

Ectopic Gestation

H. B. ATLEE

I SUPPOSE there is no painful pelvic disorder so fraught with diagnostic embarrassment as ectopic gestation. I have diagnosed it and found a normal pregnancy, pelvic inflammatory disease, uterine fibroids, no demonstrable pathology. I have diagnosed other conditions and found ectopic gestation. This is very face reddening—especially when a group of medical students, or the doctor who sent the case in, are craning their necks around you to view the exposed viscera. But I am very sure of this: If I lived the years of Methusaleh, and my mental and physical processes remained as prime as his must have done for the first seven hundred years, I would still find myself in the same unhappy situation from time to time.

But since even the dumbest of us learn something from our mistakes, I also have picked up a certain amount of low cunning which I attempt to exhibit in the face of any pelvic condition which might turn out to be an ectopic.

Of course any fool can diagnose the classical acute case. You have the clear-cut picture of internal hemorrhage associated with just enough vaginal bleeding to put you on the pelvic trail. You have the iliac pain—and so forth. It is what I call the chronic ectopic that gives you the pains in the neck.

Let me start off by saying that, if there is no vaginal bleeding of any kind, it is probably not an ectopic. This is an excellent rule to follow, since if you do follow it you will be wrong less often than by following any other rule. But, as is the case everywhere in the human body, there is no absolute rule. For instance, I used to believe that carcinoma of the cervix never occurred in a non-parous woman. For fifteen years at the Victoria General Hospital I never saw a case of cancer of the cervix in a non-parous woman. But since then I have seen at least two. So the rule about vaginal bleeding in ectopic is not always 100%: every now and then you do get a chronic ectopic where there is no vaginal bleeding. Despite the fact that I have seen a few such cases, I always keep my fingers crossed if I diagnose ectopic in the absence of vaginal bleeding—and usually I diagnose something else.

One of the reasons why chronic ectopic is so much harder to diagnose than acute, is that in the acute condition the blood poured out into the abdomen has not yet started the process that might be called peritonism. But once the blood has been in the abdomen for a while it begins to irritate the peritoneum and to cause (1) a rise of temperature and (2) a leucocytosis. If you have a patient with pain and tenderness in an iliac region with raised temperature and leucocytosis, you naturally think of pelvic inflammatory disease (let's call it P.I.D.) "But," the unwary and untutored will say, "in ectopic it's a very little temperature—a very tiny leucocytosis"! Sometimes it isn't. I've seen a temperature of 102 on several occasions: I've had a leucocyte count of over 20,000 surprisingly often. So I don't any longer use temperature and leucocyte count as yardsticks in a differential between ectopic and P. I. D. What I ask here is: Has there been any vaginal bleeding or staining dating back to the onset of the pain? If there has been such bleeding I call it ectopic: if there has not, and I can't satisfy myself it's P. I. D., I sit on my hands.

What value is a hemoglobin estimation? In acute ectopic, where you don't really need it, the hemoglobin estimation is valuable, since it is usually quite low. But in the chronic type of case, especially in that chronic type where the internal bleeding has been only a trickle, you may get a surprisingly high estimation. On the whole, however, these cases do present a low hemoglobin index—70 and under—and I personally find it very useful in making a diagnosis, though far less useful than vaginal bleeding or staining. But before leaving this subject let me relate the following: (1) Suddenly, on my service at the V. G. where hemoglobin estimations are done on all patients, I will notice that the chartings are persistently higher or lower than they were—sometimes strikingly so. The answer is that I have got a new interne. (2) On one occasion with an Adair Hemoglobinometer Dr. Colwell and I checked against one another and our then interne. Dr. Colwell and I on the first reading differed by about 15 points, with the interne in between. I made several subsequent readings of the same blood—and I differed from myself by a gamut of 20 points—which is seeing red with a vengeance! For the above reasons I do not entirely trust hemoglobin estimations.

The pelvic examination should determine the following if possible: (1) Is the cervix soft and patulous or not? (2) Is the uterus large and soft? (3) Is there a tumor in one or other postero-lateral fornix? (4) Is there a doughy mass of partially clotted blood in the Pouch of Douglas. (5) Do the fornices feel hot?

If the cervix is soft and patulous and the uterus large and soft, the condition is probably a threatened or inevitable abortion, despite the fact that the patient is complaining of one-sided iliac pain. According to the textbooks the uterus is large in ectopic gestation: my experience differs quite decidedly from this—or shall we put it this way: I am not able to appreciate in most cases the slight enlargement that is present. If there is a tumor in only one postero-lateral fornix—usually fairly, and sometimes exquisitely tender—that is confirmatory if other signs indicate an ectopic. But it is not always so. You can get P. I. D. with an unappreciable tubal swelling on one side and an appreciable one on the other. And you can have an ectopic without a palpable tumor in a tubal region. If there is no tumor, however, there will be tenderness, and I always say that tenderness is as important as tumor in pelvic diagnosis. If there has been more than the usual amount of internal bleeding in a chronic case, it lies in the Pouch of Douglas partly clotted, partly unclotted. It does not feel like a tumor: the thing it feels the most like is a half-full bladder; in short, it is an elusive and subtle, though extremely valuable clue. For when you feel it, or think you feel it, there is nothing to stop you putting the patient into the lithotomy position, painting her posterior vaginal vault, and running an exploring needle up behind the uterus. If the fornices feel hot it is almost certainly not ectopic, and almost as certainly acute P. I. D.

There are other ectopical signs which the text-books mention, but which I have found of little value because of their rarity; the passage of an endometrial (decidual) cast, purple discoloration around the umbilicus, pulsation of the uterine artery on the side of the ectopic. Of course, the passage of a decidual cast is almost in itself diagnostic of ectopic—but it happens so seldom. I think I have seen three—only one of them anything like complete. (This complete cast I had mounted for the Gynecological Section of our pathological museum. As a result when I ask students for the signs of ectopic they almost invariably mention the passage of a cast first in the list. Thus is youth led astray!)

The next thing I would mention about chronic ectopic is that the patient may not be very sick. I recall one patient who had had symptoms for six weeks and who had walked from Africville to the Clinic on the day I saw her. The condition of the patient will depend on the amount of blood lost internally. If this is small, as it frequently is, the patient will not look or feel very ill.

Finally, let us return to simple things. Here is a woman who is bleeding or staining p. v. The onset of this bleeding or staining more or less coincided with the development of pain or discomfort in the or the other iliac region. She has a slight temperature and some leucocytosis. She is tender in one vaginal fornix. No matter what other diagnosis-bedevising symptoms or signs she may have along with these, if these are present she probably has an ectopic.

I would like to mention here a condition that occurs more frequently than we think and may simulate an ectopic—excessive bleeding into the peritoneal cavity from a ruptured Graafian follicle. This condition has been associated at times with so much internal hemorrhage that the abdomen had to be opened. Usually, however, the amount of internal hemorrhage, though more than it should be, is not excessive. But it does cause pain and peritoneal irritation. The point is that if you enquire about the last period you find that it started about two weeks ago. I think that a considerable number of cases labelled acute P. I. D. that settle down within a day or two with no remaining sign of pathology and no cervical discharge, come into this category; and we have had several at the V. G. that we so diagnosed.

I have seen cases of pregnancy in the uterus where iliac pain was so prominent as to cause us to entertain a diagnosis of ectopic. On at least two occasions I have opened such and found no tubal pathology. The point about these cases is that none of them presented vaginal bleeding. I imagine that the cause of the onesided iliac pain is cornual implantation. The ovum attaches itself in one or other cornu close to the opening of the tube and as it enlarges it causes pain in the tubal region.

But once again let me repeat that if a diagnosis of ectopic is withheld in the absence of vaginal bleeding or staining, one is not likely to go wrong.

There are one or two points in treatment on which I would like to say a word. (1) Since the woman who has once had an ectopic is more likely to have another than the woman who has never had an ectopic, an attempt should be made to save some of the affected tube. This means that the uterine end of the tube should not be tied off, but left free and open. There will be bleeding from a small artery at the lower edge of the tube, but if this is caught by a fine forceps and tied with 00 catgut, there is no need to clamp and tie the tube. No matter how short the remaining stump is it may make future normal pregnancy possible. (2) Where there is any marked degree of anemia a considerable amount of free blood will probably be found in the peritoneal cavity. In preparing for operation on such a case facilities should be provided for auto-transfusion. This should most certainly be done in all acute cases where the internal hemorrhage will be great in amount. There is no sense in throwing away good blood that is needed in the patient's veins.

Remarks by President Carleton Stanley

Convocation Dalhousie University, May 13, 1941.

I should like to begin by wishing every best wish to my young friends who are about to receive degrees and diplomas.

We meet here to-day with the many "forward-looking thoughts" which are always irradiated by a band of young people, especially young people who have shown promise, in one way or another. Would that I could undistractedly trace out some of those forward-looking thoughts towards happy conclusions for all the young people who are before me, and towards an assurance of better days for us all.

But, the fact is, we meet to-day under dark and lengthening shadows, and our future for some time to come is obscure. Eight years ago, speaking from this very platform, I warned my hearers that the advent of Hitler to power, which had taken place some months before, was of momentous consequence to this University, as it was to all universities in the world, and a threat to everything for which universities stood. I went on to show that in all ages, if men and women were complacent, selfish, self-centred, then there was only the thinnest of barriers between civilisation and barbarism, between law and chaos, between the existence and the non-existence of such institutions as universities. To combat the complacency which I saw in Canadian universities, I took the trouble to publish that speech at the time, and it is still extant. In referring to one of my own addresses, I am, of course, referring to a very slight thing; and yet in saying that the record of it is still extant, I am not referring to an insignificant matter. For slight as that speech was, in many ways, it would not be extant to-day had it been delivered in an Italian university, or a German university, or a Spanish university, or a Japanese university or in any of those scores of Chinese universities which the Japanese have destroyed. Over so much of the world did barbarism and chaos quickly roll. How many of you are aware, stingingly aware, this afternoon, that only in one little corner of Western Europe, is there a single university in existence to-day?

The quality of universities in America, therefore, is of the liveliest and deadliest importance, if any rushlight of political wisdom, if any flicker of scientific curiosity, or any faint glow of humanity is to continue in the world. Well, the quality of universities in North America for the most part gives little comfort to a thoughtful man. For much longer than eight years I and many others have been pointing out that university men and women in North America were increasingly illiterate. I should not call a child illiterate who could read newspaper headlines. I should not call an ordinary adult citizen illiterate who was capable of reading and understanding most of a speech by Winston Churchill, or Franklin Roosevelt. But I do call university graduates illiterate who have not read, and who show no likelihood of reading later,—and please remember, my young graduating friends, what you do henceforth is of vastly greater importance than any of your achievements hitherto—at least some of the books which on one side or another give a man some inkling of the fabric of European civilisation. On the side of history, politics, law, for

example, a man is illiterate who has not read Thucydides' *History*, Aristotle's *Politics*, Hugo de Groot's *Law of Nations*, Guizot's *History of Civilisation in Europe*, Bryce's *Holy Roman Empire*, and at least some of the work of Maitland or Vinogradoff on law and jurisprudence, and one or two of the many great writers on the history of the Christian Church. In the same way, a university man is illiterate in mathematics who does not know Euclid's *Elements*, the extant writings of Archimedes, the work of Napier on *Logarithms*, that of Newton on *Fluxions*, and so forth.

True, a university has many functions. Our distinguished speaker this afternoon will, I am sure, deal very interestingly with some of these. I am speaking for the moment only of the duty the university has to conserve our intellectual heritage, and the studies by which it may be conserved. Now the plain and evident truth is that hardly any university in Canada is concerning itself, or concerning itself greatly, with such serious and fundamental study. The late Lord Tweedsmuir said to me not once, but several times, that the thing which seemed to him to need most serious investigation and overhauling in this country was the conduct of the universities.

In several ways, to-day, we are racing against time. There is a race against time in the North Atlantic, there is a race against time in the Middle East. Bleak and cheerless months lie ahead of us, and many defeats, it may be, because we were late in entering the race. But to my mind there is another race, about which I am much more fearful than I am about the military outcome of the war. Will there be a renaissance of learning before all learning is lost? Will a few young devoted scholars try to understand again what European civilisation is, and has been, before all the older scholars, and mathematicians and scientists have left the stage? Over most of Europe the books and monuments have been burnt and bombed. To destroy European civilisation in America, you do not need to burn its records in a single fire. Leave those records unread for a few generations and the effect will be the same.

Dr. G. S. Fahrni, of Winnipeg, President of the Canadian Medical Association, will speak on "Parathyroid Tumours and Hyperparathyroidism."

* A Dietary Survey in Halifax

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THE importance of dietary adequacy in its relation to public health is taken as axiomatic and generally acknowledged in modern medicine. As part of a plan of the Canadian Council on Nutrition to determine the status of nutrition in the urban population of Canada, Halifax was selected as representative of the Eastern Maritime area. Halifax had a population of about 60,000 when this survey began. It has few large industries but is an important Atlantic port and railway terminus. Prior to the present study nothing was known definitely of the adequacy or inadequacy of the dietary habits of the people of this section. A dietary survey was therefore undertaken simultaneously with others in Quebec, Toronto, and Edmonton. The only scientific information of this character relative to Canadian nutrition is furnished by the dietary survey in Toronto of 100 families with small incomes, averaging \$1020 annually and reported on by McHenry in 1939 (1).

Families

The survey in Halifax began in September, 1939, and extended over a period of about nine months. The records from 82 families comprising 385 individuals have provided data of sufficient accuracy for this report. All families were living within the city limits. The range of income of this group of families was between \$450 and \$1500 per annum, with \$1023 as average. This represents an income of \$19.68 per week with extremes of \$8.65 and \$28.82. It has been estimated that this sample of the population may be taken to represent about 60 per cent of Halifax families. The families were selected at random, mainly from the city directory, confining this selection to certain districts; occasionally from the files of family records in the Dalhousie Public Health Clinic; and latterly from those associated with two religious organizations situated in the north end of the city. No families on relief were included in this study. The average Halifax family in this survey contained 4.7 individuals (2.1 adults and 2.6 children), varying from 2 to 10 members as extremes. This figure may be compared with 4.9 determined in September, 1938, in the preliminary household budgetary survey of the Dominion Bureau of Statistics for this particular group in Halifax.

Method of Collecting and Calculating Data

The mothers of families cooperating kept an exact inventory of food purchases and food consumption during the course of one week. Scales were provided. In addition the consumption of each individual in the family was separately recorded in about a third of the Halifax families. Two dietitians supervised the work, making daily calls and analysing the data. About ten per cent of housewives approached refused to cooperate on grounds of the time required or suspicion of the motive. Illness occasionally invalidated the record, especially in the winter of 1940 when respiratory infections were epidemic in Halifax. Corrections were made for edible and inedible wastage, for the

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presence of guests, and for absence from meals. Edible or plate wastage was found to be so small as to be negligible in this type of family. Records of age, height, weight and sex of all children were kept. The occupation of the wage earner was also ascertained, and most skilled and unskilled labour is represented in the list. Thus mechanics, carpenters, painters, plumbers, firemen and policemen comprise the former; stevedores, truck drivers, porters and general labourers, the latter.

The data of food consumption were calculated in terms of the recognized nutritive elements,—protein, fat, carbohydrate, calcium, phosphorus, iron, the vitamins and energy value. When no analysis of a food could be found, it was analysed either in the Department of Chemistry of Macdonald College or the Chemical Laboratory of the Toronto Sick Children's Hospital. The figures were then compared with accepted standards for adequate nutrition and in particular the Canadian Dietary Standard of the Council on Nutrition (*vide* McHenry (1) or National Health Review (2).

RESULTS OF THE SURVEY

Let us first consider the results as derived from the family as a whole. It is important to learn not only whether the diet of a family was adequate or deficient but whether there was serious deficiency and what proportion of the families surveyed were to be classified thus. To this end families were classified in three groups according to their diet, (1) good or those equal to or better than the standard, (2) fair or those between 70 and 99 per cent of the standard, (3) poor or those obtaining less than 70 per cent of the standard for one or more constituents. On this basis 8 families (10 per cent) are in class 1, 16 families (20 per cent) in class 2, and 58 families (70 per cent) in class 3. This is based, however, on a consideration of *all* nutritional essentials capable of quantitative expression and the result appears worse than it actually is on closer inspection. Considered on the basis of the *average* consumption of the 82 families, there are only three deficient elements, as can be seen in figure 1. These are calcium (91 per cent), vitamin B₁ (36 per cent) and vitamin C (74 per cent). The most apparent deficiency is thiamine (vitamin B₁), with ascorbic acid (vitamin C) in second place.

From the standpoint of public health, however, the lower part of the average is justly important and it is quite apparent from the tabulated results that very appreciable numbers of the families were under the Canadian Dietary Standard. Thus one-third of the Halifax families were deficient in protein and iron, one-half in calories, phosphorus and vitamin A, and most in calcium and vitamins B₁ and C. If we lower the standard to the 70 per cent level as minimal adequacy the situation is much better. Very few families show appreciable deficiencies except in calcium and the three vitamins, A, B₁, and C. In these elements 40 per cent of families have diets definitely inadequate in calcium, 34 per cent in vitamin A, 57 per cent in C and all in B₁. The deficiency in thiamine (B₁) is the most striking result of the survey in Halifax.

Calories

The average consumption for men was 2622 calories per day. This is slightly under the Canadian standard of 2800. However only 16 per cent were under the 70 per cent minimum. This result is somewhat surprising and might raise the question whether the Maritimer works as hard as the standard allows for muscular effort. The situation as regards women is essentially the same as

for men. Only 11 per cent are under the minimum. The average consumption was 1963 calories as against a standard of 2400. The records of the children have been separated into boys and girls of 1 to 18 years. The boys were proportionately somewhat lower than the girls, as is shown in figure 1. It would

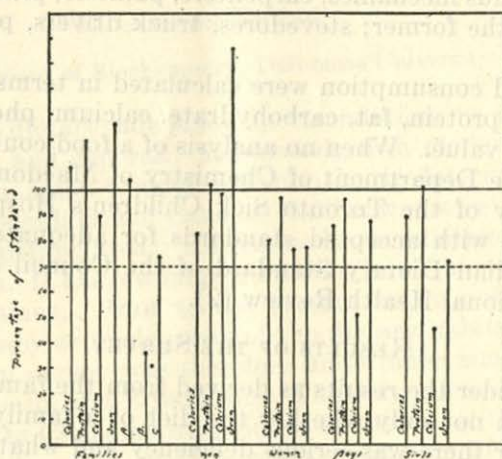


FIGURE 1.

be interesting to test the deficiencies noted against height-weight averages to confirm the relationship of diet to growth. Such cases of undernourishment should be apparent in subnormal bodies.

Protein

The family average is good at a level of 120 per cent of the standard. The adult male consumed 95 grams per day and the adult female, 68 grams. These figures represent 102 and 97 per cent of the standard. The situation was equally good for boys and girls. From inspection of the food lists it may be stated that an adequate amount of this protein was of animal origin.

Fat and Carbohydrate

Of all dietary constituents fat was the most adequate. The records substantiate the opinion previously expressed that in North America we eat proportionately more fat. Thus the average daily figure for men was 120 grams and for women 89 grams. Children did equally well. The average for the family was 148 per cent of the standard. On the other hand the figure for total carbohydrate was small,—for men, 274 grams, and for women 207 grams.

Calcium and Phosphorus

These important elements, especially for children, are frequently deficient. Although the general family averages showed 91 per cent of the standard for calcium and 108 for phosphorus, a large proportion (40 per cent) of the families surveyed was under the minimum standard for calcium. The explanation for this lies in the inadequate consumption of calcium by the children. On the basis of individual analysis of the diets it is apparent that the men fared adequately at 99 per cent of the standard and the women moderately at 77 per cent. A third of the women were under the minimum standard. It is, however, in the children that major deficiencies are apparent. The boys were

consuming an average of only 51 per cent and the girls, 45 per cent of the standard. Still worse, 88 per cent of the boys and 91 per cent of the girls were under the minimum. This is an important finding of the survey. It is substantiated by a calculation of the average consumption of milk in the whole group. This figure was 7.14 quarts per family or 1.52 quarts per caput per week.

Iron

The figures for the consumption of iron are of interest in the light of the greater requirements of women and children than men, viz., 15 and 10 milligrams per day respectively. Not a single man was under the level of 70 per cent of the standard and only a few under the standard itself. The average consumption of the women was 12 milligrams but a large proportion (44 per cent) were taking inadequate amounts daily. This was also notable in the case of the girls. The common practice of using molasses is to be commended as it supplied the group under survey with much of its iron.

Vitamins

These dietary substances present the most difficult results of the survey from which to draw sound conclusions. Methods of assay are open to large errors and human requirements are still uncertain. These facts must be kept in mind in reviewing the results obtained. The daily adult requirements have been tentatively accepted as A, 6000 I.U.; B₁, 500 I.U.; and C, 1200 I.U., with a lower scale for children. The consumption *per caput* was A, 4989 I.U.; B₁, 210 I.U.; and C, 711 I.U. for all individuals. Even if the standard of comparison is lowered to 70 per cent, at this level 34 per cent of families were deficient in A, 100 per cent in B₁ and 57 per cent in C. The children in this respect were faring better than the adults. This result may mean a serious deficiency in the Maritime food consumption or it may mean a standard that is too high. It is of interest, however, to draw attention to the recent action in Great Britain of reinforcing flour with calcium and vitamin B₁, accepting the adult daily requirement as identical with the value given above (Moran and Drummond, 3). Perhaps our policy with respect to degree of milling should be revised to incorporate more of the whole grain and hence more thiamine (B₁). The supply of vitamin A was largely due to consumption of carrots, tomatoes and dairy products. More than half of the adults were under the minimum standard. The supply of B₁ came largely from bread, milk, and potatoes. The intake for men averaged 177 I.U. per day and for women 128 I.U. as against a standard of 500 I.U. The supply of C was provided largely from citrus fruits, especially oranges, and potatoes. The level of intake for adults, however, was not high, although 76 per cent of all families were buying fresh fruit.

The Food Budget

Most Halifax families in this survey were spending between 30 and 60 per cent of their incomes for food. The average weekly food expenditure was \$9.46 per family or \$2.21 per caput. The extremes were \$0.86 to \$4.42 per person. Food costs in Halifax are relatively much higher than in Toronto or Edmonton. This fact must be considered carefully in making comparisons. On the basis of the classification of families into three classes given at the beginning of this paper it is possible to arrive at an approximate cost of an adequate diet. Class 1 spent on the average \$3.38 per person; class 2, \$2.76; class 3, \$1.10. It would therefore seem reasonable to set \$3.00 as an approximation of the amount neces-

sary to purchase an adequate ration weekly per person. One of the records showed that it could be done for \$2.18, but this was exceptional.

Summary

A dietary survey comprising 82 families and 385 individuals has been carried out in Halifax by both inventory and individual methods in the income range of \$450-\$1500 per annum. The results in terms of nutritional essentials have been compared with the Canadian Dietary Standard. The most important findings were a deplorable deficiency in the intake of calcium by the children and of the vitamins, especially B₁, by the whole group.

REFERENCES

1. McHenry, E. W., *Can. Pub. Health J.*, 1939, 30:4.
2. *National Health Review*, 1940, 8:1.
3. Moran, T., and Drummond, J. C., *Nature*, 1940, 146:117.

Dr. R. R. Fitzgerald of Montreal will give a paper on "Fracture of the Neck of the Femur".

DALHOUSIE MEDICAL SCHOOL REFRESHER COURSE DEFERRED

On account of the prevalence of war conditions, and as most of the doctors throughout the Province are very busy, it has been decided by the Refresher Course Committee not to give the Post-graduate Course this year.

JUDSON V. GRAHAM, M.D.

WANTED—ASSISTANT PHYSICIAN

Assistant physician wanted for the Saint John Tuberculosis Hospital. Salary \$1,200.00 a year and maintenance. Apply to Dr. R. J. Collins, Medical Superintendent, East Saint John, N. B.

Editor's Column

THE EDITOR TAKES A HOLIDAY

NO appointments printed in bold black letters on the page of my appointment book dated May 15th greeted my eyes and the remaining pages of the month were caught between paperclips. Probably some change in my disposition had been noted, at any rate a decision had been arrived at *in camera* by my family that a holiday was the proper treatment. Being the mere patient it was my part to bow to the ruling powers.

On the afternoon of the predetermined date accompanied by my sweet-heart, wife, dictator and nurse, Halifax was left behind and as we passed that safe haven, Bedford Basin and the miles of lakes, glistening in the sunshine, reaching almost to Enfield and aroused by that gentle glow about the forest that gives promise of buds about to burst my own enthusiasm began to rise. That night we stayed in New Glasgow and went to bed at eight o'clock—that just shows you what a transformation a hundred miles of holiday can make. Next day we crossed over the Blue Mountain on our way to East River St. Mary's and saw snow lingering in more shaded places with dandelions, violets and blood-root in blossom nearby.

The following summer-like day found us at Marshlands Inn, Sackville, N. B. This ideal stopping place, the perfect example of a well conducted inn, could be taken as a demonstration station for those desirous of serving the travelling public. As this place had been booked months ahead for relatives attending the graduating exercises at Mount Allison University we moved on to Hampton on Sunday in a cold rainstorm. At the Wayside Inn the warmth from the large fireplace and the hospitality of our hostess who entertained us with anecdotes and reminiscences made us quite forget the chill weather. The antique furnishings of this house are quite outstanding in their beauty and rarity. After refreshing slumber in a canopied bed with silken hangings we reluctantly departed.

A stretch of land more than twenty-five miles in length and three to five in width lies between the Kennebecasis and the Saint John Rivers. Following down the north bank of the Kennebecasis we journeyed towards the tip of this tongue of land. The delightful views of water, valley and mountain reminded us of the Bras d'Or Lake scenery and all Cape Bretoners will agree that this is the utmost in praise. On our way we called at the Dykeland Pottery conducted by Keld Deichmamm, born in Denmark, and his wife, Erica, from Wisconsin. Our visit to these charming artists who combine usefulness and beauty in their creations will always remain a very happy memory. We crossed the Saint John River by ferry to Westfield and then to Fredericton arriving at the Homestead Inn in time for our evening meal.

This city of Fredericton snuggled in the concavity of a bend in the Saint John River is remarkably free from all evidence of that blot on civic life, the litter lout. Presumably they shoot them at dawn and bury them at sunrise since not a discarded cigarette carton, chocolate bar wrapper, old newspaper or fruit peel was to be seen. Its clean streets, well kept lawns and gardens, its

stately elms already throwing their shade and its varied architecture leaves the visitor with a satisfied feeling. Beautifully situated on an elevation overlooking the city is the University of New Brunswick which we visited next morning. A modern gymnasium has just been completed—the gift of Lord Beaverbrook. The well appointed library has an interesting collection of historical records of the Province. It is one of the few schools in Canada with a Department of Forestry. President Norman MacKenzie of Pictonian ancestry and a son of the manse is a graduate of Dalhousie University.

Leaving Fredericton in the afternoon of the 20th we crossed the Saint John River which is one-half mile wide at this point, although over ninety miles from its mouth, and continued to follow one of its tributaries, the Nashwaak, to Stanley, where I supplied for six months "once upon a time", then across the watershed which separates the basins of the two great river systems of the Saint John and the Miramichi, finally reaching our destination, Boisetown on the South West Miramichi. This is the geographical centre of the Province and is so marked.

The Griff-Inns, with four generations of Griffins in residence, consist of a central cabin with dining-room and lounge surrounded by a number of smaller cabins, each with running cold spring water, flush toilet, electric light, stove, screened windows and comfortable beds—in a separate building are showers for men and women. The whole is essentially designed and serves as the headquarters for sportsmen given to fishing and hunting. The favourite trip taken from this camp is to go fifty miles up stream getting off the transcontinental train where the railroad crosses this river at Half Moon, forty miles from the nearest house, and to return by canoe. Each person has a registered guide to navigate the swiftly flowing waters with its many rapids. The trip is said to be one full of thrills arising from the mode of transportation and the primeval beauty of the forest. Situated amidst a grove of spruce and pine the camp overlooks two miles or more of the great river. Delightful features are the numerous wood roads, and animal trails carpeted by moss and the needles of evergreens. To quote from a letter under date of May 16th received in reply to our enquiry for accommodation, "This is our quiet season, as the black salmon season has just closed and the summer fishing for salmon doesn't open until late in June. We shall be much pleased to have guests from Halifax as so few Maritime people vacation in New Brunswick and it is good to meet our neighbours. There is a good deal of open country around the Inns and if you care for walking I am sure the little trips that the surrounding woods afford will make your holiday enjoyable."

One wishes he had the gift to describe the country side—with its endless shades and tones of green from the dark of the old spruce, the bright green of the hackmatack to those delicate tones of the young leaves of the birch and poplar enhanced by the ruddy bronze of the young maple, the abundant sprinkling of the wild cherry and Indian plum in blossom and the flowering shrubs with their white and creamy blossoms, the dark red trillium, the fragrant mayflower, the wild strawberry, purple and white violets and the yellow dog-toothed violet and the air laden with the song of birds, the last sound to be heard at night and the first in the morning.

Here we stayed for ten days some of them warm as midsummer, others cool as autumn. Whether the sun shone or the winds blew or the rains descended it made little difference. Within our snug log cabin with plenty of

hardwood as fuel and books to read, with freedom from telephone and door-bell and soothed by the wind in the pine and fir, the piping of the frogs, twittering of the birds or the pitter-patter of the rain on the roof, sleep "Nature's soft nurse" was coaxed to come and play her part.

We returned by way of Newcastle and on our way passed through Rexton. Here I called on a former classmate, Dr. Francis Kenney and his wife, now joined by their son, Francis, who graduated in medicine this year. The same old Francis with the same old twinkle in the eye who could always see fun when it was only on the horizon. It does not seem possible that a patient could resist getting well under his care as truly the writer of the Proverbs said, "A merry heart doeth good like a medicine." Well do I remember when an unusually pretty, attractive and demure maiden arrived at the Victoria General Hospital to enter its training school, and the "did you see her?" of the house staff. Both my wife and I who knew her at that time agree that she has lost none of her charm or beauty.

From the time we left to our return few miles were travelled without the company of someone in uniform who was either going or returning from leave. Many were from other provinces and it seemed by the questions they asked that they were keen on learning as much as possible about the Maritime Provinces. Whilst my wife attended to the driving I got out the map and began at 1604 with the building of the habitation by DeMonts to its restoration in 1939, referred to the varied origins of the people that have gone into the making of a Nova Scotian; directed their attention to the coal deposits and the amazing fact that coal is mined miles out beneath the bed of the ocean, the concentrated beauty of the Cabot Trail and Bear River, the Annapolis Valley with upwards of a hundred miles of orchard, a coastline close to five thousand miles in length that is rugged along the Atlantic, precipitous as related to the Bay of Fundy with its amazing tides, gentle and shelving along the Northumberland Strait where fog is unknown.

Nova Scotia with its innumerable lakes and streams—New Brunswick with its vast forests and great rivers—and Prince Edward Island that one huge rolling farm with its many woodlots—lacking both lakes and running water but never missed because of the many long indentations of the sea. Just as one was beginning to warm up to his subject the road to the military camp was reached and we had to part with our new made friends from Ontario, and as they thanked us one said—"Pardon me, Sir, but are you by any chance a professor?"

H. W. S.

Dr. J. H. Geddes of London, Ontario, will give an address on "Functional Disorders of the Colon."

Abstracts from Current Literature

THE TREATMENT OF DIFFUSE PERITONITIS BY THE DIRECT INTRAPERITONEAL INTRODUCTION OF SULFANILAMIDE. Rosenberg, S. and Wall, N. M.: Surg. Gynec. and Obst., 1941, 72: 568.

The authors discuss the effects and methods by which sulfanilamide achieves its results. According to Lockwood, it is possible that sulfanilamide combines in some way with the free amino-nitrogen of protein degradation products and renders them unsuitable for bacterial utilization; thus allowing the bacteria to die literally by starvation. Rosenberg and Wall decided to study the effect of the local application of sulfanilamide to the healing of infected tissues. They reasoned that the principle of sulfanilamide therapy is to secure an effective concentration of sulfanilamide or possibly a direct derivative at the infected site. If Lockwood's experiments have good foundation, and the writers feel that they have, then the most important aim in parenteral therapy is to obtain a high concentration of sulfanilamide at the infected site. This could often be obtained more easily by local introduction than by the systemic route.

It was felt that the peritoneum would be an ideal site to test this theory. If, on encountering a diffuse or local peritonitis at operation, one could instill sulfanilamide in the form of a crystalline product before closing the peritoneal cavity, one might have a definite protection against the further spread of the process, providing the focus were removed. It is known that the sulfanilamide introduced into the inflamed peritoneal cavity of humans, permeates the tissues rapidly and is found in the blood stream soon afterward in a fairly high concentration.

Experimental work was performed by the authors on rats which were injected intraperitoneally with varying amounts of different cultures and at the same time given a simultaneous intraperitoneal injection of sulfanilamide suspended in saline. It was found that 11 of 21 rats protected by intraperitoneal sulfanilamide lived indefinitely, while 20 of a possible 21 unprotected rats died in various stages of peritonitis. Similar results were obtained when the intraperitoneal sulfanilamide was introduced after varying lengths of time (4 to 20 hours) following the intraperitoneal injection of mixed culture, and consequently a peritonitis of varying duration was present when the sulfanilamide was introduced.

Rosenburg and Wall report 4 cases of peritonitis of widely different variety in which sulfanilamide was given intraperitoneally in doses of 1 to 4 grams after removal of the focus and before closure was carried out. These cases all recovered. They feel that their experience has been very small, and none of these cases necessarily prove anything with the exception of the fact that sulfanilamide which is introduced intraperitoneally is in no way locally destructive or harmful to the delicate tissue such as the serosa of the bowel.

The authors feel that the intraperitoneal instillation of sulfanilamide should be immediately augmented by subcutaneous sulfanilamide, in the treatment of these cases, for one cannot depend upon the one instillation of

intraperitoneal sulfanilamide. This procedure is not offered as any substitute for time honored and well established methods which are utilized in the treatment of peritonitis, but merely as an additional weapon in the constant struggle against this dread disease. Sulfanilamide given intraperitoneally and subcutaneously gives the surgeon a positive weapon with which to fight this insidious infection and with which to meet it on perhaps slightly more than equal terms.

HEMOLYTIC STREPTOCOCCAL PNEUMONIA AND EMPYEMA; A Study of 55 Cases with special reference to treatment. Keefer, C. S., Rantz, L. A., and Rammelkamp, C. H.: *Ann. Int. Med.*, 1941, 14: 1533.

Fifty-five cases of hemolytic streptococcal pneumonia and empyema have been studied and analyzed with respect to outcome and treatment by the writers. There were 39 cases of pneumonia alone and 16 cases of empyema. Fourteen of the 16 cases of empyema followed an infection of the lung.

The cases of pneumonia could be divided into three groups: (1) Those which were primary; (2) those which followed a respiratory infection; and (3) those which were superimposed on a preexisting chronic pulmonary infection.

The fatality rate has been reported as varying between 30 and 60 per cent of cases. In this group of 39 patients with pneumonia, it was only 17 per cent. Unfavourable factors in the course of the disease were, age, bacteremia, and the presence of some chronic illness such as heart disease.

Intensive chemotherapy with sulfonamide was used on all the cases, but the authors state that it is difficult to make any remarks which can be considered to be final in respect to the efficiency of these drugs since there are so many variable factors in assessing the value of treatment in this disease. A few facts of significance have emerged: namely, sulfanilamide does not produce any dramatic change in the course of hemolytic streptococcal pneumonia and it does not seem to reduce the incidence of empyema. In the 16 patients with empyema, there were only three deaths and, in all, there were other unfavourable factors which influenced the outcome of the disease, such as age (one patient was less than one year of age), heart disease, and traumatic hemothorax. It would appear, therefore, that sulfanilamide will influence the outcome of hemolytic streptococcal pneumonia and empyema in that it will reduce the fatality rate.

In the treatment of empyema the cases were divided into two groups: (1) those recovering without thoracotomy after multiple aspirations of the chest (4 cases) and (2) those following operation (9 cases). All the patients received either sulfanilamide or sulfapyridine.

The authors' experience would indicate that even when sulfanilamide is used, open drainage of the pleural cavity will be required in most cases. One must not be misled or deceived by the temporary sterilization of the empyema cavity since they have observed recurrences of infection as long as three to five weeks after such an event. It is possible that treatment with sulfanilamide for a longer period of time after the fluid has been sterilized will increase the number of cures by this method.

Aside from the use of chemotherapy and surgical treatment of empyema, other measures are of the greatest importance in the treatment of the patient. They all develop a progressive anemia which is accentuated by the sul-

fanilamide. For this reason, many of these patients are improved by using blood transfusions. Also, when large amounts of plasma protein are being removed from the chest, malnutrition and a plasma protein deficit may develop. This complication is treated most adequately by means of increasing the food intake and blood transfusions.

EFFECT OF EDEMA AND INTEGUMENTARY INFILTRATIONS ON BASAL METABOLISM, ELECTROCARDIOGRAM AND BLOOD CHOLESTEROL. Moschowitz, E.: *Arch. Int. Med.*, 1941, 67: 828.

Moschowitz considers the hypotheses for the explanation of the lowered basal metabolism in nephrosis to be inadequate. Evidence is adduced by him in this article to prove that the condition is due to the edematous fluid which acts as a suit of clothes, thereby preventing conduction, radiation and convection of heat. This mechanism of the lowered metabolism applies not only to "nephrosis" but to other conditions accompanied by edema or integumentary thickening. He refers especially to myxedema, the edematous form of scleroderma, chronic edematous right-sided cardiac failure unassociated with dyspnoea, and ichthyosis. Concomitant findings in these conditions associated with a lowered basal metabolism are (1) a low electrocardiographic curve indistinguishable from that of the myxedema heart and (2) a high level of cholesterol in the blood. Finally, these conditions are characterized by an unusual tolerance for the administration of thyroid preparations.

SULFATHIAZOLE THERAPY OF GONORRHOEA. Greig, C. H. Uren, J. L., and Mitchell, D. R.: *Can. Med. Assoc. Jour.*, 1941, 44:237.

The writers present the results in the treatment of 120 cases of gonorrhoeal urethritis in the male treated with sulfathiazole. The gross cure rate was 92.5 per cent. Of this group of 120 cases, 24 had previously failed to respond to courses of sulfanilamide or sulfapyridine, and 22 were cured with sulfathiazole.

The majority of the patients received an average of 17 grams of sulfathiazole and were cured within 3 days. The routine dosage consisted of: 1st day—1 gram, 3 times a day after meals; 2nd day and 3rd day—1 gram, 3 times a day after meals, and 1 gram on retiring; 4th and 5th days—1 gram, 3 times a day after meals. In resistant cases the above course of treatment was either repeated or supplemented by the addition of 1.5 grams per day for an additional 7 to 10 days. No complications such as prostatitis or epididymitis developed in any of the cases during the period of treatment.

The incidence of toxic reactions was noted in only ten of the 120 patients. These symptoms were invariably mild and did not in any way interfere with the normal daily activities of the patient. Among the symptoms were slight headache, vertigo, nausea and drowsiness.

The authors compared their results with sulfathiazole with the results of treatment of gonorrhoea with sulfanilamide, sulfapyridine and sulfamethylthiazole at the Toronto General Hospital. They conclude that sulfathiazole appears to be a most efficient drug in the treatment of gonorrhoea. Its use is accompanied by a higher percentage of cures and a lower incidence of toxic effects than with any other chemotherapeutic agent.

E. DAVID SHERMAN, M. D.

Sydney, N. S.

Society Meetings

A MEETING of the Cape Breton Medical Society was held on the evening of June 9th. There was first a banquet at the Isle Royale Hotel, Sydney, the chief speaker being Flight-Lieutenant Don Rankin. Also by arrangement by Dr. J. G. B. Lynch there was shown a most instructive moving picture on obstetrics. Other speakers of the evening were Captain Buchanan Carey and Colonel Bob Sutherland, R. C. A. M. C. Members of the profession attended from all branches of the services, the Navy, Air Force, Army and Merchant Marine.

New officers were appointed as follows:

President—Dr. M. G. Tompkins, Dominion;

Vice-President—Dr. J. C. Morrison, New Waterford;

Secretary-Treasurer—Dr. M. J. Macaulay, Sydney;

Executive re Medical Society of Nova Scotia—Dr. A. K. Roy, North Sydney; Dr. E. W. Macdonald, Reserve Mines; Dr. A. L. Sutherland, Sydney.

Executive re Cape Breton Medical Society—Dr. H. J. Martin, Sydney Mines; Dr. J. J. Roy, Sydney; Dr. W. W. Patton, Glace Bay.

At the meeting it was moved, seconded and carried unanimously that the Cape Breton Branch of the Medical Society of Nova Scotia invite the Medical Society of Nova Scotia to hold their annual meeting of 1942 in Cape Breton as the guest of their Society at the time and place to be arranged by the Executive.

The next meeting of the Cape Breton Medical Society will be held at St. Joseph's Hospital, Glace Bay in September.

M. J. MACAULAY, M. D.,
Secretary-Treasurer

NOVA SCOTIA SOCIETY OF RADIOGRAPHERS

ON May 21, 1941, the Nova Scotia Society of Radiographers held their second annual meeting. The present slate of officers were elected for the coming year:

President—Albert Perry, Camp Hill Hospital, Halifax, N. S.

Vice-President—Sister Mary David, Halifax Infirmery, Halifax, N. S.

Secretary-Treasurer—Mary Bertild Hyland, Victoria General Hospital, Halifax, N. S.

Registrar—Winnifred Flynn, Victoria General Hospital, Halifax, N. S.

Provincial Representatives—Sister M. Regina, for Cape Breton: Miss A. Appleby for Yarmouth: Miss E. C. Cowan for New Glasgow.

Advisory Board: Dr. S. R. Johnston, Halifax: George E. Harrison, Dartmouth.

Examining Board: Dr. S. R. Johnston, Halifax: Dr. H. R. Corbett, Sydney, and G. E. Harrison, Dartmouth.

A constitution and bye-laws were read and adopted.

Personal Interest Notes

DISTINCTION IS ACCORDED PROFESSOR OF DALHOUSIE MEDICAL SCHOOL

ANNOUNCEMENT of the election of Dr. Donald Mainland, 11 Young Avenue, Halifax, to membership in the Royal Society of Canada was made at the opening of its sixtieth annual meeting at Queen's University, Kingston, Ontario, May 20th. Dr. Mainland has been Professor of Anatomy at Dalhousie College since 1930.

Born in Scotland of Scottish parentage, he was educated in schools there and received his medical degree from Edinburgh University. After teaching anatomy there for some years he came to Canada in 1927, going to the University of Manitoba, where he was assistant Professor of Anatomy. While in that province he was married in Winnipeg. He was called to Dalhousie in 1930 and has been there since that time.

In 1938 he was made a Fellow of the Royal Society of Edinburgh. He is a member of the National Research Council, Medical Research Committee, of which the late Sir Frederick Banting was chairman.

Dr. and Mrs. S. W. Williamson of Yarmouth have recently visited in Providence, R. I.

The BULLETIN extends congratulations to Dr. G. R. Forbes of Kentville, on his recent promotion from Major to Lieutenant-Colonel; to Dr. C. E. A. deWitt of Wolfville who has also been promoted from Major to Lieutenant-Colonel and to Dr. J. A. Noble of Halifax who has been promoted from Captain to Major.

DR. A. R. MORTON ADDRESSES THE HALIFAX COMMERCIAL CLUB

Exclusive of hospitalization, public health costs 22.37 cents per head in Halifax compared with an average of 76.67 in communities of similar size, Dr. A. R. Morton, Commissioner of Health and Welfare, told a Halifax Commercial Club meeting recently at the Halifax Hotel.

At the same time he pointed out that since last October there have been 479 cases of diphtheria, of which 19 died; 434 cases of scarlet fever from which no deaths have resulted, and there have been 89 cases of the war-time disease meningitis which has caused the death of nine. These figures are taken from civilian records only.

Dr. Morton based his address on the set-up of a modern health department and sketched briefly various aspects of public health nursing and its importance in spreading health education, social hygiene, industrial hygiene, meat inspection, garbage collection and inspection services.

Major J. W. Sutherland, M. D., formerly of the North Nova Scotia Highlanders, who has been stationed in Halifax for some months, has been transferred to Ottawa.

The BULLETIN extends congratulations to Dr. and Mrs. E. F. Ross of Halifax on the birth of a daughter on June 7th.

CO-OPERATIVE MEDICINE PLAN DISCUSSED

Co-operative Medicine was discussed by a meeting of representatives of all sections of the city at St. Thomas Aquinas Hall on June 4th and suggestions for some plan of co-operative medicine for Halifax were proposed. The meeting was the outcome of a committee of five formed last year by the Halifax Medical Society to study co-operative medicine and health insurance guided by an outline furnished by the society.

Members of the committee at that meeting were Dr. R. Smith Henderson, Dr. E. I. Glenister, Dr. A. E. Murray, Dr. K. M. Grant and Dr. J. W. MacIntosh. Dr. Henderson expressed disappointment that a definite plan had not been presented to the meeting. Dr. Glenister spoke at length on the subject. Other speakers were Mrs. Beatrice Cahan, who expressed herself in favour of some form of co-operative medicine; Mrs. M. C. Mitten, who represented the South End group of co-operatives; Mrs. Andrew Burt, Mrs. Burke McInerney, G. K. Foley, W. A. Hallisey and Mrs. H. Nickerson.

Dr. J. A. Webster of Yarmouth has been visiting the hospitals in Montreal recently.

Dr. and Mrs. J. R. McCleave and son Graham were on a ten days' fishing trip at Greenfield, Queens County, early in June.

The BULLETIN extends congratulations to Dr. E. P. Brison, Halifax, who has been made a member of the American Psychiatric Association.

Dr. and Mrs. W. F. MacKinnon of Antigonish returned from Boston early in June where the Doctor underwent a successful operation on his eyes.

*ABERHART'S STORY

Illustrating his points at the short-lived Ottawa Federal-Provincial Conference, Premier Aberhart of Alberta was the only speaker that ventured into the story-telling arena to illustrate his argument. Here is one:

I am reminded of a friend of mine who once went to a doctor to be treated for a very bad cold. He said: "Doctor, I am afraid of pneumonia. A good many of my friends have died of pneumonia, and I want you to examine me very carefully, because I do not want to die of it." The doctor gave him a careful examination tapped him here and there, and after a while he said, "You have not got pneumonia. What you have is chronic bronchitis." Then he wrote a prescription and said, "This will fix you up." The man looked at the prescription and he said, "Are you sure this will make me well?" The doctor replied, "Yes, it will." Then the man asked "Have you had any particular experience with this disease?" And the doctor said: "I certainly have. I have had it myself for fifteen years."

* Reprinted from *Liverpool Advance & Queens County Advocate*, June 5th.

Obituary

THE death occurred at the Victoria General Hospital, Halifax, on May 27th, of Dr. John Bell of New Glasgow, at the age of sixty-five, following an operation. Dr. Bell was a son of the late Senator A. C. Bell and Anne Henderson Bell and was born in New Glasgow, where he received his early education and then entered Dalhousie University in 1892 where he spent two years in Arts. He then entered McGill University from which he graduated in 1898, later taking post-graduate work in London, England, and had practised in New Glasgow for the past thirty years. He was on several occasions a member of the New Glasgow Town Council and a former member of the Legislative Council of Nova Scotia. In 1919 he took a special course at the Post Graduate Hospital in New York specializing in eye, ear, nose and throat work.

Dr. Bell was secretary of the Pictou County Medical Society for nearly forty years.

Surviving are his wife, the former Elizabeth M. Kopf, and two sons; Dr. Adam Carr Bell, New York and John Kopf Bell with the R. C. A. F. at Jarvis, Ontario; and two daughters, Anne (Mrs. Evan Thompson), Halifax and Mary (Mrs. Edward Bartlett) at home.

Dr. Thomas Ives Byrne, retired physician and former deputy minister of health in the Nova Scotia Government, died suddenly at his home in Yarmouth, on May 29th, of a heart attack, at the age of sixty-seven.

Dr. Byrne was a native of Sussex, N. B., where he received his early education, later attending St. Francis Xavier University and Bellevue Hospital Medical College, from which he graduated in 1894. He interned at Bellevue Hospital, New York and was later house surgeon at that hospital. Returning to Canada he first practised in St. Stephen, next in Chatham and then Dartmouth where he practised for twenty-two years. During the first Great War he was a medical officer in the 63rd Regiment.

Surviving are his wife, the former Henrietta Blair Ross, and two daughters, Kathleen of New York and Ilene (Mrs. William Dixon), Alberta, and two sons, J. Ross of Liverpool and Edward G. of Bathurst.

The death of Dr. Kenneth Grant Mahabir formerly of Halifax occurred at the Halifax Infirmary on May 28th. Dr. Mahabir was born in Trinidad, British West Indies. He attended Dalhousie University and graduated in 1916. Following this he attended the University of Toronto where he received the Degree of D. P. H. During the first Great War he served in the R. C. A. M. C., and for a time was in charge of the hospital on Cogswell Street. Surviving are his wife, formerly Jeanne Longueil, in Halifax, his parents, a brother, and several sisters in Trinidad.

The BULLETIN extends sympathy to Major Thomas M. Creighton, M. D., of Montreal, on the death of his mother, Alice Julia, wife of Charles E. Creighton of Dartmouth, which occurred on May 31st.

Eighty-Eight Annual Meeting of the Medical Society of Nova Scotia

CORNWALLIS INN

Kentville, N. S.

JULY 9th and 10th, 1941

PROGRAMME

TUESDAY, JULY 8th.

2.30 p.m. Executive meeting, "Cornwallis Inn".

WEDNESDAY, JULY 9th.

9.00 a.m. Registration.

9.30 a.m. Welcome by Mayor of Kentville.

9.45 a.m. "Parathyroid Tumours and Hyperparathyroidism."

DR. G. S. FAHRNI, President, Canadian Medical Association,
Winnipeg, Manitoba.

10.15 a.m. "Fracture of the Neck of the Femur."

DR. R. R. FITZGERALD, Montreal.

10.45 a.m. "Functional Disorders of the Colon."

DR. J. H. GEDDES, London, Ontario.

11.15 a.m. First Business Session.

12.30 p.m. Addresses by the President and Secretary of the Canadian
Medical Association.

1.15 p.m. Adjournment.

2.30 p.m. Golf Tournament or Visit to Aldershot.

7.30 p.m. Annual dinner.

Presidential Address.

9.30 p.m. Informal dance Evangeline Beach.

THURSDAY, JULY 10th.

9.00 a.m. Second Business Session.

10.00 a.m. "Some Interesting Facts from our Recent Epidemics."

DR. A. R. MORTON, Halifax, N. S.

10.30 a.m. "Surgery and the Heart."

DR. T. A. LEBBETTER, Yarmouth, N. S.

11.00 a.m. "Pitfalls in the Diagnosis of Tuberculosis."

DR. A. F. MILLER, Medical Superintendent, Nova Scotia
Sanatorium, Kentville, N. S.

11.30 a.m. "Some Chronic Suppurative Conditions of the Lungs."

DR. V. D. SCHAFFNER, Surgeon, Nova Scotia Sanatorium,
Kentville, N. S.

12.00 Noon "Significance of Haemoptysis."

DR. J. E. HILTZ, Nova Scotia Sanatorium, Kentville, N. S.

12.30 p.m. Annual meeting of the Valley Medical Society.

1.00 p.m. Adjournment.

*SUPPLY AND DEMAND FOR INTERNS

"At present, probably more than ever previously, a need for clear thinking on the subject of the supply of interns in relation to the demand by hospitals for their services is desirable," *The Journal* of the American Medical Association for March 15 says in an editorial.

"Some hospitals have been unable to secure any interns and others have not secured their usual number. The demand exceeds the supply. The size of senior classes in approved medical schools has remained almost constant since 1934, while the number of appointments available each year in approved hospitals has steadily increased. Although statistics are not yet available, the number of graduates of European schools seeking internships in this country has diminished greatly within the past year. While the number of interns recruited from this source has never been large, the recent decrease has served to accentuate the disproportion between supply and demand.

"The approved medical schools with their present facilities cannot increase the size of their classes without sacrificing accepted educational standards. Furthermore, the function of medical schools is to educate physicians to supply the medical needs of the country, not merely to develop young physicians to meet the demand of hospitals for low cost house staff personnel. Until approved medical schools are able to train more students (assuming that more applicants could qualify for admission) the supply of prospective interns will not increase.

"Even the present flow of graduates from approved schools into internships may be reduced by the selective service act. The crucial needs of the preparation for national defence, especially the necessity of expanding the Army and Navy Medical Corps, will no doubt reduce still further the number of graduates available for hospital service beyond the first year of intern training. This will affect hospitals which have internships more than one year in length as well as those which have extended training services in the form of residencies.

"No doubt graduates will continue to prefer appointments in hospitals that provide the best training for internships and residencies. These are the hospitals in which attending staffs are not only unusual in ability but, even more important, most willing to give their time to the instruction of the house staff. There will probably also be a continued preference for hospitals with large charity wards, especially those with long-established educational services.

"With these considerations clearly before them, the boards of hospitals which have experienced difficulty in attracting the usual number of interns and residents may examine their problem and prepare to make the necessary adjustments. Physicians in many localities have taken for granted the provision, by the administration of hospitals, of medically trained personnel capable of relieving the physicians of certain time-consuming procedures necessary to the care of patients. The attending physicians should realize two principles of basic importance in this connection: First, interns and residents are employed on an apprenticeship basis whereby the compensation for their services is mainly the instruction they receive from the attending staff. Second, the duties performed by house staff personnel are properly the responsibility of the individual attending physicians, not that of the hospital administration. In the absence of sufficient house staff assistance, the attending men may well find it necessary to perform these tasks for some or even all of their patients."

* *The Diplomat*, April, 1941.

The War

THREE HUNDRED AND FIFTY CANADIAN DOCTORS REQUIRED DURING THE NEXT YEAR FOR MILITARY SERVICE

The Association is authorized by the military authorities in Ottawa to say that medical officers for the Canadian Navy, Army and Air Force are needed now, and it is anticipated that 350 will be required during the coming year. So far, and without any direct appeal having been made, the medical profession of Canada has responded well in that approximately one-tenth of its number, namely, more than 1200 Doctors are already in active military service.

It is appreciated that essential Dominion, Provincial, Municipal and civilian requirements must, as far as possible, not be embarrassed. However, the needs of the military services must be met and these may be classified for the next year's requirements, into the following groups:

- (1) For service in Canada—These may be in medical category "A", "B" "C" and in this class can be considered those over 40 years of age. Approximately 140 additional of these will be required.
- (2) For overseas service—These should be in category "A" and preferably under 40 years of age. About 210 of such will be required.

No promise can be held out to any officer of definite appointment to overseas service, nor must there be any strings attached to the offer of service, although we are assured by the military authorities that every effort will be made to see that proper recognition is made of every man's qualifications and that he is used to the best advantage. It must be recognized that care is necessary with regard to the selection of specialists according to the requirements of the services at any one given time.

All medical men who are desirous of offering their services should immediately contact one of the senior medical officers of the Services in the District in which they reside. If preferred, communications may be addressed to the General Secretary of the Canadian Medical Association, 184 College Street, Toronto, who will be glad to put the applicant in touch with the proper authorities.

T. C. ROUTLEY

WANTED—RESIDENT PHYSICIAN

Resident physician wanted for the Children's Hospital, Halifax; immediate appointment. Salary \$75.00 a month, plus maintenance. The Children's Hospital has a capacity of 80 beds, treating all childhood diseases from infancy to twelve years of age. Apply to Miss Marjorie Jenkins, Superintendent.

FOR SALE

One Thoma-Zeiss Haemacytometer. Never used. Price \$10.00. Apply to Mrs. James Lewis, Eureka, Pictou County, N. S.

Plans are now Complete for THE ANNUAL MEETING

Which will be held at

THE CORNWALLIS INN

Kentville, N. S.

JULY 9th and 10th

A well balanced scientific programme has been arranged.

There will be three contributions by members of the Canadian Medical Association's visiting team. Dr. G. S. Fahrni of Winnipeg, Manitoba, will speak on "Parathyroid Tumours and Hyperparathyroidism". Dr. R. R. Fitzgerald of Montreal will give an address on "Fracture of the Neck of the Femur". Dr. J. H. Geddes of London, Ontario, will give a paper on "Functional Disorders of the Colon". Besides this we have some excellent papers by members of our own Society.

The social side of the meeting has not been neglected. A strong local committee was appointed some time ago and has been working steadily to make the meeting a success from this angle. The annual golf tournament will be held as usual and for those who do not play golf the local committee has arranged a visit to Aldershot with a military display.

The annual dinner will be held this year and will be a mixed one.

It has been decided not to hold any formal dance, but on Wednesday evening at 9.30 following the dinner an informal dance has been arranged at Evangeline Beach.

The local committee have appointed a ladies committee to take care of the wives and children.

The Cornwallis Inn have reserved fifty double rooms.