Infectious Mononucleosis

by
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INFECTIOUS Mononucleosis or Glandular Fever is now generally conceded to be much more common than was formerly supposed. While the usual text-book picture of enlarged glands, fever and excess of mononuclear cells in the blood is still the most common form of the disease, many and varied forms are recognized but may be overlooked without adequate laboratory investigation.

Recently we have had the opportunity of studying several cases occurring in young men of the Armed Forces who were in hospital for investigation. These cases might well have been missed in civil practice since the relatively mild nature of their complaints would not then have brought them to the hospital and hence to the laboratory. Three other cases are included which were suspected clinically and later confirmed.

CASE No. 1.—White male, 24 years, gunner in R.C.A., admitted to hospital 10/9/41 complaining of headache and general malaise of one week's duration. On admission he had a sore throat and a temperature of 100.4° F. *Past History*: Acute tonsillitis in January, 1941; otherwise irrelevant. *Examination*: Bilateral enlargement of tonsils with injection of uvula and pharynx; no membrane or exudate. Tonsillar glands enlarged and tender. Otherwise, examination essentially negative. *Diagnosis*: Influenza. *Course*: For one week the temperature varied from 98° to 104° F. with occasional chills. Then, on 17/9/41, the cervical, epitrochlear and inguinal glands were found enlarged and the spleen palpable. *Laboratory Findings*: White blood count—18,600 per cu. mm., red blood count—4,600,000 per cu. mm., haemoglobin—90%. *Differential Count* — Band Forms 3%, segmented neutrophils —20%, lymphocytes — 46%, monocytes—31%. *Heterophile Agglutinins* present to a titre of 1:320. Repeated *Throat Swabs* negative for B. Diphtheriae, streptococcus hemolyticus and organisms of Vincent's angina. Blood *Kahn Test* negative; *Blood Culture* negative; chest *X-ray* negative. *Sedimentation Rate* fast (28 mm./1 hr. (Westergren). *Final Diagnosis*: Infectious Mononucleosis. The temperature approached normal on the ninth day after admission, and he was discharged afebrile and well two weeks later.

CASE No. 2.—White male, 23 years, lieutenant in Canadian Army, admitted to hospital with a sore throat and mild fever of one week's duration. His medical officer had diagnosed influenza, but, because of an unusual fluctuation in the temperature, advised hospitalization. *Past History*: irrelevant. *Examination*: Spleen enlarged and palpable. No enlarged glands. *Laboratory Findings*: White blood count varied from 4,200 to 5,000 per cu. mm., and Red blood count and Haemoglobin were within normal limits. *Differential Count*: Juveniles 2%, band forms 4.5%, segmented neutrophils 25%, lymphocytes 52.5%, monocytes 14.5%, eosinophils 0.5%, basophils

1.0%. *Heterophile Antibody Reaction*—Positive to 1:5120 on the ninth day after admission. *Widal* and *Kahn* Tests negative. *Diagnosis*: Infectious Mononucleosis. A satisfactory and uneventful recovery followed.

CASE No. 3.—White male, 23 years, private in Canadian Army, admitted to hospital 10/8/41, complaining of headache and general malaise of about two week's duration. He continued his work till the day of admission, when he had a chill and was admitted with a fever of 105° F. *Past History*: He had been in hospital three times in 1940 with similar symptoms. Diagnoses on these occasions were vaccination reaction, common cold and rubella. No blood pictures were done. *Examination*: Essentially negative. *Course*: During the next few days he had several chills with a swinging temperature and developed a stiff neck. Meningitis was suspected, but lumbar puncture was negative. On 15/8/41 his temperature was normal and he felt fine, but three days later the fever returned in a milder form and he complained of a sore throat. On 25/8/41 his cervical nodes were enlarged, and within two days the axillary, epitrochlear and inguinal glands were palpable. *Laboratory Findings*: White blood count 8,200 per cu. mm., red blood count — 4,900,000 per cu. mm., haemoglobin—86%. *Differential Count* — Band forms 2.5%, segmented neutrophils 20.5%, basophils 0.5%, eosinophiles 0.5%, lymphocytes 64.5%, monocytes 11.5%. *Heterophile Antibody Reaction*—Positive agglutination to 1:640. *Kahn Test* and *X-ray* of chest both negative. *Diagnosis*: Infectious Mononucleosis. Blood picture and Heterophile Antibody Reaction were repeated ten days later with similar results. He had an uneventful recovery and was discharged 8/9/41, still running a slight evening temperature.

CASE No. 4.—White female, 34 years, nurse, complained of sore throat, general malaise, and slight fever of four day's duration. She continued her work during this period, thinking she had a common cold, but was admitted to hospital when her temperature rose to 102° F. *Past History*: irrelevant. *Examination*: Some lymphoid hyperplasia in the tonsillar region although the tonsils had been removed previously. No ulceration or membrane present. Anterior cervical and axillary glands enlarged. *Laboratory Findings*: White blood count — 8,450 per cu. mm., red blood count — 4,220,000 per cu. mm., haemoglobin—82%. *Differential Count*—Juveniles — 1.5%, band forms—5.0%, segmented neutrophils — 35.0%, lymphocytes 35.0%, monocytes—22.5%. *Heterophile Antibody Reaction*: positive to 1:640. *Throat Swabs* and *Kahn Test* negative. *Diagnosis*: Infectious Mononucleosis. The patient was discharged one week after admission, making an uneventful recovery.

CASE No. 5.—White male, 21 years, consulted his doctor complaining of a swelling in his neck with general malaise and chills of a few days duration. *Past History*: irrelevant. *Examination*: Generalized glandular enlargement in anterior and posterior cervical regions, axilla and groin. A particularly large mass of glands, the size of a hen's egg, was present on the right side of the neck. *Laboratory Findings*: Blood smears referred for examination revealed a *Differential Count* of—Band forms 1.5%, juveniles 0.5%, segmented neutrophils 23.5%, lymphocytes 42.5%, monocytes 31%, eosinophils 1.0%. No anaemia noted. A diagnosis of Infectious Mononucleosis was suggested. Four days later a complete blood picture was done. White Blood Count—14,900 per cu. mm., red blood count 5,200,000 per cu. mm., haemoglobin —98%. *Differential Count*—Much as before, with lymphocytes 50.5% and

monocytes 22.5%. *Heterophile Agglutinins*: present to a titre of 1:160. *Diagnosis*: Infectious Mononucleosis. *Course*: Unfortunately this was a country patient and was not rechecked to see whether the agglutinins had risen. The doctor reported an uneventful recovery.

CASE No. 6.—White female, 27 years, consulted her doctor because of frequent "colds" since coming to Nova Scotia from Ontario in July, 1941. During August she had several attacks of sore throat with mild fever, some cough and fatigue. In addition she complained of dysmenorrhea and was admitted to hospital for pelvic examination. *Past History*: Irrelevant. *Examination*: Pelvic examination was negative, but enlarged glands were noted in inguinal and cervical regions. *X-ray* of chest was negative. *Laboratory Findings*: White blood count — 13,000 per cu. mm., red blood count—4,040,000 per cu. mm., Haemoglobin 78%. *Differential Count*—Juveniles —.5%, Band forms 1.5%, segmented neutrophils 20.5%, lymphocytes 63.5%, monocytes 13.5%, eosinophils 1.0%. *Heterophile Antibody Reaction*—Positive to 1:320. *Diagnosis*: Infectious Mononucleosis. *Course*: Rapid and uneventful recovery.

CASE No. 7.—White male, 21 years, private in Canadian Army, was admitted to hospital 5/5/41 with chills, fever, headache, sore back and sore throat of four days' duration. He also complained of severe pain in upper left abdominal quadrant. *Past History*: Irrelevant. *Examination*: revealed injection of fauces and enlargement of right tonsil. Glands palpable in cervical, axillary, epitrochlear and inguinal regions. Spleen not palpable. *Course*: His temperature remained elevated for ten days and he was then transferred to the Yarmouth Hospital under the care of Dr. T. A. Lebbetter. On admission, his temperature was 101.5° F, there was generalised glandular enlargement and the spleen was palpable, but not tender. Heart and lungs were normal. At this time, white blood count — 8,050 per cu. mm., three days later, 13,300 per cu. mm., and four days later, 10,000 per cu. mm. The Widal test was positive for B. Typhosus to a titre of 1:80. 22/5/41 he became definitely jaundiced, and intra-abdominal lymph glands were palpable on the left side. At this time blood films were referred to us at the Pathological Laboratory. *Laboratory Findings*: *Differential Count* — Juveniles 3.5%, band forms 5.0%, segmented neutrophils 13.5%, lymphocytes 44.0%, monocytes 34.0% *Heterophile Antibody Reaction*—Positive to 1:160. Ten days later, *Heterophile Antibody Reaction*—Positive to a titre of 1:2560. On 11/6/41, *Differential Count*—Juveniles 4.5%, band forms 8.0%, segmented neutrophils 52.0%, lymphocytes 28.0%, monocytes 7.0%, eosinophils 0.5%. *Diagnosis*: Infectious Mononucleosis. *Course*: Under supportive treatment he made a good recovery and was discharged well.

Clinical Discussion:

Each of the cases described was a young adult with initial symptoms of general malaise, headache, slight sore throat, and mild fever. The enlarged glands were discovered on examination by the physician with the exception of CASE No. 5 who consulted his doctor because of a swelling in his neck. The entire course of the illness in five of the cases was quite uneventful and similar to so-called "influenza," and if routine laboratory investigations had not been carried out the true diagnosis might well have been missed. This serves to emphasize the fact that Infectious Mononucleosis should be borne in mind in the differential diagnosis of all cases of obscure fever and not regarded as a rarity.

Bernstein,[1] in his excellent review of the disease, stresses the varied clinical types. The "influenzal" form is probably the commonest, but in addition he records cases simulating meningitis, typhoid fever, and other infectious diseases, with skin lesions such as scarlet fever or rubella, and others in which jaundice is the most prominent feature.

CASE No. 3 appeared in the early stages to be an acute meningitis because of the headache, swinging temperature and neck rigidity, but this was soon ruled out by lumbar puncture. It is of interest to note that this patient had been in hospital shortly before with what appeared to be Rubella; possibly the rash at that time was actually a manifestation of Infectious Mononucleosis, for Berstein points out that although the usual duration of the disease is about one month, relapses up to six months are not uncommon.

CASE No. 7, the most seriously ill of the patients in this series, at first simulated typhoid fever and later developed severe jaundice, the latter possibly being due to pressure on the common bile duct by enlarged glands in the region of the neck of the gall-bladder. This case was further complicated by a positive Widal reaction, but this was discounted because of previous anti-typhoid vaccination.

Thus, this relatively small series of cases of Infectious Mononucleosis, emphasizes the varied nature of the clinical picture.

Laboratory Diagnosis:

Two simple laboratory procedures are required in order to make a definite diagnosis of Infectious Mononucleosis—a complete blood picture and the heterophile antibody reaction.

Blood Picture: Table 1 gives a summary of the blood findings in the cases reported.

TABLE NO. 1

CASE	W.B.C.	Juveniles	Bands	Neuts.	Eos.	Baso.	Lympho	Monocytes
No. 1	18,600	0.0	3.0	20.0	0.0	0.0	46.0	31.0
No. 2	5,000	2.0	4.5	25.0	0.5	1.0	52.5	14.5
No. 3	8,200	0.0	2.5	20.5	0.5	0.5	64.5	11.5
No. 4	8,450	1.5	5.0	35.0	0.0	0.0	35.0	22.5
No. 5	......	0.5	1.5	23.5	1.0	0.0	42.5	31.0
No. 5	14,900	0.5	2.0	36.0	0.5	0.0	50.0	10.5
No. 6	13,000	0.5	1.5	20.5	1.0	0.0	63.5	13.5
No. 7	8,050	...	...	....	...	...	....	....
No. 7	13,300	...	...	....	...	...	....	....
No. 7	10,000	3.5	5.0	13.5	0.0	0.0	44.0	34.0

It will be noted that there was a definite leucocytosis in four of the cases, the other three being within normal limits. The total leucocyte count, however, fluctuates greatly during the course of the disease and this lessens its diagnostic value, but a rise is found at some stage of the disease, although not usually till after the first week. Dyke[2] records the average case as reaching 18,000 per cu. mm. in three weeks and dropping to 9,000 per cu. mm. by the seventh week. He also notes a secondary rise to 19,000 per cu. mm. about the tenth week. Unfortunately, in our own series we were unable to ascertain with any degree of accuracy the exact stage of the illness at which the blood counts were taken.

Microscopic examination of blood smears, and particularly the differential count is of great importance in the diagnosis. Most authorities emphasize

a high relative mononucleosis, but in our cases the relative lymphocytosis was the striking feature, associated with a raised monocyte count varying from a high normal of 10.5% to 34.0%. This seeming discrepancy may be due, in part at least, to the difficulty in distinguishing between the rather atypica lymphocytes and monocytes which are present. However it does not appear essential to the diagnosis to have a high monocyte count as this also varies with the stage of the disease. It should also be noted that in the early stages a relative polymorphonuclear leucocytosis may be present.

The most important feature in the blood films of all our cases was a special variety of mononuclear cell which is considered by most authorities to be characteristic of Infectious Mononucleosis. This cell has a deeply staining reticulated nucleus and a basophilic fenestrated cytoplasm, often containing sparse azurophilic granules. Downey[3] has described three different types of this cell which are beautifully illustrated in his paper. In the main, however, they correspond to the characters of the cell described above, and this further differentiation does not appear to be of much value, from the diagnostic viewpoint. The finding of this specialized cell type indicated the diagnosis in three of our cases, which was subsequently confirmed.

Heterophile Antibody Reaction (Paul-Bunnell Test):—This test depends on the presence in the patient's blood serum of heterophile antibodies which agglutinate sheep cells. The presence of these agglutinins in a titre of 1:160 or higher is considered diagnostic of Infectious Mononucleosis. Normal serum sometimes agglutinates sheep cells, but Barrett[4] tested a series of 100 normal sera without finding agglutinins present beyond a titre of 1:80. According to Bernstein, it may be positive by the fourth or fifth day of the illness and the peak may be reached by the end of the first week. It is invariably present by the end of the fourth week and as it persists for several months, a diagnosis can be made long after the signs and symptoms have disappeared.

The technic we used was that described by Bernstein.[1] In six of our cases the titre was 1:320 or higher and in the other it was 1:160. This latter case (No. 5) was very typical clinically and the blood findings were characteristic.

The only other laboratory findings of note are a transient weak false positive Kahn test which may occur in as high as 18% of cases, and a false positive Widal test which may complicate the diagnosis particularly in those cases which simulate enteric fever clinically. As mentioned above the latter may be due to previous anti-typhoid vaccination.

Summary:

Seven cases of Infectious Mononucleosis are reported, four of which occurred in members of the Canadian Armed Forces. The clinical picture of the majority simulated influenza, but was differentiated by the characteristic blood picture and positive heterophile antibody reaction which is diagnostic. It is pointed out that this disease is probably much more common than is realized, and it is suggested that it should be considered in the differential diagnosis of any mild obscure fever.

BIBLIOGRAPHY

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Minutes of the Semi-Annual Meeting of the Executive of the Medical Society of Nova Scotia, 1942

THE semi-annual meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, N.S., on February 25, 1942, at 3.10 p.m.

Dr. J. G. B. Lynch of Sydney presided. The following representatives of the Executive and members of Council of the Canadian Medical Association attended: Dr. Eric W. Macdonald, Dr. M. G. Tompkins, Dr. J. J. Roy, Dr. P. S. Cochrane, Dr. J. P. McGrath, Dr. D. F. McInnis, Dr. W. J. MacDonald, Dr. C. Miller, Dr. G. A. Dunn, Dr. J. J. Carroll, Dr. T. A. Lebbetter, Dr. L. M. Morton, Dr. J. S. Robertson, Dr. P. E. Belliveau, Dr. J. C. Wickwire, Dr. J. V. Graham, Dr. S. Henderson, Dr. N. B. Coward, Dr. T. B. Acker, Dr. J. W. MacIntosh, Dr. W. A. Curry, Dr. H. W. Schwartz, Dr. W. L. Muir, Dr. H. G. Grant, Dr. H. K. MacDonald, Dr. J. R. Corston, and Dr. T. C. Routley, the General Secretary of the Canadian Medical Association.

The President called the meeting to order and the first item to be considered on the agenda was the next annual meeting. The date had already been set (July 8th and 9th, executive on the 7th). The question this year with the curtailment of gas, tires, etc. is the advisability of holding the meeting. Dr. Lynch stated he had discussed the matter with members of the profession in Ontario and Quebec and certain members of the Fuel Controllers and everybody had been very emphatic that the meeting should be held. He made a motion that the Society have their annual meeting, which was seconded by Dr. Miller and carried. The place of meeting in Cape Breton was left to the Cape Breton Medical Society. Regarding the programme Dr. Lynch stated he had been in Montreal early in February and was in consultation with Doctor Routley who promised the Canadian Medical Association would finance two members to give papers in the Maritimes. Dr. Lynch suggested we should have a paper on Infantile Paralysis and the Canadian Medical Association have been considering the suggestion, but would like to get the opinion of The Medical Society of Nova Scotia before finalizing it. Dr. Miller thought the suggestions a good one. Dr. Lynch: "I was in Montreal and got in touch with some of the men and it was suggested that I get in touch with Dr. Rabinovitch. He spends a good deal of his time in Europe and he says he hopes to be in Canada at that time and would only be too glad to come and give two papers on chemical warfare."

Dr. Cochrane: "I think it would be an excellent idea."

Dr. Lynch: "The Canadian Medical Association speakers would have to come on the first day. Another thing, I think we lose a great deal from the papers, because there is no discussion. We should have a copy sent to the members so

that they can be intelligently discussed at our meeting." Dr. Lynch then read the following letter from Dr. P. S. Campbell, Secretary of the Provincial Association Medical Health Officers:

Dear Doctor Grant:

At the last meeting of the Provincial Association of the Medical Health Officers held at the Cornwallis Inn, Kentville, a resolution was passed expressing the desire that the members be given a place on the scientific program of the 1942 meeting of the Medical Society of Nova Scotia. Will you therefore please be good enough to place this matter before your Executive for consideration when the business of preparing your program for the coming summer meeting will be considered.

If a favourable decision is given, it is suggested that you might let me know the number of papers permitted or the number of hours that will be allotted to public health subjects.

Yours very truly

(Sgd.) P. S. Campbell, M.D.

Dr. H. K. MacDonald: "We have a programme committee."

Dr. Lynch stated the programme was usually left to the local society who were hosts for the meeting, and that the Cape Breton Medical Society would like the authority of the Executive to take in the Public Health Department at the meeting.

It was moved by Dr. Wickwire and seconded by Dr. Cochrane that the Provincial Health Department be asked to present a paper at our meeting in 1942. Dr. Robertson asked if it were the Provincial Association of Medical Health Officers or the Provincial Health Department. Dr. Lynch advised that it was the former and he would make that correction. Dr. Miller reminded the meeting that they already had one paper on Infantile Paralysis. Dr. Cochrane said he would like Dr. Campbell to speak as he had last year and tell what the Public Health Department are doing or trying to do. Dr. Miller said they were preventing disease. Dr. Wickwire's motion was corrected to read that the Provincial Association of Medical Health Officers be asked to present a paper, seconded by Dr. Cochrane and carried.

Dr. Lynch: "At the last annual meeting there was a motion put and passed that we invite a representative from the Workmen's Compensation Board to attend our next meeting. I took that on myself and I have arranged with the Chairman of the Workmen's Compensation Board to attend and address a luncheon meeting." It was moved by Dr. Miller, seconded by Dr. H. K. MacDonald that the annual dinner be a mixed one. Carried.

Dr. Routley: "Before you leave the annual meeting: it is not at all certain that Dr. Robertson can come. Have you any suggestion, bearing in mind you are entitled to two speakers at your annual meeting?"

Dr. Lynch: "These meetings are very largely attended by doctors in rural and urban communities. If you cannot get Dr. Robertson, we will leave the choice to you."

Dr. Routley: "The guests from the Canadian Medical Association will be obliged to leave Wednesday night and arrive in Charlottetown on Friday. There will be four in the party, the President-elect, Dr. A. E. Archer, the two guest speakers, and myself."

The next item on the agenda was the recommendation for senior membership in the Canadian Medical Association. A senior member must be in good

standing for the immediately preceding ten years and be seventy years old or over. Dr. Lynch thought if members of the different branch societies would go over their list of members and send recommendations in to the Secretary he would check up and see that proper recommendations are made. The Canadian Medical Association elect ten senior members each year, two from the Province in which their annual meeting is held, and one from each of the other Provinces.

Dr. J. R. Corston, Chairman of the Divisional Medical Advisory Committee gave a brief report as follows. "On previous occasions you have accepted an informal oral report from this committee. Since reporting last to you the Advisory Committee has not been so busy as it was previously, for the reason I think that the Nova Scotia profession was pretty well represented in the various services, having over twenty per cent of its men in the services. We have had occasional meetings to consider different names which have been sent to us by the District Medical Officer. We recommended to the Dean of the Medical School that the District Medical Officer should have an opportunity of stating the need of the services before the graduating class. This was done. Although I have no formal report on the result of that meeting, my understanding is that the members of our graduating class, and many of their friends, felt that the graduates of this school were being discriminated against. Our graduates would receive his captaincy after fifteen months in the Army, in some other schools in Canada they would receive it in three months. That difficulty has been practically ironed out. Just what the Army prospects are of getting many men from this year's graduating class I do not know, but I think the prospects should be much greater than they have been. Another phase of the work of our Committee is that we are supposed to keep an eye on the welfare of civilian practice throughout the Province. From Halifax to Sheet Harbour, a distance of 75 miles, there is no medical practitioner, due to the lamented death of Dr. Rowlings: in the northern part of Cape Breton there is no medical practitioner, nor in the Economy district. Dr. Pugh is now at Great Village. We have had the benefit of having with us this year, Dr. H. K. MacDonald, and we met irregularly when any questions came up. I move the adoption of this report." This was seconded by Dr. H. K. MacDonald and carried.

Dr. Routley stated that the status of the new graduates of Dalhousie has been a source of some anxiety not only in relation to Dalhousie but to three other schools in Canada, and an attempt had been made to straighten it out. He read the following routine order.

CANADIAN ARMY ROUTINE ORDER NO. 1671

General List—Medical Officers, R.C.A.M.C., (Active) C.A.

Routine Order No. 1277 is amended as follows:

Paragraphs 5 and 6 of Canadian Army Routine No. 1277 are hereby cancelled and the following substituted therefor:

5. Officers who have held appointments on the Active List R.C.A.M.C. (Reserve) C.A. will be appointed to the R.C.A.M.C. (Active) C.A. with rank not below that of Captain provided they held that rank in the Reserve Army. When Medical Officers are recommended for special employment acting higher rank with pay and allowances may be granted if considered necessary and upon authority of National Defence Headquarters.

6. (a) Candidates who for less than two years have held a license to practise in a Province of Canada or are licentiates of the Medical Council of Canada, will be appointed to the R.C.A.M.C. (Active) C.A. with the rank of Lieutenant, and may be promoted to

Captain providing they have held a license to practise for one (1) year and qualification has been obtained.

(b) Candidates who for more than two (2) years have held a license to practise in a Province of Canada or are licentiates of the Medical Council of Canada, will be appointed to the R.C.A.M.C. (Active) C.A. with the rank of Lieutenant (A/Captain) and may be confirmed in the rank of Captain immediately on qualification.
Effective 1st February, 1942.

(H. W. 54-27-7-233)

CONFIDENTIAL

Dr. J. R. Corston: "Our Committee is purely an advisory one. We have no instructions to say to any man what he must do, but we advise the military when they ask for our advice."

Dr. Routley then told of a conference with the Minister of Defence regarding the sending out of another questionnaire. The Federal Government apparently objected to sending out such a questionnaire through the Canadian Medical Association. The Canadian Medical Association, on the other hand, did not wish to carry out such a job unless the questionnaire plainly stated they had been requested to do same by the Federal Government.

It was moved by Dr. Cochrane and seconded by Dr. Corston that we, the Executive of the Canadian Medical Association, Nova Scotia Division, heartily endorse the action taken by the Advisory Committee of the Canadian Medical Association and stand behind them one hundred per cent. Carried.

Dr. Schwartz spoke on the lack of contributions to the Medical Bulletin, and suggested that every man present undertake to prepare one article per year for the Bulletin.

The following letter was read by the Secretary:

184 College Street
Toronto 2, Feb. 17, 1942

TO SECRETARIES OF DIVISIONS

Dear Doctor:

The executive of the Canadian Medical Association have for some time past given consideration to the possible occurrence of a major epidemic disease either towards the end of the present war or in the immediate post war period.

With the object of collecting relevant information and of recommending a suitable type of organization to cope with such a contingency the executive appointed a special committee which reported at the Winnipeg meeting of June last and made the following recommendations all of which were accepted and approved:

1. The organization of a national committee to collect, analyse and consolidate all pertinent information available, to distribute information and, if requested, give advice and assistance to any provincial organization which may be set up to deal with this problem. Such national committee to contain representation from the Department of Pensions and National Health and all provincial health departments, the Canadian Hospital Council, the Canadian Nurses' Association and the Canadian Medical Association, The Canadian Red Cross Society and the St. John Ambulance Association.

2. That each of the national associations above mentioned, be asked to arrange for the cooperation of their provincial branches or divisions, to the end that provincial committees corresponding to the national committee may be set up in each province.

3. It is perhaps necessary to emphasize that complete authority and responsibility for any and all provincial measures will be entirely in the hands of provincial committees, the national committee serving in an advisory capacity, acting as a clearing house for information and when necessary serving to coordinate effort to the advantage of all.

4. Consideration of a plan of action as well as details of procedure may properly be left to these committees when and if they are established.

In accepting the above recommendations the executive further instructed the Special Committee to proceed with the work of organization as outlined, at the same time strongly urging that the active direction of the various committees be retained by the organized medical profession.

In the interim the Special Committee has been engaged in securing the approval and cooperation of the various above mentioned national associations and their provincial branches. This cooperation is now assured, several of the associations concerned having already nominated their representatives to both national and provincial committees.

I have been asked by the chairman of the Special Committee to request each of the divisions to appoint a representative to their own provincial committee. In view of the fact that this movement was initiated and has been carried on by organized medicine, it is probably desirable that we should retain this initiative and consequently the representative appointed in each division should be prepared to assume the active direction of the work in his province by accepting the office of convener and chairman of his provincial committee.

May I ask that you forward the name of your representative as soon as convenient.

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

Dr. Grant asked if there were any objections on the part of the National Department of Health to the Canadian Medical Association organizing this.

Dr. Routley replied "No".

Dr. Grant: "They ask us to nominate one representative who would get in touch with the Red Cross and so on to form in this province a committee in case a major epidemic occured."

Dr. Cochrane: "Would it not be a proper thing to take up with the Department of Health here?"

Dr. Routley: "I think that has been done."

Dr. Corston: "Are there any communications from our Provincial Minister of Health before this Society?"

Dr. Grant: "No. I would like to suggest that we get in touch with the Department of Health before we appoint a member."

Dr. Lynch: "I will appoint a committee of three, Dr. Corston, Dr. Grant and Dr. Graham to interview Dr. Davis on this matter and report."

Dr. Routley: "This has been under consideration for a year and I am informed by Dr. Traynor that the various health authorities in Canada have expressed a keen desire that this be done."

The following letter from Dr. Heagerty of the Department of National Health to the Secretary of the Canadian Medical Association was then read.

Department of Pensions and National Health

Ottawa, February 10, 1942

Dr. T. C. Routley
Secretary
Canadian Medical Association
184 College Street
Toronto, Ont.

Dear Dr. Routley:

You will recall that at our last meeting I called the attention of your Committee to the fact that the Honourable Mr. Mitchell, Minister of Labour, had stated in a broadcast that

it was the desire of his Department to provide the people with sickness insurance, also that the Unemployment Insurance Commission was making some preliminary studies of health insurance, and that I had suggested to our Minister that steps be taken to decide what department of the Government should study health insurance and draw up a plan. The result of my conference with him is the attached Order in Council authorizing this Department to continue with the study of health insurance with the object of formulating a plan and creating "The Advisory Committee on Health Insurance." You will note that the members of this Committee are all associated with the Dominion Government with the exception of Dr. Defries who has been appointed scientific adviser on public health.

The Order in Council also gives authority for the appointment of a research assistant and an economist who will help me in gathering and analysing statistical data.

Will you have the kindness to advise your Committee accordingly.

Yours very truly

(Sgd.) J. J. Heagerty, M.D.

Director, Public Health Services

AT THE GOVERNMENT HOUSE AT OTTAWA

Thursday, the 5th day of February, 1942

PRESENT

The Deputy of His Excellency
The Governor General in Council

Whereas subsections (a), (h), and (i) of section 9 of the Department of Pensions and National Health Act provide as follows:

"The duties and powers of the Minister under this Part shall extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada over which the Parliament of Canada has jurisdiction, and, without restricting the generality of the foregoing, particularly the following matters and subjects;

(a) Co-operation with the provincial, territorial, and other health authorities with a view to the co-ordination of the efforts proposed or made for preserving and improving the public health, the conservation of child life and the promotion of child welfare;

(h) Subject to the provisions of the Statistics Act, the collection, publication and distribution of information relating to the public health, improved sanitation and the social and industrial conditions affecting the health and lives of the people;

(i) Such other matters relating to health as may be referred to the Department by the Governor in Council;"

And Whereas the subject of health insurance has been discussed on numerous occasions in the House of Commons and therein urged for adoption;

And Whereas on the 21st March, 1928, a motion was adopted by the House of Commons "that, in the opinion of this House, the Select Standing Committee on Industrial and International Relations be authorized to investigate and report on insurance against unemployment, sickness and invalidity."

And Whereas the Committee appointed under said authority in a report presented to the House of Commons on the 1st June, 1928, stated, with regard to relative legislative jurisdiction, as follows:

"That the evidence of the Justice Department makes it clear that the responsibility for such legislation rests on the provincial authorities, it being within their jurisdiction under the provisions of the British North America Act; but that it would be within the power of Parliament to contribute by grant to such provinces as adopted such legislation, following the precedents set in the matter of technical education, highway-construction, and, more recently, the Old Age Pension Act."

And Whereas on the 1st May, 1929, the said Committee on Industrial and International Relations in their second report made the following recommendations:

"(a) That with regard to sickness insurance, the Department of Pensions and National Health be requested to initiate a comprehensive survey of the field of public health, with special reference to a national health programme. In this, it is believed that it would be possible to secure the co-operation of the provincial and municipal health departments, as well as the organized medical profession.

(b) That in the forthcoming census, provision should be made for the securing of the fullest possible data regarding the extent of the unemployment and sickness, and that this should be compiled and published at as early a date as possible."

And Whereas the Dominion Council of Health at its sessions held on the 28th, 30th and 31st May, 1932, passed a resolution urging the implementing of the recommendation contained in clause (a) referred to in the immediately preceding paragraph hereof.

Now, Therefore, The Deputy of His Excellency the Governor General in Council, on the recommendation of the Minister of Pensions and National Health, and under the authority of The Department of Pensions and National Health Act, and notwithstanding anything contained in any other Act or regulations, is pleased to order and doth hereby order and direct:—

(1) That the Health Branch of the Department of Pensions and National Health under the direction of the Director of Public Health Services shall continue the study of health insurance with a view to formulating a health insurance plan;

(2) That for the better carrying out of said purpose, there shall be a special committee to be known as The Advisory Committee on Health Insurance consisting of not less than ten and not more than eleven members who shall serve as members of said Committee without remuneration;

(3) That the said Committee shall consist, at present, in addition to the said Director of Public Health Services, of the following persons:

Dr. L. C. Marsh, Research Adviser, Department of Pensions and National Health;
Mr. A. D. Watson, Chief Actuary, Department of Insurance;
Mr. J. C. Brady, Chief Institutional Statistics, Bureau of Statistics;
Mr. S. B. Smith, Chief, Business Statistics, Bureau of Statistics;
Miss M. E. K. Roughsedge, Employment Statistics, Bureau of Statistics;
Mr. J. R. Munro, Chief, Financial Statistics, Bureau of Statistics;
Mr. J. T. Marshall, Chief, Vital Statistics, Bureau of Statistics;
Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
Mr. C. E. Stevens, Employees' Compensation Branch, Department of Transport.

(4) That the duties of said Committee shall be to study all factual data relating to health insurance and to advise and report thereon to the Minister of Pensions and National Health;

(5) That Dr. Robert D. Defries, scientific adviser on public health to the Dominion Council of Health, shall be honorary adviser to said Committee, and be entitled to receive his actual and necessary out-of-pocket expenses while absent from his place of residence for the purpose of attending on said Committee;

(6) That the Department of Pensions and National Health may, subject to the approval of the Treasury Board, if and when required, employ the full time services of a Research Assistant and an Economist as well as other appropriate personnel;

(7) That all expenditures incurred for the purposes aforesaid be chargeable against funds provided under the War Appropriation Act.

(Sgd.) A. D. P. Heeney
Clerk of the Privy Council

The following resolution from The New Brunswick Medical Society was read by the Secretary.

August 28, 1941

Dr. H. G. Grant
Nova Scotia Medical Society
Halifax, N. S.
Dear Sir:

The following resolution was passed at the Annual Meeting of the New Brunswick Medical Association recently held in Campbellton: "it was provoked by the news that a bill enacting a form of State Medicine is to be presented in the Dominion Parliament at their next session," and I was instructed to forward a copy of this resolution to you for your information.

Yours very sincerely

(Sgd.) A. Stanley Kirkland, M.D.
Secretary

Resolution Re: STATE MEDICINE

"*Whereas* the New Brunswick Medical Society has been informed that legislation is about to be presented in the Dominion Parliament dealing with a form of social medicine, be it resolved that the New Brunswick Medical Society in the Annual Meeting at Campbellton, August 21, 1941, hereby places itself on record as refusing to the Canadian Medical Association or any of its representatives or spokesmen the right to commit the New Brunswick Medical Society to any legislation for any form of State Medicine or any form of Health Insurance, either now in the process of being developed or to be developed in the future, without the full details of such legislation being first submitted to the New Brunswick Medical Society for its consideration and opinion. Further be it resolved that copies of this resolution be forwarded to the Canadian Medical Association, to the various divisions of the Canadian Medical Association and to our Canadian Medical Association Executive representative for his records."

It was agreed that this resolution be filed.

Dr. Muir gave a brief statement on the advertising receipts of the BULLETIN in 1939 we received $3,246.77 from advertisements, in 1940 $2,727.49, the audit for 1941 has not yet been done, but the receipts would approximate $2,252.33, and the estimates for 1942 about $2,851.50.

Dr. Grant said the President had obtained two new advertisers, and we would be very glad if every member of the Executive would do everything he could to obtain new ones.

Regarding the drive for increased membership it was moved by Dr. Graham and seconded by Dr. W. J. MacDonald that every member of the Executive be supplied with a list of medical men who are not members of the Association in his district. Carried.

Dr. Schwartz asked if the men who were not members were old or young, and the answer was they consisted of both.

Dr. T. C. Routley, the General Secretary of the Canadian Medical Association, then addressed the meeting on the subject of Health Insurance. He reviewed the activities of the Canadian Medical Association and mentioned particularly the adoption in 1934 of a number of principles to constitute the basis of any health insurance act. He spoke of the interest of the Federal Government in health insurance; of the conference between the Minister of Health and the executive of the Canadian Medical Association and of the

formation by the Canadian Medical Association of the Committee of Seven, which has been dealing with this subject for the past few months. He then referred to the Order-in-Council of February 5, 1942, (which is published with our Minutes) appointing an advisory committee to study health insurance and report back to the Minister of Health. At the request of the meeting Dr. Routley then dealt with the questionnaire which had recently been sent out to the doctors of Canada to determine medical opinion on this subject. The questionnaire was dealt with clause by clause, many questions were asked and explanations called for. This part of the meeting was most instructive and all the representatives were able to return home with a clear understanding of the many points raised by the questionnaire. Dr. Routley mentioned the importance of each member filling out the questionnaire as the opinion of the Canadian Medical Association would be formed by a review of the answers returned by the doctors.

A few matters dealing with the annual meeting were brought up while Dr. Routley was present. He again offered to bring two clinicians to our annual meeting in Cape Breton and this offer was accepted. The other matter discussed was that of membership. Dr. Routley pointed out, especially at this time, the importance of a strong body to put our views on health insurance before the Federal Government. He asked us to put forth every effort for 100% membership in the Canadian Medical Association in Nova Scotia for 1942.

It was moved by Dr. H. G. Grant and seconded by Dr. H. K. MacDonald that the same rate as previously, that is ten cents (10c) a mile one way, be paid to members attending the executive meeting from outside of Halifax. Carried.

It was agreed that the President, Dr. Lynch, should appoint a committee to bring in a schedule of fees for the annual meeting in July.

Dr. Graham gave a cordial invitation to all out of town executive members to attend the special meeting of the Halifax Medical Society that evening, at 8.30 p.m., at the Dalhousie Public Health Clinic when the special speaker would be Dr. T. C. Routley. He also stated there would be discussion on parking regulations and gasoline rationing and driving during black-outs.

There being no further business the meeting adjourned at 6.20 p.m.

Society Meetings

HALIFAX MEDICAL SOCIETY

The regular monthly meeting of the Halifax Medical Society was held at the Victoria General Hospital on February 4, 1942.

The meeting opened at 8.40 p.m. with the President, Dr. Graham, in the chair.

There were in attendance, thirty-six members; Drs. G. H. Murphy, J. R. Corston, H. K. MacDonald, A. L. Murphy, H. MacKinnon, D. M. MacRae, A. G. MacLeod, W. M. Roy, H. G. Grant, H. E. Taylor, G. L. Covert, W. L. Muir, A. McD. Morton, E. T. Granville, C. W. Holland, M. J. Carney, K. P. Hayes, K. A. MacKenzie, A. E. Murray, G. G. Lehv, S. T. Laufer, N. H. Gosse, H. W. Schwartz, D. J. Mackenzie, J. C. Worrell, S. R. Johnston, W. G. Colwell, H. B. Atlee, J. W. Reid, J. W. Merritt, N. B. Coward, A. M. Marshall, C. S. Marshall, K. M. Grant and five students.

As guest members Major Lindsay, Major Heaton, Captain McFarlane, Surgeon Lieutenant-Commander Mitchell, Surgeon Lieutenant-Commander McLeod and Surgeon Lieutenant A. J. McLeod.

The minutes of the last regular meeting were read and approved except for the error in the name of Admiral Gordon-Taylor. This was corrected and is now in order.

Communications: Letters and cards of appreciation for flowers were received from Dr. Payzant, Mrs. Marion Macdonald (wife of the late Dr. D. J. Macdonald), Mrs. W. A. Lawson and family and the family of the late Lieutenant-Colonel Gerald Burns.

A letter of acknowledgment from Mr. H. F. Bezanson, secretary of the Board of School Commissioners of Halifax, was next read.

A letter from the Commissioner of Health, Dr. Allan Morton, was read, requesting all members to send in to the Health Department certificates of all persons successfully immunized against diphtheria.

A letter from Lieutenant-Colonel Geoff, O.C., Halifax Military Hospital, inviting the society to a clinical meeting at the Military Hospital early in April was next read.

It was moved by Dr. K. A. MacKenzie and seconded by Dr. D. J. MacKenzie that a special meeting of the Society be held on April 15th, and that a letter of appreciation be sent to Lieutenant-Colonel Geoff thanking him for the kind invitation. Carried unanimously.

There being no further business at this time the clinical programme was proceeded with.

First case—presented by Dr. J. W. Reid—was that of a female child of eleven years, who was admitted to hospital a short time ago, with uremic convulsions previous to and following admission.

The pertinent facts were as follows: child had a history of treatment for pus in the urine at $1\frac{1}{2}$ years of age. B. P. 206/160. Urine showed 1+ albumin, no sugar, few R.B.C. and few pus cells; no casts. Blood chemistry showed

Uric acid of 8.33 mg.%
N.P.N. 44
U.N. 20
Sugar 129
Creatinine 1.54

Spinal fluid negative except for very slight increase in protein. Heart, not much enlarged. Blood vessels thick and radical artery like a tough cord. Kidneys show calculus in upper end of left ureter and some opacity in lower end of ureter also. Kidney cultures not seen. Eyegrounds show albuminuric retinitis. No papillary oedema seen.

Discussion. Dr. Hal Taylor stated this case belongs to the series previously presented in his paper, viz. finding pus in urine at 1½ years, and getting the fibrotic, ischemic kidney in later years. He mentioned, however, that calculi are not found in this type as a rule, also, that even if the lesion (i.e. calculi) is unilateral, removing the kidney is probably of little or no value without proper investigation of the other kidney.

Dr. Reid stated that further investigation would be carried out in this case, re kidney function, etc.

The second case was presented by Dr. J. R. Corston. The patient was a young female adult, probably in the late twenties, who had been admitted to hospital on two previous occasions. On the first admission in June, 1941 diagnoses were—Enteritis and Mitral Heart Disease. She was advised to return in six weeks.

The second admission was on August 12th, 1941, with the clinical picture dominated by severe pain on left side of the head and occipital region, accompanied by vomiting. A diagnosis of neuralgia was made at this time.

The third admission was on October 26th, 1941, and she is still in hospital. During this time the patient has had some fever continuously, up to 100° and 101° at times, and her chief complaints have been—pain in the head, hands and feet, particularly involving the ends of her fingers, and stiffness and pain in joints generally.

On investigation the spleen was found to be slightly enlarged, which was probably not present before; heart condition much the same as previously reported; nine blood cultures proved negative; slight albuminuria with few R.B.C. cells in urine at the time of admission; no petechiae have ever been noted. The diagnosis of subacute baterial endocarditis was made and still stands. Treatment has been supportive, symptomatic and 990 grains of sulphadiazine during a ten day period, during which time the fever was less, near normal, and following cessation of the drug, the temperature rose to the same level as before within forty-eight hours.

Discussion. Dr. Lehv opened the discussion of this case by saying that in a recent issue of the Journal of the American Medical Association some 500 such cases had been treated by the sulfa drugs and the conclusion was "that it was of no avail".

Dr. Laufer, in continuing the discussion, felt the case presented many characteristics of Bank's disease, i.e. undulant fever. He stated that agglutination tests would help in the diagnosis. He also stated that enlargement of the spleen is not common in early cases of subacute bacterial endocarditis, and only appears as a terminal sign in such. He asked whether fever therapy with intravenous vaccine might not be helpful here, as he had seen several cases helped by such therapy.

In replying, Dr. Corston thanked the members for the discussion. He stated that undulant fever had been considered and two agglutination tests had proved negative. He felt the red and tender finger tips pointed rather strongly to the diagnosis of subacute bacterial endocarditis. Re the sulpha-nila-mides, he reported that Dr. Christian of Boston had five cases of this disease benefited by these drugs, and rates them of some importance in the treatment, but emphasized the importance of continuing them for a long time. Dr. Corston felt we should try such drugs again over a much longer period of time than previously used.

The next case was presented by Dr. K. A. MacKenzie. It was that of a male, age 35 years, a warehouse worker, who, on January 16th, 1942, became suddenly ill with severe headache, followed a short time later by vomiting, fever, double vision.

The outstanding signs were—Kernig's+; Head retraction+; weakness right external rectus muscle. Spinal fluid—360 mm. pressure, clear, 190 white cells, few red cells, protein 160 mgm. chlorides 660 mgm., Kahn negative, curve—3322100000. Type of cell, 98% mononuc lears, 2% polymorphonuclears, and no organisms present. Blood Kahn—negative.

With a spinal fluid picture as noted above one usually thinks of tuberculous meningitis. The history, however, in this condition is not of such sudden onset as was so in this case.

Since January 26th (ten days following admission) this patient has had no pain or vomiting and feels fine. Some diplopia still persists, but not as marked. A second spinal fluid examination revealed only 26 cells and nothing else of note.

In considering the differential diagnosis in this case one must consider as possibilities—lymphocytic meningitis, which differs little from tuberculous meningitis: poliomyelitis, but the only paralysis here is a partial one of the right external rectus muscle; hence not at all likely: encephalitis, which fits the picture in this case very well and must be considered the diagnosis.

Discussion. Dr. D. J. Mackenzie opened the discussion by stating that in recent years there have been a number of cases of encephalitis known to be due to a virus, and feels this case may well be an encephalomyelitis of equine type. He mentioned there are a number of virus neutralization tests now being done in various centres, and though we have no such facilities here yet, he hopes to have some available soon. Dr. Corston suggested it might be worth while doing a skin test to undulant fever.

The next case was presented by Dr. C. W. Holland. This was the case of a young adult female, who, two months before admission noticed some dark spots on the skin, chiefly on the legs, some of which were spontaneous and others traumatic in origin. Examination of skin showed petechiae and ecchymosis, mainly confined to the limbs, both upper and lower limbs. General examination; tonsils, somewhat infected; heart and lungs, negative; abdomen, negative; pelvis, negative except for retroversion of the uterus; and C.N.S. was negative. Blood pressure, normal; blood chemistry, normal; Kahn, negative; Hb 64%; R. B. C. 3½ million; W. B. C. 8,000; blood film was normal bleeding time, 7 minutes; coagulation time, normal; capillary resistance test, positive result with the onset of many petechiae within 15 minutes; prothrombin time (Howell method) 3½ min.; platelet count, 17,000; urine, negative. Vitamin C content of blood was slightly below normal but not significantly so.

The diagnosis in this case is Purpura Haemorrhagica of thrombocytopenic type, the low platelet count classifying it as such.

The treatment has been, Vitamin K (Synkamin) one ampoule subcutaneously three times daily; blood transfusions. Since above, there has been no abnormal bleeding, though several teeth have been extracted and will have her infected tonsils removed within a few days, as there has been considerable improvement in her blood picture (R.B.C. 4,300,000; Hb 74%; Platelet count 32,000). He mentioned that splenectomy is advised in most of these cases, but should not be attempted until the platelet count is normal.

Dr. Holland then proceeded to give a very brief but thorough discussion of the various types of Purpura, outlining his reasons in differential diagnosis why he considered this to be of the Thrombocytopenic Type.

There was no discussion on this case.

The next case was presented by Dr. Carney. It was that of a female, age 19 years, who, until 2½ weeks before admission to hospital(January 25th, 1942) had been in good health, and had no history of previous ill health. At this time she noticed her abdomen becoming larger, progressing rapidly and becoming tense, hard and painful (from tension mainly). Findings: respiratory rate, 30-35 min.; temperature 100° in evening, cheeks flushed; nutrition is fair; heart negative; C.N.S. negative; chest—impairment and diminished expansions of both bases (from enlarged abdomen).

Laboratory findings: Kahn, negative; W.B.C. 13,800. Enteric group—all agglutination tests were negative. Blood smear, etc.—showed moderate hypochronic secondary anaemia. Blood chemistry—within normal limits; stools—no occult blood;sputum—negative for tubercle bacilli; blood cultures—negative; X-ray lungs—lung fields show diffuse opacity left base suggesting pneumonia or a pneumonitis; no evidence of tuberculosis. X-ray of abdomen (flat plate) shows considerable fluid in abdomen with wide separation of intestinal loops.

Examination P.A.—abdomen symmetrical, umbilicus is flat; distension is uniform; abdomen is tender and tense. On percussion, the note is definitely tympanitic and some impairment in both flanks, which shifts with movement of the patient. Liver and spleen not palpable.

Dr. Carney then voiced a rather stirring appeal for aid in the diagnosis, as he felt rather uncertain about it.

In attempting the differential diagnosis, various questions arise, tuberculous peritonitis hardly seems likely, because, if it were such, he would expect some evidence of spread of the infection by this time, which she has not had; would also expect some blood in the stool if it were tuberculous peritonitis.

With the X-ray findings, the question arises as to whether this is a pneumococcal peritonitis? Since admission she has had ample amounts of dagenan with no improvement in her pain or symptoms.

In view of X-ray findings in abdominal cavity, he questioned the advisability of needling the abdomen because of the very apparent danger of puncturing the distended bowel.

Discussion. Dr. H. K. MacDonald opened the discussion by stating—"there should be no trouble in arriving at a diagnosis here —simply put a needle in, withdraw some of the fluid, and have it properly investigated."

Dr. Atlee felt Dr. Carney need have no fear about inserting needle in abdominal cavity and advised him to do so.

Dr. Carney replied—"I feel the patient will do as well without needling the abdomen, and the sagacity of the advice given reminds me of the old saying—'Fools rush in where angels fear to tread'."

There being no further cases, the next matter of business was brought up by Dr. J. W. Merritt, re, the elimination of evening office hours. Dr. Merritt said he felt the doctor's working day was too long and with no time at the end of the day to rest or relax himself. "Ours was the only profession which had daily evening office hours," he said, "and he felt it was high time we changed this scheme." "In the larger centres", he stated, "where evening office hours are not practised, these men have more time for themselves to read or do what they wish with their evening hours, which is as it should be." He suggested having afternoon hours from 3-5 or 4-6 as the hours which seemed most suitable, but some doctors might wish to abide by the same afternoon hours they are following at present. It mattered little, he felt, as long as the majority of the doctors would consent to eliminate the evening hours.

A long discussion followed, somewhat pointed at times, rather enlightening (as several doctors have already eliminated evening hours some time ago), and, on the whole, very encouraging. Those taking part included Dr. H. K. MacDonald, Dr. Reid, Dr. G. H. Murphy, Dr. Graham, Dr. Corston, Dr. Gosse, Dr. Carney, Dr. Atlee, Dr. A. L. Murphy, Dr. H. G. Grant, Dr. Lehv, Dr. A. G. MacLeod and Dr. A. E. Murray.

After the smoke of argument finally cleared, it was suggested by Dr. H. K. MacDonald that the feeling of the meeting should be ascertained by a vote. Those in favour of elimination, 29; those against, 0; two members did not vote.

To clear the matter for the members who were absent from the meeting, it was moved by Dr. Atlee and seconded by Dr. H. K. MacDonald, that Dr. Merritt be appointed chairman of a committee to convass all the doctors in the city and in Dartmouth re this matter, that he be allowed to choose his own committee, and to present the proposals at the next regular meeting of the society. Carried.

A request from Lederle Laboratories was read—re the presentation of some films at the next regular meeting of the society. In view of the fact that the next meeting would be held at Camp Hill Hospital, the request was refused.

The President then placed the name of Dr. Clyde S. Marshall before the meeting for acceptance. The acceptance was unanimous.

It was moved by Dr. Colwell, seconded by Dr. Holland, that the meeting adjourn. Adjournment, 11.20 p.m.

K. M. Grant
Secretary-Treasurer

Halifax Medical Society

A special meeting of the Halifax Medical Society was held at the Dalhousie Public Health Clinic, February 25, 1942.

The meeting opened at 8.35 p.m. with the President, Dr. Graham, in the chair.

The following fifty-five members were present, probably an all time high for attendance: Drs. R. O. Jones, T. B. Acker, J. J. MacRitchie, H. E. Taylor, W. M. Roy, W. G. Colwell, G. B. Wiswell, A. L. Murphy, S. T. Laufer, A. McD. Morton, G. H. Murphy, F. R. Little, P. A. Macdonald, H. A. Payzant, A. M. Marshall, J. R. MacLean, C. S. Marshall, L. Thomas, M. D. Morrison, M. G. Burris, K. A. MacKenzie, L. A. Pennington-Collier, G. E. B. Rice, H. W. Sch-

wartz, J. C. Acker, R. P. Smith, D. F. MacKenzie, G. A. MacIntosh, Ritchie Douglas, R. S. Henderson, S. H. Keshen, J. R. Corston, F. G. Mack, F. V. Woodbury, P. Weatherbe, J. W. Merritt, W. K. House, A. R. Morton, A. G. MacLeod, G. G. Lehv, K. P. Hayes, E. I. Glenister, D. M. MacRae, C. W. Holland, A. E. Doull, Jr., E. T. Granville, W. J. Keating, A. E. Murray, N. B. Coward, N. H. Gosse, Mrs. Margaret Gosse, H. B. Atlee, G. L. Covert, J. V. Graham and K. M. Grant.

A number of members of the executive of the Medical Society of Nova Scotia also attended, as well as several members of the services.

The President explained the calling of the special meeting was due to the presence in the city of Dr. T. C. Routley, who would discuss Health Insurance, as the official representative of the Canadian Medical Association.

Before calling upon Dr. Routley, communications between the society, the Mayor, and the Chief of Police were read and considered—parking regulations, gasoline rationing and blackout restrictions.

Halifax, N.S.
February 16, 1942

Mayor W. E. Donovan
City Hall
Halifax, N.S.

Dear Mr. Mayor:

The Medical profession of the City of Halifax is rather concerned with the recent parking regulations put into effect, and are desirous of having the matter clarified as soon as possible.

The doctors of this city are very busy and, in most cases, do not have the time to seek unrestricted parking space, which may be some distance from the call being made. Some of our members have already been served with tickets. This constitutes a great inconvenience and serious loss of valuable time, which we feel should not be so. The question also arises whether it will be necessary to discontinue medical services after sundown in order to abide by existing regulations?

Since a large percentage of doctors' offices are located on street car lines, the question of parking in front of or near their office is important. The necessity of putting their cars in a garage or off the carline constitutes a great inconvenience, at times, even an impossibility, and loss of time—time which may be of very great importance in case of an emergency. Since a great deal of our work is also done at night, similar conditions obtain, especially for those whose offices are located in their homes.

There is also the question of our position during blackouts. What regulations are there for making necessary emergency calls during such times?

The clarification of these various questions which have arisen will be greatly appreciated, and we feel any privileges extended to us in this regard will likewise benefit the public at large, and also feel sure there will be no abuses of such.

With kindest regards

Yours very truly

(Sgd.) J. V. Graham, President

K. M. Grant, Secretary

Halifax, N.S.
February 19, 1942

Dr. J. V. Graham
President, Halifax Medical Society
51 Coburg Road
Halifax, N.S.

Dear Sir:

I wish to acknowledge receipt of your letter of the 16th instant, from the Halifax Medical Society regarding recent parking regulations.

I immediately handed your letter to the Chief of Police for attention and his instructions, and attach herewith a copy of his reply, which I trust will clear up any misunderstanding, and is what you desire.

Yours very truly

(Sgd.) W. E. Donovan
Mayor

February 19, 1942

W. E. Donovan, Esq.
Mayor
City Hall

Dear Sir:

I wish to acknowledge receipt of the letter received by you from the Halifax Medical Society, and passed on to this Department for consideration.

With reference to the new parking regulations, may I point out that these measures are taken in view of the fact in my opinion a state of emergency exists in this City to-day. However, it is realized that in the case of doctors, necessity might compel a slight variation from this course. Doctors are asked to assist this Department, and to co-operate with them to the best of their ability by keeping their cars off the Tram Car lines as much as possible, and on the other hand all policemen have been instructed to give these vehicles every consideration which will be identified by the green cross. In the event of a doctor's car being ticketed in error, he is requested to forward same to the Chief of Police, addressed to him personally.

With reference to the type of light to be used during a blackout, the following has been adopted for general use. An auxiliary lamp attached securely to the left front fender of the car, having the reflector dimmed with white paper, and having the lens painted black, with a 2 by 3/8" opening below the centre beam of light. Those cars will have a card supplied by the Chief of Police, upon application, and it is suggested that the Society let the Chief of Police have a list showing the number of doctors in the City, so that an appropriate number of cards may be had ready.

Yours truly

(Sgd.) Judson J. Conrad
Chief of Police

The President stated it was his understanding that doctors would be allowed sufficient gasoline to cover 15,000 miles per year. Some discussion followed this information and it was suggested by the meeting that the President appoint a committee now to "study the question of gas restriction as it effects the medical profession here." The President nominated Dr. F. R. Little as Chairman of such a committee, to choose the personnel of the committee himself.

The President next introduced the speaker for the evening, Dr. T. C. Routley.

Dr Routley thanked the Society for the privilege of appearing before its members to outline the various steps which have been considered and taken during the past fifteen years along the lines leading to the Health Insurance scheme which is now becoming a vulnerable issue for the profession in Canada. He explained this was the beginning of a six weeks tour of Canada for him, to place before the medical profession the various features embodied in the scheme which may any day become a very live issue.

As a result of many meetings and much discussion between the executive of the Canadian Medical Association and the Minister of Pensions and National Health, it was proposed by the latter the Canadian Medical Association nominate a committee of seven members, this committee to be given permission to read and study all the papers issued by the Government re Health Insurance, and to be under strict obligation of secrecy and confidence to the Government not to divulge any information so far received to the public or otherwise. This committee suggested to the Minister that the Canadian Medical Association be allowed to send to every doctor in Canada a questionnaire, so constructed that no secretive information will be embodied in it, but that the answers to the questions would enable the Committee of Seven to better qualify themselves for the adoption or otherwise of any bills when they may be introduced.

The Committee of Seven includes the following—Dr. Watson of Vancouver, Chairman; Dr. Archer, Alberta; Dr. Fahrni, Winnipeg; Dr. Leggett, Dr. L. Gérin-Lajoie, Quebec; Dr. Veniot, New Brunswick; Dr. Routley, General Secretary, Canadian Medical Association.

Dr. Routley then explained that the questionnaire has recently been put in our hands and urgently requested that it be answered and sent in at once.

At the request of the meeting Dr. Routley dealt with each question embodied in the questionnaire.

Those questions which caused discussion follow with brief answers as given by Dr. Routley.

Question 1—Answer—Health Insurance in Canada will be a provincial matter, each province to work out the scheme as it sees fit.

Question 7—Answer—Re indigents—we must be firm in saying that the medical profession shall dispense its care as it sees fit and not to accept dictation by a central authority on this troublesome question.

Question 8—Dr. Burris asked "Is it likely to be the policy of the Federal Government to introduce compulsory clauses of any type whatsoever?" Answer—If the Government introduces Health Insurance it will be compulsory.

Question 10—Dr. Little asked "What about the general practitioner who also does a large surgical practice?" Answer—I do not think that the mode of practice will change over-night by any type of legislation introduced. If this legislation comes, the medical profession of Halifax has to come to grips with standard practice and see that such standards are maintained. We must see in this scheme that both profession and public get a fair deal, and must not jeopardize the privileges of either.

Question 14—Re schedule of fees—Dr. Burris asked—"Will schedule of fees adopted by the Provincial Medical Association make it impossible for any Commission or Government to question it?" Answer— "I cannot answer that directly, but probably so."

There being no further questioning of Dr. Routley on the questionnaire the President then thanked Dr. Routley for his very excellent talk and exhibition of great patience in going through it entirely. It had helped, he felt

sure, to clear up the matter of the purpose and importance of the questionnaire to the profession as a whole and urged every member to fill it in and send it to the proper authorities at once.

A question by Dr. Little followed—"Is the scheme to include nursing services, hospital services, dental services, etc.?"

Dr. Routley; "Yes."

Dr. G. H. Murphy— "Is it Dr. Routley's personal opinion that this scheme will be adopted before the end of the war?"

Dr. Routley—"I feel, in view of many circumstances which now obtain, that the Government will probably not introduce this scheme of Health Insurance during the war. It is well, however, to be prepared for any eventuality where governments are concerned, and it is well to have our house in order."

The President then called upon Dr. Merritt, as chairman of the committee investigating eliminating evening office hours, to make a very brief report at this meeting. Dr. Merritt gave a brief resume of what the committee had done, and the full report would be made at the next regular meeting.

There being no further business the meeting adjourned at 10.55 p.m.

K. M. Grant,
Secretary

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ROSE HIPS FOR ORANGES

Nine British Factories Turn 200 Tons of them Into Syrup

Two hundred tons of rose hips gathered from the hedges of England and Scotland last autumn have been turned into syrup for the older children in Britain who cannot get a regular supply of oranges.

Like the orange, rose hips are a rich source of vitamin 'C', the anti-scurvy vitamin.

Before the war it never occurred to anybody to use rose hips, but when the supply of oranges dwindled a small army of Boy Scouts, Girl Guides, teachers and Women's Institute members turned out into the lanes with their baskets.

Even housewives who were expert jam makers found it difficult to keep the hip hairs out of the syrup and the hips were therefore sent off to nine factories which have now produced from them 600,000 bottles of syrup. Young children are sipping it with relish at the rate of one teaspoonful a day. Two teaspoonsful in the twenty four hours give all the vitamin C which older boys and girls require.

Britain's Ministry of Health are so pleased with the result that they are hoping for a much bigger collection of rose hips when autumn comes round again.

NEW TREAMENT FOR "SPLIT" MIND

Saves Sugar and Insulin

IN making economies on sugar and insulin for the treatment of people who, like Jekyll and Hyde, have schizophrenia, or "split" minds, British medical men have found that the new methods, now tried out over a whole year, give better results. No sugar is now used, and the consumption of insulin has been reduced by over a quarter.

Normally, schizophrenia is treated by injecting insulin into the muscles, and when the patient falls into a coma he is fed with sucrose; on waking he is given sweetened drinks. In this way each patient requires one pound of sugar a day, whereas the ration allowance is only ½ lb. per week.

Although a certain amount of extra sugar was eventually allowed the doctors determined to find a more economical method of treatment. After unsuccessful attempts on smaller quantities of sugar. it was found better to replace the sugar entirely by potatoes mashed into a thin soup with milk and water, a pint of this being fed after the patient had been brought out of the coma with an injection of 20 c.cm. of glucose (33 per cent).

Patients now recover rapidly from the coma, and within one to three minutes they are able to answer questions and drink the soup which they much prefer to the sugar drink. What is more, there has since been not one instance of the vomiting which was quite common with sugar.

Then the doctors turned their attention to economy of insulin. Instead of administering it by the intramuscular method, they tried injecting it into the veins and found that by doing so not only could they reduce the amount given from 117 to 84 units (averaged over 24 patients), but the coma produced was much quieter and there were no relapses after treatment.

In this way the doctors saved 84 lbs. of sugar a week, or about 16 cwt. over the year, as well as 23.8 per cent of the insulin used.

NOTE TO EDITOR—This work has been carried out at the Warlingham Park Hospital, Surrey, by James S. McGregor, M. D., Ch. B., D. P. M., and R. A. Sandison, M. B., B. S., and particulars are issued by permission of the Medical Superintendent, Dr. T. P. Rees.

Received from Robert Williamson, Mowbray House, Norfolk Street, London, W.C.2.

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Abstracts from Current Literature

TOXIC REACTIONS TO SULFAPYRIDINE. Goldbloom, A. A., Greenwald, L., and Renistein, H.: Jour. Lab. and Clin. Med., 1941, 27: 139.

The authors present unusual toxic reactions of the blood to sulfapyridine in three cases with acute hemolytic anemia, and varying grades of leukemoid blood pictures and associated secondary thrombocytopenic purpura. In spite of these serious reactions all the cases recovered in a short time after transfusions. Bone marrow studies showed erythroblastic hyperactivity in two cases. The theories of the effects of the drug on hemopoiesis are discussed. It is believed that the marked hemolytic anemia may be evidence of a peripheral reaction; that leucocytosis an irritation of the myeloid element of the bone marrow; and the thrombocytopenic purpura an allergic phenomenon. The importance of frequent blood counts on any patient receiving sulfapyridine cannot be overemphasized.

ENDOCRINE ASPECTS OF HEADACHES. Goldheizer, M. A.: Jour. Lab. and Clin. Med., 1941, 27: 150.

The writer presents a series of 50 cases of headaches, observed in endocrine patients, and evidence is submitted to show a general trend of sodium chloride and water retention. Stigmas pointing to an endocrine background were prevalent; they include: lower basal metabolism, decreased specific dynamic action of proteins, relative lymphocytosis, higher values for uric acid, sodium and chlorides in the blood, lower blood sugar, and abnormalities in the configuration of the sella turcica.

Endocrine headaches, including migraine headaches, are explained as the result of increased intracranial pressure. They develop when increased permeability of the capillaries permits increased flow of water to, and subsequent retention in, tissues which have stored abnormal quantities of sodium salts.

The retentional type of endocrine headache can be recognized by the decreased output of sodium chloride and water on performing the salt tolerance test. The successful treatment of endocrine headaches consists of a high protein diet with restriction of salt, liquid, and carbohydrate intake, of medication with ammonium or potassium salts and belladonna preparations, and of endocrine substitution therapy with thyroid and pituitary extracts.

THE GASTROINTESTINAL TRACT IN HYPERTHYROIDISM. Brown, R. B., Pendergrass, E. P., and Burdick, E. D.: Surgery, Gyn. and Obst., 1941, 73: 766.

The authors studied the gastrointestinal tract in 24 hyperthyroid patients and 14 normal controls. Differences between the two groups have been noted and subjected to careful statistical study in order to establish their significance.

As a result of these studies, they felt justified in concluding that the following gastrointestinal changes are characteristics of hyperthyroidism:

(1) An increased evidence of achlorhydria.
(2) Increased prominence of gastric rugae.
(3) An increase in the rapidity with which the stomach starts to empty.
(4) A delay in gastric emptying.
(5) Increased small intestinal tone with an abnormal pattern.
(6) Increased small intestinal motility.
(7) Increased large intestinal tone.
(8) Increased large intestinal motility.

Smooth Muscle Tumours of the Gastrointestinal Tract and Retroperitoneal Tissues. Golden, T., and Stout, A. P.: Surg. Gyn. and Obst., 1941, 73: 784.

Golden and Stout studied 60 cases of smooth muscle tumours of the gastrointestinal tract seen at the Presbyterian Hospital, New York City, and report their findings.

Smooth muscle tumours occur throughout the entire gastrointestinal tract and often in the retroperitoneal tissues. They are often most commonly found in the stomach and their incidence is much higher than suspected. Classification of the tumours into benign and malignant is difficult because frequently poorly differentiated ones, which have the histological criteria of malignacy, do not display its clinical evidences, while occasionally a well differentiated tumour has grown by infiltration and metastasized. The terms leiomyoma and malignant leiomyoma are preferred to any others proposed. Early diagnosis is seldom accomplished. The presence of this type of tumour should be suspected, especially in all cases of gastrointestinal hemorrhage if the origin has not been determined. Surgery is the only method of treatment and in many instances must be of a radical nature. Prognosis is as much dependent upon the anatomical site of the tumour as upon its histological character. Tumours of the stomach, jejunum, ileum and colon are restrained for a long time by the barrier of the peritoneum, so that they can be entirely removed, usually with success. The anatomical peculiarities of the duodenum, the rectum, and the retroperitoneum make the complete removal of their tumours more difficult and sometimes impossible. For this reason, recurrence following attempted surgical removal has been more frequent and the prognosis therefore much less favorable.

The Mechanism of Ureteral Obstruction in Prolapse of the Uterus. Lieberthal, F., and Franenthal, L.,: Surg. Gyn. and Obst., 1941, 73: 828.

It has long been known that complete prolapse of the uterus is frequently accompanied by ureteral obstruction, which may lead to a dilatation of the ureters and renal pelvis. Although numerous theories have been advocated as to the manner in which this obstruction is brought about, the exact mechanism has not previously been demonstrated. The authors suggest a new mechanism on the basis of topographic anatomical studies. The broad ligament with its

contained fibrous bands, which are attached laterally to the fascias at the pelvic brim and medially to the cervix and corpus uteri, forms a sling over the ureter and pulls it downward when the uterus descends. This produces a marked downward kinking of the ureter. This downward kinking of the ureter is readily demonstrable on the living subject by radiographic means.

AN APPRAISAL OF THE MEDICAL VERSUS THE SURGICAL TREATMENT OF IDIOPATHIC ULCERATIVE COLITIS. Elsom, K. A., and Ferguson, R. K. Amer. Jour. of Medical Sc., 1941, 202: 59.

Ulcerative colitis presents a number of fundamental problems still unsolved. The wide variety of therapeutic measures now employed in this disease and the frequency of unsatisfactory results attest to the present deficiencies in our knowledge. Opinion is divided on the question of the specific bacterial nature of the disease. The second division of opinion concerns the place of surgery in treatment of the disease. Those who have had less favorable results with medical treatment employ ileostomy and analogous procedures in as high as 65 per cent of such patients.

The present study was made to determine whether medical treatment alone was superior to combined medical and surgical therapy in a group of patients with ulcerative colitis observed during the past twelve years in the University of Pennsylvania Hospital. In the first group of 23 patients, all were treated by medical measures only. A second group of 27 were first treated by the usual medical measures and subsequently by one of various surgical procedures.

The results, in the opinion of the authors, clearly indicate the superiority of surgical treatment in cases of severe ulcerative colitis. The mortality in the two groups was practically equal. Comparison of the subsequent developments led to the conclusion that those who were operated upon were more nearly restored to normal health than those who were not. The medically treated group has had continued or intermittent manifestations of the disease and is in poor or only fair health. Those operated upon made, in most instances, dramatic recoveries. The great majority have led a normal life. The surgical procedure of choice is a preliminary ileostomy with subsequent colectomy in stages, if the indications exist.

PROGNOSTIC VALUE OF VARIOUS CLINICAL AND ELECTROCARDIOGRAPHIC FEATURES OF ACUTE MYOCARDIAL INFARCTION. Rosenbaum, F. F., and Levine, Samuel A.: Arch. Int. Med., 1941, 68: 913.

The authors made a study of the cases of 208 patients with acute coronary thrombosis observed consecutively at the Peter Bent Brigham Hospital. So far as could be judged clinically, only those patients were included whose attacks were regarded as initial. The purpose of this investigation was to determine whether any of the findings during the early part of the illness can serve as a guide to prognosis. The significance of individual clinical and electrocardiographic features was therefore analyzed, with the following results:

Mortality.—The immediate mortality in the entire series was 33 per cent. Anterior infarctions occurred more commonly than posterior lesions, the proportion being 5:3, but the mortality was about the same with regard to

the two locations. The mortality was distinctly higher for patients with bundle branch block and those with auriculoventricular block, but lower for those who showed low voltage of the QRS complex. A group that had electrocardiographic findings which were regarded as unclassifiable, i.e., without significant changes or abnormalities, also had a distinctly lower mortality.

Sex.—The proportion of men to women was 7:3. The prognosis for women was somewhat more grave.

Age.—The average age at the time of the attack was 58.7 years for the entire series—57.4 years for men and 61.5 years for women. The mortality progressively increased with advancing years. This held true regardless of the electrocardiographic findings.

Previous Angina Pectoris.—Antecedent angina pectoris was present in 72 per cent of all patients and was equal in its occurrence in the two sexes. Those patients with a previous history of such a condition had a lower mortality (29 per cent) than those without it (38 per cent).

Previous Hypertension.—Antecedent hypertension was present in 57 per cent of all patients, 44 per cent of the men, and 86 per cent of the women. It tended to increase the mortality in both sexes. Coronary occlusion in women who had neither previous angina pectoris nor hypertension was particularly rare.

Blood Pressure Changes.—The occurrence of a fall in systolic blood pressure of more than 20 mm. increased the mortality slightly, although a systolic level that was maintained below 80 mm. for many hours or days appears to be serious.

Pain.—The severity or radiation of the pain had but little prognostic value, nor did it aid in the localization of the infarction. However, in the small number of patients without pain in the chest there was a mortality decidedly higher than average. Anterior infarction with pain radiating to the left arm had a lower mortality (20 per cent), than similar infarction without this radiation (41 per cent). Radiation of pain to the right arm, as well as to the left, was slightly more common in association with posterior infarction. The occurrence of initial attacks of myocardial infarction without any pain or its equivalent symptoms was rare (3 per cent).

Dyspnea.—Dyspnea of some degree occurred in 71 per cent of patients. The mortality increased decidedly as dyspnea became more prominent, from 18 per cent for those who had no dyspnea to 24, 36 and 62 per cent for those with mild, moderate and severe dyspnea, respectively. Dyspnea was much more helpful than pain in judging the prognosis.

Sweating.—Sweating occurred commonly but was of only slight prognostic significance. However, the presence of a moist skin days or weeks after the onset appeared to indicate that the dangerous period had not yet passed.

Cyanosis.—Cyanosis was found in about one-half the patients and indicated a distinctly higher mortality (45 per cent as compared with 16 per cent).

Shock.—Shock in some form or degree was present in 54 per cent of all patients. The mortality increased in direct proportion to the degree of shock; absent, 20 per cent; mild, 26 per cent; moderate, 51 per cent, and severe 93 per cent.

Auscultatory Signs.—Gallop rhythm was noted in 20 per cent of all patients and was more common among those who died. It was more commonly

associated with anterior than with posterior infarction, but was a more serious sign for patients with the latter lesion. The quality of the heart sounds was regarded as faint in over one-half the patients, and such sounds were more common in those who succumbed. The incidence of pericardial friction rub was 16 per cent.

Temperature.—The rectal temperature was above 100° F. in 92 per cent of the patients. There was a distinctly progressive rise in mortality with the increasing levels of fever.

Pulse.—When changes in the pulse rate due to such arrhythmias as paroxysmal rapid heart action and heart block were excluded, the heart rate in the great majority of patients was over 100. A slight tendency to increase mortality accompanied the more rapid rates.

Respiratory Rate.—The respiratory rate, in general, followed the pulse rate and the degree of dyspnea and was on the whole more rapid in the patients who died, than in those who recovered.

Leukocycte Count.—A leukocycte count over 10,000 during the first week following the onset of the attack, was found in 86 per cent of the patients. The mortality was 16 per cent for those with counts under 15,000 and 54 per cent for those with counts over that level.

Sedimentation Rate.—Although data concerning sedimentation rates were not numerous, the rates did not seem to be of much prognostic value.

Congestive Heart Failure.—About three-fourths of the patients showed some objective evidence of heart failure. The mortality steadily increased with increasing degrees of pulmonary congestion. A palpable liver was found in 29 per cent of the cases. Left heart failure occurred more commonly, but was slightly less serious with anterior than with posterior lesions.

Complications.—Such complications as pulmonary infarction, pneumonia, psychosis, cerebral vascular accident obviously made the outlook more serious.

Arrhythmias.—Some type of arrhythmia was observed in over one-third of the cases and tended to increase the mortality to a slight extent.

Electrocardiograms.—In a review of the electrocardiographic data in this study it appeared that the absence of any significant changes in the tracings indicated a distinctly more helpful immediate outlook. When distinctly abnormal alterations in the ventricular complex were found, with few exceptions, it did not seem to matter greatly what they were, apart from important arrhythmias.

Conclusion.—It can be stated that the immediate outlook in a case of acute coronary thrombosis is extremely difficult to predict. Although many of the clinical and electrocardiographic features analyzed may indicate that the condition is either more or less critical, there is practically no criterion which is infallible. However, weighing all the information available together with the general appearance of the patient enables the physician to make a fair estimate as to the immediate prognosis.

E. David Sherman, M.D.
Sydney, N. S.

Canadian Medical Association Seventy-Third Annual Meeting

JASPER PARK CALLING

DURING the week of June 15, 1942, the Canadian Medical Association will take over the beautiful Jasper Park Lodge for its seventy-third annual meeting. Those who have been to Jasper will realize how excellently the Lodge lends itself to a convention such as ours, and will wish to be present. Those who go for the first time have a great treat in store for them The Lodge, built on the cabin system, nestled on the shore of a beautiful lake and surrounded by majestic mountains, is unsurpassed in appointments, scenic beauty and comfort. There is splendid accommodation for 650 people. In every direction, by motor car, saddle pony or on foot delightful excursions may be made.

For those who play golf, Jasper offers the golfers' paradise. There is no finer course in the world.

For several months past, Committees have been at work on this meeting, planning for its every detail. A scientific program of a high order has been arranged for Wednesday, Thursday, and Friday, June 17th, 18th and 19th, particulars of which will appear in subsequent issues of the Journal. The two preceding days, June 15th and 16th, will be given over to business meetings of the General Council of the Association. Also, on Tuesday, June 16th, the British Columbia Division and Alberta Division of the Association will hold their annual meetings.

For combined scientific profit, healthful recreation and pleasure, this meeting will stand out as an attraction long to be remembered.

Some one asks, "Should medical conventions be held in war-time?' The answer is decidedly "Yes." The progress of scientific medicine and the dissemination of medical knowledge are if anything more needed in war-time than in peace-time. Furthermore, Doctors must have occasions to relax if they are to continue to do their best work during these hectic days of war. So the combination of learning and playing at Jasper Park in June, 1942, offers to every Canadian Doctor and his family an opportunity which, if at all possible, should not be missed.

What Will It Cost?

We are glad to announce that most attractive railway and hotel rates have been arranged. We publish hereunder a schedule of rates which includes first class railway fare to Jasper and return, standard lower berth as indicated, and four days' room and board at Jasper Park Lodge.

From:			From:		
Edmonton	(4)	$ 40.10	Toronto	(2)	$145.45
Kamloops	(5)	45.80	London	(2)	145.45
Calgary	(3)	50.60	Windsor	(2)	145.45
Saskatoon	(5)	57.95	Hamilton	(2)	145.45
Regina	(5)	64.15	Brantford	(2)	145.45
New Westminster	(1)	63.75	Ottawa	(5)	162.80
Vancouver	(1)	63.75	Montreal	(5)	170.45
Victoria	(1)	66.70	Quebec	(5)	186.00
Nanaimo	(1)	66.70	Moncton	(5)	208.90
Kelowna	(5)	64.90	Fredericton	(5)	208.90
Winnipeg	(5)	84.45	Saint John	(5)	208.90
Fort William	(5)	103.35	Halifax	(5)	218.90
Kitchener	(2)	145.45			

(NOTE: These rates are as of 1941. The rates for 1942 will not be quoted until some time later, probably in the month of May, but we are assured that these probably will be unchanged.)

Reference Numbers:

(1) denotes standard lower berth from Vancouver and return.
(2) denotes standard lower berth from Toronto and return.
(3) denotes standard lower berth from Calgary to Edmonton and return; also seat from Edmonton to Jasper and return.
(4) denotes seat Edmonton to Jasper and return.
(5) denotes standard lower berth from place named and return.

Tickets from Kamloops and Kelowna carry a six months' return limit, while others mentioned bear a final return limit of 21 days from date of sale.

Rates exclusive of accommodation and meals at Jasper Park Lodge are arrived at by subtracting $24.00 from the schedule as quoted.

Special hotel rates, apart from the all-inclusive rates presented above, are as follows:

For double rooms equipped with either private tub or shower bath, and meals, $16.00 a day or $8.00 per person.

For double rooms without private bath or shower, and meals, $12.00 a day or $6.00 per person.

All the double rooms are equipped with twin beds. In order to accommodate the entire party at the Lodge, it may be necessary to ask those travelling singly to double up.

As the regular rates at Jasper Park Lodge range from $8.00 to $18.00 a day for single rooms, and from $14.00 to $26.00 a day for two persons in double rooms, including meals, it will be noted that the rates quoted for our convention have been substantially reduced.

Hotel reservations should be made early by writing to The Manager, Jasper Park Lodge, Jasper, Alberta. Be sure to state names and addresses of members of your party, date of arrival, accommodation desired and how long you expect to stay.

Special Notes

(1) Delegates taking advantage of the Summer Tourist tickets with Vancouver or Victoria destination may be routed via Prince Rupert, either

going or returning, on payment of an additional $13.00. This amount covers meals and berth on the steamer.

(2) Summer Tourist tickets from Eastern Canada with Pacific Coast destinations may be routed on the going journey via Canadian National, and on the return journey via Canadian Pacific, or vice versa.

(3) The bus fare from Jasper to Lake Louise, one way, is $13.50, plus $1.35 Government tax, while the through fare from Jasper to Calgary, one way, is $17.60, plus $1.75 Government tax.

(4) Golf Charges—for C.M.A. registrants . . . . $1.50 per day

(5) General Drive 3.00
Maligne Canyon 2.00
Punch Bowl Falls 4.00
Glacier of the Angels Mount Edith Cavell 4.00
Miette Hot Springs and Fiddle River Canyon 5.50
Columbia Icefield Jasper-Banff Highway 10.00

We are informed by the Superintendent of Jasper National Park, that while it is impossible to definitely state that the Jasper-Banff Highway will be open by June 15th, the road was opened on May 23rd last year, and it could be taken to be reasonably certain that it will be open by the 1st of June this year.

RATES AND TIME TABLES FOR TRANS CANADA AIR LINES may be secured from this office.

H. G. Grant
Secretary
Medical Society of Nova Scotia

Personal Interest Notes

THE wedding took place in Toronto recently of Miss Edith Frances Hill, daughter of Mr. and Mrs. J. Harry Hill, Charlottetown, and Flying Officer Edward F. Thorne, M.D., son of Mr. E. F. Thorne and the late Mrs. Thorne of Halifax. The bride taught for two years at the Ontario Ladies' College of Whitby, Ontario, prior to taking a position in the Naval Department, Sydney. Dr. Thorne graduated from Dalhousie in 1941.

Dr. J. A. Donahoe of Barrington Passage and Dr. J. D. Dinsmore of Port Clyde are setting up practices in Shelburne, to fill the vacancy caused by the death of the late Dr. L. O. Fuller.

Dr. Harold R. McKean and Mrs. McKean are visiting in Truro. Doctor McKean who graduated from Dalhousie in 1934, recently returned from three years spent in medical work, with his wife and little daughter, Elizabeth Anne.

Miss M. Jean Whittier, a native of Rawdon, Hants County, Medical Missionary of the United Church of Canada, has arrived safely in India. She sailed from San Francisco last December, after spending an eighteen months furlough in Canada and the United States. Dr. Whittier graduated from Dalhousie in 1929, and has been in India since 1934.

The BULLETIN extends congratulations to Dr. and Mrs. J. A. Donahoe of Barrington Passage on the birth of a son on February 26th.

Obituary

THE death occurred on February 25th of Dr. Lewis Obid Fuller of Shelburne after a short illness. Dr. Fuller was born in Avonport, King's County in 1876, received his early education in the Annapolis Valley and graduated from Dalhousie Medical College in 1903. Except for a few weeks spent in practice at Clark's Harbour shortly after leaving college, he had practised his profession in Shelburne since 1904. Dr. Fuller was a great reader, an able speaker, and possessed many talents and was very interested in his fellow man. He was a keen sportsman, a member of the Shelburne Men's Club and a former member of the Shelburne Yacht Club. He served for many years as coroner in Shelburne and for years as Health Officer in both the town and municipality. He is survived by his wife, Jessie, daughter of the late Dr. John Purdy, two daughters and three sons.

Alexander Robert Reid, M.D.,C.M. was born in Windsor in 1897, and graduated from Dalhousie in 1920. For a short time he practised at Newport, N.S. after which he took post graduate courses at Montreal, New York and other centres. Equipped then with a good practical knowledge and the latest word from the schools, "Ted" Reid came back to his native town of Windsor, settled down and began his real professional career. Recognition of his abilities came early and with it a very large town and country practice, both in medicine and surgery. Here he labored up to a few weeks ago when his failing health took a very serious turn, and from that on there was no hope. Death came peacefully on the morning of March the 10th.

Dr. Reid's passing is another tragic break in the line of the younger ranks of our profession. For those that, keeping the faith, have bravely finished the course, the lurking Shadow in the evening of their days may take even a kindly shape. But there is a sting in the stroke when the younger and fruitful worker is brought down in the midst of his accomplishments. We have seen much of this of late, and it adds to the sorrow we feel at the untimely death of so good a docter, friend and gentleman as Dr. Ted Reid.

The writer of these lines knew him as a student, and enjoyed the privilege of having him, in his interne year, as a house surgeon. I am glad to recall our mutually pleasant relations, as we worked together in the wards and operating room, and to know our friendship stood the test of all the subsequent years.

Ted Reid grew up in a medical environment, his father being Dr. James W. Reid, a grand old general practitioner, and for a number of years a member of the local Legislature. There was much of his father in Ted; clear headed, practical, and an abundance of the milk of human kindness in his make up. And so—Farewell, and may the genial light you shed here follow in ever enhancing brightness on the distant shore.

To his wife and family our sympathy is extended, as well as to his brother, our own Doctor Jim, of this City, whose devotion and valuable attendance during his illness were noted and praised by all interested friends.

The BULLETIN extends sympathy to Dr. C. E. Kinley of Halifax on the death of his father, Captain James Kinley of Lunenburg, which occurred on February 25th; and to Dr. C. F. Messenger of Middleton on the death of his wife, Mary Adelaide Messenger, which occurred on March 6th.

Gas Rations

Since the rationing of gas I have received several letters and also have had a number of inquiries from doctors who are wondering what procedure to follow in order that they might procure more gas than that allowed under the present plan. I put the facts by correspondence before the Regional Representative for the Oil Controller of Canada, and have received the following answer. This letter from Mr. Annand makes the matter of procedure quite clear.

H. G. GRANT, Secretary

Department of Munitions and Supply
77 Upper Water Street
Halifax, N. S.
March 14, 1942

Dr. H. G. Grant
Secretary
Medical Society of Nova Scotia
Halifax, N. S.

Dear Dr. Grant:

With reference to your letter of March 13th regarding doctors' mileage for the year 1942, we would suggest that you advise any doctor inquiring regarding this to drive as far as he can under Category "C", and if he finds that this is not sufficient for his requirements, to contact us, when we shall be very glad to arrange a further allotment.

Trusting that this is the information which you require, we remain,

Yours truly

(Sgd.) F. W. ANNAND
Regional Officer Manager
For the Oil Controller for Canada

MAIL IN YOUR QUESTIONNAIRE

Of the 404 questionnaires sent to the doctors of the province, so far only 164 have been returned to the office. In order to give the Canadian Medical Association an expression of opinion on Health Insurance which will represent the Medical Society of Nova Scotia it is necessary that many more questionnaires be returned. If you have not filled out your questionnaire—Do so now and mail it in at once.

H. G. GRANT
Secretary

ARE YOU A MEMBER
of the
MEDICAL SOCIETY OF NOVA SCOTIA
and the
CANADIAN MEDICAL ASSOCIATION
if not
JOIN NOW

By so doing you will receive each month the Bulletin of The Medical Society of Nova Scotia and the Journal of The Canadian Medical Association

and

MOST IMPORTANT—there is at present under consideration by the Federal Government legislation which, if it becomes law will affect every physician in Nova Scotia. The Medical Society of Nova Scotia and the Canadian Medical Association are at present exercising every effort to see that in such legislation the rights of the medical profession are protected.

THE GREATER OUR NUMBERS THE GREATER OUR INFLUENCE.

The annual fee for the two societies is $15.00. Send in your application and fees to

H. G. GRANT
Secretary