"Virtuous activity is identical with happiness.
—*Aristotle*

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
JULY • 1948
VOL. XVIII No. 7

The weight curves represented above are to be found in actual hospital (name on request) records of 75 *consecutive* infants fed on Similac for six months or longer. Not once in this entire series of 75 cases was it necessary to change an infant's feeding because of gastro-intestinal upset.

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MEDICAL CALENDAR

1st Tuesday	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
8:30 p. m.	Monthly Staff meeting, St. Elizabeth's Hospital, St. Elizabeth's School of Nursing
Sunday following 1st Tuesday 11:00 a. m.	Monthly Surgical Conference, St. Elizabeth's Hospital Library
2nd Monday 9:00 p. m.	Council Meeting—Mahoning County Medical Society—Office of the Society—Schween-Wagner Bldg.
2nd Tuesday 11:30 a. m.	Monthly Medical Conference, Youngstown Hospital Auditorium—Nurses' Home
8:30 p. m.	Monthly Staff Meeting—Youngstown Receiving Hospital Auditorium
3rd Tuesday 8:30 p. m.	Monthly Meeting—Mahoning County Medical Society—Hotel Pick-Ohio.
4th Tuesday 8:30 p. m.	Monthly Staff Meeting—Tuberculosis Sanitarium, Kirk Road
Every Tuesday 8:00 a. m.	Weekly Medical Conference, St. Elizabeth's Hospital Solarium
Every Tuesday 11:00 a. m.	Orthopedic Conference, St. Elizabeth's Hospital Library
Every Thursday 12:30 p. m.	Orthopedic Section, Library—South Side Unit, Youngstown Hospital
Every Friday 11:00 a. m.	Weekly Surgical Conference, Youngstown Hospital—Nurses' Home
	Urological Section, Library—S. Side Unit, Youngstown Hospital
	Clinico-Pathological Conference, St. Elizabeth's Hospital Library
Every Friday 11:30 a. m.	Clinic—Pathology Conference, Auditorium Nurses' Home South Side Unit Youngstown Hospital
Alt. Saturdays 11:00 a. m.	Obstetrical Section—North Side Unit of Youngstown Hospital

COMING MEETINGS

American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.

American Public Health Association, Boston, Mass., Nov. 8-12.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Sixth Councilor District Post Graduate Assembly, Akron, Oct. 13.

International College of Surgeons, St. Louis, November 15-20.

PRESIDENT'S PAGE

★ ★ ★

To read—what and when—is often a fond wish of every doctor and as often is difficult to accomplish. Our libraries are stocked with Books and Journals but actual perusal of all the material is impossible. This self-education which is so necessary to keep up to date is an art which requires time, correct material, perfecting of reading technique and much practice. Many of our members set aside a certain period each week for study of the current medical literature and so by sheer will power the time element is solved. The tremendous volume of scientific publications requires everyone to choose only those Books and Journals which give the most straight-forward and thought-provoking value to the chooser. This is naturally very individualistic and often is by trial and error. Medical College and Hospital Residency has trained us for the many daily mental and physical gymnastics of our profession but one phase has not been stressed in the average curriculum. This is the training to choose correct professional publications. Journal Clubs with required reading and review of modern medical literature furnish a good foundation for such experience. Perhaps our hospital training should activitate such clubs among our staffs.

We learn the art of reading in elementary school but rarely try to improve it later. The fast reader is the lucky one but most of us are not so blessed. One can read the title and the summary with study of the whole article if interest is aroused. An excellent experienced internist reports that he reads the first and last sentence of each paragraph and thereby digest many modern advances in medicine.

Then there is the storing of the knowledge—card indexes?—too cumbersome and time consuming—scrap-book filing?—rarely for the same reason—most of the time it requires extra shelving in our memories and thereby practice makes perfect but practice must exist.

July and August are vacation months and some of the spare time may be allotted to reading medical publications—or so thinks one at the moment!

JOHN NOLL, M. D.

BULLETIN of the Mahoning County Medical Society
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VOLUME 18 JULY, 1948 NUMBER 7

Published for and by the members of the Mahoning County Medical Society

DR. BORTZ ADDRESSES HOUSE OF DELEGATES

A modern health program requires the participation of leaders from all walks of life in every community, Dr. Edward L. Bortz asserted in his address at the Opening Session of the A. M. A. House of Delegates at the 97th Annual Convention. Because of their professional experience and training, members of the Medical Profession should guide the forming of satisfactory health programs. "With emphasis on prevention, prophylaxis, and the maintenance of vigorous, positive health, fewer patients should require hospital care and the level of health should be improved. Likewise, the costs should decline," he said.

Far from being reactionary, the A. M. A., said Dr. Bortz, has indicated by its history, spirit, interest, and aggressiveness in the search for better medical care. "Medicine, as a profession, is socially minded in action and outlook. The effectiveness of its activities may be found in the simple yardstick of the life span," he observed. "Since the turn of the century, medical science has brought about an increase in the length of human life to an all-time high of 67 years. The monetary benefits to the consumers, since we are consumer minded these days, are beyond calculation."

Dr. Bortz noted that congress has under consideration a number of bills relating to the problem of medical care in the event of national emergency. Organized medicine is obligated to aid in the development of an over-all program which will met the needs of the entire population but the A.M.A. is vigorously opposed to "discriminatory legislation" aimed at the drafting of physicians. Such legislation, he contended, is unconstitutional and could not be sustained in court.

A complete report of the convention will appear in the next issues of the Bulletin and our state and national journals.

CONSERVATISM

Press reports concerning the Palomar telescope are to the effect that the project of making and assembling the superior instrument has every indication that it will be a complete success. We will be in touch with inconceivable distances which can be recorded only in terms of light-years. We will have new bases for marveling at the vastness and the interrelation of the forces of the universe. We will have new reasons for marveling at man's ingenuity in bringing these into human understanding.

We will have additional tangible evidence that will make more real to us the immateriality which man recognized even in the days of his savagery. We arrive scientifically to what was once intuitive. We may demonstrate conclusively what has been an hypothesis. Primeval man was satisfied to sense this relationship between causative factors and remote effects without attempting to analyze the process. He allowed his wonder to become transcendent and gave it forms of worship. Sometimes the forms gave satisfactions that otherwise would not be his.

While the ancients "lifted up their eyes unto the hills," we tend to cease looking for help from extraneous sources, and try to develop within ourselves an adequate response to the forces already available. This, we feel, makes for progress that can be sustained. While it keeps us aware of our limitations, it encourages the establishment of places from which we may project our thought.

It is not easy, in these days of constant change, to hold fast to what we consider to be unchangeable. Most people look at the conservative as a hindrance to advancement. Yet he has been in good company throughout the history of mankind. The Greeks, who anticipated us in much of our thinking, thought well of the immutable; and extended the concept of stability into their ideas of government, as they would build it into their temples.

The best of Hebrew thinkers, in seeking foundation for religious convictions and social practices, kept going back to the origin of light "with whom is no variableness, neither shadow of turning." In this, they were not at variance with the Persians, whose search for stability had taken them to the sun.

Copernicus was not without a concept of stability that permeated mutable things. In contemplating the increasing immensity of the heavens with the incessant change of relations that resulted from endless expansion, he saw also persistence of the centrifugal force on which this constant motion depended.

Newton saw, inherent in matter, properties which could be extended indefinitely throughout the universe, and which were applicable within the concept of change, properties which were changeless.

Leibnitz could see continuity, even in implied force that persisted and could be revived after motion had ceased. He could see conservation of power through persistence in the effects; and thought that nature would retrograde if it were not so preserved. Our modern concept of radiant energy supports his view.

However, it may be contended that reference to these basic inanimate forces has little or nothing to do with man's conscious, self-determining power, which has so much to do with shaping his course and in determining his end. Indeed?, Emerson would ask. To which the genial Holmes would add that "the fluent, self-determining power of human beings is a very strictly limited agency in the universe."

1948

We like to appreciate man's audacity and his increasing efficiency; but we cannot feel that his social affairs are entirely separated from natural phenomena. We may not be able to discern laws that are identical in the material and the immaterial aspects of the universe; for man, who presents both these aspects, finds himself to be the least understandable of all things of which he would have knowledge.

The skepticism which was distinctive of the eighteenth century has continued unabated into the middle of the present century. Where it has applied to physical phenomena and their interpretation, the result has been greater accuracy in observation, more careful deductions, and synthesis which excites the wonder of the age.

Where this skepticism has pertained to intellectual and ethical matters, the influence has been destructive. Through misuse and neglect, old foundations, upon which character had been built, no longer give adequate support. Insincerity and exhibitionism are to be seen in much of our esthetic, social, economic and political affairs. That which is extreme, the questionable, even the false, and sometimes the obscene, are presented as if they were legitimate successors to a decadent conservatism. These are altering our standards of judgment, and are making us less discriminating in our intellectual and moral problems. This is in contrast with our scientific insight and accomplishments.

This striking difference between our scientific and our cultural interests, tends to produce the impression that man has penetrated the universe, both near and far, and has found only mechanism. However, this attitude is not prevalent among the scientists themselves. They have found continuity and persistence of force operative in ways that are indicative of intelligence, conservative as well as constructive. To them, doubts have not become the consummation of wisdom, but its beginning.

In this age of enlightenment and of undoubted progress, we need revitalization of the ancient idea of holding fast to the good until that which seems to be better has been scrutinized, established and incorporated. We may hope for reaction from this debilitating unrestraint. Then conservatism may come into its own.

W. D. C.

THE MEDICAL CRIER

A Page of Sidelights, News, and Views in the Medical Field

Italy in the year 1500 was at the height of the second or greater Renaissance and very near its decline. Filled with brilliant scholars and artists, dominated by rich and powerful lords, populated by an industrious and pleasure loving people, the land had no national unity nor, indeed, felt any need of any. While the rest of Europe with the exception of a few cities was still comparatively poor, the wealth of Italy was incredible. Her merchants had prosperous manufactures and extensive foreign trade, her bankers were the financiers of the world. Italian silks and cloth were exported to all parts of Europe, although Venice still retained the greater part of the carrying trade of the world in her ships.

Florence and Rome vied with each other in patronizing the arts and sciences. Eustachius was professor at the Collegia della Sapienza at Rome, and Fallopius was studying the anatomy of the chorda tympani, the semi-

circular canals, the sphenoid sinus and the tubes bearing his name. Thomas Linacre, the physician to Henry VIII of England was educated in Italy and graduated at Padua.

Into such an atmosphere of learning and artistic achievement was born Benvenuto Cellini at Florence in 1500. His parents, married 18 years, had no son although they had lost two children due, he says, to the unskilfulness of the doctors. When this lusty male survived the ordeal of birth, his father said, "Let him be called Welcome-Benvenuto." Educated to be a musician, he rebelled against his father's plans and made himself a goldsmith. Although not an outstanding figure in his day, he did manage to leave behind him a few excellent examples of his art, and an autobiography which is very human and readable and affords the reader many interesting sidelights of the customs and manners of his time. Written in a bombastic style with his own prowess and skill highly exaggerated, it resembles the mouthings of Theophrastus Bombastus Von Hoheim and other individualistic characters of the past. Moreover, Cellini was greatly interested in medicine especially as it affected his own health, and his descriptions of his symptoms, methods of treatment, and of epidemics are very interesting.

Bubonic plague was the great scourge which marched with solemn tread all over Europe in the Middle Ages, and it is not surprising that Cellini describes it, for he was a victim at the age of twenty-three, at a time when thousands were dying every day in Rome. He describes his illness thus:

"I rose upon the hour of breaking fast, and felt tired, for I had travelled many miles that night, and was wanting to take food when a crushing headache seized me, several boils appeared on my left arm, together with a carbuncle which showed itself just beyond the palm of the left hand where it joins the wrist. Everybody in the house was in a panic; my friends all fled. Left alone there with my poor little prentice, who refused to abandon me, I felt stifled at the heart, and made up my mind for certain I was a dead man.

"Just then the father of the lad went by, who was physician to the Cardinal Iacoacci, and lived as a member of that prelate's household. The boy called out: 'Come, father, and see Benvenuto; he is in bed with some trifling indisposition.' Without thinking what my complaint might be, the doctor came up at once, and when he had felt my pulse, he saw and felt what was very contrary to his own wishes. Turning around to his son, he cried: 'Oh, traitor of a child, you've ruined me; how can I venture now into the Cardinal's presence?' Then the doctor turned to me and said: 'Since I am here, I will consent to treat you. Considering the sores are so new and have not yet begun to stink, and that the remedies will be taken in time, you need not be too much afraid, for I have good hopes of curing you.' And so we went on by the help of God: and the admirable remedies which I had used began to work a great improvement, and I soon came well out of the dreadful sickness."

Cellini does not say what the admirable remedies were, but his recovery was probably due to the waning virulence of the epidemic and his own robust physique. Today although the cause and mode of transmission is well known, treatment of laboratory animals with streptomycin and sulfonamides has proved disappointing. The Pasteurella Pestis yielded to the Public Health worker long before ambiotics were known.

J. L. F.

1948

SURGICAL CONFERENCE

Youngstown Hospital Surgical Staff—March 5, 1948

Reported by DOCTOR S. KLATMAN

DR. ALEXANDER: This is the case of a 29 year old colored girl who had never been pregnant before and who came into the hospital with a history of having her last normal menstrual period on the 22nd of September. She was admitted on the 24th of February. She claimed that between the 22nd and approximately the 20th of December she "spotted" and had several episodes of lower abdominal cramps with a slight brownish vaginal discharge all the time until the 20th of December at which time she had an episode of very severe abdominal cramps with moderately severe vaginal bleeding. This episode quieted down and after that she had no more vaginal bleeding, she had no more abdominal cramps, but her lower abdomen was very tender to the touch. It was so tender that she was unable to wear a tight belt. She had persistent vomiting and she vomited at least once a day between the 20th of December and the time of her admission. Her lower abdomen became progressively larger. On the morning of February 24th she had a severe vomiting spell which left her feeling dizzy and weak until she was unable to stand and she was sent into the hospital.

Examination on admission showed a well developed, well nourished, pale, washed out negress. Her pulse was 120, respiration 30, blood and general physical examination was negative, except for the abdomen. Her abdomen was soft and slightly distended. There was a mass in the lower abdomen, which gave the impression of being the uterus enlarged to approximately 2½ fingerbreadths below the umbilicus at the mid line. There was another mass which could be delineated from the smaller mass extending up the left of the umbilicus to approximately one fingerbreadth above the umbilicus. Both of these masses were extremely tender. Pelvic examination showed the cervix to be pushed anteriorly quite some distance. The cervix was very soft and dialated. It was confirmed by pelvic examination that the smaller of the masses was the fundus of the uterus. There was a large fluctuant mass which filled the entire posterior cul-de-sac and was exquisitely tender so that rubbing your fingers over lightly gave her quite a bit of pain. You couldn't make out what this large abdominal mass was due to the fact that she was so extremely tender, but a diagnosis was made at the time of an extra-uterine hemorrhage, with extra-uterine pregnancy with intra-abdominal hemorrhage. Her red blood count upon admission was 3,000,000, urinalysis showed nothing of any note. Her white count on admission was 48,750 with 94% polys. of which 9% were stab cells. She was given a blood transfusion and was taken to surgery.

Upon opening the abdomen a large amount of both bright red blood and old clotted blood was encountered. The smaller of the masses was again confirmed to be the uterus. The left tube was finally identified as the larger of the abdominal masses. The left tube was pulled down posteriorly into the cul-de-sac to which the placenta was attached. Within this tube there was a fetus which approximately was a 5 months gestation which incidentally was alive because it made 2 or 3 respiratory efforts after it had been delivered. The head was pointing downward, the buttocks upward. The head was markedly deformed, with bilateral club hands and club feet, and there was a gross deformity of the right humerus so that there was quite a bit of bowing.

A salingectomy was done and it was necessary to do a hysterectomy in order to get out all the bleeding surfaces. She did have a fibroid uterus, incidentally. There was considerable bleeding from the placental site so it was necessary to shell out the placenta and pack the cavity with gauze pack. There was tremendous *decidual* reaction within the uterus.

The woman had had an uneventful post-operative course. She suffered the first few days with a little abdominal distention, but when the pack was removed, the distention disappeared. Her temperature varied from 101.8 to normal.

DISCUSSION

DR. ALTDOERFFER: As a rule the placenta is not removed but left alone. But in this case, the placenta was loose and there was considerable bleeding from the site. We had a good anesthesia and before we were through she had 6 pints of blood and 2 pints of plasma so we did have lots of blood.

Last summer I had a case of abdominal pregnancy in which the placenta was not removed. As the woman advanced in pregnancy, the placenta stayed very high in the abdomen until 2 months ago when this mass had dropped from the right upper quadrant to the lower left quadrant. It felt very cystic and hard and I thought she had some kind of dermoid or embryonal cyst. It didn't get any smaller so I brought her in and the laboratory said it was a placenta. It looked very much like a dermoid cyst, except for the area of discoloration.

DR. ANDERSON: I've looked over some of the literature in abdominal pregnancy and also in the relation to what happens in the placenta.

About 1½% of all pregnancies are extra-uterine and most of these fall in the tubular variety. There was a series of 300 cases reported in Chicago. They reported that only one of these was abdominal, so that makes the abdominal pregnancy pretty rare, and then to come to a full term pregnancy makes it even rarer. There are a few cases reported in the literature of primary abdominal pregnancy and the diagnosis is made when no pathology or any suggestion of pathology is found in either tube and there is no evidence of the fistula connecting the uterus to the peritoneal cavity. The literature generally advised that the placenta in abdominal pregnancies be left alone, especially if they are attached to any organs such as the rectum or vascular organs, because implanted in the abdomen, there's no chance of *decidual* reaction to occur. Thus, the placenta cannot be stripped off. To remove the placenta in the abdominal pregnancy is to tear it off and this can cause a lot of damage.

DR. NELSON: I think last year we had a case, in which the diagnosis was not completely made. She jaundiced, so, we didn't do anything except give her a lot of blood and she finally, after 4 or 5 weeks went out west and she was operated on and we got word that she was obviously a tubule abortion with bleeding.

I think the idea of having to leave the placenta in should certainly be modified because when the placental site is bleeding, you have to take it out and pack it.

Health Department Bulletin

REPORT FOR MAY, 1948

	1948	Male	Female	1947	Male	Female
Deaths Recorded	186	121	65	158	86	72
Births Recorded	461	253	208	520	272	248

CONTAGIOUS DISEASES:

	May 1948		May 1947	
	Cases	Deaths	Cases	Deaths
Chicken Pox	83	0	60	0
Measles	159	0	40	0
Scarlet Fever	4	0	5	0
Whooping Cough	5	0	10	0
Tuberculosis	1	1	6	4
Mumps	4	0	2	0
Syphilis	38	0	39	0
Gonorrhea	16	0	0	0

VENEREAL DISEASES:

	Male	Female
New Cases	16	6
Syphilis	3	3
Gonorrhea	13	3

Total Patients 22

Total visits to clinic (Patients) 481

W. J. TIMS, M. D.
Commissioner of Health

UNCLE DUDLEY

The number of years we waste in our life is of no more importance than are those years in which we are extremely busy without extracting wisdom from our experience. The busy years, we usually think of as being constructive; but they may be barren of thought that lives beyond the day.

★ ★ ★

What would the world have done if men had never become ambitious? What the world has suffered because of it! Could the idea be true that whatever is, is right?

★ ★ ★

In our quest for certainty, we may be assured that the difference between what we think we see or feel and the object of our perceptions, will always keep knowledge relative. It may well be that human development consists essentially in the increasing ability to approximate the relative to the absolute.

CURRENT ASPECTS OF REHABILITATION

By MRS. ESTHER C. SPENCER

Director, Rehabilitation Services, Mahoning Tuberculosis Sanatorium

Delivered before the Mahoning Tuberculosis Sanatorium Medical Society, April 27, 1948.

You who deal daily with the problems of illness, good health, and the important attribute of good health—normal work experience, are probably seeking constantly to find something worth talking about concerning rehabilitation. I know that you would not deny the efficacy of rehabilitation. However, most of us dismiss the subject with a figurative pat on the head, covered verbally by the shibboleth that no sanatorium can afford to be without it. We generally support, with varying proportions of finance and enthusiasm, the inception of a program to bring rehabilitation to the handicapped and institutionalized. Yet our concern for the program itself usually stops there. Moreover, when the term rehabilitation is mentioned the immediate identification is somewhere away from our own lives, and frequently encumbered by the walls of the institution or by some psychological appurtenance which shuts us off from knowing realistically what is happening in that other province. Efforts should be made to overcome this attitude.

It is rather difficult to define the helping process which deals relatively tangentially with physical disability or well being. This is especially true since the most general concept of rehabilitation includes everything which makes a sick person feel better and the most limited concept speak of it as getting the handicapped individual a job, and for the sake of statistics, seeing that he keeps it. Various agencies have been set up in the former or latter philosophy and, each type of agency, can in terms of statistics, show successful figures.

The Federal Security Agency, for example, supports and gives impetus in each State to a Department of Education, which in turn activates and staffs a Bureau of Vocational Rehabilitation. This Bureau is set up to offer, under Public Law 113, five services:

1. Vocational training.
2. Room and Board, where necessary, during training.
3. Medical care which will render the person employable.
4. Psychiatric care which will render the person employable.
5. Job placement.

Consonant with this service, the Bureau should be able to provide counseling, and psychometric tests which aid in vocational guidance and training. Unfortunately the State of Ohio has never seen fit to appropriate sufficient funds to match potential Federal assistance so that all of these services may be offered. The legislature of the State of Ohio consistently maintains that it is not the function of the Bureau of Vocational Rehabiltation to provide room and board, while studying, to a promising candidate for rehabilitation. They aver that it is some other agency's function to assume this responsibility. Let us see how that works out in actual practice.

We have, at the sanitorium, an eighteen year old patient who will soon be well. He is finishing high school during hospitalization. Pre-discharge investigation reveals the fact that his home environment would be extremely detrimental to the maintenance of good health. This means that a more adequate outside situation must somehow be found before the patient may conscientiously be discharged. Our logical channel for seeking this aid is the Bureau of Vocational Rehabilitation. We are told that the Bureau can

only accept the case for vocational training,—someone else must provide the funds for living costs. This means that the patient faces discharge with more concern than that to which he should normally be subjected. He will tend anyway, to worry about his disease which he knows can reactivate. He worries about reintegrating himself into a now strange and often terrifying society. We know that all tuberculosis patients contemplate discharge with a combination of anticipation and dread. This patient has even greater conflict because, not only is he torn between wanting to be with his family and wanting to do what is most advantageous to his health, but he is beset with the insecurity of having to use the help of two agencies, and frequently more than that, when he is not even sure that one agency will be dependable in what he views as, an untrustworthy, total situation. He must submit to a division of his depleted resources for making relationships, when we know that for good mental health, and, hence, for a consolidation of the gains made in the hospital, he should learn to rebuild the structure of his interpersonal relationships around a satisfying contact with one representative of the professions set up in the goal of giving him this opportunity. This is not an isolated case.

Other types of rehabilitation agencies and programs are the sheltered workshop, the physical medicine program of the Veterans Administration and some intramural programs taking place in scattered sanatoria throughout the country. Examination of a good many of these reveal the fact that certain planning which looked satisfactory on paper has not worked out too well in actual practice. This is sometimes true because areas of function are so overlapping that there is rivalry among members of the ancillary staff. This rivalry tends to undermine the concept of teamwork making it nothing more than a tidy abstraction. In such instances, the highly advertised versions of revolutionary rehabilitation methods, and their results, hold true for only a handful of cases. The others are the expensive recidivists which we find so alarming, primarily in terms of wasted human material, but which should trouble us, too, as taxpayers.

Rehabilitation should not invariably be offered as soon as the patient has been pronounced medically feasible nor is it, at that moment, a reliable safeguard against morbid interspection. The patient demonstrably cannot be exposed to such a program before the more challenging and painstaking process of helping him use all of the services designed to get him well is undertaken. There are some basic principles which, if followed conscientiously, may result in more than lip service and which are rewarding both to patients and personnel. For the sake of professional standards, of spending community funds wisely and for long range gains in salvaging our handicapped, they are the fundamental criteria.

1. A steady and continuous effort should be made to define positively and, yet, exclusively, the peculiar function of each member of the ancillary staff. This is only accomplished where there is willingness to participate in the dynamic exchange which should take place in regular, periodic, case conference presided over by the medical head of the program and implies mutual respect for the skills and training of those participating.

2. Function may become sharpened and more clearly defined through an integrated, in-service training program including lectures by appropriate personnel and through supervision which involves ascertainment of contiguous

areas of activity. This may be utilized to highlight function and again to foster growth in the understanding of and belief in the service which the other person offers. Value of each service must be emphasized, by the supervisor, strongly and unselfishly.

3. A continuing study should be kept regarding points of referral of patients' problems and in-sanatorium education should, from time to time, center around proper channels of referral, so that problems may be handled expediently and before techniques for solution are tried by those not skilled to use them.

4. No patient should be urged to share in a vocation rehabilitation plan until he is psychologically ready to do so. Gauging of this readiness must be left to conference decision rather than to individual determination. Some patients have been so fearful regarding premature vocational discussion that they have retrogressed medically. It appears that this phenomenon is, in effect, an unconscious desire to prolong residence in the protecting environment since vocational planning symbolizes the fact that the time to give up such dependency is drawing near. Adequate and intensive preparation must take place before the patient can be expected to think outside the engrossing problem of his illness per se.

5. Efforts should be bent towards leaving as much responsibility as possible in the hands of the patient for effective rehabilitation planning. However, along with this there is a need for skillful use of the helping process in revitalizing or creating this sense of responsibility which is frequently diminished or nullified in the demands which the illness makes upon him.

6. Rehabilitation projects should be designed in a graduated plan, becoming more and more complicated as the patient demonstrates greater and greater ability to absorb. This tends to give a sense of achievement and ego satisfaction which are so necessary in the struggle to emerge from the trappings of dependency.

7. The rehabilitation setting should strive more and more to duplicate community situations so that the patient may have ample opportunity for reality testing and so that the gap between institutional and community living may be bridged.

8. All cases must be examined and re-examined not for crowing over purposes in those which have been successful, but for augmenting skills in those which yield slowly or not at all.

Parenthetically, every medically hopeful patient who leaves a hospital prematurely against advice represents a breakdown in one of the segments of the rehabilitation framework. Every patient discharged with a good prognosis who returns to the hospital in a worsened condition represents a failure in the total structure of rehabilitation, including the resources of outside agencies whose work is desperately essential throughout the course of treatment.

We are attempting to incorporate all of the above thinking in our rehabilitation plans at the Mahoning County Tuberculosis Sanatorium. These concepts are an integral part of the structure of specific rehabilitation courses which include instruction in shorthand, typewriting, bookkeeping, accounting, sewing, homemaking, and all grade and high school subjects.

Your interest in our program and in the total objective of rehabilitation is needed and wanted.

H. K. G.

DIABETES 1926—1948

MORRIS DEITCHMAN, M. D.; F. A. C. P.

In a busy lifetime one has little leisure to sit, think, and just digest ones impressions. Given such leisure it is natural that one does a certain amount of arm chair exploring—a permissable amount of reminiscing—and by combining the two one may presume to make some inductive predictions. This is ultra-unscientific, of course, in the sense that the predictions are based on assumption or hunches rather than on experimentation or facts based on research.

More than twenty years of experience with diabetics of all ages; and of various degrees of intelligence, cooperation and self control, has convinced me that there is not much question as to the truth of the statement that "70% of diabetics of 15 years duration develop arterial disease regardless of method or the degree of regulation." (Wilder) Others say the arterial disease is near 100%. This then presumes that the reason retinopathy and Kimmelstiel-Wilson's disease are so prevalent, is because we have been able, with insulin and diet, to keep diabetics alive at least the necessary 15 years for the development of this pathology. Hagedorn, the discoverer of protamine insulin, states it thus "if we venture to imagine that a vascular disease is the common cause of diabetes—retinitis, nephropathy and other complications, even the complete compensation of the diabetic symptoms cannot prevent the complications, while poor treatment may permit early death of diabetics so that complications do not develop."

After twenty years it is possible to say that any diabetic diet will presumptively achieve the same result. The only exception is the obese diabetic who can apparently escape the arterial changes by reducing weight. Adequate diet can be anything, but in general one can say that it approximates the normal diet of 200 carbohydrate, 100 protein and 100 fat. No attempt must be made to restrict the diet to avoid the use of insulin. Starvation diets were all the rage in 1914, and were a distinct addition to the armamentarium of the physician treating diabetics when Frederick Allen first introduced this method of treatment. However, there is no necessity for any such primitive treatment today.

In twenty years I have seen the prejudice among physicians, against insulin almost entirely disappear. The resistance of patients to insulin can be readily overcome by an intelligent but simple explanation of the general metabolic benefit derived from its use.

Adequate control is as difficult to define as adequate diet. Frank Allan of the Lahey Clinic summarizes his objectives as follows: (1) "Aim for complete control of hyperglycemia and glycosuria in early diabetes, in juvenile cases, and in the obese cases. (2) Less complete control may be satisfactory if glycosuria cannot be controlled without hypoglycemia or when patients are over 60 years old."

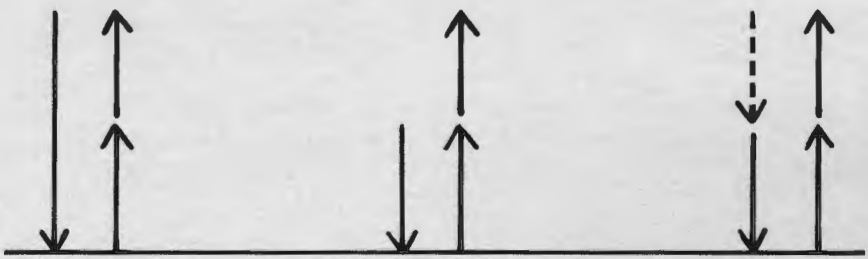
Many "diabetic specialists" insist on absolute control, i.e., no hyperglycemia or glycosuria at any time. I do not believe this is either necessary or desirable. Experience has led me to develop a great respect for hypoglycemic reactions, especially in patients with arterial disease. The manifestations are very bizarre and even an expert may not recognize some of them.

Treatment in diabetic coma is still fought over at each meeting of the American Diabetes Association by those who advocate and those who oppose the use of glucose. I believe that the experimental work of Cori, Soskin, Rabinowitch, and many others has proven that glucose given intra-venously

is more available than the glucose already in the blood hyperglycemia. Adequate dosage of insulin must be administered to cover. The insulin dosage need not be excessive if available carbohydrate is present. Acidosis and coma are evidence per se of loss of homeostasis in the liver. Hyperglycemia with its resulting glycosuria inevitably induces liver glycogen exhaustion. With glucose and insulin the homeostatic mechanism can be restored. There is no disagreement about the use of salt and fluid, but these too can be given to excess, and produce edema and left ventricular failure in a strained organism.

With understanding of the etiology of acidosis it seems evident that the mortality from diabetic coma must drop sharply if our hospitals can be organized so that a definite program could be followed. Too often the diabetic in coma is under the care of a physician whose orders are being carried out by an intern who is too busy or too tired; and nurses who cannot tell hyperglycemia from coma due to other causes. Diabetes is the 8th cause of death in the U. S. A. Fewer of these deaths should be due to coma. Perhaps the answer is a missionary lay organization similar to "Alcoholics Anonymous."

Everyone treating diabetics is intrigued by the excessive arterial disease of a rather specialized type occurring in the diabetics who have survived long enough. I have been intrigued by a possible endocrine explanation of this condition which is based on well known experimental work, up to a certain point. One must reach on from that point, into the realm of probabilities.



Homeostasis **Diabetes** **Diabetes plus Insulin**

To understand this arm chair hypothesis one must first delve into the problem of homeostasis. The sketch above is after Albright and Fraiser and the keys to it are as follows. The downward arrow is insulin lowering the blood sugar by its effect on the liver, and the upward arrows are the blood sugar elevating effect of adrenotropic and glycotropic hormones. Given a normal individual, the homeostatic mechanism is automatic, rapid and smooth without either hypoglycemia or hyperglycemia. It is presumed that there is no abnormality in the liver or in the gastro-intestinal tract to interfere with the regular absorption of carbohydrates or carbohydrate producing foods. One can graphically picture the normal homeostatic individual in this diagram as the balance between the insulin arrow lowering the blood sugar, and the adrenotropic and glycotropic arrows trying to return the blood sugar to normal levels: This is an automatic oversimplification only in the sense that we see the overall picture rather than all the intermediary steps. The second group of arrows will illustrate loss of homeostasis as it occurs in

diabetes, resulting in an elevated blood sugar due to a short insulin arrow, too short to counterbalance the adrenotropic and glycotropic arrows. The dotted arrow illustrates the addition of insulin to balance this deficiency. It is evident that even with long acting insulin the imbalance in the diabetic between insulin and the anterior pituitary and adrenal hormones probably exist a good deal of the time. Can we correct this imbalance?

Hans Selye et al reported in the Canadian Medical Association Journal in 1945 that the administration of Desoxycorticosterone acetate and anterior pituitary hormone to rats produced nephrosclerosis and lesions resembling periarteritis nodosa in coronary, renal and mesenteric arteries.

It is interesting to speculate if there is any relationship between this relative oversupply of the adrenotropic and glycotropic hormones in the diabetic and the incidence of arterial disease. Is the process so slow that it has become evident only since the increased longevity of diabetics resulting from this general use of insulin? Must our attention be directed now toward counteracting the effect of these hormones on the arteries. The greater sclerosing effect seems to come from the D. C. A. and anterior pituitary. Perhaps the administration of D. C. A. to depancreatized dogs might produce Kimmelstiel-Wilson disease somewhat similar to that in the Lukens dog. Being an armchair hypothesis, it obviously leaves much to speculation.

Summary (1) It is obvious that in spite of all optimism, diabetics are doomed to become prematurely arteriosclerotic and therefore a social and economic problem. (2) If they live long enough their care will become prohibitive for the ordinary family, and institutional care or government aid will be necessary. (3) Is our next advance to result from endocrine research which will shelve the adrenal cortex aid or the anterior pituitary?

THE RENAL FACTOR IN THE GENESIS OF EDEMA

By Dr. J. G. G. BORST

In normal man the kidney reacts promptly to the drinking of 1½ liters of water; within 3 hours the whole amount is excreted. The sodium chloride concentration in the urine is low and the amount of it excreted is not significantly higher than in a control period.

When 1½ liters of 0.9 percent saline is taken, its excretion takes more time, but within 24 hours the extra amounts of water and sodium chloride are excreted in their entirety.

Verney demonstrated that after the drinking of water the following sequence occurs:

> Fall in the sodium chloride concentration of the blood
> Decrease in secretion of anti-diruetic hormone by the neurohypophysis (posterior pituitary) into the blood Physiologic "diabetes insipidus."

A similar increase in the water excretion can be produced by the injection of a small amount of hypotonic solution of sodium chloride into the carotid artery. On the other hand, injection of hypertonic saline causes a reduction in the volume of the urine and a considerable rise of its sodium chlor-

ANNUAL GOLF MEET

PHYSICIANS DENTISTS

The Annual Golf Meet will be held in conjunction with the Corydon Palmer Dental Society at the

Youngstown Country Club

Thursday, August 19, 1948

Fun Starts at 1:30 P. M.

GOLF - - DINNER - - PRIZES

No Dinners Served Without Reservations

(Return reply postals at once)

ide concentration. This highly important mechanism is essential to the maintenance of a normal osmotic pressure of the body fluids.

The mechanism of the increase in the output of water and sodium chloride following the intake of 0.9 percent saline solution is unknown; certainly there is no detectable increase or decrease in the concentration of sodium chloride in the blood.

Patients with nephrosis and with heart failure have no such increased excretion of water and sodium chloride following the oral ingestion of saline solution. It has been assumed that in such cases sodium chloride is retained by the tissues and is not "available" to the kidneys. This explanation is unsatisfactory, as more than 100 liters of glomerular filtrate are formed each day. Normally approximately 98% of the water and sodium chloride of this filtrate is reabsorbed by the tubules, but in nephrosis and in heart failure the reabsorption is more nearly 100%.

Observations on patients with bleeding from a peptic ulcer shed a new light on this problem. Following gross hemorrhage into the gastro-intestinal tract the urinary output of water and sodium chloride is markedly reduced. The urine, quite often, is nearly free of sodium chloride, while at the same time there exists an increased sodium and chloride concentration in the blood plasma. The urinary output of potassium, urea and creatinine, concomitantly, is quite high, indicating satisfactory excretory powers of the kidney in respects other than those pertaining to salt and water.

Such retention of water and sodium chloride ceases as the volume of the circulating blood begins to reach more normal levels—whether this occurs following a blood transfusion, or spontaneously. This points to the existence of a mechanism for the regulation of the blood volume, as follows:

reduced blood volume
retention of sodium chloride and water
increase in plasma volume.

When, during the period of post-hemorrhagic blood dilution, 0.9 percent saline is administered, part of the water is lost by perspiration and (a minimal) urinary excretion; sodium chloride is retained and the level of sodium and chloride in the blood plasma rises. A rise to more than 150 percent of normal has been observed to occur when the intake of plain water is prevented and physiologic loss of water is met by repeated infusions of normal saline.

In restricting the fluid intake and promoting the urinary output of water by the administration of urea, a similar retention of sodium and chloride in the presence of their high levels in the blood plasma, has also been produced in patients with edema due to nephrosis, heart failure, and cirrhosis of the liver with ascites. This suggests the existence of a more complicated mechanism, viz:

low blood volume
low venous pressure
(Starling's law of the heart)
low cardiac output
retention of water and sodium chloride
increased plasma volume

After hemorrhage and in patients with nephrosis the blood volume is small. In Laennac's cirrhosis a large part of the circulating blood is in the portal system and a decreased venous pressure, in the rest of the circulation, results. In heart failure, the damaged heart fails to respond (with increased cardiac output) to the increased venous pressure. Transfusion of 2 liters of blood, in patients with nephrosis, increased the venous pressure from a

ANNUAL MEETING OF MEDICAL-DENTAL BUREAU

The 14th Annual Dinner Meeting of the Medical-Dental Bureau was held on Tuesday, June 29th, at the Youngstown Country Club.

The meeting was the largest in the history of the Bureau which indicates the wide interest of its members. Many important activities and services of the Bureau were discussed and a good time and mutual understanding prevailed.

The following officers will serve for the coming year: W. H. Hayden, D.D.S., President; G. M. McKelvey, M.D., Vice-President; A. J. Brandt, M.D., Secretary; C. A. Gustafson, M. D., Treasurer; M. W. Neidus, M. D., Ass't Treas.; G. E. DeCicco, M. D.; R. E. Odom, M. D.; M. W. Baker, D. D. S.; H. E. Kerr, D. D. S.

PENSION EXAMINATIONS

Any physician who is interested in doing pension examinations for the Veterans Administration either on a part time or fee basis, should contact Dr. Sidney Franklin, local Chief Medical Officer, 910 Union National Bank Bldg., Telephone 4-5161.

TRY PABENA ON YOUR VACATION

Vacations are too often a vacation from protection foods. For optimum benefits a vacation should furnish optimum nutrition as well as relaxation, yet actually this is the time when many persons go on a spree of refined carbohydrates. Pabena is a food that "goes good" on camping trips and at the same time supplies an abundance of calcium, phosphorus, iron and vitamin B complex. Pabena can be prepared in a minute, *without cooking*, as a breakfast dish or used as a flour to increase the mineral and vitamin values of staple recipes. Packed dry, Pabena is light to carry, requires no refrigeration. Easy-to-fix Pabena recipes and samples are available to physicians who request them from Mead Johnson & Company, Evansville, Indiana.

FOR RENT

PROFESSIONAL OFFICE: Waiting Room, Consulting Room and Surgery, in old established location. Suitable for physician or dentist. Can be seen at 224 North Phelps St.

TB STAFF MEETING

The staff meeting of the Mahoning County Tuberculosis Hospital will be held in the evening of July 27th, at the auditorium of St. Elizabeth's Hospital, at which time there will be a talk by Dr. M. M. Yarmy on "Care of Diabetics." This talk was originally scheduled for the June meeting but due to the A. M. A. meeting, was postponed.

low level, to one above normal, and resulted in a thirty fold increase in the urinary output of water and sodium chloride. Reinjection of removed ascitic fluid, into the veins of a patient with Laennec's cirrhosis, likewise, was followed by a rise in venous pressure and a concomitant rise in the excretion of water and sodium chloride. In all patients, except those in cardiac failure, the urinary excretion of water and chloride appeared closely correlated to the pressure in the jugular vein. After digitalization of certain patients with heart failure, the urinary output of water and sodium chloride increases markedly, and their excretion, once again, can be related to venous pressure levels.

The diuresis which occurs during the attacks of some cases of paroxysmal tachycardia is probably accompanied by an increase of cardiac output. In one patient, it was found, that, during the attack, the output of chloride increased simultaneously with the output of water.

Thus, the increase in excretion of water and sodium chloride in normal man, after the oral ingestion of normal saline, appears to be mediated through an increase in circulating blood volume, and an increase in cardiac output, secondary thereto. Conversely, the retention of sodium chloride and water in certain pathological conditions, appears correlated with a decreased cardiac output.

The pathways, through which the stimulus of an inadequate cardiac output operates on the kidney, are still unknown. The picture of retention of sodium chloride in combination with an increased urinary excretion of potassium, appears the very opposite of that encountered in Addison's disease, suggesting a hyperfunctioning of the adrenal cortex. However, the retention of sodium chloride, in the presence of a high plasma sodium level, could not be reproduced by the injection of even massive amounts of adrenal cortical extract of desoxycorticosterone.

References:

J. G. G. Borst. The cause of hyperchloraemia and hyperazotaemia in patients with recurrent massive haemorrhage from peptic ulcer. Acta Med. Scand. 97:68, 1938.

J. G. G. Borst. The maintenance of an adequate cardiac output by the regulation of the urinary excretion of water and sodium chloride; an essential factor in the genesis of oedema. Acta Med. Scand. Supplement 207, May 1948.

CYNICAL SAM

The philosophers who had thought that they had discovered order throughout the universe, didn't come to that conclusion through observing how the human being thinks.

★ ★ ★

How inconsistent we are! We read history to learn the truth of the past, yet do not resent the untruth which is now becoming history.

★ ★ ★

When some anthropologist, a hundred thousand years from now, digs into your burial site in order to find what kind of creature you might have been, all that will have remained will be a few porcelain teeth fastened to a metal bar. The dentist will have left his mark, though there be nothing left of you.

THYMOL TURBIDITY TEST IN VARIOUS DISEASES

The thymol turbidity test cannot be regarded solely as a test of liver function but should be looked upon only as a measure of abnormal serum protein pattern, not necessarily related to liver function. The test is of greatest value in following the progress of cases of infectious hepatitis. Both thymol turbidity and cepalin flocculation are frequently positive in lymphogranuloma venerean and rheumatoid arthritis. Negative thymol turbidity and cephalin flocculation tests are helpful in the differential diagnosis between obstructive jaundice and hepatogenous jaundice. Positive results, however, should not be relied on to rule out the possibility of obstructive jaundice. The thymol turbidity test is frequently positive if obstruction is complicated by cholangitis. Neither the thymol turbidity nor the cephalin flocculation test is of value in following the progress of cases of cirrhosis.—Hyman B. Stilleman, Journal of Laboratory and Clinical Medicine, May, 1948.—Submitted by Dr. J. D. Miller.

MYOCARDITIS IN INSTANCES OF PNEUMONIA

The hearts of 67 patients with bronchopneumonia, involving at least one lobe of the lungs, were studied by multiple microscopic sections. Twenty-six of these revealed inflammatory changes sufficient to warrant the term "myocarditis." The outstanding clinical criteria pointing to the diagnosis were found to be: Disproportion between the pulse rate and the temperature, drop in arterial pressure, cyanosis out of proportion to the apparent pulmonary involvement, and unexpected death. Six of these patients exhibited electrocardiographic abnormalities.—Otto Saphir and George D. Amromin, Annals of Internal Medicine, May, 1948.—Submitted by Dr. J. D. Miller.

BACKGROUND

The use of cow's milk, water and carbohydrate mixtures represents the one system of infant feeding that consistently, for over three decades, has received universal pediatric recognition. No carbohydrate employed in this system of infant feeding enjoys so rich and enduring a background of authoritative clinical experience as Dextri-Maltose.