THE BULLETIN

OF

The Vancouver Medical Association

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VOLUME XXIX. JULY, 1953 NUMBER 10

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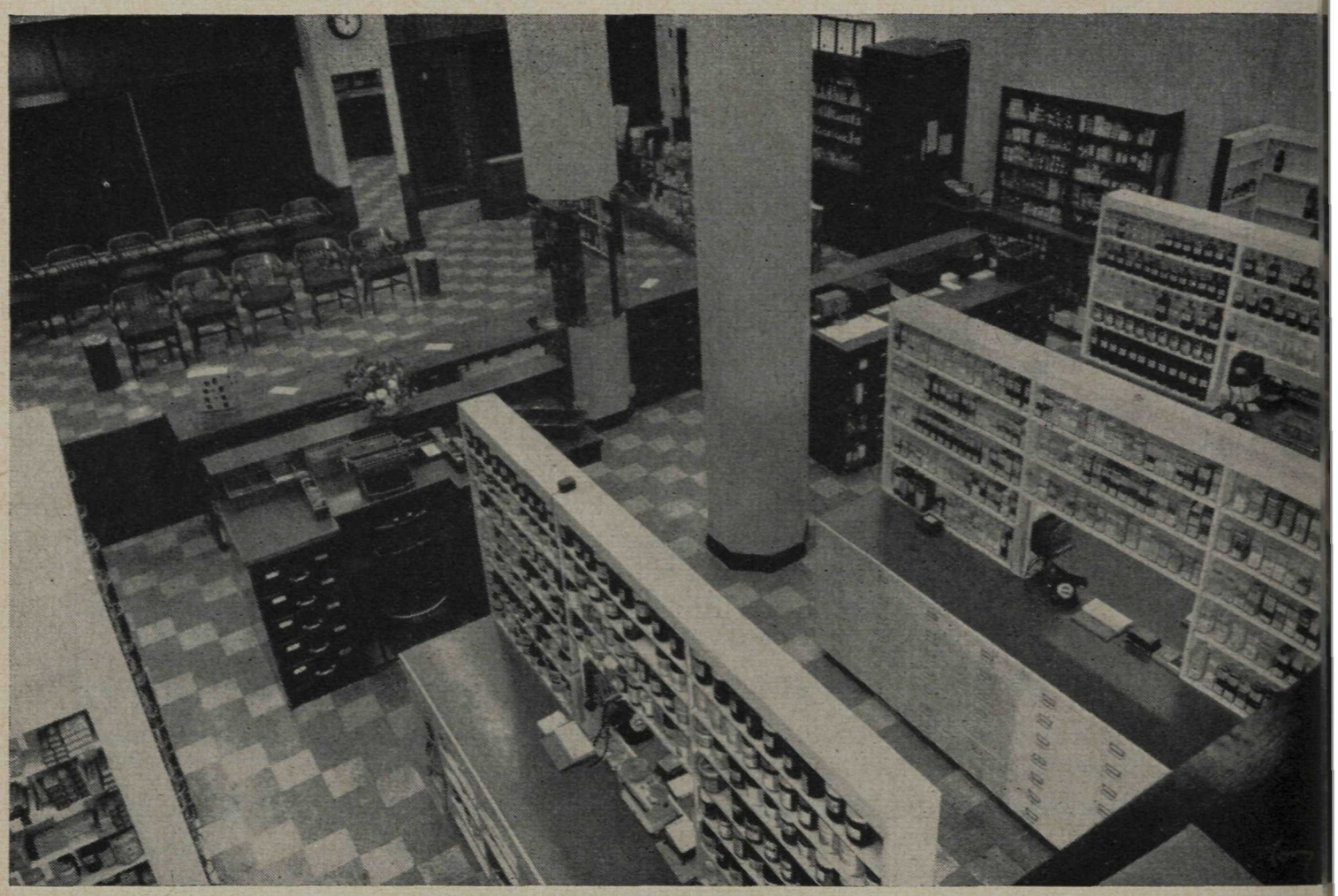

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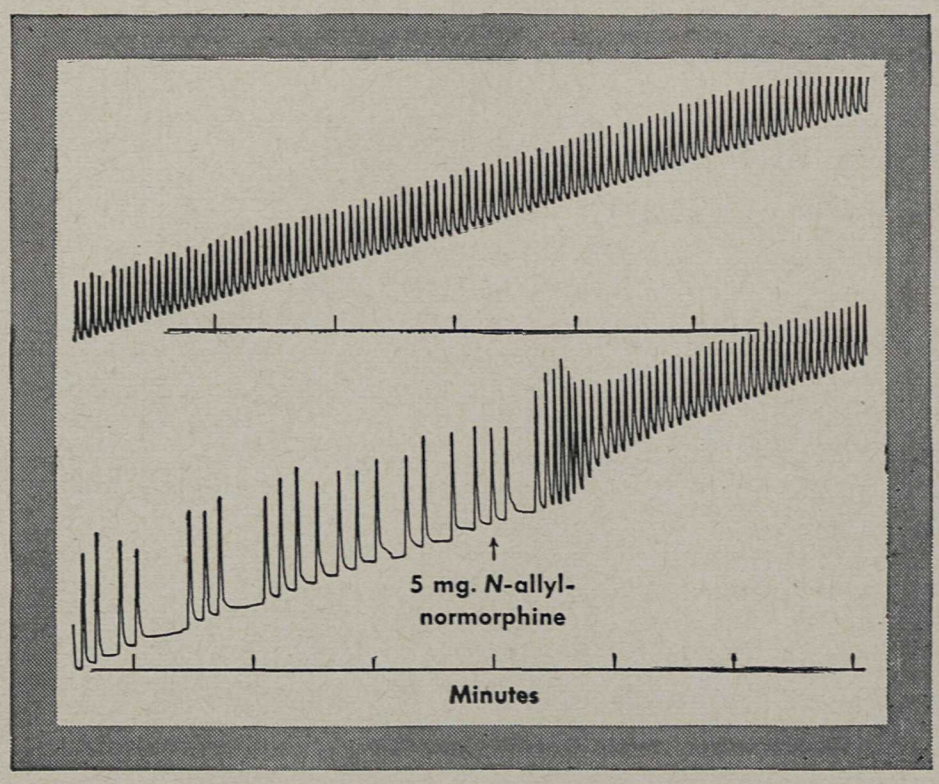

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Literature available

[1]Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Scs.* 223:191, February 1952. [2]Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

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Monday, 8:00 a.m.—Orthopaedic Clinic.
Monday, 12:15 p.m.—Surgical Clinic.
Tuesday—9:00 a.m.—Obstetrics and Gynaecology Conference.
Wednesday, 9:00 a.m.—Clinicopathological Conference.
Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.
Friday, 9:00 a.m.—Paediatric Clinic.
Saturday, 9:00 a.m.—Neurosurgery Clinic.

ST. PAUL'S HOSPITAL

Regular Weekly Fixtures

2nd Monday of each month—2 p.m.	Tumour Clinic
Tuesday—9-10 a.m.	Paediatric Conference
Wednesday—9-10 a.m.	Medical Clinic
Wednesday—11-12 a.m.	Obstetrics and Gynaecology Clinic
Alternate Wednesdays—12 noon	Orthopaedic Clinic
Alernate Thursdays—11 a.m.	Pathological Conference (Specimens and Discussion)
Friday—8 a.m.	Clinico-Pathological Conference (Alternating with Surgery)
Alternate Fridays—8 a.m.	Surgical Conference
Friday—9 a.m.	Dr. Appleby's Surgery Clinic
Friday—11 a.m.	Interesting Films Shown in X-ray Department

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Regular Weekly Fixtures

Tuesday, 8:30 a.m.—Dermatology.
Wednesday, 10:45 a.m.—General Medicine.
Wednesday, 12:30 p.m.—Pathology.
Monday, 11:00 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

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11:45-12:45 p.m.	Therapy Conference
Every Tuesday—11:00 a.m.-12:00 p.m.	Clinical Meeting
12:00 noon-1:00 p.m.	Therapy Conference
Every Wednesday—11:45 a.m.-12:45 p.m.	Therapy Conference
Every Thursday—11:45 a.m.-12:45 p.m.	Therapy Conference
Every Friday—9:00 a.m.-10:00 a.m.	Lymphoma Clinic
(during February)	
10:15 a.m.-11:15 a.m. (as of March 6)	Lymphoma Clinic
11:45 a.m.-12:45 p.m.	Therapy Conference

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—APRIL, 1953

Total population (estimated) 390,325

	April, 1953	
	Number	Rate per 1000 pop.
Total deaths (by occurrence)	450	13.8
Deaths, residents only	419	12.9

Birth Registrations—residents and non-residents
(includes late registrations)

	April, 1953	
Male	501	
Female	479	
	980	30.1

Infant Mortality—residents only

Deaths under 1 year of age	32
Death rate per 1000 live births	43.9
Stillbirths (not included in above item)	6

CASES OF COMMUNICABLE DISEASES REPORTED IN CITY

	April, 1952		April, 1953	
	Cases	Deaths	Cases	Deaths
Chicken Pox	97	—	135	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Dysentery	9	—	—	—
Dysentery Carriers	—	—	—	—
Erysipelas	1	—	2	—
Gonorrhoea	109	—	134	—
Infectious Jaundice	15	—	—	—
Measles	127	—	178	—
Meningitis (meningococcic)	1	—	—	—
Mumps	294	—	123	—
Poliomyelitis	2	—	—	—
Rubella	11	—	10	—
Salmonellosis	1	—	2	—
Salmonellosis Carriers	—	—	—	—
Scarlet Fever	37	—	115	—
Syphilis	10	1	11	1
Tetanus	—	—	—	—
Tuberculosis	38	7	46	11
Typhoid Fever	—	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Whooping Cough	11	—	—	—
OTHER REPORTABLE DISEASES				
Cancer	61	62	80	52

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MEDICAL-DENTAL BUILDING, VANCOUVER, B.C.

The Editor's Page

The forthcoming annual meeting of the B. C. Division of the Canadian Medical Association bids fair to be a memorable one. We are publishing the programme in this issue. A great deal of work is being done on it and from the announcements to date, it is going to be very well worth attending—in fact, nobody should miss it.

A great deal of interest, and also a great deal of discussion has been aroused by the latest effort of the Public Relations Committee of the Division. We refer, of course, to the public forums that were held at the Georgia Street Auditorium lately, with the co-operation of the Vancouver Daily Province, which paid all the expenses of the undertaking, and through whose publicity efforts a great deal of public interest was awakened.

We are not at all sure that the Province did not have the easiest part of the task. The amount of work done by those medical men who participated was enormous—their sacrifice of time and effort was very great.

Opinions differ a great deal about this project, running all the way from enthusiastic praise to an attitude of complete hostility. Personally, we have been tremendously interested in the undertaking, and feel like congratulating its sponsors rather cordially. It is, of course, a rather radical departure from our normal behaviour as a profession but that does not necessarily condemn it. It is the first time, we believe, that anything of the kind has been undertaken—and it is perhaps still in the experimental stage, and a matter to some extent of trial and error. To judge by some of the remarks and criticisms heard, some men feel that it is *infra dig*: others that it is a waste of time and effort. Some feel that there was rather too much publicity given.

And there is the occasional lay critic who thinks it was a stunt on the part of the profession—one kindly correspondent even suggests that it was just a commercial stunt to secure patients. One mentions this only to say that such a suggestion is beneath contempt.

But certain things stand out, which we think merit our consideration and justify further effort along these or similar lines—perhaps with some modification where experience shows this to be wise.

In the first place, it was an honest effort to educate and help the public. The tone of both meetings was optimism and reassurance and from our reading of the talks given, we should say that every attempt was made to allay unnecessary fear, and to introduce a note of common sense and helpfulness.

In the second place, it certainly aroused public interest. The public evidently wants to know facts and the truth, given in language that they can understand, and the hundreds of questions sent in show that they do want to know these things. The audiences were friendly and eager to learn.

Again, the complete coverage given by the other Vancouver newspapers, the Sun and the News-Herald, who had themselves nothing to gain by such coverage, shows what great news value such forums have, and how eager the papers are to co-operate with us in such efforts.

We are told that further forums are contemplated, and it will be very interesting to watch further developments. It took considerable courage on the part of those who organized this project, to undertake a scheme so different and so full of possible difficulties. It also took, as we have said, a very great deal of hard work, and we do not imagine that those who represented us enjoyed the limelight at all—that was merely an additional burden. Whatever the outcome, and we believe it will be nothing but good, they deserve a great deal of credit for their effort.

Nineteen hundred and fifty-four will be a very important year for British Columbia, since the Annual Meeting of the Canadian Medical Association is to be held in Vancouver next June. Canada is a large country, and it takes a long time to cover it all, but next year is our turn.

A very good beginning has already been made—in the selection of the new President, in the person of Dr. G. F. Strong. This appointment could not, we think, have been bettered—and we have heard nothing but the most cordial agreement with this view. The choice of any man as President of the C. M. A. is a signal honour—the highest honour the profession can bestow and nobody has deserved it more thoroughly than has Dr. Strong, whose record of achievement in British Columbia is a long and very full one and constitutes a great contribution to the public good.

It is perhaps hardly necessary to recapitulate all the things that Dr. Strong has done in this province—but it is a pleasure that we hate to deny ourselves. For many years, he has been a leader and a source of constructive achievement. He has filled the Presidencies of the B.C. and Vancouver Medical Associations, he has been President of the Community Chest of Vancouver, of the Greater Vancouver Health League—he organized the B. C. Medical Research Council, now actively at work at the Vancouver General Hospital and the Rehabilitation Centre for Paralytics and Spastic Diseases owes its existence mainly to his energy and organizing ability.

His work at the B. C. Cancer Institute has been outstanding. He has been Chairman of the Medical Staff at the Vancouver General Hospital and his work as an internist and particularly as a cardiologist is too well known to need comment. He is on the teaching staff of the University—in the Medical Faculty. One wonders often how one man can do all these things, and in the doing display such energy and strong leadership.

And so while we congratulate Dr. Strong on his appointment, we feel that we, as a Canadian profession, are also to be congratulated on having him as our President for the coming year.

Other B. C. men, too, have been chosen to head various Sections and Societies for the coming year. In Dermatology, for instance, Dr. D. E. H. Cleveland of Vancouver has been elected President of the Canadian Dermatological Association, which will also meet here in June 1954. With him will be associated Dr. D. H. Williams, as Vice-President and Dr. Ben Kanee as Secretary, both of Vancouver.

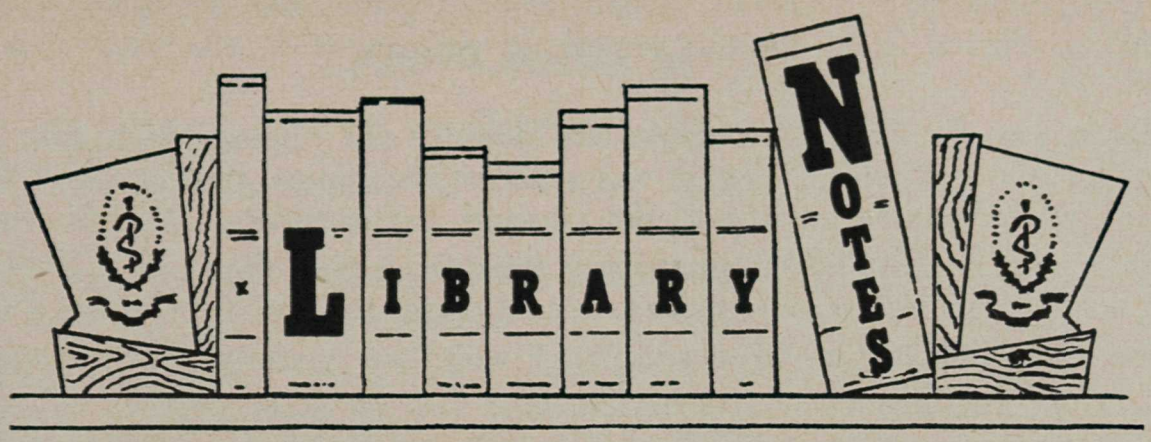
Dr. H. Fidler has been named President of the Pathologists Section of the C. M. A.

Dr. J. E. Harrison will head the North Pacific Obstetrical and Gynaecological Association which will hold its Annual Meeting here at the same time as the C. M. A.

Altogether, Vancouver will have plenty to offer next year to the Canadian medical profession, many of whom, with their wives and ladies will be our guests. It will be our duty, and a most delightful duty, to turn in and do all we can to make the 1954 Annual Meeting of the Canadian Medical Association the best meeting it has ever held.

OFFICE SPACE

Doctor returning to Vancouver to open limited practice in one of the Surgical Specialties desires to share office space with another doctor in the West Broadway Granville district. Practice is entirely a hospital one so that office requirements are minimal. Replies treated confidentially and adequate references can be provided. Forward replies care of Publisher, 675 Davie Street, Vancouver 2, B.C.



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Recent Accessions:

The Surgical Clinics of North America, June, 1953. Lahey Clinic.
Collected Papers of the Mayo Clinic and the Mayo Foundation, 1952.

Transactions of the South Eastern Section of the American Urological Association. Florida. April, 1952.

The Surgery of Infancy and Childhood, by Ladd & Gross. 1st ed. 1953.

A Textbook of X-Ray Diagnosis by British Authors: edited by S. Cochrane Shanks and Peter Kerley. 4 vols., 1952.

Influenza and Other Virus Infections of the Respiratory Tract, by C. H. Stewart-Harris. 1952.

Diseases of Children, by Garrod, Batten and Thursfield. 5th ed., 1953.

Blood Transfusion in Clinical Medicine, by P. L. Mollison. 1952.

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BOOK REVIEW

GUY'S HOSPITAL — 1725-1948

Every Canadian doctor should know something of the great teaching hospitals of Great Britain.

A glimpse is given of one of the really great hospitals of London in a short volume of 176 pages—"Guy's Hospital 1725-1948."

This handsome book is copiously illustrated and is printed in large type and has recently been added to our library through the Historical and Scientific Fund.

This record brings one into the atmosphere of some of the greatest minds of medicine of the mid-nineteenth century and gives one a feeling not only of humbleness but of great pride in belonging to a profession with such leadership and such traditions.

Richard Bright, who established the knowledge of kidney disease; Addison, who was the first to describe pernicious anaemia, and the disease of the supra-renal gland which is known as Addison's disease, were two physicians of Guy's Hospital who,

through great industry, careful observation, and the genius for correlating their facts, have added in crystal clear English something permanent to the very structure of medicine.

Hodgkin was the first to recognize and describe the disease which still bears his name. Strange as it may seem, Hodgkin was never on the clinical staff of Guy's Hospital, but in 1825 was appointed curator of the museum and lecturer of Morbid Anatomy.

There were also great leaders in surgery from its earliest days onwards, Sir Astley Cooper, Cline, Hilton and in more recent times Arbuthnot Lane, to mention a few.

Hilton wrote that classic, "Rest and Pain," which every student of medicine should read.

The all inclusive nature of this history is indicated by the special chapters dealing with the founding and development of both the dental school and of the training school for nurses. In 1855 "Guy's Hospital Reports" mention Thomas Bell, F.R.C.S., as giving a course of lectures on Dental Surgery. Bell was a man of great learning, for he was a fellow of the Royal Society and was appointed Professor of Zoology at Kings College, London.

The unfailing vigor and industry of Guy's men could not be better shown than by the two publications connected with the hospital—Guy's Hospital Reports, a quarterly which was started in 1836, and Guy's Hospital Gazette, which began in 1873. Both are still flourishing.

Guy's Hospital suffered severe damage during the last war as the enemy dropped 135 bombs of one kind or another on its premises.

The present historical volume of Guy's Hospital has been the work of the Guy's Hospital Gazette Committee with Hujohn Ripman the editor.

This is an excellent book for any doctor's spare time reading.

—William D. Keith.

DOCTOR G.L.H.—IN MEMORY—

He was too young, as we count passing years,
Though all were filled with others' pain and care,
He was well loved, which makes the worth of life—
He still is being kind—somehow, somewhere!

Sometimes he had to break his tragic news,
Even then, with sorrowing smile, his face would light—
One felt he sorrowed as one did oneself—
And that he'd bear it for one, an he might!

And so good-bye, dear friend of many years.
God rest your kindly soul, in His own peace,
There's many a lonely soul will miss you hear—
Yet thank Him for your swift and glad release!

A.H.K.

We take pleasure in printing this tribute to our late colleague, Dr. G. L. Hodgins, who died recently. The author, Mrs. Robert Kidd, is the sister of Miss Firmin, whom most of us will remember as our valued Librarian for so many years at the Vancouver Medical Association Library.

Chairman's Address at the June, 1953, Meeting of Trans-Canada Medical Plans

Winnipeg, Manitoba.

CHAIRMAN: E. C. McCoy, M.D., VANCOUVER, B.C.

MEMBERS OF THE COMMISSION, ADMINISTRATORS AND GUESTS:

It is a pleasure to welcome you to this, the 6th meeting of T.C.M.P. Commission. It is an even greater pleasure to welcome you to this meeting in Manitoba—which really is an ideal meeting place for any organization that is Canada-wide—because Manitoba is both east and west. We in the west consider Manitoba part of the east—most easterners consider Manitoba part of the west. It is thus in a very happy position to help weld east and west together, and I believe it was very fortunate that the first chairman of the commission was Manitoba's representative, Dr. Pat McNulty, who very ably guided us through the first year of organization. It is thus most appropriate that our meeting should be held here and we hope that it will be a fruitful one.

We have now come to the end of the second year since the formation of T.C.M.P. They have been two years of planning and organizing—and meetings for exchange of ideas. Two years ago we decided that we needed T.C.M.P. but hadn't too much idea of exactly what it would do—or what shape it would take. We knew only that it would help provide prepaid medical care for the people of Canada on a voluntary basis. At that time only six provinces were represented with seven plans participating. Now seven provinces are represented with nine plans participating and applications pending which will cover two more provinces—so there is a good possibility that by the end of this meeting we shall have nine provinces represented in T.C.M.P.

Also we are now ready to move from the planning stage of T.C.M.P. into the actual operational stage. Within the next month we will be establishing a head office in Toronto —and we will also have a full-time executive director. Up until now he has been on a part-time basis only.

We know now the shape T.C.M.P. will take—at least at the start. The head office and executive director will function as a co-ordinator between the various plans. Actual coverage of patients will remain on a local or provincial level with T.C.M.P. acting as a co-ordinator—in handling national accounts—and in collection and presenting statistics —and in gradually encouraging development of a more uniform type of coverage across Canada.

In selling any product or arranging for the provision of any service, you need three basic things:

(1) A demand for the product.

(2) A method of handling the product—that is to arrange for production and payment.

(3) A method of producing the product, or in the case of a service you need someone to produce the service.

In looking at the problem of T.C.M.P. and provision of prepaid medical care, I'm sure that we are now at the stage where the demand for the service is already there. We don't have to sell the service—the people want it and are demanding it.

In looking at the second point, our voluntary non-profit prepaid care plans as under T.C.M.P. certainly give us what we believe to be the best method of handling the service.

The third point is the one I wish to emphasize—that is someone to produce the service. Certainly as an organization, the Canadian Medical Association is behind these plans 100%. However, it is just as certain that all doctors are not behind them 100%, and I believe that is a point we must consider very seriously.

If a doctor is going to produce a service that is good and efficient he must like the service and to do that he must have good working conditions—he must be adequately remunerated and he must not have to spend too much time with red tape, etc.

We have to spend some effort at convincing doctors that this system of providing medical care is best for them—as well as for the patients. There may be some parts of the work they may not like—certain rulings and red tape may annoy them—but they must realize that the overall system is good. We should work very closely with C.M.A. in some good public relations with the doctors of Canada in this respect. We believe it is the plan's responsibility to acquaint the doctors with the details of coverage and terms of service of the individual plans—but it certainly should be the profession's job to acquaint the doctors with a proper understanding of what are the best basic principles of prepaid medical care and why voluntary non-profit prepaid medical care is better from both doctor and patient's point of view.

We can set up the best prepaid care plan in existence—but if the doctors providing the service are not convinced of its merits they will not be behind it, and if they are not behind it the plan cannot succeed.

The plan also must learn how to control its abuses and occasional dishonesty—by either patient or doctor—and it must do this in a firm and definite manner—and yet not in a way that makes a rule which penalizes all the honest participants. I believe there is considerable work that needs to be done to persuade or demonstrate to doctors that this is the best way to provide prepaid medical care—that is that it will provide more and better medical coverage—at a lessor cost—and with better working conditions than any other system will. If we believe this then we should all be behind this. If we don't believe it then we should be backing some other plan which we believe would be better. I believe that most of the objections that we do hear are from people who are being destructive rather than constructive. They do not know of any other method that is better, but they dislike the little inconveniences or bits of red tape in which they may become involved and as a result they criticise the whole system without having anything better to offer.

We need to work together—and iron out small inconveniences—or differences of opinion—but at all costs retain proper perspective and back the plans as a whole—and make them work.

At the last meeting—in January—we attempted to point out where T.C.M.P. can fit into a national health insurance plan for Canada, and I believe we should attempt to retain some perspective of this in our deliberations here.

Durin gthe next two days we have several important matters or problems to discuss. It is hoped that favorable consideration will be given to applications for coverage for two more provinces through T.C.M.P. and if so that would then mean that all provinces would be represented except Newfoundland, and we would be well on the way to having truly national coverage.

PROGRESS REPORT

In Winnipeg, Quebec Hospital Service Association and Maritime Hospital Service Association were taken into full membership in Trans-Canada Medical Plans for coverage in Quebec, Prince Edward Island and New Brunswick.

This means that Trans-Canada Medical Plans now offer a truly national coverage in Canada through its member plans. There are doctor-approved plans in every province except Newfoundland at the present time.

The head office is being opened in Toronto in July and a full-time executive, Mr. C. Howard Shillington, formerly executive director of Medical Services Incorporated, Saskatoon, takes over at that time.

The officers elected at the Commission meeting are as follows:

Dr. E. C. McCoy, Vancouver, B. C., chairman.

Dr. H. H. Lees, Windsor, Ontario, vice-chairman.

Dr. R. M. Parsons, Red Deer, Alberta, honorary secretary.
Dr. S. A. Orchard, Saskatoon, Saskatchewan, honorary treasurer.
Dr. H. E. Britton, Moncton, New Brunswick, member at large of the executive.
Other members of the Commission are as follows:
Dr. P. H. McNulty, Winnipeg, Manitoba.
Dr. G. C. Ferguson, Port Arthur, Ontario.
Dr. I. W. Bean, Regina, Saskatchewan.
Dr. N. H. Gosse, Halifax, Nova Scotia.
A representative from Quebec is still to be named.

All in all, a very successful meeting was held in Winnipeg and it is felt that good progress has been made in T.C.M.P. to date, as after two years we now can supply coverage on a national basis.

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PUBLIC HEALTH ASPECTS OF EPIZOOTIC RABIES

By A. John Nelson, M.D., D.P.H., and I. W. Moynihan, D.V.M., M.Sc.
(*From the Department of Public Health and the Dominion Laboratory of Animal Pathology, University of British Columbia, Vancouver, B.C.*)

AETIOLOGY AND EPIDEMIOLOGY

Rabies is an infective disease, caused by a neurotropic virus discovered by Pasteur in 1881. It is transmitted to man and most warm-blooded animals through the infective saliva of biting animals (canines). In man, ninety per cent of cases originate from dogs. The virus inoculum passes from the local wound via the peripheral nerves to the central nervous system and after a variable incubation period produces an illness of sudden onset characterized by fever, nervous exaltation and violent muscular spasms. The duration of the incubation period, which may vary from 11 days to over a year (average 42 days is determined by the extent and location of the wound, and the quantity and strength of the virus introduced. Thus, bites through clothing are not as dangerous as those on bare skin. Bites about the face, head, or neck are the most serious; for, since the infection travels along the nerve routes, the period of incubation tends to be short in the case of such bites, because of their proximity to the brain.

Rabies has never been prevalent in Canada. Localized outbreaks have been reported in Eastern Canada, for example, in Montreal (1927) and in Huron County, (Ontario (1940), probably due to the importation of infected animals from the Eastern United States, where the disease is endemic. The present epizootic of rabies appears to have originated when the first animal case was diagnosed at Baker Lake, N.W.T., in April, 1947. Since then, the disease has spread in a westerly, and latterly, a south-westerly direction, to involve adjacent provinces—thus the first case was reported in Manitoba in September of 1951, the Yukon Territory was implicated in April, 1952, the Province of Alberta in the same year, and recently the disease has appeared in Northern British Columbia. The following animal species have been implicated in Canada to date: dog, fox, pig, wolf, rabbit, lynx, horse, and cattle. At the time of writing, six positive identifications of rabies in the animal life of this Province have been reported.

Inasmuch as epizootic rabies is a reportable disease under the Animal Contagious Diseases Act, (1927) the responsibility for the control of rabies in animals is primarily a Federal responsibility through the Health of Animals' Division of the Federal Department of Agriculture. The appropriate measures of control, such as the establishment of a quarantined area, the destruction of susceptible wild animals within that area by trapping and poisoning, and the protection of susceptible domestic animals by vaccination, are properly the concern of Federal veterinarians, and medical responsibility should therefore be limited to the protection of the public within the quarantined area.

RABIES IN ANIMALS

The clinical picture of rabies is similar in different species of animals. However, certain variations are present, depending on the mode of life, temperament, and body structure of the animal.

While rabies is primarily a disease of the canine species i.e., the dog, wolf, fox and coyote, all warm-blooded animals are susceptible. The habits of the dog and his species, the unrestricted freedom which many of them enjoy, and the fact that biting constitutes their natural mode of defence, make them pre-eminently fitted for the transmission of this disease and responsible for the rapidity with which large outbreaks cover unlimited areas.

The incubation period in natural infections is extremely variable, depending for the most part on the distance between the site of infection and the central nervous system.

Clinical signs of rabies in the dog vary from "furious rabies" to "dumb rabies". The former is the type where classical "mad dog" symptoms appear.

In furious rabies the prodromal symptoms are vague and consist of a slight change in the behaviour. In the case of household pets, the only change may be an increased tendency to skulk, or they may become more affectionate than previously. Gradually the animal becomes irritable and excited. It will snap and bite at non-existent objects, become easily startled by sudden stimuli, and inflict extensive injury to its own body. Dyspnoea, anorexia, inequality of pupils, and a weakness of the vocal cords resulting in a characteristic voice change are present in the early stages of the disease. At the height of the irritable stage the animal becomes vicious and violent. If caged, it will make every effort to escape. If free, the animal will wander far from its home, attacking any living thing that appears in its path. During this time the animal finds it increasingly difficult to swallow food and water, hence it will avoid them. The characteristic salivation is due to deglutition difficulties. Paralysis ensues rapidly and the animal usually dies four to seven days after the onset of the disease. Death may occur during a convulsive seizure, or the animal may become completely paralyzed and die in coma. The furious form of the disease always progresses to the dumb form if the animal lives a sufficient length of time.

In dumb rabies the prominent symptoms consist of drowsiness, melancholia, and a paralysis of the lower jaw, tongue, larynx, and pharynx. There is a tendency for the animal to run away and hide. Food and drink are left untouched because of the inability to swallow. In contrast to furious rabies there is no irritability or tendency to bite, unless the animal is disturbed. The paralytic symptoms gradually become more pronounced, and the animal lapses into a coma and dies two or three days after the onset of the disease.

Rabid animals are relatively insensitive to pain and often mutilate themselves during an attack of furious rabies. Rabid wolves and foxes frequently invade farms and attack man and domestic animals in the daytime. Wild animals with dumb rabies avoid company, seeking death in seclusion.

When infection takes place in the cat, the disease progresses very rapidly, terminating fatally within a few days after the commencement of symptoms. The animal is extremely restless and excitable, moves about persistently in an erratic manner, and seldom remains at ease. The eyes assume an unusual brilliancy, the pupils are dilated, resulting in a wild frightened expression. Great thirst is apparent, but there is no desire for food. The animal may show a tendency, however, to pick up and swallow stones, sticks and other foreign bodies. The voice rapidly changes to a loud harsh tone. Saliva flows profusely, which with persistent licking soon moistens the coat of the animals, and adds to its dejected appearance. Any noise or excitement may be followed by paroxysms; these may occur frequently, and during them the animal jumps about furiously and will attack a dog, or other animal or man.

DIAGNOSIS OF ANIMAL RABIES

Any wild animal which is suspected of rabies, or any domestic dog which develops rabid manifestations during the observation period prescribed below, should be immediately killed by a shot through the chest. The soft tissues of the neck, and cervical vertebral column are severed, and the complete head and intact skull of the animal should be wrapped in waxed paper, and packed in ice and sawdust within a tin box or some such suitable container. The specimen should then be forwarded, with a detailed history of events preceding the death of the animal, to the Laboratory of Animal Pathology, University of British Columbia, Vancouver 8, B.C., for pathological examination of the brain, and mouse inoculation tests.

The typical pathological lesion of rabies in the central nervous system in all animals is the so-called "Negri body". This pathological aggregation is from 0.5 to 18.0 microns in length, occurring in the cytoplasm of nerve cells. The bodies are most numerous within the large motor nerve cells situated near the periphery of the hippocampus convolution (Ammon's horn) and consist of hyaline-like cytoplasm containing one or more chromatin granules.

Throughout the central nervous system of infected animals, there appear multiple foci of invasion which appear as disseminated areas throughout the midbrain and cord, as well as in typical areas of perivascular infiltration. Accurate microscopic diagnosis must be made by the use of special staining techniques.

RABIES IN MAN

By no means all patients bitten by rabid animals die, but once clinical manifestations appear the disease invariably ends fatally, since no specific treatment is known. The protection of the human subject is therefore entirely dependent upon the application of preventive measures during the relatively long incubation period.

PREVENTIVE MEASURES

(1) A *suspected* dog should be chained up, muzzled, and kept under the observation of a veterinarian. Should the animal be alive at the end of ten days, it is proof that the bitten person has not been infected. In the case of a wild animal which is suspected of rabies, or a dog which develops rabid manifestations while under observation, proceed as outlined above for diagnosis of animal rabies.

(2) *Treatment of animal bites.* Formerly, cauterization with fuming nitric acid, was recommended, a procedure accompanied by considerable tissue damage. Recent experimental work (Shaughnessy and Zichis, 1943) suggests that preferably a recent puncture wound, or one that is otherwise inaccessible, should be enlarged and irrigated to its depth with a twenty per cent aqueous solution of soft soap introduced under pressure from a 20 or 50 cc. syringe. Then, after débridement, the wound should be sutured.

(3) *Anti-rabies vaccination.* Owing to the long incubation period it is feasible to attempt to immunize patients. The modified Semple vaccine, as prepared by Connaught Medical Research Laboratories, consists of a four per cent suspension of "fixed" rabies virus prepared from the brains of rabbits and inactivated by irradiation with ultraviolet light. The vaccine contains merthiolate 1:10,000 as a preservative, and is put up in the form of courses, each containing fourteen 2 cc. ampoule doses. The volume and strength of the vaccine is the same in each ampoule. Full instructions for the administration of the vaccine by subcutaneous injection over the abdomen, are enclosed with each packaged course. Owing to the small but definite danger of neuro-paralytic accidents following anti-rabies vaccination of human subjects, the vaccine is not recommended for an immunization program of the general public within an area quarantined for rabies.

Patients for vaccination should be selected *only* if they fall into the following categories:

(a) Persons bitten by animals which have been proved rabid either by clinical symptoms or by microscopic examination of the brain.

(b) Persons whose hands or face have been contaminated with saliva of a rabid animal without being bitten. This is because of the possible presence of cracks, hang-nails or other small open wounds.

(c) Persons bitten by stray dogs, when it proves impossible to locate the dog for observation and diagnosis.

(d) Persons bitten by an animal whose behaviour or symptomatology was suspicious, pending laboratory examination of the brain of the biting animal.

Inasmuch as the immunity conferred by vaccination lasts a varying period of time, and gradually wears off, prohylactic treatment should, therefore, be repeated in persons bitten a second time. The Health Branch of the B.C. Department of Health and Welfare is prepared to supply anti-rabies vaccine for the prophylactic treatment of patients falling within the above-mentioned categories. All requests for vaccine should be directed in the first instance to the local Medical Health Officer.

RECENT DEVELOPMENTS

Current research, mainly by Koprowski and Cox of the Lederle Laboratories at Pearl River, N.Y., is proceeding along two lines:

(1) Clinical evaluation of combined passive-active immunization, the patient being given a horse or rabbit serum concentrate immediately after exposure to confer a temporary passive immunity, followed a few days later by vaccine treatment. The passive immunity so conferred would suffice to carry the patient through the greater part of the observation period prescribed for a suspect animal, while the course of vaccine therapy could be shortened considerably, thus decreasing the risk of neuroparalytic accidents.

(2) The Flury strain of rabies virus has recently been attenuated by passage in chick-embryos. Its use in the avianized rabies vaccine for the immunization of dogs suggests that it may confer a more durable immunity than that conferred by vaccines containing inactivated virus. It is understood that this avianized anti-rabies vaccine has passed preliminary clinical trials in the human subject and that field trials are to be undertaken in the near future.

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THE DIAGNOSIS OF APPENDICITIS

W. E. Austin, M.D., F.R.C.S.(Edin.), (C), F.A.C.S.

The mortality rate from appendicitis has fallen sharply in the last 20 years. Slattery[1] of New York recently analyzed 942 cases of acute appendicitis treated between 1928 and 1947 inclusive and found an over-all mortality rate of 4.1%. The first 5 years had a rate of 6.3% and last 8 years only 1.5%. During this time the mortality rate for unruptured acute appendicitis dropped from .6% to 0.4%. That of ruptured appendix in any form is still nine times greater despite antibiotics, gastric suction and intravenous feeding. Therefore one of the aims of this paper is to improve our diagnosis so as to reduce still further this more lethal group.

The second object of the presentation is to point out that appendicitis is still too often misdiagnosed. A recent survey of 350 cases diagnosed as acute appendicitis in the Vancouver General Hospital, January to June 1950 shows that 64% only were actually found to be acute by the pathologist. Another 4.6% showed some chronic changes. The remaining 31% (109 cases) were quite normal. Of this latter number the symptoms were due to other disease in 30 cases (9%). Joffe and Wells[2] report 27.5% of normal appendices in 1000 cases examined and suggest that in a good surgical practice not more than 15—20% should be normal.

There is, therefore, room for improvement both in diagnosing acute appendicitis early when we see it, and in avoiding the diagnosis when it is not there. There is a tendency to think at times that the removal of a normal appendix is not of great moment, and indeed the risk is estimated at one thirteenth that of a ruptured appendix. However, as honest clinicians we must feel chagrinned and defeated when our diagnosis is proven wrong.

Factors which influence mortality are the taking of:

1. Purgatives.
2. Delay in seeking advice by the patient.
3. Delay in early diagnosis by practitioner.

Consideration of the subject suggests a division into acute and chronic appendicitis. In the old days when pathologists were more generous chronic productive appendicitis was a common lesion. Now when they bluntly report that the organ so carefully removed is a "vermiform appendix" one may be pardoned for blushing occasionally. It is not my intention to pursue the differential diagnosis of chronic appendicitis except to say that it is probably rare. An appendix with a foreign body or a definite fecolith or pin or round worms in it might qualify, but when faced with such a diagnosis one had better consider carefully such things as mesenteric lymphadenitis, urinary tract disease or stone, regional ileitis, or that happy hunting ground, the female pelvis. A recent urologic survey showed that 25-30% of cases had had the appendix erroneously removed.

The diagnosis of acute appendicitis may be ridiculously easy in the typical case but there are so many bizarre pictures that even the most experienced may be confused. The abdomen that is opened for a suspected perforated ulcer and reveals an acutely inflammed highly situated appendix is not uncommon. The varied locations of the appendix from below the liver to the pelvis and all the areas between, both intraperitoneal and retrocaecal contribute not a little to the difficulties.

A simple classification of acute appendicitis is the following:

1. Acute unperforated—
   a. Acute catarrhal, or cellulitis or the appendix.
   b. Acute obstructive.
2. Perforated—
   a. Abscess.
   b. General peritonitis.

The typical case of acute appendicitis is in a person under 40, more commonly male, who exhibits intermittent crampy abdominal pains in the epigastric or umbilical regions, associated soon after with anorexia, nausea and vomiting. (Thorek states that if the appetite is not affected doubt the diagnosis). After a varying period the pain shifts to the lower right quadrant. If the lesion is obstructive the pains will be frequent and severe and vomiting probably a marked feature. Time is not the important element which decides the pathology but rather it is the degree of obstruction. An obstructed appendix may perforate in a few hours while the catarrhal type may be unruptured after several days. Constipation is usual in this condition. Only in pelvic appendicitis or when peritonitis is present is diarrhoea at all likely. The history of a previous similar attack is suggestive.

On examination the temperature is usually not raised more than 1° or 2°, and the pulse is often normal or only moderately increased. The tongue is usually furred and the breath heavy. The legs may be drawn up as the patient lies on his back or his side. There is localized tenderness at McBurney's point accompanied by involuntary muscle spasm. Rectal examination may reveal increased tenderness high on the right. The white blood count will range from 10,000-15,000 with increased polymorphs and staff cells. The urinalysis is negative and examination of the other systems is normal. If the patient is asked to sit up, he does so with care and if he walks he often bends forward with his hand over his right lower abdomen.

The typical case of acute appendicitis may thus often be diagnosed from the history shown—crampy abdominal pains, a "bellyache", beginning in the mid-abdomen and shifting to the lower right quadrant and associated with nausea and vomiting is appendicitis until proven otherwise. When local tenderness and muscle guarding are present the evidence is strong.

Why then do we misdiagnose so many cases, even allowing for the percentage of cases with unusual and complicating manifestations? The answer probably lies in an inadequate history and examination. Five minutes spent in getting an account of the sequence of events and the present complaints, a questioning regarding the other systems and of any past or recent illnesses or operations, would prevent many errors. Another five minutes examining the patient would eliminate many more. Checking his temperature and pulse, looking at his throat and tongue, examining his chest and doing a rectal are just as important and revealing as putting a hand on his abdomen. In a female the presence of vaginal discharge or bleeding should always be looked for despite a negative history. A urinalysis, a catheter specimen if necessary, is a must if one is to avoid operation on urologic cases and the occasional diabetic. The W.B.C. and differential are good aids to diagnosis, the latter being particularly valuable from a prognostic point of view. However, if the blood picture doesn't seem to fit in with the clinical diagnosis it may at times have to be disregarded. Even at that it should cause us to give pause for a moment's reflection and a restatement of the case.

If the history and findings are not conclusive then there are a few well known tests which may aid in a decision:

1. Observe the chest and abdomen during the inspiration. Both ordinarily come out together. If the abdomen remains still or goes in, it is suggestive of peritoneal irritation.
2. Have the patient distend his abdomen. If this causes further pain it also suggests peritoneal irritation and the patient can often tell you where it hurts.
3. The test for rebound tenderness if positive is a fairly reliable indication of peritonism.
4. The test for epicritic hyperaesthesia by pin prick or by plucking the skin with two fingers (Ligat's Test) over Sherren's triangle may be helpful as long as the appendix is not ruptured. (positive in 86%).
5. Rovsing's sign is obtained when pressure over the left colon produces pain in the lower right quadrant by increasing the intraluminal pressure.

6. The flank should be examined for rigidity in suspected cases of retrocaecal appendix when there are few abdominal signs.

7. Baldwin's test, also for retrocaecal appendix, is present when pressure is made over the painful area in the loin and the patient told to raise his right leg with the knee stiff, at which he cries out with pain or drops his leg.

8. The obturator test is applied by flexing the right thigh with the knee at a right angle and then medially rotating the thigh. This puts the obturator internus on stretch. If a pelvic appendix is present this may cause abdominal pain in the hypogastrium.

9. The psoas test is performed with the patient on his left side when the right thigh is hyperextended and abducted. If an inflamed appendix is in contact with the muscle, the manoeuver is painful.

From the typical case there may be many variations. The temperature or pulse or both may be normal. There may be very little tenderness or rigidity when the appendix is in a posterior position. There may be no vomiting. The patient may have forgotten or fail to tell you that the original pain was mid-line. There may be no appreciable rectal tenderness. There may be a few pus and red cells in the urine when an acute appendix lies against ureter or bladder.

There is a non-localizing form of appendicitis which in the early (3) stages, especially the first 8 hours, will exhibit few signs of its presence. It has been suggested that the diagnosis may be made by a history of:

1. Mid-line pain which persists for 8 or more hours.

2. Anorexia.

3. A downward urge to defecate. The pain persists despite bowel movement and even despite diarrhoea.

Three questions may help in this connection:

1. At the onset of the attack did you have a sensation of gas stoppage in your bowels?

2. Did you feel if you could pass gas that you would be relieved?

3. Were you relieved when you were able to pass gas through the rectum?

If you happen to see the patient in the so-called "stage of illusion", just after the appendix has ruptured, he may state that he no longer has pain, there may be little tenderness or rigidity, and only a rising pulse and fever may explain his position.

If a tender mass is palpable it may be an abscess but it may also be an appendix wrapped in omentum and safely removable. This is one of the arguments in favor of exploration of an abscess. If diarrhoea and mucus are present a pelvic abscess is almost certain.

When general peritonitis is present the pulse and temperature will be elevated, the patient will look ill, hollow-eyed and anxious. The abdomen will move little and will have widespread rigidity and peritonism. This is the state to be avoided for even with antibiotics the mortality is many times that of the risk of a simple appendectomy.

Before we consider the differential diagnosis there are a few special considerations—

In children—8.6% of acute appendices are in children under 10 years. Acute appendicitis is rare under 2 years of age. It is more common in the late winter and early spring months. The history of a purgation is more serious and the condition runs

"a more rapid and deadlier course" (Ladd and Gross[4]) and general peritonitis is more often present. The shorter omentum, the higher position of caecum and appendix, and the wider calibre of the appendix are factors favouring wider spread of the disease. Vomiting is practically always present. Appendicitis may occur during an upper respiratory infection or an acute exanthem, particularly measles. Careful inspection and gentle palpation are essential.

In the aged—acute appendicitis is less common than—

1. Acute obstruction due to hernia or other causes.

2. Acute cholecystitis, and

3. Diverticulitis, but occurs in about 10% of acute abdomens. The reaction in these old people is below normal and yet the disease often runs a fulminating course. Of 17 cases over the age of 65 reported by Beck[5] all had either a gangrenous appendix or an actual performation. A low grade fever, a pain which is often minimized by patient and relatives alike and a little tenderness, may suggest a lesion much less acute than it really is.

In the pregnant woman—the symptoms are those of ordinary acute appendicitis but because of the pains which accompany pregnancy and because of the vomiting which may also be a feature of that condition the possibility of appendicitis may not even be considered. With advancing pregnancy the situation of the appendix rises so that at 5 months it is on the level with the umbilicus and in the last trimester it is higher. In acute appendicitis the point of maximum tenderness will be at the corresponding higher level. A moderate leucocytosis may not be of much help because there is a leucocytosis of pregnancy. Because of these features diagnosis is often late and gangrene and perforation are 3 to 5 times more common. The mortality of peritonitis cases is given as high as 30%. The dangers of abortion increases sharply from 11.4% in ordinary acute appendicitis to 72% in cases with peritonitis. Delay in diagnosis is the main factor responsble. If appendicitis is suspected and a catheter specimen of urine is negative operation should be carried out without delay.

During menstruation appendicitis may occur and not be considered because dysmenorrhoea is often present. A recent editorial stressed this strongly.

The differential diagnosis of appendicitis is legion but a few of the more common ones may be briefly mentioned.

1. *Pyelitis*—dysuria, frequency, chills, tenderness over the kidney, pus in the urine.

2. *Pneumonia*—signs of respiratory embarrassment, use of the alae nasi, cough, increased respirations. Absence of deep abdominal tenderness. Rigidity which may disappear if the chest is splinted. Fever higher, leucocytosis higher. Chest film—especially necessary in children.

3. *Salpingitis*—often with or just after a period. Pains low, bilateral, usually backache. Vaginal discharge. High leucocytosis. Tender masses in fornices.

4. *Ruptured Tubal Pregnancy*—period missed or just due. Sudden pain and fainting. Low crampy menstrual-like pain. Pallor, sub-normal temperature. Boggy mass in pouch of Douglas. Spotty bleeding and intermittent pains in subacute attacks.

5. *Ruptured Graafian follicle*—onset half way between periods. Pain low. No fever. Peritonism present from blood.

6. *Mesenteric lymphadenitis*—in children and young adults. May have pain, fever, vomiting, tenderness and elevated W.B.C. Usually appears less ill than signs suggest. When less acute, local abdominal tenderness and rigidity are less than they would be in appendicitis.
7. *Meckel's diverticulitis*—Not common. Tenderness more subumbilical. May bleed.
8. *Terminal ileitis*—Acute, usually diagnosed as appendicitis. May be palpable swelling. May have diarrhoea.
9. *Primary peritonitis in children*—after upper respiratory infection, prostration. High fever. W.B.C. 30,000-50,000, due to streptococcus or pneumococcus.
10. *Renal colic*—Pain in loin referred to genitals. Worse on jolting movements. Blood in urine.

Other conditions which are mistaken for appendicitis are: lead poisoning, diabetic coma, Herpes Zoster, epididymitis, torsion of the testicle, intussusception in children acute enteritis in children, acute cholecystitis, acute pancreatitis, perforated ulcer, perorated diverticultis, torsion of ovarian cyst.

In conclusion, may I again reiterate that most cases of acute appendicitis can be diagnosed by an adequate history and examination. There is nothing so satisfying as a substantiated diagnosis and the sense of achievement that goes with it, and nothing so humiliating and so unfair to the patient, as a wrong diagnosis made because of an inadequate investigation.

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CANADIAN MEDICAL ASSOCIATION, B.C. DIVISION, 1953 ANNUAL MEETING

. . . *Programme* . . .

TUESDAY September 22	WEDNESDAY September 23	THURSDAY September 24	FRIDAY September 25
MORNING SESSIONS			
8:00 a.m.—Nominating Committee Breakfast Meeting	**8:30 a.m.**—Registration	**8:30 a.m.**—Registration.	**8:30 a.m.**—Registration.
9:00 a.m.—Registration	**9:00 a.m.**—Dr. J. Kilgour, "Epidemiology and Control of Viral Hepatitis."	**9:00 a.m.**—"Obstetrics." Speaker to be Announced.	**9:00 a.m.**—"Psychiatry." Speaker to be Announced.
9:00-12:00—General Assembly C.M.A.—B.C. Division	**9:40 a.m.**—Dr. Harold M. U'Ren, "Eye Injuries."	**9:40 a.m.**—Sir Charles Symonds. "Closed Head Injuries."	**9:40 a.m.**—"Gynaecology." Visiting Speaker to be Announced.
	10:30 a.m.—Exhibits.	**10:30 a.m.**—Exhibits.	**10:30 a.m.**—Exhibits.
	11:00 a.m.—Dr. C. Burns, "Acute Peptic Perforation."	**11:00 a.m.**—Dr. J. Kilgour, "Pneumonia."	**11:00 a.m.**—Dr. E. S. Judd, "Surgical Treatment of Carcinoma of Colon."
	11:40 a.m.—Dr. M. Weaver, "Experiences in Founding Medical School in B.C."	**11:40 a.m.**—Dr. E. S. Judd, "Present Status of Surgery in Treatment of Toxic Goitre."	**11:40 a.m.**—Dr. J. Eden, "Fluids and Electrolyte Management in General Practice."
	12:30 p.m.—Annual Luncheon.	**12:30 p.m.**—Luncheon.	**12:30 p.m.**—Luncheon.

AFTERNOON SESSIONS

2:00-5:30 p.m.—General Assembly C.M.A.—B.C. Division

2:00-5:30 p.m.—Medical Round Table. "Present Status of ACTH and Cortisone Therapy."

Dr. D. M. Whitelaw
Dr. H. McIntosh
Dr. J. Kilgour
Dr. R. A. Wilson
Dr. H. M. U'Ren

GOLF
Shaughnessy Golf Club.

2:00-5:30 p.m.—Surgical Round Table., "Differential Diagnosis Management of Gastro-Intestinal Hemorrhage."

Dr. Rocke Robertson
Dr. J. Kilgour
Dr. E. S. Judd
Dr. Roger Wilson
Dr. T. R. Sarjeant

EVENING SESSIONS

8:00 p.m.—Annual Meeting College of Physicians and Surgeons of B.C.

8:00 p.m.—Annual Meeting. C.M.A.—B.C. Division.

Gala Buffet
Dinner Dance,
H.M.C.S. Discovery

Annual Dinner.
Hotel Vancouver.

+ + +

Monday Night—Sectional Meetings

British Columbia Division
Canadian Medical Association

1807 West 10th Ave., Vancouver, B.C. Dr. G. Gordon Ferguson, Exec. Secy

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PUBLIC MEDICAL FORUMS

The recent spread of medical forums for the public apparently began in Florida. The reception was so enthusiastic that it has spread to other parts of the States. I understand that in Atlanta the tremendous response has encouraged them to put it on television in the near future. In spite of these reports of the great success of these forums there was considerable trepidation on the part of the Public Relations Committee about starting them in Vancouver when the Vancouver Province approached the B. C. Medical Association in this regard. It was felt by the executive and the chairman of the Public Relations Committee that they should inflict the responsibility for the first two on the

members of the Public Relations Committee. The above mentioned trepidations of that committee were felt a hundredfold by the two moderators, more espcially when the terriffic publicity appeared in the press. The doctors whose pictures were so prominently displayed are tending to slink around town with their coat collars up so that no one will recognize them. However, the executive and the rest of the committee, back them up completely so that the groups chosen appeared on the two respective forums even though their knees were knocking.

As far as the public were concerned, we were assured by the response and by the newspapers that the forums were a terrific success. They are apparently having considerable effect along the lines which we desired. The expression was used by one person that "The doctors are again becoming part of the community."

The whole subject of these were discussed again at the last meeting of the Public Relations Committee and it was felt that they should be continued in the fall. The present plan is to hold them monthly, beginning in September. It will, of course, be an entirely new moderator and panel for each forum so that the names of those appearing will tend to be forgotten, and the public will remember only that it was doctors representing the B. C. Medical Association.

We certainly appreciate the co-operation and sponsorship of the Vancouver Province which made these forums possible with no cost to our Association.

F.L.S.

M-S-A COVER FOR EMPLOYEES IN DOCTORS' OFFICES

That employees in offices of the doctors in active private practice may have coverage under M-S-A, it is proposed to enter into a trustee-type plan with M-S-A. This provides that the doctors enter into an agreement amongst themselves and appoint a trusee who will do for them collectively those things that an employer normally does when entering into a contract with M-S-A. This type of plan is necessary because few offices have sufficient numbers of employees to qualify for a group contract of their own.

Full details together with a timetable for organization of the various areas will be mailed to each doctor's office.

For Your Information

THE HEALTH CENTRE FOR CHILDREN—Vancouver

The Health Centre for Children was formed under the Societies Act of British Columbia in 1947 with the purpose of supporting child care in the Province of British Columbia. The board of directors of the society were responsible for the raising of sufficient funds to equip and set up the Outpatients Department in Paediatrics at the Vancouver General Hospital in a small separate building on the hospital grounds. In the years which have elapsed since the inception of the society, there have been few calls upon its fund-raising abilities since there was no opportunity to expand the functions of the Paediatric Outpatients in their crowded area. Nevertheless, the attendance at the Outpatients Department in Paediatrics has risen steadly from less than 1,200 cases per year to 15,000 cases per year in 1952.

With the new plans for the expansion of the Department of Paediatrics at the Vancouver General Hospital, the outpatients services and the inpatients services will be housed in the Semi-Private Pavilion on Twelfth Avenue, which is being remodelled to an infants' and children's hospital. Under these circumstances, the functions of the Health Centre for Children have been expanded to include the support of inpatient as well as outpatient care. The new children's unit will be occupied in late 1953 and, at that time, will provide 155 beds for inpatients in the childhood age group, an outpatients' department which will be expanded considerably over the cramped facilities which have previously been available, teaching and administrative areas and research laboratories.

A second step in the development of the building will occur some three years hence when the entire building will be turned over to paediatric care and a total of 240 beds will be available. At that time also, an operating room area will be created on the top floor which will provide three operating room suites.

Hereafter, the entire area will be termed The Health Centre for Children and the Board of Trustees of The Vancouver General Hospital will be responsible for administration within this area, while the Board of Directors of the Health Centre for Children will have the following functions:

1. To provide advice and support in the development of a program for the treatment of childhood disease to the physicians of the Health Centre for Children.
2. To provide financial support for the facilities required in a first-class children's hospital, which are not presently available from other sources.
3. To corelate the activities of all auxiliary groups functioning in the Health Centre for Children.

MEDICAL AID TO MARINERS AND FISHERMEN

The following letter has been received by the Executive-Secretary from Doctor G. D. W. Cameron, Deputy Minister of Health, Ottawa:

"Dear Doctor Ferguson:

"It has been brought to my attention that physicians in coastal communities of British Columbia are having some difficulty in securing payment for treatment of coastal fishermen whose claims for medical aid have been rejected by the Workmen's Compensation Board of B. C.

"This difficulty appears to arise through ignorance of seamen and masters of vessels of sub-section (6) of section (25) of the Workmen's Compensation Act of British Columbia. The sub-section mentioned denies medical aid benefits to any employee of a vessel for any period in respect of which port duties have been paid or are payable under Part V of the Canada Shipping Act. It is our belief that a great many, probably the majority, of fishing vessels are so covered.

"While Part V of the Canada Shipping Act authorizes free treatment for certain sick or injured mariners, such benefits are conditional on the production by the mariner of a written recommendation from the person in command of his ship, endorsed as "approved" by the Collector or Chief Officer of Customs of the particular port or area. Officers of this department in charge of administration of the Sick Mariners' Service have no authority to waive this provision of the act in paying out public funds for medical services rendered. The fact that considerable time may elapse before a doctor is notified by the Compensation Board of rejection of a claim for medical aid, may aggravate the difficulty of securing the proper treatment authority from the customs officials.

"It is suggested, therefore, that whenever one of your members has occasion to treat a sick or injured mariner or coastal fisherman, he should request at the commencement of treatment, or as soon after as possible, the production of a properly-completed authority for such treatment as required by the Canada Shipping Act. If such authority is not available because the crew of the vessel are not eligible for Sick Mariners' Service, claim for medical aid will probably be accepted by the Workmen's Compensation Board.

"If you would be so kind as to give the above information wide distribution among your members who may have occasion to treat mariners or coastal fishermen, it might assist in simplifying the collection of their accounts for treatment."

"G. G. Ferguson, M.D., Executive Secretary."

The Medical Director of Medical Services Division, Department of Welfare, requests that "when providing services (prescriptions) to welfare cases to please use the same M-S-A number on the prescription that you use in rendering your account to the Social Assistance Medical Services."

PUBLIC HEALTH AND MENTAL HEALTH NEWS

G. F. AMYOT, M.D., D.P.H.,
Deputy Minister of Health, Province of British Columbia

A. M. GEE, M.D.,
Director, Mental Health Services, Province of British Columbia

IMPORTANT ANNOUNCEMENT

In many health departments are found Divisions of Child Health, but the Health Branch of the Province of British Columbia has at no time had such a division. There have been many reasons for this policy, perhaps the most important being that the basic public health program which has been developed in British Columbia by the Health Branch has been directed primarily at the maternal and child health level.

Two years ago a public health nurse was trained in maternal and child health and appointed a Consultant in Public Health Nursing to encourage and accelerate the program of child health within local health services. It has been felt, however, for some time that activities in that field could be further improved if consultative services in child health were supplied by highly skilled paediatricans who also have a direct interest in the field of preventive medicine. Such people, however, are not too easily obtainable and for this reason it has not been possible to expand the program as contemplated.

In recent months with the formation and growth of the Department of Paediatrics at the University, conversations between the Dean of Medicine and the Deputy Minister of Health have provided what appears to be a suitable solution to this problem.

The Health Branch has been fortunate in that plans have been completed whereby the Department of Paediatrics, Faculty of Medicine, University of British Columbia, has been named as the official consultants in Child Health to the Health Branch, Department of Health and Welfare. With such an arrangement, assistance and guidance will be available to the Health Branch from a paediatrician specially trained in the particular field wherein the problem lies.

In recent weeks the extreme value of such an arrangement has been apparent in the assistance that paediatricians on the staff of the Department of Paediatrics, working in co-operation with local health services, the Consultant in Epidemiology of the Health Branch, practising physicians and hospital authorities, have been able to give in a problem relative to skin infections in the newborn at Mission and breast abscesses at Tofino.

Further examples are the co-operative effort between the medical profession, the Department of Paediatrics, and the Health Branch in the development of the Crippled Children's Registry and the proposed plans whereby the Department of Paediatrics will supply the paediatric services necessary in the Bureau of Special Preventive and Treatment Services.

The Provincial Health Branch feels that arrangements such as these bring additional valuable services to the people of this province and welcomes this trend to bring the specialty of paediatrics still closer to the specialty of public health. This is further recognition of the fact that paediatricians in their day-to-day practice are furthering the cause of public health.

This development by no means completes the future plans in this province for child care, and will be subject to review from time to time in the light of further advancements.

IMPORTANT ANNOUNCEMENT

Admissions to Mental Hospital of Patients Suffering from Chronic Alcoholism

The treatment of the patient suffering from chronic alcoholism has been a most difficult problem for some considerable time due largely to the fact that there has been no suitable place set aside for the handling of this type of individual. Although the

Provincial Mental Hospital is primarily devoted to the care of the mentally ill, a policy was established a few years ago of accepting certain patients with a view of offering some assistance in their management.

In order to control the admission of this type of patient an order-in-council was passed in March of 1952 setting forth certain regulations pursuant to the provision of the Mental Hospitals Act and dealing with the alcoholic patient. These regulations were:

1. The number of male alcoholics without psychosis who have been admitted pursuant to Section 13 (1) of the "Mental Hospitals Act" and who are receiving care and treatment in the Provincial Mental Hospital, Essondale, shall be restricted to twenty-five (25) at any one time;

2. The Senior Medical Superintendent may refuse further admissions of patients in this category until the number under care and treatment is less than twenty-five (25);

3. Requests for admission of this category of patient shall be made in advance and the patient shall not proceed to the Provincial Mental Hospital, Essondale, until notification has been given by the Senior Medical Superintendent that he may be admitted;

4. The hours of admission for patients in this category shall be from eight (8) a.m. to ten (10) p.m. daily.

Many of these patients, however, who have been seeking admission to the Provincial Mental Hospital on a voluntary basis have been doing so merely for the purpose of "drying out" after a particularly heavy drinking bout. They have only been remaining in the hospital for a few days and then have been requesting their discharge from hospital, which they are privileged to do as voluntary patients. It is felt that the Mental Hospital should not be used for such a purpose. We still will be glad to offer our services to those patients who have a real alcoholic problem, who recognize it and who are desirious of receiving some help for it.

With this fact in mind an amendment to the Mental Hospitals Act was passed at the last session of the Legislature. Now, under Section 13, subsection 3, any person suffering from alcoholism and who is considered suitable for care and treatment may make application for a voluntary admission to the Provincial Mental Hospital under Form "K" (instead of Form "F" as formerly). This form also requires to be completed by a duly qualified medical practitioner. Under this provision any person may be received and detained in the Mental Hospital for a period of not less than 30 days or more than one year. After 30 days in residence the patient detained under such certificate who wishes to leave the hospital may do so by giving notice in writing of his desire to the Medical Superintendent, and the Medical Superintendent shall not detain that person for more than five days after receipt of his notice. In this way it is hoped that patients applying for help for their alcoholic problem may be detained for a sufficient period of time to make some honest attempt along these lines.

It is to be noted that this new form of voluntary admission under Form "K" is only to be used for the admission of those suffering from chronic alcoholism. Others requesting voluntary admissions to the Mental Hospital will still apply by using Form "F" of the Mental Hospitals Act.

Forms "K" will become effective on August 1, 1953, after which date no patient suffering from chronic alcoholism will be admitted using Form "F".

Copies of Form "K" may be obtained on request from the Medical Superintendent, Provincial Mental Hospital, Essondale, B. C.

RETIRED PHYSICIAN WISHES TO SELL OFFICE FURNITURE

Phone: MArine 7441 or PAcific 3707

News and Notes

Dr. G. E. Singer, who has been in practice at Sandspit, is now on staff at St. Joseph's Hospital, Victoria.

Dr. R. C. Anderson, of Victoria, is now practicing in Regina.

Dr. Gavin Chisholm, of Victoria, is holidaying in Eastern Canada.

Dr. Jean M. MacLennan, of the Metropolitan Health Service, was recently certified as a specialist in paediatrics.

Mark the week of September 21st off on your calendar, for this is when the B. C. Division holds its annual convention in Vancouver. A sparkling social and medical programme has been arranged and all your friends will be there.

Dr. Jack Kilgour, of Winnipeg, will speak on toxic effects of antibiotics and control of hepatitis. *Dr. E. S. Judd,* of the Mayo Clinic, will speak on toxic goitre and surgery of the colon. *Dean Myron Weaver,* of U.B.C., will discuss problems encountered in establishing the medical school. *Dr. H. M. U'Ren,* of Portland, will discuss eye injuries and common ocular conditions. In addition there will be two papers on obstetrics and gynecology and one on psychiatry by speakers not yet finally settled.

A distinguished speaker will be *Sir Charles Symonds,* of England, who will discuss closed head injuries. *Dr. John Eden,* of the Vancouver General Hospital, will outline electrolyte management in general practice and there will be a round table on cortisone therapy and one on gastro-intestial surgery.

Forty-five drug houses will exhibit in the Vancouver Hotel, while the Vancouver hospitals, the Cancer Institute, the Institute of Medical Research and U.B.C.'s department of neuropathology will have stimulating displays in the same hall. There will also be the Hobby Show.

An innovation this year will be a public panel discussion on health insurance which will draw 1,000 people.

For the ladies there will be a fashion show, a sherry party, a gala dinner dance at HMCS Discovery in Stanley Park, luncheon at the Panorama Roof of the hotel and a tea at the Art Gallery.

This promises to be the highlight of the annual convention series and most physicians would do well to attend, particularly the general practitioners.

Dr. W. J. Couldwell is now associated with *Dr. Howard Black,* of Vancouver.

Dr. A. M. Inglis is temporarily associated with *Dr. F. P. Patterson,* of Vancouver.

Dr. W. J. Kazun is now in practice with *Dr. D. A. Steele,* of the Vancouver Broadway medical district.

Dr. David Boyes and *Dr. G. Ankenman,* of Ganges, are now interning at the Vancouver General Hospital. *Dr. T. Wilkie* has taken over their practice.

Dr. A. D. Young is now associated with *Dr. R. D. Morrison,* of Hope.

Dr. J. W. Irvine is now practising at Dawson Creek.

Dr. J. Marshal is now practising in West Vancouver.

Dr. A. S. Atkins, of Vancouver, has returned to practice in Vancouver after receiving his F.R.C.P., Toronto.

BIRTHS

Born to Dr. and Mrs. *David Herberts,* of Vancouver, a son.

Born to Dr. and Mrs. *Bruce Cates,* of Vancouver, a son.

Born to Dr. and Mrs. *Purie Wolfe,* of Victoria, a son.

Born to Dr. and Mrs. *D. Moyer,* of Vancouver, a daughter.

Born to Dr. and Mrs. *T. Wilkie,* of Ganges, a son.

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