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EDITORIAL

CHARITY AND THE DOCTOR

Since World War II high pressure techniques of fund raising have increased the income of most charitable organizations. This is so generally recognized by them that never a week goes by without some Fund launching a Drive, regarded in all sincerity by members of the sponsoring organization, as the one Fund most worthy of universal support. This situation has led to open conflict between important fund raising bodies. Annually this conflict is increasing in bitterness and spreading in scope.

Charity has many meanings, none referring to the situations above mentioned. These include "tolerance in feeling or opinion"; "generosity to the poor"; and, in law—"a gift in trust for promoting the welfare of the community or of mankind at large." The majority of the Annual Funds operate in support of two categories of organization, the prime interest in the one instance being Welfare, and in the other Health. One may maintain that Welfare is the doctor's concern only as a citizen. But no one in practice can deny that in most instances welfare agencies simplify care of the medically indigent. Sometimes, in well meant ignorance, these agencies interfere. Both situations would be improved by more active medical participation in policy making and direction of welfare agencies. Turning to the health agencies, we find organized medicine at various levels being asked to endorse in principle, programs of most such groups. Here the doctor's responsibility is clearly a dual one, general and professional. The voluntary health agencies have accelerated research and stimulated public interest. This has led to government action and further acceleration not only of research, but of important public health measures, immeasurably easing the task of the medical profession in the control of important diseases, e.g., tuberculosis, poliomyelitis, and cancer. While medical advisory committees to the voluntary health agencies have, in large measure, insured programs generally acceptable to the profession, greater active participation by the doctor would develop far more lay interest and accelerate progress, and would serve to combat the development of attitudes of unbalanced enthusiasm which are the basis of the conflicts mentioned earlier.

Exemplifying unbalanced enthusiasm is the spreading trend among the Funds to tell the donor what his "donation" should be.

As an authority in Health, and as one especially interested in Welfare, the doctor has a clear responsibility to assume an active role in diagnosis and treatment of the ills affecting Charity to-day.

L.C.S.

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THE NATURAL HISTORY OF EMPHYSEMA IN MAN*

BY RICHARD V. EBERT, M.D.

THE AMERICAN REVIEW OF RESPIRATORY DISEASES,
JULY, 1959.

In describing the natural history of a disease we must first establish a definition. To do this, we classified a group of patients into a category on the basis of one or more common characteristics. Once this is done, the clinical symptoms and course of the disease can be described.

Defining Emphysema

The problem in emphysema lies in the area of definition of the disease and hence classification of patients. If the records of any hospital are scanned, it will be found that the term emphysema is often loosely used and applied to a diversity of clinical problems. Hence, to give any coherent account of the clinical course of the disease, we must establish a rigid definition. The traditional method of classification of emphysema is based on clinical-pathological correlation. This method has severe limitations. The pathology of emphysema is not an all or none phenomenon. One can state with some assurance that a patient has or has not bronchogenic carcinoma or pulmonary tuberculosis. In the case of emphysema the degree of change in the lung may range from a few bullae or dilated air spaces to a condition in which both lungs may be almost entirely replaced by bullae. In emphysema the pathology must be defined quantitatively as well as qualitatively.

There are other problems related to the pathologic definition of emphysema. Most pathologists do not fix the lungs in an inflated state. Hence, the gross and microscopic evaluation of the disease lacks precision. The pathologic process is not accurately reflected in the roentgenogram and we must await the death of the patient for an accurate appraisal of the changes in the lung.

For these reasons clinicians have begun to rely more and more on a physiologic definition of emphysema. Unfortunately, the data are not available to correlate precisely this physiologic definition of the disease with the pathologic definition.

Clinical Course

A description of the clinical course of patients with typical diffuse hypertrophic or obstructive emphysema, in essence, differs little from the original description of Laennec. There are patients, however, who present a less typical clinical picture.

The chief symptom of emphysema is dyspnea beginning as exertional dyspnea. The patient notes that his activity is being limited progressively because of shortness of breath. Often this limitation of activity is attributed to aging or loss of physical fitness. Finally the patient is unable to walk even a short distance without being tortured by dyspnea. Episodes of dyspnea occur at rest and are accompanied by wheezing. These acute episodes, often

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referred to as "asthma," are usually precipitated by an upper respiratory infection. Administration of adequate amounts of antimicrobial drugs usually gives dramatic relief.

Cough is a persistent symptom in most patients with emphysema. The sputum production is greatest following a respiratory infection. Many patients with emphysema have a slight decrease in the oxygen saturation of the hemoglobin of the arterial blood and a slight increase in carbon dioxide tension. There appears to be little correlation between the degree of hypoxia and the severity of the dyspnea.

The most serious threat to the life of the patient with emphysema is the sudden increase in hypoxia and hypercapnia which accompanies an exacerbation of the bronchitis. He has a sudden increase in dyspnea and becomes cyanotic, and often disoriented and confused. Cough and fever may be absent, and secretions accumulate in the trachea and bronchi. Administration of oxygen may lead to improvement, or the patient may lapse into coma as a result of an increase in carbon dioxide tension in the arterial blood and resultant respiratory acidosis. Death may occur if treatment is not prompt and effective.

Right heart failure is commonly found in these patients and is manifested by cardiac enlargement, elevated venous pressure, and hepatomegaly. There is no evidence to indicate that this adversely influences the function of the lungs. The heart failure is usually not chronic but clears when the acute bronchial infection subsides and the hypoxia improves.

The prognosis of emphysema is not well defined. In part this is related to difficulties of classification and definition. There are a number of patients who apparently have emphysema but who do not follow the classical clinical course just given.

Associated Conditions

One of the controversial aspects of emphysema is its relationship to bronchial asthma. A number of patients with typical emphysema will give a previous history of bronchial asthma. The episodes of dyspnea accompanying acute bronchial infection in emphysema are difficult to differentiate from true bronchial asthma. Hence it is difficult to determine whether previous episodes were asthma or bronchitis. The incidence of pulmonary emphysema in patients with known bronchial asthma is also difficult to establish. The relationship between bronchial asthma and emphysema needs further clarification.

A similar problem exists in the relationship between chronic bronchitis and emphysema. It is clear that chronic bronchitis is often associated with pulmonary emphysema and that acute bronchial infection precipitates the more severe episodes of dyspnea and hypoxia.

There also appears to be a relationship between bronchiectasis and emphysema. A mild cylindrical dilatation of the bronchi is found on the bronchograms of many patients with emphysema, but certain patients have the findings of saccular bronchiectasis. The bronchiectasis precedes by some years the symptoms of emphysema. Moreover, a number of patients with severe bilateral bronchiectasis develop pulmonary insufficiency. There also appears to be an undue incidence of diffuse pulmonary emphysema complicating other chronic inflammatory diseases of the lung. A focal type of emphysema has been described in the lungs of coal miners.

Certain changes in pulmonary function occur with aging. There is a decrease in vital capacity and an increase in residual volume in association with a change in the elastic properties of the lungs. These elderly persons have no respiratory symptoms but if such persons develop bronchitis, the physiologic findings could readily be confused with emphysema.

Many patients with emphysema will demonstrate an increase in the anteroposterior diameter of the chest associated with hyperresonance to percussion and a tendency to obliteration of the cardiac and hepatic dullness. Similar changes occur in many elderly persons without emphysema. Moreover, some patients with emphysema do not exhibit this phenomenon. It would appear that the barrel-chest phenomenon is related to aging changes in the skeleton. For some reason it tends to occur prematurely in patients with emphysema.

Testing Higher Visual Functions. Quigley, J. H.: Amer. J. Ophthal. 48: 819, 1959.

In spite of lengthy and complete tests of peripheral visual functions, very little has been done in the line of testing of the higher visual functions. These include not only patterned awareness of sense data, but also psychological association with other sensory stimuli. Since this will become of increasing importance in neuro-ophthalmology, a preliminary method of testing patients is outlined and a case presented.

J. H. Q,

Primary Hypertension in the Elderly. Perera, G. A.: Ann. Int. M., 51: 537, 1959.

One hundred patients followed at the Presbyterian Hospital, New York, because of hypertension at or before the age of fifty, with documented primary hypertension, were reassessed clinically after age sixty. Long survival and normal life expectancies were observed frequently. Minimal elevations of diastolic blood pressure were encountered in the majority of this group, in the others marked liability of diastolic pressure was demonstrated. The suggestion is made that the "floor" of the diastolic blood pressure may be more important than the mean or peak values in terms of a development of complications.

L.C.S.

DECOMPENSATED SKIN DISEASE

Lecture to the Dalhousie University Medical Refresher Course
October 19, 1959

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It seems to me that when the majority of general practitioners see a patient with a skin disease, they immediately push the panic button and say to themselves "I don't know a thing about skins—what will I do"? They suddenly remember some detail man who left some samples, reach over to the sample drawer, grab the first thing that comes to their mad clutching fingers, quickly hand this to the patient and say "Try this".

Why do you panic when you see a rash? Our teachers must have failed to teach us even the first principles. Things have not improved any in the past decade or so since I have been teaching. This failure in teaching has troubled me a good deal. No doubt we could teach more if we did have more time. The under-graduate curriculum is already over crowded and it is natural that we spend more time on the life taking diseases than on the nuisance disease, even though the latter group constitutes most of our practices. Nevertheless, we as teachers should make some impression.

Today, I wish to offer a slightly different approach to the subject. I did not come to talk about a new type of dermatitis, but to try and explain what happens in many cases of dermatitis in terms that you are accustomed, in the hope that when next you are confronted with a patient with skin disease you will pause and think a little, rather than give it "the panic treatment".

First, let us remember that the skin is a vital functioning organ. If more than forty percent is removed or destroyed, life is threatened. It has several important functions. Some of these are:

1. Protection
2. Sensation
3. Secretion
4. Excretion
5. Heat regulation
6. Absorption
7. Respiration
8. Vitamin Formation
9. Antibody Formation

Today, we are most concerned with the various means of protection including antibody formation. In normal health a number of simple and complex mechanisms exist to protect our body from the harmful elements in our environment. Some of the mechanisms are:

a. Horny layer affords some protection against trauma. The corium and subcutaneous fat cushion the blow and due to the loose attachment they withstand tangential stress. The hair helps to some extent to cushion the trauma.

b. The horny layer is relatively inert and is resistant to chemicals. It is impervious to water and prevents excessive loss from the body and excessive absorption when immersed in water. It is a poor conductor of electricity.

e. The skin protects against noxious effect of light, ultra-violet etc. by means of the thickness of the keratin and the pigment.
d. The fatty layer, the sebum protects against water soluble irritants, and keeps the skin pliable.
e. The sweat washes off or dilutes the irritating substances. It is weakly acid and affords some protection against weak alkali.
f. Bacteriocidal, bacteriostatic, fungicidal, fungostatic, virocidal and virostatic action has been attributed to sweat and sebum.
g. Protects as an organ of touch.
h. The skin is a poor conductor of heat.
i. Ability to contract its blood vessels to prevent hemorrhage in trauma.
j. Disinfection in the deeper layers. R.E. cells remove noxious substances. Among the albuminous fraction of the skin there are fractions which destroy many toxins and form innocuous compounds with phosphorus and heavy metals.
k. Production of immune bodies and allergic alterations afford protection against various infections.
1. The impenetrability of the stratum lucidum and the stratum granulosum (due to electric charges) protects against invasion of micro-organisms and electrolytes. The weak points are the pilo-sebaceous orifices.

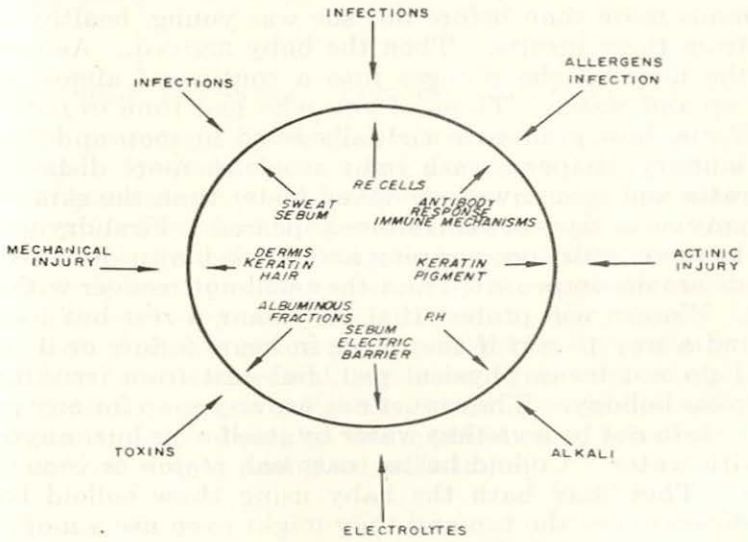

Figure (1) represents the normal balance between the skin and the environment. In health we are continually being attacked from without and our skin is constantly fending off these attacks. When the skin is able successfully to ward off the attacks, it is in a compensated state. That is, it compensates for the various stresses which act upon it and due to its reserve, like all vital organs, it can compensate for additional insults up to a point. When the insults become too great or when the defence-mechanisms becomes exhausted, then it becomes decompensated or goes into skin failure. Thus when your patient arrives with a dermatitis he has skin failure and why not think of this as you would of heart failure.

If he had heart failure you would recognize that he had done more than his heart could stand. You would immediately order rest so that the heart may regain its powers to compensate once again. Why not try this in skin failure.

How can we rest the skin? We can rest the skin by removing all possible stresses and irritants. Once the skin fails from one stress it loses its ability to cope with many other stresses. Thus we order a bland routine. We avoid such common irritants as soap, wool, detergents etc. We institute simple treatment to sooth the angry skin. I will outline these in detail later. Once the acute phase passes we will permit some exercise as we would our cardiacs. We will allow exposure to mild irritants and we will gradually increase this to tolerance. As in our cardiacs we must instil in the minds of our patients that they must live within this tolerance. If they persist in insulting their heart or skin, they will come to grief once again.

Now let us apply this principle to a common form of dermatitis—the so called housewive's dermatitis. The typical patient is a young married woman with a baby of three to four months of age. She never had any trouble until three or four months ago, and she is not handling anything new. Prior to her marriage she did a little housework, the occasional dishes and she washed out her hose and lingerie two or three times per week. After marriage, she washed a few more dishes, and possibly her husbands sox and underwear. She insulted her hands more than before but she was young, healthy and her skin compensated from these insults. Then the baby arrived. As soon as she returned from the hospital she plunges into a routine of almost unbelievable exposure to soap and water. Those of you who had time to notice will recall in your own home, how your wife virtually lived in soap and water—dishes, baby's bath, laundry, diapers, wash baby woolens, more dishes, more baths etc.. The keratin and sebum were removed faster than the skin could replace them and in many cases signs of skin failure appeared. First dryness, erythema and pruritus, later vesiculation, weeping and a full-blown dermatitis.

Such hands are decompensated and they will not recover without rest and soothing care. Women will protest that they cannot rest but we must insist. They would find a way to rest if they were in heart failure or if they had had pneumonia. I do not mean physical rest, but rest from irritation. I place them on a soapless holiday. They must not use any soap for any purpose until I tell them to. I do not believe that water by itself ever hurt anyone, so I permit contact with water. Colloid baths (oatmeal, starch or bran) are ordered for cleanliness. They may bath the baby using these colloid baths. They may rinse the dishes under the tap and they might even use a mop, but in most cases it is best, although probably less popular with him, to have the husband or some other person perform the dishwashing. The laundry must also be done by others unless a fully automatic machine is available. Rubber gloves are not well tolerated once a dermatitis develops and I will not permit their use.

While on this rest treatment, cold open wet dressings will reduce the inflammation and add to the comfort of the patient. These are applied for one hour on and one hour off during the day. (This does not mean soaking the parts in a bowl of solution). Mild anti-inflammatory preparation such as 0.5% Hydrocortisone cream may be applied, and in the subacute phase I add 5% Oil of Cade in Ihles Paste at night.

On this routine the skin subsides within seven to ten days. We are now ready to test the skins ability to compensate again. We start off with easy exercises. We permit the use of mild soaps such as Ivory—I like to use a protective cream if it does not burn (note—if your applications "burn" the skin, stop them, they are doing harm.) At present I am using Kerodex No. 77 (Stanley Chemical Co. Montreal) as a barrier cream.

If the patient tolerates this routine, then I will permit a trial with a mild detergent (Dreft or Vel powder). The patient must be aware that she has to live within her tolerance. Once she overdoes it, she will relapse into failure again. Too often the patient and possibly her medical advisor fails to realize this fact. Once her hands are clear she feels she is "over it" as she would recover from an attack of scarlet fever, and now feels she can do anything. She then starts in with the Spic & Span or other such irritants and she is back at your office or your colleagues saying that you did not cure her.

SUMMARY

The physiology of the skin has been briefly reviewed. The skin is compared with the heart. It has been shown how skin failure may develop and the management of such a state has been compared with that of the management of cardiac failure. The patient must have a rest period, a period of trial of exercise and finally they must learn to live within their tolerance.

SUB-THRESHOLD DIABETES. Pomeranze, J.: Ann. Int. M. 51: 219, 1959.

The author presents a discussion based on an historical analysis of 1,140 diabetic patients. He feels that a more astute attitude could have diagnosed many of these patients in their early stage, paying attention to the family history, obstetric history, and the presence of obesity, the occurrence of neuropathies, of thalamic lesions, dermatologic conditions, hepatic enlargement, coronary and peripheral vascular sclerosis. He emphasizes that each patient must be asked every two years "Does anyone in your family have sugar diabetes?" He feels that the practice of overlooking intermittent or occasional glycosuria, may constitute medical neglect; and also that the glucose tolerance test is not sufficiently sensitive, the awareness of early diabetes being a critical diagnostic element. He advocates the application of a balanced eucaloric diet maintaining normal weight and good nutrition.

L.C.S.

THE SURGICAL TREATMENT OF MASSIVE UPPER GASTRO-INTESTINAL HAEMORRHAGE

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During the past 7 years 52 cases of massive upper gastro-intestinal haemorrhage have come under my care and were either submitted to emergency or early surgery following admission to hospital.

I wish to present to you a brief analysis of these cases, to mention a few difficulties encountered in management, as well as the salient features and final conclusions.

You are probably all aware of the difficulties in assessment of criteria of what really constitutes a massive upper gastro-intestinal haemorrhage.

In answer to this question the following cases were all admitted to hospital as acute emergencies. They were all in a state of collapse or peripheral hypotension on admission and required at least three bottles of blood in the first-twenty-four hours before stabilization. They all had a recent history of hæmatemesis or melæna or both. A few of these cases were transferred by ambulance from distant hospitals with a blood running.

All cases who continued to bleed for 24-48 hours after admission were prepared for emergency surgery. The remainder of the group, in whom bleeding had ceased or was controlled, were kept under observation until further investigation was carried out, if thought necessary, before a delayed or elective operation was performed.

Management of Cases After Admission

This in general consisted of shock therapy:-

1. Bed rest, foot of bed raised.
2. Morphia for sedation.
3. Half-hourly pulse and blood pressure.
4. Intravenous fluids of glucose, saline or intradex.
5. Hæmoglobin, complete, blood count group and cross match and blood urea.
6. Oxygen administration.
7. Passage of a Levin or stomach tube for lavage with saline solution.
8. Blood tranfusion started when ready and administered as required.
9. Hæmoglobin estimations repeated every 4 hours.

Indications For Urgent Operation

1. If after 6 and before 24 hours the patient continued to have hæmatemesis or severe melæna or both.
2. If the pulse and blood pressure failed to stabilize and the hæmoglobin failed to rise.
3. If the patient complains of abdominal pain during the progress of bleeding, suggesting perforation.
4. All cases over 45 years of age who continued to bleed after 24 hours unless contraindicated by severe pulmonary, cardiac or kidney disease.

Indications For A Delayed Or Elective Operation

1. Recurrence of bleeding after 48 hours, especially in cases showing signs of shock.
2. Any patient 45 years or over with a definite history of bleeding (massive) before this admission.
3. X-ray evidence of a gastric ulcer, a penetrating duodenal ulcer (posterior wall), pyloric stenosis, hour glass stomach, etc.
4. A history of previous perforation.

Cause of Bleeding in this Series

Duodenal ulcer	— 29	cases
Gastric ulcer	— 9	,,
Erosive gastritis	— 9	,,
Stomal ulcer	— 1	,,
Carcinoma of stomach	— 1	,,
Oesophageal varices	— 1	,,
Meckel's Diverticulum (ulcer)	— 2	,,
Total cases	— 52	,,

There were 6 females and 46 males; the average age was 54 years, the average haemoglobin on admission was 7.5 gms. and the average units of blood required was 9 bottles. The youngest patient (with one exception in a Meckel's diverticulum) was 30 years, and the oldest 91 years. There were only 5 patients under 45 years of age.

Urgent or emergency operation was required in 23 cases. A delayed or elective operation was performed in 29 cases.

Operations Performed

Partial or subtotal gastrectomy	— 48	cases
Total gastrectomy or removal of the remaining portion of stomach	— 2	,,
Resection of gastro-jejunal anastomosis	— 1	,,
Ligation of oesophageal varices	— 1	,,
Resection of segment of ileum	— 2	,,
Total mortality	— 3	,,
	— (5.8%)	

At operation many difficulties were encountered after exploration, especially in the erosive gastritis group. The site and cause of bleeding must be determined. A systematized plan of exploration is essential.

1. Examine the most common sites of bleeding, e.g. first portion of the duodenum (posteriorly), the lesser curvature of the stomach, the pylorus, cardia and lower oesophagus.
2. Examine for evidence of portal hypertension - - - dilated veins, cirrhosis of the liver and an enlarged spleen.
3. Next examine the second portion of the duodenum, tracing down the small intestine to the ileo-caecal valve.
4. Note the small intestine for the presence of old blood.
5. If no lesion is revealed, the anterior wall of the stomach should be opened and then the first part of the duodenum.
6. If only gastritis is found, decide whether a subtotal or total gastrectomy is required.

When operating on these patients, many factors had to be considered, e.g. general condition of the patient, obesity, build and age.

In this series a partial or subtotal gastrectomy of a Polya-Hofmeister type was performed in all peptic ulcer and erosive gastritis cases, as well as one case of carcinoma of the stomach.

There was one bleeding stomal ulcer in which a gastro-jejunal resection was performed.

Not all the duodenal ulcers were removed if the procedure was found too difficult, but were usually underrun with a suture.

There were 3 deaths in the series. One occurred in a patient of 91 years, who had a bleeding duodenal ulcer. He had been treated for 12 days conservatively before transfer to surgery. He died on the fourth post-operative day in a comatose state (uraemia).

The two other deaths will be discussed with the erosive gastritis group.

The most interesting and perplexing cases consisted of the acute erosive of ulcerative gastritis group. There were nine of these cases. The onset of haemorrhage was sudden and with little past history of ulcer symptoms. There appeared to be an anxiety, emotional or stress factor in all these cases. All were admitted to hospital soon after severe haematemisis, followed by shock and collapse.

The etiology of acute haemorrhagic gastritis is probably in the neurogenic area. Considerable experimental and case history evidence supports this contention and the histological pattern tends to rule out an inflammatory basis.

Three microphotographs from the study of one of my cases demonstrates the development sequence of this multifocal lesion involving the most superficial aspect of the mucosa of the promimal 2/3 of the stomach.

1. Capillary dilatation in the upper subepithelial zone of the mucosa.
2. Subepithelial haemorrhage with the beginning of the surface mucosal loss.
3. The broader surface mucosal ulceration and the more extensive haemorrhage pattern.
4. This slide the lower half of the mucosa at site No 3 shows no lesion.

These cases are summarized as follows—

EROSIVE GASTRITIS

Patient	Age	Hb	Blood	Hours to Operation
A. F.	47	6 gms	8 bottles	(within) 24
A. P.	64	5.2	8	24
M. C.	72	7	12	24
J. B.	52	5	60	24 (2 Ops) D
M. R.	67	4.1	24	48—D
E. C.	53	4	11	48
H. B.	62	4	9	24
A. U.	45	6	12	24
W. L.	44	4.4	24	48 (2 Ops).

You will note in this group the average age was 56 years, the average haemoglobin 5 gms., and the average units of blood given was 15.

All were operated on within 48 hours after admission. Three cases were transferred from other hospitals. One had had 30 bottles of blood over a period of one week before transfer. All cases had a subtotal gastrectomy.

Two cases had a recurrence of haemorrhage and required a second operation for removal of the remaining portion of the stomach.

There were two deaths in this group, one in a man of 52 who had a total of 60 bottles of blood and two operations. He died of peritonitis and bronchopneumonia—P.M. The second death occurred in a woman of 67 years with hypertensive disease, who had been bleeding at home for 48 hours and was treated for another 48 hours in hospital before operation. Following surgery she became listless, anuric and died in coma on the 14th post-operative day. P.M. revealed ulcerative gastritis, infarction of the spleen, pulmonary edema, pleural and peritoneal effusion and uraemia.

The miscellaneous group is included to illustrate several features—

1. Carcinoma of the stomach in a woman of 40 years who had massive haematemesis on the fifth day post-partum. After rapid administration of six blood, an emergency gastrectomy was performed. She had a large papillary and ulcerative lesion, high on the posterior wall of the lesser curvature. She did well following resection and survived over five years.
2. One case of oesophageal varices in a woman of 67 years, who was admitted with gross haematemesis. A splenectomy had been performed five years previously for splenomegaly and splenic neutropenia. A barium swallow demonstrated oesophageal varices. the bleeding veins were ligated through a left thoracotomy. She is living and well after two years, with no recurrence of bleeding.
3. One case of bleeding stomal ulcer was admitted following continuous haematemesis in a man of 54 years. Four years previously he had a sub-total gastrectomy for a perforated duodenal ulcer. He had a gastro-jejunal resection and did well after operation.
4. Two cases of Meckel's diverticula with bleeding ulcers. These are included to illustrate how bleeding may occur in the lower small intestine and could easily be missed at operation unless thoroughly explored. One case was a man of 30 years with a history of duodenal ulcer and was unable to work because of gross melaena and fainting spells. He had a peptic ulcer of a Meckel's which was easily dealt with at operation.

The second case was in a child of two years who three weeks previously had been admitted for melaena. Investigation failed to find the cause. He was readmitted with a recurrence of melaena and a haemoglobin of 4 gms. Operation revealed an intussusception of a Meckel's diverticulum with ulceration and haemorrhage. He did well after resection of this segment of ileum.

Summary and Conclusions

1. A series of 52 cases of massive upper gastro-intestinal haemorrhage have been presented.
2. Urgent and active shock therapy was essential.
3. Early or urgent surgery was required in 23 cases and a delayed or elective operation in 29 cases.
4. The overall mortality was 5.8 per cent.
5. The erosive gastritis group presented many problems in diagnosis and treatment.
6. Prolonged conservative treatment in cases of continuous bleeding, especially in the over middle aged group, is to be condemned.

CHRONIC PULMONARY DISEASES IN PATIENTS WITH LUNG CANCER*

WALTER FINKE, M.D.,
NEW YORK STATE JOURNAL OF MEDICINE,
DECEMBER 1, 1958.

An intimate relationship between nonmalignant and malignant pathology in the lungs is suggested by an investigation of the clinical history of a hundred cases of lung cancer.

Pulmonary pathology, such as pneumonia, atelectasis, or tuberculosis, often masks the presence of a lung cancer and creates diagnostic difficulties. The question arises whether such pathologic changes are secondary complications, are merely coexistent, or have preceded the carcinoma. The prevalent view is that usually lung cancer develops in a previously healthy organ, and that in general nonmalignant pathology is due to the new growth or is coincidental.

However, judging from case histories as well as roentgenologic and pathologic findings, chronic lung processes antedate a cancer in many cases. This suggests that an intimate relationship between nonmalignant and malignant pulmonary pathology may exist in the lungs.

Clinical investigations on a possible link between common nonoccupational lung diseases and pulmonary cancer have been few and inconclusive. Still, in some series of patients with lung cancer previous chest ailments were prevalent, and follow-up statistics indicate an increased risk of respiratory cancer in persons with chronic bronchitis. It is commonly reported that many patients with lung cancer have had a long history of chronic cough. Whether this symptom is considered insignificant, or is labeled "smoker's cough," it usually signalizes some respiratory disorder.

These considerations gave rise to the clinicoroentgenologic study reported here, which attempted to determine retrospectively the amount of important pre-existing respiratory sickness in a group of patients with lung cancer.

Methods of Investigation

The basic material for this investigation was the records of 100 unselected patients with proved primary lung cancer of any histologic type who had been admitted to The Genesee Hospital during the past 15 years. The routine histories proved to be inadequate so records of previous admissions were reviewed. Additional information was sought from the patients, their families, physicians, and institutions which had knowledge of the case. Only acute, respiratory illnesses which had occurred at least ten years prior to the diagnosis of lung cancer were included in the final analysis. Similarly, only chronic pulmonary disorders that had existed at least ten years were considered significant.

A reasonably accurate picture of the previous respiratory status could be reconstructed for 86 of the 100 patients. In addition to this clinical information, a roentgenologic history of 63 of the 86 patients was obtained.

Chronic Respiratory Diseases

Over 90 per cent of the 86 patients whose previous respiratory health could be reinvestigated had had a chronic cough for at least ten years and in most cases for twenty years. As a rule, the cough was productive or, if "dry," associated with dyspnea or "asthma."

Frequency of Chronic Pulmonary Disease of Ten Years' Duration or More in 86 Patients with Lung Cancer

Chronic Respiratory Disease		Number of Cases
Chronic bronchitis (moderate or very severe)		56
with chronic asthma	27	
observed for tuberculosis	29	
Chronic pulmonary tuberculosis		6
Silicosis or sequela to gas poisoning in World War I		3
Total		65

Most of these patients had required frequent medical care for years. Many had been disabled repeatedly, and some had become pulmonary cripples long before the malignant disease supervened. Thus, the illness that proved to be lung cancer often seemed at first an aggravation of an old chest ailment rather than a new and different disease.

Acute Respiratory Illnesses

A history of frequent respiratory episodes was found in over 80 per cent of the investigated patients with lung cancer. Forty per cent had suffered an almost fatal respiratory sickness in childhood, severe pleurisy, or major chest injuries with pulmonary complications. The most frequent of these illnesses was influenza or pneumonia during the epidemic of 1918-1920 and pneumonia at some other time in the patient's earlier life.

For tentative comparison 86 individuals hospitalized between 1955 and 1957 for various nonmalignant surgical and medical conditions were selected to match the study group as closely as possible in age distribution. They were questioned thoroughly about chronic pulmonary diseases of at least ten years' duration, influenza in 1918-20, and pneumonia at some other time at least ten years prior to their admission. Fully developed bronchitis, which had existed in 65 per cent of the group with lung cancer, was found in 30 per cent of the controls. Similar differences were found also with regard to suspected or proved tuberculosis. Among the patients with pulmonary malignancy the number of those who had influenza in 1918-1920 was twice that among the controls. Multiple episodes of severe pulmonary illness has occurred in 50% of the patients with cancer but in only 19% of the control group.

Current research on the cause of lung cancer concentrates on extrinsic carcinogens in cigarette smoke and air pollution. These studies tend to overshadow others which support anew the older view that tuberculosis and other lung diseases may predispose to pulmonary malignancy. Early cancer in the walls of old bronchectases, near tuberculous and other scars and in areas of chronic inflammation is being reported frequently. The findings of a multicentric origin of lung cancer and of cancer in situ beside an invasive tumor indicate that generalized pulmonary inflammation can pave the way for cronchegenic carcinoma. These investigations add weight to the concept of a profound cell injury as a cause of the malignant transformation. Severe lung insults of any type merely initiate or further those pathologic changes which produce continuous tissue unrest and disorganized proliferation. The neoplasm may not arise where macroscopically the lung had seemed most damaged.

Various factors have been suspected as causes for the present "pandemic of lung cancer." The theory which points toward the pandemic of 1918-1920, may well explain why lung cancer rose sharply following the epidemic and why in recent years a substantial increase is noticeable only in the older age group.

In other organs chronic inflammation is widely recognized as potentially malignant. It is then, conceivable that similar pathologic processes have some part in the genesis of malignant diseased lungs also.

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*Abstracted by National Tuberculosis Association.
Printed through co-operation Nova Scotia Tuberculosis Association.

THE SIGNIFICANCE OF PLEURAL EFFUSION COMPLICATING OTHERWISE OPERABLE BRONCHOGENIC CARCINOMA. BRINKMAN G. L.: DIS CHEST 36: 152, 1959.

Bronchogenic carcinoma complicated by pleural effusion presents a difficult problem in management, especially when the patient appears otherwise suitable for operation. Most surgeons are agreed that the presence of malignant cells in pleural effusion indicates inoperatibility, but the significance of fluid in which malignant cells are not seen is debatable.

In order to establish the significance of pleural effusion in these otherwise operable patients, 360 cases of bronchogenic carcinoma seen in a large U.S. hospital from 1936 through 1955 were reviewed. There were 21 with pleural effusion who had no evidence of secondary spread elsewhere and as far as could be judged clinically, were operable and potentially curable patients.

All 21 patients underwent thoracotomy, at which time 17 were found to have mediastinal involvement, while five had obvious pleural secondaries as well. Eleven of these 21 were considered inoperable. The other 10 had pneumonectomy, eight of which were on the left side. In six this was a palliative procedure with subsequent survival varying from one to 24 months. The mean survival time was seven months, compared to a mean survival for untreated bronchogenic carcinoma of four to six-and-a-half months. Four patients had pneumonectomy with removal of all recognizable tumor. However, three of these died within six months of operation.

It is apparent that the presence of pleural effusion, whether malignant cells are demonstrated in the fluid or not, is of serious prognostic significance. It is questionable whether a major procedure such as pneumonectomy, especially in an elderly person, is justified when the chance of cure is so poor.

S.J.S.

WHAT DO YOU KNOW ABOUT YOUR BLOOD TRANSFUSION SERVICE?

HAROLD C. READ, M.D.*

March is National Red Cross Month! In recognition of this fact the Editors of your Bulletin felt that this would be an appropriate time for me to tell you something about your Blood Transfusion Service. In talking to my colleagues I find that there is much that is not known about it. There are perhaps a few things that one would like to know and certainly there are a number of things that should be known.

The National Blood Transfusion Service was an early post-war development. A survey of blood transfusion facilities in Canadian hospitals was sponsored by the Canadian Red Cross Society in 1945, following which it was generally agreed by individual hospitals, Provincial Hospital Associations, Dominion and Provincial Departments of Health and Provincial Workmen's Compensation Boards that a National Blood Transfusion Service should be set up to provide all hospitals in Canada with blood, plasma and blood transfusion equipment, free-of-charge. It was also generally agreed that such an organization should be administered nationally in order to provide a service of uniform efficiency across Canada; in addition, it was considered by most that the Canadian Red Cross Society, with its wartime experience in blood donor panel organization, was the agency which could best provide and administer such a Dominion-wide service. As with any new proposal there were dissenting voices, but, encouraged by most, the Red Cross Society accepted the challenge of this great undertaking and in 1946 organized what is now known as "The Canadian Red Cross Blood Transfusion Service." The country has been divided into administrative regions, each with a central Depot. The Maritimes Depot was established in Halifax in 1948. At present every service in Canada has at least one major Depot, there being a total of 15 Depots in Canada.

The function of each Depot is to procure, transport, properly store, process, test and distribute blood to the hospitals of its province or region. The procurement of donors and the arranging of donor clinics is a function of each Provincial Division of the Red Cross Society. Close co-operation and co-ordination of the Blood Transfusion Service activities and the Provincial Blood Donor Procurement Service are therefore vital to the total programme.

I have mentioned the above facts in order to provide some insight into the origin and magnitude of the organization. From the practical standpoint, this "Free Blood Transfusion Service" is a great public health and medical service in which practically everyone is or should be participating. It is everybody's programme. The key figure is the Volunteer Blood Donor. Other corner-stones are the provincial governments, the hospitals, the medical profession and the Canadian Red Cross Society; the latter is merely administrator of this service which is so vital to the welfare of our people through its tremendous importance in modern surgery and medicine.

It is interesting to note that almost 5,000,000 bottles of blood have been collected since the inception of this service in Canada; it is even more interesting that in our Province of Nova Scotia over 275,000 bottles of blood have been donated by volunteer donors throughout the length and breadth of our

*Provincial Medical Director, Maritime Depot, Canadian Red Cross Blood Transfusion Service.

Province and that, as a result of this, over 100,000 patients have received free blood transfusions. In 1959 alone 36,000 bottles of blood were collected and over 11,000 patients were transfused. In addition, almost 500 bottles of serum albumin and 500 bottles of fresh frozen plasma were used. In contrast, the survey in 1945 revealed that less than 3,000 bottles of blood were transfused in this province that year.

In the field of blood transfusion, increasing knowledge and experience are resulting in more scientific usage of blood and blood-products. Various fractions of blood in place of whole blood will undoubtedly receive increasing demand. The provision of fractionation-products is therefore a major project of the service. It should be pointed out that it requires the equivalent of 5 or 6 bottles of blood to produce 1 bottle of serum albumin, 3 or 4 bottles of blood for 1 bottle of fibrinogen, and 1 bottle of blood for each vial of gamma globulin; antihemophilic globulin is now also available, and each unit of this requires approximately 4 bottles of blood. It can thus be seen that blood donations far in excess of those required for whole blood transfusions are essential if the full benefits of blood are to be made available to the medical profession and so to our people. During 1959 the Maritimes Depot was able to send 2,285 liters of plasma for fractionation purposes. In spite of this, as is well known, the fractionation products are in limited supply.

An additional service offered by the Red Cross Blood Transfusion Service is a free maternal-foetal incompatibility investigation service. During 1959 over 11,000 blood specimens were examined and over 300 of these contained abnormal antibodies; the latter were from 172 different mothers, 81 of whom were tested for the first time in 1959. It is felt that this service is a very vital one for the detection of maternal sensitization and thus for the reduction of infant mortality from erythroblastosis foetalis. It is interesting to note that blood specimens were submitted by 210 doctors of this province during 1959; the question arises as to whether or not this includes all of our profession who do obstetrics within their practice.

I trust that in this brief resumé I have given you some insight into the activities of your Blood Transfusion Service. I feel that you must agree that it is one of the greatest public health and medical services which our country enjoys. I think that you would agree that the availability of free blood transfusions has been one of the major factors in the revolutionary advances which we have seen in medicine and surgery during the past decade. If you do, then I trust that you will bear with me in my appeal to you as a colleague and as a member of the medical profession, that you voice your approval of the programme and especially of blood donation to the many with whom you come in contact within your community. The medical profession has great influence; in this particular matter its influence is tremendous! If we are to have available to us the increasing amounts of blood and blood-products that we consider necessary, then we must encourage its donation. This vital product cannot be manufactured nor can animal sources be used; human donation is the only answer. This service represents a form of "Sickness and Accident Insurance" for ourselves and our loved ones. Should we not be interested? Everyone must realize that if he wants the health and life-saving security provided by blood, then he must help to pay the premiums—volunteer blood donations. Although 35% of our population are potential donors with respect to age and health, it should be noted that at present only 15% donate. Do you not agree that too few are bearing the burden for the many? Are you, your friends or your patients' friends and relatives in arrears? Remember—March is Red Cross Month and every week is Blood Donor Week!

MARITIME MEDICAL CARE INCORPORATED

NOTES

Probably every participating physician has had, at some time, an account returned by M.M.C. with the notation "baby not registered." Many physicians do not understand how this situation can arise, particularly since M.M.C. may already have paid for the confinement, and therefore presumably know that a baby has been born to the subscriber in question. The event of being born does not, however, automatically entitle that baby to M.M.C. benefits. It is necessary that the child be registered as a dependent of the subscriber, under his or her full and correct name, before he can be covered by M.M.C.

Responsibility for registration of new-born children, under the terms of subscriber's agreements, lies with the parents who must notify the company in writing in order to register the child for benefits. This must be done within thirty days following the birth. Subscribers sometimes appear very dilatory in registering new-born infants. In a few painful incidents the child may be still-born or survive for only a short time, and is thus not registered. In other instances the registration is not made because it may involve an increase in premium, as in the case of a first-born child. In other instances the subscriber may be confused as to his responsibility in this regard, having failed to properly read his contract. It is perhaps understandable that a subscriber could forget to register his child with M.M.C. having already been required to register with vital statistics, Family Allowances, and perhaps other agencies.

In view of the foregoing it has been the policy of M.M.C. to accept the first account submitted for an unregistered infant. At this time a "baby letter" is sent out to the subscriber, pointing out his responsibility, and inviting him to register the new-born. If the subscriber does not comply with this request, subsequent accounts for the baby are refused and returned to the submitting doctor.

To date we have been unable to improve on this procedure, although from time to time suggestions have been made, such as making it the responsibility of the attending physician to register new-born children. The difficulties of such a procedure are quite obvious in that it would add more load to the doctor, and probably result in inaccurate reporting as to name, etc. We are, however, open to suggestions in this regard, and give the assurance that all suggested improvements will receive due consideration.

G.B.S.

ANNUAL MEETING—1960

HOUSING APPLICATION FORM

The Medical Society of Nova Scotia

White Point Beach Lodge,
Queen's Co., N. S.
June 27th., 28th., & 29th, 1960

DR. L. A. MacLEOD,
Liverpool, N. S.

Please reserve for me the following accommodations—

A. **Main Lodge**
Double room with bath—including meals—$10.00 a day per person.

B. Cottage with single bedroom for two people—including meals—$10.00 a day.

C. Cottage with two bedrooms for four people, including meals—$9.00 a day.

I WILL EXPECT TO ARRIVE JUNE ..... A.M. ..... P.M.

I WILL EXPECT TO DEPART JUNE..... A.M. ..... P.M.

Name of persons who will occupy above accommodations:

Name (Dr. and Mrs.) .....

Address .....

In view of large attendance expected, no single rooms will be available at White Point Beach Lodge unless cancellations permit. If coming alone and willing to share a room please check here..... If you have a preference for some party to share a double room with (or couple(s) to share cottage with) please insert name(s) below:

I would prefer to share accommodation with

Name .....

Address .....

Name .....

Address .....

This form valid until May 15, 1960. After that date the committee assumes no responsibility for rooms.

Confirmation of Accommodations

Dr. and Mrs. .....have reservations as follows for White Point Beach Lodge.

Cabin No.....

Room No.....

Date .....

SCOTIA BREEZE*

J. W. REID, M.D.

Halifax, N. S.

Mr. President, Your Honor, distinguished guests, ladies and gentlemen. May I first say how happy we are here in Nova Scotia to welcome to Halifax and to Dalhousie this first regional meeting of the Royal College. We are particularly pleased because it is an October meeting and because it brings together so many Fellows and friends from our neighbouring provinces. We realize that circumstances related to hard work and responsibility in College affairs dictated the change in the time of the Annual Meeting from the fall to January, and we also appreciate that the sharp, frosty atmosphere of the central Canadian winter complements the sharp and icy-clear intellects of the officers of the College. We further realize that those *born* to such inclemency bear it with equanimity, and that those from the mid-west would happily go to a meeting anywhere to escape for a few days from the rigors of their own climate; but for those from the Pacific or Atlantic coasts, it is a sad exclusion, the average aging coast dweller requiring a mellower atmosphere to turn him to his journey. Anyhow we hope that this Eastern meeting will continue as an Autumn gathering. Those of us with good Red Indian blood still in our veins recall the lines of Carman,

"There is something in the Autumn that is native to my blood,
Touch of manner, hint of mood,
And my heart is like a rhyme,
With the yellow and the purple and the crimson keeping time."

It is indeed a season to hunt knowledge as well as moose, and what can you get in January but a few pale bunny rabbits! ! !

We are also happy because this meeting gives us a feeling of participating in an event of national significance, a feeling all too rare in Nova Scotia between wars, when we sometimes begin to feel like the strip of tooled and gilded leather that limply marks the place between the pages of the book of national achievement.

It has been unkindly said by persons from otherwhere that enterprise and achievement passed from Nova Scotia with the departure of the last of the wooden ships and iron men; and they further say that the foam in the wake of that scudding windjammer swelled into a great froth and congealed into a scum of iron ships and wooden-headed men. It is also intimated that numerous splinters succeeded in passing the placental barrier, appearing in successive generations and establishing a new regional disease known as "Atlantitis Lethargica."

Much thought has been given to the cause and cure of this condition by politicians, statesmen, cabinet ministers, Royal Commissioners, scientists and psychiatrists. There are two current theories of etiology. The first promulgated by nutritional scientists, is that the condition is due to an inborn error of metabolism brought about by a suboptimal intake of dried peas, salt meat, and rum in an organism long conditioned to its digestive end-products, and that this suboptimal intake is in turn consequent upon the more rapid passage between ports of call achieved by steam navigation. It is a sobering fact

*Address delivered at the President's Dinner, Eastern Regional Meeting, the Royal College of Physicians and Surgeons of Canada, Halifax, October 30, 1959.

that prolonged and intensive therapeutic trials ashore, using mostly rum and lobster have entirely failed to reverse this disorder. Some hope for the future, however, may be expected from frequent inoculations with an attenuated strain of the organism "Smallwoodia Josephicans"!

The second theory is based on the concept of mental conflict. The Nova Scotian, having been always a sturdy, hard-working, conscientious individual, was so long inured to the rugged life of sail, that he was unable to accept readily the easy wages and profits which accompanied the soft life of steam navigation. The more he thought of it the more his conscience bothered him, and this conflict grew into a state of complete psychosomatic inertia. The keenest clinical observer and the most profound psychologist of all time described this etiological sequence hundreds of years ago when Shakespeare had the Prince of Denmark say:

"Thus conscience does make cowards of us all;
And thus the native hue of resolution
Is sicklied o'er with the pale cast of thought,
And enterprises of great pith and moment
With this regard their currents turned awry,
And lose the name of action."

Thus you can see that our disorder is both an ancient and an honorable one.

Another reason for our joy in this meeting is that our childish minds sense something of a Yuletide setting in this gathering. It is perhaps suggested to us by the presence here of the members of the Council from beyond our borders, and we are led to think of the lovely legend of the first Christmas in this journey of the 'Three Wise Men' To the East! And as we picture these gowned and turbaned Caliphs of the College, led by the bright star of Maritime intellect, riding their winged camels through the desert places of the air, we know that they bear with them their treasures of colds, and common-sense and mirth to offer at the cradle of Canadian culture in Nova Scotia!

The third joy we feel in this meeting is due to the excellence of our guest teachers and is akin to that which a creditor must know who sees at last a substantial payment made on a long overdue account. For over a hundred years we in Nova Scotia have been sending the brightest blossoms from our "garden of the mind" to carry beauty and much-needed light to the gloomy intellectual barrens of New England, and Central Canada, and the great desert places of the West! You can imagine our happiness, then, to find, in these charming guests, the choicest petals of the flower of Medicine come drifting back to us on the tide. We are reminded again of Bliss Carman's lines in his *Low Tide on Grand Pre*,

"The sun goes down, and over all
These barren reaches by the tide
Such unelusive glories fall,
I almost dream they yet will bide
Until the coming of the tide.

And yet I know that not for us
By any ecstasy of dream,
He lingers to keep luminous
A little while the grievous stream
Which frets, uncomforted of dream. . ."

We should like very much to have you all bide with us a while here by the old Atlantic tide, and illumine our lecture halls and wards with your teaching, but we know that that cannot reasonably be.

To show our appreciation of your generous contribution to this meeting, it is our pleasure to present to you, our guests, some slight remembrance as a token of our esteem.

In earlier times, when our forests rang with the thunder of the bull moose and big game hunting was a thrilling adventure, it was our custom to present a gift of shooting targets, pressed out of the finest Nova Scotian clay, in the shape of a bull moose, rampant. This gift was offered in the hope that our departing guests would continue as skillfully at home, as they had done while with us, to shoot the bull—ah—moose!

Now, alas, the moose have left our forests and big game hunting has become a matter of sneaking into the woods to try for a timely pot shot at the boss! So we have turned to something much more truly Nova Scotian for your gift. It is a priceless commodity for which the people of this province endure hardship, poverty, and hunger to possess, and which our exiles will cross mountains and rivers, lakes and burning prairies to obtain. It is a delightful thing, with aspects as variable as a maiden's moods and as numerous as a politician's promises. It may be calm or turbulent, soft or stiff, still or drifting, dry or humid, hot or cold, expansive or compressed, and so is capable of being blown or shot off.

We have been at great pains to package this material and gift-wrap it for you, in the hope that it will replace any that you may have lost through overheating during your stay with us.

Pray accept this can of Pure Nova Scotia Air!

J. W. REID.

HEALTH INSURANCE

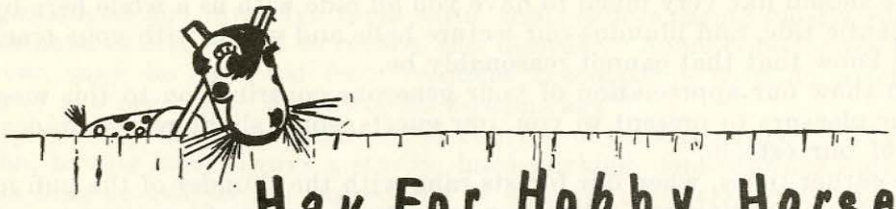
Questionnaire to all Physicians in Canada

About the end of February, 1960, a questionnaire will have been distributed by the Canadian Medical Association to all physicians in Canada.

The purpose of this questionnaire is to elicit the views of each physician on the very important subject of Health Insurance. It has been carefully prepared. The final form is the result of three revisions and a "dry run" to some 200 physicians. It is the opinion of consultants and C.M.A. that the final questionnaire is intelligible and interpretable.

You are earnestly requested to give to the questions and your answers the careful consideration which its purpose merits. Please complete and return it.

C.J.W.B.



Hay For Hobby Horses

A Letter to a Young Spartan

Dear Jimmy;

I am glad that you have decided on general practice. I tried to keep out of your decision and you may have been troubled by my apparent unconcern. This choice like most others early in life is an act of faith. You could not possibly know enough about yourself or the profession to choose it for the correct reasons. I will spare you the usual pious phrases trotted out on occasions like this, dedication to suffering humanity, devotion to high ideals etc., not because these attitudes do not exist but because at your time of life a man finds such talk faintly embarrassing.

I'm glad you want to be one of us. There is no job in the world like it. Your career in medicine will be whatever you can make out of it. Certain sanctimonious old maids (of both sexes) would have you believe that all medical doctors are touched with holiness. This is unrealistic. We have a much higher proportion of saints, or better still, of men with an unselfish devotion to the welfare of our fellows than do other professions but we also have frustrated accountants, sticky-fingered entrepreneurs and plodding failures. Our long course of study and the admissions committee discourage many (but not all) of the undesirables.

We can use any of the talents the Creator blessed you with in medicine. You don't suspect it from the outside but this is not *one* profession but ten-thousand-in-one. In a large medical center almost 40% of the doctors on staff (M.D. and Ph.D.) never come in direct contact with the patient. Henry Plummer, one of the giants of my post-graduate school, was a frustrated engineer. His father took him into medicine but what a triumphant life Henry made from the blend of engineer-inventor-physician. It is not narrow, Jimmy, this world seen through medical eyes. Bring what ever you have, add it to our inheritance and create a newer miracle.

My pleasure in seeing you begin your medical career in general practice will not be lost even if you leave it after a few years to return to a university hospital for further training. As a family physician, you will discover what the people want from their medical advisers. Their needs run far beyond the hospital-taught notions of diagnosis and therapeutics. You will understand why the obligations of the profession were originally assumed and why our ancient guild must survive to provide them in the future. Because I believe in the need for good physicians in whatever future is left to us, I offer this sober advice on a subject no one ever mentioned to me, certain aspects of our relationship with our masters, the Canadian people.

Learn as much as you can about the society in which you will soon practice. Frequently these days doctors say, "The government will soon take over medicine. I would not encourage any boy to go into the profession. The profession as we know it is finished." If these grim forebodings are accurate, more than ever the profession needs the *best* young men to main-

tain our essential freedoms during the difficult days ahead. Socialized medicine under its many synonyms is being widely discussed, rationally and irrationally, at all levels in the profession. The spectre of government participation in the provision of medical care in Canada has become palpable since Premier Douglas made it part of the programme of his party in Saskatchewan. If you are to be a Spartan at Thermopylae you must know what things are worth fighting for so that in future you can stand on (and for) *realities.* Hug this advice to your bosom.

1. Do your homework on Health Insurance faithfully. Learn as much as you can about the three methods of providing health care. (a) private purchase, the fee-for-service arrangement that is the basis of our current practice (b) prepaid health insurance like our Maritime Medical Care or Blue Shield and finally (c) government sponsored health care as represented by the activities of the Nova Scotia Hospital Insurance Commission, the Department of Veterans Affairs or the National Health Service in Great Britain. If you don't know this basic material then keep still. The average minor official in the labor movement can make the unprepared physician look like a reactionary ass because labor gives its members some indoctrination.

2. Insist on a clear definition of terms early in any discussion. Avoid vague or loaded terms like doctor-patient relationship, State medicine, free medical care, red tape and waste. Health insurance is a good general term to begin with. A thorough search for a comprehensive definition often resolves superficial differences. Encourage your opponent to set out his plan in detail and examine it using these criteria (a) is it based on the insurance principle? (b) what method is proposed to cover the cost of the plan? (c) who determines the method and scale of payment to the physician? (d) has the program covered ancillary physical and personnel requirements for increased service?

3. When your opponent says that plan X will work here because it worked well in New Zealand, Sweden or Pago-Pago remember the advice of Tacitus "Refer each thing to its own hour." A medical care plan is a complex excrescence of the social organism. A given plan is appropriate to the social structure from which it comes. It cannot be grafted to another.

4. Don't assume that the physician or organized medicine has a God-given monopoly on all matters affecting health. Health and medical care are everybody's business. If the people of Canada decide they want a government-sponsored medical care we must oblige or abdicate. We will work with their representatives to design the best possible plan for Canadians but we cannot say "our way or *else.*"

You are welcome to my own views on the immediate future of our beloved profession if you wish them later. I am sending under separate cover the paper Profession or Business (Means J. H., N.E. Med. J., Oct. 15, 1959. Vol. 261, No. 791) and Honor a Physician (Philip Auld. London. Hollis and Carter 1959). The latter is a harrowing account of the life of a family physician under the National Health Service of Great Britain. I suspect it is a bit over-done but nevertheless an important book.

Good luck in medicine

As ever,

TIMOTHY

PERSONAL INTEREST NOTES

The Physician's Art Salon Committee cordially invites Canadian physicians and medical undergraduates to enter paintings, photographs, or color slides in the 1960 salon to be held in Banff Springs Hotel, June 13-17. This will mark the 60th year this interesting art and photographic feature will be held at the Annual C.M.A. convention. It is again sponsored by Frank W. Horner, Ltd., Montreal, Quebec.

Conditions of entry: entries will be accepted in three sections—

1. Fine Art; 2. Monochrome Photography; 3. Color Photography. The Fine Arts section is further subdivided into three catagories—traditional, contemporary (modern), and portrait. Classification into these catagories is done by the judges. There is no restriction on media, oil, tempora, gouache, water color, charcoal, pencil, or dry brush is acceptable in each.

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

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, Quebec. A short note or post-card will bring the form with complete instructions on how to prepare and ship your entries.

Halifax Medical Society

February 10, 1960—Fourth Regular Meeting at Halifax Children's Hospital. The clinical presentation was, "Acute Laryngo-Tracheo Bronchitis," presented by Drs. W. A. Cochrane, Joan Crosby, K. Aterman, and "Retropharyngeal Abscess" by Dr. N. B. Coward.

The threatened resignation of twenty-two of the twenty-eight nurses in the operating room section of the Victoria General Hospital, because of inadequate salaries, has received a great deal of local publicity. The Civil Service Commission currently has the question of provincial employees—including nurses—salaries under consideration.

Dr. Arthur Murphy, Halifax, will have his second television play presented on the C.B.C. within the past year. The play, entitled "The Death Around Us" (presented March 6/60) concerns a mysterious infection that begins with the death of a 17 year old, and which cripples an entire hospital, forcing the chief surgeon to enforce rigid emergency.

Western Nova Scotia Medical Society

Dr. Ian Bruce, formerly of Dartmouth, has taken over the practice of the late Dr. Andrew Weir. Dr. and Mrs. Bruce were introduced to the medical fraternity at an "at home" by Drs. Webster and Colwell, recently.

University

Dr. Leon Cudkowicz has recently been appointed Associate Professor of Physiology and Associate Professor of Medicine (Research) and Director of the Cardio-Pulmonary Unit. Dr. Cudkowicz is a graduate of the University of London (M.B., B.S. 1946, M.D., 1951, and MRCP 1954). He spent from

1946 to 1956 taking post graduate training in Internal Medicine, spent the following two years doing research at Yale and Harvard, and just prior to coming to Dalhousie he was Registrar in the Cardiac Department of St. Thomas Hospital, London, England.

Births

Dr. and Mrs. Michael MacSween, a son, Michael Joseph, Halifax Infirmary, February 24, 1960. A brother for Louise Marie.

Dr. and Mrs. Donald Seaman (nee Joan Campbell), a daughter, at City of Sydney Hospital, February 16, 1960.

Dr. and Mrs. John B. Steele (Patricia Nicholson), a daughter, Rebecca Lynn, at Dawson Memorial Hospital on February 27, 1960.

Dr. and Mrs. J. M. Williston, a daughter, Lorraine, at Aberdeen Hospital. A sister for Royce.

Marriages

Jan., 1960—Dr. Irwin J. Nudelman, formerly of Halifax, to Brenda Rachelle Silbert, Baltimore, at the Blue Crest North, Pikesville, Maryland. Dr. Nudelman is presently taking post graduate studies in Baltimore.

Coming Meetings

April 13, 1960—Halifax Medical Society—6th Regular Meeting—Nova Scotia Hospital.

May 31-June 2, 1960—Canadian Public Health Association—48th Annual Meeting—Halifax, N. S.

June 13-17, 1960—Canadian Medical Association—93rd Annual Meeting—Banff, Alberta.

June 27-29, 1960—The Medical Society of Nova Scotia—107th Annual Meeting—White Point Beach, N. S.

Obituary

Dr. Joseph Anthony Donahue, Truro, died on December 26, 1959. A Dalhousie Medical graduate (class of 1939), he had practiced for the past 16 years in Truro, and previously in Barrington Passage and Shelburne. He was born in Rosemeath, P.E.I.

Dr. Frank C. Hazen, East Riverside, N. B. died on January 8, 1960. A Dalhousie Medical graduate (class 1944), he was at the time of his death, St. John District Medical Health Officer. He was born in Newcastle, N. B.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of December, 1959

	NOVA SCOTIA				CANADA	
	1959		1958		1959	1958
	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	1	0	0	0	6	8
Diarrhoea of newborn, epidemic (764)	0	0	0	0	5	0
Diphtheria (055)	0	0	0	0	8	7
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	71	0
(c) Unspecified (048)	0	0	0	0	3	0
Encephalitis, infectious (082.0)	0	0	1	1	1	0
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	0	0	0	0	0	0
(c) Unspecified (049.2)	1	0	0	0	23	0
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	101	0	37	0	379	0
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	0	0	0	0	22	0
Meningococcal infections (057)	0	0	0	0	9	43
Pemphigus neonatorum (Impetigo of the newborn) (766)	0	0	0	0	1	0
Pertussis (Whooping Cough) (056)	15	1	0	0	537	815
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0	58	3
Scarlet Fever & Streptococcal Sore Throat (050, 051)	89	0	169	0	2105	1508
Tuberculosis:						
(a) Pulmonary (001, 002)	28	2	15	0	337	847
(b) Other and unspecified (003-019)	2	1	3	0	82	56
Typhoid and Paratyphoid Fever (040,041)	0	0	0	0	13	24
Venereal diseases						
(a) Gonorrhoea—						
Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	33	0	24	0	887	1506
(b) Syphilis—						
Acquired—primary (021.0, 021.1)	0	0	0	0	0	0
—secondary (021.2, 021.3)	2	0	0	0	0	0
—latent (028)	1	0	0	0	0	0
—tertiary — cardiovascular (023)	1	1	0	0	0	0
— ,, — neurosyphilis (024, 026)	1	0	0	0	0	0
— ,, — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	0	0	3*	1	149*	187*
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases:						
Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Pssitacosis & ornithosis (096.2)	0	0	0	0	0	0
Rabies in man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial infections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	0	0	0	0	0	0
Trichinosis (128)	0	0	0	0	0	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0
Other	0	0	2	0	0	0

C — Cases D — Deaths

*Not broken down