

The NOVA SCOTIA MEDICAL BULLETIN

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EDITORIAL

PHYSICIAN OR EMDEE?

R. L. Stevenson, in his dedication of a volume of poems, *Underwoods*, pays an unforgettable tribute to the medical profession,

"There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarer still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when the stage of man is done with, and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heracleian cheerfulness and courage. So it is that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing."

This tribute is the more meaningful because it comes from a man who suffered a great deal throughout his relatively short life (he died at 44) and who had little benefit from the medical science of his day. Did the majority of our profession ever merit such high praise? Is it realistic to hold up such high ethical standards to future aspirants to the profession?

The good physician is a member of one of the learned professions bound to serve humanity by the practice of an art and science accumulated, conserved and extended by his predecessors. He is a great deal more than an individual with an M.D. degree . . . how much more depends on the individual's intuitive grasp of the traditional nature and role of the priest-physician. The hallmark of a true professional is the service he will render beyond that which the law can compel of him. The good physician will render the best service of which he is capable, out of a devotion to his concept of the grand tradition to which he has voluntarily apprenticed himself, indifferent to appreciation or reward. Such a man is the flower of our profession in any age.

At the opposite pole from the faithful, dedicated and competent physician who stands on the shoulders of his predecessors to serve mankind better is another kind of doctor. A cynical definition might run like this. "A medical doctor is a self-seeking individual who slips through the coarse meshes of the net of a medical school curriculum, acquires the degree of Doctor of Medicine, and thereafter is not caught committing murder or does not become violently insane." This definition points up some of the temptations to which we are subjected, the fallibility of our system of pre-professional selection and the indifferent machinery for maintenance of professional standards after graduation. The doctor of medicine retains his awful powers

(Continued on page 173)

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to his dotage and beyond. His privileges are rarely subject to review or recall.

How should the hard-working committee on admissions of the Faculty of Medicine be guided? Are they to believe that all academically-qualified young men and women are equally capable of becoming good physicians? For the student's part, is it necessary to accept the burdens of the guild of physicians when one wishes no more than a good living at the "doctor business?" In a provocative but pseudepigraphous paper (Haig-Edd, J.P., *The Trials of the Perfect Profession*, Bull. Med. P. R., XV, 2, 57-63) the author proposes that the medical student have a choice between a vocation and an occupation. He can elect to become a physician and serve humanity, holding himself responsible for all the traditional obligations of his profession or he can become an "emdee" presumed to be capable of providing the same service as the physician but free of any greater obligation than "giving a day's work for a day's pay."

How good is the average physician in Canada to-day? Definitive measures of the criteria of good medical practice are essential if acceptable standards are to be maintained. At present a man need do little to retain the rights and privileges of a physician after graduation. The emdee need never open his books again and is not obliged to subscribe to a medical journal. He may attend conventions solely for the purpose of rising by time-serving into the upper levels of the medical political hierarchy, or to enjoy the golf and after-hours recreation. The medical profession endures its erring and incompetent members with tireless tolerance. If the medical schools occasionally confer their degree on an inadequate, undisciplined or unbalanced individual, can we assure the public that the machinery now exists to protect the public from such a man? This problem aside, the necessity of maintaining standards would persist, for even the finest graduate from a Grade A medical school is not a finished product and, at best, he has been taught only how to teach himself.

The public is curiously ambivalent about our profession. The individual loves his own physician but distrusts organized medicine ("the faceless multitude"). Would a distinction between kinds of medical doctors, like Haig-Edd's physician and emdee, solve any of our problems in medical public relations? We have led the public to expect far too much of many medical men by encouraging the myth of the immaculate profession. Many of the utterances of organized medicine and certain kinds of para-medical educational material imply that all doctors are equally trustworthy, equally well-trained and alike dedicated to the highest traditions of the profession. This is unrealistic. The average citizen, on reflection, knows it to be untrue. The myth of the immaculate profession will carry increasing risk in the continuing absence of machinery for intra-professional discipline.

There are rough times ahead in medicine. We will need the best men we can attract to the profession to maintain standards in the face of third-party participation in medical care. The profession will need the faith and loyal support of the public to maintain its essential freedoms. We cannot merit that faith unless we demonstrate the ability and desire to maintain the highest standards of medical practice through the exercise of greater self-discipline.

SURGICAL TREATMENT OF DIVERTICULITIS*

BENTLEY P. COLCOCK, M.D.

Boston, Mass.

Less than 25 years ago the surgical treatment of diverticulitis was associated with a mortality rate as high as 50 per cent. At the present time the mortality rate approaches 0. While many factors have played a part in this remarkable change, most of the credit must be given to improved surgical technique. Surgeons treating this disease have long realized that patients with the complications of diverticulitis, such as obstruction, perforation or fistula, may die if a direct surgical attack is made upon the disease process. On the other hand, if a proximal colostomy is carried out and sufficient time is allowed for the inflammatory process to subside, the diseased colon can be removed with few, if any, deaths.

Several important points should be emphasized concerning the staged surgical treatment of diverticulitis. (1) The proximal colostomy should be made using the transverse colon just beyond the hepatic flexure. Thus, at the subsequent resection, the colostomy will not interfere with mobilization of the splenic flexure if this is necessary. (2) Provided the presence of malignant disease has been ruled out, a period of at least four to six months should elapse between the time of the colostomy and the subsequent resection. (3) Even though all of the symptoms have subsided and the patient apparently is well, to close the colostomy without resection is to invite a recurrence of the disease. (4) At the time of the resection, removal of as much of the diverticula-bearing colon as possible will decrease the risk of recurrence. Thus, mobilization of the splenic flexure and resection of part or all of the descending colon as well as the sigmoid colon are frequently necessary. (5) If the acute inflammation has completely subsided and a good anastomosis can be secured after resection of the diseased bowel, it may be possible to close the colostomy at the same operative procedure. This should not be done, however, if there is any question regarding the integrity of the suture line. With a proximal colostomy, a small defect in the anastomosis will heal without difficulty. Without the proximal colostomy, a defect may lead to an abscess or a fistula.

Although the mortality rate of the surgical treatment of diverticulitis has been greatly improved, the morbidity rate remains high. Multiple operative procedures, a period of months with a colostomy during which time the patient may or may not return to work, and prolonged medical and nursing care represent a tremendous financial drain on any family.

A review of our experience at the clinic indicates that one of the reasons for the high morbidity rate is the continued use of operative procedures which are unsatisfactory for the surgical treatment of diverticulitis. In a group of 131 patients on whom we have operated for this disease during the last ten years, 40 patients or 30.5 per cent of the group had had previous unsuccessful surgery (Table 1). Frequently a patient had had an incision and drainage of an abscess caused by a perforation of the diverticulum, without a proximal colostomy. This, of course, resulted in a persistent fecal fistula. Excision of the fistula with suture of the perforation was then attempted. This usually results in another perforation and another colocutaneous fistula. They still had to have the colostomy, the resection of the colon and the closure of the

From the Department of Surgery, The Lahey Clinic, Boston, Massachusetts.

*Presented at the Dalhousie University Medical Refresher Course, October 29, 1959.

colostomy, which they should have had in the beginning. Some of these patients required as many as seven or eight operative procedures before they were cured.

TABLE I
UNSUCCESSFUL PREVIOUS SURGICAL PROCEDURES
(Excluding Patients Referred for
Definitive Operation following Colostomy)

TYPE OF PROCEDURE	CASES
Incision and drainage of abscess without colostomy	9
Suture of perforation or excision of fistula	8
Closure of colostomy without resection	10
Complications following resection	6
Miscellaneous	7
	—
Total	40

(30.5% of entire group)

It is obvious, however, that the staged operative procedure, itself, is associated with a high morbidity rate. One illustration of this is the number of days which the patient must spend in the hospital. In our experience, patients who required a three stage procedure had an average hospital stay of 60 days. For patients having a one stage primary resection, it was 15 days. For many years surgery has been reserved for the treatment of patients with diverticulitis who have a complication, such as a perforation, complete obstruction of the large bowel or a fistula into the bladder or vagina. These are serious complications and to avoid a fatality, the surgeon must accept the associated morbidity. On the other hand, if patients with recurrent or persistent diverticulitis are advised to have a resection of the diseased bowel before these complications occur, they can be operated upon safely by a one stage procedure. This group includes patients who are having recurrent attacks of diverticulitis which are increasing either in severity or in frequency; patients who show an increasing amount of distortion of the sigmoid colon on barium enema studies, and patients with diverticulitis who have urinary symptoms, such as dysuria. The incidence of complications is much higher in patients with diverticulitis who are 50 years of age.

The treatment of any patient with diverticulitis—whether it be medical or surgical, three stage or one stage—must be based on one essential point, namely that carcinoma has been excluded. The ages of patients with carcinoma of the sigmoid and diverticulitis are essentially the same. The sex incidence is the same. The symptoms of abdominal pain or discomfort, a change in bowel habit and rectal bleeding are very similar. When we realize that the sigmoid is the most common site for carcinoma of the colon and that diverticulitis in practically all cases arises in this same segment of the large bowel, it is not surprising that the two conditions may coexist. To employ conservative means or a colostomy with delayed resection in the treatment of a patient with diverticulitis who also has carcinoma is a tragedy. It has happened, it is happening and it will probably continue to happen. For many years we have relied on the barium enema study to distinguish between these two conditions. In our experience the roentgenologist cannot distinguish with certainty between diverticulitis and carcinoma in at least 15 per cent of these patients.

In another 10 per cent the lesion completely obstructs the bowel and will not be outlined by the barium. Unless it is possible to exclude carcinoma before surgery, the surgeon is placed in very a difficult situation. As we all know, it is frequently impossible, even with the lesion exposed, to determine whether it is benign or malignant. If the surgeon decides it is malignant and carries out an extensive resection of the mesentery of an acutely inflamed area of diverticulitis, he commits himself to a much more difficult operative procedure than is necessary. On the other hand, if he divides the mesentery, as he would for diverticulitis, and carcinoma is present, carcinoma cells may be disseminated from one end of the operative field to the other. In an effort to determine whether some help could be obtained from the history of these patients, we compared the records of 50 patients with carcinoma of the sigmoid and 50 patients with diverticulitis of the sigmoid (Table 2). There was little difference so far as age and sex are concerned; however, abdominal pain and colic were much more frequent in patients with diverticulitis than in those with carcinoma, and gross rectal bleeding was much more frequent in patients with carcinoma than in patients with diverticulitis. The duration of symptoms was also much longer in patients with the inflammatory disease.

TABLE 2
DIVERTICULITIS AND CARCINOMA OF THE COLON

	DIVERTICULITIS	CARCINOMA
Age	53.5 years	61.5 years
Sex	62% males	46% males
Abdominal pain	74%	26%
Abdominal colic	80%	38%
Rectal bleeding	22%	64%
Duration of symptoms	40.2 months	8.5 months
Nausea and vomiting	} higher	
Chills and fever		

One hundred thirty-one patients have been operated on for diverticulitis at the Lahey Clinic during the last ten years; 74 were males and 57 females, which is about the usual sex distribution. The ages ranged from 30 to 77 years, as would be expected in patients with diverticulitis. Since it has been estimated that only 5 to 10 per cent of all patients with diverticulitis are under 50 years of age, it is significant that 25.2 per cent of our patients were under 50 years of age. Thus, a complication of diverticulitis or recurrent or severe disease requiring surgical intervention developed in a significantly larger number of patients in the younger age group. The age is of significance in deciding for or against surgery in patients with persistent or recurrent diverticulitis. It should also be noted (Table 3) that over 56 per cent of these patients who came to surgery because of diverticulitis had had symptoms of the disease for over a year.

Most patients with diverticulitis give ample warning of the persistence of their disease. The fact that primary resection and anastomosis could be carried out in 52.6 per cent is evidence of our conviction that more of these patients should be operated on before obstruction or a perforation of the colon develops. If primary resection is advised for patients with diverticulitis, however, it must be shown that the operation can be done without increasing

the mortality rate. The mortality rate for the entire group of 131 patients was 1.5 per cent (Table 4). One hundred and two of these patients were operated on during the last seven years and no deaths have occurred during that time. Sixty-nine patients have had a primary one stage resection of the diseased colon with no deaths. The two deaths in the series occurred more than seven years ago. They illustrate the problem presented by the possible coexistence of carcinoma. Both patients had had a perforation of the colon and carcinoma could not be excluded. Accordingly, the lesion was resected within three weeks after the proximal colostomy was established. A marked inflammatory process was still present and peritonitis developed in both patients following resection. One patient died six months later from continued sepsis; the other patient died three weeks later from a cerebrovascular accident. If this patient had not had a peritonitis secondary to an extensive operative procedure carried out in an infected field, the cardiovascular complication might not have occurred.

TABLE 3
DIVERTICULITIS—10 YEARS' EXPERIENCE
131 Patients

SEX DISTRIBUTION		
74 males		57 females
AGE		
30 to 77 years; 25.2% under 50 years		
	CASES	PER CENT
DURATION OF SYMPTOMS		
Over 1 year	74	56.5
TYPE OF RESECTION		
One stage	69	52.7
Two stage	20	15.3
Three stage	27	20.6

TABLE 4
MORTALITY

	NUMBER OF PATIENTS	DEATHS	
		NUMBER	PER CENT
Total	131	2	1.5
Last 7 years	102	0	0
One stage resection	69	0	0

SUMMARY

The mortality rate for the surgical treatment of diverticulitis is extremely low at the present time, largely as a result of diversion of the fecal stream by a proximal colostomy which allows the acute inflammatory process to subside completely before the diseased colon is removed. It is now time that surgeons accepted the challenge of reducing the high morbidity associated with the surgical treatment of diverticulitis. This can be done by eliminating those operative procedures which are known to be unsatisfactory for the treatment of diverticulitis and by advising patients with persistent or recurrent attacks of this disease to have the diseased bowel resected before perforation, obstruction or a fistula occurs.

OBSCURE CARDIOMEGALY*

IAN G. MILNE, M.D.

Montreal, Canada

In recent years at the Montreal General Hospital, we have been increasingly faced with problems of differential diagnosis of Cardiomegaly in the young adult. In the absence of evident congenital abnormality or rheumatic heart disease, these are difficult problems. Previously, the labels of Idiopathic Hypertrophy or Obscure Cardiomegaly were applied, but as our knowledge improves our terminology becomes more precise. However, in many cases, even after careful necropsy, the actual cause of the Cardiomegaly may remain unknown.

Recently we have come to focus on a group of conditions which have been recognized with increasing frequency as causes of Cardiomegaly in the second to fifth decade. These conditions cannot be classified at present but are characterized by varying degrees of endocardial thickening and interstitial myocardial fibrosis and scarring. Two broad groups are being described in the literature, namely, those which morphologically resemble congenital endocardial fibro-elastosis and secondly, cases where endocardial fibrosis and elastosis are associated with diffuse interstitial myocardial fibrosis. The latter cases are now being described under the term "endomyocardial fibrosis."

Our first case is representative of the lesions of "endomyocardial fibrosis" in the adult. *Case 1.* The patient was a 33 year old male. At age 19, the patient was declined insurance because of tachycardia at rest with a pulse irregularity. The electro-cardiogram at that time showed a wandering auricular pacemaker and tracings suggestive of right ventricular hypertrophy. He was subsequently accepted for Army service at age 20 and discharged one year later because of slight cardiac enlargement and an apical systolic murmur. However, he continued asymptomatic until his first admission at age 27 when he developed acute pulmonary oedema associated with a ventricular tachycardia. The course over the next six years was characterized by repeated admissions for recurrent acute congestive failure and syncope, believed to be Adams-Stokes attacks. He died suddenly at home at age 33.

Chest radiography (Fig. 1.) showed generalized cardiac enlargement involving all chambers, and at fluoroscopy the cardiac pulsations were noted to be faint in character. The E. C. G. in later years showed a left ventricular strain pattern. Cardiac catheterization showed only moderate elevation of right heart and pulmonary pressures and the pressure curves showed normal configurations.

At necropsy the heart weighed 885 gm. The endocardium of the right ventricle and auricles was grossly normal. The left ventricle was grossly dilated and hypertrophied, and the endocardium showed areas of patchy thickening and even an area of calcification of the endocardium was noted. (Fig. 2) The coronary arteries were patent and the valve leaflets showed no lesion. On section, the thickened endocardium is composed of dense

*From the McGill University Clinic, The Montreal General Hospital.

Presented at the Atlantic Regional Meeting of the Royal College of Physicians and Surgeons, Halifax, October 30-31, 1959.

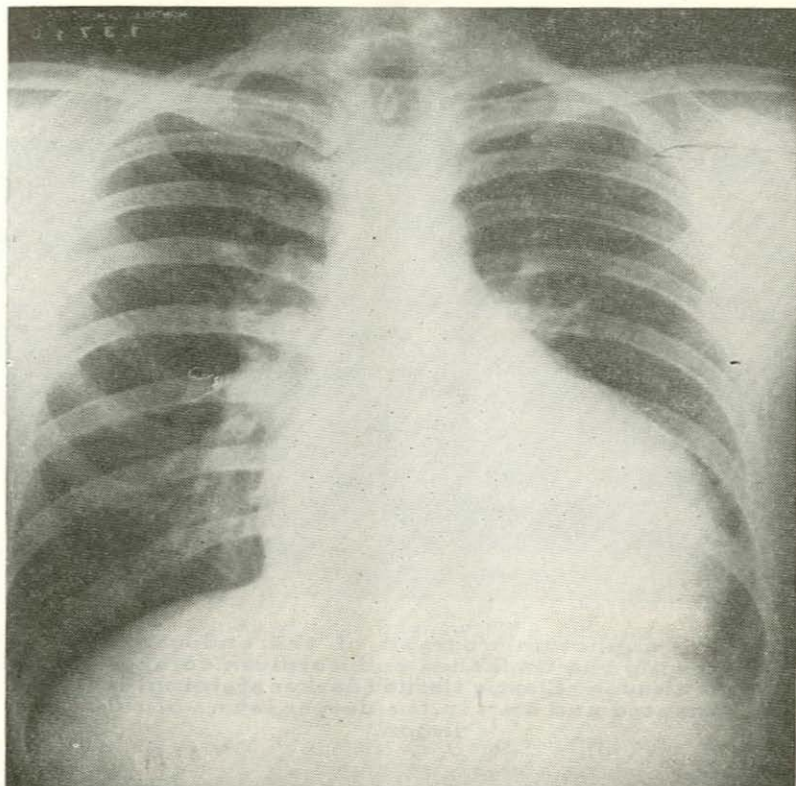


Fig. 1. Case 1 — chest radiograph showing generalized cardiac enlargement

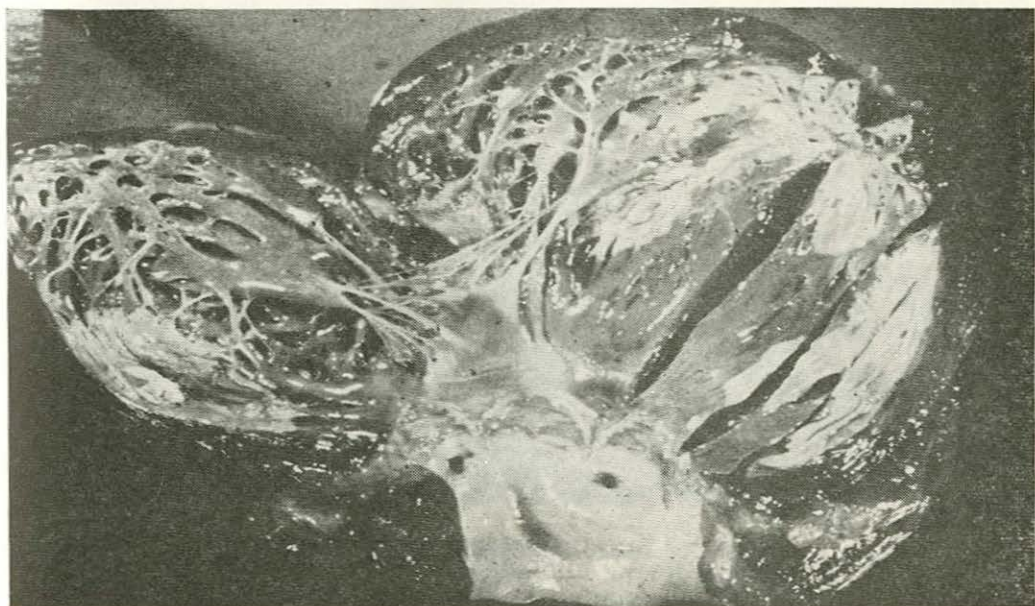


Fig. 2. Case — the endocardium of the left ventricle shows patchy thickening with a small area of endocardial calcification.

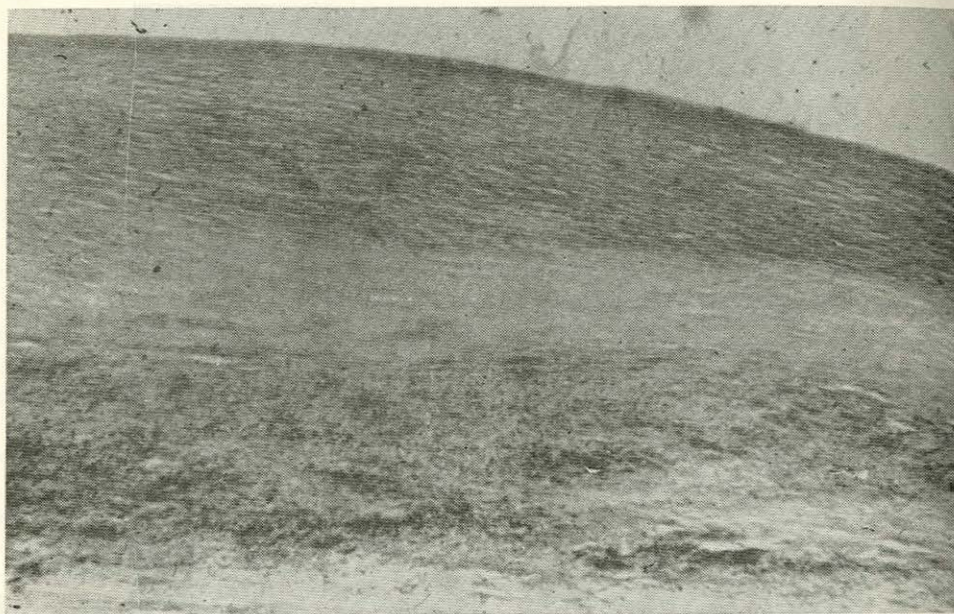


Fig. 3. Case 1 — a photomicrograph of the endocardium of the left ventricle showing the thickened endocardium composed of dense fibrous tissue. Elastic tissue (darker staining) is fragmented and seen in the deeper layers of the lesion.

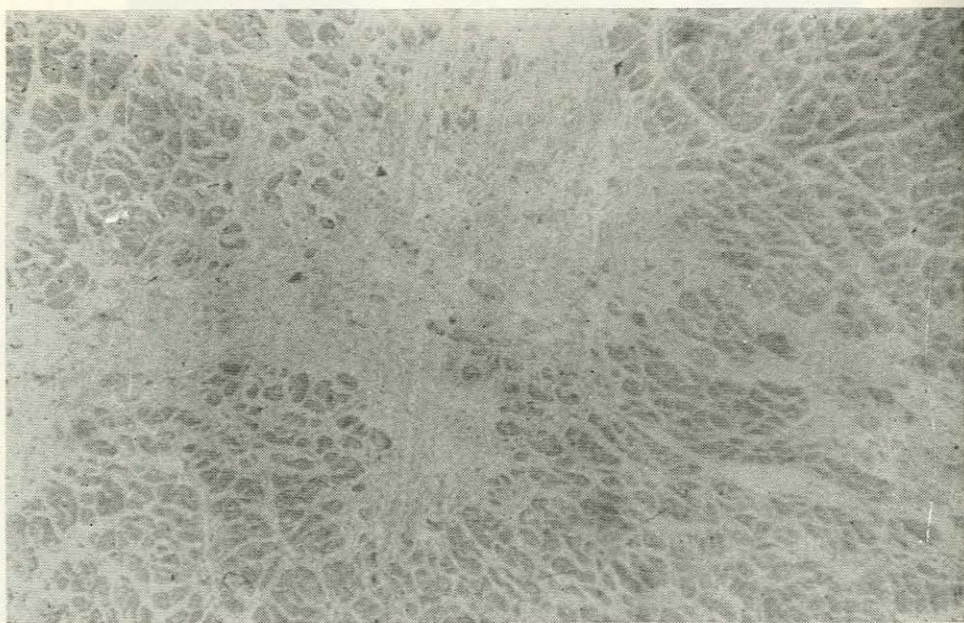


Fig. 4. Case 1 — a photomicrograph of the myocardium of the left ventricle showing diffuse interstitial fibrosis.

and moderately cellular fibrous tissue without inflammatory reaction. Elastic stains showed abundant elastic tissue in the endocardium but it is fragmented and seen only in the deeper layers of the lesion. (Fig. 3) A feature of the sections was the diffuse interstitial fibrosis which extended throughout the inner half of the myocardium incorporating atrophic muscle fibers. (Fig. 4).

The second case is representative of the group morphologically similar to congenital endocardial fibro-elastosis. *Case 2.* The patient was a 19 year old male. He had been performing hard manual labor until three months prior to admission and was entirely asymptomatic. He then suddenly developed paroxysmal nocturnal dyspnoea and rapidly progressed to severe congestive failure with generalized anasarca. When transferred to our Hospital, he proved unresponsive to therapy and died within 9 weeks. The chest radiograph and fluoroscopy showed generalized cardiac enlargement, again with the cardiac pulsations being markedly diminished. The E. C. G. showed right axis deviation with non-specific left ventricular myocardial changes. (Fig. 5) shows the findings at right heart catheterization. The right heart and pulmonary pressures are seen to be markedly elevated. A noted feature is the extremely low cardiac output of 1.4 liters per minute with a stroke volume of only 11.5 cc. At time of death, this boy had gangrenous lesions at the tips of the extremities. In (Fig. 6) we have compared the pressure curves in the right ventricle of this case with a case of constrictive pericarditis. Although this case does show a high endiastolic pressure in the right ventricle, the early diastolic dip and the plateau effect of a constricting lesion is not seen.

At necropsy the heart weighed 540 gm. The coronary arteries were patent and showed no lesion. The heart chambers were grossly dilated and the endocardium was thickened and opaque, particularly in the outflow tract of the left ventricle and over the interventricular septum. The right

Patient A.B. ♂ 19 yrs.

Pressures (mm. Hg.)

Rt. Auricle —	22
Rt. Ventricle —	62/22
Pulmonary Art. —	60/39
Pul. "Capillary" —	35
Brachial Artery —	118/82

Oxygen Consumption — 231 cc/min.

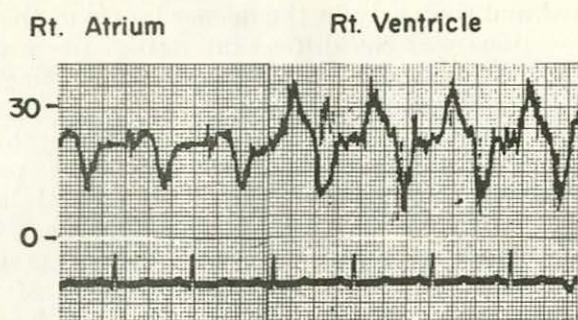
A-V Difference — 16.6 vols. %

Cardiac Output — 1.4 L/min.

Stroke Volume — 11.5 cc

Fig. 5. Case 2—right heart cardiac catheterization data.

CONstrictive PERICARDITIS



ENDOCARDIAL FIBROBLASTOSIS

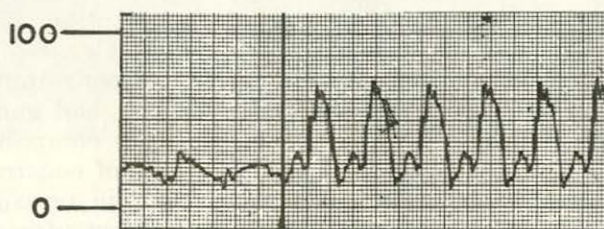


Fig. 6. Comparison of pressure curves in the right atrium and ventricle between a case of constrictive pericarditis and endocardial fibroblastosis (Case 2).

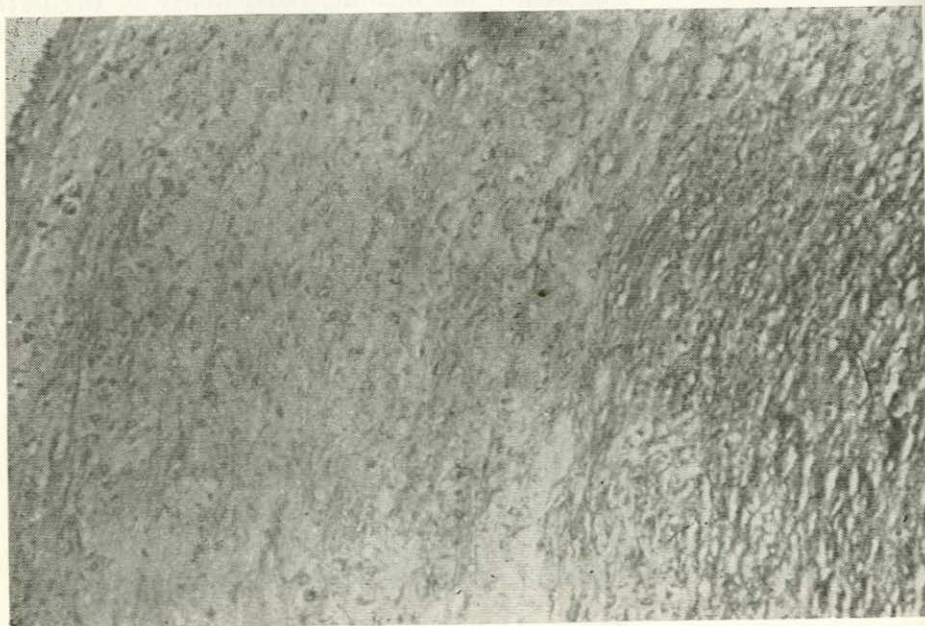


Fig. 7. Case 2—a photomicrograph of the endocardium of the left ventricle showing endocardial thickening due to spindle-cell collagen proliferation. Elastic tissue (darker stain) is seen throughout the collagen matrix.

ventricle also showed two small areas of endocardial opacity. The microscopic sections showed the endocardium to be markedly thickened by a spindle cell perforation with an abundance of intervening collagen. The endocardium is relatively avascular. Elastic stains showed an abundance of elastic fibers in the collagen matrix. (Fig. 7) The myocardial fibers are intact and myocardial degeneration and fibrosis was not a feature. This endocardial lesion was also found throughout the left auricle.

The above are two representative cases, one showing endocardial lesions associated with interstitial fibrosis and the other showing an endocardial elastosis without myocardial lesions. These lesions, until recently, were thought to be primary endocardial dysplasias of uncertain etiology. It was thought that the cardiac hypertrophy was secondary to the increased work necessary to contract and expand the thickened fibro-elastic tissue. Another theory was that the elastosis occluded the ventricular openings of the arterio-luminal vessels and the Thebesian veins interfering with myocardial blood supply with resultant injury and myocardial hypertrophy. We have had five such cases in the past two years at the Montreal General. In addition to the two described, we have seen this lesion in a case with a malignant carcinoid syndrome, in a young male with chronic alcoholism and as an incidental finding in a young male dying of influenzal encephalitis.

Recently, there has been a re-emphasis of the primary role of cardiac dilation in the pathogenesis of endocardial fibro-elastosis. The role of cardiac dilatation has been recently proposed by Dr. Black-Schaffer¹ of Cincinnati following the application of hydraulic principles similar to those used by Burton² in his work on muscular arteries and by Willis³ to explain the localization of arterio-sclerotic plaques at arterial bifurcation. Fig. 8 illustrates the fundamental Laplace's law where T is the tension in the wall of a cylinder, P is the hydrostatic pressure which acts perpendicular to the cylinder wall with the radius of R . T then is proportional to $P \times R$. We may consider a heart chamber being likened to a spheroid. Thus, in the left ventricle if the pressure remains constant, the tension in the wall of the heart will rise as the diastolic volume increases, that is, as the radius increases. It actually can be shown that in a ventricle whose radius is doubled with the blood pressure maintained, the mural tension increases not twice but eight times.

La Place's Law

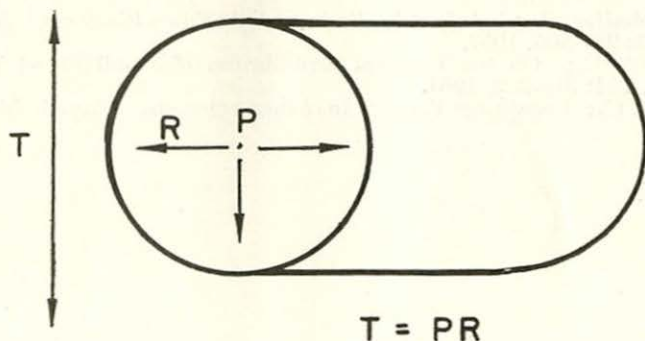


Fig. 8. LaPlace's Law as in hydraulic principles.

Thus, we may initially accept a concept of a weakened myocardium with increased residual diastolic volume and compensatory hypertrophy of the muscle fibers. If the elongation and hypertrophy of the fibers do not adequately reinforce the ventricular stroke, then further dilatation will occur. The tension in the endocardium will rise proportional to the cube of the increasing radius. The ventricle can then be considered as a muscular artery and the characteristic response of these arteries to increased stretch is increase and reduplication of the intimal elastic fibers. This reaction, for example, is seen in the renal interlobular arteries in systemic hypertension and in the smaller pulmonary arteries in mitral stenosis. The endomyocardium may well respond in a similar fashion with elastic reduplication and thickening resulting in the lesion of fibro-elastosis. Black-Schaffer has shown in infants that the degree of fibro-elastosis correlates with the degree of cardiomegaly. Also, characteristically the earliest stage of elastosis is seen near the base of the interventricular septum which is the flattest area of the left ventricle and consequently has the largest radius.

Finally, the reaction of the elastica of the endocardium may be thought of as an auxiliary aid to the myocardium to reduce the progression of dilatation as it supplies a counter-force to the hydrostatic pressure tending toward dilatation. It may be that because of the elastic resistance of the thickened endocardium, the stroke volume and blood pressure, and hence the coronary flow, are better maintained allowing cardiomegaly to proceed. It obviously does not act as a constricting lesion as has been suggested, with interference of diastolic filling.

It would appear that the lesion of endomyocardial sclerosis is a further progression of the fibro-elastosis lesion. The elastica is more fragmented and fibrous collagen perforation more marked. The interstitial fibrosis may well represent the results of relative anoxia with progression of the myocardial hypertrophy and dilatation. In the infant, the frequent association with congenital cardiac lesions may provide the initial stimulus to hypertrophy and dilatation. These anomalies have included aortic valvular atresias, hypoplastic aortic lesions and anomalies of the left coronary arteries. In the adult, unrecognized myocarditis or vitamin deficiency can be the initial stimulus to cardiomegaly with resultant elastosis.

I am indebted to Dr. W. H. Mathews, Pathologist-in-Chief of The Montreal General Hospital, for the pathological material used in this manuscript.

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BOOK REVIEW

DRUGS OF CHOICE, 1960-1961. Modell, W., Ed. The C. V. Mosby Co., St. Louis, 1960, 2nd ed. 958 pp. \$13.50.

The 1960-1961 edition of this valuable text is a monumental piece of work in which the material has been provided by 47 contributors as compared with 37 in the previous edition. The editor is a well-known clinical pharmacologist at Cornell University Medical College and the author of several earlier contributions, among which is a text book for nurses. The list of contributors reads like a roster of the greatest names in American medicine, heavily weighted because of the place of residence of the editor, by teachers and physicians from New York City and Northeastern U.S.A. These names include Thomas P. Almy, Alvan Barach, David Barr, William Bean, McKeen Cattell, William Dameshek, Chester Keefer, John Moyer, Tracy Putnam, Marion Sulzberger, and many others. The book consists of 42 chapters, each of which deals with "drugs of choice" for a specific disease or group of diseases. However, the arrangement is not strictly that of a manual of materia medica, but approximates closely that of an encyclopedia. In other words, it does not function as a simple codex which provides only a list of disease entities faced by the drugs used in each. Instead, each chapter begins with an introductory statement, which provides all that is necessary for an adequate understanding of the disease process and the exact mode of action of each drug, whenever this is known. Much information, other than pharmacologic, can therefore be obtained from a perusal of the material of any disease. In the opinion of the reviewer, the contributors and the editor have been eminently fair in their assessment of the value of the drugs discussed throughout the book, and have not hesitated to state that a certain drug has been found to be useless, or that the efficacy of a drug is still *sub judice*. On the other hand, in preparing any publication of this sort, there is an almost unavoidable tendency to include every drug that has appeared on the market during the past few years. This tendency greatly increases the size of this particular volume, is probably unnecessary, and leads one to ask the question, "Drugs of whose choice?" It seems probable that a more useful reference volume might have been provided by the exercise of somewhat greater discrimination in the choice of drugs discussed; this is, however, a moot point. A very valuable feature of this book, also present in the previous edition, is the "drug index" which, in the present edition, comprises 100 pages. In these days of confusion between generic and brand names, such an index becomes extremely valuable. The paper stock is excellent, and there is little if any, reflected "glare" when reading under a light. The print is clear and easily read, and the format is excellent. Your reviewer considers that this volume should be on the bookshelves of most physicians, and in all medical school libraries.

S. J. S.

LETTERS

Dept. of Anaesthesia
Victoria General Hospital
13th April, 1960.

To the Editor:

I was most interested to read the article on Obstetric Anaesthesia (N. S. Med. Bull. 39:48, Feb., 1960) and would like to congratulate Dr. Pasquet on his presentation of the modern anaesthetic approach to this age old problem.

The astonishing reduction in maternal and foetal mortality over the past century would not have been possible without anaesthetic agents and physician anaesthetists. In drawing attention to this fall in mortality, Prof. Jeffcoate has shown that this has been accompanied by a steady rise in the incidence of forceps delivery and caesarean section (Jeffcoate, 1953).

During this period of advances contributing to obstetric safety, there have been far greater advances in anaesthetic techniques and agents, together with the development of a new generation of highly skilled anaesthetists. While the general surgeons have been quick to appreciate the advantages of newer methods, obstetric anaesthesia has remained virtually unchanged since the days of Simpson and Clover. Thus it is that today the greatest hazard facing the patient undergoing operative delivery is the anaesthetic required for this procedure. The introduction of safer techniques, and the wider use of skilled anaesthetic consultation in obstetric problems is considered by many to be long overdue (Wrigley, 1955; Crawford, 1958).

The solution to the problem of the hazards of obstetric anaesthesia, whether regional or general, cannot be found in excluding anaesthetists from obstetric institutions, or in maintaining the fiction that anaesthesia is not required for our deliveries. Under these circumstances, when, as is inevitable in a small number of instances, an anaesthetic is required, an unskilled nurse or interne is called upon, sometimes with disastrous results. Safety in obstetrics comes from timely interference by a skilled obstetrician, safely provided with the conditions he needs by a skilled anaesthetist, who is well aware of the permutations and combinations of agents and techniques available in the particular obstetric circumstances, to give that particular mother and infant the safest and least depressant anaesthetic.

While I wish to stress the individuality of each labour in each patient, there are certain basic principles which need restatement.

Normal deliveries are best carried out under analgaesia, which should be provided by a minimum of systemic analgaesic drugs, supplemented by local or inhalational analgaesic agents. Without question, the rapid excretion and non-cumulative analgaesic properties of nitrous oxide administered with oxygen make this the inhalational agent of choice.

The great majority of forceps deliveries can be carried out under pudendal block, supplemented where necessary by inhalational or systemic analgaesia or both.

The choice of anaesthetic for caesarean section as between spinal anaesthesia and a modern anaesthetic technique using nitrous oxide-oxygen and relaxant for maintenance depends largely on the degree of skill of the anaesthetist, and the anaesthetic facilities available. In skilled hands the two methods carry approximately equal hazards to the mother and infant, so that the choice becomes one of preference of the patient and the obstetrician. However, in placenta praevia, foetal distress, and pre-eclamptic toxemia, there are distinct advantages in the use of the general anaesthetic technique described.

Dr. Pasquet has performed a great service in drawing attention once again to the need for a renewed attack on the anaesthetic contribution to maternal and foetal morbidity and mortality. Such an attack can be successful only where there is full cooperation and understanding between the patient, the obstetrician and the anaesthetist.

Yours faithfully,

I. E. PURKIS, M.B., B.S., F.F.A.R.C.S.

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Jeffcoate, T.N.A., *Brit. Med. J.*, 2: 951, 1953.
Wrigley, A. J., *Proc. Roy. Soc. Med.*, 48: 1089, 1955.

PREVENTION OF RECURRENT RHEUMATIC FEVER IN CHILDREN AND ADULTS WITH ORAL AND REPOSITORY PENICILLIN. Thomas W. Mou, M.D., Feldman, Harry A., M.D., and Hartenstein, Hans., M.D., *Am. J. Med. Sci.*, 239:403, (Apr.), 1960.

During a 3-year period, 139 patients with either rheumatic heart disease or an acceptable history of previous rheumatic fever were provided with streptococcal prophylaxis either with benzathine penicillin G 200,000 u. daily by mouth or 900,000 u. intramuscularly at approximately monthly intervals. Each regimen appeared to be effective in preventing clinical Group A streptococcal infections and recurrent acute rheumatic fever. Modest increases in Antistreptolysin - O titer were noted with equal frequency in the two treatment groups and were unrelated to clinical illness. These were noted particularly in the spring months.

There was a constant downward progression of the median Antistreptolysin - O values for the entire population during the observation period, except that some minor increases were observed during the fall-winter season. Few allergic reactions were noted and these were of little consequence except for one episode of anaphylaxis following an initial injection. Postinjection pain and discomfort were common but not a deterrent to repeated injections.

S.J.S.

NEWS ITEM

Kitchener, April 29—Canadians have demonstrated they want personal responsibility and freedom of choice—not government control—in the field of medical care, W. Douglas Bell, managing director of the Canadian Health Insurance Association said here today.

Addressing the annual meeting of the Canadian Life Insurance Medical Officers Association, Mr. Bell said "phenomenal growth in accident and sickness insurance, has been taking place during a period when all levels of government have encroached on this type of voluntary insurance."

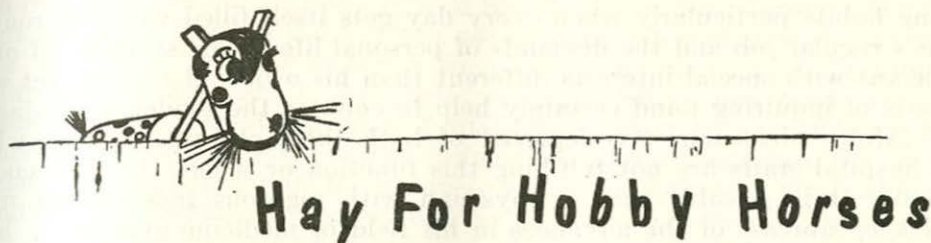
However, in spite of government activity in health services, Canadians purchased six times more accident and sickness insurance last year than in 1947 and 25 times more than they did 20 years ago, Mr. Bell said.

Regarding medical care, Mr. Bell said the present combination of governmental and voluntary private insurance plans could meet the needs of the great majority of Canadians.

"All indications also point to the fact that publicly financed plans are very costly, difficult or impossible to control and in fact raise the question of whether the cost of a complete plan can be supported by the economy."

Mr. Bell also said standards of medical care would deteriorate under any local government medical care plan.

"Equally important, is the departure from Canadian principles and philosophy that would be involved in the adoption of a complete government plan. Government must regulate that which it subsidizes . . . herein lies the basic defect in the governmental approach to the highly personal matter of health care. The growing acceptance of voluntary insurance methods by Canadians indicate their ability to assume personal responsibility in this field. They should not be forced to cede their freedom of choice to a governmental body which must look to the problems of the masses to the exclusion of the rights of the individual," Mr. Bell said.



"COME TO THE MONO. BREAKFAST?"

The subject this month is the problem of the clinical needs of the incomplete physician. At the time of this writing three conventions have been through me and I have a fourth beginning in a few days. I was sitting in the Carolina Room of the Chalfonte-Haddon Hall at Atlantic City doing my best to keep from being overwhelmed by a paper by Andre Cournand when the subject of this month's Hay was given to me. Dr. Cournand is a Nobel prize winner and a skilful leader in clinical research but he does his material less than justice when he presents it himself. As I struggled with Dr. Cournand's delivery, I had a moment of despair, wondering whether I should be back in Halifax rendering some routine medical service (and reaping some small financial reward) rather than getting up on my intellectual tiptoes to snatch at these esoteric pearls. This feeling abated a bit for the next two papers were on idiopathic hypertrophic sub-aortic stenosis and hypertrophic pulmonary osteoarthropathy. These were things one heard about from time to time and might expect to meet occasionally in practice. However, this relief was short-lived for Dr. Sidney C. Werner depressed me again with his presentation on the experimental production of infiltrative ophthalmopathy. This was not because malignant exophthalmos is not a fascinating problem of practical importance but because Dr. Werner had allowed himself to be saddled with some very poor slides.

For many reasons the young physician may be obliged to accept a niche in medicine in which he engages in an unbalanced type of medical practice. The incomplete physician is one whose professional life is of a kind that will inexorably lead to atrophy of some important part of his medical whole. A director of post-graduate education would prescribe for him some supplementary clinical exercise to prevent such atrophy. A young friend of mine is a general physician, who has acquired some but not all the badges of excellence of his specialty, and teaches geographic pathology at an Eastern Canadian medical school because he is interested in teaching and also because he must earn his bread and butter. He has a small private practice and he occasionally says in a rueful way "Come to my office, it's the quietest place in town." He serves as assistant physician on the public ward of the university hospital and does his share of the dozen unpaid jobs that are inherited by a junior physician in a university medical center. He is useful to the students only if he remains a well-informed and well-oriented general physician. His *raison d'être* is the practice of his profession and he is acceptable to the rank and file of physicians only on this basis. However, three-quarters of his time is spent in teaching which is not directly related to the realities of medical practice. In concocting a prescription for the treatment of his clinical deficiencies how broad a coverage should we consider? Few of us have good

reading habits particularly when every day gets itself filled with the routine of one's regular job and the demands of personal life. The stimulus of other physicians with special interests different than his own and the contact with students of inquiring mind certainly help to counter the tendency to stagnation. Many physicians are deprived of both these stimuli in areas where local hospital staffs are not fulfilling this function or where the physician is isolated. It is possible that a physician with vigorous independent mind could keep abreast of the advances in his field of medicine even when he is isolated from his fellows. But let us omit that rare bird, the compleat physician, who can keep in shape clinically, continuing to respond to the challenge of the unsolved problems in his practice and is able to sustain himself from his library and other resources. This man stays fit because, like Thoreau's philosopher, he never forgets his ignorance which is essential to his growth. The rest of us need to get away from our practices each year and get "cross-fertilized" by the ideas and experiences of others. No one is likely to thank you for your exertions in keeping up. Your colleagues, who mind your practice or add your load of ward work to their own during your absences, inquire if the plays were good and if you are well rested on your return.

The chief by-product of the average medical meeting is the opportunity to discuss details of knowledge and practice with others of a bent similar to yours. Occasionally, such serendipitous discoveries far outweigh the value of the formal papers. Unfortunately, there are only a few first-class clinical meetings in each branch of medicine. The programme committee of any medical organization faces an unpleasant dilemma, i.e. whether to stress the social aspects and get reasonable attendance for the business meetings or to present a stiff scientific programme at the risk of finding many physicians unwilling or unable to make the effort. A purely scientific gathering seems not to present this problem at all. Experience teaches the young physician to risk an esoteric and oppressive title in hope of being rewarded with a new concept that will bridge a gap in his knowledge and carry him a little further forward. Such a paper was "The Influences of Antimetabolites Inhibiting Nucleic Acid Metabolism on Embryonic Development." Now I don't know anything more about nucleic acid metabolism than does Mr. Khrushchev, but a great number of far-reaching possibilities came directly from this one paper—a new approach to the bio-assay of new drugs, a caution to the physician using anti-metabolites in the therapy of leukemia and a method of study of congenital anomalies. Two papers were presented together that gave rise to much comment and impressed me a good deal: "Etiocholanolone-Periodic Fever; a Clinical Entity," (Philip K. Bondy) and "A Dietary Treatment for Familial Mediterranean Fever" (Sherman M. Mellinkoff). The first paper suggested a much more satisfactory explanation of biliary fever than had been available. The second report, in which episodes of fever and peritonitis were halted by lowfat diet, makes one wonder what other disease entities will respond to dietary adjustment. Space does not permit further recital of some of the provocative papers presented at this meeting. There were many that were completely over my head, but, by and large, there were enough within my grasp to fertilize my clinical thinking for some time to come.

It was my first attendance at a Young Turks' meeting and I would have wasted much time and enjoyed myself less had I not fallen in with Douglass Thompson (New York University Medical School) in Toronto. He was my guide and mentor throughout the meetings. I also met an old crony

from resident days, Virgil Place now of Saddle River, New Jersey. We stuck it out faithfully through most of the papers even a few that were cast in the outer reaches of medical esoterica such as "Abnormalities of Tryptophan-Kynurenine Metabolism." At these meetings, all is not hard work and tension from the painful extension of intellectual resources. Outside the hours of meeting, there was the new swimming pool at the Chalfonte, the sundeck overlooking the beach and the ocean beyond, the mile-long stroll along the Broadwalk to Hackney's and an endless variety of seafood. Douglass was a great hand for getting up before 7 A.M. for squash, bicycle or horseback riding, and even bird watching on Brigantine Island. I met an ex-patriate Nova Scotian, S. Clyde Strickland, who wants to be remembered to his friends in the profession here at home.

During the previous week I had attended the first Canadian meeting of the American College Health Association. It was a stimulating affair and gave me the title of this essay. I had just registered when a friendly physician of middle years, Dr. Leona Yeager, came up and introduced herself. I said that one item on the program that was of particular interest to me was a review of infectious mononucleosis. "You must come to the Mono Breakfast!" replied Dr. Yeager. The breakfast began at 7.30 A.M. on the final morning of the convention and lasted until 9.30 A.M. It was an open discussion of many aspects of this intriguing disease. I was glad to hear that it is not regarded as a cause of chronic hepatitis. I learned a trick or two about its diagnosis. A physician from Phoenix has found that he can abort the disease completely by a short course of prednisone. Infectious mononucleosis appears to be like infectious hepatitis in that a very high portion of the population become immune very early in life. However, some patients can transmit the disease for periods up to a year. Eight laboratory technicians, followed from 3 to 5 years, had recurrent showers of pro-lymphocytes and one had an enlarged spleen for the entire period. Do we have Mono Annies in our midst as well as Typhoid Marys?

Exhausted from clinical exercise, I am yours,

BROTHER TIMOTHY.

PERSONAL INTEREST NOTES

HALIFAX MEDICAL SOCIETY

April 27, 1960—Annual Business Meeting was held at the Dalhousie Public Health Clinic. Reports from the various committees were heard, including a rather complete report from the President of Maritime Medical Care, Dr. F. M. Fraser. The nominating committee under Dr. A. M. Marshall brought in the new slate of officers: President: Dr. D. M. MacRae, Vice-President: Dr. F. J. Barton, Secretary: Dr. J. A. Myrden, Treasurer: Dr. A. S. Wenning. On the executive were Drs. J. W. Merritt, H. C. Still, J. H. Charman, A. W. Titus, S. J. Shane, J. M. Crosby, and K. M. Grant. The representatives to the Nova Scotia Medical Society executive will be Drs. J. W. Merritt, D. M. MacRae, and F. J. Barton.

May 7, 1960—Annual Dinner Dance and installation of officers of the Society was held at the Lord Nelson Hotel. Phyllis Ensher, harpist, performed during dinner, and dancing was to Eddie Richards orchestra.

May 8, 1960—A special meeting of the Halifax Medical Society with some members of the staff of the Victoria General Hospital and of the College of General Practice was held in the Dalhousie Public Health Clinic. A committee was drawn up to pursue actively the subject of obtaining more hospital beds in the Victoria General Hospital, the present enlargement being considered in light of evidence presented, to be entirely inadequate for future needs of the Halifax Metropolitan area. Rather interestingly, the chairman of the Victoria General Hospital Board of Governors, Mr. M. I. Zive agrees that the expansion should be to at least 1000 beds rather than the projected 853 beds. One of the major problems is the establishment of some hospitalization for the convalescent and chronic cases, which are becoming so numerous in the area.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

The Western Nova Scotia Medical Society concluded a very successful series of post-graduate lectures sponsored by the Dalhousie Post-Graduate Committee on April 21, 1960.

Dr. W. C. O'Brien is again resuming practice after having been in hospital with a knee injury.

Dr. I. B. Barclay's suit against the Yarmouth Hospital has been settled with a payment to him of \$15,000.00.

UNIVERSITY

April 25, 1960—Dr. F. J. C. Roe of the Cancer Research Department, London Hospital Medical College presented a paper on "Some New Concepts in the Etiology of Carcinoma of the Lung."

April 29, 1960—Dr. George Komrower, Manchester, England, presented two papers the first on "Galactosemia" at the Children's Hospital and the second on "The Adreno-Genital Syndrome" at the Victoria General Hospital. He was jointly sponsored by the Departments of Medicine and Paediatrics.

Dr. Elmer K. Lyon, Deputy to the President of the Canadian Medical Association addressed the recent annual meeting of the Quebec Division of the Canadian Medical Association, stating that hospital insurance has encroached

to some mild degree on private practice, but government has so far interfered as little as possible. Some politicians advocate complete medical care insurance, so doctors should be prepared. Dr. J. J. Lussier, Dean of the Medical Faculty of the University of Ottawa stated that hospital insurance is reducing the number of hospital patients available for training of new doctors. Traditionally, public patients had been referred to teaching wards, but public patients started to diminish in number when private forms of hospital insurance began to be popular and technically do not exist at all where general state hospital insurance has been introduced.

BIRTHS

To Dr. and Mrs. J. R. Buchanan, Lunenburg, a daughter on April 27, 1960.

To Dr. and Mrs. A. W. Elliot, Belleville, Ontario, a son on February 20, 1960.

To Dr. and Mrs. K. Flegg, Halifax Infirmary, a son, on April 29, 1960.

COMING MEETINGS

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

October 10-14, 1960—46th Annual Clinical Congress of the American College of Surgeons, San Francisco, California.

November 7-10, 1960—34th Annual Dalhousie Refresher Course, Halifax, N. S.

Guest speakers will include Dr. D. G. Cameron, Professor of Medicine, McGill University, Dr. R. M. Janes, Professor Emeritus of Surgery, University of Toronto, and Dr. F. B. Carter, Professor of Obstetrics and Gynaecology, Duke University. The John Stewart Memorial Lecturer: Dr. D. F. Cappell, Professor of Pathology, University of Glasgow, Scotland.

November 17-19, 1960—International Symposium on "The Extrapyramidal System and Neuroleptics"—Department of Psychiatry, University of Montreal, P.Q.

November 30-December 3, 1960—Joint Annual Meeting of the Canadian Heart Association and National Heart Foundation of Canada—Royal York Hotel, Toronto, Ontario.

WANTED

Used physician's scales. Please contact Mrs. C. M. Harlow, Y.W.C.A., Halifax, N. S.

PERSPECTIVES IN THE TREATMENT OF DIABETES. Duncan, Garfield G., *Am. J. Med. Sci.*, 239:397, (Apr.), 1960.

The author, a highly-respected leader in his field, emphasizes that there is no substitute for diet therapy in the treatment for diabetes. Claims that more than one-half of the known diabetics in this country are receiving tolbutamide suggest, in his opinion, gross violation of this conservative truism.

More liberal quotas of protein and carbohydrate are indicated as a practical means of reducing the fat content of the diets. This seems to be especially desirable for the atherosclerotic patient with hypercholesterolemia. Also, in these cases benefit accrues when the fat is provided in a high proportion of unsaturated forms.

Insulin in one form or another or in suitable combinations and timing of administration is the most effective anti-diabetic agent known.

Oral therapy is a treatment of convenience and not of necessity. The sulfonylureas are most effective, numerically, in those patients whose diabetes can be controlled without drug therapy. They have, however, a justified place in the management of approximately 10% of diabetic patients. They are effective supplements in the treatment of the overweight diabetic but the likelihood that such effective agents might receive widespread adoption as a substitute for appropriate dietary measures must be guarded against. Failing in this would, and apparently does, mean that diabetes in this preponderant group of overweight subjects is not being as well treated, in the overall picture, as it was before these drugs were available.

Phenformin is a potent blood sugar lowering agent and may prove to be of long term value in the management of the juvenile type of diabetes. This has not yet been established. Phenformin is not considered a suitable substitute for sulfonylurea compounds in cases in which they are satisfactorily effective.

The optimum therapy for diabetes depends upon diet, insulin and oral preparations being kept in their proper perspectives.

This is the first such evaluation of the relative merits of insulin and oral antidiabetic agents that has come to your abstractor's attention.

S.J.S.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of March, 1960

Diseases	NOVA SCOTIA		CANADA	
	1960	1959	1960	1959
	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	0	0
Diarrhoea of newborn, epidemic (764)	0	0	0	5
Diphtheria (055)	0	0	0	3
Dysentery:				
(a) Amoebic (046)	0	0	0	0
(b) Bacillary (045)	0	0	0	222
(c) Unspecified (048)	0	0	0	23
Encephalitis, infectious (082.0)	0	0	0	1
Food Poisoning:				
(a) Staphylococcus intoxication (049.0)	0	0	0	0
(b) Salmonella infections (042.1)	0	0	0	0
(c) Unspecified (049.2)	0	0	0	45
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	154	0	21	1
Meningitis, viral or aseptic (080.2, 082.1)				
(a) due to polio virus	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0
(c) due to ECHO virus	0	0	0	0
(d) other and unspecified	0	0	0	22
Meningococcal infections (057)	0	0	1	0
Pemphigus neonatorum (Impetigo of the newborn) (766)	0	0	0	0
Pertussis (Whooping Cough) (056)	7	0	13	0
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0
Scarlet Fever & Streptococcal Sore Throat (050, 051)	131	0	100	0
Tuberculosis:				
(a) Pulmonary (001, 002)	14	1	21	4
(b) Other and unspecified (003-019)	6	0	2	0
Typhoid and Paratyphoid Fever (040, 041)	0	0	0	0
Veneral diseases				
(a) Gonorrhoea—				
Ophthalmia neonatorum (033)	0	0	0	0
All other forms (030-032, 034)	27	0	17	0
(b) Syphilis—				
Acquired—primary (021.0, 021.1)	0	0	1	0
—secondary (021.2, 021.3)	0	0	0	0
—latent (028)	0	0	0	0
—tertiary — cardiovascular (023)	0	0	2	0
— „ — neurosyphilis (024, 026)	0	0	1	0
— „ — other (027)	0	0	0	0
Prenatal—congenital (020)	0	0	0	0
Other and unspecified (029)	1	0	1	0
(c) Chancroid (036)	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0
Rare Diseases:				
Anthrax (062)	0	0	0	0
Botulism (049.1)	0	0	0	0
Cholera (043)	0	0	0	0
Leprosy (060)	0	0	0	0
Malaria (110-117)	0	0	0	0
Plague (058)	0	0	0	0
Psittacosis & ornithosis (096.2)	0	0	0	0
Rabies in man (094)	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0
Rickettsial infections:				
(a) Typhus, louse-borne (100)	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0
Smallpox (084)	0	0	0	0
Tetanus (061)	0	0	0	0
Trichinosis (128)	0	0	0	0
Tularaemia (059)	0	0	0	0
Yellow Fever (091)	0	0	0	0
N.S.U.	3	0	3	0

C — Cases D — Deaths

C.D.C. 2

*Not broken down

Nova Scotia Summer School of Alcohol Studies
Third Annual Session
August 14 - 20, 1960

Pine Hill College

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Dr. C. A. Swinyard, Belliveau Medical Centre, New York.

Dr. Albion Roy King, author of "Basic Information on Alcohol."

Mr. A. Keith Ellinwood, Educator, Counsellor to Alcoholics in Federal and State Prisons, New York State.

Mrs. Ruth Ellinwood, Medical Social Worker, New York State Hospitals.

Dr. John Godden, Associate Professor of Preventive Medicine, Dalhousie University.

Scholarships are available for residents of Nova Scotia.

For copies of programs, registration forms and information concerning scholarships write to:

Supervisor of Alcohol Education
Department of Education
Box 609, Pictou, N. S.