

The NOVA SCOTIA MEDICAL BULLETIN

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EDITORIAL

ANOTHER CRACK IN THE MIRROR

Medicine is still concerned about its 'public image' and is anxiously studying its reflection for some certain glimmer of the old halo, some comforting assurance that the horns, the barbed tail, and the split hooves are not as obvious as so many vocal individuals and groups would have it appear.

The reflection is not too clear. The glass throws back a confusion of images compounded of ancient sorcery, medieval ignorance, victorian earnestness and modern science. At the corners, where the silver has peeled a bit, there are ugly blotches of charlatanism, cultism, over-specialization, greed, incompetence and dishonesty. But these, we still hope, are comparatively small specks considering the area of the mirror and the multiplicity of faces reflected from the hydra-headed national body.

So much the more distressing, therefore, is it to see a new crack in the mirror; one which appeared across the reflection of our vacuous smile as we paused to enjoy a moments reassurance of our worthiness: it came suddenly, without warning and striking swiftly across the glass, distorted the smugly smiling lips into the twisted smirk of exposed incompetence. The jar which newly marred the glister was the shock of the Sabin vaccine withdrawal, appearing as it did while the Press and Public were in full cry to carry the vaccine into the remotest hamlets of the province and nation, urged on by the trumpets of the Health Department and accelerated by the approval and blessing of organized medicine.

It is this latter point which should give us pause. Our unqualified approval was a feature of the publicity campaign setting up this program. How much more cheaply must the public regard our opinion after this. Indeed it is such an event as to cause concern and alarm in an informed people as to the value of our opinion in particular matters and to bring into question our oft vaunted competence in the whole field of health care.

Are we careful enough in giving our approval to new ventures in preventive and treatment medicine? How many of those present at the meeting of the Halifax Medical Society which gave unanimous approval to the inauguration of the program in the Halifax area, know anything about the Sabin vaccine except that it was live and oral? How many knew personally the effectiveness of the steps taken to ensure that the administration of a live vaccine would not cause disease? How many, indeed, were familiar with the various steps in the preparation of the material? I hesitate to be explicit here,

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF

THE CANADIAN MEDICAL ASSOCIATION

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except to say that when one member asked the Meeting for a description of the preparation of this vaccine there was little interest and less discussion.

Although we realize that every possible precaution was taken by those having primary responsibility for this effort, and that any member or committee of this Society must in good faith and sincerity have approved the program from consideration of the data available to us, none the less our failure to study and discuss a matter of this magnitude in open meeting before voting unanimous approval for its instigation indicates a whole hearted confidence in our Public Health Dept. (which we believe is merited), but also, unfortunately, leaves an opening for men of ill will to accuse us of complete dereliction of our public duty and responsibility as physicians!

In future when we are asked to approve any such undertaking, we must appoint a committee to study the project and report to the Society out of knowledge, rather than vote unanimously out of ignorance. Further, the Dept. of Health, in using whatever remains of prestige to the Medical Society in initiating these programs, should have the courtesy to consult the Society and acknowledge publically our concurrence if any such precipitate withdrawal ever becomes necessary in the future.

J.W.R.

FROM THE BULLETIN OF 40 YEARS AGO

The Medical Society of Nova Scotia Bulletin, Sept. 1922

STANDARDIZATION OF DRUGS

In the treatment of the sick there are three factors to be considered, viz., the diagnostic ability of the Physician, the recuperative powers of the Patient, and the treatment administered. Just as no chain is stronger than its weakest link, so too in the treatment of disease it must be admitted that the Prognosis depends upon the efficiency of all the factors mentioned. If the treatment administered only does 50% of the work for which it is intended it is obvious that the Patient is working against odds.

A year or more ago it was pointed out to the Provincial Association that many of the Drugs being used by the Profession were not Physiologically Standardized, in many instances tinctures being found only 50% efficient.

When the attention of the Federal Government was drawn to this matter we were informed that no action could be taken until the demand sufficiently strong was voiced by the Profession. From Coast to Coast the subject was discussed with the result that from the Canadian, Provincial, and smaller Medical Societies came such a deluge of requests that the Government has seen fit to establish a Bureau of Standardization, and we are informed that during the coming year many of the important tinctures will be Standardized, guaranteeing to the Profession that they are 100% efficient.

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SATURDAY, SEPTEMBER 22, 1962, M.M.C. INC., BOARD ROOM

LORD NELSON BUILDING, HALIFAX, N. S.

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2ND REGULAR MEETING OF THE EXECUTIVE COMMITTEE 1962-63

SEPTEMBER 22ND, 1962

M.M.C. INC., LORD NELSON HOTEL, HALIFAX, N. S.

RE—24—The second regular meeting of the Executive Committee was convened by the Chairman, Dr. L. C. Steeves, at 9.30 a.m., in the Board Room, Maritime Medical Care Inc., Lord Nelson Building.

Present were:

PRESIDENT - - - - -	Dr. D. F. Macdonald
PAST-PRESIDENT - - - - -	Dr. R. F. Ross
PRESIDENT-ELECT - - - - -	Dr. C. L. Gosse
CHAIRMAN, EXECUTIVE - - - - -	Dr. L. C. Steeves
VICE-CHAIRMAN, EXECUTIVE - - - - -	Dr. J. E. H. Miller
EXECUTIVE-SECRETARY: - - - - -	Dr. C. J. W. Beckwith
HONORARY TREASURER - - - - -	Dr. J. F. Boudreau
EDITOR, MEDICAL BULLETIN - - - - -	Dr. J. F. Filbee

Representatives from Branch Societies:

ANTIGONISH-GUYSBOROUGH - - - - -	Dr. T. W. Gorman
CAPE BRETON - - - - -	Dr. D. H. MacKenzie
COLCHESTER-EAST HANTS - - - - -	Dr. H. R. McKean
CUMBERLAND - - - - -	Dr. J. C. Murray
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	Dr. K. M. Grant
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PICTOU - - - - -	Dr. C. B. Smith
VALLEY - - - - -	Dr. J. A. Smith
WESTERN COUNTIES - - - - -	Dr. C. K. Fuller

Observers:

Representative to C.M.A. Executive—Dr. D. I. Rice.
Chairman, Public Relations Committee—Dr. S. C. Robinson.

Present to Present Reports:

Chairman, Special Research Committee—Dr. A. A. Giffin.
Chairman, Committee on Fees—Dr. C. H. Young.
Chairman, Committee on Insurance—Dr. A. J. Brady

RE 25—The Minutes of the Fourth Regular Meeting (1961-62) May, 1962 were adopted as read.

RE 26—The Minutes of the First Regular Meeting (1962-63) May 24, 1962 were approved as written.

Business arising from these Minutes.

RE 27—(a) The Executive Secretary reported that a Directory had been compiled for the Society, listing the Officers, Representatives to the Executive Committee, Chairmen of Committees, Presidents and Secretaries of all Branch Societies, etc., and that this had been forwarded to each Branch Society, the Officers and the Representatives of the Executive Committee.

RE 28—(b) Dr. D. F. Macdonald, President and General Chairman for the Annual Meeting, 1963, reported that the Chairman of his Committees for the Annual Meeting had been appointed and plans were being developed.

RE 29—(c) The Executive Secretary reported the recent scheduled Branch Society meetings prior to this Executive Meeting of September 22nd. Progress was noted toward the objective of having a complete schedule of such meetings. The Executive Secretary was directed to pursue further the development of such a schedule.

RE 30—Reports of Committees.

Report from the Committee on Medical Economics — Chairman, Dr. H. E. Christie.

The report from the Committee on Medical Economics was approved. This report covered several items, one of which was remarks on the increasing use of the "team approach" for certain medical and surgical conditions. Out of this discussion the following resolution was carried:

RE 31—"That the Resolution of two years ago be reasserted, requesting the Special Research Committee to review the philosophy of fees of the Medical Society of Nova Scotia with regard to changing forms of medical practice in all concepts and to make recommendations regarding the same."

Report of Committee on Fees — Chairman, Dr. C. H. Young.

RE 32—Dr. Young reported that it was expected that this new schedule would be available in printed form, not later than the end of 1962. The report was accepted.

Report of Committee on Insurance — Chairman, Dr. A. J. Brady.

RE 33—This Committee reported on a study for the office and business overhead expense insurance. It was regularly moved and seconded and carried:

RE 34—"That the Report of the Committee on Insurance be accepted and that this Committee be invited to submit a further Report at the next meeting of the Executive, after further information has been obtained on premiums from competitive insurance companies."

RE 35—In reference to group disability insurance, it was noted that membership in good standing is a condition of participation in these benefits. Recent review of the records show a number of physicians who, while participating in group disability insurance, have not as yet paid 1962 membership dues. It was agreed that the matter of membership in good standing should be taken up with each of these physicians.

Committee on Child Health — Chairman, Dr. R. S. Grant.

RE 36—This report for information, indicated that progress was being made toward the study of Erythroblastosis and its management in Nova Scotia.

Special Committee on Specialist Register — Chairman, Dr. H. J. Martin.

RE 37—Dr. F. J. Barton member of this Committee, gave a verbal report. On resolution and because of the recent illness of Dr. H. J. Martin, Dr. Barton was appointed interim Chairman of this Special Committee.

Committee on Finance — Chairman, Dr. J. F. Boudreau.

RE 38—Dr. Boudreau reported that the Finance Committee is having monthly meetings. His report included current financial status of the Society. The Executive Committee authorized the bonding of the Treasurer and Bookkeeper. The report on motion was approved.

Report of Nova Scotia Representative to C.M.A. Executive Committee — Dr. D. I. Rice.

RE 39—The report provided a comprehensive review of the C.M.A. Executive Committee meeting in Toronto on September 14th and 15th. The Canadian Medical Association has requested a meeting of representatives of each of the divisions. The Executive authorized the President, Dr. D. F. Macdonald and the Executive Secretary, Dr. C. J. W. Beckwith to attend this meeting on December 6th and 7th, 1962 in Toronto. Dr. Rice's report was on motion, adopted.

Special Research Committee — Chairman, Dr. A. A. Giffin.

RE 40—The Report of the Special Research Committee, consisted of presentation to the Executive Committee of the Supplementary Brief, to the Royal Commission. The review of this document took some time. There were certain minor amendments and Dr. Giffin referred to three items which still had to be written.

RE 41—Dr. Giffin said that with this editing, the final document would be prepared and it was proposed to have it in the hands of the Royal Commission not later than October 1st. The Supplementary Brief was 34 legal sized pages in length. The Executive Secretary stated that copies would be sent to the members of the Executive Committee and to Secretaries of the Branch Societies.

RE 42—The following Resolution was regularly moved, seconded and carried:

“That whereas the preparation of the Brief and Supplementary Brief to the Royal Commission on Health Services by the Special Research Committee has entailed a truly vast amount of work; and whereas the Briefs have been of the highest quality in due honor to the Medical Society of Nova Scotia;

It is resolved that the Executive Committee of the Medical Society of Nova Scotia extend to Dr. Giffin and members of the Special Research Committee its most sincere commendation and gratitude.”

RE 43—Communications.

Five communications, of which four were for information and one from the Atlantic Society of Obstetricians and Gynaecologists requiring the attention of the Executive, were presented.

RE 44—New Business.

An application from the recently formed Inverness-Victoria Medical Society for recognition as a Branch of the Medical Society of Nova Scotia was approved on the basis of the following Resolution:

RE 45—“That the Inverness-Victoria Medical Society be accepted as a Branch Society of the Medical Society of Nova Scotia.” Carried.

RE 46—The elected officers of this Branch Society are:

President	—	Dr. A. J. Ratchford, Cheticamp
Vice-President	—	Dr. N. J. MacLean, Inverness
Secretary	—	Dr. Wilfred MacIsaac, Margaree Forks
Treasurer	—	Dr. C. L. MacMillan, Baddeck

RE 47—An application from ten members in good standing of the Medical Society of Nova Scotia to form a section for salaried physicians was presented. It was moved, seconded and carried:

RE 48—“That the application from ten members to be recognized as a Section for Salaried Physicians within the Medical Society of Nova Scotia be accepted pending submission and approval of their By-Laws.”

RE 49—An application from ten members in good standing of the Medical Society of Nova Scotia to form a section for Internists was presented. It was regularly moved, seconded and carried:

RE 50—“That the application from the ten members to be recognized as a Section for Internal Medicine within the Medical Society of Nova Scotia be accepted pending submission and approval of their By-Laws.”

RE 51—Resolutions from Branch Societies.

A resolution from the Antigonish-Guysborough Medical Society established their founding date as November 16, 1922. This was approved by the Executive.

RE 52—A resolution from the Cumberland County Medical Society established their founding date as 1890. This was approved by the Executive Committee.

RE 53—A resolution from the Antigonish-Guysborough Medical Society requesting the Medical Society of Nova Scotia to approach the Nova Scotia Pharmaceutical Association about the identifying labels, drugs and prescriptions was referred to the Committee on Pharmacy and Branch Societies,

RE 54—The nomination of Dr. D. C. Brown of Amherst, as Branch Representative to the Board of Directors of Maritime Medical Care was approved. Dr. Brown acts for the unexpired term of Dr. Elmik who is now practising outside the area of the Cumberland Medical Society.

RE 55—Annual Meeting 1963.

The Executive Committee approved the location and dates for the 110th Annual Meeting (1963) as Braemar Lodge, Yarmouth County July 2nd (Tuesday) to July 5th (Friday) inclusive. The Executive Committee will meet on June 30th and July 1st.

RE 56—Action on three resolutions received from Maritime Medical Care Incorporated, was deferred to the Executive Meeting of December 1st, 1962.

RE 57—Date of Next Meeting.

The Third Regular Meeting of the Executive Committee will take place on December 1st (Saturday) at 9.30 A.M. in the Board Room of Maritime Medical Care Incorporated, Lord Nelson Building.

RE 58—Adjournment.

The Second Regular Meeting of the Executive Committee was adjourned at 7.30 P.M.

C.J.W.B.

SECTIONS WITHIN THE MEDICAL SOCIETY OF NOVA SCOTIA

Chapter X of the By-Laws (1962) of The Medical Society, entitled "Sections", deals with the procedure to be followed by members who desire to form Sections within the Society.

Chapter X recognizes that, within Medicine as a whole, there are members who have particular interests and problems which they wish to discuss. The development of Sections will provide such facilities. Sections should be mutually advantageous to the Society and to its members. On the one hand the Society can seek advice from a Section and, on the other, a Section may bring to attention of the Society such matters as they deem advisable for consideration of the Society as a whole.

Applications for recognition as a Section must be signed by ten members in good standing of The Medical Society of Nova Scotia. Such applications are presented to the Executive Committee for consideration.

As of September 30, 1962, applications for recognition as Sections have been approved for Surgery, Internal Medicine, Salaried Physicians.

The Executive Secretary will be pleased to provide any information requested.

MARITIME MEDICAL CARE DEVELOPS CONTRACT CHANGES

In keeping with the expressed wishes of the Canadian Medical Association for medically sponsored plans to broaden their coverage, the Board of Directors of Maritime Medical Care, early in 1962, directed that present contracts should be redesigned to provide as wide a range of benefits as possible, and that additional contracts covering paramedical services should be developed.

To this end a sub-committee was appointed to study present contracts and recommend changes which would result in a program that will come within the reach of a greater number of Nova Scotian citizens. The final redesigning of Maritime Medical Care basic contracts is not yet complete, but a recent interim report to the Board of Directors indicated that real progress was being made.

In addition to the proposed new basic program Maritime Medical Care will offer, at first on a group basis only, and to those subscribers who are currently enjoying a Maritime Medical Care basic plan, supplementary contracts which will augment and round out their basic Maritime Medical Care coverage. It is hoped that at a later date, the supplementary contracts will be offered on an individual basis. Two plans will be offered. The first, or supplementary Hospital Services program, is designed to close the gap between benefits provided by the Nova Scotia Hospital Insurance Commission and Maritime Medical Care comprehensive coverage. It will provide payment of the differential between basic ward and semi-private room rates, and payment for such hospital services as are not presently covered by the Commission. The second plan is an Extended Health Benefits program, which, while including all benefits of the Supplementary Hospital Services contract will go further, covering paramedical and ancillary services as they are ordered by the attending physician. Co-insurance and deductible features will be applied to this plan, and it is the intention that these two plans will be self-supporting, in order that they should in no way interfere with Maritime Medical Care's present operation.

With a complete program of this nature, offered at the most reasonable rate possible, the Board of Maritime Medical Care feel that MMC's position will be extremely competitive, and the Corporation will be in a very good position to offer this truly comprehensive coverage to all Nova Scotians.

Inverness-Victoria Medical Society

The Bulletin welcomes the recently formed Inverness-Victoria Medical society as a Branch of The Medical Society of Nova Scotia. Discussions over the past two years culminated in a meeting of the physicians in that area at which the Society was formed, and an application for recognition as a Branch Society was forwarded to the Executive Committee. That application was approved at the 2nd. Regular Meeting of the Executive Committee, September 22, 1962.

The officers of the Inverness Medical Society are:

PRESIDENT	—	Dr. H. A. Ratchford, Cheticamp
VICE-PRESIDENT	—	Dr. N. J. MacLean, Inverness
TREASURER	—	Dr. W. MacIsaac, Margaree Forks
SECRETARY	—	Dr. C. L. MacMillan, Baddeck

SYSTEMIC—LUPUS ERYTHEMATOSIS

A REVIEW OF THE RECORDED EXPERIENCE AT THE VICTORIA GENERAL HOSPITAL AND A REVIEW OF THE CURRENT LITERATURE.*

A. Hugh Little, M.D.,
Halifax, N.S.†

Systemic Lupus Erythematosus was first described in Vienna, 1872, when Hebra and Kaposi were preparing a text book of diseases of the skin. In 1895, a syndrome of polymorphic skin lesions, arthritis and a variable number of visceral manifestations was described by Osler and labelled Exudative Erythema. Further contributions occurred in 1924 when Libman and Sacks reported 4 cases of non-bacterial endocarditis and in 1932, Gross described hematoxylin bodies in various viscera. The modern era of S.L.E. began when Hargraves described the LE cell phenomenon in 1948. Analysis of this phenomenon has revealed the presence of antinuclear antibodies and has prompted much investigation of S.L.E. as an autoimmune disease.

The aim of this paper is threefold: **first**, to review the recorded experience of S.L.E. at the Victoria General Hospital and to compare it with published material from other centres, **secondly**, to review the mechanism and specificity of the LE cell phenomenon, and **thirdly**, to review the prevalent concept of the pathophysiology of the disease.

PART ONE.

There are no universally accepted criteria for the diagnosis of S.L.E. Therefore, only those patients whose charts were completed with a firm or probable diagnosis of S.L.E. have been admitted to this study. Four charts completed with a diagnosis of possible S.L.E. were not included.

There have been 24 recorded cases of S.L.E. at the Victoria General Hospital since 1947. 21 of these were female and 3 were male. The age of onset of their symptoms varied from 12 to 55 years. (table 1) 100 cases from Detroit were reported by Rupe in 1959 and these are included in table 1 for comparison. Their cases show a gradually decreasing incidence from the peak at 20 to 30 years. In the material from this hospital the peak incidence occurs between the ages of 15 to 20 years and a second peak at 35 to 40 years. When plotting the age at diagnosis, these two peaks persist but they occur five years later. (table 2)

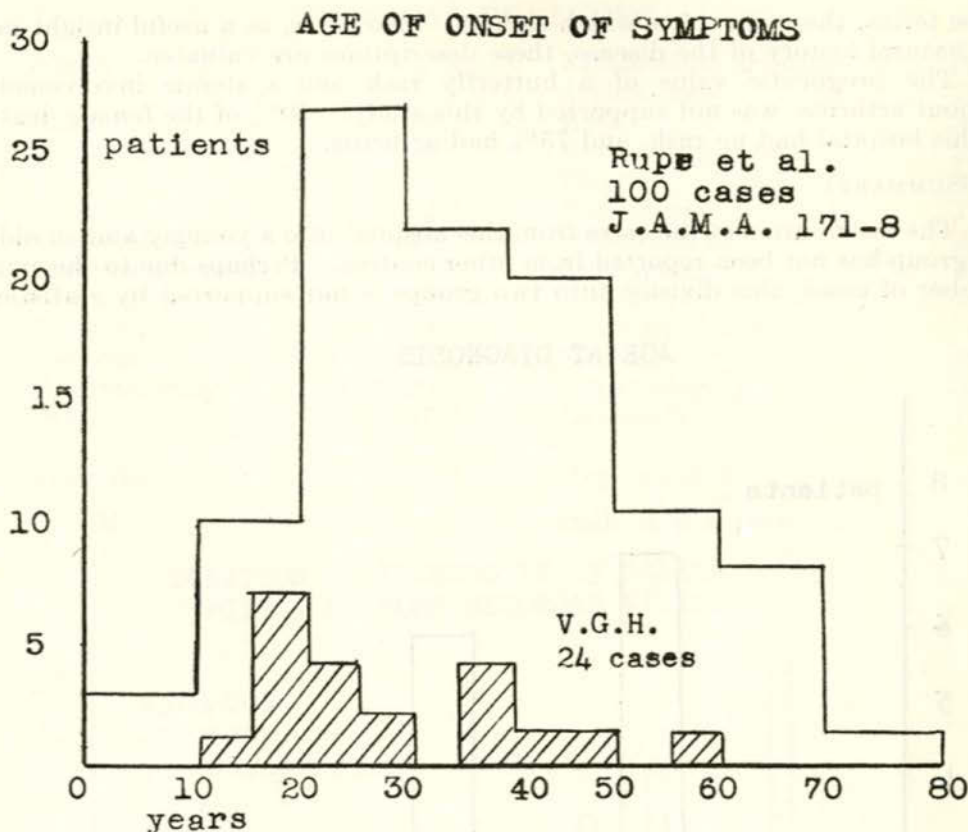
Table 3 records the relative frequency of the presenting symptoms in the cases from this centre compared with those reported by Hill in 1957. Joint pain, rash and fever are the main presenting symptoms in both studies. It is interesting to note that in the group of patients from this hospital whose diagnosis was made at the age of 40 or more, joint pain was the presenting symptom of 76%, whereas, in the younger group, only 29% presented with this symptom.

Table 4 records the relative frequency of system involvement in the cases from this hospital and those reported by Hill. The two striking differences are in the renal and nervous involvement. A trace of proteinuria was not accepted as evidence of renal disease in the material from this hospital, which, perhaps, explains most of the difference. There is no apparent explanation for the difference in the nervous system involvement.

Many patients were lost to follow-up after their first visit. Of the 24, only 12 had two or more recorded visits and one died on her first admission.

*From the Department of Medicine, Dalhousie University and the Victoria General Hospital.

†Present address: Cottage Hospital, Burin, Newfoundland.



The course of illness in those patients adequately followed is demonstrated in table 5. The vertical bars represent the duration of illness in each patient. The horizontal line represents the point in their illness at which the diagnosis was made. The duration of symptoms prior to diagnosis is probably not a valid measurement of the duration of the illness. Thus, the material above the horizontal line must be somewhat suspect.

The circled subscriptions represent the hospital deaths all of which had necropsy findings to support the diagnosis. Five of the six hospital deaths are included in this group. The sixth is not included because the chart is missing and only a brief clinical note is in the necropsy report.

Despite the uncertainty about the duration of illness prior to diagnosis, the variability of the clinical course is evident. An early age of onset is consistent with a prolonged course, as in the second case, or an acute fulminating course, as in the fifth case.

The most recent material on the natural history of S.L.E. was published by Rupe in the J.A.M.A. 171-8. He arrived at several conclusions from a review of 100 cases and these are summarized in table 6.

The longest course in this series was a postulated 13 years of symptoms prior to diagnosis at autopsy. The longest course post diagnosis was 7 years. Rupe reports one patient functioning well after 37 years.

34% of Rupe's cases were male; 12% in this series.

Rupe's clinical classification is difficult to evaluate. The three types are not accurately defined, and although many of our cases could be described by

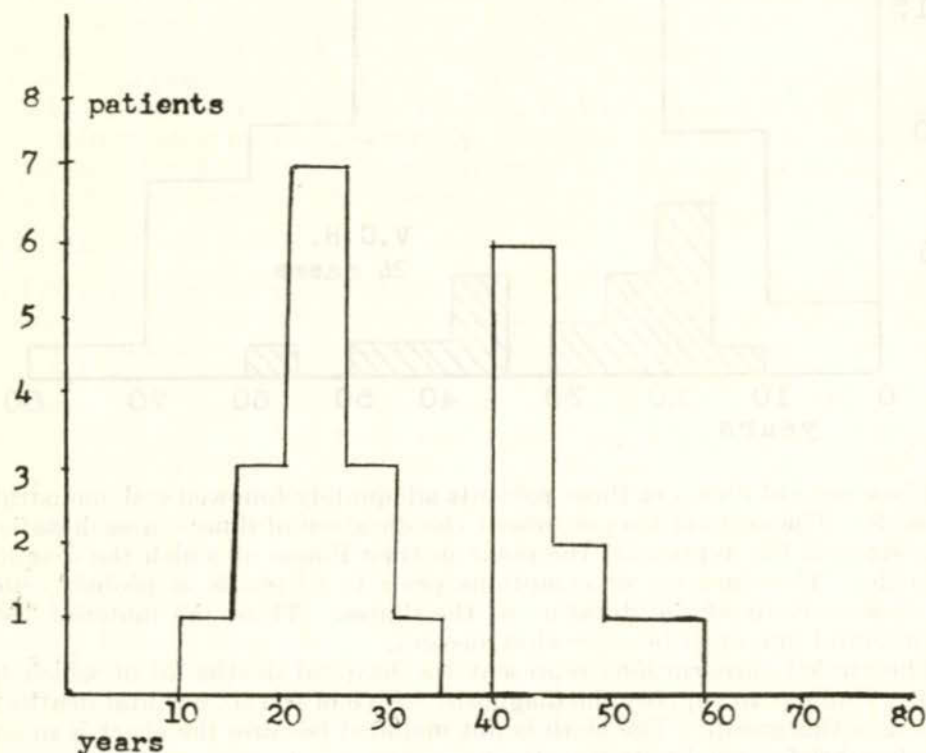
these terms, there are a few which cannot. However, as a useful insight into the natural history of the disease, these descriptions are valuable.

The prognostic value of a butterfly rash and systemic involvement, without arthritis, was not supported by this study. 50% of the female deaths in this hospital had no rash, and 75% had arthritis.

IN SUMMARY:

The distribution of the cases from this hospital into a younger and an older age group has not been reported from other centres. Perhaps due to the small number of cases, this division into two groups is not supported by statistical

AGE AT DIAGNOSIS



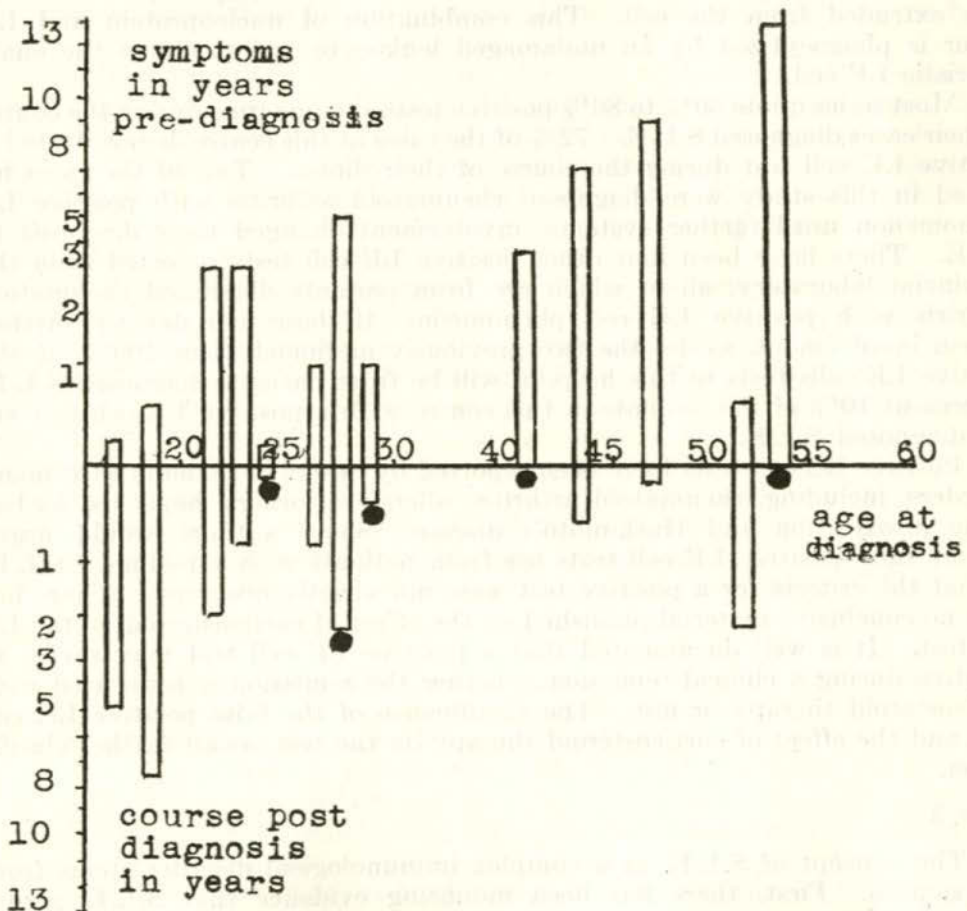
PRESENTING SYMPTOMS

Joint pain	50%	Chronic arthritis	60%
Rash	21%	Arthralgia	20%
Fever	17%	Rash	8%
Oedema (nephrotic)	8%	Fever	8%
Pneumonitis	4%	Pleurisy	2%
		Raynaud's	2%

CLINICAL FEATURES

Joints	87%	Rheumatoid arthritis	69%
		Arthralgia	25%
Rash	71%	Rash	49%
Respiratory	58%	Respiratory infect.	22%
		Pleurisy	39%
Renal	33%	Proteinuria	77%
Splenomegaly	33%	Splenomegaly	29%
Lymphadenopathy		Adenopathy	29%
Pericarditis	29%	Pericarditis	15%
Purpura, etc.	20%	Blood dyscrasia	6%
Nervous	12%	Nervous	49%
Hepatomegaly	20%	Hepatomegaly	33%
Fever	67%	Raynauds	15%
Anorexia	33%	Hypertension	6%
V.G.H.		Hill, B.M.J. Sept./57	

DURATION OF ILLNESS IN 13 CASES
WITH 2 OR MORE RECORDED VISITS



analysis; however, two interesting comparisons arise. 76% of the older age group presented with joint pain in comparison with 29% of the younger group. No appreciable difference in the course of the illness between these two groups could be determined from the 13 cases adequately followed.

This review has the limitations of every analysis of casually recorded observations. It is particularly limited by the high proportion of patients lost to follow-up.

PART 2

The first positive LE cell test performed at the provincial laboratory was recorded in 1952. The method involves incubating 5cc's of clotted blood for 2 hours and then squashing it through a sieve. This material is then spun down and a smear is made from the buffy coat. The smear is stained and examined for the characteristic inclusions in the phagocytic leukocytes.

In the past 10 years the essential aspects of the LE cell phenomenon have been elucidated. Most patients with this disease have a serum protein fraction called the nuclear phagocytosis promoting factor, or the LE factor. When serum containing this factor is exposed to a source of nucleoprotein a firm combination is formed and serum complement is decreased. The nucleoprotein can be supplied as the nucleus of a damaged leukocyte, which may come from the patient or any other source. As the LE factor enters the cell the nucleus has been observed to swell, lose its characteristic staining quality, and finally it is extruded from the cell. This combination of nucleoprotein and LE factor is phagocytized by an undamaged leukocyte and produces the characteristic LE cell.

Most series quote 60% to 80% positive tests at some time during the course of their cases diagnosed S.L.E. 72% of the cases at this centre demonstrated a positive LE cell test during the course of their illness. Two of the cases included in this study were diagnosed rheumatoid arthritis with positive LE phenomenon until further systemic involvement changed their diagnosis to S.L.E. There have been four other positive LE cell tests reported from the provincial laboratory, all of which are from patients diagnosed rheumatoid arthritis with positive LE cell phenomenon. If these four develop further system involvement, as did the two previously mentioned, then 100% of the positive LE cells tests in this hospital will be from patients diagnosed S.L.E. At present 10% of the patients in this centre with a positive LE cell test are not diagnosed S.L.E.

Positive LE cell tests have been reported by others in patients with many disorders, including, rheumatoid arthritis, allergic disorders, hepatitis, hydralazine intoxication and Hashimoto's disease. Some authors would argue that all false positive LE cell tests are from patients with sub-clinical S.L.E. or that the criteria for a positive test were not strictly observed. There has been no conclusive material published on the effect of corticosteroid on the LE cell test. It is well documented that a positive LE cell test may revert to negative during a clinical remission, whether the remission is associated with corticosteroid therapy or not. The significance of the false positive LE cell test, and the effect of corticosteroid therapy on the test, await further clarification.

PART 3

The concept of S.L.E. as a complex immunological disorder stems from two sources. First, there has been mounting evidence that S.L.E. serum

contains many antibodies that will combine with substances not usually antigenic. These antibodies can affect the formed elements of the blood resulting in hemolytic anemia, leukopenia and thrombocytopenia. The LE factor, rheumatoid factor, antithyroglobulin and false positive Wasserman factor are known to occur in S.L.E. serum and their concentration can be measured. Recently, an antibody to the desoxyribonucleic acid (DNA) of nucleoprotein has been demonstrated. Since DNA is a major constituent of all nucleoprotein and is therefore found in all cellular tissue, the potential site of action of this antibody is unlimited.

The other suggestive evidence comes from tissue transplantation studies. A rat can be made to tolerate a homologous but antigenically different tissue graft if it has been exposed to that tissue as an embryo, or if its immune responses are depressed by ionizing radiation. If the graft is not sloughed the rat may develop "runt disease", a syndrome of weight loss, skin disturbances, anemia and leukopenia. This is possibly due to antibodies against the host tissue formed by immunologically competent cells of the graft. Although no LE cells have been reported in this "graft-vs-host" response, the clinical and pathological picture is reputed to resemble S.L.E.

There are major problems as yet unanswered. What stimulates the production of the antibodies? Are they evoked by abnormal tissue breakdown products? Are they randomly secreted by plasma and lymphoid cells? Are they due to a disruption in the mechanism by which the organism differentiates its own tissues from foreign protein and thus normal breakdown products become antigenic and evoke antibodies.

This last concept is supported by the work of Burnet. He postulates that the embryo can potentially make antibodies to every antigen. This ability lies in the mesenchymal cell groups which will eventually become protein secreting plasma cells and perhaps lymphocytes. Late in embryonic life the organism "takes stock of itself" and those cells which could make antibodies to its own tissues are somehow eliminated or suppressed. Thus the organism becomes tolerant to its own tissues.

If this elimination or suppression process is not complete, those unsuppressed cells may multiply enough to secrete significant amounts of antibodies to its own tissues and possibly cause the syndrome of S.L.E.

The role of antibodies in the etiology of S.L.E. has not been established. The clinical picture of S.L.E. has been reported in patients with hypogammaglobulinemia. LE positive mothers have given birth to unaffected yet transiently positive children. The LE factor has not been demonstrated to affect an undamaged leukocyte *in vitro*. The weight of evidence favors the position that the antibodies do not cause S.L.E. It has been suggested that the lymphocytes and plasma cells might be the aggressive element in the pathological process, not only secreting the antibody but also attacking the tissues.

SUMMARY OF THE CONCLUSIONS OF RUPE ET AL

- prolonged and frequently benign course
- more common in males than previously reported
- classification—chronic continuous 89%
- severe intermittent 10%
- acute fulminating 1%
- prognosis—worst female with butterfly rash, systemic lesions and no arthritis
- best male without evidence of renal disease

IN SUMMARY

The clinical picture of 24 cases of S.L.E. has been reviewed and compared with findings from other centres. The course of 13 of these cases, followed throughout their illness at this hospital, has been noted. The experience at this centre has been similar to that of other centres except there is a lower percentage of males and an unusual distribution suggesting the occurrence of two groups. The mechanism and specificity of the LE cell test was reviewed and the low incidence of false positive tests reported by the provincial laboratory was noted. The concept of S.L.E. as a disease of autoimmunity was briefly explored and some of the outstanding problems were mentioned.

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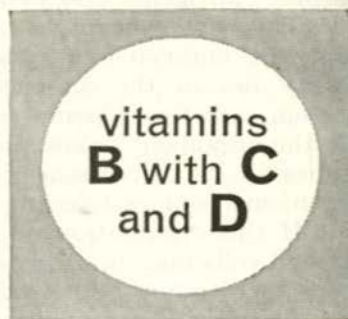
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TUBERCULOSIS - 1962

J. E. HILTZ, M.D.

Kentville, N. S.

Tuberculosis 1962 differs from Tuberculosis 1952 mainly in that there has been a very satisfactory reduction in the death rate but an unsatisfactory reduction in the incidence of new cases and reactivations. There are now shortened periods of in-sanatorium stay for some patients due to the availability of effective antimicrobial therapy and the undertaking of earlier resectional therapy to remove potentially dangerous residual lesions. There is an increasing incidence of primary and secondary drug resistance of the tubercle bacilli to the first line antimicrobial drugs. There are now fairly effective though potentially dangerous second line drugs for those persons resistant or hypersensitive to the first line drugs, streptomycin, PAS and isoniazid. Finally, there is a greatly increased need for more intensive clinic services for the supervision of patients discharged from sanatorium to continue home treatment for prolonged periods of time.

Tuberculosis of parts of the body other than the lung, such as kidneys, spine, hip or meninges, is the result of haematogenous or lymph spread of tubercle bacilli. In almost every case, there was a prior active lung lesion. Milk as a source of infection is no longer an important factor in the Western world. Spread of tuberculosis from a patient with the disease to one without it is the only method of propagation and perpetuation of tuberculosis worth considering. For this reason, the treatment in a tuberculosis hospital of a patient with active disease is a prime means of preventing its spread to family or other members of the community.

The first and most lasting indication that tubercle bacilli have attained a foothold within the body tissues is a positive tuberculin reaction. Neither a tuberculin test nor an X-ray examination of the chest will reveal positive findings during the first five or six weeks following primary infection. After this interval, the X-ray examination will sometimes show evidence of early infection but the tuberculin will almost invariably do so and will usually continue to indicate this original infection, whether healed or active, throughout the patient's lifetime.

Except for vaccination against tuberculosis, nothing will cause a tuberculin test to be positive other than tuberculous disease. This is why tuberculin test surveys are such good indicators of the degree of tuberculous infection, past or present, within any population group. They make it possible to disregard large numbers of negative reactors when searching for cases of unsuspected tuberculosis in the community at large.

Every recent conversion of a tuberculin test from a negative to a positive reaction indicates a recent implantation of tubercle bacilli within the body. As such, treatment with antimicrobial drugs is indicated. In the absence of symptoms and a demonstrable lesion treatment should continue for a year with one or more drugs augmented by the maintenance of a high degree of general body resistance by good food and adequate rest. Schooling or normal work routines should not be interrupted but X-ray examination of the chest is indicated three times in the first six months and then every three months for the next eighteen months and then yearly.

If an obvious lung lesion is present, work or school routines must be altered. If a primary lesion is very small and does not produce symptoms and gastric washings do not demonstrate tubercle bacilli on culture, the patient will benefit from moderate bed rest to augment drug treatment. This may be carried on safely at home. When the lesion is gross and the sputum or the gastric washing cultures reveal tubercle bacilli, institutional treatment is indicated.

In almost all cases, primary infection tuberculosis heals, frequently without the patient being aware of its presence. Four to five per cent of such persons, however, will develop reinfection tuberculosis during the next one to thirty years. All such reinfection tuberculosis should be treated in a tuberculosis hospital or sanatorium. Indeed, this is the type of tuberculosis generally seen among adults.

Tubercle bacilli exposed to a single antimicrobial drug will develop resistance to it in four to eight weeks. A combination of two drugs will prevent the development of this resistance if the bacilli are sensitive to both of the antimicrobials. If the bacilli are resistant to one of these drugs, the result is the same as if the other drug had been administered alone; that is, the bacilli become resistant to the second drug in four to eight weeks.

Depending on the area of Canada under discussion, five per cent to 25 per cent of all new cases of active tuberculosis admitted to hospital for treatment will have tubercle bacilli already resistant to one or all of the three first line antimicrobial drugs, streptomycin, PAS and isoniazid. Unfortunately, it usually requires three to four months to demonstrate this fact in the laboratory.

For these reasons, new cases of tuberculosis now must begin treatment with all three drugs in the hope that the tubercle bacilli will be sensitive to at least two of them which will therefore be an effective form of treatment for many months or years. If, however, the bacilli are resistant at the beginning of treatment to two of the drugs, the third drug will be effective for two to four months; if originally resistant to all three, the drugs will be almost useless and the patient will have to rely only on the old curing principles of bed rest, good food and general supportive measures such as fresh air. Bed rest is finding an increasing place in the treatment of tuberculosis once again. The form of bed rest is usually somewhat modified from the old "strict bed rest" which now is required for only seriously ill patients.

Our second line drugs include ethionamide, pyrazinamide and cycloserine, which are moderately effective in combination, and also the less useful terramycin, thiosemicarbazone, viomycin and kanamycin. All are relatively toxic especially to the liver, the nervous system or the gastrointestinal tract. Each must be given only under strict laboratory supervision.

Every year, about one per cent of all the known cases of inactive tuberculosis develop active disease once again. As there are over 10,000 such persons in Nova Scotia this represents quite a sizable number of reactivations. They are, however, kept to a minimum by resecting, whenever surgically possible, all appreciable lesions which remain after adequate medical treatment. If not resected, they may well reactivate after a lapse of two, five, ten or twenty years.

Modern control of tuberculosis on both the individual and the community basis, then, consists of preventing the spread of tuberculosis to others by the

institutional treatment of patients with lung disease; by providing triple anti-microbial therapy with the first line drugs for all new cases, at least until definite drug sensitivities can be determined by the laboratory in three to four months; by using second line drugs only when the preferred ones are ineffective and then only under strict laboratory supervision; by providing general supportive measures such as modified bed rest, fresh air, good food and control of concomitant disease such as diabetes for all cases but most especially for those infected by wholly or partially drug resistant tubercle bacilli; and by the surgical removal of appreciable residual pulmonary lesions which do not disappear following adequate medical treatment.

Extrapulmonary tuberculous lesions are evidence of a systemic spread of tuberculosis from a primary focus usually in the lung. This primary lung lesion may have healed before the systemic lesion produces symptoms and so becomes evident. Such extrapulmonary lesions are often multiple. One-fifth of all cases of spine tuberculosis also have this disease in the genito-urinary tract. Such extrapulmonary systemic disease requires treatment for the local manifest lesion, investigation for latent or unsuspected complicating lesions and general supportive treatment for at least three to six months in a tuberculosis hospital to help overcome the systemic infection.

It is important and gratifying to bring about recovery of the patient. It is equally important to forestall the spread of tuberculosis to others and prevent the perpetuation of this disease which still costs the taxpayers of Nova Scotia over two million dollars annually.

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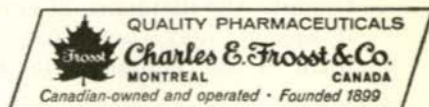
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CYSTIC DUCT REMNANTS

J. C. VIBERT, M.D., F.R.C.S. (C.)

Truro, N. S.

When the gall bladder is removed, a portion of the cystic duct where it attaches to the common duct is left behind. When this cystic duct remnant is removed subsequently it is found to contain cystic duct, sometimes a portion of the gallbladder and in addition the cystic vessels autonomic nerves, connective tissue and sometimes lymph nodes. In the surgical literature, especially in the past twenty-five years, cystic duct remnants have been considered to be a frequent cause of persistent or recurring symptoms after cholecystectomy. I recently reviewed the experience at the Mayo Clinic with these lesions.

On reviewing the literature, one finds that Oddi described changes in the biliary tract after cholecystectomy as far back as 1887. He stated that after the gallbladder was removed from dogs, the hepatic, common and cystic ducts all dilated to two or three times normal size and the cystic duct seemed to be transformed into a reservoir for bile and had the appearance of a newly formed gallbladder. These experiments were repeated and confirmed by Judd and Mann in 1917 and by Hartmann and others in 1922. Hartmann stated that the cystic duct hypertrophied as well as dilated and concluded that when a cystic duct was left after surgery, it usually dilated to form a pseudo gallbladder and hence a recurrence of symptoms could follow after cholecystectomy. In 1936 Beye spoke of cystic duct remnants as "reformed gallbladders". In sixty-six secondary operations on the biliary tract he found four large club shaped remnants of cystic duct containing stones and he believed these had caused the persisting distress after cholecystectomy. Since then many surgeons have written on this subject: Glenn, Cole, Garlock, Gray and others. Glenn has even stated that cystic duct remnants are one of the commonest causes of post cholecystectomy symptoms—perhaps even more common than residual common duct stones or strictures. On the other hand, Weir and Snell stated that colic attributable to incomplete cholecystectomy is rare and Judd said he had never seen a cystic duct remnant cause symptoms. The Swedish surgeon, Millbourne, studied 379 cystic duct remnants at surgery or at autopsy. He stated that in all cases of cholecystectomy the surgeon leaves a cystic duct stump and that because of the variable anatomy of the area, it is often longer than he realizes. But in no case that he studied did he think that the cystic duct stump caused any symptoms.

Womack and Crider and others have written that they believe it is neuroma formation in the cystic duct remnant that causes trouble. The cystic duct region is one rich in nerves as can be seen at every cholecystectomy. These nerves are parasympathetic from the vagus and sympathetic from the coeliac ganglia. The sympathetic nerves are post ganglionic grey rami communicantes, and although non-medullated they do have a neurilemma or sheath of Schwann and, therefore, according to Masson, they can regenerate and form a neuroma. There have been a few isolated reports in the literature of jaundice due to a neuroma obstructing the common duct after cholecystectomy.

The question of where gallstones form is an interesting one. Beye and Peterson believed that they often formed in cystic duct stumps. Glenn also thought the incidence of stones in cystic duct remnants was so high (30%) that it was unlikely they were left at cholecystectomy and, therefore, they must form in the remnant after cholecystectomy.

Most writers have indicated that the results of removing cystic duct remnants are good. Mock stated that "careful removal of the excess stump or reformed gallbladder brings about a cure in almost every instance."

MATERIAL AND METHODS.

For the purpose of this study I reviewed the case records of all patients seen at the Mayo Clinic who had a diagnosis of cystic duct remnant from 1916 to 1955, a period of 40 years. One hundred and seventy-eight such cases were found; they had all had a cholecystectomy, either at the Clinic or elsewhere; and they all had a cystic duct remnant removed. In addition, I studied the specimens which were preserved in the pathological museum, both grossly and microscopically and obtained follow up information on as many of the patients as possible.

FINDINGS

My findings were as follows: Of the 178 patients who had cystic duct remnants removed, 63 were found to be harbouring common duct stones which were removed at the same time, 7 had gastric resections and one had gastro enterostomy at the same time, 2 had resections of portions of pancreas, one had ectopic pancreas removed from the stomach, 2 had hiatus hernias repaired, 7 had sphincterotomies and 4 had choledochoduodenostomies. Since it is impossible to say how important the cystic duct remnants were in the symptomatology of these patients, or how significant their removal was in the patients' subsequent course, these 87 patients will not be discussed further. There are left 88 patients who had cystic duct remnants as the main pathological finding at operation.

The interval between cholecystectomy and the onset of symptoms referable to the biliary tract was determined. In 33 of the 88 patients there was no interval at all; they were not relieved at all by cholecystectomy. The interval in the other patients varied all the way up to 34 years.

The symptoms they complained of were: 72 had pain; in 55 it was colicky; in 17 not colicky; 24 had jaundice or history of jaundice; 15 had definite fever and chills.

Intravenous cholangiography was not done in any of these cases. The only lab and X-ray procedures that were commonly done and that proved of much value were the flat film of the abdomen and the direct reacting bilirubin determination. The flat plate was only of value when it was positive and showed calcific densities in the right upper quadrant. The direct reacting bilirubin was present in 14 cases; absent in 52 and not determined in 22.

In assessing the results these patients obtained from having a cystic duct remnant removed, one year was taken as a minimum follow-up period. Failing information after this time, the result was classified as "not known." Results from the remaining cases were classified as "good" or "bad." If a patient had any of the three major symptoms of biliary tract disease, namely upper abdominal pain, jaundice or chills and fever related to the biliary system, it was classified as a bad result. Thirty-five patients had good results; 38 had bad results and in 15 the result was not known. The percentage of good results was not higher in those patients who had stones in the remnant; it was not higher in those patients who had neuroma in the remnants; it was not higher in those patients who had choledochostomy and T-Tube drainage as well as removal of the remnant; however, the percentage of good results was much higher in those patients who had positive tests for direct bilirubin—that is those patients who clinically or sub-clinically had obstructive jaundice.

Cystic duct remnants were not very common in the experience at the Clinic. They were seen once in about 250 operations in the biliary tract and once in about 20 secondary operations on it. In one-third of the cases in which remnants occurred common duct stones were also present.

They did not always cause symptoms. One was found incidentally at necropsy; others were observed roentgenographically in patients who did not have clear cut symptoms and did not come to surgery. More than half of the patients who had remnants removed continued to have the same distress afterwards so there must have been some other explanation for their symptoms.

Most of the patients who had cystic duct remnants removed also had the common duct explored and T-Tube drainage of it for 10-30 days. This reflected the reluctance of the surgeons to place the blame on the remnant. It seems reasonable to say that in all these cases the common duct should be explored unless the surgeon is satisfied by operative cholangiography or by examination and palpation that it contains no stones.

Some writers have stated that stones form in cystic duct remnants and this is probably so occasionally. However, this study would not lead one to believe that stones form in a remnant very often because many of these patients had symptoms as soon as they recovered from cholecystectomy and it would seem that they were afflicted with a residual rather than a new disease.

In summary then cystic duct remnants are uncommon. The symptoms they produce are the same as common duct stones and stricture—pain or jaundice or chills and fever or indigestion. In a study of 178 patients who had cystic duct remnants removed, about a third had common duct stones. Of 88 patients who had cystic duct remnants removed and no other pathology found, 35 were relieved of their symptoms. In some cases it was easy to explain why, for the remnant was obstructing the common duct or contained stones which could cause colic and obstruction. But in some cases the reason was not obvious. Possibly cystic duct remnants are like diverticula elsewhere which are sometimes symptomatic, sometimes not. Perhaps they allow stagnation of bile and infection which spreads throughout the biliary system. Possibly they allow precipitation of bile constituents and formation of new calculi but it is more likely that calculi found in them were left when cholecystectomy was done. Perhaps they disturb the motility of the bile duct and the relaxation of its sphincters. In any case their removal is not a certain cure.

RESIDENCY TRAINING IN OPHTHALMOLOGY

Applications for enrollment in a four year training program in the teaching hospitals of the Faculty of Medicine, Dalhousie University, for the year beginning July 1st, 1963 and subsequent years, may be obtained from

The Post-Graduate Division, Faculty of Medicine,
Dalhousie University, Room 209,
Dalhousie Public Health Clinic, University Avenue,
Halifax, Nova Scotia

This training program is accepted by the Royal College of Physicians and Surgeons of Canada as preparatory to their examinations.

PARA-MEDICAL ORGANIZATIONS (4)

HOW CAN WE SERVE YOU?*

From time to time it becomes clear that a Physician practising in some part of the Province is unaware of the services provided by the Canadian Arthritis and Rheumatism Society (Nova Scotia Division). This note is intended to clarify the situation:

(1) **DIRECT TREATMENT SERVICES.** For the most part this takes the form of Mobile Physiotherapy Units, that is a registered Physiotherapist with an automobile can go to your patient's home and administer physiotherapeutic treatment. This treatment should be carefully prescribed, and we suspect that sometimes doctors hesitate to order Physiotherapy because of unfamiliarity with the writing of physiotherapeutic prescriptions. Because of this we have recently simplified our physiotherapy requisitions so that little more than check marks are required to produce the desired form of treatment.

Physiotherapy services are available in Halifax, Dartmouth, Sydney, Glace Bay, Pictou County, Colchester, East Hants, and Yarmouth County. In some instances in addition to home treatments it has been possible to find a place where equipment could be stored and a Centre provided, so that patients could go to the Physiotherapist, thereby making it possible for her to treat more people more easily in the same time.

The Society's policy is moulded by the Medical Profession through Medical Advisory Committees and casual contacts. If you have suggestions or inquiries address them to 353 Bayers Road, Halifax, N. S.

(2) **FELLOWSHIPS - CLINICAL - RESEARCH.** If you are interested in a career in a specialty closely related to the Rheumatic Diseases field, the Society has clinical Fellowships usually for training aimed at Specialist qualification.

If you are interested in Research in the Rheumatic Diseases field, the Society makes grants for approved studies of this kind.

(3) **SPEAKERS ON RHEUMATIC SUBJECTS.** If your Medical Society wants a speaker in the Rheumatic Diseases field, the Society will endeavour to see that one is available for your meeting. We co-operate with the Post-Graduate Division of Dalhousie University in this field. It might be added that we have at present an excellent film in colour with sound "The Prevention of Deformity in Rheumatoid Arthritis" which we would like to exhibit to every Doctor in Nova Scotia. A word from you to the Secretary of your Medical Society would help us to arrange this.

(4) **REGIONAL COURSES.** Still on the subject of medical information and education, the Medical Post-Graduate Division of Dalhousie worked with us in arranging a Regional Course consisting of five evening sessions, dealing with various aspects of Rheumatic Diseases, last Fall. We are anxious to go ahead and organize more such programs.

(5) **TREATMENT.** How can we help you with the treatment of your Arthritic patients? We have available to you, handbooks for patients with

*The Canadian Arthritis and Rheumatism Society

Rheumatoid Arthritis, Osteoarthritis, Gout and we hope soon to have one on Spondylitis. We believe that you will find these helpful in helping your patient to understand his illness and its treatment. A simple set of diagrams of essential therapeutic exercises is available to accompany these booklets. They may be obtained by Physicians from the Society's Nova Scotia Office, the address at the foot of this article.

(6) LOCAL BRANCHES. It may be that you feel that there is a need for the services of the Canadian Arthritis and Rheumatism Society in your district of the Province, and in this event you can communicate with the Society and we will be most happy to consider establishing a Branch in your neighbourhood.

(7) TRAVELLING CONSULTING SERVICES. In Cape Breton County the Society's Medical Consultant is available one morning each month in each of four Centres (Sydney, North Sydney, Glace Bay and New Waterford) to see medically indigent individuals formally referred in consultation by their personal Physician. If you refer your patient to him you will receive within a short time a written report of his findings, conclusions and recommendations. No drugs will be prescribed. The patient will not be seen again unless you refer him again.

In Yarmouth a Travelling Medical Consultant has been visiting twice a year for the same purpose.

(8) BULLETIN OF THE RHEUMATIC DISEASES. Most Physicians receive the "Bulletin of the Rheumatic Diseases". This 2-4 page pamphlet is published by the American Rheumatism Foundation about ten times a year, and distributed by C.A.R.S. in an effort to provide quick, easy, authoritative information about recent thinking and advances in the field of Rheumatic Diseases to practitioners. If you want to receive the Bulletin and are not already doing so please notify the Society at the address at the foot of this article.

The Canadian Arthritis and Rheumatism Society,
353 Bayers Road,
Halifax, N. S.



FIVE YEARS OF FLUORIDATION, HALIFAX

GORDON DAWSON, D.D.S., D.D.P.H.*

Halifax, N. S.

PROGRESS REPORT

In June 1956, the Public Service Commission at the request of the Halifax City Council started to adjust the fluoride content of the city water supply to 1.2 p.p.m. This was set as the optimum dosage for this area where the average maximum daily air temperature is 53.3 F. The formula used for correlating average temperature and fluoride dosage was developed by Dr. Galaghan of the United States Public Health Service.

The decision to adopt fluoridation was made by the City Council following recommendations from the City Board of Health and the Halifax County Medical and Dental Societies.

Following the pattern of other centres where fluoridation programs are in progress, a pre-fluoridation dental survey was carried out in eight city schools in 1956. The schools selected for this survey were Bloomfield, St. Thomas Aquinas, Alexandra, St. Agnes, LeMarchant, St. Patrick's Elementary, St. Patrick's Junior High, and Cornwallis Junior High. It was felt that these eight schools would yield a representative sample of varying economic levels. The statistical methods of sample selection laid down in "A Methodology for Conducting Fluoridation Surveys," (National Health & Welfare) were followed.

In all, some 1,500 children were examined, 500 in each of the following age groups: (6 - 9); (9 - 11); (12 - 14). This pre-fluoridation dental survey provided a base line against which subsequent surveys, planned for five year intervals, could be compared.

In 1961 a second dental survey was carried out in the same eight schools, using the same method of sample selection as the 1956 survey. Only those children who were continuous residents of the city since birth, with no one absence of more than six weeks were included in these surveys. The improvement shown by a comparison of these surveys followed the same pattern established in other fluoridation surveys viz., the greatest improvement in the younger age groups (6 - 11). There was no significant change in the 12-14 age group.

CITY OF HALIFAX

Comparative results of pre-fluoridation and five years experience

	1956		1961		1956		1961	
	6-8 yrs.		9-11 yrs.		12-14 yrs.			
Number of children examined and charts completed.....	509	528	629	522	519	544		
Total.....	1651	1594						
A. D.M.F. per 100 children (diseased, missing & filled)	180.15	110.79	394.12	366.01	658.18	797.79		
B. Mortality Index per 100 children (extracted teeth).....	27.50	10.4	92.37	87.28	158.57	80.34		
C. % of children caries free...	35.95	53.97	4.92	11.11	1.15	.18		
D. D.M.F. per 100 teeth.....	20.10	12.58	22.38	21.17	25.39	32.16		

* Director of the Division of Dental Health with the Province of Nova Scotia.

In 1956 the average child (6 - 8) group had 1.8 decayed, filled or missing permanent teeth.

In 1961 the average child (6-8) group had 1.1 decayed, filled or missing permanent teeth.

A 39% REDUCTION

In 1956 the average child (9 - 11) group had 3.9 decayed, filled or missing permanent teeth.

In 1961 the average child (9 - 11) group had 3.6 decayed, filled or missing permanent teeth.

AN 8% REDUCTION

In 1956, thirty-six percent of the children in (6 - 8) group had no tooth decay. (permanent teeth)

In 1961, fifty-four percent of the children in the (6 - 8) group had no tooth decay. (permanent teeth)

In 1956, five percent of the children in (9 - 11) group had no tooth decay. (permanent teeth)

In 1961, eleven percent of the children in (9 - 11) group had no tooth decay. (permanent teeth)

While it is a well established fact that fluoridation will substantially reduce the incidence of tooth decay in the child population, the exact mechanism of how it works is not as yet fully understood. The current and accepted theory is that there are two processes at work, viz.:

1. The fluoride ion is incorporated into the tooth structure during the development of the tooth.
2. The fluoride ion is absorbed into the surface layer of the tooth enamel after the tooth erupts.

One would judge from the pattern shown by the surveys at Brantford, Newburgh and Grand Rapids that No. 1 is more important. In order to obtain the maximum benefit from fluoridation a child must spend his entire lifetime, from conception to late adolescence in a fluoridated environment.

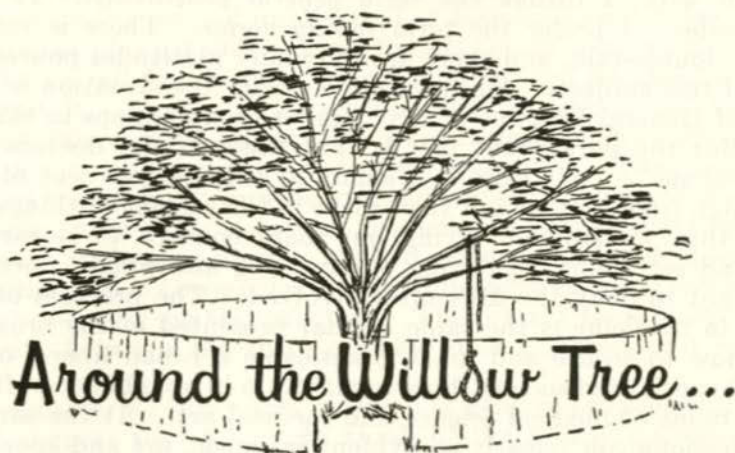
The encouraging progress that has been made after five years of fluoridation bears out the assumption that this is a valuable adjunct in the control of dental disease. In a relatively short time the prevalence of tooth decay can be reduced to a point where it can be economically controlled by treatment and practically eliminated among those who practice good eating habits and good oral hygiene. The annual cost of fluoridation in Halifax is under eleven cents per capita.

“There is not one single thing in preventive medicine that equals in importance mouth hygiene and the preservation of the teeth.”

- Sir William Osler. -

Editor's Note:

We wish to thank Allan R. Morton, M.D., C.M., M.P.H., Commissioner of Health and Welfare, for his assistance in preparing this article.



MEN OF THE MIDDLE PROPOSITIONS*

E. P. SCARLETT, M.D.

We as a profession have a good deal of re-thinking to do, and based on it, practical action to initiate, on a number of subjects that should be causing us immediate concern. The necessity is not in any sense a new one. Nonetheless as our society becomes more complex and urbanized, and as the body of available knowledge in all fields continues to expand, the task of medicine takes on a new urgency and new dimensions. We must achieve broad perspectives to insure that our development is in a direction commensurate with medicine's increased social responsibility. Medical care is now a matter of major concern for the nation. The commodity of health is now the fifth freedom to which all are entitled. This is part of the social revolution of our time. The doctor as a result has become in a sense a public utility—a state of affairs, of course, which goes against the grain of our traditional medical stiff-necked individualism.

It is increasingly evident that as a profession we can no longer rest in the assurance that the well-being of medicine in the body politic is being adequately served by advances in scientific knowledge and by pronouncements from medical associations that all is going well. That line is played out. Medicine must adapt its corporate organization to the new order. In the process we should not fear that a more effective accommodation of medicine to social needs and national goals will necessarily destroy the freedom and individual initiative and creativity of the body of medicine.

The truth of the matter is that, like so many other departments of our society, our medical establishment presents many anomalies, weaknesses and imbalances, some due to social and economic pressures, some to professional

*Most of this material has recently appeared in *Group Practice*, the *Journal of the American Association of Medical Clinics* to whose editor, Dr. E. P. Jordan, we are indebted for permission to reproduce here.

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development, and others to plain *laissez-faire*. Take, for example, the position of so-called general practice in the medical scheme of things.

To begin with, I dislike the term *general practitioner*. It suggests a Jack-of-all-trades. I prefer the term *family doctor*. There is much cloudy thinking and double-talk, and there are too many platitudes poured out in the discussions of this subject. An attempt to clarify the situation is being made by Colleges of General Practice and by similar organizations in this and other countries. But the paramount fact is that these family doctors—"the yeomanry of medicine"—constitute in Canada at least 65 per cent of the profession. It is high time that we got their place in the scheme of things into better perspective, that we stopped giving our main concern to research and the specialties, and set about organizing our training and practice accordingly.

That is not to deny the difficulties involved. The problem of the family doctor body in medicine is the same as that presented in the broader field of education—how to secure and make practicable a broad liberal outlook in a technical and specialized society, how to maintain in a viable and effective form the Siamese twins of medical science and medical art. At the same time the curse of professionalism (clearly so evident in music, art and sport) must not be allowed to blight medical practice, to place a distorted premium on the special performer, for the result is a false scale of judgment, distorted values and the destruction of unity in society.

But the task is not impossible. There are many powerful factors favouring a clear delineation of general practice and its effective part in the medical task-force. Most of the ills of the public do not require elaborate agencies or highly specialized practitioners; people want a family doctor rather than the services of super-hospitals and a ring of specialists; the general practice order is more economical; medical currents are beginning to flow in the direction of the family doctor.

So the time has come for a better integration of medical practice, linking general and specialized practice, so that the best assets of each can be combined to the full advantage of the patient. Great changes are in the making, and it seems that we are about to write another chapter in medical history. It is imperative, however, that we get down to the business more actively than we have been doing. Medicine has always monitored and governed and improved itself, and we must continue these disciplines in this instance. In doing so much of the present confused criticism of our profession would be obviated and fewer doctors would hanker after the fancied fleshpots of the specialist. There would be less tendency to impose (and that, loosely) the metropolitan type of medical practice and standards on less densely settled and less complex areas. Education in our medical schools could clarify their aims and teaching.

No Privileged Aristocrats in Medicine

The re-orientation I think is beginning to take form. Experimental programmes are being launched in medical schools here and in Europe. Stimulating influences to this end are the development of group practice with its central core of family doctors, and the formation of medical centres. Both movements are charting novel pathways and creating a new vitality in the old order by developing and maintaining principles and standards and creating a new pattern of integration of the resources of surgery and medicine for society.

In this movement into new channels of medical practice there are many reactionary voices to be heard and much ill-informed criticism—a lot of it from the comfortable and privileged strongholds of the contented specialists. There is a great deal of nonsense talked about the impossibility of one mind being able to grasp the whole field of medicine. This frankly is a Bourbon argument if

there ever was one. There are no privileged aristocrats in medicine. As I see it, it is perfectly possible to have applied knowledge and working skill to deal with the vast majority of human ills. However excellent specialisation has been for the advance and application of technical knowledge, it is ruinous in practice unless planted on the firm foundation of general medical learning and skill. We are all for the most part empirics, and we should know it and honestly admit it. A man of experience and conscience in the practice of medicine is by this very token capable of referring his more difficult problems. Such a man has acquired the instinct of his ignorance. That is my definition of an educated man—and it applies to an educated physician as well.

There is an indivisible trinity in medicine — experimental science which resides in the schools of medicine, applied science exhibited most effectively in the specialties and in the medical schools and centres, and practical medicine, the sphere of so-called general practice. There must be a reasonable balance and reciprocity between the three. They must intersect and react on each other.

In thus considering this whole question of general practice within the medical world, I suggest that we might think of the family doctors (the general practitioners) as "men of the middle propositions."*

This splendid phrase I owe to one of the saints of medicine, Dr. John Brown of Edinburgh (better known to the world as the author of the immortal story "Rab and His Friends"). In a book of medical essays entitled "Locke and Sydenham" published in 1882, Brown deals eloquently and in language full of good sense, learning and wit with the character of the general practitioner in medicine. In words as applicable today as eight decades ago, he considers how we may leaven what Mill has called the *generalia* of knowledge.

"The great problem in the education of our young men for the practice of medicine in our times," he writes, "is to know how to make the infinity of particulars, the prodigious treasures of mere science, available for practice—how the art may keep pace with, and take the maximum of good out of the sciences." This fine phrase stems from Plato (it embodies the classical virtues of the Greeks) and occurs in a passage from Bacon's *Advancement of Learning*. The passage itself is so remarkable that I must quote it.

"Particulars are infinite, and the higher generalities give no sufficient direction in medicine; but the pith of all sciences, that which makes the artisan differ from the inexpert, is in the middle propositions, which in every particular knowledge, are taken from tradition and experience."

So, I say, family doctors should be "men of the middle propositions." They are men who take their stand between speculative science and active application of that science, between specialized knowledge and facts and their selection and application, between technology and informed art, between the desirable maximum of knowledge and the essential minimum of sagacity and judgment. In such a stance is to be found the whole art of medical practice. Such men will have stereoscopic lenses fitted into the frame of a physician's duty. These are the "men of the middle propositions."

* A correspondent has objected to this phrase "middle propositions", stating that it really means "mediocre" and could be construed as a defence of osteopathy, chiropractic and all varieties of "*laissez-faire*" in medicine. The family doctor with limited training, he argues just cannot do the job I am asking of him. "Gunbarrel vision," he says, "is not confined to solo specialists". I still stand by my thesis. I am not pleading for a levelling down, but rather asking for a broad human approach in practice which is so often missing in the specialized ranks of medicine. Admittedly all physicians, whether family doctors or specialists, are far from reaching my expressed ideals—but that should not deter us from setting up such ideals. My point of view might possibly be better expressed if one spoke of "men of the *human* propositions". It is this *human* or *middle* ground that is the saving grace of medical practice. I refuse to concede that this middle ground means a lack of skill and knowledge.

PERSONAL INTEREST NOTES

We are glad to welcome Dr. Roberta Nichols as the author of this column, and the Notes below are her first contribution in this role. Thank you Dr. Nichols, it is nice to have you with us.

Unfortunately this does mean that we have regretfully to accept Dr. Jack Quigley's resignation. He has edited this column for three years now, and under his sure hand it has become a well loved and valued part of the Bulletin.

Branch secretaries please note that Dr. Nichols is always looking for copy. If it interests you it will probably interest some other member of the Society. She can always be reached at the Halifax Children's Hospital.

HALIFAX MEDICAL SOCIETY

The Semi-annual Dinner Meeting of the Society was held on October 10th at the Lord Nelson Hotel. The guest speaker was Professor Ronald Hayes of Dalhousie University who spoke on Oceanography in Halifax. Dr. Hayes has been one of the pioneers in this new development so it was interesting to learn of it from the inside as well as "down under".

The Medical Arts Building, Spring Garden Road has just added two new floors. Many of the former occupants are busy changing offices while new ones are settling in. There are about fifty doctors now using this building.

Dr. W. A. Cochrane is back from the International Paediatric Conference in Lisbon, Portugal at which he spoke on Cystic Fibrosis. At the Great Ormond St. Children's Hospital in London, he was also a guest speaker, and earlier in this month gave the "Eccles Memorial Lecture" at the University of Western Ontario.

The International Paediatric Conference was also attended by Drs. Helen Hunter, Halifax, and Dr. U. Weste, Dartmouth.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

Most of the Doctors have had their summer holidays by now. Probably the most notable of these is the month spent in South America by Dr. F. Melanson. He enjoyed himself tremendously and tells us he missed an earthquake by half a day.

We would like to congratulate Dr. J. J. Maillet of West Pubnico who was married recently to Miss Rose Howell of Hebron. They are honeymooning in the Caribbean.

We are pleased to see that Dr. P. Belliveau of Meteghan is now back home after spending a few weeks in hospital in Montreal. We are very pleased to say that he is in better health and doing some practice.

The last meeting of the Western Nova Scotia Medical Society was held at the Riverside Inn at Meteghan River, September 20th. The meeting was mostly routine business and this was preceded by a delicious chicken dinner. Our guest was Dr. C. J. Beckwith.

Dr. Robert Belliveau was again successful in boating a tuna at the Cape. A visiting Doctor, Dr. Norman Belliveau, originally from Belliveau's Cove also was successful in landing two tuna at the cape. Our congratulations to both these doctors.

THE SECOND ATLANTIC REGIONAL MEETING

The Second Atlantic Regional Meeting of the Royal College of Physicians and Surgeons of Canada was held at the General Hospital, St. John's, Newfoundland in conjunction with the Annual Scientific Meeting of the St. John's Clinical Society, The Newfoundland Chapter of the College of General Practice of Canada and concurrently with the Annual Meeting of the Atlantic Orthopaedic Society from October 8-10. An excellent programme was presented. Papers were given by Drs. R. C. Dickson, E. B. Grantmyre, Lee Steeves, and J. L. Woodbury of Halifax, and Dr. J. J. Quinlan of Kentville. Hurricane "Daisy" made necessary some alterations in the order of the presentations as guest speakers from Boston and Montreal were delayed in arrival. The famed hospitality of Newfoundlanders was enjoyed by all.

NOVA SCOTIA DIVISION OF THE CANADIAN ANAESTHETIST SOCIETY

The guest speaker at the September meeting was Dr. Robertson from Montreal who gave a most interesting talk on recent experimental work on the Neurogenic control of Respiration. The Recent Refresher course in Anaesthesia was attended by among others, Drs. Drury, Amherst; MacFarlane, Sackville; Skinner and Munro, North Sydney; Bird, Liverpool; Donaldson, Mahone Bay; Davidson, Wolfville; Carroll, Truro and Dr. Irene Cassels, Yarmouth. Most interesting discussions followed papers by the Guest Speakers, Dr. Stephens of Duke University and Abijayan of the University of Illinois.

BIRTHS

To Dr. and Mrs. J. R. Bishop (née Carol Ann Boland) of Dartmouth a daughter, Patricia Marie, at the Halifax Infirmary, September 29, 1962.

To Dr. and Mrs. F. G. Dolan, a daughter at the Grace Maternity Hospital on September 25, 1962.

To Dr. and Mrs. Donald Macfie (née Ruth Hart), a son, Ian Donald at the Grace Maternity Hospital on October 6, 1962.

To Dr. and Mrs. Nicholas Sinclair (née Florence Brigden, R.N.), Ketch Harbour, at the Grace Maternity Hospital a son, Roderick William Reay, on October 6, 1962.

CONGRATULATIONS

To Dr. F. A. Dunsworth, Associate Professor of Psychiatry, Dalhousie, who was elected President of the Canadian Psychiatric Association at the annual meeting in June 1962. Since then Dr. Dunsworth has been visiting the provincial divisions of the Canadian Psychiatric Association from Ontario West and has just returned to Halifax.

To Dr. Sol Hirsch, Associate Professor of Psychiatry at Dalhousie, on his election as President-Elect of the Maritime Psychiatric Association Meeting in Charlottetown, September 14 and 15.

To Dr. Robert O. Jones, Head of the Dept. of Psychiatry as he represents the Canadian Medical Association this month in Chicago at the American Medical Association's Conference on Mental Health and Disease.

OBITUARY

"A man who gave unstintingly of his time, his services, his life to the people of Bay of Islands, Newfoundland". So ended the tribute paid by "The Western Star" to Dr. J. I. O'Connell who died at Curling, Newfoundland, on September 25, 1962. He was born in Sydney, Nova Scotia in 1874, and graduated from Dalhousie in 1905. He was always keenly interested in his native Province and was a life time subscriber to the Bulletin. After practice in various places in Newfoundland and a distinguished military service during the first World War in which he was twice wounded and mentioned in dispatches for bravery, he settled in Curling, Newfoundland. There for 36 years he covered a huge area under most primitive means of conveyance and working conditions. He was one of the pioneers in that area in the field of Public Health and made use of all modern means as they came available to press the lessons home. As Medical Health Officer for that large and rugged area, he saw to it that the children, 2500 of whom he had brought into the world, were protected as far as possible against the scourges against which he had fought in the past. To his patients scattered in the coves and on the islands of that harsh territory he was their personal Grenfell or Schweitzer. To his family the Bulletin offers its sympathy.

PHYSICIANS' CHURCH SERVICE

On October 14th took place under the organization of Dr. C. M. Bethune, the first of what we hope will become an annual ceremony in Halifax, and which could well be followed in other communities. Robed in academic costume, over 30 of the Medical fraternity of Halifax, processed up the central aisle of the Cathedral Church of All Saints to their reserved seats under the pulpit. This Service was held this year on the Sunday nearest St. Luke's Day (Oct. 18). The First Lesson was read by Dr. K. M. Grant, President of the Halifax Medical Society and the Second Lesson by Dr. C. B. Stewart, Dean of Dalhousie Medical School. The Sermon was preached by Dean E. B. Cochrane and members of the Phi Rho Medical Fraternity acted as ushers. The church was filled by members of the doctors' families, as well as the regular congregation.

