

Editorial

The Bulletin is now reaching your desk in a slightly changed form and colour. However, that has not relieved our responsibilities of bringing to you a journal of worthwhile medical articles, historical papers and news items. We are finding the editorial problem of publishing that type of Bulletin increasingly difficult because of the lack of support from members of The Medical Society in general.

We would like to recall to you the Editors report read at the Annual Meeting last fall published on page 345 of the September Bulletin. The resolutions presented at that time were as listed:

1. That the Society lay the task at the door of each of its Branch Societies of producing at least TWO papers a year for the Bulletin.

2. That the Society appoint the Secretaries of all Branch Societies to the Editorial Board of the Bulletin.

3. That the Society enjoin the Officers of all Branch Societies not only to give effect to the first of these recommendations, but to make monthly contributions of notes of interest, and to furnish adequate obituary notices when the need arises.

4. That several Committees of the Society, and in particular those dealing with Public Relations, Economics, and History, contribute articles, notes of interest from other countries in their field of effort, and otherwise continuously demonstrate to the Society their participation in the task entrusted to them.

5. That Dalhousie University Medical School and the various specialist medical groups, such as the Atlantic Division of the Canadian Public Health Association, Nova Scotia Division of the Canadian Arthritis and Rheumatism Society, etc., be asked to make regular contributions to the Bulletin.

It is suggested that many members of the Society could contribute articles on various aspects of practice in their locality, problems of practice, hospital facilities, etc. These would be of immediate value to practitioners in other areas and would also have a permanent value as future sources of reference to present day practice. The Bulletin is extensively used at the time of our anniversaries as a source of historic data.

6. That the Society require of the Editors a specific report of what has been done by each of the above individuals and groups each year.

7. That the Society establish an award, known as the President's Award, to a value of One Hundred Dollars per annum, to be made annually to the Member of our Society exclusive of the members of the Editorial Board who contributes the best article or articles each year to the Bulletin. The Editorial Board would be the Judges and the Award would be given on the basis of time and work involved in production as well as on the excellence of presentation and interest.

We submit that the above is constructive and reaches every member of the Society. Unless there is general and active interest the quality of the publication will deteriorate, advertising will fall off with consequent financial loss to the Society, and the comment, "When I work up something I wish to put it in a worthwhile journal, and not the Bulletin," will be amply justified.

Your Editors feel that this must not happen at all costs. The Bulletin in the past has proven its worth. In future it can be made better than ever. No money is required. A bit of interest, a morsel of honest effort on the part of every member will produce the desired result.

It was moved and passed "That the Society give full approval to the above recommendations, and require that they be implemented to the fullest extent."

We sincerely hope these resolutions, and in particular the first one, will receive the attention they deserve.

POLIOMYELITIS VACCINE

This issue contains an important statement from the Provincial Department of Health on the availability of Salk poliomyelitis vaccine for use in this province. It had been the hope of research workers and public health officials that a report on the extensive trials of Salk vaccine, conducted last year in the U.S.A. and Canada, would have been available before this date. However, no information has yet been released as to the value, or lack of value, of the vaccine in preventing poliomyelitis. The trials did show, however, that the product was safe.

The Department of Health is providing vaccine for 18,000 children in a further trial this spring. Since physicians throughout the province will undoubtedly receive requests for information and advice from parents of the children offered this vaccination, your attention is directed to Doctor Robertson's message.

THE EDITORS.

Sudden Death in Infancy and Childhood*

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IN recent years in this country we have observed a noteworthy and gratifying decline in neo-natal and infant mortality rates. Better pre-natal care, immunization, improved social and economic conditions, and many other factors have contributed to this reduction in mortality statistics for the earlier years of life. Along with this, increasing attention has been given to some of the less common causes of infant death and, in particular, there has been a growing interest in the investigation of the causes of relatively sudden death in the young.

The occurrence of sudden death in infancy and early childhood, while fortunately not common, nevertheless constitutes a problem of some importance. This problem has many facets; first of all it is frequently medico-legal in that the cause of death has to be properly certified and neglect or foul play ruled out; secondly, it is a source of grief to the family and a satisfactory explanation may do much to allay any feelings of guilt which are commonly associated with cases of this nature; thirdly, these cases offer a challenge to all those interested in preventing such tragedies and to those who might wish to explain them with some degree of scientific accuracy.

While laboratory examinations are necessary, the earliest steps in the investigation of a case are most important and those will frequently be the responsibility, not of the pathologist, but of the family physician. With this in mind, and in view of the fact that we have encountered here within the past year several unusual, interesting and unsuspected lesions which resulted in the sudden passing of an infant, it is proposed to present a brief review of the morbid processes encountered in cases of this kind, especially those coming within our own experience. An attempt will be made to outline the various causes and some suggestions will be offered to any who might be interested in performing an autopsy in such cases.

It is quite impossible to cover all of many causes of sudden death but certain broad groups are recognized. In considering those we shall try to point out what one should look for at autopsy and what steps may be taken to insure that the investigation will reasonably cover all of the possible causes of death. It is obvious, of course, that the autopsy should be as complete and thorough as possible and that an orderly examination of the various organs and systems should be carried out. In this connection it should be remembered that gross morphological changes may sometimes be minimal, that the history of the case is extremely important, and that bacteriological examination may be of the utmost value.

Bacteriology. The importance of cultures at autopsies can hardly be overstressed as the results may so often be very valuable and this is particularly true in those obscure cases where the cause of death has been a rapid and ful-

*Presented at the 28th Dalhousie Refresher Course, Halifax, October 25, 1954.

minating infection. If, for example, cultures of the larynx, main bronchi, and lungs should yield a pure growth of staphylococci in a case where structural changes are minimal, one can reasonably assume that death has been due to an overwhelming staphylococcal infection. It is also well to recall that organisms which are non-pathogenic or only feebly so in the adult may be highly pathogenic in the young child. *B. coli*, which rarely produces meningitis or septicaemia in the older child or adult, is the commonest cause of meningitis in the new-born. One should also remember that an organism may produce lesions which are quite different from those with which it is commonly associated in the adult. Dysentery organisms may produce a severe meningitis with no evidence of enteritis. So, if a culture taken at autopsy yields a pure growth of bacteria ordinarily regarded as non-pathogenic, one should consider the possibility, that, in this particular case, those organisms may have been highly pathogenic and this, taken in conjunction with the history and known findings at autopsy, may provide quite a satisfactory explanation for the cause of death. Carefully taken cultures which are entirely negative are still of value in that this usually, though not always, rules out a fulminating bacterial infection. If facilities for plating a culture are not immediately available at the time of the autopsy, swabs may be sent to the laboratory for plating and portions of the lungs, spleen or other organs may be sent in a sterile container for bacteriological examination.

Respiratory Infection. Only a few years ago one of the commonest causes of sudden death in the young was given as overlying. This diagnosis was given where, in crowded slum conditions in many of our large cities, children sleeping with their parents were found dead in the morning. Sometimes these cases led to prosecutions, especially in those instances where it was proven that the parents had been drinking. It was assumed that either the body of the adult or clothes pressed by the adult had suffocated the child; indeed at the autopsy some of the changes associated with suffocation, such as cyanosis and petechial haemorrhages in the pericardium and pleura, were present. However, more careful attention at autopsies has disclosed that most of these cases can be proven to be due to fulminating respiratory infection. This is proven in several ways: first of all by bacteriology. In many cases it has been shown that cultures from the larynx, trachea, bronchi and lungs, heart blood, and spleen have yielded staphylococcus pyogenes. This could not be assumed to be an agonal or post-mortem invader, and one can only conclude that, by bacterial competition, this organism had successfully excluded all agonal invaders. Secondly, it was proven by epidemiology; cases have been associated with epidemics of infection in nurseries where the mothers have had a high incidence of puerperal mastitis in which the organism was the staphylococcus and in which, not only was the staphylococcus found in the respiratory tree in fatal cases, but was often found in skin blebs in children who did not die. Sometimes this has assumed such great proportions that hospital maternity wards have had to be closed, and in some cases where appropriate tests were carried out it was proven that the staphylococci in the breast lesions and in the lung lesions of fatal cases were of the same strain.

Now it must be admitted that, while bacteriology is often valuable even a

considerable time after death, in some cases it is inconclusive. The organisms cultured may not be accepted pathogens, but, as previously mentioned, organisms which are non-pathogenic or only feebly so in the adult, can produce respiratory infection in children. Aside from bacteriological and epidemiological investigations, these cases have been proven to be due to infectious noxa in that sections taken from many parts of the respiratory tree have consistently shown degeneration and focal necrosis. In a few cases inclusion bodies have been found in the lungs and the conclusion in such cases must be that death was due, not to overwhelming bacterial infection, but to viral infection. The classical lesions of lobar pneumonia and bronchopneumonia are not found. However, if a child survives for three or four days he almost always develops an abscess of the lung or empyema, and once again the organism can be shown frequently to be the staphylococcus.

We have stressed the staphylococcus in that many current textbooks do not emphasize it, but some cases are due to streptococci and other organisms.

The rarity of accidental mechanical suffocation, or as it was so commonly designated, overlying, was quite clearly shown in one survey of 318 cases in England where asphyxia was considered as a possible cause. There, out of the 318, careful post mortem examination revealed that only 24 could have died as a result of accidental mechanical suffocation. Most are agreed that all infants, except the abnormally weak will resist suffocation with great vigor. Therefore, by a careful examination of the respiratory tree and by suitable cultures, which we have to emphasize, you can quite frequently prove that an otherwise mystifying and apparently unexplained death, associated with signs of asphyxia, is in fact due to a fulminating respiratory infection.

Vomitus. Closely allied to infectious noxa is the question of aspirated food or vomitus with obstruction of the main respiratory pathways. As in the case of accidental smothering this is an uncommon cause and is likely to be found only in the very weak and debilitated. However, the presence of regurgitated food or vomitus on the infant's clothing, as well as the presence at autopsy of foreign material in the trachea and main bronchi, may justify this diagnosis. One should not be misled, however, by the presence of a small amount of vomitus on the bed or on the child as the act of vomiting may merely have been a terminal one in the lethal process of an entirely different condition.

Another well recognized entity which can produce asphyxia is the excessive aspiration of amniotic fluid during parturition with the development of so-called congenital pneumonia. The histological picture in such cases is usually quite characteristic.

It is emphasized then that acute respiratory disease, even where there are minimal signs of asphyxia, is the major factor in the causation of sudden death in infancy and early childhood.

You should also know that another interesting and peculiar condition found in infancy in Canada and on the western plains of this continent is methemoglobinemia. The first two fatal cases in Canada were reported from Saskatchewan, and both were medico legal autopsies where backtracking proved that the well water had a high nitrate content. The wells were being contaminated by cattle manure which reached a high concentration during a dry period.

So this type of death may be encountered in the summer and in those areas, especially flat country, where there is a surface run off of water. In this condition the blood is brown in color due to the methaemoglobin.

Cardiac Death. Death is less commonly due to myocardial conditions. There is the occasional case of a child with a nasal discharge who is not recognized to have diphtheria, who dies with acute left heart failure and who has an acutely dilated left ventricle in which the characteristic signs of an interstitial myocarditis are found. There are rarer forms of myocarditis which we have not encountered. Recently we have seen two congenital cardiac lesions which led to sudden death. These were apparently not productive during life of physical signs suggesting any intrinsic structural defect but were only brought to light by a careful autopsy following the relatively sudden death of an infant. In both cases the history was that of a brief respiratory infection which did not produce signs of extreme toxicity but which resulted in a rapid termination with clinical evidence of cardiac insufficiency. At autopsy in each instance there was gross cardiac enlargement, involving particularly the left ventricle. Examination of the lungs revealed little apart from passive congestion. On opening the left ventricle in the first case the mural endocardium was found to be thickened and of an opaque greyish white color. Histological examination confirmed that this was due to a great excess of fibro elastic tissue. The condition is known as congenital fibro elastosis of the endocardium and the etiology is unknown. Although the affected child usually appears well at birth and may progress well for a time, the disease is usually manifested early in life and symptoms may appear suddenly. Death is commonly brought on by a brief respiratory infection complicated by sudden cardiac failure. In the second case the left ventricle, while enlarged, also appeared extremely fibrosed for the age of the patient. The heart and great vessels were removed whole and on further examination it was found that the left coronary artery arose from the pulmonary artery while the right coronary artery arose normally from the aorta. Here then the left ventricle was being supplied, not only with blood having a low oxygen content, but by blood under a considerably lower pressure than if the artery had arisen normally from the aorta. This had led to myocardial fibrosis and the stress of a mild respiratory infection had proven too much for the unhealthy myocardium. While not common, lesions such as these are mentioned because of their interest and in order that such conditions might be kept in mind in the case of any infant who develops sudden cardiac decompensation without obviously sufficient cause and in the absence of any evidence of other congenital cardiac abnormalities.

Some Autopsy Details. It appears obvious then from what has been said that in the performance of an autopsy one should pay particular attention to the thoracic organs. While special approaches may be determined by different cases, in general the busy practitioner should: (1) Carefully inspect the heart, great vessels and lungs. In removing these one should dissect up along the trachea into the neck and remove the structures from the base of the tongue downwards in one block. In this way one may look for aspirated foreign material and laryngeal edema; (2) Take cultures from the trachea and main bronchi; (3) Send portions of tissue from all levels of the respiratory tree

fixed in formalin for histological examination; (4) Include a whole lobe of lung fixed in formalin; (5) Send also a whole lobe of lung unfixed in a sterile, or even an unsterilized but clean, container; (6) Include the spleen with (5) in cases of suspected septicemia and, despite all the hazards of contamination, one can frequently prove that death has been associated with a pathogen. If adequate facilities are available one can also take samples of the heart blood for culture as a further step. These are frequently positive for pathogens in cases of fulminating respiratory infection and thus serve to illustrate that many of these cases are associated with septicemia.

Meningeal Infection. While a fulminating infection is most commonly pulmonary, it may be localized in other sites, chiefly the gastro intestinal tract and the meninges. A meningitis or meningo-encephalitis may be of very short duration and yet be so severe as to produce rapid prostration and death. In cases of this nature carefully conducted autopsies may often fail to demonstrate gross lesions but cultures of the meninges are positive in a high percentage and histological examination reveals slight but definite evidence of damage, usually in the form of focal necrosis and focal acute inflammatory reactions. It would appear that in such cases the course of the illness must be very brief and that extreme toxicity is the outstanding feature, so much so that only minimal morphological changes have time to develop before death supervenes. In some cases a blood tinged cerebro spinal fluid may be found and the C. S. F. should of course be cultured. In those cases where ordinary cultures are negative one should again keep in mind the possibility of a viral infection. Polio may strike with great rapidity and relatively sudden death may result. If polio is suspected the spinal cord should be removed at autopsy as the cord will almost always show lesions in such cases.

Vascular Accidents. Intracranial haemorrhage is commonly due to birth injury but may also be the result of vitamin K deficiency, or may be a manifestation of purpura, or it may be secondary to anoxia from various causes. When one encounters an asphyxial death associated with haemorrhage and perhaps other evidence of injury, it is often not possible to say for sure whether the haemorrhage and asphyxia came first and led to a liability to injury or whether the injury came first and led to the haemorrhage and asphyxia. While the rupture of a congenital aneurysm is one of the commoner causes of sudden death in young adults, it is practically never encountered in infants and young children. In contrast also with adults, thrombosis and embolism of cerebral arteries in children are practically unknown. However, thrombosis of the intracranial dural sinuses may result in a rapid termination and is almost always secondary to adjacent infection. In the case of a sudden infant death, where the patient was believed to have middle ear or mastoid disease, one should be alerted to the possibility of finding thrombus in a nearby dural sinus. Conversely, if a thrombus is found in a dural sinus, the area which it drains should be carefully inspected for evidence of infection. It is of interest that a thrombosed sinus is about the only source of the rarely encountered pulmonary embolism in children. While middle ear disease may lead to thrombosis of a dural sinus, it may be sufficient of itself to produce few clinical signs and at the same

time produce an overwhelming septicemia. Inspection and cultures of the middle ear are therefore necessary in obscure cases.

Alimentary Infections. While we have written with some confidence in regard to the identification of fulminating respiratory infection, the question of overwhelming alimentary infection is much more difficult. If classical dysentery organisms are found in a case of diarrhoea, the diagnosis is obvious. Often, however, the organisms are more ordinary—staphylococci, *B. proteus*, etc. and the cause can only surely be identified by having the contaminated source examined, as pre-formed bacterial toxins are often the actual lethal agents. While this is often brought to light in institutional epidemics it is more likely to be missed in sporadic cases, especially where a young child may be wandering around and sampling things which an older child or adult would not touch. Even in epidemics the problem may be a very difficult one and there have been great outbreaks of fulminating gastro-enteritis in nurseries where detailed investigations by scientific teams have not yielded a clue as to the etiology. One should do a careful autopsy and take cultures but clues are more likely to come from careful detective work and, in large outbreaks, from epidemiology. One should keep in mind "antibiotic cholera" in a case where a child has been receiving antibiotic therapy. Alterations in the flora of the gastro-intestinal tract may lead to severe diarrhoea from organisms which ordinarily are not present in sufficient numbers to produce pathological changes.

Poisons. We shall not discuss poisons in any detail but wish to emphasize that a general examination of the various organs for poisons is much less satisfactory than an accurate investigation on the spot. The post-mortem examination will serve at most to illustrate the major effects of the noxious agent.

Adrenal Insufficiency. In cases of sudden death one of the organs commonly incriminated is the adrenal gland and acute adrenal insufficiency is, of course, a well recognized cause. There is some variation, however, in the exact mechanism by which the acute insufficiency is brought about. In the newborn the adrenals are friable, vascular organs and adrenal haemorrhage, with sudden death, may be the direct result of birth trauma. It may occur as a manifestation of hypoprothrombinemia secondary to vitamin K deficiency, or it may occur in the course of an acute infection. In the older child acute adrenal insufficiency is almost always associated with fulminating sepsis and the causative organism is usually the meningococcus. Some cases are unusual in that the acute insufficiency may occur in the absence of clinically manifest septicemia. However, in such cases, bacteriological and histological examination of other tissues will almost always reveal that an overwhelming infection was the causative agent.

Anaphylaxis. Increasing attention has been given in recent years to the question of acute anaphylaxis as a cause of sudden death. Undoubtedly it does occur but the manifestations are often not specific enough to be absolutely sure. For this reason it is often difficult to say with any certainty how frequent an occurrence it really is. Anaphylaxis may be manifested in the form of urticaria, as a purpura, as an acute and very severe pulmonary oedema and

sometimes as a marked laryngeal oedema. It has been known for a long time that children with eczema are prone to sudden death, and many feel that in some way or other this is related to allergy. In those cases of sudden death where there have been no gross abnormalities at autopsy, the pathologist may be able to suggest anaphylaxis as a diagnosis from characteristic changes in the lymphoid elements in the spleen or other tissues. In other cases it may be diagnosed from the accumulation of a peculiar sludge in many tiny blood vessels in widespread areas. This amorphous material is believed to be composed of fused platelets although this is not certain. Recently we encountered a case of sudden death in an infant which was associated with purpura fulminans and in which an exfoliative dermatitis was also present. One can reasonably assume that death here was due to acute allergy. Another infant in the same family died previously in a similar manner. In another recent case a child died from staphylococcal portal pyemia and this was also associated with allergy, as manifested by generalized urticaria during life and by a gross excess of eosinophiles observed in the liver and spleen when these organs were examined histologically.

Periostitis. Although detailed examination of the extremities is not usually a part of the routine autopsy, a child may develop pyemia from a periostitis and a history of recent trauma or a history of a peculiar posture before death may give the clue to the correct diagnosis. In these cases microscopic abscesses may be found in the lungs and also in the myocardium. Mention of the latter site reminds us that coronary embolism is not nearly so rare as was commonly believed until quite recently.

Thymic Death. We discuss briefly, in order to dismiss, the concept of status thymicolymphaticus. This was long considered to be a constitutional abnormality in which there was hyperplasia of the thymus and other lymphoid tissues, sometimes said to be accompanied also by hypoplasia of adrenals and aorta and lack of gonadal development. As is well known, it was fashionable for many years to regard this as a cause of sudden death in the young. However, there is practically unanimous agreement at present that such a condition probably does not exist at all and that the term should be discarded. It would appear that in the past this concept has served merely to inhibit a more exhaustive search for the cause of death. The thymus is a large organ in normal infants and is usually prominent at autopsy in the very young. Lymphoid tissue, especially in children, is a very labile and responsive tissue and if evidence of hyperplasia is found one should look for a cause other than some inborn defect in the lymphoreticular system. Cases have been cited where a large thymus is alleged to have compressed the trachea but such must be extremely rare and many have questioned whether it actually ever occurs at all. In short, it is highly unjustifiable to blame the thymus or lymphoreticular system for the sudden death of a child.

SUMMARY

In investigating sudden death in infancy and childhood the importance of a careful and thorough autopsy is stressed and mention has been made of the paucity of gross abnormalities in many cases. The value of bacteriological

examinations is underlined and attention is directed to possible variations in the pathogenicity of various organisms in the younger age groups.

Certain congenital defects may result in sudden death and these may only become apparent at autopsy. Vascular disturbances and infections of the central nervous system are important and examination of the brain and, in obscure cases, the cord, should not be omitted. Acute adrenal insufficiency, usually the result of haemorrhage, can cause very sudden prostration and usually occurs as a complication of septicemia. Accidental mechanical suffocation is practically never a cause of sudden death in infancy. The concept of a thymic death can safely be discarded. Acute anaphylaxis, acute laryngeal edema, aspiration of foreign material, pulmonary embolism, and pyemia with abscess formation are uncommon but well recognized causes. Fulminating alimentary infection is still an obscure cause, and difficult of assessment. In this, and in poisoning, epidemiological work by the practitioner may be much more important than any other investigation.

The vast majority of cases of sudden, apparently unexplained death in early infancy are due to overwhelming respiratory infection and this is well supported by bacteriological, epidemiological and histological studies.

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Carcinoma Of The Colon*

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CARCINOMA on the colon and rectum comprise seven percent of all carcinoma and ninety-five percent of the gastro-intestinal tract. It is more common after the first decade of life, but almost no age group is immune.

This paper is confined to a discussion of carcinoma of the colon proximal to the sigmoid.

The following table shows the distribution of the lesion in 510 cases of carcinoma of the colon at Roosevelt Hospital, New York, 1940 to 1950, and in 90 cases at the Tumor Clinic of the Victoria General Hospital, March 31, 1953 to March 31, 1954.

Percent of Cases by Bowel Segment

	Roosevelt Hospital	Victoria General
Caecum	10.8	9
Ascending Colon	5.7	7
Hepatic Flexure	2.4	2
Transverse Colon	5.5	8
Splenic	2.1	4
Descending	4.3	9
Sigmoid	28.0	20
Recro-Sigmoid	10.9	18
Rectum and Anus	30.0	23

From a surgical viewpoint the types of cancer of the colon are:

1. Ulcerating and -or polypoid
2. Constricting

Carcinoma, not infrequently, appears to have its origin in pre-existing polypi, approximately twenty-five percent of patients with malignancies have benign polypi in the resected specimens.

The symptomatology is governed by (a) the site of the lesion and (b) the type of growth. Therefore a constricting lesion of the sigmoid will produce symptoms much earlier than if the same type of lesion involved the caecum. However, if the ilio-caecal valve is encroached upon by a lesion within the caecum, obstructive signs and symptoms appear earlier.

Generally we must distinguish between the symptomatology of right and left colon lesions. In the former there is often the presence of a mass associated with blood loss from an ulcerating tumor, with insidiously developing ill health. In the latter, more particularly the sigmoid because of its narrowing, obstructive signs are more common.

Since either of these groups of symptoms mean fairly advanced disease, it behooves us all to try to recognize cancer in an early or curable stage. Any abdominal pain or distress demands early investigation and should not be dismissed or palliated to see what happens, or advice given to come back if they are not better. I believe that these patients should have their investigation at the first visit if any suspicion of a large bowel neoplasm exists. I vividly recall an early caecal carcinoma which was spotted by an astute medical con-

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frere who ordered a barium enema because of a few indefinite abdominal twinges. Barium enema, stool examination, and sigmoidoscopic examination, along with careful history and physical examination, constitute the essential ways to arrive at a diagnosis of carcinoma of the colon.

A barium meal is a menace when an obstructing lesion is present in the colon. It frequently has been the factor which has precipitated an acute intestinal obstruction. A barium enema should be administered first if a colonic lesion is suspected to avoid this serious complication.

The modes of spread are as follows:

1. Direct extension
2. Peritoneal spread
3. Lymphatic spread either intramural or extramural
4. Venous spread

The treatment of carcinoma of the colon logically falls into two groups (1) the treatment of the growth (2) the treatment of complications, particularly obstruction. Varying degrees of obstruction are frequently encountered when the disease is first diagnosed and the degree thereof will govern the management.

I would like first to discuss the management of these cases with milder degrees of obstruction, rather sub-acute in type. These are not emergencies and time spent pre-operatively to empty the proximal bowel is of great importance. The administration of a low residue diet, a saline cathartic and perhaps colonic irrigations for several days before laparotomy increases the safety of operation. The ideal operation is that in which the continuity of the bowel is re-established after resection. It is unsafe to do a primary anastomosis in the presence of a poorly decompressed, distended, proximal bowel. You, therefore may be forced to do a Miculicz operation with a colostomy. When the bowel is adequately emptied this extra operation may be avoided. Along with bowel decompression an intestinal antiseptic, e.g. neomycin, aureomycin, sulphamucid, or sulphadiazine, etc., is of great importance, and the correction of anaemia, hypo-proteinaemia and vitamin deficiencies is indeed paramount.

A careful exploration of the abdomen is done except, of course, in the presence of acute obstruction when it is usually impossible and hazardous because of the risk of rupture of distended bowel. The exploration will reveal any evidence of spread from the primary growth to the lymph nodes, liver, etc. and give much information as to the type of operation to be performed and an estimate of prognosis. Also careful exploration will reveal the presence of double bowel carcinomas which exist in a small percentage of cases.

I here would like to emphasize the place of the palliative resection in those cases where cure is not possible, but where the removal of primary lesion, when technically feasible, will result in marked improvement which is sometimes surprisingly sustained. This method is vastly superior to a colostomy proximal to the growth; of course we are forced so frequently to accept the latter, or a side tracking operation, as the only possible help we can give.

In the absence of distant metastases to liver, etc. there is an opportunity to eradicate the malignant disease and this can only be done by radical removal

of the growth and the lymph node area immediately draining. (Figures 1 to 6). Chronic (or sub-acute) obstruction may then be managed by diet and catharsis before surgery is performed.

Acute obstruction occurs in over five percent of large bowel carcinomas and must be treated before the obstructing lesion is removed. We must recognize two entities in this regard—the open loop and the closed loop; in the former the ilio-caecal valve is not competent, that is, it does not exert any valve like action and there is distention of the small and large bowel of moderate degree and vomiting results. This type can be handled by suction from above by Levine, Miller-Abbot or Harris tubes. Colostomy may prove necessary when suction methods are not satisfactory. The second type of acute obstruction is the closed loop where the ilio-caecal valve is closed with the result that the distention is confined to the large bowel. (Figure 7). This distention cannot be relieved by suction, but a vent must be made in the form of a colostomy or caecostomy. If this is not done, bowel rupture will follow, most likely the caecum, with increased morbidity and mortality. Some weeks later then, one may deal with the obstructing carcinoma. Colostomy is the more satisfactory and adequately decompresses the proximal colon. There are times when the distention is so large that a simple caecostomy is the safer procedure, but because it less completely decompresses, a colostomy may be necessary before definitive operation is undertaken.

The present day management of carcinoma of the colon has evolved over the past several years from the time when resection with primary anastomosis could infrequently be done with safety, through the period where it was replaced by the Miculicz procedure because of its equal efficacy and greater safety, to the present day management made possible by adequate decompression, antibiotics, fluid balance maintenance, nutritional factors, and modern anaesthesia.

The prognosis varies of course with the stage and extent of the growth. Those which have involved the serous coat are considered to have a fifteen percent lower rate of cure than those which are confined to the muco-muscular layers.

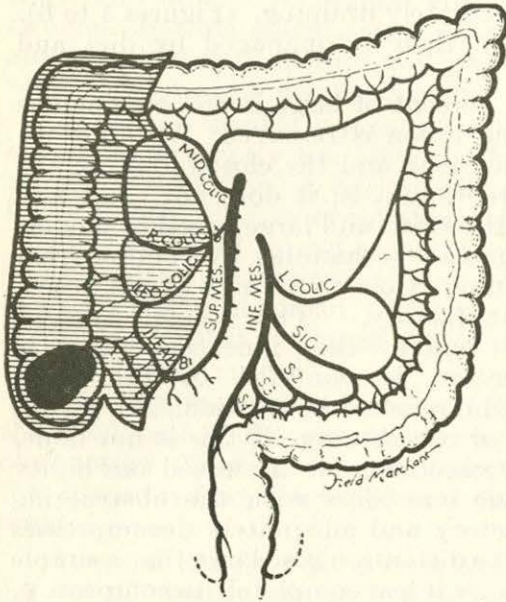
	Percent of Cures	
	5 year	10 year
Cases without lymph node involvement	65	57
Cases with lymph nose involvement	21	15.7

SUMMARY

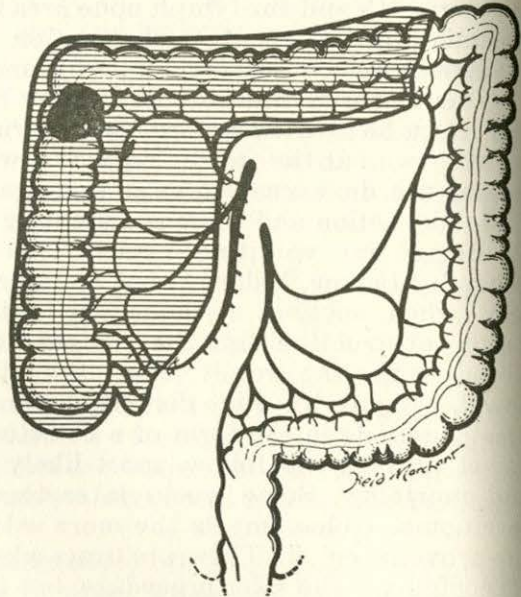
1. Early diagnosis is stressed.
2. Acute intestinal obstruction must be dealt with primarily.
3. Radical surgery offers the best hope of cure. Resection with primary anastomosis can usually be accomplished when the obstruction is sub-acute or less.
4. Palliative resection should be performed when feasible.

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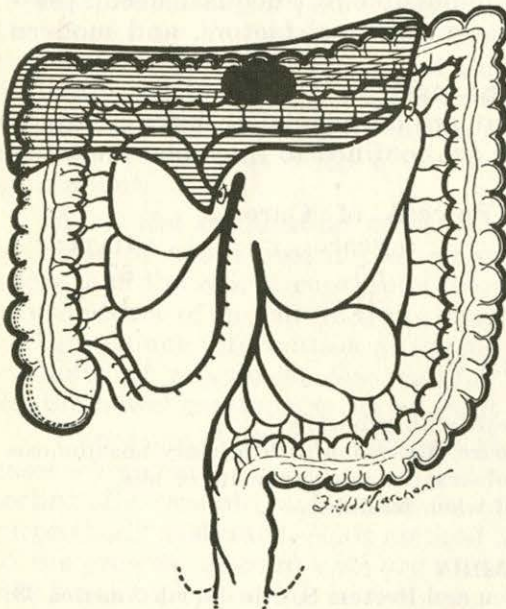
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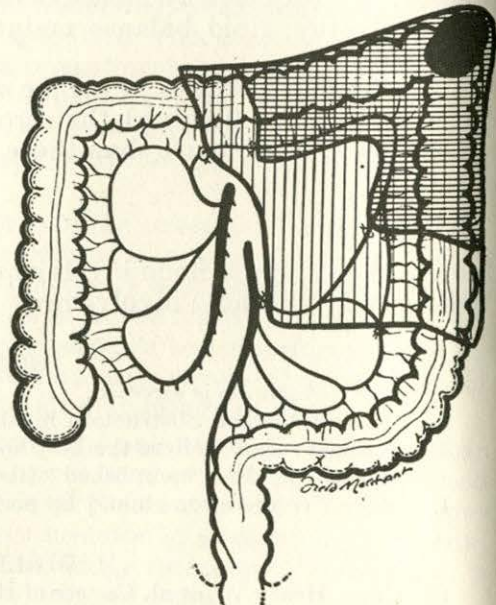
CAECUM Figure 1



HEPATIC FLEXURE Figure 2

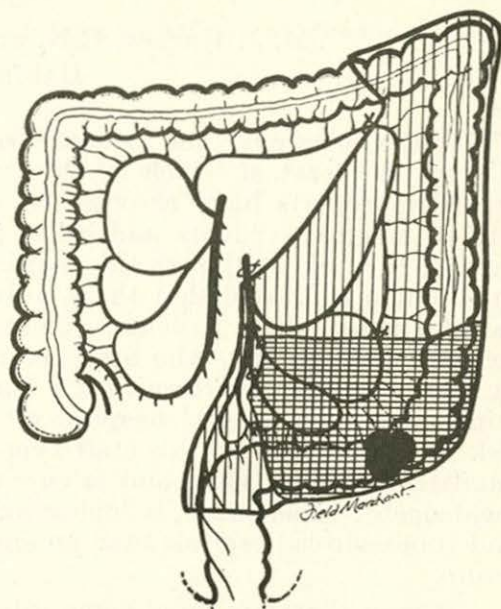
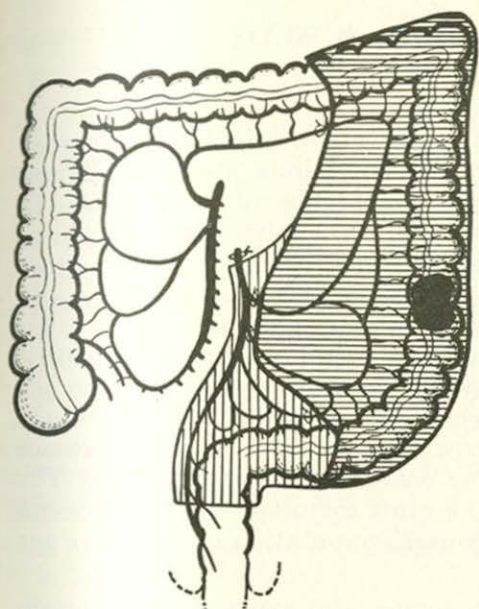


TRANSVERSE COLON Figure 3



SPLenic FLEXURE Figure 4

Figure 1 to 4 Showing extent of bowel and mesentery resection.



DESCENDING COLON Figure 5

SIGMOID COLON Figure 6

Showing extent of bowel and mesentery resection.



X-RAY PHOTOGRAPH Showing closed loop obstruction with marked large bowel distention.

The Prevention of Tuberculosis in Nurses

M. J. Harlow, R.N. and C. B. Stewart, M.D.,
Halifax, N. S.

THOSE who care for the sick are subject to certain occupational hazards not the least of which is the exposure to infectious diseases. Many published reports have emphasized the higher incidence of tuberculosis in nurses, medical students and other professional or technical personnel who care for the sick. Although this fact is well established, one occasionally hears the opinion expressed that there is little or no risk of infection to those who care for tuberculosis patients. Sometimes this statement is made by a sanatorium administrator, who may perhaps allow his judgment to be influenced by the difficulties of recruiting a nursing staff. On the other hand, the administrator of a general hospital may suggest that there is no tuberculosis risk to the members of his staff because known cases of tuberculosis are not admitted. Neither viewpoint is supported by available statistical data. The incidence of tuberculosis is higher among the staff members both of general and tuberculosis hospitals than among the general population of the same age group.

It may therefore be of some interest to review the experience in certain Halifax hospitals, both as an illustration of the extent of the problem and certain methods of dealing with it. Since 1947 a BCG vaccination program has been in operation for the four schools of nursing in Halifax city and for the medical students of Dalhousie University. At the start of this program the health records of the four hospitals and of the student health service of Dalhousie University were reviewed for the preceding ten years, 1937-47. These health records had been well kept and included reports on periodic chest x-rays or fluoroscopic examinations, as well as annual physical examinations and illness records. In only a few instances the illness reports were not absolutely clear as to whether a student had suffered from pulmonary tuberculosis. A small number of students had discontinued training before a definite diagnosis had been made. Nevertheless, most of the diagnoses were clearly established and the following data are therefore reasonably accurate.

Table 1 shows the incidence of proven tuberculosis from 1937 to 1947 among the nursing students, medical students and, for comparison, female students of the faculty of arts and science of Dalhousie University.

983 nurses had entered the four schools of nursing during the ten year period and had received a total of 1826.1 person-years of training by September, 1947, when BCG was first given. This is an average of only about two years per person, It is less than the full training period of 3 years not only because of withdrawals or failures, but because of the fact that the large classes of 1946 had completed only one year of training when the BCG program began.

There were 47 proven cases of tuberculosis during this period. Six were reactivations, in whom the disease was known to exist on entry into training, but 41 were new cases. The rate was 25.7 cases of tuberculosis per 1000 person-years of follow-up, including both reactivations and new infections; or a rate of 22.5 *new* cases of tuberculosis per 1000. Expressed in percentages this

TABLE I

Incidence of Tuberculosis in Students of Nursing (1), Medicine (2) and Arts and Science (2), 1937 to 1947

Student Group	No. Admitted to Training	Proven Tuberculosis			Person-Years in Training	Average Tb. Attack Rate per 1,000 per Annum
		Reactivation	New	Total		
Nurses, Hospital A	482	6	27	33	935.7	35.3
" " B	333	0	11	11	674.9	16.3
" " C	111	0	2	2	173.1	11.5
" " D	57	0	1	1	42.4	23.5
Total, Student Nurses	983	6	41	47	1,826.1	25.7
Arts and Science (Female)	442	1	0	1	647.5	1.5
Medical Students	491	2	8	10	1,496.2	6.7

(1) In four Halifax Schools of Nursing.

(2) In Dalhousie University.

means that 2.6 per cent of each class developed clinical tuberculosis each year, or almost 8 per cent in the three-year training period.

At the same time 442 female students in the faculty of Arts and Science of Dalhousie University experienced only one case of tuberculosis. This was a reactivation. The total rate of tuberculosis in this group was 1.5 per 1000 person-years. The incidence of tuberculosis was therefore 16 times as great in nurses as it was in female university students from the same areas of Nova Scotia and of the same age range.

Several points might be emphasized. None of these nursing students prior to 1947 had any training in a tuberculosis hospital. This defect in training was probably not good from an educational standpoint, but it incidentally provides clear-cut proof that there is a great risk of tuberculosis in the *general hospital*. All four hospitals also excluded all *known* cases of pulmonary tuberculosis or other infectious forms of the disease. Only orthopedic cases were accepted in the one pediatric hospital. The total burden of risk therefore arose from the hidden or undiagnosed cases of tuberculosis.

Secondly, none of the hospital or nursing school administrators was aware of any unusual tuberculosis problem. The BCG vaccination program was proposed and instituted because of "outside" influence. It is suggested that a careful review of staff health records of many hospitals, and the calculation of tuberculosis rates, would often be equally revealing. Another Nova Scotia hospital with "no tuberculosis problem" was recently investigated and found to have had an average annual tuberculosis rate over the last ten years of 17 per 1000.

Two programs are suggested for the control of this problem:

- (1) Tuberculosis case-finding in all patients admitted to general hospitals.
- (2) Protection of nursing personnel and others who have close contact with patients.

Many general hospitals now require an admission photo-fluorographic plate or "miniature x-ray" on all patients. Most of the larger hospitals in Nova Scotia have received special equipment from the Department of Public Health and have begun this program within the past two years. In some instances, facilities are also made available for the patients of practising physicians of the area on an out-patient basis. The admission x-ray program has proven to be an extremely fruitful case-finding mechanism. Far more cases of tuberculosis are uncovered by this means than by mass radiography of the "normal" population.

One point, however, requires emphasis. In order to protect the staff of the hospital, these must be *admission* x-rays and not *discharge* x-rays. There are a number of problems involved in obtaining chest x-rays of all patients on admission. It is extremely easy for all concerned to postpone this apparently unnecessary procedure until the seriously ill patient is more comfortable, or even to leave it until the day of discharge. Of course, if it is finally done some time before the patient leaves, it will result in the discovery of all cases of tuberculosis. Its value as a case-finding procedure is not lessened. However, the discovery will be too late to protect the nursing staff and others who have been exposed to infection while the patient was in hospital. Delay also increases the difficulty of investigating the case thoroughly. A complete investigation of a suspicious pulmonary lesion can more readily be made while the patient is in hospital than after discharge.

For these two reasons, the full support of all doctors and nurses should be directed toward the improvement and successful operation of such an admission X-ray program. Nurses are in a key position to make this program a success. In some instances a nurse may be directly responsible for getting the patient x-rayed. In other instances the nursing supervisor must check the records, and if for any reason the admission film has been neglected or delayed, it is her responsibility to have it done as soon as conditions permit.

Protection of the student nurse is largely dependent upon two features; (1) adequate training in the control and treatment of communicable diseases, including tuberculosis (2) protection by specific immunization with BCG vaccine.

It should not be necessary to emphasize the importance of training nurses in communicable disease techniques. Modern nursing schools are supposed to make provision for such training, but there are still some gaps to be filled. The day of the separate communicable disease hospital is almost at an end. General hospitals should be prepared to care for all types of illnesses, including infectious diseases. Trained personnel are required. Every nurse learns in the operating room the fundamental techniques for preventing the spread of infection. It requires merely the adaptation of these techniques to the care of the medical case. Many hospital authorities still refuse to admit infectious cases, with the statement that the staff is not qualified to deal with them. The nursing profession should not permit its reputation to be besmirched by such an accusation of ignorance. There are few practical aspects of nursing in which the average student gets better training than in the prevention of the spread of infection in an operating room. Why has the idea been allowed to grow that communicable disease technique is a separate branch of knowledge?

The use of BCG to protect persons exposed to specially high risk is strongly recommended. There are very few modern immunization procedures that are easier to carry out and that produce less reaction. For many years the value of BCG vaccination was argued, without any clear-cut evidence to settle the question. However, during the past ten years, there have been several very well controlled studies which have demonstrated conclusively that BCG vaccine will produce approximately 80 per cent reduction in the incidence of tuberculosis. Anyone who has in the past received teaching to the contrary should read the reports of the well-controlled studies of Aonson (1, 2) and Ferguson (3). There is, of course, no complete immunity or protection against this disease. However, a reduction from 5 to 1 is sufficient to warrant a recommendation that the vaccine be employed for those who are unavoidably subjected to a high risk of infection.

Table 2 shows the tuberculosis experience in the Halifax nursing schools and Dalhousie Medical School from 1947 to 1952 inclusive, as compared with the pre-vaccination period.

TABLE 2.
Incidence of Tuberculosis in Nurses and Medical Students before and after the Introduction of BCG Vaccination

	Nurses		Medicals	
	Before BCG	After BCG	Before BCG	After BCG
Persons	983	1183	491	382
Person Years	1826.1	1883.3	1496.2	820.1
Reactivations	6	2	2	2
New Cases	41	7	8	1
Total Tb.	47	9	10	3
Tb. Rates per 1000 person years				
New Cases	22.5	3.7	5.3	1.2
All Cases	25.7	4.7	6.7	3.6

This table shows that 1183 nurses were in training during this six year period, a larger number than in the preceding 10 years. Nine cases of tuberculosis were discovered, two reactivations and 7 new cases. This is a rate of 3.7 new cases of tuberculosis per 1000 person years as compared with 22.5 in the period 1937 to 1947.

The question may be raised as to whether all of this reduction was accomplished by the BCG vaccination program. No such claim is made. There had been a reduction in tuberculosis morbidity and mortality in the province

of Nova Scotia during this period, and it is probable that some reduction occurred in the number of "hidden cases" of tuberculosis admitted to general hospitals. In addition, the routine chest x-ray program for all admissions was started in some of the hospitals in 1951 and in others in 1952, thus reducing the risk of infection from undiagnosed cases. On the other hand practically all of the student nurses after 1947 had affiliate training in a Tuberculosis Hospital and none did so prior to 1947. Some factors therefore would have increased the risk of contact while others probable resulted in a decreased risk. It is a moot point which was greater. In any event the value of BCG has been proven in other well controlled studies, as noted above, and this is not an attempt to justify its value statistically. Suffice it to say that the reduction of tuberculosis morbidity occurred suddenly after BCG was begun, and no such reduction occurred at that time in other Nova Scotia hospitals.

One final point should be emphasized. We are in serious danger today of *epidemics* of tuberculosis. This is a completely new problem, and one that is very little appreciated either by the nursing or medical professions. The reason is that the present generation of students is the first to have lived their whole lives in an environment almost free of tuberculous infection. Surveys of tuberculin status in the 1920's showed that 80 to 90 per cent of adults had a positive tuberculin reaction, indicating a previous infection. Incidentally, these figures are still quoted in some textbooks, although long out-dated. By the 1930's this proportion had fallen considerably. The Dalhousie medical classes of 1935 and 1936 had 64 per cent positive to tuberculin. In 1947 the proportion was 25 per cent, and today it is only 13 per cent. An undiagnosed case of tuberculosis in a general hospital 25 years ago was not a very great hazard, since 80 to 90 per cent of the nurses and doctors had a naturally acquired immunity from an earlier infection. Today the reverse is true with 80 to 90 per cent susceptible. One outbreak of tuberculosis in a Nova Scotia hospital in recent years involved 8 nursing students. This should serve as ample warning that BCG vaccination is necessary, and it was by no means the only such episode of its type in recent years.

The methods of BCG vaccination will not be discussed here. It is the purpose of the authors simply to emphasize to the medical and nursing professions the importance of the admission x-ray program, the training of nurses in the care of patients with communicable diseases, including tuberculosis, and the value of a BCG vaccination program for nurses and other hospital personnel who care for the sick. The co-operation of both the medical and nursing professions is required in the initiation and effective operation of all three of these programs.

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The Grim Visitation

Bertha Ogilvie Archibald
Halifax, N. S.

FEW people know that smallpox broke out in Halifax, Nova Scotia, at least three times in the past fifty years.

Just seventeen years ago, in 1938, a Hindu from a freighter, which was being fumigated, fainted on the dock and was rushed to Camp Hill Hospital. Although Doctor Hugh Collins had not seen a case of smallpox before he diagnosed the case as such. The patient was immediately taken to Lawlor's Island by the Immigration nurse, Miss Mary Lindsay. The patient died two days later.

Lawlor's Island, about a mile long and a half mile wide is near MacNab's Island in the mouth of Halifax Harbour. For many years it was the quarantine station for the Immigration Department of the Federal Government. There were several old buildings on the island, sheds with double bunks. Those sheds were heated by coal stoves. One shed was painted red and known as the smallpox hospital. The others were the caretaker's cottage and the doctor's cottage. The patient was taken to the doctor's cottage as it was not occupied.

Nine days following contact with this patient, Reginald Smith, one of the orderlies who had helped to undress the Hindu, became very ill. Doctor Murray MacAuley soon reported that Smith had smallpox. Mr. Smith was at home and two nurses from Camp Hill Hospital were sent to take care of him. He was also transferred to Lawlor's Island. Doctor Hugh Collins, Mrs. M. C. MacDonnell and Mr. Walter Wilson, the latter two members of the Camp Hill Hospital nursing staff were instructed to take the case over, and open up the Immigration Hospital which had been closed for some time.

When they arrived they discovered that the hospital was about one-quarter of a mile from the wharf. It was a very cold day in March, and raining. The only means of transporting the patient was by means of a stretcher. When they opened up the hospital they found that the pipes were frozen, so there was no water. There were no supplies or equipment of any kind as the hospital was being dismantled. The Federal Government was planning to open a quarantine station at Rockhead at the entrance to Bedford Basin. Retracing their steps they again moved into the doctor's cottage. Water was pumped to them by the boat and this was done daily during their long quarantine.

When the quarantine boat returned to her berth at King's Wharf an orderly was there with another patient. He was the other man who helped undress the Hindu. With the new arrivals the occupants of the cottage were now seven persons. The cottage had three bedrooms, a living room, a kitchen and a bath room. Being an overseas nurse of World War I, Mrs. MacDonnell soon rose to the occasion. She persuaded Mrs. Martin, the wife of the caretaker, to do the cooking. Mr. Walter Wilson was an excellent nurse and they all played their role well with courage, devotion and ability.

There was no telephone service and the only contact with the outside world was the little boat that came every day with supplies and mail.

Every day Doctor E. Kirk Maclellan, Doctor M. A. MacAuley and Doctor P. S. Campbell would make the trip on the boat from Halifax to see how the patients were progressing.

Mr. Smith and Mr. Liggin were very, very ill and for days Mr. Smith was at death's door. When the disease attacked the respiratory area Mr. Smith's cough was incessant, due to the pocks in the trachea. The pocks got under the finger nails and toe nails. Their teeth became loose and they lost their hair. The sores on their bodies were dressed three times a day with melted carbolated vaseline.

Both patients, although dreadfully marked, recovered from the disease.

The quarantine continued through the Easter season. Many were the presents and thoughtful remembrances from their friends at Camp Hill Hospital, which included a turkey for their Easter dinner.

They went down to the island the 18th of March and did not return until the 10th of May. It was a long two months vigil.

The chief immigrant officer from Ottawa visited the patients. Later Mrs. MacDonell and Mr. Wilson received letters from Ottawa in appreciation of their faithful service. These two nurses were graduates of the Victoria General Training School.

Mr. Smith is still working at the Immigration Department and Mr. Liggin is on superannuation from Camp Hill Hospital.

What might have been a dreadful epidemic was averted due no doubt to vaccination. The public demand for vaccination was so great that all the vaccine in the city was used. The complete stock at the Connaught Laboratories in Toronto was also exhausted. Finally the city of Montreal came to the rescue and shipped vaccine to Halifax. People were lined up in the streets in front of the doctors' offices and the Dalhousie Public Health Clinic was equally busy.

1917-1920

In the winter of 1917, the year of the great explosion, (December 6th) smallpox also visited the city. During the year 1918-1919 there were two thousand five hundred cases in Halifax. It was not until 1920 that the epidemic was really controlled. This was achieved through vaccination clinics. The clinic at City Hall alone vaccinated over five thousand people.

All the doctors' offices were crowded with frightened people. General vaccination was the order from the city fathers.

The disease was brought to the City by a workman from Quebec. There were deaths from the disease but not as many as feared as it was rather a mild type of smallpox.

1907

In the year 1907 the old Victoria General Hospital was quarantined for smallpox. All the non-resident staff members who happened to be on duty were quarantined with the resident staff. In those days the hospital had a Church room where services were held each Sunday. In this room the quarantine staff decided to hold service. Mr. Percy Webber, the bookkeeper, called on the old pharmacist, Doctor Charles Puttner to open with prayer. Instead of standing he knelt down beside his chair and prayed with the humility of a child for mercy and protection, for them all, from the dreadful disease. His voice trembled, the tears came and the old gentleman broke down. It was a service long to be remembered. A few days later the danger had passed.

POLIOMYELITIS VACCINE

J. S. Robertson, M.D., D.P.H.,
Deputy Minister of Public Health

FOR many years, it has been recognized that the most probable method of control of Poliomyelitis would be through the use of a preventive vaccine. Several obstacles had to be overcome before such a vaccine could be prepared in the large quantities required—only within the last two or three years has it been possible to grow virus in large quantities. The other obstacle was the belief that only a living attenuated virus could produce the level of immunity required. Apparently, this obstacle is removed since it is now believed that the so called Salk Vaccine will produce a high level of immunity and that this immunity remains at a high level for at least two years—and the Salk Vaccine contains only killed virus.

This vaccine was that used last year in the U.S.A. and Canada in the trial carried out which involved hundreds of thousands of children. In that trial, half the children were given the vaccine, the other half were given a non-virus containing injection. In addition, blood specimens for immunity level estimations were taken from 2% of the children. Because of the huge numbers involved, the report of that trial is not yet available. However, one definite conclusion has been given, namely that the material appears to be innocuous. No harmful or untoward reactions resulted, so it would appear that, if the injections do no good, they at least have not done any harm.

The Salk vaccine is being made in the U.S.A. by six commercial companies and in Canada at the Connaught Research Laboratories, Toronto. Huge expenditures of money had to be made to get the plants into operation and special personnel had to be trained. Since the experts were quite hopeful that the trial would be successful, it appeared reasonable to continue the operation of these plants in the hope that a favourable report would be received before the start of the new polio season. If the plants were closed until the report was received, it might take about a year before a new batch of vaccine could be prepared. So a calculated risk was taken by the Polio Foundation in the U.S.A., and the Federal and Provincial Governments in Canada and orders for vaccine were placed.

And so we come to the present position in Nova Scotia, namely, that we expect to have available by April 1st enough polio vaccine to treat 18,000 children.

There are, of course, two schools of thought on the procedure to be followed—one, that we should withhold usage of the present supply until the report on the previous trial is submitted approving the value of the vaccine. We have no indication as to when this report will be released; however, it is doubtful if it will be before April 1st.

The second school of thought suggests that since the vaccine is harmless and is available that it should be given on a further trial basis in the hope that it will prevent cases of poliomyelitis. The original experiments on animals and humans seemed to indicate this. A further point is that if the vaccine is to effect this year's crop of cases, it should be given before the start of the "polio season"—it takes about eight weeks after the first injection for the level of immunity to reach a satisfactory level—so that the series of three injections

should start early in April if "protection" is to be achieved before the warm weather.

The series consists of two injections of 1 c.c. each one week apart and a third injection one month later—the important rise in antibodies is only after the third injection and a high titre apparently remains for at least two years according to reported observations.

The Department of Public Health have decided after discussions with the Polio Advisory Committee and other interested bodies to offer polio vaccine to 18,000 children throughout the Province in the 5-6 year age group. This is the group which appears to have the greatest prevalence. The material available will cover about 60% of the children in this age group so that a selection will have to be made for the trial. The responsibility for this selection has been given to the Divisional Medical Health Officers. To them will also go the responsibility for arranging the clinics, providing of nurses, voluntary assistants, equipment and so on.

Since this vaccine is to be provided free of charge, it is hoped that we will have the co-operation of all physicians in carrying out this further trial. Even the prevention of a few cases of polio will justify the expenditures of money, time and effort. It is again to be emphasized that from all information available the material is harmless—the Halifax City experience of last year supports this.

The above was prepared in a rush to meet an overdue deadline. More information will be made available in direct releases to physicians and from our Divisional offices.

NOTICE RE GENERAL PRACTICE

In June of this year a general practice will be open in Mulgrave, which includes a home and office and equipment. General medicine with considerable compensation work. Further information may be obtained by writing to Doctor G. M. Fraser, Mulgrave, N. S.

Dalhousie Notes *NSMS 1955: 34: 65-67*

This issue contains an announcement of a post-graduate course in Anaesthesia. It is hoped that there will be a good registration.

Doctor H. B. Atlee, Professor of Obstetrics and Gynaecology, has recently returned from a lecture tour in Ontario and Saskatchewan. He was guest speaker at the Refresher Course in Obstetrics and Paediatrics of the University of Saskatchewan, January 20th to 22nd. While in that city he also met with medical and public health groups interested in Child and Maternal Health. On his way to the West he stopped off in Hamilton, Ontario, on January 18th, where he spoke on "Natural Childbirth" before the Academy of Medicine. The following day in London, Ontario, he performed a demonstration operation of vaginal hysterectomy and addressed the medical students of the University of Western Ontario. The same evening he spoke to the Western Ontario Obstetrical Society on "Surgery of Carcinoma of the Cervix."

Knowing Doctor Atlee's abilities as a witty and stimulating speaker, readers need hardly be informed that his tour was an outstanding success.

Doctors Norman and Margaret Gosse have returned from a very interesting trip to Lima, Peru. They attended the meeting of the Inter-American College of Surgeons, travelling by the "Mauretania" from New York. A number of the scientific and clinical sessions were held en route, and the remainder of the programme was presented at Lima by the leading lights of the American College of Surgeons. Visits were also made to Kingston, Jamaica, and Havana, Cuba, where meetings were held with the local medical associations. The new Medical School of the West Indies at Kingston, which graduated its first class last year, was a point of interest, but the highlight of the tour was a visit to Cuzco, the Holy City of the Incas in the mountains of Peru.

It is hoped that the Bulletin will receive a more detailed account of this trip for publication in a later issue.

Doctor Joseph Edward Stapleton, of Sydney, Australia, arrived in Halifax in January to accept appointment as chief of radiation therapy at the Victoria General Hospital, and Associate Professor of Radiology in Dalhousie University. Just prior to his new appointment Doctor Stapleton practised in Regina, Saskatchewan, where he was a senior member on the staff of the Allan Blair Cancer Clinic. A graduate and post-graduate of the Sydney (Australia) University, he was in private specialist practice there, later becoming a staff member of the Holt Radium and Cancer Institute in Manchester, England, in

1948. Two years later, after further post-graduate qualification, Doctor Stapleton was appointed to the staff of the Royal Cancer Hospital in London, England. In 1952, he established the isotope department of the M.D. Anderson Hospital at the University of Texas. Later, as a Bertner Fellow, he visited and studied in major cancer centres in the United States.

His talents also extend to music in which he holds two degrees.

One of the articles in this issue deals with the prevention of tuberculosis in nurses. What is said about nurses applies with equal importance to doctors, and to all others who care for the sick.

During the past two years a number of hospitals in Cape Breton have undertaken a B.C.G. vaccination programme under a plan proposed by the Department of Preventive Medicine of Dalhousie University. This month a memorandum is going to the Superintendents of all other hospitals in Nova Scotia offering free B.C.G. for the vaccination of nurses and other hospital staff, provided that tuberculin tests are done according to a standardized technique and records kept for research purposes. The hospitals can thus assist in a University research project and at the same time obtain assistance in financing an anti-tuberculosis programme to protect their own staff.

The support of this project is requested by the writer, who is of course not unbiased on the matter, since it is his own pet research.

C. B. S.

SHORT COURSE IN ANAESTHESIA

March 28th - 31st, 1955

The Post-Graduate Committee of the Faculty of Medicine of Dalhousie University, in co-operation with the Department of Anaesthesia brings to the general practitioners an opportunity to gain practical knowledge in the administration of Anaesthetics, with lectures and round table discussions on new drugs and procedures, etc.

Each morning of the course will be spent in the Operating Rooms of the Victoria General Hospital. Candidates who wish to administer anaesthetics under supervision may do so and are asked to give advance notification of their request.

Monday, March 28th, 1955.

4th Fl. Clinic Room V. G. H.

- | | |
|------------|--|
| 2.30- 3.15 | Spinal Anaesthesia—its Indications, Contraindications and Complications.
—Surg. Cmdr. H. Little, R.C.N. |
| 3.15- 3.45 | Anaesthesia in Children—Tonsillectomies, Appendectomies, Emergencies—
Dr. A. S. Wenning. |
| 3.45- 4.15 | Curare and Curare-like preparations in Anaesthesia—Dr. C. H. L. Baker. |
| 4.30- 5.00 | Evaluation of the Newer Drugs in Anaesthesia—Dr. C. M. Kincaide. |

Tuesday, March 29th, 1955

4th Fl. Clinic Rm. V.G.H.

- 2.30- 3.15 Pentothal Sodium and Surital Sodium as Intravenous Anaesthetic Agents.—Dr. A. S. MacIntosh.
3.15- 3.45 Endotracheal Anaesthesia—Dr. R. W. M. Ballem.
3.45- 4.30 Anaesthetic Emergencies—Dr. R. A. P. Fleming.

Wednesday, March 30th, 1955.

4th Fl. Clinic Rm.V.G.H.

- 2.30- 3.15 Nerve Blocks—Diagnostic and Therapeutic Somatic Nerve Blocks—Dr. C. C. Stoddard.
3.15- 3.45 Anaesthesia for the Poor Risk Patient—Dr. R. A. P. Fleming.
3.45- 5.30 Round Table—Obstetrical Anaesthesia.
Moderator: Dr. C. M. Kincaide.
Dr. H. B. Atlee, Dr. W. R. C. Tupper, Dr. C. H. L. Baker,
Dr. R. W. M. Ballem, Dr. D. V. Graham.

Thursday, March 31st, 1955.

4th Fl. Cl. Rm.V.G.H.

- 2.30- 3.15 Factors Involved in the Transport of Oxygen and Carbon Dioxide in Anaesthesia and the Mechanics of the Gas Machine.—Dr. A. S. MacIntosh.
3.15- 3.45 Anaesthesia for Chest Surgery—Endotracheal Tube, Acidosis, etc.—Dr. C. G. MacKinnon.
3.45- 4.15 Pre-Medication in Children—Dr. R. Bond Nichols.
4.15- 5.00 Interesting Clinical Cases—Dr. C. C. Stoddard.

Registration Fee for the course is \$20.00 payable on your arrival in Halifax. Your early application would be appreciated. Kindly address it to the Executive Officer, Post-Graduate Committee, Victoria General Hospital, Halifax, N. S.

NOVA SCOTIA CHAPTER, COLLEGE OF GENERAL PRACTICE

DOCTOR F. Murray Fraser, Chairman of the Nova Scotia Chapter of the College of General Practice, announces that the members of the College in Pictou County have been granted authority to form a sub-chapter.

The Pictou County sub-chapter has elected Doctor H. B. Whitman, Westville, as its President, Doctor Ian E. Mackay, Stellarton, as Secretary and numbers among its members Doctors Howard A. Locke, C. G. Harries, Henry J. Townsend, Lewis M. Sproull and C. E. Stuart of New Glasgow, Doctor J. B. MacDonald of Stellarton and Doctor C. B. Smith of Pictou. Several others have announced their intention of joining this group, which is to be heartily congratulated on its initiative.

A meeting of the Halifax and Dartmouth area members of the College of General Practice of Canada was held at the home of Doctor F. Murray Fraser, January 30, 1955.

The questions of vital importance to general practitioners and their patients were discussed at Great length. (1) The possibility of admitting emergency (medical and surgical) cases to the Victoria General Hospital on a semi-public basis until such time as semi or private beds are available was discussed from the point of view of patient, doctor, hospital and teaching material, and it was decided to forward a letter to the Halifax Branch of The Medical Society of Nova Scotia for their discussion and recommendation to the proper authorities. (2) Doctor H. C. Still outlined the present operation of the out-patient department in medicine and surgery at the Victoria General Hospital and suggested the way that this department could be operated by the general practitioners of the area in a very efficient manner.

The advantages of this scheme are many, both from a teaching point of view of general practitioners to students, and the relief of the overburdened specialist of one of his many extra duties.

It was decided that this question should be presented to the Faculty of Medicine and the staff of the Victoria General Hospital for discussion.

In the meantime a survey of general practitioners in the area is being made to discover those doctors who would be willing to give up their time to make this venture a success.

A meeting is contemplated of the College of General Practice of Nova Scotia in the future and suggestions as to the time and place of such a meeting would be welcomed as soon as possible by the Chairman, Doctor F. Murray Fraser.

It has been approved by the Board of Representatives of the College to have weekly broadcasts over C.B.C. on medical subjects of interest to the public. Any members wishing to participate in the lecture series are asked to contact Doctor F. Murray Fraser.

All general practitioners in Nova Scotia are asked to rally behind the newly formed College and give their support by applying for membership. If application forms are not available in your area the Secretary will be pleased to forward same on request.

C. HENRY REARDON, Secretary

The Canadian Medical Association

Statement of Policies and Principles of Health Insurance in Canada

THIS is the Third Draft of the Statement of Policies and Principles of Health Insurance in Canada, revised in accordance with the decision of the Committee on Medical Economics of The Canadian Medical Association in November, 1954.

The Medical Economics Committee of The Medical Society of Nova Scotia would like the members of the Society to study it. Any comments or recommendations in regard to this Statement of Policy would be appreciated. They should be forwarded to Doctor H. J. Devereux, Chairman of the Medical Economics Committee, Sydney, Nova Scotia.

On the question of health insurance, The Canadian Medical Association.

1. Reaffirm its long established policy of giving consideration to and co-operating in proposals, official or unofficial, that are in the public interest and genuinely aimed at the improvement of the health of the people.
2. Will gladly participate in the formulation of programmes designed to make quality medical services more readily available and which respect the essential principles of medical practice.
3. Approves of the adoption of the principle of contributory health insurance and favours a plan or plans which will assure the development and provision of the highest standards of health services, preventive and curative, provided the plan be fair both to the insured and all those rendering the services.
4. Having seen demonstrated the successful application of the insurance principle in the establishment of the voluntary prepaid medical care plans recommends the extension of these plans to cover all Canadians, the government assuming responsibility for those unable to pay the premiums in whole or in part.
5. Recommends for those areas where it is evident that the voluntary medical care plans cannot achieve adequate coverage that provincial health authorities and officials of these plans collaborate in the administrative task of extending health insurance to all citizens and that the existing voluntary prepayment plans, their administrative personnel, and their administrative experience be used to the fullest possible extent in the accomplishment of this objective.

To maintain consistent progress in health care.

6. Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease. Among the factors essential to the achievement of good health are adequate nutrition, good housing and environmental conditions generally; facilities for education, exercise and leisure; and not least, wise and sensible conduct of the

individual and his acceptance of personal responsibility for maintenance of health.

7. The community's responsibility for health services includes not only maintenance of a high level of environmental conditions and the provision of an efficient preventive service but assurance that adequate medical facilities and services are available to every member of the community whether or not he can afford the full cost.
8. The confidential nature of the patient-doctor relationship must remain inviolate; this implies free choice of doctor by patient and free acceptance of patient by doctor.
9. The granting of a license to practise the healing art should be restricted to those qualified by education and training in the basic sciences and adequately prepared in the clinical and technical subjects in conformity with provincial licensing requirements.
10. Standards of medical services should be maintained at the highest possible level through:
 - (a) adequate facilities for clinical teaching in the medical colleges and hospitals
 - (b) post-graduate training for all medical practitioners at frequent intervals.
 - (c) expanded programmes of medical research.

To assure economy and efficiency in the provision of services.

11. Hospitals, health departments, and all other health agencies should co-ordinate their activities so as to provide their services more effectively and economically.
12. Hospitals should be located, and their facilities and size determined on a planned, regionalized basis to assure the availability of hospitals where they are needed, the provision of technical assistance to smaller hospitals by the larger, and the ready transfer of patients as required.
13. An adequate system of institutional facilities and services requires the balanced development of diagnostic facilities, active treatment general hospitals, rehabilitation centres, chronic care facilities (including mental and tuberculosis hospitals), and home care programmes.
14. Lay and professional organizations and government health agencies should participate in community, provincial and federal health planning activities.

In the application of the insurance method to payment for medical services.

15. The opportunity of insuring through a prepayment medical care plan should be available to every Canadian, including dependents.
16. Benefits of a health insurance plan should include preventive, diagnostic, treatment and rehabilitation services, and the services of specialists and consultants should be available. Benefits should be so organized that no undue incentives are placed on the demand for any type of service.

17. The methods of remuneration of medical practitioners and the rates thereof should be as agreed upon by the representative bodies of the profession and the insuring agency.
18. The provision of services under any plan of health insurance should be undertaken only by physicians qualified and licensed as indicated in No. 9 above.

In the event of government participation in the universal extension of health insurance to all citizens.

19. Health insurance should be administered by an independent, non-political commission representative of those providing and those receiving the services.
20. Appointments of medical personnel to the Commission and its staff should be made only after prior consultation with organized medicine in the respective province.
21. Each province should be adequately served by a well-organized Department of Public Health providing preventive services wherever possible through the practising physician.
22. In addition to the medical service, a balanced health programme should include the following services, all but the dental service being available through the medical practitioners:
 - (a) hospital care
 - (b) nursing services, including visiting nurses
 - (c) auxiliary services, usually in hospital
 - (d) pharmaceutical services, subject to regulation
 - (e) dental services.
23. Additional services should be introduced as benefits by stages, careful planning being given to the order in which each is introduced.
24. The medical services benefits and cash sickness benefits should be administered from separate funds.
25. It is the responsibility of government to provide the insurance premium in whole or in part for those persons adjudged unable to provide the premiums for themselves.

Society Meetings

CAPE BRETON MEDICAL SOCIETY

The January meeting of the Cape Breton Medical Society was held in the new St. Elizabeth Hospital, North Sydney January 12th, 1955.

Dr. C. M. Harlow presented a very interesting and instructive paper on "Fluid and Electrolyte Balance" and discussed a difficult subject in a simple and interesting manner.

This meeting gave the members of this area an opportunity of seeing the various departments of the recently constructed modern hospital.

The president of the Society, Dr. Arthur Ormiston was chairman for the evening.

H. R. CORBETT, M.D.,
Editorial Board Member,
N. S. Medical Bulletin

LUNENBURG-QUEENS MEDICAL SOCIETY

The Quarterly meeting of the Lunenburg-Queens Medical Society took place in Bridgewater, N. S., at the Fairview Hotel on February 14, 1955, and this being the annual meeting election of officers was held.

The following officers were elected.

President—Doctor W. W. Bennett, Bridgewater.

Vice-President—Doctor B. W. Skinner, Mahone Bay.

2nd Vice-President—Doctor Rayfield G. A. Wood, Lunenburg.

Secretary-Treasurer—Doctor R. M. Rowter, Bridgewater.

Members of the Executive—Doctor D. A. Campbell, New Ross and Doctor M. G. Feener, Bridgewater.

Representative on the Executive of the Medical Society of Nova Scotia—Doctor W. W. Bennett.

The President of Maritime Medical Care Incorporated, along with Mr. Macneill, the Manager was present and considerable discussion was carried out regarding policy and other factors of the Maritime Medical Care.

A motion picture on the use of cyclaine as a local anaesthetic was shown.

R. M. ROWTER, M.D.,
Secretary

REGIONAL MEETING OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

A regional meeting of the Southern Region of the American College of Gastroenterology will be held in Memphis, Tenn., on Sunday afternoon, 24 April, 1955. The Scientific Session will be held in The Skyway, at the Hotel Peabody, commencing at 2.00 P.M., and following the semi-annual meeting of the Board of Trustees of the College.

Participating in the program of the Scientific Session will be E. G. Campbell, M.D., F.A.C.G., Memphis, Tenn.; Jerome S. Levy, M.D., F.A.C.G., Little Rock, Ark., Edward A. Marshall, M.D., F.A.C.G., Cleveland, Ohio; John M. McMahon, M.D., F.A.C.G., Bessemer, Ala.; James T. Nix, M.D., F.A.C.G., New Orleans, La.; E. L. Posey, Jr., M.D., F.A.C.G., Jackson, Miss.; N. E. Rossett, M.D., F.A.C.G., Memphis, Tenn.; Henry G. Rudner, Sr., M.D., F.A.C.G., Memphis, Tenn.; L. C. Sanders, M.D., F.A.C.G., Memphis, Tenn.; S. L. Stephenson, Jr., M.D., Jackson, Miss.; I. Frank Tullis, M.D., Memphis, Tenn.

Lynn A. Ferguson, M.D., F.A.C.G., Grand Rapids, Mich., President of the American College of Gastroenterology will preside. The program for the regional meeting is under the chairmanship of John E. Cox, M.D., F.A.C.G., Memphis, Tenn., and E. G. Campbell, M.D., F.A.C.G., Memphis, Tenn., Governor of the College for Tennessee.

The Southern region consists of the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained from the Secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Physicians' Art Salon

June 20th - Toronto

INVITES EXHIBITORS

The Physicians' Art Salon Committee invites any Canadian physician or medical undergraduate to enter his work in the 1955 Salon to be held in Toronto's Royal York Hotel from June 20-24. This will mark the 11th year for this popular art and photographic feature of the annual C.M.A. Convention. It is sponsored by Frank W. Horner Limited, Montreal.

Conditions of Entry.

The Salon structure will undergo few changes. As in previous years, entries will be accepted in three sections.

1. Fine Art
2. Monochrome Photography
3. Colour Photography

The Fine Art section is further subdivided into Traditional, Contemporary, and Portrait categories. There is no restriction on medium,—oil, tempera, gouache, water colour, charcoal, pencil, or dry brush is acceptable in each.

However, each exhibitor is limited to three entries in Fine Art and Colour Transparencies, but in Monochrome Photography four prints are permitted. And any exhibitor may enter up to the limit in one or more sections.

There is no charge,—all costs, including transportation of entries to and from Toronto, will be borne by Horner.

Judging and Awards.

All acceptable entries will be displayed prominently in the Salon and then judged for awards by a competent jury to be selected by the Art Salon Committee.

To obtain entry form.

Any physician or medical undergraduate interested in submitting work may obtain an entry form with details by writing the sponsor at P.O. Box 959, Montreal. A short note or post card will do. The entry form contains complete instructions on how to prepare and ship your entries.

Art Salon Calendar.

A novel feature of the Salon, the Physicians' Art Salon Calendar, will again be prepared by Frank W. Horner Limited. The Calendar reproduces award-winning work in full colour and is distributed to all physicians in Canada with the compliments of the Company.

Personal Interest Notes

Doctor Patrick Guthro, a native of Cape Breton, is now associated with Doctors Abie and David Gaum. Doctor Guthro has had five years post-graduate training in surgery, including four years at the Winnipeg Clinic and Winnipeg General Hospital.

Doctor Josef Kereczsturi, radiologist, has returned to the Cape Breton area following a year of post-graduate training in radiology at the Herbert Reddy Memorial Hospital, Montreal. He is now on the staffs of St. Elizabeth Hospital, North Sydney and St. Joseph's Hospital, Glace Bay.

Doctor C. Gyorfi is on one year's leave of absence from the Glace Bay General, St. Joseph's and St. Rita Hospitals, taking a post-graduate course in pathology at St. Mary's and Children's Memorial Hospitals, Montreal.

Doctor Malcolm J. Chisholm, New Waterford, is now doing post-graduate work in Boston, Mass.

Doctor Bernard J. Steele, formerly associated with the New Waterford Clinic, has moved to Inverness town.

Doctor W. M. Roy of Halifax attended the Canadian Association of Radiologists in Ottawa in January.

Congratulations to Doctor S. W. Williamson of Yarmouth who recently celebrated his 86th birthday. He has been in practice for a period of fifty-nine years. In January he joined the many on Lake Mile to enjoy a period of skating.

Doctor Helen M. Hunter of Halifax returned from Montreal early in December where she successfully completed her examinations for certification in the specialty of paediatrics.

Doctor Miles Gregory Tompkins, Jr., of Glace Bay, has been given an extension of a McEachern fellowship granted a year ago by the Canadian Cancer Society. Doctor Tompkins has been studying with Doctor John L. McKelvey of the University of Minnesota.

Doctor Stanislaw Donigiewicz, of Poland has been appointed principal anaesthetist at St. Martha's Hospital in Antigonish. His plans for university training were altered by the Second World War and he left Poland after its occupation in 1939. He joined the Polish forces in the Middle East in 1940 and took part in the Libyan campaign and the defence of Tobruk. He transferred to the Polish Navy in 1942 and served on the destroyers under British command. Following discharge he studied medicine at the University of Leeds Medical School, and graduated in 1950. He served in a number of hospitals in England and became interested in anaesthesia while interning at Yorkshire. In 1952 he went to the United States to specialize in this branch of medicine. He subsequently served as resident in anaesthesia at St. Vincent's Hospital, Worcester, Mass., and as chief resident at Boston City Hospital.

Doctor N. J. MacLean who has been practising in Inverness, is taking a two-year post-graduate course in surgery at St. Vincent's Hospital, Worcester, Mass.

Doctor and Mrs. R. O. Jones, of Halifax spent a holiday trip in Boston in January.

Doctors R. S. Grant and B. S. Morton of Halifax have opened a branch office in Dartmouth in the specialty of diseases of infants and children.

Doctor Martin S. MacDonald, who had been practising in Sydney, has opened an office in Dartmouth for the general practice of medicine.

It was announced early in February by the Federal government that a grant had been made to Doctor Hugh N. A. MacDonald of Halifax towards the cost of a two-year course in Neurology at the Mayo Clinic.

Doctor and Mrs. C. M. Jones of Halifax were on a ten day visit to Boston early in January.

Doctor L. M. Morton of Yarmouth returned early in February from a visit to California.

Doctor and Mrs. H. W. Schwartz of Halifax are at present spending a vacation in Jamaica.

Hon. Geoffrey Stevens of Dartmouth was sworn into office as provincial Minister of Health and Welfare by the Lieutenant Governor of Nova Scotia, Hon. Alistair Fraser, on February 3rd.

Doctor C. M. Harlow of Halifax enjoyed a flying trip to British Columbia and California in December. On January 17th he addressed a meeting of the Junior League of Halifax on "The Knowledge of Cancer."

The Bulletin extends congratulations to Doctor and Mrs. J. Allan Myrden (Linda Gemmell) on the birth of a daughter, Lindsay Jane, on January 29th, at the Royal Victoria Hospital, Montreal.

It was reported from Ottawa recently that three Nova Scotians, Doctor M. G. Tompkins of Glace Bay, Hon. Harold Connolly, former Premier of Nova Scotia, and Doctor Donald Smith of Liverpool, were likely to be appointed to the Senate.

Doctor E. H. Evans of Rockingham recently addressed the members of Halifax Kiwanis Club on "Poliomyelitis in a Prairie Village."

Obituary

DOCTOR E. F. J. DUNLOP

The medical profession was profoundly shocked to learn of the sudden passing of Dr. Eric Fergus John Dunlop of Bridgewater on Sunday evening, February 6th, 1955. He had apparently been in good health and death was due to a heart attack.

Born in 1906 at Wembley, England, he was the son of Mrs. Peter Fergus Dunlop and the late Mr. Dunlop of Aberdeen. He attended Grammar School in Aberdeen and graduated in 1929 from the Medical School of Edinburgh University. From 1929 to 1933 he studied at the University of Wales, obtaining from that University, a diploma in tubercular diseases. Following this he interned at various hospitals throughout England, until 1938 when he joined the Colonial Medical Services and was stationed in the Falkland Islands.

In 1945 he took study leave and studied at Moorfield's Eye Hospital in London, receiving, in 1946, his D.O.M.S. from the R.C.S. of England. He then went to British Guiana as ophthalmic surgeon in the Georgetown hospital, resigning from there in 1947 to come to Canada where he entered private practice in Bridgewater specializing in eye, ear, nose and throat.

Dr. Dunlop was an active member of the Grace United Church and was immediate past president of the Nova Scotia Association of Ophthalmologists and was a member of the Association of Ophthalmologists of the United Kingdom as well as a member of the British Medical Association.

A keen sportsman, Dr. Dunlop belonged to the Halifax Gun Club and to the Bridgewater Kiwanis Club.

Surviving are his wife, the former Elizabeth (Nancy) Carlisle of Port Rush, Northern Ireland, his two sons Peter and Derek aged fifteen and thirteen respectively and his mother who resides in England. Funeral services, conducted by Dr. Gerald Rogers, were held in the Grace United Church on Tuesday, Feb. 8th. at 3.30 P.M. Attending the services were members of the Lunenburg-Queens Medical Society and members of the Kiwanis Club.

Interment followed in Brookside Cemetery, Bridgewater.

DOCTOR BURTON ELLIOT GOODWIN

Doctor Burton Elliot Goodwin died in Highland View Hospital, Amherst, on January 27th, 1955. He was 74 years of age.

He was the son of Mr. and Mrs. E. B. Goodwin of Lorneville, Cumberland County, where he grew up. After attending High School in Amherst he taught school for a time and then entered McGill University from which he graduated in Medicine in 1908. From McGill he went to London for post-graduate work and held appointments at the Royal Ophthalmic Moorfields and Central London Eye Hospitals as well as at Grey's Inn Road Hospital for Eye, Ear, Nose and Throat.

On his return to Amherst he engaged first in general practice but later confined his work entirely to the field of his specialty. He was a most capable

practitioner with a clear, logical mind. His opinions were definite but were based upon sound knowledge and a very wide experience. He was a leader in his specialty in Nova Scotia.

During his professional life he was at one time President of the Cumberland Medical Society, and a member of both The Medical Society of Nova Scotia and of the Canadian Medical Association. He also served for a term on the Provincial Medical Board. Besides these he was a past president of the Nova Scotia Ophthalmology and Otolaryngology Association and a member of both the Canadian Ophthalmological and Canadian Laryngological Societies.

His wife, the former Audrey Fox of Falmouth, predeceased him by about eight years. Surviving are a sister, Mrs. George Beharrell of Amherst, and one brother, Doctor O. M. Goodwin of North Battleford, Saskatchewan, besides nieces and nephews. To all of these the Bulletin extends sincere sympathy.

DOCTOR GEORGE GAW GANDIER

The last surviving member of the Class of 1898 in Medicine of the Halifax Medical College and Dalhousie University, Doctor George G. Gandier died at his home in Dartmouth January 27th.

He was born in the Thousand Islands, Ontario. Following graduation from Dalhousie he pursued post-graduate studies of a general nature in England. On his return he settled in Pictou where he practised for three years. After a second period of work in England, this time in the field of Eye, Ear, Nose and Throat, he returned to Nova Scotia and settled in Dartmouth in 1904. From that time onwards he practised his specialty in that town, and continued to do so until overtaken by the infirmities of age.

He was a quiet man, possessed of a keen sense of humor. Few of his confreres of the present generation knew him well, but those who did treasured his friendship highly. He was honored by the Halifax Medical Society on the Fiftieth Anniversary of his graduation in Medicine.

Mrs. Gandier predeceased him by eleven years. A sister, Lady Falconer of Toronto, survives as well as nieces and nephews.

To all members of the family the Bulletin, extends its sincere sympathy.

The Bulletin extends sincere sympathy to Doctor J. Arnold Noble of Halifax on the death of his mother, Mrs. Duncan A. Noble, which occurred suddenly in Moncton, N. B., on December 22nd.

Correspondence

Dear Sir:

The Department of Veterans Affairs request your kind assistance in allowing the use of your publication to bring to the attention of the medical profession throughout the Province, an amendment to the Department's Schedule of Fees for the doctor-of-choice plan which has been authorized. The amendment deals with charges for office and house calls to entitled veterans and is an amendment to Page 1 of the General Schedule of Fees.

Visits may now be charged for at the following rates:

CALLS:

Office:	Day Visit.....	\$2.50
	If specially called, Night (8.00 p.m. to 8.00 a.m.) Sunday and Emergency visits.....	3.50
House:	Day Visit.....	3.50

Sincerely yours,

T. E. KIRK, M.D.,
Senior Treatment Medical Officer,
Camp Hill Hospital

January 17, 1955.

NOTICE RE MINIMUM SCHEDULE OF FEES

The Minimum schedule of fees of The Medical Society of Nova Scotia is at present under revision. If you have any errors, omissions or revisions would you please forward these to either the Secretary of The Medical Society of Nova Scotia or to myself as Chairman of the Tariff Committee at 32 Connaught Avenue, Halifax. The dead-line for this information will be April 15th, since committee work has to be done in order to prepare a revised schedule for approval at the annual meeting in Amherst in September. If no information is received by April 15th we will assume you have no changes to suggest.

A. W. TITUS, M.D.,
Chairman, Tariff Committee

MARITIME CONFERENCE ON SOCIAL WORK

The Maritime Conference on Social Work will be held in Halifax on June 21st, 22nd, and 23rd.

Mr. L. T. Hancock, Director of the Maritime School of Social Work, is President of the Conference. Subjects of interest to the public, as well as to professional workers, will be included in the programme.

Outstanding social workers from Canada and the United States have agreed to lead the various discussion groups and to address the general sessions.

THIRTY WAYS TO KILL AN ORGANIZATION¹

1. Don't come to the meetings.
2. But if you do come, come late.
3. If the weather doesn't suit you, don't think of coming.
4. If you do attend a meeting, find fault with the work of the officers and other members.
5. Never accept an office or committee appointment, as it is easier to criticize than to do things.
6. Nevertheless, get sore if you are not appointed on some committee; but if you are, do not attend committee meetings.
7. If asked by the chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting tell everyone how things ought to be done.
8. Do nothing more than is absolutely necessary; but when other members roll up their sleeves and willingly and unselfishly use their ability to help matters along, howl that the Association is run by a clique.
9. Don't bother about new members. Let the Secretary do it.
10. When a banquet is given, tell everybody money is being wasted on blow-outs which make a big noise and accomplish nothing.
11. When no banquets are given, say the Association is dead and needs a can tied to it.
12. Don't ask for a banquet ticket until all are sold.
13. Then swear you were cheated out of yours.
14. If you do get a ticket, don't pay for it.
15. If asked to sit at the speaker's table, modestly refuse.
16. If you are not asked, resign from the Association.
17. Hold back your dues as long as possible or don't pay at all.
18. If you don't receive a bill for your dues, don't pay.
19. When you do receive a bill for your dues, postpone payments until the Secretary writes for the money—then get sore because you've been dunned.
20. If you receive a bill after you've paid—resign from the Association or at least suggest to some of the members that the Treasurer tried to work you or is manipulating the accounts.
21. Don't tell your Association how it can help you, but if it doesn't help you, resign.
22. If you receive service without joining, don't think of joining.
23. If the Association doesn't correct abuses in your neighbour's business, howl that nothing is done.
24. If it calls attention to abuses in your own, resign from the Association.
25. Always think and don't fail to talk about the "mote" in the other fellow's eye—never consider the "beam" in your own.
26. Keep your eyes open for something wrong and when you find it, resign.
27. At every opportunity threaten to resign and then get your friends to resign.
28. When you attend a meeting, vote to do something, then go home and do the opposite.
29. Agree to everything said at the meeting and disagree with it outside.
30. Always delay replying to communications from the Association or better, don't answer at all.

N.Y.S. Association of Chiefs of Police.

¹Forwarded by—A.F.W. Peart, M.D., Assistant Secretary, Canadian Medical Association; reprinted from the Bulletin of the Orange County Medical Association, August, 1954.