Vol. XXXVIII No. 5

The Nova Scotia Medical Bulletin

MAY 1959

OFFICERS OF THE MEDICAL SOCIETY OF NOVA SCOTIA AND THE BRANCH SOCIETIES

The Medical Society of Nova Scotia

President - - - - - - - - - - - - Dr. H. J. Devereux, Sydney, N. S.
President Elect - - - - - - - - - - - Dr. W. A. Hewat, Lunenburg, N. S.
Immediate Past President - - - - - - - - Dr. A. L. Murphy, Halifax, N. S.
Chairman of the Executive Committee - - - - - - Dr. D. I. Rice, Halifax, N. S.
Treasurer - - - - - - - - - - - Dr. A. W. Titus, Halifax, N. S.
Executive Secretary - - - - - - - Dr. C. J. W. Beckwith, Halifax, N. S.

Antigonish-Guysborough Medical Society—President—Dr. A. Elmik, Canso, N. S.
Cape Breton Medical Society—President—Dr. G. W. Sodero, Sydney, N. S.
Colchester-East Hants Medical Society—President—Dr. D. F. MacInnis, Shubenacadie, N. S.
Cumberland Medical Society—President—Dr. K. V. Gass, Pugwash, N. S.
Halifax Medical Society—President—Dr. A. M. Marshall, Halifax, N. S.
Lunenburg-Queens Medical Society—President—Dr. D. A. Campbell, New Ross, N. S.
Pictou County Medical Society—President—Dr. V. H. T. Parker, Stellarton, N. S.
Valley Medical Society—President—Dr. Frank W. Morse, Lawrencetown, N. S.
Western Nova Scotia Medical Society—President—Dr. G. V. Burton, Yarmouth, N. S.
Nova Scotia Association of Radiologists—President—Dr. H. R. Roby, Windsor, N. S.
The Nova Scotia Society of Ophthalmology and Otolaryngology—President—Dr. A. Ernest Doull, Halifax, N. S.
Nova Scotia Society of General Practitioners—President—Dr. A. G. MacLeod, Dartmouth, N. S.
Nova Scotia Chapter of The College of General Practice—Chairman—Dr. D. I. Rice, Halifax, N. S.
Nova Scotia Division of the Canadian Anaesthetists' Society—Chairman, Local Division—Dr. R. A. P. Fleming, Halifax, N. S.

Editorial

Dr. Gordon Blanchard Wiswell

Among the many changes that time produces, that of growing older year by year is one that we all undergo. Eventually we reach a period when by rule or order, if not by desire or necessity, other changes come about. So it was at the Children's Hospital when on September 1st, 1958, the Professor of Paediatrics and Chief of Medical Service at the Children's Hospital for the past fifteen years, Dr. Gordon Blanchard Wiswell retired from the pertinent demands of these positions though still remaining active in his private practice.

To honour Dr. Wiswell the Active Staff of the Children's Hospital presented him with an illuminated address.

I am sure there could be no better editorial for this Paediatric issue than to publish among the profession as a whole what was said in the narrower confines of a Staff Meeting of the Children's Hospital.

"On the occasion of the retirement of Doctor Gordon Blanchard Wiswell as Chief of the Medical Service of the Children's Hospital and Professor and Head of the Department of Paediatrics at Dalhousie University, the members of the Attending Medical Staff of the Children's Hospital wish to place on record their appreciation of him as a man, a medical doctor and a leader.

As a man, Doctor Wiswell's keen mind, high ethical standards and sound judgment combined with his integrity and courtesy, have made it a pleasure and a challenge to be associated with him.

As a paediatrician who has been on the Staff of this hospital for twenty-five years and Chief of the Medical Service for the past fourteen years, Doctor Wiswell has won an enviable reputation among his associates.

As a consultant, his fellow practitioners found in him a wise Counsellor who possessed a thorough and comprehensive grasp of his subject and an ability to understand their problems.

As a medical practitioner with a large and busy practice, he has had the joy of seeing the trust and devotion of parents carried over to their children and their children's children who responded to a heart filled with kindly and unfailing consideration for their difficulties.

As a leader, the Staff realizes that it is largely due to his tact, diplomacy and executive ability that such a fine spirit of co-operation exists between the Medical Staff and the Board of Management who each appreciate the difficulties and problems arising in a developing and expanding hospital.

In his association with the Medical Faculty of Dalhousie University, his breadth of vision, wide knowledge and intense interest in the Department of Paediatrics have been largely responsible for the present high standard in this department. Doctor Wiswell leaves with the satisfaction of knowing that the Department of Paediatrics is established on a firm basis and is on the threshold of still further expansion. The students of the future will owe much to him as have the students of the past who found in him a wise teacher and kind friend.

His colleagues of the Staff of the Children's Hospital have ordered that this expression of their appreciation and gratitude be recorded in the minutes of the Staff and a permanent copy be presented to Doctor Wiswell as a token of their sincere admiration and affection."

N. B. C.

Cystic Fibrosis of the Pancreas

W. A. Cochrane, M.D., F.R.C.P.(C)

In the past 20 years cystic fibrosis has become one of the most intensively studied diseases in pediatrics. A knowledge of the clinical picture of the disease is important not only to the general practitioner and pediatrician but also to the internist as ever increasing numbers of these patients are surviving to the second and third decades. The first detailed description of the disease was by Anderson[1] in 1938. This author described the familial incidence, the pancreatic changes and the progressive fatal course. Farber[2] suggested the disease was a generalized disorder involving the mucous secreting glands of the body and gave it the name of "muscoviscidosis." A variety of names have been given to this disease and include: congenital steatorrhoea; fibrocystic disease of the pancreas; familial pancreatic fibrosis etc. In 1953 de Sant'-Agnese[3] recorded the important observation that sweat from fibrocystic patients contained a very high content of sodium and chloride. This suggested an abnormal function of all exocrine glands. Today the basic etiology remains obscure. The incidence of the disease is said to be one child affected in every 600 to 1000 births[4]—a much more common disease than nephrosis, poliomyelitis, muscular dystrophy or congenital heart disease. The disease occurs among siblings with the frequency of a recessive trait, although some families have as many as three and four affected children.

Pathology

The pathological findings have been well studied and described by Andersen,[1] Zuelzer et al[5] and Bodian.[6] The most consistant findings are malnutrition, retarded growth and lesions in the pancreas and respiratory tract. In the pancreas there is inspissation of thick, tenacious, eosinophilic material in the ducts and acini leading to distension and dilatation of these structures. Atrophy of the acini occurs with interstitial fibrosis and chronic inflammatory reaction. The islets of Langerhans are rarely involved and Diabetes Mellitus in conjunction with cystic fibrosis is most uncommon.

Pulmonary changes are most frequently the cause of death. The lungs are normal at birth but in patients dying with respiratory symptoms the most common findings are marked emphysema, chronic purulent tracheo-bronchitis, lobular pneumonia and focal or segmental atelectasis. The bronchial epithelium is usually necrotic and multiple small bronchogenic abscesses are evident. The common organism cultured is the staphlococcus areus hemolyticus with pseudomonas aeruginosa also being found. Why the staphylococcus should be so prevalent is not known.

There has been no abnormality noted of the sweat glands on microscopic examination.

Clinical Symptoms

The clinical picture of cystic fibrosis may be classified into three main groups:

(1) Meconium ileus—10 to 15 percent of infants born with cystic fibrosis have congenital intestinal obstruction due to meconium ileus.

(2) Respiratory—with symptoms usually occurring by 6 months of age; many of the infants have had diarrhoea and relatively poor growth.

(3) A mixed type in older infants and children presenting with chronic malnutrition and steatorrhoea and some respiratory difficulty.

(1) Meconium ileus presents in the newborn period as intestinal obstruction due to inspissation of an excessive amount of meconium in the terminal ileum. The absence of trypsin with its mucolytic and proteolytic activity has been suggested as the etiology of this condition. An X-ray of the abdomen may reveal distension of the small bowel with bubbles of air distributed throughout the meconium generally in the right flank. Small calcified areas are occasionally seen in the peritoneal cavity suggesting ante-natal perforation and peritonitis. The mortality of this group is very high, the patient usually dying with or without surgical intervention.

At the Hospital for Sick Children, Toronto, of 19 cases operated upon for meconium ileus 17 died post-operatively. Conservative therapy has consisted of intravenous therapy and colonic enemas containing pancreatic extract to encourage the liquefaction of the inspissated meconium.

(2) Recurrent respiratory infection is characteristic and is almost a constant feature of the disease. In most cases the cough begins in the second or third month of life and may be diagnosed as asthmatic bronchitis. Recurrent bronchitis and pneumonia is usually associated with the infant's failure to gain weight often in spite of a voracious appetite. Over 70 percent of cases develop symptoms by six months of age. Mothers occasionally will admit when asked that they have observed a bitter or salty taste after kissing their offspring—evidence of an abnormal concentration of salt in the sweat. This abnormal salt loss may be marked in the hot summer months and fibrocystic infants have been admitted to hospital in acute collapse and died due to acute salt depletion. Death in this group usually results either from asphyxia because the trachea becomes filled with mucopurulent material or occasionally from right heart failure.

(3) The older child, 3 to 5 years of age, clinically appears as a thin, poorly nourished child with marked emphysema with scattered rales and rhonchi heard over the whole chest. The face is often round and the cheeks are pink, the latter due to the polycythemia. The extremities are thin with poor muscle bulk and the buttocks are wasted. The abdomen is protuberant with the superficial veins being quite prominent. The liver is frequently enlarged. Clubbing and cyanosis of the extremities may be pronounced. An X-ray of the chest reveals emphysema with marked peribronchial fibrosis with scattered increased densities not unlike miliary tuberculosis.

With increasing numbers of patients surviving to later childhood or adolescence certain complications of the disease have become more frequent. Among these are multilobular cirrhosis of the liver, peptic ulcer, hematemesis and spontaneous mediastinal emphysema and pneumothorax. Some 1 percent of the cases may present as cirrhosis of the liver with splenomegaly. McIntosh[7] has described a group of children whose apparent clinical onset was after 10 years of age.

Most older patients show slow or no progression of pulmonary changes but usually have some clubbing of the fingers and moderate reduction in vital capacity.

Laboratory Diagnosis

The two most important tests for the diagnosis of cystic fibrosis are related to:

I—The measurement of trypsin in the duodenal juice.
II—The concentration of sodium and chloride in sweat.

I—Duodenal intubation is carried out after the patient has been fasted overnight. In cystic fibrosis the fluid collected is usually very viscous. Tryptic activity is measured by the addition of various dilutions of duodenal juice to gelatin and the subsequent liquefaction observed and recorded. In cases of cystic fibrosis trypsin is usually absent or present in only very small quantities. In very early cases of cystic fibrosis normal tryptic activity may be found. In certain cases of malnutrition or chronic diarrhoea unrelated to cystic fibrosis the tryptic activity may be very low. Because of the possibility of misdiagnosis in such cases repeat duodenal fluid examination is always warranted at a later period to confirm the absence of tryptic activity.

Stool tryptic activity may be measured but is much less reliable as organisms with tryptic-like activity normally present in the intestinal tract may give a false positive result in patients with absent trypsin in the duodenal juice.

II—The determination of sodium and chloride content in sweat is of great value in recognizing a case of cystic fibrosis. More recently it has been found that chloride determination alone is sufficient to indicate an elevation of sweat electrolytes. The normal value for the thermal sweat test is a chloride concentration up to 70 mEq/litre. Cystic fibrosis cases usually range from 80 mEq/litre to 160 mEq/litre. Various series reported indicate that the test is diagnostic in 95 percent to 100 percent of cases.

The sweat is collected by enclosing all or part of the patient in a plastic bag. A heat cradle is usually placed over the patient for 30 to 60 minutes and 1 to 2 ml. of sweat is collected and the chloride content determined.

Schwachman[8] has developed a special agar plate containing silver chromate. Placing the patient's palm or sole of the foot on the plate results in the sodium of the sweat combining with the silver to change the brick red colour of the silver chromate to the light yellow colour of liberated sodium chromate. The reaction takes place when there is a concentration of sodium above 60 mEq/litre. The actual procedure consists of washing the infant's or child's hand and then keeping the hand covered for 20 minutes. The print test is then done. The test is quite accurate although false positive results will occur. It has the advantage of allowing the physician to test suspect cases in his office.

Young infants under 6 weeks of age may not show a reaction because of the small amount of sweat normally present at this age on the hands and feet.

Webb and Geiger of the Children's Hospital, Toronto, suggested a modification of Schwachman's test. A drop of 10 per cent silver nitrate solution is placed on a piece of filter paper and allowed to spread until all the water has been absorbed by the paper. The patient grasps the damp spot between the thumb and forefinger for a few seconds. Two percent potassium chromate is added—normally a brick red spot develops with no evidence of a finger print. However, if the chloride concentration on the hand is elevated a distinct yellow finger print is seen against the red background. In a small percentage of cases false positive and false negative results may occur.

Of interest is the finding that up to 20 per cent of apparently normal parents and siblings of fibrocystics have been found to have an increased excretion of sodium chloride to their sweat.

Therapy

The pancreatic deficiency is irreversible and the susceptibility to respiratory infection and to heat prostration is also permanent. However, prophylaxis and treatment of the sequelae are most important. Prior to 1938 approximately 75 percent of cases died before the age of one year. Since the advent of penicillin and broad spectrum antibiotics the majority of infants have survived the initial infection. Today the peak in the frequency curve of age at death is now the fourth year.

(A) Respiratory Infections:

Unnecessary exposure to intercurrent infection should be avoided and if exposure to rubeola etc. is known gamma globulin should be given.

Antibiotics are given therapeutically and then prophylactically. Chlortetracycline or oxytetracycline may be given in amounts of 5 to 15 mgm. per kilogram per day by mouth continuously. Repeat sputum culture with sensitivities should be done every three months to observe any change in the sensitivity of the organism to the drug being used. Aerosol or inhalation therapy may be quite effective. A nebulizer or a special pump for inhalation therapy may be used at home by the patient three or four times a day, for ten or fifteen minutes. The solution used may contain an antibiotic, a detergent to thin the mucus, an antispasmodic, an if the gram negative organism, pseudomonas aeruginosa is present, small amounts of acetic acid may be added to the solution.

Such substances as Tryptar, streptodornase, alevaire and the antihistamines have been tried but have not been too effective.[9] Postural drainage may be tried and bronchoscopic suction in certain cases is a valuable therapeutic adjunct. Complete bed rest should be postponed as long as possible. Most toddlers benefit from moderate intermittent activity.

(B) Diet:

The dietary objective is to provide an abundance of calories and vitamins in spite of the nutritional handicaps. Protein and carbohydrate intake should be high with only a moderate restriction of fat. Supplements of water soluble vitamins are given in twice the usual prescribed dosage.

Pancreatic substitution therapy is of great help in improving the utilization of dietary fat and protein. This is given in the form of granules or powder one half to one teaspoonful three times a day.

During the hot weather added sodium chloride, 2 to 4 Gm. a day should be prescribed to avoid excessive loss of electrolytes in the sweat.

Close observation and frequent clinical assessment by a physician is most important once the diagnosis has been made. The future of the individual patient is unpredictable especially in infancy. Although the diagnosis carries with it a serious prognosis it is far from hopeless. At the present time various centres in Europe, Canada and the United States are devoting a great deal of study and investigation into the cause of this baffling disease. It is hoped that in the not too distant future some answer will be forthcoming. It is important that all physicians should be aware of the multiplicity of symptoms and signs that may exist in a case of cystic fibrosis, and only by this awareness will an early diagnosis be made and appropriate therapy instituted.

REFERENCES

1. Andersen, D. H.: Am. J. Dis. Child 56: 344, 1938.
2. Farber, S.: J. Michigan M. Soc. 44: 587, 1945.
3. di Sant'Agnese et al: Pediatrics 12: 549, 1953.
4. Goodman, H. O. and Reed, S. C.: Am. J. Human Genet. 4: 59, 1952.
5. Zuelzer, W. W. and Newton, W. A.: Pediatrics 4: 53, 1949.
6. Bodian, M.: Fibrocystic Disease of the Pancreas, London 1952, Wm. Heinemann, Medical Books, Ltd.
7. McIntosh, R.: Acta Paediat. Suppl. 100, 43: 469, 1954.
8. Schwachman, H. and Gahm, N.: N.E.J. Med. 255: 999, 1956.
9. Andersen, D. H.: J. of Chronic Diseases 7: 58, 1958.

VOLUNTARY HEALTH PLANS IN BRITAIN

Abstracted from The Canadian Doctor, March 1959.

"Britons are buying voluntary health insurance at an increasing rate despite their National Health Insurance, according to J. F. Follman, Jr., director of information and research of the Health Insurance Association of America in New York. In the voluntary programs alone, he said, the British United Association increased from 34,000 contributors in 1949 to 300,000 at the present time. Its total coverage is 600,000. Benefits provided in the private plans are directed at costs of more serious illnesses. There are four major reasons for the decline in interest in the Government program and the rise in contributions to the voluntary programs according to Mr. Follman. He listed them as follows: A continued increase in the cost of certain services provided under the Government program, this being particularly true in the area of dental care, drugs and optical appliances. A desire for private rooms that are not available under N. H. S. A limited number of Government hospital beds. The patient's lack of freedom in selecting surgeons, specialists and consultants."

Gastroenteritis

"Why do these babies die."

Presented at February 1959 meeting of The Halifax Medical Society
by Drs. R. S. Grant, Joan M. Crosby, Peter Handforth and
K. Aterman of Halifax Children's Hospital.

Gastroenteritis in infants has been a problem in management from the beginning of time. In the light of present day knowledge of fluid and electrolyte balance, feeding and antibiotic therapy there appears to be something amiss when we continue to lose these little patients in too great numbers.

Following are two case histories:

1. C.M. aged five months was admitted to H.C.H. December 29th, 1958, with a three day history of gastroenteritis. He had previously been in hospital with bronchopneumonia two weeks before this. On admission he was moribund and was given intravenous fluids, electrolytes, steroids, vitamins, and serum albumin. On this regime he improved over the next forty-eight hours and was then started on oral glucose and water followed by skimmed boiled milk. At this point his gastroenteritis returned with renewed vigour. He was continued on I.V. therapy. Two days later when oral feedings were resumed he became extremely distended and tympanitic and began vomiting old blood, temperature rose to 104°. He was then given I.V. penicillin and chloramphenicol and his course was progressively downhill and he expired. Post mortem showed gross peritonitis with thick exudate over the transverse colon and severe denudation of the ileum and colon. Stool and peritoneal cultures–staphy and E. coli.

2. M. MacN. a five week old female infant admitted November 1958, to H.C.H. with a four day history of loose blood stained stools. Weight seven pounds. A female sibling had expired in this hospital one year previously with the same symptoms. This infant was given similar therapy to Case I. initially and then tried on milk substitutes ana acidified milks. Despite these measures her course was slowly downhill over a one month period with continuing bloody stools which grew staphy, coli, monilia. The baby expired weighing four pounds. Post mortem showed severe gastroenteritis, malnutrition, and an early empyema.

From these illustrative cases we shall attempt to answer the question in the title under the following headings:

Disturbance of Fluid Balance in Gastroenteritis

It is quite safe to say that the tremendous improvement in mortality statistics of gastroenteritis is in large part due to the better understanding of fluid and electrolyte disturbances, and the proper intravenous fluid replacement therapy of same.

In assessing a baby suffering from gastroenteritis, it is well to recognize that he may be in a state of having lost salt and water proportionately, more salt than water, or he may have lost more water than salt. In the first instance, he would present the usual picture of dehydration with fatigue, apathy and somnolence, hypo-active reflexes, tachycardia, thin pulse, low blood pressure, anorexia, moist mucous membranes, flaccid muscles, cool skin and hypothermia.

If the baby happened to have proportionately a greater loss of salt than water, as may occur when only glucose and water are administered in replacement therapy, he would be in a state of salt depletion, or water intoxication, and might present symptoms of increased intracranial pressure, headache, coma, convulsions, hyperactive reflexes, bradycardia and low blood pressure.

When more water than salt is lost, as occurs in a very hot or dry atmosphere, or when the thirst mechanism is disturbed or when concentrated salt solutions are administered, the state of salt concentration or hypernatremia is experienced, with symptoms of restlessness, delirium, maniacal behaviour, tachycardia, hyperpnoea, marked thirst, dry sticky mucous membranes, and hyperthermia.

These clinical states are easier to describe than they are to recognize, but fortunately, if the disturbances are not too severe, they each respond to a routine of intravenous replacement which we find safe, and effective. This routine is based on the assumption that natural mechanisms are better equipped to establish fluid balance than is the physician, and if the kidneys and the lungs are working well, we need only provide as intravenous feeding, a solution which contains an excess of water and all of the electrolytes necessary for normal cell activity. Such a solution is 1/2 strength Ringers in $2\frac{1}{2}\%$ dextrose.

In the not too severely dehydrated infant, then, we first run in glucose and water until the baby voids. When we are satisfied the kidneys are working, we switch the I.V. fluid to 1/2 strength Ringers and give amounts according to the usual determinations relative to the size of the infant. If one is not sure of the amount or rate at which the I.V. fluid should be given it is better to give too little than too much, and to try to establish oral feedings early and discontine the intravenous feedings. If the fluid and electrolyte disturbance is severe, the above mentioned routine is not adequate and in fact, no rule-of-thumb routine would suffice. In the severe disturbances, each case must be assessed on its own merit, and resort must be had to the biochemical lab for accurate and serial electrolyte determinates and consequent adjustment of therapy. It is not within the scope of this presentation to discuss in detail severe electrolyte disturbances, but potassium deficiency and calcium deficiency frequently occur during the course of intravenous replacement therapy and are worth mentioning.

During the acute phase of gastroenteritis, both potassium and calcium flow from the body cells, through the extracellular space and out of the body in the vomitus, stool and urine. The concentration of each of these ions in the serum during the acute phase, may and probably will be quite normal. However, when the acidosis is corrected and the toxicity countered during treatment, the tendency is for each of these substances to return to its normal habitat, the potassium to the intracellular space, and the calcium to the bones. This will result, in some instances, if the replacement fluid does not contain sufficient of these ions, in a lowering of serum levels, and development of symptoms. The potassium depletion will result in weakness, lethargy, depression and confusion, tachycardia, hypotension, dyspnoea, paralytic ileus, muscular weakness and flaccidity.

The calcium depression will result in tetany with twitching of the muscles, carpo-pedal spasm, stridor, and convulsions. These symptoms appear after therapy has begun and should be watched for, as specific replacement is required for each of these clinical conditions.

Investigation and therapy

Before specific therapy is started it is important to know, if possible, what organisms are present. Therefore three fresh stools should be sent for culture and sensitivity including shreds of mucous or blood if present. Any other site of parenteral infection from the meninges through the respiratory tract, genito-urinary tract to the skin should be carefully sought after and appropriately treated. Haemoglobin level should be carefully followed as these babies become anaemic very quickly.

Once the above investigation has been carried out it is important not to be too zealous in treatment. Antibiotics, especially those of the broad spectrum group, should be used with caution and discretion as their injudicious use promotes the over-growth of staphylococci and monilia in the gastrointestinal tract. This can be more dangerous than the initial infection. Local acting drugs such as neomycin, furoxone, tinct. camph. co. are safe to use in moderation if the cultures and symptoms warrant them.

Steroid therapy in these patients should only be used as a desperate measure to save moribund patients in severe shock. When utilized they should be discontinued as quickly as is safe. The main dangers in their use lies in spread of hidden infection and electrolyte disturbances.

Last but not least, cross infection must be carefully guarded against in an infant ward especially during an epidemic when the wards are overcrowded.

Feeding in gastroenteritis

As already intimated it is desirable to begin oral feedings in these infants as soon as is feasible to prevent malnutrition. Practically, however, as demonstrated in Case No. 1 the appropriate fasting period varies from patient to patient. If oral intake is initiated too early the irritated gastro-intestinal mucosa continues to secrete mucous and blood and further diarrhoea results. On the other hand if feedings are witheld for much over 48 hours the process of malnutrition has begun. A great deal depends on the state of the intestinal mucosa which, unfortunately, we are unable to visualize until too late at post mortem.

The usual feeding regime which is used at our hospital begins with either oral electrolyte solution or glucose and water for 12 hours followed by either skimmed boiled milk, lactic acid skimmed milk or cultured acid milk for one to several days until stools assume a fairly normal consistency. Then half skimmed milk and evaporated milk formulas may be used. Occasionally milk substitutes such as Mulsoy or nutramagen are used and appear to be beneficial probably as the protein is hydrolysed.

Pathologists viewpoint

Gastroenteritis is a clinical syndrome characterised by diarrhoea, vomiting and dehydration in which certain serological types of E. coli are frequently found in the stools. The mortality of infantile gastroenteritis used to be about 50% and many of the deaths were due to dehydration—this word is used in a wide sense to include disturbances of electrolyte as well as water balance. With modern treatment the proportion of deaths due to dehydration is smaller and two other reasons for death are becoming more important. One of these is the occurrence of complications, such as bronchopneumonia or peritonitis, and the other is acute malnutrition or starvation.

The pathological changes in infants dying of starvation following gastroenteritis differ from those seen in the acute phase of the disease. In the acute phase the infants are dehydrated but have not lost their subcutaneous fat, the intestinal mucosa is moderately congested and there is fatty change in the liver. Microscopic changes in the intestinal mucosa are usually obscured by autolysis but localized ulcers are not present. Death may also occur four to six weeks after the onset of symptoms and is then associated with remarkable emaciation. The body weights of infants several months old may be little more than at birth; subcutaneous fat is lost and there is no longer fat in the liver. All the internal organs are atrophic and the mucosa of the intestine is thin and smooth instead of being covered by villi. These changes closely resemble descriptions of famine disease in German concentration camps[1].

The clinical significance of these pathological findings is that infants with gastroenteritis enter a phase of acute malnutrition as soon as their dehydration has been corrected. This malnutrition may delay repair of the damaged intestinal mucosa and may cause intestinal atrophy which further impairs digestion and absorption of food. It is obviously important to provide adequate calories and protein early in the disease but these must be given in a form which is well tolerated and which does not cause further irritation of the intestinal tract. Methods of doing this are described in the literature and do not need elaborating here.[2 3]

REFERENCES

1. Per Helwig Larsen et al: "Famine Disease in German Concentration Camps and Sequels," Acta Medica Scandinavica, Supplement 274, 1952.
2. Schlesinger, B. et al: Arch. Dis. Childh. 24: 15, 1949.
3. Young, W. F. et al: Arch. Dis. Childh. 24: 250, 1949.

The Diagnosis and Treatment of Jaundice In The First Week

Bruce Morton, M.D.

Part of the presentation given to the Western Nova Scotia Medical Society at Yarmouth, April 1958, as a part of the Post Graduate Course.

This article is being presented as a plea for Medical men to look upon all cases of jaundice, in the first week of life, as "something serious" until proven otherwise. It is not meant to be a comprehensive coverage but rather a practical approach to this interesting subject with emphasis on diagnosis and management.

The following is a brief physiological background. Red blood cells are constantly being broken down in the reticuloendothelial system. This leads to a release of haemoglobin with subsequent liberation of a pigment called bilirubin globin. This pigment then reaches the liver by way of the blood stream where it is changed by certain liver cells into free bilirubin, the globin being separated off. The free bilirubin is then excreted into the small intestine through the bile ducts. Here through the action of bile salts and bacteria, the pigment is changed to urobilinogen. Part of the urobilinogen is excreted in the stool as stercobilin, the remainder passing into the blood stream where part of this pigment is excreted by the kidneys and the remainder passing back to the liver to be re-excreted again.

It is apparent that jaundice will occur when there is either too much bilirubin globin being formed as a result of a hemolytic reaction, or when there is an impairment of excretion through the bile ducts from an obstructive process thus leading to elevated serum levels of free bilirubin. In the newborn infant we have another reason for jaundice. There appears to be an inability of the liver to excrete a normal amount of bilirubin globin presented to it. Apparently the liver has a reduced capacity to transform bilirubin globin into free bilirubin. The actual mechanism for this is not known. There is no other sign of liver disease.

One of the first laboratory steps in diagnosis is to see whether the jaundice is due to a high level of indirect bilirubin (bilirubin globin), i.e. a hemolytic process or due to a high level of direct bilirubin (free bilirubin), i.e. an obstructive process. As the hemolytic jaundices are commoner in the first week of life and obstructive jaundices are commoner after the first week, it is convenient to divide the causes of jaundice into two periods. The First Week and After The First Week. This article is concerned with jaundice in the first period.

In the newborn period jaundice is often missed mainly because we as doctors are not looking for it. The nurses also aren't looking for it. At the Grace Maternity Hospital in Halifax there is now a tag on each crib in the nursery calling attention to this.

The main causes of jaundice in the first week are:

(1) Physiological jaundice.
(2) Erythroblastosis Foetalis due to RH or ABO incompatability.
(3) Infection.

Physiological jaundice occurs in two-thirds of all mature infants, making its appearance on the third day of life. The serum bilirubin level is actually elevated above normal prior to this but jaundice in the skin does not appear until the level has reached 4 mgm%. The peak level is reached usually by the third or fourth day and seldom goes over 7-10 mgm%. The jaundice then begins to fade and is usually gone by the end of the first week. This is a benign type of jaundice and calls for no investigation, only reassurance to the parents.

However, in the premature infant this physiological process is exaggerated and peak levels are not reached until the fifth or sixth day. The jaundice then slowly subsides around the end of the second week of life. The serious nature of this is that high levels of bilirubin will occur, sometimes going over 20 mgm%. Cases of kernicterus have been reported in the literature associated with prematurity. Therefore jaundice in a premature requires observation and follow-up because an exchange transfusion may be indicated.

Jaundice due to Erythroblastosis usually makes its appearance in the first two days of life and any jaundice occurring during this time is considered as such until proven otherwise. The big distinguishing feature between this and physiological jaundice is the rapidity with which the bilirubin level rises once it becomes apparent in the skin, peak levels being reached within hours.

The main reason for diagnosing erythroblastosis is because of the threat to the baby's life. If the hemolytic reaction is tolerated, kernicterus becomes a major cause of morbidity and mortality. This is a neurological complication associated with yellow pigment staining of the basal ganglia and related to a high level of fat soluble indirect bilirubin. Direct bilirubin, being water soluble, will not pass the blood brain barrier. The exact reasons why kernicterus occurs at this time of life is not wholly understood. Immaturity is a probable factor.

Statistically with bilirubin levels over 20 mgm%, there is a 25-50% risk of kernicterus. Of those infants who get kernicterus, 75% die within one week, and the remaining 25% make up 10% of all cases of cerebral palsy.

The diagnosis and treatment of erythroblastosis is made by analysing the following clinical observations and laboratory investigation.

(1) History of previous pregnancies, affected or not, stillbirth, etc. If due to RH, the first and often second baby is unaffected. If due to ABO, it is the first baby that is usually affected. A previous blood transfusion may be the cause of a first born being affected by RH incompatability. The Prenatal history of the RH groups and the antibody titer levels, if they were indicated, is important.

(2) Physical exam—Besides the jaundice there may be an enlarged spleen and liver and paleness. This is more apt to occur with RH babies than ABO babies. Often, there are no pertinent findings save the jaundice.

(3) Coombs Test—This is done on the infant's blood and is an attempt to look for sensitized red blood cells and is positive in cases of RH incompatability. If negative then ABO incompatability should be considered.

(4) Blood Grouping—RH and major blood grouping is done on the infant and also the mother if it had not been done during the prenatal period. ABO incompatability, for example, may occur when the baby's group is A or B and the mother is an O with A and B antibodies. With RH incompatability, the

mother is usually RH negative and the baby RH positive. It is important to remember that sometimes this incompatability can occur when the mother is RH positive.

(5) Hemoglobin–The normal level in a newborn averages 17-20 Gm%. 15 Gm% or lower is significant for a hemolytic process. It is more common for an anemia to occur in cases of RH incompatability in the first two days of life than with ABO incompatability.

(6) Serum Bilirubin—This is the most important laboratory test because no matter what the jaundice is due to, it is usually the bilirubin level that decides one when to do an exchange transfusion.

If the above steps have been followed then it is probable that a cause for the jaundice has been found. ABO incompatability statistically is not as common as RH incompatability. However, it is being diagnosed more and more because it is being looked for more and more. There are probably many cases of ABO incompatability than are misdiagnosed as so-called physiological jaundice. In general the levels of bilirubin tend not to be as high as in RH, but nevertheless the threat from kernicterus is just as great and the same careful observation is required.

In the past, the "wait and see" method was used in watching the bilirubin level and if it rose to 20 mgm% an exchange transfusion was done. Now, rather than waiting, it is possible to tell initially which case is going to have an eventual high bilirubin level. The following criteria are used: if the bilirubin level is (1) 4 mgm% or more at birth, (2) 6 mgm% or more at 6 hours, (3) 10 mgm% or more at 12 hours or in the first 24 hours, (4) 20 mgm% at any time (5) rising more than 1 mgm% per hour, an exchange transfusion is indicated. These criteria are also indications for a repeat exchange.

Hyper bilirubinemia is an easier phenomenon to prevent than treat, because once the level is high, repeat exchanges are often required to bring the level down, in contrast to doing one exchange when the bilirubin level is low. These procedures carry a definite risk and doing one is much better than doing two or three. Actually, exchange transfusions should only be performed by those who have had training and experience with the procedure.

Kernicterus is a preventable disease with the proper use and timing of the exchange transfusion. Impending kernicterus may be suggested by a lethargic baby with an exaggerated motor reflex to any slight stimulus, such as stroking the baby's abdomen or foot. Exchange transfusion, if done immediately, will prevent this picture from going on to the later signs of convulsions, opisthotonous, respiratory disturbances, etc., when no treatment will be of any avail.

The other main cause of jaundice in the first week is infection. Here, besides jaundice, the baby's general condition is not good. There is usually a poor sucking reflex and often respiratory or gastro-intestinal symptoms. The jaundice is related to an elevated level of direct as well as indirect bilirubin, thus distinguishing the case from a pure hemolytic process. Generally it is not too difficult to rule out infection but it should always be kept in mind because intensive antibiotic therapy may be indicated.

There are other causes of hemolytic jaundice in the first week—syphilis, toxoplasmosis and cyto megalic inclusion disease. Syphilis is rare but always should be kept in mind. Toxoplasmosis and cyto megalic inclusion disease are very rare. They can exactly simulate erythroblastosis but the prognosis is poor and at the present time no definite therapy is available.

Results in 79 cases of erythroblastosis seen at the Children's Hospital in Halifax over a five year period—1953-1957 inclusive—showed a mortality rate of 8.8%. This compares favourably with other major centres. It is hoped that a future article will give more detailed results of the experience with erythroblastosis at this hospital.

In Summary: An approach to the diagnosis and management of jaundice in the first week of life has been made. The material has been compiled from current literature and from observation of cases at the Children's Hospital in Halifax. It is hoped that this article has emphasized the need of diagnosing erythroblastosis early to help decrease infant mortality. We should remember that jaundice in the first week of life, from no matter what the cause, can be a major threat to the infant's life. A serum bilirubin is a simple test to do and may be quite revealing.

Thrombophlebitis of the Superficial and Deep Veins Treated with Phenylbutazone (**Butazolidin**), Egmont J. Orbach, M.D., New Britain, Conn. Journal of International College of Surgeons, **31**: 165-168, (Feb.) 1959.

The author evaluates the results of short-term therapy with phenylbutazone in the treatment of 22 patients with acute thrombophlebitis affecting superficial and/or deep veins of the extremities. Signs of acute inflammation subsided rapidly and completely in almost every case, and it proved unnecessary to administer phenylbutazone for longer than one week to any of the patients treated. Phlebitis recurred in two patients; a second course of phenylbutazone was successful with one, but was not attempted with the other. The absence of toxic affects of phenylbutazone under these conditions indicates that this agent may be extremely helpful in the management of thrombophlebitis involving either superficial or deep veins. Further investigation of its potentialities in the treatment of these disorders is indicated.

Tracheotomy In Infant Pneumonia

Henry B. Ross, B.Sc., M.D.,C.M.

Despite the use of antibiotics and oxygen therapy the mortality rate of pneumonia in infancy still constitutes a serious problem. The following case report is presented because it suggests that tracheotomy may be a life saving measure for some of these seriously ill infants.

Clinical Summary: A two month old female infant was admitted to the Children's Hospital in Halifax on January 23, 1959. The history revealed that the child had been well until two days prior to admission when the nose became slightly blocked and a respiratory wheeze was noted. Although the temperature was 100.8° feedings were poorly taken and the infant extremely cranky. The child was admitted to hospital when a cough developed, respirations became more difficult and all feedings were refused.

At this time although the child cried vigorously without cyanosis, the temperature was 98.6°, pulse 150 and respirations 44 per minute. The respirations were shallow and slight subcostal indrawing was present. The chest was hyper-resonant to percussion, the breath sounds were harsh and fine rales were heard at the left base. The inspiratory and expiratory phases of respiration were equal. X-ray examination revealed a broncho-pneumonia with a generalized patchy infiltration and moderate emphysematous changes bilaterally. White blood count was 8000, neutrophils 25%, lymphocytes 62%, monocytes 12%, eosinophils 1%.

The infant was placed in a croup tent with moist atmosphere and approximately 30% oxygen mixture. Therapy consisted of crystalline penicillin 300,000 units stat., S. R. penicillin 300,000 daily and chloromycetin palmitate 50 mgm. q.6.h.

During the first 24 hours of hospitalization the infant's condition deteriorated. Breathing became more rapid and shallow with extremely poor air entry. The dosage of the antibiotic therapy was increased, oxygen was given in higher concentration but the respirations rose to 78, the colour became poor and the subcostal indrawing more marked. Only small quantities of mucus could be aspirated from the posterior pharynx. Laryngoscopic examination did not reveal any laryngeal obstruction nor did there seem to be any injection of the mucous membrane in this area. Meanwhile the infant had become semiconscious with gasping respirations and grey cyanosis. Administration of pure oxygen by tight fitting mask did not improve the colour.

At the suggestion of Dr. Wenning our anaesthetist who was present, a tracheotomy was performed to reduce the dead-space air and facilitate suctioning of mucus which was presumed to be present in the trachea and bronchi.

At operation a large quantity of thick, tenacious mucus was removed from the trachea by suction. A No. 1 short tracheotomy tube was inserted in the trachea with immediate improvement. Respirations fell to 60 per minute and although there was still slight indrawing in the subcostal area, on auscultation the air entry to the lungs was greatly increased. The infant was returned to the Ward and placed in the croup tent with moist oxygen. Chloromycetin 100 mgm. q.6.h. intramuscularly and crystalline penicillin 300,000 units q.6.h. were given. Intravenous therapy was begun and oral feedings were stopped.

During the subsequent 24 hours post-operatively the child continued to improve and relatively large quantities of mucus were suctioned from the tracheotomy tube. On one occasion some difficulty was encountered when the tube became blocked with some of this material, but when it was removed the colour improved and the infant became comfortable. Oral feedings were instituted on the second post-operative day and I.V. therapy discontinued four days after operation. Large quantities of mucus continued to be suctioned from the tracheotomy tube and twelve days post-operatively an X-ray showed clearing of the bronchopneumonia. The appetite returned and feedings were taken eagerly. On February 9, 1959, sixteen days post-operatively the tracheotomy was removed and the infant breathed without any respiratory embarrassment. She was discharged twenty-three days after operation and the tracheotomy wound at that time was well healed.

Discussion: Adequate pulmonary function of course depends on three factors, namely pulmonary ventilation, respiratory gas exchange and pulmonary blood flow. Interference with any one of these may result in distress.

In this case we feel that there was considerable interference with gas exchange due to the large quantities of mucus which could not be removed until tracheotomy had been performed.

With the shallow, rapid respirations in pneumonia, the tidal volume is minimized, resulting in hypoxia and a building up of CO_2 in the blood stream. The resulting acidosis could explain in part the toxicity of many pneumonias in the terminal stage. Tracheotomy, by reducing the dead space air between the nares and the alveoli, promotes and maintains adequate oxygenation and reduces the CO_2 retention until the pneumonia subsides.

Decreased hyperpnoea with the reduction of oxygen requirement of the respiratory muscles is also a factor.

Subsequent experience has confirmed our impression that tracheotomy can be a life-saving measure in selected cases of pneumonia in infancy. Further studies are being undertaken.

Kaposi's Varicelliform Eruption

By Maureen H. Roberts, M.B., D.C.H.

Kaposi's Varicelliform Eruption is the name applied to a generalized varicelliform skin eruption occurring as a complication of atopic eczema and due either to the virus of herpes simplex or to the vaccinia virus. The exact incidence of the disease is uncertain and Jackson[1] feels that many minor cases may be missed or called infected eczema unless the patient is seen in the early stages when the appearance of the lesions is typical.

Two cases are reported, one of each variety:

Case No. 1—Baby George—This child aged 9 months, was attending the Dalhousie Public Health Clinic with atopic eczema. He was seen there the week before admission when his condition was under control. He was admitted because he suddenly became fevered and listless and the skin rash on his face began to spread. The primary diagnosis was broncho pneumonia, confirmed by chest X-ray. Treatment was in a croupette with general pneumonia care. Chloromycetin 125 mg. was given intramuscularly every 6 hours. Phisohex was used to wash the skin and Vioform 1% ointment was applied. The temperature which was 105° on admission, continued to swing for 3 days around 104° - 105° and the child appeared much more ill and toxic than the lung condition warranted. The skin of the face became very swollen and oedematous and the eye-lids puffy. On the 5th morning there were noted small 1-2 mm. greyish flattened lesions erupting on the surface of the oedematous skin, and these enlarged, became umbilicated, coalesced and started to crust within the space of 36 hours. There was more swelling of the face and the child's general condition deteriorated a great deal. His antibiotics were changed to penicillin and achromycin systemically and the treatment of the face continued as before. Kaposi's Varicelliform Eruption was diagnosed and a herpes simplex virus was thought to be the most likely cause as no exposure to a recent vaccination was known. Gamma globulin was given intramuscularly in doses of 2 cc., 2cc., 5 cc., on 3 successive days. Supportive therapy and antibiotics were continued. The child began to improve after 4 days and eventually made a good recovery. Material from the eruption was investigated by Dr. van Rooyen and a herpes simplex virus infection confirmed.

Case No. 2—Alice—This 6 year old child was a known severe case of infantile eczema at least one third of whose life had been spent in the Children's Hospital. Not only are both the parents allergic but of the 6 children, 4 have had severe eczema. The mother had been warned many times not to have the child vaccinated but while attending for polio inoculation she was offered vaccination for her non-allergic baby and she "thought it wouldn't matter so long as Alice wasn't done." Ten days after this Alice was covered with eczema vaccinatum, her face was badly affected with confluent pustular umbilicated lesions which were beginning to crust. She was unable to open her eyes and could drink only with difficulty. Her upper chest and all limbs also had lesions on them but to a much less extent. Her temperature on admission was 104° and she was in a seriously ill condition. This was recognized at once as a

case of Kaposi's Varicelliform Eruption and she was transferred to the Infectious Disease Hospital immediately as there were several other cases of atopic eczema in the Children's Hospital at the time and the risk to all the others seemed unjustifiable. She recovered after a stormy week. The second sister was also admitted directly to the Infectious Disease Hospital with the same condition two days after Alice. She also recovered.

Discussion: These two cases are presented to illustrate the dangers that eczematous children may be exposed to apart from the obvious ordinary ones of the staphylococcus and streptococcus. Exposure in the first type of case is more or less fortuitous as the herpes virus is very widespread. In the second case the infection is definitely preventable by avoiding any contact whatsoever with a smallpox vaccination. In the circumstances it should be advised that no member of the family of a child with atopic eczema should be vaccinated except in the presence of a smallpox epidemic when the risk of that infection might conceivably be greater than the dangers of the other. We should try to ensure that the parents of all allergic children have been warned to avoid this danger.

Treatment: There is no specific treatment for the viral infections themselves. Supportive measures such as intravenous fluids are necessary in very sick children to prevent dehydration caused by lack of feeding or by the pyrexia. Nursing on a plastic sheet has been found satisfactory in preventing excoriation by rubbing. Antibiotics are good in combatting the almost inevitable secondary infections. Gamma globulin may contribute to the recovery in some cases as there are probably antibodies for herpes simplex in this material[2]. This might also be more helpful in the vaccinia cases or might act as a prophylactic after known accidental exposure. Serum from a recently vaccinated adult might be of value in a severe case. The use of steroids is controversial. The virus of chickenpox infecting a child on steroid therapy can produce a fatal encephalitis[3], presumably due to uncontrolled viral spread. Yet in measles encephalitis Cortisone is advised[4], but the virus here is thought to be already neutralized before the encephalitic reaction takes place. We felt therefore that as the herpes virus does not become eliminated rapidly from the tissues but may persist as a life infection[2], there might be danger in facilitating a spread where its affinity for the C.N.S. is well recognized in young children.

SUMMARY: (1) Two cases of Kaposi's Varicelliform Eruption complicating atopic eczema are reported.
(2) Treatment is discussed.
(3) Recommendations to prevent this serious complication are suggested.

I wish to thank Dr. N. Barrie Coward for permission to publish these cases and Dr. D. R. S. Howell for help in the treatment.

REFERENCES:

1. Jackson, A. D. M., Dudgeon, J. A., Gt. Ormond St. J. No. 2, 125, (1951).
2. Rhodes, A. J., van Rooyen, C. E., Textbook of Virology, Williams & Williams Co., Baltimore, 3rd Ed., 1958.
3. Haggerty, R. J., Eley, R. C., Paediatrics 18: 160 (1956).
4. Allen, J. E., Paediatrics 20: 87 (1957).

A Case of Congenital Spherocytosis

By U. A. Weste, M.D.

It is a logical wish of medical thinking to try to correlate all findings on a patient in order to come to one final diagnosis. This is a desirable attitude of thought provided that each individual finding has been clarified to its justifiable limits. Otherwise this correlating tendency may be a deceiving short-cut that may prove not to be to the advantage of a patient. The following case review may serve as an example.

A 7 year old boy (M.F.G. H.C.H. 80923) had intermittent unexplained bouts of fever ranging from 100° to 104° accompanied by left sided abdominal pain for one year. For the same period he was noted to be listless and irritable. During the last 3 months he had lost 6 pounds in weight and become pale. Recently he was confused at times and performed a nervous mannerism with his hands.

The family had just returned from Europe where they had lived for the last two years. There a splenomegaly had been noted but remained unexplained. The family history revealed tuberculosis and diabetes in distant family members. His past history revealed allergy to fresh cow's milk.

Physical Examination:

(1) An ill looking, feverish, apprehensive boy, of fair nutritional appearance (age 7½ years, weight 48 lbs.)
(2) Skin moist, pallor of the mucous membranes noted.
(3) Several carious teeth.
(4) Left nostril crusted, left sided nasal secretion, tenderness over left paranasal area. X-ray showed hazy left maxillary sinus. Nasal culture—no pathogens.
(5) Discrete generalized lymphadenopathy. Spleen enlarged 3 cm., edge rounded. Liver enlarged 3 cm. clinically and on X-ray.
(6) A soft systolic murmur was noted over the heart base (Rate regular 130/min., temperature 103°, haemoglobin 7.9 Gm.) considered to be functional.
(7) Course of temperature intermittent, septic-like.

Further Investigation:

Tuberculin Test negative.
Chest X-ray negative.
Urinalyses negative.
Haemoglobin 7.9 Gms.
W.B.C. 11,900

Differential	
Myelo	1
Juvenile	3
Bands	6
Poly	59
Lymph	36

Platelets plentiful. R.B.C. spherocytes seen.

Two blood cultures and a Widel test—the latter done with regard to his recent stay in Europe—were positive for Salmonella-B.

The anaemia, the observation of spherocytes in connection with the long standing splenomegaly called for further classification of the hemolytic process. Its presence was confirmed by the finding of an increased R.B.C. fragility. The reticulocyte count was increased to 8.3%. Closer inspection of the blood smear showed polychromasia, anisocytosis, poikilocytosis and numerous spherocytes. The liver function tests and bilirubin values were normal.

It remained questionable whether this hemolysis was secondary to the Salmonella infection, i.e. an acquired hemolytic anaemia or if this was a congenital spherocytosis. An aid for differentiation was given by the negative Coombs test which indicated a non-acquired but congenital spherocytosis. This was further confirmed by the finding of increased Red cell fragility in the boy's father. The father is therefore a carrier of this inheritable dominant anomaly without frank disease.

Treatment and Prognosis:

The boy showed a prompt recovery from his paratyphoid following treatment with Chloromycetin. Repeated stool and urine cultures done after withdrawal of Chloromycetin were negative before discharge.

However, the ultimate treatment for this boy will be splenectomy which we hope will bring about a clinical cure. In this connection one has to remember that following this procedure a lowered resistance against infections has been observed.

I wish to thank Dr. D. S. MacKeigan for the privilege of publishing this case.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of March, 1959

Diseases	NOVA SCOTIA 1959 C	NOVA SCOTIA 1959 D	NOVA SCOTIA 1958 C	NOVA SCOTIA 1958 D	CANADA 1959 C	CANADA 1958 C
Brucellosis (Undulant fever) (044)	0	0	0	0	0	0
Diarrhoea of newborn, epidemic (764)	0	0	0	0	0	0
Diphtheria (055)	0	0	0	0	2	5
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	2
(b) Bacillary (045)	0	0	0	0	76	57
(c) Unspecified (048)	0	0	0	0	5	0
Encephalitis, infectious (082.0)	0	0	0	0	2	3
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	0	0	0	0	0	0
(c) Unspecified (049.2)	0	0	0	0	26	0
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	14	1	33	0	562	0
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	0	0	0	0	4	0
Meningococcal infections (057)	0	0	0	0	15	23
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	5	0	49	0	434	538
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0	1	3
Scarlet Fever & Streptococcal Sore Throat (050, 051)	43	0	408	0	2719	1324
Tuberculosis						
(a) Pulmonary (001, 002)	xx	4	31	0	443	605
(b) Other and unspecified (003-019)	xx	0	1	0	108	55
Typhoid and Paratyphoid Fever (040, 041)	0	0	0	0	13	34
Venereal diseases						
(a) Gonorrhoea — Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	17	0	15	0	973	1304
(b) Syphilis — Acquired—ordinary (021.0, 021.1)	1	0	0	0	0	0
— secondary (021.2, 021.3)	0	0	0	0	0	0
— latent (028)	0	0	0	0	0	0
— tertiary — cardiovascular (023)	1	0	0	0	0	0
— ,, — neurosyphilis (024, 026)	0	0	0	0	0	0
— ,, — other (027)	1	0	0	0	147*	203*
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	1	0	2	0	0	0
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases: Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Psittacosis & ornithosis (096.2)	0	0	0	0	0	0
Rabies in Man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial unfections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	0	0	0	0	0	0
Trichinosis (128)	0	0	0	0	0	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0

C — Cases D — Deaths

*Not broken down

xxNot available

REMARKS:

RE: INFLUENZA

During the months of March and April of this year, influenza-like disease in Nova Scotia reached epidemic proportions. According to epidemic reports received by the Department of Public Health from Halifax City Health Department and the various Provincial Health Units, there were many thousands of cases in the Province. Some business firms reported as high as 30% of employees absent from work at one time and one of the large hospitals reported 37% of its nursing staff affected. Up to 30% absenteeism in the schools has been reported. Reports from Ottawa indicate that the disease is world-wide.

The disease has not been severe either here or in other parts of the world. Deaths have been few and occurred almost entirely in elderly and debilitated persons. The disease has commonly been complicated by pneumonia. However, pneumonia deaths in Nova Scotia for the period February 1 to April 15, 1959, have not been significantly more frequent than during the same period in 1958. There were 181 pneumonia deaths in 1959, 170 in 1958 and 150 in 1957 (February 1 to April 15). Of the 181 deaths in 1959, 124 occurred in aged persons.

Reports from Europe state that influenza virus B has been the predominating etiological agent, although influenza A and A Asian have also been isolated. In Nova Scotia, in other provinces of Canada, in Ottawa and in the United States, much difficulty is being experienced in isolating the causal agent. Reports to date indicate that it is a variant of influenza Type B.

At present a survey is being conducted locally to determine the efficacy of polyvalent influenza vaccine in the prevention of this disease. Work to date suggests that those who availed themselves of the vaccine last fall were significantly less susceptible to the disease than those who did not avail themselves of the vaccine. A more complete report of this survey should be available soon.

One additional death from pulmonary tuberculosis for the month of February.

THE MEDICAL SOCIETY OF NOVA SCOTIA

(Nova Scotia Division of C.M.A.)

ANNUAL MEETING—KELTIC LODGE, INGONISH, N. S.

Programme

Tuesday, June 23, 1959

4.00 p.m.- 8.00 p.m.	Registration.
9.00 p.m.	Cape Breton Ceiliah. Get Together, Refreshments, Music, Dancing, Entertainment, Sandwiches, Coffee.

Wednesday, June 24, 1959

8.30 a.m.	Registration.
9.30 a.m.	Annual Meeting Convenes.
9.30 a.m.-11.00 a.m.	Business Meeting.
11.00 a.m.-11.30 a.m.	Coffee Break—Visit Exhibits.
11.30 a.m.-12.30 p.m.	Clinical Session, "Office Management of Diabetes." Dr. M. M. Hoffman, Montreal.
1.00 p.m.	Luncheon—Speaker—R. McD. Black, Chairman, Hospital Insurance Commission, Nova Scotia.
2.30 p.m.	Afternoon off! Take your choice, Deep Sea Fishing, Golf Tournament, Sight Seeing, Lawn Bowling, Trout Fishing, Drives, Walks, Beaches, Tennis or Just Loafin'.*
7.00 p.m.- 9.00 p.m.	Lobster Party on Keltic Beach.

Thursday, June 25, 1959

9.30 a.m.-11.00 a.m.	Business Meeting.
11.00 a.m.-11.30 a.m.	Coffee Break—Visit Exhibits.
11.30 a.m.-12.30 p.m.	Panel* Discussion—Public Relations. Moderator—Dr. F. A. Dunsworth.
1.00 p.m.	Luncheon—Speaker—Dr. J. W. Reid. Subject—"The View from Other."
2.30 p.m.- 3.30 p.m.	Clinical Session—"Evaluation of Symptoms commonly met in office practice." Dr. M. M. Hoffman, Montreal.
3.30 p.m.- 5.00 p.m.	Business Meeting.
6.00 p.m.	President's Reception.
7.00 p.m.	Annual Banquet.
10.00 p.m.- 2.00 a.m.	Annual Ball.

Friday, June 26, 1959

9.30 a.m.-11.00 a.m.	Business Meeting.
11.00 a.m.-11.30 a.m.	Coffee Break.
11.30 a.m.-12.30 p.m.	Panel* Discussion—Health Insurance. Moderator—Dr. D. M. MacRae.
2.30 p.m.	Meeting of New Executive.

Ladies Programme

There will be a coffee party on Wednesday, Thursday and Friday (June 24, 25, 26) 10.00-11.00 a.m. in the Lounge of Keltic Lodge.

Each luncheon will be attended by members and their wives.

The ladies are invited to attend all social functions listed in the Annual Meeting Programme.

The Executive Committee will have a regular meeting on Monday, June 22.

The Annual Meeting of the Executive Committee will be on Tuesday, June 23.

N.B.—The hotel charge of $13 per person per day includes meals.

A Social registration fee will take care of all entertainment.

*The Cape Breton Historical Society extends an invitation to members to attend a ceremony at which a bust of John Cabot will be unveiled at Cabot Landing beyond the village of Cape North. The ceremony starts at 3.00 p.m. Wednesday, June 24th. Among the distinguished guests will be the Lord Mayor of Bristol, England.

Detailed information will be available at the registration desk, Keltic Lodge.

*Members of panel to be announced.

WELCOME FROM CAPE BRETON MEDICAL SOCIETY

"From the lone shieling of the misty isle,
Mountains divide us and the waste of seas,
Yet still the blood is strong, the heart is Highland,
And we in dreams behold the Hebrides."

The Cape Breton Medical Society extends a cordial invitation to all Nova Scotia doctors and their wives to attend the annual convention of The Medical Society of Nova Scotia being held at Keltic Lodge, June 23rd to the 26th. As you drive to Keltic Lodge, Ingonish, via the west coast of Cape Breton Island, you travel over the French, MacKenzie and North mountains. The latter, 1,460 feet, is the highest point in Nova Scotia. Along the way visit the "Lone Shieling," a stone replica of a Scottish crofter's hut.

COMMITTEE CHAIRMEN
ANNUAL MEETING—KELTIC LODGE—JUNE 23-26, 1959

H. J. Martin	—	Programme Committee.
H. R. Corbett	—	Housing Committee.
C. A. D'Intino	—	Exhibition Committee.
N. K. MacLennan	—	Entertainment Committee.
Mrs. H. R. Corbett	—	Ladies Committee
		Ex Officio
H. J. Devereux	—	President, The Medical Society of Nova Scotia
J. B. Tompkins	—	President, Cape Breton Medical Society.
G. W. Sodero	—	President-elect, Cape Breton Medical Society.
C. J. W. Beckwith	—	Executive Secretary.

Housing Application Form

The Medical Society of Nova Scotia
Keltic Lodge, Ingonish, N. S.
June 24, 25 & 26, 1959

MR. FRED IRWIN,
Manager,
Keltic Lodge,
Ingonish, N. S.

Please reserve for me the following:—

A. Main Lodge

( ) Double room with bath—twin beds—including meals $13.00 per day.

B. In Cottage

( ) Cottage with sitting room and two twin bedded bedrooms—including meals $13.00 per person per day.

I WILL EXPECT TO ARRIVE JUNE..... A.M..... P.M.....

I WILL EXPECT TO DEPART.....

Names of persons who will occupy above accommodations:

Name (Dr. and Mrs).....

Address.....

In view of the large attendance expected, no single rooms will be available at the Keltic Lodge, unless cancellations permit. If coming alone please check here.....
If you are willing to share a room. If you have a preference for some party to share a double room with (or couple(s) to share cottage with) please insert name(s) below:

I would prefer to share accommodation with

Name.....

Address.....

Name.....

Address.....

RESUME OF MINUTES
EXECUTIVE COMMITTEE MEETING
of
MEDICAL SOCIETY OF NOVA SCOTIA
March 23rd 1959

The Meeting was convened in the West Seminar Room of the Dalhousie Public Health Clinic at 9.45 a.m. by the Chairman of the Executive Committee, Dr. D. I. Rice.

Those attending the meeting were:

H. J. Devereux, M.D.	—	President
W. A. Hewat, M.D.	—	President Elect
A. L. Murphy, M.D.	—	Past President
A. W. Titus, M.D.	—	Treasurer
D. I. Rice, M.D.	—	Executive Chairman
J. A. MacCormick, M.D.	—	Antigonish-Guysborough Medical Society
L. S. Allen, M.D.	—	Cape Breton Medical Society
C. A. D'Intino, M.D.	—	Cape Breton Medical Society
S. G. MacKenzie, M.D.	—	Colchester-East Hants Medical Society
F. A. Dunsworth, M.D.	—	Halifax Medical Society
*A. M. Marshall, M.D.	—	Halifax Medical Society
J. W. Merritt, M.D.	—	Halifax Medical Society
L. M. Sproull, M.D.	—	Pictou County Medical Society
J. P. McGrath, M.D.	—	Valley Medical Society
D. R. Campbell, M.D.	—	Western Nova Scotia Medical Society
H. C. Still, M.B.	—	Editor-in-Chief, N S. Medical Bulletin
R. O. Jones, M.D.	—	Representative N. S. Division to Executive C.M.A.
C. J. W. Beckwith, M.D.	—	Secretary

No representative was present from the Cumberland or Lunenburg-Queens Medical Societies.

*R. M. MacDonald, M.B., Alternate for Dr. Marshall, attended the afternoon session.

In his opening remarks, Dr. D. I. Rice informed the members that due to illness, Doctors H. J. Martin and F. J. Granville could not be present. The Secretary was instructed to convey to these gentlemen best wishes for a complete and early recovery.

The Chairman stated that the most pressing matter on the Agenda was a review of the Group Disability Insurance Plan. He expressed the hope that the other business before the Executive could be completed during the morning session so that the Group Disability Insurance could have thorough review during the afternoon.

The Minutes of the regular meeting of the Executive on January 26th were formally approved as distributed to the members of the Executive and as printed in a resume form in the Bulletin for March, 1959.

Business Arising from the Minutes

Progress Report on Welfare Group. Dr. Sutherland, Chairman of the Committee on Medical Economics in his report stated that as a result of a meeting of his Committee with the Hon. Minister of Public Welfare, Mr. M. S. Leonard, an agreement had been reached which included payment of $1.15 per recipient per month for medical services on behalf of the Welfare Group.

Dr. L. S. Allen, a member of the nucleus of the Committee on Medical Economics, gave an outline of the meeting with the Hon. Minister in which he stated that some modification of the wording of the contract would be necessary since it would become effective April 1, 1959 and be subject to review with the Department of Welfare after completion of the calendar year, the statistics of the experience of the previous year being available after December 31st. It was pointed out that the Schedule of Fees of 1953 would be applicable. By way of explanation it was stated that since Maritime Medical Care Inc. had not yet adopted the 1958 Schedule it did not seem advisable to use it at this discussion.

The Report of the Committee on Medical Economics was adopted and the following Resolution presented:

Moved by Dr. A. M. Marshall, seconded by Dr. S. G. MacKenzie, "The Committee on Medical Economics be given the authority to accept a new contract of $1.15 per recipient, on behalf of The Medical Society of Nova Scotia.

"They are also given the authority to change the wording of the contract to bring it up to date, including the change of fiscal year beginning April 1st." Carried.

Interim Report of the Committee on Legislation. In the absence of the Chairman of the Committee on Legislation, Dr. J. McD. Corston, the Secretary read the report.

It outlined the work which the Committee had done preparing opposition to the Chiropractic Bill (No. 67—1959). The Report stated that the nucleus committee had met on several occasions and discussions had been held with the Registrar of the Legislation Committee of the Provincial Medical Board, particularly in reference to the suggestions for amendments to the Medical Act. The Chiropractic Bill and the Amendments to the Medical Act had found themselves to be "fellow travellers" in the Legislature and both had been reviewed at a public hearing before the Law Amendments Committee of the Legislature on Wednesday, March 18th, during a period of approximately 6 hours. The results of the deliberations of the Law Amendments Committee were not known at the time of this meeting. It was moved and seconded that this Report be adopted and it was open for discussion.

Dr. McGrath, who is a member of the Committee on Legislation, reviewed the background of opposition to the Chiropractic Bill and the proposed amendments to the Provincial Medical Act. He emphasized the inherent danger of chiropractic to the public health and stated that it was the obligation of medicine to bring this to the attention of the Legislators and the public in every possible way. The Secretary stated that the Branch Societies had been kept informed of developments, that a letter had been forwarded on March 6th to the Presidents and Secretaries of the Branch Societies and that it appeared that each Branch was taking effective measures along the lines mentioned.

The Chiropractors were stating that they enjoyed approval by the Department of Veterans Affairs in Canadian Government. Inquiry of the facts concerning this led to the receipt of the following communication:—

"DEPARTMENT OF VETERANS AFFAIRS

Ottawa 4, Ontario
31 August, 1956

Senior Treatment Medical Officer,
Halifax, Nova Scotia.
Attention of Dr. T. E. Kirk

SUBJECT Treatment Services Policy regarding
Chiropractic Treatment

In the Ottawa Journal, 30 August, 1956, an advertisement appeared, worded as follows:

Applications Now Being Accepted
for Fall Enrollment in
THE CANADIAN MEMORIAL
CHIROPRACTIC COLLEGE
252 Bloor St. West Toronto,
a four year course and
Clinic Internship
APPROVED BY DEPT. OF VETERANS AFFAIRS
CANADIAN GOVERNMENT
FOR FURTHER INFORMATION
WRITE THE REGISTRAR OR
VISIT OR PHONE THE FOLLOWING ALUMNI

It is feared that the wording of this advertisement may lend itself to misinterpretation. The approval by the Department of Veterans Affairs refers to the approval which was given to the College as a training ground in chiropractic for veterans who wish to study chiropractic under the Veterans Rehabilitation Act. The same sort of approval was extended to Barber Colleges, Schools of Motor Mechanics and many other trade schools.

Approval by the Department of Veterans Affairs of the College of Chiropractic does not extend to approval of the methods of chiropractic in the Treatment Services of D.V.A. There is no intention on the part of Treatment Services to change treatment policy so as to introduce methods of chiropractic into the Treatment Services.

It is possible that similar advertisements have appeared in other newspapers in Canada and that you will be asked questions about it. The foregoing statement of policy is therefore for your information.

(Signed) J. N. Crawford, M.D.,
Director General of Treatment Services."

On completion of further discussion, which included an explanation of the proposed amendments to the Medical Act, it was voted that this Report be accepted.

Progress Report of Advisory Committee on Health Insurance

The Chairman welcomed the following:

Dr. D. M. MacRae, Chairman, Committee on Health Insurance
Dr. W. A. Taylor, President, N.S.A.P. (Observer)
Dr. R. H. James, Secretary-Treasurer, N.S.A.R. (Observer)

The Chairman requested Dr. MacRae to present the report of the Advisory Committee on Health Insurance, which is as follows:

March 22, 1959

"Dear Dr. Rice:

The Advisory Committee on Health Insurance wishes to report the action taken on the two motions passed by the Executive Committee on Monday, January 26th. A letter was sent to Mr. Rod Black, Chairman of the Hospital Insurance Commission, on January 31st, informing him of your motion relative to uninsured in-patient medical services, and that we would like to discuss this at our next meeting with the Commission. The Chairman of the Executive Committee and the Chairman and nucleus members of the Advisory Committee met with representatives of the Radiologists and Pathologists to inform them of your motion "to appoint a representative committee to apply the recommendations of The Medical Society of Nova Scotia concerning work-loads in individual hospitals." Terms of reference of this committee were discussed and the Radiologists and Pathologists were asked to nominate a member from their respective societies. Subsequently, the following special committee was appointed:

Dr. A. Titus, Chairman	Dr. D. Howell
Dr. W. Taylor	Dr. A. Sutherland
Dr. I. MacLeod	Dr. C. B. Stewart

This committee met on two occasions with the Advisory Committee and twice with Dr. O. C. MacIntosh.

Doctors D. I. Rice and D. M. MacRae had an informal discussion with Mr. Rod Black and Doctors G. Simms, H. Devereux and H. MacKay. We reviewed the principles on which our recommendations of September were based and restated our belief that these would result in a high quality of medical services at a realistic cost. We urged them to accept their responsibility in providing hospitals with information and advice, so that they would be in a position to make arrangements with physicians providing insured services.

This Committee has increased the nucleus members by the addition of Doctors R. Dickson, I. MacLeod and W. Taylor. It also plans to add another three members (corresponding) to provide more representation from the Province.

We understand all the hospital interim budgets will have been reviewed by this week, and with the progress being made by Dr. Titus' committee, we hope to be in a position to meet with the Hospital Insurance Commission and Hospital Advisory Committee and resolve our present problems.

Respectfully submitted,
(Signed) D. M. MacRae, M.D., Chairman,
Advisory Committee on Health Insurance."

Discussion

Dr. MacRae stated that the Special Committee had been very active and was making progress toward fulfilling its terms of reference. He gave as his opinion that difficulties could be resolved within a few weeks; he did not wish

to leave the impression that everything is satisfactory, but he believed that the situation had improved since his last Report of January 1959. Questions directed to Dr. MacRae covered again a review of the situation up to the present time with explanations of many details. In answer to a question concerning the situation in other divisions across Canada, specifically in Ontario, it was stated that there is no finalization of any agreement in any Province of Canada up to the present time. Dr. Devereux, who is a member of the Hospital Insurance Commission, agreed with this statement and expressed his opinion that it was most desirable to come to an agreement with hospitals on these matters and then the two groups approach the Hospital Commission. He emphasized that the Commission basically deals with hospitals. He did not think that the hospital budgets would be finalized for another 6 or 8 weeks and after that they may be re-opened on the 1st June. He advised that all hospitals should be made aware of our plan when approved by The Medical Society.

In summing up, Dr. MacRae stated that his Committee continues to study the application of the recommendations for a basis of a formula for remuneration of Radiologists and Pathologists based on the principles as adopted by the Society in September of 1958.

It was voted that the Report of the Advisory Committee on Health Insurance be accepted.

In order to cover as much of the Agenda as possible before the Luncheon recess the Chairman changed the order of the Agenda and next took up the presentation of the N. S. Flag to C.M.A. house. This was a progress report and 2 resolutions were passed:

(1) To the effect that a suitable staff be purchased for the N. S. Flag.

(2) That the presentation of this flag and staff to C.M.A. House take place at the Annual Meeting at Keltic Lodge in June 1959. The presentation to be made to the President of the C.M.A. or his representative.

Composition of Resolutions Committee

This was a verbal report by the Chairman Dr. D. I. Rice who stated that the authority for such a Committee had been approved at the previous meeting of the Executive but that the Committee had not been formed.

Moved by Dr. J. P. McGrath, seconded by Dr. D. R. Campbell, "The Resolutions Committee be appointed by the officers of the Society."

Committee on Job Evaluation

This Special Committee reported through its Chairman Dr. F. A. Dunsworth. This was in the form of a Progress Report stating that following discussion at the Executive Meeting of January 26th a letter had been forwarded to the Hon. R. L. Stanfield, Premier, with a copy to the Hon. R. A. Donahoe, Minister of Health, on February 20th, which presented the viewpoint of The Medical Society of N. S. in relation to the Job Evaluation study as it applied to profession medical services. We had had an early reply from Mr. Stanfield, but, in the opinion of the Committee, the reply had not taken into consideration the main points presented by the communication from the Society.

The Committee requested authority to proceed further with this matter.

Dr. Dunsworth's report also referred to a directive of the Executive of January 26th, 1959 to study the problems of Salaried Physicians and reported that it was the considered opinion of this Committee that such terms of reference did not properly come under 'Job Evaluation'. Further discussion on this important subject was sought. It was regularly moved and seconded that the report of this Committee on Job Evaluation be adopted.

During discussion the proposed Committee on Salaried Physicians was re-examined. It was pointed out that a goodly number of salaried physicians were already members of this Society; that there is error in considering that the only salaried physicians are the Divisional Medical Health Officers. Further discussion resulted in the opinion that such a committee would be of value to salaried physicians and it was finally decided that, for the time being, the 'Committee on Job Evaluation' should have its name changed to the 'Committee on Salaried Physicians'.

Dr. R. O. Jones, Divisional Member to the C.M.A. Executive Committee reported that the C.M.A. had circulated the salaried physicians in Canada with questionnaires and that the information presently accruing is being studied. Considerable information will be available within the next few months. The following Resolution was put forward

Moved by Dr. D. R. Campbell, seconded by Dr. H. J. Devereux, "The name and function of the Job Evaluation Committee be changed to the Salaried Physicians Committee with the present Committee having power to add to its members as required." It was voted that the Report of the Committee on Job Evaluation be adopted.

The Meeting was recessed at 1.15 p.m. for luncheon at the Nova Scotian Hotel.

The Executive Committee meeting was reconvened at 2.20 p.m. in the Harbour Room of the Nova Scotian Hotel by the Chairman Dr. D. I. Rice.

NEW BUSINESS

Group Disability Plan. In presenting this subject the Chairman reviewed the background. The first information relative to the proposed changes was contained in a letter from Second Vice-President, Group Administration of the Union Mutual Life Insurance Company of Portland, Maine, dated January 22nd, 1959. This had been delivered by hand to the Executive Secretary by Mr. Leo McKenna on February 10th. Further inquiries had been made immediately and the information had been forwarded to members of the Executive Committee on February 27th, 1959, so that study and consultation in preparation for the debate at the Executive Meeting would be possible. The Company had been informed that the matter would be presented to the next meeting of the Executive on March 23rd. Because of the proximity of that date to the anniversary date of the policy (premium due April 1st, 1959) the Company extended the grace period to 6 weeks (May 15th) instead of the usual 30 days. He remarked that there were approximately 270 participating physicians.

The Chairman stated that Mr. Leo McKenna of Blaker, Hearns & Co. was waiting to be called to the Executive Meeting and invited discussion prior to asking Mr. McKenna to appear. The Chairman explained that the claims experience had not been satisfactory in so far as the claims plus reserve for open claims and the reserve for unreported claims exceeded the total of premiums. Resulting from this the company (1) proposed that it was necessary to

continue the same premium with a modification of benefits, or (2) to have the same benefits at a markedly increased premium. The point to be decided is whether we are going to accept one of these proposals or explore other companies.

A member asked whether enquiries had been made of other Companies. The Secretary replied that such inquiries had been made but that from these inquiries it became apparent that the **Group** principle for disability insurance was the difficulty. Any inquiries had established the fact that applicants would have to produce proof of insurability before becoming accepted. One Company had what was termed as a "group concept" plan but in this plan individual proof of insurability would be required and the Society would be responsible for collecting the premiums. It appeared to be generally agreed that the group principle was a good one from the standpoint of the Society for the reason that members would be accepted for disability benefits without proof of insurability; the problem was in following through the group type of plan to make it sufficiently attractive for those who could prove insurability under individual plans to be attracted to.

In answer to further questions the Chairman stated that the same Company has Group Disability Plans in the Ontario, Quebec, Newfoundland and P.E.I. Divisions. Dr. R. O. Jones stated that he was convinced that at the time the insurance plan had been accepted, that the firm was regarded as a reputable company. Several other points were discussed and one member stated that from the general trend it would probably be difficult to get a reasonable number of members from The Medical Society to continue with the Union Mutual Company. Dr. Jones again emphasized that this was a "group" plan, which certainly had the advantage of providing disability insurance without proof of insurability. Mr. McKenna was then invited to come in. In introducing Mr. McKenna Dr. Rice stated that he was prepared to answer any questions and give any explanations desired.

In his opening remarks Mr. McKenna stated that he believed his Company gave the widest disability insurance coverage available; that the Company had had neither a contested nor unpaid claim; that his Company regretted very much the change which was necessary and that it had occurred only after 3 years of operation. A member asked if premiums paid by the Nova Scotia division would be used to cover claims from that area, to which Mr. McKenna replied that the original approach had been through the C.M.A. on a national basis and that this approach had not developed. The plan is set up so that each division, for instance Nova Scotia had developed its own claims experience on the basis of its own premiums, consequently claims experience in other Divisions would not affect Nova Scotia. In answer to question about other possibilities of adjustment, Mr. McKenna replied that such were not possible at the present time since the company cannot leave participants unprotected while the contract is being considered. In further discussion the following points came out:–That if the plan were dropped those disabled would be protected: that the Company has available a plan for individuals but proof of health would be required; that it had been necessary for this plan to be in operation to have 50% of the membership participating and this having been achieved, the plan would continue to operate if not less than 50 members continued to participate. Again the fact that this was a **group** plan and as such has advantages to the membership of this Society was emphasized and, in answer to a question, Mr. McKenna intimated that it may be possible to sell disability insurance as a supplement to the Group Plan. Mr. McKenna was

asked if his Company had something to offer which would be competitive with any other Company, to which the answer was "Yes." Another question was to the effect that if the Society wanted to continue the Group Plan so that physicians with disability were looked after as well as those who could produce proof of insurability, would the Company have something to offer, and again the reply was "Yes." Inquiry was also made of the possibility of grouping the experience of the Atlantic Provinces. Mr. McKenna's opinion was that this could be studied.

The Chairman thanked Mr. McKenna for coming to the meeting, to which Mr. McKenna replied that he welcomed the opportunity of discussing the situation with the Executive.

After further discussion the following Motion was put forward:

Moved by Dr. W. A. Hewat, seconded by Dr. F. A. Dunsworth, "That we accept the revised provisions (1) Sickness reduced from 5 to 2 years benefits, (2) Accident reduced from life to 5 years benefits, (3) Weekly indemnity reduced 20 per cent, and (4) Waiting period 14 days instead of 7 except when payment starts the first day of hospitalization; and that negotiations be carried on to improve the above conditions."

In discussing the motion the matter of the necessity of referring this to the Annual Meeting came up, but it was agreed that the Executive had to make some decision within a definite period of time. The motion was put forward and adopted unanimously.

Resulting from further discussion the following Resolution was presented and carried.

Moved by Dr. A. W. Titus, seconded by Dr. D. R. Campbell, "A Special Committee (with the Chairman appointed by the officers of the Society) be appointed to investigate all aspects of our present and other Disability Insurance Plans and make recommendations to the Annual Meeting of the Society in June, 1959."

It was agreed that the appointment of this Committee be left to the officers of the Society.

The Chairman now returned to the Agenda and completed the "Business out of the Minutes" by giving a Progress Report for the committee studying Annual Meetings. As of March 22nd, replies to the questionnaire concerning Annual Meetings have been received from 6 of the 9 Branch Societies. It would appear that this committee would make a final report on recommendations to the next Executive Committee Meeting for discussion and presentation to the Annual Meeting 1959.

Annual Meeting 1959. Dr. Devereux, President-Elect, reported that his committees were continuously at work on the program for the Annual Meeting to be held at Keltic Lodge, Ingonish, on June 24, 25 and 26th. It was planned that a provisional program would be published in the April issue of the Bulletin and a final program in the May issue. The cooperation of the members of the Executive was requested in stimulating interest in the Annual Meeting and improving attendance.

REPORTS

Interim Report of the Committee on Traffic Accidents. Dr. Rice, in the absence of Dr. A. L. Murphy—Chairman of the Committee, presented the report. The report stated that the Committee has met with heads of the

Motor Vehicle Department and recommends that The Medical Society of Nova Scotia submit a brief to the government through the Committee on Traffic Accidents, on how the licence of a motor vehicle operator can be best carried out and supervised. It was regularly moved and seconded that this report be accepted.

Report from the Representative on the C.M.A. Executive Committee. Dr. R. O. Jones presented his report. The following points were discussed in the report. The C.M.A. Annual Meeting 1959. The installation of H.R.H. The Duke of Edinburgh as President of the Canadian Medical Association will take place on June 30th, 1959 in Toronto. It had been decided not to change the dates of the General Council of the C.M.A. which is still being held for Friday May 29th and Saturday May 30th at the Royal York Hotel, Toronto, in conjunction with the Annual Meeting of the Ontario Medical Association. The Annual Meeting with the installation of the President will be Tuesday, June 30th, 1959. The adjourned General Meeting is to take place in Edinburgh on July 18th, 20-24th. This rather unusual situation created some problems and he suggested that the Nova Scotia division should arrange to have official representation at the installation proceedings.

Moved by Dr. C. A. D'Intino, seconded by Dr. H. J. Devereux, "That Dr. N. H. Gosse be approached to act as official representative of the Society on the installation of the new President of C.M.A., June 30th, 1959." (Dr. N. H. Gosse has indicated willingness to act as official representative at this function).

Another item was the Divisional representation to General Council of C.M.A. under the conditions of the present year. After examining this subject the following resolution was put forward.

Moved by Dr. F. A. Dunsworth, seconded by Dr. H. J. Devereux, "A $100 will be allowed towards expenses of each delegate from Nova Scotia attending General Council Meeting since this year's meeting brings us special consideration and is not to be established as a precedent. All steps will be taken to have the delegates raise funds from other sources to keep the drain on the Treasury to a minimum." Carried.

His report also referred to the special need to teaching beds for undergraduate and post-graduate medical education. He pointed out that the situation had changed since the introduction of the Hospitalization Plan and that the situation might become acute unless it was examined closely. It was pointed out that there does not appear to be a distinct problem in this division but that it does exist in other areas. It was regularly moved and seconded and carried that this report be accepted.

Cogswell Library Fund. The Secretary reported that an amount of $250. had been forwarded to the Medical Library from this fund.

NEW BUSINESS

Report on Workmen's Compensation to Amend Workmen's Compensation Act. Dr. Titus, Chairman of the Special Committee on the Brief, reported to the effect that in July 1957 The Medical Society had presented to the Royal Commission inquiring into the Workmen's Compensation Act (Judge A. H. MacKinnon) and that the recommendations from The Medical Society had been incorporated in the recommendations of the Commission to Government. He also stated that the Bill presenting amendments to the

Workmen's Compensation Act, based on the recommendations of the Royal Commission, had been presented to the legislature on Thursday, March 12, 1959, by the Minister of Labour, but that these amendments had contained none of the recommendations relative to Medical Services. After inquiry it was decided that it was not advisable to appear at the public Hearing on this omission. Further inquiries indicated that it is probable that the Workmen's Compensation Board will be discussing this matter with The Medical Society.

This report was accepted and a motion passed to the effect that

"The Special Committee appointed in 1957 to prepare a brief for presentation to the Royal Commission inquiring into the Workmen's Compensation Act, continue to function and take appropriate action to deal with the present situation."

Appointments to Board of Directors of Maritime Medical Care Inc.

It was moved and seconded that the nominations to the Board of Directors for Maritime Medical Care Inc. be appointed as listed. These were:

Branch Society	Appointee	Term of Office
Cape Breton Medical Society	G. C. Macdonald, M.D.	1959-1961
Colchester East-Hants Medical Society	R. F. Ross, M.D.	,,
Cumberland Medical Society	D. R. Davies, M.D.	,,
Pictou Medical Society	H. B. Whitman, M.D.	,,
Valley Medical Society	A. A. Giffin, M.D.	,,

Pamphlet "Information for Patients"

A copy of this pamphlet had been forwarded to all members of the Executive.

Moved by Dr. F. A. Dunsworth, seconded by Dr. C. A. D'Intino, "This pamphlet be referred to Public Relations Committee for study and revision appropriate to the local situation and be returned to the Executive Committee at the next meeting."

Report on Membership

It was reported that paid up membership all classifications as of March 20th, 1959 is 300.

Letter from the Nova Scotia Dental Association

This letter was a request from the Committee of the Nova Scotia Dental Association on Hospital-Dental services requesting a meeting with the Committee of The Medical Society of Nova Scotia. It was regularly moved and seconded and carried that this letter be referred to the Advisory Committee on Health Insurance for consideration and action as necessary.

Letter from the Nova Scotia Association of Radiologists for recognition as a Branch Society and representation on the Executive, was referred to the Committee on Bye-laws.

Senior Membership in the C.M.A.

Letter from Dr. A. D. Kelly advised that the nomination of Dr. J. C. Ballem had been accepted for election to C.M.A. Senior Membership.

THE MEETING WAS ADJOURNED AT 6 P.M.

Maritime Medical Care Newsletter

May, 1959

The Annual Meeting of the Board of Directors of Maritime Medical Care, Incorporated, was held on April 29th, 1959. Directors present were: Dr. F. M. Fraser, President; Dr. H. B. Whitman, Vice-President; Dr. J. McD. Corston, Dr. A. A. Giffin, Dr. W. A. Hewat, Dr. J. A. MacDonald, Dr. T. B. Murphy and Dr. R. F. Ross.

Several important decisions were made in relation to the future operation of Maritime Medical Care which will be of immediate interest and concern to all participating physicians, effective July 1st, 1959, as follows:—

(1) That the 1958 Schedule of Fees of The Medical Society of Nova Scotia be adopted as the basis of M.M.C. payments. Adoption of the 1958 Schedule will, of course, necessitate a raise in subscribers' rates. A table of the new rates which will be applied will be found at the end of this report and it is hoped that they will provide enough income to pay at least eighty-five per cent of the new Schedule.

(2) That immediate steps be taken to establish a Reserve Fund by applying two per cent of subscribers' dues to this Fund each month. The necessity for a monetary reserve has long been recognized as being essential in preventing fluctuations in pro-ration due to epidemics, etc. This reserve will be used solely for payment of doctors' accounts, when such need arises in future.

(3) A clause permitting limited "extra-billing" by all physicians will also be introduced under the new contracts. This provides specifically "that all participating physicians be given the privilege of extra-billing within the adopted Fee Schedule of The Medical Society of Nova Scotia and respecting the principles of Maritime Medical Care." That is, in essence, if a physician should have his submitted account reduced by the Corporation for "over-service," he may bill the subscriber for the difference between the fee allowed by M.M.C. and the fee scheduled by the 1958 Schedule of The Medical Society. Extra-billing for pro-rated balances and for amounts in excess of the 1958 Schedule of Fees is not authorized.

Due to the necessity of making changes in agreements with subscribers and participating physicians and the fact that one month's notice must be given to all parties in advance of such changes, the foregoing resolutions will go into effect as of July 1st, 1959.

Following are the new rates which will apply to M.M.C. contracts with former rates for purposes of comparison:—

Comprehensive Plan

Present Rate		New Rate	
Single	$ 2.80	Single	$ 3.00
Married	5.30	Married	6.50
Family	7.30	Family	9.00
Widow plus one child	4.90	Widow plus one child	6.00
Widow plus two children	5.80	Widow plus two children	7.10

Armed Services Plan

Wife	$ 3.60	Wife	$ 4.40
Wife plus one child	5.20	Wife plus one child	6.40
Family	6.80	Family	8.40

Surgical and Obstetrical Plan

Single	$ 1.00	Single	$ 1.20
Married	2.20	Married	2.60
Family	3.00	Family	3.60

Surgical and Obstetrical Plan for Armed Services

Rates

Wife	$ 2.60
Family	3.60

Pay-Direct Rates (May elect to pay monthly or quarterly)

Present Rate		New Rate	Monthly	Quarterly
Single	$ 9.90	Single	$ 4.20	$12.60
Married	17.40	Married	9.00	27.00
Family	23.40	Family	12.50	37.50

Small Groups

Present Rate		New Rate	
Single	$ 3.50	Single	$ 4.20
Married	6.70	Married	9.00
Family	9.20	Family	12.50

At the present time Maritime Medical Care is in a very advantageous selling position in relation to other carriers of prepaid medical care. With the adoption of the 1958 Schedule and consequent rise in premium rates, this situation will no longer exist as these rates are now among the highest in Canada.

It is therefore essential, if Maritime Medical Care is to be maintained in a competitive position with other carriers such as insurance companies, that physicians should charge full scheduled rates to all patients. They must be unwilling to accept an insurance settlement by a commercial carrier or other agency as the full fee for services rendered unless this fee is wholly in accord with the 1958 Schedule. In the instances where the physician feels he must reduce his charges somewhat the patient should, in all cases, be appraised of the amount of the reduction and the fact that it has been made.

Only in this way, with the full co-operation of all participating physicians, will the present advantageous position of Maritime Medical Care be maintained.

Yours truly,

MARITIME MEDICAL CARE INCORPORATED,

G. B. SHAW, M.D.,
Medical Director.

Society Meetings

Antigonish-Guysborough Medical Society

A meeting of the Antigonish-Guysborough Branch of the Nova Scotia Division of the Canadian Medical Association was held at St. Martha's Hospital, Antigonish on Sunday 8th March 1959. Eighteen members were present and had the pleasure of welcoming Dr. G. J. H. Colwell and Professor W. R. C. Tupper.

Dr. Colwell presented a short paper on "Physical Medicine and Rehabilitation" which described the training received by Physiotherapists, their capabilities and the equipment with which they work. He outlined various forms of treatment and gave the indications for their use together with a summary of conditions in the treatment of which physical medicine can play a valuable part. He stressed the preventive as well as the curative value of such treatment.

Professor Tupper addressed the meeting on the subject of pre-natal classes and gave details of the syllabus which has been drawn up for the use of Obstetric Nurses who instruct groups of expectant mothers in the anatomy and physiology of pregnancy, the normal course of labour and the puerperium and the care of new-born babies. He stressed the indirect value of such classes in raising the standard of hospital care as well as the direct value of the information given to the mothers.

Both these presentations aroused much interest among the members and the speakers were warmly thanked by the President.

After the reading and adoption of the Minutes of the previous meeting, the proposed Bye-Laws of the Branch were considered and approved. The questionnaire on the Annual Meeting of The Medical Society of Nova Scotia was completed after some criticism of the wording which it was felt "loaded" a few of the questions.

Dr. J. A. MacCormick reported on the last meeting of the Executive Committee of The Medical Society of Nova Scotia. It was moved and carried unanimously that a letter be sent to Dr. MacRae and his Committee expressing the appreciation of all our members for the efforts made on behalf of medical practitioners directly affected by the Hospital and Diagnostic Services Insurance Plan.

There was some discussion on Maritime Medical Care and Dr. T. B. Murphy undertook to convey the points raised to his fellow Directors at the next Board Meeting later in March.

An excellent dinner was served to our members by the Sisters of St. Martha. The meeting adjourned at 7.40 p.m. The Annual Meeting of the Branch is expected to be held on Sunday May 10th, 1959.

A. J. M. GRIFFITHS,
Secretary,
Antigonish-Guysborough Branch.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

The annual meeting of the Western Nova Scotia Medical Society was held at the Grand Hotel Yarmouth, on April 16, 1959, under the chairmanship of Doctor P. H. LeBlanc of Little Brook. Following the grace, Doctor Fuller proposed a toast to our honorary member, Doctor S. W. Williamson, who has entered his 90th year. During the course of the dinner, Doctor LeBlanc welcomed Doctor G. G. Imrie, who has recently set up practice in Clark's Harbour. A nominating committee brought in the following slate of officers who were elected on motion.

President—Doctor G. V. Burton.

Vice-Presidents—Doctors Robert Belliveau, W. C. O'Brien, A. M. Wilson.

Secretary—Doctor D. F. Macdonald.

Treasurer—Doctor R. M. Caldwell.

Member of the Nominating Committee—Doctor P. E. Belliveau; alternate Doctor Don Muir.

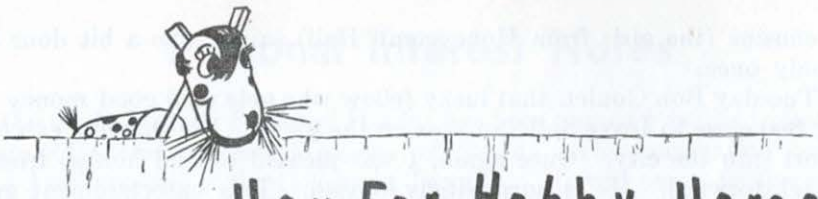
Member of the Executive—Doctor D. R. Campbell; alternate Doctor Don Sutherland.

Mediation Committee—Doctors L. M. Morton, H. J. Pothier, D. M. Robb.

Member to M.M.C. Directorate—Doctor D. F. Macdonald.

Following the dinner a business meeting was conducted by Doctor P. H. LeBlanc, ably assisted by Doctor Donald Rice, chairman of the Executive Committee of the Parent Society, Doctor Beckwith, the executive secretary and Doctor Shaw, representing Maritime Medical Care. This discussion was carried on until a late hour and a good many of our difficulties were ironed out through the co-operation of our guests. Attention was called to the further encroachment on medical practice by governments, and the problems resulting therefrom. Doctor Campbell reported on his attendance to the Executive meetings and this matter too was fully discussed. The greater part of the evening was spent on problems relating to Maritime Medical Care and it was the opinion of the meeting that both doctors and subscribers are still not sufficiently informed as to the limitations of the plan, and a motion was passed that we notify Maritime Medical Care of our feelings on that matter. Doctor Williamson gave thanks to the visiting speakers and the meeting adjourned.

D. F. MACDONALD, M.D., Secretary.



Hay For Hobby Horses

The hobby-horse for May is travel. Travel is broadening; travel is exhilarating; travel is unsettling; travel is lonely; travel is hard on the feet, and lastly, travel is one of the principal etiological factors in that distressing condition walleticus aplastica.

Brother Timothy accompanied the exhibit "Prevention of Eructation" to the Third Annual Scientific Assembly of the Canadian College of General Practice in Toronto last week. Other universities, and particularly commercial firms, had teams to erect their exhibits in the Canadian Room of the Royal York on the weekend preceding the Assembly. On Saturday afternoon it looked like the beach on D-day plus one. Our effort was achieved with less staff but considerable panic and nail biting as the weekend wore on. The exhibit was very well received by the members of the College. It was a pleasure to meet and talk to members of the profession from all across the country. As far as the touchy matter of eructation went, the atmosphere had improved over that present at the CMA meeting last June. More and more physicians are ready to accept air swallowing as an important cause of epidemic dyspepsia. Now the thoughtful physician is more apt to ask what can be done about prevention rather than wasting his time and mine rehashing the old arguments about "proof." As the French say, "things will march" when the profession finally gets off the fence. We will then say to the public (both verbally and by example), "yes, I'm an air swallower. At times I wish I was not, for the habit is clearly a dangerous one. I recommend that many of my patients should stop if they can, if not, they should practice the habit in moderation. I am seriously considering the significance of example, particularly to my patients and to adolescents not yet committed to the habit. The widespread acceptance of this attitude among us would do more in the next ten years to prevent epidemic dyspepsia and gastric neurosis than a million dollars spent in any specific problem in Gastro-Intestinal research.

I had a pleasant surprise this week. Many good people feel a little betrayed when some public figure who presents a charming and likable face to the world turns out to be a self-centered egoist, a wife beater or otherwise an S.O.B. in "real" life. In the past few days I have met two well-known figures in Canadian television. They were completely likable human beings. My faith in the ultimate rightness of the universe has had "a leg up" as our English cousins would say. On Monday last Brother Timothy was interviewed on Tabloid by Max Ferguson. I had never met Rawhide in Halifax, although like the rest of Nova Scotia within television range, I was a Gazette fan. He looked surprisingly boyish and was relaxed and casual as we waited in the shadows of a great barn-like studio. I lectured him grimly about globus and flatus and related problems and their relation to personal habits. He didn't seem to mind and, apart from agreeing on what the opening question would be, there was very little rehearsal. It went off as merry as a wedding bell, although

my kid cousins (the girls from Honeycomb Hall) said I was a bit dour and smiled only once.

On Tuesday Bob Goulet, that lucky fellow who gets paid good money for standing real close to Joyce Sullivan, was on the plane. We shared a cab from the airport into the city. Once again, I was pleased to find him so friendly and straightforward. He is surprisingly boyish. This entertainment game may be hell on the nervous system, but it seems to endow these two men with an elixir of youth. Bob (it seemed natural to call this Canadian star Bob almost at once) was direct and unaffected in a most refreshing way. I can hardly imagine anyone of similar stature in another profession being so free from pomp or side. Without anticipating the formal announcement I can say that Bob Goulet's personality and talent have been recognized in a way that does himself and Canada proud. Since I was there when it happened and, figuratively, standing in the wings with my fingers crossed, I would like to wish him all the success in the world. (Discounting something for the writer's impressionable nature, it was still a pleasant and memorable experience meeting these fellows.)

As a souvenir from cancer-land, I might tell a story current here to illustrate the reservations some people cling to in the problem of eructation. Olga and Ivan were a happily married, Russian couple. Ivan's happiness was complete except that he wondered if Olga was entirely faithful. He pretended to go to Leningrad and returned to watch the house. Within an hour or so a handsome cavalry officer stopped, gathered up the beautiful Olga and swept her off to a downtown hotel. To make a long story short, Ivan watched them through the successive stages of their rendezvous until at the moment of consummation the lights in the hotel room went out. Ivan swore silently "if only the lights had stayed on I would have known for sure. Now there is nothing but doubt, doubt, doubt."

Brother Timothy is now at cancer-land "observing." There is much too much to be seen out of doors to bother going indoors for the first week or so. The trees are budding here and the weather is good. Cancer-land is a tremendous place and the air buzzes with new approaches to the treatment of cancer. I am trying for a broad experience and will report next month on some impressions in cancer therapy.

Best wishes,

BROTHER TIMOTHY

Personal Interest Notes

Doctor F. Murray Fraser of Halifax has been named President-elect of the College of General Practice (Medicine) of Canada. This nomination took place at the April meeting of the College in Toronto. He will assume office in April of 1960.

Three Dalhousie University Cancer Research workers, Doctor J. A. McCarter, Doctor W. I. Morse, Doctor S. D. Wainwright, have been granted a total of $20,600 in Cancer Research Grants and Fellowships for 1959-60 by the National Cancer Institute of Canada.

Doctor McCarter will receive $10,300 for studies in epiderman carcinogenesis, Doctor Morse $5,300 for studies in estrogen metabolism in carcinoma of prostate, and Doctor Wainwright $5,000 for studies in mechanism and genetic control of protein biosynthesis.

Doctor S. G. Burke Fullerton, a Halifax general practitioner who graduated from Dalhousie in 1952, has been honoured by a scholarship given by the College of General Practice of Canada. Doctor Fullerton plans to take a refresher course at the Montreal General Hospital in May of this year.

Seven Halifax and Dartmouth doctors attended the recent sectional meeting of the American College of Surgeons in Montreal. Doctors Saul Green, Fred J. Barton, W. A. Curry, Harry D. O'Brien, Edwin F. Ross, J. Arnold Noble and Leo Green were among the thousand delegates from Canada and the United States.

Doctor O'Brien presided over the Wednesday noon general surgical session, and Doctor Ross gave a talk on Neonatal Intestinal Obstruction.

Doctor and Mrs. J. C. Acker returned on April from an enjoyable holiday in Florida.

Doctor D. K. Murray, accompanied by his son Duncan, travelled to New York aboard the S. S. "Sylvania" during the past month. Doctor Murray attended clinics in New York and Boston before returning to Halifax.

Doctor Michael Thomas Casey has been appointed to the Surgical Staff of the Victoria General Hospital as an Assistant Surgeon. Doctor Casey was born in New Aberdeen, Cape Breton, and graduated from Dalhousie Medical School in 1953. His interneship was spent in the Victoria General Hospital and he did one year post-graduate surgical training in this institution. In 1954 Doctor Casey was appointed to the Resident Interne Staff at the Bellevue Hospital, New York at which hospital he was to spend the next four years in post-graduate training. He received his F.R.C.S. (Canada) in 1958.

Doctor J. A. Webster of Yarmouth attended the meeting of the American College of Surgeons in Montreal in April.

Doctor A. D. R. Lapp has retired from the D.V.A. Hospital at Camp Hill. Doctor Lapp spent from 1946 until 1949 in association with the Department of Veterans Affairs, first in Cornwallis and later at Camp Hill Hospital.

Doctors Ian MacGregor, J. W. MacIntosh, Jr., and Hereford C. Still have been appointed assistant physicians to the Out-Patient Department of the Victoria General Hospital. This appointment carries with it the obligation and privileges of staff meetings.

This is the first occasion that general practitioners have been so honoured in the Victoria General Hospital.

The Bulletin extends sympathy to Doctor F. L. Akins of Windsor on the death of his father Mr. Thomas Bernard Akin after a lengthy illness on April 27th.