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Coronary Thrombosis In General Practice

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I KNOW of no sympton, and I make no exception of pain in the belly, which calls so urgently for a swift and sure diagnosis as pain in the chest. The public are now well aware of what may lie behind this "frontier incident" in our troubled state; and we, as doctors, know that round the next corner lie in ambush the men of Fear against whose weapons, once they are discharged, we have little or no defence. I shall not labour this point but it seems to me to be obvious that a man in the full tide of life cannot be torn from his tasks without great and sufficient reason; and, again, to leave such a man with a scar on his psyche when there is no corresponding scar on his myocardium would appear to be a situation that contains the elements of tragedy. Diagnosis, then, is important; and, particularly in this disease, diagnosis can be compared to justice, in that it must not only be done but it must be seen to be done. The confidence of the patient and that of his relatives must be won, and no time or trouble should be spared to gain this end.

Diagnosis

I shall only mention those points of diagnosis which seem to me to be important in general practice. The fever, the leucocytosis and the increased sedimentaion rate are useless signs for me because they are delayed and I cannot wait. For the same reason the fall in blood pressure is of little value.

When there is a dramatic fall, the diagnosis is usually so obvious that to put the patient to the distress of even taking his blood pressure is unnecessary and unkind. More frequently the blood pressure falls gradually over a period of four or five days and when this happens it is significant but it happens too late for my purpose. Perhaps I might be permitted to mention here a simple manoeuvre which would improve the cardiovascular health of the country beyond measure. It is that the instrument maker should transpose two of his price labels so that now the electrocardiograph would cost £10 and the sphygmomanometer would cost £300. If all existing sphygmomanometers could, at the same time, be collected and destroyed, great benefits would follow.

Of the points of importance in home diagnosis I would place first the site, distribution and type of pain and indeed the whole story of the attack and every variation in health that led up to it. Getting this story right may be troublesome but it is very rewarding. Secondly I would place the family history. There can be no doubt of the strong influence of heredity in this disease but it is well to bear in mind that history must have a beginning and we may be looking at the first of a long line of cardiac accidents. Nevertheless, I think it is true to say that, sometimes, when the history of the onset is equivocal, when there are no physical signs, and when the electrocardiographic changes may be delayed, then, if properly attuned, one can clearly hear ancestral voices speaking the diagnosis from the grave.

The Electrocardiograph

Last, but by no means least, comes the electrocardiograph. I am aware that there are many conditions outside the heart which may produce changes in the electrocardiogram, and also that it is possible to get a normal record from a patient who has scarcely a branch left on his coronary tree. I do not believe that these exceptions will often deceive us if full and due attention has been given to the clinical side of the picture. I make it a point to form a firm diagnosis before taking an electrocardiogram, one on which I would be prepared to act if I were deprived of electrocardiographic aid. I find that in practically all cases in which I have made a diagnosis of cardiac infarction this diagnosis is verified by the machine. But what often happens is this. I have decided that the patient has not sustained an infarct, that in a few minutes' time I shall tell him to get up and go about his business. While I am coming to that decision I have put on the electrodes and warmed up the machine; the patient is now relaxed and I switch on and there I see, slowly unfolding on the snowy paper, the fresh spoor of the Abominable Thrombosis. I cannot say in what percentage of doubtful cases this happens, but it is often enough for me to have no conceit left of my powers of diagnosis. The frequency with which it happens makes me wonder how many cases I miss; and then again I wonder whether it matters that I should miss them.

Treatment

The first point of treatment is the relief of pain. So far as I know, morphine is the only drug that attains this end satisfactorily, and it should be given freely. I combine it with a little pethidine because I have the feeling that this combination is less likely to cause vomiting than morphine alone.

The next point that a practitioner has to decide is whether the patient should or should not be admitted to hospital. For my own part this decision has never been difficult because I believe that the best place to treat a patient who has a myocardial infarct is in his own home. I do not know whether any relative figures of survival have been compiled and I am not primarily concerned with survival: but even on this score I have an impression that patients treated at home do at least as well as those treated in hospital. What I am chiefly concerned with is the high rate of mental morbidity shown by patients whose cardiac efficiency has been restored in a hospital ward. Although the reasons for this may seem to be obvious, I am never quite certain that I fully understand it. One knows, of course, that the patient discusses his complaint with the house doctors, the nurses and even the ward cleaners, and that such discussions, except at the highest levels, are exceedingly harmful. Then perhaps the patient in the next bed with whom he has been happily swapping symptoms for ten days drops back on his pillow and is quietly dead. One can guess that all these circumstances lead to a state of mind, the treatment of which by the practitioner is infinitely more troublesome than that of the disease which led up to it. Consequently when the hospital has discharged the patient as cured it is not the end but the beginning of treatment.

Therefore, the choice for me has not been difficult. Some years ago, however, the advent of special forms of treatment in the shape of anticoagulants caused me "furiously to think." I frequented "Doctor and Saint, and heard great argument about it and about: but evermore Came out by the same Door as in I want." I formed the view that, in my hands at least, anticoagulant treatment was not one that could properly be carried out in the home. I

thought that those who recommended it "protested too much" and were not really judges but advocates of a cause. Perhaps, too, those who dismissed it as useless were expressing an opinion of the opposing advocates rather than an opinion of the treatment itself. I felt that my patients were missing nothing by being kept out of this faction fight and I continued to keep them at home whenever the home circumstances would permit.

I still continue to do this, although I confess that I am gradually coming round to the view that anticoagulant treatment in the home may well become a safe and beneficial procedure.

After the first few days, during which the bowels are usually closed, I allow the patient up to a bedside commode, or even to walk a few guided steps to the lavatory. This is much less harmful than the breathless indignities of the bedpan. (Perhaps something could also be done about the bedpans on the Feast of the Breaking of Sphygomomanometers). I encourage the patient to keep his legs moving in bed and a little daily massage of the limbs to help to prevent peripheral thrombosis and will certainly help to keep an anxious wife or daughter happy.

I keep the diet very low for the first few days and after that I follow the advice of the greatest of all dietitians. The advice is simple and covers not only this disease but practically all diseases I am called on to treat: it is that "a *little* of what you fancy does you good."

Whatever one's views may be about alcohol, tobacco, and, more latterly, milk, now is not the time to deprive the patient of the moderate use of these substances. Later on he will be in a stronger position to "scorn delights and live laborious days" if his doctor thinks that this is necessary or desirable. In these matters a doctor must inevitably project on his patients something of his own personal philosophy and, speaking for myself, I should be very slow to ask anybody to give up something which largely contributed to his personal happiness even if I knew that he would be in better health because of his abstention. I have, at the same time, every respect for those who consider it their duty to their patients to urge that human sacrifice should still be offered up on the altar of good health.

My chief concern in treatment is to occupy the patient's mind and thereby check the inroads of anxiety which are so insidious and so strong. I never cease to be surprised at the poverty of resource which patients display against the ravages of empty time. I find myself taking a partisan interest in such subjects as horse racing, the breeding of greyhounds and the relative merits of scrum halves. For a punter who is laid by the heels the best treatment is a few winning tips, although like many other forms of treatment this is not without its dangers. I am ever grateful for the graces of the curious religion which I call "golfolatry," even though I cannot pretend to an understanding of the mysterious pages in the daily press devoted to the permutations of soccer football and its pools. I feel these must be what Yeats meant when he spoke of the "Secret Scripture of the poor." I lend patients books and make them give me their criticism. I do not really know why I keep this up. I lost many good books and the results are most disappointing and indeed depressing but every now and then one strikes a few feeble sparks which keep the fires of hope alight.

What to Tell the Patient

I come now to what I consider my most important task in the management of this disease and that is that I am going to tell the patient and his relatives

and what attitude I am going to adopt towards this important event in their lives. We all know how readily cardiac neurosis can be superimposed on a recent cardiac infarction. The patient soon becomes a plaintive and querulous bore. The affection and respect of his family are replaced by a tolerant contempt, whilst on his part "the load of their loveless pity" is worse than anginal pain.

It is a common misuse of words to describe death as a tragedy. However untimely it may seem or whatever tragic possibilities it may hold for those who are left behind, death itself is not a tragedy. Tragedy lives on; and it lives on most poignantly, for me, in the person of a patient whose body has made an adequate recovery, but who is so maimed in mind and spirit that he can no longer take his place in the stream of life.

It may seem to be irrelevant when I say that I consider it odd in this age, when death on the roads is almost natural death, and death in the air a commonplace event, and when a great part of our talents and resources are devoted to the development of means of death for our fellows—death "not in single spies but in battalions"—in this day and time when we are as it were collectively preoccupied with death, that it must not be mentioned in the home where death would seem most natural and most right. When we are faced with illness which may have a fatal conclusion we are forced into a furtive conspiracy to hide the truth from the person who would appear to have the greatest right to know it. The warning look, the finger on the lips and the slow shutting of doors, all seem to say that nowhere is to be found a man who can face the prospect of death with dignity and with an equal mind. Although I do not believe this, I find myself constantly being included in this macabre game; but I do feel that in so far as I allow myself to be drawn into this conspiracy of silence and deceit, in that measure am I guilty of demeaning the standards of human dignity and courage.

Telling the Truth

For this reason I find it satisfying to deal with coronary thrombosis, a disease in which I can be almost entirely truthful. I tell the patient what has happened to him, the mode of cure and the time it will take. I tell him that I have no doubt that he will regain full health and resume his occupation. Many years ago when I cared more about my personal reputation than I do now I would subsequently tell his wife that there were many uncharted rocks that he would have to navigate before coming into harbour. In fact, I undermined in the kitchen all the confidence I had established in the bedroom. I did even worse that that: I formed a barrier of reserve between husband and wife which did something to break the harmony of the home. I soon found out that this cowardly hedging would not do. If I were to establish a climate of confidence and trust, which was my objective, then I found that I had to tell the relatives what I told the patient, and that there should be no reservations to throw a shadow over this fellowship of hope. I find I have to be most guarded in word and action because patients sometime lay traps, but these can be easily avoided if one is vigilant. I try at all times to maintain an attitude of cheerful confidence because it is in my confidence that lies the patient's strength.

It may be said that, if I adopt this attitude in all cases, I must often be wrong, and indeed this is true. I can be wrong in two ways only. In the first place the patient may die and then I say that I had hoped and expected him to live and I was wrong. It is as simple as that. Secondly the patient may live and find himself with cardiac limitations within which he has to re-arrange his

life. In my opinion it is time enough to jump this fence when I come to it and it is not a difficult situation to handle because the patient will have been making adjustments within himself and effort angina is a strict disciplinarian that requires little reinforcement from me. I am not presuming to recommend this attitude (and it certainly will not commend itself to anyone who had to nourish and sustain a reputation for infallibility), but I may mention that patients will often forgive your mistakes when you have the good word, whereas they sometimes will not forgive you for a gloomy prognosis that proves to be correct.

In speaking to patients I avoid entirely the use of the word "thrombosis" and, if challenged directly on this point, I deny it completely. It is interesting to recall the changes in significance of certain words in our vocabulary. When I started in practice I always used the words "peripheral thrombosis" so as to avoid the dreaded word "phlebitis." Now I hear a gasp of relief when I make a diagnosis of phlebitis. And the might word "stroke" with all its undertones of heavenly wrath and inevitable doom has been entirely displaced from its high command in the armies of fear. Decline in greatness is always a sad spectacle and even the fading glory of a word can cause us a pang of regret. Indeed, I do something myself to diminish its dread by using a contradiction in terms of which I always feel slightly ashamed. When a patient is slurring her words, and has dropped her teacup a few times, and I am asked "What is the matter with Mother?" I say: "She has had a "little stroke." I always stand still for a moment after this, waiting for the thunderbolt to strike me but so far I have escaped. Perhaps even the Gods are not what they used to be. However much we may regret it, it is evident that the word "thrombosis" is now the atom bomb of our nomenclature, and I consider that a civilized doctor should not use it against his fellow-men.

Conclusion

I never cease to wonder at the advances in medicine during my time in practice but it is still a solid and sombre fact that in the great majority of cases with which I deal I can do little or nothing to alter the course of the disease. In coronary thrombosis I can move the props and set the stage for Nature to play her part; after that I devote myself entirely to those side-effects where my efforts may be of some use. Cardiac infarction in its long-term effects is not so much a disease as a state of mind. We all share some measure of the heritage which is well described by Constance in "King John." She says:—

> "Thou shalt be punished for thus 'frighting me,
> for I am sick and capable of fears;
> oppressed with wrongs and therefore full of fears;
> A widow, husbandless, subject to fears;
> A woman, naturally born to fears."

If I substitute "Man" for "woman" in those lines they are still equally true. When there is added to this common inheritance the fears engendered by a disease like coronary thrombosis it is only an exceptional human being who can cope with such a situation under his own steam. Mostly they need our confidence and support and if we do not give them this, we give them nothing.

In the edition of Osler's great textbook of medicine I read as a student the first chapter was on typhoid fever and it was almost interminably long. Most of the general principles of medicine both preventive and curative were focused and brought to bear on the problem of typhoid. One day some students were grumbling about the length of this chapter and one of them made the shrewd

remark: "What does it matter under what heading you learn your medicine—when you know Typhoid Fever you know almost all medicine." If *I* were to write a textbook of medicine the first and the longest chapter would be on fear; and, maybe, some student in the future might truthfully say: "If you know Fear you know the greater part of the practice of medicine."

There is said to be much dissatisfaction to-day in the ranks of general practice. Although it is true that it has lost some of its savour, I cannot say that I share in all our so-called frustrations. After all the provision of stays for sagging abdomens and of skewed keels for fallen arches are narrow, pedestrian tasks which properly come within the province of the specialist. We practitioners can take comfort from the fact that two tasks still remain to us which cannot be taken away; and we face them both in the treatment of coronary thrombosis. They are the relief of pain and the conquest of fear. These are tasks not unworthy of our best efforts; "works of noble note" that are not unrewarding, provided we are prepared to accept at least some of our reward in coinage other than that of the realm.

Treatment of Anxiety States With Meprobamate*

Meprobamate was administered to 312 patients treated at the Psychiatric Department of Albany Hospital. It showed definite effectiveness in psychoneurotic anxiety states, and it appeared to have a selective action in conditions in which anxiety and tension were prominent factors.

The combination of meprobamate with sodium amytal in certain cases seemed to be of greater value than either drug given alone. A few patients reported drowsiness or dizziness, but the former subsided spontaneously upon continued administration. Three patients developed mild skin rashes. Other side effects were not reported. While meprobamate appears at least as effective as other tranquilizers, it seems to be safer and better tolerated and has the added advantage that it does not affect the autonomic functions of the body.

During recent years a number of excellent drugs have become available for the treatment of the emotionally disturbed. With the exception of meprobamate, those most widely used are either antihistamines or *Rauwolfia* compounds. Both these groups appear to act primarily on the hypothalamic area of the brain, with resultant powerful effects on the autonomic functions.

Chemically, meprobamate is entirely different from either of these two major families of tranquilizing drugs. It exerts its action primarily on the thalamus rather than on the hypothalamus. Therefore it is able to produce therapeutic results without distributing the delicately adjusted autonomic equilibrium of the body.

This fact is of special importance in treating outpatients who must carry on with their every day work and activities, and in whom such autonomic side reactions as stuffy nose and diarrhoea may be very disturbing. Of even greater importance in outpatient treatment is the low toxicity of meprobamate. While the incidence of agranulocytosis, jaundice, parkinsonism, and depression resulting from the antihistamine and *Rauwolfia* tranquilizers may not be unreasonably high in relation to the total number of patients treated with them, still the possibility of their occurrence makes necessary a constant vigilance that is usually not feasible in outpatient practice. With meprobamate, transient drowsiness and an occasional skin reaction are the worst that can be expected. Therefore meprobamate therapy would seem to be the treatment of choice for this type of patient.

Osinski, W. A., Annals of the New York Academy of Sciences. 67: 1957.
* Medical Abstracts, August, 1957.

Nutrition – A Public Health Challenge

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NUTRITION teaching is a vital aspect of preventative medicine. Many diseases have been almost completely wiped out with improved methods of sanitation and the use of new drugs. Many diseases which now take a high toll in sickness and death may be wholly or partly controlled by a better understanding of the foods we eat.

Never in the history of man has there been available more accurate scientific knowledge concerning food and its relationship to body health. Never has there been more confusion and misunderstanding in the public mind regarding proper eating habits. Every professional person with access to true facts has a responsibility to keep the public accurately informed.

The Nutrition Division of the Department of Public Health accepts the guidance of the Canadian Council on Nutrition. Its aim is to encourage good eating habits for all groups of people. Nutrition activities touch on the school lunch programme, health instruction in the schools, work with community groups, and welfare organizations, budgetting for low income families, and instruction in professional schools of nursing and social work. A major part of the work includes a food consultant service offered to all hospitals, municipal and child-caring institutions, and community feeding groups. In this respect, the DIET MANUAL was prepared in 1953, and is now widely used in hospitals and in private practise.

The staff of Nutrition Division numbers a Director and three staff nutritionists, plus one student doing graduate work in public health nutrition at the University of Toronto. Further plans provide for one nutritionist for each health division of the Province, making a total of nine.

The progress of nutrition education is seriously hampered by social and economic changes which in themselves are good, but have undersirable effects as well. The majority of Nova Scotians have received sufficient instruction to know that nutrition is important. They are fair target for all the "new scientific information" with which they are bombarded day and night. This so-called truth overwhelms them whenever they pick up a popular magazine, turn on their radio or T.V. sets, or enter a drugstore or supermarket.

The nutritionist must continue to emphasize the importance of eating a variety of foods especially those recommended in Canada's Food Rules. In addition she must bring to the public attention these serious trends:

1. Commercial advertising cannot be relied upon for true facts. In many instances, the public is misled by statements that are half true.
2. Food faddists and popular writers distort and glamorize. Countless numbers of people are seriously endangering their health by following fad diets.
3. Chemicals are being added to foods at a greater rate than can be properly controlled by food and drug laws. This is particularly true in the United States. This practice increases food costs.
4. Indiscriminate use of high potency mineral and vitamin preparations is a dangerous habit. Evidence is mounting to prove that serious metabolic

disturbances may result. Often mothers erroneously believe their children to be receiving adequate nutrients and thus become careless with family food habits.

5. Prizes and bonuses in food packages increase food costs, and are detrimental to intelligent consumer purchasing. Simple shopping comparisons are impossible. The "prizes" can usually be purchased more cheaply in a department store.

6. The Financial Post has recently issued a warning that food costs will rise due to an ever-increasing demand for ready mixes and packaged foods. This trend, solely for the sake of convenience, is creating a problem for low income families who find it impossible to buy simple ordinary foods with which to prepare their own home cooked meals.

Additives, prizes and prepackaged foods which on the surface appear to raise our food standards, are actually lowering the level of nutrition for many people.

The Public Health Nutritionist will continue to do her teaching, but too little will be accomplished unless all allied professional workers will stand guard to help stem the tide of unfortunate and untruthful nutrition propaganda.

Combined Corticosteroid and Anti-Microbial Therapy in Tuberculous Meningitis.

Thirty patients with tuberculous meningitis were given combined treatment with streptomycin, aminosalicylic acid, and corticosteroid preparations. Hydrocortisone in an initial daily dose of 200 mg. was used as the corticosteroid of choice. Twenty-five patients made a complete recovery and five died. One of the patients who died had a complete infarction of the right cerebral hemisphere that appeared to preclude recovery by any form of treatment. Another two patients were admitted to the hospital in extreme collapse, so that no method of treatment could have been expected to bring about a satisfactory result. If these three patients are excluded, there remain 25 patients who recovered out of a total of 27 treated.

This recovery rate represents a distinct improvement over that of current reports in the literature.

Five of the twenty-five patients were comatose or their conditions were deteriorating when treated with aminosalicylic acid, streptomycin, and isoniazid, yet they recovered. Dramatic clinical and laboratory evidence of improvement was noted in these patients shortly after corticosteroids were added to their therapeutic regimens.

It would seem that the addition of corticosteoids to the standard methods of treatment in tuberculous meningitis is capable of effecting striking improvement when the prior condition of the patient has been unsatisfactory. Neurological sequelae were distinctly less frequent in the corticosteroid-treated patients than in the others. There was no evidence of the exacerbation of non-meningeal tuberculosis or any evidence of the occurrence of intercurrent non-tuberculous infections resulting from the use of corticosteroids in this disease.

Shane, B. J., Canadian Medical Association Journal. 74: 1957.
Medical Abstracts, August, 1957.

Report On Family Allowances For 1957

FAMILY Allowance payments reached a new high in 1957. The total payments for Nova Scotia families came to almost $19,000,000, an increase of almost a million dollars over 1956. Part of this increase came as a result of the normal growth in families and children. But the largest part of it, over $150,000 a month for the past four months, came as a result of the higher rates that became effective in September.

The past twelve months brought approximately the same amount of general increase as has occurred over the years. The number of families receiving allowances in December of this year is up by fifteen hundred to 100,124, an increase of 1.6 per cent. There was a slightly higher rate of increase in children registered, up five thousand to 252,302.

1957 saw a record number of new children applied for: 18,967. This was a thousand more than those added in 1956, although, as it happens, last year brought an exceptionally low registration of newly born children.

There was an interesting aspect to this increase in children registered. The additions to families already receiving allowances was about what might be expected, an increase of just over two per cent. On the other hand, the new families coming into pay for the first time, those applying for their first child, showed an unusual jump. In 1955, there were 5257 families who began receiving allowances for their first child. In 1956, there was a drop to 4832, but 1957 came up with a record 5587, an increase of sixteen per cent.

New Rates Bring Higher Benefits

Over the years, since Family Allowances began in 1945, there have been a number of changes which have tended to widen the benefits, and at the same time, simplify the administraion of the Act. Originally, the rates were set in accordance with two principles: that the older a child gets the more it costs to maintain him, and, secondly, that the individual child tends to cost less as the family grows in size. So the original rates increased with age, from five to six to seven to eight dollars per month, but decreased by a dollar a month as the family increased in size.

Some eight years ago, an amendment removed the decrease for size in family. Then, last spring, Parliament reduced the number of rates from four to two. Now there is a six dollar rate for children up to ten years of age, and an eight dollar rate from ten to sixteen. This was done by raising the monthly rate for children up to six years by one dollar a month, and, by a similar amount for those from ten to thirteen.

This increase in monthly rates brought an extra $150,000 a month to Nova Scotia families. As a result the average family payment was increased by $1.53 a month to $16.68. The average payment per child moved from $6.08 to $6.69 a month. The total Family Allowances that can be received for one child has risen from $1188 to $1296 for the full sixteen years.

Record Number of Nova Scotians Move to New Addresses

For some years now, there has been an increasing tendency for Canadian families to break away from the established settled living in the family dwelling. In the year just passed a record 18,480 Nova Scotia families reported changes of address to the Family Allowance office. This means that, on the average, one

out of every five families moved to a new address in Nova Scotia. Actually this is a minimum figure, for it does not include changes of dwelling place that did not involve a change in mailing address.

In addition, there was also a record movement of families in and out of Nova Scotia. Altogether, in 1957, some 3297 families moved in from other provinces, while 4016 families went to one of the other nine provinces. Even after we allow for transfer of military personnel, these figures show that a great number of families made major moves within the year.

Totalling up the figures for both movements, we find that, on the average, every family in Nova Scotia is apt to move to a new address within the next four to five years. Of course, some families will move several times in that period, and obviously also some families will not move at all. But, in general, it seems clear that we have left behind the tradition of spending generations in the family dwelling.

One aspect of the records of transfers between provinces raises an interesting question concerning the future with respect to movement away from this Province. Generally speaking, the trend has been clearly outwards. Not nearly enough to offset the normal increase in population, but still serious. Last year was particularly striking in this respect, for in 1956, some 1200 more families moved out than came in. This year, 1957, there was a very significant change. While it is still true that far more families moved out, some seven hundred of them, yet the number of families coming in increased with a big jump from 2777 to 3297. Over the same period the number of families moving out was up by only 43, the smallest increase in recent years.

Because the Family Allowance figures are not tied up to individual families, or to the reasons why people move to other provinces, it is not possible to know whether this change indicates a change in the trend. It could mean that the net loss to Nova Scotia is decreasing. On the other hand, it may be a temporary change and have no significant indication as to what will happen in future.

Diphenhydramine Hydrochloride as a Local Anaesthetic Agent

The authors initially give a comprehensive review of the various antihistaminics used for the purpose of producing local anaesthesia. It was often observed during minor surgical operation that some patients are sensitive to procaine or else they do not obtain anaesthesia from it. It was felt that a substitute drug of different chemical structure would be of definite value. Antihistaminics came in quite handy for the purpose as one of their physiologic properties was that of producing local anaesthesia on topic application.

Diphenhydramine hydrochloride (Benadryl) was selected by the authors as a local anaesthetic for various minor surgical procedures for removal of skin lesions like keratosis, nevi, verruca, hemangiomas, biopsy, etc., by electrocautery. It was used in 0.5 per cent and 1.0 per cent solution and compared with 2 per cent procaine solution. A double blind control method evaluation was employed so that neither the surgeon nor the patients knew about the nature of the anaesthetic used. The results showed that a 1 per cent solution of diphenydramine was at least as satisfactory as 2 per cent procaine. Thus it will serve as a substitute in either contingency stated above.

Steffen, C. G., Zimmerman, M., and Mohan, R., Archives of Dermatology. 74: 1957.
Medical Abstracts, August, 1957.

Nova Scotia Mental Health Clinics

Reprinted from Canada's Mental Health, June, 1958.

The Mental Health Clinics in the Province of Nova Scotia are operated not by the Provincial Division of Mental Health, but by a Board of Directors, most of whose members are locally appointed. At the Fundy Mental Health Centre at Wolfville, for example, the Board of Directors consists of ten members, four of whom are appointed by the local branch of the Canadian Mental Health Association and four by the Acadia University Institute. The remaining two are from the Provincial Department of Health: the Divisional Medical Health Officer and the Director of Mental Health. An Advisory Committee, representing a variety of local groups, is appointed by the Board. The Board directs policy, employs its staff, is responsible for finances, purchases, etc.

Finances

Finances come from two sources. The Province (through the National Mental Health Grants, in the case of the Fundy Clinic) pays salaries, travelling expenses and some other items. Initially, it also provided the equipment. The local community provides the quarters and money for rent, heat, light, office supplies, etc. About 90 per cent of the operating cost comes through the Provincial Government; the remaining 10 per cent is raised locally.

The other clinics are operated on the same basic plan, but with local differences. In the new clinic being set up in Sydney, the Board consists of 20 members, 17 of whom are locally appointed. The local Mental Health Association appoints eleven, the Medical Society two, the clergy two, etc. No national Mental Health Grant funds go into the operation of this clinic. The Provincial Treasury bears most of the cost.

Advantages

This method of operation has many advantages. The most important is that the local community has a real stake in the clinic. If it is to run successfully, the community must raise some of the money and provide policy direction. And this is just what is done. The clinics are reported to have a lot of local support.

In all the four clinics the Director of Mental Health is also a director on the Board. The clinics must conform to certain basic standards determined by the Department of Public Health. Apart from this, there is a great diversity of approach to the different clinics' problems and in the ways they handle them. There is room for considerable elasticity which avoids a rigid common mould. The Provincial Director of mental health reports this variety of pattern is both stimulating and interesting.

Of course, the clinics do have problems. They report, for example, as elsewhere, obtaining qualified staff is difficult. The Province pays salaries which conform to Provincial Civil Service scales and hours of work. The local community may add to these salaries if it wants to and may grant more opportunities to psychiatrists for private practice than is available in the government. But, since the staff are not civil servants, the superannuation problem is difficult, although plans are being worked out.

All in all, Nova Scotia seems to be quite happy about this method of operating its mental health clinics and is planning to develop more along similar lines.

Canadian Tuberculosis Association

CHEST X-RAY AND RADIATION HAZARDS

During the past few months a number of statements have been made and a great deal of publicity has been given to the possible effects of radiation. Any dose of radiation may have an effect on the body to some extent, and there is no justification for unnecessary X-ray exposures. However, X-ray screening programmes must continue to be conducted with the knowledge that through the years the public has derived enormous benefit from the early diagnosis of chest disease on routine screening surveys. The gonadal dosage received by a person in these surveys was much less than that received from other radiation sources. In fact only 0.1% of all the radiation received by the population up to age 30 years from background, medical, diagnostic and other sources, came from mass chest X-ray surveys in the past. With improved techniques this already minute amount is being considerably decreased.

In a statement by the Surgeon General of the U.S. Department of Health, in November 1957, the following guiding principles were laid down as the policy of the U.S. Public Health Service in regard to tuberculosis X-ray case-finding surveys:

1. Mass radiography of the chest, operated under competent auspices, is a fundamental technique in the detection of tuberculosis.
2. Mass X-ray case finding should be applied selectively in groups at high risk of tuberculosis in infection and disease.
3. All tuberculosis X-ray survey programmes should have the prior approval of the applicable state or local health department.
4. Consideration should be given to the tuberculin test as an initial screening device in low-prevalence groups.
5. Every community should evaluate on a continuing basis its tuberculosis programme needs and resources, so that local X-ray surveys may have efficient use and maximum effect.
6. Adequate safeguards should be utilized to protect all persons from unnecessary radiation.

In October 1957, Dr. O. M. Solandt addressed the meeting of the Industrial Medical Association on the potential radiation hazards of the future. He said that the medical profession was not always conscious of the radiation dosage used in extensive diagnostic X-ray procedures. His remarks were misinterpreted by a large number of newspapers who reported him as having said that "Annual chest X-rays might be subjecting some persons to radiation in excess of the safety level." When later asked for clarification of this statement, Dr. Solandt said that he had made no specific mention of chest X-rays, and had made it clear that the vast majority of diagnostic X-rays were harmless and very necessary.

Similarly, in answer to a question in the British Medical Journal of November 23rd, 1957, a very definite statement was made on the question of genetic hazards of chest X-ray radiation. The question was:

"Does radiography of the chest, miniature or full size, involve any genetic or other hazard to the person X-rayed? If so, how frequently is it justifiable to radiograph the chest of (a) those such as teachers, nursery staff and others in close contact with children (b) those whose work especially exposes them to the

risk of tuberculosis infection such as nurses and laboratory workers? With regard to the latter, is there an age at which their radiological surveillance becomes less imperative?"

(2) Do mass X-ray surveys on the scale for instance of those now proceeding in Scotland carry any genetic or other risk?

The answer was:

"There is no evidence that radiography of the chest, miniature or full size, involves any genetic or other hazard to the person X-rayed. The rigorous standards of the Medical Research Council's report permit 250 miniature or 1,000 large X-ray films to be taken during any one individuals lifetime, using present techniques. People in contact with children should be X-rayed annually, irrespective of their age. People whose work exposes them to the risk of tuberculosis infection should have a 6-monthly radiograph up to the age of 30 and an annual radiograph after that age."

"(2) Mass radiography surveys carry no genetic or other risk."

The background dose of radiation is 3,000 mr up to the age 30 years. The British Medical Research Council have recommended that the radiation dose from all radiation, additional to background, should not exceed twice this background level, that is, 6,000 mr. When one considers these figures in relation to chest X-rays, it will be seen that the radiation dosage to the individual is minute.

With careful radiological technique, the male gonadal dose can be reduced to 0.1 mr and the female dose to 2 mr, using the lens camera. With the mirror camera these doses could be reduced to one quarter, that is the male dose would be 0.025 mr and the female dose 0.5 mr. The use of the 14 x 17 film would involve the individual in a very minute fraction of these already small doses. In fact the margin of safety is so wide, with any camera properly used, that it would allow for far more miniature or full-size chest X-rays than any one individual could possibly have taken during his lifetime.

It is very important that the X-ray techniques should be kept at a very high standard and the following points must be emphasized:

1. The apparatus should be of a high standard of efficiency and should be checked to ensure that there are no unnecessary radiation leaks. For the protection of personnel, full use should be made of the radiation monitoring service provided by the Federal Government.
2. There should be accurate centering of the X-ray beam.
3. Coning should be extremely accurate to cut down any unnecessary X-ray beam. In addition a device should be fitted to cut off the lower portion of the beam to conform to the shape of the disphragm, and an aluminum filter 2 mm's thick will cut out the softer radiation.
4. Radiological techniques should be kept at a very high standard with careful attention to exposure and processing details to avoid unnecessary repeat X-rays.
5. The use of faster films and image intensifiers would further cut down on the dose of radiation to which the individual is exposed.
6. The improvements listed above are now being introduced in all provinces.

Summary:

There has been some distortion and misplaced emphasis as to the extent of hazards in medical radiation, but there has also been reasonable advice on some

radiation precautions. The aim should be to keep the dose of radiation as low as possible. X-ray apparatus and X-ray technique should be kept at an extremely high standard. There has been no evidence that specific medical uses of radiology should be abandoned because of possible radiation hazards, while the great benefit to be derived from judicious use of X-ray examination should be borne in mind. As the incidence of tuberculous infection falls it may be practical to substitute tuberculin surveys in the younger age groups, X-raying only those found to be positive and concentrating mass chest X-ray programmes in those groups and areas where a high incidence of tuberculosis could be expected, rather than on a general community or mass X-ray basis of all ages. In older age groups, where gonadal radiation is not genetically significant, there is no reason to limit routine X-ray surveys. In view of the high incidence of tuberculosis and lung cancer in older persons, routine radiography should be encouraged in those over 40 years of age.

The Dietetics of Coronary Heart Disease

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

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

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

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

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

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

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

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

INFECTIOUS DISEASES — NOVA SCOTIA
Reported Summary for the month of May, 1958

Diseases	NOVA SCOTIA 1958 Cases	NOVA SCOTIA 1958 Deaths	NOVA SCOTIA 1957 Cases	NOVA SCOTIA 1957 Deaths	CANADA 1958 Cases	CANADA 1957 Cases
Brucellosis	0	0	0	0	0	0
Diarrhoea of Newborn	0	0	0	0	0	0
Diphtheria	0	0	0	0	8	6
Encephalomyelitis Infectious	0	0	0	0	2	2
Food Poisoning	0	0	0	0	0	0
Gastroenteritis (1) Infectious	14	3	40	0	31	48
Hepatitis—Infectious Including Serum Hepatitis	132	0	7	0	0	0
Impetigo of Newborn	0	0	0	0	0	0
Influenza (if unusual number of cases)	146	2	247	2	713	458
Meningococcal Meningitis and Meningococcimia	0	0	0	0	25	31
Pertussis	34	0	10	0	570	433
Poliomyelitis (paralytic) non-paralytic)	0 0	0 0	0 0	0 0	6 3	3 3
Scarlet Fever and Streptococcal Sore Throat	90	0	208	0	807	596
Tuberculosis (pulmonary) (non-pulmonary)	0 0	3 0	0 0	0 0	548 70	507 39
Typhoid and Paratyphoid Fever	0	0	0	0	32	21
Venereal Disease (syphillis) (gonorrhoea)	2 27	0 0	1 14	1 0	178 1080	179 839
Anthrax	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0
Rabies	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trichinosis	0	0	0	0	0	0
Tularemia	0	0	0	0	0	0
Other rare diseases	0	0	0	0	0	0
Other (if unusual number of cases)	0	0	0	0	0	0

(1) amobic and bacillary dysentery and salmonellosis

Remarks:

During the month of May, a case of typhoid fever was removed from a boat in Halifax enroute for New York. The case was treated at the Infectious Diseases' Hospital in Halifax and recovered satisfactorily.

During the month, W.H.O. reported 10,000 cases of smallpox in Pakistan and the incidence was on the increase. A 40% mortality was reported. Six cases were reported in Liverpool, England. It is understood that these cases occurred in people who had arrived in Liverpool from the far East. Laboratories all over the western world are sending smallpox vaccine to the far East in an effort to stop the epidemic.

During the month, there was a rabies scare near Liverpool, Nova Scotia, A young man was bitten by a young fox which he had caught in the woods. The following day the fox died. The head of the fox was sent to the laboratory for examination, but no evidence for rabies was discovered. The young man was given hyper immune anti-rabies serum.

As far as is known, there has never been a case of rabies in Canada, east of the Province of Quebec.

During the month, there occurred in the Province an outbreak of what appeared to be food poisoning. After attending a church supper some fifty people suddenly became ill. Diarrhoea and vomiting were the predominating symptoms. This outbreak was not officially reported and this information was obtained from one of the persons involved.

The number of cases of tuberculosis for this month has not been received to date.

Psychotic Episodes Heralding the Diagnosis of Multiple Sclerosis*

Four cases have been presented where patients with psychotic reactions were admitted to psychiatric hospitals and who, it was subsequently found, were concurrently suffering from multiple sclerosis. These patients' psychological illnesses could not be differentiated from those of patients on locked wards whose illnesses were not complicated by neurological disease. The patients reported were not classified into any single type of psychotic reaction in the nomenclature. No correlation could be made, in this series, between type of psychiatric diagnosis, severity and course of psychological incapacity, and the severity and course of the multiple sclerosis. Though no characteristic personality or nosologic type could be drawn, all four patients seemed to have had strong passive dependent patterns, emotional and sexual immaturity, and poor marital relationships. All patients suffered from forms of impotence or frigidity. Associated with the onset of psychiatric illness in all four cases were divorce, separation, or serious consideration of both.

This report re-emphasizes the importance of a careful neurological evaluation of every psychiatric patient, with a careful review of the past medical history. It is recommended that neurological evaluations be repeated regularly if there has been any history of unexplained neurological symptoms, or if certain physical complaints or apparently unimportant neurological findings on initial examination are not specifically accounted for.

Geocaris, K., Bulletin of the Menninger Clinic. 21: May 15, 1957.
*Medical Abstracts, August, 1957.

Book Review

Medicine and the Navy 1200-1900, Volume I: by J. J. Keevil, 255 pp. E. & S. Livingstone Limited, Edinburgh and London. Published in Canada by The MacMillan Company of Canada Limited, Toronto, 1957. $6.75.

For many hundreds of years the prosperity and at times the very survival of Britain depended on maritime strength. In turn this strength has stemmed from the ability and fitness of the men who served in the Royal Navy and the earlier government fighting ships. Readers of Naval History may have been curious that seemingly so little attention was paid to the health of seamen over the years.

Certainly the louse-ridden, scorbutic, and often ill-treated sailor had little cause to love his service, but to believe that no thought was given to his health and welfare is to malign the men who, for humanitarian or purely practical reasons, strove to improve his lot and the medical services available to him. The book under review chronicles the development of medical facilities for sick seamen and it tells a story of great interest the previous neglect of which is most surprising.

We read about the Laws of Oléron—a mediaeval charter for seamen developed by Eleanor of Aquitaine and adopted in Britain after she and her husband Henry II came to the throne. These Laws sought to ensure a minimum standard of treatment for sailors landed because of injury or illness.

The story of the Armada is known to every schoolchild, but it is enlightening to read that, at the time of the action, the British ships had provisions left for only two days and that their crews were so affected by virulent food-poisoning that the fighting efficiency of the Fleet was seriously jeopardised. In such circumstances the driving of the Spanish Fleet into the North Sea by a gale must indeed have appeared providential.

The sea exploits of Howard, Hawkins and Drake were spectacular but few realize that these brave seamen showed for their men a consideration rare for those days and that in 1590 they established the Chatham Chest to provide small grants and pensions for crippled sailors.

Even when the necessity for ships surgeons was accepted the evils of impressment resulted in the forced employment of poorly trained medical men—"sory surgeons" as they were aptly described by William Clowes who himself stands out as one of the few having both the experience and ability to teach those who were to practise surgery in the King's Ships.

Those who are deterred by administrative history need not shy from this most ably written narrative. The late John Keevil, M.D. received his baptism of fire as a Naval Surgeon, and a D.S.O., when H.M.S. ILLUSTRIOUS was badly damaged by German bombs. He was for years interested in naval medical history and few were better qualified to produce an authoritative work of this kind. His premature death may well prevent publication of the remaining volumes but this one will stand alone as a handsome memorial.

Society Meetings

VALLEY MEDICAL SOCIETY

The Annual Meeting of the Valley Medical Society was held on May 14, 1958, at the Nova Scotia Sanatorium, Kentville, N. S. The following points arose from the report of our member to The Medical Society of Nova Scotia Executive, Dr. J. P. McGrath.

The Department of Veteran's Affairs, Department of National Defence and the Department of National Health and Welfare are now pro-rating our professional accounts 10 per cent. This was agreed to by the C.M.A., although under protest. At this time, when wages and costs are rising, and increases have been granted by the government to Civil Servants, Military Personnel and others, one is at a loss to understand why our fees, which are the same as five years ago, should be reduced or taxed 10 per cent. The Medical Society of Nova Scotia should enter a vigorous protest.

The presence of Group Insurance Schemes set up by private companies without consultation with the medical profession are posing a problem inasmuch as the forms are not standardized, resulting in a great increase in the clerical work by the attending physician. Some effort should be made by the society to have these forms standardized.

The matter of no provision for payment to the assistant in a surgical procedure should be rectified; as there is no reason why a fee should be allowed for the operator and anaesthetist, but none for the assistant.

The sale of cheap insurance plans to the public should be protested. Many people who buy this type of coverage are totally unprepared for the small return that they receive from such policies.

Several features of the problems of the chiropractors bill were discussed, put to a motion and passed.

The following motion was passed unanimously that The Medical Society of Nova Scotia be notified and the suggestion made through them to Dalhousie University that students in fourth year medicine be given:—

(a) special instructions and lectures in the use of physiotherapy and manipulation in the treatment of low back pain.

(b) A short series of lectures on ethics, including patient-doctor relationship and physician to physician relationship, and the capabilities and limitations of the recent graduate.

(c) A short course of instructions on elementary bookkeeping and economics pertinent to the practice of medicine.

The following is the slate of officers for 1958-1959.

President—Dr. J. Avery Vaughan, Windsor.

Vice-President—Dr. Frank W. Morse, Lawrencetown.

Secretary-Treasurer—Dr. Harold R. Roby, Windsor.

Member to the Executive of The Medical Society of Nova Scotia—Dr. J. P. McGrath.

Alternate—Dr. H. E. Kelley.

Member to the Nominating Committee of The Medical Society of Nova Scotia—Dr. G. W. Turner.

Corresponding Member to the Cancer Survey Committee—Dr. V. D. Schaffner.

Member to the Board of Directors of Maritime Medical Care—Dr. A. A. Giffin.

Members to the Planning Committee of the Medical Society of Nova Scotia re Annual Meetings—Doctors G. L. Mahaney and D. MacD. Archibald.

Representative to the Board of Directors Fundy Mental Health Centre—Dr. D. MacD. Archibald.

Member to Taxing Committee of Maritime Medical Care—Doctors G. R. Forbes, D. H. Kirkpatrick, R. W. Healy.

To date we have about thirty-five paid up members of this Branch.

The Hypoglycemic Sulphonylureas.

The uncritical and uncontrolled use of the sulphonylureas, even in responsive patients, is dangerous. Apart from inherent toxicity, especially with carbutamide, there may be excessive gain of weight with its attendant dangers, and it may not be appreciated that the drugs sometimes fail to prevent serious hyperglycemia developing, especially during an acute infection, when insulin treatment will be necessary. Although there is as yet no evidence in man of impairment of liver function, the drug seems to act on liver enzymes and it is possible that long-term treatment will damage the liver. Phemister's observation that carbutamide (the only drug he investigated) increases capillary fragility suggests that the development of retinopathy and nephropathy, both essentially vascular disorders, may be accelerated. It is at present far too early to know whether the incidence of "degenerative" complications (retinopathy, cataracts, arterial disease, neuropathy, diabetic nephropathy) in patients whose blood sugar has been adequately controlled with the sulphonylureas will differ from that in similar patients treated with insulin.

The danger of agranulocytosis and thrombocytopenia is such that *carbuamide should never be used therapeutically.* Tolbutamide appears to be safe, but, because its mode of action and long-term toxicity are unknown, should be used only in patients in whom frequent and detailed observation is possible.

Walker, G., Post-Graduate Medical Journal. 33: May, 1957.
Medical Abstracts, August, 1957.

The Annual Meeting

ANTIGONISH - GUYSBOROUGH BRANCH OF THE MEDICAL SOCIETY OF NOVA SCOTIA JUNE 8, 1958

The Annual Meeting of the Antigonish-Guysborough Branch of The Nova Scotia Division of The Canadian Medical Association was held in the board room of St. Martha's Hospital at 4:00 P.M., June 8th, 1958, with Dr. R. C. Griffin in the chair. Present were: Doctors T. B. Murphy, Dan Chisholm, G. Silver, W. Guzdziol, S. Donigiewicz, J. J. Carroll, E. Dunphy, R. C. Griffin, R. H. Fraser, J. A. MacCormick and Doctor Deveau from Arichat. Letters of regret at inability to attend were received from Doctor Beckwith and Doctor and Mrs. Sers.

The minutes of the last meeting were read and adopted.

Business Arising from Minutes

Pursuant to the motion of the last meeting, letters were sent out to the doctors of Inverness and Richmond counties inviting them to attend this meeting and pointing out their eligibility to join this Branch Society if they choose. Doctor Ian MacLean of St. Peter's and Doctor MacKay of Inverness sent letters indicating that they hoped to attend and Dr. Deveau was actually present. There have been no actual applications for membership from the Inverness and Richmond counties.

Letters to the Committee of Economics and Fees have not yet been sent regarding dissatisfaction with certain fees, etc., but these will be sent. No opportunity of bringing up the points regarding Maritime Medical Care Incorporated practices has been obtained so far.

Committee Reports

The Treasurer reported no change in the bank balance of $6.87 remaining since the last meeting.

Doctor T. B. Murphy reported that he was unable to attend a meeting of the Board of Directors of Maritime Medical Care Incorporated which was held on the day of graduation exercises at Saint Francis Xavier at which he had a daughter graduating.

Doctor MacCormick reported no meeting of the Executive of the Nova Scotia Division since our last meeting of the branch society.

Doctor R. C. Griffin, chairman of the Mediation Committee had no activity to report over the past year.

Correspondence

A letter was read from Doctor C. J. W. Beckwith accompanying a report from the Hospital Services Planning Commission which is now available for study by interested members of the Branch Society.

New Business

Some discussion arose concerning the low level of our funds in the Branch Society at present. It was moved by Doctor Carroll, seconded by Doctor Fraser, that a levy of $5.00 each be made on each of the members of the Branch Society to cover expenses for 1958 and that the Secretary-treasurer be authorized to make an additional levy if it should become necessary. Carried.

It was moved by Doctor Fraser, seconded by Doctor Carroll, that a donation be made to the Hospital authorities as a token of gratitude for the part they play in helping the meeting to be a success. Carried.

Election of Officers

The President, Doctor Griffin, appointed Doctor Carroll and Doctor Silver as a nominating committee. They promised the following slate of new officers which was approved by the meeting:

President—Doctor C. N. MacIntosh.
Vice-President—Doctor W. Guzdziol.
Secretary-Treasurer—Doctor A. Griffiths.
Executive Committee—Doctors G. Silver, A. Elmik, T. Gorman.
Mediation Committee—Doctors C. N. MacIntosh, E. Dunphy, R. Sers.
Executive Member to Nova Scotia Society—Doctor J. A. MacCormick.
Alternate—Doctor C. N. MacIntosh.
Member of Nominating Committee of Nova Scotia Division—Doctor J. A. MacCormick.
Alternate—Doctor C. N. MacIntosh.
Program Committee—Doctors J. E. MacDonell, A. Griffiths, P. D. Ferguson.

There being no further business, the meeting adjourned and was followed by an excellent dinner provided by the St. Martha's Hospital authorities.

UROLOGY AWARD

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in Urology.

The first prize essay will appear on the program of the forth-coming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, April 20-23, 1959.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1958.

Minutes of Annual Meeting

CAPE BRETON MEDICAL SOCIETY

The Annual Meeting of the Cape Breton Medical Society was held in the Cafeteria of the City of Sydney Hospital on May 29, 1958. There were 41 members in attandance.

The President, Doctor Lamond, was in the Chair The minutes of the last regular meeting, held March 19, were read and approved, with one correction that is, the name of Doctor John R. Macneil be erased in favour of Doctor J. A. McDonald. That refers to the Board of Directors, Maritime Medical Care.

Doctor Gordon Macdonald brought up the question of membership in the local Society with reference to a discussion on the new By-Laws which are now ready for printing. After considerable discussion and explanation by speakers, Doctor J. A. McDonald, Doctor C. J. W. Beckwith and Doctor H. D. Land, it was moved by Doctor Land and seconded by Doctor Gordon Macdonald that a medical man does not have to be a member of The Medical Society of Nova Scotia to be a member in good standing of the Cape Breton Medical Society. This motion carried. It was moved by Doctor J. A. McDonald that this motion would be incorporated in the new By-laws.

Doctor Ross spoke of the necessity of a strong organization in medicine and the importance of maintaining solidarity with the parent body, especially in view of the impending trends in socialized medicine. There was some discussion regarding the $75.00 fee. Doctor J. A. McDonald thought that it should be lower for the younger men who are starting out in practice. With reference to this, Doctor Beckwith pointed out that the fee for the first year in practice was $15; for the second year $40; and the third year, and so on, the regular $75. fee. However, if a member was taking a Post-Graduate Course, the fee reverts back to $15 for that year or during the years of the Post-Graduate Course. Doctor Ray Ross pointed out that there were now in existence many and varied voluntary medical and lay organizations for various diseases mental disease, heart disease, tuberculosis, polio, etc., and that there should be some understanding regarding the collection or regarding canvassing for these various conditions, especially among medical men. Doctor Beckwith, in reply, stated that there was a Committee of the Executive studying this matter.

Doctor J. A. McDonald, Chairman of the Regional Post-Graduate Course Committee gave a review of the recent course, held this spring. He pointed out that the attendance and the amount of money collected was very disappointing indeed and the refresher course committee was considering against any future sessions being held in Cape Breton unless some improvement was carried out. Doctor Arthur Sutherland moved the following:

Unless we are sure of satisfactory attendance at the Post-graduate Courses, we should not make arrangements with the committee to have any future sessions held. This was seconded by Doctor Martin. Doctor D'Intino, speaking on the motion, stated that he thought the fall session would be more favorable than the sessions held in the spring. Doctor J. A. McDonald gave various reasons for not having the course in the fall such as, the October annual refresher course, Dalhousie—the fact that the children were returning to school and so on.

Doctor C. J. W. Beckwith gave information received from Dr. Lea Steeves, Chairman of the Nova Scotia Post-graduate Course Committee, in which Doctor Steeves explained the history of the Kellogg Grant, with reference to financial support during the six years and recent withdrawal of the Grant, requiring higher fee. He also stressed the importance of the Refresher Course.

It was suggested by Doctor Arthur Sutherland, and agreed to by the members, that included in the motion, a questionnaire be sent to all members of the Cape Breton Medical Society as to their ideas and intentions of having the course continued. Also, that this matter be left in the hands of the Post-graduate Course Committee, headed by Doctor J. A. McDonald.

Doctor Gordon Macdonald attended the last meeting of the Directors of the Maritime Medical Care and gave a short account of the proceedings. He stated, incidentally, that there was a deficit of $50,000 last year in the Maritime Medical Care Budget, due to the epidemic of 'flu which caused the amount of money disbursed to exceed considerably that of previous years.

Mr. M. R. Chappell, one of the Committee men of the Planning Commission, gave a short address and answered several questions pertaining to the proposed Health Insurance Bill which is due to come into effect early in the year. Mr. Chappell was thanked by the President for his time and trouble.

The Nominating Committee was named by the President and consisted of Doctor Arthur Green, Doctor Arthur Sutherland and Doctor Philip Macdonald. When the Nominating Committee was out to select a new slate of Officers, the President gave his presidential report and thanked the members for their close co-operation during the year, wishing all success to his successor in office.

The Treasurer presented a fairly detailed report concerning the activities of the Society during the past year and he also presented the financial report for approval. This report showed an operating profit for the past year in the amount of $160 and the balance in the bank at the present time $330 dollars.

The Nominating Committee returned and presented the new slate of officers. The slate, which is as follows, was adopted unanimously.

President—Doctor J. B. Tompkins, Dominion.
Vice-President—Doctor G. W. Sodero, Sydney.
Secretary—Doctor H. R. Corbett, Sydney.
Treasurer—Doctor N. K. MacLennan, Sydney.

Members—Cape Breton Executive

Doctor D. Nathanson—New Waterford.
Doctor H. Davidson—Sydney.
Doctor T. McKeough—Sydney Mines.

Executive—Medical Society of Nova Scotia

Doctor H. Martin—Sydney Mines.
Doctor L. Allen—Sydney.
Doctor C. A. D'Intino—Sydney (alternate)

Public Relations

Doctor J. P. Macdonald—Sydney.
Doctor Al Ormiston—Sydney.
Doctor Wm. Nicholson—Reserve Mines.

Nominating Committee—N. S. Medical

Doctor Gordon Macdonald—Sydney.
Doctor J. A. McDonald—Glace Bay.

As there was no further business, the meeting adjourned at 10.45 for a lobster supper held in the adjacent dining room.

The time and place of the next meeting is to be left in the hands of the in-coming Executive.

(Signed) H. R. Corbett, M.D., Secretary.

SECRETARY'S PAGE

New Office Space

The location of the office of The Medical Society of Nova Scotia has been changed from the west wing of the second floor to the ground floor at the back of the Dalhousie Public Health Clinic. This move took place the first of July. The new quarters are somewhat larger and the space is such that it can be put to much more effective use. The Society is most appreciative that Dalhousie University has found it possible to continue to accommodate this office.

C.M.A. Meeting

The 91st Annual Meeting of the C.M.A. is now a matter of history. Information is that 1000 doctors were registered. This number is exclusive of wives and non-medical registrations. By any standard it appears to have been successful and is a tribute to the joint endeavour and planning by the host Division, New Brunswick, with the co-operation of the P.E.I., Newfoundland and Nova Scotia Divisions.

The closed circuit T.V. of a panel on heart disease together with the operation for patent ductus arteriosus was carried concurrently on a public station (C.B.H.T.) for the first time in Canada. Many favourable comments have been heard.

Membership

Members who have not yet paid 1958 dues are requested to send them along to the Executive Secretary. 1958 bills were first sent out in January. In May, a second notice was sent to those who had not paid. The response was again good. Members who have not yet remitted dues for 1958 are reminded that they should have been paid prior to June 30th. This is undoubtedly a matter of oversight and we would be very grateful to have your co-operation.

The Secretary has recently heard a discussion as to whether a physician is to be a member of The Nova Scotia Society prior to becoming a member of his Branch Society. The Constitution requires membership in a Branch Society prior to membership in the Nova Scotia Division and C.M.A. membership is contingent on membership in a Division (e.g. The Medical Society of Nova Scotia).

Resignation of Honorary Treasurer

Doctor Crossman H. Young submitted his resignation to the Executive Committee to be effective June 30th, 1958. Dr. Young is continuing his post-graduate training in Internal Medicine at Sunnybrook Hospital, Toronto. The resignation was accepted with regret. Expressions of appreciation of the effective manner in which he had discharged the duties of his office were made and recorded.

Doctor W. A. Murray of Halifax has accepted the post until the Annual Meeting at which time the Nominating Committee will sit.

Personal Interest Notes

Dr. Arnold J. Noble, Chief Surgeon at Camp Hill Military Hospital, and Colonel in the Reserve Army in Nova Scotia, has been appointed an Honorary Surgeon to Her Majesty the Queen.

It is understood that confirmation of this appointment has come from Buckingham Palace that the Queen is pleased with the appointment.

Dr. Noble graduated from Acadia University in 1926 and received his M.D. in Medicine from the University of Edinburgh in 1930. After post-graduate work in the United Kingdom he joined the surgical staff of the Victoria General Hospital in 1933. He served overseas during the Second World War in the Royal Canadian Army Medical Corps. Dr. Noble is a member of the Order of the British Empire, and a holder of the Efficiency Decoration.

He is a Fellow of the Royal College of Surgeons of Canada and Edinburgh, and is Assistant Professor of Surgery on the Faculty of Medicine at Dalhousie University.

Dr. E. H. Evans of Rockingham, N. S., received in April this year a cheque for $700.00, being the top award in the 1957 Berger prize for original observations in general practice. This cheque was presented by Dr. J. McKenty, President of the College of General practitioners of Canada.

The subject of Dr. Evans' paper was, "The Susceptible State of Viral Infections." More than one hundred papers from twelve countries were submitted for this competition and Dr. Evans is to be heartily congratulated on his outstanding achievement.

Dr. James C. Vibert, a 1951 graduate of the Dalhousie University School of Medicine, received the degree of master of science in surgery from the University of Minnesota on June 14, 1958. Dr. Vibert has completed a fellowship in surgery at the Mayo Foundation, Rochester, Minnesota, which is a part of the Graduate School of the University of Minnesota.

For his outstanding services in the field of poliomyelitis Cecil E. Kinley, M.D., C.M., F.R.C.S., has been the recipient of a scroll marking the award of a bursary. The scroll marks the foundation by the Nova Scotia Chapter of the Dr. C. E. Kinley lectureship at Dalhousie Medical School as one of the major objectives of the foundation is to ensure that professional men are kept abreast of developments in physical medicine.

The honour was accepted by Dr. Edwin Kinley on behalf of his father.

Dr. Kinley was the first doctor in Nova Scotia to take action against the disease of poliomyelitis, and directed the first polio clinic in the Province founded at the N. S. Hospital in 1942. In 1948 he was one of the founders of both the Canadian foundation and its Provincial Chapter.

The scroll was designed by H. P. Bernasconi of Truro.

Dr. Austin A. Macdonald of Halifax and Sydney has been awarded a fellowship by the Canadian Arthritis and Rheumatism Society. This announcement was made recently by W. O. Twaits, the society's president.

A lovely spring wedding was solemnized at St. Matthew's Church, Inverness, Cape Breton, when the Rev. R. T. Humby, united in marriage Anne MacRae (Patty), eldest daughter of Dr. and Mrs. Frank John Macleod of Inverness, and Richard Hunter, son of Mrs. and Mr. Hunter B. Vogel, of Langley, B. C.

The bride was attended by her sister, Miss Louise Macleod, Miss Frances Stanfield of Truro, and Miss Jean Ritcey of Riverport. The toast to the bride was proposed by Dr. William Murray, of Halifax.

The popular couple will reside in Halifax for the summer months. The groom is a graduate of the Dalhousie Law School, while the bride is a recent graduate of the Dalhousie Medical College.

THE CANADIAN LIFE INSURANCE OFFICERS ASSOCIATION

The Canadian Life Insurance Officers Association reports that, through its Public Health Committee, the life insurance companies doing business in Canada are making grants and awarding fellowships amounting to more than $100,000 this year. These grants include the second instalment of $30,000 of the $60,000 made available last year to the National Heart Foundation of Canada for its organizational expenses.

One of the major new grants is to Dalhousie University to support a cardiopulmonary unit at the University's Medical School. This apparatus takes the place of the heart and the lungs as circulators of the blood so that the surgeon can operate on the lungs without the presence of blood in these vital organs. The apparatus also keeps blood circulating through the body during heart operations while the heart is out of action.

The Canadian Highway Safety Conference receives financial aid for its programme to reduce highway accidents in Canada.

In the field of medical research, grants are being made to the Montreal General Hospital and to Queen's University.

The grant to the Montreal General Hospital is to support a combined clinical and pathological study of strokes. This study is being conducted by Dr. D. A. Howell in the neurological and pathological departments of the Hospital under the direction of Doctors J. Pritchard and H. Elliott.

Queen's University receives its grant for a study of anoxia, which is a condition caused by a lack of sufficient oxygen in the body in order to keep the cells alive. This study is being conducted in the Department of Physiology under the direction of Dr. J. D. Hatcher.

Obituary

Doctor Kenneth Alexander MacKenzie, well-known Nova Scotian physician, died suddenly May 12th at the Victoria General Hospital, Halifax. He had practised medicine in Halifax for more than fifty years and was recognized as a leader in his field, both locally and nationally.

Born in Pictou in 1880 he was educated in schools there and in Springhill. In 1903 he graduated from Dalhousie Medical School. After practising for a short time in Cape Breton, Doctor MacKenzie moved to Halifax. In 1909 and 1913 he took post-graduate studies in England in Internal Medicine.

During the First World War, he fought with No. 7 Dalhousie Unit, and after further post-graduate studies he returned again to Halifax. In 1926 he was appointed Professor of Medicine at Dalhousie University, a post he held until 1945.

One of the founding fellows of the Royal College of Physicians of Canada, he was President of The Medical Society of Nova Scotia 1932-33 and President of The Canadian Medical Association in 1937. He was long associated with Camp Hill Hospital.

In 1950 Dalhousie University conferred the honorary degree of Doctor of Laws upon him.

He was deeply interested in the natural sciences, geology and botany, and wrote extensively on these subjects and on medicine for provincial and national publications.

He held the 50-year jewel in the Masonic Order and was a member of the Royal Sussex Lodge and Fort Massey United Church.

He is survived by his wife, the former Christine Morrison; two daughters, Marjorie (Mrs. Dr. W. A. Murray) Halifax; Shirley (Mrs. Albert Burditt) of Quebec City; two sisters, Anna and Linda of Springhill, and four grandchildren. A brother Charles predeceased him.

Dr. Frank Ernst Rice, age eighty-nine, died at his home in Digby on the 31st of May, 1958. Born in Weymouth, Dr. Rice was the son of Mr. and Mrs. John Rice. He received his early education at the Digby Academy and graduated from the Dalhousie University with his M.D. in 1893. He interned at the Royal Victoria Hospital at Montreal and served as a general practitioner at Sandy Cove for the past fifty years.

For many years Dr. Rice served the Municipality of Digby as Medical Health Officer. He was a senior warden of the Anglican Church of the Nativity in Sandy Cove and was also a member of the King Solomon Lodge A.F. and A.M., Digby. He is survived by his wife, the former Minnie Denton, a step-daughter, Mrs. Marion Harrington, Needham, Mass.. and a grandson, Robert Crowell of Kinghurst, N. B.

Dr. Seymour Gourley MacKenzie, M. D., C. M., retired, age seventy-three, died on the 20th day of May, 1958, at his home at Truro. Dr. MacKenzie was Truro's Health Officer for many years.

He was a graduate of the Colchester County Academy and received his M.D., C.M., from the Dalhousie Medical College in 1914.

During the First World War he enlisted with the Army Medical Corps and served in Canada, England and France. Following his return from over-

seas he served for a time on the staff of Camp Hill Hospital and later practised in Halifax and Westville. Dr. MacKenzie returned to his native Truro in 1938, and practised there until his retirement.

Dr. Mackenzie was a keen sportsman, a hockey player of note, a base-ball player and enthusiast. For many years he was active in the Truro Kinsmen Club, the Truro Curling Club and the Medical Association.

He is survived by his wife, Mary Gordon MacKenzie, one daughter, Mrs. Elizabeth MacPhail, Belle River, Ontario, one son, Dr. Seymour Gordon MacKenzie of Truro, and seven grandchildren.

The death occurred on May 19 at the Victoria General Hospital of Miss Margaret Frances Barton of this City.

She was the daughter of the late Dr. and Mrs. W. J. Barton of Halifax. She was a graduate of the St. Patrick's High School and Mount St. Vincent College and attended the Maritime School of Social Work. Prior to her illness she was employed by the Department of Immigration, Montreal.

She is survived by a sister, Rita, Halifax, three brothers, Dr. Fred Barton, Dartmouth, Dr. William Barton, Pittsburgh, and Frank, Halifax.

Dr. Leo Paul Doucette, age fifty-five, died on June 10 at Cheticamp.

He had practised his profession in that area for the past ten years. Before that he had resided in the British West Indies. Dr. Doucette was widely known as an amateur radio operator, and was co-ordinator in the emergency set-up on several occasions in recent years.

He was active in the affairs of the Progressive Conservative Party, and is widely known among its members.

Dr. Doucette was a graduate in medicine from the University of Mexico.

He is survived by his wife, Mrs. Jean Kenney Doucette, a native of Point Crosse. Burial was carried out in Boston.

Dr. Judson Vye Graham, age sixty-seven, died at his home on Sunday, June 15. His death occurred while he was convalescing from a surgical operation performed at the Lahey clinic.

A Gold Medallist, Dr. Graham graduated from the Dalhousie University in 1915 with the degree of M.D. He was Chief of the Surgical Staff of the Halifax Infirmary, and was Associate Professor of Surgery at Dalhousie University, as well as Associate Surgeon at the Victoria General Hospital and Surgeon at the Children's Hospital.

He was past-president of the Halifax Medical Society and a Past-president of the Halifax Infirmary Staff.

Dr. Graham was a leader as well in the Masonic Order. He was past master of Burns Lodge No. 10 A.F. and A.M., Past High Priest of the Royal Union Chapter No. 1 of the Royal Arch Masons of Nova Scotia, a member of the Antiquity Preceptory Knights Templar and a member of the Philae Temple, Order of the Mystic Shrine.

He is survived by his wife, two sons, Dr. Donald Graham, Anaesthetist at the Halifax Infirmary and Dr. Bernard Graham of Montreal. He is also survived by three brothers, George T. and B. W., both of Halifax, and C. L. of Cranford, N. J., and three sisters, Mrs. James A. Dunlap, Edmonton, Mrs. J. Welsford MacDonald, Pictou, and Miss Prudence Graham, Halifax.