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The NOVA SCOTIA MEDICAL BULLETIN

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EDITORIAL

PHYSICIAN, HEAL THYSELF[1]

Since the editorial column has become a regular feature of the Nova Scotia Medical Bulletin, we have usually tended to be objective and impersonal in our rather philosophical approach. On this occasion I would reverse this attitude and become subjective and personal.

Over the past few months, the writer has been bothered by a nagging chest pain, especially noticeable when overtired. The past year and one-half has seen 3 of my 12 confreres, with whom I took post-graduate training suffer heart ailments, two of them fatal (these were all men below 40 years of age.) Obviously, my own chest pain is psychogenic—or is it? But my hesitation to approach one of my fellow doctors for a proper examination, even an electrocardiogram and blood tests (e.g., serum cholesterol) stems from my own embarrassment at being considered a potential neurotic. The truth is I am neurotic, but my Anglo-Saxon "stiff-upper-lip" forbids me to admit it publicly. (The reader will realize already that this must be good psychotherapy for the writer). However, I have been approached professionally for examination by enough of my confreres to be aware that this ambivalent attitude, fear of one's personal health versus fear of being considered a neurotic, is quite prevalent among the medical group.

Any comparable group, economically or educationally, would consider this problem as one easily solved. While I am aware that there can be many arguments about the loopholes in a complete physical check up and our inability to predict future health, nevertheless, these seem to be highly theoretical objections in view of the advantages to be obtained by routine health care.

I would, therefore, respectfully suggest that each local Medical Society organize teams, each team to include a general practitioner, a cardiologist and various other specialties (which could be worked out in advance). Each doctor-member of the society would be given a set of appointments with the examiners over a period of one or two days and any laboratory tests (e.g., X-ray, hematology, electrocardiography) would be done during this time. The results would be discussed with the examinee by the general practitioner at the end of the examination period. These results could be kept at some central office available to the Society, for comparison purposes every one or two years, when the examination could be repeated by either the same or another team chosen by the examinee.

While this suggestion may be greeted with cynicism (though I doubt it), much more do I fear lethargy. Possibly we should continue in the light of St. Luke's advice: "Physician, heal thyself".[1]

J. H. Q.

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1. Holy Bible - (King James Version): St. Luke: IV: 23.

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THE CANADIAN MEDICAL ASSOCIATION

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No, this isn't meant for you but tear it out and pass it along. (Ed.)

TEN WAYS TO WRECK YOUR MEDICAL SOCIETY

(1) Don't join it. (You can get most of its benefits without paying the $75. anyway.)

(2) If you join, don't go to the meetings. If you show any kind of interest, they'll want you to do some work.

(3) If you do go to the Branch Society meetings, get a little high and be the life of the party but don't listen to the Executive member. He's trying to get you involved.

(4) Don't read the transactions of the Executive meetings in the Bulletin. It's fatal to know what's going on. You are likely to get drawn in. It's all cut and dried anyway. Some clique in Halifax runs the Society.

(5) If you go to the annual meeting of the Society, go for the golf and the parties. Stay away from the business meetings. They are a bloody bore and the Executive (that Halifax crowd) are going to ram things through anyway.

(6) If you're fool enough to go to the business meetings, don't read the committee reports that are sent to you beforehand. Make the Executive Secretary or the Chairman explain it all to you personally. That's what the b-----ds are paid for anyway.

(7) Don't trust the Committee recommendations even if you have taken time to read them. Only fools would do months of work on these projects without pay. It's probably safest to vote down all these new suggestions anyhow.

(8) Boycott the Special Research Committee. They are 'armchair physicians' trying to plan a method of co-operating with Government in the provision of medical care. They can never see things the way a real doctor, like you and me, does.

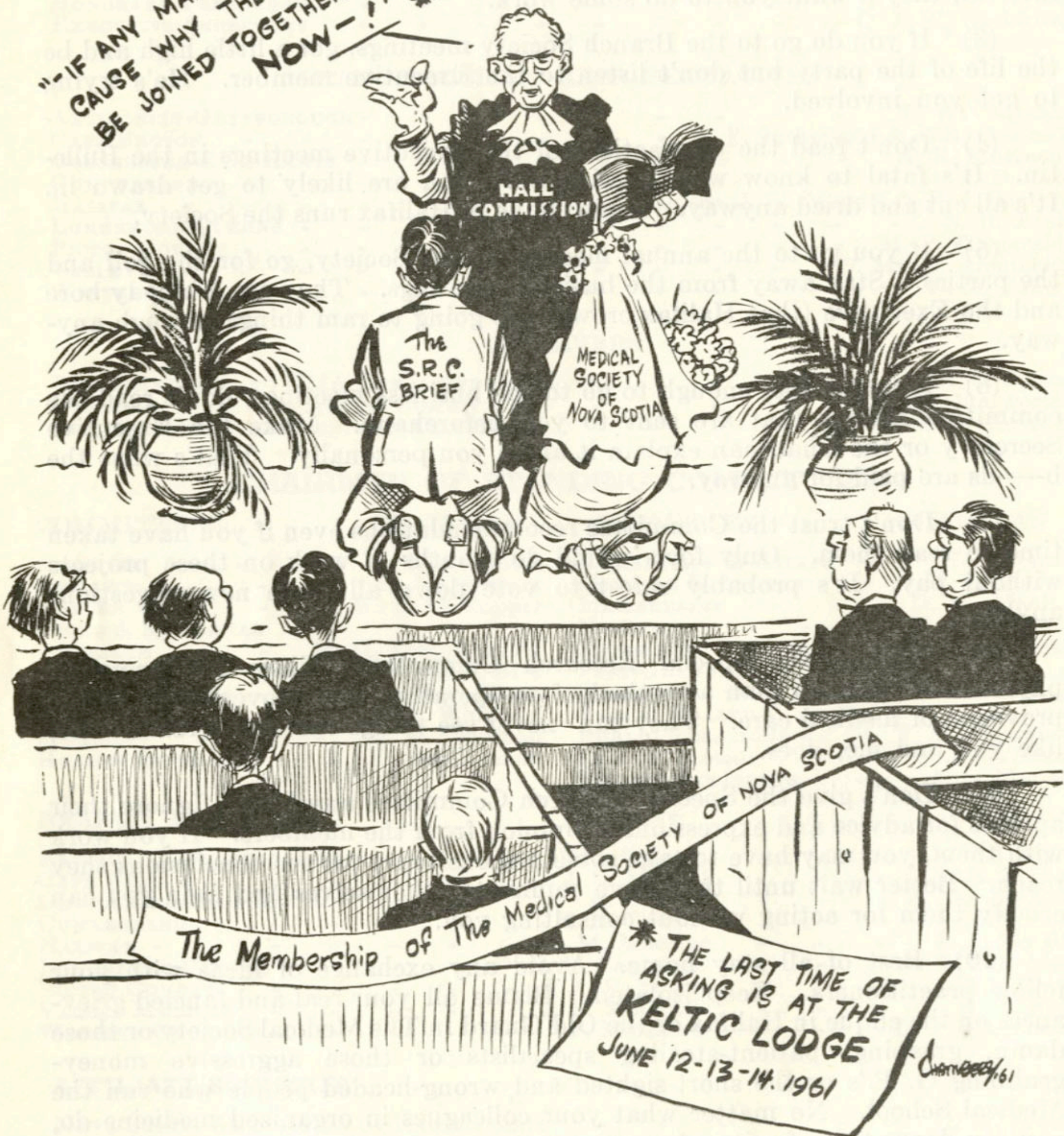
(9) Don't give the Special Research Committee any help. Ignore their appeals for advice and expressions of opinion from the members. If you work with them, you may have to take some responsibility for the conclusions they reach. Better wait until they have committed themselves and then you can crucify them for acting without consulting you.

(10) Best of all stay home. Avoid any exchange of ideas with your fellow practitioners. Keep isolated. Blame all your real and fancied grievances on the clique in Halifax or the Old Guard in The Medical Society or those damn, grasping, patient-stealing specialists or those aggressive money-grubbing G. P.'s or the short-sighted and wrong-headed people who run the Medical School. No matter what your colleagues in organized medicine do, you can damn them for it as long as you

SIT STILL AND DO NOTHING.

J. O. GODDEN

Feb. 1961


"-IF ANY MAN CAN SHOW JUST CAUSE WHY THEY SHOULD NOT LAWFULLY BE JOINED TOGETHER, LET HIM SPEAK NOW-!" *
HALL COMMISSION
The S.R.C. BRIEF
MEDICAL SOCIETY OF NOVA SCOTIA
The Membership of The Medical Society of NOVA SCOTIA
* THE LAST TIME OF ASKING IS AT THE KELTIC LODGE JUNE 12-13-14 1961
Chambers/61

Place: Keltic Lodge, Ingonish, Cape Breton
Dates: General Sessions — Business and Clinical

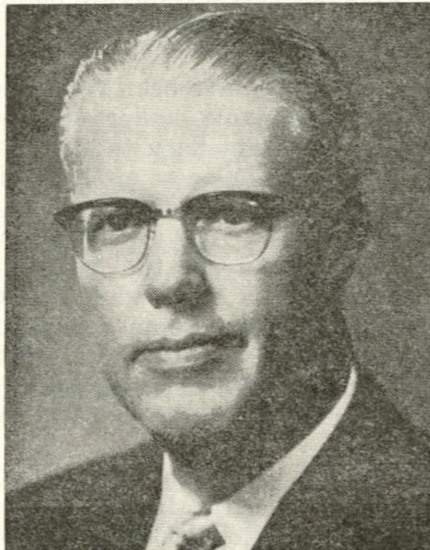
Monday, June 12th
Tuesday, June 13th
Wednesday, June 14th

5th Regular Meeting Executive Committee — Saturday, June 10th
Annual Meeting, Executive Committee — Sunday, June 11th
1st Meeting New Executive 1961-1962 — Thursday, June 15th

Many are familiar with Keltic Lodge and Ingonish; for them an additional pleasure will be that the road is now paved over "Smoky". The drive to "Keltic" is even more beautiful; at Port Hastings one moves on to the new Trans-Canada highway, through Whycocomagh and Baddeck, skirting St. Ann's Bay, then the road has the Highlands on one side and the Atlantic ocean on the other. This beautiful drive culminates in the even more attractive scenery as one approaches the Ingonishes after crossing "Smoky". There are many opportunities to break the pleasant drive to admire scenery and points of interest beckon such as the Alexander Graham Bell Museum at Baddeck and the Gaelic College at St. Ann's. The scenery at and attractions of and about Keltic Lodge are legend.

This introduction to the site of the Annual Meeting, 1961, serves as a pleasant backgound for a well-balanced programme. *Please note that the General Sessions start Monday, June 12th at 9.00 A.M. Members should plan to arrive at Keltic Lodge on Sunday, June 11th.* Sunday evening at 9.00 P.M. there will be a Pictou County Ceilidh which will afford a pleasant opportunity to renew acquaintances and get set for the ensuing busy and pleasant three days.

The Pictou County Medical Society is host to The Medical Society of Nova Scotia. Under the general chairmanship of President F. J. Granville, committee chairmen have come up with a well-balanced programme including business, clinical sessions and social events which may be summarized as follows:



DR. W. C. MacKENZIE

Clinical Sessions. Dr. W. C. MacKenzie, Dean of Medicine and Professor of Surgery at the University of Alberta, will be the visiting Clinical Speaker. On *Monday*, June 12th, at 11:30 A.M., he will give a paper (subject to be announced). He will also act as moderator of a panel on a surgical topic on Monday at 2:30 P.M. The members of the panel will be Drs. E. F. Ross, Halifax, G. W. Sodero, Sydney, Jas. T. Balmanno, Yarmouth, M. Thos. Casey, Halifax, and R. G. Munroe, New Glasgow.

A new approach is made this year to diversify the clinical subjects in the time available. On *Tuesday*, June 13th, at 11:30, Group Clinical Discussions are planned in Medicine, Paediatrics and Obstetrics. Drs. R. C. Dickson, R. M. Ritchie, and M. G. Tompkins, Jr., have been invited to lead these Group Clinical Discussions. Each member is invited to attend the discussion of his choice.

Panel Discussions. The very important "Medical Services Insurance" will be dealt with by a panel on Tuesday at 2:30 P.M. Dr. A. A. Giffin, Kentville, Chairman of the Special Research Committee, will be the moderator.

Social Activities. These start with the *Pictou County Medical Society Ceilidh* on Sunday, June 11th at 9:00 P.M. Monday, June 12th, will see a *lobster party* from 7:00 to 9:00 P.M. Tuesday, June 13th, the *President's reception and Annual Banquet* will take place starting at 6:30 P.M. The Hon. R. A. Donahoe, Minister of Public Health, will be guest speaker. Wednesday, June 14th, the *Annual Ball* is scheduled for 9:00 P.M.

Wednesday afternoon is "free". The annual *golf tournament* will be played; prizes will be presented during the Annual Ball. For the non-golfers, Wednesday afternoon will be available for explorations by car, foot or boat and other pastimes, organized or unorganized.

The programme for the ladies includes a sherry party on Monday morning and coffee parties on Tuesday and Wednesday mornings. All luncheons are mixed; those on Monday and Tuesday will have special speakers.

Business Sessions. Five business sessions are planned, one each morning and afternoon on Monday and Tuesday with the fifth on Wednesday morning.

The "business of Medicine" may have been viewed as routine at one time but such an attitude is untenable under current conditions. Social events and clinical sessions are ancillary to the purpose of the Annual Meeting the nub of which is the business of the Society.

Each Standing and Special Committee (22 in all) has a "shirt sleeve" job to do between Annual Meetings. Any of the committees may report for information or seek advice at any of the five regular meetings of the Executive but each committee is required to present its report to the Annual Meeting. Each report represents a facet of the Society's work and is available for the scrutiny, endorsement, modification or rejection by the members assembled at the business sessions. The sum total of this examination and results of debate determine the policy for guidance in the ensuing year.

Of the business to be placed before the membership, none is more important than that having to do with Medical Services Insurance and the presentation to be made to the Royal Commission on Health Needs and Resources. Both subjects will be presented and debate and conclusions are of vital importance.

Copies of "The Reports to Annual Meeting, 1961" will be forwarded in advance of the meeting, to members who have sent in the Housing Application form so that each will have the opportunity to review them preparatory to debate at the business sessions.

The Annual Meeting, 1961, is destined to be significant in the life and development of this Society. It is one which merits attendance of as many members as possible. Housing application forms are in each issue of the Bulletin. Will you complete yours now, thereby ensuring a reservation, an advance copy of the "Reports" as well as an interesting three days under delightful surroundings.

C.J.W.B.

March 21, 1961.

UNMET MEDICAL NEEDS

Organized Medicine cannot take the position that there are no unmet medical needs. It can, with the help of its members try to find out what and where these needs are, taking care to distinguish such needs from theoretical and unrealistic wants.

To the humanitarian "rights" of adequate food, shelter and clothing there has been added the fourth "right" to medical care, i.e. to medical and paramedical services. Whereas, in the case of the first three, some limitation (on the degree of governmental aid required) is accepted as reasonable, no such restriction is placed on health services.

Moreover, an organized segment of society, Labor, is not only pressing for the "free" provision of all health services but is adamant in its view that, as important as the provision, is "the context in which the services are to be rendered," by which they mean complete and exclusive governmental control of those giving the services, including remuneration and geographical placement. In short, the civil conscription of a profession.

It behooves Medicine to resolve some of its ambivalent attitudes both within the profession and toward the public and to seek some common unity upon which to form a united front.

A.A.G.

MENINGOENCEPHALITIS DUE TO CRYPTOCOCCUS NEOFORMANS*

C. D. CHIPMAN, M.D., F.R.C.P.(C), M. A. MACAULY, M.D., W. F. GAVIN, B.Sc.

Halifax, N. S.

Generalized visceral infections due to fungi are claiming the attention of clinicians and laboratory workers as more cases are being reported from different parts of the world. The local experience with these cases is not extensive so we are reporting a case of cryptococcal meningoencephalitis, the first generalized primary infection due to this organism described in Nova Scotia.

Systemic fungus infections are frequently seen as super-infections in patients treated for bacterial infections with antibiotics or in patients whose resistance has been lowered by malignant or metabolic disease.[1] Occasionally however, a fungus infection may be apparently primary and may present great difficulty in diagnosis. The isolation and accurate identification of the causative organism is of more than academic interest now that newer therapeutic agents are at hand for the treatment of many of these infections. This case of cryptococcal meningoencephalitis is reported because the infection occurred in a patient without pre-existing illness and resident in Nova Scotia at the time.

Case Report

Mrs. F. H., age 56 was admitted to the Victoria General Hospital June 21, 1960 with depression, confusion and slurred speech. In May 1960 the patient and her husband both had severe upper respiratory infections from which she recovered prior to the onset of the present illness. She had frequent headaches, dizziness and blackouts for more than 20 years but about two weeks before admission she complained of unusually severe headaches and at this time her relatives noted unusual behaviour. The patient was a local resident for many years and did not have undue exposure to soil or animals.

On admission the patient was confused, apparently disorientated and described "animals" that she saw. She was observed to be weak but there was no fever. Neurological examination was negative and nuchal rigidity was absent. Investigations showed;—Kahn negative, urinalysis negative, hemoglobin 15.9 grams, W.B.C. 9,200 with 72% polymorphs, 25% lymphocytes and 3% monocytes. Lumbar puncture was performed and the fluid contained 106 cells, all mononuclears; protein 55 mg.%, sugar normal, and culture negative after 48 hours. An electro-encephalogram showed changes indicating organic brain disease and the possibilities of tumor or metabolic disorder were suggested.

The patient continued to be depressed and confused and there was nausea and vomiting. The spinal tap was repeated and the fluid was found to be under high pressure and only a little was removed. On July 5th. the plantar reflexes were observed to show an extensor response and Hoffman's sign was elicited. On July 6th. the C.S.F. pressure was 700 mm. water; there were 70 cells, 85% mononuclear; protein 50 mg.%, sugar normal. A form of yeast was noted in the fluid and the specimen was sent to the Department of Bacteriology for further study.

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*From the Departments of Pathology and Bacteriology, Dalhousie University, and the Pathology Institute, Halifax, N. S.

At this time the patient's condition had deteriorated rapidly. Although previously afebrile there was now a low grade fever with elevation to 99 or 100 degrees daily. Rales were heard in the chest. On July 7th. a ventriculogram was done and no tumor was seen. A needle biopsy of brain was taken through the burr hole. The material was examined in histological sections and the presence of organisms suggestive of fungi was noted.

The patient expired later in the day of July 7th. before the information regarding the presence of fungi could be made available.

Autopsy Findings

The autopsy was performed July 8th, 1960.

Gross—The body is that of a well developed, well nourished middle aged white female. The skin is normal apart from two incisions in the scalp over the occipital burr holes. The structures in the neck and the thyroid gland are normal. The right lung weighs 600 grams and the left 470 grams; both show congestion and edema and the lower lobes are firm and airless. The heart is normal; there is minimal atheroma of the aorta and coronary vessels. The abdominal organs are normal apart from slight congestion. There are burr holes in the occipital region of the skull. There is a moderate amount of translucent gelatinous material under the arachnoid membrane and this material can be squeezed out by gentle pressure on the surface. The brain weighs 1180 grams. There is no localized hemorrhage or tumor found in serial coronal sections and no areas of cystic change are noted. The cord shows similar changes in the arachnoid membrane. A Nigrosin preparation of the gelatinous exudate under the meninges reveals spherical organisms with a clear outer capsule. The morphology is that of *Crypiococcus neoformans.* The remainder of the organs are grossly normal.

Histology—The meninges of the brain and cord are greatly thickened and the subarachnoid space is expanded by an exudate of lymphocytes and macrophages mixed with abundant organisms. The organisms are spherical or oval and faintly refractile. They are of variable size and show budding; a clear capsular zone is present around some of them. Similar aggregations of organisms are present in the Virchow-Robin spaces of the cortical gray matter. Here the amount of lymphocytic exudate is variable and there is no reaction of the brain tissue surrounding intracerebral collections of organisms. In some parts of the subarachnoid space there are Langhans giant cells with organisms in their cytoplasm; there is no granuloma formation and no necrosis. The organisms stain well with mucicarmine and periodic acid Schiff stains. There is a focus of necrosis in the pituitary gland and there are organisms present in the gland and in the membranes around the capsule of the gland. Small focal aggregations of organisms are found in the liver and spleen but there is no other evidence of generalized visceral involvement. The lungs show congestion and edema and there are focal areas of early bronchopneumonia. No fungi are present in the bronchopneumonic areas of the lung but bacterial clumps are present.

Cultural Studies—Yeast forms resembling cryptococci were isolated from the second and third specimens of spinal fluid drawn on July 6th and 7th, shortly before the patient's death. The material from the brain, taken at autopsy, was cultured on blood agar plates and in dextrose yeast extract broth and incubated at 37 degrees C. Sabouraud's dextrose agar slopes and Mycosel® agar slopes were inoculated and left at room temperature. Growth appeared on the blood agar places and in the broth after overnight incubation,

on the Sabouraud slopes after 48 hours, and not at all on the Mycosel ® slopes. The latter contain cyclohexamide intended to inhibit the growth of saprophytic fungi and apparently the growth of Cryptococus was inhibited also. The colonies of organisms were at first punctate but on further incubation they became larger, tan to orange brown and confluent with a definite mucoid appearance in areas of heavy inoculation. Nigrosin mounts from the colonies showed organisms similar to those seen in examination of the smears taken from the brain at autopsy. Repeated tests for urease using Christensen's urea medium were negative, contrary to Seliger's findings in forty-six strains of *C. neoformans* which hydrolysed urea rapidly.[2] Sugar fermentations using lactose, glucose, sucrose, maltose and galactose were negative except for slight, delayed acid production in glucose. These findings confirmed that the organism was a non-fermenting yeast.

Three day old mice, injected intracerebrally with a saline suspension of the organism died after one week; adult mice injected intraperitoneally died after three weeks and showed typical domed swelling of the skull. Cryptococci were recovered from the thickened gelatinous covering found over the brain and in the peritoneal lining of these mice.

Carbon assimilation tests using Wickerham's method with fluid media were performed; glucose, maltose, sucrose and galactose were assimilated and this reaction is characteristic of *C. neoformans.*

Thus with the exception of urease production, the organism isolated from this case showed all the cultural characteristics of *Cryptococcus neoformans.*[3]

COMMENT

Cryptococcus neoformans, also known as *Torula histolytica*, is a yeast-like budding fungus characterized particularly by the presence of a wide polysaccharide capsule. The latter accounts for the characteristic diagnostic appearance in Nigrosin and India ink preparations of cerebro-spinal fluid or exudates, and for the gelatinous character of the exudate in the subarachnoid space. The organism is present in the soil and may cause disease in animals and man although the number of cases reported indicates that this is a fungus of low pathogenicity. Systemic and cutaneous forms of infection are described and one of the peculiarities of the organism is its predilection for the tissues of the central nervous system when the infection is generalized.[4] More than 300 cases have been reported[5] and recently five cases from the Montreal area were reviewed in the Canadian Medical Association Journal.[6] The greatest number of case reports is from the United States and it is not known whether this is a reflection of increased awareness of the disease or whether there is a higher incidence of infection in that country.

Infection with *Cryptococcus neoformans* is frequently associated with neoplastic diseases of the reticulo-endothelial system, especially with Hodgkin's disease. The fungus infection usually occurs in the terminal stages of the malignant disease and may not be suspected clinically. 30% of the cases of cryptococcus infection on file at the Armed Forces Institute of Pathology are associated with malignant disease of the reticulo-endothelial system.[7]

Primary generalized infections affect the central nervous system and the symptoms and signs point to disease in that system. The respiratory tract, however is thought to be the portal of entry and the initial site of infection; although sometimes infection cannot be demonstrated in the lungs. In some reported cases, the infection has been apparently confined to the lungs and amenable to cure by surgical excision of the diseased area.[5]

The duration and course of this disease are variable. In some cases the infection is acute and rapidly fatal; in others the infection has persisted for many years without treatment and organisms have been demonstrated continuously in the cerebrospinal fluid. Sometimes there is not much febrile reaction and the presence of infection may not be suspected until the examination of the spinal fluid shows increased cell count. Psychiatric symptoms may predominate and a degenerative or metabolic disorder of the brain may be suspected. The host resistance factors in this infection and the reasons for individual susceptibility are poorly understood. There is great variation in the tissue reactions which may be seen in response to the presence of the organism in the body. In some cases the organisms are present in large clusters or groups and large cysts filled with gelatinous material from the capsule of the organisms may be visible in the brain. Solid masses of organisms are present with little or no cellular reaction on the part of the tissues in which they are contained. In other cases, as in this one, there may be infiltration of lymphocytes and macrophages with giant cell formation. Caseous necrosis and suppuration have been observed but they are uncommon responses[8].

This case illustrates the potential importance of needle biopsy of the brain and meninges as a method of making a precise diagnosis. Frequently the infection may be chronic and the clinical picture may indicate that ventriculographic studies are needed to rule out tumor. A needle biopsy which may be cultured or examined by histological methods can be taken at the time that the air studies are made. Cultural studies must be done on all cases as sometimes the morphological appearances are not characteristic. The importance of etiological diagnosis is apparent now that it has been shown that treatment with Amphotericin B may be of benefit in cryptococcus infections.[9]

Summary:—

A case of meningoencephalitis due to *Cryptococcus neoformans* is reported. This is the first recorded case from Nova Scotia and appears to be a primary infection without underlying disease of the reticuloendothelial system. The factors which determine host susceptibility in this infection and the pathogenicity of the organism are unknown. The fungus is widely distributed in the soil and yet very few infections are observed. This case indicates that this type of fungus infection may occur in Nova Scotia and cryptococcus infection must be suspected in patients with a long history and bizarre symptoms and signs of neurological involvement. The importance of needle biopsy of the brain and meninges is illustrated.

Recent reports have indicated that treatment with Amphotericin B may be successful in controlling the infection.

Acknowledgement:—

We would like to thank Dr. W. Leslie for permission to use the clinical records of this case, and Dr. F. Blank of the Department of Bacteriology, McGill University for confirmation of the identity of the fungus.

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CANCER DETECTION

S. C. ROBINSON, M.D.
Halifax, N. S.

With the development of good treatment facilities through the Nova Scotia Tumor Clinic and in the various larger hospitals, the treatment of malignant cancer in the Province has kept pace with the latest developments the world over and is of a very high standard. It is sad to observe that in the related field of cancer detection much less has been accomplished. For example, at the present rate at which cytology screening for uterine cancer is being done, it would take about 100 years to cover the relevant female population *just once*.

The following comments relate to cancer detection in adult females. The principle applies also (although less easily) to other components of the population. Many cancers are insidious, remaining well-masked to even the most alert physician until they reach a stage when they are difficult or impossible to treat. The large group of cancers peculiar to the female sex are unusual in that there are generally early signs or symptoms, or techniques for even earlier detection. The results of early treatment are generally satisfactory and, in uterine cancer, extremely satisfactory.

The benefits from a widespread continuous campaign for early case finding are well known in the field of pulmonary tuberculosis. An even more satisfactory result should attend the application of similar methods for the control of uterine cancer because the menace of contagion is absent. In theory, it should be possible to eliminate deaths from uterine cancer. Put in another way, we can state that there are roughly 4300 unknown cases of incipient or active uterine cancer in Nova Scotia. Treatment methods are available and are uniformly successful in the earlier cases. It follows that the major problem is one of *case finding.*

The transformation of this possibility to reality should not be beyond the capacity of a society which can send satellites around the moon. But, enthusiasm and persistence are required from many physicians.

It seems to me that our responsibility as physicians is to ensure that each woman who appears at our offices is examined for cancer. For a start, all our women patients should be examined and arrangements made for an annual follow-up sequence. However, to succeed we shall also have to somehow influence the general female populace so that each and every woman will seek such an examination. How may this be done?

Let each of us engage in the "Big Sell". Let us truthfully place the facts before our patients and urge them to tell friends and relatives. Let us miss no opportunity to address relevant groups to disseminate this information. Excellent films are available through the Canadian Cancer Society for use as the basis for such meetings. Let us, if need be, use the public communication media for this purpose. Newspapers, weekly and daily, as well as radio and television can be effectively employed for this purpose.

What of the examination? Let me immediately explode some myths. A satisfactory examination need not be time-consuming—10 minutes should be sufficient. The techniques are simple, known to all of us or can be easily learned. No major equipment is required beyond what is present in any doctor's office. Only a few supplies are needed. These are cheap and easily obtained. The "tests" are remarkably reliable, when properly performed.

The essential steps in an examination should include:

Careful history—general and specific;

Inquiry should be made regarding the weight, general symptoms and sense of well being, the breasts, the menses, the bowel and bladder, and any discharge from breast or vagina;

Examination of the breasts and nodes, using a good light;

Inspection of the vulva and introitus for leukoplakia or other suspicious lesions;

Palpation of pelvic, viscera, inspection through the speculum; biopsy of any lesion, cytology smear of all normal appearing cases—particular note should be made of any solid or expanding or large ovarian mass;

Rectal examination.

More than 3/4 of all female malignancies occur at these sites and are amenable to early diagnosis.

The technique of the cytology smear and the method of handling the slides are as follows:

List of Equipment:

Vaginal speculum;

Tongue depressor;

Ordinary glass microscope slides;

Glycerin;

Isopropyl Alcohol;

Requisition form for cytology examination;

Mailing container (e.g. round cardboard carton as used for stool samples, etc.)

Method: Insert a dry vaginal speculum. Inspect the cervix. Rotate the end of a tongue depressor against the external os of the cervix and also pick up some material from the posterior fornix. Spread this evenly, thinly, on a clean dry slide, and *immediately* drop it in a jar of isopropyl alcohol. Allow it to remain for at least 30 minutes (you may safely leave it until next day), then remove it, place a drop of glycerin on the smear surface, and drop a second clean slide on top. Wrap the two slides in the completed requisition form, place in cardboard carton, (padding with cleaning tissue if necessary), and mail to:

Cytology Laboratory,
62 University Ave.,
Halifax, N. S.
or your local pathologist

Your smear will be examined and a report returned within a few days. Suspicious or positive cases should have full cone biopsies performed.

The obvious lesion is usually better handled by performing an initial biopsy, but the cytology technique is useful for superficial lesions.

Final Note: TREAT NO CERVICAL LESION WITHOUT FIRST DOING A SMEAR OR BIOPSY.

In British Columbia, over 1000 physicians are regularly submitting Cytology specimens to a central laboratory. It is estimated that over one-third of the adult female population has been effectively screened in the last few years. Many are returning for regular annual re-examination. This dynamic programme has been carried out to date without resort to mass "clinics".

Each doctor's office has become a cancer detection centre. In Nova Scotia we ought to do no less. Our difficulties are somewhat less because of shorter distances and a more static population.

The latest report of the Nova Scotia Tumor Clinic shows that 1/3 of cervix malignancies occur before the age of 40, and 1/3 of breast malignancies before the age of 50. It follows that these cancers are not diseases of the elderly, but occur also in the reproductive years. The various prenatal and postnatal examinations which we all carry out afford a magnificent opportunity for cancer detection. The cytology smear should be part of every full pre-natal examination and as the breasts will be examined anyway, one can take the extra minute to look for lumps or other aberrations.

Until the Utopian era arrives, when we shall have an effective systemic "cancer cure", we must struggle on with our present limited treatments. These do, however, offer good results in the early cases and excellent results in the pre-invasive states. We can only see major improvement through the application of early diagnosis. To this duty, let us direct our efforts.

THE SIGNIFICANCE OF LATERAL AND GENERALIZED RETINAL SHEEN. Finnerty, W. D., Jr., et al. Ann. Int. Med. 52:819, (Apr.) 1960.

Generalized retinal sheen is a wet, glistening appearance of the entire retina, including the nasal field, which is frequently associated with toxemia of pregnancy and glomerulonephritis. It is seldom seen in the normal population. It is almost always associated with retinal arterial spasm, which helps greatly in differentiating it from *lateral* retinal sheen. Its prompt decrease or disappearance following diuretic therapy suggests that it represents retinal edema.

Lateral sheen is a wet, shiny appearance of the lateral portion of the retina seen in the normal population under 40 years of age. This glistening appearance is more intense around the macula. Although it frequently extends just beyond the midline, its medical extent is seldom more than 1 disc diameter. The younger the patient, the more intense and greater its area of distribution. Although wet in appearance, lateral sheen probably does *not* represent retinal edema, since it is not influenced by diuretic therapy. It probably represents the anterior limiting membrane of the retina.

S. J. S.

A New Home?

Anyone visiting the headquarters of MMCI on Duke St., Halifax, will realize that one of the most urgent problems facing the organization is that of office accommodation. With the growth of the corporation, particularly in the last two or three years, necessitating increase in staff and additional machinery, we have far outstripped the limits of our present location. At present 60-70 people are working in quarters which health rules would assign to half that number; storage space is at a premium, rest rooms are inadequate, ventilation is poor and the whole set-up produces inefficiency, slugginess, high sickness rate, absenteeism, and, consequently, low morale on the part of our employees.

At present we are in the process of seeking alternative accommodation, but this is not an easy task when it is realized that we require approximately 8-9000 sq. ft. However, we have a few leads and hope to be able to announce a change of address to more healthy quarters shortly. This will, needless to say, increase our rental expense.

It is a pity that ten years ago, when the idea of the Corporation building its own plant was first mooted, when land was cheap and building costs more reasonable, that our membership vetoed the idea on the grounds that not until "proration" was abolished should "doctors' money" be used for this purpose.

At the present time, discussions are being carried on with the Medical Society of N. S. with a view to having the Medical Society, whose need for space is almost as great as our own, erect a building suitable for themselves, M.M.C.I. and other paramedical organizations, with M.M.C.I. providing the financial aid for a "lease-purchase" type of program, by investing in interest-bearing bonds. The suggestion is of recent origin and has only reached preliminary stage of discussion, but, to a Scotsman, it is tragic to see so much money being paid out in rent with nothing to show for it!

New Competition for the Medical Care Dollar

The Public Service of Canada Medical-Surgical Plan went into effect on July 1/60. This was available to all federal employees, including Civil Service, Armed Forces, R.C.M.P. and Crown Corporations, and is subsidized to the extent of approximately 50% of the cost by the Federal government.

Since over 25% of our total business originates from government sources, the advent of the P.S.C. Plan caused us considerable apprehension, even though it compared unfavorably with MMC coverage, in that it had standard commercial carrier deterrents, such as deductibles and co-insurance. An intensive retention campaign was carried out by our sales staff which met with considerable success, as our losses to the P.S.C. Plan were much lower than anticipated. In the case of the R.C.N., our largest service group, we retained 90% of subscribers, and our overall retention rate was approximately 75%, the highest in Canada.

The P.S.C. Plan introduced difficulties for M.M.C., however. The government denied to new subscribers payroll deduction facilities for all carriers, except the P.S.C. Plan, although deductions for contracts in force at July 1st were continued. We immediately made arrangements for pay direct facilities for all service personnel and are continuing to enrol them; but obviously this is a nuisance to them and increases our administrative costs for this

group. We have evidence that many of the subscribers who dropped MMC in favour of the P.S.C. Plan are far from happy after their initial experiences. Certainly many of our doctors are most unhappy with it as in many instances the "deductibles" are never paid by the patient. The outlook for gaining back many of our former subscribers is good, but it will be a year or two before any definite trend is noticeable. Meanwhile, the Executives of the Medical Society and the Corporation are working closely together in an effort to acquaint our Federal members in Ottawa with the situation. We hope to have pressure brought to bear on the appropriate Federal department to have the pay-roll deduction privilege serve all members—old and new. All we ask is equal competitive opportunity with the P.S.C. Plan, knowing that MMC is popular with the Armed Forces and will not come off second-best! It is understandable, as has been stated in Ottawa, that in order to make a success of the P.S.C. plan and maintain current rates as quoted by the underwriters: i.e. a group of commercial carriers, every recourse must be used to "encourage" as many as possible Federal employees to join. This is the attitude adamantly adopted in Ottawa at the present time and it remains to be seen how it is to be changed. This is an excellent example of the power of government departments, once given the "green light" on a project, to impose restrictions on any form of free enterprise which competes with it!

Our sales force spent most of their time at this "retention" campaign in 1960 but were still able to promote sales among the general public as shown by a small increase in the number of subscribers for the year. They were finding, however, that industrial concerns, particularly those with branches in other provinces, are demanding "comprehensive" contracts for their employees with increasing frequency. These contracts include not only the basic "physicians' services" but what has come to be known as E.H.B., i.e. "extended health benefits", such as nursing care, drugs, appliances, ambulance, etc. The demand for E.H.B. is becoming commonplace; many of our present subscribers, on the expiration of present contracts, are requesting this change. In the past and at present we have been able to supply this form of contract on request by allying ourselves with a commercial carrier. In this arrangement, MMC takes the basic and the commercial carrier the E.H.B. factor of the contract. But competition, since the advent of the hospitalization plan, is becoming tougher. Most commercial carriers are now prepared, and do, "tailor-make" any type of contract desired by the prospective subscriber, including physicians' services. Only when, for various reasons, all hope of securing the entire coverage for themselves is lost, will they ally themselves with MMC in hope of picking up the E.H.B. factor of the contract. This has become so obvious recently that the Executive of MMC is discussing the wisdom and possibility of organizing a subsidiary of MMC to deal with E.H.B. At the next meeting of the Board of Directors this question will be very seriously considered.

'Controls' on Insured Services

The question of "controls" exercises the minds of your Executive at all times. The well-meaning doctor who over-services his patient, the patient who demands service from the doctor above the average; these groups are costing the Corporation a great deal of money. It is estimated by the B.C. Plan that if each participating physician made one less call per patient per year, the saving would be almost $500,000. It is a little over twice the size of MMC. In an effort to obtain this result, the suggestion has been made that in many

cases the doctor, instead of saying "I shall see Mary again on Friday" might well say "if things are not progressing satisfactorily, call me again on Friday". This is not an attempt to dictate conditions of medical practice but merely food for thought!

Experience of other plans, as well as our own, indicate that there is no simple solution to the problems of over-service by doctors and excessive demand by subscribers. This does not mean, however, that we should resign ourselves to this situation. We have a responsibility to the majority of our member doctors who are billing the plan fairly and conscientiously and to the subscriber who is using his protection reasonably and prudently. In the case of the subscriber who persistently demands over-service, the Medical Director has been given authority to write a letter of warning pointing this out. Subsequently if improvement is not noted, on the authority of the Executive, the subscriber may have his contract reduced to the Health Security Plan, thus eliminating home and office calls.

Similarly a study of history cards will reveal, by the pattern of his practice, the doctor who continually over-services subscribers. This problem will be discussed by the Executive with the individual doctor concerned at which time it will be pointed out that, in fairness to all participating physicians, his accounts will have to be drastically reduced or taxed by formula based on average treatment of similar cases by his confreres. Again, this is not an attempt to dictate the methods of practice for any doctor but to distribute the patients' premiums, among all providing service, in a fair and equitable manner.

Formerly, because of our system of posting patients' history cards, Drs. A., B., and C working together could all visit a patient with measles on successive days and each be paid for a visit! With our recent change in posting, the patients' history card will be scrutinized before payment is made and should such a situation arise the doctor and, no doubt, the patient will be questioned closely as to the necessity for such (apparent) over-service.

Some form of educational program must supplement these efforts, possibly periodic newsletters to subscribers and doctors, outlining our problems and stressing the need for co-operation of all if we are to hold subscription rates at present levels.

We view with dismay the practice of doctors accepting payment by third parties, where such payment does not comply with the schedule of fees of The Medical Society of Nova Scotia as payment in full for services rendered. We feel strongly that where this happens, the doctor should:

a) return the cheque with his own account (based on the schedule of fees) enclosed, or
b bill the third party for the difference between cheque received and the actual scheduled fee or
c) bill the patient for the difference, or
d) make clear to payee and patient that it is being accepted as payment in full because of certain particular circumstances, when such exist.

Details of Claims Processing

Each month, Maritime Medical Care is processing and paying in excess of forty thousand claims, submitted by some seven hundred physicians. Many problems have arisen in the past in regard to claims processing and our methods of handling claims are under constant revision. New procedures,

calculated to facilitate processing, must be adopted from time to time; we find, unfortunately, that some innovations do not meet with the approval of all members of the profession.

In this category, we must place a recent change in our processing methods which, in some instances, reduces the amount payable to the specialist physician for his services. Formerly medical accounts were assessed without reference to the patient's previous history, due to the work necessary before an appropriate history could be presented to the assessor with each medical account. By changing our system of filing histories and by re-allocation of staff, this situation has now been eliminated, with the result that every claim is now assessed in reference to the previous history of the patient.

Maritime Medical Care subscribers' agreements provide that the first visit or consultation to a specialist for any condition shall be paid at the specialist's rate, provided that the condition is within his specialty, but that subsequent visits for the same condition shall be paid at rates accepted by the Corporation, that is rates applying at the General Practitioner's level. The interval to be established between consultations in a given specialty is under review by the corporation.

Previous to recent months, due to the fact that a patient's history was not available to the assessor at the time accounts were being assessed, it was the custom to allow one first specialist's visit per month. This procedure, although not strictly in conformity with subscribers' contracts, appeared as the only practical solution at that time. However, with accounts being assessed with reference to previous history, previous treatment for the same condition becomes immediately apparent and the proper values may be assigned to each visit, as stipulated by the subscribers' agreements. The new procedures will, of course, apply to all specialty groups and we feel will contribute materially to the more efficient operation of Maritime Medical Care.

These then are some of the problems continually facing your representatives on the Board of Directors, your Executive and yourselves, as participating physicians in MMCI.

Only by solving these problems and many others like them can MMC successfully fulfill its function in the future.

F.M.F.

NOTICE

Assistant required by general practitioner, in Halifax, after April 30, 1961. Practice active and varied. Salary to be mutually agreed upon after starting at $600.00 plus bonus.

Apply: Box No. 1, Nova Scotia Medical Bulletin,

77 University Ave., Halifax, N. S.

ANNOUNCEMENT

Consultation Clinics in Arthritic Diseases

Sponsored by the Canadian Arthritis and Rheumatism Society, Nova Scotia Division and with the assistance of Federal Provincial Health Grant, a Consulting Service in the Rheumatic Diseases was commenced in Yarmouth in September, 1960. On this occasion the physicians in the Western Counties area were invited to refer their patients to the Consultation Clinic. About 10 patients were examined and reports forwarded to the referring physicians. Five patients whose applications did not arrive on time could not be seen.

An internist and a physiotherapist from the Society were in attendance, and those patients who were felt likely to benefit from an active exercise programme received instruction in exercises tailored to their needs at the time of the clinic.

Yarmouth Hospital co-operated by supplying space, laboratory and X-ray examinations.

It is anticipated that a further Consultation Clinic will be held in the near future. This venture is regarded at present by the Society and the Department of Health as a pilot study to determine the effectiveness and desirability of such Travelling Consulting Services.

Cape Breton Clinics:

The Cape Breton Branch of the Canadian Arthritis and Rheumatism Society, with approval of the Cape Breton Medical Society, announces the opening of a monthly arthritis consultant service in April, 1961. The service will be held at the following hospitals:

St. Joseph's Hospital, Glace Bay
New Waterford General Hospital
City Hospital, Sydney
St. Elizabeth Hospital, North Sydney

It will be available only to referred patients, considered by their physicians as unable to pay for private consultant services, and will cover diagnosis and advice regarding treatment.

The Society will have Dr. A. A. Macdonald as the consultant.

John F. L. Woodbury, M.D.,
Medical Director,
The Canadian Arthritis and Rheumatism Society,
Nova Scotia Division

VITAMIN SUPPLEMENTS

March 16th, 1961

To the Editor.

Recently the Nutrition Division, Department of Public Health, Halifax, Nova Scotia, prepared and distributed to all physicians in the province two pamphlets entitled "Comparative Costs of Vitamin and Mineral Preparations" and "Information Concerning Infant Foods."

The cost and content of the various vitamin preparations are outlined and should be of considerable interest to all physicians. The opening remarks of the supplements state that "if the child is in normal health and his diet is based on Canada's Food Rules, he will not require nutrition supplements other than vitamin D." I feel this statement is entirely correct and could also be applied to adults. However, some infants in Nova Scotia are suffering from a marked deficiency in vitamin C and iron. Some of the responsibility may rest on the shoulders of the family physician. The chief cause of ascorbic acid and iron deficiency in children is ignorance on the part of the parent regarding proper feeding of the infant. In some cases the physician may not take the time to teach the mother the importance of providing certain foods for the young infant with a result that certain qualitative deficiencies occur. A free vitamin supplement is frequently given to the new mother on leaving the hospital with no adequate explanation, by the physician, why vitamins are necessary. In some cases the physician is surrendering his responsibility of teaching nutrition to the pharmaceutical firm providing the vitamins and the accompanying brochure.

As physicians we may be partly responsible for extremes at both ends of the nutrition scale. The excessive ingestion of vitamins by the public should also be of concern to all physicians and nutritionists.

As an example, consider vitamin D. Remembering that the requirement of vitamin D has been established at 400 units per day, studies have indicated that 70 per cent of physicians prescribe an additional 1000 units per day to infants who are already receiving evaporated milk which has been fortified with 400 units per can.

Of interest is the U.S. Tariff Commission's figures for vitamins produced in the U.S.A. in 1955. Some of the figures given reveal that in 1955, 1160 tons of niacin, 1200 tons of ascorbic acid and 95 tons of vitamin A were produced (one ton equalling 900 million mgms.) The 2460 pounds of vitamin D produced was enough to provide twice the amount needed for every man, woman and child in the U.S.A. for one year. It is quite likely that similar over-production and over-ingestion of vitamins also occurs in Canada.

There are perhaps two major criticisms that can be made with regard to the two prepared supplements. First is that the cost and dosages of the various vitamin supplements have been calculated on the basis that 4 c.c. are equivalent to 1 teaspoon. Many of the companies have calculated on the basis of 5 c.c. equal 1 teaspoon. Secondly, the calculated cost per day of the vitamin supplement is expressed in terms of providing 400 I.U. of vitamin D. In some cases the amount of the vitamin preparation sufficient to provide adequate vitamin D would not provide adequate vitamin C intake and further supplementation would be necessary.

However, I feel the brochures will be of interest and of assistance to all physicians in caring for the nutritional needs of their young patients.

Yours sincerely,

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

THE CAUSES OF EDEMA

March 20, 1961

To the Editor,

The recent series of six papers in the Bulletin on the pathogenesis of edema[1], show evidence of careful study of this difficult subject.

There is however, no mention of the role of abnormal thirst in this series or most publications on the topic. Clearly, sufficient reduction of fluid intake would make edema development impossible. Although the kidney plays a key role through retention of administered fluid, there is a sense in which these patients literally drink themselves into a state of edema. In some instances the abnormal thirst may, of course, result from salt retention with the expected osmotic stimulus of slight *hyper*natremia to thirst (and anti-diuretic hormone production). But one seldom observes frank hypernatremia with edema, and cases with chronic refractory edema are often *hypo*natremic. For this latter group Dr. L. G. Welt notes that "there must be a stimulus to thirst as well as a limitation on the excretion of water by the kidneys.[2]" Dr. Welt then makes an observation which all of us who use the serum sodium concentration as a guide to therapy cannot afford to forget. "The most significant feature of chronic dilutional hypo-natremia is that it develops as part of the natural progression of the physio-pathology of the underlying disease, and therefore it is most *unlikely* that the restoration of the concentration of serum sodium is desirable. If such attempts are made they are followed by intense thirst, the ingestion (or administration) and retention of water, and re-dilution.[2]"

Dr. R. M. Read, in the final paper of the Symposium on edema[1] points out that "while causing edema, aldosterone is making a valuable contribution to the body's economy. . . . ." It is often assumed that excessive salt and water retention, while obviously related to dyspnea and other disabling concomitants of edema, serves no useful purpose and should, therefore, be fully corrected in every *instance* of heart failure, etc. But, one asks, how often vigorous salt depletion therapy (with low salt diet plus daily administration of potent sodium diuretics) may itself cause significant symptoms before an edema, refractory to moderate therapy, has cleared? When these patients notice increasing fatigue, anorexia, lethargy, oliguria and developed a rising blood urea nitrogen, consideration should be given to discontinuing the diuretic for a few days and administration of 6 to 12 grams of sodium chloride orally over a two-day period. The edema may increase but if the above symptoms disappear the patient will often be improved.

Dr. Read's paper contained several statements with which both reviewers disagreed, but the author had left for Europe shortly after submitting it so your Editorial Board decided to publish it as it was. The latter part of the paper especially is recommended to the reader interested in the details of current thought about this difficult subject.

W. I. MORSE, M.D., F.R.C.P.(C)

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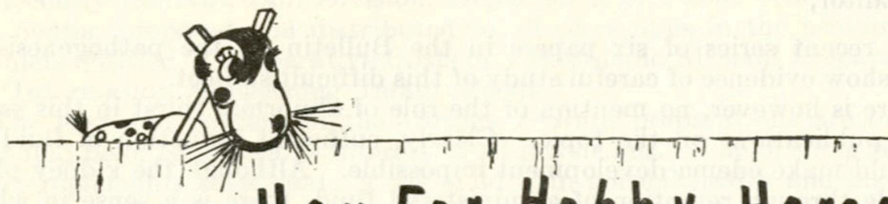


Hay For Hobby Horses

ANOTHER LAMP, ANOTHER BUSHEL

"Nor do men light a lamp and put it under a bushel but on a stand and it gives light to all in the house."

(Matthew V, 15, R.S.V.)

This past week-end I attended the second annual meeting of the Nova Scotia Society of Internal Medicine. I gave you a tongue-in-cheek report of the first annual meeting of last March under the title "Gone to Wentville". The Nova Scotia Society of Internal Medicine—N.S.S.I.M. (pronounced nossim) puts on a first-class meeting with a high quality of scientific papers sponsored by a small well-knit group whose members get along excellently together. It comes very close to the ideal medical gathering characterized by my friend N. H. Gosse as "a meeting that leaves the impression of being among friends."

The group was favoured on Friday March 17 with two fine papers. Helen Holden presented a review of patients seen, with both tuberculosis and diabetes mellitus, at the Nova Scotia Sanitorium in the years between 1930 and 1960. It was a valuable paper which all would wish to see presented for publication. Unless my memory plays me false, Dr. Holden said that with a sanitorium population of approximately 206 there were about 35 diabetics. She found a marked variation in the contribution of various Nova Scotia Counties to this number. At variance with these findings, Clarence Nottold noted that a Cape Breton sanitorium had a far smaller number of diabetics among its tuberculous population.

The second paper was presented by Arts Scissors a local but renowned, expert on medical mechanics. He described a new clinical sign which he proposes to call "Colwell's Crinkly Condylomata" in honour of another well-known body man. I am forbidden on pain of expulsion from the society to divulge more on this matter, for the Russians are working on it too. I am even forbidden to say that it has something to do with Scotty dogs, with and without collars.

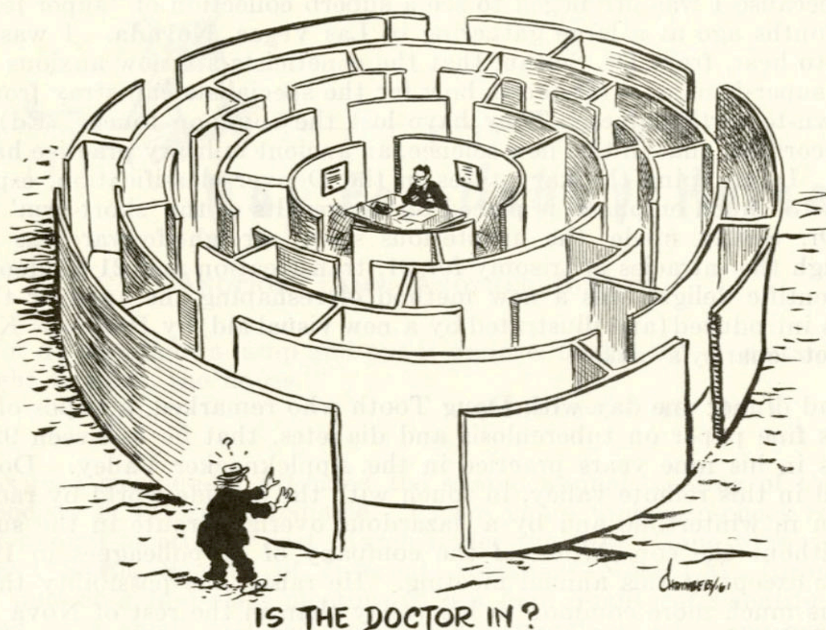
Our old comrade, Ron Aridvale was ill with pneumonia (I send our wishes for a speedy recovery) so that an additional business meeting was added to allow discussion of the request from the Special Research Committee for a brief from the N. S. S.I.M. A new member, Leon Pulmone, picked up where Leonardo da Vinci left off with the bronchial circulation and shared with us his valuable and unique studies. I hope my chief, Sam Shane, can prevail upon Leon to favour the readers of the Bulletin with a review in this field. He has, among other intellectual goodies, an explanation of the mode of production of hypertrophic pulmonary osteo-arthropathy. The last paper on Saturday afternoon brought to us a skilful and congenial interpreter of the

occult mysteries of human cytogenetics. I was intensely interested in the whole matter because I was privileged to see a superb collection of "super females" a few months ago at a large gathering in Las Vegas, Nevada. I was disappointed to hear, from Dr. Soltan, that the geneticists are now anxious to discourage super-females. (It shows how far the specialists can stray from real, live, down-to-earth values. They have lost the common touch. Ed) It is worth recording, that in this new science, an ancient military practice has been revived. In grouping the karyotytes in the Denver classification, especially types 13-15, much emphasis is placed on the results of the 'short-arm' inspection. Dr. Soltan made the mysterious seem straight-forward as he led us through the intracies of trisomy for 21, translocation and 21 Skidoo. The final scientific delight was a new method of reshaping the anterior thoracic contours introduced (and illustrated by a new visual aid) by Professor K. Read for sweet charity's sake.

I had dinner one day with Doug Tooth who remarked, apropos of Helen Holden's fine paper on tuberculosis and diabetes, that he had seen 926 new diabetics in his nine years practice in the Appleknocker Valley. Doug has practiced in this remote valley, in touch with the outside world by radio and dog-team in wintertime and by a hazardous overland route in the summertime, without the consolation of the company of his colleagues in Internal Medicine except at this annual meeting. He raised the possibility that diabetes was much more common in his valley than in the rest of Nova Scotia. Johnny Balloon was much interested in this and lamented, in a rueful aside, that diabetes mellitus was a special interest of his but the vagaries of consultant practice in Halifax only brought him a few each year. This exchange set me to ruminating about the wonderful intricacy of the referral system in medicine, a system which derives much of its complexity from the way in which the new growth, specialism, has grown up cheek-to-jowl with the older way of life, general practice.

Special training, special talent and new knowledge are lamps which should give light to all the house. How is it that, in this age of perfected communication, special talents should remain little used for years and expert knowledge permeate outward only a short distance from the source or from the local repository? Take any physician off his guard and he will tell you how badly his particular 'baby' is managed by the profession at large; ask the hematologist about the differential diagnosis of the anemias; the physician interested in cervical cancer about the state of early diagnosis in this malignancy; the gastro-enterologist about general knowledge of esophageal disease; the family physician about management of the total patient; knock on any door and the cry is the same, "Matters of medical practice that are as clear as daylight to me, seem to be dark mysteries to my colleagues but they never seek consultation".

My friend, 'Woody' Sayve-Life, was at the N.S.S.I.M. meeting presenting a paper on the epidemiology of coronary artery disease, dealing particularly with his observations on the relationship of occupation and coronary artery disease. That evening Woody, Hoona MacDonald, Dense Howl, Jack Dogberry and I were taking our ease when we returned to the topic of the referral system. We were belting the grape (after our modest and muted fashion) so some of the details of the discussion have escaped me but I think I can recapture the gist of it.



IS THE DOCTOR IN?

I set up the following proposition for discussion "Given a patient X in the community of Appleville presenting to her family doctor with the unusual sign of Colwell's Crinkly Condylomata, how long will it take this patient to reach the one physician, Specialist X, who can solve her problem quickly? What are her chances of being referred to him, either directly or indirectly, within six months?" A subject like this is good for a weekend in itself. The discussion, even in a specialist group, is not one-sided because most of the participants have had considerable experience and can see most of the major variables at once. The discussion which follows is in the form of a dialogue between my pure-hearted friend E. Wood Sayve-Life M.B. (etc.) and the Devil's Advocate. (Please bear in mind that the D.A. is a mischief-making fellow who will not find favour with my God, your God, the Professor of Medicine or any other deity.)

W.S-L. "In the British system, once Professor Limbo or Mr. Beadle have been recognized as authorities in a single disease such as pseudo-hypoparathyroidism, all patients suspected of having this disorder are channeled to one or the other. The only delay is that inherent in a hospital-based consultant system. None of their (consultant) colleagues would dream of keeping a case of 'hypo-para' away from Limbo or Beadle and the family physician who recognizes the entity is not anxious to become involved. How is it different in this country?"

D.A. (with a malicious smile) "It is a matter of pride in our country that the average self-respecting physician should trust his ability to be a specialist in all things. As the medical philosopher Max-Joe Relic once said "Seventy-five per cent of our physicians think they are surgeons but ninety-five per cent are sure they are born internists."

W.S-L. "That attitude is necessary one for a man isolated from his fellows but does it obtain when special skills and knowledge, which are close at hand, are needed to solve the patient's problem?"

D.A. "What special skills and knowledge? The doctor's duty is to relieve the patient's symptoms and make him happy. You mistake your narrow scientific view of medicine for the patient's wants."

W.S-L. (A little annoyed) "Doctor, you don't do your own bronchoscopy, your own cataract surgery, your own burr holes. Why try to handle complex medical problems for which you are no better equipped?"

D.A. "I don't do burr holes and those other things because I don't like doing them; not because I couldn't if I wanted to or because the law can forbid me once the patient trusts himself in my hands. The patient wants *me* not some young hotshot in Hogtown who doesn't have a tenth of my experience." (Woody saw that he was being led up the garden path so he did not reply. The D.A. waited a moment and then in a milder tone, began again) "I *did* push you too hard, Woody. What would you say to this? A physician should go as far as he can on his own resources before asking another to see his patient."

W.S-L. "You are still baiting me! When a physician recognizes that his patient's problem is one that is beyond his competence or one that another physician, conveniently at hand, can resolve more efficiently than he; then that physician should step down at once."

D.A. "Will all physicians recognize the problem for what it is? Do all physicians know the wide range of services at present available in this province? Are all physicians equally able to say "this problem is not my cup of tea" meaning (and admitting this meaning before his patient) that some other doctor knows more than he does about abdominal pain, jaundice or whatever?"

W.S-L. "Doctor, stop acting like a Fourth Form debater! I have been practicing medicine for 12 years and I have some concept of how complex this problem is. If physicians did, or could, trust one another they should pool their resources much more efficiently than now is the case, for the sake of the patient."

There was much more than this. Dense Howl and Jack Dogberry are most seasoned campaigners, veterans of many skirmishes in the medicoeconomic wars. Hoona contented himself with being an amiable host and didn't take part in the cut-and-thrust of argument, unless asked a direct question. He was preoccupied by an aspect of the Cuban situation that had been brought to his attention by one of the ladies in the party. He has been studying Fidel Castro's bearded visage with renewed interest ever since the meeting.

This topic, the referral system, is not without practical importance. Can you imagine what the Commissar (Atlantic Command) of Medical Services would conclude if he called us together and said "Demonstrate to The People's satisfaction that the profession's method of distributing specialist medical services is efficient". Yea, verily, there would be wailing and a gnashing of teeth. Another topic that kept us until dawn's rosy light sent us to bed, was the methods in vogue for attracting and sustaining young physicians, especially young specialists, during that arid period while they are attempting to take root in the community. Perhaps I can deal with that next month, if the D.A. and Woody have not duelled to death in the meantime.

Yours for a Donnybrook,

Brother Timothy.

PERSONAL INTEREST NOTES

Antigonish-Guysborough Medical Society

Dr. J. E. MacDonell spent a week skiing in Stowe, Vermont during February.

Dr. T. W. Gorman attended the meeting of the Royal College of Physicians and Surgeons in Ottawa (January, 1961) followed by a week of skiing in Stowe, Vermont.

Dr. J. J. Carroll, was recently enjoying the sunny weather of Fort Lauderdale, Florida.

Cumberland Medical Society

February 1, 1961—The annual meeting of the Society was held at McQueen Residence, Highland View Hospital, Amherst, with election of officers: Pres., Dr. R. E. Price; 1st Vice-Pres., Dr. D. R. Davies; Sec.-Treas., Dr. R. A. Burden; representative to the Executive of the Medical Society of Nova Scotia, Dr. J. C. Murray.

Dr. George Saunders has returned from 3 weeks in Mexico City where he attended the regional meeting of American College of Surgeons. Previous to this, he and Dr. H. E. Christie attended meetings of the Royal College of Physicians and Surgeons in Ottawa.

Dartmouth Medical Society

February 23, 1961—The first meeting of the Society was held at the Business Men's Club, Newcastle Street. This was a social evening primarily with dinner and refreshments. An organizational meeting was held during the course of the evening to draft rules and regulations. The group's meetings will be social—limited to male physicians, and will be held only 4 times a year. Approximately 30 physicians attended. (Dartmouth is now a city).

Halifax Medical Society

March 8, 1961—The monthly meeting of the Society was held at the Dalhousie Public Health Clinic, to discuss extra billing for Maritime Medical Care patients. A report on the Special Research Committee was presented By Dr. J. O. Godden and discussed by Dr. J. W. Reid. The secretary, Dr. J. A. Myrden was attending a meeting of the American College of Surgeons in Philadelphia, so his position was ably filled by Dr. H. C. Still. Dr. F. Murray Fraser, resigned as Halifax Society representative to Maritime Medical Care and was replaced by Dr. C. H. Young.

It is of interest that, of some 165 eligible doctors who are *not* members of the Medical Society of Nova Scotia, 96 are in Halifax and 26 in the Sydney area. Of the Halifax non-members, some 16 are post-graduate students, 18 are service personnel, 20 are full-time University staff, 23 are salaried doctors.

As a result of a recent survey by the Canadian Council on Hospital Accreditation, it was recommended that all histories, physical examinations, progress notes and discharge summaries of Medical Records in Halifax Hospitals should be signed or countersigned separately by the attending physician.

Western Medical Society

March 9, 1961—The first of a series of post-graduate lectures at the local Hospital in Yarmouth was given by Dr. R. C. Dickson, Halifax, on the subject of liver disease.

Nova Scotia Chapter of the College of General Practice

Dr. F. J. Granville, Stellarton, has replaced Dr. A. W. Titus as President.

Nova Scotia Society of Internal Medicine

The second annual meeting of the Nova Scotia Society of Internal Medicine was held on March 17 and 18 in Kentville, N. S. A large turnout of internists made this meeting a distinct success. The business and scientific meeting were held in the new, well-furnished and comfortable Miller Hall at the Nova Scotia Sanatorium. Social events were held at the Cornwallis Inn. Dr. John M. Tainsh, Halfax, was elected to active membership. Dr. A. F. Miller, former superintendent of the Nova Scotia Sanatorium, became the first Honorary member of the N. S. Society of Internal Medicine.

A number of stimulating scientific papers were presented. Dr. Helen Holden, assistant superintendent at the N. S. Sanatorium, gave a comprehensive and interesting review of the relationship between tuberculosis and diabetes as observed at that institution during the past quarter century. A new clinical sign, useful in detecting spondylolisthesis or spondylolysis, and consisting of a band of pale horizontal striae over the lumbosacral region, was described by Dr. Arthur Shears. This useful clinical sign, dubbed "Shears' silvery striae" by Drs. Godden and Beckwith, has not been described previously in the literature and Dr. Shears is to be congratulated for its discovery. It is a real contribution to clinical medicine and an excellent example of astute observation. Dr. Leon Cudkowicz presented an interesting and provocative account of the bronchial circulation and the effects of disorders of this circulation. Dr. Cudkowicz has done a great deal of original research in this field and has been responsible for establishing that the first description of the bronchial circulation was by Leonardo da Vinci. Dr. Hubert Soltan, assistant professor of Biology at St. Mary's University, gave an interesting review of the present state of knowledge of human cytogenetics. There have been great advances in this field during the past few years and Dr. Soltan presented his subject with amazing clarity. (I wish to thank Dr. H. N. A. MacDonald for this note.—J.H.Q)

Defence Medical Association of Canada

The Annual Dinner Meeting is scheduled for Tuesday, April 25, 1961 at 7:15 p.m. for 8 p.m. at Eastern Command Officers Mess, R.A. Park (at Queen and Sackville Sts.). Dress—black tie with miniatures or uniform. The speaker is to be Col. J. M. Delamere of Army Headquarters, Ottawa. Tickets may be obtained from the Sec.-Treas., Col. J. E. H. Miller or from one of the executive.

University

March 15, 1961—Dr. A. E. Kerr, President of Dalhousie University announced plans for the construction of a new central building to serve the Faculty of Medicine. Cost of this new building construction was roughly

estimated at several millions of dollars. He also gave notice of the establishment of a Faculty of Health Professions, which will include the School of Nursing and the Maritime College of Pharmacy. In the course of time, new divisions will be added one of which, the School of Physiotherapy, has already been approved in principle.

Last year the University obtained the portion of Carleton Street that traverses the present medical campus from the City of Halifax. This addition will give the University much greater freedom in planning this new faculty. The present facilities were taken into use in 1921 to accommodate 50 students and 6 professors, since that time the enrolment has grown to 80 students and 31 full time professors. The Departments also give Medical Science courses to students of Dentistry, Pharmacy and Nursing.

March 16, 1961—Dr. George W. Miller, National Director of Red Cross Blood Transfusion Service spoke on "Blood Transfusion Services Around the World," at the Victoria General Hospital Auditorium.

April 10, 17, 24 and May 1, 1961—Dr. D. L. Roy will give a course in cardiac auscultation at the Victoria General Hospital under the auspices of the post-graduate division of the Faculty of Medicine. This is supported in part by a grant from the National Heart Foundation of Canada.

Births

To Dr. and Mrs. C. R. B. Auld, a daughter, at the Grace Maternity Hospital, Halifax, on March 18, 1961.

To Dr. and Mrs. L. M. Cameron (Anne Watts) a daughter, Susan Elizabeth, at University Hospital, Saskatoon, February 14, 1961.

Coming Events

June 4-10, 1961—Third World Congress of Psychiatry, at Allan Memorial Institute, 1025 Pine Ave., West, Montreal 2, Quebec.

June 12-14, 1961—108th Annual Meeting Medical Society of Nova Scotia at Keltic Lodge, Ingonish, Cape Breton. Host: Pictou County Medical Society.

June 19-23, 1961—94th Annual Meeting, Canadian Medical Association at Montreal, Quebec.

Dr. Arthur Ernest Doull: An Appreciation

I have been asked to write a few words in appreciation of the late Ernest Doull. You will probably say—"that is easy as you will have plenty of material." That may be true, but the trouble is I am not a poet and lacking insight and imagination have difficulty in weaving such together to present a worthy and deserving pattern. What was my own reaction on learning of his death—I wept—as if he were a member of my own family.

I admired Ernest as a colleague and loved him as a friend. I succeeded his father as head of our Department at the Victoria General Hospital and found myself surrounded by an exceptional group of men, Ernest being the senior. On my retirement due to age and impaired health, he was my successor. My sympathy goes to the Staff of the Hospital on losing such an agreeable associate. "In life he maintained a respectable and exemplary

character and in death resembled the upright and perfect man whose end is peace."

May I conclude with a quotation from "The Cotter's Saturday Night" by Robert Burns:

"Princes and lords are but the breath of Kings,
An honest man's the noblest work of God."

Hugh W. Schwartz, M.D.

(An appreciation of Dr. John Cameron was published in the January, 1961 issue of the Bulletin (Page 28), but we are quoting here from a letter to a Dalhousie graduate, which might be of interest to the members of the Medical Association. Ed.)

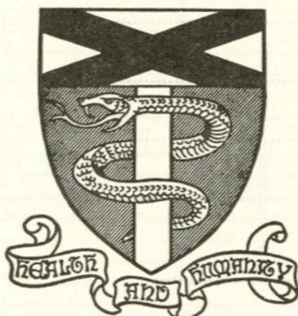
"I much regret to tell you that Dr. Cameron passed peacefully away on November 27, aged 87. He had been failing mentally for some 18 months, but gallantly continued to live alone since Mrs. Cameron died 13 years ago. He was very independent and would not let his friends help him. However, in late September he suffered a cerebral thrombosis and was taken to a nursing home. He regained the use of his limbs, but his mind was completely clouded and he knew nobody. His condition gradually deteriorated and he sank into a coma and passed peacefully away on November 27."

Sympathy

The editors of the Nova Scotia Medical Bulletin extend sympathy to:

Dr. C. E. Kinley on the recent death of his wife.

Dr. Joseph A. MacDonald, Glace Bay and Dr. M. S. MacDonald, Dartmouth on the March 15th death of their brother Dr. John Leonard MacDonald at Colorado Springs, Colorado, U.S.A.



Housing Application Form

108th Annual Meeting
The Medical Society of Nova Scotia
Keltic Lodge, Ingonish, N. S.
Monday, Tuesday, Wednesday, June 12, 13, 14, 1961

Dr. C. J. W. Beckwith,
Medical Society of Nova Scotia,
77 University Avenue,
Halifax, N. S.

Please reserve for me the following:—

A. Main Lodge

( ) Double room with bath—twin beds—including meals $14.50 per person per day.

B. In Cottage

( ) Cottage with sitting room and two twin bedded bedrooms—including meals $14.50 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 ....

Address ....

In view of the 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 ....

Signed.. Date.........................

INFECTIOUS DISEASES—NOVA SCOTIA

Reported Summary for the Month of January, 1961

	NOVA SCOTIA				CANADA	
	1961		1960		1961	1960
Diseases	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	0	0	5	5
Diarrhoea of newborn, epidemic (764)	0	0	0	0	2	6
Diphtheria (055)	1	0	0	0	3	2
Dysentery:						
(a) Amoebic (046)	0	0	0	0	1	1
(b) Bacillary (045)	0	0	0	0	73	395
(c) Unspecified (048)	1	0	0	0	40	23
Encephalitis, infectious (082.0)	0	0	0	0	0	3
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	1	0	0	0	108	0
(c) Unspecified (049.2)	0	0	1	0	1	290
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	204	0	176	0	690	642
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	12	24
Meningococcal infections (057)	0	0	3	0	6	18
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	2	0	19	0	348	690
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0	2	47
Scarlet Fever & Streptococcal Sore Throat (050, 051)	83	0	142	0	1194	3149
Tuberculosis						
(a) Pulmonary (001, 002)	1	0	**	0	0	386
(b) Other and unspecified (003-019)	8	5	**	0	0	106
Typhoid and Paratyphoid Fever (040, 041)	1	0	0	0	15	20
Venereal diseases						
(a) Gonorrhoea — Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	24	0	55	0	1158	1475
(b) Syphilis — Acquired—primary (021.0, 021.1)	0	0	0	0	0	0
— secondary (021.2, 021.3)	0	0	0	0	0	0
— latent (028)	0	0	2	0	0	0
— tertiary — cardiovascular (023)	0	0	0	0	0	0
— ,, — neurosyphilis (024, 026)	0	0	2	0	0	0
— ,, — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	2	0	1	0	169*	195*
(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 infections:						
(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	1	0
Trichinosis (128)	0	0	0	0	1	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 **Not available

C.D.C. 2