



National Meeting Draws Big Attendance

At the 70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association in Winnipeg last month, it was quite evident that our voluntary associations across Canada are moving into a new decade with a new spirit, a new perspective and a bold new generation of physicians and health workers to guide them.

Gone forever is the long held premise that tuberculosis is a cause apart. The pathway into the seventies will be broad and exciting, encompassing all chronic respiratory disease and the various factors that contribute to this rapidly mounting health problem.

A total of 260 delegates from all parts of Canada registered for the three-day sessions at the Hotel Fort Garry. In addition, an unprecedented number of students, young physicians and nurses turned out for some of the special events. The hotel ballroom was filled nearly to capacity for such program highlights as a film and discussion on the management of chronic respiratory disease, lectures on the uses and merits of anti-tuberculosis chemoprophylaxis and BCG vaccine, and a presentation by field nurses on the problems of health service delivery in remote and urban areas.

Over 200 nurses attended the meeting of the Nurses' Section on June 1, which took a comprehensive look at respiratory disease nursing; and over 100 physicians and students turned up to hear about major developments in respiratory research in Canada at the sessions of the Canadian Thoracic Society.

The scientific papers were presented at the C.T.S. meeting by junior investigators from seven Canadian research centres. On hand to hear them and to participate in the discussions were such leading respiratory disease experts as Dr. David V. Bates, professor and chairman of the Department of Physiology at McGill, Dr. E. J. Moran Campbell, chairman of the Department of Medicine, McMaster University, and Dr. Sol Permutt, professor of environmental medicine at Johns Hopkins University.

The sessions were probably the liveliest and most stimulating in the 12-year history of the C.T.S. With its larger, enthusiastic membership, the Society may well emerge as a leading force in a new national campaign to deal with the serious and mounting problem of chronic lung disease.



Dr. A. L. Paine, new president of the Canadian Tuberculosis and Respiratory Disease Association (right), is pictured with the out-going president, Dr. A. B. Colohan of St. John's, Newfoundland, Mrs. Colohan (second from left) and Mrs. Paine.

(Photo by David Portigal)

Dr. Alfred L. Paine, medical superintendent of the Manitoba Sanatorium, Ninette, assumed the presidency of the Canadian Tuberculosis and Respiratory Disease Association, at the final sessions of the annual meeting in Winnipeg, June 3.

He succeeds Dr. A. B. Colohan, medical director of St. John's Sanatorium, Newfoundland.

A 1929 graduate of the University of Manitoba Medical School, Dr. Paine has been a member of the Ninette staff since 1933. In 1941 he became the chief surgeon at the sanatorium, and six years later he was appointed medical superintendent.

OFF TO SWITZERLAND

Dr. Earl S. Hershfield, associate medical director of our Tuberculosis and Respiratory Disease Service, will fly to Lausanne, Switzerland, on August 1 to take part in the annual congress of the International College of Chest Physicians.

Dr. Hershfield will present a paper on August 5 on blastomycosis in North America. He will also show the D. A. Stewart Centre film on the management of chronic lung disease.

Later in the month Dr. Hershfield (who will be accompanied by wife Betty-Anne) will visit chest facilities in Tel Aviv.

Special Sanatorium Care Unnecessary

For nearly three-quarters of a century, sanatorium treatment had a prominent part in tuberculosis control — but that part now belongs to history, according to Dr. E. S. Hershfield, associate medical director of the Tuberculosis and Respiratory Disease Service of the Sanatorium Board of Manitoba.

In an address to delegates to the 70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association in Winnipeg last month, Dr. Hershfield urged that the tuberculosis patient be treated henceforth in the main stream of medicine, in much the same manner as any other individual with a chronic chest disease.

With potent drug therapy and modern methods of controlling transmission of infection, isolating the TB patient in a remote sanatorium is no longer necessary to safeguard public health, he said. "It doesn't do the patient any good — and it certainly doesn't ensure a continuing medical interest in tuberculosis diagnosis and control."

Tuberculosis patients (particularly those in the acute phase) should be treated by internal medicine specialists who have an interest and training in chest disease, Dr. Hershfield suggested.

The ideal treatment facility is a chest clinic or hospital, separate from but in proximity to, general teaching hospitals.

Here patients would benefit from comprehensive and up-to-date medical and para-medical care. And the chest clinic — indeed the whole tuberculosis cause — would benefit from a continuous stream of young physicians and para-medical students wishing to train in respiratory disease.

People concerned with the future control of tuberculosis should be working now to integrate its treat-

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Address all communications to:

THE EDITOR, SBM NEWS BULLETIN
800 Sherbrook Street, Winnipeg 2, Manitoba
Second Class Mail Registration Number 0324.

Laryngectomy Patients Sought For Special Club

Do you know anyone who has undergone surgical removal of the larynx?

Such individuals have become the object of a province-wide search by the Department of Communication Disorders at the Manitoba Rehabilitation Hospital.

The purpose is to interest people who have had laryngectomies in the formation of a Lost Cord Club, similar to those that now flourish in other major Canadian centres.

Many people who have lost their vocal cords get individual help in learning to speak again — using esophageal speech or, if this is not possible, an artificial larynx. But according to speech clinician Mrs. Marijke Vogel, a Lost Cord Club — through meetings and correspondence — would go beyond this, offering members continuing moral support, encouragement and counselling.

Above all it would demonstrate to members, to other people facing this sort of surgery, and to the professions and the public, that loss of the larynx usually does not mean loss of the ability to produce speech or to attain a full and useful life.

Mrs. Vogel believes that there are a good number of people in the province who would benefit from membership in this type of organization. The Department of Communication Disorders provides speech therapy and counselling to about four new laryngectomy patients each year. But these, she feels, represent only a small percentage of the number of people who have this surgery.

So if you know any candidates for membership in a Lost Cord Club, the Department of Communication Disorders (c/o Manitoba Rehabilitation Hospital, 800 Sherbrook Street, Winnipeg 2) would be very happy to have their names and addresses.

The first meeting is scheduled at 8:30 p.m., September 16, in the hospital auditorium.

Drug Prophylaxis Will Reduce TB Problem

"At the present rate of decline, tuberculosis will still be very much with us at the turn of the next century," according to Dr. Stefan Grzybowski, associate professor of medicine at the University of British Columbia. In 1965, a total of 5,703 cases of active tuberculosis were reported to the Dominion Bureau of Statistics, while three years later, in 1968, there were 5,579 cases and last year over 5,000.

In an address to the 70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association on June 1, Dr. Grzybowski suggested that one means of acceler-

one-fifth of the Canadian population is positive to the tuberculin skin test and it would be highly impractical to place four million people on anti-TB pills.

Which groups of infected Canadians should receive chemoprophylaxis? Dr. Grzybowski named those people with inactive tuberculosis, who had no previous adequate drug treatment, as the most important group, as about one percent of them develop active disease every year. Secondly, persons who have come into contact with active tuberculosis for the first time should be offered a course of drug prophylaxis, since

the risks of developing disease are very high.

"Tuberculosis infection is particularly dangerous in infancy and adolescence," the doctor continued. Recently infected individuals in these two groups should also receive priority. So should Eskimos, who for some reason show an extremely high risk of developing active tuberculosis for a long time after they become infected.

Although it is important to be selective in recommending persons for chemoprophylaxis, Dr. Grzybowski concluded by appealing for the "extensive use of chemoprophylaxis in high risk groups, as this will go a long way towards the rapid reduction of the residual tuberculosis problem in Canada".

—From a CTRDA News Release



DR. STEFAN GRZYBOWSKI

ating this rate of decline is chemoprophylaxis — the administration of the anti-tuberculosis drug INH in order to prevent the disease.

Any person infected with the tubercle bacillus is under some risk of developing tuberculosis, and that risk can be appreciably diminished by a course of preventive drug therapy. However, Dr. Grzybowski pointed out, "in most of us, who have a positive tuberculin reaction as the only evidence of encounter with tubercle bacilli, that risk is very small — and it may seem like using a sledge hammer to crack a nut to take drugs for 1½ years in order to make this very small chance still smaller."

Furthermore, he explained, over

CTRDA HONORS TB WORKERS

Three Manitobans were among those honored at the annual dinner of the Canadian Tuberculosis and Respiratory Disease Association, held at the close of its 70th annual meeting at the Hotel Fort Garry, June 3.

Dr. Donald L. Scott, Miss Evelyn McGarrol and Miss Gladys Wheatley were recipients of honorary life memberships in the association, in recognition of their long, devoted service to the anti-tuberculosis cause.

Dr. Scott — a native of Morden, Manitoba, and a graduate of the Manitoba Medical School — became the first medical head of the former Central Tuberculosis Clinic when it was opened in Winnipeg in 1930. He held that position until his retirement in 1968 — and assumed the additional posts of assistant medical director of the Sanatorium Board of Manitoba and superintendent of tuberculosis preventive services in 1946.

Dr. Scott was also on the honorary attending staff of the Winnipeg General Hospital for 20 years, a lecturer in medicine for the University of Manitoba for many years, and consultant in tuberculosis for the Department of Veterans' Affairs for over two decades. Following his retirement, he stayed on with the Sanatorium Board for one year as a special consultant in tuberculosis.

Miss Evelyn McGarrol was in charge of all secretarial work at the former Central Tuberculosis Clinic (now called the D. A. Stewart Centre) for 37 years. She came to Canada from Aberdeenshire, Scotland, at the age of nine. She completed her schooling and business training in Winnipeg, then eight years later became ill with TB. She joined the staff of the newly opened C.T.C. on her recovery and made an

outstanding contribution to its work until her retirement in 1967.

Another long-time TB worker, Miss Gladys Wheatley, was honored for 37 years as secretary to the medical superintendent of the Manitoba Sanatorium at Ninette. She was born in Portsmouth, England, and as a child of six emigrated with her family to Strasbourg, Saskatchewan. In 1924 she moved to Winnipeg, took business training, then joined the Ninette staff in 1929. For about eight years she was an exceedingly capable secretary to Dr. D. A. Stewart, first medical superintendent of Manitoba Sanatorium and following his death in 1937, she served as secretary to succeeding medical superintendents, Dr. E. L. Ross and Dr. A. L. Paine.

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Three former CTRDA presidents were also awarded honorary life memberships at the annual dinner.

They are Colin Dobell, who for many years has been active in TB work in British Columbia; Kenneth More, who has actively supported the Saskatchewan Anti-tuberculosis League since 1939 and is presently a member of its Board of Directors; and Dr. Eric Found, former director of Tuberculosis Control and superintendent of the Provincial Sanatorium at Charlottetown, P.E.I.



A group of delegates to the CTRDA annual meeting are pictured with their wives at a reception at the Manitoba Centennial Concert Hall on June 1st. From left to right are: T. A. J. Cummings, executive director of the Sanatorium Board, Mrs. Cummings, Dr. Ben Schoemperlen, associate medical director of the D. A. Stewart Centre in Winnipeg, Mrs. Schoemperlen, Ralph Ricketts, executive secretary of the Nova Scotia TB-RD Association, Frank Froh, executive secretary of the Saskatchewan Anti-Tuberculosis League, and Mrs. Ricketts. The reception was followed by a sumptuous buffet dinner provided by Versafood Services, then a performance at the planetarium. (Photo by David Portigal)

RESEARCH IS A VITAL FUNCTION OF MODERN MEDICINE

At our Manitoba Rehabilitation Hospital — D. A. Stewart Centre, a Research Fund has been established to finance important investigations into basic problems related to major disabilities.

A contribution or bequest to the Research Fund offers an opportunity to support the search for greater understanding of the means of preventing and treating disabling illness and injury. Contributions or inquiries should be directed to the Executive Director of the Sanatorium Board of Manitoba, 800 Sherbrook Street, Winnipeg 2.

MRH Fund Aids Research in Diseases of Nerves

A \$6,246 investment from the Manitoba Rehabilitation Hospital Research Fund is beginning to pay dividends in the search to understand and treat diseases affecting the sensory nerves.

Using a special purpose computer and a graduate research student to conduct the investigations¹, a project was started two years ago to establish an adequate method of assessing sensory nerve function.

The first objective — which has now been successfully accomplished — was to find a set of normal values for comparing the speed at which messages are transmitted along the nerve pathways to the brain, when electrical stimulation is applied to peripheral and other nerves in the body.

Armed with these normal values, the physician should now find it easier to measure delays in response to electrical stimulation in patients with disease of nerves, and to pinpoint the site of the delay — particularly when he cross-checks the results of sensory conduction velocity tests with other tests to determine muscle response to electrical stimulation of a nerve. (Motor conduction velocity tests.)

In the following article, research student Graham Ball describes how the testing of sensory nerves has become more accurate when a computer is used to visualize low amplitude responses in the brain from electrical stimulation of the nerves.

By Graham Ball

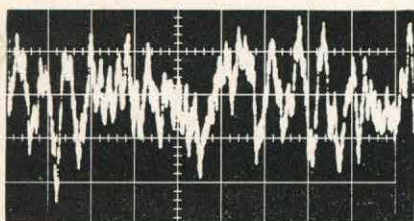
Although the velocity of conduction in sensory nerves is simple to calculate, the basic procedures necessary to process the electrical impulses in the nerves, and to analyse responses in the brain to electrical stimulation of nerves, are so complicated that they can be accomplished only with the aid of a computer.

Figure 1 shows the connections necessary to test the sensory nerves.

Figure 2 shows a patient being tested.

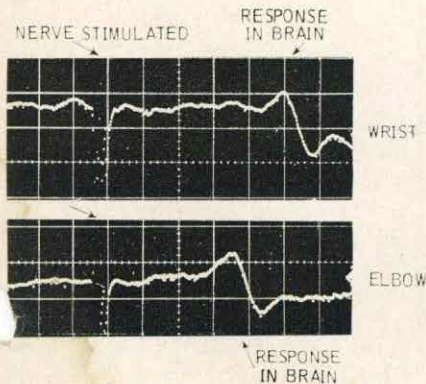
The patient lies comfortably on a couch, and two little electrodes are gently placed on the scalp, over the part of the brain that detects sensations from the arms or legs. The nerve to be tested is stimulated first at the wrist or ankle and then at the elbow or knee. About one hundredth of a second after the electrical

FIG. 3



This shows the continual brain activity that hides the tiny brain responses from stimulating nerves. The computer separates the responses from all this activity to show the real patterns seen in Figure 4.

FIG 4



This shows the responses of the brain to stimulation of a nerve at the wrist and then at the elbow. (Note the response from the wrist appears earlier — 4-1000th of a second). The distance between stimulus points was 360 mm. The conduction velocity is therefore 90 meters per second.

stimulation of the nerve, the brain receives the message from the point of stimulation. This message is in the form of a tiny change in the electrical currents of the brain; it is about three-millionths of a volt in amplitude.

The basic idea is to stimulate the sensory nerve at one point and to record the tiny electrical response of the brain. Then the electrode is moved up to a higher point over the nerve and the stimulus is given again. As this stimulus point is closer to the brain, it takes less time for the message to get there. A measurement of time difference between the brain's response to the distant stimulation and to the closer one tells the investigator how long it takes the nerve to send a message between the two points of stimulation. From this information and a measurement of the distance between the two points of stimulation, the speed at which the message is transmitted can be calculated. This is called *nerve conduction velocity* and is measured in meters per second.

Testing the brain's response to sensory nerves, however, is not really this simple — because the tiny electrical signals that are picked up in the brain are masked by the much bigger electro-encephalogram signals the brain makes all the time. The amplitude of EEG signals is around 30-millionth of a volt, or 10 times the amplitude of the brain response to stimulation of the nerve. So great is this amplitude, in fact, that the response to nerve stimulation in Figure 3 cannot be seen, even though it is there.

It is therefore necessary to use a computer to separate the response to the stimulus from the EEG activity hiding it. The computer does this in the following way:

The research worker presses the keys on a keyboard controller (or teletype), which sends a message to the computer instructing it to get the desired program from the library stored on a magnetic disc.

With the program in place, the computer signals the stimulator to stimulate the nerve at the first selected point.

At the same time, the computer takes in for a short time the ampli-

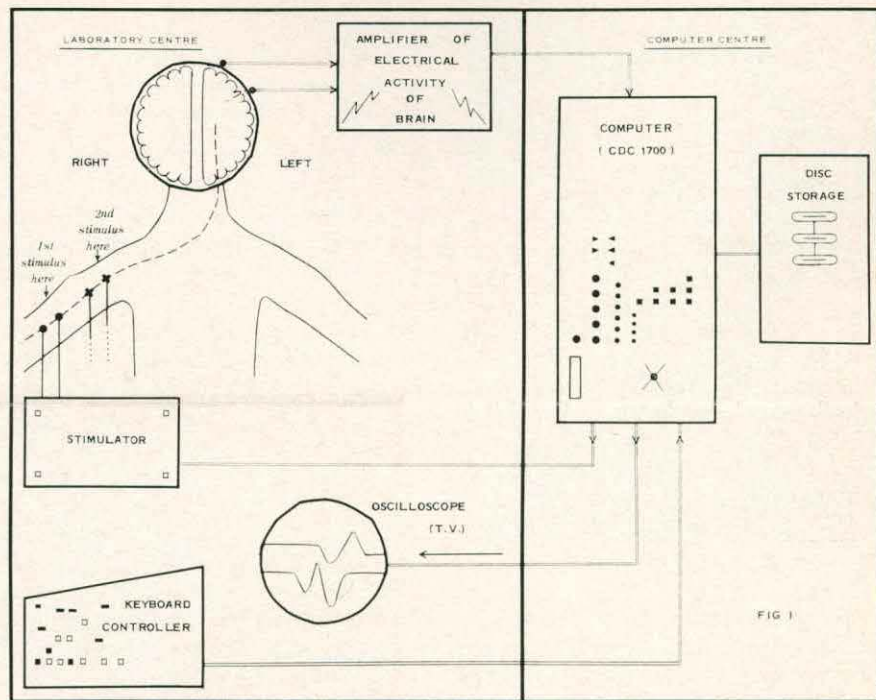


FIGURE 1. This is a diagram of the connections from patient to the amplifiers, stimulator and computer (which is 1500 feet away in the Medical College). The research worker can watch and photograph the brain responses on a TV screen.

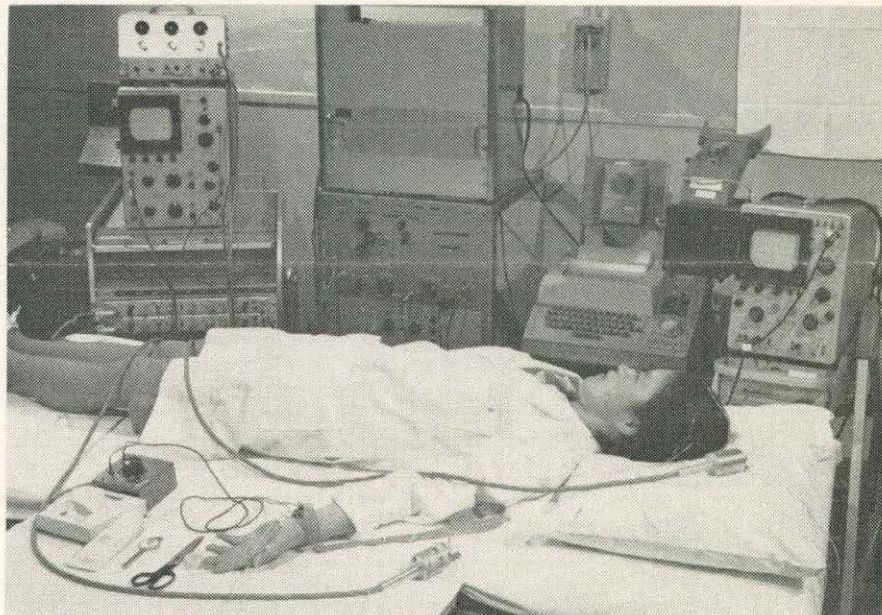


FIGURE 2. A normal subject is tested. The oscilloscopes, stimulator, amplifiers and camera are seen in the background. The teletype connected to the computer is next to the left oscilloscope, which is itself connected to the computer. In this picture, the conduction of nerves in the left arm is being tested.

fied activity from the brain, makes calculations on this pattern and sends the new pattern back to the oscilloscope (TV screen) stationed beside the patient.

The computer then waits for a second, sends another stimulus, receives some more brain activity, and sends back another picture.

This is repeated up to 100 times and gradually the brain response becomes clear enough to be visible and to enable the investigator to measure sensory conduction velocity from the time of stimulation to the beginning of the brain's response.

The response on the oscilloscope is photographed. Then the stimulating electrode is moved to a new position over the nerve and the process repeated. The results are shown in Figure 4.

Tests of this nature have been conducted on over 40 normal subjects (for six different nerves in each subject), and investigators now feel that they have a good set of results

to compare with patients suffering from diseases affecting the sensory nerves. With respect to the nerves in the arms of normal individuals, for example, the sensory conduction velocities are estimated to be around 80 to 90 meters per second. For the nerves in the legs, the velocities are about 60 meters per second. In the patient suffering from nerve disease, these velocities can drop by 20 to 70 percent. When the disease is successfully treated, they gradually become more normal.

This research — supported by the Manitoba Rehabilitation Hospital Research Fund and the Medical Research Council of Canada — will be of great value for diagnosis and aiding treatment in patients with some types of diseases of the nerves.

Studies on people with such diseases are continuing.

1. The project is under the direction of Dr. M. G. Saunders, director of the Computer Department for Health Sciences, University of Manitoba School of Medicine, and consultant (in electrophysiology) to the Manitoba Rehabilitation Hospital.

New Assistant



RONALD G. BIRT

The Sanatorium Board extends a warm welcome to Ronald G. Birt, who on May 25 joined our staff as Executive Assistant (Planning).

Mr. Birt was born and educated in Winnipeg, and in 1962-63 he trained as a laboratory technologist at the Winnipeg General Hospital.

Subsequently, he earned his Bachelor of Arts degree at North Dakota State University, then completed a 21-month post-graduate course in hospital administration at the University of Toronto. As part of this course, he served for the past year as an administrative resident at the Humber Memorial Hospital in Toronto.

In his new position, Mr. Birt will work closely with Plant Superintendent Bill Evans in taking inventory of our existing hospital space and interpreting, in non-architectural terms, the expansion plans for the Manitoba Rehabilitation Hospital — D. A. Stewart Centre.

Sanatorium Sixty Years Old

With no fanfare — but doubtless a great deal of reminiscing — the Sanatorium Board marks the 60th anniversary of the opening of our Manitoba Sanatorium at Ninette.

Manitoba Sanatorium was an early leader in the fight against tuberculosis in Canada. Construction began — after a prolonged discussion about an ideal site — in the early part of 1909. In May, 1910, the first group of patients was admitted and on June 22, the sanatorium staff, along with Board members and guests, gathered for the official opening.

The sanatorium began in a small way with only three buildings (accommodating about 60 patients), a meagre budget and a skeleton staff. As the years passed, however, the facilities were enlarged and the sanatorium gained prominence as a

spearhead for many bold health measures.

It was the first sanatorium, for example, to take medical students and graduates for training in tuberculosis work, and it was from here in the 1920's that the first travelling clinics set out on their "missionary journeys" to check the spread of tuberculosis in the community. Some of the early pioneering efforts in chest surgery were also undertaken at Ninette, and in the early 1940's, our sanatorium was the centre for the first successful rehabilitation program for TB patients.

Manitoba Sanatorium has had an important, indeed dramatic, part in the long war against an age-old disease. Although it is anticipated that tuberculosis treatment will be discontinued here within the next few years, it is also hoped that this proud record will never be forgotten.

Rehab Roadrunners Try Harder!

BULLETIN - Rehab Roadrunners defeated Municipal Hospitals fastball team 12-10, in the sixth game of the season, June 29.

"Rehab Roadrunners? They have great rehabilitation potential," allowed Ron Thomas, president of the Metro Hospital Fastball League. "Perhaps with a little more practice . . ."

A late entry (they managed four practices) in this year's fastball competitions between staff members of Metropolitan Winnipeg hospitals, the Manitoba Hospital Commission², and the Manitoba Hospital Association, the redoubtable Roadrunners³ began the season with four straight losses — but with great hopes for improvement.

"Actually, we blew three of the games (16-15, 17-15, 19-15)," confided team captain Barry McDermott. "The fourth one (16-8)? Well, that was hopeless from the start."

Even so, with a few minor exceptions, Sanatorium Board staff members stand solidly behind their team — staunch in their belief that with time and practice, the Roadrunners will emerge as a strong contender for the Grand Challenge Trophy.

The team has been equipped with handsome red and white uniforms, a whimsical (but oddly familiar) insignia and a schedule for play (Monday evenings at 7, see hospital bulletin boards for place).

Team members, in addition to Mr. McDermott, are Bill Wiseman, Paul Sears, Darwin Darker, Rudy Trnka, Arnie Thompson, Ray Fortnam, Bill Skoropata (pitcher) Brian Fortnam, Len Williams, Rick Bender, Roland Darel and Paul Larkin.

1. Sanatorium Board accountant, who plays for the Manitoba Hospital Commission.

2. See footnote 1.

3. Representing, of course, our Manitoba Rehabilitation Hospital. See footnote 1.

SPECIAL CARE

Continued from Page 1

ment with other chest diseases, he concluded. If they don't, they must anticipate a lack of trained personnel and a diminishing interest in a disease that still remains an important health problem.

MAGAZINES

(recent issues)

Before you throw them out, think of the PATIENTS' LIBRARY at the Manitoba Rehabilitation Hospital — D. A. Stewart Centre.

The VOLUNTEER SERVICE is in need of both magazines and books . . . and will welcome your contributions.

BULLETIN BOARD

In recent months, the Sanatorium Board staff (or their offspring) seems to have set some kind of record for picking up awards and degrees, making speeches and getting elected to high office.

At the 91st Convocation of the University of Manitoba, May 22, Miss Joan Edwards and Miss Martha Treichel, chief physiotherapist and assistant chief physiotherapist respectively, at the Manitoba Rehabilitation Hospital, were awarded Bachelor of Physiotherapy degrees. A week later Miss Edwards, accompanied by the department's clinical supervisor Miss Sharon Dandy, BPT, attended the annual Congress of the Canadian Physiotherapy Association in Toronto . . . where Miss Edwards reported on a *Shoulder Survey*, which had been conducted in the department for 18 months as a clinical observation study of two exercise techniques; and Miss Dandy presented a philosophical treatise on physiotherapy as a profession.

Also at the meeting Miss Edwards was elected vice-president of the C.P.A.

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Mrs. Marijke Vogel, speech clinician in the M.R.H. Department of Communication Disorders, was also elected to the office of vice-president (and president-elect) . . . at the annual meeting of the Manitoba Speech and Hearing Association.

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There are two particularly proud fathers in our midst these days. Lynne Zayshley, 19-year-old daughter of Surveys Organizer Jim Zayshley, received a Bachelor of Arts degree, plus the university Gold Medal for excellence in French studies, at the University of Manitoba Convocation. Lynne has been awarded a teaching assistantship in France and she will proceed there next fall to teach conversational English to Normal School students at Clairmont-Ferrand, as well as pursue post-graduate studies.

Charles Hayter, son of our Director of Physical Medicine Dr. R. R. P. Hayter, has been awarded the provincial scholarship to Queen's University and the Governor-General's Medal for top scholastic standing. He is a graduate of Kelvin High School.

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Lee Lacey, executive director, William Hetrick and Nick Hoffman, of the Harmarville Rehabilitation Centre in Pittsburgh, visited the Sanatorium Board and Manitoba Rehabilitation Hospital on May 20, for a one-day consultation with the executive director and staff with respect to an expanded rehabilitation facility at Harmarville. The proposed facility is expected to have a relationship to nine other hospitals in the area.

DR. IAN H. K. STEVENS

The Sanatorium Board was greatly saddened by the unexpected death on June 16 of a good friend and former medical staff member, Ian H. K. Stevens, MB, MRCS, MRCP, DRCOG.

As a consultant in physical medicine, Dr. Stevens gave outstanding service to the Manitoba Rehabilitation Hospital from the time he came to Winnipeg in 1962 until his retirement from our staff in August, 1966. He was particularly noted for his special interest in the rehabilitation program for hemiplegic patients, which he helped organize, then supervised.

Dr. Stevens was born and educated in Southampton, England, and as a youth during the First World War he served in India with the Royal Signal Corps. Following discharge from the army, he received his medical training at the University College Hospital, University of London, and at the Queen Charlotte Hospital and Great Ormond Street Hospital for Sick Children. He began practice in North London in 1932, then in 1938 moved to Canterbury where he became Chief of Medical Staff at Kent and Canterbury Hospital and head of the Complicated Maternity Unit. From 1945 until his retirement from the National Health Service in 1962, he served as consultant in physical medicine and geriatrics for East Kent.

Dr. Stevens will be long remembered by our staff for his warm interest in people, his love for music and theology, his enthusiasm for sports, and perhaps above all, his intense devotion to medicine.

Our deepest sympathy is expressed to his wife Mary, his children Janice and Barry and to the other members of his family.