NEWS BULLETIN

The Sanatorium Board of Manitoba

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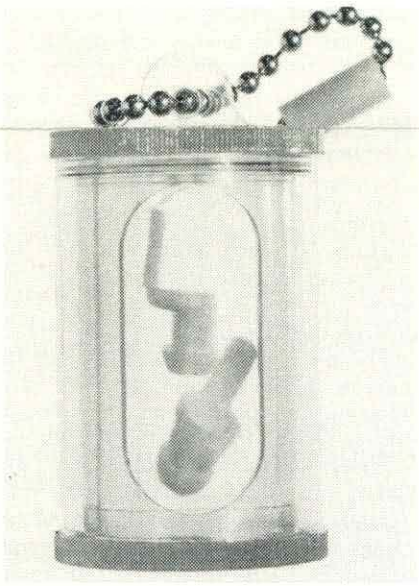
An "Ounce of Prevention" Is Essential — There Is No Cure

For a small outlay of around one dollar, the Manitoba hunter can own a set of plugs to protect his hearing from the damaging sound of gunfire. But chances are that when he sets out for the marsh or field he won't have a pair with him.

One can hardly blame the hunter. He may not be aware that special ear plugs, or "defenders" as they are called, exist for this purpose (many sporting goods stores don't stock them); nor may he appreciate the gamble he takes when he exposes his ears to loud noise.

Noise is an important cause of hearing loss, and once hearing has been lost because of noise it cannot be restored.

It is the extremely loud, high pitched sounds — such as the high screaming sound of a jet engine, or



The "ounce of prevention"
— Photo by Children's Hospital Photography Department

the sharp, intense, instantaneous report of gunfire — that can permanently damage the nerve endings in the inner ear. They may result in a condition known as acoustic trauma, which is characterized by irritating ringing and other noises inside the head and loss of hearing, particularly in the high frequency range. The onset is insidious and may not be suspected, since the individual may hear the voiced sounds of speech, but fail to realize that he is not hearing the "voiceless sounds", such as t, ch, s, f, th, pk and sh.

Some people are more susceptible to noise-induced hearing loss than others. Cases have been reported of total loss of hearing in one ear as a result of exposure to one pistol shot; others seem to suffer only minor hearing loss from exposure to repeated gunfire over long periods.

The wise hunter, however, will not wait to find out whether he is susceptible or not. A properly fitted set of ear defenders will reduce damaging noise levels at the inner ear, yet permit the wearer enough hearing to perceive speech around him, as well as other lower pitched, harmless sounds. On the whole the plugs will not interfere very much with his ability to hunt.

Contrary to popular opinion, dry cotton affords little or no protection; but cotton impregnated with wax or some other creamy substance will. Ear muffs, designed to cover the outer ear, also give protection, but they are used most often in industry (sometimes along with ear plugs) or on the shooting range where there is a very high noise exposure-level.

Ear plugs are designed to occlude the ear canal. So they come in about five different sizes, and the really good store that stocks them will have a special device to measure the size and shape of the customer's ear canal. Here in Manitoba ear plugs are available at some gun shops, at safety equipment outlets, and at some hearing aid dealers.

COME TO THE FAIR!

The Volunteer Services of the Manitoba Rehabilitation Hospital cordially invites staff, patients and their friends to attend the:

CHRISTMAS CANDLE FAIR

Friday, November 1st, from 9:00 a.m. until 4:00 p.m. in the M.R.H. Auditorium.

This annual event will again feature lovely Christmas candles of all colors, shapes and sizes, Small Gifts, Cards and Giftwrap, and Patient Handicrafts (including our celebrated Rocking Horses).

Don't miss the Fair. Proceeds will again be used in support of the hospital's special equipment fund.

CHRISTMAS SEALS

The South Winnipeg Kiwanis showed up at the Sanatorium Board on the night of October 8 to help prepare Christmas Seal letters for mailing.

Early Mailing Avoids New Rates

The 1968 Christmas Seal letter to raise funds for the province-wide campaign against tuberculosis and other respiratory diseases is going into the Manitoba mails about two weeks earlier than usual this year. The idea is to beat the new higher postal rates that go into effect on November 1.

The Sanatorium Board plans to deliver some 200,000 metred, sorted letters to the Winnipeg post office on October 31. By doing so, the campaign will save 1½ cents per letter — or in all, about $3,000.

In order to meet the up-dated deadline, volunteers are stuffing Christmas Seal envelopes at a feverish pace. Among the new groups helping us this year are Air Cadet Squadron 170, City of St. James (Kiwanis), under Commanding Officer Alec Morrison; and some 100 Boy Scouts, Girl Guides and Air Cadets from the City of St. Vital, who were rounded up by Rudy Trnka, SBM mailing room supervisor and District Scouter for St. Vital. The St. James cadets came for a special blitz night on October 18th; the St. Vital group appeared the following day.

The Board is proud and appreciative of the volunteer work that goes into our annual campaign. The anti-tuberculosis program has always largely been a community effort in which the public has actively participated in our fund-raising drives and the carrying out of preventive programs in the community.

Groups who have helped us this year with the folding of Seals and the envelope stuffing include residents of the Metro Kiwanis Courts and the Fred Douglas Lodge; members of the Granite and Victoria Women's Curling Clubs, the West Winnipeg Rotary-Anns, Calvary Mission Temple, Ladies' Auxiliary to the Associated Canadian Travellers (Winnipeg Club), the Professional Engineers' Wives of Winnipeg and the South Winnipeg Kiwanis; the women of various Winnipeg business firms, the junior volunteers of the Manitoba Rehabilitation Hospital, and the Sanatorium Board staff.

Some have come during the workday. Others have participated in evening blitzes.

Address all communications to:
THE EDITOR, SBM NEWS BULLETIN,
800 Sherbrook Street, Winnipeg 2, Manitoba

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A Physician Talks About Arthritis Treatment and Research

Dr. F. D. Baragar

There are more than 60 kinds of arthritis, and maybe 60 — or even 600 — unsolved riddles concerning their cause and cure. But unlike sufferers of yesteryear, who were largely neglected by medicine simply because it did not know how to deal with their problems, the more than one million Canadians who suffer from rheumatic disease today can take heart in the fact that at long last an attack has been launched. It is not yet a massive attack, but it is a beginning; and in this interview Dr. Fletcher D. Baragar, rheumatic disease specialist at the Manitoba Rehabilitation Hospital, tells how the new attitude and some findings from research have already influenced treatment and prevention.

Q. Just how much has our attitude to arthritis changed over the past 10 or 20 years?

A. Largely through the active encouragement and support of the Arthritis and Rheumatism Society, we have seen an awakening of interest in the problems of arthritis and the other rheumatic diseases. In Canada the society has been a dynamic force behind new and intensive programs of research and professional education; it has done much to improve services and facilities for diagnosis, treatment, rehabilitation and welfare of arthritis patients; and it has undertaken broad programs of public education. There are now more than 100 physicians in Canada who — through the CARS fellowship program — have taken advanced clinical training in rheumatology, either here or abroad; and across the country Rheumatic Disease Units are being established at teaching hospitals to provide and promote the highest possible standards of patient care as well as scientific investigation and undergraduate and graduate training. Special consulting clinics have been organized to provide treatment, assessment and review services to patients outside the hospital — particularly in the rural areas. In addition, home therapy is provided by physiotherapists and occupational therapists who work under the direction of the physician. Although we still suffer from a shortage of rheumatologists and other professional personnel and need further development of rheumatic disease facilities, we are evolving a very active program for arthritis patients — in fact we are on the threshold of one of the best arthritis control programs in the world.

Q. Just how optimistic are you about finding the cause and cure?

A. Within the past 10 years our volume of knowledge concerning the nature of arthritis has steadily increased. Research is taking place on all levels — in both humans and animals — and at the very basic cellular level. There have been some very interesting developments which have added to our knowledge about factors influencing the disease . . . and with continuing emphasis on research I'm convinced that the cause will become apparent and an eventual cure possible.

Q. What are some of these developments in research?

A. For one thing, we have recently seen an exciting breakthrough in the management of gout. Gout, as we know now, is usually an inherited disorder — a metabolic abnormality in which excess uric acid in the blood is deposited as crystals in tissue, including the cartilage in and around the joints. Accumulated deposits set up an irritation, leading to acute attacks of burning pain, redness and swelling.

For some time we have been able to ward off these attacks by the administration of drugs that hasten urinary elimination of excess uric acid. But now we have an even better drug (allopurinol) that goes beyond this. It actually inhibits the enzyme (xanthine oxidase), which is necessary in the production of uric acid.

There have also been one or two leads in our understanding of the development of osteoarthritis. It may be possible that certain types of this degenerative arthritis can be prevented — or at least the risk of development minimized — by more cautious handling of infants at birth and in the months following. Experimental work, carried out by Dr. Robert Salter of Toronto, has indicated that marked hyperextension of infants' legs during delivery and later in the care (and especially in the *carrying*) of children can cause mechanical stress on the head of the femur, forcing it out of alignment with the joint and provoking the condition known as congenital hip. This is predisposing to extra wear and tear at the joint and in later life leads to the development of degenerative arthritis.

Through a campaign of education and the careful testing of newborns, much could be done to prevent this form of arthritis.

Q. You mentioned that medical science is continually increasing our knowledge about rheumatoid arthritis. What new things are known?

A. While stressing that we do not yet know the specific cause of rheumatoid arthritis, we are steadily accumulating information about several factors that seem to precipitate or influence the disease. Many investigators believe that an infective agent — perhaps viral — triggers off the process, but no definite organism has been isolated. And many believe that traumatic injury and such other things as personality structure and stress have an important bearing.

With respect to personality structure and stress, several studies are being undertaken here in Winnipeg. One of these is a psycho-social study which, with the cooperation of our social service department, will involve close observation of patients with early polyarthritis, of their social problems and the impact of these problems on the clinical course of the disease.

Another concerns a study of protein changes in the blood plasma of rheumatoid arthritis patients and how these changes correlate with the disease process. And a third is a study of the relationship between emotional factors and physical illness.

Abnormal protein molecules — or what we call the *Rheumatoid Factor* — are usually found in rheumatoid arthritis, but strangely enough they have been turning up in a significant number of people with schizophrenia. Rheumatic symptoms — although not rheumatoid arthritis itself — have also been found in patients with early schizophrenia. And it has been suggested that some individuals, whose symptoms and serology show a predisposition to rheumatoid disease, might develop schizophrenia instead. But please don't infer that rheumatoid arthritis patients are crazy! It's just that protein changes in the blood seem to have some connection with physical disease and psychiatric disorders — that some people with this abnormal factor may develop schizophrenia, while others may develop rheumatoid arthritis.

Q. Could this mean that rheumatoid arthritis has psychosomatic implications?

A. It's too early to give a definite answer . . . but in all likelihood the disease is due to a combination of factors. For some time we have known that stress can alter protein levels in plasma, and there is a growing body of knowledge suggesting some link between stress, emotional upsets, anxiety, worry and depression and the onset, recurrence and exacerbation of disease. We do not have a clear understanding of the mechanism behind this relationship.

Personality factors seem to make some people react badly to stress and in certain investigations a number of personality factors have been associated with a predisposition to disease. The rheumatoid arthritis patient, for example, has been pictured as one who is compliant, introverted and conservative, self-sacrificing, inhibited, nervous, perfectionistic, sensitive to anger but bottling it up. But no really adequate study has been made, and it could also be that this personality pattern is due in a large part to the burden of the patient's disease. To know the whole story we will have to learn more about the patient's personality prior to the onset of disease, and in that third project I mentioned, Dr. H. C. Hendrie is going to look further into this aspect of the problem.

Q. If there is a link between stress and emotional disturbances and rheumatoid arthritis, might it be true that, due to the stresses and strains of modern living, rheumatoid arthritis is increasing in the population?

A. Perhaps physicians are seeing more arthritis patients — but you must take into account improved diagnosis and also the fact that more people are living longer and becoming subject to chronic disease. Even more important, more people are seeking medical attention for arthritis. Remember, it wasn't so long ago that very little was done for arthritics; so they didn't bother the doctor with their aches and pains.

As for the stresses of modern life . . . it has long been believed that rheumatic diseases are more prevalent in the temperate climates where life is perhaps more complex. But this theory may be exploded. A few investigations have been made in the simpler cultures of warmer climates and these are turning up evidence of rheumatoid arthritis in the population. And don't forget that we have looked at the skeletons of the ancients and found evidence of rheumatoid arthritis. It is a very old disease.

Q. What medications are there for rheumatoid arthritis? Are there any new drugs?

A. There are many drugs . . . which reminds me of Sir William Osler's dictum, 'If many drugs are used for a disease, all are insufficient'. However . . . while we do not yet have a drug that actually halts the disease, there are a number that influence its course. These include steroids, gold compounds, prednisone, a host of others with fancy names and, of course, salicylates, which are the safest and most beneficial. Gold compounds, a second choice, are sometimes beneficial; steroids have some rather bad side effects, but in some cases they help a patient to achieve functional improvement.

Acetylsalicylic acid (salicylates)—contrary to popular belief — is not just a pain reliever, and patients should never look on it as only that. It is an extremely fascinating drug: whole books have been written about it and recently in England a medical conference was devoted to nothing else. Perhaps its greatest attribute is its ability to reduce inflammation. Rheumatoid arthritis is a systemic disease affecting the whole body, as manifested in a general feeling of malaise, fatigue, anemia, sometimes weight loss and fever as well as pain and swelling and stiffness in the joints. A.S.A. affects so many body functions. It has a dramatic effect on stiffness—particularly morning stiffness — and although we don't know why, it seems to stabilize the action of lysosomes within the cell. (Lysosomes are enzymes within the cell. concerned with some of the basic cell functions.)

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ARTHRITIS — from the Greek words for joint and inflammation — is the term used for those rheumatic diseases which affect the joints. It is a major health problem: more than one million Canadians suffer from arthritis and the other rheumatic diseases, of whom over one-quarter of a million are disabled to some degree and 63,000 are totally or severely disabled. A big cause of poverty, it is responsible for an estimated nine million days of lost work and more than $100 million in lost wages annually.

There are many kinds of arthritis. The most common are:

Rheumatoid Arthritis, a systemic disease affecting the body as a whole as well as the joints. It is more common among women and usually occurs first between the ages of 20 and 50. But it may occur as early as infancy and late in life. It may begin suddenly, but usually the onset is slow, even insidious. It is a remitting disease, with fluctuations in severity.

Osteoarthritis, or degenerative joint disease, results from the wearing out of the cartilage covering the weight-bearing joints. It is almost universal to some degree in people who live beyond middle life.

Ankylosing Spondylitis mainly affects the joints of the spine, although sometimes other joints become involved. It is more common among men, usually starting in the 20 to 30 age group.

Gout results from a disorder in the body's chemistry. It may run in families, and most often occurs in men over 30 years of age. The ancient Greeks called it *Podagra* (meaning pain in the foot), because it usually affects the big toe . . . although other joints may be involved.

For further information write to: Canadian Arthritis and Rheumatism Society, 825 Sherbrook St., Winnipeg 2; or to C.A.R.S., Western Manitoba Branch, C/O Assiniboine Hospital, Brandon.

A.S.A. doesn't arrest the disease, but it probably slows it down. It is our first drug in the treatment of rheumatoid arthritis . . . it is the cheapest, the most beneficial and the safest. There are sometimes a few side effects . . . but that brings to mind another saying that even the best measures in medicine have their bad aspects.

Q. What do you consider the most important advice you can give arthritis patients?

A. I guess my attitude is one of optimism tempered with realism. The first thing I tell a patient is: Look. I can't solve your problem, but with your help, I can teach you how to live with it.

The most important thing the patient can do is to listen to his doctor and follow through with a regimen that includes plenty of rest, a well balanced diet, the maintenance of an ideal weight, drugs, therapeutic exercise and such other measures as heat, and splints to provide rest, relieve spasm and prevent deformity.

It is important to cultivate a positive attitude in the patient. Emotional rest cannot be overemphasized . . . the patient does need a great deal of psychological support. Hospitalization at any stage of disease will beneficially alter the course of disease for many patients; other patients can be adequately treated outside the rheumatic centre, making use of local treatment facilities, available medication, and the consultation of specialists in the field when necessary. I could say much more about treatment, but let's just say that with our present methods, and with early treatment, serious disability can be prevented in four out of five cases. Even patients who are severely affected can usually be helped to regain or retain enough function in their joints to lead useful lives.

Q. When should the patient see his doctor? As soon as he is troubled by aches and pains?

A. Yes. Certainly any individual who has continuing and increasing aches and pains, and localized pain at the lower back or to any joint, would be well advised to seek medical attention. Doctors are faced with a large number of patients with these complaints; but when they continue and are troublesome, the physician can investigate and perhaps discover the early signs of more serious arthritis. The patient can then be put on a program of prevention.

Q. Do you have anything to say about quacks and their remedies?

A. Plenty. Rheumatoid arthritis, as you know, often goes into spontaneous remission, and there are unscrupulous quacks who prosper by these remissions, claiming that this dramatic abatement is due to the pills, potions, charms or whatever the patient happens to be using or taking from him at the time. Because we don't have a cure, desperate patients (and that includes intelligent patients) are vulnerable to quacks. They'll try anything.

So I repeat: It's extremely important that patients follow only the advice of their physicians. Otherwise they run the risk of worse damage to themselves.

TB Drug Used For Prevention

An inexpensive drug, which for the past 15 years has been our most effective agent in the treatment of active tuberculosis, is now also being used as an important tool in prevention.

The drug is Isonicotinic Acid Hydrazide — better known as INH or isoniazid — and at present 426 people in Manitoba are swallowing it daily as a prophylactic.

The recipients — which include children as well as adults, whites as well as Indians, people with recent infections and people with remote infections — are all members of a great pool of 200,000 individuals in the province who harbour the tubercle bacillus in their bodies. But unlike others in the pool, they are at special risk of developing active disease at some point in their lives.

The idea is to attack these germs inside the body with a year's course of INH, a synthetic substance related chemically to the B-complex vitamin family. By a method not fully understood, the properties of the drug readily penetrate diseased areas and, while they do not actually kill tubercle bacilli, they incapacitate them.

INH is easy to administer (it is manufactured in the form of a small whitish tablet); it is generally non-toxic (toxicity is apparent in only 0.2 to 0.4 percent of those taking the drug, and even then is easily reversible); and it is cheap, costing health authorities only a few pennies per patient per day. It is also the most potent anti-tuberculosis drug available.

First synthesized in Prague in 1912 and then tragically forgotten because no one knew what to do with it, INH was rediscovered simultaneously in 1952 by three groups of chemists (one in New Brunswick). When it appeared on medicine trays across the country, hundreds of sick people

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FAREWELL PARTY FOR ANNE LAW

FAREWELL PARTY — Miss Anne Law (right), who joined our Sanatorium Board nursing services on New Year's Night, 1937, and retired last month, receives the best wishes of a longtime friend and former nursing staff member, Miss Edna Dillon of Vancouver, B.C. *(Photo by Jim Zayshley)*

Sadie Ross, an old friend and one-time fellow worker, came to the party. So did Evelyn McGarrol, Fred and Joan Day, Margaret Busch and the guest of honor's niece and her husband, Betty and Stan Newman. Former nursing staff members Edna Dillon and Mrs. Gail (Albi) Rutledge came from Vancouver for the event; others who could not make long trips sent greetings.

In all, 84 people turned out for dinner at the Paddock Restaurant on September 26, to honor Miss Anne Law who, after 31 years of devoted service, retired from the registered nursing staff at the D.A. Stewart Centre. During the evening Sanatorium Board Executive Director T. A. J. Cunnings, former tuberculosis chiefs Drs. E. L. Ross and D. L. Scott, and Day Supervisor Mrs. P. Torgerson all paid tribute to Miss Law's fine contributions to tuberculosis work. On behalf of the staff, past and present, Dr. Scott also presented her with a portable TV set (on a stand); and Mr. Cunnings, acting for the Board, gave her a gold Cross of Lorraine pin and a bouquet of red roses.

As for most of us, Anne Law's life story is not out of the ordinary: Born at Dominion City, Manitoba; primary education in Emerson, high school in Winnipeg; nurses' training at the Winnipeg General Hospital (graduating in 1929); a year or two as a patient at Ninette; then, after a brief period on the staff of the Dauphin General Hospital, 31 years of nursing other tuberculosis patients — mostly in Winnipeg.

But as a bedside nurse — and particularly in the care she gave children — Miss Law radiated a love and warmth that will remain a shining example to all who follow her. She has been a highly valued nurse and friend, and it was not at all surprising that so many came to the dinner in her honor . . . or indeed that, for lack of room, a number of people had to be turned away.

RICHARD HENRY GARDYNE BONNYCASTLE

It was with deep regret and shock that the Sanatorium Board and members of the staff learned of the death on September 29 of Richard Henry Gardyne (Dick) Bonnycastle.

Mr. Bonnycastle, who devoted so much of his life to public service . . . who served as first chairman of the Metropolitan Corporation Council of Greater Winnipeg, became first chairman and chancellor of the University of Winnipeg, and contributed greatly to the conservation of wildlife as president of Ducks Unlimited (Canada) . . . had also been a highly valued member of our Board since 1948. He joined the Sanatorium Board when his father-in-law, the late G. W. Northwood, retired as chairman; and from that time he served on our Executive Committee, acting for 17 years as chairman of our former Clearwater Lake Hospital Committee.

Mr. Bonnycastle was born in Binscarth of pioneering parents who came west from Ontario in the 1880's. He came to Winnipeg in 1912, was educated at St. John's College and later at Trinity College in Toronto, and afterwards studied law at Oxford University. While he was at Oxford he toured Europe with the university hockey team and had as teammates his boyhood friend, our former Prime Minister, Lester B. Pearson, and Roland Michener, present Governor-General of Canada.

After graduating in law, Mr. Bonnycastle returned to Canada in 1924 and a few years later joined the Hudson's Bay Company as manager of the Western Arctic region. In 1945 he went into business for himself and became president and general manager of Advocate Printers (now Stovel-Advocate Printing Ltd.)

Throughout his career, Mr. Bonnycastle was connected with many national and community organizations, and in addition to his work with the Sanatorium Board, he served as chairman of the Board of Directors of the Manitoba Development Fund, president of the Winnipeg Canadian Club and of the Winnipeg Chamber of Commerce and chairman of the provincial Business Advisory Council.

He will be greatly missed in this province, and here at the Board he will always be remembered with the deepest affection and respect.

Respiratory Disease Rates Climb in England

Respiratory disease is responsible for 23 percent of male and 12 percent of female deaths in England. It also accounts for 23 percent of the conditions for which doctors are consulted, according to Dr. Leslie Wollaston, president of the British Tuberculosis Association.

The two greatest menaces are chronic bronchitis and emphysema. Bronchitis — commonly known as the English Disease — accounts for 39 million lost working days, as compared with 27 million for psychosis and 20 million for rheumatism. It costs over $28 million in sickness benefits.

In males the death rate from bronchitis is now about 90 per 100,000 population, and in females about 40 per 100,000.

Death rates for bronchial carcinoma are also rising. In males they have increased from 30 to 80 per 100,000 in the last 20 years; and in the age group 45 to 64, they have increased from 85 to 180 over the same period.

"There is a very close correlation between the death rate and the number of cigarettes smoked and the increase in carcinoma, and this correlation also applies to females," the doctor said.

Among women there has been a very appreciable rise in the lung cancer death rate over the past 10 years.

Dr. Wollaston expressed the hope that the next generation will benefit from efforts to reduce atmosphere pollution "and that it will be possible to change the social habits of the community so that cigarette smoking becomes unacceptable."

RD IN CANADA

Here in Canada health workers are also becoming painfully aware of chronic obstructive lung disease as a serious and mounting health problem.

Although no nation-wide statistics are available with respect to the incidence of chronic bronchitis and emphysema, these diseases are now believed to constitute an epidemic. For example, a survey conducted in a British Columbia community showed that among a group of residents, 25 to 74 years of age, 29.3 percent of the men and 18 percent of the women had bronchitis, and 12.6 percent of the men and 8.7 percent of the women had C.O.L.D. sufficient to be classed as such.

Across the country the number of deaths caused by emphysema has more than quadrupled in the last 10 years. In 1967 there were 908 deaths from emphysema among Canadians. Emphysema complicated by bronchitis accounted for another 785 deaths.

ANTI-TB DRUG

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who had been going downhill in spite of newer forms of treatment, began to get better and the drug gained front page fame as a leading tool in tuberculosis treatment. From the time of its discovery deaths in Canada dropped from 3,335 (in 1951) to 658 in 1967.

By the mid-fifties a number of countries began testing INH as a prophylactic. Denmark used the drug in wide-scale preventive programs, particularly in Greenland; then other countries started following its lead.

Around eight years ago the U.S. Public Health Service began five extensive trials to test the value of INH prophylaxis, and early this year a report was issued on the long-term follow-up of the 70,000 participants in the program. According to the scientific data accumulated from these trials, the PHS reported in a joint statement with the National Tuberculosis Association and the American Thoracic Society, "it seems reasonable to expect that chemoprophylaxis can reduce future morbidity from tuberculosis in high risk groups by some 50 to 75 percent. The extensive use of chemoprohylaxis now would likely reduce by 300,000 the total number of cases in the United States in the next 15 years."

Manitoba has employed INH prophylaxis for the past several years, but in recent times the program has been broadened considerably. Groups now receiving it include:

1. Recent tuberculin converters.
2. Contacts who have been exposed to tuberculosis infection.
3. Children and adolescents with positive reactions to the tuberculin test.
4. Certain inactive cases — including some ex-patients who have had active tuberculosis but no drug therapy (or inadequate drug therapy); plus persons with x-ray findings consistent with healed, adult-type pulmonary tuberculosis and a positive tuberculin test.
5. Certain special clinical situations.

Fine Support For "Way"

Sanatorium Board staff members showed a fine response to a pilot campaign conducted by the United Way in Winnipeg last month.

The purpose of the project, we were told, was for hospital employees to take part in a special pre-campaign publicity program and serve "as an inspiration to all volunteer workers and organizations participating in this civic project".

A fine inspiration we were! Contributions rose by 104.6 percent over last year's giving, and the number of staff who gave also more than doubled.

The Board expresses gratitude to the contributors — and to the hospital department heads who helped organize this support.

BULLETIN BOARD

The annual University of Manitoba Symposium on Orthopedic Disabilities and Rehabilitation is devoting the entire program this year to the rheumatic diseases. Guest speakers from Sweden, England and the United States are taking part in the sessions to be held in the auditorium of the Manitoba Rehabilitation Hospital on October 24, 25 and 26. All medical and para-medical personnel are welcome. There is no registration fee.

* * *

The D. A. Stewart Centre and the Sanatorium Board had a very special visitor the other day. He was Dr. David B. Stewart, professor of obstetrics and gynaecology at the University of the West Indies in Kingston, Jamaica, and son of the first medical superintendent of Manitoba Sanatorium, after whom our new TB and respiratory disease clinic is named.

* * *

Among the recent visitors to our Manitoba Rehabilitation Hospital were Dr. P. J. R. Nichols, physical medicine consultant from Oxford, England, who toured our physical medicine and prosthetics facilities following the International Congress in Physical Medicine in Montreal last August; Dr. A. H. Bottomley, medical director of the Biomechanics Research and Development Unit at Queen Mary's Hospital in Rochampton, England; and Dr. Pham Van Hoang, Director of the Rehabilitation Centre in Can Tho, South Vietnam.

Through the assistance of the Columbo Plan Council for Technical Co-operation in South and Southeast Asia, Dr. Hoang was making a study tour of major rehabilitation facilities in Canada. He told us that out of a total population of 20 million people in South Vietnam, there are an estimated 35,000 amputees.

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Our congratulations to Miss E. L. M. Thorpe, Sanatorium Board nursing consultant and administrative assistant, and to Ron Thomas, senior accountant, who have successfully completed the Canadian Hospital Association's two-year extension course in Hospital Organization and Management.