

MAHONING COUNTY  
MEDICAL SOCIETY

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## CONTENTS

August, 1946

PRESIDENT'S PAGE . . . . .	252
CANFIELD FAIR . . . . .	253
ANURIA—DIFFERENTIAL DIAGNOSIS AND TREATMENT . . . . .	255
CANCER DETECTION CENTER . . . . .	267
SAN FRANCISCO A. M. A. MEETING . . . . .	269
LIBRARY CORNER . . . . .	271
NEWS . . . . .	271

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PATRONIZE THEM — THEY MAKE THE BULLETIN POSSIBLE

Beil-Rempes Drugs, Inc. . . . .	248	McKelvey's . . . . .	246
Blair's . . . . .	248	Mead-Johnson Company . . . . .	272
Buffington's, Inc. . . . .	248	Mercer Sanitarium . . . . .	251
Cassaday's . . . . .	245	Pitman-Moore Company . . . . .	249
Central Square Garage . . . . .	249	Professional Pharmacy . . . . .	247
Ciba . . . . .	258	Renner's . . . . .	249
Cross Drugs . . . . .	251	Scott Company . . . . .	244
Fellows Medical & Mfg. Co., Inc. . . . .	242	Similac . . . . .	256
Isaly Dairy . . . . .	254	Spencer . . . . .	250
James & Weaver . . . . .	248	Lloyd T. Stillson . . . . .	268
Laeri's . . . . .	247	Strouss-Hirshberg . . . . .	245
Lester's . . . . .	245	Thornton's . . . . .	264
Eli Lilly & Co. . . . .	260	H. H. Treudley & Company . . . . .	247
Lyons . . . . .	246-268	White's Drug Stores . . . . .	244
		Zemmer Company . . . . .	263

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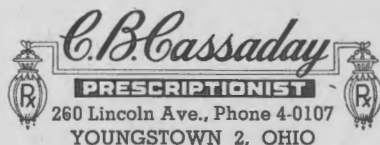
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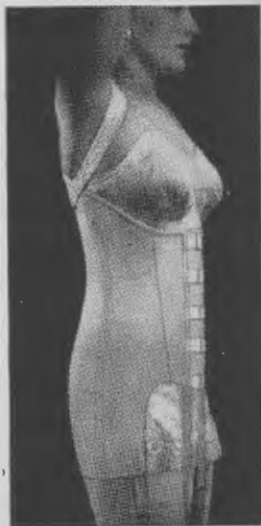
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## PRESIDENT'S PAGE

There has been considerable dissatisfaction both within and without our Society over the fact that returning service men, not members of our Society, have been unable to participate in the Medical Care Program for Veterans. A bulletin from the Ohio State Medical Society reads as follows:

"Since the Ohio State Medical Association medical care program for veterans went into effect, the Association has received quite a number of letters from non-member physicians asking to be certified as fee-designated physicians.

"Since this is a State Association program, officials of the Association feel the certified list should be confined to members, *except in the case of former World War II medical officers who have located in Ohio since their release from the service.*

"A policy has been established whereby former medical officers not now members, but who intend to become members, can have their names placed on the list.

"These men are being informed that a written statement from either the President or the Secretary of the County Medical Society or Academy of the county in which they are practicing to the effect that the former medical officer has an application for membership on file and that he (the President or Secretary) approves placing the doctor's name on the list will suffice."

The above has been taken care of, and the returning non-members have been certified to the State Association.

The Compulsory Health Insurance Plan was voted out of committee July 22, 1946. This is the Wagner-Murray-Dingall Bill S 1606.

Rarely is it that a country or individual profits by another's mistakes, and it seems the good old U. S. A. is no exception. This bill is just a forerunner of many more like it to come, and soon we will be in the same deplorable condition as was Germany, which allowed men like Hitler to gain control of the country.

It would behoove the rank and file of the unions who are most loudly demanding socialization of everything, to read a pamphlet published in Berlin in 1935 entitled "Results of Half a Century's Practice of Social Insurance in the Land of Its Inception," by Gustav Hartz, a German labor economist.

He gave its history and its ever-increasing scope in benefits until it was requiring 20% of a workman's pay and then an ever-decreasing benefit until just as his pamphlet was being published, unemployment insurance had to be discontinued by the German government.

One of our own members, a refugee from Germany, made this remark two years ago, "You are doing in this country, step by step, like they did in Germany."

Are we selling our birthright (all that we have fought for, freedom and the American way of living) for a mess of porridge? Socialism?

Will America copy Germany's mistakes? *Medical Economics* of July, 1946 has an interesting article on "Consequences of S1606" by Marjorie Shearon, Ph. D.

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

# BULLETIN *of the* Mahoning County Medical Society

AUGUST

1946

## CANFIELD FAIR MEDICAL EXHIBIT

Time is growing short for preparation for the exhibit at the 100th Anniversary of the Canfield Fair. We still need help to put the exhibit on. Your committee, headed by Dr. Patton, cannot do more than they are doing, but when cards were mailed to each member, only five or six volunteered to aid in giving their time to show the public what we are trying to do for the sick.

This exhibit will try to show 100 Years of Medicine here in our county. Old and new instruments will be shown, old pictures and equipment, old and new drugs and their uses, old and new methods of travel, old X-ray machines, laboratory procedures of today and the past, showing specimens, etc. An Iron Lung will be operated with exhibits of lung diseases. Also included will be cancer, its diagnosis and treatment; founders of medicine; diseases contracted from all types of animals; diseases brought back to us from the tropics by our returning soldiers and sailors. There will be a section on the Wagner-Murray-Dingall Bill and a lot more too numerous to mention. Also a section of a 40x60 foot tent will be equipped with motion pictures so that both sound and still pictures will be shown from 12:00 o'clock noon until 8:00 o'clock P. M. There will be a complete change of pictures every day.

We want you to come and see the show, but can we depend upon your coming to our aid for the running of this show?

We have been very much disappointed in our Auxiliary, which we

thought would give us some help. They have not responded.

Please let us hear from you at once. It is not much to give four hours of one day during the Fair. You and your wife attend, together. Fill out the card or call the Society Office—43285. W. H. S.

### Loyalty Plus!

The Mahoning County Medical Society has been, and we believe is, the best Medical Society in the State of Ohio. It has been brought to this high standard by the untiring efforts of these members who are advanced to the point where they would like to see the younger members carry on. Many of our hardest working members have been carrying on for more than twenty years and the younger members will certainly have a challenging task before them if they carry on in the example that has been set.

As you will read in the Ohio State Medical Journal of this month under the title of "Medical Politicians"—"What the profession needs is more members willing to sacrifice their time and money in behalf of organized medicine, taking on the jobs that have to be done in the county, state and national medical societies. Anyone so inclined does run the risk of being labeled a 'medical politician' by those who shun the thankless tasks, but there is a lot of personal satisfaction in the knowledge that he has done his share in the battle to strengthen medical organization and preserve the private practice of medicine." C. A. G.



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## ANURIA—Differential Diagnosis and Treatment

*An address given before Mahoning County Medical Society, June 11, 1946.*

ELMER L. DEGOWIN, M. D.

*Department of Internal Medicine  
State University of Iowa Hospitals*

The occurrence of anuria or extreme oliguria during the course of disease is always cause for great concern on the part of the physician. The daily excretion of urine is reduced to less than 500 c. c., or ceases entirely. Few symptoms are produced immediately, but daily chemical studies of the blood reveal rapidly increasing concentration of urea, creatinine, and nonprotein nitrogen. The patient may appear mentally clear and experience no great discomfort, or there may be nausea and vomiting. But unless prompt treatment is successful the prognosis is nearly hopeless. Average duration of life with complete anuria is about 10 days, with a range of four to 15 days. One case, however, has been reported in which recovery occurred after complete urinary suppression for 19 days. Toward the end, the patient lapses into coma. Hypertension may or may not develop, depending on the mechanism which causes the renal insufficiency. Some nervous irritability may occur but convulsions, such as are seen in the uremia of chronic nephritis, are not common.

Urinary suppression occurs during the course of many diseases, frequently after several types of treatment have been given. The differential diagnosis of the cause of the anuria becomes a complicated problem the solution of which is necessary to intelligent therapy. There is some merit to a consideration of the causes of anuria under the headings of "prerenal", "renal", and "postrenal". An outline on such a basis follows:

### A. Prerenal

1. Shock
  - (a) primary shock
  - (b) secondary or hemorrhagic shock
  - (c) "medical shock" (from infections)
2. Electrolyte imbalance (acidosis and alkalosis)
3. Dehydration
  - (a) lack of fluid intake
  - (b) accumulation of exudates (peritonitis and lobar pneumonia)

### B. Renal

1. Acute glomerular nephritis
2. Chronic glomerulotubular nephritis
3. Precipitation of sulfonamides in the tubules
4. Calculi in the renal pelvis
5. Parenchymal damage from mercury or phosphorus
6. Cortical renal infarction

### C. Postrenal

1. Precipitation of sulfonamides in ureters and renal pelves
2. Ureteral calculi
3. Carcinoma occluding ureters
4. Ligature of ureters
5. Reflex from ureteral catheterization

### D. Unclassified

1. Hemolytic disorders (transfusion hemolysis, blackwater fever, etc.)
2. Crush syndrome

Physiologists long have known that when the systolic blood pressure in the periphery falls below 60 to 70 mm. of mercury the glomerular circulation ceases. If the renal arteries of a dog are occluded for less than six hours and the circulation is re-established, renal function is resumed. If the period of anoxia be much longer, however, restoration of the glomerular blood flow will not result in the secretion of urine. The renal

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tubules have been damaged permanently.

In both primary and secondary or hemorrhagic shock, the renal circulation probably ceases. Experience in World War II has re-emphasized the necessity for the early treatment of shock. If the patient has been in shock too long before adequate circulation is restored by suitable means, the kidneys and the brain are damaged permanently by the anoxia. Anuria is one sequel. The treatment of this condition only can be in the prophylaxis, the prompt and adequate treatment of shock.

A condition sometimes seen in overwhelming infections is referred to as "medical shock". There is apathy and hypotension. The patient usually does not respond to the measures employed for the restoration of blood volume which are so efficacious in secondary shock. The treatment lies in the management of the infection itself.

In severe cases of acidosis or alkalosis the kidneys may be damaged or the fluid required for normal renal function is lost because of an insufficient amount of base. The treatment depends upon the proper recognition of the condition by chemical studies and the administration of the needed electrolytes and water. The determination of blood chlorides and of the carbon dioxide combining power of the plasma are the tests of most value in establishing the correct diagnosis.

Patients who have been very ill may become dehydrated and oliguric if the fluid intake has been inadequate. The water should be supplied by mouth or in the form of solutions of dextrose or saline intravenously.

During the development of peritonitis the accumulation of water and electrolytes in the peritoneal exudate may contribute to the lack of urinary excretion. The infection may be sufficient to cause "medical shock" which adds a second factor in the causation

of anuria. Such an example recently was seen in a case of bile peritonitis. After an operation on a stenotic common bile duct the patient received a blood transfusion. Twelve hours later the output of urine ceased. The question was raised as to whether the patient had transfusion anuria. There had been no signs of hemolysis and the post-transfusion urine specimen contained no hemoglobin. The patient was dyspneic and febrile. The pulse was weak and thready; the blood pressure was immeasurable. The condition was not improved by further blood transfusion. The patient died within forty-eight hours. At autopsy there was evidence of leakage of the bile into the peritoneal cavity. This is an example of "medical shock."

Occasionally a patient with lobar pneumonia develops oliguria or anuria. Presumably this is caused by the accumulation of sodium and water in the consolidated lung. The parenteral administration of saline solution and the injection of antibacterial substances is indicated.

In the course of acute glomerular nephritis anuria occasionally develops. Usually the diagnosis does not present much difficulty. There is a history of an acute infection which is accompanied by the development of peripheral edema and some hypertension. Before excretion ceases, the urine contains protein, casts, and red blood cells. There is chemical evidence of nitrogen retention in the blood. If the kidneys are examined at this stage it will be found that they are frequently edematous. When the parenchyma swells it is confined by the unyielding capsule of the kidney and pressure is exerted upon the lumina of the tubules which are occluded. When such a state exists decapsulation of one or both of the kidneys allows expansion and the tubules may be opened sufficiently to allow urinary flow. In judiciously selected cases



this operation may be life-saving.

In chronic glomerulotubular nephritis oliguria or anuria occurs as a terminal feature of the disease. The diagnosis is made readily in most cases because of the long history of the renal disorder. The cessation of renal function marks the point at which the nephrons are damaged beyond all function and little can be expected from any form of therapy.

Hematuria may be quickly followed by oliguria or anuria during the administration of sulfonamides. If available, urine specimens are found to contain the typically shaped crystals of the drug which can be identified by inspection with the microscope. The administration of fluids and alkalies, both by mouth and intravenously, is indicated. Occasionally the crystals will dissolve and urinary excretion will be resumed. The condition may be prevented by insuring sufficient intake of water and alkalies along with the sulfonamides.

Rarely a calculus in the renal pelvis will cause anuria. The diagnosis is made by the X-ray visualization of the ureters after the retrograde injection of radio-opaque substances. Surgical removal of the stone is indicated.

Parenchymal damage from mercuric chloride or phosphorus causes anuria. The diagnosis is made from the history and the concomitant signs of poisoning by the metals. Little can be expected from treatment if the damage is extensive.

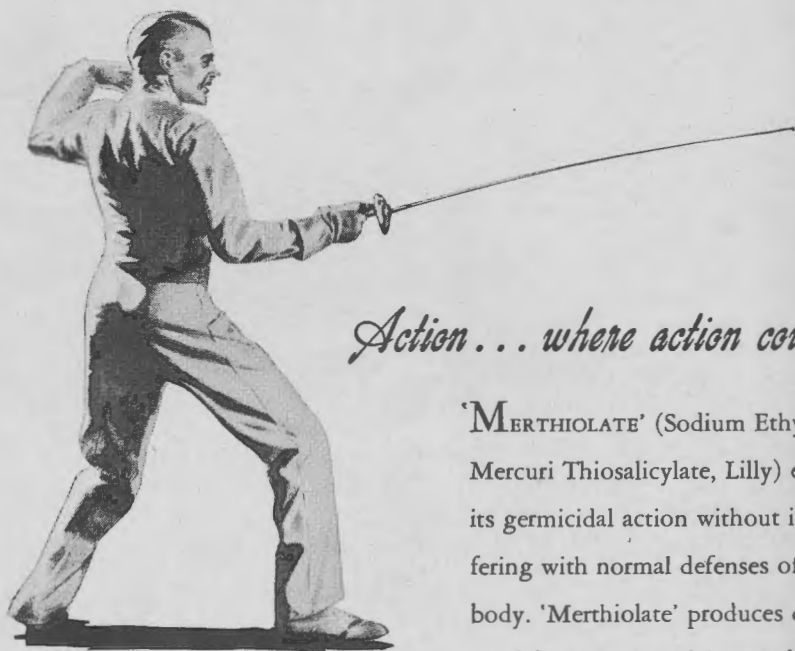
Infarction of the renal cortex occurs after infections and operations and is also a result of infiltration with carcinoma. The diagnosis is difficult to make during life and not much is known concerning treatment.

The postrenal causes of anuria are readily diagnosed and frequently successfully treated by the urologist. The ureters may be cleared of calculi or sulfonamide crystals in various ways. Ureterointestinal anastomosis is some-

times feasible when occlusion has occurred from carcinoma. Many surgeons of considerable experience have found that the ureters have been ligated inadvertently in the course of operations in the pelvis.

Frequently in the course of modern therapy one is confronted with the problem of whether anuria is due to one of the previously mentioned conditions or whether it is associated with hemolysis accompanying the transfusion of blood. A common situation is encountered in the patient who has been operated upon for a gastric lesion. Blood transfusion has been given for hemorrhagic shock in the operating room while the patient is under a general anesthetic; vomiting has occurred after operation and anuria develops. The question arises as to whether the anuria is due to acidosis, alkalosis, dehydration, renal damage from shock, or hemolysis from blood transfusion. If it can be demonstrated that hemolysis has occurred, the presumption is strong that the anuria is a result of this. When a blood specimen can be obtained within a few hours after transfusion it should be centrifuged and the supernatant serum or plasma compared with the specimen which was obtained before transfusion for blood grouping and cross-matching. If the post-transfusion serum is colored red with free hemoglobin or yellow with bilirubin, the evidence favors the diagnosis of hemolysis. If urine was obtained after transfusion, it should be examined for the presence of hemoglobin. When hemoglobin is present, without red blood cells, this is evidence of hemolysis. If hemoglobinuria has not occurred, hemoglobinemia has not been excluded because the pigment does not appear in the urine until a level of approximately 40 mg. per 100 c.c. has been attained in the blood plasma.

Clinicians have known for a long time that in a variety of conditions in which hemolysis occurs anuria occa-



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sionally is a complication. This is notably true in hemolytic transfusion reactions, blackwater fever, crush syndrome, favism, hemolysis from sensitivity to sulfonamides and quinine, and paroxysmal hemoglobinuria. Perhaps most of the patients exhibiting hemolysis in these conditions show no signs of renal impairment, but a relatively few develop oliguria or anuria with nitrogen retention, which frequently leads to death. Various observers are agreed that the histologic picture in the kidneys in all these conditions is similar. There is some edema of the interstitial tissue. The glomeruli are normal. The tubular epithelium shows varying amounts of cloudy swelling and necrosis in the region of the proximal convoluted tubules. The lumina of the distal convoluted and collecting tubules contain pigment and desquamated epithelium. Pigment deposits also occur in the tubular epithelium.

Although the occurrence of hemolysis seems to be the common denominator in all these disorders, there has been considerable controversy as to whether hemoglobin is toxic to the kidneys. Foy and his associates (1) state that in blackwater fever as much as three-quarters of the patient's blood may be lysed in the course of two or three days, resulting in the release of 600 to 700 grams of hemoglobin. Some of the patients develop renal insufficiency but others do not. On the contrary, fatal cases of anuria have developed from the hemolysis of 200 c.c. of blood transfused from another person, an equivalent of 30 grams of hemoglobin. Cannan and Redish (2) prepared solutions of pure crystalline human hemoglobin and injected them into human beings. No symptoms were encountered until doses of 0.64 gram per kilogram of body weight were given. With these amounts the recipients became nauseated, vomited and had epigastric pain for several hours. In a man of 70 kilograms this

dose would amount to 45 grams of hemoglobin. If impurities in the hemoglobin can be excluded this experiment suggests that at least some of the symptoms experienced during intravascular hemolysis are caused by the hemoglobin itself.

Many mechanisms have been suggested for the production of the renal failure by hemoglobin. There are some who deny that hemoglobin itself is toxic to the kidneys. The anuria which occasionally occurs in blackwater fever has been attributed to the concomitant effects of the disturbance in electrolyte and fluid balance which frequently accompanies the disease (1, 3). Diminution in the body chlorides, acidosis, and alkalosis all are observed clinically to result in impaired renal function and azotemia. Slowing of the glomerular circulation in these disorders has been demonstrated by inulin and creatinine clearances, (4, 5). There also is confusion as to whether depletion of chloride or sodium is responsible for some of the experimental and clinical facts which have been observed. The development of anuria after a hemolytic transfusion reaction often occurs in patients in whom the electrolyte and fluid balance is not normal. Occasionally, however, anuria results from the hemolysis of rather small quantities of transfused blood in patients in whom there has been no previous imbalance, so that the renal insufficiency could not possibly be attributed to the electrolytes released by the rupture of the erythrocytes. It is suggested that the antigen-antibody reaction may in some way damage the kidneys.

Attempts have been made to attribute the anuria to the spasm of renal vessels. Mason and Mann (6) and Hesse and Filatov (7) demonstrated that the presence of free hemoglobin in the blood plasma in certain concentrations produces a decrease in the volume of the kidneys which occur as

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a result of vasoconstriction of the renal vessels. It is not clear, however, whether this effect persists long enough to cause the serious damage to the kidneys which is encountered in clinical disorders.

In 1911 Yorke and Nauss (8) concluded from experiments on rabbits that the kidneys were damaged by the plugging of the lumina of the tubules by the precipitation of pigment derived from hemoglobin and that this mechanism was enhanced by measures which produced deprivation of water. Baker and Dodds (9) reported studies in rabbits which led them to conclude that the precipitation of hemoglobin or derived pigments occurred when the urine was acid in reaction and contained a concentration in excess of 1% chlorides. They established the concept of blockage of the renal tubules as the cause of the anuria in hemoglobinuric disorders. Later, DeGowin, Osterhagen, and Anderson (10) and DeGowin, Warner, and Randall (11) repeated these experiments in dogs. The group of dogs which received infusions of dog hemoglobin when the urine was alkaline suffered no ill effects. In order to produce an acid urine, it was necessary to feed high protein diets and to give ammonium chloride in rather large amounts. Under these conditions hemoglobinuria frequently resulted in oliguria and death from azotemia. The kidneys were found to contain casts of pig-

ment derived from hemoglobin in the lumina of the tubules. The dilation of the glomerular capsules indicated that the plugs were actively obstructing the nephrons. This was accepted as satisfactory confirmation of the studies of Baker and Dodds. But when the microscopic appearance of the dog kidneys was compared with that of human beings who had died from transfusion anuria, it became evident that the mechanism of obstruction could not account for the renal failure which was observed clinically. Casts of pigment were present but the paucity of plugged tubules made the obstruction theory untenable. There was, however, necrosis of the epithelium of the proximal convoluted tubules which suggested a toxic effect from the hemolysis. There has never been any clear proof, however, that the pigment casts were not a result of diminished excretion of urine rather than the cause of the oliguria.

Largely from the work of Baker and Dodds attempts to alkalinize the urine have been widely practiced. Many writers have warned that the procedure led to dangerous alkalosis in some cases. Furthermore, DeNavasquez (12) reported the occurrence of transfusion anuria in cases in which the urine was alkaline.

Bing (13), from his experiments on dogs, concluded that oxyhemoglobin was not toxic to the kidneys but that the damage was caused by the ac-

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tion of methemoglobinemia. Observations on human beings, however, have not demonstrated the presence of significant quantities of methemoglobin in the circulation after the occurrence of hemolysis.

Much interest has been shown in the permeability of the glomerular membranes to hemoglobin and the reabsorption of the pigments by the tubules. After hemoglobinuria, hemoglobin derivatives are found deposited in the tubular epithelium but there has been no proof that this interferes with renal function.

During World War II great interest was aroused in the subject of crush syndrome. During the air raids on England in 1940 the British established emergency medical services to care for the civilian casualties. The physicians who were working in these services were confronted with a clinical entity about which little was known. After patients, who had been pinned beneath fallen timbers and masonry, were rescued, they were treated for shock in the usual way only to develop anuria some hours later. Many of these patients died of renal insufficiency. The pathological picture in the kidneys resembled closely that seen in transfusion anuria, and many of these patients had received blood transfusions in the course of treatment. But similar pathologic findings were observed in those in whom transfusions had not complicated the situation. Metmyohemoglo-

bin was found in the urine by Bywaters and his co-workers (14). This pigment is presumably derived from the myoglobin of the injured muscle. There is no clear evidence that its deposition in the kidney interferes with renal function. Some observers believe that substances are released from the damaged tissue which are toxic to the kidney. Others consider that the condition is actually one of secondary shock and that the lowering of the blood volume is accounted for by the increase in the fluid volume of the crushed extremities.

So long as the mechanism of renal insufficiency in hemolytic disorders remains unknown therapy can be nothing but empirical. The evaluation of therapeutic measures is, likewise, very difficult. No single physician sees many patients with anuria and some patients are known to recover spontaneously although the prognosis in general is very grave. In a series of 10 cases of transfusion anuria which we have seen, eight patients have died and two have recovered. Furthermore, when one encounters a patient with anuria many therapeutic measures are used so that recovery, if it occurs, cannot often be attributed to any single procedure. The variable length of time which intervenes before spontaneous diuresis occurs is a factor disturbing to the physician who must make the decision as to the proper time to institute radical surgical procedures.

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The treatment of anuria due to damage in the kidney itself has not proven spectacularly successful up to the present. In all cases care should be taken to ensure an adequate intake of fluid. If the chlorides have been depleted by the previous illness, they should be supplied in the form of isotonic solution of sodium chloride. The administration of alkalis is not recommended unless it can be shown that the patient is in acidosis. Regardless of whether the conclusions of Bakers and Dodds are accepted, the administration of alkali to change the reaction of the urine after transfusion anuria has occurred is like locking the barn after the horse is stolen.

In transfusion anuria the kidney pelves have been lavaged with warm water through ureteral catheters, the lumbar regions have been irradiated with X-rays and diathermy. To compensate for the possible factor of vascular spasm in the renal circulation high spinal anesthesia has been given. Compatible blood transfusions have been advocated. After all these procedures recoveries and failures have been reported, as is also the case when the disorder is untreated.

In acute nephritis, damage to the kidneys by sulfonamide drugs, and in transfusion anuria the renal parenchyma is often edematous early in the course of the anuria. Several children with acute nephritis and anuria have undergone renal decapsulation by our urologists with prompt recovery of function. Unilateral decapsulation was performed recently on another patient in which the kidney did not seem to be edematous at operation. At autopsy, four days later, both kidneys were found to be the sites of a hopeless amount of acute and chronic nephritis but the decapsulated kidney showed definitely less damage than did the other. Decapsulation also is theoretically indicated in some cases of anuria caused by the

deposition of crystals of sulfonamides in the renal parenchyma.

For years pathologists have recognized that the kidneys in patients dying of anuria from hemolytic transfusion reaction or from sulfonamides show little histologic evidence of irreparable damage. In fact, the number of mitotic figures in the tubular epithelium furnish evidence that at the time of death from uremia the processes of repair are well under way. Several unsuccessful attempts had been made previously to employ the peritoneum as a dialyzing membrane through which the products of metabolism temporarily could be filtered until the kidneys should sufficiently recover to resume their function. Frank, Seligman, and Fine developed a technique in dogs (15) which they recently successfully applied to the treatment of patients (16).

A man entered the Beth Israel Hospital in Boston with anuria of five days' duration, presumed to be due to sulfathiazole. He was semistuporous. He was observed and treated conservatively for five more days after which the situation seemed desperate. At the end of that period the blood nonprotein nitrogen was 185 mg. per 100 c.c., the blood urea nitrogen, 126 mg., and the carbon dioxide combining power of the plasma was 23 volumes per cent. At this juncture peritoneal irrigation was begun. A mushroom catheter was inserted on one side of the abdomen and a sump drain on the other. Tyrode's solution was allowed to run in continuously through the catheter and was aspirated through the sump. The rate of flow of the irrigating fluid was about 26 c.c. per minute, or about 35 liters every 24 hours. The patient began to improve clinically and by the fourth day the urinary output was 400 c.c. for 24 hours. Thereafter it steadily increased until it attained a volume of 5750 c.c. on the eleventh

day. There was a steady decline in the blood urea nitrogen which reached normal values on the thirteenth day. The patient apparently completely recovered.

Tyrode's solution is a mixture of electrolytes similar to Ringer's but to which sodium bicarbonate and dextrose have been added so that all substances are in equilibrium with those in normal blood. When it is employed as an irrigating fluid the urea, creatinine, and other products of nitrogen metabolism are washed out and at the same time the electrolyte balance is restored to normal. Heparin was added to the solution to prevent the formation of fibrin which would have plugged the drainage system. Sodium penicillin and sodium sulfadiazine were also incorporated in the solution to prevent possible infection.

The day after the published report reached us in the mail, a woman was admitted to the University Hospitals who had been anuric for 10 days, after an upper respiratory infection for which she had received an unknown amount of sulfadiazine. There was no history of physical findings suggesting chronic nephritis so that it was supposed that the anuria was caused by either acute nephritis or sulfonamide damage to the kidneys. She was semistuporous with a blood urea nitrogen of 110 mg. per 100 c.c. and a creatinine of 11 mg. After a telephone conversation with Dr. Fine it was decided to attempt peritoneal irrigation. Dr. R. H. Flocks of the Department of Urology performed a decapsulation of the right kidney and took a biopsy of it. The organ did not seem to be edematous at the time of operation and the surface had the granular appearance seen in chronic nephritis. The patient was then placed in the supine position and Dr. R. T. Tidrick of the Department of Surgery placed a mushroom catheter in one peritoneal gutter and a stain-

less steel sump in the other. Tyrode's solution then was run into the catheter and attempts made to aspirate it through the sump. The fluid was administered at the rate of about 30 liters in 24 hours for the next four days. Difficulty was encountered with the irrigation system. The fluid ran in at the proper rate and the abdomen did not distend, but most of the fluid leaked out through the incision for the intake and not through the proper channel for aspiration. In spite of this, the patient seemed to improve somewhat for a day or so but gradually became worse and died on the fourth day.

The autopsy was attended with great interest. The color of the peritoneum was perfectly normal with no sign of infection or fibrin formation. Apparently the difficulty with the irrigation was caused by the application of too much suction to the aspiration line so that it had become plugged with epiploic appendages. The intake catheter had apparently been placed so that it filled a small pocket of the peritoneal cavity and overflowed through the incision without bathing much of the peritoneal surface. These small but important points had not been emphasized in the publication and we hope to profit by the experience in the future.

Another interesting observation was made at necropsy. The histologic study of the sections of the two kidneys revealed extensive acute and chronic nephritis in both but the one which had been decapsulated four days before death showed much less involvement than the other and also less damage than the section taken from it by biopsy at the time of decapsulation. These experiences suggest that combined decapsulation and peritoneal irrigation may prove life-saving in selected cases.

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## DATA REGARDING CANCER DETECTION CENTER

The function of these centers is to keep people well. The examinations in these centers are not intended for those who are ill. Sick people should go to their family physician or to the special services which have been established at all hospitals. The people, who are under the care of a physician or who are sick, will be admitted to the cancer detection center only on referral in writing by their physician.

In cancer, early diagnosis and treatment is especially important. Discovered early and treated promptly and adequately, such cancer can frequently be cured. If any thing is found which does not look or behave as it should the family physician will be notified, so that he can take care of it and give such treatment that will restore it to normal. The centers will give no treatments. Their one function is examination with the special emphasis on the conditions which may lead to cancer.

As for financing these, each person registering, who is able to do so, will be asked to make a contribution of five dollars toward the expenses of the examination. Obviously, this amount cannot be expected to cover the entire cost, and it is expected that the local cancer funds will make up the deficit. If anyone cannot afford to contribute five dollars, he will be given the examination just the same.

Since only a few can be examined at any period, those planning to come are urged to telephone for appointments. The work done in the cancer detection center consists of a history and a complete physical blood count, urine analysis, and survey of chest films. Whenever there is a positive finding, the examinee is referred to his private physician. If he has no physician, he will be referred to a list of names of physicians in his vicinity. This list will be compiled by the medical society.

When medical attention of any kind is indicated a letter is sent to the personal physician noting the findings, advising consultation, or whatever is relative. Should the condition be urgent, there is a follow-up telephone call within a week or two. If the condition is not serious, the follow-up may be deferred for some weeks. Records will be available to all personal physicians.

If the examinee cannot afford to make the usual contributions toward the expense of the examination, this is adjusted to his ability to pay. The examinee will be asked to get in touch with his private physician within ten days or two weeks. This allows time for laboratory and X-ray reports and compiling of a letter containing the findings of the private physician. E. C. B.

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## IMPRESSIONS OF THE MEETING OF THE HOUSE OF DELEGATES — SAN FRANCISCO — 1946

WM. M. SKIPP

The A. M. A. House of Delegates meeting July 1 to 5, 1946, in San Francisco, was very busy and of much interest. The sessions were so active and interesting that roll calls found all seats filled. Full attendance is 175 and usually 165 to 170 were present to answer roll. The delegates believe in their task and attend all sessions so that scientific sessions are missed entirely, for many would like to attend the sessions in which they are interested. The opening session is addressed by the Speaker, President, and President-elect. These consume a lot of time but no doubt are necessary, yet after all, they are just a re-hash of the doings of the organization since the last meeting of the House, taking to task the whole profession for its inactivity toward government and other groups that are continuously working toward the socialization of the profession. That part of the profession present realized the need for action of every member but unfortunately the inactive members are not present and do not hear the call to arms. Yes, the addresses will be published but not read by 99%. Following this is the appointment of reference committees of which three members of the eight from Ohio received appointments. These are small bodies that carry the great volume of work that is presented to the assembled body. These committees do a tremendous amount of work which requires hours of hearings so that the proponents and opponents may present their views on the resolutions in which they are interested. Hours of time are spent in getting reports ready so that the whole assemblage can digest them in a very short time. It is on their recommendations that the resolutions are either accepted, modified, rewritten or rejected.

Many resolutions presented seem to be of very little importance and come from selfish interests. Usually the committee to which such resolutions are assigned will cut them to pieces and when returned will be voted as directed by the committee. The Speaker assigns presented resolutions to the Committee under whom it shall be studied.

The House of Delegates is the policy-making body of the Association, but many policies are formulated by the Board of Trustees and passed by the House as such. The Board of Trustees being the governing body when the House is not in session. Naturally there would be a long and extensive report which is given at various times during the several days of the session. The report dealt with reorganization of the various departments and a partial report of a group of public relations experts hired by the Board. The report recommended that the activities of the Editor of the *Journal* be curtailed to being the editor, which for years has been the subject of many resolutions which the House has rejected. Also recommended changes in other standing committees or councils and offices of the Association which the House

approved. These consultants reported that our relations toward the public, Government, and ourselves in many instances, were off key. The House met in executive session or as a committee of the whole to discuss these matters. It became a very hot and argumentative session, some members of the Board and delegates at times losing their tempers. It finally developed that the whole report was not studied but would be reported to the House at its December meeting, which was a new departure—to hold House of Delegates meetings twice a year.

The Council of Medical Service and Public Relations made an extensive report of medical service plans with its efforts to get low cost medical service plans in every State in the Union. Also asked financial aid for some, which the Board of Trustees rejected. The Washington office was approved, but it was felt that its activities did not cover enough ground, but the Trustees hold that we do not have a lobbyist, but just an office of information which to many of us is wrong, holding that we should attempt to direct legislation rather than just stand by. In the reorganization, the council is to be called "The Council of Medical Service," with the Bureau of Medical Economics being revitalized and a permanent head appointed with full powers of public relations. The House approved the report of the Veteran's Committee in that all veterans shall be treated by the physician and hospital of his choice in his home community, such as the set-up that has been approved by the Veteran's Administration and the Ohio State Medical Association, and requested all members of every Society to co-operate thus so that the plans can operate for the benefit of all disabled veterans.

The Ohio delegation introduced a resolution requesting that Senate Bill 2143 (known as the Taft-Smith-Ball Bill) be approved in principle and that proper persons of the Board of Trustees or Council of Public Relations be named to meet with the Senators and proper adjustments, additions, and corrections be made so that the bill can be made workable. This bill is proposed as a counter to the Wagner-Murray-Dingall Bill which bill, including the Pepper-Child Welfare Bill, was disapproved by the House. The recommendation of the Taft Bill, after much and varied discussion was passed, with the recommendation that it be properly gone over and recommended to Congress for passage at an early date. Also from Ohio was a bill asking that there be a determined effort made to the effect that the mentally sick be properly housed and medically treated. This was approved.

The election procedure was changed a little so that all nominations for every office to be filled were made from the floor. Then a ballot, with names to be written in for each office, was passed and at the call of the delegate's name he answered to the roll and deposited his ballot in a box at the front of the room—ballots being counted in front of the whole assembly. There was one contested position, that for the Speaker of the House. The Speaker, R. W. Fonts, Omaha, was elected over an able opponent, L. S. Goin, of Los Angeles.

The sessions were long and tiresome at best but much was accomplished by the men who gave freely of their time for the welfare of the profession. One thing that was noticed was the change to younger men in the House. There was much more of interest, but read the *State Journal* for August and the *A. M. A. Journal* for July 13th and 20th, for full details.

## THE LIBRARY CORNER

Reinhard, E. H.; Moore, C. V.; Bierbaum, O. S.; Moore, S., "Radioactive Phosphorus As a Therapeutic Agent." J. Lab. & Clin. Med., V. 31, pp. 107-218, 1946.

Radioactive phosphorus used in 30 patients with polycythemia vera produced remissions lasting from 6 months to several years with one course of treatment.

Keeney, E. L.; Ajello, L.; Lankford, E. and Mary L., "Sodium Caprylate, a New and Effective Treatment for Dermatomycosis of the Feet." Bull. Johns Hopkins Hosp. V. 77, 1945.

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I would like to again bring to your attention the fact that many journals have been removed from the Youngstown Hospital Staff library without any record having been made of that fact. An appeal is being made to those that use the library to abide by its rules.

Do not remove any books or journals from the library unless you record your name, name of book or journal, and date.

Also, please replace books on shelf after using. The value of the library lies in its completeness. Every effort is being made to make the library something living and valuable. This can only be done with the co-operation of everyone and your co-operation in this effort is solicited. S. K.

## NEWS

Mrs. J. J. McDonough and children, Jimmy, Billy and Carol, are spending the summer at the Red Bird Beach at Madison on the Lake.

Dr. and Mrs. L. G. Coe and daughters, Joan and Norma, are spending the month in Miami, Fla.

Dr. and Mrs. Morris Deitchman have arrived home from a sojourn at Balsam Lake, Fenelon Falls, Ont., where they were guests at Cedar Villa Lodge.

Dr. and Mrs. M. J. Kocialek have returned from a month's visit at Eaglesmere, Pennsylvania.

Dr. and Mrs. Barclay Brand-

millier, Mr. and Mrs. John Post, accompanied by Dr. and Mrs. Myron Owen, of Ravenna, were recent guests in the home of Mr. and Mrs. Wm. Neville Mullane, Newton Falls.

### Promoted To Major

Even though out of service, Uncle Sam didn't forget Dr. O. A. Axelson. Dr. Axelson received word the other day that as of November 28th, 1945, he was promoted to rank of Major.

Dr and Mrs. Stephen W. Ondash announce the birth of a daughter, Daleria Ann, July 8th, St. Elizabeth's Hospital.

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**"GOLF MEET"**



STEAM-WASHED PLATING ROOM where bacteriological analyses are made with every precaution to prevent contamination. All air taken into this glassed-in room is filtered. At frequent intervals, jets of live steam are employed to wash the air free of dust.

LARGE INCUBATORS, each with a capacity for 1600 Petri dishes, offer facilities for the numerous bacteriological tests made daily to assure the purity of Dextri-Maltose. Electrically heated and equipped with recording thermometers, the incubators can be varied from room temperature to 60° C. Uniform temperature is maintained within  $\pm 1$  degree.



## Only the Most Modern Equipment for Testing DEXTRI-MALTOSE

EVERY type of equipment conducive to speed and accuracy in bacteriological tests is available in the Mead Johnson Laboratory. Steam- and electrically heated sterilizers are automatically controlled. One of these has a capacity of 75 liters of media and required installation of a special steam line. Besides the large incubators shown above, the laboratory has a number of smaller ones which, together with cold-storage rooms, permit any desired temperature from  $-20^{\circ}$  to  $80^{\circ}$  C. There is complete centrifuge equipment, including a supercentrifuge with a capacity of 40,000 R.P.M. Small equipment is of similar high standard—precipitation glassware for measuring and sensitive balances for weighing, as examples. All these facilities, together with many others, have been proved worth while for sanitary control in infant feeding, as is shown by a quarter century of experience.

*"The True Measure of Economy Is Value, Not Price"*

**SANITARY CONTROL OF DEXTRI-MALTOSE . . . (NO. 6 OF A SERIES)**

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons. MEAD JOHNSON & COMPANY, Evansville 21, Indiana, U.S.A.