

The Nova Scotia Medical Bulletin

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Editorial

During the past eighteen months it has been the policy of the Editorial Board to publish a number of issues of the Bulletin devoted to a particular aspect of Medicine. These articles have in the main been prepared by members of the various departments of the Faculty of Medicine of Dalhousie University and their object has been to present those aspects of their specialty which have some application to the work of the majority of doctors in the Province.

We feel that not only have we had the wholehearted co-operation of the Faculty of Medicine in this project but that the resulting Bulletins have been good ones and appreciated by our readers. We are concerned now lest those—the majority of us—who are not engaged in the writing of articles for these special issues should sit back on our oars, as it were, and let the others do all the rowing. Your Editors are most anxious not to have such a situation arise. We still welcome scientific or other suitable articles from individual members of the profession throughout the Province, or would be delighted to consider publication of a series of papers from, say, one of the medical centres outside Halifax.

The Cogswell Library

A question raised more than once at meetings of The Medical Society of Nova Scotia Executive has been "What is this Cogswell Library Committee all about?" In an effort to answer it we have sought the advice of Doctor Kenneth MacKenzie and are indebted to him for the following information.

Doctor Charles Cogswell was born at Halifax, N. S. in 1813. He studied Arts at King's College in 1831 and gained his Edinburgh, Scotland, M.D. in 1836 and subsequently undertook further study in London and Paris. He appears to have been a man of ample means and was interested in all ways of promoting the welfare of the medical profession, and in hospital improvement. He was also active in community affairs and one of the organizers of the Halifax Medical Society. He did not, however, do much active practise in Halifax and moved to London, England in 1839 and became a consulting physician in that city. He was awarded the prize of the Harveian Society of London for a dissertation on the physiological action and medicinal properties of Iodine. He wrote and published several other papers and poetry.

In 1864 he was elected Vice-President of The Medical Society of Nova Scotia.

When he died in 1892 he left in his will \$5,000 to The Medical Society of Nova Scotia with instructions that the interest be used for the purchase of books for the benefit of the Medical profession of Nova Scotia. This collection has been known as the Cogswell Medical Library and these are presently housed in the Dalhousie Medical and Dental Library. The Medical Society of Nova Scotia appoints annually a representative to the Cogswell Library Committee.

An Outbreak of Tuberculosis In A Public School

V. K. RIDEOUT, M.D., D.P.H.

DURING the period from February, 1954, to July, 1956, a total of fourteen (14) active cases of tuberculosis were discovered in the schools of the town of Digby, N. S. There were three schools involved in this outbreak, namely the Regional High School, the Elementary school and a parochial school. Nine cases occurred in the High school, three in the elementary school and two in the parochial school. Six of these cases were resident in Digby town and the remaining eight lived in the surrounding municipality.

The town of Digby is situated in the western part of Nova Scotia on the Bay of Fundy, almost directly across from the city of Saint John, N. B. The population is about 2200. The town is the centre of a moderately large rural area and the Regional High School serves both the town and part of the rural municipality. The economy of the area is based largely on fishing, but there are several small industries as well. The C.P.R. steamer to Saint John, N. B. docks in Digby as its Nova Scotia terminus and the work provided by this service is a large factor in community prosperity.

The tuberculosis rate in this area of the province is not notably high and showed no increase among the general population at the time of the school outbreak.

The first case in this series was discovered at the Children's Hospital in Halifax in a 13 year old boy (N. M.), a student in Grade 8 at the High School. The patient had developed an acute febrile illness in mid December, 1953, with anorexia, loss of weight and cough. He failed to respond to treatment at home and was referred to the Children's Hospital on February 3, 1954, for investigation. This boy had been X-rayed on the Mobile Chest X-ray Unit in November, 1953, during a routine survey of the schools, and this film showed no abnormality. On admission to the Children's Hospital he was found to have a strongly positive tuberculin patch test and chest X-ray on February 7 revealed left mediastinal enlargement and an infiltration in the left upper lobe. A provincial diagnosis of pulmonary tuberculosis was made and the case was referred to the Divisional office of the Department of Public Health. The patient was admitted on February 24, 1954, to the Tuberculosis Section of Roseway Hospital in Shelburne, N. S. for further investigation and treatment. On admission the boy had developed a miliary spread of his disease and a paralysis of the left vocal cord. This latter complication was attributed to compression of the recurrent laryngeal nerve by enlarged mediastinal glands, and cleared fairly rapidly after therapy was instituted. A few weeks after admission he also developed a right sided pleurisy with effusion which also resolved uneventfully with aspirations and antimicrobial therapy. A positive sputum was never obtained from this patient. Gastric washings were also negative for tubercle. The patient received $18\frac{1}{2}$ months of combined antimicrobials in hospital with excellent recovery. He was discharged home on September 4, 1955, with his disease classified as inactive. He returned to school after discharge and since then has been leading a normal life. Recent recheck X-ray was quite satisfactory.

This boy's family and known contacts were investigated, but no evidence of tuberculosis was found among them. His two siblings had and still have a negative reaction to the tuberculin patch test.

The second case (M.H.) was discovered in March, 1954, in a 15 year old girl. This child developed chest pains in February and later became quite ill. She developed a left side pleurisy with effusion, and was also found to have a positive patch test. She was referred to the D.M.H.O. by her family doctor and the diagnosis was confirmed by X-ray and aspiration. She was placed on bed rest at home and the effusion subsided for a time, but a recurrence occurred in July and she was admitted to Roseway Hospital on August 27, 1954. She received medical treatment, with aspirations as necessary, combined with antimicrobials. She made a good recovery and was discharged on May 15, 1955, returning to school that same autumn. This girl stated that she had no direct contact with any of the other children who subsequently developed tuberculosis, nor with the previously diagnosed case. Her family history is entirely negative and seven siblings all have negative patch tests. This girl lived in a rural area so would have had little occasion to mingle with the other students after school hours. A definite source of her infection has not been found. Her present condition is satisfactory.

In April, 1954, a case of far advanced, open pulmonary tuberculosis with multiple cavitation was discovered in a 20 year old man (A.S.), who was a caretaker at the local rink. He was in contact with many of the school children at the rink and in town generally and later was considered to be the source of infection of at least two of the cases. This man was admitted to Roseway Hospital on April 8, 1954, and remains there till the present, still having a positive sputum and open cavities despite intensive treatment. His source of infection was found to be an elderly grandmother who was admitted to Roseway one week after him. She died at Roseway in August, 1957, from other causes, but with her tuberculosis still active. This man's case is mentioned because of the possible contact he had with some of the other cases in the school outbreak. It is believed that he may have been the source of two cases directly and one indirectly. No other possible sources were discovered for these two cases. He may also have played a part in several other cases although there seems to be a more direct line of contact.

A fourth case was discovered in September, 1954, in a 14 year old girl (C.C.), who was not a student at the Digby Schools, but was home for the summer vacation from a school in Moncton, N. B. This girl became ill during the summer months and was suspected of having a lung abscess. Subsequent investigation revealed far advanced, open tuberculosis and she was admitted to the Halifax Tuberculosis Hospital on September 27, 1954, for treatment. She subsequently underwent a left lower lobectomy, and developed a right sided tuberculous bronchopneumonia post-operatively. She made good recovery from her disease and was discharged on August 5, 1955. I.N.H. and P.A.S. were continued on an out-patient basis until February, 1956. Her condition has remained satisfactory since discharge.

This girl was believed to be a focal point for a possible four of the cases of tuberculosis, which later developed and possibly more if all the ramifications of the contact chain could be followed.

A 14 year old boy (B.E.), who was known to have had a direct and prolonged contact with this girl, was the next case found, in October, 1954. It is also possible that he had slight contact with the rink caretaker. This boy attended the parochial school during the 1953-54 term in Grade 8 and trans-

ferred to Grade IX in the High School in September, 1954. He became obviously very ill the latter part of September and was sent home for referral to his family physician. He was found to have a positive patch test, and chest X-ray on October 4, 1954, revealed far advanced, bilateral disease with cavitation. He was admitted to Roseway Hospital on October 15, 1954, for treatment. He quickly showed marked improvement on antimicrobials, but a left upper lobectomy was required and was carried out at the Nova Scotia Sanatorium, Kentville, in February, 1956. He was finally discharged from hospital on August 22, 1956, and since then has gradually returned to a normal life. Family contacts were X-rayed and one brother had a positive patch test and showed evidence of primary tuberculosis which later proved to be inactive.

In November, 1954, following discovery of this case the 68 pupils in Grades IX (a) and IX (b) were patch tuberculin tested. These were the classes who were associated with the first case discovered and this latest case. Of the 68 done there were eight positive reactors. Two of these were children whose father had died of tuberculosis some years previously, and this contact may account for their positive reaction. All eight positive reactors were X-rayed at a clinic held shortly after and one boy of 15 years of age (A.C.), was found to have a minimal lesion. He was treated at Roseway Hospital for a period of nine months and was discharged with his disease classed as inactive. Followup has revealed no evidence of reactivation. Investigation of the family contacts revealed one sibling with a positive patch test, but no significant disease. Three other siblings had negative tuberculin reaction, and the parents had negative X-rays. The classmates with positive patches were again X-rayed in February, 1955, with no cases being found.

At this same time, that is in November, 1954, a case was discovered in Grade 5 in the Elementary school. This was a boy of 15 years of age (C.W.) with a family history of tuberculosis. His mother had a diagnosis at that time of moderately advanced, inactive, and his father was in hospital undergoing treatment for pulmonary tuberculosis. This boy was taken under supervision in 1948 as a contact of his parents. In August, 1948, he had a negative patch test. X-rays and patch tests were carried out with negative results in both June and September, 1949, in February and September, 1950, in September, 1952, and April, 1953. In May, 1954, a strongly positive patch test reaction was discovered, but chest X-ray on May 26 was again considered negative. A repeat X-ray on November 2, 1954, revealed slight inflammatory changes between the left 1st and 2nd ribs and a diagnosis was made of suspected minimal, active tuberculosis. Repeat X-ray on December 21, 1954, confirmed the presence of a lesion and sputum was later reported positive on culture for tubercle bacilli. The patient was admitted to the Nova Scotia Sanatorium on February 16, 1955, and on admission was found to have a marked extension of disease with cavitation in the left lung. He received antimicrobial therapy and later had a left upper wedge resection carried out. He was discharged in July, 1956, and has since been leading a normal life.

At the time of this patient's breakdown his father was receiving treatment in sanatorium, having been readmitted in May, 1953, following a reactivation and extension of disease. He was home from December 22, 1953, to January 4, 1954, on a pass, during transfer from one institution to another. Sputum examinations at that time, however, were reported as negative and the patient had been on antimicrobials. However he could still have been the source of his son's infection, and no other outside contact has been found.

This case points up the necessity of continued close surveillance of contacts and the use of the tuberculin test. This boy was patched and X-rayed at six monthly intervals for two years and then yearly for four more before he showed a conversion. Six months following the discovery of this conversion the boy had developed a moderately advanced lesion with cavitation. I hesitate to think of what might have happened in this child's school grade if he had not been followed closely and removed from school at the first X-ray evidence of disease. Again, this one case could be used as a recommendation for the institution of therapy at the time of conversion of the patch test as a preventive measure. I have no doubt that in this particular case it would have been invaluable and may have prevented the loss of 1½ years of his life in hospital and the necessary surgery.

In March, 1955, another case was found in a 15 year old girl (J.R.) attending Grade IX. This girl had contact in school with the first and fourth cases mentioned. She also had a contact with her grandmother 2 years previously, prior to her admission to a sanatorium in N.B. This girl had a negative patch test in March, 1954, during the tuberculin survey of the school after discovery of the initial cases. A re-survey was carried out in March to May, 1955. This girl was then found to have a positive patch and showed X-ray evidence of active primary tuberculosis in her lungs. This was confirmed by further X-rays in April and she was removed from school and treated at home with bed rest. She made excellent improvement and was permitted to return to school in January, 1956. Her subsequent history has been uneventful and she continues to lead a normal life. Her family history is negative for tuberculosis except for slight contact with her grandmother as mentioned previously.

The seventh case to occur in this outbreak was discovered indirectly through an attempted army enlistment. A 17 year old boy (W.K.) left school in January, 1955, and during pre-enlistment examination in March, 1955, was found to have a lesion in the right mid lung field. He was sent home and the Divisional Medical Health Officer was notified. A tuberculin patch test was done and reported positive on March 29, 1955. The X-ray diagnosis was also confirmed on recheck films and the patient was placed on bed rest at home. This proved unsatisfactory and following re-examination in April, 1955, he was referred to Roseway Hospital, being admitted there on May 25, 1955. A small cavity was demonstrated in December, 1955, but this healed without resection. The patient was discharged on August 23, 1956, and to date his condition remains satisfactory.

This patient was a classmate and contact of two previous cases reported in this paper. He was missed in the original patch test survey carried out in his grade so no record of his tuberculin status was available prior to his breakdown. The more likely contact source for this patient was the rink caretaker since the boy worked with him closely at the rink during the previous winter. Family contacts were all negative and have remained so. Four siblings all have negative patch tests.

During a patch test survey carried out in March, 1955, an 11 year old boy (F.B.) attending Grade VI in the Elementary School was found to have a positive reaction, and subsequent chest X-ray revealed a suspected minimal lesion which was later confirmed. No other contact source was ever found so it has been assumed that he received his infection from a previous case in school. He was admitted to Roseway Hospital in May, 1955, and discharged in December, 1955. Drug therapy was continued at home until June, 1956. He re-

turned to school in September, 1956, and is leading a normal life. All siblings have negative tuberculin tests and parents' X-rays are negative.

In April, 1955, a 16 year old boy (R.G.) attending the parochial school, was found to have a minimal lesion as a result of the patch test survey. This was later confirmed and he was admitted to Roseway in June, 1955, and discharged in June, 1956. No cases of tuberculosis were found in his family and all siblings had negative patch tests. This boy, however, did have considerable contact with the rink caretaker and the other case discovered in March, 1955, who also worked at the rink. Since discharge from hospital his condition has remained satisfactory.

Another case located as a result of a positive patch test during survey was that of a 17 year old boy (F.M.) attending Grade 12. This boy had a minimal lesion and was admitted to Roseway Hospital in July, 1955, and discharged in April, 1956. He subsequently entered university and is leading a normal life. This boy's contact source has not been definitely established, but it is possible that he had contact with a taxi driver in his home district who was found to have open tuberculosis. Family contacts have all proven negative.

A second case was found in the parochial school as a result of the patch test survey. This was a 13 year old boy (M.R.) who was diagnosed as primary tuberculosis in April, 1955. He was placed on bed rest and antimicrobial therapy at home, but developed a drug sensitivity so was admitted to Roseway on September 14, 1955, where treatment was continued until discharge on June 10, 1956. Drug therapy was carried out at home for an additional three months following discharge. The patient returned to school in September, 1956, and is presently leading a normal life. The possible source of contact in this case was in school, he having contact with two of the cases found previously. Family contacts have been negative and no other source of infection has been found.

A case of minimal tuberculosis was found in April, 1955, in a 15 year old boy (F.C.) attending Grade 7. This boy had previous contact with his mother and had a known positive patch test since May, 1953. He was found to have a small lesion, but it was never proven to be active. He was referred to the Nova Scotia Sanatorium for investigation in August, 1955, but again no evidence of activity was found. He has been carried since then as an inactive case. No contact source other than his mother was found. There does not seem to be any school contact with other cases.

A ten year old boy (A.D.) has a positive patch during school survey in May, 1955. Chest X-ray in June showed slight left apical clouding, but he was considered to be non-tuberculous on subsequent films. During the fall of 1955 this boy developed pain and oedema in his left knee. He was treated conservatively by his physician for some time and was then referred to the Halifax Children's Hospital in December, 1955, for investigation. A diagnosis was made of tuberculosis of the knee and the child was referred to the Nova Scotia Sanatorium in February, 1956, being admitted on February 13, 1956. Treatment consisted of immobilization of the joint in a plaster cast and combined antimicrobial therapy. He made good recovery and was discharged on December 9, 1956. At this time no evidence of reactivation of the knee infection or of pulmonary infection has been found. The patient is leading a normal life. Family contacts were all negative. This boy's contact source was not definitely found.

SUMMARY OF 14 NEW CASES OF TUBERCULOSIS DISCOVERED

Cases	Date	Diagnosed	Initials	Age	Sex	Grade	Diagnosis	Probable Source
1	Feb.	1954	N.M.	13	M	8	Far Advanced (Miliary)	Unknown
2	March	1954	M.H.	15	F	8	Pleurisy with Effusion (Minimal)	Unknown
3	Oct.	1954	B.E.	14	M	8	Far Advanced	Outside contact (C.C.) *
4	Nov.	1954	A.C.	15	M	9 b	Minimal	Case No. 3 (B.E.)
5	Nov.	1954	C.W.	15	M	5	Moderately Advanced	Familial
6	March	1955	J.R.	15	F	9 c	Primary	School contact (Case No. 3?)
7	March	1955	W.K.	17	M	10 b	Minimal	Outside contact (A.S.) **
8	March	1955	F.B.	11	M	6 b	Minimal	School contact most probable
9	April	1955	R.G.	16	M	8	Minimal	Outside contact (A.S.) **
10	April	1955	F.M.	17	M	12 a	Minimal	Outside contact
11	April	1955	M.R.	13	M	8	Primary	School contact (Case No. 3 and/or No. 9)
12	April	1955	F.C.	15	M	7 b	Minimal	Familial
13	May	1955	A.D.	10	M	5 a	Tuberculosis of Knee	Possibly School contact
14	July	1956	J.G.	16	F	12 a.	Far Advanced	School or Familial (Case No. 10?)

* C.C. — Student from Moncton

** A.S. — Rink caretaker

The final case found to date was discovered in July, 1956, in a 16 year old girl (J.G.) from an outside district, but attending high school in Digby. This girl had a positive patch test during survey in March, 1955. A chest X-ray in April was considered negative, although a slight change was noted in the right 1st interspace. The girl failed to have a recheck film until July, 1956, when she was referred because of illness. She was at that time found to have a caseous lesion in the left upper lobe with cavitation, and lesser changes on the right side. The patient was immediately referred to the Nova Scotia Sanatorium, being admitted on August 6, 1956, with a diagnosis of far advanced pulmonary tuberculosis and she is still in hospital receiving treatment at this time.

Family contacts were X-rayed and found to be negative and her sister had a negative patch test, but shows conversion in 1957. This girl had a possible contact with at least one of the previously located cases in school. Her grandmother has repeatedly refused to have a chest X-ray, so the possibility of family contact has not been completely ruled out.

In November, 1953, prior to the discovery of the first case of tuberculosis in February, 1954, a chest X-ray survey of all pupils of 12 years of age and over was carried out in these schools by the Mobile Chest X-ray Unit. Ten of the pupils who later developed active pulmonary disease were included in this survey and all were reported as having no evidence of disease at that time. Within three months the first case was found with X-ray evidence of disease. This boy had a clinical illness within one month of X-ray. The second case occurred within four months. For these two pupils a definite contact was never found.

During the period from March to May, 1955, a tuberculin patch test survey was carried out in all Grades in every school. Some mention has already been made of the cases found during this survey, but the complete picture has not been presented to you. A total of 1159 pupils were tested. of these 130 positive reactors were found representing 12% of the total school population—38 of this number had a previously known contact outside of school and 92 had no known contact other than in school.

The 130 positive reactors were X-rayed and five (5) new cases of pulmonary tuberculosis were discovered—2 primary actives and three minimal cases. Two other cases were later discovered in this group on follow-up X-rays.

Summary

In the outbreak a total of 14 cases of active tuberculosis (13 pulmonary and 1 non-pulmonary) occurred in the schools during the period from February, 1954, to July, 1956—3 girls and 11 boys were infected. Of these 14, a total of 10 were found because of follow-up X-rays after the discovery of a positive tuberculin patch test. Three were found by referral from the family physician and one was found on Army enlistment chest X-ray. There were 2 Primary cases, 1 pleurisy with effusion, 6 minimal, 1 moderately advanced and 3 far advanced cases.

Four contact sources were definitely found and were responsible directly and indirectly for eight (8) of the cases—2 family contacts, the rink caretaker and the girl from Moncton.

Three other tuberculosis cases in the communities involved were considered as suspected sources of four (4) other cases in the school.

No possible source was found for the remaining two cases, but one may possibly have had a contact in the school.

Since the outbreak occurred a continuing program of patch testing has been carried out in these schools. The patch conversion rate has been very low and no new cases have been found. All but two of the cases in the outbreak occurred before June, 1955. During the winter term of 1955-56 the schools were again surveyed and a total of 1695 patch tests were done, with 132 positive reactors. All were X-rayed and found to be negative. During the 1956-57 term the Primary department and Grade IX classrooms were again patch tested and a total of 11 positive reactors were found, most of these being previously known. In all 54 children were X-rayed, that is the 11 mentioned, plus 43 other known positive reactors and no evidence of active disease was found in this group. Such a tuberculin test program will be continued, but it is hoped that no further cases will be discovered.

Progressive Pulmonary Tuberculosis*

With the aid of slides, the various complications seen in children with primary tuberculosis were presented. The most common complication is that resulting from partial or complete obstruction of the airway resulting in an emphysema in the former, and in an atelectasis where complete obstruction of the airway occurs. The airway may be obstructed from within the lumen by redundant mucosa or granulation tissue, or it may be obstructed externally by compression from enlarged lymph glands. Pleural effusions occur more commonly on the right side and may vary from a small amount of fluid in the costophrenic angle to almost complete filling of the pleural cavity. Films were shown of cases of miliary tuberculosis with a haematogenous spread through both lung fields. One case was presented in which the miliary lesions in the spleen became calcified, and were visible radiologically. Associated with miliary tuberculosis, we may have tuberculosis meningitis. Skeletal complications were presented as seen in Potts' disease and tuberculosis of the hip.

Those cases with primary infections that have gone unrecognized for some time, where the contact is unknown, may progress to the re-infection type disease and may ultimately require surgery as a segmentectomy, lobectomy or pneumonectomy.

Comments on the treatment of primary infection where the child has a positive tuberculin test with no X-ray findings followed. The importance of the early separation of the infected child from the contact case was stressed. Our control of tuberculosis in children rests largely upon the proper handling of the adult case, especially the adult who has received treatment and may consider himself cured. It was emphasized that the antimicrobial drugs are bacteriostatic and not bacteriocidal, and that the lesions that were inactive at the time of discharge may, under proper conditions, become reactivated and be a source of infection to others, especially to children.

Schapiro, I. E., Proceedings of the Institute of Medicine of Chicago. 21: May 15, 1957.

* Medical Abstracts, August, 1957.

Hemorrhage From the Upper Part of the Gastrointestinal Tract

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THIS presentation will consider the management of a patient admitted to the hospital because of hemorrhage into the upper part of the gastrointestinal tract. The attending physician will be faced with a series of problems beginning with the recognition of hemorrhage into the gastrointestinal tract as the cause of the patient's condition, and followed by treatment of the acute symptoms of such hemorrhage, if they exist, by the diagnosis of the cause of the bleeding, and finally by the definitive treatment of such cause, if this be possible.

In table 1 are shown the primary clinical manifestations of bleeding into the gastrointestinal tract. Blood which is vomited may be either red or coffee-ground in color. Vomiting of red blood indicates that the lesion is above the ligament of Treitz and often above the pyloric sphincter. It also indicates that the gastric juice has not had time to alter hemoglobin to acid hematin. For this reason, it is usually associated with greater degrees of shock than is the vomiting of coffee-ground material. An exception to this generalization is that in cases of bleeding from a duodenal ulcer most of the blood may be passed downward and only a small part may be regurgitated into the stomach. In such cases, coffee-ground vomitus may be associated with severe degrees of shock.

Melena, the passage of tarry stools, is the result of the loss of at least 75 cc. of blood into the gastrointestinal tract from a lesion usually above the cecum, but rarely as low as the transverse colon. The passage of red blood in the stool is usually the result of bleeding from a lesion below the terminal portion of the ileum or below the cecum, but may arise as high as the duodenum. If the lesion is high, the bleeding must be rapid and massive, so as to produce a mass peristaltic movement which carries the blood through the intestine unaltered. It, therefore, follows that bleeding from the upper part of the gastrointestinal tract which is evidenced by red blood in the stools will be accompanied by a moderate to severe degree of shock. Occasionally, a patient is seen in a state of shock before the blood has left the intestine. In such a case, the cause of the shock may at first be puzzling.

Patients may come under medical attention because of the anemia resulting from bleeding into the gastrointestinal tract. This anemia may be either that associated with acute blood loss, in which case the picture is that of a normocytic normochromic anemia with increased numbers of polychromatic cells which are shown to be reticulocytes when stained with vital stains; or the picture may be one of a chronic microcytic hypochromic anemia due to the continued loss of blood over a long time producing depletion of iron stores and this characteristic type of anemia. The daily loss of much less blood than that necessary to produce a tarry stool will in time exhaust the iron stores with-

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out the patient's being aware of bleeding. The patient consults a physician either because of symptoms of an anemia which is found to be due to a bleeding lesion in the gastrointestinal tract, or because of symptoms of the primary lesion.

The secondary manifestations of acute hemorrhage of the upper part of the gastrointestinal tract are shown in table 2. Thirst and nausea are almost constant accompaniments of acute hemorrhage. The cause of thirst is obvious and is similar to that accompanying acute blood loss from any cause. Nausea is associated with atony of the stomach which may contain considerable amounts of blood clot. The recognition of the significance of this symptom is important in the treatment of the patient, and will be considered later.

Fever and leukocytosis follow hemorrhage of any significant degree in about 12 to 24 hours. An oral temperature of 102° F. is quite compatible with such bleeding, but, if the temperature is higher than this, a further cause should be sought. Leukocyte counts up to 15,000 are encountered commonly.

TABLE I
Primary Manifestations of Hemorrhage
Into the Upper Part of the
Gastrointestinal Tract

Hematemesis
Melena
Red blood in stools
Shock
Anemia

Less commonly, the leukocyte count may be as high as 25,000, but counts higher than this indicate a further cause. The leukocytosis is accompanied by an increased percentage of polymorphonuclear leukocytes in the peripheral blood. Elevations of the serum nonprotein nitrogen to levels of 50 to 80 mg. per 100 cc. are not uncommon. It has been shown that such azotemia is due to a combination of sufficient shock to impair renal function temporarily and the absorption of nitrogenous substances from the blood in the intestine. Occasionally, the renal damage is of such a degree as to cause renal shutdown owing to changes associated with the anoxic kidney.

The emergency treatment of the symptoms of hemorrhage into the upper gastrointestinal tract is in effect the treatment of shock due to acute blood loss. In such treatment, transfusion of whole blood constitutes the most effective measure available. This should, of course, be accompanied by the use of all other measures which have been shown to help in the management of this problem, including rest in bed, possibly with the feet elevated, and, in rare instances, with the extremities bandaged; sedation; warmth to the body;

TABLE 2
Secondary Manifestations of Acute
Hemorrhage Into the Upper Part of
the Gastrointestinal Tract

Thirst
Nausea
Fever
Leukocytosis
Azotemia

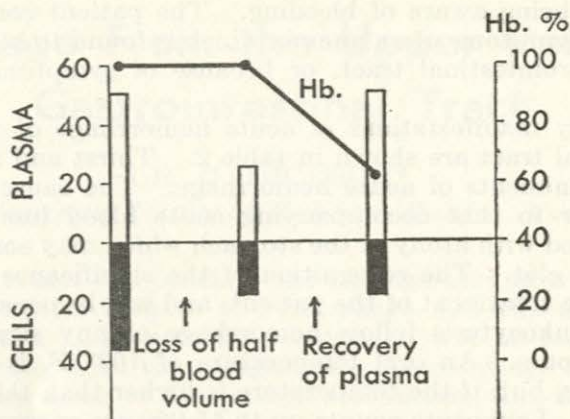


Figure 1 Relationship between the concentration of hemoglobin and restoration of the plasma volume after acute hemorrhage.

(Bennett, Dow, Lander and Wright in *The Lancet*)

reassurance, for surely few episodes can be more frightening to a patient than the sudden vomiting of blood. In some cases these measures may, in themselves, be quite sufficient, and the patient may rapidly recover from a state of mild or moderate shock. In such cases, transfusion is not indicated. If, however, by the time the patient's blood has been typed and cross agglutinated, and blood made available, a state of shock still exists, transfusion should be undertaken forthwith. While such a method may result in a small number of instances of so-called single bottle transfusions, in most cases in which the shock has persisted for this length of time, the transfusion of 1000 cc. or more of blood will be required.

When whole blood is not available, blood substitutes provide the second best means of treatment. In figure 1, a theoretical situation is shown to indicate further the importance of the clinical state of the patient in assessing the need for transfusion. Here is represented a situation in which a patient suddenly loses about 40 per cent of the circulating blood volume. Immediately after the hemorrhage, there will be profound shock, and determination of the value for the hemoglobin and the hematocrit reading will show the same findings as immediately before the hemorrhage. Later, when the plasma volume has been restored, the patient will not be in shock and hemoglobin value and the hematocrit reading will be approximately 60 per cent of normal. The patient is usually seen somewhere between these two extremes.

In cases in which bleeding continues or recurs at intervals of a few hours to a few days, the amount of blood transfused should be sufficient not only to correct shock but also to restore the hemoglobin to a level of 75 per cent or higher, in order to prevent the patient from suffering the effects of acute anemia. By such treatment, the risk of emergency operation, should such become necessary, is reduced.

When the patient has recovered from shock, the next step in treatment is the correction of the anemia. If the iron stores are adequate, regeneration of blood following the acute blood loss is just as rapid without iron therapy as with it. However, in rare instances the hemorrhage may have produced the final depletion of iron stores necessary to produce microcytic hypochromic

anemia. Such a situation is shown in figure 2. It is, therefore, reasonable and wise to prescribe iron by mouth at a suitable time when the acute symptoms have subsided, and the patient is taking a good diet. The anemia of chronic blood loss will, of course, require the administration of iron by mouth as soon as this can be reasonably introduced into the patient's treatment. Parenteral administration of iron is indicated rarely and only for patients who do not tolerate iron by mouth.

The diet during the early stages is largely dictated by the patient's appetite. Immediately following hemorrhage into the upper gastrointestinal tract, the stomach is atonic and often filled with blood clot. This is associated with nausea, and to give food to the patient at this time is unwise. Parenteral administration of fluids should be continued until the nausea has subsided. Thereafter, milk or other suitable fluids may be given frequently in small amounts, and the patient's diet increased as rapidly as his appetite permits. In most cases, by the third day the patient will take a full bland diet including meat and vegetables.

To this point, the consideration of the problem has not involved diagnosis beyond the recognition of hemorrhage into the gastrointestinal tract as the cause of the patient's condition. In order, however, to carry on with the problem and deal in a definitive manner with the cause of the bleeding, accurate diagnosis becomes essential. Many classifications of the cause of such bleeding have been given. Bockus'¹ modification of Balfour's classification lists some 50 causes, but, as many of these are excessively rare, the classification can be simplified for all practical purposes to that given in table 3.

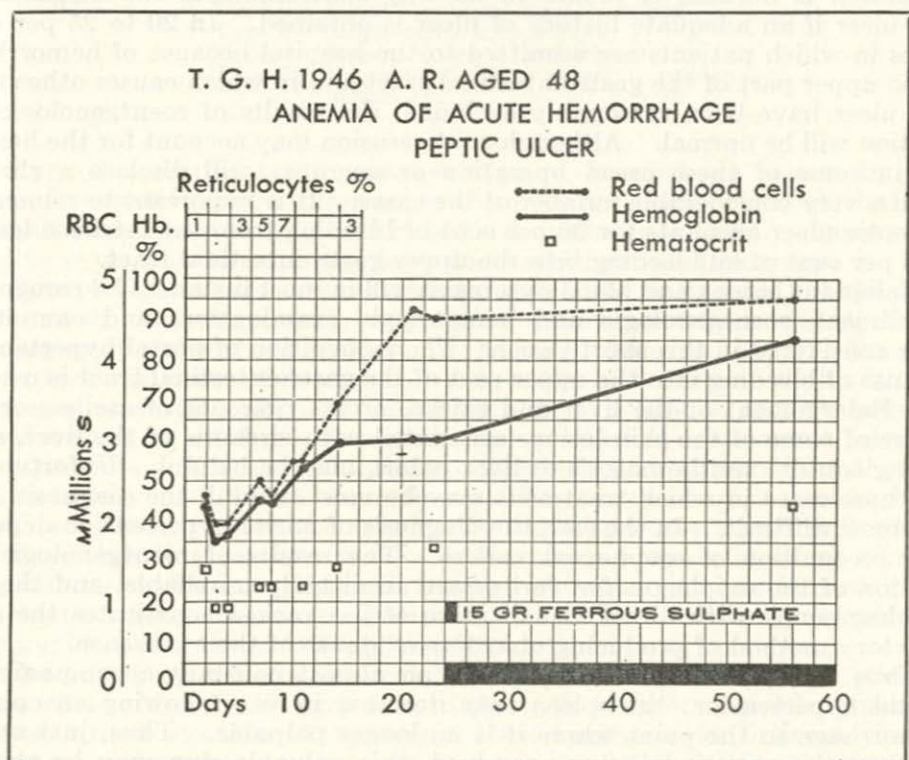


Figure 2. Anemia caused by acute hemorrhage in case of peptic ulcer.

TABLE 3
Causes of Gastrointestinal Hemorrhage

<i>Intrinsic causes</i> —Diseases of the esophagus, stomach or duodenum (in 90 per cent of cases)
Peptic ulcer—esophageal, gastric, duodenal or anastomotic
Neoplasms of the esophagus, stomach and duodenum
Esophagitis, gastritis or duodenitis
Postoperative bleeding from suture line
<i>Extrinsic causes</i> —Disease outside the esophagus, stomach or duodenum (in 10 per cent of cases)
Portal Hypertension
Cirrhosis of liver
Thrombosis of portal vein
Cavernous transformation of portal vein
Anomalies of portal vein in children less than one year of age
Banti's syndrome: splenomegaly, anemia, leukopenia, portal hypertension, and sometimes thrombocytopenia
Blood dyscrasias including jaundice with prothrombin deficiency
Malignant lesion eroding the esophagus, stomach or duodenum
Swallowing of blood—epistaxis, oral bleeding, hemoptysis and malingering

In most cases, the diagnosis of peptic ulcer will be clear from the patient's history. However, in about 25 per cent of the cases of hemorrhage from peptic ulcer, the hemorrhage is the first manifestation of an ulcer, or the first evidence of reactivation of an ulcer. In such cases, roentgenologic examination and possibly gastroscopy will be necessary to establish the diagnosis. In any case, roentgenologic examination should be carried out for the information it may give in regard to the localization of the ulcer. If the result of roentgenologic examination is normal, it should in no way contraindicate the diagnosis of peptic ulcer if an adequate history of ulcer is obtained. In 20 to 25 per cent of cases in which patients are admitted to the hospital because of hemorrhage into the upper part of the gastrointestinal tract and in which causes other than peptic ulcer have been reasonably excluded, the results of roentgenologic examination will be normal. Although acute erosion may account for the hemorrhage in some of these cases, operation or necropsy will disclose a chronic ulcer in a very considerable number of the cases. It is important to remember that peptic ulcer accounts for 90 per cent of bleeding from the intrinsic lesions and 75 per cent of all bleeding into the upper gastrointestinal tract.

Malignant lesions and blood dyscrasias will in most instances be recognized from clinical, roentgenologic and hematologic examination, and cannot be further considered in this short paper. The recognition of portal hypertension as a cause of bleeding into the upper part of the gastrointestinal tract is usually easy. Enlargement of the liver and spleen, or the presence of ascites, or the presence of some of the skin lesions associated with cirrhosis of the liver, such as telangiectasia, xanthomatosis or liver palms, may be helpful. Unfortunately, in those cases in which treatment may be most helpful, the diagnosis may be the most difficult. In the end, the diagnosis of portal hypertension depends on the recognition of esophageal varices. The results of roentgenologic examination of the esophagus for varices are admittedly unreliable, and the use of esophagoscopy with direct visualization of the varices constitutes the only satisfactory method of producing objective evidence of their presence.

While enlargement of the spleen is an almost constant accompaniment of portal hypertension, the spleen may decrease in size following an episode of hemorrhage to the point where it is no longer palpable. Thus, just at the time when the patient is being examined, this valuable sign may be absent. The results of liver function tests usually are abnormal in cases of portal cirrho-

sis; in particular, retention of **Bromsulphalein**® is of value in cases in which jaundice is not present. However, in cases in which the patients are amenable to treatment, the results of liver function tests may be within normal limits or only very slightly abnormal. In fact, shunt operations may be most helpful in cases in which patients have recurrent episodes of hemorrhage due to portal hypertension as the only demonstrable evidence of liver disease or of extrahepatic portal obstruction.

The discussion of treatment of the underlying cause of the bleeding must of necessity be limited to the most important types, and for this reason will be confined to peptic ulcer and portal hypertension. In considering the treatment of hemorrhage due to peptic ulcer, some classification of bleeding is necessary, and a slight modification of that proposed by the late Lord Moynihan² is useful (table 4). Types 1 and 5 are of no clinical importance. It is probable that all patients with peptic ulcer have occult blood in the stools from time to time, and its discovery will depend entirely on the enthusiasm of the search. In type 5, death is so rapid that there is no time to consider treatment.

Type 3 represents more serious bleeding than type 1; it is sufficiently severe to cause depletion of iron stores. The administration of iron, usually mouth, is required as well as the treatment of the active ulcer.

TABLE 4
**Classification of Hemorrhage Caused
by Peptic Ulcer**

Type 1.	Occult blood in stool
Type 2.	Silent bleeding; chronic anemia
Type 3.	Single acute hemorrhage
Type 4.	Repeated acute hemorrhage
Type 5.	Erosion of large vessel; sudden death

Type 3 constitutes the common type of hemorrhage caused by peptic ulcer. The patient may suffer a greater or lesser degree of shock, but, when he is put under treatment at rest in bed with suitable supportive measures, the bleeding stops and the patient goes on to an uninterrupted recovery.

Type 4 bleeding starts in exactly the same way as type 3, but the patient continues to bleed at intervals varying from a few hours to a few days, or else bleeding is persistent. It is this type, as might be expected, which accounts for the large majority of deaths, and it is in the management of this type that emergency operation plays an important part. Various studies have been carried out in an effort to obtain knowledge which would permit forecasting which patients will bleed serially or continuously and which will not. So far, no satisfactory method has been found. Treatment must, therefore, be conservative at first, but, at the same time, must be well planned and adequate so that, if bleeding persists and an emergency operation becomes advisable, the patient's condition will be such as to permit operative interference with the minimum of risk. To achieve this end, the patient must be prevented from suffering from acute anemia for a long time.

Emergency operation must deal directly with the bleeding point, preferably by excision. Modern surgery has made such excision possible much more commonly than was true 15 years ago. It is usually easier to excise the ulcer-bearing area when the ulcer is in the stomach than when it is in the duodenum. This may account for the fact that, whereas in the past the mortality rate of

bleeding gastric ulcer was higher than that of duodenal ulcer, the reverse now appears to be the case. Wherever a skilled surgeon is available to undertake the treatment, emergency operation is indicated for those patients who bleed continuously or serially for more than 24 hours following the institution of conservative treatment in the hospital, provided that such conservative treatment has been successful in restoring the patient to a condition in which the operative risk involved is acceptable.

It must be remembered that the over-all mortality rate of hemorrhage from ulcer, treated conservatively, is in the neighborhood of 10 per cent. By careful preparation and emergency operation when indicated, it is possible to reduce the mortality rate to 5 per cent or a little less. Other factors have been recognized as influencing the mortality rate in cases of bleeding peptic ulcer. Perhaps it would be more accurate to say that these factors influence the incidence of type 4 hemorrhage. The age of the patient is one such factor. In patients under the age of 40 years, death from bleeding ulcer is rare. With increasing age, it becomes more common. This would appear to be closely related to the chronicity of the ulcer and to the presence of coexistent serious disease. It has also been pointed out that the mortality rate rises with each succeeding episode of hemorrhage. Yet it is true that about 80 per cent of the deaths occur in the first episode of hemorrhage. Therefore, while the history of one or two previous episodes of hemorrhage may constitute a valid indication for surgical intervention, such action will not greatly affect the over-all mortality rate of this disease.

Elective operation will be indicated in certain cases. In any case in which a patient has had a second episode of hemorrhage while on an adequate ulcer diet, surgical intervention should be given serious consideration. A patient who is fortunate enough to survive a type 4 hemorrhage should be operated on at an early suitable time, since the pathologic finding in most such cases has been that of a pipestem, sclerosed artery in the base of a chronic peptic ulcer. Patients who have hemorrhage from a gastric ulcer which does not heal after a reasonable period of medical treatment should have a partial gastrectomy.

The problem of treatment of portal hypertension involves, first, such measures as may be used to control the acute bleeding from esophageal varices. Of these, the use of the hydrostatic bag distended in the lower part of the esophagus is perhaps the only one now widely in use. More definitive treatment has been the subject of considerable discussion over many years. Various operations designed to increase anastomotic circulation between the portal and systemic venous systems have been devised. At present, those most favored are portacaval shunt and splenic-renal shunt. The indication for shunt operations has not as yet been clearly defined, but, as experience increases, it would appear that if jaundice is present, or if more than 20 per cent of Bromsulphalein is retained at the end of 45 minutes, a shunt operation is contraindicated because it is likely to cause hepatic coma. Those patients who have portal hypertension as the only evidence of disturbed hepatic function or in whom the block is extrahepatic are the most suitable for such operations. In between these two extremes, the selection of patients is difficult, and as yet not clearly defined, but, broadly speaking, the more the group is widened to include patients with greater degrees of liver damage, the higher the mortality rate will become.

The differentiation of the patients with intrahepatic obstruction to portal circulation and those with extrahepatic obstruction becomes important because of the different surgical approach necessary. For intrahepatic obstruction, portacaval shunt appears to be the operation of choice. For extrahepatic obstruction, such an operation is usually impossible, and splenorenal shunt is the desirable procedure. The use of splenography in the future elucidation of this problem, while at present still in its infancy, is proving helpful in many cases. In effect, the treatment of portal hypertension by surgical means has limited scope, but may be of great value in the small group concerned. It is important for the practitioner to recognize the possibilities of treatment and to be prepared to refer suitable patients to surgeons interested in and capable of dealing with this problem.

REFERENCES

1. **Bockus, H. L.:** Gastro-enterology. Philadelphia, W. B. Saunders Company, 1946' vol. 1, p. 561.
2. **Moynihan, B. G. A.:** Duodenal Ulcer. Philadelphia, W. B. Saunders Company, 1910

Skin Manifestations of Drug Allergy

Therapy of allergic reactions depends on the type of response that is experienced. The drug should be stopped and antiallergic measures instituted.

The most serious complication is the anaphylactoid reaction. An adequate airway must be maintained and measures to combat shock instituted. If the drug is injected into the arm a tourniquet is applied above the site of injection and 0.3 cc. of epinephrine, 1:1000, is given. Cortisone, 100 mg. given intravenously, may be lifesaving, and a bronchospasm may be combated by administering aminophylline intravenously. Antihistamines are helpful and may be given either intramuscularly or intravenously. As a means of promoting elimination of the drug, 5 per cent dextrose in water is administered intravenously.

The management of the cutaneous symptoms depends on their type. In urticaria and angioneurotic oedema, antihistamines are indicated. Pruritic, vesicular, pustular, exfoliative and papular eruptions require topical therapy which includes baths, wet dressings, lotions, pastes and ointments. It may also be necessary to combine oral and parenteral with topical treatment.

If, because of an urgent situation, it is vital to continue the administration of a drug to which a patient has become sensitized, it is possible to prepare the patient with ACTH or cortisone and continue this medication during and even beyond the time the essential drug is given. This plan of treatment is dependent on the extreme need for the specific drug and the type of reaction that has occurred previously.

A review of 83 cases of drug allergy at the Lahey Clinic revealed that barbiturates were the aetiologic agent in 40 per cent and penicillin accounted for 24 per cent of the group.

Nova Scotia Chapter of The College of General Practice of Canada Executive Meeting

A meeting of the executive of the Nova Scotia Chapter of the College of General Practice of Canada was held in the Board Room of the Aberdeen Hospital, New Glasgow, at 1.30 p.m., March 1, 1958.

Dr. H. B. Whitman, Chairman of the Nova Scotia Chapter, presided, and present were Dr. F. M. Fraser, Representative to the Board of Representatives of the College, Dr. C. G. Harries, Treasurer, and Dr. M. F. Fitzgerald, Secretary.

A letter from G. R. Berry, President, Dalhousie Medical Students' Society, to Dr. A. W. Titus regarding preceptorship for the students, was read.

Moved by Dr. F. M. Fraser and seconded by Dr. G. C. Harries that we agree with this in principle and suggest that a committee be set up to look after this matter. Motion passed.

Dr. F. M. Fraser was appointed chairman and asked to select his own committee.

The Chapter received four applications for the Upjohn Bursary for post-graduate training.

Moved by Dr. F. M. Fraser and seconded by Dr. M. F. Fitzgerald that a committee be set up to name a recipient for the Bursary. Motion passed.

Dr. James Muir was named chairman, Dr. Joseph A. MacDonald and Dr. C. L. Gass were chosen to help Dr. Muir with this selection.

The executive felt that the income tax regulations should be amended to allow deductions for post-graduate study. It was suggested that the general meeting should be asked to approve a resolution saying "that whereas post-graduate education is becoming, more and more, a requirement of general practice, the Nova Scotia Chapter of the College of General Practice feel that recommendations should be made to have the expenses entailed in this post-graduate education deductible for income tax purposes."

At the conclusion of the meeting a nominating committee, consisting of Dr. F. M. Fraser, Dr. F. J. Granville, Dr. Joseph A. MacDonald and Dr. Kevin Smith was appointed to bring in a slate of officers for the coming year. There being no further business the meeting adjourned on motion.

Annual Meeting.

The Annual meeting of the Nova Scotia Chapter of the College of Canada was held in the Nurse's classroom of the Aberdeen Hospital, New Glasgow at 4.30 p.m., March 1, 1958.

The Chairman of the Nova Scotia Chapter, Dr. H. B. Whitman, presided. There were approximately fifty doctors present.

A letter from C. R. Berry, President of the Dalhousie Medical Students' Society regarding preceptorship was read. The executive director of the College, Dr. W. V. Johnston, gave an explanation of preceptorship. The students are not to be regarded as assistant physicians but as students. They are to live with the preceptor and study the methods of practice carried on by the doctor. Preceptorship training is about to start in the Toronto area. The idea is enthusiastically backed by the Canadian Association of Medical Students and Internes. All plans should be associated with the parent University. The committee appointed by the executive were asked to review the matter and report to the next annual meeting.

The meeting was informed by the President that four applications had been received for the Upjohn Bursary and a committee including Dr. Jas. Muir, Dr. C. L. Gass, and Dr. J. A. MacDonald was appointed by the executive to select the recipient.

The deduction of expenses for post-graduate studies was considered.

Dr. J. W. Beckwith, Secretary of the Nova Scotia Medical Society, felt we should go slowly in seeking the allowance. The Canadian Medical Association has already won an allowance for conventions. This legislation is poorly defined and may possibly include post-graduate training. Dr. W. V. Johnston said that the College would appreciate it if we made an attempt to have exemptions approved similar to the exemptions enjoyed by the American Physicians in General Practice. Dr. J. A. MacDonald pointed out that many hospitals now either require or at least urge its staff to undertake post-graduate training. Dr. A. G. MacLeod moved, and Dr. F. J. Granville seconded a motion that we all approve of working through Dr. W. V. Johnston and the executive of the College in attempting to obtain income tax exemption for post-graduate training. Motion passed.

The secretary was instructed by the meeting to express our thanks to Dr. Martin Hoffman for his splendid clinical presentation. The secretary was further instructed to convey thanks to Dr. Lea Steves for his help with the programme for this annual meeting. Thanks were also to be sent to Dr. Hugh MacKay, Superintendent of the Aberdeen Hospital, and to the Aberdeen Hospital Commission for the use of the hospital and its facilities.

The Nominating committee then presented the following slate of officers for the coming year. It was moved by F. M. Fraser, seconded by F. J. Granville that the officers be accepted. Dr. L. M. Sproull moved, and Dr. C. G. Harries seconded that nominations cease. Motion passed and these will be the officers for the forthcoming year:

Chairman	Dr. Donald Rice, Halifax
Vice-Chairman	Dr. John R. Macneil, Glace Bay
Secretary	Dr. D. F. Smith, Halifax
Treasurer	Dr. Kevin Smith, Spryfield
Prov. Rep. to Board of Representatives	Dr. H. B. Whitman, Westville
Ch. Education Comm.	Dr. H. I. MacGregor, Halifax
Ch. Hospitals, Residence and Training Comm.	Dr. J. A. MacCormick, Antigonish
Ch. Fellowship Comm.	Dr. J. A. Muir, Truro

Dr. W. V. Johnson said that provision has been made for honorary membership in the College.

Honorary membership is granted by the Board of Representatives on the recommendation of the Provincial Chapter. It was moved by Dr. F. J. Granville and seconded by Dr. J. A. MacDonald that the incoming executive consider the matter and make at least one recommendation to the Board of Representatives for honorary membership for some Nova Scotian doctor.

Dr. C. G. Harries, the treasurer of the Provincial Chapter, suggested to the meeting that we should have a small annual levy to carry on business. The Executive Director pointed out that we are entitled to ten per cent of the annual fee. Ontario and Nova Scotia are the two Chapters that have not taken advantage of this. Dr. Johnston went on to say that the British Colum-

bia Chapter has an extra levy, but the members felt that the next executive should apply for the ten per cent of the annual levy to help run The Provincial Chapter.

At the close of the meeting Dr. Whitman invited the members to a social programme at the Norfolk Hotel.

There being no further business, the meeting was adjourned on motion.

H. B. Whitman, Chairman

M. F. Fitzgerald, Secretary

Upjohn Fellowship Award

The Upjohn Company of Canada has made available to the College an annual post-graduate scholarship fund of \$6000. This will be divided into 12 individual awards of \$500 each.

The object of these scholarships is to provide substantial assistance to those who are particularly interested in pursuing courses of study to aid them with their general practices.

SUMMARY

Executive Committee Meeting

The Medical Society of Nova Scotia

January 27 - 1958

The meeting was convened at 9:00 a.m. by the Chairman Doctor A. G. Macleod.

Present were:

Doctors A. L. Murphy, Halifax; H. J. Devereux, Sydney; J. R. McCleave, Digby; C. H. Young, Halifax; A. G. MacLeod, Dartmouth; C. J. W. Beckwith, Halifax; J. A. MacCormick, Antigonish; S. G. MacKenzie, Jr., Truro; W. M. Grant, Amherst (replacing Doctor D. Drury,); F. A. Duns worth Halifax; N. B. Coward, Halifax; D. I. Rice, Halifax; A. W. Ormiston, Sydney; H. J. Martin, Sydney Mines; R. G. A. Wood, Lunenburg; F. J. Granville, Stellarton; J. P. McGrath, Kentville; D. R. Campbell, Shelburne; H. C. Still, Editor-in-Chief, Halifax.

The Minutes of the last meeting of the Executive Committee (August 27, 1957) and those of the meeting of the New Executive (August 31, 1957) were approved as sent to the Executive Members, as well as the resumé which had been published in the November issue of the Bulletin.

The final agenda contained 46 items—of these, the following are brought to attention:—

Reports of Committees

Committee on Medical Economics

The Welfare Contract

Maritime Medical Care paid Welfare accounts at the rate of 80% for September, which was the month the new \$1.00 per month per recipient of the Welfare Group came into force. I am enclosing a copy of my letter to Mr. D. C. Macneill dated November 5, 1957, and also his reply dated November 12, 1957.

As the amount we will receive from the Government in the future will depend on the cost of the plan during the year beginning September 1, 1957, I would suggest to the Executive, that they take up with Maritime Medical Care, who in this instance are only administering the fund for the Medical Society, that they pay the remaining 20% due on the September accounts,

so that the Society would have a true valuation to discuss with the Government, when the cost of the plan comes up for revision a year hence.

The Nucleus Committee are working on the request of the Executive that they consider the matter of payment for total disability pension examinations, with the suggestion that they also look into other areas in which the medical profession renders free service to government. We have nothing further to report on it at the present time.

I attended the fall meeting of the C.M.A. Committee on Economics in Toronto, November 28th and 29th. (Incidentally, we saw the Grey Cup game the following day, due to the courtesy of the Committee members from the Western cities).

The following was the agenda:

(1) **D.V.A. Fee Schedule**

The Department shall pay for medical services provided from non-departmental sources on and after January 1, 1958, not in excess of 90% of the amounts specified in official provincial fee schedules.

You will remember that in our Committee report to the Nova Scotia Executive, we suggested that the provincial scale would give us a smaller fee than we were presently obtaining from D.V.A. I brought this to the attention of the C.M.A. Committee again, who through the Executive took the matter up with Department officials, so that the Nova Scotia Division has been assured that their proposed new schedule would be used at once. It is imperative that our Committee on Fees get their new schedule into the hands of members as soon as possible.

It is also regrettable that it appears to be the future policy of the Treasury Board to pay at a rate of 90% for any medical services, as the different medically sponsored service plans across the country do at the present time.

(a) **Relative Value and Job Evaluation Studies**

The Committee on Economics recommend that we should proceed further with relative value studies, and that job evaluation should be studied by the Secretariat, both concurrent and subsequent to the current relative value study.

(3) **Bureau of Medical Economics**

(a) The Canadian Medical Retirement Savings Plan had taken up most of the time of the Assistant Secretary for Economics (Mr. Freamo) for the past few months. At the present time, he is still tied up with the C.M.R.S.P. and the Relative Value Study.

(b) There was some concern as to the lack of adequate communication between the Divisions on Economic matters. This leads to duplication of work as the problems do not greatly differ from Division to Division. Hope was expressed that a way may be found of channelling economic information to the Central office, where it could form the basis of a regular news letter to Divisions.

(4) **Library**

The Committee considered that we should have as an objective the setting up of a library on Medical Economics. This would facilitate the provision of specific information to Divisions upon request.

(5) Universal Hospital Care

The present set-ups in the different provinces were reviewed and also any information that could be gathered by the C.M.A. Advisory Committee from the Minister of National Health and Welfare. It was suggested to the Minister that in Bill 320, two major points be considered:

(1) That diagnostic services in hospital should be considered as medical services rather than hospital care and should be kept separately in mind under the universal hospital care programme. The Committee suggested that an amendment be made to the Act to define professional services. There was objection to the employer-employee relationship that was implicit between the relationship of radiologists and pathologists to hospitals under Bill 320. It was suggested that if the Act could not be amended, medical services should be defined under the regulations to the Act.

(2) The second point made was that the C.M.A. is apprehensive about the effect of Bill 320 on medical education, and recommended special administrative and financial considerations for teaching hospitals. The Committee asked to be allowed to see and comment on the regulations under the Act. In a subsequent letter from the Minister, they were advised that the regulations are under review at the present time, but will be available to the C.M.A.

(6) Plans For Health Services

General Council had directed that a study should be made of a plan or plans for health services which could be implemented within our statement of policy. Dr. Chester Stewart has been asked to chair such a Committee, with a Nucleus Committee in Halifax, and that the corresponding members of the Committee would be Chairmen of Divisional Committees on Economics.

(7) T.C.M.P.

Dr. Kelly reported on the Executive Committee Conference with T.C.M.P. Commission.

Service and Indemnity Plans

The Committee was advised that the C.M.A. Executive Committee considered that service benefit programmes are more desirable and more beneficial and likely to remain more beneficial to the subscribing public and the profession, and therefore recommended to those Provincial Divisions who do not have service plans available, that it is considered urgent that they develop such plans. There was no unanimity among the members of the Committee on Economics on this suggestion of the C.M.A. Executive.

(8) Methods of Arbitration and Negotiation with Government

The Committee considers it is not qualified to finalize this matter, and wishes to have further technical and legal information.

(9) Standardized Insurance Forms

Agreement had been reached between the Committee on Economics and the Medical Officers of the Life Officers Association as to four forms in connection with claims for medical and surgical indemnity insurance. The Committee have been asked to discuss with Life Officers Association possibility of one single form.

(10) **C.M.A.J.**

There is to be an issue of the C.M.A. Journal devoted to Health Insurance likely one of the May issues.

All of which is respectfully submitted,

(signed) A. L. Sutherland,
Chairman, Committee on Medical Economics,
The Medical Society of Nova Scotia,

Moved for adoption by— Dr. H. C. Still.

Seconded by— Dr. D. I. Rice.

Discussion: (a) **Welfare Contract**

The pro-ration of 80% for September accounts was debated in the light of the second paragraph of Dr. Sutherland's report.

Moved by Dr. C. H. Young

Seconded by Dr. F. A. Dunsworth

"The Executive Secretary advise Maritime Medical Care Inc., that in the administration of Welfare Funds, accounts rendered by physicians for medical services should be paid at 100% in order to properly discuss per capita payments on account of recipients with government."

Carried.

(b) **D.V.A.**

The 10% pro-ration of fee for service under D.V.A. was thoroughly debated. The Chairman remarked that the C.M.A. and its Divisions had been waiting for some time to have D.V.A. recognize the provincial Schedule of Fees; that the 10% pro-ration had been vigorously opposed and that D.V.A. had reviewed the matter. The final ruling had been made by the Treasury Board. A mail ballot of the C.M.A. Executive members had been conducted and the result had been to accept it under protest. The Government of Canada had been so notified.

Discussion:

It was remarked that under the present arrangements, physicians would probably net less than previously; that these funds originated from the Federal Treasury and, therefore, payment for medical services should be uniform across Canada to which the reply was—general agreement had been reached that the provincial schedules should be allowed by D.V.A. and this had been accomplished. The provincial schedules of fees varied across Canada being tied in with the various economics and therefore, there had to be some variation.

It was generally agreed that the principle of pro-ration was applied outside of its original purpose in connection with voluntary non-profit prepaid medical service plans and if the trend continued, that it would mean, in effect, that the doctors would receive 90% of fee for service from any insured service. This new interpretation of the original intent of pro-ration (the purpose being to take care of administrative costs and provide a reserve against epidemics, etc. in the insured group), was deplored and discussion indicated that active steps must be taken to stop the apparent trend.

(c) **Universal Hospital Care**

The Chairman remarked that a report from the Advisory Committee on Health Insurance would review the present situation in this Division.

(d) Methods of Arbitration and Negotiation with the Government

The Secretary remarked that this was also under study by the Advisory Committee on Health Insurance (Nova Scotia).

The motion for adoption was carried.

Committee on Cancer

January 3rd, 1958.

A meeting was held of the above Committee on the 3rd of January, 1958, and the following matters were discussed:

(1) In June, 1957, the C.M.A. Cancer Committee recommended that a pilot study project (refresher course in cancer) be conducted by one of the divisions of the C.M.A. Medical Society. As a result of correspondence between the Dalhousie Post-Graduate Division and the C.M.A., approval has been given by the C.M.A. Cancer Committee and the Nova Scotia Division of the C.M.A. for the conduct of such a refresher course to be held in Nova Scotia under the Post-Graduate Division of the Faculty of Medicine. An Ad Hoc Committee of the Post-Graduate Division of Dalhousie University was set up to bring forth a suggested programme which could be presented to the C.M.A. Cancer Committee for their approval under the Chairmanship of Dr. Lea Steeves. A final draft programme of this suggested refresher course in cancer was presented to our committee for its approval. The programme is included in this report. After much discussion, the Committee recommends that The Medical Society of Nova Scotia approve of this programme and that the final draft be sent on to the C.M.A. Cancer Committee for its final acceptance.

(2) Since the terms of reference of our Committee is to look into all aspects of cancer in this Province, the first requirement would be to know the incidence of the various types of cancer in Nova Scotia. A study of this sort has already been carried out in several of the Provinces of Canada and much information has been provided. Dr. Norman Gosse states that 'IF THE MEDICAL SOCIETY OF NOVA SCOTIA APPROVES OF SUCH A STUDY AND IF WE CAN SECURE THE CO-OPERATION OF THE DOCTORS TO GIVE US INFORMATION, THE CANADIAN NATIONAL INSTITUTE ON CANCER ARE WILLING AND READY TO HELP US SET UP SUCH A STUDY'. If the Society feels that such a study would be worthwhile in Nova Scotia, your committee will then look into further details as to how it may be carried out. Your committee unanimously recommends that such a study be carried out.

(3) Since this committee covers such a wide field geographically speaking, and since the co-operation of all doctors of Nova Scotia will be necessary if any worthwhile effort is to be put forth, your committee feels that regional representation on this committee is absolutely necessary. This would mean that in each society of Nova Scotia we would have one corresponding representative who would be our contact with the doctors in that area. A good example of this would be that if an incidence study is to be set up, certain forms would have to be filled out on every cancer by every doctor in Nova Scotia. The representative on our committee would be responsible to see that all doctors carried out this matter. Also any problems on cancer that might arise in this area could be brought to this committee by our representative.

(4) A number of verbal complaints re the relationship of the surrounding doctors and the Tumor Clinic have seeped into our Committee. Many of

these are vague but nonetheless, suggest that there is an undercurrent of discontent. The impression of the committee on discussing these complaints was that most of them arose from the misunderstanding of the workings of the Tumor Clinic and, therefore, we would suggest that a letter or pamphlet be made out with the present set-up outlined, with particular reference to the method by which a patient is handled. Particular reference should also be made to those of private patient status. We would suggest that this go to every doctor in Nova Scotia.

(5) The old problem of using hospital beds for cancer patients requiring X-ray treatments lasting only 15 to 30 minutes, still confronts us. Your committee recommends that further study be given to the establishment of a hostel for these patients.

Respectfully submitted,
Dr. C. Tupper, Chairman.

C.M.A. Refresher Course in Cancer Final Draft Programme

December 19th, 1957.

Prepared by an Ad Hoc Committee of the Post-Graduate Division, Faculty of Medicine, Dalhousie University, as a Pilot Study for the Committee on Cancer, C.M.A.

1. To reach the maximum possible number of practitioners in Nova Scotia, it is necessary to stage regional meetings.
2. A programme of short illustrated lectures, followed by case presentation and discussions is favoured. Cases from the local area, pre-selected from the Nova Scotia Tumour Clinic records are to be jointly presented by the visiting speaker and the patient's family doctor.
3. To ensure successful programmes, much advance preparation by the Tumour Clinic, the local Hospital Staff and the Post-Graduate Division Staff will be necessary; to include considerable publicity.
4. To sustain interest, and to cover a broad field, repeated programmes are planned, two in the Spring and two in the Fall. Each would deal with two different fields, permitting during the full tour presentations in the field of (a) breast carcinoma, (b) head and neck carcinoma, (c) lung and stomach carcinomas, (d) rectum and colon carcinomas, (e) bone and skin carcinomas, (f) gynaecological carcinoma, (g) urological carcinomas, (h) medical neoplasms. This parallels the Cancer Clinic organization of the Nova Scotia Tumour Clinic and will facilitate the selection of cases throughout the Province and of speakers from the Dalhousie Faculty.
5. A team of two authorities should visit each centre on each occasion. There should be twelve from Dalhousie and four from other centres. This will allow comparison of the drawing power of a presentation by two Dalhousie speakers compared to that of one presented by one Dalhousie speaker and one visitor from another area. Local doctors should participate by facilitating presentation of cases they have referred to the Nova Scotia Tumour Clinic and by joining freely in discussion.
6. Speakers should not be asked to participate in a tour consuming more than five days of their time. This will require the division of Nova Scotia

into two areas. The suggested division is Amherst, New Glasgow, Sydney, in one group; Bridgewater, Kentville, Yarmouth in the other. The meetings to be held Tuesday, Wednesday and Thursday of one week in one area and Tuesday, Wednesday and Thursday of the succeeding week in the other area. This arrangement being made to permit the Director of the Post-Graduate Division to be in attendance on all occasions to assist in details of organization that may otherwise be overlooked by the local Medical Society participants.

Moved for adoption by
Seconded by

Dr. A. W. Ormiston
Dr. W. M. Grant.

Discussion:

The five items in this report were considered separately. All items were agreed to, but item 4, which concerned relations with the Tumour Clinic, and resulted in considerable discussion and the following motion made:—

Moved by Dr. A. W. Ormiston
Seconded by Dr. H. J. Devereux

“The Executive of The Medical Society of Nova Scotia bring forcibly to the administration of the Tumour Clinic the fact that there is still a great need of improving their public relations both with patients and family physicians.”

Also—

Moved by Dr. H. J. Devereux
Seconded by Dr. C. H. Young

“The Tumour Clinic draw up a public relations pamphlet and submit it to the Executive of The Medical Society of Nova Scotia for approval before it is sent to the physicians of Nova Scotia.”

Carried.

The motion for adoption was carried.

Advisory Committee on Health Insurance

The first meeting of the present Advisory Committee on Health Insurance was held on September 6, 1957. The plans for activities of the Committee were formulated on the basis of (1) the changed terms of reference resulting from the Annual Meeting. i.e. “be made a standing committee” and “the terms of reference be broadened to permit the committee to participate in or initiate discussion with government or other interested groups.” (2) A review of the instructions from the Annual Meeting.

The Chairman of the Hospital Services Planning Commission had requested, in a letter dated August 2, 1957, that The Society submit names of nominees from which one would be appointed to the Advisory Committee of the Hospital Services Planning Commission. From the names submitted Doctor D. M. MacRae was appointed. That committee has been convened for four full day meetings.

A communication to the Minister of Health included the motion from the Annual Meeting expressing “dissatisfaction at the lack of opportunity for participation of The Medical Society of Nova Scotia in decisions reached to date pointing out that hospitalization intimately affects medical practice. It urgently requests that The Society be instantly informed of the progress of future discussions having the opportunity to study these and express the medical opinion **before** policy decisions are finalized.” In the same letter the re-

quest was made that the Advisory Committee of The Society have direct access to the Hospital Services Planning Commission. This request was granted and has resulted in four meetings of which the first was requested by your committee and the other three have been held at the request of the Commission. Each of these meetings occupied three to four hours. There is the understanding with the Commission that your Committee may request a meeting at any time.

The Brief of The Medical Society of Nova Scotia to the Planning Committee on Hospital Insurance and Diagnostic Services, presented on October 31, 1956, was reviewed and edited. Our recommendation that "a deterrent or some principle of co-insurance should apply to hospital admissions" and also to Diagnostic Services was removed in accordance with the recommendation from the Annual Meeting. The amended brief was presented to the Commission and discussed at our first meeting with them on November 1, 1957.

Twenty-four meetings of the Advisory Committee on Health Insurance of The Medical Society of Nova Scotia have been held to date. Included were four meetings with the Hospital Services Planning Commission, three meetings with the Radiologists, one with Doctor J. S. Robertson, Deputy Minister of Health, and Doctor O. C. MacIntosh, Director of Laboratory and Radiology Services, and two with chairman of special groups. The latter meetings were held in an attempt to obtain information on problems that might occur to various specialties or groups on implementation of a Hospitalization Plan. The committee felt it did not know enough about the details of problems that might be experienced by these groups to speak on their behalf. For a similar reason, the Branch Societies were each asked to appoint an Advisory Committee to study potential problems that might arise in their district and make recommendations to us. The Medical Staff of the Victoria General Hospital was also asked to provide advice on a number of potential problems. Representative members of the specialty or group of Radiology, Pathology, Internal Medicine, Surgery, General Practitioners, Psychiatry, Anaesthesia, Paediatrics, and Obstetrics and Gynaecology met with the Committee on October 11, 1957, to hear a review of Bill 320 by Doctor C. B. Stewart. Following meetings with their respective groups, the chairman met with the Committee on November 21st to bring recommendations from their groups.

Doctor C. J. W. Beckwith attended the following Branch Society Meetings to provide information and discuss Bill 320: Valley Medical (2), Cumberland Medical, Antigonish-Guysborough Medical, Cape Breton Medical (2), Lunenburg-Queens. The Chairman has taken part in discussions at meetings of The Halifax Medical Society, Valley Medical Society, and the Victoria General Hospital Medical Staff. Communications have been received from the Valley Medical, Cumberland Medical, Antigonish-Guysborough Medical and the Halifax Medical Societies; also from the Nova Scotia Association of Radiologists, the Victoria General Hospital Medical Staff, Doctor W. A. Taylor (Pathology), Doctor C. E. van Rooyen (Bacteriology), Doctor A. W. Titus (General Practice), Doctor D. R. S. Howell (Dermatology), Doctor F. A. Dunsworth (Psychiatry), Doctor W. R. C. Tupper (Obstetrics and Gynaecology), Doctor J. E. Stapleton (Radiotherapy). The Committee is very appreciative of the help received from members taking part in the above-noted activities, which had to be undertaken, of necessity, on very short notice.

Enclosed you will find a report sent to Mr. R. MacD. Black, Chairman of the Hospital Services Planning Commission in answer to specific questions on which the Commission requested advice. In this report, as well as in the "Brief", we have strived to provide for the maintenance of high quality medical services, and respect for the principles and policies of Canadian Medicine. We ask the Executive Committee of The Medical Society of Nova Scotia to endorse this report.

Respectfully submitted,
D. M. MacRae, M.D., Chairman.

The letter to Mr. R. McD. Black is as follows:

January 15, 1958.

Dear Mr. Black:

The Hospitalization Plan as proposed under Federal Bill 320 would appear to be essentially a plan for the provision of insured hospital services. However, it is considered necessary to have certain medical diagnostic services available to hospital patients as an insured service. It must be recognized though, that these are distinctly Medical Services (with a professional and a technical component) even though performed in hospitals. The medical profession wishes to have this distinctly understood. We feel that Bill 320, despite the phraseology of 3-2-A does not wish to have hospitals engage in the practice of medicine or to sell Medical Services. We think that it should be possible to draw up a provincial agreement, acceptable to Ottawa, that would permit Medical Services to be kept separate and distinct from Hospital Services by provision of a section of the budget that would be used to cover only the professional component of insured services. If, because of administrative or legal difficulties, Maritime Medical Care could not be used as the distributing agent, it might be that the hospital could be regarded as an agent for distribution of the funds for Medical Services and not as an employer of medical personnel. The methods of remuneration of medical practitioners and the rates thereof, should be as agreed upon by the representative bodies of the profession and the insuring agency.

The Advisory Committee of the Medical Society of Nova Scotia wishes to express its appreciation for the reception accorded it at the four meetings with the Hospital Planning Commission. As a result of the free discussions that took place, we know you are well aware of the complexities of the specific problems on which you requested advice. In the light of this, we wish to make the following recommendations:

Quality Control of Medical Services in a Hospitalization Plan

This should be a medical responsibility entirely when the confidential nature of the patient-doctor relationship is involved or when professional practice in a hospital is involved; for examples, problems involving admissions, long stay patients, drugs, medical diagnostic procedures and necessary nursing services, etc. Such problems should be considered by one or more of the following committees:

1. The Committee of the Hospital Medical Staff.

This committee should provide necessary supervision and advice on medical problems of the above-noted areas. It should meet when necessary with the appropriate administrative authorities to deal with problems of mutual concern.

2. The Regional Medical Committee.
The duties of this committee could best be expressed in terms of study, research and education in addition to dealing with problems referred to it by the committee of a hospital medical staff or by the medical staffs of small hospitals.
3. The Committee of the Medical Society of Nova Scotia.
This Committee should maintain close liaison with the Hospital Commission, as well as dealing with problems referred from regional committees. It should have the opportunity of meeting with a representative group from the Commission, on request, to discuss problems of mutual concern. It could provide information and act in an advisory capacity to Hospital Medical and Regional Medical Committees.
"Administrative Committees" at hospital, regional and provincial level could be set up to deal with problems of an administrative nature and be available to discuss mutual problems with representative committees of the medical profession at the hospital, regional or provincial level.

In-Patient Diagnostic Services to be insured

1. Diagnostic Radiology Services. We are advised by the Nova Scotia Association of Radiologists that the present staffs and radiological equipment in the province should be adequate to cope with the increased demand and provide an insured in-patient diagnostic radiological service.
The Pathologists advise that while some are carrying a rather heavy work load, it should be possible to provide a satisfactory in-patient insured laboratory service.
3. Electrocardiograms, to be an insured service to in-patients.
The members of the committee who were present at the last meeting with the commission, presented reasons why they thought such a service should not be insured, but the majority opinion of the full committee is in favour of it being an insured service to in-patients.
4. Electro-encephalograms to be an insured service.

Drugs and Biologicals, etc. to be an insured service

We are of the opinion that no drugs or biologicals should be denied to insured in-patients.

Out-Patient Diagnostic Services to be insured

1. Diagnostic Radiological Services.
We feel that the present staffs and X-ray facilities are totally inadequate for even a partially insured Out-Patient Service. Such a service on implementation of the plan would result in lowering of the standards and quality of the services, long waiting periods, and public dissatisfaction with the plan. As conditions improve, Out-Patient Radiological Services could be insured gradually with the following list as a priority rating to lessen the demand on hospital admissions: 1. Gastro-intestinal; 2. Gall Bladder; 3. Genito-urethral; 4. Chest; 5. C.N.S.; 6. Heart; 7. Traumatic;

8. All others.
2. Laboratory Service.
Due to the shortage of trained personnel and facilities, we recommend that insured Laboratory Services be limited to those presently being provided without cost to the patient. As more staff become available, the insured services could be increased.
3. Out-Patient Electro-encephalograms to be an insured service.

Other Services to be insured Services

1. Out-Patient Emergency Service.
The hospital component of this to be provided as an insured service, available at the time of the emergency or within 24 hours of an accident.
2. Out-Patient Psychiatric Service.
The hospital component of this to be provided as an insured service.
3. Out-Patient Rehabilitative Service.
The hospital component of this to be provided as an insured service.
4. Radiation therapy of malignancies to be an insured service to both in-patients and out-patients.

We wish to stress the importance of an adequate publicity campaign to fully inform the public of what they are entitled to under a Provincial Hospitalization Plan. It is important to stress that patients can only be admitted for necessary medical care. Patients cannot be admitted simply for diagnostic purposes unless their condition requires admission to a hospital.

In conclusion, we wish to again endorse the recommendation in our Brief, that the plan be administered by an independent commission, representative of those providing and those receiving the services, and that one member be appointed from nominations of The Medical Society of Nova Scotia.

Please regard the services of this Committee as available to you on call and we will continue with the understanding that this Committee may request a meeting with the Commission if so desired.

The foregoing will be submitted to the Executive Committee of the Medical Society of Nova Scotia on January 27, 1958, with the recommendation for approval.

Yours truly,

D. M. MacRae, M.D., Chairman.
Dr. D. I. Rice
Dr. F. J. Granville.

Moved for adoption by:

Seconded by:

Discussion:

The Chairman, Dr. D. M. MacRae was present to present his report. It was moved by Dr. Rice, seconded by Dr. F. J. Granville that this report be adopted. Several points were brought up for clarification which Dr. MacRae answered. The report as written, including the letter to Mr. R. McD. Black, Chairman of the Hospital Services Planning Commission was adopted by the Executive.

Committee on Public Relations

The Committee on Public Relations has not held a full Committee Meeting. There have been two meetings of the Nucleus Committee, one with the

Committee on Legislation relative to Chiropractors in anticipation of this group again presenting proposed legislation to the Legislative Assembly; the other with the Committee on Fees at the request of the Chairman of that Committee. Your Chairman, as a member of the Advisory Committee on Health Insurance, and from discussions relative to the two Committees mentioned above, is firmly convinced that the time has now arrived when organized medicine must take positive action in its relations with the public. In the past, the traditionally conservative attitude in this field of endeavour has resulted in a virtual timidity, but I would suggest that present practices and foreseeable trends are such that it is most desirable to recognize few, if any, relationships closer than that of medicine to the public. Because of this, the public has every right to expect information, relative to the attitudes of the profession on such matters as Hospital Insurance, opposition to Chiropractic Legislation etc. By the same token, we believe that a press interview on the revised schedule of fees is indicated. I would request therefore, endorsement by the Executive Committee of a policy in the field of public relations, whereby this Committee may when considered desirable, go to the press and other media with these and other matters as they may arise. I believe such endorsement is necessary to avoid misunderstanding with the profession, and to provide the Committee on Public Relations with more freedom in its activities.

Resulting from the meeting with the Committee on Fees, it is proposed sending to insurance companies a letter outlining the official attitude of the Society as regards the remuneration of doctors for services rendered. A copy of this proposed letter is attached for your information, comment and ultimate endorsement.

Further activities of this Committee have resulted in a letter to all members of the Society, outlining the implementation of the recently revised Schedule of Fees. A copy of this letter likewise, forms a part of this report.

During recent weeks, considerable thought has been given to the proposed enabling legislation for hospital insurance. It is anticipated forwarding to all medical members of the legislature, a copy of the brief submitted to the Hospital Planning Commission by the Advisory Committee on Health Insurance. It seems imperative in the interests of public relations, that all members of the profession be conversant with this brief, particularly, those doctors who are members of the legislative assembly.

All of which is respectfully submitted.

D. I. Rice, M.D., Chairman.

Dr. D. I. Rice

Dr. J. A. MacCormick.

Moved for adoption by:

Seconded by:

Discussion:

It was agreed that a more aggressive policy in the field of public relations as recommended in the report should be undertaken. The letter which the Chairman had drawn up to accompany the Schedule of Fees to insurance companies was examined in detail and agreed to. It was also agreed that there should be a notice of the application of the revised Schedule of Fees as of January 1, issued to the press, and that a press interview be undertaken.

The motion for adoption was carried.

Committee on Legislation

Herewith an interim report of your Committee on Legislation.

At the time of the Annual Meeting of The Medical Society (August 29,

1957), action was taken by the Committee to notify the Honourable Minister of Health and the Premier, of the endorsement by the Society of the annual report of the Committee on Legislation. Coincidentally, a statement was issued to the press outlining the Society's position as regards our opposition to proposed legislation to legalize Chiropractors in this province.

Correspondence took place between the Executive Secretary and the Solicitor for the Chiropractors in which Dr. Beckwith summarized the position of the Society and the Provincial Medical Board at the present time. Dr. Beckwith concluded his letter to the Chiropractors' lawyer by stating that the "Committee on Legislation of The Medical Society of Nova Scotia will be pleased to meet yourself and/or a Committee from the Chiropractors for discussion on this matter at any mutually convenient time." No request for a meeting has been received from the Chiropractors since this communication.

Because of the distinct possibility that the Chiropractors once again will be seeking legal recognition at the forthcoming session of the N. S. Legislature, your Committee considered further action at a meeting on December 23rd, 1957. The Nucleus Committee invited Dr. Donald Rice, Chairman of the Committee on Public Relations, to be present. It was decided to request publication of two communications in the Bulletin from members of The Medical Society. These communications are on file in the Executive Secretary's office for your perusal. It is our desire that each doctor should know the facts so that he will be in a position to take a definite and informed stand in discussions with the lay public.

We are also intending to meet with the physician members of the N. S. Legislature at the beginning of the Session in order to brief them as to the definite stand of orthodox medicine regarding this matter.

At the moment then, your Committee is adopting an attitude of watchful expectancy and is ready to take positive action when the occasion arises.

My report to the Annual Meeting recorded that the local Branch of the Canadian Physiotherapy Association indicated that legal recognition would probably be sought at the 1958 Session of the House. On January 14th, 1958, the Executive Secretary received the proposed legislation with the request that it be reviewed and receive endorsement of The Society. The Nucleus Committee on Legislation met on January 15th. As a result of review, the intent of Paragraph 8—page 5, was in doubt in the minds of the Committee. Subsequently, this has been reviewed and it has been ascertained that this refers to "schools" outside of Canada. With this point made clear, your Committee recommends this legislation for endorsement by the Executive Committee.

Respectfully submitted,

J. McD. Corston, M.D., Chairman.

Dr. H. J. Devereaux

Dr. R. G. A. Wood.

Moved for adoption by:

Seconded by:

Discussion:

The motion for adoption was carried.

I beg to submit a report of the Budget Committee on anticipated revenue and expenditures for the year 1958 and as such constitutes a Budget.

Revenue

Membership dues after deducting C.M.A. Levy.....	\$ 20,548.00
Net Proceeds from Nova Scotia Medical Bulletin.....	150.00
Post-Graduate Grant C.M.A.....	1,000.00
Investment Income.....	800.00
Post-Graduate Levy (474 at \$5).....	2,370.00
Net Proceeds from Annual Meeting.....
	<hr/>
	\$24,868.00

Expenditures

Salaries and Wages.....	\$13,400.00
Travelling Expenses.....	1,700.00
Postage.....	250.00
Bank Charges.....	125.00
Telephone and Telegraph.....	250.00
Office Supplies and Stationery.....	315.00
Printing, Publishing and Mailing Fee Schedule.....	1,000.00
Legal, Audit and Accounting.....	400.00
Contributions to Pension Plan.....	1,544.16
Annual Meeting.....
Sundry Expenses.....	350.00
Post-Graduate Committee.....	3,370.00
Net Income for Year.....	2,163.84
	<hr/>
	\$24,868.00

Pursuant to resolution of Executive Committee, we recommend that a sum up to \$1,000 be made available for Capital Expenditures to purchase office equipment.

All of which is respectfully submitted.

C. H. Young, M.D., Treasurer, Chairman.

Moved for adoption by:

Dr. D. I. Rice,

Seconded by:

Dr. A. W. Ormiston.

Discussion:

The Treasurer, Dr. C. H. Young, gave explanatory remarks concerning some of the items. The new system of bookkeeping is now in operation and as a result, the net proceeds appear to be lower. The accounting for the Bulletin had been changed in that, legitimate charges are now shown against profits, whereas previously there had been only the cost of publication. Surplus monies have been invested. The cost of publication, addressing and mailing the Schedule of Fees is not a recurring item. No amount has been put in opposite the Annual Meeting, as the matter is being explored in the light of the proposed one day meeting. It was felt advisable to have some funds available in case legal services were required. The amount up to \$1000 for office equipment would be regarded as capital expenditure.

He also stated that the financial situation was such, that consideration could be given to paying all honorarium to members of the Executive for attendance to at least one meeting a year.

The report of the Treasurer which included the Budget for 1958 was moved for adoption by Dr. C. H. Young and seconded by Dr. F. A. Dunsworth.

Moved by Dr. J. P. McGrath

Seconded by Dr. F. J. Granville

"As the Treasurer has stated that the Society is now in a position to pay an honorarium to Executive members not already receiving salary or remuneration from the Society, it is therefore moved that the resolution as passed in March, 1957, be implemented. This honorarium is in addition to the regular expenses which are now allowed."

Dr. Young stated that the terms of reference for the Finance Committee in the Constitution are not as clear as they might be. This resulted in a motion.

Moved by Dr. C. H. Young

Seconded by Dr. H. J. Devereux

"A memoranda be forwarded to the Committee on By-Laws requesting that the duties and responsibilities of the Finance Committee be clearly defined."

The motion for adoption was carried.

Membership Committee

The Secretary reported membership in the Society as follows:

1957 — 523

1956 — 478

1955 — 503

He also reported that there had been sixteen deaths in 1957 as compared with seven in 1956. New members for

1957 — 57

1956 — 30

It was also reported that of the membership as of December 31, 1956 three are in arrears for 1957 dues. Of these, one is in the Province and two outside the Province.

Discussion:

In answering to a question relative to membership in The Medical Society of Nova Scotia only, the Secretary explained that every endeavour was made to have conjoint membership. However, there were a few members of The Medical Society of Nova Scotia who frankly stated that they could not afford membership in the two organizations. It is hoped that as time goes by, these few members may find it possible to be conjoint members. The Secretary pointed out that since the Branch Societies reported membership as of December 31st in each year, it was only possible at that time to have factual knowledge that members of The Medical Society of Nova Scotia are members in good standing in their Branch Society.

The Secretary pointed out that there are still eighteen members in arrears for 1956 from whom nothing has been heard in response to three letters sent. Of these 18, five have Group Disability Insurance, six have Group Life Insurance, but none have both. Enquiry from the Insurance Companies indicate that the terms of insurance require membership in good standing in the Society, and that on information from the Society that a member is not in good standing, the policy will be discontinued at the next premium date. There are eleven members in arrears for 1955-56. The Secretary pointed out that this was a

serious matter and he wished to have the matter again reviewed before taking final action. The discussion resulted in the following motion.

Moved by D. I. Rice

Seconded by Dr. J. A. MacCormick

"The motion as duly approved by the Executive on March 18, 1957, meeting governing the management of delinquent members be affirmed, and that in future a standard practice of notifying members of suspension be adopted to include—

- (a) Form letter enabling member to identify type of practice.
- (b) Regulations governing maintenance of Group Life and Accident Insurance to be pointed out."

The request for a membership committee which was considered later, resulted in the following motion—

Moved by Dr. D. I. Rice

Seconded by Dr. D. R. Campbell

"The Chairman of the Executive be empowered to appoint a Committee of three members to act in the capacity of a Membership Committee to meet with the Executive Secretary when requested to discuss minutes relative to membership."

Dr. H. J. Martin, Chairman of the Special Committee to study the definition of "specialist" gave an interim report and submitted correspondence.

Interim reports were also received from the Committees on Fees; Rehabilitation; By-Laws and Traffic Accidents, as well as the Editorial Board of the Bulletin.

Summary of Other Business

(1) A Committee was appointed to study and make recommendations as to the method to obtain best representation from this Division to the General Council of the Canadian Medical Association (on the basis of the number of members of this Division who are also members of the C.M.A., we are entitled to nine representatives).

(2) The Special Committee appointed to prepare and present a brief from The Medical Society of Nova Scotia to the Royal Commission enquiring into the Workmen's Compensation Act was reconstituted for the purpose of further discussion with the Commission if called on. The Committee Chairman is Dr. A. W. Titus.

(3) The invitation from the Cape Breton Medical Society to hold the 1959 Annual Meeting in Cape Breton was accepted.

(4) Endorsation was given to the plan of the Committee on Poison Control for Nova Scotia. Dr. G. B. Wiswell was named representative of the Medical Society to that Committee.

(5) The programme of the National Heart Foundation of Canada received endorsation.

(6) Endorsation was given to the type of clinic conducted by the Nova Scotia Society for the Care of Crippled Children.

Relative to the Voluntary Lay Organizations, discussion led to the following resolution moved by Dr. H. J. Devereux, seconded by Dr. A. W. Ormiston and carried—

“That the Executive of The Medical Society of Nova Scotia appoint a Committee of three to study the various voluntary lay groups concerned with health in regard to duplication of effort, service etc., and report their conclusions to the Medical Society.” The Committee was appointed under Chairmanship of Dr. R. G. A. Wood of Lunenburg.

(7) Dr. C. H. Young, Honorary Treasurer, was named as representative of this Division to the Trusteeship Committee of the C.M.A. This Committee has to do with the Canadian Medical Retirement Savings Plan.

(8) The names of nine members were submitted to the Executive Committee of which one was to be nominated for Senior Membership in the Canadian Medical Association. By closed ballot, Dr. M. G. Tompkins of Glace Bay received the nomination.

(9) Re: Annual Meeting 1958—The Refresher Course Committee granted the request of the Society, that Friday, October 24th, which is usually the last day of the Refresher Course, be given to the Medical Society for the Annual Meeting. The Annual Meeting of The Medical Society will be on October 24th and 25th.

(10) A motion was presented to the Executive from the Cape Breton Medical Society to the effect that a review of the Sickness and Accident Policy be undertaken “with the possibility of increasing the waiting period from one day to a month for accidents.” Prior correspondence with the underwriters was read. To have the policy changed will require the unanimous request of all insured members. The members are to be written asking expression of opinion.

(11) Application for membership in the Atlantic Provinces Economic Council (A.P.E.C.) was authorized.

(12) The following physicians have been accepted by the Executive Committee as new members since the Annual Meeting.

R. F. H. Bedford, Sydney; G. D. Belliveau, Yarmouth; G. H. Daglish, Mahone Bay; F. J. Hanco, Dartmouth; E. E. Henderson, Sydney; J. Kereszturi, North Sydney; T. K. Kryzyski, Sydney; D. T. Mosher, Louisbourg; J. K. M. McKay, Inverness; R. G. Simpson, Sydney; H. W. Soby, Halifax; B. J. Steele, Rockingham; C. E. van Rooyen, Halifax; D. G. Woods, Halifax; J. E. Stapleton, Halifax; J. F. Filbee, Halifax; A. N. Lamplugh, Westphal; C. N. Morehouse, Noel.

The meeting adjourned at 6.45 p.m.

C. J. W. B.

REPORTED INFECTIOUS DISEASES — NOVA SCOTIA
 Summary for month of January, 1958

	NOVA SCOTIA				CANADA	
	1957 Cases	1957 Deaths	1958 Cases	1958 Deaths	1957 Cases	1958 Cases
Brucellosis	0	0	0	0	0	0
Diarrhoea of Newborn	0	0	0	0	0	0
Diphtheria	0	0	0	0	15	11
Encephalomyelitis Infectious	0	0	0	0	0	2
Food Poisoning	0	0	0	0	0	0
Gastroenteritis (1) Infectious	14	2	25	3	12	30
Hepatitis—Infectious Including Serum Hepatitis	12	0	12	2	0	0
Impetigo of Newborn	0	0	0	0	0	0
Influenza (if unusual number of cases)	144	2	499	2	300	1111
Meningococcal Meningitis and Meningococcemia	1	0	0	0	24	30
Pertussis	10	0	68	0	703	583
Poliomyelitis (paralytic) non-paralytic)	2 0	1 0	0 0	0 0	4 0	3 1
Scarlet Fever and Streptococcal Sore Throat	170	0	789	0	911	1419
Tuberculosis (pulmonary) (non-pulmonary)	3 0	0 0	16 3	0 0	441 46	551 24
Typhoid and Paratyphoid Fever	0	0	0	0	19	19
Venereal Disease (syphilis) (gonorrhoea)	5 40	0	2 29	0	191 937	144 1198
Anthrax	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0
Rabies	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trichinosis	0	0	0	0	0	0
Tularemia	0	0	0	0	0	0
Other rare diseases	0	0	0	0	0	0
Other (if unusual number of cases)	0	0	0	0	0	0

(1) amoebic and bacillary dysentery and salmonellosis.

Secretary's Page

Maritime Medical Care Incorporated

Under the revised bye-laws the "House of Delegates" is being replaced by a "Board of Directors." The following are the representatives from Branch Societies and the term of office.

Branch Society	Name	Term of Office	
		One Year	Two Years
Antigonish-Guysborough	T. B. Murphy, M.D.		Two Years
Cape Breton	J. A. McDonald, M.D.		Two Years
	G. C. Macdonald, M.D.	One Year	
Colchester-East Hants	R. F. Ross, M.D.	One Year	
Cumberland	H. E. Christie, M.D.	One Year	
Halifax	F. Murray Fraser, M.D.		Two Years
	J. McD. Corston, M.B.		Two Years
	W. A. Hewat, M.D.		Two Years
Lunenburg-Queens	H. B. Whitman, M.D.	One Year	
Pictou	A. A. Giffin, M.D.	One Year	
Valley	D. F. Macdonald, M.D.		Two Years
Western			

Opposition to Proposed Chiropractic Legislation

The Committee on Legislation, Chairman, Doctor J. McD. Corston, has continued to be very active in the interval between the recess of the House on March 31, 1957, and the reopening on April 8th. The public hearing is to be held before the Law Amendments Committee on April 9th, at 8.00 p.m. The Provincial Medical Board will have a brief for presentation. The Medical Society of Nova Scotia will have the legal aspects presented by its solicitor and the clinical aspects of opposition will be presented by Doctor A. L. Murphy. Representatives from the medical profession have accepted invitation to be present so that the rebuttal to the Chiropractors presentation will be effective.

The policy of The Medical Society of Nova Scotia is to place before the Committee and the members of the House in a forthright and factual manner the reasons for opposition. This resolves to the fact that Chiropractic is a positive danger to the public health. The danger lies in the field of diagnosis (by Chiropractic standards) and the management of disease on the basis of that diagnosis and inadequate treatment.

Hospital Insurance Plan

The nucleus of the Advisory Committee on Health Insurance, Chairman Doctor D. M. MacRae, continues to have meetings each week. The Hospital Services Planning Commission of Nova Scotia has announced that a Hospital Insurance Institute will be held in Halifax April 21-23 inclusive. Hon. J. W. Montieth, Minister of National Health and Welfare, will be present as well as other representatives of the Federal Department. Invitations to be present have been extended to representatives of The Medical Society.

Abstract of Clinical Research Meeting, February 12, 1958*A Study on the Final Distribution of the Autonomic Nervous System in the Gastrointestinal Tract*

N. I. E. NEMETHY and AILEEN GRAVES

Department of Anatomy, Dalhousie University.

PARASYMPATHETIC and sympathetic nerve degeneration studies were performed on rabbits and white rats, compared with control animals and human material using vital and supravital methyleneblue and silver impregnation methods.

The morphological picture of the peripheral (distal) portion of the autonomic nervous system has been demonstrated in the gut as a continuous, closed, 3-dimensional protoplasmic nervous network, morphologically adapted to the effector system. There are no end organs or free terminations related to the peripheral efferent structures, nor protoplasmic continuity between the finest nervous structures and the effector cells.

The esophagus represents an interesting transition in the neuro-effector complex in that motor end organs could be demonstrated for the striated muscle fibers, but protoplasmic networks for the smooth muscle fibers.

Simple and complex loops and receptor like structures were observed in the submucosa of the colon. It is considered that, owing to their distributions and connections with the adventitial plexuses, they represent vascular regulatory receptors.

This work has been carried out with the aid of grants from the National Research Council.

Thanks are due to Professor R. L. de C. H. Saunders for facilities, encouragement and suggestions, to Dr. F. W. Fyfe for helpful suggestions and to Dr. A. Trias, Dr. K. E. Wardill and Mrs. E. Fraser for help in the surgical and injection procedures.

Abo Blood Groups and Disease*

Conclusive evidence of an association between the ABO blood groups and disease has been found. Gastric carcinoma occurs more frequently in persons with blood type A than in those with the other blood types, peptic ulcer more frequently in those with blood type O, and pernicious anaemia more frequently in those with blood type A. No evidence of such an association was found in patients with carcinoma of the colon and rectum, leukemia, ulcerative colitis, or those with congenital anomalies. Evidence of associations between rheumatic heart disease, hip fracture, and the ABO blood groups also has been found.

Buckwalter, J. A., Colter, D. C., and Knowler, L. A., *Journal of the American Medical Association*: 172: 1956
* Medical Abstracts, August, 1957.

Personal Interest Notes

Dr. Carl J. Mader, a 1954 graduate of Dalhousie Medical College, attained the second highest standing in the recent Ohio State Medical Examinations held at Columbus.

Dr. Mader is at the present time Chief Resident at the St. Thomas Hospital, where he is completing his fourth year graduated course in internal medicine. He and Mrs. Mader plan to return to Nova Scotia this coming summer.

On December 31, 1957, Doctor H. L. Scammell retired as Registrar of the Provincial Medical Board after serving in that capacity for twenty-six years. Doctor M. R. Macdonald, Assistant Superintendent, Victoria General Hospital, has been appointed in his place. Communications should now be addressed to Doctor Macdonald, Victoria General Hospital, Halifax, N. S.

Dr. J. J. Stanton, Pictou, Nova Scotia has recently been appointed Director of Health Grants Division, Nova Scotia Department of Public Health. In this capacity, he is directly responsible for the administration of federal health grants to this Province. Dr. Stanton was born in Mulgrave, Nova Scotia and received his B.A. degree from St. Joseph's University in 1935. In 1941 he received his M.D., C.M. from Queens University. During the year 1941-42, he did a post-graduate internship at the Ottawa General Hospital.

During the years 1942-49 Dr. Stanton did general practice in Canso, Nova Scotia, and following a highly successful practice in that area, he took his D.P.H. at the University of Toronto in 1950. Following this Dr. Stanton did post-graduate work in Tuberculosis at the Nova Scotia Sanatorium during the year 1950-1951, after which he assumed the position of Divisional Medical Health Officer for the Northumberland Health Division with headquarters in Pictou, Nova Scotia. We are happy to congratulate Dr. Stanton on his latest appointment and wish him much happiness in his new work.

The Nova Scotia Medical Bulletin congratulates Doctor E. H. Evans of Rockingham, N. S., on the award of the first prize in a new international competition open to general practitioners sponsored last year by the British Pharmaceutical Firm of Benger Laboratories Limited. The award was offered for the best paper concerning "original observations in general practice" and the entries were judged by the Awards Committee of the British College of General Practitioners.

**ROYAL COLLEGE OF PHYSICIANS AND SURGEONS
OF CANADA**

The Bulletin extends congratulations to those who were successful in passing the examinations of the Royal College of Physicians and Surgeons of Canada in 1957. Of particular interest to our readers are the following:

John Edmund Bethune, Berwick, (Dal. 1953) Fellowship in Medicine and Certificated in the Specialty of Internal Medicine.

James Kent Blair Purves, Halifax, (Dal. 1951) Fellowship in General Surgery.

Michael Thomas Casey, University Hospital, New York 3, N. Y., (Dal. 1953); Ian MacKenzie, Halifax, N. S., (Edinburgh, 1933); James Allan Myrden, Halifax, (Dal. 1950) and Patrick Joseph Whelan, St. John's, Newfoundland, (Dal. 1949) Certificated in the Specialty of General Surgery.

Donald Wilson Brooks, Prince's Lodge, Halifax County, (Toronto, 1950); John Oakley Godden, Halifax, (Dal. 1951); Richard Howell Roberts, Halifax, (Liverpool, 1938); Hugh Neil Archibald MacDonald, Dartmouth, (Dal. 1953) and Donald John MacGregor, Regina, Sask., (Dal. 1952) Certificated in the Specialty of Internal Medicine.

Robert Frederick Hand, R.C.N. Hospital, Halifax, (Glasgow, 1937) Certificated in the Specialty of Ophthalmology.

Roy Wilfred Fanjoy, Rothesay, N. B., (Dal. 1948) Certificated in the Specialty of Otolaryngology.

Norman Epstein, Toronto, Ont., (Dal. 1953); Elizabeth Douglas Ross, Toronto, Ont., (Dal. 1952) and Ulrich August Weste, Dartmouth, (Freiburg, Germany, 1946) Certificated in the Specialty of Paediatrics.

John Hanwell Cooper, Glace Bay, (Glasgow, 1945) Certificated in the Specialty of Pathology.

Robert Gordon Forsythe, Charlottetown, P.E.I., (Dal. 1953) Certificated in the Specialty of Psychiatry.

Arthur William Elliot, Belleville, Ont., (Dal. 1951); Douglas Willard Blake Keating, Bathurst, N. B., (Dal. 1949) and Donald Hector MacKay, Wallaceburg, Ont., (Dal. 1953) Certificated in the Specialty of Diagnostic Radiology.

Joseph James Hazel, Montreal, Quebec, (Dal. 1952) Certificated in the Specialty of Therapeutic Radiology.

Ottor Bruckschwaiger, Glace Bay, N. S., (Vienna, Austria, 1940) and Robert Arthur Wentzell, Dartmouth, (Dal. 1952) Certificated in the Specialty of Urology.

PHYSICIANS' ART SALON INVITES EXHIBITORS**JUNE 17-20, HALIFAX**

The Physicians' Art Salon Committee cordially invites physicians and medical undergraduates resident in Canada to enter the 1958 Salon to be held in the Art Room of the Halifax Memorial Library from June 17-20. This will be the 14th consecutive year that this popular art and photographic competition will coincide with the C.M.A. Convention. It is again sponsored by Frank W. Horner Limited, Montreal.

Conditions of Entry

Entries will be accepted in three sections—

1. Fine Art
2. Monochrome Photography
3. Colour Photography

The Fine Art Section is further subdivided into three categories—Traditional, Contemporary (Modern), and Portrait. Classification into these categories is done by the judges. There is no restriction on media,—oil, tempera, gouache, water colour, charcoal, pencil, or dry brush is acceptable in each.

Each exhibitor may submit up to three entries in Fine Art and Colour Photography and four in Monochrome Photography, and may enter up to the limit in one or more sections. There is no charge. All costs, including transportation to and from Halifax will be borne by Horner.

Judging and Awards

All accepted entries will be displayed in the Salon and then judged for awards by a competent jury selected by the Art Salon Committee.

To obtain entry form

Any physician or medical undergraduate may obtain an entry form and complete details from the sponsor at P. O. Box 959, Montreal, Que. A short note or post card will bring the form along with complete instructions on how to prepare and ship your entries.

Art Salon Calendar

The Physicians' Art Salon Calendar, an attractive desk piece based on Salon exhibits will again be prepared by Frank W. Horner Limited. The Calendar reproduces selections from the award winners and is distributed to all physicians in Canada with the compliments of the Company.

Obituary

Dr. George H. Murphy, age 82, died suddenly Friday, March 7 at his home. He was well known as a surgeon, teacher and writer.

He was born at Cross Roads Ohio, Antigonish County, and was the son of the late Mr. and Mrs. Peter W. Murphy.

He graduated in medicine from the Halifax Medical College in 1902. His first practice was a general one in Dominion, but he also served as surgeon to the St. Joseph's Hospital in Glace Bay.

In 1906 and 1907, Dr. Murphy undertook post-graduate work in London, England, and in 1914 he moved to Halifax. Dr. Murphy was a prominent surgeon in Nova Scotia from 1914 until his retirement some years ago. During his surgical career he was surgeon at the Halifax Infirmary, and chief of one of the surgical services of the Victoria General Hospital.

He was a Fellow of the Canadian College of Surgeons, the American College of Surgeons, and one-time Regent of the American College of Surgeons.

In 1930, Dr. Murphy became Nova Scotia's first Minister of Health, and during his term of office initiated a program for tuberculosis control, setting the pace for subsequent developments in this field. In 1956 he received one of the highest honors granted by the Canadian Medical Association when he was made a Senior member of the Association. Other honors of which he was justly proud were those of Doctor of Law of both Dalhousie and St. Francis Xavier Universities.

He is survived by his wife, Helena, and two sons, Dr. Arthur L. Murphy of Halifax, and Dr. George H. Murphy of Winchester, Virginia.

The Bulletin extends deepest sympathy to the Editor, Dr. Hereford Still, on the death of his father, Rector William Herbert Still of Leicestershire, England, who passed away suddenly on March 19.

A TRIBUTE

(Reprinted from The Halifax Chronicle-Herald)

The death of Doctor George Murphy of Halifax at the age of eighty-two brings to an end a long life devoted to the best interests of this province and its people. Both physician and teacher, he became Nova Scotia's first Minister of Health in 1930. During his tenure of office, he was responsible for many public health measures including that providing for the tuberculosis treatment and control programme we have to-day.

A man of quiet dignity, Doctor Murphy was respected by members of all parties during his term of office and was accorded high honours by his profession and by both Nova Scotia Universities which educated him in his youth. The honorary degrees from St. Francis Xavier University and Dalhousie are particularly significant, for it is not often a native son is given such recognition in his own province. A retired Dalhousie Medical School professor, he was a fellow of the Royal College of Surgeons (Canada) and one of a small group of his country's out-standing doctors elevated to senior membership in The Canadian Medical Association.

One of the deans of his high calling, this native of a tiny Antigonish hamlet contributed much to the province of his birth. Even his main hobby—writing—was devoted largely to medicine. He was a former Editor-in-Chief of the Nova Scotia Medical Bulletin and contributed several articles to The Canadian Medical Association Journal and Dalhousie Review. His one book, "Wood, Hay and Stubble," published in Antigonish in 1956, is a 143-page recollection of his work and times.

Abstracts

The Dietetics of Coronary Heart Disease*

It is now widely accepted that the "Westernized" communities are experiencing an epidemic of coronary disease. Although genetic predisposition and sex are important and uncontrollable determining factors it is suspected that the epidemic could be controlled by modification of environmental factors.

The environmental factors which have been blamed include stress and strain, lack of physical exercise, diet, and possibly smoking. It is likely that there are others. Of the uncontrollable factors it is postulated that none is more important or more easily modifiable than diet.

Many differences distinguish Westernized diets from the diets of underprivileged populations, in whom the incidence of coronary heart disease is low. Some of the differences have been discussed. It is suggested that of these differences the most important may be the quantity and/or quality of fat.

Privileged populations consume a diet containing large quantities of fat. They have a high incidence of coronary heart disease and higher levels of blood lipid than under-privileged races. It is assumed, but not proved, that the level of blood lipid is the link between dietary fat and coronary atherosclerosis. High blood lipids may predispose to coronary heart disease through either or both of two mechanisms, namely atherogenesis and thrombogenesis.

The serum-cholesterol level has been chosen as the most convenient index of the blood lipid. It is, however, subject to considerable unexplained fluctuation and wrong conclusions may be drawn if too much significance is attributed to isolated readings of the serum cholesterol.

Evidence is reviewed which indicates that certain fats which are of vegetable and marine origin, and which are highly unsaturated, do not elevate the serum-cholesterol level and may, in fact, depress it.

Tentative dietary advice is offered for the management of acute cardiac infarction and for the prevention of coronary heart disease in persons particularly at risk and in privileged communities as a whole. It is emphasized that the advice is tentative and subject to modification in the light of further knowledge.

Brock, J. F., and Gordon H., *South Africa Medical Journal*, 31: July 6, 1957.

*Medical Abstracts, August, 1957.

The Use of Electroencephalography in Differentiating Psychogenic Disorders and Organic Brain Diseases*

The authors divide the neuropsychiatric cases for which electroencephalography is usually considered a useful diagnostic measure into four categories. The first group comprises those instances where epileptic seizures must be differentiated from hysteria, syncope, and other psychogenic symptoms. Secondly, those patients with psychogenic or neurologic symptoms with or without organic brain disease. The third group includes known epileptics who require investigation for personality changes and antisocial behaviour. Finally, electroencephalography is used in certain conditions such as childhood schizophrenia and psychomotor seizures whose aetiology is uncertain.

Bergman, P. S., and Green, M. A., *American Journal of Psychiatry*: 1957.

*Medical Abstracts, August, 1957.