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GUEST EDITORIAL**THE POWER OF TRUTH**

The only lasting power public relations has is the power of truth.

Have we heard too much about "hidden persuaders," "Unconscious motivation" and "propaganda?" Are we afraid we will all be manipulated and lose our ability to make personal decisions and our free will? Is this why we feel ill at ease when as physicians, we honestly discuss medical public relations?

No responsible individual will deliberately plan a public relations campaign based on lies. The aim of public relations techniques is to create a positive image, but to be effective and to last, it must be based on truth. No longer can "the public be damned"; now the public needs to be informed if for no other reason than the fact that approximately every four years we have an election!

Why shouldn't The Canadian Medical Association "lobby" in the Canadian Parliament like the American Medical Association lobbies in Washington?

Simply stated, our parliamentary system has no place for the lobby system as votes follow party lines.

It is the opinion of the writer that even in the United States the A.M.A., lobbying campaign is beginning to fail. For eight years it was "successful" and it has won many battles but it has probably lost the war!

Revulsion against its lobbying techniques has spread to Canada and the negative aspects of the American Medical Association campaign appear in the writings and speeches of prominent Canadian journalists who mistakenly assume organized medicine in Canada has the same attitudes of reaction and laissez-faire.

In Canada the Medical Profession's Communications must be honest and constructive. We do NOT have the very best medical care—medical care can always be improved. But we must be realistic too. Our politicians will give us anything we are willing to pay for and social services have now the greatest vote-getting appeal and their costs always greatly exceed the estimates.

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Our immediate task is to compile all available information on Medical Services Insurance. We must know our present facilities and resources and their actual cost. We must also assess the "unmet needs", the possibilities of filling them and their probable costs.

Then we must, in all honesty and without political taint, transmit our facts and opinions to the public and in the process we must avoid a negative attitude or hostility towards any group or groups in the country.

As unemotionally as is humanly possible, we must take our message to the people, not by hidden persuasion or propaganda but by public relations with honesty and fairness and based on our good reputation.

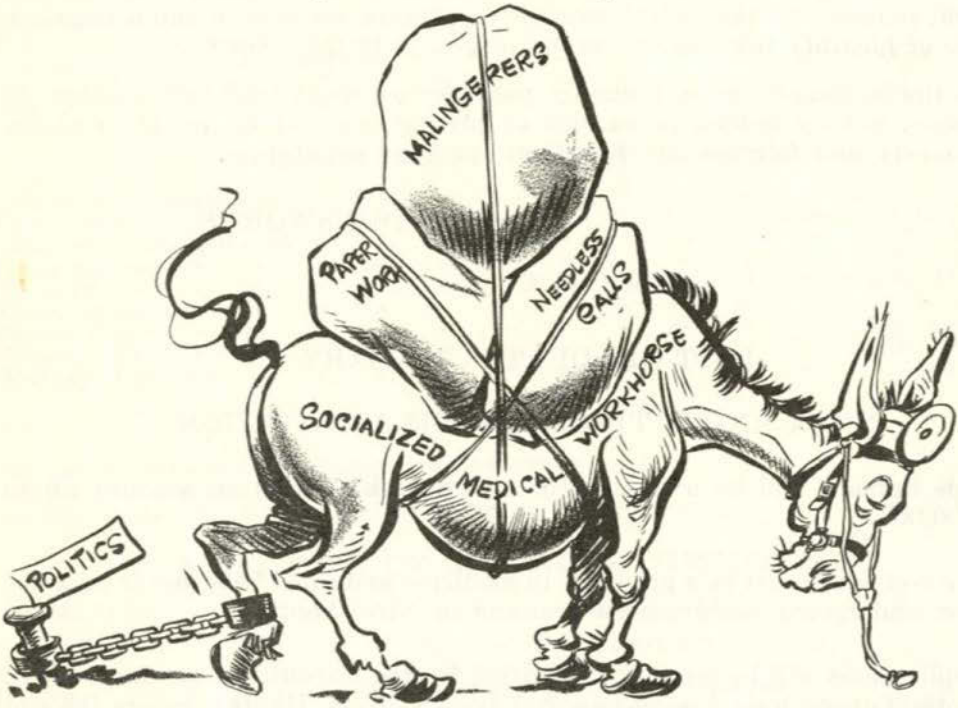
F. A. DUNSWORTH.

POST-GRADUATE BURSARY

NOVA SCOTIA TUBERCULOSIS ASSOCIATION

1. This bursary will be available for award each year in an amount up to \$300.00.
2. The recipient must be a graduate in medicine and must be either in practice or undergoing postgraduate training in Nova Scotia.
3. Applications will be received in writing by the Executive Secretary, Nova Scotia Tuberculosis Association, 353 Bayers Road, Halifax, before the end of January. These applications will be referred to a selection Committee to include a representative from Dalhousie Medical School and The Nova Scotia Medical Society.
4. The Bursary is to be used to meet expenses of the recipient involved during attendance at an approved postgraduate course in "Diseases of the Chest" such as those sponsored by the Canadian Thoracic Society, American College of Chest Physicians, American Thoracic Society or a like organization.
5. Each recipient will be expected to provide a written report of the post-graduate course attended within a month of the completion of it.
6. For further information address inquiries to Mr. R. J. Ricketts, Executive Secretary, Nova Scotia Tuberculosis Association, Suite 21, 353 Bayers Rd., Halifax, N. S.

THE JACKASS!



PICK IT UP AND GET GOING, DOCTOR!

Chambers

HIGH FISH DIET, OBESITY AND BLOOD CHOLESTEROL

C. M. HARLOW, M.D., Ph.D., D.Sc.

Camp Hill Hospital

Cardiovascular-renal disease continues to be the leading cause of death in this country, with the highest proportion of these deaths due to the complications of atherosclerosis. Happily, the less prevalent cardiovascular diseases are coming under better control. Because of the widespread use of sulfa and antibiotic prophylaxis and treatment of the infections underlying rheumatic and syphilitic heart disease, and with the advent of open-heart surgery for correction of congenital defects, these types of heart disease and their sequelae are being reduced. Not so happily ischemic heart disease, secondary to coronary atherosclerosis, remains the real challenge in the field of prevention and control. It is this challenge that we have been concerned with at Camp Hill Hospital for the past several years.

Atherosclerosis is a well-described arterial disease in which the focal lesions are characterized by intimal thickening, intimal and subintimal lipid deposition, deformation and fragmentation of the internal elastic membrane, vascularization and eventual fibrosis and/or calcification. The concept that atherosclerosis is a natural process of aging is no longer accepted by most medical authorities.

The pathogenesis of atherosclerosis has been only recently linked up with a variety of etiological agents and the concept of its arising from a single cause is obsolete. Olsen¹ has postulated the inter-action of the host and environment results in the production of the "Agent" of the disease.

ETIOLOGY OF HUMAN ATHEROSCLEROSIS (Olson).

(a) HOST

- | | |
|-------------|------------------------------|
| 1. Heredity | 5. Endocrines and metabolism |
| 2. Race | 6. Stress |
| 3. Age | 7. Concomitant Disease (i.e. |
| 4. Sex | Diabetes and Hypertension) |

(b) ENVIRONMENTAL

- | | |
|-------------|---------------|
| 1. Diet | 4. Occupation |
| 2. Drugs | 5. Climate |
| 3. Exercise | |

(c) AGENT

1. Serum lipids
2. Lipoprotein clearing factors
3. Coagulability of blood.
4. Local factors that effect response of the artery (anatomy etc.)

The possible role of diet, and in particular the quantity and quality of dietary fat, in the etiology of atherosclerosis and its complications, has aroused intense interest and considerable controversy. This aspect only will be discussed at the present time.

I am one of those who believe that a case has been made for dietary modification on the part of those who are a possible risk; that is, those who have

*October 25th, 1960, Staff Meeting.

already had a coronary occlusion, those who suffer from effort angina, or those who have a strong family history of coronary heart disease, those who are obese with hypercholesteremia, and finally the group of people who have Idopathic hypercholesteremia and are the most resistant to treatment. Even though all the facts are not scientifically proven, the motivated patient is entitled to make his own experiment, provided the dietary advice given by the doctor does not conflict with established principles of nutrition.

The hypotheses on which we have based our studies are as follows: (1) that diet may play an important role in the pathogenesis of atherosclerosis. (2) that the fat content and the total calories in the diet are probably important factors, (3) that it may be more the type of fat than the total fat, or the ratio or balance between the saturated and unsaturated fats that is the basic determinant, (4) that a wide variety of other factors, dietary and non-dietary may be of equal importance. Dr. Paul White describes ischemic heart disease as a 20th century epidemic. This atherosclerotic process affects the aorta, cerebral and larger vessels in the legs as well as the coronary arteries. It appears to be a single fundamental disease which can now be held accountable for much of the illness and more than half of all deaths occurring each year in the United States and Canada.

It appears that most people on this continent, whether we know it or not, consume an unbalanced obesity-producing diet. Katz and Stamler called it "a pernicious combination of overnutrition and undernutrition—excessive in calories, carbohydrates, lipids and salt; and frequently substandard in certain critically important amino acids, minerals and vitamins."

Protein is the keystone of human nutrition. It is essential for every form of life, for growth, pregnancy, formation of blood, bone and every vital tissue. It is essential for the healing of wounds, the warding off of infection, the maintenance of body weight, and the conduct of vital organs and glands in the body.

Meat, fish and milk are the greatest sources of animal protein. Vegetable sources of protein are wheat, beans, peas, lentils, soybeans, nuts, corn, rye and yeast. Normal adults and growing children require one gram of protein for every 2.2 lbs. of body weight. This means that the average man or woman weighing 125 to 175 lbs. needs from 60 to 80 grams of protein daily for normal nutrition. This would be contained in the equivalent of 1 lb. of steak, a pound of fish or a pound of cottage cheese.

In our discussions with well over two hundred men ages 25 to 59 we have found there is a marked lack of understanding of and more particularly the application of our laws of nutrition. How did we combat this weakness of over and under nutrition in this group? The first step was to motivate the interested patient to do something about his diet. The second step was a medical history and the third a physical examination and coordinated tests.

The patients for treatment were placed in four different categories. (1) Coronary artery disease with ischemia of heart muscle and hypercholesteremia. (2) Obesity with hypercholesteremia. (3) Idopathic hypercholesteremia. (4) Controls.

At the outset of treatment the patient was familiarized with Canada's Food Rules—namely:—

MILK

Children (up to about 12 years).....	at least 1 pint
Adolescents.....	at least 1 1/2 pints
Adults.....	at least 1/2 pint

FRUIT

One serving of citrus fruit or tomatoes or their juices:
and one serving of other fruit.

VEGETABLES

At least one serving of potatoes:
and at least two servings of other vegetables, preferably leafy, green or yellow
and frequently raw.

CEREALS AND BREAD

One serving of whole grain cereal:
and at least four slices of bread (with butter or fortified margarine).

MEAT AND FISH

One serving of meat, fish, poultry, or meat alternates such as dried beans,
eggs and cheese.

Our federal, provincial and urban government health and/or educational departments have been reasonably successful in making our children aware of these Health Rules in our schools, however, on the other hand we find our adults woefully ignorant of their existence.

The preliminary counselling of the patient by a nutritionist took place during the first step. Then after steps two and three were completed a decision was reached as to which one of the four groups the patient would be placed in for dietary treatment. At this stage the patient was aware of his disease or metabolic problem and the meaning of a balanced diet. He was then asked to keep a detailed account of his food and liquid intake (including alcoholic drinks) for one week; then further counselling was undertaken to help him arrange a balanced diet according to The Food Rules. We were always willing and encouraged the wives of these patients to take part in these interviews.

Our next problem was to educate the patient to eat a variety of foods within the plan in order to control the amount and the type of fat he was to get each day. This was partly carried out by substituting fish with its high protein and varying unsaturated fatty acid content in place of much of the weekly quota of meat with its high saturated fatty acid content. Butter and foods fried in animal fat were eliminated in most cases and eggs were restricted. In order to simplify their understanding of the variety of foods available we introduced them to the dietary pattern developed by the American Diabetic Association which is a simplified method for planning and following a diet. The whole system is based on the idea of "Food Exchanges."

All of the common foods are divided into 6 groups or lists, each one being called an "Exchange List". The six lists are: (1) Milk Exchanges (2) Fruit Exchanges (3) Vegetable Exchanges (4) Bread Exchanges (5) Meat and Fish Exchanges (6) Fat Exchanges. These lists follow quite closely our Canada Food Rules and the practical application of them is quite easy to follow. It almost eliminates the difficult problem of calorie counting. For example a patient having 2 oz. of hamburger for dinner from the Meat and Fish list could substitute 2 oz. of halibut or 2 oz. of chicken from the same list and receive a similar number of calories.

The obese patients were placed on an 1800 calorie diet of which 180 grams was carbohydrate, 80 grams protein and 85 grams fat. The weight loss of the obese hypercholesteremic man approximated 2 pounds per week and the cholesterol depression became more apparent as we replaced meat by lean meat and fish, eliminated butter in favor of corn oil margarine and corn oil supplements. This diet approximates the unsaturated fatty acid recommendations of Jolliffe². When the obese patient reached his considered normal weight the daily calorie intake was increased to 2600. Naturally the increase would greatly depend upon the type of work the man was doing daily. The added 800 calories would largely come from carbohydrate.

The patients of normal weight and the above mentioned obese patients now consumed approximately 2600 calories per day, and attempts were made to keep the unsaturated fatty acid to saturated fatty acid ratio approximately 3:1.

We are presenting 3 patients who have been under treatment for nearly 2 years. Patient number one (J.G.S.) was an obese man age 38 with hypercholesteremia and without known atherosclerosis. Patient number two (B.M.) is a 40 year old man with known myocardial infarction, hypercholesteremia and obesity. Patient number three (H.C.) was a 44 year old man of normal weight with familial essential hypercholesteremia and xanthomatosis.

RESULTS

Figures 1, 2 and 3 reveal the cholesterol and weight levels for these three men during their extended periods of treatment.

Figure No. 1 with its graph shows (J.G.S.) a supposedly healthy 38 year old male of 230 lbs. and a member of the R.C.M.P. This man noticed in-

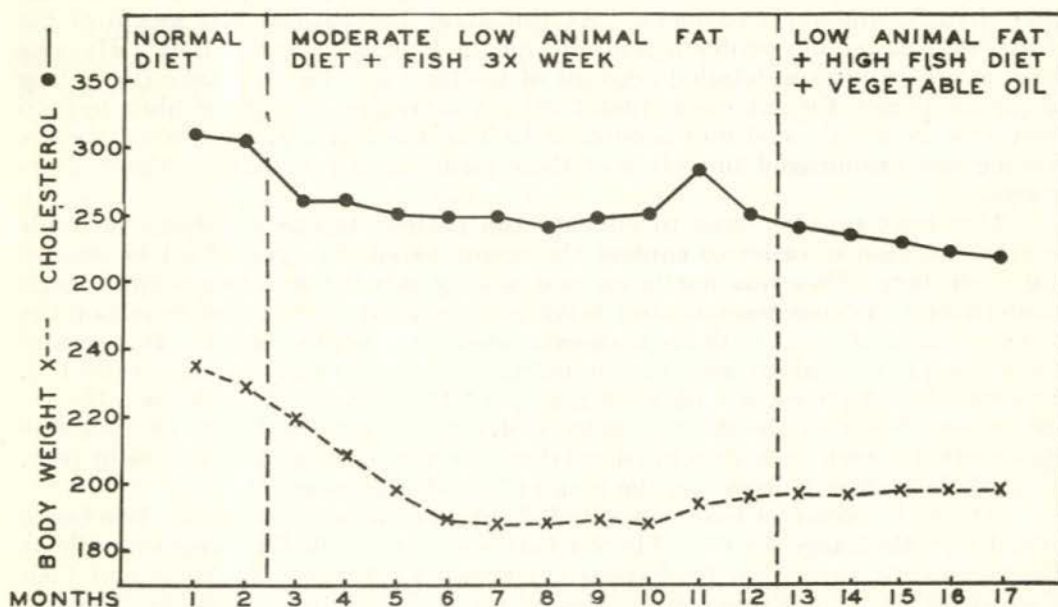


Fig. 1 (J.G.S.) A case of obesity and hypercholesteremia. The diet was patterned after our Canada Food Rules and fish (7X) replaced half of the weekly quota of meat and eggs. This man through his enthusiasm for this new-found rejuvenation has influenced many others to follow a similar course. It is also quite apparent to this man that his former unbalanced obesity-producing diet could be a factor in the early appearance of some of our degenerative diseases such as coronary artery disease and diabetes.

increased shortness of breath on exertion and realized he was considerably overweight. His physical examination revealed no active disease and he appeared to be an interested well-motivated patient. During the first 8 months of treatment J.G.S. cut out fried foods, ate lean meat, consumed fish 3-5 times a week, enjoyed plenty of vegetables and fruit, however he continued to eat two eggs per day, cheese and butter. Over this period the cholesterol dropped from 310 mg. per cent to 240 mg. per cent and his weight loss was 40 pounds. At the beginning of the 9th month J.G.S. went on summer holidays and his revised diet was interrupted by frequent barbecued steaks which resulted in a weight increase and a cholesterol rise to 284 mg%. On his return to duty and previous eating pattern the cholesterol again leveled off around 250 mg%. Several months later we mutually agreed that eggs should be reduced to 3 per week, Canadian cheese replaced by cottage cheese and corn oil margarine substituted for butter; this was an attempt to lower the cholesterol towards the 200 mg% mark and increase the ratio of unsaturated to saturated fat to the 3:1 level.

Three months after instituting this regimen the cholesterol had fallen to the 220 mg% level where it remains. J.G.S. now feels and looks physically fit and his new way of eating with regular exercise has influenced many of his friends to start the same pattern.

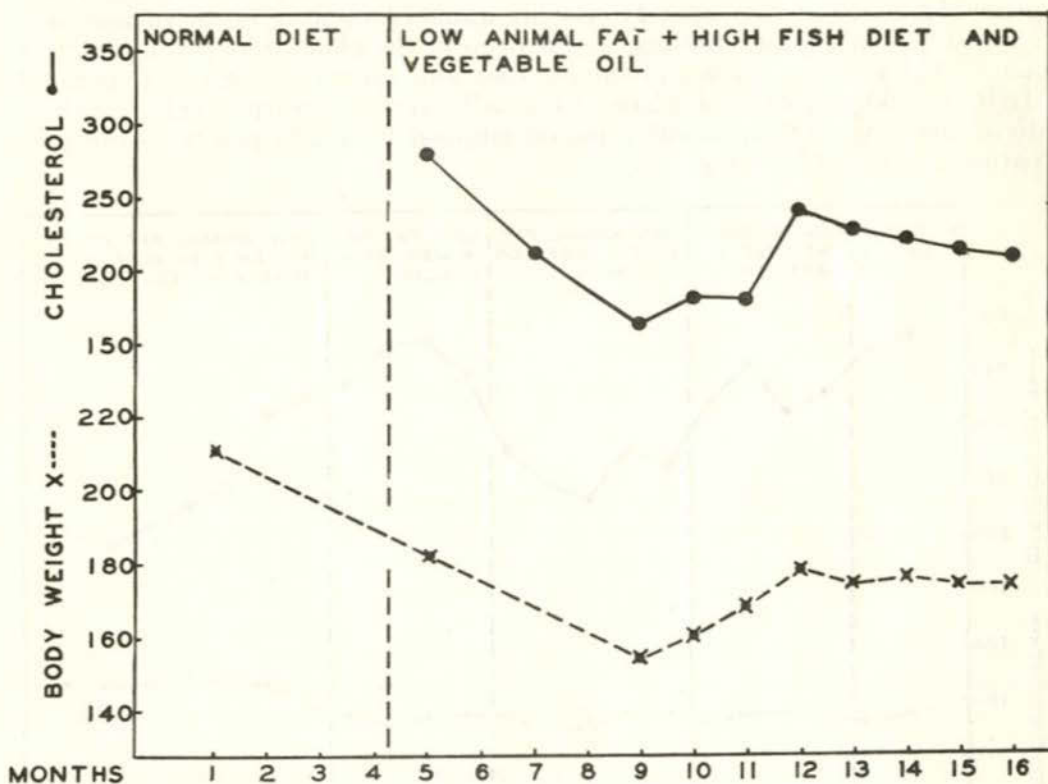


Fig. 2 (B.M.) This 40 year old man had a severe myocardial infarction. Cholesterol determinations were not available until the 5th month when the weight was down to 182 and the cholesterol was 280 mg%. During his dietary treatment he was hospitalized with a severe systemic virus infection which resulted in a weight loss below his considered normal and a cholesterol of 162 mg%. During convalescence and summer holidays diet did not receive strict attention which resulted in a cholesterol rise to 243 mg% on the 12th month. However (B.M.) is now well adjusted to the high fish diet and the cholesterol level is 210 mg%.

Figure No. 2 shows the graph of B.M.'s 16 months treatment. This man suffered a severe myocardial infarction at a time when his weight was approximately 210 lbs. A cholesterol level of 280 mg% was not available until 5 months later when the patient came to us at a weight of 182 lbs. and started on a high fish diet and low animal fat regimen. The cholesterol dropped to the 220 mg% level and has remained there except for a short period, when he was ill in the hospital with influenza and the percentage dropped to 162 mg% (certain infectious diseases are known to have a depressive action on cholesterol metabolism). During convalescence there was a gradual return of the cholesterol to pre-flu level followed by a short-lived rise during his summer holidays when an increased amount of animal fat was eaten.

B.M. is still under the watchful eye of his physician (a cardiologist) with whom we have cooperated during the dietary portion of his treatment. The patient now carries on his full-time former work (government executive) and feels capable of doing more as each month passes. His weight remains near the 174 lb. mark and his cholesterol between 210 and 220 mg%.

Figure No. 3 illustrates the cholesterol changes of (H.C.) a 44 year old male with familial hypercholesteremia. A low animal fat diet plus 2 oz. of safflower oil lowered the cholesterol level approximately 100 points over a 4 month period. This was followed by another 4 months period during which 1 gram of niacin daily was added to the low animal fat and safflower oil regimen. This resulted in another 100 mg% plus drop in the cholesterol level. At this time (H.C.) still on a low animal fat diet and niacin was given triparanol (MER-29) 250 mg. daily in place of the safflower oil. Surprisingly the cholesterol level over a four month's period climbed back 260 points to the pre-treatment level of 560 mg%.

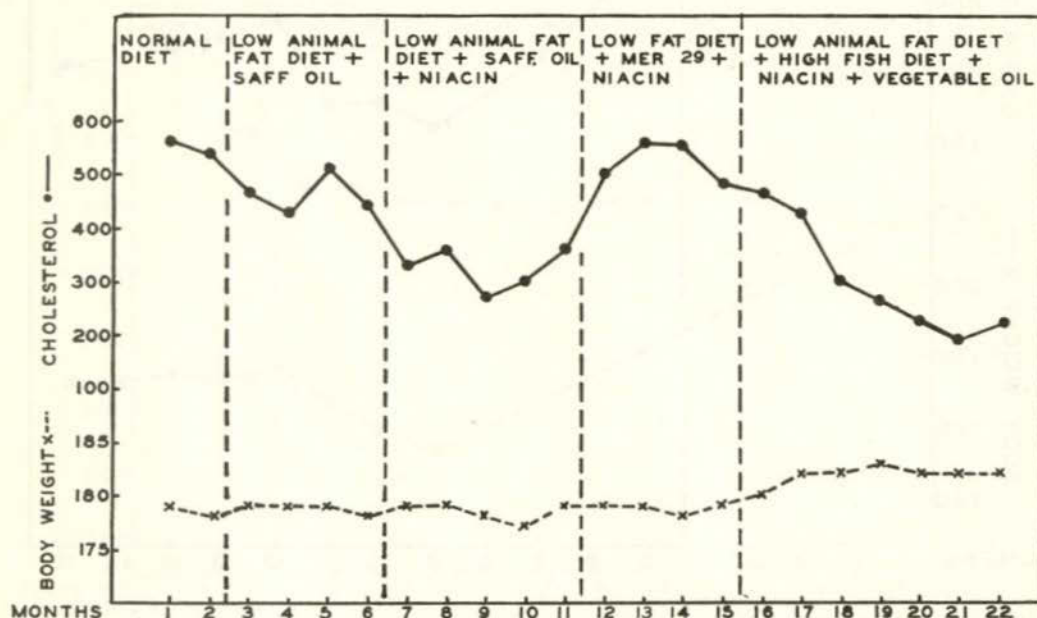


Fig. 3 (H.C.) Normal cholesterol levels were attained on a case of familial hypercholesteremia on a well balanced diet in which fish was one of the main sources of protein. One gram of niacin was given daily for its added hypocholesteremic effect. The vegetable oils used in cooking and salads made the meals enjoyable and at the same time gave a ratio of 3:1 of unsaturated fat to saturated fat.

At this point a diet high in fish (5-7 times a week) with its high protein and varying amounts of unsaturated fatty acids replaced over half the lean meat with its hidden saturated fat. The one gram of niacin daily was continued and the unsaturated fatty acid content of his diet was markedly increased by taking 2 oz. of corn oil daily in tomato juice. Corn (Mazola) oil was also used in cooking and corn oil margarine was consumed as a butter substitute. MER-29 treatment was eliminated.

(H.C.) was greatly pleased in being able to return to a moderately high fat (unsaturated) diet again as it greatly increased the tastiness of his food, and we have been very gratified to see the cholesterol level over a six month period drop consistently from 556 mg% down to 190 mg%. During the 20 months of treatment (H.C.'s) weight varied very slightly from normal. There has also been a very noticeable regression of the Xanthoma planum.

DISCUSSION

DIET AND OBESITY

Weight reduction was achieved without difficulty in two patients by moderately reducing the carbohydrate quota to about 40% of the daily food intake. In Canada carbohydrates provide nearly 50 per cent of the calories in the dietary.

The fat content of the 1800 calorie diet remained at the generous level of 43 percent. However the ratio of unsaturated fat to saturated was 3:1. Yudkin³ believes that by limiting carbohydrate and consuming as much fat and protein as one wishes no one consumes significantly more fat or protein than before. Therefore the diet is not high (within the normal 40-50% range for this country) in fat, contains fewer calories, and is nevertheless satiating. The protein content of this diet fell within the normal recommended⁴ range of 1 gram per kilogram of body weight. When the obese patients reached a weight level compatible with their body build and age the daily calorie intake was increased to 2600. This latter figure will be scaled upwards or downwards according to sex, age and type of work. Most of the 800 calorie increase is due to carbohydrate which now brings the relative fat content of the diet down from 43% to the 30-33% range recommended by the American Heart Association⁵.

DIET AND BIOCHEMICAL CHANGES

At the present time the most practical test to determine an abnormal tendency to develop atherosclerosis, if any test we have provides us with such information, appears to be the serum cholesterol determination. There is no question that coronary artery disease is more prevalent in individuals with an elevated serum cholesterol⁶. A serum cholesterol below 180 mg. percent can be regarded as "nonatherogenic", a level above 250 mg%, as constituting "high risk." Cholesterol levels between these two limits are intermediate insofar as the occurrence of clinical coronary artery disease is concerned.^{6, 7}

Reduction of serum cholesterol values to or near normal levels in 3 patients with hypercholesteremia was effected principally by a balanced diet featuring the 3:1 percentage of unsaturated to saturated fat. This was achieved with ease by limiting animal fat to 10% of the diet and increasing the fat obtained from fish and vegetable oils to 33%. By the frequent use of fish with its high, easily digested protein we were able to lower the animal fat significantly. Lean meats still contain varying amounts of hidden fat within the muscle fibers after all outside fat has been trimmed.

These findings agree with previous reports on the efficacy of saturated fat restriction and of the substitution of unsaturated fat; further, they show that a lipid-lowering diet is a feasible and attractive proposition. In other words we use Canada's Food Rules as our guide and by the Exchange system substitute foods with saturated fat by natural foods with unsaturated fat as the need arises.

These diets do not necessarily influence the prognosis of ischaemic heart disease, and much more extensive trials must be carried out over a period of years before a definite conclusion can be drawn about ultimate benefits. However in the meantime we might be well advised to consider the recent recommendations by a committee of the American Heart Association⁵.

"Who in Particular Should Modify the Fat Content of His Diet?"

(A) Most persons in the United States who are overweight will find it profitable to reduce their total caloric intake. Reducing the amount of fat in the diet is one way to do this. In addition to the possibility that atherosclerosis will be prevented, obesity will certainly be controlled. Regular, moderate exercise, exemplified by walking, is also desirable.

(B) Men with a strong family history of atherosclerotic heart or blood vessel disease, who have elevated blood cholesterol levels, an increase in blood pressure, are overweight and/or who lead sedentary lives of relentless frustration should consider modifying their diets. A diet moderate in calories and fat (about 25-35 per cent of total calories from fat) may be helpful for these coronary-prone persons. Substitution of poly-unsaturated for a substantial part of the saturated fat in the diet may also be a valuable addition to this program.

(C) Those people who have had one or more atherosclerotic heart attacks or strokes may reduce the possibility of recurrences by such a change in diet.

It should be borne in mind that moderate amounts of fat, particularly those containing an appreciable quantity of the poly-unsaturated type, are necessary for good health. Fat is an economical, and in limited amounts, a wholesome food. Food faddism of any sort should be avoided and significant changes in diet should not be undertaken without medical advice.

Therefore the reduction or control of fat consumption under medical supervision, with reasonable substitution of poly-unsaturated for saturated fats, is recommended as a possible means of preventing atherosclerosis and decreasing the risk of heart attacks and strokes. This recommendation is based on the best scientific information available at the present time.

More complete information must be obtained before final conclusions can be reached. Such information can be obtained only through intensified research into the causes and prevention of atherosclerosis—a program to which the American Heart Association is fully dedicated."

In our project on obesity and cholesterol control we have encouraged our patients to partake in a program of regular exercise. This will promote better health and aid in the normal absorption of our daily stresses.

SUMMARY

Three cases* of hypercholesteremia treated over nearly a two year period have responded well to a balanced dietary regimen. The diet following Canada's Food Rules and using the Exchange system has been generous in its

use of fish and vegetable oils. This plan brought the ratio of unsaturated fat to about the 3:1 level. Obesity when present was corrected and the cholesterol percentages dropped to or near normal values.

In our present state of knowledge a moderately low animal fat diet of sensible degree is a key step in the prophylaxis and treatment of the basic process of atherosclerosis and its sequelae. Unsaturated fats should be substituted in the diet not supplemented to it.

Possibly the physician should classify patients into low and high-risk groups as far as the appearance of clinical manifestations of atherosclerosis is concerned. Risk is increased by obesity, hypertension, hypercholesteremia and by a "bad" genetic background.

*A Complete report on a larger group of cases with controls will appear in another journal.

This study has been assisted by the advice of Dr. Lea Steeves, Associate Professor of Medicine and Chairman of Post Graduate Medical Studies, Dalhousie University; also Dr. Robert Aekman, of the Fisheries Research Station, Halifax.

Financial grants from the Department of Veterans Affairs and the Nova Scotia Fish Packers Association supported this investigation.

Our thanks are also extended to Dr. W. A. Murray, Assistant Professor of Medicine, Dalhousie University and to the Canadian Forces Hospital, Halifax for use of patient information.

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THE MEDICAL MANAGEMENT OF DROWNING AND SMOKE VICTIMS

By H. BRUCE PARLEE, M.D., C.M.
Saint John, N. B.

A great deal has been written and a great deal of instruction has been given to both the medical profession and the general public concerning first aid to drowning and smoke victims, and in all cases it has been stated that this is what you do until the doctor arrives! What can the DOCTOR do when HE arrives? Taking first the care of the drowning victim, it must be ascertained whether the victim has been immersed in salt water or in fresh, for on this fact hinges his treatment.

During the past seventy-five years, considerable information has been reported about the variations in physiology following submersion in salt water versus fresh water. When fresh water is inhaled, it is rapidly absorbed from the lungs and enters the blood stream, so that within a few minutes as much as 70% of the circulating blood may be composed of fresh water. This great dilution causes a critical fall in serum electrolytes and also ruptures the circulating red blood cells. These lose their hemoglobin and can no longer carry oxygen to the tissues and organs of the body. In addition, there is a prompt increase in blood potassium. This may cause grave changes in intracardiac conduction of the electrical impulse, resulting in fatal ventricular fibrillation. Moreover, the proteins in the blood rapidly accumulate in the alveoli and produce bubbling edema of the lungs.

If the victim has been submerged in sea water, the physiological picture is almost opposite. Instead of being diluted, the blood rapidly becomes concentrated because of the hyposcopic action of the salt in salt water, which pulls water out of the blood serum and into the lungs. Moreover, because the concentration of salt in sea water is 4 or 5 times greater than in the normal human body, salt is rapidly absorbed from sea water into the circulatory system until the sodium and chloride of the blood serum rise to extreme heights and produce convulsions. In addition, the magnesium content of sea water is very high, and in death by drowning in salt water, the blood magnesium may rise to 30 or even 40 times the normal. The exact physiologic effect of this very high blood magnesium has not as yet been clearly demonstrated, but presumably it impairs the conduction of the electric impulse within the heart muscle itself. Furthermore, the blood proteins in the plasma are sucked into the pulmonary alveoli by the salt water in the lungs. Pulmonary edema occurs almost immediately and unless relieved, will drown the victim in his own fluids.

Aftercare of the patient of near-drowning depends chiefly upon whether the patient inhaled fresh or salt water, therefore. In cases of the fresh water submersion, the doctor has a patient with a very dilute blood stream with a marked fall in the essential electrolytes. Treatment may be given by cautious intravenous administration of 1 litre of sterile, hypertonic sodium chloride solution (Sodium 3-5%). If the patient has been submerged in seawater, however, the doctor is faced with the opposite problem of a highly concentrated blood stream. The treatment of choice then is intravenous administration of sterile water, not "normal saline" solution, nor salt in any form.

Death occurring several hours or days later, due to "exposure", is in all probability the result of previously unrecognized electrolyte imbalance, edema

of the lungs, or pneumonia, or a combination of all three. These "complications" can largely be avoided by proper medical care of the victim of near-drowning based upon physiological rationale.

In the consideration of fire victims, we come to a very complicated situation. The concept of smoke poisoning is not uniform. It is not equivalent to carbonmonoxide poisoning in spite of the fact that carbonmonoxide is the most important of the toxic components of smoke and is usually responsible for the fatal result. The composition of smoke varies with the nature of the heated or burned material. In addition to carbonmonoxide and carbondioxide, the smoke may contain sulphur dioxide, acids, formaldehyde, nitrogen gases and other gases which are irritating to mucous membranes. The differences are less apparent in the acute stage. Here, at the onset, and at the height of the intoxication, the carbonmonoxide effect is most prominent. However, in the afterphase, it is the irritative gases which give concern, their action depending on their water solubility. The greater the solubility, the greater the irritative effect on the upper respiratory passages. The poorly soluble irritative gases exert their effect only after a certain length of time, and then only in the depths of the bronchioles and aveoli where the action has much more serious consequences. Irritation of the larynx, trachea and bronchi may lead to dangerous edema of the glottis, severe inflammation with secondary infection and prolonged lung complications. Damage to the bronchioles and alveoli leads to severe disturbances of respiration, to fatal pulmonary edema and heart failure. Characteristically, there is a latent period of several hours during which the affected person does not seem to be very ill and when there is increased danger due to physical exertion.

The clinical picture of acute carbonmonoxide poisoning is associated with conversion of half the hemoglobin into carbonmonoxide-haemoglobin, which requires a concentration of 0.2% carbonmonoxide in the inspired air. There is deep coma followed by excitement with convulsions and vomiting and death is due to respiratory paralysis. If the death does not occur immediately, it may be preceded by hypostatic pneumonia or severe myocardial damage. The mild preliminary stages are associated with headache, vertigo, apathy, somnolence. The carbonmonoxide is demonstrable in the circulating blood for a period of 24 hours.

The usual first aid measures should be implemented as soon as possible,—artificial respiration and warm blankets, with oxygen being administered as soon as possible. The patient should be kept at rest, lying down to avoid any strain on the heart. There may be some value in reducing the hyperglycemia with alkaline solutions. Stimulants such as strychnine, 1/30 grain, or atropine, 1/1000 grain, should be given periodically. The diet should be light and nourishing, with ample water to keep the kidneys flushed out. A cathartic should be given as routine procedure.

SUMMARY

The difference in treatment between salt water and fresh water immersion of drowning victims is discussed, the treatment for fresh water victims being the opposite to that of salt water victims. Smoke victims are treated primarily for CO poisoning, with a great deal of respect for other noxious gases which can do serious injury to the respiratory tract. The possibility of heart damage must not be overlooked.

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RADICAL LOBECTOMY. Cahan, W. G., *J. Thor. and Card. Surg.* 39:555, (May) 1960.

A radical lobectomy is defined as an operation in which one or two lobes of an entire lung, are excised in a block dissection with certain of their regional hilar and mediastinal lymphatics. This is to be distinguished from a simple lobectomy, in which the operation is restricted to a lobe or lobes alone. The rationale, for including the hilar and mediastinal lymph nodes in either a radical lobectomy or a radical pneumonectomy, is that the lymph nodes are the most frequent sites of metastases from cancer of the lung.

There are two major indications for a radical lobectomy. It is used to excise a peripherally placed primary cancer of the lung, in patients who cannot tolerate a radical pneumonectomy, or a lung tumor whose nature is ambiguous by reason of its association with a primary cancer at another site. It is also used for intrapulmonary masses whose nature remains equivocal even at operation.

Results of 48 radical lobectomies are listed in this paper. These were performed for 34 primary lung cancers, 9 metastases to the lung, and 5 benign, tumor-like conditions. In these patients who had a radical lobectomy either for a primary cancer or a metastasis to the lung, 41.5 per cent had hilar and mediastinal lymph node metastases. Eight patients were operated on 5 or more years ago, and 5 had positive mediastinal lymph nodes. Three of these are alive and well without evidence of disease. The survival for 5 or more years of those who had excision of cancer-containing hilar and mediastinal lymph nodes is attributed in large part to the more extensive lymphatic dissection associated with a radical lobectomy.

The author believes that the careful study of excised hilar and mediastinal lymph nodes as part of a radical lobectomy or pneumonectomy provides a valuable basis for prognosis. The pathologic study of these lymph nodes, together with the knowledge of the histology of the primary cancer and evidence of blood vessel invasion by tumor are three essential aids in forecasting survival.

The technique for removing each lobe with its regional lymphatics is described and diagrammed.

S.J.S.

THE MANAGEMENT OF HYPERTENSIVE DISEASE

DOUGLAS L. ROY, M.D.

Assist. Prof. of Med. Dal.

Assoc. Physician, V.G.H.

The treatment of hypertensive disease remains most unsatisfactory. This is due in part to our lack of knowledge as to the etiology and natural history of the disease, but mostly as a result of the poor principles of therapy which are generally practised. The latter is partially due to the high pressure promotion practised by most of the drug houses, but more due to our own gullibility, and to our zeal in making the patient better at any cost. The association of the many serious side effects, i.e., mental depression with rauwolfia, and the serious results of lowering blood pressure too rapidly with the use of the more potent drugs, far outweighs the little good that has resulted from the use of these drugs. This sounds like nihilism, but it happens to be true. If a fraction of the money spent on antihypertensive drugs which have been thrown down the drain were available for a concentrated research programme, the answer to the cause, the course and treatment of this disease might be available to us.

What does one do then with the patient with hypertensive disease? About 85% of patients with a blood pressure of over 150 mm systolic and 100 mm diastolic fall into the essential group. The remainder are due to renal disease (either diffuse parenchymal disease, as in glomerulonephritis, or unilateral, as in ischemic disease), coarctation of the aorta, pheochromocytoma or Cushing's disease.

A patient presents himself for the first time and his blood pressure is found to be 160/100. You will check his blood pressure at five minute intervals, and you will find that it drops to 135/90. You reassure him, perhaps will prescribe mild daytime sedation, recheck him at monthly intervals with the main object being common sense psychotherapy. If you are not successful, you should continue to check him at six month intervals, as the chances are this person will develop honest to goodness hypertension. This person requires no particular investigation except a good urinalysis.

Patient number two has an initial blood pressure of 180/110, which after (20) twenty minutes falls to 160/100. After doing your urinalysis and having palpated for femoral pulsations, you will see him again. If the blood pressure remains at an average of 160/100, you will have an intravenous pyelogram performed on an out-patient basis, and will collect a 24 hour urine specimen for urinary catecholamines (to help rule out pheochromocytoma). If these are negative you continue to see him at monthly intervals, and may prescribe daytime sedation or may use a drug of the thiazide group, e.g. chlorthiazide, continuing this drug only if blood pressure levels are favourably affected. Recently a derivative of reserpine has been synthesized* which reputedly does not have the mental depression effect which other drugs of this group frequently display. This drug may prove to have a place in this type of patient. The use of potent antihypertensive drugs has no place in the treatment of this patient.

*Decaserpyl, by Roussel of Canada

The third patient presents with a blood pressure of 240/150, which may or may not fall slightly after twenty minutes rest. He may have early symptoms of congestive heart failure or angina, or he may be asymptomatic. You perhaps find retinal haemorrhages and his heart may be enlarged. He does however have good femoral pulsations. This patient requires hospitalization, where he is kept at semi bed rest, and where blood pressures will be recorded every four hours. His cardiac, renal and cerebral systems are assessed. Pheochromocytoma and Cushings Disease are excluded by appropriate investigations. If his blood pressure falls precipitously on bed rest alone, you discharge him, and follow him at regular intervals. The effort in this patient will be directed to changing his way of life. Drugs used will be as with patient number two. Possibly the help of a psychiatrist may be enlisted. If none of these measures work, then more potent drugs will be required, but only if he is under 65 years of age.

Let us assume however that the blood pressure remains elevated after a week's bed rest. If advanced renal insufficiency is not present, one should proceed with a renal arteriogram and possibly the differential sodium excretion test. These will help to exclude renal arterial disease as an etiological factor. Having arrived at a diagnosis of "essential" hypertension of a severe degree, one then proceeds with a therapeutic regime. The therapy of choice in this instance in our present thinking would be guanethidine.*

Guanethidine has recently become available for general use, and appears to bear the most promise of the antihypertensive drugs of the more potent type. It appears to act on the sympathetic vasomotor system only, and does not affect parasympathetic impulses. Hence unfavourable side effects such as dryness of the mouth, constipation, impotence and paralytic ileus, which were features of the autonomic ganglionic blocking group, are not seen. A particularly good feature is its slowness of action, taking three to four days before reaching maximum effect. It is commenced at a dosage level of 25 mgm once daily, increasing by increments of 10 mgm every four days until a desirable effect is reached, or until side effects are noted. Side effects which can occur are postural hypotension, frequent bowel movements, weakness of the extremities, parotid gland tenderness, and bradycardia. The average dosage is about 60 mgm once daily. At times as much as 400 mgm daily may be required to achieve an effect. As the drug is frequently more effective when the patient is in the standing position, it is mandatory that blood pressures be recorded in the standing as well as the lying positions. This drug is reputed^{(1) (2)} to produce satisfactory clinical response with lowering of blood pressure below 160/100 in the standing position in about 40% of cases, with a fair response in another 40%, and no or unfavourable effects in the remaining 20%. This drug, or any other potent antihypertensive drug, should be used with great caution, and best not at all, in patients over sixty-five years of age.

If no appreciable effect has been achieved with Guanethidine despite high dose levels, then one adds a drug of the thiazide group, using a dosage of something like 500 mgm of Chlorthiazide twice daily, remembering to add liberal amounts of potassium salt to their diet. If this regime fails, then one commences with a drug of the autonomic blockader group, i.e. mecamylamine hydrochloride.** This group has found disfavour because of the severity and prevalence of side effects, and also because of the tolerance which frequently develops. If this fails one again adds a drug of the thiazide group. If this

*Ismelin Ciba.

**Inversine, Ciba.

fails then one would try hydralazine,* followed then by other drugs of the ganglionic blocking group, with the hope that a better drug will be developed before the patient suffers some catastrophic event.

If on the other hand this patient is found to have significant renal insufficiency characterized by low fixation of specific gravity and urea retention, as caused either by primary renal disease or renal disease secondary to hypertension, then one avoids this more potent group of drugs. Blood pressure depression by this group of drugs will likely accentuate the renal insufficiency and possibly precipitate frank uremia. The drug of choice in this instance is hydralazine, which may effect blood pressure depression and yet not cause decrease in glomerular blood flow.

To summarize:

- (1) Hypertension remains a vexing therapeutic problem.
- (2) The milder labile hypertensives are best treated by office psychotherapy and daytime sedatives.
- (3) The moderate hypertensives are best treated by this same routine, with the possible use also of one of the newer reserpine derivatives, or a drug of the thiazide group.
- (4) Guanethidine with or without a drug of the thiazide group appears to be the best regime for the severe hypertensives, although there remains considerable latitude for improvement.
- (5) Blood pressures are to be checked in the standing as well as the lying positions when drugs of the autonomic blockader group are used.
- (6) Caution is to be used in the use of antihypertensive drugs in people over sixty-five years of age.
- (7) Be assured that before you treat hypertensives in a non-specific manner that you are not dealing with a type of hypertension that has a known and remediable cause.
- (8) Hydralazine appears to be the drug of choice when hypertension is complicated by severe renal insufficiency.
- (9) Above all, be ever conscious of the balance of good and bad which your treatment is achieving.

*Apresoline, Ciba.

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INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of July, 1961

Diseases	NOVA SCOTIA				CANADA	
	1961		1960		1961	1960
	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	0	0	6	24
Diarrhoea of newborn, epidemic (764)	0	0	0	0	6	4
Diphtheria (055)	0	0	0	0	3	1
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	2	0	0	0	45	157
(c) Unspecified (048)	135	0	0	0	161	62
Encephalitis, infectious (082.0)	0	0	0	0	4	2
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	2	0	0	0	51	0
(c) Unspecified (049.2)	0	0	0	0	2	137
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	35	0	36	0	627	249
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	2	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	2	0	0	0	21	165
Meningococcal infections (057)	0	0	0	0	5	11
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	0	0	23	0	225	357
Poliomyelitis, paralytic (080.0, 080.1)	0	0	1	0	6	90
Scarlet Fever & Streptococcal Sore Throat (050, 051)	36	0	195	0	416	748
Tuberculosis						
(a) Pulmonary (001, 002)	20	0	15	1	xx	518
(b) Other and unspecified (003-019)	3	0	2	0	xx	68
Typhoid and Paratyphoid Fever (040, 041)	0	0	0	0	27	23
Veneral diseases						
(a) Gonorrhoea —						
Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	13	0	25	0	1121	1439
(b) Syphilis —						
Acquired—primary (021.0, 021.1)	0	0	0	0	0	0
— secondary (021.2, 021.3)	0	0	0	0	0	0
— latent (028)	0	0	2	0	0	0
— tertiary — cardiovascular (023)	0	0	0	0	0	0
— „ — neurosyphilis (024, 026)	0	0	1	0	0	0
— „ — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	1	0	3	0	151*	181*
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases:						
Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Psittacosis & ornithosis (096.2)	0	0	0	0	1	0
Rabies in Man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial infections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	0	0	0	0	3	0
Trichinosis (128)	0	0	0	0	5	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0

*Not broken down

C — Cases D — Deaths xx—figure unknown

Complete figures for Nova Scotia not available

COMMENT

I. H. VIRUS

Working with prison populations Rightsel et al¹ and Biggs et al² have elaborated techniques permitting the isolation and propagation of viruses capable of causing hepatitis in man. The development of diagnostic antigens and vaccines to infective hepatitis is an early possibility now that these first necessary steps have been taken.

1. RIGHTSSEL, W. A., et al. Status Report on Tissue Cultured Hepatitis Virus. J.A.M.A., 177, 671 (1961).
2. BIGGS, J. D. Ibid. Clinical Trials.

MEASLES INOCULATION

The prospect that measles may soon be added to the growing list of infectious diseases protected by attenuates has become something near a reality with the publication of the first clinical trials. Karelitz et al¹ used an attenuated vaccine prepared from the Edmonston strain of Enders. Of 88 children who had been non-immune, the 86 who were followed up gave serological evidence of immunization similar to that following ordinary measles. In ten of the non-immunes the fever and malaise resembled that of ordinary measles whilst the remainder 'carried on as usual'. One ml. of the vaccine was injected subcutaneously into the arm and the mean day of onset was D7, the range being from D5 to D12. Three differently processed vaccines were used in the experiment with some difference in response. Three cases of mild catarrhal otitis media were noted and one of bronchitis. An interesting observation is that the disease was non-infective. Cabasso et al² report a similar series with the same strain of virus and similar results. He failed to demonstrate virus in the blood.

One suggestion could be usefully tried out in future trials. The evolution of the natural disease often shows itself at its most intense at the portals of entry—the eyes, pharynx, bronchi and lungs. The progress of the rash and the severity of the skin lesions also tend to be at their most severe in relation to these sites, tending to diminish considerably as the rash progresses away from the portals of entry. There is, therefore some clinical support for reversing this progression by allowing the first evolutions of the induced disease to take place as far from the vital centres as possible so that the defence mechanisms may have the maximum time to come into play. The lower thigh would seem a suitable site.

1. KARELITZ, SAMUEL, et al. Measles Vaccine. J.A.M.A. 177, 537. (1961).
2. CABASSO, V. J., et al. Measles Immunization. J. Pediat. 59, 324. (1961).

BOOK REVIEW

Resuscitation of the Newborn Infant. Edited by Harold Abramson. The C. V. Mosby Co., 1960, St. Louis. pp. 274. Price \$10.00.

As the preface says, "This is the story of the resuscitation of newborn infants—what we know and what we do not know." The editor chose as collaborators eminent specialists in the relevant disciplines, many of whom have been associated with the now famous Special Committee in Infant Mortality of the Medical Society of the County of New York.

Essentially this book is a compilation of existing information and speculation on newborn resuscitation. As such it is a rich source and reference volume for the teacher and investigator, or others with particular interest in the subject. It is not a book for the tyro or one who wants a straight-forward 'how to do it' manual.

Several paragraphs took me by surprise, for example:

The statement is made: "It is also surprising that the obstetrician should . . . be called upon to be the pharmacologist and physiologist and have a readily available knowledge of the various volatile anesthetic agents and the many drugs used for conduction anaesthesia *as well as the sedatives and analgesics, their compatibilities and incompatibilities, and their antidotes*". Why, we ask, since he assumes over-all responsibility for a delivery, should he not be expected to have and use this knowledge? It's all very well to treat by committee in the sense that consultation is a useful habit, but surely one doing obstetrics ought to have general competence.

And again it is suggested that the anesthesiologist should, with regard to the infant, (a) be responsible for the airway, (b) oxygenate, (c) laryngoscope, (d) intubate, (e) do the Apgar scoring, (f) aspirate the stomach, (g) detect anomalies, (h) and keep records—we presume he shall also see to the mother?

The authors have done their homework well, and there is a magnificent bibliography and a useful glossary. In sum then, this book is a very useful contribution for the specialist who studies these matters, and is a good reference work which should be in every medical library.

S.C.R.

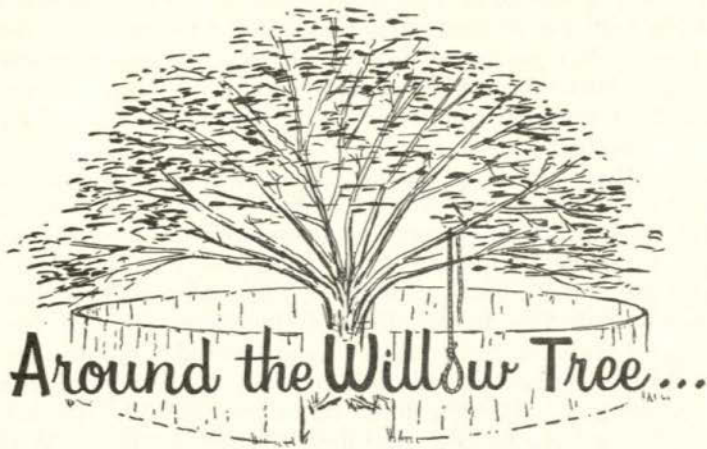
BOOKS RECENTLY RECEIVED

MEDICAL PHYSIOLOGY, 11th Edition. By Philip Bard, 1339 pages; The C. V. Mosby Co., St. Louis, Missouri. Price \$16.50.

APPRAISAL OF CURRENT CONCEPTS IN ANAESTHESIOLOGY. By John Adriani, 279 pages; The C. V. Mosby Co., St. Louis, Missouri. Price \$7.75.

REHABILITATION OF A CHILD'S EYES, 3rd Edition. By Herbert Katzin and Geraldine Wilson, 107 pages; The C. V. Mosby Co., St. Louis, Missouri. Price \$3.75.

THE DOCTOR'S COLUMN



The Editor,
N. S. Medical Bulletin.

Sir,

May I avail myself of some of your space on the subject of Dr. Atlee's article in MacLean's Magazine. I write as a G.P. so that I have no particular surgical axe to grind.

The general tenor of the article is quickly evident when the title "Why Surgeons Operate" is seen to be completely at variance with the opening words of the first paragraph. "Why Surgeons Operate" is a reasonable and interesting topic to the lay public and if reasonably and interestingly pursued could be a valuable contribution to public relations at a time when the profession is putting its case before the Royal Commission. But the topic is not pursued at all. The first line of the first paragraph proceeds "Is too much Surgery being done"? and we are instantly aware that one of those dreary 'blow the gaff on surgery' outpourings, so much favoured now-a-days by editors in frantic efforts for a circulation boost, is forthcoming, and we find that our hunch is correct.

Surgeons operate for good and well-defined reasons. These are well understood not only by surgeons but also by all those actively engaged in any branch of medicine. In the general climate of acceptably good surgery it has been my experience that the rules have not only been observed but have been scrupulously observed. Indeed, when the abdomen has been opened and a normal appendix has been removed, a sense of failure has been the usual reaction on the part of the surgeons I have worked with. If the question had been framed "Do some surgeons operate beyond the accepted indications" then I would say that here and there that a few do, that they are known to all of us and are not used by any GP who values his good name. I would also say that as the practice of Surgery continues to evolve not only technically but ethically, and as more and more good well trained young surgeons from the teaching centres are adding their services to the pool available, such offenders are gradually retreating to the periphery. Certainly with mounting modern controls, tissue committees and such like any institution that condones such practices is not worth the name of Hospital.

Dr. Atlee has clearly acquired all the arts of sensational journalism and most especially the practice of picking out the exception to illustrate the general. First he turns his guns on ventral suspension of the uterus. At the end of my student days twenty-five years ago this was then a declining practice in gynaecological surgery. But it must be remembered that at one time it had the sanction of the best surgical opinions of the day until surgical opinion itself proclaimed its ineffectiveness.

Then he cites the instance of the noted London surgeon who was removing most of the large bowel to cure chronic constipation—'*not long since*'. This old standby for telescoping the years—inadmissible in good factual writing—referred in fact to what happened *some forty years ago*. The surgeon was no less a light than Sir William Arbuthnot Lane who had persuaded himself that much illness—including tuberculosis of the hip in children—was attributable to intestinal toxæmia from large bowel 'stasis'. Consequently instead of tending the hip he gave the children permanent diarrhoea in addition by performing a colectomy. His methods of course quickly fell into disrepute and he ended up by writing faddish diet articles for the "Daily Mail" for which he got struck off the register. So ended the career of a brilliant technical surgeon but slightly screwy upstairs. There are quite a few around it seems.

But the real villain of the piece is not our elderly Emeritus Professor whose amiable eccentricities we have long learned to tolerate. It is to Mr. Blair Fraser, the Editor, that this type of article must be attributed. No editor can absolve himself from the content of what he publishes merely by quoting its source (with inset photograph) however exceptionable the author. Maclean's partly owes its existence to its role as the Canadian national magazine and in this sense it bears some responsibility towards its patrons in conveying the proper Canadian Climate on every aspect of Canadian life. To publish a sweeping condemnatory article of this type with nothing save the word of the author to substantiate it is surely an excursion into hysterical journalism that only the most foolhardy of editors would undertake. The recent blood transfusion article was another case in point. It had been recognized by reports in the medical journals that this most valuable and life-saving procedure *was* being overused to some extent and since occasional tragedies or illnesses ensued, doctors were enjoined to adhere to strict standards of necessity in all cases where the transfusion of blood may seem desirable. Thus the weights to restore a proper balance came from within and through the usual channels of the profession itself but they were used by the authors and published by the editor to add a little more confusion to the general fallout from the press.

The truth is that anything of outstanding use in Medicine tends at first to be overused so that every patient might have the very best chance of recovery. Penicillin and the antibiotics are instances where this is so. There is no reason why Mr. Blair Fraser should not publish something along the lines of "Penicillin,—the New Killer" because anyone with time and inclination could easily quote a hundred cases of death directly attributable to penicillin from the medical journals of the West and conveniently slur over the huge benefits that have accompanied its use.

It is not then that we wish to deny Dr. Atlee his views, but that like the blood transfusion article they do not reflect the views of the generality of medicine as practised today and for that reason should not be offered for reading by a responsible editor. That may not bother Mr. Blair Fraser, but it bothers me. A few surgeons make a lot of money—yes. A few so-called surgeons like a few so-called editors are not too scrupulous—yes. But the

general run of surgeons who don't talk or write much, who stick around with the job and only drop out when the trumpets sound on the Other Side—they constitute the true surgical climate of Canadian medicine and they are good and solid citizens.

A LOCAL G.P.

AS DR. BENGE SEES IT.

Sir,

Dr. Bengé is right. Yes Sir. I should know *for I have suffered myself** Allow me some of your valuable space to tell you my story in the hope that others may be spared my misery.

I passed out with my surgical fellowship thirty years ago from Oklohoma State University. The first few years went along very quietly for me—just a little *social* surgery here and there—a few tonsils and VV's the odd appendix, a hysterectomy now and again—all very quiet and peaceful enabling my wife and I to live comfortably above the bread line. But gradually I began to extend my field—I mixed it a little. I was content with this for a while, but the mixture was heady. I thirsted for more. Then suddenly it really got me. I cut, I sutured, I drained, I excised, anastomosed, otomied, ectomied, yes—I even suspended. Even at night I would cry out from my sleep, 'snap, sponge, cut, blockhead, how stupid can you get, 'Serub, for God's sake give your sterile self a shake' until my wife, who was still living with me, put one of her cold feet on my back and quickly woke me up. But finally the worst of all happened. *I started before breakfast*. Well of course that lead to the usual thing—I soon didn't take any breakfast at all. Right through the day I went on late into the night, sometimes steadily, but usually with an all-consuming, compulsive fever. This went on for twenty years. Everything came my way. I got three wives, five homes, six Cadillaacs, a pile of real estate and a stash of bonds. I had everything, but it was not enough. I thirsted, thirsted, I THIRSTED FOR MORE. I couldn't leave it alone.

But one day a fine friend of mine saw my pitiable condition and put me in touch with Surgeon's Anonymous. Ah, my friends, the relief. Let me tell you of my first refusal. A woman came into my office one day shortly after I had joined. "It's my gall bladder acting up" doctor" she said. "They tell me you're the best" "There's only one thing for that" I said from long force of habit, cutting her short. Then it was that SA came to my aid. Suddenly I thought of the thousands of SA's like myself, firmly resisting the scalpel and putting the temptation quietly behind them. But, oh the strain of it. In a moment of weakness I walked to the instrument cupboard and lifted a scalpel lovingly from its case. How it shone and glinted in the cold light. With a quavering hand I snapped a new blade in it, one with a seductive curve that I had learned to love so well. Then it all came back to me . . . the room of silent, watching eyes, the 'sleeper' stabbing frenziedly at an elusive vein, the inviting slab of flesh stretched on the table before me, the hiss of the scrub nurse to her minions, the ham-handed GP coming in for his cut . . . I tested the blade gently on my palm. . . But my SA training won out in the end. "Mrs. Bulge," I said hoarsely, "for God's sake don't tempt me. I'm off it now. Go to Dr. Smith in the next block. He'll fix you up." When I recommended my foremost competitor to her I knew that I was cured.

Now I'm back to my own happy self again. My three wives, five homes, Cadillacs, real estate and bonds have all gone. I live in a two-roomed shack with my '56 Volkswagen. Most of the time I fish and when I don't fish I hunt. And I don't cut any more. I just scratch. SA trained me in Allergy. It doesn't get you the same.

I am, Sir,

Julius McCroncken (S.A.) Allergist.
Late FRCS (A, C & E)
Indian Gulch. Pa.

RE D.P.T. POLIO VACCINE

Recently several doctors in the Halifax area have returned, to the Department of Health, a number of vials of D.P.T. Polio Vaccine, lot number 464-1, stating that it was cloudy or more yellow than usual or that it contained crystals. They were afraid that this particular lot of vaccine might be unfit for use.

I suspect that these doctors were more concerned about the color of the vaccine than about its cloudiness. The product is supposed to be cloudy since it contains a suspension of hemophiles pertussis. We were unable to detect any crystals in any of the vials returned to this office.

We had some of this vaccine examined at the Connaught Medical Research Laboratories and the following report was received.

"The whole of lot 464 is a little more orange in color than some others. This is due to the presence of a little more red carbon dioxide than we usually have. Repeated tests for toxicity and for contamination have been entirely negative.

We have no complaints of unfavourable reactions from this lot and we see no reason why it should not be used. Doctors who are concerned might be advised not to keep partly used vials for more than a few days. It is easy for them to become contaminated in office practice with one or more varieties of Pseudomonas which are resistant to bacteriostatic preservatives and which often will grow at refrigerator temperatures."

Further tests on this lot of vaccine carried out more recently have also proved to be entirely negative.

The Health Department,
Halifax.

AN APPRECIATION—WALTER LESLIE, M.D., F.R.C.P. (C).

The life of this man of ability, integrity and good will was prematurely and suddenly cut off at the age of 59 years on October 7th, 1961.

Walter Leslie will be remembered in Halifax and throughout the province as a physician and servant of mankind. He was a Fellow of the Royal College of Physicians of Canada and chief consultant in neurology at the Victoria General and Camp Hill Hospitals. He also gave faithful service as a member of the Medical Faculty of Dalhousie University. The breadth of his clinical experience was acknowledged by those who worked with him and he was an able diagnostician in his specialty.

He served Canada well in the Armed Forces during the Second World War. His interest in community affairs and education was exemplified by his support of the Halifax Grammar School, to which he gave willingly of his time and resources. He was President of the Parents' Group at the time of his death.

He will be remembered as a good husband and father. His love for his wife, Catherine, was apparent to those who knew them well. He worked for superior education for his children: Joyce, Gertrude and Walter, Jr.

Walter Leslie will also be remembered as an intellectual and philosopher. He was a voracious reader and an unconventional, independent thinker. His hobbies included building radio sets and working out calculus problems. He was an uncompromising searcher for truth, a constructive critic.

"The constructive critic maintains organic fellowship with other members of society It is a bond which makes him meek before the lowly and fearless before the mighty; for he knows that his need and their need is the same and that all men are helpless without one another Furthermore this community cheers and sustains him because it is the promise and potency of that richer, better life and more adequately organized society for which he works."

(Henry Nelson Weiman, *Methods of Private Religious Living*.)

In leisure moments Walter Leslie would gladly and effectively debate almost any subject one would be likely to raise. These encounters will be missed by many of his friends. To sit at a table with him at a Medical Society dinner ensured its success.

He and his family recently indulged their fondness for animals, fields and woods and the wholesome rural life by taking on the responsibilities of a farm. This setting provided the quiet atmosphere, conducive to thought and study, which he often sought. His last illness—unfortunately brief—took place in these surroundings.

Walter Leslie will long be remembered for his significant contribution as a physician, for the influence of his able mind on many, for his readiness to serve, and for his courage, loyalty and trusty friendship.

W. I. MORSE, M.D.

AN APPRECIATION—DR. FREDERICK JOSEPH GRANTILLE

“Let us continue to advance, to give as a free and united profession, as a profession willing to give freely, forgetting that sense of greed, as giving and receiving in return a just reumeration for service we always willingly gave to a people of a free and democratic state.” It was with these words that our late colleague, Dr. F. J. Granville, closed his presidential address at The Nova Scotia Medical Society Meeting in June, 1961.

Dr. Granville died suddenly on the morning of September 19, 1961, in the anteroom of the operating theatre of the Aberdeen Hospital in New Glasgow, while he was preparing to do surgery.

Frederick Joseph Granville was born in Halifax, Nova Scotia, April 7, 1907, a worthy son of kind, but firm parents. His early school education was in Halifax followed by a brief spell in North Sydney during and immediately after the First World War. He continued his school education at College St. School, Halifax, followed by high school at St. Mary's College. He then entered Dalhousie University for his pre medical and medical studies, from which university he received his M.D., C.M. in 1933. He was on the staff of Camp Hill Hospital following graduation until September, 1934 when he went to Stellarton, at first associated with the late Dr. G. W. Whitman, and then taking over the entire practise on Dr. Whitman's death in April, 1939.

He was always very active in community affairs as well as in those of his profession. He was an active member of Aberdeen Hospital Medical Staff since 1934 and was president of the staff in 1959 and previously. He was a past president of the Pictou County Medical Society. He served well on the executive of The Nova Scotia Medical Society for several terms and was honoured by the society to be its president in 1960-1961. He has been a member of the Provincial Medical Board since 1957, and was president of the Nova Scotia Chapter of the College of General Practise of Canada at the time of his death. He had been the physician for the Department of Indian Affairs in the Pictou area since 1957 and had been assistant medical officer at the Dosco Trenton Plants since 1957.

He served in the Reserve Army from 1937 to 1945. He was also a past president of the Holy Name Society in his parish, and of the Stellarton Red Cross Society. He was a member of the Board of Directors of the Junior Technical Institute of New Glasgow.

He was very interested in sports and had been a member of the executive of the Albion Baseball Club and was a vice-president of the Canadian Boxing Federation.

He is survived by his wife, the former Greta Newhook, whom he married in 1939, and by three daughters, Alma, R.N. on the staff of the Halifax Infirmary, Carol and Jean at home; and by two sons, Fred in Halifax and James at home. He is also survived by three brothers, Right Reverend James B. Granville, Halifax, Dr. E. T. Granville, Halifax, and Francis, Mexico City. He was predeceased by his parents, Mr. and Mrs. James Granville, and by a sister, Mrs. Theresa Wallace.

J. A. McDONALD, M.D.

Miss Joan Hudson was present to announce the coming of a physiotherapist, who will be in charge of this department at the new Yarmouth Regional Hospital.

October 18, 1961—the \$1,623,023 Yarmouth Regional Hospital was opened by Premier Stanfield. The Hospital Commission Chairman, C. W. Dean stated that the Hospital would have a capacity of 173 beds and 36 bassinets, with a staff of approximately 240 people. The opening ceremonies were addressed by Hon. G. A. Burrige, MLA for Yarmouth County and minister without portfolio in the Provincial Government, Provincial Health Minister R. A. Donahoe, Q.C., Felton F. Legere, MP. representing the federal minister of health, Yarmouth Mayor W. F. Allen, Warden Ray Hurlburt of the Municipality of Yarmouth, and Brig. H. W. Murdock, Chairman of the Nova Scotia Hospital Insurance Commission. Dr. J. T. Balmanno is president of the Yarmouth Medical Staff.

UNIVERSITY

September 28-30, 1961—The 20th Anniversary of the founding of the Department of Psychiatry at Dalhousie University was held in conjunction with the meeting of the Maritime Psychiatric Association at the Victoria General Hospital. Dr. R. O. Jones, head of the Department of Psychiatry, chaired the reunion day program which was addressed by Dr. H. B. Atlee, and Dr. C. B. Stewart, Dean of Medicine. Papers were presented by Dr. Noel Murphy (Psychiatric illness in university students); Dr. H. N. A. MacDonald (physiology of emotions); Dr. E. Ryan (aspects of psychotherapy); Dr. N. Destounis (morbid dependency); Child Guidance Clinic Staff (child guidance presentation). The reunion ended with a beach dinner and reception at the Shore Club in Hubbards, the guest speaker being Dr. Iago Galdston.

October 2, 1961—A post-graduate evening on "The Prevention of Deformity in Rheumatoid Arthritis" was presented at the Victoria General Hospital by Drs. G. J. H. Colwell, B. F. Miller, A. H. Shears, and J. F. L. Woodbury.

October 4, 1961—Dr. Adam J. Sortini, Director of the Hearing and Speech Clinic, Children's Hospital Medical Centre, Boston, Mass. spoke on "The Importance of Early Diagnosis and Therapy for Children with Speech and Hearing Problems" at the Victoria General Hospital Auditorium.

October 10, 17, 24, and 30, 1961—The Post-Graduate Division, Faculty of Medicine, Dalhousie University presented a Halifax-Dartmouth Regional Course in the Rheumatic Diseases, this being the second of a series of Clinical courses prepared at the suggestion of the Halifax-Dartmouth Chapter, College of General Practice of Canada to deal with the fields of special interest to the family doctor. Participants were Drs. G. J. H. Colwell, B. F. Miller, A. H. Shears, and J. F. L. Woodbury. Subjects presented were: Diagnosis of the Rheumatic Diseases, Osteoarthritis (demonstration of joint infections); Other Rheumatic Syndromes (particularly painful shoulders and necks); Management of the Severely Disabled Arthritic (with display and demonstration of self-help devices).

BIRTHS

To Dr. and Mrs. Felix Doucette, Weymouth, a son, in August, 1961.

To Dr. and Mrs. Albro MacKeen (née Marilyn Oyler) a daughter, Diane Dobson, at the Grace Maternity Hospital, Halifax on September 20, 1961. A sister for Palmer Ann.

To Dr. and Mrs. Malcolm Stephen (née Joan Crowell, R.T.) a son, at the Hotel Dieu Hospital, Moncton, N. B. on September 30, 1961. A brother for Tracey Ann.

To Dr. and Mrs. R. A. Wentzell, a daughter, at the Grace Maternity Hospital on September 28, 1961.

COMING MEETINGS

May 21-23, 1962—109th Annual Meeting of The Medical Society of Nova Scotia, Nova Scotian Hotel, Halifax, N. S.

June 18-22, 1962—95th Annual Meeting of the Canadian Medical Association, Winnipeg, Man.

October 7-13, 1962—The 4th World Congress of Cardiology will be held at the Medical Centre, Mexico City, Mexico. Address inquiries to the General Secretary: Dr. Isaac Costero, 4th World Congress of Cardiology, Institute N.De. Cardiologia, Avenida Cuauhtemoc 300, Mexico 7, D.F.

June 10-14, 1963—96th Annual Meeting of the Canadian Medical Association, Toronto, Ont.

OBITUARY

Dr. Ralph R. Withrow, 71, Springhill, died on September 25, 1961 after a short illness. Born in Upper Rawdon, Hants Co., N. S. he attended the local schools and later graduated from the Halifax County Academy. A Dalhousie Medical School Graduate (1915) he practiced medicine and surgery in Springhill from the time of his graduation. He was also a registered pharmacist in Springhill. He was certified in General Surgery in 1946. He was a member of St. Andrew's United Church; of Laurie Lodge, Number 70, AF and AM; and the Oddfellows Lodge. He is survived by his wife, two daughters, two sisters, and one brother.

Dr. Walter Leslie, 59, Halifax, died October 7, 1961 at Aberdeen Hospital, New Glasgow following a heart attack. Dr. Leslie was born in Wallasey, England, received his medical degree from the University of Manitoba (1929), served in the Armed Forces during World War 2, and joined the Staff of Dalhousie Medical School in 1945. In 1946 he received certification from the Royal College of Physicians and Surgeons (Canada) in Neurology and Psychiatry and two years later became a Fellow of the College. He was Chief consultant in Neurology at the Victoria General and Camp Hill Hospitals in Halifax and was Assistant Professor of Medicine (Neurology) at Dalhousie University. He was a member of The Medical Society of Nova Scotia, Canadian Medical Association, the American Academy of Neurology, the Canadian Neurological Society and the New York Academy of Sciences. He is survived by his wife, two daughters, and one son.

GLAUCOMA CLINIC

A glaucoma clinic has been established at the Victoria General Hospital, Halifax, N. S. This was felt to be a necessity as glaucoma affects approximately 2% of our population over forty years of age.

This clinic though mainly for investigation will also carry out treatment and follow up of cases. Ophthalmologists may refer patients directly, but other physicians are requested to refer through the Outpatient Department Eye Clinic. Private patients of Ophthalmologists may be referred for investigation or certain tests at no charge and the patients of course will return to their referring Ophthalmologist for treatment and follow up.

C.F.K.

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