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The NOVA SCOTIA MEDICAL BULLETIN

Editorial

The Deaf Hear

How many doctors throughout the Province have been confronted by the parents of a very young child who did not seem to be responding normally to ordinary hearing stimuli? How many have been frustrated by their inability to decide whether the infant was mentally retarded or only not hearing properly? How often has a doctor been able to hold out no encouragement other than the suggestion to take the child to Boston or Montreal - a disruptive and expensive proposition at the best of times, and prohibitive in many cases?

In the April issue of the Bulletin, appeared the announcement of the first clinic east of Montreal for accurate assessment of hearing loss. Until then physicians and dispensers of hearing aids had at their disposal in this area, few means to ascertain accurately which ear, what part of which, and how much of which, was or was not functioning. This "HEARING AND SPEECH CLINIC", 1318 Robie St., Halifax, which operates under the provincial Department of Public Health, was officially opened in the presence of the Hon. R. L. Stanfield, Premier of Nova Scotia, and of Dr. Henry Hicks, President-elect of Dalhousie, on May 7th, 1963. Before that date stretch weary months of negotiations. To Dr. N. Barrie Coward, Head of the Department of Paediatrics at Dalhousie and the Childrens' Hospital, must go the accolade awarded to one "who never turned his back" and was "baffled to fight better". Behind him was Mrs. Freda Vickery, Head of the Social Service Department of the Childrens' Hospital, whose fervour originally aroused "Zonta", a women's service club in Halifax to be instrumental in organizing a group of people, mainly parents of very young hard of hearing children, to get a small class for pre-school age started for them. This class is now under its own Board and acts as a feeder to the Interprovincial School at Amherst. For it the clinic acts as a clearing house.

It is well known that the crucial years for the deaf child are between 3-7, the years when its parents, well meaning but unversed, struggle to communicate with their unresponsive offspring. Little have they realized that the unhearing baby needs to be talked at just as much as the hearing one and that every time a child reaches school-age, able to communicate only by signs- thus limiting him to conversation with those like himself or those specially trained, - that child has lost the period in which he can most readily learn lip-reading and also training in speech. Recognize and give training to that child and the

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more certainly will he become a useful member of society, - handicapped? yes - but not shut off in a world more silent than that of an astronaut whose "intercom" has failed.

This clinic is for adults also. All patients must be referred by a doctor for whom application forms are available. A nominal fee is charged for public cases and there is a scale of fees for those desiring private consultation. So far there have been almost 400 patient visits, including 50 adults. The age range is from 4 months to eighty years. Already it is necessary to book from a week to a month in advance.

The success of this clinic is assured as doctors throughout the Atlantic Provinces realize the tremendous advantage to their patients of not having to go to Montreal or Boston, and to their older patients, who find that an hearing aid best suited to their particular need can be suggested and adjusted at the clinic. Here the unresponsive child may be assessed for his hearing loss, for his speech difficulty, his mentality. Here, be he 4 months or four years he can be fitted with a hearing aid, possibly assisted to obtain it, and the parents can receive assurance that their child will grow to be a useful member of society.

To make this clinic effective, the cooperation of the doctors throughout the provinces is most necessary. So, too, must they, active as always in community welfare, mobilize the resources of their community to make use of the advantages gained. One pre-school class for hard of hearing children is not enough. Isolated mothers may hear of aids for her and her child. Taxpayers money will be saved as some of these children are able to continue in regular school classes. Led by Dr. Sortini and his associates may it soon be true that many of those now handicapped by hearing loss throughout Nova Scotia "shall hear the words".

R.B.N.

FROM THE BULLETIN OF FORTY YEARS AGO

The Medical Society of Nova Scotia Bulletin, July 1923.

The first modern organization for the prevention of disease on this continent of which we have any knowledge through an organized record, was the formation of the Massachusetts State Board of Health in 1863. This association was urged to take action because of the awful toll of typhoid fever in the towns bordering the rivers of the state. In 1880 Bacillus Typhosus was first discovered and isolated by Eberth and five years later by Gaffky. Among the first to make a national fight against typhoid fever were the Japanese, who in their war against Russia made a world record. This record for the prevention of typhoid was a brilliant contrast to that of the American Army in the Spanish-American war, when more soliders died of Enteric Fever at the camp of Miami, Florida, than were killed in the war.

From Dr. Black's address to the Medical Health Officers' Association Annual Meeting, 1923.

Report of the Delegate to Medical World International Conference

On Organizing Family Doctor Care

Norman G. Glen, M.B., Ch.B. D.R.C.O.G., M.C.G.P.

Amherst, N.S.

The "Medical World", aware of the interest expressed in many countries of varying cultural backgrounds in the place of the family doctor in their societies, decided to hold an International Conference - the first of its kind to be held. This Conference was held from Monday, October 22nd to Friday, October 26th, 1962, in London, England. Over 200 doctors from 24 different countries participated. These included doctors from all parts of Great Britain, from Europe - Belgium, Denmark, France, German Federal Republic, Holland, Sweden, U.S.S.R. Hungary, Poland, Rumania and Yugoslavia; from Asia - India, Pakistan, Israel; from Africa - Egypt, Ghana and Nigeria; and from the U.S.A., Canada, Australia and New Zealand. Papers were also sent from South Africa and the German Democratic Republic.

I had the honour to be present as the delegate of the College of General Practice of Canada.

The discussions at the Conference were concerned first with the Place of the Family Doctor in 20th Century Society; second with the Organization of Family Doctoring; third with its relations to the other medical services, (My contribution was the presentation of a paper on General Practice in Canada and the Relationship between the Canadian General Practitioner and the Hospital Services); and lastly with finance.

The Conference had before it fifty papers written by participants which were circulated beforehand. Discussion took place on these papers. Although it is impossible to summarize all the opinions expressed, certain general conclusions can be placed on paper, and these were agreed to at the last session of the Conference.

(1) Because of the great advances in scientific medicine and in medical specialism; because of the great cost of hospital medical care; because of the increase in stress disorders, mental illness and degenerative diseases it is imperative for all countries to strengthen their domiciliary medical services. The developing countries have an equal need for these services.

It was pointed out that in all countries the costs of treating patients in hospitals are soaring and the problem of meeting these costs is a universal one. The provision of high quality family doctor care is a much less expensive proposition and improved family doctor care can markedly reduce the demand for hospital beds and save expense. This is especially so if stress is laid upon preventive services and social medicine in the G.P.'s activities.

(2) The family doctor, helped by a team of nursing and social workers and practising near to the homes of his patients, is the proper person to render this domiciliary care.

(3) It is essential for the establishment of a good family doctor-patient relationship that wherever it is practical there should be a free choice of doctor by the patient, and a free choice of patient by the doctor except in emergency. The Conference recognized that owing to the shortage of doctors in many parts of the world, and also because of different systems of organization, this free choice may sometimes have to be curtailed.

The Conference did not approve of the patient having direct access to a Consultant without being referred by a family doctor. The ludicrous situation which can arise in these circumstances of different members of the same family all having different doctors is an example of complete lack of family medical care.

(4) The role of the family doctor, although understood in general terms. should be more clearly defined. This role should be investigated nationally and internationally, so that it may be more precisely determined. This Conference has taken the first step to this end. There is an urgent need for research in this field on the widest possible basis. Such research is going forward in many countries.

(5) Pending further studies of the role of the family doctor, the Conference did not specify all his functions, although it considered carefully many interesting suggestions made by participants. The one unanimous point of agreement was that he should provide primary continuing personal care of a high quality.

(6) It was stressed that the family doctor, despite the myriad of medical specialties and subspecialties, is a specialist in his own right - practising the specialty of domiciliary medicine, equal in every way in importance to other specialties.

(7) Once the scope of his specialty has been more clearly defined, undergraduate and graduate training should be orientated to produce graduates who are fitted for it. His training should include thorough academic treatment of family medicine itself as a specialist skill. Preventive and social medicine, some aspects of sociology and social work, and psychiatry are all most relevant. Various methods of achieving this result based on experiments made in many countries were discussed and it was felt that these might well be tried out in other countries. The work of the College of General Practice of Canada towards introducing improved under-graduate training for general practice was well regarded by the Conference, as was its program of General Practice Residencies. The Conference also felt that the family medicine research units, such as have been established in Manchester, Edinburgh and by the University of Vermont, will provide much useful information here. and similar units should be attached to all medical schools.

(8) The family doctor's future status in the community and amongst his professional colleagues will depend on the recognition of his special skills. Special postgraduate training is needed to enable the doctor to acquire and maintain this knowledge. Much of this training can only be given by those with skill and training in family medicine itself. The Conference was much impressed by the experiments carried out in Yugo-

slavia, Israel, the U.S.S.R. and the U.S.A. in this field. Much more thought should be given to this subject in all countries and there is a need for a proper evaluation of the best type of training.

The approach of the University of Zagreb, Yugoslavia, to the postgraduate training of general practitioners for a higher degree in family medicine, is extremely constructive and interesting and would be of great value to the Fellowship Committee of our College of General Practice. The Conference was also impressed by the thinking of the Fellowship Committee of the College of General Practice of Canada, in particular by the idea that one requirement should be a medical audit of the applicant's own practice.

(9) No specialist, whatever his specialty, can retain his skill unless he can keep up-to-date with his subject. Therefore continuing postgraduate education is essential. The Conference stressed the need for greater provision of postgraduate training facilities for general practitioners throughout the world and considered that the facilities available in Canada were excellent. Canadian G.P.'s, however, were deemed fortunate in having sufficiently few patients to care for that they had time enough to take advantage of the postgraduate training facilities available.

(10) The family doctor cannot function in isolation. Just as the surgical specialist needs a team of workers to assist him, so does the specialist in domiciliary care need a team to work with him. This team, comprising perhaps other doctors (G. P.'s and/or specialists) must also include nurses, health visitors, and social workers specializing in different fields of domiciliary care, such as mental health or geriatric or child care.

This idea of a team approach to family doctor care recurred several times during the Conference. It was pointed out that many of the things done by general practitioners do not actually need a doctor's training and skill. They could be equally well or better done by adequately trained social workers or nurses, leaving the family doctor more time to concentrate on the things for which his training is needed.

The growth of group practices throughout the world was welcomed. It was agreed that the G.P. could not be doing his best work if on constant call and without periods of freedom from responsibility. Regular hours for family doctors become more nearly attainable in conditions of group practice and when the latter is developed to the degree of the Polyclinics of the U.S.S.R. and allied countries, the doctor's working hours become as normal as those of the layman.

As mentioned above, better family doctors and better conditions for family doctoring would keep many patients out of hospital and do much to curb the spiralling costs of hospital care. However, although the hospital doctor is provided, by Government in most countries, with the premises wherein, and equipment wherewith, to work - in many places "family medicine is practised under conditions which differ little from those obtaining at the turn of the century. All too often the general practitioner is being expected to do a 20th century job in a 19th century setting."(1) The Conference felt that one way in which governments might save some of the money they are spending on hospitals is by giving

consideration to the provision of premises and equipment for family doctors. To date in most countries of the western world, at any rate, the G.P. provides his own premises and equipment.

(11) With regard to the family doctor's access to hospital facilities, the Conference agreed tht it was essential that the G.P. should have access to all the ordinary radiological and pathological investigations likely to be of use to him, but the concept of the G.P.'s access to hospital staff privileges was not universally accepted, especially in the United Kingdom. Some countries were swinging one way on this question and others the opposite way. Those who did not favour general practitioners in hospital seemed to me to base their objection to the fear that this might lead to general practice becoming "hospital-based" as was the tendency in the U.S.A., and this would be harmful to the practice of true family medicine.

When patients are referred from family doctor to specialist and also when the latter refers them back to the family doctor the Conference stressed the importance of prompt and adequate communication. The breakdown of continuity of medical care which is liable to happen particularly following discharge from a teaching hospital, should not be permitted to happen.

(12) The family doctor should be responsible for the personal preventive services. If he is to do this work effectively, he must be properly trained for it. The public health doctor would be available as a consultant in this field while remaining responsible for environmental hygiene.

(13) The Conference discussed various systems of financing family doctor care. It was fully realised that each country had adopted a system applicable to its own society for historical and other reasons. Nevertheless it was agreed that any system of finance should:

(a) Encourage doctors to use to the full the skills which they have acquired in training.
(b) Discourage doctors from undertaking work for which they are not adequately trained.
(c) Enable the doctor to enjoy a good standard of living.
(d) Not place an excessive financial burden on the patient.

Much interesting material was presented by the delegate of the London School of Economics on this subject, but in general it seemed that remuneration of family doctors by salary was the most suitable for low income countries or areas, whereas fee-for-service would be preferred in countries or areas of higher income.

(14) The enormous problems facing those organising family doctor care in the developing countries fascinated the whole Conference. These countries - "despite the enormous difficulty of their task - are, in some ways, in a better position . . . . . to organise comprehensive family doctor care. They are uninhibited by the old traditions of practice, which are, in some ways, obstacles to our own further progress. In a developing country the family doctor must be all things to all men. He must have diagnostic skill and know his limitations; and he must be able to teach his patients about infectious disease, hygiene, family planning, nutrition,

maternal and child welfare, and the care of the sick. Indeed, in primitive villages, he must use his diagnostic and therapeutic ability to gain the confidence of the community so that they may be receptive of his teaching of the elementary rules of hygiene. In this setting there is no distinction between preventive and curative medicine. The distinction which has grown up between them in . . . the "developed" countries is meaningless and absurd to-day; the family doctor should play his full part in the preventive personal services." (1)

The team approach to family doctor care, mentioned above, and developed to a high degree, is the only possible way in which family doctor care can be brought to the masses in such places as Pakistan and Nigeria. (For example, in Ibadan, Nigeria, there are only eleven G.P.'s for well over half a million people!)

Another interesting sidelight on the problems in such countries is what to do about the native "witch doctor". Initially these were felt to be a great hindrance to the development of scientific medicine in these countries but gradually now the attitude of the planners of scientific medicine is changing and in some places the witch doctor and the scientific doctor are co-operating one with the other, each in his own field. The natural field for the witch doctor, of course, is in psychosomatic and psychiatric conditions, in the treatment of which he is often extremely successful. So far has the idea of co-operation with the witch doctor, rather than antagonism to him, developed that a native practitioner has been appointed to the faculty of one of the medical schools in West Africa!

Another way in which co-operation between the native doctor and the scientific doctor may benefit scientific medicine is exemplified by the establishment of a special department in the Kwame Nkrumah University of Technology and Science at Kumasi, Ghana, engaged on the examination of all the local herbs and substances used by the native witch doctors. At the time of the Conference, it was reported, at least one new alkaloid likely to be of use in scientific medicine had already been discovered by this means.

(15) The Conference realized that each country would have to apply the principles enumerated above in different ways, for each has its own history, its own culture, and its own system of social organization.

(16) It was agreed that the Conference had given a good opportunity to participants to clarify their minds and to exchange views. The proceedings at the Conference and the results will be published in book form by Messrs. Pitmans.

(17) The Conference could not - nor did it expect - to achieve immediate concrete results. Nevertheless, participants were very loath to go home without considering some further positive action. It was agreed as a first step to set up an international study group of interested participants. The first subject to be considered would be the postgraduate education of the family doctor. This was apposite because the World Health Organization is shortly to hold a seminar on the subject. Participants agreed to send to London a detailed account of all the schemes and experiments in postgraduate education undertaken in their coun-

tries so that these could be analysed and forwarded to the seminar for study. The various medical associations, colleges and academies of General Practice throughout the world would be approached to co-operate. This request has already been passed on by me to the College of General Practice of Canada.

(18) It was finally agreed that further conferences should be organized in the future and that a clearing house for information on all aspects of family doctor organisation should be established. I would recommend strongly that the College of General Practice of Canada be represented at all future international conferences of this type. An enormous amount can be learnt from the experiences of those concerned with family doctoring in other countries which would be of inestimable value to our College.

(19) Editorial comment on the Conference appeared in the British Medical Journal, October 27th, 1962, Page IIII, The Lancet November 3rd., 1962, Page 923, and, despite the Conference being held at the height of the Cuba episode, which occupied much newspaper space, the Conference received wide publicity in the British lay press. In particular, it was well reported from the layman's point of view in "New Society", Volume 4, 25th October, 1962, Pages 3 and 7.

(20) Despite the fact that I have not had the opportunity to take part in any similar activity in the past, I am convinced that this International Conference on the Organisation of Family Doctor Care marks an important step forward for the General Practitioner the world over. It will have done much towards his establishment as a recognized specialist in family medicine.

Finally, I wish to thank the College of General Practice of Canada for appointing me its delegate to this Conference.

Reference (1) Lancet (editorial) Nov. 3, 1962. P. 924.

BOOK REVIEW

EARLY DETECTION AND DIAGNOSIS OF CANCER
Walter E. O'Donnell, M.D.
Emerson Day, M.D., F.A.C.P.
Louis Venet, M.D., F.A.C.S.
The C. V. Mosby Company, St. Louis, - 1962

This short book summarizes in an orderly fashion the available means we have for the early detection of cancer. In the introduction, reasons are provided for the assumption that early detection followed by good standard treatment leads to the greatest number of cures. Assuming this, the various regions of the body are taken up one by one and using diagrams as well as summary tables, the relevant steps are clearly outlined.

Because techniques change so rapidly, not everyone will want to buy this book but everyone in clinical medicine could profitably borrow it from the library and spend an evening reading it through.

S.C.R.

Case Report

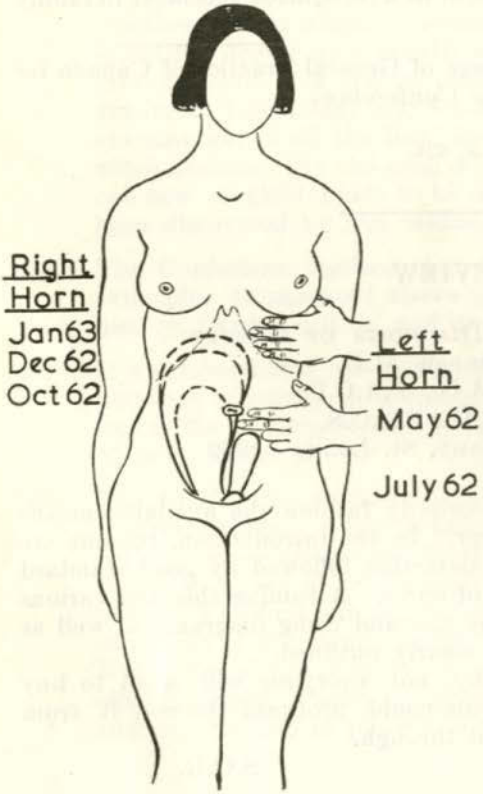
The Case of the Missing Foetus

J. McD. Corston, F.R.C.O.G.
Halifax, N. S.

C. B. Smith, M.D., C.M.
Pictou, N. S.

The mother is a 30 year old Para 0, married 8 years and known to have a bicornuate uterus which was proved in March 1960 at laparotomy. At that time the double uterus with one cervix were identified with the left horn emptying into the cervical canal of the right. Insufflation of the Fallopian tubes (two in number) showed them to be patent.

A pregnancy ensued in the left horn beginning approximately in October 1961. However, she continued to have regular monthly bleeding until "periods" ceased after 29th April 1962. Regular monthly visits confirmed the steady increase in size of the left horn until April 1962 at which visit the patient claimed to have felt foetal movements. The fundus was just below and to the left of the umbilicus and there was a questionable foetal heart heard on auscultation.



From May onwards the pregnant horn diminished in size gradually until by the beginning of July it was just palpable above the symphysis and to the left.

In August it was noted that a soft swelling about the size of a three months pregnancy was involving the right horn of the bicornuate uterus. This continued to increase in size. By 5th October 1962 the fundus of the right horn was above and to the right of the umbilicus. The foetal heart could be heard distinctly. The left horn, presumably containing the missed abortion, could still be palpated and was about the size of an eight to ten weeks cyesis.

The pregnancy continued without complications and she was admitted to the Grace Maternity Hospital, Halifax, on the 14th January 1963.

It was estimated at this time that the E.D.D. should be approximately the end of January. The foetus was lying obliquely and to the right as it was occupying the right horn of the

bicornuate uterus. The head was quite free above the brim of the pelvis. An X-ray taken the day after admission to hospital showed: "A single foetus V.R.O.A. with the head laterally flexed and displaced anteriorly away from the pelvis as if something bulky was down in the lower pelvis. No other foetus is noted."

On the morning of 16th January 1963 under general anaesthesia a lower segment Caesarean Section was performed and a living male child weighing 5 lbs. was delivered. The baby was perfectly formed and had an Apgar rating of 10. The placenta was extracted without difficulty. The opening into the left horn as it entered the side of the middle third of the main cervical canal was then explored. Sponge forceps were introduced through this channel into the main cavity of the left horn and tissue was extracted until it was empty. No foetal parts were identified. The Pathologist later reported this as decidual tissue only. The lower segment was closed in layers and reperitonealised.

Appearance at time of Caesarian Section.
R.L.Saunders.

The patient made an uneventful recovery except for a slight pyrexia on the fourth day which responded to tetracycline.

The baby was nursing well and gaining when he and his mother were discharged from hospital on 30th January 1963.

"HAS ANYONE SEEN MY BROTHER"

Summary and Discussion

This case presents some interesting and difficult to explain features.

In the first place the patient was pregnant in the left horn of the uterus from November to April 1962 as diagnosed by two independent observers examining at regular intervals. During this time, however, she continued to have regular monthly bleedings from the non-pregnant right horn.

Secondly, when the pregnancy in the left horn ceased to develop (missed abortion) a pregnancy commenced in the right horn and menses ceased. This pregnancy continued and resulted in the ultimate delivery of a healthy child. The missed abortion in the left horn concurrently regressed and at operation no evidence of foetal remains was found thus indicating total aborption of foetal tissue.

One of our more cynical colleagues has propounded the theory that the patient was probably a devotee of the 'Twist' in the early months of her pregnancy with a resultant twist in the uterus and that there never was a pregnancy in the other side! – Q.E.D. This does not, however, explain the definite swelling in the left horn almost up to the umbilicus with persisting menses and subsequent regression in size down to the symphysis and to the left.

What do you think?

Our sincere thanks to Dr. R. L. Saunders, Professor of Anatomy, Dalhousie University, for the lucid drawings.

Driver Licensing

The report which follows indicates some of the steps being taken by the Provincial Government to ensure the medical fitness of drivers in Nova Scotia.

Such steps can only be as effective as is the accuracy and completeness of their application.

All members of the Medical Professions are invited to give their interest and cooperation to the work of this committee, as they already do to other aspects of highway safety.

Report
Medical Advisory Committee on Driver Licensing, 1962

General

The Medical Advisory Committee on Driver Licensing was constituted by the Honourable Minister of Highways upon recommendation of The Medical Society of Nova Scotia.

The purpose of this Committee is to study medical reports and other relevant information concerning persons whose eligibility to hold a driver's license may be questioned on medical grounds and to advise the Registrar as to that person's medical fitness to hold a license. The Committee is purely advisory and the decision as to what action should be taken on their recommendation rests with the Registrar.

Membership

The Committee consisted originally of five members:

- a medical practitioner (Internist) - Dr. J.W. Reid - nominated by The Medical Society of Nova Scotia
- a psychiatrist - Dr. H. Kenneth Hall - nominated by The Medical Society of Nova Scotia
- a psychologist - Dr. Wesley H. Coons - nominated by The Association of Psychologists of Nova Scotia
- the Registrar of Motor Vehicles - Mr. E. S. Campbell - recommended by The Medical Society of Nova Scotia.
- the Director of Highway Safety - Mr. J. C. Douglas - recommended by The Medical Society of Nova Scotia.

In line with this recommendation for the constitution of the Committee, upon the retirement of Mr. E. S. Campbell as Registrar in Sepember 1962), Mr. D. D. MacAskill, the new Registrar of Motor Vehicles, became a member of the Committee. At that time the Honourable Minister of Highways approved the recommendation of the Committee that Mr. E. S. Campbell continue as Chairman of the Committee for a period of one year.

Regional Representatives

The Medical Society of Nova Scotia recommended that, in addition to the members of the Central Committee, Regional Representatives of the Medical Advisory Committee be appointed throughout Nova Scotia. The recommendation suggested that one such Regional Representative be appointed in each of the areas of the Province served by the various branches of The Medical Society of Nova Scotia, such representative to be nominated by The Medical Society for the approval of the Honourable Minister.

The following Regional Representatives were so nominated and approved in 1962:

Dr. R. Sers, Antigonish	— Antigonish-Guysborough Medical Society
Dr. P. R. Little, Truro	— Colchester-East Hants Medical Society
Dr. R. E. Price, Amherst	— Cumberland Medical Society
Dr. H. C. Still, Halifax	— Halifax Medical Society
Dr. R. G. A. Wood, Lunenburg	— Lunenburg-Queens Medical Society
Dr. J. N. Park, New Glasgow	— Pictou County Medical Society
Dr. F. W. Morse, Lawrencetown	— Valley Medical Society

The purpose of these Regional Representatives was for referral of local cases to them at the discretion of the Committee. During 1962 no cases were so referred.

Meetings

The Committee held its first meeting in January 1962. At that meeting it nominated Mr. E. S. Campbell, Registrar of Motor Vehicles, to act as Chairman and the Director of Highway Safety assumed the office of Secretary (pro tem.).

Regular monthly meetings of the Committee were held during each month of 1962 but no cases were actually studied by the Committee until May. Meetings up to that time were devoted to the clarification of procedures and the preparation of an adequate medical report form for the use of the Committee.

Proceedings

During the months from May to December inclusive 44 cases were studied As the result of the ensuing recommendations made by the Committee:

Five persons had their licenses suspended for reasons of medical unfitness.

Seven unlicensed persons were refused licenses on the grounds of medical unfitness.

One person was required to submit a certificate of vision before renewal of his license each year.

Three persons were required to submit medical certificates before renewal of their licenses.

One person's license was suspended for failure to submit a medical report as required.

Sarcoidosis

O. J. PUDYMAITIS, M.D.*

Dartmouth, N. S.

In the past few decades the chest physician encounters with increasing frequency pulmonary conditions which on the X-ray may present the picture of tuberculosis. We know already at least 50 diseases which may give rise to miliary or nodular foci. To mention only a few: silicosis, sarcoidosis, farmers' lung (bronchomycosis fenisecarum), progressive diffuse interstitial fibrosis (Hamman – Rich syndrome), cystic lung, pulmonary alveolar proteinosis, and histoplasmosis. The causes of these conditions may be bacteria, viruses, fungi, parasites, ricketsiae; the disorders may be due to inhalation of vapour or foreign materials, they may be associated with cardio-vascular disease; they also may be of allergic nature. Sometimes such changes in the lungs may mirror the presence of a systemic disease, representing either the end-stage of the disease or the first line of attack as a shock-organ.

Our concern here is with one of these diseases: **Sarcoidosis.** The condition was first described by Hutchinson in 1869, and 30 years later Boeck gave the disease the name "sarcoidosis" because the histology resembled sarcoma. These two authors and many others during the next 50 years thought of the condition as primarily a skin disease which became the domain of the dermatologist. And only 20 years ago (in 1941) Schaumann was the first to express the view that Boeck's sarcoidosis was a systemic disease, a benign lymphogranuloma.

Sarcoidosis concerns now not only the dermatologist, but also the ophthalmologist, the neurologist, E.N.T. specialist, the gastro-enterologist, the surgeon. But mostly it concerns the chest physician, because the lungs are involved in up to 85 per cent of cases.

Pathology. Histologically the sarcoid nodules resemble tubercles. The chief components are epithelioid cells, together with macrophages and giant cells, which are larger than those of tuberculosis, and contain more nuclei. Very often inclusion bodies are found in the giant cells, so-called "asteroids" and the spherical "Schaumann bodies" with calcified concentric laminations. Characteristic for the sarcoid nodule is the absence of caseation, and there is generally no surrounding lymphocytic infiltration. No acid-fast bacilli can be cultured from the sarcoid tissue and this is decisive in differentiating sarcoidosis from tuberculosis.

Manifestations. There is no organ or tissue which is immune to sarcoid reaction. The chief tissue affected are the lungs, the lymph nodes, the skin, and the uveal tract of the eye. But there also may be splenomegaly and hepatomegaly; the myocardium may be affected, also the pancreas, testis, tonsils, the parotid and lacrymal glands; and the bones. Boyd saw a sarcoid lesion in the hypothalamus which caused diabetes insipidus, and Rubin also reported a case of sarcoidosis with diabetes insipidus.

Boeck's publication on sarcoidosis appeared in 1899, only 3 years after Roentgen announced his discovery of the X-rays. No wonder the "classical" sarcoid was limited almost exclusively to the visible manifestations on the skin. With improved roentgenological technique, with more and more frequent chest X-rays and particularly thanks to the mass X-ray surveys the whole outlook on sarcoidosis changed. We see now the bulk of sarcoidosis manifestations

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inside the thorax. The extrathoracic manifestations are greatly in the minority.

Thoracic Sarcoidosis. The lungs are affected in 75 – 85 per cent of cases. Pulmonary sarcoidosis progresses through 3 stages. In stage one there is only involvement of the hilar and mediastinal nodes. The second stage is characterized by the extension of the process into the lung parenchyma by way of the lymphatics and the pulmonary circulation. A generalized miliary spread through the entire lung may occur together with some isolated haematogenous foci. In stage three the X-ray shows conglomeration of the pulmonary lesions and interstitial fibrosis. Even at this stage arrest of the disease or even clearing of the lesions is still possible. Further extension of the process leads to circulatory failure and death.

Extra-Thoracic Sarcoidosis. The "classic" sarcoid of the **skin** presents as a papula, as a small nodule, or as a larger granuloma. Since the recognition of the systemic nature of the disease skin involvement is now encountered in only 10 - 15 per cent of cases. In Negro patients the percentage is much higher. Sarcoid lesions of the **eyes** are now seen with increasing frequency, in up to 50 per cent of cases. Affected is mostly the uveal tract (iridocyclitis). Chronic uveitis may lead to blindness. Sarcoid lesions of the uveal tract may be associated with painless, bilateral swelling of the parotid glands and a prolonged, low-grade relapsing fever: "uveoparotid fever" (Heerfordt's disease). Ocular lesions frequently co-exist with skin lesions. Involvement of the **bones**, skeletal lesions, are practically limited to the phalanges of the fingers and toes. Less frequent the metacarpals and the metatarsals are involved, also the wrists, the ankles, and the long shaft bones. The typical appearance on the X-ray of a sarcoid phalanx are the "punched-out" circumscribed areas of rarefaction. There is never sequestrum formation nor involvement of joints. Bone changes are foun in about 17 per cent of cases. The **C.N.S.** may also be affected. Sarcoidosis of the hypothalamus is already mentioned. There are also isolated cranial nerve lesions and involvement of the meninges. Forty cases of sarcoidosis of the **myocardium** are reported up till now, with resulting sudden heart death in 50 per cent of cases. Sarcoidosis of **abdominal organs**: there may be a massive enlargement of liver and spleen; rupture of sarcoid spleens have been reported; also sarcoid ascites.

Etiology. For decades etiological studies concentrated on the tubercle bacillus as causative agent, but no definite proof has been obtained. Present evidence indicates that only exceptionally the mycobacterium tuberculosis may be responsible for the disease. Other causative agents are also disputed e.g., fungi, viruses. Recent epidemiological studies indicate a relationship between pine pollen and sarcoidosis. Prevalence of the disease was noted in residents of the south-eastern parts of the U.S.A., i.e. in areas which correspond with the pine forest distribution. In the rural areas the rate of attack was higher. And the ratio of Negroes affected as compared with Whites was 18:1 (? habit of chewing pine pitch). High incidence of sarcoidosis was also noted in other countries where pine forests are common: in the Scandinavian countries, France, Germany, and Switzerland. It was found that pine pollen take up acid-fast Ziehl-Neelsen stain like tubercle bacilli because they contain diaminopimelic acid, a phospho-lipid, which we find in mycobacteria but not in other micro-organisms or in normal human tissue. Pine pollen with their content of diaminopimelic acid, when injected into guinea-pigs, produce localized sarcoid-like lesions, and, vice versa, diaminopimelic acid was found

in sarcoid lesions. This is proof that substances other than mycobacteria can stimulate sarcoid-like lesions. We know e.g. that after inhalation of certain compounds of beryllium a disease may occur which closely resembles sarcoidosis clinically and is identical with it histologically.

It is now generally agreed that the causes of sarcoidosis are multiple and vary from one part of the world to another, e.g. in Great Britain mycobacterium tuberculosis may be one of the most frequent causes; in the pine tree forest regions of the U.S.A., Scandinavia, etc., the most incriminating agent are pine pollen. Sarcoidosis is probably a non-specific syndrome resulting from the individual reactions (hypersensitivity) to various agents. Of interest may be a new hypothesis: it is believed that granuloma formation is preceded by a diffuse mononuclear cell proliferation and infiltration, this is actually found in early stages of the disease. It seems that a foreign agent is taken up by the mononuclear phagocytes, and the sarcoid granuloma is a stabilization of the phagocytic process the purpose being to isolate the foreign agent.

Diagnosis. Chest X-rays and radiography of hands and feet are indispensable, as is the tuberculin test (Mantoux or Heaf). One of the best means of obtaining histological evidence of pulmonary sarcoidosis is scalene node biopsy alone or in combination with bronchial biopsy. Another method is needle biopsy of the liver. The blood chemistry shows increase in serum globulin (the albumin-globulin ratio may be reversed), chiefly in the gamma fraction; these changes return to normal when the active disease subsides. In 25 per cent of patients with sarcoidosis there is an increase in the serum calcium level which may be responsible for nephrolithiasis, nephrocalcinosis and renal failure. Sarcoidosis associated with hypercalcemia has to be differentiated from hyperpara thyroidism. In hyper parathyroidism there is more generalized decalcification of bones, there is raised alkaline phosphatase level and the serum protein level is normal. Moreover, administration of cortisone causes a fall in the serum calcium level in sarcoidosis, but not in hyperparathyroidism or other diseases associated with hypercalcemia.

The Kveim test is now often used as a diagnostic help in sarcoidosis. It is an immune biological reaction. The antigen is a saline suspension of sarcoid tissue obtained from a patient with active sarcoidosis. When injected intracutaneously it produces a nodule which is histologically identical with a sarcoid tubercle. The Kveim test originated in Norway and was introduced 20 years ago. The test is not specific, it is positive in patients with active sarcoidosis but often negative in the chronic form; the test may be positive also in tuberculosis. The diagnosis of sarcoidosis must be based on the correlation of clinical, radiological, immunological, laboratory data, and the histological picture.

Course of the Disease. Sarcoidosis is a chronic illness. The disease may last for years with a tendency to fibrosis and healing. Healed lesions present as scars. Many cases of the past of so-called "healed miliary tuberculosis" were undoubtedly healed pulmonary sarcoidosis. In the first two stages of the disease there are remarkably few symptoms or complaints. Only stage three, with extensive interstitial pulmonary fibrosis, leads to progressive dyspnoea, cough, weight loss, and weakness. Later on the dyspnoea increases, also the cyanosis due to failure of the right ventricle. There may be spontaneous arrest or even healing of the lesions still during the third stage. Sarcoidosis affects chiefly adults in the third and fourth decades, but children and aged are not immune.

Treatment. There is no specific treatment for sarcoidosis. Only the corticosteroids have an immediate beneficial effect on both clinical and histologic features of sarcoidosis. But after discontinuance of the medication the disease progresses further. The corticosteroid therapy is reserved for specific conditions only:

1. in ocular lesions (uveitis) which may lead to blindness
2. in progressive pulmonary fibrosis leading to disabling dyspnoea
3. in disfiguring skin lesions
4. in the presence of hypercalcemia, and particularly in persistent hypercalciuria to prevent nephrocalcinosis.
5. in involvement of the C.N.S.

Antituberculous drugs are ineffective in sarcoidosis. During pregnancy there is often improvement of the condition probably due to increase in production of steroids during gestation.

Case presentation. Mrs. P. A., age 42, on the staff of the Nova Scotia Hospital for 10 years. Family history: father died of a stroke at the age of 60; mother, age 62, is living and healthy; two brothers and four sisters are healthy; no cases of chronic pulmonary or skin diseases in the family or among the neighbours in the Hubbard, Nova Scotia area where patient was born and lived for 20 years. Personal history: ordinary childhood diseases, normal schooling; no operations; patient was always healthy; 4 children, 3 grandchildren. In the fall of 1961 she had an "upper respiratory infection" which persisted for four months; she felt tired, depressed, irritable, and lost weight, 30 pounds during this period; there was marked breathlessness and some cough; no haemoptysis.

Because the patient was already known as being a suspect case of sarcoidosis (routine chest X-rays at the Nova Scotia Hospital) a reassessment of her condition at the Victoria General Hospital was undertaken. The tuberculin tiest (intermediate P.P.D.) was negative, also the sputum for tubercle bacilli The examination of the respiratory system showed expansion normal and equal bilaterally. No râles or rhonchi detected. Cardio-vascular system: blood. pressure, 150/95; pulse, 74 and regular; heart sounds, normal Abdomen: normal. E.E.N.T.: normal. Urine analysis: negative. Blood: Hb., 14.5 gm.%; P.C.V., 43%; W.B.C., 4.800; nomal differential. Blood chemistry: B.U.N., blood sugar and serum electrolytes, normal; total protein 8.6 gm.%; albumin 4.8 gm. %; globulin 3.8 gm. %. Electrophoretic pattern: albumin 63.9% of total, globulin 36.1% (alpha one 2.5%, alpha two 5%, beta 7.9%, gamma 20.7%). Calcim 11 mg.%. The chest X-ray showed diffuse nodular shadowing on both sides. "The appearances are non-specific, they could be due to sarcoidosis. One could rule out the possibility of pulmonary tuberculosis." Pulmonary function studies revealed mainly a reduction of the vital capacity and maximum expiratory flow rate. "These findings are indicative of restricted pulmonary disease such as sarcoidosis." Scalene node biopsy, was performed which showed changes of sarcoid.

The chest X-ray together with the biopsy confirmed the final diagnosis of sarcoidosis. The biochemistry showed slight elevation of the total serum protein, 8.6 gm.% (normal : 6 – 8 gm.%), and of the globulin, 3.8 gm.% (normal: 1.5 – 3.0 gm.%). The urinary calcium is now still slightly elevated, 154 mg. (normal: less than 150 mg./24 hours.)

The patient's chest X-ray began to show changes ten years ago, when an

enlargement of the hilar area was noted (stage one); three years later the disease has already progressed to stage two: extension of the process into the lung parenchyma; in November of 1961 the stage three has already set in: conglomeration of the pulmonary lesions and interstitial fibrosis. This corresponded with the clinical course at that time (breathlessness, cough, loss of weight, and weakness).

A trial treatment with corticosteroids was indicated. The patient received dexamethasone (Decadron) 0.75 mg. t.i.d. for three weeks, then the dose was reduced to 0.75 mg. b.i.d. for four weeks; for three more months she was kept on 0.75 mg. once daily. Already after three weeks from the beginning of the treatment the patient began to feel stronger, more active, the dyspnoea began to disappear. Now, after five months, the patient feels as strong as before, she gained weight again, no signs of breathlessness. The therapy is now discontinued. The recent chest X-ray (May 1962) shows slight clearing in both lungs. Further courses of treatment will probably be required. But the prognosis is dubious. The pulmonary changes will in time progress beyond the third stage and the damage will be irreparable.

Conclusion. A case of pulmonary sarcoidosis is presented together with a general discussion of the etiology, pathology, manifestations, diagnosis and treatment of the disease.

Acknowledgement:

The patient was in the Victoria General Hospital under the care of Dr. R. L. Aikens to whom I wish to express my thanks for the permission to use the data of the Victoria General Hospital records.

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RESUSCITATION OF THE MORIBUND ASTHMATIC AND EMPHYSEMATOUS PATIENT

Mechanical means of treatment are called for when patients are near death from bronchial obstruction. Ventilation can be induced by a manually operated portable resuscitator, followed by procedures to draw out viscid mucus.

The increasing awareness of a relatively high mortality in severely asthmatic and emphysematous patients, whether due to a better understanding of the pathophysiology involved or to a changing character of the disease, appears much more realistic than the attitude of ten years ago when death from an attack of bronchial asthma was considered rare.

In a three-year period, while an anesthesiologist at a 275-bed general hospital of a medium-sized city, I was consulted in the emergency treatment of five moribund patients—thre in status asthmaticus and two with advanced pulmonary emphysema. All these patients wer considered moribund by the attending internists, that is, they were expected to die within a matter of minutes. They were either unconscious or semicomatose, with severe cyanosis and in marked hypoventilation.

Preconceived Approach

These five consecutive cases were successfully treated by means of resuscitative procedures. The importance of a preconceived and active approach in this emergency situation must be emphasized. The technical details of the method of resuscitation are simple and within the scope of every practicing anesthesiologist. The basic equipment is modest and should be readily available in every hospital. Decisive use of these available skills and devices may be of benefit to many moribund patients with obstructive hypoventilation.

After ventilation had been started, in each case an endotracheal tube was inserted by the nasal route and suctioning of the tracheobronchial tree was alternated rapidly with ventilation. In the last two consecutive cases, the tube was connected with a Bennet respirator during the recovery phase to maintain normal breathing.

Drugs used with the mechanical measures were theophylline ethylenediamine, hydrocortisone, and epinephrine. Aerosols were also used in two cases.

Stripped of any incidental element, the principle of the method is a mechanical one, that is, the prolonged use of the suction-ventilation cycle to overcome the obstructive crisis. Although bronchial asthma and pulmonary emphysema are complex diseases, a purely mechanical problem is involved in the terminal phase.

Psychosomatic and allergic factors, broncho-spasm, infection, organic changes of the bronchi and alveoli, disturbances of the ratio of ventilation to blood flow and a decreased diffusing capacity all play their parts in the natural history of the process. However, at the time of the crisis the many aspects are reduced to the clinical picture of generalized obstructive hypoventilation. This change appears when the work of breathing exceeds the limits of compensation and large amounts of viscid mucus begin to accumulate. Respiratory acidosis and anoxemia increase rapidly and add central-nervous-system depression to the failure of pulmonary respiration. These cases have advanced

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Kurt O. Leonhardt, M.D., *New England Journal of Medicine*, April 20, 1961.

beyond the reach of drug therapy. A mechanical means of treatment is called for to cope with a mechanical cause.

Respirator A Help

The use of a well-constructed respirator can be of great help in the recovery period after the mechanics of breathing have been normalized to the extent of complying with the physical characteristics of the machine. It guides the patient through the critical hours, guarding against the ever-present danger of a relapse. It also provides for intensive aerosol therapy, with bronchodilators, antibiotics, and detergents being used as necessary.

The danger of rupturing alveoli by positive pressure applied to the airways is overrated in general and especially in patients with severe obstruction. The rigidity of the muscles, the very high resistance in the airways, and the generalized nature of the obstructive process are the reasons that high inspiratory pressure of a short duration is not only tolerated but also required for good results. Occasionally, however, this complication may constitute a calculated risk, and equipment for decompression of a tension pneumothorax should be available. By the same token, the presence of an intrathoracic pneumothorax or of mediastinal emphysema is a contraindication to the use of any positive-pressure method.

A second possible danger of high-pressure ventilation is impairment of venous return and a fall of cardiac output. This is especially true for patients with a low blood volume or capillary damage. In the present study, no marked cardiovascular effects were observed despite advanced cor pulmonale in three patients.

Drug Therapy not Excluded

This emphasis on the mechanical aspects does not exclude drug therapy when an adequate response can be expected. This is true in the prevention of a crisis and in the recovery phase and always for the treatment of an intercurrent or superimposed infection. All the patients received systemic antibiotics and one was treated intensively with penicillin aerosol. Furthermore, drugs must be used when any additional indication is present such as heart failure, prolonged hypotension, and over-dosage of narcotics.

In all cases the question of performing a tracheostomy in the recovery phase was given careful consideration. However, since none of the patients required endotracheal intubation for more than 18 hours and since ventilation and evacuation of mucus were well under control at the time of extubation, a tracheostomy was not considered necessary. If there is any doubt, one should not hesitate to use this procedure.

The duration and severity of the underlying pulmonary disease is of importance in determining factors that may have contributed to the development of an obstructive crisis.

A last but most important aspect of prevention is the time factor. In all cases in the series there was a substantial delay ranging from 30 minutes to 24 hours before the ineffectiveness of drug treatment was recognized and more adequate help called for. If the possibility of this catastrophe is sufficiently appreciated, an early diagnosis of drug resistance and the prompt availability of a well-established plan of action should save valuable time.

The Prophylactic Use Of Isoniazid

TUBERCULOSIS MORBIDITY AMONG HOUSEHOLD CONTACTS*

Results of a controlled study among close contacts of newly reported tuberculosis cases suggest that isoniazid prophylaxis may be a valuable addition to a tuberculosis contact program.

Isoniazid has four requisites of the ideal prophylactic agent for tuberculosis; it is extremely effective in treatment, safe, cheap, and easy to take. Therefore, the Tuberculosis Program of the Public Health Service has undertaken a series of controlled trials of the prophylactic usefulness of isoniazid in different situations.

One of these trials was among household associates of new cases of tuberculosis who were enrolled in the study at the time the index case was reported to the health department. The present report is limited to tuberculosis morbidity observed in this trial.

Plan of Study

Contacts of 5,677 persons with newly re-reported tuberculosis entered the trial. They were located in 39 communities across the southern part of continental United States and in Puerto Ruco. After excluding 479 cases of active tuberculosis found on original examination of the contacts, 25,033 were entered in the prophylaxis trial. Of these, 12,594 were assigned placebo and 12,439, isoniazid. The plan of the study was such that only the central office (PHS) knew the code by which bottles of placebo or isoniazid were assigned. All contacts within one household were assigned the same medication, that is, all had isoniazid or all had placebos. Each contact was asked to take the prescribed number of pills for one year. Daily dosage was on the basis of 5 milligrams per kilogram of body weight, or, for adults, approximately 300 mg.

During the medication year, 24 persons on placebo and 34 on isoniazid (excluding five known not to have taken the pills) died of nontuberculous causes.

Boards of clinical investigators reviewed the clinical, bacteriologic, and roentgenographic evidence on all cases of tuberculosis without knowledge of the prophylactic medication the subjects had received.

Activity Status

Roentgenographic evidence of active primary tuberculosis was detected during the medication year in 29 persons receiving placebo and 22 receiving isoniazid. Among those uninfected at the start of the trial, 16 cases occurred in the placebo group and 5 in the isoniazid group. Twelve of the placebo cases and 3 of the isoniazid involved only enlargement of the lymph nodes, while 4 placebo cases and 2 isoniazid showed both parenchymal lesions and enlargement of lymph nodes.

Isoniazid had no effect on the number of cases of primary tuberculosis detected during the year among those infected (tuberculin positive) at the start of the trial, with 13 cases in the placebo group and 17 in the isoniazid group. It is generally agreed that the perifocal reaction discernible on roentgenograms appears at approximately the same time as skin sensitivity to tuberculin. This suggests that cases among the initially infected detected

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after the start of trial may represent primary disease actually present on entry.

Only 12 cases of primary disease have been observed since the participants completed their year of medication, 6 in the placebo group and 6 in the isoniazid.

During the year, extrapulmonary tuberculosis developed in 20 contacts, 16 of these had been assigned placebo and 4 isoniazid.

Pulmonary tuberculosis developed during the year in 62 persons assigned placebo compared with 14 persons assigned isoniazid. The difference is highly significant statistically.

The review board classified each case by the stage of disease at the time the case was discovered by the health department. Nearly one fourth had minimal disease; one half had moderately advanced disease; the others, far advanced disease.

Risk Factors

The risk of tuberculosis, chiefly primary disease, was high for children less than 5 years of age, but very low for children from 5 to 9 years. Ten to 14 years appeared to be a period of transition from low risk to the high rate of pulmonary disease in young adults. After age 15, the risk remained high until age 30, when it declined slightly, with a considerable reduction after 45 years of age.

The size of the initial tuberculin reaction was directly related to the risk of disease. The risk was lowest for contacts with reactions of less than 5 mm. of induration to 5 TU of PPD-S and increased with the size of reaction to a rate of 20 per 1,000 for those with the largest reactions.

Adult contacts in the placebo group who subsequently developed active tuberculosis weighed less than the average at the time they entered the trial. The initial weights of children who developed tuberculosis did not differ from the average.

Whether a course of isoniazid will eradicate an old infection so that it will never activate may be learned from continued observation of the participants. At present, the data will not support the hypothesis that isoniazid can permanently affect a dormant tuberculous focus. On the other hand, it would seem possible that isoniazid could permanently alter the course of a new infection by eradicating the tuberculous focus and its seedings, thus making subsequent endogenous reactivation impossible. The prevention of primary disease among the initially uninfected and the prevention of extrapulmonary disease give encouragement to this point of view. If this possibility should prove correct, prophylactic isoniazid could be particularly useful in populations in which much new infection is occurring. However, all populations with high rates of tuberculin reactors cannot automatically be assumed to have much recent infection.

At least two thirds of the contacts in this trial apparently took their pills with a high degree of regularity. From a strictly practical point of view, enough contacts took enough pills to cause a considerable reduction in tuberculosis. This response must be credited largely to the interest taken in these families by the cooperating health departments and probably also to the awareness of danger on the part of the immediate family.

Efficiently organized, the cost of adding isoniazid prophylaxis to an established contact program should be very little. Furthermore, an active procedure to prevent tuberculosis added to the usual passive policy of watchful waiting should improve considerably the cooperation of contact families.

Letter to the Editor

June 25, 1963.

To the Editor:
Dear Sir:

The editorial entitled Chronic Illness and Medical Care in the June, 1963 issue of The Nova Scotia Medical Bulletin was very timely. I would like to discuss several points raised by the author which are of particular interest. The suggestion is made that the use of chronic care facilities for teaching purposes would be of great value. I would fully agree, provided that the standards of these institutions are raised to the level expected in any teaching facility. The fact that the standards and quality of care provided in many long term care facilities leaves much to be desired has been well documented as a result of surveys and evaluations carried out in many communities in North America.

Efforts to improve these facilities have often begun with an increase in the number and types of facilities and services according to an over-all community or regional plan, such plans developing out of an evaluation of the community's needs. The provision of these facilities has not only released hospital beds for more appropriate use but has helped to ensure that the proper facility is available for the right patient at the right time.

In order to improve their standards, many hospitals have taken over the responsibility for medical care and other services in these long term institutions and some have even constructed their own nursing homes, chronic care wings and established home care programs etc. By so doing, these hospitals have not only raised the standards in these facilities but have provided the medical student with experience in the comprehensive care of the long term patient. Indeed, some hospitals have co-operative programs with nursing homes for the exchange of patients, when appropriate, and the joint training of nurses.

The editorial states the practitioner may feel "uncomfortable, insecure and frustrated" in not being able to help the chronically ill. I suggest that the provision of adequate long term care facilities and services of good quality and within the patient's financial means would go a long way to relieve this feeling of insecurity and frustration in both the physician **and** his patient.

Yours sincerely,

P. C. GORDON, M.D., D.P.H.
Assistant Professor of Preventive Medicine.

Personal Interest Notes

FISHING! What about the doctors who as we write, are in Labrador for trout? Who caught the biggest this year? Some folk do not go so far away, but lose no chances to try anyway. We are fishing too, - for NEWS ITEMS. What are the chances down YOUR way?

Colchester-East Hants Medical Society

Dr. Peter Handforth, of the staff of the Provincial Laboratory and Camp Hill Hospital, has been appointed Pathologist to the Colchester County Hospital (effective June 1, 1963).

Halifax Medical Society

"In the News"

Dr. E. M. Fogo was sworn in as Commissioner of Health for Halifax, June 18th.

Dr. N. H. Gosse has recently been elected President of both the Men's Canadian Club of Halifax and of the Halifax Rotary Club. In his speech at the 50th anniversary dinner, Dr. Gosse stressed the concept that the brotherhood behind Rotary's ideal of International Service must begin with each individual's realization of the unity of life. He queried whether Canada's foreign aid mirrored that realization when so little protest was made when even what this country does give was reduced.

June 18. Dr. S. H. Kryszek, provincial director of emergency health services, who has recently qualified as a Major in the Militia Group, was in charge of the practice evacuation of patients from the Victoria General Hospital. The 100 patients, volunteers from various sources, were moved by Maritime Warehousing to Gorsebrook school, the actual destination for patients in the event of a disaster, in 42 minutes. Dr. Kryszek hoped this example of experimental evacuation would be followed by other hospitals faced with similar problems of evacuation.

Dr. Gordon Wiswell, reporting, as medical director of the Central Registry office of the N. S. Society for the Care of Crippled Children said there were 2060 new cases reported this year - a total registration of 11,800 of these children, with speech defects forming the largest group, followed closely by mentally defective children.

The May Bulletin reported the holding of three clinics under the auspices of the N. S. Society of Crippled Children. Actually many more clinics by various "teams" have been held this season and others are planned for next fall. Places in which clinics have been held include:

Truro, Springhill, New Glasgow (2), Digby, Bridgewater, Liverpool, Shelburne, Lunenburg, Pictou, Port Hawkesbury, Baddeck, Neil's Harbour,

Guysboro, by Dr. Jack Acker and Dr. Coward, with an average of 65 patients seen, including an increase in new patients.

Going out in October will be the team of Drs. Ritchie and Sinclair with 2 day clinic in Port Hawkesbury.

A new clinic was held in Windsor this spring by Drs. Roberts and Acker when 50 cases were seen.

Births

To Dr. David MacD. Archibald and Mrs. Archibald (née Ruth Ann Morse) at Soldiers' Memorial Hospital, Middleton, June 9, 1963, a son.

To Dr. and Mrs. J. H. Altshuler (Barbara Ramage) at the Brookline Hospital, Boston, Mass., on May 31, 1963, a son.

To Dr. and Mrs. Bernard Badley, Inverness, at the Sydney City Hospital on May 26, 1963, a daughter.

To Dr. and Mrs. Peter A. Fillmore (née Anne Ellen Garvock), Chicago, Illinois, U.S.A., on June 5, 1963, a daughter.

To Dr. and Mrs. Wm. F. Mason (Fran Thomson) at Yarmouth Regional Hospital on June 7, 1963, a son.

Deaths

We regret to record the death of Dr. Frederick C. Garrow which occurred suddenly at his home, the Canso Medical Centre. Dr. Garrow who was 57, was born in Aberdeen, Scotland. After serving in the Second World War in North Africa and Italy he succeeded Dr. A. Elmik at the Canso Medical Centre and on the staff of the Eastern Memorial Hospital. We extend our sympathy to his wife and family.

We also extend our sympathy to Dr. J. G. D. Campbell and his son, Dr. John. Mrs. J. G. D. Campbell died on June 7th.

The Bulletin records with regret that Dr. Hugh W. Schwartz, who since his retirement from practice has been living in Bedford, has left to make his home in Ottawa. We congratulate him on his recent honor of being elected an honorary member of the Canadian Medical Association at the Annual Meeting in Toronto.

Dalhousie University

Dalhousie has been awarded the capital sum of $500,000 towards construction of a new Medical Science Building, by the Provincial Government. It has since been suggested in the press that such a building be erected on Anderson Square (now occupied by the Air Force).

Congratulations

To Dr. W. T. Josenhans, professor of Physiology who has received a $5,000 grant-in-aid from the Muscular Dystrophy Association of Canada for his project "Pulmonary ventilation and oxygen consumption during sustained contraction."

To Dr. R. L. Saunders, Head of the Department of Anatomy, who has been elected a Fellow of the Royal Microscopical Society London, England. His election followed the tercentenary celebrations of the discovery of the microscope, recently held in Washington, D.C. by the Royal Society. Work from the Dalhousie Anatomy Department was shown during the presidential address, "X-Ray Microscopy and its Implications for Biology".

Dalhousie will open a School of Physiotherapy this fall, thus becoming the fifth Canadian centre to establish such a school. Dr. Arthur Shears, medical director, N. S. Rehabilitation Centre announced at the Third Maritime Regional Conference on Cerebral Palsy that the centre will get 20 in-patient beds for intensive long-term management of cerebral-palsied and other cases as well as additional out-patient facilities.

Doctors throughout the Province who are graduates of Dalhousie will learn with nostalgia that "Mac" is retiring from his post as caretaker of the Forrest Building. For the past forty years, Mr. John R. MacLeod - to give him his official name, has been a very present help in time of trouble to many a med. student. Waiting for orals was made easier by his merry quip as he passed by. All will join in wishing him good luck.

Dr. and Mrs. T. K. Murray and family have left for Nashwaaksis, N. B., where Dr. Murray will begin practise. They have been visiting their respective families as well as friends in Boston and New York.

Sometimes it has been said that Doctors children shun their father's profession. Certainly this has not been borne out at Dalhousie, where in the Convocation of May of this year, eleven - 20% of the class, - doctors' sons received their M.D.

The following is a list of their names:

Brown, Robert L., son of Dr. and Mrs. R. J. Brown, Moncton, N. B.
Buffett, Lawrence M., son of Mrs. L. L. Buffett and the late Dr. L. L. Buffett of Glace Bay, N. S.
Curtis, John E., son of Mrs. E. M. and the late Dr. E. M. Curtis of Truro, N. S.
Gregory, James S., son of Dr. and Mrs. R. A. Gregory of Lancaster, N. B.
Holland, James G., son of Dr. and Mrs. C. W. Holland, Halifax, N. S.
Jacobson, Stephen A., son of Mrs. Morris and the late Dr. Morris Jacobson of Halifax, N. S.
Kaplan, Alan S., son of Dr. and Mrs. Wm. Kaplan of Great Neck, N. Y.
Langille, Roland A., son of Dr. and Mrs. J. A. Langille, Amherst, N. S.
McCleave, J. Graham, son of Dr. and Mrs. J. R. McCleave of Digby, N. S.
MacNeil, Arthur R., son of Dr. and Mrs. J. R. Macneil of Glace Bay, N. S.
Marshall, A. Cleland, son of Dr. and Mrs. A. M. Marshall of Halifax, N. S.
Murchison, Alexander J., son of Mrs. A. J. Murchison and the late Dr. Murchison of Charlottetown, P.E.I.
Murray, David C., son of Dr. and Mrs. J. C. Murray, Springhill, N. S.
Rosenthal, Gerald C., son of Dr. and Mrs. B. Rosenthal of Brooklyn, N. Y.

All over the Province as the various High Schools and private institutions close, proud parents receive congratulations on their childrens' accomplishments. Doctors in the Halifax area so to be congratulated include Drs. S. W.

Bethune, C. A. Gordon, D. V. Graham, L. S. Goldberg, C. Gordon MacKinnon, W. A. Murray, E. F. Ross, D. S. Roy, J. Slayter, L. Steeves, H. Still, H. G. Quigley and J. F. L. Woodbury.

Four professors from the Medical School presented papers at the sixth annual meeting of the Canadian Federation of Biological Studies, held in University of Western Ontario, London, Ont., June 17-19.

Dr. J. A. McCarter, head of the Dept. of Biochemistry spoke on phases of his cancer research.

Dr. J. G. Aldous spoke on the effects of poisons on cell metabolism. He is head of the Dept. of Pharmacology.

Dr. John Szerb, professor of Pharmacology presented results of his research into the effect of drugs on the brain cells.

Dr. S. J. Patrick, professor of Biochemistry, in cooperation with Mrs. L. C. Stewart, gave a paper on liver metabolism.

Doctors in the News Throughout the Province

In Digby County, Dr. Philip LeBlanc, Little Brook was the guest speaker at the graduation of 25 women in a Home Nursing Course at St. Alphonse. This course was sponsored by the Civil Defence and Canadian Red Cross branches of Meteghan and Saulnierville, and was under the direction of Mrs. Dave Dube, R.N., Meteghan.

In Annapolis County, Dr. Frank W. Morse, read portions from the recently compiled history of the Lawrencetown Baptist Church at its 90th anniversary. Dr. Morse has been chairman of a committee to compile this history. He discovered that Acadia University had its genesis in Nictaux Baptist Church - and so did the temperance movement in Nova Scotia. So also in Paradise, Annapolis Co., Dr. O. R. Stone, a graduate of Dalhousie in 1922, gave an interesting interview telling of his early years of practise, first in Guysboro County and later in the Valley. Not content with Medicine, Dr. Stone for over 20 years directed a non-denominational male choir who gave their services freely to entertain organizations in the Valley.

FIRST CLINIC IN NOVA SCOTIA set up in Nova Scotia by the Red Cross Society to collect this special blood for making the new anti-tetanus serum (TIG) was held on June 18 at Tri-Service Hospital (formerly Stadacona). It is hoped that TIG will soon be readily available to all hospitals.

NOVA SCOTIA CHAPTER - COLLEGE OF GENERAL PRACTICE OF CANADA

ANNUAL MEETING AND SCIENTIFIC SESSION

Held at Halifax, N. S. Sat. May 4th, 1963

With upwards of sixty practitioners attending and a first rate scientific program, this turned out to be perhaps the most successful and enthusiastic College Meeting held in Nova Scotia. The day itself, sunny and warm, after a long spell of miserable weather set the mood for the occasion and no doubt tempted the more distant membership out of winter hibernation for a day in Halifax. The morning sessions, both business and clinical were held at the

Children's Hospital. Dr. W. A. Cochrane and Dr. D. A. Gillis, assisted by members of the College who presented the case histories, picked out a fascinating series of medical and surgical paediatric problem patients for our distinguished guest teacher, Dr. Sydney S. Gellis, Professor of Paediatrics, Boston University School of Medicine, to discuss. Following luncheon at the Halifax Infirmary the afternoon sessions were held in that hospital's fine new auditorium. Commencing with another clinical program, the working part of the day ended with a second business meeting.

Dr. W. A. Cochrane, Professor of Paediatrics, Dalhousie University spoke on "Chronic Respiratory Diseases in Children", and Dr. Sydney Gellis then gave the Mead Johnson Modern Paediatrics Lecture on "Clues to the Early Detection of Birth Defects", which was generously illustrated by the most remarkable collection of medical colour slides that this writer has had the privilege of viewing. Subsequent enquiry revealed that these were but of a few of some thousands he has collected over the years!

The Annual Reception and Dinner of the Chapter completed the day and was held at the Nova Scotian Hotel where a large gathering of members, wives and guests assembled. We were glad to welcome at the head table, Dr. C. P. Gendron, Montreal, President-Elect of the College, and Dr. W. V. Johnston, our genial Executive Director. We were also happy to have as guests, Drs. Cochrane, Gillis and Gellis, who had done such an excellent teaching job during the day, and Dr. L. C. Steeves, Director of Post Graduate Studies, Dalhousie University whose cooperation made planning of the clinical sessions possible. Not least, we were happy to welcome as our guests several members of the Dalhousie Graduating Class of 1963 who intend to enter general practice.

Dr. Ian MacGregor, Halifax, re-elected President of the N. S. Chapter for the ensuing year presided at the dinner. Dr. Johnson and Dr. Gendron spoke briefly about college affairs and future aspirations, and Dr. Gendron presented the Upjohn and Schering post graduate study awards to Dr. D. C. Cantelope, Lunenburg and Dr. H. C. Still, Halifax respectively.

In summary, a most rewarding and worthwhile day for those who made the effort to leave their practice and attend.

H.C.S.

The following officers were elected to represent the Nova Scotia Chapter, College of General Practice of Canada, for the year 1963-64:

President	—	Dr. Ian MacGregor
Secretary	—	Dr. R. L. Langdon
Treasurer	—	Dr. D. Weir

Committee Chairmen

Membership	—	Dr. R. MacLean
Hospitals	—	Dr. A. W. Titus
Preceptorship	—	Dr. S. G. B. Fullerton
Internship and Residency Training	—	Dr. W. A. Condy
Continuing Education	—	Dr. K. Smith
Constitution and By-Laws	—	Dr. J. R. MacNeil
Fellowship	—	Dr. H. Still
Research	—	Dr. A. Prossin
Medical Recording Service	—	Dr. W. Verge
Public Policy	—	Dr. A. Sutherland
Sustaining Fund	—	Dr. J. Williston

Dalhousie Post-Graduate Division-Intra Mural Courses 1963-64-

Short Course in Anaesthesia : September 23rd to September 27th.

Dalhousie Refresher Course - November 4th to November 7th.

Eight extra mural courses will be presented throughout N. S. during the 1963-64 academic year.

Branch Medical Societies or Community Hospital staffs wishing to participate in such a course consisting of six meetings dealing with subjects of their own choice should contact the Director of the Post-Graduate Division, Dr. Lea C. Steeves promptly.