation*—the acute primary inflammation—that type which occurs primarily in the genital organs. This type may follow complications of pregnancy or labour, whether the latter be normal or instrumental. Or, secondly, it may follow *gonorrhoea.*

Besides occurring, as has been said, as a sequel to normal or interrupted labour, it may, and frequently does, follow criminal abortion, and here, of course the added risk of ignorant handling, sepsis, etc., makes the probability of infection all the greater. But other forms of mechanical upset are frequently responsible for pelvic infection. Douches, various appliances, such as pessaries, may be the causative agent, and contraceptive devices, too, have to be taken into account.

Infections from the cervix and vaginal mucosa are a very frequent cause of infection, and at this point Dr. Philpott laid special stress on the importance of the pH of these areas. This plays a great part in the causation or prevention of pelvic infection. Normally, the higher we go in the pelvic tract, from the vaginal outlet, the more alkaline the pH. The normal and proper pH of the cervical mucus should be 7.1% at least. Streptococci will not live in a vaginal cavity or cervical mucus higher than pH 5, and staphylococci grow freely at this pH level. Therefore, if the pH of the vagina or cervix is acid or at any significant level below 7.1, we have a very good medium for bacterial growth, i.e. pathogenic bacterial growth.

There is another important consideration here; two, in fact. The first is that the spermatozoon wants a pH of 7. This is the optimum level from its standpoint, and, of course, in normal conditions, this is the pH it would find, with a normal cervical pH of 7.1, as defined above. But there is another micro-organism which thrives at this pH of 7, and that is the gonococcus—so that this, uniquely among the pathogenic bacteria that we have reason to fear, thrives in the presence of a normal pH.

Contraceptive preparations which are alkaline, do harm. As one can see from what has been said, their use predisposes to bacterial growth. The use, too, of alkaline douches can be injurious, and lessens the chances of pregnancy, if this is desired.

Bacillus coli will thrive in any pH.

The spread of infection takes place in any one of three ways:

1. Surface spread—as in the case of the gonococcus, which can ascend by this method to the endometrium, and spread thence to the parametrium and adnexa.

2. Lymphatic spread, as through lacerations of the cervix—extending to the parametrial tissues, giving rise to parametritis, and so to further involvement of the peritoneum, etc.

3. Haematogenous—where there is a pelvic thrombophlebitis, for example.

Salpingitis, parametriittis, pelvic peritonitis, may occur singly or all together at a time.

In diagnosing acute pelvic isflammation, we are guided by the following main signs and symptoms:

1. *Pain*—on movement or even when the patient is at rest.
2. *Fever*—101-103, or even 104.
3. Rapid *pulse.*

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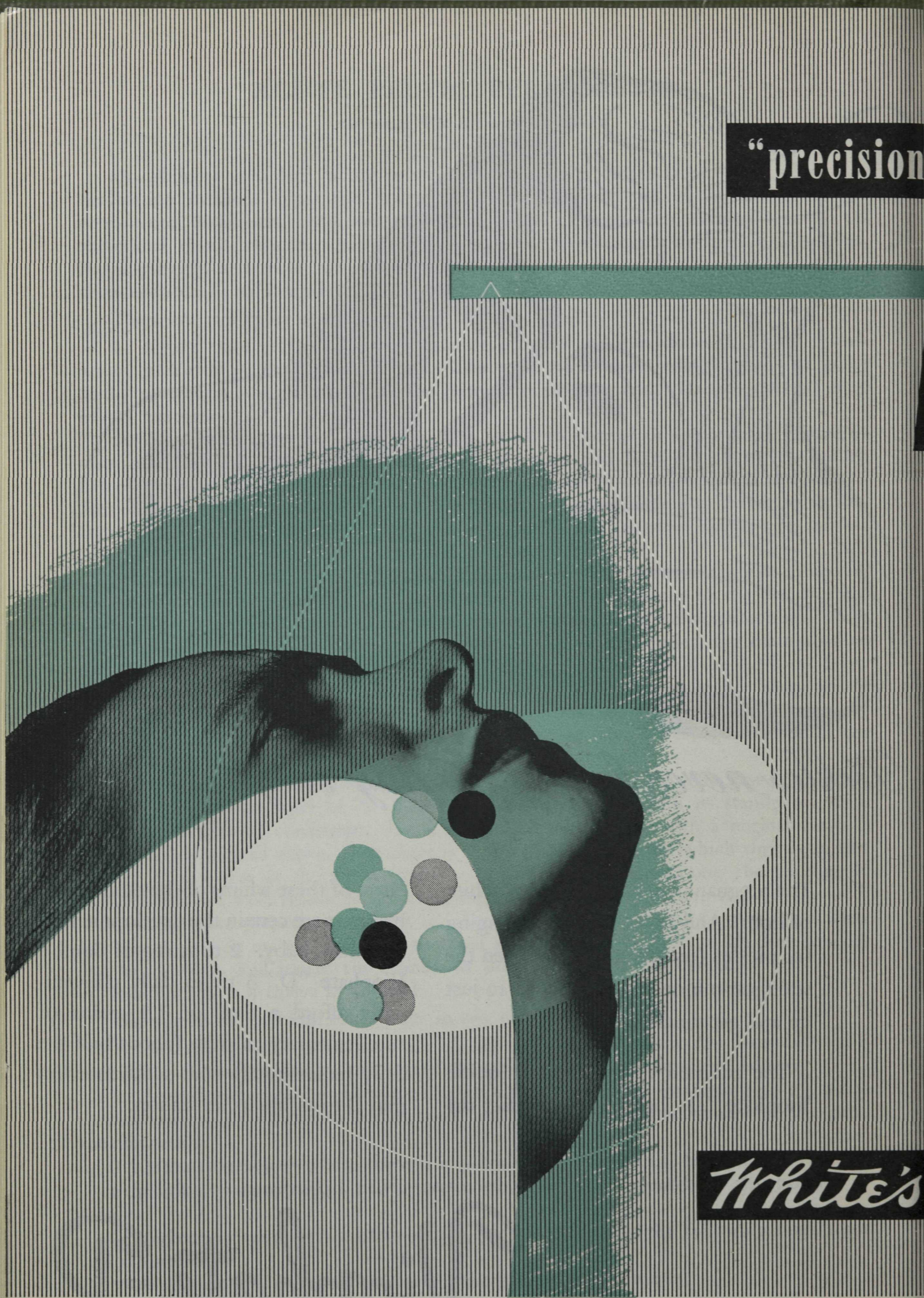

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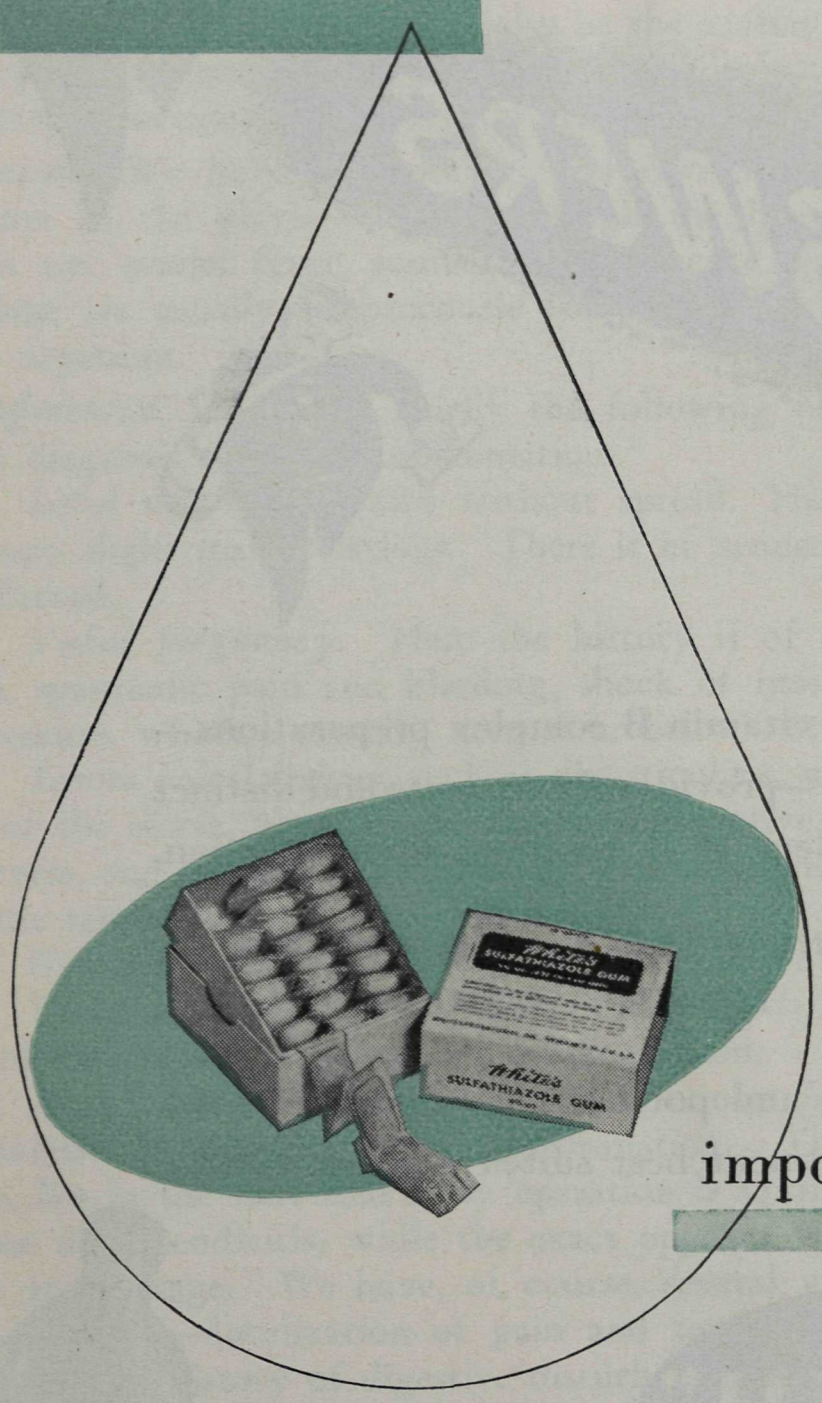

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4. *Spasticity* and *tenderness* of the lower abdomen, usually bilateral. There is pain on movement of the cervix or uterus on vaginal examination.

5. Sometimes there is abscess formation, in the later stages.

So far the speaker had dealt with the acute primary type of pelvic inflammation. He referred next to the secondary type of infection, where the primary source of the bacterial invasion is elsewhere in the body, and the pelvic tissues and organs are invaded secondarily. This infection may come:

First, from the vicinity—e.g. the bladder, or urinary tract. This is, of course, quite often the case. The bowels may also be the source of secondary infection of the pelvis, and even the appendix may give rise to such infection. But there are other sources of secondary infection, often very far removed from the pelvic area.

Second—We have non-specific, and non-gonorrhoeal infections causing secondary infection in the pelvis—carried through the blood stream. Among these, the commonest are: scarlet fever, acute tonsillitis, acute upper respiratory infections.

These are usually streptococcic infections, but the staphylococcus may be the exciting organism.

Differential Diagnosis. Briefly the following main conditions have to be excluded in our diagnosis of pelvic inflammation:

1. *Local uterine infection* without spread. Here we note the absence of pain, except very slight manifestations. There is no tenderness—the temperature and pulse are less affected.

2. *Tubal pregnancy.* Here the history is of great importance—the missing of a period, spasmodic pain and bleeding, shock of more or less intensity—absence of high temperature, which is usually normal or below normal.

3. *Lower bowel lesions,* such as diverticulitis, ulcerative colitis, etc. Here the character of the stools, blood in the faeces, obstructive symptoms, localization of masses or tenderness, and rectal and proctoscopic examinations, are all important in differentiation, as is the temperature and the history.

4. *Urinary tract infections.* Here examination of the urine tells the tale.

5. *Twisted ovarian cysts,* degenerated *fibroids,* occasionally present difficulties, and demand careful examination and differentiation.

6. Acute appendicitis is, of course, the most important condition that we have to differentiate from acute pelvic inflammation. The importance of this diagnosis, of course, lies in the fact that early operation is so often a matter of urgent necessity, in the case of appendicitis, while the exact opposite is true as regards pelvic inflammation in the acute stage. We have, of course, several very definite points of difference between the two—localization of pain and tenderness, a lower temperature in appendicitis as a rule, history of digestive disturbance, and so on—but with all this, there will be cases where a subsequent general peritonitis has set in, which will tax all our powers of diagnosis. Dr. Philpott considers the sedimentation rate of very great value in making a differential diagnosis, as this, in his experience, is never high in acute appendicitis. In doubtful cases, he feels that it is a grave error to start therapy too quickly, as this is apt to mask symptoms, and confuse us in our diagnosis. As soon as this is made, we begin therapy at once.

Treatment of acute pelvic inflammation—pelvic peritonitis.

Dr. Philpott divided this into four stages:

1. Immediate—acute stage.
2. Following acute stage, when there is abscess formation.
3. Where there is no abscess formation, and when patient has got over the acute stage, and is recovering.
4. Later stages, when operation may be done, if this is necessary or advisable.

As regards the first stage. Treatment during this acute stage should be immediately instituted, and it is of the greatest importance that there should be no delay or waiting.

This is because it is vital to avoid secondary spread and permanent residual damage, and this end cannot be achieved if there is delay.

The first step is *bed rest,* which must be complete.

Next, we apply hot or cold applications. Either is good, and the choice varies with the individual case to a great extent.

Mild sedation must be given, to the point of being effectual, even if we have to use morphine or dilaudid. But before these are given, the diagnosis must be absolutely certain.

An enema may, and generally should, be given.

Chemotherapy. Vaginal cultures should be made as a routine. Seventy per cent of g.c. cases will give a positive culture.

Penicillin, to the amount of 200,000 to 250,000 units daily, should be given. We may also give the sulphonamides, and in acute cases, we usually obtain a prompt response.

In the second stage, when these is abscess formation, this may be in the tubes, or in the pouch of Douglas. Ninety to ninety-five per cent of cases show a dropping down of the abscess into the pouch, where it is readily accessible. On examination we feel a mass, sometimes a large mass, which may be quite hard. We recognize the formation of pus by the onset of a septic type of temperature, or we may feel fluctuation. If this occurs, we must secure drainage. In nine out of ten cases, this can be done most readily and safely through the posterior fornix. If the collection is not drained, it will rupture, either through the bowel wall, or into the bladder, and this is a very deplorable ending, as it often results in fistula formation, and these fistulæ are apt to be very hard to get healed.

In the third stage, when there has been no abscess formation, and the patient is getting better. These patients should be thoroughly checked in a month. The white blood count, and especially the sedimentation rate, should be taken. At this stage, treatment by short wave, heat in various forms, may be given. The red blood count and the haemoglobin level should be checked.

Patients suffering from this disorder are frequently *hypothyroid,* and the B.M.R. will give us a valuable lead as to treatment. Thyroid medication is often of very great value.

We must be on the lookout for the tuberculous type of pelvic peritonitis. This is subacute in type, and is of long duration. It is practically always secondary to infection elsewhere, either in the lungs or in the gland. The diagnosis can always be made, as distinct from other types, by diagnostic curettage, done immediately before the menstrual flow is due.

Treatment consists in X-ray therapy, and operation should not be done.

Lastly—and this takes in the last stage of the four mentioned above—do not be too anxious to operate on women after acute pelvic inflammation. Most women will weather the storm, and recover without operation. Remember, that if anything is done everything must be done, and this involves considerable mutilation, especially in young women, and these women are usually young. So be conservative as far, and as long, as possible.

No operation should be done within from three to six months after the acute attack has subsided. Always check the sedimentation rate. If this is over 30, Dr. Philpott is very emphatic that no operation should be done.

News and Notes

Sympathy is extended to Dr. O. E. Kirby in the loss of his brother, Mr. Harold Kritzweiser of Regina, and to Dr. I. B. Cameron of Youbou, who lost his father recently.

* * * *

Dr. Gordon McL. Wilson of Kelowna, Dr. David Christie and Dr. C. W. E. Seale of Vancouver, have our sympathy in the loss of their mothers.

* * * *

Congratulations are being received by Dr. and Mrs. C. J. F. Phillips-Wooley on the birth of a son on September 2nd, by Dr. and Mrs. A. C. Walsh on the birth of a daughter on September 10th, and by Dr. and Mrs. E. J. P. Badre on the birth of a son.

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Lieut.-Col. G. W. C. Bissett, who served with the R.C.A.M.C., is now in practice in Victoria.

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Major C. G. G. Maclean of Vancouver, following his discharge from the Army, is with the Department of Veterans' Affairs.

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Lieut.-Col. E. F. Christopherson has returned to Vancouver from overseas, and will be resuming practice shortly. For the past year Dr. Chistopherson has served as Officer in Charge of Medicine with No. 22 Canadian General Hospital, Bramshott, England.

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Capt. L. E. Margetts, R.C.A.M.C., who recently received his discharge, is now serving on the staff of the Provincial Mental Hospital ,Essondale.

* * * *

Capt. J. A. McLaren, R.C.A.M.C., has received his discharge, and is doing postgraduate work in Montreal.

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Capt. C. J. F. Phillips-Wooley has taken up practice in West Vancouver, following his discharge from the R.C.A.M.C.

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Dr. G. O. Hallman is now in practice at Cloverdale. Capt. Hallman served with the R.C.A.M.C.

* * * *

Lieut.-Commander Eric Boak, D.S.C., R.C.N., son of Dr. E. W. Boak of Victoria, has been awarded one of the oldest military orders in the world. For his service as commander of H.M.C.S. *Sioux* in Norwegian waters, in 1945, the Norwegian government has made him a Knight First Class of the Royal Order of St. Olav.

* * * *

Dr. W. H. Hatfield, Director of the Division of Tuberculosis Control for B. C., has been honoured by the Surgeon-General's Department of the United States by being invited to become a consultant in its Tuberculosis programme.

* * * *

Lieut.-Colonel J. S. McCannell, O.B.E., has recently been posted to Headquarters, Military District 11, as District Medical Officer. Prior to 1939, Colonel McCannell was in practice in Victoria. He enlisted with 13 Canadian Field Ambulance in September, 1939, and proceeded overseas in 1942. He commanded 24 Canadian Field Ambulance in Italy, and in Northwest Europe, and later served as A.D.M.S., First Canadian Army in Holland.

Dr. T. C. Holmes of Burns Lake has been enjoying a well-earned vacation. During his absence Dr. F. N. Elliot has taken over the practice.

* * * *

Dr. John Nay, who for many years served as Chief Medical Officer of the Workmen's Compensation Board of B. C., has resigned. Dr. Nay filled a difficult position with wisdom and ability, and he has enjoyed the respect and confidence of the doctors of this Province. On retiring from office we wish him many long and happy years in which to enjoy the leisure so well deserved.

* * * *

Dr. Nay will be succeeded by Dr. John F. Haszard. On assuming his new duties Dr. Haszard has the best wishes of the medical profession in the Province. He brings to the task a wealth of valuable experience that assures his success. Prior to Great War II, he had a large indutrial practice at Kimberley. He enlisted for active service at the outbreak of hostilities in September, 1939, and served with distinction until late in 1945. He commanded 8 Canadian Field Ambulance, then 16 Canadian General Hospital in Europe. Later he served as A.D.M.S. of various formations in England before returning to Canada in 1945.

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DISTRICT ANNUAL MEETINGS

Annual meetings of District Medical Associations have been arranged or the following dates:

East Kootenay Medical Association Annual Meeting to be held at Cranbrook on the afternoon and evening of September 30th.

West Kootenay Medical Association meeting to be held at Trail on the afternoon and evening of October 2nd.

District No. 4 Medical Association meeting to be held at Penticton on the afternoon and evening of October 4th.

Victoria Medical Society meeting on the evening of October 7th.

Dr. Ethlyn Trapp, President of the British Columbia Medical Association, accompanied by Dr. Karl Haig of Vancouver, Dr. D. W. Johnstone, Department of Veterans' Affairs, and the Executive Secretary will attend these meetings. The party will be joined by Dr. A. E. Archer, Consultant in Economics for the Canadian Medical Association.

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