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APRIL 17, 1946 BULLETIN

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JOHN A. McKAY, M. D., Medical Director

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PRESIDENT'S PAGE

●

At our last meeting, held March 19th, one of our members asked the question, "What, if anything, is the Society doing about the matter of a full time Health Commissioner for the City of Youngstown?"

For many years the Society has tried to work with the administration on the matter of a full time Health Commissioner, but failed in its attempts. Our present Mayor, Hon. Ralph W. O'Neill, in co-operating with the Society in this matter, requested a survey which has been completed and findings reported to Dr. R. E. Herring, State Director of Health, and Mayor O'Neill. A copy of this report has been submitted to us, and is now in the hands of your legislative committee and as soon as they report back to Council, their recommendations will be published in the Bulletin.

CENTENNIAL ANNIVERSARY

The One Hundredth Anniversary meeting of the Ohio State Medical Association will be held at Columbus, May 7th, 8th and 9th. This is one meeting that should be well attended.

Our own county is celebrating its one hundredth anniversary of the Canfield Fair. Dr. S. G. Patton has been appointed chairman of a committee to secure space and have an exhibit for the Society, thus further educating the people of this county in the advancement of medicine and acquaint them with the functions of the medical profession.

On March 2nd, 1946, the Y. W. C. A. held their Annual Convention at Atlantic City. One of the bills being considered for endorsement by the organization was the Wagner-Murray-Dingell Bill. Due to the tactful handling—by our Auxiliary to the Mahoning County Medical Society—and informing the delegates of the true facts about this bill, it was not introduced.

Don't forget our Postgraduate Day, April 17th. Bring your friends, as this is going to be one of the best Postgraduate Days yet.

EDWARD J. REILLY, M. D., *President*

●

MANAGEMENT AND TREATMENT OF SYPHILIS

By P. J. McOWEN, M. D.

In the last few years the treatment of syphilis has made rapid strides in the technique and treatment of this disease especially in the all-important Primary and Secondary stages of syphilis.

It is at this stage in which the proper and thorough treatment, or insufficient and poor treatment of syphilis determines the outcome of the disease. Under intensive and thorough treatment we can expect 80-90% cures whereas under insufficient and poorly managed treatments, the patients develop the various complications of late syphilis which becomes very resistant to any therapy.

There are several treatment schedules for early syphilis with arsenicals and Bismuth. The objective of all these methods is to instill into the patient as much arsenicals and bismuth in as short a period of time that the host can safely stand. Therefore a thorough physical check-up should be given the patient to find any physical defects that contraindicate any heroic method of treatment.

In selected cases you may use the massive dose arsenical treatment. Oxophenarsine hydrochloride (Mapharsen) is the arsenical of choice, because it has proven to be less toxic than the other forms of arsenicals used in anti-syphilitic treatment.

The technique in Massive dose therapy is as follows:

1st. *The Five Day Drip Method*, which consists of giving a grand total of 1000 mg. to 1200 mg. of Mapharsen, the equivalent of 20 standard doses, by continuous drip intravenously over a period of 5 days. This treatment requires hospitalization. The dose is divided into daily doses of 200 mg. to 240 mg. of Mapharsen dissolved in 2000cc to 2400cc of a 5% glucose solution given intravenously at the rate of 30 to 40 drops per minute over a period of 8 to 12 hours daily. The patient then may be allowed out of bed at this time.

Some clinicians like to give Bismuth intermuscularly concurrently with the above treatment. In these cases .25gm of Bismuth subsalicylate in oil is given the 1st, 3rd, and 6th day. The patient remains in the hospital 2 days after the treatment, and if no complications arise, may go home.

2nd. *Multiple intravenous injections by the syringe technique.*

This calls for 1200mg of Mapharsen over an average period of ten days, giving two injections of 60mg each dissolved in 10cc of sterile water, per day until 1200 mg. have been given. Bismuth subsalicylate in oil .25gm is given concurrently on the 1st, 4th, 8th, and 12 day intramuscularly.

3rd. Mapharsen, Bismuth, and Fever Therapy given in one day consists of Bismuth salicylate in oil .25gm intramuscularly, 24 hours before Fever Ther-



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apy is instituted. Continuous Fever Therapy for 5 to 10 hours with temperature of 105F to 106F. Intravenous Mapharsen total 120mg to 240mg in divided doses is given at the height of the fever. It has been shown that Fever Therapy combined with Mapharsen gives as good results with 50 less Mapharsen. In patients not selected for the above intensive treatments for various reasons you have, *Semi-Intensive Courses*

1st. The 26 week course known as the Army Plan, in which the patient is given 2 injections weekly for ten weeks of 60mg of Mapharsen per dose, with Bismuth salicylate in oil .25gm for the 1st 5 weeks concurrently, then once a week for the next 6 weeks. Then repeat the Mapharsen therapy as described above for the next 10 weeks, giving Bismuth salicylate once a week concurrently, the last five weeks. This makes a total number of 40 Meparsen 1.V. treatments making a total of 2400mg of Mapharsen and 16 Bismuths (4.00 gms.)

2nd. *The Twelve Week Treatment Schedule* (Eagle Plan) calls for 36 injections of Mapharsen with a total of 1800 to 2500mg. (depending on body weight) and 12 injections of Bismuth salicylate in oil .25gm with a total of 300 gm over a period of 12 weeks. This consists of 3 weekly injections of Mapharsen 1.V. 60mg per dose for 12 weeks and one weekly injection of Bismuth Salicylate .25 gm per dose for 12 weeks.

3rd. *The Standard Long Term Course* which consists of 40 doses of Mapharsen in four ten-week courses once a week, supplemented by 54 intermuscular injections of Bismuth .25gm once a week in 10, 12, 16, 16 weekly courses, making a total of 80 weeks.

The comparable results in all the above treatments with the proper technique in which 1200gm of Mapharsen is given are practically the same. The immediate results of intensive treatments are as follows:

- 1st. Disappearance of the treponema in the primary lesions in 24 hours or less in 95 to 98% of cases.
- 2nd. Healing time 5 to 15 days.
- 3rd. Serological reverses in 12 to 16 weeks.
- 4th. Serological cures 80-90%.
- 5th. Infectious relapses 5-15%.
- 6th. Seroresistant cases 5-10%.
- 7th. Asymptomatic neurosyphilis 1% or less.
- 8th. Late relapses none.

The above results are very good, but this does not cover the whole picture, for we must remember that these are heroic treatments and as reported in a series of 5000 cases of ultra-intensive therapy under expert management there was a mortality rate of 1 to 200 which is considered very high.

In the semi-intensive treatment as described above, the Eagle Plan of therapy reported mortality rates of 1 to 400 to 1 to 1000 in a series of cases.

In the Army Plan the mortality rate was the best, from 1 : 1000 to 1 : 3000.

Our greatest advance in Early Syphilis treatment has occurred since the advent of Penicillin. This form of therapy was first tried by a group of doc-



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*Friedenwald, J., and Morrison, S.: Functional Disturbances of the Digestive Tract, in Nelson New Loose-Leaf Medicine, 1941, vol. 1, p. 161.

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APRIL

tors, Mahoney, Arnold, and Harris, in 1943 at which time they demonstrated that Penicillin was an effective agent in the treatment of early Syphilis. An organized investigation was then instituted by the Army, Navy, U. S. Public Health and the Committee on Medical Research and some 25 civilian clinics under one master plan. They divided their studies into 3 phases of syphilis, 1st, early syphilis, 2nd latent, 3rd, neurosyphilis.

In this paper we shall confine ourselves to the early stage of anti-syphilitic treatment by Penicillin. After considerable investigation, it was decided that the intermuscular and intravenous routes were the best methods of choice, both equally as good under the proper technique, but the intermuscular method is the most popular mode of therapy because it requires less technique, is easier for the clinician and less tiresome for the patient.

We should remember that it is the bacteriostatic action of Penicillin which impedes the growth and spread of the spirochete, and raises the resistance of the host so that he can develop his anti-bodies sufficiently enough to destroy the invading organism. We must also remember that it is necessary to keep a constant therapeutic level of Penicillin in the blood stream which has been decided as a minimum of .15 per lcc of blood stream.

The next question is "How Much? How Often? and How Long"? should Penicillin be given. After a lot of experimentation it has finally been decided (up to date) that 40,000 units of Penicillin I.M. given every three hours for 60 doses keeps the serum level of Penicillin at an optimum level of .15 units. The total dose is 2,400,000 over a period of $7\frac{1}{2}$ days.

If we give the total dose over a period of 4 days we do not give the host a sufficient amount of time to develop his own anti-bodies and as a result the therapeutic result is only $\frac{1}{2}$ as efficacious as when we extend it over a period of 7 to 10 days.


A combination of Penicillin and Mapharsen therapy is at present in the experimental stage and not enough data is available.

Patients after treatment should be followed up for 5 years. They should be given weekly quantitative serological tests for the 1st month, then once a month for 6 months, then once every 6 months for 5 years.

The immediate results of Penicillin treatment are a rapid disappearance of the *Treponema* from the surface lesions, healing of open lesions and disappearance of gummatous formations, rapid reversal of serology in both blood and spinal fluids.

In conclusion I would like to say that a new era in the treatment of early syphilis has arrived with the advent of Penicillin Therapy, which is rapidly replacing the arsenicals as first choice in treatment. The main reason for its wide acceptance is due to its non-toxic effect, which allows Penicillin to be used in all types of patients with early syphilis regardless of their physical condition. Whereas only selected cases can be treated with intensive arseno-Bismuth, Fever Therapy, because of their very toxic qualities, with a resulting high mortality rate.

The next reason is that Penicillin gives as good if not better results, when compared with Arseno-Bismuth-Fever Therapy.



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STUDY OF ANEMIA

By A. E. RAPPOPORT, M. D.

Within recent years there has been increasing criticism of the older methods of classification of anemia, inasmuch as they are inadequate to include all of the various types of anemias. The classification based on primary or secondary types offers no aid in correlating the laboratory findings and the clinical syndrome. Recently, increased emphasis has been placed on a classification based on the morphological characteristics of the cells, inasmuch as the changes in the size and hemoglobin content of the red corpuscles may indicate to the therapist the type of anemia on one hand and the therapy which may be used to combat it. When such a classification is established the clinical types of anemia differ according to their fundamental cause and fit into four (4) morphologic groups.

When anemia develops, the reduction in the number of the red cells may be accompanied by a proportionate decrease in their hemoglobin content or the volume of packed cells. Since these cells have not been changed in size and hemoglobin content this anemia may properly be called *Normocytic*. In some anemias, the reduction in the number of cells is greater than the reduction in hemoglobin or volume of packed cells. This is due to the fact that the cells are larger and thus we have the term, *Macrocytic* anemia. The reverse may also take place in which there is a greater decrease in hemoglobin and volume of packed cells than in the red cell count. This type of anemia is called *Microcytic*. There may occur a greater decrease in hemoglobin than in the volume of packed cells owing to a reduction in the quantity of hemoglobin in proportion to the size of the cell, giving rise to the term, *Hypochromic* anemia. Since the corpuscles in this type of anemia are also reduced in size it is called an *Hypochromic, Microcytic* anemia.

From the above considerations, it is obvious that the present habit of studying anemia by performance of a red count and hemoglobin determination, is inadequate to supply us with the information necessary to utilize this classification. In order fully to exploit the laboratory possibilities for the analysis of a given anemic syndrome, it is necessary to perform not only an enumeration of the erythrocytes and a determination of the hemoglobin in grams, but it is essential to carry out a determination of the packed cell volume. The latter is a simple procedure and offers considerable information in its own right. By application of proper formulae utilizing the results of these three (3) examinations, a precise quantitative and morphological description of the anemia may be obtained which will conform to the classification just elucidated.

The question may be asked, "What is the advantage of this method?" The following table offers a logical reason for analyzing the anemias in this manner.

Type of Anemia	Mean corpuscular volume (c. u.)	Mean corpuscular hemoglobin concentration (%)	Cause
I. Macrocytic	>94*	>30	A. Deficiency of anti-anemic principle in liver. B. Intense activity of bone marrow.
II. Normocytic	80 to 94	>30	A. Sudden loss of blood. B. Destruction of blood. (a) Acute (b) Chronic C. Lack of blood formation. D. Hydremia (?).
III. Simple Microcytic	<80	>30	A. Imperfect formation of blood. B. Deficiency of vitamin B ⁶ .
IV. Hypochromic Microcytic	<80	<30	A. Deficiency of iron. B. Cause unknown.

*The sign > indicates "greater than". The sign < indicates "less than".

Since the morphologic characteristics of the anemias stand in direct relationship with the cause, one can establish general principles in therapy based on the adherence of a given type of anemia to a given group. The *Macrocytic* anemias are basically due to lack of liver, liver extract and related substances and are represented by such diseases as Pernicious anemia, Sprue, Anemia of Pregnancy and Anemia due to Fish Tapeworm. The *Normocytic* anemias require replacement of lost blood due to hemorrhage, and the removal of cause if known in the hemolytic type. Splenectomy is also required in certain forms. In cases due to lack of blood formation, transfusions, dietary control and removal of cause are indicated. The *Simple Microcytic* anemias are due to sub-acute and chronic inflammatory diseases and thus the treatment is logically the removal of infection and replacement of blood by transfusion. The *Hypochromic Microcytic* anemias are caused by deficiency of iron which may in turn result from deficient diet, defective absorption in diseases of the bowel, chronic loss of blood and excessive demands for iron in growth or pregnancy. The treatment in this form of anemia by iron and removal of cause will lead to gratifying therapeutic results.

The North and South Side Laboratories are prepared to carry out the complete study. The reports are given with the following data:

1. Total red count.
2. Hemoglobin in grams, as well as %.
3. Mean corpuscular volume.
4. Mean corpuscular hemoglobin.
5. Mean corpuscular hemoglobin concentration.
6. Packed cell volume.

Inasmuch as the determination of the sedimentation rate can be associated with the determination of the packed cell volume on the same specimen without additional labor, the sedimentation rate is also reported.

It is hoped that increasing use of this method will be made. In special cases bone marrow examination and adrenalin test may be necessary. Personal consultation between the practicing physicians and the clinical pathologists will lead to more precise analysis of a given anemic syndrome which should prove fruitful to patient, practicing physician and pathologist.

SERVICE RECORD

LT. COL. STEPHEN W. ONDASH

Dr. Ondash enlisted in September of 1940 and served one year as assistant Chief of Surgery at Station Hospital, Ft. Hayes, Ohio. He left for Greenland to the northernmost base in the Arctic, as surgeon and hospital commander to an expeditionary force in September of 1941. After 10 months Arctic service he was transferred to the British West Indies, and served there as surgical chief and hospital commander until January, 1943. He then made a three month medical survey in the Northwest Country, spending time in northwest Canada, the Yukon and Alaska. In March of 1943, he became a member of the 4th Auxiliary Surgical Group, and served as team chief of a general surgical team. Prior to overseas shipment with that group, he was detached to Finney General Hospital, Thomasville, Ga., where he served on the surgical staff. He left for overseas in March, 1944, and his team served in various field and evacuation hospitals of the 3rd Army to which the 4th Auxiliary Group gave surgical support. On September 22, 1944, he, with two other team chiefs of the 4th Auxiliary Surgical Group were in addition to their duties as surgical team chiefs, given command of platoons of the 30th Field Hospital. The units were charged with first priority definitive surgery in close support of infantry and armored divisions. He was discharged on October 26, 1945. Dr. Ondash wears 5 battle stars, the Legion of Merit, Bronze Star Medal with Oak Leaf Cluster, the Meritorius Unit plaque award and ribbons of all theaters.

MAJOR SIDNEY DAVIDOW

Dr. Davidow was commissioned in June of 1941 and was in the Army for 55 months. He was in the invasion of Attu in 1943 and after duty in the States, went to Europe with the 178th General Hospital and took part in the Battle of the Bulge. He was chief of both the officers section and contagious service while serving with the 178th. Since his discharge in January he has been at the University Hospital, University of Michigan for a refresher course in pediatrics.

COMMANDER JOHN A. RENNER

Dr. Renner served in the Navy for four-and-a-half years. He saw service in all theaters of war during his 32 months overseas. He was aboard a sea plane tender for two years and an attack transport for four months. He specialized in the treatment of rheumatic fever, meningitis and polio at Great Lakes Naval Training Station for 18 months. Before the Pearl Harbor attack he assisted in establishing seaplane bases in Newfoundland, the Caribbean and in South America. Service also took him into the European and Mediterranean theaters and to the Pacific. The longest time he was at sea in one trip was while practicing with PT boats in Panama Bay, when he didn't see land for three months.

COMMANDER ALFRED R. CUKERBAUM

Dr. Cukerbaum spent 46 months in the Navy. All of his service was spent in the field of dermatology. For 21 months he was stationed at Great Lakes, Ill., and in 1943-44 he spent 10½ months in Wellington, New Zealand, and Espiritu Santos, an island in the New Hebrides, where he treated lots of American servicemen suffering from tropical skin diseases. Upon entering the Navy he was stationed at the U. S. Naval Hospital in Corpus Christi, Texas. He entered the service as a lieutenant, was promoted to lieutenant commander in May of 1944 and commander in 1945.

18th Annual
POSTGRADUATE ASSEMBLY

APRIL 17, 1946

PICK-OHIO HOTEL

PROGRAM

by

**GROUP FROM JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE**

•

WILLIAM F. REINHOFF, JR., M. D.

Associate Professor of Surgery—Johns Hopkins University

CHARLES W. WAINWRIGHT, M. D.

Associate Professor of Medicine—Johns Hopkins University

LEROY M. POLVOGT, M. D.

*Associate Professor of Laryngology and Otology
Johns Hopkins University*

RAYMOND E. LENHART, M. D.

Associate in Orthopedic Surgery—Johns Hopkins University

HOUSTON S. EVERETT, M. D.

Associate Professor of Gynecology—Johns Hopkins University

MORNING SESSIONS

10:00 A. M. Clinical Pathological Conference at St. Elizabeth's
Hospital Dr. Chas. W. Wainwright

10:00 A. M. Surgical Clinic at Stambaugh Nurses' Home, South
Unit Dr. Wm. F. Reinhoff, Jr.

12:30 - 1:30 P. M. Registration, Ballroom Pick-Ohio
Hotel

AFTERNOON SESSIONS

1:30 P. M.—Low Back Pain, Diagnosis and Treatment
Dr. R. E. Lenhart, *Associate in Orthopedic Surgery*

2:30 P. M. Some Problems in the Treatment of Rheumatism
Dr. C. W. Wainwright, *Associate Professor of Medicine*

3:30 P. M. Treatment of Urinary Infections with Sulfasuxidine
and Sulfathiazole Dr. H. S. Everett
Associate Professor of Gynecology

4:30 P. M. The Relation of the Nasopharynx to Impairment of
Hearing Dr. L. M. Polvogt
Associate Professor of Laryngology

DINNER—6:30 P. M.

8:00 P. M. Peptic Ulcer, Diagnosis and Treatment
Dr. W. F. Reinhoff, *Associate Professor of Surgery*

POSTGRADUATE

Wm. F. Rienhoff, Jr., M. D.
Associate Professor of
Surgery

Dr. Rienhoff was born in Springfield, Missouri, on October 10, 1894. He was graduated from the Drury Academy, Springfield, Missouri, in 1910; attended Culver Military Academy and Cornell University where he received his A. B. degree in

1915. In 1919 he received his M. D. degree from Johns Hopkins.

From 1919 to 1925 he served on the resident staff of the Johns Hopkins Hospital, being resident surgeon from 1923-1925. In 1925 he was appointed assistant surgeon, which position he held from 1926 to 1938. In 1938 he was appointed visiting surgeon. In 1933 he was appointed Associate Professor of Surgery, Johns Hopkins University. He has been instructor in surgery and surgical anatomy at the Johns Hopkins University and also the University of Maryland Medical School. He is on the staff of the Women's Hospital, Union Memorial, Mercy, Church Home and Hospital, Provident, and Marine Hospitals, and is surgical consultant at the Emergency Hospital, Annapolis, Maryland.

Dr. Rienhoff is widely known for his work in Thyroid, Chest and Stomach Surgery and has written a number of articles on these subjects as well as other fields of general surgery. He is associate editor of the "Annals of Surgery" and "Surgery".

Charles W. Wainwright M. D.
Associate Professor of
Medicine

Dr. Charles W. Wainwright was born in Chicago, Illinois, on April 17th, 1895.

Graduated from Johns Hopkins University with A. B. degree in 1918.

Received his M. D. degree from Johns Hopkins Medical School in 1922.

He has been associated with the medical department of the Johns Hopkins Hospital since May 10th, 1922. He is Associate Professor of Medicine, Johns Hopkins University and visiting physician Johns Hopkins Hospital.

He is a fellow of the American College of Physicians and a member of the American Medical Association, Central Society for Clinical Research, Baltimore Medical Society and Maryland State Medical Society.

Leroy M. Polvogt, M. D.
Associate Professor of
Laryngology and Otology

Dr. Leroy Matthew Polvogt was born in Wilmington, North Carolina, on September 21st, 1896.

Education and Training: A. B. Roanoke College, Salem, Virginia, 1918; M. D. Johns Hopkins University, 1923. Interne at Church Home Infirmary, 1923-

24; interne Johns Hopkins Hospital Otolaryngology, 1924-25; Assistant Resident Johns Hopkins Hospital, 1925-26; Resident Johns Hopkins Hospital, 1926-27; University of Zurich, Switzerland, 1928; University of Austria, 1929.

Currently: Associate Professor of Otolaryngology Johns Hopkins University; Director of Out-Patient Department of Otolaryngology Johns Hopkins Hospital; Member of Staff of Johns Hopkins Hospital and Church Home Infirmary.

He is a Fellow of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society, and a member of the Baltimore Medical Society, American Medical Society and the American Otolaryngological Society.

DAY FACULTY

Graduate of Johns Hopkins University with A. B. degree in 1918.

Graduate of Johns Hopkins Medical School with M. D. in 1922.

Interned in Orthopaedics at the Johns Hopkins Hospital: 1922 to 1923.

Resident in Surgery at the Toronto General Hospital: 1923 to 1924.

Resident in Orthopaedics at the Johns Hopkins Hospital: 1924 to 1925.

Associate in Orthopaedics at the Johns Hopkins University Medical School, Visiting Orthopaedic Surgeon at the Johns Hopkins Hospital, St. Joseph's Hospital, Union Memorial Hospital, and the Children's Hospital School.

Member of the American Academy of Orthopaedic Surgeons.

Diplomate of the American Board of Orthopaedic Surgery.

Raymond E. Lenhart, M. D.

Associate in Orthopedic Surgery

Born: June 27, 1900, Richmond County, North Carolina.

Education: Rockingham High School, Rockingham, N. C.; University of N. Carolina, 1916 to 1921, A. B. 1920, A. M. 1921; Johns Hopkins University 1921 to 1925, M. D. 1925.

Internship, Johns Hopkins Hospital, Sept. 1, 1925 to August 31, 1936. Assistant Resident in Gynecology, The Johns Hopkins Hospital, Sept. 1, 1926 to August 31, 1929.

Resident Gynecologist, The Johns Hopkins Hospital, Sept. 1, 1929 to Feb. 28, 1931.

Hospital and Dispensary Staff Appointments: Gynec. Dispensary, Johns Hopkins Hospital, Sept. 1, 1927 to present; Female Cystoscopic Dispensary, Hopkins Hospital, Sept. 1, 1929 to present; Gynecologist in Charge of Female Cystoscopic Dispensary, Sept. 1, 1939 to present; Assistant Visiting Gynecologist, Hopkins Hospital, March 1, 1931 to present; Visiting Gynecologist, Church Home and Hospital, March 1, 1931 to present; Visiting Gynecologist, Hospital for the Women of Maryland, 1933 to present; Visiting Gynecologist, University of Maryland Hospital, 1938 to present.

Teaching Appointments: Assistant in Gynec., J. H. U., Sept. 1, 1927 to Aug. 31, 1929; Instructor in Gynec., J. H. U., Sept. 1, 1929 to Aug. 31, 1940; Associate in Gynec., J. H. U., Sept. 1, 1940 to Aug. 31, 1943; Associate Professor of Gynec., J. H. U., Sept. 1, 1943 to present; Associate in Gynec. (Pathology), U. of Md., Nov. 1, 1936 to present.

Has published numerous articles pertaining to Gynecology and Female Urology. Also, "Gynecological and Obstetrical Urology," Williams and Wilkins Co., Sept. 1944.

Houston S. Everett, M. D.

Associate Professor of Gynecology

Eighteenth Annual

POSTGRADUATE ASSEMBLY

April 17, 1946

Pick-Ohio Hotel

May Meeting

ELMER L. DEGOWIN, M. D.
UNIVERSITY OF IOWA

Subject: "THE DIAGNOSIS AND TREATMENT OF CIRCULATORY EMBARRASSMENT FROM PARENTERAL ADMINISTRATION OF FLUIDS"

TUESDAY, MAY 21st, 1946, 8:30 P. M.
YOUNGSTOWN CLUB

POSTGRADUATE ASSEMBLY

The Academy of Medicine of Cleveland
The School of Medicine of Western Reserve University
The Division of Health of Cleveland

ANNOUNCE

A "Refresher Course" in Obstetrics and Pediatrics

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NATIONAL CHILD HEALTH DAY

APRIL 29 - 30 and MAY 1

A faculty of national authorities in Obstetrics and Pediatrics will present lectures on subjects chosen because of their application to the problems of the practicing physician.

No registration fee is to be charged.

You will receive a copy of the final program on April 3.

Hotel reservations should be made immediately.

CENTENNIAL ANNIVERSARY MEETING

OHIO STATE MEDICAL ASSOCIATION

MAY 7, 8 and 9 1946 COLUMBUS, OHIO

NEIL HOUSE — DESHLER-WALLICK HOTEL

Opening of Registration Headquarters, May 7, 9:00 A. M. . . . First General Session, May 7, 2:00 P. M. . . . Second General Session, May 7, 8:15 P. M. Section Sessions, May 8, 9:00 A. M. . . . Third General Session May 8, 2:00 P. M. . . . Centennial Anniversary Banquet, May 8, 7:00 P. M. . . . Section Sessions, May 9, 9:00 A. M.

President's Proclamation for "Know Your Public Health Nurse Week" April 7th to April 13th

The observance of "Know Your Public Health Nurse Week" brings long overdue public recognition to one of the most important groups of health workers in the country. I am pleased that this annual tribute has been inaugurated at a time when our people are awakening to the necessity for a greatly expanded public health program.

If we are to attain "health security for all, regardless of residence, station or race—everywhere in the United States," as requested in a recent health message to the Congress, we shall need not only more medical facilities, but also more doctors, scientists, dentists, nurses and other specialists. Adequate public health nursing service for all will require 65,000 public health nurses—or more than two new nurses in addition to every one now on duty in local, state and federal agencies.

There is scarcely any public health activity in which the services of the specially trained nurse are not utilized. Her skills complement those of the family physician when she carries out his instruction for home care of the patient in a wide variety of situations. Today, when our civilian hospitals report as serious personnel shortages as they experienced during the stringent war years, the stay of patients is being cut to a minimum and follow-up care in the home is of paramount importance.

Thus, the public health nurse is one of the strongest links in the chain of disease prevention and the promotion of good health on the part of both children and adults. Her contribution to better individual and community health cannot be overestimated. It gives me genuine pleasure to pay tribute to the public health nurses of America. I hope the day will not be far distant when their services will be available to the total population.

(Signed)

HARRY TRUMAN

President of the United States

FIRST POST WAR ASSEMBLY OHIO SOCIETY OF X-RAY TECHNICIANS

The first post war assembly of the Ohio Society of X-Ray Technicians will be held on Saturday, May 4th and Sunday, May 5th, 1946, at Hotel Hollenden, Cleveland.

Under the chairmanship of Warner Williams, Cleveland Clinic, a worthwhile program is being secured.

The American Registry of X-Ray Technicians will hold a written examination for the degree of Registered Technician on Saturday morning, May 4th, 1946, at 8:30 a. m. To be eligible for this examination, application must be filed with the Executive Secretary, Alfred B. Greene, R. T., 2900 East Minnehaha Parkway, Minneapolis 6, Minnesota, not later than April 10th, 1946.

All persons interested in X-Ray are invited to attend this Sixth Convention of the Ohio Society of X-Ray Technicians.

Films will be exhibited under the chairmanship of Jack Hogan, R. T., Cleveland City Hospital.

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NEWS ITEMS

Dr. and Mrs. J. J. McDonough spent a few weeks' vacation at Montego Bay, Jamaica, having made the trip by plane.

Dr. James A. Patrick, Warner Rd., has reported for military duty at the Army's Fourth Service Command Headquarters in Georgia.

Dr. and Mrs. M. J. Kocioled returned from a month's sojourn at Miami, Florida.

Dr. and Mrs. O. J. Walker and son, O. J. Walker, Jr., have returned from Hollywood, Fla., where they spent three weeks.

Dr. Armin Elsaesser suffered a torn muscle in his right leg while he was exercising a horse at his country home at Woodworth.

Dr. Nathan B. Belinky spoke on his experiences in a Japanese prison camp at the meeting of District No. 3, Ohio State Nurses' Association.

Dr. and Mrs. W. Stanley Curtis spent a short vacation at Boston, Mass.

Dr. Eugene Elder addressed members of the Woman's Auxiliary to the Mahoning County Medical Society at a meeting March 25th, South Side Hospital Nurses' Home.

Dr. and Mrs. George McKelvey arrived home after a few weeks' vacation in Florida.

Dr. and Mrs. Barclay Brandmiller are in Philadelphia, where Dr. Brandmiller is taking a course at the American College of Physicians.

Dr. and Mrs. M. P. Mahrer, 361 Fairgreen Ave., have returned from a month's visit in Miami, Florida.

Dr. and Mrs. F. W. McNamara enjoyed a month's vacation in Miami Beach, Florida.

Dr. Francis G. Kravec, resident physician at the Mahoning County Tuberculosis Sanatorium, was guest speaker at a meeting of the Center Women's Association. He spoke on the Care and Prevention of Tuberculosis.

A round table discussion on obstetrics featured a meeting of Youngstown Hospital Nurses' Alumnae Association held at Tod Nurses' Home. Taking part in the discussion was Dr. J. A. Altdoerffer.

Dr. A. R. Cukerbaum addressed the Lawrence County Medical Society March 7th, Castleton Hotel, New Castle, Pa. Dr. Cukerbaum's subject was, "Common Skin Disease, Diagnosis and Treatment."

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FROM THE NURSES VIEWPOINT

Because of the stress under which we have all been working the past years most of us have developed habits that are not conducive to good relationships, so instead of getting satisfaction and joy out of our work we feel frustrated and build up resentments that too frequently are reflected in the quality of service rendered or in our contacts. Herewith are some concrete suggestions that might improve our daily relationships and therefore react in better patient care:

Mutual respect indicated through common courtesy as a civil "good morning"—it is too bad when life becomes too rushed for common courtesies.

An occasional expressed recognition of the contribution the nurse is making in the patient's recovery, recognition is basic in a satisfactory life. No one can do their best under frustration. You would be surprised the dividends you could get through an occasional expression of appreciation when deserved. Some recognition, direct or implied, in the patient's presence often stimulates the patient's confidence in both the nurse and the doctor and contributes to her morale and recovery.

Loyalty to the nurse—it is a poor rule that does not work both ways. Have you known many nurses who have advised their patients to change doctors when the patient-doctor relationship was strained, or to consult a cultist or pseudo doctor? Some doctors without conferring with the nurse or getting her point of view in a personality clash will arbitrarily condemn the nurse, demand her replacement. Thus through implication demote her efficiency record. Or how about the doctor who employs a practical nurse in a professional nurse's capacity and impetuously extolls the respective qualities of one favored untrained person to the disadvantage of all professional nurses.

There are misfits in nursing profession as is self-evident. However, misfits are the exception, not the rule, and the nursing profession does not have a monopoly on the state.

We agree there is a definite need for persons of good judgment with limited training to assist in the care of advanced convalescents, chronically ill persons and to take responsibility for the mechanics of home keeping during illness. Such a position should be given dignity and support, but such a person should not be used to take the place of the professional nurse. It is most unfortunate that the title "practical nurse" has been attached to this position because of its inherent confusion in the public mind.

Would it not prove advantageous to the patient's welfare and increase mutual confidence and satisfaction if more frequent and detailed discussions could be held between the doctor and the nurse or nurses responsible for the patient's care? After all the patient is a person with all the emotions, fear, anger, love, joy and yearning of you and I. To restore him to society requires more than surgery, medicine or baths—It takes the combined information and plan of doctor, nurse and family. So the closer we can work together the more certain the outcome.

CLINICO PATHOLOGY CONFERENCE

At the weekly conference of the Youngstown Hospital Association a case of Waterhouse Friderichsen Syndrome (meningitis—usually meningococcal—associated with extensive hemorrhage into one or both adrenal glands and a shock-like picture usually ending in death) was presented.

The patient was a 20 months old white female who was dead on arrival at the South Side emergency room. Her illness had begun the day before with some fever and malaise. She went to bed that evening with only these symptoms, but at 4 a. m. she suddenly awakened and wanted her bottle. She was very irritable at this time and rapidly began to lose consciousness. She was rushed to the hospital but was dead on arrival. The only positive physical finding was petechiae over the lower thorax and upper abdomen.

Several days before the onset of the illness the child was playing with a cousin who was later admitted to a local hospital with a diagnosis of meningococcal meningitis.

Post mortem examination of the child revealed hyperemia of the meninges with a non-purulent exudate. Both adrenal glands were deep purple and no normal adrenal tissue could be found microscopically. On cross section the glands were found to be completely infiltrated with blood. Too much time elapsed between the death and the autopsy to allow satisfactory bacteriological examination.

The discussion of the case was led by Dr. A. E. Rappoport. He first called on Dr. Delfs who gave an interesting and informative discussion on sudden death of children. She stated that entirely too many children die as a result of suffocation by excessive loose bed clothing. Foreign bodies in the trachea is another too common cause. Waterhouse-Friderichsen Syndrome is not a common cause but should be remembered especially if there is a history of exposure to meningitis. These children usually die 2-48 hours after the onset of illness with a shock-like picture. Of seventeen cases who had exactly similar symptoms and who were diagnosed as having this syndrome, only nine showed hemorrhage into the adrenal glands. This, she stated, throws some doubt on the non-fatal cases of this disease which are reported.

Dr. Rappoport agreed that post mortem examination was the only method by which diagnosis could be assured. He also brought forth the point that death was probably due to overwhelming sepsis rather than actual adrenal destruction. He pointed out that although a lot of meningococcal meningitis was seen in the army, very few cases of this syndrome were seen. Ninety percent of cases occur under the age of nine years and seventy percent under three.

It is interesting to note the changes which occur in the adrenal gland during early life. At birth the adrenal is one-third as large as the kidney but in the adult it is only one-thirtieth. It is during the early years that the size of the glands diminishes; it is also during this time that Waterhouse-Friderichsen is most frequent.

Interesting but as yet unanswerable questions which were considered are: Why does hemorrhage occur into the adrenal gland and not other organs? What accounts for the age incidence? What is the cause of death?

JAMES F. LAND, M. D.

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ABUSE OF PENICILLIN

Last May, when the War Production Board removed the restrictions on the distribution of penicillin, there was every reason to anticipate that its use would become widespread. When the manufacturers found it possible to reduce the price to a reasonable figure, the temptation to use it even more extensively and in larger amounts became greater. In the case of the sulfonamide drugs, at least some physicians exercised reasonable caution in prescribing them because of the toxic effects that so frequently accompanied their use. The relative freedom of penicillin from toxic side effects does not impose this limitation.

It is probably fair to say that penicillin is now being used in large amounts and in many conditions irrespective of any demonstrated beneficial effects. Until recently the only reasonable restraint that many physicians felt was caused by the necessity of giving the penicillin by injection. Thus, penicillin had to be administered either by a doctor or by a trained nurse and its use was essentially limited to hospitals or to homes in which private nursing service was available. In recent months, shortage of nurses and of hospital beds has considerably limited the ability of many physicians to prescribe the agent. Furthermore, the objections of patients themselves to repeated and prolonged injections have often reminded the physician that continuation of treatment could only be justified by reasonable indications.

It is in the hospitals, especially the larger ones, that penicillin has been most flagrantly abused, particularly from the point of view of the quantities dispensed. Orders for penicillin have been written lavishly for all patients with fever and for most of those in whom fever or infection might be anticipated, irrespective of any possible benefits that could reasonably be expected from its use. Interns and visiting physicians alike have shared in this spree. In one large Boston hospital alone, the amount of penicillin used in the past six months was equal to the entire world production only two years ago. The amount used in a single day in October was considered quite adequate, during the period when penicillin was being rationed, to fulfill reasonably the entire needs of all the patients of the same hospital over a period of three months. In another large Boston hospital, one of its administrators made a brief survey of the use of penicillin when the amount of money expended for this drug was found to be equal to the total amount being spent for all other drugs. It was obvious that totally excessive amounts were being given, that the patients were receiving injections without any reasonable indication and that the drug was being continued almost indefinitely after the time when further benefit could reasonably be expected. Following this survey and certain recommendations, the amount used in the hospital declined from 60 to 80% without interfering with the proper treatment of any patient.

It is not unlikely that the patients in the latter hospital actually benefited through this reduction in the amount of penicillin dispensed. Nursing services had been much curtailed, and the amount of nursing time that was released from unnecessary penicillin injections was undoubtedly well used for the essential care of patients. Furthermore, when penicillin is not given until there is reasonable evidence that it is indicated, or if it is discontinued promptly after a brief but adequate period has demonstrated that it is not producing a desirable result, the patient will benefit, because then the physician

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will make a greater effort to arrive at a proper diagnosis and a more reasonable method of therapy.

At present, when the incidence of infections requiring penicillin therapy is greatest, there is an acute shortage of penicillin. This is due to many factors not easily controlled. It would be well for physicians to take stock of their use of penicillin from time to time and to be sure that they are prescribing it in a reasonable manner. The fact that large doses may be safely given does not mean that all patients should receive these amounts, which should be reserved for conditions in which big doses are clearly indicated. Furthermore, in cases in which prolonged treatment is not necessary, the drug should be discontinued at the earliest possible moment. The widespread prophylactic use of penicillin in the treatment of colds or of uninfected wounds should be discouraged—particularly during the present shortage.

Editorial, New England Journal of Medicine, Dec. 27, 1945.

MEMBERSHIP AND FELLOWSHIP DEFINED

Every *member* in good standing in the constituent medical association of the state in which he is engaged in practice whose name is officially reported to the Secretary of the American Medical Association for enrollment becomes automatically a *member* of the American Medical Association is not called on, as such, to pay any dues or to contribute financially to the Association.

Members of the American Medical Association who graduated at recognized medical schools are eligible to apply for *Fellowship*.

To qualify as a *Fellow*, a *Member* in good standing is required to make formal application for *Fellowship*, to pay *Fellowship* dues and to subscribe for *The Journal*. Applications must be approved by the Judicial Council. *Fellowship* dues and subscription to *The Journal* are both included in the one annual payment of \$8.00, which is the cost of *The Journal* to subscribers who are not *Fellows*.

Only those *Members* who qualify as *Fellows* are eligible for election as officers, may serve as members of the House of Delegates, may register at the annual sessions of the Association

or may participate in the work of its scientific sections.

Members of constituent state medical associations pay dues to those bodies, but as *Members* they pay nothing to the American Medical Association. *Fellows* pay dues and subscription to *The Journal* in the sum of \$8.00 a year, which has nothing to do with county or state dues.

According to an amendment to the By-Laws of the American Medical Association, no physician may be officially recorded as a *Member* of the American Medical Association except on the basis of membership in one constituent state medical association and that one the association of the state in which the physician concerned maintains legal residence and engages in the practice of medicine.

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Approved by the Council on Medical Service of the A. M. A.

Development of plans affecting the distribution of medical care, in accordance with the principles adopted by the House of Delegates is one of the principal functions of the Council on Medical Service and Public Relations. First in importance in the development of plans affecting the provision of medical care is the utilization of the prepayment method to help spread medical and surgical costs.

The Council on Medical Service and Public Relations suggests that special recognition be granted to plans organized and operated in accordance with standards which adequately protect the interest of the public and the medical profession.

In granting this recognition the Council will consider each prepayment medical care plan in the light of established knowledge, authoritative opinion, and according to standards adopted from time to time by the Council in the interest of the public. Plans that conform with the requirements thus formulated will be accepted by the Council.

Under the conditions defined in the following paragraphs, the Council grants the right to print its seal on all official papers of accepted plans and in any promotional literature or display material used by these plans.

This official seal should appear without comment on its significance unless such comment has been previously approved by the Council. A statement proposed for such use follows: "The seal of acceptance denotes that (name of plan) has been accepted within the standards set forth by the Council on Medical Service of the American Medical Association."

The acceptance of a plan and the seal of the Council are intended to signify that the plan conforms with or meets the following standards or requirements:

Local Approval

(1) The prepayment plan must have the approval of the state medical association—or if local, of the county medical society in whose area it operates.

Professional Control

(2) The Medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified legally and by education to accept responsibility for the character of medical services rendered.

Arbitration

(3) Provision should be made for a medical director acceptable to the county or state medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a per diem basis for the time involved in handling such matters.

Free Choice of Physician

(4) There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

Patient-Physician Relationship

(5) The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

(6) The plan should be organized and operated to provide the greatest

possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of subscribers, the physicians and the plans are presupposed as necessary considerations for successful operation.

(7) The dues from subscribers through premium rates should be adequate to provide for the benefits offered and the risks involved.

In determining such factors the Council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations.

Statement of Benefits

(8) These benefits may be in terms of cash indemnity or service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

Promotion

(10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the Council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the Council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

Enrollment

(11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with state statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate state authority.

(13) Each accepted plan must submit periodic reports of financial enrollment experience and in the manner prescribed by the Council.

Duration of Acceptance

Acceptance of plans by the Council will be for a period of two years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements be re-examined. A shorter period of approval may be granted at the discretion of the Council. Any changes in contracts or literature during the period of acceptance must be submitted to the Council for review.

STATEMENT OF RECOMMENDATIONS OF THE COUNCIL AS APPROVED BY THE BOARD OF TRUSTEES

The Council on Medical Service and Public Relations recommends the employment of a Director of its Division of Prepayment Medical Care Plans and the necessary staff. It is recommended that the Council appoint an Advisory Committee representing medical care plans and their associations.

The Council has determined standards for medical care plans, a copy of which is attached. Plans which meet these standards shall be entitled to the use of the Council Seal during the period of their approval.

The Director of the Division of Prepayment Medical Care Plans of the Council on Medical Service and Public Relations with his staff and with the assistance and cooperation of the Advisory Committee, the State Medical Societies and the Association of Medical Care Plans shall be available to assist in developing plans, increasing the number of persons covered by already existing plans and facilitating reciprocity among them.

The Council believes that responsibility for the development of medical care plans rests with state and county medical societies. Stimulation, coordination and federation of such plans under the instructions of the House of Delegates is deemed to be the function of the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association.

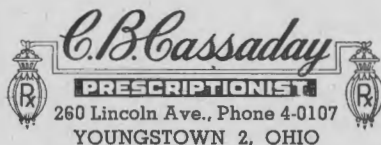
The duty of the Advisory Committee shall be to advise the Director of Prepayment Medical Care Plans and the Council on the methods of implementing the program and, on approval of the Council, the Director of Prepayment Medical Care Plans will undertake the functions described in paragraph 3.

The Advisory Committee shall consist of five members, appointed for one year. For the first year it is suggested that the following comprise the committee: Mr. Jay Ketchum, Dr. F. Feirerabend, Dr. Herbert Baucus, Mr. William Bowman and Mr. Charles Crownhart.

A tentative cost of this program is estimated at \$50,000 for the first year.

AMPOULES - VIALS

BIOLOGICALS



SURGICAL DRESSINGS

SICK ROOM SUPPLIES

DENTISTRY AND MEDICINE

A few years ago Harvard threw a bombshell by announcing that dentistry is a branch of medicine and surgery and that it should, therefore, be included in the medical curriculum. Columbia agreed. Now its school of dental and oral surgery is outlawed by New Jersey under pressure of the State Dental Society. The reasons given are specious and contradictory.

If Columbia's future dental graduates are unable to pass New Jersey's examinations a strong case will be made out against the new conception of dentistry as a branch of medicine. But New Jersey judges the experiment in advance without knowing what the outcome will be. We are told that the "autonomy of dental education" must be preserved, and yet no branch of medicine or surgery, not even nursing, is autonomous. Dentistry is as much a part of medicine as surgery or otolaryngol, and it is thus that Columbia properly regards it.

New Jersey's State Board is not consistent in its argument. It does not "doubt the ability of Columbia to graduate good products in the beginning," but it is already convinced that "the product will suffer in the long-range program." How does it know? If the "product" will be good in the beginning, why not ten years hence? And where does the board get the idea that dentistry is to be "subjugated"? No one can maintain that surgery has been subjugated to medicine or medicine to surgery or that bacteriology has subjugated the study of nutrition. The more the argument is examined the less tenable it becomes.

Dentists now have to study some medicine at school. When they treat pyorrhea, abscesses and other afflictions of the teeth and gums, they practice as specialists in a branch of medicine. The city of Newburgh, N. Y., is now making a ten-year experiment to determine the effect of fluorine on tooth decay. This is medicine as much as it is dentistry. The whole conception of the etiology of tooth decay has changed since the vitamins were discovered and it would be a backward dentist, indeed, who did not recognize the importance of this advance, which belongs to medicine as much as it does to dentistry. It is hard to believe that dentists prefer to be erroneously regarded as mere mechanics.

Physicians often have a snobbish way of looking down on dentists—a relic of the Middle Ages. It is time that dentists should be regarded for the highly trained professionals that they are—men and women who should rank with the best physicians and surgeons and who should not stand apart. Columbia has taken a forward step in breaking down professional class distinctions that should have passed years ago. The inclusion of dentistry in the medical curriculum should result not only in better treatment of dental and oral defects, but in an improvement in the dentists' professional position.

—*Editorial Opinion of New York Times*

MEMBERS RETURNED FROM SERVICE FOR QUICK REFERENCE—POST IN CONSPICUOUS PLACE

W. H. Atkinson, M. D.	3370 Wilson Avenue	
O. A. Axelson, M. D.	Medical Arts Bldg.	84118
B. M. Bowman, M. D.	604 Home Savings & Loan Bldg.	41396
Peter L. Boyle, M. D.	413 Mahoning Bank Building	42633
B. M. Brandmiller, M. D.	2020 Market St.	29114
John R. Buchanan, M. D.	608 City Bank Building	41432
R. V. Clifford, M. D.	19 Lincoln Avenue	77322
Joseph Colla, M. D.	518 Dollar Bank Bldg.	32256
C. H. Cronick, M. D.	160 W. Princeton Avenue	25300
A. R. Cukerbaum, M. D.	408 Home Savings & Loan Building	73211
Sidney L. Davidow, M. D.	338 Lincoln Avenue	77093
G. E. DeCicco, M. D.	1008 Market Street	31215
Samuel Epstein, M. D.	2004 Elm Street (Dr. Yarmy's Office)	32625
W. H. Evans, M. D.	Dollar Bank Bldg.	42147
B. I. Firestone, M. D.	508 Home Savings & Loan Bldg.	36722
J. L. Fisher, M. D.	224 N. Phelps Street	77713
S. D. Goldberg, M. D.	506 City Trust & Savings Bldg.	31223
John Goldcamp, M. D.	810 Dollar Bank Bldg.	34168
M. B. Goldstein, M. D.	Stambaugh Bldg.	32554
R. A. Hall, M. D.	Home Savings & Loan Bldg.	36656
Harold E. Hathhorn, M. D.	2547 Glenwood Ave.	21821
H. H. Ipp, M. D.	306 Home Savings & Loan Bldg.	27086
P. M. Kaufman, M. D.	304-5 Home Savings & Loan Bldg.	45121
M. M. Kendall, M. D.	Home Savings & Loan Bldg.	36762
J. P. Keogh, M. D.	812 Home Savings & Loan Bldg.	79217
J. E. L. Keyes, M. D.	617 Home Savings & Loan Bldg.	73643
Samuel Klatman, M. D.	409 City Bank Bldg.	31422
Herman Kling, M. D.	317 So. Solan St., Albuquerque, New Mexico	
O. M. Lawton, M. D.	Mahoning Bank Bldg.	33314
A. Marinelli, M. D.	1204 Central Tower	
P. R. McConnell, M. D.	19 Lincoln Avenue	38112
W. D. McElroy, M. D.	1006 Central Tower Bldg.	41677
R. H. Middleton, M. D.	Medical Arts Bldg.	21211
A. W. Miglets, M. D.	61 E. Florida Avenue	41764
Stanley Myers, M. D.	810 Dollar Bank Bldg.	34168
M. W. Neidus, M. D.	Home Savings and Loan Bldg.	31912
G. G. Nelson, M. D.	138 Lincoln Avenue	77650
John Noll, Jr., M. D.	101 Lincoln Avenue	30916
R. E. Odom, M. D.	510 Dollar Bank Bldg.	42147
S. W. Ondash, M. D.	2514 Mahoning Avenue	95358
A. K. Phillips, M. D.	250 Lincoln Ave.	33608
Robert L. Piercy, M. D.	613 Home Savings & Loan Bldg.	34189
Asher Randall, M. D.	5th Floor, Schween-Wagner Bldg.	78611
Lewis K. Reed, M. D.	634 Market Street	
H. J. Reese, M. D.	2714 Market Street	23413
John Renner, M. D.	Dollar Bank Bldg.	34168
John A. Rogers, M. D.	603 Home Savings & Loan Bldg.	41944
M. S. Rosenblum, M. D.	406 Home Savings & Loan Bldg.	31912
J. M. Russell, M. D.	2726 Market Street	29113
C. W. Sears, M. D.	3031 Market Street	24617
L. S. Shensa, M. D.	Dollar Bank Bldg.	75125
Henry Sisek, M. D.	317 Home Savings & Loan Bldg.	39873
Ivan C. Smith, M. D.	210 Home Savings & Loan Bldg.	73257
J. J. Sofranec, Jr., M. D.	1007 City Bank Bldg.	79249
William E. Sovik, M. D.	20 Twelfth Street, Campbell, Ohio	550012
M. M. Szucs, M. D.	608 Dollar Bank Bldg.	47315
W. J. Tims, M. D.	19 Lincoln Avenue	37698
L. W. Weller, M. D.	1006 City Bank Building	30127
John Welter, M. D.	19 Lincoln Avenue	34464
Herman Zeve, M. D.	228 Lincoln Avenue	77650
Sam Zlotnick, M. D.	Home Savings & Loan Bldg.	36722

Extreme Cleanliness Used in Packing DEXTRI-MALTOSE



Washing and steaming empty cans



Automatic filling machines

Glass-enclosed, dust-free room in which Dextri-Maltose is packed

THE EXACTING CARE used in manufacturing Dextri-Maltose is maintained, even to the final packing and wrapping. The empty cans are washed inside and outside by hot water under pressure, then steamed and dried. Cans are filled in a glass-enclosed, air-conditioned room the atmosphere of which is washed to free it from dust and bacteria. Enclosed conveyors leading to this room send Dextri-Maltose to machines which automatically fill and close the cans without human handling of the product. The cans are again washed and inspected for imperfections. At this step specimen cans are selected for bacteriological examination to insure that there has been no break in the sanitary control. Finally the cans are wrapped to prevent the covers from accumulating dust. Dextri-Maltose is then held in storage and released for the market only after final approval from the bacteriological laboratory. At every stage in the manufacture of Dextri-Maltose our effort is concentrated on supplying the physician with the carbohydrate that will best promote and maintain the health of his patient.

"The Measure of Economy is Value, Not Price"

MEAD JOHNSON & COMPANY, Evansville, Indiana, U. S. A.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized channels.