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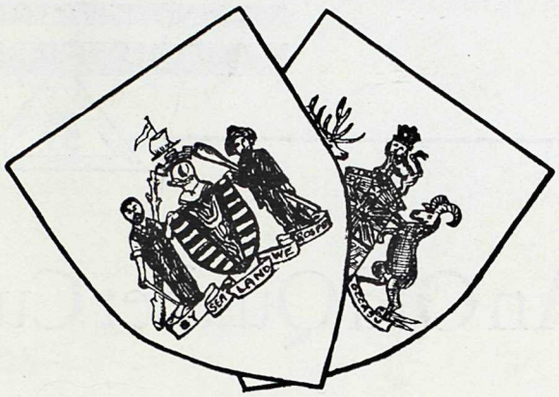

OF THE VANCOUVER MEDICAL ASSOCIATION

Contents

POST-GRADUATE TOUR

ANGINA PECTORIS AND CORONARY THROMBOSIS

A DISCUSSION OF THE PROSTATIC PROBLEM

SUMMER SCHOOL

September 13th to 16th

Vol. VIII. SEPTEMBER, 1932 No. 12

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BULLETIN

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Vol. VIII. SEPTEMBER, 1932 No. 12

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VANCOUVER HEALTH DEPARTMENT

STATISTICS, JULY, 1932

Total Population (Census 1931)		246,593
Asiatic Population (Estimated)		15,000
	Rate per 1,000	Population
Total Deaths	162	7.8
Asiatic Deaths	13	10.2
Deaths—Residents only	146	7.0
Birth Registrations	305	14.6
Male 154		
Female 151		
INFANTILE MORTALITY—		
Deaths under one year of age	20	
Death rate—Per 1,000 births	65.6	
Stillbirths (not included in above)	12	

CASES OF CONTAGIOUS DISEASES REPORTED IN CITY

	June, 1932		July, 1932		August, 1st to 15th, 1932	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	0	0	0	0	0	0
Scarlet Fever	15	0	14	1	6	0
Diphtheria	2	0	3	0	0	0
Chicken-pox	68	0	9	0	6	0
Measles	2	0	2	0	0	0
Mumps	75	0	4	0	0	0
Whooping-cough	32	0	5	1	1	0
Typhoid Fever	1	0	1	0	0	0
Paratyphoid	0	0	0	0	0	0
Tuberculosis	60	12	26	9	14	–
Poliomyelitis	0	0	0	0	0	0
Meningitis (Epidemic)	2	0	0	0	0	0
Erysipelas	0	0	3	0	3	0
Encephalitis Lethargica	0	0	0	0	0	0

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Canadian Stand on Pasteurization

We quote the following excerpts from an editorial which appeared in the January 1932 issue of the Canadian Public Health Journal.

Association Stands for Pasteurization.

"The Canadian Public Health Association stands unequivocally for the pasteurization of ALL milk supplies as the one and only means at our disposal for the final safeguarding of the health of the public from the dangers associated with the consumption of raw milk."

Dr. A. R. B. Richmond, (Toronto)

"The cost is often advanced against the installation of pasteurization. But let any municipality balance the cost of pasteurization against an epidemic such as occurred at Lee, Mass., in 1928, when 1,000 out of 4,000 population were ill at one time and 45 deaths occurred; or that at Kirkland Lake, Ontario, in December, 1930, when there were 500 cases of septic sore throat from the use of raw milk."

Dr. J. W. McIntosh, (Vancouver)

"The point raised by Dr. J. W. McIntosh in the DISCUSSION in regard to the necessity for a standard set of specifications for pasteurization equipment, is important. The specifications should clearly stipulate proper valves, automatic temperature recorders, absence of dead ends, etcetera, and should be such that the dairyman cannot be misled into purchasing or erecting equipment that will not be approved by the health authorities."

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EDITOR'S PAGE

In the sudden death recently, of Dr. A. S. Monro, Vancouver has lost a citizen who has been prominent in its activities for over a quarter of a century. We of the medical profession have lost a colleague whom all of us have known and loved. He died on his way home from the Annual Meeting of the Canadian Medical Association at Toronto. As President of that body, he had attained the highest position open to members of the Canadian profession, and it is pleasant to think that he was privileged to end on so high a note.

We shall miss sorely his vivid and genial personality. "Alec" Monro was one of the most generous and kindly of men and has done kindnesses to many, who will never forget him. It was not in him to advertise his good deeds, and only those whom he helped know the full extent of them. To young medical men, starting on their career, he was especially helpful and friendly. There was no bitterness in his composition, no room for grudges or enmity against any one, though he possessed a quick temper, and could flare up as quickly as he could subsequently cool down and return to his usual mood of pleasant friendliness.

Monro has left his mark on the city he lived in for so long. He was one of the men who led in the establishment of the Vancouver General Hospital and was one of those who supported the idea of placing it in its present site—at a time when Fairview was regarded as the outermost fringe of the city, too far ever to be accessible by ordinary people. He was prominent in the designing of the original building, and was a director for many years; serving as well on the staff.

Of later years, he had developed an intense interest in medical economics and was fully alive to the urgent necessity for reform in this. With characteristic fervour, he plunged into this subject, and in and out of season was ready to discourse on the problems that confront our profession, and the need for facing and grappling with them He felt that the medical profession was being exploited and its generosity abused, by the powers that be, and the public at large, and constantly urged with all the eloquence at his command, that we must resume the control of our own affairs that we appear to have partly lost, lest in time to come, we lose even the part we yet have. His presidential address dealt with this matter —in fact he was wrapped up in the subject, and had made it his religion for the time being. We need more men like this, to whom this question is a burning one, and who are ready to urge it on all occasions, and keep others aware of it

For many reasons, we shall miss Alec Monro. As a friend first, a warm-hearted, kindly friend, who never lost his friendship for those whom he knew, who had no snobbishness in him, no self-seeking in his friendship, no drop of gall in his angers; a likable, lovable fellow that always had a smile and cheery word for those he knew, with numberless little eccentricies and quirks that those who knew him will remember with an amused affection. As a fellow-practitioner who did his work honestly and well, who loved his profession and worked for it, and as a fellow-citizen, who served his city, and loved it and believed in it. He died in harness, and is lucky in that.

ANGINA PECTORIS AND CORONARY THROMBOSIS

Delivered before the Osler Club, by Dr. W. H. Hatfield

I have chosen for discussion tonight the subject of angina pectoris and coronary thrombosis for several reasons. In the first place these are two conditions which are becoming more and more common and may almost be said to be peculiar to western civilization and picking out the more prominent and valuable members of a community. Secondly, our ideas of these conditions a few years ago were vague, but are now becoming clarified by the vast amount of careful clinical and experimental work that has been done of late all over the world. The coronary artery holds as prominent a place in medical literatue today as any part of the human anatomy. The problem is still far from settled, but out of the maze which has always surrounded this subject have come many definite and interesting facts. Coronary artery disease until a few years ago was thought to be extremely rare and was associated with death. Angina was a word that included almost anything giving a pain in the chest, giving rise to such terms as true and false angina, vasomotor angina, angina dolore and others. The whole subject was vague. Many cases called angina were in reality coronary disease. The terms were used loosely and at times synonymously. We now know that all pain in the chest even when associated with heart disease is not angina, and that angina pectoris and coronary artery disease must be looked upon as two separate entities, each giving a well defined clinical picture.

Let us consider for a moment the blood supply to the heart, as a knowledge of it must be kept in mind to understand the pathological processes involved. Contrary to the old belief, we now know that there is a definite anastomosis between the branches of the coronary arteries. However it has been shown by Huber and Silverthorn that there is an inadequacy of communicating branches in human hearts for purpose of complete anastomosis. Following a gradual occlusion of a coronary vessel there is no myocardial damage. So that gradual occlusion is essential to adequate collateral circulation. Some of the difficulty in understanding coronary disease and its sequence is directly attributable to a general disposition to regard the coronary arteries and their arterial bed as an anatomic invariable. Not only are there many normal variations but a still greater variation is brought about by disease. There have been shown to exist some interesting anatomic variations between the right coronary supplying the right ventricle and the branches of the right and left coronary arteries supplying the left ventricle. The branches supplying the left ventricle pass along the surface of the heart just beneath the epicardium. Their branches leave at right angles and pass directly through the myocardium, giving off very few branches until they reach the endocardium, where they again turn at right angles and end in a mass of fine arterioles. By this anchoring of the branches it can be assumed that in hypertrophy of the left ventricle, the blood vessels become elongated and tortuous more readily leading to narrowing and occlusion. The heart has an enormously rich blood supply, averaging one capillary for each muscle fibre in the ventricular wall. There are about twice as many capillaries per square millimetre in ventricular muscle as in skeletal muscle. There is some evidence that there is a direct connection through the

thebesian veins other than that through the capillaries between the coronary arteries and the chamber of the heart, and the capillaries drain directly into the thebesian veins. Under certain conditions as much as 90% of the arterial flow may escape *via* the thebesian veins, and in the event of gradual closure of the orifices of the coronary arteries the thebesian veins can supply the heart muscle with sufficient blood to enable it to maintain an efficient circulation. There has been demonstrated lately an anastomotic blood vessel in the auricular walls, which links up the right and left coronaries. It also supplies branches to the aortic and mitral valves and the base of the aorta.

The coronary arteries are subject to many pathological changes such as atheroma, arteriosclerosis, syphilitic arteritis and the various forms of chronic endarteritis. Sudden occlusion is due to thrombosis and less frequently embolism.

Angina Pectoris

It was Heberden in 1768 who gave us our first clear cut description of angina pectoris. He states that "the seat of it and the sense of strangling and anxiety with which it is attended may make it not improperly be called angina pectoris" and again "in some inveterate cases it has been brought on by the motion of a horse or carriage or even by swallowing, coughing, going to stool, speaking or any disturbance of the mind"—"Angina pectoris as far as I have been able to investigate belongs to the class of spasmodic, not of inflammatory complaints."

He summarizes as follows:

> "In the first place the access and the recess of the fit is sudden.
>
> "Secondly, there are long intervals of perfect health.
>
> "Thirdly, wine and spirituous liquors and opium afford considerable relief.
>
> "Fourthly, it is increased by disturbance of mind.
>
> "Fifthly, it continues many years without any other injury to the health.
>
> "Sixthly, in the beginning it is not brought on by riding horseback or in a carriage as is usual in diseases arising from cirrhosis or inflammation.
>
> "Seventhly, during the fit the pulse is not quickened.
>
> "Lastly its attacks are often after the first sleep, which is a circumstance common to many spasmodic disorders.

He concludes by stating that he has little or nothing to advance in the way of treatment and that "quiet, warmth and spirituous liquors help to restore patients who are nearly exhausted and to dispel the effects of a fit which does not soon go off. Opium taken at bedtime will prevent the attacks at night." Heberden has thus ably described the clinical picture of this condition.

There have been eighty different theories propounded as to the causation of angina. These have varied from tension in a damaged aorta

to deficient oxygenation of the heart muscle. The two theories that have prevailed for several decades are the aortic and the coronary. As increasing number of clinicians are becoming adherents of the coronary artery theory; assuming that the origin of pain is the heart muscle, the nerve supply of the heart muscle and its coverings as related to that of other viscera and adjacent tissues become an important factor in understanding the distribution of cardiovascular pain.

Let us consider for a moment the mental and nervous factors in angina. It is found that the individuals afflicted with angina belong in one group. It is the busy man working at high tension, burdened with many responsibilities, pressed for time and given to worry, that falls a victim. Nervous and mental influences hinge largely on the emotions, which in turn are related, below to the instincts, and above to the ways of the intellect. Life is becoming more strenuous. Speed is a paramount factor. It is difficult to keep pace with the rapid development of things today. The adjustment to life is becoming more and more complex from day to day. Competition is more keen. The really busy and ambitious man has few idle moments mentally. I think we must endeavour in angina to study the personal pathology of the patient. "Are the waters of his life calm and deep or wind blown and wave-tossed?" It is difficult to describe how a mixture of emotion instinct and higher mental control, all affected by environment and education can, fanned by strain and worry, angered by injury or injustice, grieved by disappointment, cause something in the chest which is so severe and disabling, which was described by one author as a veritable epilepsy of the circulation. It is interesting to note that angina is practically unknown in the Negro and Chinese. Both have a placid nature. It is said the Negro never worries for very long, as he cannot worry very well when standing up, and on sitting down falls asleep. In 20,000 negro cases admitted to a southern hospital angina was not diagnosed in one case. Among 24,000 Chinese patients in the Peking Union Medical College only 1 per 1000 suffered from evidence of pain of unstriped muscle. Among the Indian tribes in Panama there is not a record of a single case. When an individual becomes afflicted with angina, we find not only the disability and discomfort caused by the pain but the added element of fear. All people have a dread of heart disease, but especially such a one as this which comes suddenly without warning and creates in many a feeling of impending death. It is truly said that only the anginous have angina and to have angina is to be more anginous. Are we doing our duty to the patient if we only treat the attack, giving the patient something to relieve the pain? Our attention too often is drawn to the heart where lies the centre of pain, with consequent neglect of the personal pathology involved.

Thoracic pain is a common complaint, but only a few of these cases are angina. It is essential in making a diagnosis to have in mind what may cause pain in the chest.

1. Angina pectoris:—a paroxysmal pain which may or may not be associated with demonstrable cardiac disease ranging from a sensation of substernal weight to a severe paroxysm with pain radiating from the epigastrium down to the finger tips.

2. Coronary thrombosis:—A sudden severe thoracic pain usually of longer duration than angina and associated with fever, leucocytosis and often a friction rub.

3. Acute Aortitis:—Syphilitic or rheumatic—usually substernal in location and anginal in kind.

4. Organic heart disease, valvular disease and heart failure.

5. Neurocirculatory asthenia—effort syndrome.

6. Pain involving tissues of left chest wall. This includes hyperthesia of skin, panniculitis of adipose tissue, fibrosis of connectice tissue, myalgia of intercostal muscles and intercostal neuralgia, referred pain from other areas and trauma.

7. Grosser lesions:—Pericarditis, pleurisy, empyema, aneurysm, mediastinal growths, lung tumours and referred pain from diseases of cord and vertebrae.

8. Rare conditions, e.g., phlebitis of the thoraco-epigastric vein.

If one keeps in mind such a differential diagnosis the final diagnosis should not be very difficult. It has been shown that pain as such is felt only in areas supplied by the cerebrospinal system of nerves, and when it arises in a viscus is perceived as pain, only by means of the connection of that viscus with the cerebrospinal fibres distributed to the body wall, corresponding in segmental area to the organ involved, and it comes about when the contractions are unduly strong or when the organ is poorly supplied with blood, or when the central nervous system becomes unduly sensitive. This arises from a damaged heart muscle or secondarily when a normal stimulus is exaggerated by a hypersensitive nervous system. Therefore, pain brought on by exertion, radiating down the arm and accompanied by anxiety and respiratory oppression and subsiding with cessation of effort, may be due to coronary disease or aortic syphilis, or may occur when neither is present. Our attention, therefore, must not be focussed on the type of pain in an effort to distinguish the underlying pathology, but rather on other accompanying signs, such as evidence of arterial disease in retinal vessels or radial artery, blood pressure, hypertrophy of the heart, X-ray, electrocardiograph and serological evidence of syphilis. A definite diagnosis must be made to remove the anxiety and fear element which is such a prominent feature of angina.

Coronary Disease

The problem of angina pectoris and that of coronary disease are closely linked. Angina may be present alone, i.e., the symptom complex without any evidence of heart disease, or it may be complicated by change in the coronary vessels. Coronary thrombosis with cardiac infection has been recognized for a long time, but it was Herrick in 1912 who made it known as a clinical entity and showed that it was not always fatal. A case has recently been reported where a young man received a stab wound in the chest, the knife severing the left coronary artery. He was operated upon immediately and the left coronary ligated, thus producing a sudden coronary occlusion. He made an uneventful recovery.

Conorary occlusion, however, occurs in those of more advanced years where the arterial system is not able to readjust itself as readily as in the young. Herrick in 1919 proposed an appropriate classification of the clinical forms into four types.

1. Those of instantaneous death.
2. Those in which death occurs in a few minutes or a few hours.
3. Those where death is delayed days or months.
4. A group that is assumed to exist, embracing cases of a mild type, i.e., due to obstruction in the smaller branches of the arteries.

The clinical picture of coronary occlusion has now become so clearly defined as to permit of its ready diagnosis. The important feature is to have it in mind. Pain is the outstanding and most characteristic symptom. It is severe and prolonged and not relieved by nitrites. There may or may not be a history of previous chest pain, but the patient immediately realizes this is something new. It is sudden and agonizing, necessitating large doses of morphia for relief. It may extend into the upper abdomen, which at times has led to a diagnosis of an upper abdominal catastrophe requiring surgery. The patient is usually in a state of shock, the blood pressure drops, the heart sounds are weak and a praecordial friction rub is occasionally heard, usually between the second and fourth day, and usually transient. Leukocytosis with fever is a characteristic response to the cardiac infarction.

Electrocardiography

The electrocardiograph gives us most valuable diagnostic information in coronary disease. The changes in the tracing are mainly concerned with the QRS complex and the T waves. There is the typical coronary type T wave ,originally described by Pardee in 1920. This was present in one-third of his patients who gave symptoms of coronary narrowing of infarction. It has a high take-off from the descending arm of the R wave and has a toboggan-slide effect, being sharply inverted, and thus obliterating the usual ST isoelectrical interval. Pardee has recently called attention to a type of Q wave in lead III. This wave must be at least 25% of the greatest excursion of the QRS complex in any lead and succeeded by a definite upward deflection R and no S wave. Only those of left axis or normal axis deviation are included. In 63% of cases exhibiting this one finding there occurred the anginal syndrome. Willius reports 300 cases all but 3 of which had cardiac abnormality. Although this occurs in some cases of angina, many cases will be found which show a normal tracing.

Prognosis in Angina

Coronary thrombosis is a frequent complication of angina pectoris along with other cardiac abnormalities, so that the prognosis depends to a great extent whether we are dealing with uncomplicated angina or angina plus some other heart disease. White and Bland report a series of 500 patients of which 213 are dead with an average duration of life of

4.4 years after the onset of the disease. Of the ones who died, death was due to failure of the heart in 82%. 19% had normal hearts on physical examination, normal blood pressures and normal electrocardiograms. This combination of findings is found to be unusually favorable. The presence of hypertension did not seem to be of importance.

Prognosis in Coronary Thrombosis

The patient often survives coronary thrombosis for many years in good or fair condition. A careful history and physical examination and electrocardiogram often reveal evidence that such an event has occurred in the past. Of a series of 200 cases reported by White & Bland, 101 are dead with an average duration of life following the attack of 1.5 years. The younger patients as a rule live longest Conner & Holt in reporting 287 cases give an immediate mortality in the first attack of 16.2%. In 62% of their cases the attack supervened without antecedent circulatory symptoms. The sex appears to be of little importance. The previous occurrence of angina irrespective of its duration seems to have little bearing. Hypertension is of little or no importance and syphilis is encountered rather rarely. Cardiac enlargement of considerable degree is to be looked upon as unfavourable. There are few diseases in which the prognosis in any individual case is more difficult to predict than in coronary thrombosis.

Treatment

To treat a disease implies diagnosis. There is nothing in medicine that we have to be more definite about than heart disease. To the lay mind anything referable to the heart implies impending death and gives to the individual an outlook of hopelessness. In angina we must not only give relief to the attack but consider the interval. The patient must be viewed not physically only, but as a personality. To increase the tension of the nervous system in an aging vascular system is in many people to bring on the pain. We must not only ascertain the physical condition of the individual, but discover what he is doing to life. All people have two businesses, i.e., their vocation, the other is just living, their ambitions, endeavours and problems and particularly their reactions. Dr. James Stewart in speaking of cardiac drugs said "But the greatest of these is hope"—Let us therefore study our patients, re-assure them, and lift the added burden which heart disease has come to mean to them. Many of these patients with angina have either lost or have never learned the art of relaxing. An emotional upset is all they need to throw them into an attack. As John Hunter has said "His life was in the hands of anyone who chose to annoy him." The cellular pathology in many is to be ignored and stress placed on the personal pathology. As Roberts in a recent article states concerning a case, "Each weekly visit was spent in psychotherapy which is nothing more than clinical power, presence and personality flowing through conversation, explanation and encouragement. Written instructions are often necessary concerning rest, habits, etc. Long periods of bed rest have not been dramatic. Relative rest by starting later in the morning, a longer noon hour and stopping earlier at night with a

longer night's rest in bed and with no exertion immediately after meals is of more benefit.

For medication the theobromine derivative metaphyllin or emphyllin O.1 gm. three times a day is useful. It would be impossible of course to get along without the use of the nitrites which were first introduced in 1867.

In coronary thrombosis morphine in large doses is essential. The nitrites are not only useless but may even be harmful in the acute attack. The relief of pain is very necessary, for while in pain rest is impossible and there is nothing more important than rest. Special nursing is essential and the patient should not even be allowed to feed himself for several days.

The use of digitalis is dependent upon the development of signs of myocardial failure. It is often advisable to give digitalis soon after the onset of coronary occlusion. After the acute symptoms subside, signs of myocardial failure may develop and it is here that digitalis has its main use.

It has been shown that the heart is extremely sensitive to changes in blood supply. The experiments of Smith and his co-workers indicate that the rate of coronary flow is greatly altered by the change in diastolic pressure, so that the maintenance of an efficient coronary circulation is dependent on the height of the diastolic pressure. Drugs which produce an increased coronary flow increase diastolic pressure.

It has been shown by perfusion experiments in cats that caffeine in dilution of 1 to 25,000 and 1 to 50,000 increased coronary flow 41% and theophyllin in the same dilution 25% to 45%, while emphyllin increased the rate from 40% to 90%. Theobromine, itself, may be employed and recently theocalcine has been recommended. The manner of action of these drugs in producing an increased coronary flow and their diuretic action is not yet properly understood.

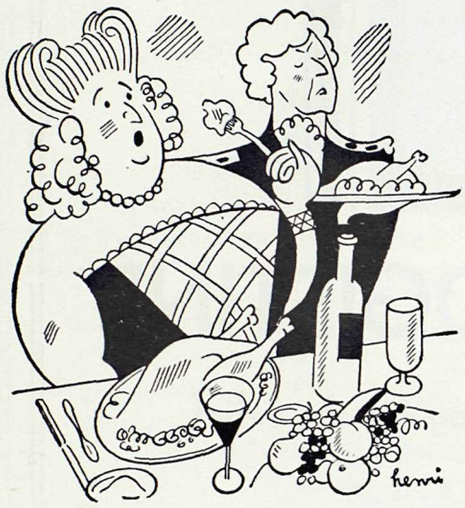
After the acute stage in coronary thrombosis, a period of weeks in bed is essential to enable the establishment of a maximum collateral circulation. The management after the patient is allowed out of bed is also of great importance. All activities must be carefully regulated and graded exercises have an important function. The patient must not be allowed to extend himself to the point of shortness of breath.

In a number of cases medical treatment has been of little avail, as the patients have frequent and severe attacks of pain.

The field of surgery was opened to these cases and now operative treatment has become a necessary and most valuable aid in treatment. Operative treatment of praecordial pain was first practised by Jonnesco in 1916 with the idea of abolishing the nervous arc between the heart and the sensorium. It is analogous to the treatment of tic douloureux. Alcoholic paravertebral injection gives relief in approximately 50% to 75%. It is apparently free of most of the ill effects of operation. This of course gives only symptomatic relief, and special care is necessary to avoid unnecessary effort, as the warning signal has disappeared.

GASTRIC FABLES

The sad but INTERESTING *Case of Mme. de Sable*



The Marquise de Sable loved good things, was something of a gourmande, and enjoyed a reputation as a "veritable gastronomic authority." La Rochefoucauld praised highly her potage with carrots, capon stuffed with prunes, and rated her truffles above his own "Maximes."

But Madame de Sable suffered from the venerable disease of hypochondria. Her morbid anxiety to safeguard her health, which finally became the ruling passion of her life, began innocently enough in a healthy appetite. But careful as the Marquise was to avoid disease, she let her appetite rule and her stomach suffer.

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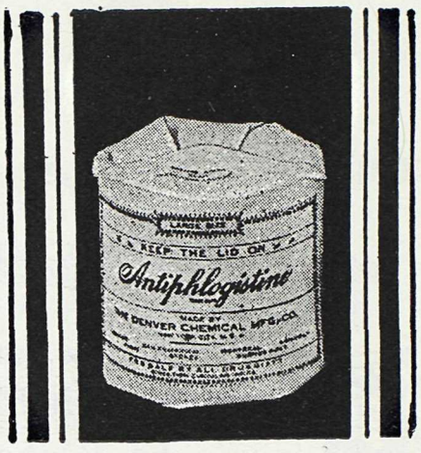

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Nine cases of complete ablation of the sympathetic ganglion on both sides are reported with complete relief in all cases with no mortality. In 18 cases of left sided ablation there was complete relief in 8 cases, improvement in 5 and no results in 2 with three deaths. Posterior nerve root procedures have been reported in 26 cases with doubtful results in all. In the procedure of alcohol injection, there occasionally develops distressing hyperaesthesia. Lasting 2 to 6 weeks after anaesthesia has worn off, improvement has continued 6 to 7 months after injection and a number of patients have returned to work. Operative procedure has produced some dramatic results, but the results are not uniform and there has been a fairly high mortality. It is to be used as a last resort, but as time goes on and more work has been done from the surgical angle the procedure may become more valuable. Alcoholic injection is still preferable to surgery.

The treatment of a case of angina pectoris or coronary thrombosis is more or less an individual matter. It is impossible to lay down any definite rules applicable to all cases.

* * *

A DISCUSSION OF THE PROSTATIC PROBLEM

(An abstract of paper delivered by Dr. Wm. E. Lower at a recent meeting of the V.M.A.)

It has long been known that the growth and development of the prostate gland was influenced by the testes. In order to determine the physiological relationship between the gonads and the prostate and to ascertain the source of the hormones which govern prostatic activity, various studies were made on castrated animals and eunuchs. Following bi-lateral orchidectomy the prostate became small, firm and fibrotic. In our series of ten eunuchs the prostates were all small and atrophic. However, castration is an undesirable clinical procedure from the psychogenic point of view, and it, therefore, seems necessary to develop some method by which testicular function can be inhibited without the removal of the gonads. We found ligation of the vasa deferentia in rats did not change the prostate, testicles or seminal vesicles, but when the spermatic vessels were ligated there was pronounced degeneration of the interstitial and testicular cells of the gonads with generalized fibrosis of the prostate. Experimentally we were able to abolish testicular function by the implantation of massive doses of radium seeds into the testes or by subjecting

the glands to destructive doses of the X-ray. In animals so treated the prostate became small and atrophic. The tubular tissue of the gonads was very sensitive to radiation, while the interstitial cells were quite radio-resistant. To determine the influence of the tubules, therefore, we subjected the testes of rats and dogs to small doses of radium and X-ray. In all animals the testes were decreased in weight and size by fifty per cent. There was a complete destruction of the tubular tissue with an increase in the number of the interstitial cells, and both the prostate and seminal were hypertrophied. Thus it is apparent that the testicular tubules, germinal epithelium and spermatogonia do not exert a regulatory control over the prostate. The interstitial cells of the gonads, not being injured, were able to produce sufficient hormone to maintain prostatic growth.

The testis is not a self-contained functioning organ, but is in turn dependent on secretions from the anterior lobe of the hypophysis for its power to provide male hormone. In order to study the influence of the hypophysis on the secondary sex organs and eliminate any extraneous factors, we carried out a series of experiments by parabiosis, joining two animals together by a common opening of their peritoneal cavities. This union, we found, did not disturb the normal physiology. When castrated male rats were twinned with normal males the prostate and seminal vesicles of the castrate became small and atrophic and the pituitary gland increased in size. In the normal partner the testes, prostate and seminal vesicles were hypertrophied but the pituitary remained normal. When the rats were permitted to live for thirty days the prostate was increased both in size and weight from three hundred to five hundred per cent. The gland was quite firm and had a preponderance of glandular tissue, and the enlargement was uniform. After ablation of the gonads the hypophysis increases in size and function. The excessive prehypophyseal hormone passed from the castrated animal over into its normal partner and caused the testes to secrete an excess of the sex hormone which resulted in hypertrophy of the prostrate. That the hypophysis of a castrated male is hyperfunctioning can be demonstrated by twinning a castrate with a normal female. The pituitary secretion passed into the female and stimulated the ovaries and produced a protracted oestrous cycle and enormous enlargement of the horns of the uterus and vagina. Similar results were obtained by injecting anterior pituitary extract directly into a normal female.

Thus by merely altering the endocrine system so as to cause hyperfunction of the pituitary gland and permit the hormone to pass into a normal rat, we have obtained a prostatic hypertrophy. A control of this regulatory mechanism of the influence of the hypophysis upon the sex glands may furnish the solution for the prostatic problem.

* * *

THE POST-GRADUATE TOUR—MAY, 1932

DIARY OF DR. A. GIBSON (*Member of Tour*)

We have Dr. Gibson's kind permission to publish the following, which explains itself. It was written with no thought of publication, but it is so vivid and fresh an account of impressions gained by a visitor to B. C. that it is with great pleasure we publish it.—(Ed.)

May 22nd, 1932—Left Winnipeg at 9:45 a.m. Dust storms all the way through Saskatchewan. Changed at Medicine Hat, 2:15 a.m.

23-5-32—Met Pope at Crow's Nest. On the train talked with Dr. Corson of Fernie. At Cranbrook we arrived at 2:30 p.m., and went off at once to the Nurses' Home, St. Eugene Hospital. There were 11 doctors, two medical students and about 12 nurses. Pope spoke on Disorders of Sensation. I gave a clinic on a case of injury to the back of four years duration with all the hall-marks of Hysteria. Pope demonstrated the sensory changes. I spoke on Injuries to the Back, and emphasized the point of hyperextension. Hunter of Vancouver spoke on Urological Emergencies, shewing lantern slides. Adjourned to the hotel where had dinner, and after that we returned to the Hospital where I spoke on some fractures, with special reference to Colles' fracture. General discussion was good. To bed about 1 a.m.

24-5-32—Up about 7 a.m. Breakfast and out to the Sullivan Mine at the invitation of Dr. Hazard of Kimberley. Were met by Montgomery, Mine Supt., also Mr. Archibald and Mr. Lindsay. We went through the mine under their guidance; went in the tunnel at the 3900 foot level. Goes straight in for 9000 feet. From there we walked through different drifts, cross-cuts and saw all sorts of processes. They have their tool-shops, electric light, electric furnace for sharpening the drill points, excellent water with drinking fountains through the mine. There is a model of the ore body which shows the developed portion and some of the undeveloped, also the prospects for further excavation. We brought a small specimen shewing zinc and lead. Had lunch with Dr. and Mrs. Hazard, then drove back the 20 miles to Cranbrook and caught the train with practically nothing to spare.

The Sullivan Mine is evidently being thought of as not for the next few years but for an indefinite time. Tremendous concrete pillars are being put in to support the roof where the ore has been removed. The ore body is in places over 200 feet across. The richness of the mine is apparently almost inexhaustible.

Some of the men came a great distance to hear the papers. One came from Invermere, a distance of about 120 miles.

Train to Nelson. Arrived at the Hume Hotel and found opposite it a group of tents, the temporary abode of a number of the arrested Doukhobors. The meeting was held in the Nurses' Home of the Hospital. There were present 15 doctors and about 23 nurses. Refreshments were served afterwards and we got back and to bed about midnight. Three men had driven from Trail a distance of 48 miles and one from Nakusp 100 miles distant. I spoke again on Fractures of the Spine. Pope spoke on Disorders of Sensation, and Hunter on Urological Emergencies.

25-5-32—Up at 6 a.m. Breakfast at 7 a.m. with Hunter. Hunter drove with Laishley, I with Shaw to Trail. We spent the whole morning in the Plant of Consolidated Mining and Smelting. It is a wonderful place. The chief metals produced are Zinc and Lead; there is also a

certain proportion of cadmium, silver and gold. We saw all the processes, but were unable to see the whole of the plant on acount of the shortness of the time. We passed the Fertiliser Plant up on the hill, but it would take at least a whole day to make even a cursory examination of the place. In the afternoon played golf with Thom; played badly. Evening supper with Dr. and Mrs. Thom at their home. Am greatly surprised at the beauty of the gardens. Evidently the smoke nuisance has been pretty well overcome. After supper saw the Hospital at Trail, and then was driven by Leonard to Castlegar where I joined up with Pope who had spent the day resting. I did not mention how interesting was the drive to Trail in the morning. We saw the hydro-electric developments of the West Kootenay Power Co., at Bonnington Falls. The Columbia River is almost at high water, and the scenery is striking. We also passed through the midst of the Doukhobor settlement where there is so much trouble. No nude parade was staged for our benefit. Apparently these people work hard and cultivate the ground, but they spend very little, and in no sense mingle with the general interests of the community as a whole. Their interests are concentrated on their own community. We saw the grave and monument of Peter Veregin, who was blown up by a bomb. The monument has been partially destroyed by his enemies. They are at variance among themselves; the recalcitrant party are the Sons of Freedom, and their quarrel is not against the ordinary inhabitants but against another sect of their own persuasion. Their religion forbids them to go to law, so they obey the Scriptural Command, "If any have taken from thee thy coat, give him thy cloak also." Hence the nude parades. It appears to be noteworthy that the parades are always staged on a Sunday when there is likely to be a fairly large gathering of spectators. The problem appears to be a very grave one to the good people of Nelson. I also forgot to mention that we brought away a small piece of ore from the Sullivan mine which gives some idea of the richness of the mine and from the C. M. and S. a small ashtray of zinc 99.9% pure. They make interesting little souvenirs.

26-5-32—Arrived at Penticton at 8:30 a.m., and had two hours to wait for the bus to Kelowna. We spent most of the time in the Hotel Incola; I was able to finish a skeleton of the paper on Arthritis. It was rather pathetic to see the large dining-room set out for perhaps a hundred people for breakfast, and not one person to patronize it. We had already rushed our breakfast on the train or we might have lent a little patronage. The stage drove along the west side of Okanagan Lake for about 27 miles and then was transported over a ferry from Westbank to Kelowna. It was a warm day with pitiless sunshine. At Kelowna we put up at the Royal Anne Hotel, a new building run on the American plan and quite up-to-date in every respect. We spent the afternoon playing golf, a threesome; the course was potentially very attractive, but the ground was hard and parched and the greens were of sand. I found the round very tiring and was relieved when it was finished. The evening meeting was held in the Oddfellows Hall and was attended by some 35 members of the B. C. Association. I spoke on Arthritis and there was some discussion. Evidently there is a good deal of interest in this condition. Pope spoke on Medical Emergencies and put in a plea for the special teaching of these, to counteract the idea that practically all emergencies are surgical.

27-5-32—Up at 6:30 a.m. Had a walk before breakfast at 7:30. After that to the Hall, where Hunter spoke on Haematuria, a good paper, and after that a paper from Williams, of Trail, on the Pelvis. It was very practical and devoted a good deal of time to the Anatomy of the pelvic floor. This paper was enthusiastically received. I next spoke on the Mechanism of the Foot. There was some discussion but I rather think the paper is a little too anatomical to make much of an appeal to the general practitioner, and I doubt if I did much to convince them of the question of springs as against arches. It is so simple (although so ineffective) to send patients to get "foot supports" instead of making them work out their own salvation that I feel doubtful if the presentation was worth while. In the evening there was a public meeting. Pope spoke on the subject of "Sleep" and I followed with "The Craft of Surgery; then and now." Both papers went faily well. We then went to a dance in Scout Hall and got back to bed about 1:30 a.m. The Public meeting was attended by about 125 people.

We had lunch as the guests of Dr. Knox, The President. I sat next to R. E. McKechnie. He is the doyen of the Coast Surgeons and made an interesting dinner-companion. He told of homesteading in Southern Manitoba about fifty years ago. He has seen the West grow up from the time of the arrival of Steel. In the evening midway through the Dance, Purvis and myself went to Dr. Knox's home and saw a number of pictures of the progress of his brother who had had an excision of a good part of the cheek on account of a malignant growth. This was followed by a whole thickness transplanted from the forehead and he seems to be doing well. Also met Underhill, a former student now in practice in Kelowna; seems to be doing well; he had charge of the arrangements for the meeting. Went with him to the High School Auditorium to look over arrangements for the Public Meeting.

28-5-32—Felt a little tired this morning and did not get up until 8 a.m. F. M. Black came to the Hotel and we had a chat. The Mayor, Dan Gordon, a good Scot from Beith, Ayrshire, also came down to invite us to lunch and after that to have a drive around the district. This was the alternative to taking part in the Golf Tournament, and as the day was hot, it seemed the better plan. Pope and myself had lunch at his home, and then with T. Norris, a lawyer and apparently a very good fellow, drove around the vicinity for about 70 miles. We saw the orchards and the vineyards which are somewhat of a new venture. Down in the flats the soil is chiefly suited for truck gardening, but on the "Benches," i.e., former lake shore levels, the apples, cherries, plums and grapes flourish best. There were also remains of a former trade in tobacco, but this has largely disappeared owing to mismanagement and cupidity. We next went to one of the fruit packing plants, but of course on account of the season there was no work going on. However, we went through a cold storage part of the warehouse, and were treated to some apples of the "Delicious" variety which had been in cold storage since the previous September. Cool almost as ice they were good indeed on a warm afternoon. An attempt to see if any of the wine of the country were available for appraisal was frustrated by the building being closed, and we went to the Club for a little refreshment. Later in the evening the Banquet was held. Both

Pope and myself spoke in appreciation of the hospitality we had received. After that there was dancing and so to bed.

29-5-32—Nothing much to do to-day until leaving for Kamloops about 3 p.m. The way lay north through Vernon; on the way we passed Long Lake a very attractive sheet of water. We bowled along in Wallace's new Auburn car and made Kamloops shortly before 6 p.m. We had dinner and then went for a drive to the Sanatorium at Tranquille. This was about ten miles distant. Kamloops is situated at the junction of the Thompson and the South Thompson rivers. The Indian name Kamloops is said to mean "Meeting of the Waters." We loafed around the Plaza Hotel until train time 11:50 p.m. and then got aboard the main line train for Vancouver. We reached this spot at 9 p.m. and had breakfast. Fred Bell came to see us and arrange for our entertainment to-day, and again when we return on Friday next.

We had dinner in the Vancouver Hotel as the guests of Dr. Murray Blair. Present were Drs. Gillies, Turnbull, Fred Bell, Vrooman, Seldon and ourselves. At 8 p.m. we went to the Auditorium of the Medical-Dental Building, and gave our papers. Pope spoke on a Simplified System of Spinal Neurology, and I on fractures of the Spine. There were about 80 men present. Discussion by several. After the meeting we went with Dr. George Seldon to the home of Dr. Gillies, where light refreshments were served. At midnight we sailed on the S. S. Princess Elizabeth.

31-5-32—Had a good night's sleep and got up after the boat had reached the dock at Victoria. We decided to have breakfast aboard, and after his meal went to the Empress. The morning bright and rather warm.

Had a visit from Dr. Moore, the president of the Victoria Medical Association. He took us to St. Joseph's Hospital and to the Jubilee Hospital. No clinical work was done but we chatted with some of the men.

We went to the home of Dr. Herman Robertson for refreshment or *medicamentum restitutionis* as it was called, and then to the Union Club for lunch. After that Baillie, Pope and myself went to the golf course at Oak Bay for a round. This was exceedingly sporting. Baillie played our best ball and we were a shade the better. We left for Victoria about 6:30 p.m., and got ready for dinner. This was a rather formal affair held in the Empress. There were 38 present, and all had taken the trouble to dress for the occasion. After dinner Pope spoke on Scoliopathexis, and I followed with "Some Knee Joint Conditions." There was a little discussion afterwards but all were keenly interested or at least appeared to be so. Tomorrow we leave shortly after 9 a.m. for Nanaimo.

1-6-32—Up about 7 a.m., after rather a poor night's sleep. We did not get to bed until about 2 a.m. and the morning arrived too soon. Visited by Dr. Barrett and his son regarding the condition of the latter's feet. Says I saw the boy in 1926. Double Claw Foot but manages to do his work and play rugby. Suggested exercises, no operative measures. Breakfast in the Empress, then on the road. MacPherson had very kindly set the time aside to drive us to Nanaimo, about 80 miles, rather than have us go on the bus.

On the way stopped at the Solarium at Mill Bay. Shown around by Dr. Wace. Arrived Nanaimo about 2 p.m. and found a gathering of about 14 awaiting us. Had lunch, then Thomson and Pope spoke while I went with Dr. Eakins to see the big primeval timber at Cameron Lake about 40 miles north. It was a fine drive and we came back through Qualicum Beach of which I had heard so much. Got back to find dinner begun; joined in, made a speech of sorts and then went out to see the Bastion, a relic of the Indian fighting days, of which the inhabitants of the city are very proud. Thereafter to another meeting when I spoke on the subject of Arthritis (by request), Pope followed with Scoliopathexis, and afterwards I spoke shortly on Treatment of Fractures of the Spine by hyperextension, a matter of topical interest. Meeting finished with the usual vote of thanks. To bed after 12 p.m. Some of the Doctors had to drive 70 or 80 miles after 11 p.m. It makes one feel that one has not done enough for these fellows. They are thirsting for information and are willing to give of their best in recognition of a very moderate offering. Some 14 of them were at the meeting. A fair amount of discussion.

2-6-32—Up at 7 a.m. Fletcher, Thomson, Pope and I travelled by boat to Vancouver, arriving about 10:30 a.m. Walked up from the boat, called in at the C.N.R. and arranged about validating our tickets over the Union Steamship Co.'s boat. Back to the Hotel and arranged our *pied a terre*. At noon met Dr. Mackay and was taken out by his care to Hollywood Private Asylum where Dr. John Robertson received us and provided lunch. We saw over the place and Pope spent some time examining a case of doubtful Tabes. At 3 p.m. we made our way to the hospital and found a large gathering of Doctors (45 to 50) to hear us. Five cases were present for clinic by myself; arthritis and two accident cases, both Finns, in whom the physical element was overwhelming. It is very instructive to see how prominent the factor of fear is when times are bad and the prospects of work are doubtful.

After the clinic, Thomson spoke on the after treatment of abdominal cases, while I saw one or two more cases for individual men, including an interesting fracture of the humerus with rather slow union. Dinner was appointed for 6:30 at the golf club, but we were as usual a bit late on account of going to "Number 9" to see especially a family, five brothers who had been brought in from Round Top, B. C., all of whom were imbeciles; three others are at home who have just sufficient intelligence to escape being certified. The family had come to B. C. from Alberta, so it may be imagined that the opportunity of teasing Pope was not lost. There was another family of five in the same mental state. This matter of the preservation of mindless pets by the state is one of the utmost seriousness. Dinner at the Club was accompanied by the customary speeches. Pope suggests that whereas at the beginning of the trip it was a bit of a punishment to be forced to make a speech, by the end of the tour it will be looked upon as rather a dirty trick if we do not get an opportunity to orate. Perhaps he is right. In any case it is not nearly so much of an ordeal as it was at first.

(*To be continued*)

INDEX

Abdominal Operations, Emergency, J. W. Thomson 157
Abstract, W. K. Burwell 29
American Urological Association Meeting 233
Angina Pectoris and Coronary Thrombosis, W. H. Hatfield 240
Annual Dinner 46
Annual Meeting, B. C. Medical Association 156, 198
Appleby, L. H., "Recent Surgical Advances" 176
Associated Clinics of Physio-Therapeutics 42
B. C. Medical Association Annual Meeting 156, 198
B. C. Medical News 147
Baird, M. McC. "Clinical Aspects of Some Blood Diseases" 89
Birchard, C. C., "Heart Signs and Symptoms" 7
Blood Diseases, Clinical Aspects of Some, M. McC. Baird 89
Burris, J. S., "Surgical Treatment of Pulmonary Tuberculosis" 68
Burwell, W. K., Abstract 29
Cancer of the Breast, J. W. Thomson 15
Cancer Meetings 67, 88
Challenge of Status Lymphaticus, W. N. Kemp 141
Clinical Aspects of Some Blood Diseases, M. McC. Baird 89
Clinical Meetings 26, 67, 88, 155
Coleman, R. E., "Medical Economics" (1) 121
Coleman, R. E., "Medical Economics" (2) 144
Coleman, R. E., "Medical Economics" (3) 168
Coleman, R. E., "Medical Economics" (4) 191
Coleman, R. E., "Medical Economics" (5) 201
Coleman, R. E., "Medical Economics" (6) 222
Day, E. E., "Indications for Endoscopy" 136
DesBrisay, H. A., "Syphilis in Medical Practice" 47
"Diseased" Buildings, from Mental Hygiene Bulletin 98
Dyer, H., "Tracheotomy in Children" 110
Early Colonial Hospitals, A. S. Monro 226
Emergency Abdominal Operations, J. W. Thomson 157
Endoscopy, Indications for, E. E. Day 136
Etiology of Status Lymphaticus, W. N. Kemp 210
Fractures, Modern Management of Some Common, D. M. Meekison 77
Fractures, Modern Management of Some Common, D. M. Meekison (Cont.) 99
Fractures, Principles in the Treatment of, A. B. Schinbein 72
General Meetings 26, 47, 67, 88, 134, 155
Gibson, A., Diary on Post-Graduate Tour 248
Gibson, A., "Injuries to the Spine" 199
Graham, Colin, "Inflammation of the Nasal Sinuses" 117
Hatfield, W. H., "Angina Pectoris and Coronary Thrombosis" 248
Heart Signs and Symptoms, C. C. Birchard 7
Home Treatment of Tuberculosis, A. S. Lamb 33
Hospital Records 30
Hunter, A. W., "Urological Emergencies" 206
Indications for Endoscopy, E. E. Day 136
Inflammation of the Nasal Sinuses, Colin Graham 117
Injuries to the Spine, A. Gibson 199
Kemp, W. N., "Challenge of Status Lymphaticus" 141
Kemp, W. N., "Etiology of Status Lymphaticus" 210
Kidd, G. E., "Tumour Metastasis" 164
Laboratory Bulletins 126
Laboratory Specimens, Collection and Delivery of 9
Lamb, A. S., "Home Treatment of Tuberculosis" 33
Library News, Abstracts, Additions 89, 214, 224
Library News, Book Reviews 31, 216, 224
Lockhart, W. T., "Treatment of Syphilis" 54
Lower, W. E., "A Discussion of the Prostatic Problem" 247
Medical Economics (1), R. E. Coleman 121
Medical Economics (2), R. E. Coleman 144
Medical Economics (3), R. E. Coleman 168
Medical Economics (4), R. E. Coleman 191

Medical Economics (5), R. E. Coleman 201
Medical Economics (6), R. E. Coleman 222
Meekison, D. M., "Modern Management of Some Common Fractures" 77
Meekison, D. M., "Modern Management of Some Common Fractures" (Cont.) 99
Meetings: Cancer 67, 88
Clinical 26, 67, 88, 155
General 26, 47, 67, 88, 134, 155
Special 5, 199
American Urological Association 233
B. C. Medical Association Annual Meeting 156, 198
Moffat, W. A., Case Report of Purpura Haemorrhagica 32
Monro, A. S., "Early Colonial Hospitals" 226
Monro, A. S., Obituary 239
MacKay, Fred, "Poliomyelitis" 5
Nasal Sinuses, Inflammation of, Colin Graham 117
Ootmar, G. A., "Undulant Fever in the Okanagan Valley" 126
Osler Dinner 134
Physio-Therapeutics, Associated Clinics of 42
Poliomyelitis, Fred MacKay 5
Pope, E. L., "Simplified Spinal Neurology" 199
Post-Graduate Tour, Diary of Dr. A. Gibson 248
Principles in the Treatment of Fractures, A. B. Schinbein 72
Procter, A. P., "Struggle to Maintain the Educational Standards of the Country in the Treatment of the Sick" 148
Prostatic Problem, A Discussion, W. E. Lower 247
Purpura Haemorrhagica, Case Report, W. A. Moffat 32
Recent Surgical Advances, L. H. Appleby 176
Schinbein, A. B., "Principles in the Treatment of Fractures" 72
Simplified Spinal Neurology, E. L. Pope 199
Special Meetings 5, 199
Spinal Fluids, Provincial Board of Health Laboratories 110
Status Lymphaticus, Challenge of, W. N. Kemp 141
Status Lymphaticus, Etiology of, W. N. Kemp 210
Struggle to Maintain the Educational Standards of the Country in the Treatment of the Sick, A. P. Procter 148
Summer School 176, 200, 234
Summer School Programme 236
Surgical Advances, Recent, L. H. Appleby 176
Surgical Treatment of Pulmonary Tuberculosis, J. S. Burris 68
Syphilis in Medical Practice, H. A. DesBrisay 47
Syphilis, Treatment of, W. T. Lockhart 54
Thomson, J. W., "Cancer of the Breast" 15
Thomson, J. W., "Emergency Abdominal Operations" 157
Tracheotomy in Children, H. Dyer 110
Tuberculosis, Home Treatment of, A. S. Lamb 33
Tuberculosis, Surgical Treatment of Pulmonary, J. S. Burris 68
Tumour Metastasis, G. E. Kidd 164
Undulant Fever in the Okanagan Valley, G. A. Ootmar 126
Urological (American) Association Meeting 233
Urological Emergencies, A. W. Hunter 206
Vital Statistics 1, 21, 43, 63, 83, 106, 131, 152, 173, 196, 218, 238

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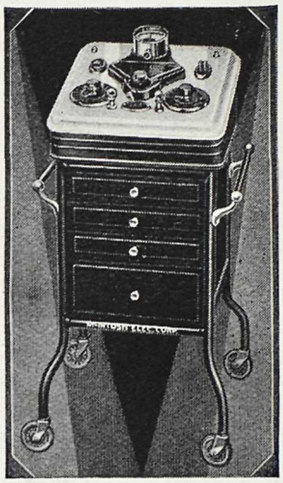

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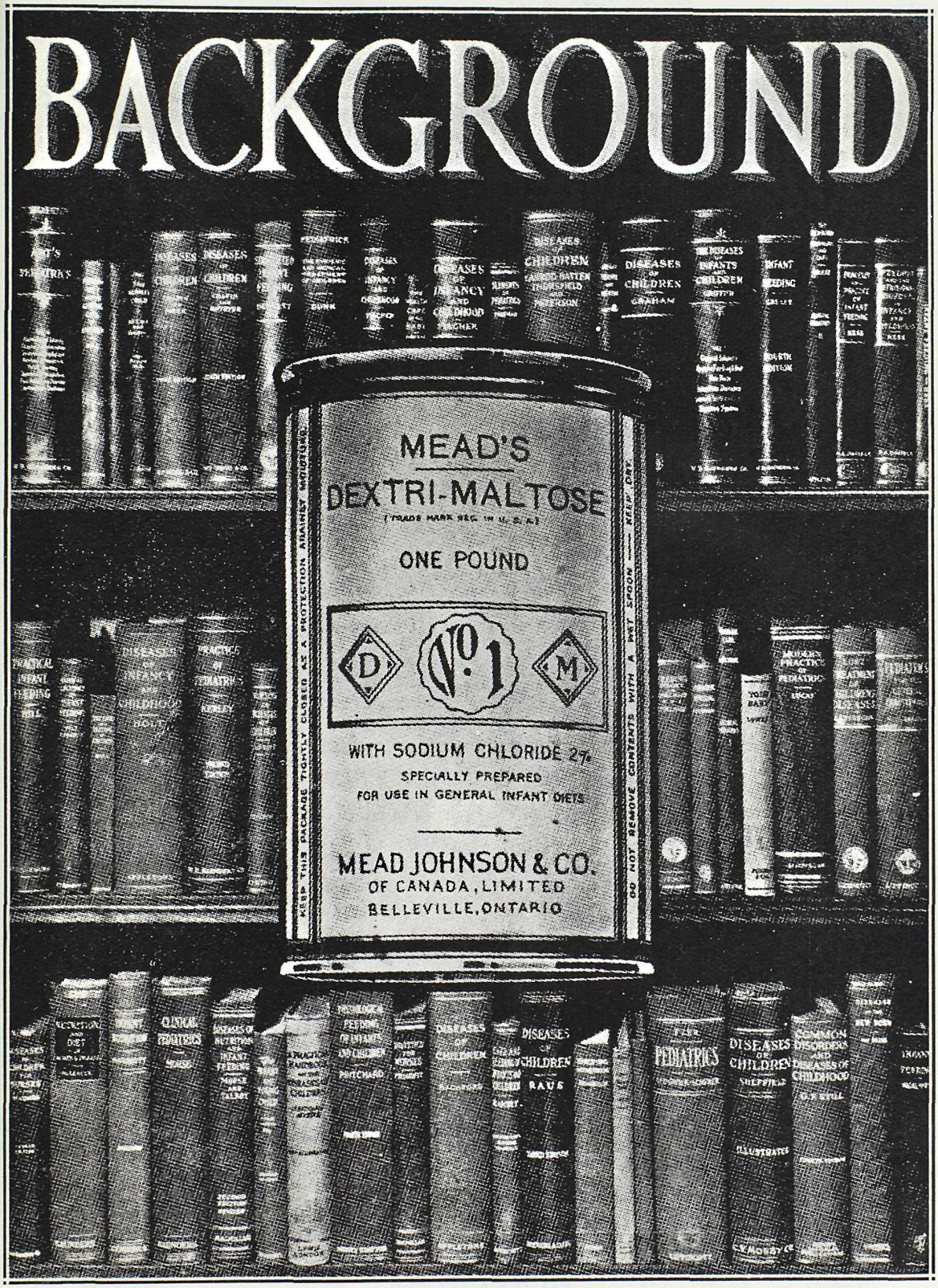

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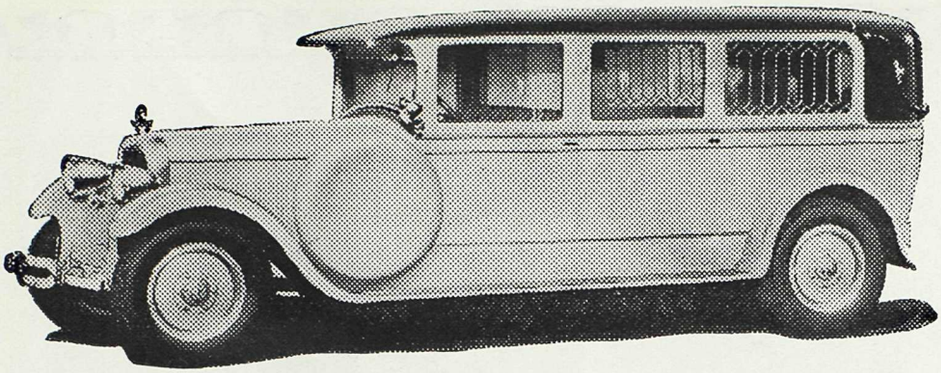

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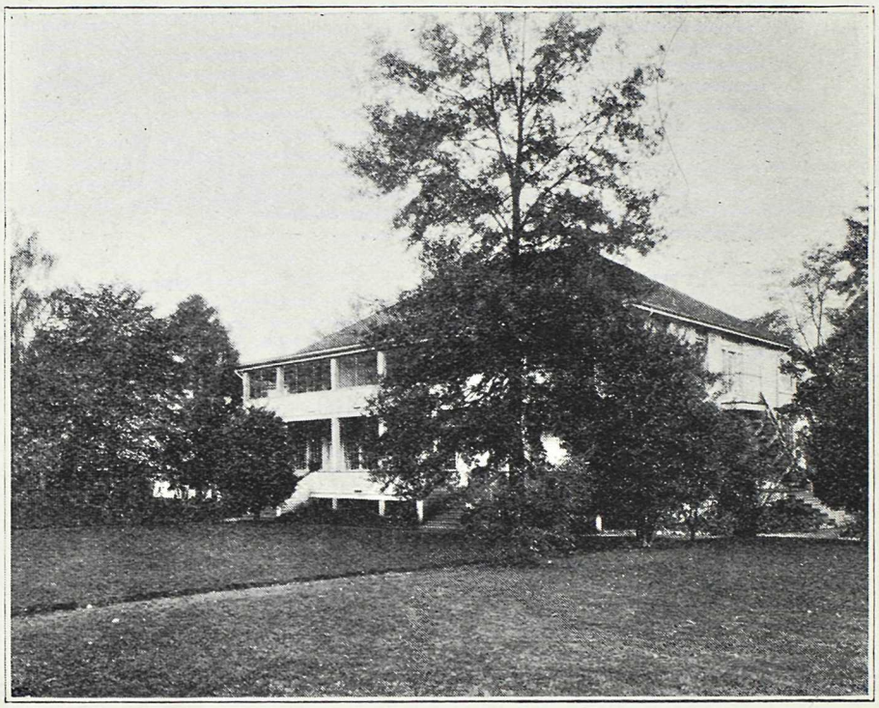

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