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The BULLETIN
OF THE
VANCOUVER MEDICAL ASSOCIATION

Vol. XIII. SEPTEMBER, 1937 No. 12

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IN EUROPE

TUMOURS OF THE UTERUS

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

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DR. M. McC. BAIRD — DR. D. E. H. CLEVELAND
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VOL. XIII. SEPTEMBER, 1937 No. 12

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—JULY, 1937

Total Population—estimated	253,363
Japanese Population—estimated	8,522
Chinese Population—estimated	7,765
Hindu Population—estimated	352

	Number	Rate per 1,000 Population
Total deaths	188	8.7
Japanese deaths	4	5.5
Chinese deaths	8	12.1
Deaths—Residents only	164	7.6
BIRTH REGISTRATIONS—		
Male, 172; Female, 163	335	15.6

INFANTILE MORTALITY—	July, 1937	July, 1936
Deaths under one year of age	12	9
Death rate—per 1,000 births	35.8	32.6
Stillbirths (not included in above)	3	5

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	June, 1937		July, 1937		August 1st to 15th, 1937	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	0	0	0	0	0	0
Scarlet Fever	25	0	13	0	1	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	68	0	12	0	1	0
Measles	6	0	3	0	1	0
Rubella	2	0	0	0	0	0
Mumps	115	0	11	0	0	0
Whooping Cough	9	0	2	0	0	0
Typhoid Fever	0	0	2	0	0	0
Undulant Fever	1	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	29	12	37	8	14	..
Meningitis (Epidemic)	0	0	0	0	0	0
Erysipelas	5	0	3	0	0	0

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BRITISH COLUMBIA MEDICAL ASSOCIATION

FORTY-FIFTH ANNUAL MEETING

BALLROOM — HOTEL GEORGIA

Lectures one-half hour with ten minutes for discussion.

MONDAY, SEPTEMBER 13th—9:00 a.m.

Addresses of Welcome:

His Worship Mayor G. C. Miller, Vancouver.

Dr. G. H. Clement, President Vancouver Medical Association.

DR. ADAMSON: "The Use of the Sedimentation Test in General Practice."

DR. MacCHARLES: "Diverticula of the Colon."

DR. GORDON: "A Study of 3,000 Cases of Obesity."

DR. OSGOOD: "Therapeutic Thinking."

12:30 p.m.—OFFICIAL LUNCHEON—Hotel Georgia Ballroom, 75c.

SPEAKERS:

Dr. T. H. Leggett, Ottawa; President, Canadian Medical Assn.

Dr. T. C. Routley, Toronto; General Secretary, Canadian Medical Association.

2:00 p.m.—Motion picture—"Heart."

3:00 p.m.—Demonstrations of Newer Technique—Vancouver General Hospital, Main Operating Room.

5:00 p.m.—Meeting of the Council of the College of Physicians and Surgeons of British Columbia.

7:00 p.m.—Motion picture—"Heart."

8:00 p.m.—Conference on Public Health.

Brief papers followed by questions and discussion.

TUESDAY, SEPTEMBER 14th

8:00 a.m.—Motion picture—"Heart."

9:00 a.m.—DR. OSGOOD: "Recent Advances in Hæmatology."

DR. ADAMSON: "The Treatment of Chronic Constipation."

10:30 a.m.—ROUND TABLE CONFERENCES:

1. Anæmia. Conducted by Dr. Lyall Hodgins.
2. Fractures. Conducted by Dr. F. P. Patterson.
3. Infant Feeding. Conducted by Dr. E. J. Curtis.
4. Gynæcological Endocrinology. Conducted by Dr. W. N. Kemp.

11:30 a.m.—DR. HENRY: "Surgical Treatment of Intra-Capsular Fractures of the Hip."

12:30 p.m.—NO HOST LUNCHEON—Hotel Georgia.

1:30 p.m.—Conference on Contract Group Practice.

Three papers—questions and discussion.

4:00 p.m.—Conference for Coroners.

Four brief papers and discussion.

7:00 p.m.—Motion picture—"Heart."

8:00 p.m.—Annual Business Session of the British Columbia Medical Assn.

Chairman: Dr. G. F. Strong, President.

9:00 p.m.—Annual Meeting of the College of Physicians and Surgeons of B.C.

Chairman: Dr. S. Cameron MacEwen, President.

WEDNESDAY, SEPTEMBER 15th

8:00 a.m.—Motion picture—"Heart."

9:00 a.m.—DR. MacCHARLES: "Some Problems of Biliary Surgery."

DR. ADAMSON: "Respiratory Sepsis."

DR. HENRY: "Fusion of Spine with Bone Chips."

DR. OSGOOD: "Hypertensive Cardiovascular Renal Disease."

12:15 p.m.—LUNCHEON—Board of Directors, British Columbia Medical Association.

1:30 p.m.—GOLF—New Capilano Golf Course, British Properties, West Vancouver.

7:00 p.m.—ANNUAL DINNER—B. C. MEDICAL ASSOCIATION.

NOTE: THERE IS NO REGISTRATION FEE.

EDITOR'S PAGE

We were among those who had the pleasure of hearing Dr. Ethlyn Trapp, who has just returned from a two years' trip to Europe, give an account of her wanderings and observations, and it is with pleasure that we publish this in the present issue of the BULLETIN. Dr. Trapp was, of course, devoting most of her time to studying the whole question of cancer therapy in its various forms as best exemplified in various centres, and apart from the aesthetic value of her travelogue, and this was high, it is a rather important contribution to our present attempts in British Columbia to meet the cancer problem successfully and establish adequate diagnostic and treatment facilities.

Of course British Columbia has its own peculiar difficulties. We cannot hope, with our limited population and equally limited financial resources, to equal the efforts of large and wealthy centres of population; but it is vitally important, as Dr. Trapp points out, that the problem be attacked from the right angle. We must pay close heed to the advice, based on long and sometimes bitter experience, given us by the authorities whom Dr. Trapp quotes. These people stress again and again the necessity for a co-ordinated and coherent plant of construction, based on a central nucleus, and limited to this at every step. Decentralization, the spreading of one's efforts over various inco-ordinated centres, they deprecate most urgently. It has frustrated and limited efficiency and retarded progress wherever it has been tried, notably in such a city as London. Research has been stifled, and energy dissipated. We should take this to heart here, where our B. C. Cancer Foundation has made such a good start, and is at present at a rather critical crossroads in its existence. We can not make Dr. Trapp responsible for our personal opinion, that the Foundation must at all costs, even at the cost of some delay and apparent waste of time, preserve its identity as a central provincial unit, controlling absolutely any subsidiary centres that may be established. It should not run the risk of being submerged in any other organization whatever—even if this would seem temporarily to give an advantage in speed and apparent efficiency.

To quote Dr. Trapp: "The absolute necessity of centralization as a *sine qua non* of efficient cancer work has been established. Here in British Columbia . . . we are tragically behind the times, but we have the tremendous advantage of beginning from nothing, with nearly thirty years of the trial and error of other places by which to profit."

* * * *

Medicine has many great and honourable traditions—and in no profession, we think, has a member greater cause to be proud of his calling—but one of the greatest things, we think, about the art of medicine is its complete freedom from national, religious and racial prejudice of any kind; also—and this is perhaps a natural corollary of the other—the complete freedom of interchange between all medical men; we have no secrets, no patents, no proprietary rights in any knowledge we may have, any discoveries we may make, any skill we may acquire: all is freely and gladly given *à deux mains* to any and every brother in the craft. It is one of the greatest glories of medicine that this should be so—and we feel sure that it will ever remain so. Dr. Trapp, to quote her again, in her travels through a Europe which is filled to the brim with suspicion and hate and fear, born of national, racial and religious prejudices and conflicts, moved serenely in a high and clear atmosphere, untroubled and untouched by any breath of doubt or suspicion. What a magnificent thing this is! How clearly one sees that the only hope for the world of men, for the endurance of civilisation, is that we should attain in some degree to this exalted ideal of life. The moral underlying it is perhaps that this is our reward, often undeserved, always unappreciated, for the fact that the noblest exponents of medicine have always put the service of others first, and self-interest last. Perhaps this may encourage and cheer those of

us who sometimes feel that life is all giving, and not much getting; and perhaps, paradoxically, the opposite is the more really true.

Consider our everyday experience, that any and every medical man of note that passes through Vancouver gladly and freely gives of his store to his professional brothers here, and this is true all over the world. It was not personal profit or self-advertisement that made Dr. Walter Schiller of Vienna give three evenings to us, and three lectures that were of priceless value—that brings the Rowntrees and the Boyds, and the Grahams, and all the rest of them here, to tell us of their best and latest work in their respective fields; that brought Dr. Emil Ries here last week to tell us of some work he has done, of great value, which has not yet even been published. It is all part of the same habit of giving that, as we said, is a part of the daily work of these, our big men. One feels that it is good, from time to time, to think of these things. It is like a deep breath of fresh air, refreshing and stimulating, and we need it occasionally.

BRITISH COLUMBIA MEDICAL ASSOCIATION
B. C. MEDICAL ASSOCIATION

We urge all our readers to take the fullest advantage of the meeting of the B. C. Medical, from September 13th to 15th inclusive. It is being held in the Hotel Georgia in Vancouver, and has been thoroughly prepared for. There is abundance for everyone, and the economics of medicine are especially in evidence. The sectional meetings are bound to be of great value and interest, and we congratulate the Executive on their wisdom in introducing this feature, a new one to our meetings.

The B. C. College of Physicians and Surgeons is holding its annual meeting too, and this will be of great significance.

We bespeak a large attendance for this most important meeting. It is one of the few occasions when no fee is charged, and this may be of some help.

NEWS AND NOTES

VANCOUVER MEDICAL ASSOCIATION

Programme for Fall and Winter Session

Details of the Programme for the Session of 1937-38 are being completed and will be published in the October BULLETIN. The first lecture of the season, at the General Meeting on October 5th, will be given by Dr. Howard Spohn, the title being "Conditioned Reflexes and Their Relation to Medical Practice."

The profession throughout the whole province extends its sincere sympathy to Dr. and Mrs. A. McBurney of Langley Prairie in their deep sorrow sustained in the loss of their son Albert by death from a diving accident.

Dr. and Mrs. Murray McC. Baird are being congratulated on the birth of a daughter on August 19th.

* * * *

Dr. C. W. Prowd, Dr. F. H. Bonnell, Dr. B. J. Harrison and Dr. Ethlyn Trapp will attend the Fifth International Congress of Radiology, to be held in Chicago September 13th to 17th.

* * * *

Dr. W. T. Ewing has left by automobile for a six weeks' holiday in the East. He will go as far as Montreal.

* * * *

Dr. G. L. Watson, who has been at the Vancouver General Hospital for some years, is relieving Dr. Ewing, during the absence of the latter in Eastern Canada.

* * * *

Dr. T. McPherson and Dr. L. H. Appleby have left for Ottawa to attend the meeting of the Medical Council of Canada.

We are very glad to welcome back Dr. Ethlyn Trapp, who has been on an extended trip to Europe. Dr. Trapp was away over two years, and during that time travelled extensively, going by way of China and returning direct from Europe.

* * * *

Dr. W. M. Paton has left by motor for Mexico for a holiday of a month or six weeks.

* * * *

Dr. J. Wright has opened offices in the Medical-Dental Building.

* * * *

Dr. H. H. Caple, who returned from England a few months ago, where he did post-graduate work in various hospitals, will open an office with Dr. W. S. Turnbull in the Medical-Dental Building.

* * * *

Dr. and Mrs. H. M. Ross are receiving congratulations on the birth of a daughter on July 30th.

* * * *

We offer our heartiest congratulations to Dr. W. E. Harrison on his marriage to Miss Freda A. Garthorne. The wedding took place in West Vancouver on July 31st.

* * * *

Another event of great interest to members of the Association was the marriage on August 19th of Dr. J. A. Smith to Miss Gwendolyn Rothwell. Following the ceremony Dr. and Mrs. Smith left on the *Empress of Russia* for Honolulu.

* * * *

We are glad to hear that Dr. A. W. Bagnall, who has been in the Private Ward Pavilion of the Vancouver General Hospital for nearly one month, is well enough to leave the hospital, although it will be some weeks before he will be able to resume his practice.

* * * *

Dr. C. W. Sanders, ship surgeon on the *Empress of Russia*, is recuperating at his home at Gordon Head, near Victoria.

* * * *

Dr. Giles B. Murphy sailed on August 19th as ship surgeon on the *Empress of Russia*.

* * * *

Dr. A. N. Beattie, having returned from England, has left the *Empress of Japan*, on which he served as senior ship surgeon of the Canadian Pacific Steamships fleet. Dr. Beattie is now located at Ioco, having taken over the practice of Dr. E. K. Pinkerton.

* * * *

Dr. E. K. Pinkerton has moved from Ioco and is opening offices in the Medical-Dental Building in Vancouver. He has almost recovered from the effects of an automobile accident from which he escaped as an innocent ,but unfortunate victim.

* * * *

Dr. R. W. Garner of the Albernis on Vancouver Island is away on a vacation. Dr. J. King Kelly is associated with Dr. J. C. Thomas as *locum tenens* during Dr. Garner's absence.

* * * *

Dr. R. W. Irving of Kamloops has spent his vacation between his Celesta camp on Shuswap Lake and Vancouver. He always takes his horses along, and during the racing season his horses have put the Sunshine Stud Farm on the map, having captured two firsts, two seconds and a third place in five days' racing at Lansdowne Park.

July 26th was a great day, according to Dr. Lyon Appleby, who shared Dr. Irving's thrill when the latter's two two-year-olds finished first and second. Dr. Irving says it is more fun than surgery, and more sure pay.

* * * *

Dr. L. C. Steindel, who is well known at St. Paul's Hospital, Vancouver, and at St. Joseph's Hospital in Victoria, and who has made many friends as *locum tenens* at various points in this province, has been at Burns Lake during August, relieving Dr. Holmes. Dr. Steindel was in charge of Burns Lake Hospital when Lord Tweedsmuir and the Vice-Regal party honoured this splendid institution in the north by a visit en route to Tweedsmuir Park.

* * * *

Dr. W. T. Kergin of Prince Rupert has returned to that port and is reported to be in excellent health following a most enjoyable round-the-world tour.

* * * *

Dr. W. A. Kergin, who accompanied Dr. W. T. Kergin and did special work in Great Britain, is now returning to Premier, where Dr. Kritzwiser has been relieving him during several months.

* * * *

Dr. G. D. Oliver of Quesnel, who is associated with Dr. Gerald Baker in the practice in the Cariboo centre, called on the Executive Secretary while on a visit to Vancouver in August.

* * * *

Dr. D. A. Steele recently returned to the Province, and will share offices in the Medical-Dental Building with Dr. Pinkerton.

* * * *

Dr. S. Cameron MacEwen of New Westminster accompanied the gubernatorial party into Tweedsmuir Park. Dr. MacEwen had his Hardy along, and we are certain he will soon make the Front Page with a mammoth trout in his creel.

* * * *

Dr. J. Ross Davidson, after spending several years in practice at Ocean Falls, has moved to Vancouver and is opening offices.

* * * *

Dr. R. D. Coddington, who returned to the Province several months ago, is now associated with Dr. R. Gilchrist in the practice at Ocean Falls.

* * * *

Dr. W. S. Huckvale is associated with Dr. D. W. Davis of Kimberley as *locum tenens* during the absence of Dr. J. S. F. Haszard on vacation.

* * * *

Dr. Huckvale will go to Hazelton and be associated with Dr. L. B. Wrinch in the practice there.

* * * *

Dr. F. R. G. Langston and wife (Dr. Kathleen Woods) are away on holidays, returning in August. Dr. D. C. MacKenzie is associated with Dr. W. B. Cannon while Dr. Langston is away.

* * * *

Dr. H. T. Hogan is at Blakemore during the absence of Dr. H. W. Cannon.

* * * *

Dr. S. G. Baldwin and wife are leaving Vernon and will be absent from the Province until next Spring. Dr. Baldwin will visit European centres before coming to Vancouver to practice.

* * * *

Dr. H. J. Alexander has left for Vernon, where he will take over the practice of Dr. Baldwin, and be associated with Dr. Frank H. Pettman.

IMPRESSIONS OF THE CANCER SITUATION IN EUROPE

ETHLYN TRAPP, M.D.

First may I say how pleased I am to be back among my associates and thank your President for having asked me to address this meeting. There is nothing like a trip abroad to make one appreciate one's native land. One sees with fresh eyes advantages that have always been accepted as a matter of course, and discovers conscious pride in a Canadian birthright.

Second-hand travel is notoriously dull, but I ask your patience while I briefly sketch in a few of the highlights of a tour of European cancer centres, in search of methods of organization and treatment that could be brought back and be of use in British Columbia.

London, of course, seemed the obvious place for a Britisher to begin, so I set out to renew my acquaintance with the London clinics, of which there are some eight treatment and three research centres. Excellent individual work is being done in each of these places, but as far as treatment goes there is absolutely no centralization or co-ordination, with the result that each place must learn through its own experience which methods are good and which bad, and clinical research of any magnitude is quite impossible. This fact is bitterly regretted by all those involved, but up to now all efforts at co-ordination have been fruitless, and one is warned again and again to beware of this mistake of decentralization and advised to begin with a central nucleus, however small. This was the opinion of every cancer therapist I talked with. As a result of that mistaken initial policy, London still lags years behind the Continent, and even some of the English provincial centres, in its grasp of the cancer problem. The National Radium Trust and Commission, when they took over the distribution of the large quantities of radium purchased in 1929, made centralization one of their chief objects. They also laid down rules concerning the personnel of centres using this national radium. These must have at least one full-time radium therapist with a recognized standard of training and an adequate physics department. By this step the National Radium Commission recognized the paramount importance of centralization and of a trained personnel for the treatment of cancer, and the new centres established in Great Britain since that time are practically all on this satisfactory basis.

In London itself there are only two clinics whose work is recognized abroad as being of international importance. They are the Radium Beam Research Branch of the Radium Institute and the Marie Curie Hospital for the Treatment of Cancer in Women. The latter has the best five-year survival rate in the world for cancer of the cervix and uses the Stockholm technique.

Becoming a little discouraged with the time spent in going from one London clinic to another, I decided to set out for the Continent and return to the London attack later. The fact that my sister and her car were available had some bearing on this decision, and to the horror of our English friends the two of us set out for Berlin in mid-winter in an open Ford—an English one at that. On looking back, I cannot recommend too highly this means of transportation for a medical tour; cheap and reasonably comfortable, and affording unlimited opportunities for seeing the countries through which we passed. We did have fool's luck—just missing a three-day English fog and arriving in Berlin before the worst snowstorm of the year effectively blocked the roads for some days.

Berlin hospitals are colossal, but a few letters of introduction and a smattering of German make the way very easy. Neither of these is really essential, but they do help. Medicine is truly international and I have never yet visited a hospital where a professional card did not assure a welcome. This is an interesting anomaly of the fear-ridden Europe of today, where no man dares to trust his neighbour, or, at times, even his own brother.

Germans have been pioneers in the field of x-ray therapy and in their thorough and painstaking way have investigated all that can be accomplished by voltages up to two hundred thousand. Post-war poverty has prevented their doing much with radium, though each centre makes use of a certain amount. The same reason has prevented the development of super-voltages which are so popular in America, but not the use of contact therapy as used first by Chaoul at the Charité, and imported into Vancouver about a year ago by Dr. Prowd. This is an ideal type of therapy for certain superficial cancers and is now being widely used throughout the world.

Of course, as in other countries, surgery plays its own essential part in the management of cancer, but that is not a new development, and in some fields, notably cancer of the cervix, it has been almost entirely replaced by radiological treatment.

The weather being bad, and we not caring to trust our luck too far, the "Flying Hamburger" took us to Professor Halthusen's clinic in that city. To my mind he is the most important of the German x-ray giants. It was he who put the measurement of depth dosage on a scientific basis. He speaks excellent English and gives frequent lectures in England and in the United States.

After some weeks of Berlin clinics we set out for Frankfurt, on the way spending a month at the gynæcological clinic of Professor Martius in Göttingen. This is the oldest university town of North Germany and one of the bitterest Jew-baiting centres of the country. It affords a good demonstration of the effect of the National Socialist regime on German scientific work. In the first place the actual number of students has shrunk from six to two thousand, and professors complain bitterly, though not openly, that Nazi activities are so sapping the energy of their young men that none is left for adequate research work, or indeed any other scientific endeavour. However, Professor Martius himself has developed an interesting three-fold method of treatment for cervix cancer; an x-ray contact tube after the type of the Chaoul tube, applied to the parametria, as well as the usual radium applications and deep x-ray therapy. He believes that this method has materially improved their results, but the thesis has not yet been published and it is too early to draw accurate conclusions.

Professor Holdfelder at Frankfurt is another of the very well known German radiologists. Some ten or twelve years ago he developed the Holdfelder "Canon" and ingenious methods of tumour localization. The tangential method of treating breast cancer also originated with him. His methods, or modifications of them, are still widely used in all x-ray clinics.

Wintz in Erlangen is famous for his short massive dosages and still steadily maintains the virtue of this method, in spite of the opposite trend throughout the rest of the radiological world.

It is now cherry blossom time and we bid a reluctant farewell to the Rhine and follow the Danube to Vienna. This was my third visit to that city of misfortunes and each time one marvels afresh at her survival, but as somebody has remarked, "Whoever heard of a beautiful woman starving?" To quote Stephen Spender: "The two traditions that still live and seem to have a future are medical science and the performance but not the creation of music."

Vienna is pre-eminently a surgical and pathological centre and is the only place of note on the Continent that still considers early cancer of the cervix a surgical problem; and it is handled with consummate skill, largely by vaginal hysterectomy.

This city is also unique in having specialists in pathology, notably such men as Schiller in the gynæcological field, who has recently lectured to you here in Vancouver, demonstrating the possibility and importance of the early diagnosis of uterine cancer. Radium and x-ray therapy, however, have not

been neglected. For years each hospital has had its own department for this type of treatment, and since my last visit some five years ago, a large new cancer centre has been established at Lainz, on the outskirts of Vienna, and here one finds the same sort of co-ordinated work that has proved itself to be of value elsewhere.

With Vienna as a centre we drove into Hungary and Czecho-Slovakia. Brünn has one of the best cancer institutes in Europe, simply but completely equipped for all types of treatment, an adequate and enthusiastic personnel and a very efficient record and follow-up system. It also has research facilities and maintains an excellent physics department.

Budapest has a new centre of the same type as that in Brünn and its staff is equally enthusiastic over the success of their efforts. It is difficult to associate cancer with that fairy-land city of dreamlike buildings and gypsy music, and after an exhaustive tour of the new Institute we forgot the medical side of Budapest.

From Vienna we returned to the Rhine once more and made our way back to England. After further visits in London clinics we flew to Moscow, where we had arranged to meet the Spohns, and had a three weeks' glimpse of the Soviet Union. A fantastic three weeks it was, difficult and uncomfortable, but one of the highlights to be remembered. We saw no medical work in Moscow, but on reaching Leningrad, Professor Krasnagorski, formerly an associate of Pavlov's and now a pædiatrist of international note, took us in hand and kept us enthralled for a fortnight. We saw Pavlov's town laboratory and his experimental farm, where conditioned reflexes are being investigated in apes as well as in dogs. The former fared better than any humans we saw, including tourists like ourselves, and our mouths watered when bowls of ripe raspberries appeared to complete their lunch of fresh beef and vegetables. We had not set eyes on such luxurics since arriving in Russia.

Cancer work, like everything else, is in the throes of new development. There is a tremendous new institute in Leningrad which carries on extensive research work as well as the usual clinical activities. Patients there are in unbelievable numbers but one gets an impression of chaos, and must reserve judgment. An interesting sidelight is the way in which state medicine is carried to its logical conclusion, medical students being trained by the State and actually given a small salary during their training. The entrance examinations are competitive and the first five years after graduation must be spent in a country practice.

Then followed Scandinavia, the only sane countries of Europe. The Radiumhemmet in Stockholm was established in 1910 with a very modest beginning. There are now three centres in Sweden and, to the best of my knowledge, it is the only country in the world where cancer is adequately dealt with from the point of view of the whole population. It was the pioneer in the field of centralization for cancer work and has been the inspiration for similar centres throughout the world. Their methods of treatment have been more widely used than any others, Paris being the only rival in this field. In this connection it has been well said that the whole world follows either Stockholm or Paris.

Brussels and Louvain, the most important Belgian clinics, having the advantage of large quantities of radium at their disposal, have been pioneers in pure radium therapy, and were responsible for the inauguration of beam or telecurie therapy. They were also pioneers in physical measurement and were the first to use the roentgen "r" to measure the gamma rays of radium. This was a great advance and has made possible the accurate physical measurement of radium dosage, which gives a common basis for comparison of treatments from patient to patient and clinic to clinic.

This particular phase of the Brussels work was adopted and simplified in Manchester. It has been successfully used there for the past five years and has played no small part in the phenomenal development of this clinic.

The Second International Cancer Congress was held in Brussels last September and was an interesting event, although no new facts of outstanding importance were forthcoming. However, it did give one a very good birdseye view of the present position of cancer research as well as therapy. In this connection it may be of interest to quote the summing up of the *Lancet* report of this meeting, which was attended by five hundred delegates representing forty-two countries:

> "In retrospect two main impressions emerge from the papers read at this important congress. As regards treatment, much hope must be attached to future developments in x-ray therapy; with growth in knowledge concerning the application, combined with scientific standardization of the dosage, this mode of attack appears to carry the greatest promise. In the laboratory the present recognition of carcinogenic agents of an extrinsic character seems to mark a definite stage in research, and the feeling is widespread that efforts must now be directed towards the discovery of some more fundamental intrinsic factor or factors which may determine the development of cancer in the presence of one of these known extrinsic agents."

Two British scienists, Professor Cook in association with Professor Kennaway, investigating the carcinogenic properties of certain chemical agents, won the prize offered through the International Cancer Union for the best research of the year. The work was carried out in the research laboratories of the Royal Cancer Hospital in London.

Political tensions were not absent and there were incidents to remind one of the fantastic nationalism of modern Europe. The Italian delegate, though speaking both English and French, was ordered by Mussolini to read his paper in Italian and addressed empty chairs, which was a pity as he was a distinguished man and had important research work to report.

The Poles refused to give their addresses at all, and left the Congress in high dudgeon because Polish was not made one of the official languages.

The Germans had almost to return through lack of funds, being limited to the usual fifteen marks on leaving Germany. The Nazi Government had given them maintenance cheques, but these the Brussels banks refused to honour. The German Consul eventually came to the rescue out of his own private funds.

Paris and the Foundation Curie, the home of Regaud and Coutard, is, like Stockholm, too widely known to require much comment. An impressive feature was the meticulous clinical observation and care of the patients under treatment. Coutard himself examined each patient before or after treatment, which was twice and sometimes three times daily. In no other way could he make such accurate prognoses. It is a leisurely clinic and no patients are accepted for treatment unless there is some hope of cure. There is no so-called "palliative" treatment, which involves so much of the time of other clinics. Villejuife, the city cancer institute, takes care of the hopeless cases and a large and well-equipped institute it is, supported entirely by the French Government.

More days in London, then Edinburgh, which has not yet got its cancer work successfully co-ordinated, though reorganization has recently been undertaken by a man trained in Manchester. I was advised to stop in that city on my way south, which I did, planning to remain for a few days, and finding myself still there at the end of six months; I might add with a few week-ends in London in the interval, which lightened the prevailing atmosphere of smoke and depression.

Nothing could be a greater tribute to Manchester work than a prolonged stay in that dark city of the Midlands, which accepts philosophically the worst that the English climate can offer, together with the worst of economic depressions. Such a clinic combined with the delights of Vienna, Paris, or even London, would be too much for this imperfect world.

However, here I found what I had been seeking on the Continent for months—that is, a reasonably accurate method of radium dosage established on a combined physical and clinical basis, and thus not entirely dependent for its success on the experience of one particular radio-therapist; a method which could be used elsewhere without the usual learning by experience which may be paid for so dearly by the patient.

Centralization began in Manchester in 1915 with the formation of the Manchester District Radium Institute, which at first was merely a pooling of the available quantities of radium, so that the supply should always be adequate for different types of treatment and also that it be kept constantly employed, a most important practical consideration with such an expensive commodity.

It soon became obvious that specialized medical attention was necessary and a medical director was appointed, this in spite of the difficulties of carrying out treatments in different hospitals.

In 1921 a central nucleus of beds was provided by the purchase of a small nursing home.

In 1929, when the National Radium Trust and Commission was formed for the purchase and allocation of radium throughout Great Britain, the University, the Radium Institute and the Manchester Infirmary became the Manchester centre of the Commission.

Soon after the Institute amalgamated with the Christie Cancer Hospital and large new quarters were built. These were completed in 1932.

Since then, under its present Director, Dr. Ralston Paterson, it has grown to be one of the most important centres of Europe, and visiting doctors come from all parts of the world.

A striking demonstration of the influence such an Institute can exert in a community is shown by the fact that whereas in the early years of its career the percentage of deaths to admissions was eighty, in the last annual report it had decreased to eight. This fact must be largely attributed to the greater percentage of early cancer rather than the improvement in the technique of treatment, though that, no doubt, played its part. It also exemplifies the statement that early and late cancer are two different diseases, one curable and the other not.

It seemed to me that the Manchester plan which has been in successful operation for some years would, with some modification, be suitable for adaptation in British Columbia, so I propose to briefly outline their work.

There is a central unit with a whole-time specialist radio-therapeutic staff, a pathologist, physicists, technicians and a well-organized record and follow-up system; adequate radium and x-ray equipment, and the ordinary ancillary services of a hospital. The surgical work is done by the honorary surgical staff, with specialists in the various fields, who, of course, receive fees for private patients. Daily diagnostic clinics are carried on throughout the year with consultation on all new and recurrent cases. In addition to this a radium service scheme was evolved by which specialist services became available by voluntary agreement to towns of the surrounding hinterland. A "radium clinic" is held in the local hospital at regular intervals, dependent on the number of patients. This clinic is conducted by a member of the staff of the central Institute in collaboration with the local staff. All new patients are seen first in this clinic and all post-treatment follow-up visits are also here. The patients go to Manchester for radium treatment, but any surgical procedure is carried out locally and when possible collaborative treatments, that is, surgery of access and radium. X-ray treatment depends on the available local equipment but frequently must be carried out in Manchester.

Arrangements for this can be made comparatively easily, as hospital beds are not often necessary.

As well as this work carried on in nearby towns, other agreements have been made with the large voluntary hospitals of Manchester itself. Regular "treatment visits" have been arranged for and visiting therapists from the Radium Institute carry out these treatments. For example, the Manchester Infirmary has placed a whole ward at the disposal of the Radium Institute and an operating room is available for an afternoon a week. For x-ray treatment bed patients are daily transported by ambulance to the central unit—an expensive method, but at that cheaper than providing the large number of beds that would otherwise be required.

One is tempted to continue indefinitely about Manchester, which is an inspiring clinic and has solved so many of the problems of cancer organization and treatment, Dr. Paterson having picked out the best from the various English and Continental centres and adapted it to his own particular needs. However, my half hour must be nearly over and I would like to just touch on Rome.

I had not previously planned to go so far afield, but a last-minute decision took me to Egypt and I thus had the opportunity for a birdseye view of Italy's most important cancer clinics. I was not long enough there to see a great deal of the actual treatment, but it seemed to follow the general trend of other Continental capitals. The cancer work is centralized in special institutes, and amazing places there are in Rome, even surpassing the American conception of luxury in equipment. Mussolini evidently believes in doing all his building on the grand scale and does not confine it to huge forums named after himself.

In passing may I mention Cairo's 2,000-bed hospital with its daily quota of 8,000 outpatients. The interminable corridors were a test of endurance, but fortunately a taxi took us from one department to the next and the panorama from the roof was a rich reward. Cairo and her mosques, the Nile and the pyramids and the endless desert. The effects of the new regime were already apparent and British and American doctors were being rapidly replaced by Egyptians.

I have deliberately confined my remarks to European clinics, though equally important work is being done on this side of the Atlantic.

On returning to Vancouver I am astonished to find the situation apparently the same as when I left two years ago. At that time the B. C. Cancer Foundation had been inaugurated and I thought then the foundation stone of a Cancer Institute practically laid. I learn that there have been various upheavals in the interval. However, the work of the cancer foundation has gone on. The Government guaranteed a loan for the purchase of three and a half grammes of radium. The King George V Silver Jubilee Cancer Fund gives us their moral and mildly financial support with a $14,000 annual grant for organization purposes throughout Canada, and the United Commercial Travellers of Canada have dopted cancer as their permanent charity.

The absolute necessity of centralization as a *sine qua non* of efficient cancer work has been established. Here in British Columbia, where nothing of a public nature has been done, we are tragically behind the times, but we have the tremendous advantage of beginning from nothing, with nearly thirty years of the trial and error of other places by which to profit.

So, gentlemen, with no mistakes to rectify, we have here the opportunity of establishing the very best type of cancer work that present-day knowledge permits, indeed of leading Canada in this field. With the spade work already done, now is the time to seize our opportunity and to act.

BRITISH COLUMBIA MEDICAL ASSOCIATION

FORTY-FIFTH ANNUAL MEETING
SPECIAL FEATURES

Monday, September 13th, 3:00-5:30 p.m.

Demonstration of Various Technical Procedures of General Interest.

All of these will be held in the Main Operating Room of the Vancouver General Hospital, with the exception of ARTIFICIAL PNEUMOTHORAX, which will be held in the Tuberculosis Centre of the Provincial Department of Health, Tenth and Willow St.

1. 3:00-5:00 p.m.—"Artificial Pneumothorax"—Dr. Wesley Simpson. (Tuberculosis Centre, Tenth and Willow St.)
2. 3:00-3:25 p.m.—"Various Anæsthetic Procedures"—Dr. D. D. Freeze.
3. 3:00-3:55 p.m.—"Taking Blood Specimens in Infants, Intravenous Therapy in Infants"—Dr. E. J. Curtis.
4. 4:00-4:25 p.m.—"Examination of the Eye for Foreign Body and Technique for Removal Thereof"—Dr. F. W. Brydone-Jack.
5. 4:30-4.55 p.m.—"Cistern Puncture—Diagnostic Novocaine Block in Cervico-thoracic Sympathetic Chain"—Dr. Frank Turnbull.
6. 5:00-5:30 p.m.—"New Appliances for the Treatment of Fractures"—Dr. J. R. Naden.

Note: These demonstrations will start and finish on time.

Conference on Public Health

This special meeting has been developed by and will be presided over by Dr. J. R. Naden, Chairman of the Committee on Public Health of the British Columbia Medical Association. All members are requested to attend this important meeting. It will commence at 8 p.m. promptly on Monday, September 13th. The programme provides for presentation of papers as hereunder:

1. "Provincial Tuberculosis Control"—Dr. W. H. Hatfield.
2. "Provincial Venereal Disease Control"—Dr. S. C. Peterson.
3. "Provincial Vital Statistics Division"—Dr. K. F. Brandon.
4. "Provincial Laboratory Services"—Dr. C. E. Dodman.
5. "Rural School Medical Services"—Dr. J. R. Naden.
6. "Provincial Mental Hygiene Programme"—Dr. E. J. Ryan.
7. Metropolitan Health Department—

   "General Outline of Metropolitan Health Department"—Dr. J. W. McIntosh.

   "Infant and Pre-School Programme"—Dr. S. Stewart Murray.

   "School Medical Services"—Dr. Harold White.

   "Communicable Disease Control and Immunization"—Dr. E. D. Carder.

Papers will be limited to 7½ minutes by the clock and gong. Discussion and questions will require three minutes, and speakers will thus have 2½ minutes for replies. Owing to the length of the programme the speakers must be restricted in time and discussion must be similarly prompt.

The idea underlying this feature is to *define* the programme of Public Health rather than to *defend* it and to assure sympathetic understanding and enlist support and co-operation of the general practitioner.

Thursday, September 14th

Round Table Conferences, 10:30 a.m.

Four separate conferences in four separate rooms, as follows:

1. "Anæmia"—Dr. W. Lyall Hodgins.
2. "Fractures"—Dr. F. P. Patterson.
3. "Infant Feeding"—Dr. H. A. Spohn.
4. "Gynæcological Endocrinology"—Dr. W. N. Kemp.

These Round Table Discussions are a new feature. You will attend the discussion of your choice. Questions are invited, to carry on the discussion.

Conference on Contract Practice, 1:30 p.m.

Three brief papers as detailed hereunder:

1. "Some Salient Points in Contract Work"—Dr. J. B. Thom, Trail, B. C.
2. "A Study of Medical Service in Logging Operations"—Dr. G. W. C. Bissett, Duncan, B. C.
3. "The Mining Industry and Its Medical Service"—Dr. R. J. Wride, Princeton, B. C.

The presentation of the various phases by these three speakers will open the discussion. Many interesting speakers will be heard and much will be learned which should be productive, leading towards improvement in conditions.

All members of the Association should attend these conferences.

Dr. S. Cameron MacEwen, Chairman of the Committee on Economics of the Council, will act as Chairman at this meeting.

Conference for Coroners, 4:00 p.m.

This Conference is under the chairmanship of Dr. Osborne Morris of Vernon. The following definite programme will be presented:

1. "The Relation of the Coroner to the Profession and Public"—Dr. J. D. Whitbread, Coroner, Vancouver, B. C.
2. "Observation of Causes, Natural and Other"—Dr. A. W. Hunter, Coroner's Physician, Vancouver, B. C. ffl
3. "Examination at Autopsy"—Dr. H. H. Pitts, Pathologist, Vancouver General Hospital.
4. "The Laboratory in Coroner's Investigations"—Inspector J. F. C. B. Vance.

The above programme will be presented, leading up to discussion and questions. All members are invited to attend this meeting.

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Lecture Periods

The lecture periods are all confined to the morning sessions of all three days. Please see the General Programme for details of speakers and subjects. The lectures are arranged as follows:

Four lectures on Monday morning.

Three lectures on Tuesday morning.

Four lectures on Wednesday morning.

Official Luncheon, Hotel Georgia Ballroom
Monday, September 13th, 12:30 p.m.

This luncheon should be largely attended. The Mayor of Vancouver will be present and speakers and visitors will be introduced and welcomed. Dr. T. H. Leggett of Ottawa, President of the Canadian Medical Association, and Dr. T. C. Routley, General Secretary, will be present and will address the members at this luncheon. Please secure tickets at the Registration Desk at the Ballroom entrance.

Registration

Dr. Roy Huggard is in charge of Registration and requests that all members register early and signify what functions they wish to attend.

Dr. Bilodeau will want to know how many will play golf on Wednesday.

Dr. N. E. MacDougall will want to know:

1. How many for Official Luncheon on Monday.
2. How many for Annual Dinner on Wednesday.

Dr. L. W. McNutt will want to know how many will require transportation:

1. To the Vancouver General Hospital for Demonstrations at 3 o'clock Monday.
2. To the North Shore for golf on Wednesday at noon.

IMPORTANT: Members residing in Vancouver are requested to register early on Monday. There will be no registration fee.

Annual Meetings

The Annual Meeting of the British Columbia Medical Association will be held at 8:00 p.m. on Tuesday and will precede the Annual Meeting of the College, which will convene at 9:00 on the same evening. These are YOUR meetings.

Golf

The British Columbia Medical Association Trophy will be competed for by the members. This trophy has been provided for the competition by the Mead Johnson Company.

Many other prizes are offered by Dr. Bilodeau and his Committee, and will be presented at the Annual Dinner.

To be able to play on the new golf course on the British Properties at West Vancouver, on Hollyburn, is going to make this feature very popular. Golf play is on Wednesday, September 14th.

Annual Dinner

The Annual Dinner of the British Columbia Medical Association will be held on Wednesday at 7:00 o'clock in the Ballroom, Hotel Georgia. The guest speaker will be the Honourable Gordon S. Wismer, Attorney-General of the Province of British Columbia, who will address the members on "Law and Medicine."

Representatives of other Provincial professional bodies will be present at the Annual Dinner, as guests of the British Columbia Medical Association. Dr. J. Reid Morrison, of Bellingham, President of the Washington State Medical Association, will attend as a guest, as will also the visiting speakers at the Convention.

Commercial Exhibits

The members are requested to reciprocate by visiting the exhibits on the Mezzanine Floor in the Hotel Georgia.

Hotel Georgia

Reservations may be made at the Hotel Georgia, the Convention Headquarters, by communicating directly with the Hotel.

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PROGRAMME OF ENTERTAINMENT FOR LADIES

Monday, September 13th

9:00 a.m.—Registration—Mezzanine Floor, Hotel Georgia.

All ladies, whether resident in Vancouver or other points, are requested to register, signifying their intention of participating in the various features of entertainment.

Tuesday, September 14th

2:00 p.m.—Scenic drive for visiting ladies, leaving from Hotel Georgia.

4:00 p.m.—Tea at Jericho Country Club, as guests of the British Columbia Medical Association.

Local ladies are invited to attend the tea and are requested to secure invitation cards at the Registration Desk before 1:00 p.m. on Monday.

Wednesday, September 15th

7:00 p.m.—Ladies' Dinner at the Georgian Club. Tickets $1.25.

The limited accommodation restricts attendance to 100. Tickets may be obtained at the Registration Desk on the Mezzanine Floor, Hotel Georgia.

The Committee in charge of the Ladies' Dinner requests that the ladies residing in Vancouver arrange to secure their tickets for the dinner before 1:00 p.m. on Monday.

Ladies residing in Vancouver may have registrations made, tickets for Dinner purchased, and Tea invitations secured, either by themselves or by their husbands, on Monday morning, commencing at 9 o'clock.

Golf

Ladies wishing to play golf will be assisted by the Ladies' Committee.

The Ladies' Reception Committee will be in attendance on the Mezzanine Floor, Hotel Georgia, during the Convention.

TUMOURS OF THE UTERUS

DR. DONALD V. TRUEBLOOD

(Read at Vancouver Medical Association Summer School, June, 1937)

Tumours of the uterus, whether large or small, are in many instances important factors in the health and comfort of the patient. Often a large one is symptomless, while a small one—depending upon its location and type—may cause severe illness.

It is the purpose of this discussion to deal primarily with the clinical features of uterine tumours, rather than the pathological peculiarities of them. We will be obliged, in certain instances, to refer to the pathological characteristics of some tumours, in order that the clinical picture can be properly presented. A thorough understanding of these features, peculiar to a few tumours, will aid the clinician materially in visualizing the pathological disease which the patient is harboring, permitting thereby more intelligent treatment.

A good clinician, before examination is made, will obtain a complete history which has not neglected the story of pregnancies, abortions, miscarriages, operations, nursing, breast difficulties and abnormalities of the menstrual cycle past or present. Physical examination must certainly include, beside other areas, examination of the lymph gland bearing regions, thyroid, breasts and rectum. The pelvic structures are examined last, beginning with the vulva. One inspects and palpates the clitoris, urethra, both labia, the vaginal orifice and the perineum. A speculum is now passed, and with the aid of a good light a thorough inspection of the cervix is made. The condition of the vaginal walls is also observed. On uterine examination, the commonest abnormality that is seen is endocervicitis. This condition is not a tumour, yet it must be labelled with tumour significance because of the frequency with which cancer of the cervix has been attributed to this disease. Inasmuch as the major significance of it is its relationship to cancer, we will discuss it later at the proper place.

Bimanual examination is next instituted. With two fingers of one hand in the vagina and the other hand on the abdomen, the uterus, adnexae and other tissues are palpated. Before the fingers are removed, they should be turned anteriorly, palpating the anterior vaginal wall and base of the bladder. Then they are turned posteriorly, feeling the cul-de-sac and rectum. Lumps thought to be in that organ may be in the septum. If such masses are found, examination should be repeated after the rectum has been emptied. I have found it of diagnostic help, after washing off the glove, to place one finger in the vagina and the other in the rectum, repeating the bimanual procedure. Occasionally it is advisable to use the opposite hand to better explore the opposite pelvic area.

The most common symptoms relative to the uterus of which the patient may complain are bleeding, increased discharge, pain, menstrual disorders, backache, pressure symptoms relative to bladder and rectum, or merely a bearing-down sensation within the pelvis. As one or more of these symptoms may occur with the majority of uterine tumours, it is thought advisable to discuss the general symptomatology of each of the more common neoplasms in turn, rather than to concentrate upon the relative frequency of each of these symptoms individually.

POLYP: Polyps of the cervical or uterine canal may be single or multiple. They are often symptomless. Bleeding is the usual sign. If the polyp is visible in the cervical canal, one is tempted to believe that that is the only causative factor of the bleeding. The removal of such a polyp may cure the patient; but inasmuch as all polyps have a cancer significance, and inasmuch as there may be others invisible within the uterus, the cervical canal should be curetted first, bringing with it the visible polyp with its base for microscopic examination, and then the uterus should be curetted, offering to the pathologist the

mucous membrane lining of that organ to be separately studied microscopically. This procedure is suggested because the cervical polyp may not be the cause of bleeding, and the patient might have hidden evidence of more serious disease within the uterus. As the patient is under an anæsthetic this additional procedure carries with it much to gain and nothing to lose should a malignancy or other pathology be found. If nothing but the cervical polyp is found, its base should be cauterized.

When multiple polyps are encountered, as shown by the curettage, further treatment is not indicated at the time unless malignancy is found. If, within the uterine cavity, a large submucous fibroid presents into the uterine cavity or cervical canal a hysterectomy is often indicated, because there are doubtless other fibroids in the organ which will continue to grow.

If conservatism is desired, pass a tonsil snare around it at its pedicle base, severing it gradually. The application of the coagulating current to this instrument is an advantage.

Uterine Fibroid (*Myomata*) : This tumour may be large and symptomless, or bleeding may be the only symptom (whether the fibroid is large or small) associated often with evidence of secondary (sometimes profound) anæmia. There may be symptoms of pressure, as described above. The treatment of such a tumour is surgical. I have not been convinced that radiation therapy is indicated except in those individuals who cannot be considered surgical risks. But it must be remembered that those who are very anæmic by reason of loss of blood cannot withstand radiation therapy as well as surgery. Most of these, after blood transfusion (having at hand the immediate facilities for additional blood transference), can often survive a rapidly performed supravaginal hysterectomy. A 40% hæmoglobin is probably the low limit of safety. Additional blood is indicated to raise a lower percentage to this more favorable level.

Here we can logically discuss the advisability or inadvisability (in the well conditioned patient) of removing the cervix with the uterus, obviating thereby the possibility of cancer developing at some later date in the cervical stump. Statistics tell us that this happens in from one to two and a half per cent.

It is my opinion that if the cervix is badly infected and badly deformed—the correction of which would require considerable valuable operative time in the vagina—panhysterectomy is indicated. Should such a patient be very obese, or have a very deep pelvis, surgical experience testifies that the enucleation of the cervix would be very difficult. In such patients I believe the cervix should be thoroughly coned out from below by the Sturmdorf method, or amputated; in either case, removing sufficient of the cervical mucosa and cervical glands high enough to obviate the possibility of cancer having an epithelial bed in which to originate. Following this, during the hysterectomy, the cervical canal is thoroughly cauterized from above, destroying most of the remaining potential field for cancer.

If the cervix, associated with a uterine fibroid, suggests a suspicion for cancer, the abdominal operation for hysterectomy should not be undertaken until after the pathologist states from a frozen section that cancer is not found. Should malignancy be found in the cervix, sufficient radium should be introduced into the cervical and uterine canal—as well as around the coned or amputated cervix—for the purpose of destroying that disease, leaving the uterine fibroid for later operation if still indicated. This radium application will stop the uterine bleeding.

I have learned by my own experience and that of others that in those instances where the fibroid is in close association with the rectum because of size or location, a proctoscopic examination should be performed before the operation, and that at operation the rectosigmoid flexure should be palpated as far down as possible. I know of three cases during the past three

years in which uterine fibroid was removed and cancer of the rectum in that location was overlooked.

ADENOMYOMA ENDOMETRIOMA: Such tumours confined to the uterus were first brought to the attention of the medical profession by Von Recklinghausen in 1896. In 1908, Cullen produced his excellent monograph on the subject, showing that this tumour not only arose in the uterus, but was found in the broad ligament, rectovaginal septum, around the umbilicus, and in postoperative wounds. He proved that these tumours had a central though irregularly located lining of endometrial tissue, and in the uterus he was able to trace this misplaced endometrial tissue as having arisen from the endometrial mucosa in that organ and penetrated down through the characteristic stoma (myomatous tissue) into the depths of the uterine wall. The majority of those tumours that were extra-uterine also had, in most instances, momatous tissue surrounding the extraneous endometrium. A striking characteristic, and a symptom-producing one, was that at menstrual time this misplaced endometrial tissue would undergo hyperplasia and bleed, causing symptoms of pain due to tension, the hæmorrhage having no outlet.

In 1912, Sampson* began adding knowledge to this interesting subject. It was his belief that at menstrual time endometrial cells could escape from the uterus through the tubes, and implant themselves on the nearest structures, namely, the ovary, pelvic floor and intestinal wall. There, they would invade, somewhat similar to the invasion of cancer. Those landing upon the ovary—where it is suggested they obtained a more fertile field for growth—would eventually cause chocolate-coloured cysts increasing in size with each menstrual blood accumulation. If such a chocolate-coloured cyst should be ruptured at operation, it is his belief that further implantation was permitted. Rarely does one of the endometriomas invade the bowel sufficiently to produce obstruction; but it has occurred, requiring resection.

The major symptom of this interesting condition is primarily dysmenorrhœa if the adenomyoma is uterine. Bleeding is not expected because the uterine mucosa is normal. If the endometrial implants have grown to sufficient size in other areas, they will produce symptoms relative to those areas and organs.

On examination, the uterus may or may not be found large. If large, it would be difficult to differentiate from a fibroma. Such a finding, associated with enlarged ovaries, is more diagnostic, but not absolute. A mass in the rectovaginal septum creates more suspicion, and an umbilicus that bleeds with menstruation approaches a specific diagnosis. A small, very hard uterus is not beyond suspicion.

A lump in any area (inguinal or vaginal) that increases in size at menstrual time is very suggestive of an endometrioma. However, most of these tumours are diagnosed only at operation. A chocolate-coloured cyst of the ovary should be removed without breaking the capsule. Small chocolate-coloured or bluish-black spots found elsewhere are easily eradicated by means of the coagulating cautery tip, and all other implants should be so treated, if possible.

This disease is cured spontaneously by the menopause. When menstruation ceases, these tumours are no longer stimulated to activity, and either regress entirely or leave small or large innocuous cysts. Castration of the patient by removal of both ovaries may be justifiably considered in those instances in which—by reason of extensive adhesions, which are characteristic of these tumours—the involved tissue cannot be removed. For instance, the uterus, tubes and both ovaries may be in such an adhered mass that complete removal is impossible, but the removal of all the ovarian tissue on each side might be accomplished. Then the spilling of chocolate-coloured cyst contents would be of no consequence. Further, if the bowel has been obstructed by reason of

* Sampson, Surgery, Gynaecology and Obstetrics. January, 1924, v. 38.

an endometrial tumour, which is apt to cause much more serious damage to the patient than castration, bilateral oophorectomy and colostomy are sufficient.

Any surgeon hesitates to castrate a young woman. I agree with those observers who believe that removal of only the most involved ovary with its chocolate,coloured cyst is justified, hoping that the smaller cyst on the opposite gonad can be safely resected. The uterus is always removed if possible, because (avoiding embryological argument) it is a likely source of future endometrial implants. When, however, the uterus is small, creating no suspicion of containing adenomyoma, its removal depends on symptoms, examination, age of the patient and surgical judgment. I believe it is wise, however, when conservatism of ovarian tissue or uterus has been selected, to notify the family and patient that subsequent developments might require another operation.

Sufficient radiation applied to the ovaries, producing a premature menopause, will have the same effect upon the activity of these tumours as castration; but such treatment can be applied intelligently only after the proper visualization of the disease by operation. If surgery at that time cannot cope with the extent of the disease, radiation therapy is indicated. Fortunately, these tumours are not common; but they are more common than has been suspected, and very important.

CHORIOMA: These are tumours arising from and composed of chorionic epithelium. The first one of this group worthy of consideration is the hydatidiform mole. It is a degenerated lesion of the placenta. It is rather rare, occurring one in about every 1,500 pregnancies. It has the symptoms and signs of pregnancy, and occasionally its complications, such as toxæmia and eclampsia. During this pregnancy, vaginal hæmorrhage begins. If grape-like masses are passed, they are diagnostic. When one examines this bleeding patient, the uterus is found to be larger than the pregnancy time would warrant. The absence of fœtal heart sounds and the failure of an x-ray film to reveal small bones creates suspicion. One would hesitate to interrupt such a gestation unless the bleeding continues. Another test that will be of help prior to curettement is the Ascheim-Zondeck test, which if positive only confirms the pregnancy, but in hydatidiform mole will be positive in more dilute urine. The curettement, if it is a hydatidiform mole, will bring into view the characteristic gross pathology of the disease. If the patient persists to bleed after this procedure, a positive Ascheim-Zondeck test then indicates that portions of the tumour still remain within the uterus, and curettement is again indicated. Hysterectomy may be necessary for continual bleeding or may be chosen as a means of precluding the development of a more serious tumour, namely chorio-epithelioma.

Ewing specifies three types of this tumour, differentiation of which will not be discussed here, because the diagnosis and treatment are the same. These types, however, differ in degree of malignancy. This tumour may begin months after a normal delivery, may follow miscarriage, abortion or ectopic pregnancy. They more commonly occur in the multipara. Rarely the first symptom of the disease is hæmoptysis.

The Ascheim-Zondeck test is very valuable here because, if positive, it means that chorionic epithelium exists. Curettage is helpful if diagnostic tissue is obtained; but such tissue may be missed. Should the curettings be negative, and the Ascheim-Zondeck test persists, a second curettage is indicated. If curettage is still negative and the hormone test positive, a hysterectomy for chorioma is indicated.

CANCER: The most important tumour arising in the uterus is, of course, cancer. Cancer of the cervix is to be considered separately from that of the fundus, because the treatment of one is definite, while that of the other is still being discussed by authorities.

Cervical cancer seems, according to statistics, to arise most commonly from a childbirth wound that nature is attempting to heal. A cervix once split tends to stay open. The gaping lips are held apart by the anatomical arrangement of cervical musculature and fibrous tissue. There are no anatomical structures which tend to pull them together. The healing of such a wound must, then, depend upon epithelium to spread over the raw surface. This epithelium must come either from the mucous membrane of the uterine canal or the squamous covering of the cervical surface. Doubtless, this attempt is more or less continuous, but rarely successful.

Many observers have suspected this repeated effort and failure on the part of the epithelium (associated with chronic irritation ever present) as a cause of cancer. The high percentage of cervical cancer in women who have borne children is confirmatory evidence, inasmuch as practically all of them have cervical tears to a greater or less degree.

The symptoms of endocervicitis may be nil; or there may be increased discharge, or bleeding, or urological symptoms. Most women do not know that they have it. If women could see their cervices they would force the profession to do its duty. It is easily found by examination. If found, it should be corrected either by surgery or by a cautery. I prefer surgery, the Sturmdorf, inasmuch as it gives to the pathologist a larger amount of tissue for examination than does a removal of a small piece. This small piece might be selected from one area and be proven negative, while cancer might exist in another. All cervical tears should be removed in one way or another. However, before doing the Sturmdorf operation, or amputation if selected, the cervix is dilated, and the cervical canal endometrium is removed separately, and then the uterine endometrium is removed. These two specimens are sent to the pathologist, as described earlier in this paper. If they are negative, cervical surgery is undertaken. If the tissue from the cervix, amputation, or Sturmdorf is negative, nothing further need be done. If positive, radium is the method of choice.

Schiller has proposed the application of an "iodine solution"* for that type of cervix that lacks erosion or ulceration and therefore would not be ordinarily biopsied. On such a cervix a spot of leukoplakia will not take the stain as deeply as the normal epithelium. He believes that an early cancer lying under the surface will cause that surface to also fail to take a good stain. Finding these poor or unstained areas, he institutes a biopsy of that tissue, and believes that early cancer is thereby diagnosed. His test is of clinical value because it stimulates the average clinician to search further for cervical lesions than he otherwise would, and in such an exercise he will certainly not overlook the ordinary erosion and ulceration which is visible and so important. Many pathologists disagree with Dr. Schiller in his interpretation of the microscopic evidence of cancer in those cases positive for his test.

For those who are so situated that they have not at hand such expert pathological aid as I have described, it is permissible for them to send the tissue away in one, two or three labelled containers, accompanied by a full history of the case, and await the pathologist's report.

Cancer of the Uterine Fundus: Cancer of the body of the uterus may produce no symptoms until it has reached a large size; or it may produce a water-like discharge or bleeding. If the uterus has become enlarged by reason of it, there may be pressure symptoms—as in fibroid. Physical examination is negative in most instances, the curette being our best diagnostic instrument. Curettage should be very cautiously performed, as it is possible—and has often happened—to pass that instrument through the uterine wall in advanced cases. If these curettings are positive for cancer, the subsequent treatment rests between panhysterectomy, including tubes and ovaries (not

* Schiller's formula: Tincture of iodine, 1; potassium iodide, 2; water Q.S., 300.

the Wertheim) or radiation therapy (meaning radium in the uterine cavity, and applied also to and in the cervix, followed by external deep x-ray therapy).

Statistics seem to indicate that with operable cases either procedure, in good hands, is satisfactory. Poor surgical risks should receive radiation. But if the condition feared is anæmia, transfusion and surgery is better than extensive radiation directed toward a cure. Such patients can't stand that regime. One or two x-ray doses might help to control the bleeding temporarily in preparation for surgery. Those patients evidencing advanced cancer are all treated by radiation.

The good risk apparently has equal chances for a cure in a good clinic regardless of which therapeutic method is chosen. However, outside of such centres there are more surgeons capable of doing a thorough panhysterectomy than there are radiologists equipped with apparatus and experience sufficient to offer curative measures. Furthermore, I believe that, when radiation therapy has been selected in favorable patients, it is wise to later remove the uterus and adnexa. That tissue harboured cancer at one time and might still do so. Why not remove it?

The choice of radium for cervical cancer, and surgery for cancer of the body of the uterus, is based upon two or three important factors. One is that cervical cancer, by reason of the richer lymphatic connections from the cervix to the parametrium, broad ligament, iliac glands, as compared to that of the uterine body, permitting thereby a more rapid and earlier spread of the disease from the cervix than from the fundus, created a different problem for therapeutic attack. Second, the extensive and radical Wertheim operation for cancer of the cervix performed by the best operators produces a mortality of 19%, and a higher morbidity (damage to ureters, bladder and rectum). Third, the five-year cures following such radical procedure are no better than those obtained by the use of properly administered radium; while the radiation treatment has practically no mortality and little morbidity.

Cancerof the fundus, having a less abundant lymphatic field through which to spread, does not require for its removal such an extensive operation. The five-year cure reports obtained by surgery, in cancer of this part of the organ, are apparently just as favorable as those from radiation therapy.

When doing a hysterectomy for any tumour I agree with Sampson that it is wise to avoid grasping the uterus with any sort of a compression clamp for fear that endometrial tissue being capable of producing endometriomata or cellular elements from a chorioepithelioma or cancer be forced out through the tubes to implant themselves for growth elsewhere.

Before the abdomen is closed the surgeon should cut open the uterus for inspection. Important information might be discovered requiring attention at once.

If enlarged lymphatic glands are palpated along the iliac vessels, aorta or within the sigmoid mesentery, these can be thoroughly cooked by puncturing them individually with the cautery tip and turning on the current, theoretically destroying in this manner the more advanced spread of the cancerous disease.

SUMMARY

A complete history and thorough physical examination emphasizing certain areas and organs are expected if the clinician hopes to obtain a thorough picture of the problems offered by each new patient.

Inasmuch as cancer is the most feared disease likely to involve the uterus, its possible presence must be constantly kept in mind. Eradication of its forebears is essential, such as cervical or uterine polyp and endocervicitis.

For uterine fibroid, supravaginal hysterectomy is selected after the cancer potentialities of the cervix have been eliminated. Panhysterectomy is chosen if the same objective can be obtained easier. Blood transfusion is advisable for the woman poor in blood. Radiation therapy is indicated only for those who, not because of anæmia, are poor surgical risks.

If the patient is pregnant and shows alterations from normal progress, many complications can be thought of, but amongst those must be remembered hydatidiform mole. Following the delivery or the removal of the products of conception, subsequent symptoms should cause the clinician to remember that there had been a recent pregnancy, and amongst the other diseases suggested he must not forget chorioepithelioma and the value of an Ascheim-Zondeck test.

When the abdomen is open, thorough search for pathology throughout its contents, which is undertaken by every surgeon, should include a recognition of the importance of chocolate-coloured cysts on the uterus, ovaries, broad ligament, mesentery, intestines, even though some may be minute. These are endometriomata, prone to grow with each menstrual effort, may cause serious complications, but are futile after the menopause—artificial or natural.

Cancer of the cervix should be entirely separated by biopsy and curettage of the cervical canal from suspicious tissue of the uterine fundus, because the treatment of these two portions of that organ is different.

BRITISH COLUMBIA MEDICAL ASSOCIATION FORTY-FIFTH ANNUAL MEETING

September 13, 14 and 15, 1937

The programme of the Forty-fifth Annual Meeting of the British Columbia Medical Association is published in this issue of the BULLETIN of the Vancouver Medical Association. The generous acceptance of the material is acknowledged with thanks.

The sessions will open on September 13th with addresses of welcome by the Mayor of Vancouver and the President of the Vancouver Medical Association, Vancouver being the host city. The lecture programme will commence each morning at 9 o'clock, morning sessions being devoted to lectures, with a diversion on Tuesday at 10:30 a.m. when the Round Table Discussions will be held. These Round Table discussions are a new feature at our meetings and will be held in four separate rooms, four subjects being covered, *i.e.*, Anæmia, Fractures, Infant Feeding and Gynæcological Endocrinology. It is proposed that these be opened by three or four brief introductory talks and that the remainder of the hour be left open for questions and discussion. Such meetings have an immense practical value, this method of study providing for the elimination of many details, the elaboration of some practical points, the elucidation of the obscure, and the introduction of the new.

Whenever one speaks of the Annual Meeting Dr. J. P. Bilodeau pops up with his "Golf Announcements," and let us silence him by emphasizing the fact that the British Columbia Medical Association will this year, "thanks to Joe," play off on the "new" Capilano Golf Course just completed on the British Properties at Hollyburn, at West Vancouver. Thanks to Dr. Bilodeau, we are to play on this new course, which is reputed to be the last word in smoothness and will help to reduce the handicaps. Let us not hope that this will prove to be the *raison d'etre* for attendance at the Annual Meetings. Come to the meetings and plan to play golf.

In addition to the Round Table discussions, the newer features include a motion picture showing the Heart in ordered and disordered action. Dr. Vrooman, who saw these films in the East, tells us they are worth seeing several times. They will be screened on every possible occasion. It may require two viewings to see it all.

Then there is the programme developed by Dr. Frank A. Turnbull whereby demonstrations of Newer Technique will be held in the Vancouver General Hospital on Monday at 3:00 p.m. Six demonstrations will be featured. (See announcement elsewhere in this issue.) Transportation for this trip to

the hospital and for the golf will be provided by Dr. L. W. McNutt and his Committee on Transportation.

Public Health will be paraded in a pageant of ten brief papers on Monday evening at 8 o'clock. (See announcement elsewhere in this issue.) These will be presented by members of the Association who work in this field. Many phases of the various ramifications of Public Health work will be covered in 7½-minute papers, and time will be allowed for discussion, questions and reply. This meeting should attract a crowded house. Every opportunity will be provided for questions and discussion and it is hoped that much misunderstanding will be cleared up, and a better and more sympathetic understanding developed, and that the result will be beneficial to this important department of medicine. It is to be hoped that co-operation by the man in practice will be secured as the just dessert of the Public Health programme in this Province.

The Conference on Contract Practice on Tuesday at 1:30 p.m. will attract a large group, and its programme, with three feature speakers representing the Industrial, Mining and Logging operations, will allow ample time for questions and discussion. (See announcement elsewhere in this issue.)

The Conference for Coroners (see announcement elsewhere) is another of the newer features of the Annual Meeting and will introduce Dr. Osborne Morris of Vernon as Chairman. Dr. J. D. Whitbread, in the exordial paper, Dr. A. W. Hunter and Dr. H. H. Pitts, of Vancouver, will discuss Observations and Examinations, and Inspector J. F. C. B. Vance, of the Criminal Investigation Department of Vancouver, will deal with Crime Detection in the Laboratory.

The Annual Meetings of the College of Physicians and Surgeons of British Columbia and the British Columbia Medical Association will be held on Tuesday evening, the latter commencing at 8 p.m. and the former at 9 p.m. This announcement seems confused, but what does it matter, in that you will attend both meetings! Dr. Routley will have something to tell us at the 9 o'clock meeting, and other important announcements wlil be made at that session. These Annual Meetings are important and space will be provided for a large number of members.

The lecture programme is inviting and has been developed by the Committee under chairmanship of Dr. Colin Graham with a view to being practicable.

Dr. Bilodeau thinks that all this will lead up gracefully to relaxation on the "New Golf Course at the British Properties," on the North Shore. Be that as it may, "dinna forget" that the 19th hole will precede the Annual Dinner of the Association at 7 p.m. Wednesday, September 15th.

The Annual Dinner will be informal and will be largely attended. The British Columbia Medical Association will have as its guest speaker the Honourable Mr. Gordon S. Wismer, Attorney-General of the Province of British Columbia. This should assure the attendance.

Dr. Bilodeau insists on appearing at the Dinner with an armful of prizes for golf. He reports a large list of prize-winners and prizes. We agree that Joe has reason to be proud of his past record, and of his achievement on this occasion in providing for play on this Wonder Course on the new British Properties at West Vancouver.

Dr. G. F. Strong, the President of the British Columbia Medical Association, joins Dr. S. Cameron MacEwen, the President of the College of Physicians and Surgeons of British Columbia, in an invitation to each member of the College and of the Provincial Association to attend the Annual Meetings.

The Ladies' programme is in the capable hands of a ladies' committee, under the convenorship of Mrs. Strong, wife of the President of the British Columbia Medical Association. (See announcement elsewhere.)

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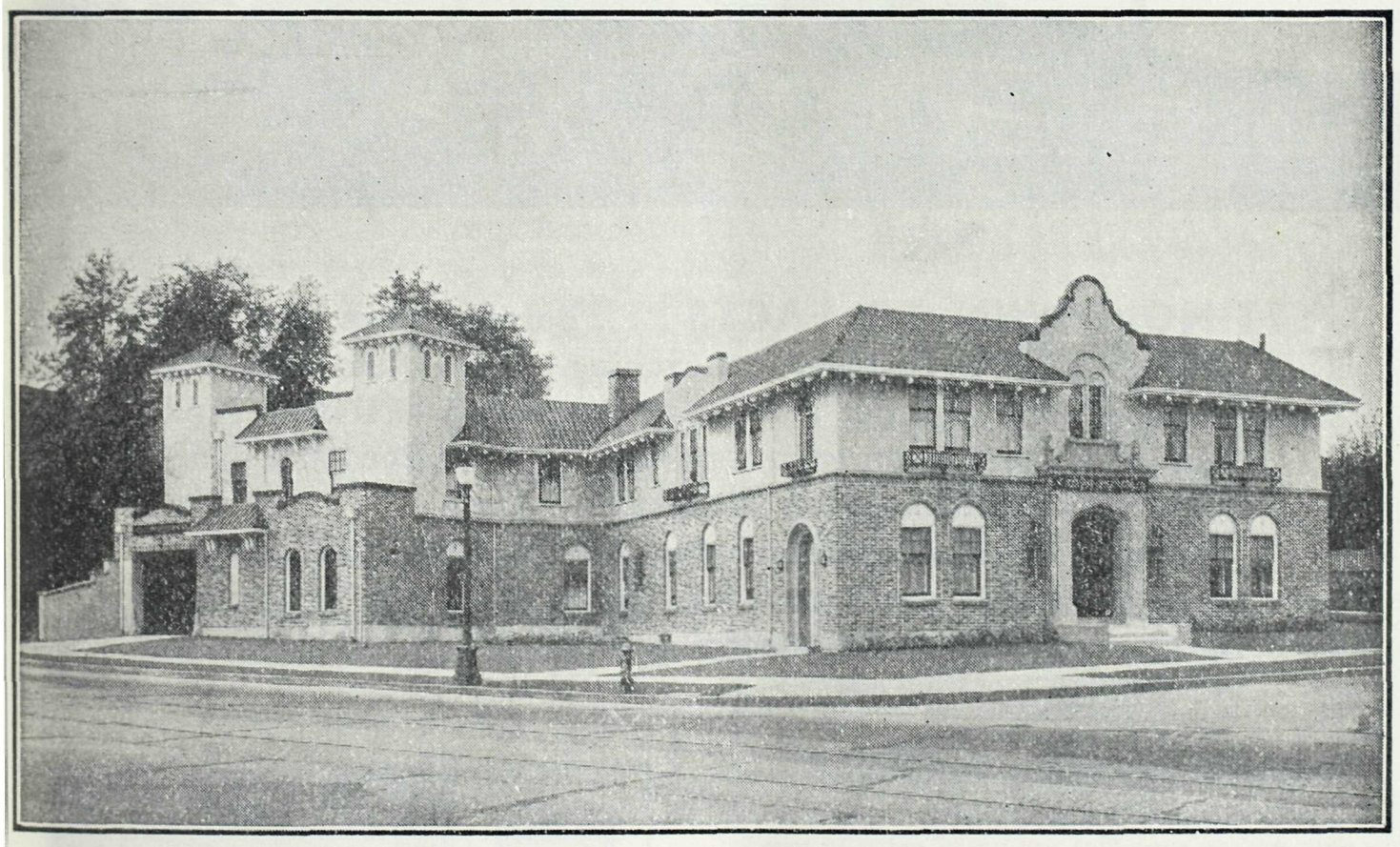

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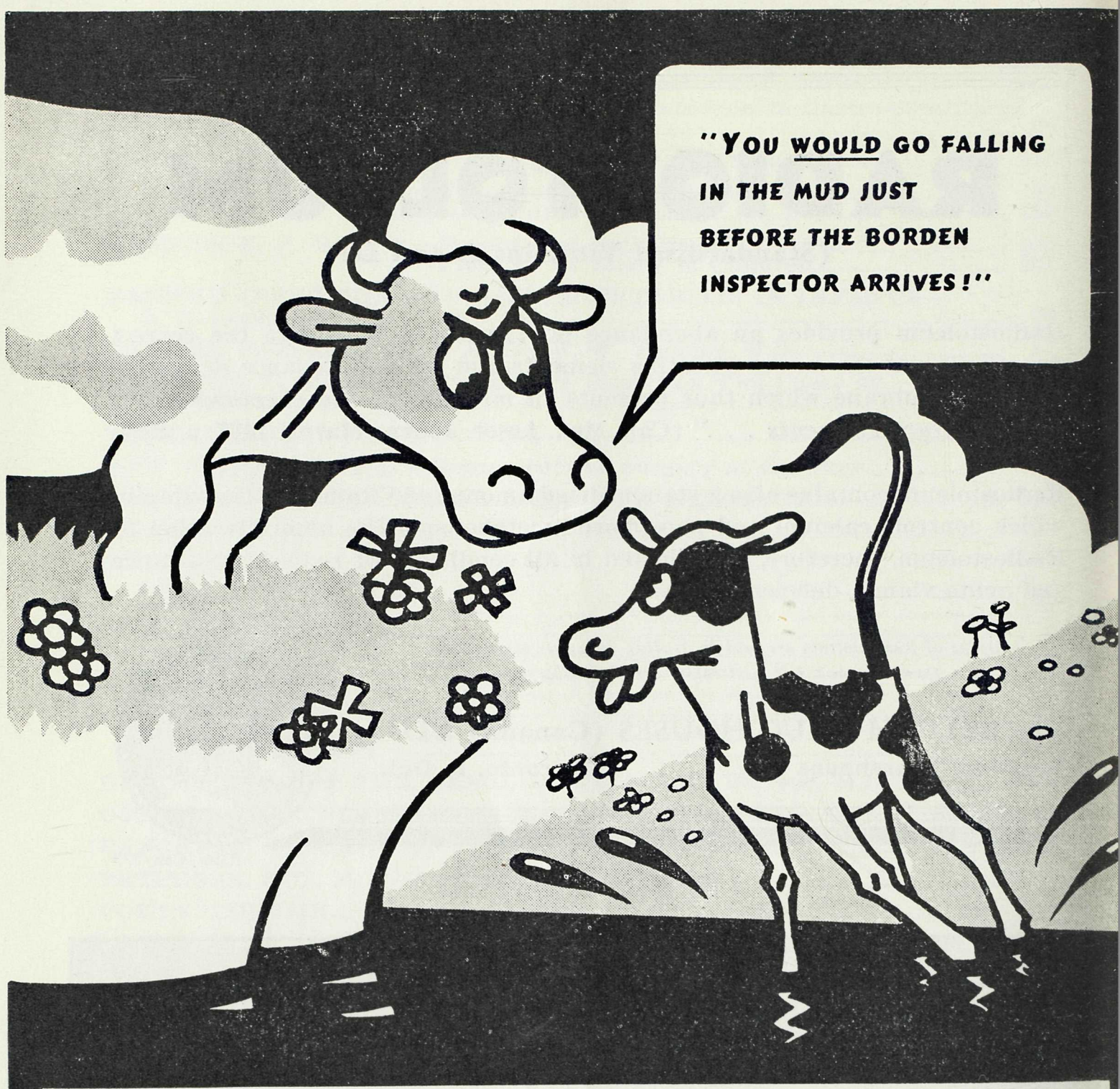

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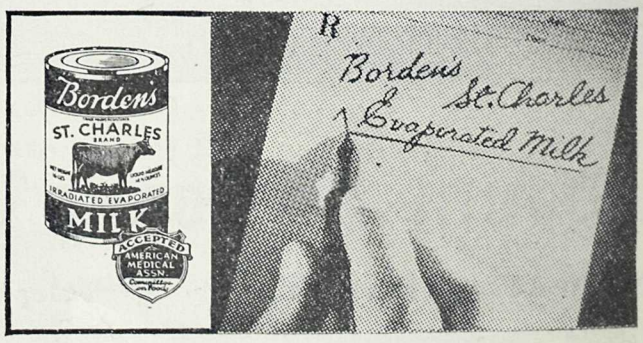

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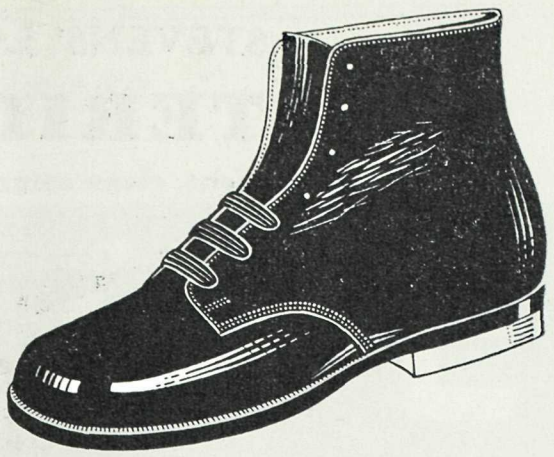

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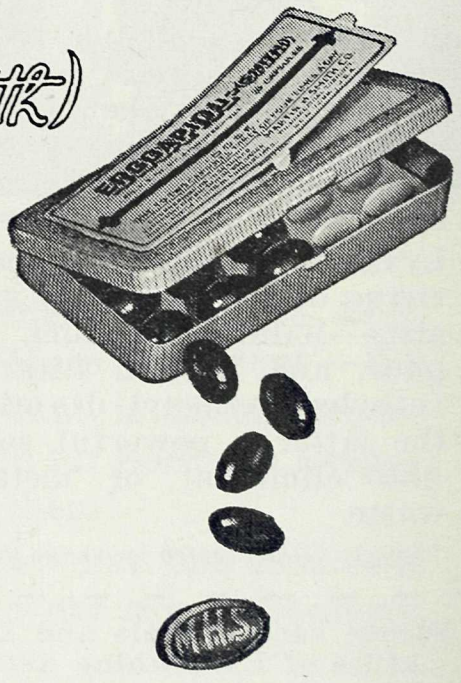

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Chemotherapy of Streptococcal Infections

Clinical data to date has established the efficacy of Septazine

administered orally

in erysipelas, puerperal sepsis, phlebitis, scarlet or rheumatic fever, otitic and pharyngeal conditions, etc. SEPTAZINE tablets are absolutely tasteless and always well tolerated in therapeutic doses by the digestive tract.

Supplied in tubes of 20 tablets, each gr. 7½

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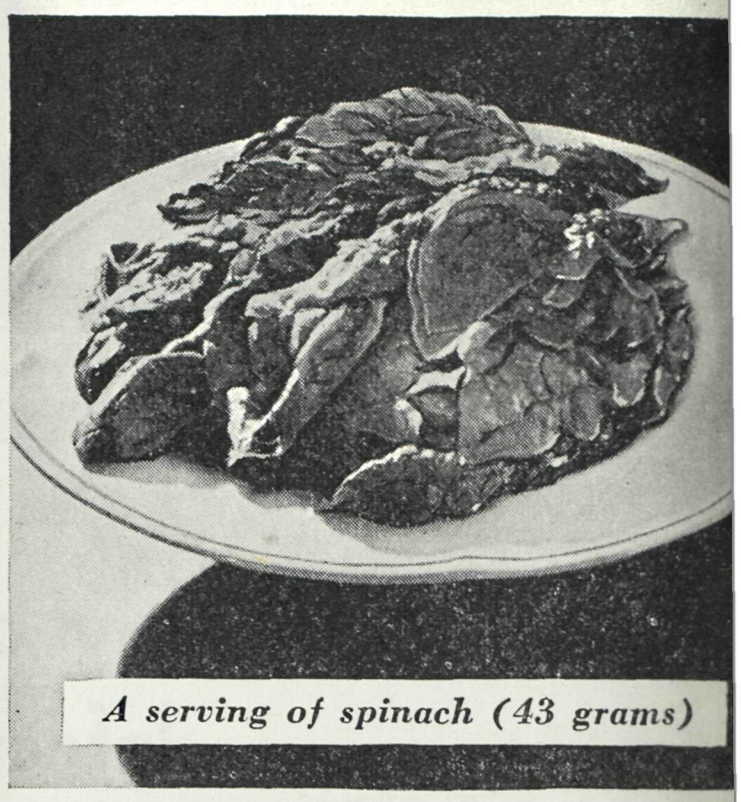
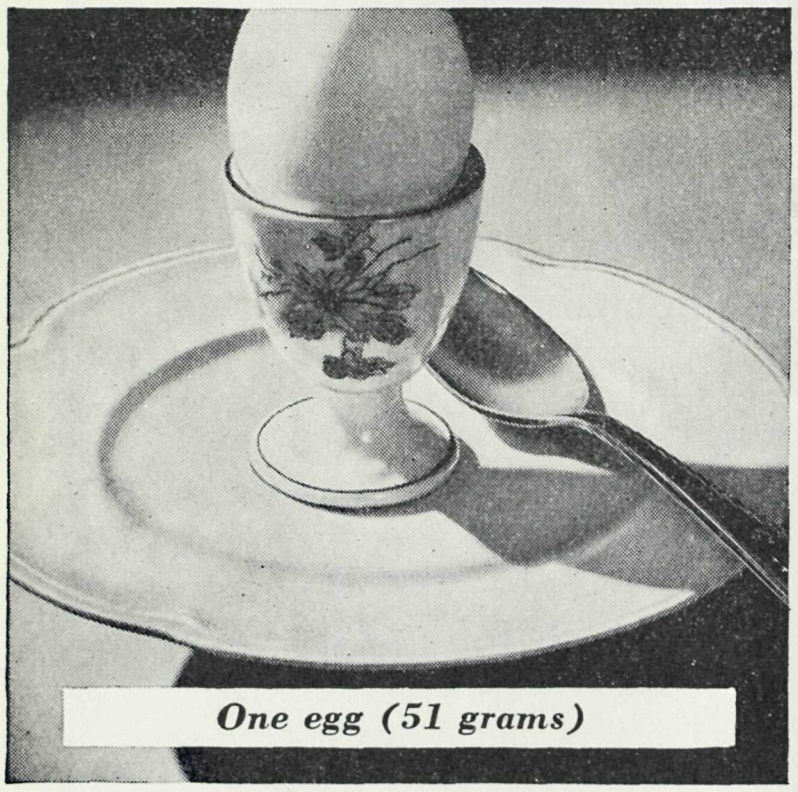
Kellogg's ALL-BRAN furnishes iron for the blood

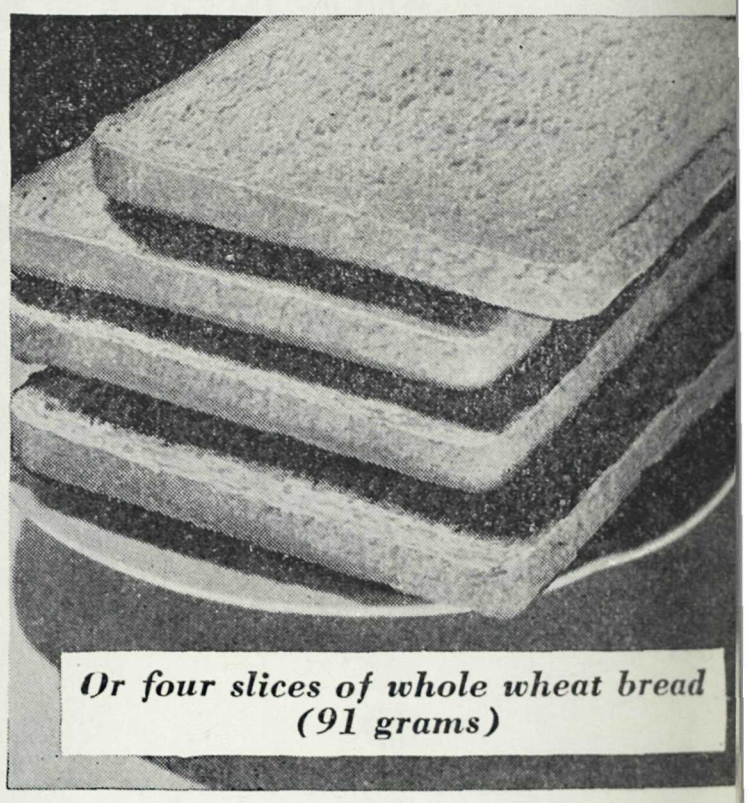
Two tablespoonfuls (14 grams) contain about as much iron as is found in the following common foods:



A serving of spinach (43 grams)



One egg (51 grams)



Or four slices of whole wheat bread (91 grams)

IRON is one of the important elements of the blood. Laboratory analyses show that Kellogg's ALL-BRAN is an excellent source of iron, in easily available form. It contributes a substantial amount of the iron needed daily.

This laxative cereal also furnishes vitamin B, which helps to maintain the muscular tone of the intestine And ALL-BRAN also supplies gene ous "bulk." Within the body, AL BRAN absorbs twice its weight i water, and cleanses the system.

ALL-BRAN may be served as cereal with milk or fruits, or cooke into recipes. Sold by all grocer Made by Kellogg in London, Ontari

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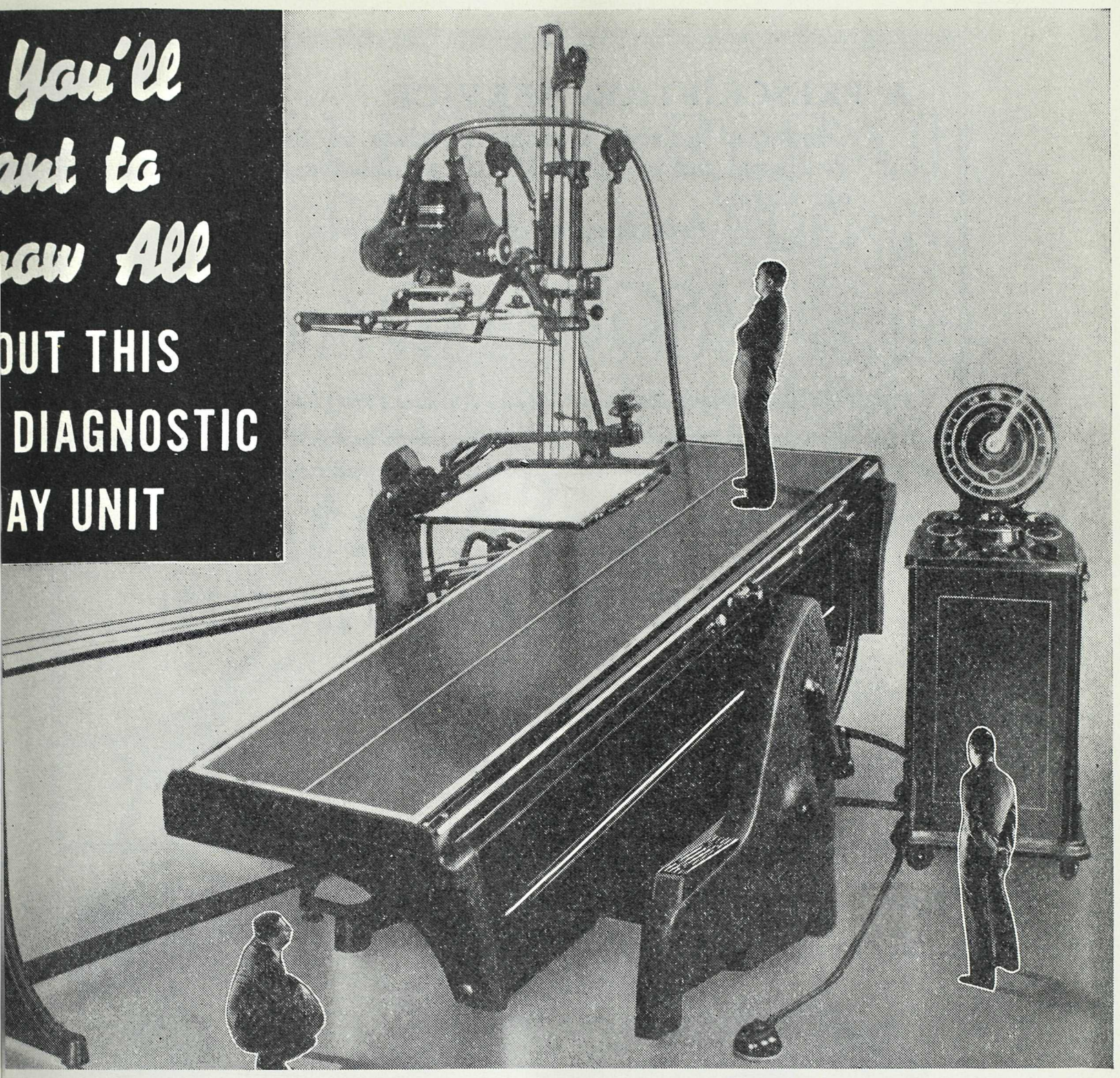

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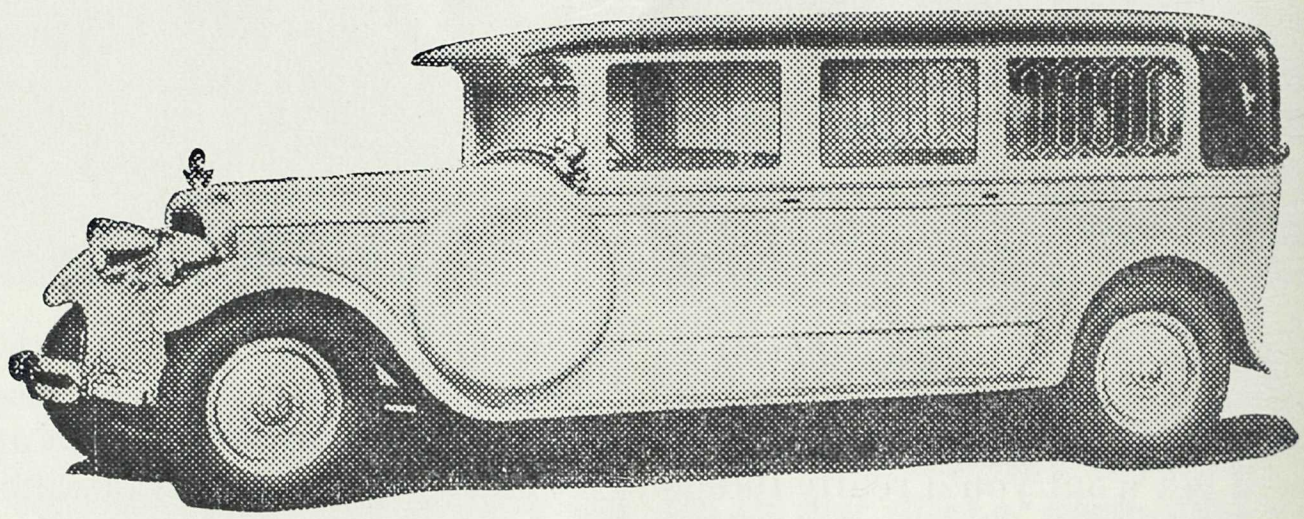

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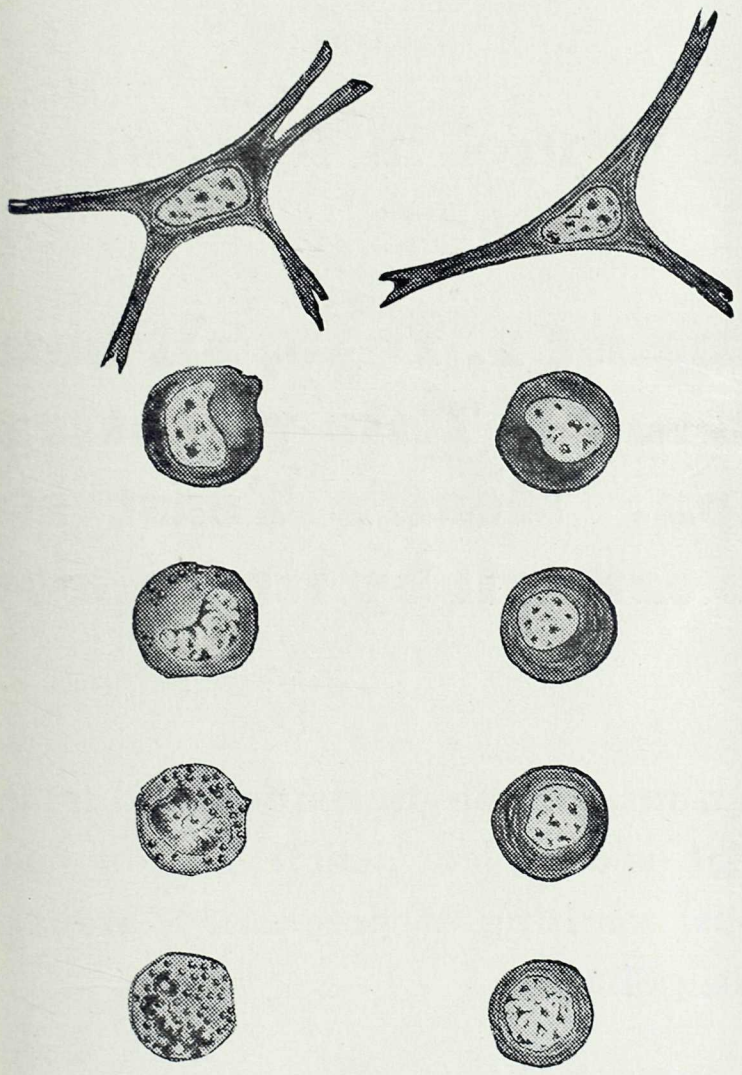

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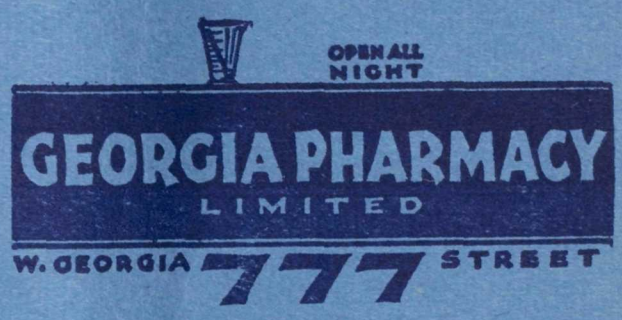

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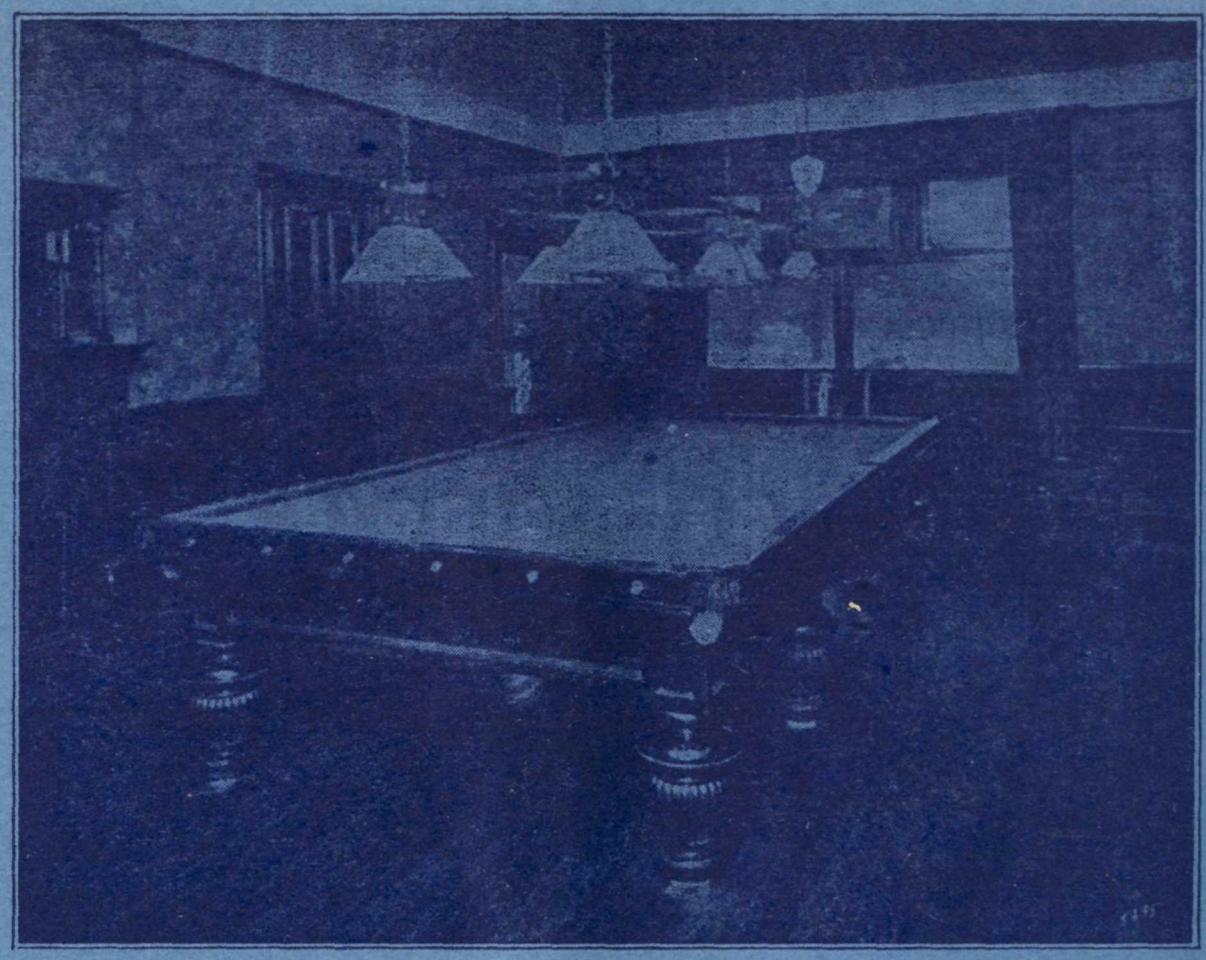

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