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Contents August, 1947

The Story of the National Leprosarium*

The United States Marine Hospital, Carville, Louisiana

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Introduction

LEPROSY is one of the oldest diseases of the human race, its origin lost in antiquity. Yet for centuries it has been one of the most misunderstood and dreaded diseases of mankind. Any person who became afflicted with leprosy was condemned to a hopeless life of isolation. Even to the present day an unjustified fear of leprosy lingers among the general public.

But there is no cause for this leprophobia. The fact is that leprosy is an infectious, mildly contagious disease, which is transmitted from the sick to the well in some uncertain manner. It is not so contagious as tuberculosis, yet people have less fear of contact with a tuberculous person. The danger of exposure to leprosy is slight and not sufficient to warrant the widespread terror of earlier times.

It is noteworthy that leprosy is most feared in countries where the disease is scarce and the danger of contagion relatively insignificant, whereas in certain tropical countries, where leprosy is most prevalent and the risk of contagion greatest, it is generally regarded with indifference by the natives. This illustrates the adage that familiarity breeds contempt, for in such countries, those afflicted with leprosy are seldom prevented from mingling with the public.

Although there is little danger of contracting leprosy in most civilized nations, where it is a rare disease, it must be admitted that the only sure means of eradicating leprosy from any land is segregation. In the absence of a specific curative remedy and of the knowledge of the exact mode of transmission, the isolation of infectious cases is the only means of controlling the disease. Voluntary segregation should be encouraged, because compulsory segregation, since it conflicts with human freedom, often fails. The modern leprosarium should have special attractions for the prospective patient, and no expense should be spared for his comfort and welfare. Primarily, it should be a hospital and a home, not an asylum. Every effort should be made to permit the leading of a normal life.

The public should know that recent improvement in the treatment of leprosy renders it no longer a hopeless disease. Moreover, early voluntary admission greatly enhances the patient's chance of discharge from the institution in restored health. An ever-increasing number of patients is being discharged from leprosariums as "arrested cases" and no longer a menace to the public.

Although leprosy is one of the oldest known diseases, it was not until 1873 that its causative agent, the "leprosy bacillus," was discovered by the Norwegian scientist, G. Armauer Hansen. Prior to that time, the disease had been confused with other conditions; now it can be identified more easily.

Leprosy in the United States

The origin and spread of leprosy in the United States is most interesting. Following its introduction from foreign lands, it generally did not spread,

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finding infavorable soil in the native-born population of most localities. The State of New York is a good example of this relative immunity of the population. Five or six cases of leprosy are encountered there annually. The board of health institutes a thorough investigation of each reported case. It has been found that, with possibly one or two exceptions, leprosy has never originated in New York State. Leprosy in New York and most other Eastern States is an imported disease. In the majority of cases the infection has been traced to the West Indies, South America, the European nations bordering the Mediterranean, and other infected countries.

In the central and northern States, only occasional cases of leprosy have been found, usually among immigrants. Minnesota, Iowa, and Wisconsin have been an exception to this rule. There leprosy was introduced by Norwegian and Swedish settlers in the middle of the 19th century. Although, between 160 and 200 Scandinavians afflicted with leprosy settled in these States, the largest number of them in Minnesota. Although no new cases of leprosy developed in the Scandinavian settlement during the first 50 years, seven new cases occurred between 1895 and 1916, most of them in families of the imported cases. None have occurred since then, showing that, although the disease spread temporarily in Minnesota and the neighboring States, it did not thrive there and soon was extinguished.

Leprosy is constantly being introduced into California and the other Pacific Coast States by Chinese immigrants, as well as by Filipinos and Hawaiians. Most of these immigrants are in the latent stage of the disease upon entering the country, and leprosy may not manifest itself until years later. In the southern part of California, the disease is introduced by Mexicans. So far, comparatively few native-born Californians have contracted leprosy in California. These number 21 or 22 cases among the 233 patients admitted to the Carville leprosarium from that State.

Geographically, we recognize the Gulf Coast States as the most active focus of leprosy in the United States. Here, especially in certain parts of Florida, Texas, and Louisiana, leprosy has become a public health problem.

The origin of leprosy in Florida can be traced to the early Spanish settlers and their imported African slaves. Romans's history of Florida, written in 1776, describes the existence of leprosy among the Negroes of that State. Since then, the disease has no doubt also been imported from Cuba and other islands of the West Indies. In certain parts of Florida, leprosy has become endemic and is being slowly transmitted from one generation to the next.

In Texas, leprosy has established a foothold, mostly along the Rio Grande. The early cases in this State came from Mexico, but to-day the disease is communicable on Texas soil. The records of the United States Marine Hospital at Carville, La., indicate that 226 cases of leprosy were admitted from Texas and that there were 171 natives of that State admitted, most of whom were infected in Texas.

To-day there is a greater incidence of leprosy in proportion to population in Louisians than in any other State of the Union. Two possible sources of leprosy in Louisiana were considered by that eminent student of leprosy, Isadore Dyer. These were: importation from the West Indies, and origination among the Acadians, who came from Canada between 1756 and 1760. The former is the more probable source of the two.

The Louisiana Leper Home

Although leprosy continued to spread in southern Louisiana, particularly among the Acadian descendants, it was not until 1894 that any constructive action was taken against the disease. In that year the State legislature passed an act creating a board of control, whose function was to provide a home for sufferers of leprosy. By the end of the year, a temporary site had been leased for 5 years in Iberville Parish. This was the old Indian Camp Plantation, about 80 miles up the Mississippi River from New Orleans.

On November 30, 1894, eight patients were transported from New Orleans by night on a coal barge towed by a tug. The next morning they arrived at their new home. About a year after the opening of the home, the board of control, realizing that the patients were not receiving sufficient attention, requested the Sisters of Charity to care for them. A contract was drawn up between the Community of Sisters and the State of Louisiana, whereby the Sisters assumed the gratutous domestic charge and nursing care of the patients. Four Sisters volunteered their services and came to stay with the patients. The Sisters took up residence in the old colonial home of the abandoned plantation, and the patients were housed in the old slave cabins. This was a temporary arrangement while a site more convenient for administrative purposes was being sought nearer New Orleans.

In 1900, the State legislature appropriated a sum of money sufficient for the purchase of such a site and the building of a leprosarium. Unfortunately, misguided neighbors were so strongly opposed to this plan that, when the transfer of the patients was proposed, they burned the buildings.

Thereafter, attempts to find a new location for the leprosarium were abandoned and, instead, new cottages housing 10 patients each were constructed on the plantation to replace the old slave shacks. Gradually, suitable housing to accommodate comfortably a hundred patients and a new building for use as a dining room and kitchen were provided. This was the condition of the efficiencly functioning Louisiana Leper Home in 1920, when the Federal Government negotiated to take it over.

Many years previously the Federal health authorities had already become aware of the necessity for more stringent measures to check the progress of leprosy in the United States. A committee of experts testified before Congress that leprosy existed in practically every State of the Union, that the disease had been present for a number of years, that it was on the increase, and that the only known means of effectively controlling it was segregation. By 1916 the information gathered through scientific investigation in previous years had been compiled; it indicated the advisability of Congressional provision for a home where all persons afflicted with leprosy might be cared for and treated.

However, not until February 3, 1917, did Congress enact legislation to be under the administration of the United States Public Health Service.

Because of World War I, action on this legislative measure was postponed for several years. Then a committee of Public Health Service officers was appointed to select a suitable site for the proposed leprosarium. Great difficulty was experienced in this task. No State cared to cede territory to the Government for use as a sanatorium for leprosy. Finally, the matter was settled by purchasing from the State of Louisiana on January 3, 1921, the property occupied by the Louisiana Leper Home.

The National Leprosarium

The State of Louisiana then transferred the patients, hospital, and grounds to the United States Public Health Service. At a flag-raising ceremony, the national leprosarium was officially opened on February 1, 1921,, with O.E. Denney as its first medical officer in charge. There were at that time 90 patients in the home. It immediately became necessary to enlarge and rehabilitate the existing buildings, because of the expected rapid increase in population. Soon new patients were admitted from many States, and the census of the institution quickly rose to 172.

On March 4, 1923, the sum of $645,000 was appropriated by an act of Congress in order to expand further the capacity of the leprosarium. This building program was completed in 1924, when housing facilities for approximately 425 patients became available.

The act of Congress of February 3, 1917, authorizing the construction of the national leprosarium, had directed the Surgeon General of the Public Health Service to prepare rules and regulations for the type of patients to be admitted. These regulations stipulated that there should be admitted to the leprosarium:

(1) Any person afflicted with leprosy who presents himself or herself for care, detention, and treatment, or

(2) Who may be apprehended under authority of the United States quarantine acts, or

(3) Any person afflicted with leprosy duly consigned to said home by the proper health authorities of any State, Territory, or the District of Columbia.

Leprosy was the first disease for which the United States Government made specific regulations pertaining to the transportation of infected persons. Since 1912 the Interstate Quarantine Regulations have provided rules for the safe transport of persons who present symptoms of leprosy.

After the necessary State permits are received, patients are transferred to the leprosarium accompanied by a medical officer of the Public Health Service. A compartment is provided for the patient, who is strictly isolated during that trip. All dishes and utensils are disinfected before leaving the compartment, all secretions or discharges are disinfected and properly disposed of, and the space occupied is disinfected upon being evacuated by the patient. As now practised by the Public Health Service, the transportation of persons with leprosy is effected without exposing the public to any danger of infection.

In this country, there is evidence that the greatest menace of leprosy is to the health of the other members of an afflicted person's household. The risk of contagion is considerable, especially to children, in the intimacy of the family circle. It has been estimated authoritatively that a patient can expect that approximately 10 per cent of the members of his family who continue to live with him will develop the disease. This should be an inducement for him to seek early hospitalization. He should realize that one of the greatest boons of his segregation in a leprosarium is the protection it insures his loved ones at home. The high incidence of leprosy in certain families is well demonstrated in the records of the Carville Marine Hospital and has frequently been commented upon by certain writers and experts on the subject. The concealment of a person with leprosy by his family often strikes home again, as it

may lead to the infection of other members of the family. Concealment and transmission of leprosy within the family group seems an important factor in keeping the disease alive in this country. On the other hand, the rather feeble contagiousness of leprosy among nonrelatives is striking. At the Carville leprosarium, during the 51 years of its operation, only one case of leprosy developed among the employees, in spite of their continued proximity to the patients. This is a good record and shows the feebleness of communicability of the disease when ordinary precautions are taken..

Recent Improvements in the National Leprosarium

Until recently, most of the buildings of the Federal leprosarium at Carville were of wooden frame structure and therefore a fire hazard. Starting in the spring of 1940, at a cost of approximately $2,500,000, the Government undertook to rebuild the institution almost completely, in order to make it fireproof. This building program was completed by the end of 1941. Facilities have been increased to take care of 480 ambulatory patients, in addition to the 65 hospital rooms for bed patients. At present, the leprosarium at Carville can be considered the finest and most modern in the world.

The visitor who approaches the Federal leprosarium at Carville for the first time is surprised to see such imposing buildings in an otherwise rural district. After he enters the reservation of 350 acres, he is impressed by the fact that it is a self-sustaining community, resembling a small town. There is a power plant for the generation of electricity, the manufacture of ice, and the operation of a central steam-radiator heating system. A modern sand-filtration plant with attached chlorinating apparatus furnishes over 200,000 gallons of potable water a day. Both hot and cold water is piped to all the buildings of the colony. The water consumption per capita is above that of most large cities cities in the United States. This meets with the approval of the administrative force, since cleanliness is conducive to health and the source of supply, the Mississippi River, is inexhaustible. There are two modern sanitary laundries, ohe for the patients, the other for the personnel. A large sanitary dairy with pasteurization and cold-storage facilities produces 180 gallons of grade A milk a day. Cattle are raised to furnish beef products. Protestant and Catholic churches and their respective resident chaplains afford the patients religious comfort. A well-equipped fire department is ready to function at all hours. The sewage system with its septic tanks and the incinerator plant for the disposal of garbage assure the complete sanitation of the community and protection of the neighboring public. An extensive drainage system demands constant attention to prevent a mosquito nuisance and a possible malaria menace. Besides the numerous buildings for the use of the patients and the large nurses' home, there are 25 residences for doctors, administrative and clerical personnel, mechanics, and other employees. All the personnel are employees of the Federal Government; there are no volunteer workers. Paved roads connect the different parts of the reservation.

Passing from the personnel to the colony side of the estate, the visitor comes first to the hospital, where the bed patients are treated. This is a two-story concrete building containing 44 rooms for men and 21 rooms for women patients. In addition, it contains a first-class operating room, an adequate X-ray department, a dental clinic, a bacteriologic and pathologic laboratory,

a physiotherapy department, dressing-room clinics for men and women, offices, and examining rooms.

The ambulatory patients, who are by far in the majority, are domiciled in 16 two-story concrete buildings. Each of these buildings contains, on each floor, 15 individual bedrooms, bathrooms, a reception room, and front and back porches. The front porches are connected upstairs and downstairs by concrete passageways, screened and covered for the protection of the patients in going about the colony.

Every effort has been made to provide the patients with the comforts of home. For the most part, they are contented and well satisfied with all that is being done for them. They can pursue their avocations and enjoy a variey of community activities. Each patient has his own room with adequate modern fireproof furniture. He may arrange and decorate his room to suit his taste. Visitors are allowed daily from 7 a.m. to 7 p.m. Under certain conditions patients are permitted to visit their homes for periods of 10 days to 2 weeks, twice a year. There are no restrictions in correspondence with relatives or friends except that all outgoing mail is disinfected.

On each side of the hospital is a building for occupational therapy. Each of these two-story buildings has 18 rooms. These rooms are used, respectively, as sewing room, music room, school room, photograpy room, barber shop, tailor shop, pressing shop, carpenter shop, shoemaker's hop, bicycle-repair shop, radio-repair shop, rooms for various other arts and crafts, and finally the printing offices of the patients' local paper, "The Star." This is an interesting monthly periodical, the purpose of which is "radiating the light of truth on Hansen's disease." It contains many splendid article from the pens of patients. Its outside circulation is increasing and has now reached 2,500.

Occupational therapy in its different forms is a useful part of the patients' treatment. Occupation has a good moral effect upon the patient; it prevents his brooding upon his malady. The employment of 112 patients on a small salary basis by the Government serves the same purpose. It also affords them ready cash for the purchase of the little luxuries not furnished by the Government. The government provides all patients with food, clothing, toilet articles, books, magazines, newspapers, a golf course, tennis courts, baseball, basketball, and other sporting equipment, and three motion-picture shows each week.

The new recreation building has filled a long-felt need at the National Leprosarium. This beautiful, spacious, two-story structure is the feature of the new construction program which has pleased the patients most. It cost approximately $140,000 and was well worth the price for the recreational facilities it affords this group of shut-in citizens from practically every State of the Union. A modern motion-picture theater, a canteen operated by patients for the benefit of the patients, smoking rooms for men and women, a pool room, and a splendid library with many excellent books are on the first floor. On the top floor is a huge ball-or concert-room with an orchestral platform on one side. Here frequent dances are given by the patient body. Baton Rouge and New Orleans bands come to play the latest swing music. Between dances the floor space is used for indoor games such as ping-pong, darts, shuffleboard, bingo, cards, and dominoes.

The patients are served their meals cafeteria style at 7 a.m., noon, and 5 p.m. The dining room adjoins a clean, well-equipped kitchen. Menus are

carefully planned; the food is well cooked, tasty, and nutritious. The meals served can be compared to those of a first-class hotel. Food plays a direct part in the fight against the disease, and no effort is spared to provide the best.

Activities of the National Leprosarium

The medical, surgical, and nursing services are qualified to cope with the disease. The nursing is in the hands of 21 Sisters of Charity, some of whom were retained by the Federal Government from the Louisiana State regime. The Sisters are graduate nurses and have always given satisfactory service. The patients appreciate their gentle manner and tender nursing care.

The medical staff consists of six medical officers, one dentist, and three consultants from New Orleans. The consultants are specialists in dermatology, orthopedics, and neuropsychiatry and make monthly visits to the institution.

In addition to keeping up with all new developments in general medicine, the medical staff specializes in leprosy. The medical library is well stocked with books and medical journals dealing with the subject.

Besides general institutional care, the patients are given any special treatment which may be thought beneficial to their condition. With few exceptions, all of the patients take some form of treatment. During the last fiscal year, a smaller number of patients than usual were taking chaulmoogra-oil treatment either by mouth or by intra-muscular injections. Since chaulmoogra oil and its derivatives have not proved to be specifics for leprosy, their popularity is declining. The impression, however, persists that chaulmoogra-oil products are of some benefit in certain types of the disease and so continue to be used in those cases.

Several new experimental treatments have recently been undertaken on a number of patients. Diphtheria toxoid, for which enthusiastic claims were made elsewhere, was subjected to an extensive study in a carefully-controlled experiment on a large group of patients. The results were disappointing.

Vaccine and serum therapies have been tried and have proved unsatisfactory. Penicillin also has proved unsuccessful.

Vitamin therapy has been given an extensive trial. Multiple vitamins have been found useful for their general tonic effect. Massive doses of vitamin A and of vitamin D did not produce any direct effect on leprous lesions. Vitamin B_1 (thiamin chloride) in large doses was found efficacious in relieving painful leprous neuritis. Riboflavin (vitamin B_2 (was used in certain leprotic eye manifestations, but without definite benefit. Pyridoxine (vitamin B_6) has been helpful in symptomatic relief of some debilitated patients.

The most outstanding scientific advance made at the National Leprosarium has been the discovery of the beneficial effects of the sulfone drugs in the treatment of leprosy. These new drugs, promin, diasone, and promizole, are at present the treatment of choice and are rapidly replacing chaulmoogra oil in this hospital.

Promin, after more than 4 years' experience, is now considered to be a chemotherapeutic agent of established value. Diasone, after more than 2 years' use, is beginning to prove as effective as promin. Promizole, used on a smaller scale for only 1 year and still considered to be in the experimental stage, is already showing favorable therapeutic action.

The good results of the sulfone drugs are reflected in the increased number of patients discharged during the last fiscal year in comparison with the numbers for previous fiscal years. Thirty-four patients were discharged with arrested disease last year, approximately twice the usual annual number. The increase in the number of patients discharged last year can be attributed largely to sulfone therapy. Thirteen of these discharged patients reached the clinically and bacteriologically negative stage after 2 to 4 years of promin treatment and one patient after 1½ years of diasone treatment.

Although the above results are extremely encouraging, the search for a more rapidly acting specific remedy continues. Streptomycin now under thorough clinical investigation at the National Leprosarium, may or may not prove to be the long-sought solution to this baffling ancient problem.

Besides special medication during institutional treatment, attempts are made to discover and remove any intercurrent disease which might react unfavorably upon leprosy. The eye, ear, nose, and throat complications of leprosy are frequent and require energetic treatment. A full-time specialist devotes all of his time to his work. He is able to give relief to the patients and prevent some disabling conditions from developing.

The physiotherapy department is a busy service. Approximately 15,000 treatments are given yearly in electrotherapy, thermotherapy, hydrotherapy, and massage. These various forms of physiotherapy are found useful in relieving nerve pains, restoring muscular functions, and healing ulcerations.

In the dental clinic, a dentist and his assistant keep the patients' mouths and teeth in hygienic condition. This helps them in regaining their health.

The laboratory is equipped for scientific research in the various phases of leprosy. In connection with it there is a well-kept annimal house for guinea pigs, rabbits, mice, rats, opposums, and Syrian hamsters, which are used for experimental purposes. Attempts at the reproduction of leprosy in these various laboratory animals are being continued. A full-time bacteriologist conducts these research experiments.

The dermatologic, orthopedic, and neuropsychiatric clinics are well attended. They supplement the other medical activities of the hospital and afford the patient expert professional advice in these specialties.

The Carville Marine Hospital, being the only leprosarium in the United States, serves as a centre for the dissemination of knowledge on the subject of leprosy. Numerous letters of inquiry are received and answered annually.

The institution is also used as a postgraduate instructional centre on leprosy. During the past year, 295 doctors, 6 dentists, and 217 nurses visited the station, seeking clinical information on the disease. Some of the visiting physicians came from distant States and several from foreign countries. The postgraduate class in tropical medicine of Tulane University attended a clinical demonstration on leprosy at Carville. Members of the medical staff of the Carville leprosarium went to New Orleans to lecture to these doctors on different aspects of the disease. Every year leprosy clinics are attended by the senior medical students of Louisiana State University and of Tulane University and by the senior dental students of Loyola University, all of New Orleans. It is felt that this practical experience will aid these doctors in the earlier diagnosis of leprosy in their future medical careers.

Statistical Data

During the period of State control, 338 patients were admitted, all but 16 of them from Louisiana. Ninety of these patients were in the State hospital on February 1, 1921, when the Federal Government took charge, and were tramsferred to the National Leprosarium. From February 1, 1921, to January 1, 1946, 1,179 patients were admitted, making a total of 1,517 admissions since December 1, 1894. Of this number, 685 have died at the hospital, 54 have been deported to foreign countries, and 354 have been discharged as arrested and no longer a menace to public health. Seventy-one of these have relapsed and returned to the hospital for further treatment.

Of the total admissions, 448 were foreign-born, the largest number (172) coming from Mexico. All patients, of course, were in the United States when their disease was discovered. Among the States from which patients were admitted, Louisiana leads with 613, California follows with 227, Texas is third with 226, New York fourth with 131, and Florida fifth with 80. All other States have sent a total of 240. Patients have been received from 41 States, the District of Columbia, the Philippine Islands, Hawaii, and the Canal Zone.

Table 1 shows the nativity of patients admitted during the past 10 years.

TABLE 1.—Nativity of Patients (Calendar Year)

Nativity	Year									
	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
United States	17	23	26	26	41	29	25	19	23	20
Insular possessions	2	3	1	3	6	1	5	2	3	4
Other countries	7	14	11	14	15	12	11	13	16	5
Total	26	40	38	43	62	42	41	34	42	29

In Table 2 is given the number of men and women in the hospital at the end of each year during the past 10 years.

TABLE 2.—Number of Patients in Hospital (Calendar Year)

Cases	Year									
	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
Male	274	258	239	248	246	249	258	261	260	251
Female	113	113	113	116	131	123	122	123	120	118
Total	360	371	352	364	377	372	380	384	380	369

Table 3 gives the number of patients discharged as "arrested" and no longer a menace to public health during the last 10 fiscal years, each year ending on June 30 of the year given in the table.

TABLE 3.—Patients Discharged from Leprosarium (Fiscal Year)

Discharged as "Arrested"	Year									
	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946
Male	16	11	12	11	8	5	6	13	11	22
Female	5	7	5	2	6	5	5	7	2	12
Total	21	18	17	13	14	10	11	20	13	34

Conclusions

At present the Carville leprosarium is fully equipped for properly dealing with leprosy. There is an increasing local interest in the welfare of the patients. Achievements in treatment are growing more important each year, and discharges of "arrested" cases show a corresponding increase. It is felt that there is need for a more general education of the public in order that the unwarranted popular fear of leprosy may be replaced by a more enlightened attitude. There is need for replacement of the odious words "leprosy" and "leper," which are usually unjustly associated in the public mind with "unclean." The patients at Carville prefer to call their malady Hansen's disease. This name meets with the approval of the professional staff. In addition, a better education of persons afflicted with leprosy and their families is also necessary in order that more patients may seek voluntary admission during the early stages of the disease.

Everything possible should be done to encourage voluntary admission. Prospective patients should realize that early institutional care and theatment will give them a better chance of arresting the disease. Voluntary admission is the goal for which we strive. With the renewed hope offered by the new sulfone drugs, this goal is not beyond our reach.

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Syphilis of the Nervous System

Review of Cases and Treatment of Neurosyphilis

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THIS study covers cases seen and treated at Camp Hill Hospital within the last year. The number treated in this time is about 45, but due to difficulty in obtaining medical files and complete information only 21 cases have been reviewed. That the follow-ups are not complete, is admitted, due largely to the fact that the Provincial Department of Health is notified when these patients leave hospital and the cases are followed to completion through the usual agencies.

Terminology

Neurosyphilis covers all infections of the nervous system due to treponema infections.

Tabes covers infections primarily of the spinal cord that show neurological signs (Argyll Robertson pupils, loss of tendon reflexes, loss of sensation, Charcots joint, etc.).

Tabo-Paresis covers those cases that show marked combined neurological-cerebral signs. I do not propose to attempt to discuss the various theories concerning the causative organism or toxins in tabes, but shall assume that tabes is a neurological manifestation of an earlier syphilitic infection.

Incidence of Syphilis and Neurosyphilis

The purpose of this outline is to emphasize several facts, which, though they may be commonly known, are often overlooked. They are:

1. The brief period between primary syphilis and changes in the spinal fluid. As early as four months after primary infection a colloidal gold curve change and signs of meningitis may be detected. The spirochaete may be present, or be eradicated by treatment or natural resistance. If it remains definite changes of a progressive nature can be detected in the C.S.F. long before clinical signs of C.N.S. lues appear. The period before symptoms appear is variously stated as between 10-20 years but our cases indicate a much shorter period, change in tendon reflexes etc., appearing in *less than* 5 *years*. Cases of anything from a few months to a few years, show C.S.F. changes and it is during this period that treatment should be instituted. This brings me to the second point.

2. Neurosyphilis should, if possible, be discovered, investigated and treated before clinical signs appear, i.e. in the asymptomatic stage. If one waits for the classical symptoms of ataxia, euphoria, optic atrophy, etc., a large amount of destruction will have occurred and this tissue can never be replaced. All any treatment can hope to do at this stage is prevent progression and clear away the reactive edema and endarteritis that comes from active inflammation.

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3. Adequate early treatment includes chemotherapy *and* fever therapy.

Signs and Symptoms

(a) **Tabes**

The classical signs of Tabes are well known. They are:

1. Ataxia—hence the older name "locomotor ataxia," tested with heel to knee test, Rhomberg T. and gait changes, finger to nose, finger to finger.
2. Hypotonus—due to interference with kinesthetic muscular impulses.
3. Changes in Tendon Reflexes:

   1st—irritative—increased.

   2nd—associated with hypotonus—diminished.
   A. J. and K. J.'s most important. Cutaneous reflexes last longest.
4. Disturbance of sensibility: (i) Superficial—radicular hypesthesias-band in trunk—"girdle pains"; longitudinal in extrems.—"burning pains." (ii) Deep—Vibration and joint sense lost or diminished.
5. Trophic Disturbances: e.g. Brittle bones, Charcots joint, perforated ulcer.
6. Radical Irritation Signs—pain and crises.
7. *Ocular Signs* (in tabes and paresis): (i) Pupils—(a) Argyll Robertson (react to accom. not to light); (b) dilate imperfectly to atropine; (c) irregular in size and shape. (ii) Optic nerve changes—Optic atrophy, narrowed fields, color loss. Diagnosis of these by Ophthalmoscopic examination. (iii) Palsies extraocular M.S. —early —last short time.
8. Other Cranial Nerve Changes—e.g. VIII, I, V, VII.
9. *Genital and Sphincter Signs*: In males impotence may occur early but may retain power long time. In females—anesthesia of genitalia. Bladder: difficulty in voiding, e.g. starting and complete emptying with intermission in symptoms.

(b) **Paresis**

1. Pupillary changes (see foregoing).
2. Speech—slurring, poor pronunciation of involved words.
3. Motor irritative phenomena—twitchings of lower portion face and about mouth; tongue and hand tremors.
4. Changes in writing—different in size, shape and shading and spelling and syntax.
5. Paretic facies ("morning after" look).
6. *Psychic Changes*: Amnesia recent events; Disorientation (confused for person, place and time); Diminished judgment; Changes in sleep cycle, day/night, i.e. restless at night, sleeps by day; Euphoria/Agitation/Depressive/Demented—psychic reactions.

The disease often shows remissions but usually is eventually progressive to death when not treated adequately.

Discussion

Reviewing our cases in comparison to classical symptoms with a view to finding consistent symptoms to aid others in the diagnosis we found:

The ages varying from the youngest at 29 to the oldest 52, with an average of 39.

The average time since infection 12 years but this includes 4 "old" cases, whose infection were between 17 and 32 years duration (the latter from the Merchant Navy); leaving these out the average time since infection was 8 *years.*

Treatment for original infection varied from none to one year I.V. arsenicals but none were followed up with C.S.F. investigations after initial treatment. The commonest clinical signs (in 21 patients) were:

(1) 13 had pupillary changes.

(2) 6 knee jerks lost or markedly diminished.

(3) 7 ankle jerks lost or markedly diminished.
4—optic atrophy, 3 deteriorated to demented.
Only 2 had cardiac involvement.

Five cases completely free from clinical symptoms.

The laboratory results were much more consistent.

(1) *Every* patient had a positive blood W.R.
(This is usual in paresis, but no more than 75% of tabetics show positive W.R. according to the literature.)

(2) 14 had increased cells, and 13 had increased protein.

(3) Midzone Colloidal curve tabetic: 4.
First zone Colloidal curve paretic: 17.

(4) C.S.F. W.R. positive in all cases.

Normal values:

Normal cells—up to 6 cells
Normal protein—up to 25 mgms. % } Increase in these indicates meningeal irritation.

Pandy test shows increased protein in either Alb. or globulin.

Colloidal Gold Curve (due to changes and their fractions A/G ratio)
—normal up to 1's or 2's e.g. 0011200000
0110000000

The so-called "typical tabetic" or "typical paretic" curves are not typical —they could better be referred to as midzone or first zone, because paretic curves may be present in non-syphilitic or tabetic infections of nervous system, disseminated sclerosis, tumours, meningitis, etc.

Treatment

In our neutopsychiatric ward there is a fairly routine method of therapy, but this varies slightly depending on—(1) Amount of previous therapy; (2) Severity of infection (judged from clinical and laboratory findings).

Generally there are 10 injections IV mepharsen in 10 days and 4 injections of Bismuth I.M. (2.0 gram). Patient is then inoculated with Benign Tertian Malaria (4 cc.-I.M.). After 8 chills, treatment is terminated with

atabrin and quinine. Patient is then checked for (1) R.B.C. and W.B.C.; (2) Hb. These are often lowered and appropriate therapy is instituted. After malaria another course of mepharsen and bismuth is instituted, varying from 10 to 30 injections, depending on the factors mentioned above.

Patient is put on therapy for 30 days then C.S.F. is rechecked. Immediate improvement, though gratifying, is not to be expected too soon and a lowering of cells and protein is only expected after 30 days.

Patient is usually discharged to Provincial Department for routine mapharsen and bismuth with recommended recheck every 3 or 6 months.

Results

In one case malaria therapy had to be stopped because he went out and developed pneumonia before his chills appeared.

No case has progressed clinically during observation, in fact every one improved clinically, and 5 of the cases seen 6 months after treatment showed almost complete remission of laboratory findings. Two of the cases that showed marked psychic changes showed remission to their previous "normal" behaviour and left hospital to go to work steadily.

Certain things, in relation to treatment, should be borne in mind:

Ordinary trivalent arsenicals are by themselves not active in C.N.S. Lues, but in combination with fever therapy they are quite effective. The question might be asked why not try parsamide, the pentavelent arsenical? The drug is active without combined fever therapy but presents certain disadvantages: (a) It is not spirochaetocidal; (b) It is toxic to optic nerve; (c) It cannot be given in large doses in a brief period, while Mepharsen can be given in very large doses in a short period and even if patient evades all further therapy the chances of continued quiescence are good.

Penicillin: Had been used on patients before they reached us on about 6 cases, 4 of which are included in this review. As a sole treatment it is not impressive. There is no use using less than 5 M. units—8-10 M. is the usual dose.

Reported results of treatment with penicillin in popular publications are confusing to say the least. The apparent failure to duplicate the early "cures" with penicillin in infections was probably due to manufacturers concentrating on the rapidly growing prolific K strain, whose tests in vitro were as strong as many other strain, but whose results in vivo were less than half as good. Most manufacturers are now producing the potent G strain, but in case the batch of penicillin might be of some age, dosages should be trebled or at least doubled.

All we can do is consider penicillin therapy another method of treatment where fever is not indicated or has not led to a marked improvement. However, the contraindications to malaria are few. Severe chest or heart conditions are the main contraindications.

Prognosis

In tabes it is still doubtful; in fact some consider fever therapy makes little difference in tabes, but, considering the long course of the disease and destructiveness of the lesions any improvement is better than none.

In paresis with clinical signs the previous "hopeless" prognosis has given way to a "serious" prognosis, with fever therapy. Destroyed nervous tissue

cannot be restored but prevention of progression and the improvement of active inflammatory reactions may be hoped for.

Asymptomatic neurosyphilis, with only positive C.S.F. findings has a still better prognosis and hopes for the future depend on the discovery and treatment during this stage.

In conclusion it is suggested that:

Patients with a history of untreated or inadequately treated lues, have a Spinal Report.

Patients with unexplained neurological findings, especially pupillary and tendon reflex changes, have a C.S.F.

Malarial fever therapy is cheaper, more easily controlled and gives better results than any other mode of therapy at present available.

NEUROLUES

Summary

Number of Cases	21
Average Age	39 (29 to 52)
Average Time since Primary	12 yrs. (8)
Average Findings	14/21 Pupillary Changes
	7/21 Deep Reflex Changes
	3/21 Dementia
	(5/A Symptomatic)
Laboratory	100% Pos. W. R. Blood
	66% Increased Cells
	66% Increased Protein
	90% Curve Change
	95% Pos. W. R. C.S.F.

Sale and Advertising of Proprietary Medicines In Great Britain

Summary of Memorandum submitted to the Minister of Health

THE Minister of Health has been asked by the Pharmaceutical Society of Great Britain to bring the sale and advertising of proprietary medicines under statutory control. The Society proposes that:

(a) the duty of securing the maintenance of proper standards for proprietary medicines and their advertisements should be placed by statute upon the Minister of Health in England and the Secretary of State in Scotland;

(b) in carrying out these duties, they should be assisted by an advisory committee including pharmacists, medical practitioners and representatives of the appropriate Government departments and persons with a specialized knowledge of the subject;

(c) a registrar having pharmaceutical qualifications will be needed, together with

(d) a registrar of medicines and of manufacturers;

(e) the sale of unregistered medicines should be prohibited;

(f) standards for medicines and for advertisements should be prescribed by regulations made on the advice of the Committee; these standards should include:

(i) a requirement that the disclosure of composition must be in approved words and quantities;

(ii) the prohibition of false, misleading or exaggerated claims;

(iii) the prohibition of offers of diagnosis through the post;

(g) similar provisions should be applied to surgical appliances and to "treatments";

(h) complaints of non-compliance with the regulations would be heard by the Committee, who would advise the Minister whether or not the medicine or the manufacturer should remain on the register; any action by the Minister would be subject to appeal to the High Court;

(i) the services of the inspectors of the Pharmaceutical Society should be available for the necessary duties of enforcement.

The Society submits to the Minister of Health a report, 14,000 words in length, based upon five years' investigation, in which the advertising of proprietary medicines is reviewed in detail. Tribute is paid to what the newspapers, advertisers, pharmacists, and the manufacturers of proprietary medicines themselves, have done to suppress abuses since 1914, when the Select Committee of the House of Commons published its Report on Patent Medicines, but the conclusion is reached that the position to-day is little less objectionable than it was then.

"Throughout the pages of most newspapers and periodicals in general circulation," it is stated, "sufferers from all manner of diseases and ailments are offered beans, tablets, wipes, powders, salts, pills, ointments, tonics, hormones, glands and vaccines that will bring them youth, health, charm slimness, strong nerves, inner cleanliness, lively livers, freedom from pain, increased (or decreased) weight, iron for the blood, purer blood, vitamins, contentment, resolution, immunization, vitality and so on. The advertisers' claims are frequently so fantastic that one would not be surprised to find them offering secure jobs and large salaries into the bargain."

The introduction of a comprehensive Health Service is not expected in itself to minimize demand in any way. It is pointed out that, whereas the Select Committee ventured to prophesy in 1914 that the sales of secret remedies would tend to decrease by the operation of the National Insurance Act, the volume of proprietary medicine sales actually doubled during the next ten years. The public are not expected to react any differently to the new Service; nor is their right to self-medication denied. It is contended, however. that protection is needed in the exercise of that right.

"Unless, therefore," the report concludes, "appropriate steps are taken to provide this protection, the era of a comprehensive health service may bring with it the golden age for commercialized charlatanism, which makes a butt of the orthodox practitioners on whom the service depends and a victim of the public to the prejudice of the service. It is therefore desirable, before the compelling pressure of these selling methods can be exerted still further, to direct attention to the following conclusions which, it is suggested, are to be drawn from the facts set out in this report:

1. Proprietary medicines are advertised in terms of the grossest exaggeration advancing claims which are frequently fraudulent.
2. The persistent and ubiquitous advertising of proprietary medicines makes the public conscious of disease, teaches that ill-health is the normal condition of human beings and encourages self-medication as a habit.
3. The claims made for some medicines lead to the public postponing seeking skilled advice and encourage symptomatic treament, thereby prejudicing the success of treatment directed to the cause of the symptoms.
4. Many advertisements for proprietary medicines are based upon creating an atmophere of fear—fear of ilhealth or of an operation; of premature old age, of an incurable disease.
5. Reliance is placed upon uncritical testimonials as evidence of the value of proprietary medicines.
6. Exaggerated claim are made for medicines for the relief of chronic conditions such as asthma and rheumatism and hopes are held out which cannot be realized.
7. By implication or indirectly the advertising of proprietary medicines undermines public confidence in a State medical service and in the registered medical practitioners at whose hands such a service must be provided.

8. Questionnaires are sent to patients with the suggestion that the manufacturers of the medicine will diagnose from the patient's answers what his complaint is and what medicine should be given him. These forms are sometimes never looked at and there is evidence that the same medicine is supplied without regard to the information which the patient gives.
9. Pamphlets and advertisements are published which advertise articles as sexual tonics.
10. Excessive prices and fees are charged for some medicines and for some treatments and money that can ill be spared is extracted from the sick.
11. Many advertisements are couched in scientific or semi-scientific terms, often meaningless or having a pretence to scientific advance, designed to impress or deceive uneducated and credulous people.
12. Endeavours are made to circumvent legal requirements relating to disclosure of composition.
13. Certificates of analytical bodies referring to qualitative and quantitative particulars are issued to proprietary medicine manufacturers on a commercial basis and are used by them in advertisement in implied support of claims concerning which the certificates have no relevance.
14. Preparations are compounded in a manner and of such substances as to defy analysis and preclude the production of evidence at law as to composition.
15. The advertising of proprietary medicines is so extensive that the influence of advertisers prevents the ventilation of reforms in the public press and so derogates from the principle of the freedom of the press.
16. The volume of advertising of proprietary medicines gives these articles a significance which is out of all proportion to their true value to the community.

The Quarantine Service, Guardian of the Gates

An address by

THE HON. PAUL MARTIN

Minister of National Health and Welfare, Ottawa

"CAPTAINS or masters of vessels, bark or brigantine, from all Mediterranean ports or which touched there should anchor in the stream off Isle aux Coudres. There, those who have cannon or swivel-guns shall fire three shots a quarter of an hour apart. The same signal shall be repeated at intervals of two hours until such time as those whose duty it is to board the vessels will be cognizant of their arrival."

The words I have just quoted were written a little more than 225 years ago by the Intendant Begon in Quebec. They are the earliest Canadian record of a quarantine service to prevent the infiltration of disease from abroad into Canada. Begon's problem was an epidemic of plague which had carried off 30,000 people at Marseilles. But he got off easily. In the three years the quarantine regulations were in force only one vessel from Marseilles entered the port of Quebec.

Needless to say, matters aren't quite so simple for the health officers of the Department of National Health and Welfare, now that the Atlantic can br bridged in three or four days by an ocean liner carrying several thousand passengers at a single run or by an airplane able to make the crossing in a few hours.

What's the story now?

As many hundreds of thousands who cross our border know, check-ups on the health of those who travel, whether for business or pleasure, are purely routine. We rely mainly on the good sense and a spirit of neighborly responsibility to see that contagious diseases do not cross the border between Canada and the United States. Only in special cases when an epidemic has developed in a specific area is it necessary to interrupt the free and friendly intermingling of our two peoples. Thanks to the highly efficient public health organizations in all parts of the United States, we rarely need to take such precautions.

The situation is somewhat different when travellers come by sea, often from the other side of the world. This is what happens then.

When a vessel approaches one of our larger ports on either coast, the captain prepares a statement as to whether or not anyone on board is suffering from a contagious disease. If the vessel carries a medical officer, both he and the captain are jointly responsible for preparing the report. The essential facts of their report are sent by wireless to the quarantine station on shore. If the report shows no disease on board and there are no other unusual circumstances, the quarantine station radios its approval and the vessel proceeds to dock without delay. The only exceptions are vessels from the Asiatic coast. These are all boarded by the quarantine medical officer before making customs entry.

But what of there is contagious disease on board? That's quite a different story. As soon as the vessel nears port, it is boarded by the quarantine medical officers. The patient or patients are taken to the quarantine hospital on shore to receive treatment. The passengers and crew are carefully exam-

*Delivered in the radio series, "Report from Parliament Hill", June 14, 1947.

ined. If the disease is one for which vaccination or immunization techniques have been developed, a check-up is made to discover how many on board have already been protected. Those who have not been are vaccinated or immunized. All bedding which may have been contaminated is landed and the quarters occupied by the patient are fumigated.

This all sounds a bit complicated, but as a matter of fact the service is now so well organized that even the largest passenger liners can be released with only a few hours' delay.

The precautions which must be taken vary, of course, with the disease and the number of patients and contacts involved. Back in 1937 cholera became dangerously epidemic on the Asiatic coast. Special measures were called for. All crews and third-class passengers on vessels coming to Canada from the infected areas were innoculated with cholera vaccine. Special care had to be taken by ships' officers in observing and reporting all signs of disease. The quarantine station laboratory was alerted to take care of the analyses required in detecting the infection. A year or so ago, you may recall, there was an outbreak of smallpox in Seattle, Washington. Vaccination was immediately required of all passengers entering British Columbia from that area as long as the epidemic lasted.

In the past year no case of smallpox, typhus, yellow fever, bubonic plague or cholera was found on vessels arriving in Canadian ports, although these diseases were present in ports of countries from which many of these vessels sailed. Only 30 cases of minor infectious diseases were found among 256,648 persons inspected by the medical officers of the quarantine service.

I mentioned bubonic plague a moment ago with a specific purpose in mind. This disease—known as "the black death" in the Middle Ages—is widespread in parts of India, Africa, the East Indies and South America. It can be carried not only by humans but by rats and mice. Hence, all vessels which come from plague-infested ports are inspected for vermin. Those which show signs of infestation are fumigated. Last year there were 151 in this category out of 659 inspected. The Pied Piper of Hamelin probably still holds the world's record as a rodent destroyer; but the totals liquidated annually as a result of the quarantine officers' work demonstrate the importance of this protective measure.

You may well ask how the quarantine officers are kept informed of outbreaks of disease in distant parts of the world and hence know when to exercise special precautions. Before the war two international agencies, the League of Nations and the International Health Office, gathered this information and transmitted it to member nations. During the war this service was almost completely suspended—just when it was needed most. After UNRRA was organized late in 1943 it did effective work in this field. Now all these agencies are being consolidated in the World Health Organization, one of the branches of the United Nations. In addition, there is most cordial cooperation between the United States Public Health Service, the British Ministry of Health and our own officers.

To keep pace with the phenomenal growth of international travel by air, the department has extended the quarantine work at Dorval airport, near Montreal. Similar controls will be put into operation at whatever airport becomes the permanent trans-oceanic terminus on the west coast.

A few minutes ago I mentioned that members of ships' crews as well as

the passengers are examined by the department's medical officers. In the services which it provides to sick mariners from ocean-going vessels Canada occupies a unique place. Under a provision of the Canada Shipping Act most ships arriving at any of our ocean ports are required to pay a levy of two cents per ton, based on their registered tonnage. The money thus collected is earmarked for the medical care of seamen who have the misfortune of being injured or of falling ill while in a Canadian port. Foreign sailors receive treatment on exactly the same basis as Canadian citizens, provided their vessels have paid the levy required by law. What unquestionably started as a selfish measure of self-protection, to make sure that sick mariners of foreign-going vessels would not be dumped destitute on a seaside community, has developed into a fine example of international co-operation in the important business of maintaining health.

The conditions under which treatment is obtained have been kept as simple as possible. The sick seamen applies to the captain of the vessel who sends him to the local collector of customs with a written statement setting forth his period of employment on the vessel and giving details about payment of sick mariners' dues. If the collector is satisfied that the facts are correct, he refers the patient to the doctor or hospital previously named to give service to mariners. Emergency cases are taken direct by ambulance from ship to hospital. Whenever possible a choice of hospital is provided. The treatment is free for one year, if needed. In no instance has any hospital given anything but the fullest co-operation. No matter how crowded they were at the time, they have never turned away a sick mariner.

Every attempt has been made to maintain a high standard of medical service. Twenty-four doctors work part time on salary for the sick mariners' service and more than 200 doctors and dentists' work on a fee basis. The fact that sailors have kept returning for check-ups on illnesses requiring long periods of treatment is an indication that the medical staff has the confidence of the men.

During the war special services had to be provided. By a war-time order-in-council medical care was extended to Canadian seamen not otherwise entitled to it, including repatriated merchant seamen who had been prisoners of war. In all 477 men, 40 of them former prisoners of war, benefited from this extension of treatment facilities. Similarly, seamen of foreign nationality stranded in Canada because of physical or mental disability and who could not be repatriated due to war conditions were given maintenance and treatment. Prompt hospital care for all rescued seamen brought to Canadian ports was provided.

At the two Atlantic convoy ports a hospital ship service was begun in 1939 and continued until May, 1945, at Halifax and until January, 1946, at Sydney. Medical officers made daily rounds of ships at anchor in these ports, boarding every vessel which displayed the flag requesting such service and rendering suitable treatment.

Prior to the recent war, revenues from the duties collected exceeded expenditures by a substantial margin. This is no longer true. During the war, of course, because of the hazards of their occupation, larger numbers of merchant seamen were treated for illness and injury than ever before and for more serious conditions which required long hospitalization. Hospital charges have also risen. Another important factor is that in the past 10 years

the number of deep-sea fishing vessels receiving this service has more than tripled. These vessels make a relatively small financial contribution but receive the full benefits of sick mariners' services. The time may not be far distant when the scale of duties will have to be revised to bring this service back to a self-sustaining basis.

To those of us who have spent all our lives in central Canada, many hundreds of miles from the sea, the work of the quarantine medical officers and the care of sick mariners may seem too remote to have any connection with us. Years ago that may have been true. Not now, with our modern methods of travel. Disease is no respecter of persons, of international boundaries or of distances. Both the services I have sketched for you are vital bastions in our constant campaign to raise the level of public health for the whole Canadian people.

Society Meetings

Cumberland Medical Society

The mid-summer meeting of the Cumberland Medical Society was held at Dr. Cochrane's summer cottage in Minudie on June 25, 1947.

A short business meeting was held. In the absence of our President, Dr. Goodwin, Dr. Gilroy was asked to take the chair. The minutes of the last meeting were read and approved. Dr. Cochrane as representative to the Executive of the Medical Society of Nova Scotia, gave his report on the last meeting.

Dr. Cochrane moved that the Secretary-Treasurer be instructed to draw up a congratulatory message to Dr. J. G. MacDougall on celebrating fifty years as a physician. Motion carried.

The chairman instructed the Secretary-Treasurer to write Dr. B. E. Goodwin expressing the Society's regret and sympathy in the recent passing of Mrs. Goodwin.

Dr. Hill moved a hearty vote of thanks to Dr. Cochrane and his wife. He expressed our sincere appreciation of the time and trouble that they both had gone to make our meeting such a success. Dr. Gilroy conveyed the vote of thanks to Dr. Cochrane who responded fittingly.

Following the meeting dinner was served by Mrs. Cochrane and friends. The dinner was most enjoyed by all and climaxed an extremely pleasant afternoon.

The annual meeting will be held in Parrsboro this fall at the request of the Parrsboro men.

Those present were: Doctors Hill, Gilroy, Cochrane, Hirtle, Sutherland, Gordon, Roby, Walsh, Rodger, Johnson and Price.

R. E. Price, M.D.
Secretary-Treasurer
Cumberland Medical Society

Valley Medical Society

The 40th annual meeting of the Valley Medical Society was held at the Masonic Hall, Bridgetown, N. S., at three p.m., on Wednesday, June 18, 1947.

Doctor G. R. Forbes presided.

Present were: Doctors H. B. Atlee, R. P. Smith, Gordon W. Bethune, J. R. Kerr, G. R. Mahaney, W. R. Dickie, E. D. Dickie, Wm. I. Morse, D. B. Morris, R. A. Young, Mrs. R. A. Young, G. Wheelock, G. W. Turner, Frank W. Morse, H. E. Kelley, R. A. Moreash, G. R. Forbes, J. H. Slayter and A. A. Giffin.

The minutes of the last meeting were read and approved and the financial report was read and accepted.

The following new members were accepted into the Society: Dr. Seaman, Woodville, Dr. G. Wheelock, Wolfville and Dr. D. G. Black, Bear River.

After some discussion in which the meeting expressed itself as being behind the work of the Cancer Society, it was moved by Doctor Slayter and seconded by Doctor Kerr that the Valley Medical Society go on record as being in favour of the Cancer Society. Passed.

Doctors A. A. Giffin, O. R. Stone and D. G. Black were chosen to form the cancer committee of the Valley Medical Society—one of these (to be chosen by themselves) to be a representative to the Central Cancer Committee of The Medical Society of Nova Scotia.

The President appointed Doctors R. A. Young, J. H. Slayter and W. R. Dickie as a nominating committee to bring in a slate of officers for the following year.

The following scientific programme was presented:

(1) Avoidable Pelvic Surgery—Doctor H. B. Atlee.

(2) Phlebothrombosis and pulmonary embolism with illustrative cases and prevention—Doctors R. P. Smith and Gordon W. Bethune.

Dinner was served at the Colonial House, Bridgetown.

The following slate of officers was brought in by the nominating committee:

President—Doctor G. R. Mahaney, Bridgetown.

Vice-Presidents—Kings County—Doctor Frank W. Morse, Lawrencetown; Digby County—Doctor E. D. Dickie, Digby; Annapolis County—Doctor J. R. Kerr, Annapolis; Hants County—Doctor G. W. Turner, Windsor.

Secretary-Treasurer—Doctor R. A. Moreash, Berwick.

Two representatives to the Executive of The Medical Society of Nova Scotia—Doctor H. E. Kelley, Middleton and Doctor P. S. Cochrane, Wolfville.

R. A. Moreash, M.D.
Secretary-Treasurer
Valley Medical Society

Personal Interest Notes

FOUR Dalhousie University professors were included in the list of those to whom grants exceeding $100,000 were awarded recently by the National Cancer Institute of Canada. In announcing the grants, Doctor J. L. Little, registrar of the institute, explained that they will support research projects in nearly every fully-equipped medical school in the Dominion and over fifty workers, including many top-ranking scientists, will devote their energies to cancer investigations. Support of this research work has been made to the following Halifax men: Professor John Gray Aldous, Doctor Robert William Begg, Professor Frederick Roland Hayes, Professor Dixie Pelluet, all of Dalhousie University.

Doctor Clarence L. Gosse of Halifax addressed the meeting of the American Urological Association in Buffalo, New York, early in July. Over one thousand doctors attended the conference, including members and guests from Canada, the United States, England, South Africa and South America.

Dalhousie University has announced the award by the Nuffield Foundation of a Fellowship in Medicine to Doctor Harold Cecil Read of Elmsdale, N. S. "The purpose of these fellowships is to enable some medically qualified persons to obtain in the United Kingdom, such post-graduate training and experience as may be necessary to prepare them to undertake subsequently medical teaching and research work in their own countries."

Graduating from Dalhousie Medical School on January 5, 1943, Doctor Read was at once commissioned in the Royal Canadian Army Medical Corps. He served in England and on the Continent during the bitterest fighting. On discharge from the Army he joined the staff of the Victoria General Hospital, Halifax, as a resident in medicine, and has remained there up to the present.

The award was made on the recommendation of the National Research Council of Canada after consideration of a large number of candidates. It will permit Doctor Read to work with one of Britain's most noted pathologists, Doctor Janet Vaughan, on diseases of the blood. From a monetary standpoint it is one of the most valuable Fellowships obtainable, and while granted for a year's duration this may be extended.

Not only does the award indicate the excellence of Doctor Read's general ability and scholarship. It is a gratifying tribute to the quality of the training received at Dalhousie University and at the Victoria General Hospital. Accompanied by Mrs. Read, the former Kay Bottomly of Halifax, Doctor Read will sail for England in the early autumn.

The BULLETIN extends congratulations to Doctor and Mrs. H. G. Quigley of Halifax on the birth of a daughter on July 21st; to Doctor and Mrs. N. Grant (Hyla MacDonald) of Saint John, N. B., on the birth of a daughter, Gwendolyn Mary, on August 4th; to Doctor and Mrs. John P. Debly of Mulgrave on the birth of a son, Peter, on August 6th; and to Doctor and Mrs. Kenneth A. Frase (Isabel Morrison) of Sydney Mines on the birth of a son, Gordon Alexander, on August 6th.

The marriage took place at Halifax on August 9th of Miss Joan Marion Cooley, daughter of Mr. and C. L. Cooley of Halifax and Doctor Peter Godfrey Loder, son of Rev. and Mrs. T. E. Loder of Corner Brook, Newfoundland. Doctor Loder graduated from Dalhousie Medical School in May of this year and is at present resident doctor in radiology at the Victoria General Hospital.

Correction

It was erroneously announced in the July issue that a son had been born to Doctor and Mrs. J. W. Merritt of Halifax. The Doctor Merritt concerned is a dentist who has come to Halifax within the last year, and who happens to have the same surname and first name as Doctor Merritt. The **Bulletin** regrets its mistake and apologizes to Doctor and Mrs. Merritt for any inconvenience they may have suffered.

NOTICE

The Provincial Hospital is interested in Junior Physicians, particularly interested in Psychiatry.

Salary begins at $3540 with yearly increases of $120 to a maximum of $4020, perquisites deducted.

Qualifications are graduation from a recognized Medical School and one year medical interneship.

Junior Staff Physicians who show promise have the possibility of obtaining further post-graduate training in Psychiatry.

Any interested persons will please contact the Superintendent of the Provincial Hospital, P. O. Drawer 20, Fairville, N. B., giving age, marital status, medical school, the date of graduation, and the particulars about his interneship.

Obituary

Doctor James Alton Ross, formerly of Stellarton, died after a lingering illness at his home in Salisbury, N. B., July 27th, at the age of thirty-two. He was born in Stellarton, son of the late James Ross and Mrs. Ross. He graduated from Dalhousie Medical School in 1941. Before the late war he went to Salisbury where he made his home. During and after the war he made about forty trips on the hospital ship *Lady Nelson*. After the war he went back to his medical profession in Salisbury when he took ill last May. He leaves to mourn his wife, formerly Betty Bauld of New Glasgow, one daughter, Judith Ann, and his mother, Mrs. James Ross, of Stellarton. The burial took place from his mother's home in Stellarton, on July 30th.

Doctor Wilfrid Gordon Joseph Poirier died suddenly at his home in Cheticamp on August 14th of a heart attack, at the age of fifty. Doctor Poirier was born in Halifax, November 2, 1896, son of Mr. and Mrs. M. Poirier of New Waterford. He served overseas in the first world war and on returning to Canada entered Dalhousie University and graduated in medicine in 1924. He practised for a short time in Mulgrave, one year in Inverness, seven in New Waterford, and for the past fifteen years in Cheticamp. Doctor Poirier is survived by his father and mother, his wife, the former Yvonne Doucet, and two children.