

THE NOVA SCOTIA MEDICAL BULLETIN

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Who, Me?

A certain man made a great supper, and bade many: And sent his servant at supper time to say to them that were bidden, Come; for all things are now ready.

And they all, with one consent began to make excuse. The first said unto him, I have bought a piece of ground and I must needs go and see it: I pray thee have me excused. And another said, I have bought five yoke of oxen, and I go to prove them: I pray thee have me excused. And another said, I have married a wife, therefore I cannot come.

Luke, 14; 16-20

A couple of years ago, a young woman was stabbed several times over the space of half an hour in New York City, before many witnesses, none of whom lifted a finger in her aid, even as far as to call the police. Such attitudes seem to be a symptom of our age, when a doctor, seeing an accident will step on the gas pedal rather than stop, become involved, and even risk possible court action for malpractice. Happily such risk is negligible in Canada and particularly in Nova Scotia, and we believe that our native physicians would not consider the possibility of such an unchristian action.

Unhappily, however, in the more everyday matters of life we find increasingly that people, and people include M.D's, do have a tendency to shun

involvement. Any nominating committee member is only too aware of the difficulty he has in filling any post that the nominee believes will entail a little work.

At the same time, the plaint is heard that the Club, Society, or whatever, is run by a clique and "do nothing for me."

The plain fact is that the clique is made up of the few who are ready to put a little in to the organization, reckoning to get nothing out of it except a jot of satisfaction and more than a little of blame when things go wrong. The odd part is that these same few soon find that they are indeed getting a great deal of value and satisfaction out of their labours, and that they come to identify themselves with it, to the benefit of all.

Occasionally, however, there comes a time when a man has had enough, or finds that he is called on to do more than he can do well. Gone are the rewards and satisfaction if he then can not find a replacement. And another good friend is lost. We heard it said the other day by one such "I wonder why we go on doing it all for them?"

Let us all, when asked to take on a task say not "what does it entail, and how can I get out of it?" but rather "How have I deserved such trust from my peers, and what can I put into it?" The reward will not be in dollars and cents, but in pride and satisfaction in a job well done. □

J.F.L.

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NOVA SCOTIA DIVISION

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Bill No. 148, 1966

An Act to Provide for a Study of Medical Care Insurance

BE IT ENACTED by the Governor and Assembly as follows:

1 In this Act:

(a) "Commission" means the Medical Care Insurance Advisory Commission appointed under this Act;

(b) "Minister" means Minister of Public Health.

2 The Governor in Council may appoint a Medical Care Insurance Advisory Commission, consisting of not more than seven members, and may appoint one member to be chairman and another to be vice-chairman of the Commission.

3 The members of the Commission shall receive such remuneration as the Governor in Council determines.

4 With the approval of the Minister the Commission may engage such professional, scientific, technical, secretarial and clerical staff as it considers necessary to assist it in performing its functions.

5 It is the function of the Commission to inquire into and investigate matters relating to the establishment, operation and scope of medical care insurance plans, including:

(a) methods of operating and conducting such plans;

(b) the medical services provided by such plans;

(c) proposals by the Government of Canada for participating in and sharing the costs of such plans;

(d) any other matters relating to such plans that the Commission considers material or that the Governor in Council or the Minister directs the Commission to examine.

6 For the purposes of exercising its functions or making any inquiry, the Commission has all the powers and privileges of a commission appointed under the Public Inquiries Act.

7 Not later than the thirty-first day of December, 1966, the Commission shall report to the Minister and present to him:

(a) a plan or plans for the provision of publicly operated or controlled medical care insurance for residents of the Province related to a plan or plans proposed by the Government of Canada;

(b) proposals respecting a method or methods of operating the plan or plans;

(c) its recommendations respecting any other matters relating to such a plan or plans that it considers advisable or necessary.

Comment

This Act was presented as Bill No. 148 to the Nova Scotia Legislature for first reading on Monday, March 28, 1966. It received second reading on Friday, April 1 when it was referred to the Law Amendments Committee. It was returned to the Legislature with the approval of the Law Amendments Committee for third reading and became law prior to adjournment of the Legislature on April 7, 1966.

The officers of the Medical Society had studied Bill No. 148 prior to its referral to the Law Amendments Committee. The Chairman of the Law Amendments Committee (Hon. R. A. Donahoe) was informed prior to the public hearing that the Society agreed with this legislation.

Fitness to Drive

The Nova Scotia Guide for Physicians in Determining Fitness to Drive a Motor-Vehicle is published as an insert in this issue. It is separately bound for easy removal and preservation.

KEEP IT ON YOUR DESK

Ovulen 1mg.*

Each tablet contains: Ethynodiol Diacetate 1.0 mg., Mestranol 0.1 mg.

100 percent effective conception control reported ...¹

Tyler, E. T. "The use of Ovulen as a contraceptive agent." A Paper given at Guadalajara, Mexico (November 3rd, 1964). "...The tolerance to Ovulen in the combined series of studies is statistically very good, and in a dose of 1 mg. of the progestin the effectiveness is excellent. No pregnancies were reported in a total of almost 44,000 cycles."

fewer side effects ...

Physicians throughout the world have confirmed that Ovulen 1 mg. produces fewer side effects.

"It is believed that Ovulen is the most satisfactory oral contraceptive that has been produced."—Flowers, C. E. (1964) North Carolina Medical Journal 25,139.

unparalleled experience ...

1. Searle introduced the first oral contraceptive 12 years ago. Today over 3,000,000 women use Searle oral contraceptives daily.
2. Years of research have given Searle unequalled experience in this field.
3. A logical outcome of this leadership in research was Ovulen 1 mg., the low dosage oral contraceptive.

maximum patient acceptance ...

"The reduced dosage made possible by the increased potency of the ethynodiol diacetate has been accompanied by reduced incidence of side effects and has thus enhanced the acceptability of progestin therapy."

Andrews, W.C., and Andrews, M.C.: Reduction of Side Effects from Ovulation Suppression by the Use of Newer Progestin Combinations, Fertil. Steril. 15:75-83 (Jan.-Feb.) 1964.

Summer Meeting, The Pines, Digby, N. S. July 4th, 5th, & 6th, 1966

You are invited to complete and return the Housing application form on this page.

Dr. A. J. M. Griffiths and his Committee Chairmen are developing the program which starts on Sunday evening July 3. The detailed program will be outlined in the June issue.

You can be assured of an interesting program which will include time for relaxation to enjoy the surroundings and pleasures associated with The Pines at Digby.

HOUSING APPLICATION FORM The Medical Society of Nova Scotia The Pines Hotel, Digby, N. S. July 4, 5, 6, 1966

Executive Secretary
The Medical Society of Nova Scotia
Dalhousie Public Health Clinic
Halifax, N. S.

Please have reserved for me the following: -

Please check
IN HOTEL

1. () Double room with bath - twin beds - including meals \$14.00 per person per day. (accommodates 2 persons)

IN COTTAGE

2. () Cottage with sitting-room and two twin bedded bedrooms - including meals \$14.00 per person per day. (accommodates 4 persons)

3. () Cottage with sitting-room and three twin bedded bedrooms - including meals \$14.00 per person per day. (accommodates 6 persons)

4. () Single occupancy: If attending alone please indicate with whom you wish to share accommodation.

5. () CHILDREN under 14: Rate \$8.50 per day per child. Please give ages of children accompanying you.

Date for arrival JULY.....AM.....PM.....

Date for departure

Name of persons who will occupy above accommodations:

NAMES

ADDRESS

.....
.....
.....

In view of the attendance expected, single occupancy of rooms cannot be guaranteed. If coming alone, and you are willing to share a room in the hotel, please check here.....

N.B.—Space will definitely be available at "The Pines" for applications received up to June 10, 1966. Accommodations at the Pines or a motel can be provided for applications received after June 10.



Polonium²¹⁰ in Pulmonary Tissues of Cigarette Smokers¹

When amounts of the radioactive isotope Po²¹⁰ were measured in lung tissue, higher concentrations were found in cigarette smokers than in nonsmokers. The evidence indicates that Po²¹⁰ may be a factor in the development of bronchial cancer in cigarette smokers.

Cigarette smoke contains trace amounts of an alpha-particle-emitting radioactive element, polonium²¹⁰ (Po²¹⁰), a naturally occurring daughter isotope of radium²²⁶. In establishing whether this source of radiation exposure may be involved in the initiation of bronchial cancer in smokers, an important step is to show that pulmonary tissues of smokers, particularly certain regions of the bronchial epithelium, contain more of this element than those of nonsmokers.

The present investigation was undertaken to measure Po²¹⁰ concentrations in various pulmonary tissues of smokers and nonsmokers.

Lung specimens from 36 patients were studied. The specimens were either whole lungs obtained at autopsy or whole lungs or lobes surgically removed. Twenty-five of the patients were cigarette smokers two were pipe smokers, one was a former cigarette smoker, and eight had never smoked.

Radioactivity was measured in gas-flow proportional counters, with background rates of 0.2 to 0.6 counts per hour, and efficiencies of 51 per cent for polonium alpha particles.

The Po²¹⁰ concentrations found in lung parenchyma, peribronchial lymph nodes, and bronchial epithelium are expressed as picocuries (10⁻¹² curies, or 2.2 disintegrations per minute) of Po²¹⁰ per gram of wet tissue. The average concentration in peripheral parenchyma of current cigarette smokers was 0.0074 picocurie per gram as compared with 0.0016 for non-smokers. Parenchymal concentrations in the two pipe smokers were similar to those of non-smokers.

No correlation was found between concentrations in the lung parenchyma with total cigarettes smoked expressed as pack years (packages per day times number of years smoked), or with the age of the individual at death. However, there was a trend toward higher Po²¹⁰ levels in persons whose daily cigarette consumption was high.

Correlation with daily cigarette consumption, but not with total cigarettes smoked, is not unexpected because of the rapid clearance time for

particulates by the lung and the relatively short half-life of the polonium isotope. When parenchymal Po²¹⁰ was studied as a function of time since cessation of smoking, a significant trend toward higher levels was evident only in those who had smoked up to 24 hours or less before death or surgery, but the scatter was great. The parenchymal Po²¹⁰ concentration in the one former cigarette smoker was very low (0.0015 picocurie per gram).

Though the Po²¹⁰ concentration in bronchial wall was similar to that present in lung parenchyma, it was about two orders of magnitude greater in bronchial epithelium than in parenchyma or lymph nodes. By far the highest concentrations were found in epithelium from segmental bifurcations where levels as high as 13.9 picocurie per gram were measured.

Measurable Po²¹⁰ was also present in superficial mucus from all smokers. The concentrations ranged from 0.002 to 0.044 picocurie per gram of mucus, except in one case in which the concentration was much higher.

No correlation existed between number of cigarettes smoked, or time since the last cigarette, and the Po²¹⁰ levels in bronchial epithelium. Similarly, there was no correlation between parenchymal and epithelial concentrations. In the two pipe smokers epithelial Po²¹⁰ content was similar to that of cigarette smokers though the parenchymal concentrations were very low. Significant, though low, levels of activity were found in the lobar bronchus and one bifurcation of the single past smoker.

Mode of Entry

"Unsupported" Po²¹⁰, or polonium not present with its long-lived parent, lead²¹⁰, may be taken into the body directly. Because its half-life is only 138 days, exposure to the isotope would have to be fairly continuous for a steady-state concentration to be reached in tissues. On the basis of preliminary measurements of lead, we believe that most of

Continued on page 137

John B. Little, M.D.; Edward P. Radford, Jr., M.D.; H. Louis McCombs, M.D.; and Vilma R. Hunt, B.D.S. *The New England Journal of Medicine*, December 16, 1965.

¹Reprinted from the Abstracts of the National Tuberculosis Association, March 1966.

Printed through cooperation Nova Scotia Tuberculosis Association.

Abdominal Tumours in Children¹

COLIN C. FERGUSON, M.D., F.R.C.S.(C)²

Winnipeg, Man.

It is a great honor for me to have been asked to participate in this Dalhousie University Refresher Course and to present the first Rebecca Cohn Memorial Lecture.

Rebecca Ethel Cohn, (née Wurm) was born in Poland in 1869. Sometime at about the turn of the century she emigrated to New York City. Around 1910 she moved to Halifax where relatives resided. Here she married Moses Cohn, a citizen of Halifax. In 1922 he died. They did not have children and Mrs. Cohn remained a widow until her death on October 23, 1942.

Her Will directed that her estate be distributed to charitable and benevolent causes to be selected by her executors twenty years after her death.

I have learned that this woman had a background of learning and was a devout and pious individual of strong will and complete independence. Throughout her life she was a charitable person, but in a manner that was not publicized.

Many charitable organizations, religious institutions and universities have benefitted under the terms of her Will. The people of the Province of Nova Scotia have apparently without knowing it reaped many benefits from this woman who in her lifetime was not known in any sense of the word to those who benefitted from her efforts. It can be truthfully said of her that the good she did will live long after her.

It is my understanding that this memorial lecture has been established according to the terms of her Will by a grant donated to the Nova Scotia division of the Canadian Cancer Society. It is my hope that in some way what I have to say will be of help to you in your efforts to treat children suffering from malignant disease.

Malignancies in children belong to the rarities of general medical practice. Yet, malignancy is the third commonest cause of death in children over the age of one year. It has been estimated that a general practitioner will see only one child with a malignant tumour over a period of twenty years and that even a consulting pediatrician is

not likely to see more than four cases in any one year.

The commonest type of childhood malignancy is leukaemia, and this now kills eight times as many children as does tuberculosis. It is usually of an acute form, although in a few cases the chronic myeloid variety occurs.

Solid tumours in children differ in type from tumours encountered in the adult age group. The vast majority of tumours in children are sarcomatous in nature, in contrast with the epithelial lesions which dominate the picture in the adult. Despite this general statement, practically every adult type of tumour appears in a child sooner or later.

Of the abdominal tumours that occur in infants and in children, the neuroblastoma and the nephroblastoma or Wilm's Tumour are the two most commonly encountered.

Neuroblastoma

These tumours are almost certainly congenital in origin and the vast majority of them are diagnosed before the child has reached the age of five years. It is generally agreed that the earlier in life the lesion is diagnosed and treated, the better is the prognosis.

Neuroblastoma arises from sympathetic nervous tissue, including the adrenal gland and therefore its primary site may be in the pelvis, in the retroperitoneal areas, in the adrenal glands themselves or in the thoracic or cervical sympathetic ganglia.

Most commonly the primary site of the tumour is within the abdomen and most frequently within the adrenal gland itself (for some unknown reason more commonly on the left side than on the right). These tumours can behave in a variety of ways.

The primary tumour may remain relatively small and metastasize to the retro-orbital tissues producing proptosis. When this type of metastatic disease occurs the prognosis for survival is very good indeed.

¹The Rebecca Cohn Memorial Lecture. Delivered at the 39th Dalhousie Refresher Course, November 23, 1965.

²Professor and Head, Department of Surgery, The University of Manitoba.

The primary tumour in the adrenal may remain small and yet widely metastasize to the bones. In older children with this type of osseous involvement the children are frequently mistakenly diagnosed as having rheumatic fever because of the joint pains. X-ray examination, however, will reveal the typical osteolytic lesions of metastatic neuroblastoma.

The tumour, while still remaining small, may metastasize to skin, lymph nodes, to the opposite adrenal and as a terminal event, may also produce multiple metastases to the lungs.

If the tumour metastasizes to the liver with a diffuse infiltration of that organ, at laparotomy the situation may appear hopeless and in most instances only a biopsy of the liver is obtained to confirm the diagnosis. With radiation therapy, however, this particular type of neuroblastoma with extensive spread to the liver has a good prognosis. Many of these children sent home from hospital to die have gone on to make a remarkable recovery and have returned several years later apparently completely free of their malignant disease.

These tumours can produce an intractable diarrhoea. The correct diagnosis in these children is not usually established until after all investigations to find a bacterial cause for the enteritis have proven negative and the astute clinician has asked for a determination of urinary catechol amine excretion.

Most neuroblastomas, however, grow to a large size and the first sign of the disease may be the obvious enlargement of the patient's abdomen and the easy palpation of a large, firm nodular mass.

When a child with an abdominal mass suspected of being a neuroblastoma is admitted to our hospital, besides the routine investigations of the urine and blood, an intravenous pyelogram is performed. When doing the intravenous pyelogram it is advisable to give the radio opaque material by rapid injection into a vein in the leg and thus simultaneously obtain an inferior vena cavagram. Sometimes this study will provide additional information as to the extent of the retroperitoneal spread of the tumour and may be of help to the surgeon in planning his operation. Typically, the neuroblastoma will displace the kidney on the side of the lesion either downward or laterally, but in contradistinction to Wilm's tumour will not distort the pelvis of the involved kidney. Fine punctate calcification is a common finding and can be seen on the X-ray film. In addition to the intravenous pyelogram, a chest film is taken and radiological examination of the long bones and of the skull is performed to determine the presence or absence of osteolytic lesions. A sternal aspiration is done so that the bone marrow also may be examined for the presence or absence of tumour cells. A 24-hour collection of urine is made and is sent to the labora-

tory for determination of catechol amines. In the hope of minimizing the chances of hematogenous metastatic spread vigorous palpation of the tumour is avoided.

When all of the diagnostic studies have been completed these children are generally subjected to laparotomy with the hope that if not all of the tumour, at least the major bulk of the tumour can be removed. Since it is known that these tumours are quite radiosensitive, it is the prudent surgeon who decides to leave residual tumour, rather than perform mutilating surgery in his attempt to encompass the lesion. Immediately following removal of the tumour, x-radiation directed to the tumour bed should be commenced. The end results in these children appear to be better when the dose of radiation given is relatively small, as compared to the dose that for example is given to the child with a Wilm's tumour.

Children with metastatic neuroblastoma have been given a variety of chemotherapeutic agents in addition to roentgen therapy. These agents include Leurocristine (Vincristine); Mitomyein C; Vinkaleukablastin; 5 Fluorouracil and Cytoxan. The nitrogen mustards have been tried and it has been reported that Vitamin B 12 may bring about a maturation of these tumours to a more benign form.

Of all the agents employed, probably Cyclophosphamide is the most useful.

Practically all of the neuroblastomas secrete in the urine end products of norepinephrine metabolism and these can be determined by paper chromatography as venil mandelic acid. Not only is the v.m.a. level of diagnostic help, but gives an indication as to the effectiveness of treatment. Only when the levels of v.m.a. excreted in the urine return to normal can one feel thoroughly secure in the knowledge that the child is tumour free.

Wilm's Tumour (Nephroblastoma)

In contrast to the various ways in which a neuroblastoma may first present in a child, Wilm's Tumour most commonly presents as an obvious palpable mass in one or other flank of the abdomen. The child may have symptoms of anorexia, lassitude and may appear pale; but in most other respects up until a few days or weeks of the discovery of the abdominal mass the child has usually been well. Occasionally blood may have been passed in the urine. On examination there is usually a large, smooth, easily palpable mass which appears to be confined to one side of the abdomen and does not extend across the midline. This is in direct contrast to the neuroblastoma which is usually nodular and which may frequently extend anterior to the vertebral column to the other side of the abdomen.

Children suspected of having a Wilm's Tumour have an intravenous pyelogram performed. Again

we prefer to give the radio opaque material via a vein in the leg, thus hoping to obtain an inferior vena cavagram. If there is non-visualization on the affected side a repeat study is carried out with double dose of contrast media. By this means it is usually possible to obtain films of diagnostic significance without resorting to retrograde pyelography. Since the Wilm's Tumour arises within kidney substance the intravenous pyelogram usually reveals a marked distortion of the renal calyceal system and the diagnosis can usually be made with a high degree of accuracy. These children have chest X-rays taken to determine whether or not pulmonary metastases are present. The urine is examined for blood and for tumour cells.

Once the diagnosis of nephroblastoma has been made and plans are underway for operation the child is given a dose of Actinomycin D, usually on the day preceding his operation. This drug is also given during the operative procedure and is continued for a total of about five days. The surgeon plans his operative approach with the hope of removing the tumour in its entirety. Because of the large size of most of these tumours the incision required is also large and may be either an extensive transverse abdominal incision, a long vertical abdominal incision, or a thoraco-abdominal incision. Once in the abdomen, manipulation of the tumour should be deferred until the veins leading from the tumour have been brought under control. In this way it is hoped that tumour metastases by way of the inferior vena cava may be minimized. Once the renal pedicle has been controlled then every attempt is made to remove the tumour without rupturing its capsule. Careful search for metastatic disease within the abdomen should then be carried out. Rarely these tumours occur bilaterally and in a few instances it has been necessary to perform a partial nephrectomy on the opposite kidney. Occasionally solitary nodules within the liver have been found and have been excised. Immediately following the operation most of these children are given radiation therapy to the tumour bed.

Even when pulmonary metastases appear, the situation is not hopeless. Again, using a combination of Actinomycin D and local radiation these metastases may be brought under control. If there is then no further evidence of spread, the pulmonary metastases should be excised by surgical means. I know of two children in my own experience with Wilm's Tumour who each have had two pulmonary metastases removed and both children are alive and well, one now for four years after the onset of disease and the other some fifteen years after his first operation.

Actinomycin D appears definitely to be the drug of choice to use in the treatment of Wilm's Tumour. The dose given intravenously is 15

micrograms per kilogram per day, usually for a course of five days. The drug is toxic and must be stopped if severe gastrointestinal disturbances, bone marrow depression or alopecia occur. A repeated 5-day course of the drug may be given as is necessary. Approximately 50-60 per cent of children with Wilm's Tumour treated by the foregoing combination will be long-term survivors.

Pheochromocytomas

Most commonly, pheochromocytomas occur in young or middle aged adults, but they can occur in children and may be familial in nature. Our experience at the Winnipeg Children's Hospital is confined to one family in which three members had a total of four pheochromocytomas removed, since in one child the tumour was found to be bilateral. All involved members of the family had episodes of paroxysmal hypertension, had increased catechol amine excretion in their urines and on presacral air insufflation were found to have tumours in their adrenal glands. The father and his two children underwent operative excision of their tumours. In each instance preoperative sympathetic blockade using Dybenzamine was employed to minimize the effects of the increased norepinephrine excretion caused by manipulation necessary during excision of the tumour.

Adrenal Carcinoma

One child aged three years was admitted to our hospital with a large abdominal mass situated in the right upper quadrant. No definite preoperative diagnosis was possible and laparotomy was performed. Through a thoraco-abdominal incision we encountered a large tumour involving the right side of the liver which grew downward to involve the right adrenal and the right kidney. On frozen section of the tumour it was thought that we were dealing with a hepatoma and it was decided to proceed with a radical operation in the hope that the tumour could be removed. A partial right hepatectomy was carried out and the mass along with the right adrenal and the right kidney were removed. Unfortunately it was not possible to remove all tumour and small remnants remained. Paraffin sections revealed this tumour to be a primary adrenal carcinoma not a hepatoma, as had previously been thought. In retrospect, it was obvious that we should have been more astute clinicians because this child did show a slight enlargement in the size of his penis and it is known that these adrenal carcinomas have a virilizing effect. Post-operatively this child was treated with radiation therapy in combination with DDD. Following this therapy the child did well for approximately two years, then returned with a massive recurrence for which no further treatment was of value.

TABLE I

TUMORS OF CHILDREN
THE WINNIPEG CHILDREN'S HOSPITAL
TO DECEMBER, 1964

Leukemia	81 (10 years only)	
Brain	87	
Wilms	28	
Bone	17	
Neuroblastoma	19	
Retinoblastoma	9	
Lymphoma	13	
Teratoma	19	
Miscellaneous	38	

TABLE II

TERATOMATA

Sacrocoecygeal		
Benign	6	
Malignant	5	11
Ovary		
Benign	2	
Malignant	1	3
Spinal Cord		2
Retro Peritoneal		3
		19

Teratomas

Teratomas are most commonly encountered in the mediastinum, the retroperitoneal area, the sacrocoecygeal area, the ovaries and the testicles. If recognized early and if excised early in life they are usually benign and have an excellent prognosis; but if not recognized or if left untreated they may all undergo a malignant change and the changes for survival markedly diminish.

When the teratoma occurs in the retroperitoneal area it may present as any other abdominal tumour such as has already been discussed. X-ray examination may be of some help, in that calcified material resembling bone can sometimes be identified, giving the lead to the correct diagnosis. One patient seen in our hospital was considered to have an inoperable abdominal tumour and was given palliative x-radiation therapy. The mass, however, became so large that needle aspiration was performed. A large amount of caseous, sebaceous material containing squamous epithelium was aspirated and this gave the lead to the correct diagnosis. At laparotomy it was found that this teratoma could be removed intact without sacrificing vital structures and this child is now alive and well some fifteen years after his operation.

When teratomas arise in the ovary they are usually termed dermoids and usually are benign. These children may present with abdominal pain due to twisting of the ovarian dermoid with infarction and are frequently thought to have ap-

TABLE III

MISCELLANEOUS TUMORS

Sarcomas		
Rhabdomyosarcoma		
Retroperitoneal	4	
Middle Ear	4	
Calf	1	
Scapula	1	
Liposarcoma	—	
Fibrosarcoma		
Synovial Sarcoma		
Lung		
Dermatofibrosarcoma		
Carcinomas		
Liver	2	
Breast	1	
Thymus	1	
Nasopharynx	1	
Pancreas	1	
Kidney	1	
Mixed Tumor Salivary		
Papillary Carcinoma Thyroid		
Rhabdomyoma		
Myxoma Atrium		
Mixed Mesoblastic		

pendicitis. Others have presented with a large mass in the lower mid pelvis. If an X-ray film reveals calcified bone or teeth in the tumour then the diagnosis is obvious, but in others laparotomy is required.

Sacrocoecygeal teratomas cannot be considered truly abdominal in nature, but on occasion they do have an abdominal extension. These tumours are usually large and the diagnosis is obvious immediately following birth. Indeed the birth itself may be complicated by difficulties in delivering the aftercoming large tumour. X-ray examination gives an indication as to the extent of the tumour and a barium enema may show the presence of an intra-abdominal extension of the lesion from out of the pelvis. A chest film should be obtained to make certain that pulmonary metastases are not present. While not an emergent procedure, surgical excision of these lesions should be carried out as early in life as is possible. Usually the excision of the tumour can be achieved through an incision below the sacrum and posterior to the anus. The tip of the coccyx should always be removed, since this structure is invariably involved by the tumour itself. Occasionally an abdominal approach has also been required in order to remove an extensive sacrocoecygeal teratoma with a large intra-abdominal protrusion. Small sacrocoecygeal teratomas may go undetected and become

recognized only when the examining physician carries out a meticulous search for the origin of pulmonary metastases.

Lymphosarcoma and Reticulum Cell Sarcoma

These diseases can involve the lymph tissue in the small bowel of infants and children. Symptoms are produced either by the development of intestinal obstruction, by the production of an intussusception, or by the presence of an abdominal mass. The diagnosis is not usually made until laparotomy is performed. If these lesions are localized and can be excised easily then in combination with postoperative radiation many of these children will be long term survivors. However, when the disease process is extensive and it is impossible to resect all of the lesion these children usually develop overwhelming lymphatic involvement.

Hepatoblastoma

This is a rare tumour of infants and children with which I have had no personal experience. The tumour usually presents as a large mass in the liver and there may be associated obstructive jaundice. Since these tumours are not generally radio-sensitive, nor do they respond to chemotherapeutic agents, every effort to remove these tumours by surgical means should be instituted. Essential to the successful outcome of partial hepatectomy is good control of venacaval and portal blood supply by temporary occlusion during resection of the liver tissue.

Summary and conclusions

In the accompanying three tables is presented the total experience up to 1964 of the Winnipeg Children's Hospital with respect to malignant disease in infants and in children.

In conclusion I wish to emphasize that while on initial physical examination the prognosis of a child with a large abdominal tumour may seem hopeless, if prompt and efficient treatment is given close to 50 per cent of all these small patients can survive to grow up to lead normal lives. □

FORTY YEARS AGO

From the Nova Scotia Medical Bulletin, May 1926

These magicians attempted to create the impression, as do our modern quacks, that by administering medicine they were able to direct the treatment of the ailing in a rational manner. Their drug therapy included everything under the sun. The less suitable a substance was the greater efficiency it shewed in therapeutics. They made use of gold, silver, precious stones and pearls because of the esteem they held due to value. Human faeces, urine and menstrual blood were introduced into the materia medica. The awe inspired by corpses was utilised by the administration of powdered human bones to the ailing. Talismans and amulets engraved with exorcisms were worn and these continue even in our time in medical and religious superstitions. Numerals possessed great power in therapeutics due to the so-called language of numbers taught by Pythagoras. This Greek sage, at first an athlete and later a philosopher, was a man of marvellous knowledge. As you know, it was he who invented the theorem of the square on the hypotenuse and he first divided the year into 365 days, 6 hours. The language of numbers developed thusly: The unit one was the essential principle of all things, and God was designated by this digit. Matter was represented by the figure two; the universe was therefore expressed by twelve representing the juxtaposition of one and two. As twelve results from multiplying three by four, Pythagoras conceived the universe as composed of three distinct worlds, each of which was developed in four concentric spheres and these spheres corresponded to the primitive elements of earth, air, fire and water. The application of the number twelve to express the universe was received from the Chaldeans and the Egyptians - it being the origin of the institution of the zodiac. The mystical influence which is exerted by the numerals 3, 7, 9, and still more so by the dreadful 13, upon the life and health of man, haunts the minds of the multitude of this century of enlightenment exactly as it did in remote antiquity.

From 'Bygone Beliefs' by D. Olan Meeker, B.S.

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The Role of the Medical Examiner

A. E. MURRAY, M.D., C.M.¹

Halifax, N. S.

Society has found it necessary to enquire into the circumstances of sudden and unexplained deaths since the earliest times. Coroners, or King's Officers, were charged with this duty, and records of the period of the Norman Conquest show that Coroners were active at this time. From the 16th Century on, Coroners became paid government officials, presumably to ensure their impartiality. The person appointed Coroner did not necessarily have any medical knowledge, or any knowledge of legal procedure, but was empowered to employ others at his discretion as Coroner's Officers, to investigate the circumstances of any death reported to him.

In modern times, the growth of the investigative side of the Police has outmoded investigation by the Coroner's Officers, and conflict could arise between these two investigative agencies. In addition, problems have arisen where the Coroner was not a medical practitioner, and adequate medical information was not obtained at the time the death was investigated. Lastly, because of lack of knowledge of legal procedure, the Coroner's inquest may result in premature judgments about the guilt of persons concerned in the death.

For these reasons, the office of Coroner was abolished in the Province of Nova Scotia by the Fatalities Enquiries Act of 1960, and the Provincial Government now appoints a Medical Examiner for each county to assist the law in determining the medical circumstances surrounding unexplained deaths; the police bear the responsibility of investigating the other circumstances surrounding the death.

While all other Provinces of Canada at present retain the Coroner system, they all require that Coroners must be licensed Medical Practitioners, and have delineated and defined the duties and responsibilities of a Coroner in a number of ways in each province. For example, in Ontario the Coroner may not perform an autopsy, but must appoint a pathologist to perform any autopsy required. He must also depute a Constable to secure witnesses, and to take charge of the remains before burial. If criminal charges are liable to be laid, an inquest must be deferred until in-

vestigation is complete and any inquest in progress must be adjourned if it is found that criminal charges may be laid. The Ontario Coroner must be notified of all deaths in mental institutions or licensed nursing homes, and in all cases of deaths associated with alleged malpractice.

In Nova Scotia, the Medical Examiner should be informed of deaths occurring in the following circumstances:

1. When there is reasonable evidence to suspect that the person died of violence, undue means, or where death may have involved culpable negligence.
2. When the person died under circumstances requiring an inquest under any statute.
3. When the cause of death is undetermined.
4. When a death occurred in jail or prison.

In examining the circumstances of any death, the Medical Examiner has complete authority to enter premises, to take charge of the dead body and may call upon the Police for their full cooperation. He can carry out, or authorize others to carry out any investigative analyses or tests, including autopsy, which may be necessary to determine the cause of death, and can authorize payment for the services performed for him by others.

When his findings are complete, the Medical Examiner forwards his report, with or without a recommendation that an inquest be held, to the appropriate Provincial Magistrate. The Police also report to the Provincial Magistrate, who is thus informed of all the facts concerning the death. The Provincial Magistrate may order an inquest, may rule that an inquest is not necessary, or may dispense with an inquest if criminal charges are to be laid in connection with the death.

If an inquest is held, the written report of the Medical Examiner may be accepted as evidence. When called to give evidence before the court, the Medical Examiner is accepted as an expert witness, provided the court has qualified him as such, and can therefore have his opinion received as evidence. In addition, Pathologists reports, Laboratory reports and photographs are admissible as evidence, but, as in other legally constituted courts, hearsay is not acceptable.

¹Medical Examiner for Halifax and Halifax County.

In the interests of deterring, preventing and detecting crime leading to death, everyone who dies must have the cause of death certified before the body can be disposed of. Normally, the medical practitioner attending the patient in his last illness will certify the cause of death, but where the death is sudden, or unexpected, or where the person has not been attended by a doctor during his last illness, the medical examiner must investigate the circumstances of the death. Since cremation involves complete disposal of a body, and the possibility of further investigation by exhumation is precluded, a certificate authorizing cremation must be signed by the Medical Examiner.

In investigating unexplained deaths, the Medical Examiner must satisfy himself that the person is legally dead, that is, that all phenomena and signs of life are absent. He must take all reasonable steps to establish the identity of the dead person, and to determine the actual cause of death. In so doing, the Medical Examiner must make a careful note of the position of the body in relation to its surroundings, the attitude of the body, marks of external violence and estimate the time at which death occurred.

A reliable estimate of the time of death is often difficult. The body temperature falls at a rate depending on the difference between it and the environmental temperature, and if the rectal temperature is found to be the same as the surrounding temperature, the person will usually have been dead for 24 hours. Hypostasis, a bluish discolouration of the skin of the under surfaces of the body, is usually noted after two hours, while rigor mortis starts in three to four hours, beginning with the muscles of the jaw and

progressing gradually downwards, becoming complete in six to eight hours. It passes off gradually in the same order, disappearing in twelve to fourteen hours. Rigor mortis must be distinguished from cadaveric spasm, a rare phenomenon present from the time of death, where an object is held in a rigid grip. The cause of cadaveric spasm is not known, but it cannot be artificially produced by anyone wishing to mislead those investigating the death.

At autopsy, all external marks are noted, and from surrounding bruising or bleeding it will be known whether these marks were made before or after death. Where indicated, cultures, microscopic examination and chemical analyses may be made from body fluids or organs.

As a result of these examinations, the medical examiner is usually able to satisfy himself as to the cause of death. The final diagnoses of unexplained deaths investigated by Medical Examiners and Coroners are vascular in 40%, respiratory in 23%, attributed to the central nervous system in 18%, and associated with the digestive system in 6.5%. Miscellaneous causes, including drug deaths and deaths of infants in cribs account for the remaining 12.5%.

In summary, the Medical Examiner has replaced the office of Coroner in the Province of Nova Scotia. He has full legal authority to make all the investigations necessary to determine the medical cause of death. Apart from this, the securing of witnesses and collection of evidence is the responsibility of the Police, and both the Police and the Medical Examiner report to the appropriate Provincial Magistrate who undertakes a judicial enquiry into the circumstances of the death if it seems desirable in the public interest. □

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Health Services as an Industry¹

T. W. GORMAN, M.D., F.R.C.S.(C)

Antigonish, N. S.

Employment in the Health Services Sector of the national economy has increased more rapidly than the average for the total labour force. In the 1941 - 1961 period, the increase of the total labour force was 40 per cent (2 per cent annually). But, during the same period, the increase in the Health Services Sector was 120 per cent (6 per cent annually). During the 30 years, 1931 - 1961, employment in the Health Services Industry increased from 1.9 per cent to 4.3 per cent of the total labour force.

The experience in Nova Scotia is similar. In 1951, there were 7,097 people employed in Health Service and in 1961, there were 11,725². This increase of 4,628 represents 6.5 per cent annual increase. Thus, 4.9 per cent of the total employed labour force in Nova Scotia was employed in Health Services in 1961.

We can reasonably assume continued growth in this Sector, 6 per cent annual increase at least. In other words, we can postulate increased employment in the Health Services by some 700 new jobs per year for the next four or even eight years. That is to say, this increase in the health sector would account for 18 - 23 per cent of the target figures of 3000 - 4000 new jobs per year.

Two thirds of those employed in the Health Services are professionals or highly-skilled individuals. It is reasonable to suppose that the increased employment would have a similar distribution. Thus, the increase would be 470 professionals and highly skilled and 230 semi-skilled or unskilled.

The 470 figure would include some 36 doctors; 158 nurses; 100 nurses aides; 56 laboratory technicians; etc. The 230 figure would range from tradesmen in the maintenance area to maids.

It is important to realize that an appreciable number of the professional and highly-skilled would enter the Province as immigrants of one type or another. Thus, some of the increase in employed would not be new jobs for Nova Scotians. If you want proof of this, realize that there are sizable towns in Nova Scotia now where 30 - 50 per cent of the medical men in practice are foreign-born and foreign-trained. The same is true in some highly-

skilled technical jobs. Please do **not** misunderstand me, I have nothing but praise for these people. They are most proficient and skilled but there must be something wrong when we cannot attract our own young people into these fields of endeavour.

The Nova Scotia Medical Society is at present beginning an intensive campaign in medical education at all levels - recruitment, medical school and post-graduate. Also, the medical society is sponsor of a survey to determine the unmet Provincial medical needs in personnel and distribution.

Recently, I had occasion to meet with some 80 pre-medical students at St. Francis Xavier University and was most concerned by the frustration and defeat which many of them felt because they could not gain admittance to medical school. There is a strange anomaly here - many, quite well-qualified young men and women eager to start the long study of medicine, and yet there just are not enough places in the existing medical schools to take them. On the other hand, we in Canada and Nova Scotia scour the world for personnel to satisfy our present and growing needs for professionals and skilled technicians.

Many of these young people could be directed to other careers in the Health Services Industry if they but knew about them sooner.

This whole area of professional and skilled technical personnel in the Health Services needs much thought and planning. Facilities and personnel to set up training programs are expensive. Once trained, some or many leave the Province and perhaps represent some of the "Hemorrhage of Quality" which 'The Report on Progress' mentions on Pg. 58. Why they leave varies; but better income, research facilities for themselves and educational facilities for their families are at least some of the reasons.

It is important to note that the teachers in these projects represent employed people - in other words, an industry. Education is a sizable industry in Nova Scotia - indeed, the town I live in exists mainly on this industry of Education. Antigonish has grown at the rate of 10 per cent per year in the past thirteen years.

¹Paper given at the Voluntary Economic Planning Trade Services Sector Truro, N. S., March 26, 1965.

Is it possible to combine the objectives:

- a. Training Health Services Personnel.
- b. Creating jobs for an increasing number of our young people?

The answer is most definitely "yes" but most of the jobs will not be in Nova Scotia. Every year for the next ten or even more, the Canadian Health Services will absorb approximately 16,000 people. We need jobs for 2000 or 3000 of our people. Why can we not be the suppliers of this much-needed commodity? The answer is obvious - money. But is there not some way we can "invest in humans" as suggested by Prof. Samuelson?³

Is there some way in which the financing of such a project could be Federalized as was done after the war with Funds for Education in re-establishment credits programme. A "Portable" education fund concept of federal assistance to education in all its aspects. Certainly, the money given to Veterans for education has been repaid many fold in higher income and taxes. However, there is much more involved than just money. We live in a society of increasing "Welfarism". . . . "Scarcity for none" is the order of the day. No amount of wishing or preaching can turn back the clock. *It is possible to live in Western society with little effort.* The fundamental needs are, or soon will be, available to all. This proposition of life without effort appeals particularly and understandably to the young, the poor and the uneducated. Somehow, we must ascertain the formula of how to motivate our young people "to want"; "to know" and "to be." Then, they can be expected to apply themselves, study and persevere, reaching their full potential as human beings. A way to instill pride of person, pride of achievement, self-reliance in these young people is our greatest challenge - and will be most rewarding.

In conclusion, it is suggested that a study be made - a conference, if you like, on the problems of:

1. Personal motivation in an increasingly Welfare society.
2. The possibility of Federalizing Educational Grants along the lines of Portable Personnel Education Grants.
3. A study be made of the feasibility of Nova Scotia becoming a sort of Educational "Complex" for the rest of the Country - more particularly in the area of Health Services Industry but with a broad approach to all Sectors of the National Economy. □

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Write or phone Paul C. Doyle, LL.B., President of Hospital Board, Phone 68, Arichat, Nova Scotia.

The Canadian Medical Retirement and Savings Plan (C.M.R.S.P.)

CROSSMAN H. YOUNG, M.D.¹

Dartmouth, N. S.

The Canadian Medical Retirement and Savings Plan was established September 1, 1957 as a new and untried activity of the Canadian Medical Association. The rapid growth of savings by participating physicians through this arrangement has long since exceeded any initial expectations. The objective was, and is, provision of a flexible and systematic method of accumulating funds for a retirement annuity, while taking advantage of tax deferral during the period of savings. Both of the purposes have been achieved and already retired physicians are enjoying the annuities which their savings have produced.

Since the adequacy of retirement income depends both on savings and the purchasing power of the dollar, two methods of saving are made available:

- 1 An Insured Annuity Plan, underwritten by the National Life Assurance Company of Canada, incorporating long-term guarantees in addition to participation in the profits of the insurer.
- 2 A Common Stock Investment Plan, managed by the Royal Trust Company, which translates participant's contributions into common shares in leading companies permitting participation in the growth of the Canadian economy.

Enrollment demands membership in the Canadian Medical Association and may be arranged by completion of an application form during the year and up to Feb. 9th of the subsequent year that contributions will be eligible as a tax deduction against the year's income. Through special arrangement this date may be extended to February 28th though inevitable delays must occur in providing statements under these circumstances.

Contributions may be made after enrollment by deposit of monies to a special savings account at the Bank of Montreal not later than 9th February, 9th May, 9th August and 9th November. Transfer of these monies by the Bank of Montreal to the Royal Trust Company effects allocation to the savings arrangements above, according to the participants wishes expressed in the application form and annually thereafter. A minimum contribution of \$300 annually must be made, except under special circumstances, and the maximum allowed by government regulations cannot be exceeded.

Encouragement of younger members of the profession by the Trusteeship Committee to establish a pattern of regular savings and investment appears effective in that of 569 new participants enrolled during 1965 some 80 per cent were below the age of 45 yrs.

Interest by the profession promoted subsequent formation of two companion funds. The Canadian Medical Equity Fund effective September 1, 1960 and the Canadian Medical Non-registered Insured Annuity Fund. Neither fund enjoys benefits of tax relief applicable to earned income, but do provide professional management of savings more readily available if required than from the locked-in C.M.R.S.P. Subsequent amendments approved by the General Council of the C.M.A. extended benefits of participation in the Canadian Medical Equity Fund to member's wives, children and grandchildren, widows of a former C.M.A. Member, lay staff members of the C.M.A. and Divisions, Corporations, Foundations or Trusts in which C.M.A. Members and their immediate families have a beneficial interest.

Of particular interest to recent and current entrants into private medical practice the Canadian Medical Association through C.M.R.S.P. have made arrangements with the Bank of Montreal that special loans be available to establish practice. Eligibility extends to any medical graduate, who is a member of the C.M.A. and who has been accepted as a member of C.M.R.S.P. and who applies for a loan within two years of his entry in private practice after graduation or within one year of his re-entry into private practice after graduate specialty training.

The purposes to qualify for a loan are broad and approved applicants may borrow up to \$7500 while choosing a repayment period up to five years. Interest will be charged at 5½ per cent on that portion of the loan which is repaid in 24 months and 6 per cent on that portion wherein the repayment period is longer than 24 months. Group Life Insurance is arranged through payment of a small annual premium by the borrower that any outstanding balance of the loan be repaid in the event of death of the borrower.

Application forms are available at all Bank of

¹Divisional Representative, The Canadian Medical Retirement and Savings Plan.

Montreal branches though preferably are obtained by writing the C.M.A. Office, 150 St. George St., Toronto, Ontario. or to the Medical Society of Nova Scotia, Dalhousie Public Health Clinic, Halifax, N. S.

A recent review of performance by C.M.R.S.P. was reported to the Executive Committee of the Medical Society of Nova Scotia and principal features are summarized as follows:

- 1 Total enrollment in C.M.R.S.P. reached 4866 by 28th February 1966. An additional 13 members enrolled from the Nova Scotia Division for a total enrollment of 163 participants.
- 2 Average contributions increased to \$1475 per participant and a total of more than \$7,000,000 was subscribed during the year. An additional \$1,800,000 accrued through contributions to C.M.E.F.
- 3 An additional 13 doctors and wives from this

Division enrolled in C.M.E.F. during the year increasing total registrants to 42.

4 Common Stock Funds as at 28th February 1966 were valued \$34,105,835. The Unit value increased during the year to \$21.14 and compared to a Unit value of \$10.00 at 30th November, 1957.

5 The Insured Annuity Fund will bear interest at the rate of 5.90 per cent during the current year.

6 Some 145 loans to establish private medical practice have been approved by the Bank of Montreal for C.M.R.S.P. participants.

Further information regarding features of The Canadian Medical Retirement and Savings Plan, The Canadian Medical Equity Fund and other services to participants may be obtained from the offices of the Nova Scotia Division, the Divisional Representative or The Canadian Medical Association, 150 St. George St., Toronto 5, Ontario. □

Fractures of the Hip

The physicians in the Halifax - Dartmouth area are requested to cooperate in an epidemiological study of persons with fractures of the hip. The study is to be conducted by Dr. Peter Gordon of the Department of Preventive Medicine and will involve interviewing all patients admitted to the hospitals in this area with fractures of the hip, as well as selected patients with other types of fractures. The interviews will be conducted by a Registered nurse on the project staff. From time to time physicians will be contacted by one of the project staff requesting certain information regarding the patients. All information will be coded and kept strictly confidential. In the final analysis and report, individual patients, physicians or hospitals will not be identified in any way.

The overall purpose of the study is to investigate the relationships between various host and environmental factors and fractures of the hip and more specifically.

1. To determine the incidence of fractures of the hip in a defined population.
2. To determine the relationship between this condition and various factors of possible

etiologic importance, such as age at menopause, weight, previous corticosteroid therapy, previous X-ray therapy, diabetes, degree of activity prior to the fracture etc.

3. To determine the succession of events leading up to, and immediately preceding the occurrence of the fracture.

In the conduct of study the nurse interviewer will be instructed to use her discretion and not interview at length any seriously ill patient.

It is expected that the study will bring to light certain predisposing factors which, together with information regarding the succession of events leading up to the injury, could lead to the development of preventive measures of practical importance.

A study of this type is difficult to carry out, particularly as it involves older people and will continue over a two year period. It is therefore hoped that the practicing physicians will co-operate fully with the project staff and thus participate in one of the first controlled epidemiological studies of fractured hips to be conducted. □

Polonium²¹⁰ in Pulmonary Tissues

Continued from page 122

the Po²¹⁰ in smokers' lungs comes from such unsupported Po²¹⁰ present in cigarette smoke.

The relatively low Po²¹⁰ concentration in lung parenchyma of cigarette smokers as compared to nonsmokers suggests that the majority of inhaled particles is rapidly cleared from the lung. The distribution of polonium activity in the lung parenchyma of cigarette smokers suggests that either deposition or clearance of smoke is not uniform. Because deposition of cigarette smoke depends on diffusion, it should be relatively uniform within the lung. The lower polonium content in peripheral parenchyma probably reflects a more rapid clearance of smoke from peripheral lung tissue into the bronchial tree than from more central regions. Clearance of the majority of inhaled cigarette-smoke particles appears to be rapid and to occur primarily by way of the bronchi.

Not Only Factor

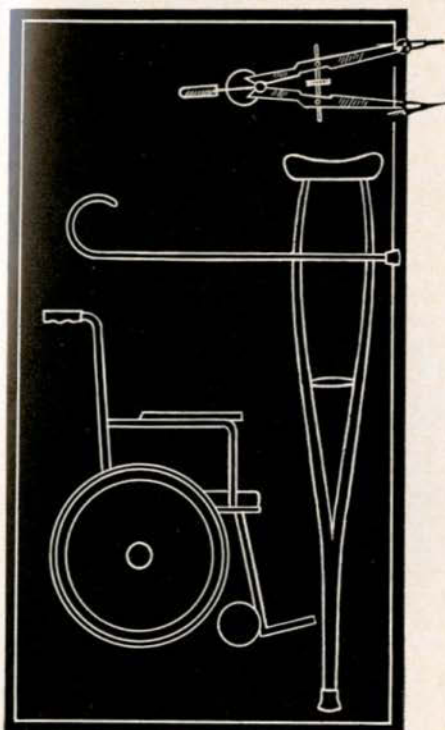
It is unlikely that alpha radiation is the sole factor responsible for bronchial tumors in smokers. Other agents in cigarette smoke may well contribute significantly as cocarcinogens, and the effect

of a small radiation dose may be considerably magnified by their action.

Because of the uncertainty associated with dose estimates to bronchial stem cells in cigarette smokers, it is premature to assert that Po²¹⁰ is or is not likely to be the major factor in induction of bronchial cancer in smokers. It is unlikely that there is a threshold dose below which no effect would be produced by alpha radiation; on this basis any dose, no matter how small, would have a certain probability for tumor induction. Finally, recent preliminary studies in animals indicate that alpha radiation may be a much more potent carcinogen in the production of certain skin cancers than more sparsely ionizing radiation.

As for the distribution of Po²¹⁰ within the lung, the high levels found in segmental bifurcations are in regions where bronchial carcinomas frequently arise. The relatively low concentrations in lung parenchyma indicate that significant localization does not occur in the alveoli and, indeed, parenchymal tumors are relatively uncommon in cigarette smokers.

On the basis of the available evidence, it may be concluded that radiation from Po²¹⁰ may be an important factor in the initiation of bronchial cancer in cigarette smokers. □



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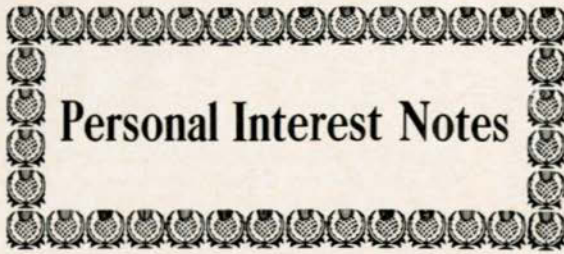
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Personal Interest Notes

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Damage your health?

Buy it? Of course not" - excerpt from a pamphlet produced by the Canadian Tuberculosis Association on Cigarette smoking.

What fools we mortals be!

CAPE BRETON

Baddeck: **Dr. S. C. Robinson**, Director of the Uterine Cancer Detection Programme in Nova Scotia addressed the members of the Alexander Graham Bell Club and their guests recently. He showed the films, "Uterine Cancer" and "Self Examination of the Breast", and stressed the importance of yearly medical examinations to assure early detection of cancer.

Sydney: **Dr. F. K. Kelly** has been appointed general chairman of the annual campaign of the Canadian Cancer Society in Cape Breton, covering nine units in all.

Sydney Mines: **Dr. W. J. Lamond** has been honoured by the Dr. W. T. McKeough Nursing Division of the St. John's Ambulance for his outstanding efforts on its behalf. He was presented with a certificate in appreciation of his work as division surgeon at a meeting at which various out of town guests joined in paying tribute.

Dr. W. Siddall was a guest speaker at a meeting recently of the **Port Hawkesbury** Board of Trade, on the feasibility of a hospital for the strait area.

Glace Bay: **Dr. C. J. W. Beckwith**, Executive Secretary of the Nova Scotia Medical Society and **Dr. A. J. M. Griffiths** the President, met recently with officials of U.M.W. to see what steps could be taken to alleviate the shortage of doctors in the mining areas. It is especially severe in Glace Bay. The physicians in this area are required to carry too heavy a load. In some cases, men injured in the mines have had to wait in hospital several hours before medical attention.

A committee has been named to make a study of the need for a nursing home in the Glace Bay area, following a conference with **Dr. J. J. Stanton**, Administrator, Health Unit Services and Chief Inspector of Nursing Homes for the province. This conference was proposed by the Glace Bay Ministerial Association and Catholic Family Service. **Dr. Stanton** gave them a comprehensive survey of what the proposal involved in money, space and personnel.

North Sydney: At a recent meeting of Town Council, **Mayor (Dr.) J. S. Munro** made it abundantly clear that of the "Mayor's expense fund" as budgeted last year, not a cent had been spent by him but nearly all had been given to various worthy causes. He asked that in future this fund be listed under a different heading.

Dr. Lilia Aquino, Radiologist at the Sydney City Hospital was the guest speaker at the regular meeting of the Rt. Hon. Vincent Massey Chapter of the I.O.D.E. recently. She gave a most interesting and informative talk on her native country, the Philippines.

CUMBERLAND

Medicare was the subject of an address by **Dr. G. M. Saunders** to the Amherst Rotary Club in March. He outlined the proposals of the national health programme and told of the recommendations presented by the Nova Scotia Medical Society and the Canadian Medical Association with respect to physicians' services insurance.

Dr. J. P. Donachie was the guest speaker at the annual meeting of the Amherst branch of the VON. He spoke on public health nursing in other countries mentioning particularly the work done in Egypt, Norway and Australia.

EASTERN SHORE

Dr. Chas. Murchland who has been practising in Sheet Harbour has left and is now at the Clinic Hospital in Oromocto, N.B.

LUNENBURG-QUEEN'S

Dr. Dennis A. N. Drury has joined **Dr. A. J. M. Griffiths** in partnership in the practice of radiology in the South Shore hospitals. **Dr. Drury** comes from Hornechurch, Essex, England, where he was a Consultant Radiologist of some years standing. He is accompanied by his wife and six-year-old twin daughters. **Dr. Drury** expects to make his home in Lunenburg Co.

The **Lunenburg-Queen's Medical Society** entertained lawyers from the two counties at a reception at the Fairview Hotel, Bridgewater on March 31. Following the reception a joint dinner was held. This was followed by two hours of stimulating and interesting discussion on the common problems of medicine and law. It was agreed that further

meetings should be held from time to time. Plans call for the lawyers to sponsor the next meeting in the fall. Honoured guests were Judge R. Clifford Levy, Provincial Magistrate Hiram Carver and Dr. Ian D. Maxwell of the Medical-Legal Liaison Committee of the Medical Society of Nova Scotia.

The announcement of the award of Senior Membership to **Dr. H. A. Creighton** in the Medical Society of Nova Scotia gave much pleasure to his colleagues.

HALIFAX

David Kendall, D.M. (Oxon), M.R.C.P. (London) has joined **Dr. Hugh MacDonald** in the practice of Neurology.

Dr. John E. MacDonell has recently been appointed to the National Advisory Council on Physical Fitness and Amateur Sport. Dr. MacDonell, who is at present doing postgraduate studies at the Victoria General Hospital, is a native of Antigonish, a graduate of St. F.X. and McGill University in Medicine. He has done postgraduate work in Montreal General Hospital and Hammersmith Hospital, London, England. He was a former head of the department of Medicine at St. Martha's Hospital, Antigonish. He is now a Consultant in Internal Medicine for the Nova Scotia Hospital Insurance Commission, a member of the Advisory Board of the Nova Scotia Tuberculosis Association and an executive member of the Nova Scotia Society of Internal Medicine.

Dr. R. M. Cunningham, who went to Burma to install the first atomic energy cobalt machine in the far east and who is now a member of the Radiotherapy Department of the Victoria General Hospital told the Armdale Kiwanis Club recently that the greatest problem facing us today is to educate school children to appreciate the danger of disease associated with smoking. He stated that the place to start was

in the schools and in cooperation with service clubs fraternal associations and youth groups.

Dr. W. A. Cochrane spoke to the Dalhousie Woman's Club at their last meeting of the year. The meeting was open to faculty husbands and other guests. He proposed that a two-pronged attack on the overall problem of congenital deformities be made by coordinating all the various people interested, the paediatricians, and other doctors, the educators, social workers the employers in the formation of a health council who would oversee every aspect concerned with the benefit of the victims of congenital deformities and their families.

Dr. Douglas Waugh, Head of the Department of Pathology at Dalhousie and **Dr. R. S. A. Prentice** presented a paper at the annual meeting of the Federation of American Societies for Experimental Biology at Atlantic City in April.

Dr. Ian Maxwell listed arguments in favour of implementation of breath alcohol legislature in Nova Scotia for members of the Kiwanis Club in Halifax. The breathalyzer test was a convenient method of estimating blood alcohol levels with minimum difficulty and maximum ease and accuracy. The magistrate's task would be easier and those persons who appeared drunk, but who were really ill would be protected.

Spring Vacations become more and more popular with many citizens of this northern clime and doctors are no exception.

Dr. J. J. Carroll and Mrs. Carroll of Antigonish were in Florida: **Dr. and Mrs. Robert Greening** were in South Carolina: **Dr. John MacCormack** and his wife of the Antigonish Clinic were in the West Indies at a medical conference while **Dr. and Mrs. H. J. Devereaux** and **Dr. and Mrs. Gordon Simpson**, Sydney, were in the Barbados.

Back from the Caribbean cruise which so felicitously combined business with pleasure have come,

Dr. C. L. Gass, key lecturer, **Dr. R. G. A. Wood**, Lunenburg, who was a member of a panel on a symposium entitled "The Role of the Physician in Community Affairs", and **Dr. R. O. Jones** president of the CMA. To the Halifax county area have returned **Dr. C. D. Vair** and **Dr. D. A. Weir**, **Dr. Rex Langdon** and **Dr. Jack Boudreau**, and **Dr. Phillip Jardine**. All were accompanied by their wives. No doubt doctors from other parts of the province went also - but who can tell?

CONGRATULATIONS

We extend our congratulations to **Miss Olga Dimitriadis**, daughter of **Dr. and Mrs. George Dimitriadis** of Halifax for having been awarded a scholarship to study German at the University of Kansas this summer. **Mr. Charles Morrison**, son of **Dr. and Mrs. N. A. Morrison** who is at present director of the Cobequid Health Unit and was formerly at Musquodoboit Harbour, last year won the silver award offered for General achievement by the Duke of Edinburgh. This year he received the gold medal from H.R.H. Prince Phillip himself. He was one of 12 Canadians receiving an award and the only one east of Toronto. This movement, headed by Sir John Hunt, (Everest) is activated by voluntary committees throughout the Commonwealth. About 130,000 young people between the ages of 14-20 have won awards. It encourages public service, hobbies, fitness and expeditions with self reliance the key note. Charles Morrison, in his last year at Upper Canada College has been active in sports, stage productions, benefit work at Toronto hospitals and this summer expects to begin a career with the department of external affairs. He recently, to qualify for the award, went on a 50 mile overland hike, sleeping outdoors in 20-below-zero weather.

ATLANTIC PROVINCES FAMILY DOCTORS PLAN SCIENTIFIC ASSEMBLY

In view of the success of the first Conjoint Scientific Assembly held by the Maritime Provinces Chapters of the College of General Practice of Canada in Charlottetown, Prince Edward Island in October of last year, the Nova Scotia, New Brunswick and Prince Edward Island Chapters of the College are planning a second such Conjoint Scientific Assembly, in co-operation with the Postgraduate Division of the Faculty of Medicine of Dalhousie University.

The second Assembly, like the first, will be held in the new Confederation Centre in Charlottetown at Thanksgiving weekend,

October the 10th and 11th, 1966. It is expected that this Assembly will attract a large number of family doctors from the Maritime Provinces, both members and non-members of the College of General Practice.

BIRTHS

To Dr. and Mrs. Alan Drysdale, (née Myrla McCully), a son, Donald Alan, at the Grace Maternity Hospital, Halifax, on April 4, 1966.

To Dr. and Mrs. Donald F. MacLennan, (née Peggy Funchion), a son Donald Scott, at Hotel Dieu de St. Joseph, Edmunston, N. B. on March 30, 1966.

To Dr. and Mrs. Carl Mader, (née Jessie Mielke), a daughter in

Cuyahoga Falls, Ohio on March 13, 1966.

To Dr. and Mrs. Joseph Yin, (née Violetta Caniaverai, RN), a daughter, Stella Mary, at the Grace Maternity Hospital, Halifax, on March 19, 1966.

OBITUARY

Mrs. Muriel G. Currie passed away Friday, April 15th at the Eastern King's Memorial Hospital, Wolfville. The physicians of Nova Scotia will remember Mrs. Currie for the faithful work performed for the Medical Society of Nova Scotia over the many years prior to her retirement in 1960. An Appreciation will be published in the next issue of the Bulletin. □

WANTED

Medical graduates, men and women, for part time teaching in Medical School, to give elementary instruction in Anatomy to Paramedical students (Physiotherapists, Dental Hygienists, and Nurses, etc.)

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