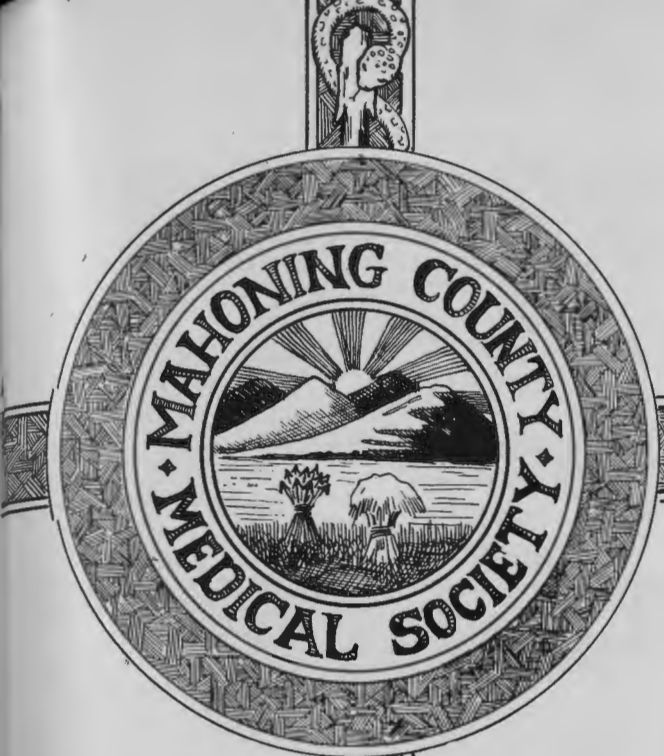

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

November • 1953
Vol. XXIII • No. 11
Youngstown • Ohio

Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has ". . . caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."[2]

In FELLO-SED, supplementation with calcium bromide and atropine sulfate largely overcomes unwanted side-actions, enhances the sedative effect and provides valuable antispasmodic activity. It is presented in palatable liquid form.

[1]N.N.R., 1947, p.398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles. Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.

FELLO-SED

Formula: Each fluidram (4 cc.) contains, in a palatable aromatic vehicle: Chloral Hydrate, 0.5 Gm. (7½ gr.); Calcium Bromide, 0.5 Gm. (7½ gr.); Atropine Sulfate, 0.125 mg. (1/480 gr.)

26 CHRISTOPHER ST.
NEW YORK 14, N. Y.

Fellows MEDICAL MFG. CO. INC. *Pharmaceuticals*

OFFICERS AND COUNCIL

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Volume XXIII—No. 11 **November, 1953**

ADVERTISERS' LIST

Our President Speaks

THANKSGIVING

Deep rooted is our feeling daily to give thanks for many blessings—but at this time of year it has been customary to also think of material progress.

We, as doctors, are particularly thankful because we can serve so many of our fellows. This has been made possible by many who contributed both time and money to establish medical schools; by men who had a gift for teaching in our medical schools; practicing physicians who, during our interneships and residencies left their busy practices and firesides to guide us in our early days.

We have tried to maintain free choice of physicians for our patients; to improve medical schools and teaching facilities; to keep medical schools' enrollment on a competitive basis and not controlled by "Politicos" as is the trend among other countries throughout the world.

These and many other factors are responsible for the high standard of health in the United States today. We are thankful for the many, many people in all walks of life who have made possible this progress.

V. L. Goodwin, M.D.

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 23 NOVEMBER, 1953 NUMBER 11

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

H. J. Reese
3720 Market Street

EDITORIAL

"—AD NAUSEAM"

During the past Spring our nation was suddenly hit by statements made by the Director of the American College of surgeons. The entire medical profession was smeared with newspaper headlines following a magazine interview granted by the august Dr. Paul Hawley. He looked with majestic horror at "wide-spread fee-splitting, unnecessary operations," and other unethical practices. From a superficial viewpoint, a considerable segment of the American people inferred that most of the medical profession was at fault, instead of the probable insignificant few who pursued such professional practices.

Evidently the medical profession at large did not agree with Dr. Hawley. There was an immediate flood of protests. From several groups came suggestions that Dr. Hawley be fired. Other forms of censure appeared, including an official A.M.A. resolution of reprimand.

Following that flurry, the entire matter quieted down. Nothing more was heard until the recent meeting of the American College of Surgeons in Chicago. Now again a voice was heard. This time not the stentorian tones of Dr. Hawley, but the entire organ console of the Executive Directors of the A. C. S. Again we hear of "fee-splitting, unnecessary operations, unethical practices". To this, another charge is now added—operations are too expensive. According to the newspaper headlines, the "medical profession" was again at fault. They didn't say that this applied to only relatively few.

It appears to your editor that this has gone on long enough. Either the A. C. S. must come forth with an effective program which will produce positive results, or else it must stand ready to be measured by its ineffective bleatings. It must stand ready to publicly clear its ranks. If it does not do this within a reasonable period of time, it will behoove the general medical profession to show that the A. C. S. is not an effective organization. As the gambler says, "Put up or shut up." How long must all doctors suffer such indignities?

H. J. Reese, M.D.

KEEPING UP WITH AMA

KIND WORDS ABOUT MEDICINE—Dallas, Texas Morning News:

Dick West, member of the editorial staff of the Dallas (Texas) Morning News, attended his first AMA meeting in June, and wrote a series of editorials for his newspaper. These editorials gave a straight-forward report on the AMA session and blasted some long nourished delusions about medicine at work.

"You may think that your doctor's ethics, or his political beliefs, or the policies of the Society to which he belongs are sometimes dogmatic. You may think they are formed by a higher clique undemocratically. Actually, doctors are governed professionally in a most democratic way . . . The AMA is the most industrious convention this reporter ever observed . . . Newspapermen have every facility. The AMA is open and aboveboard as to publicity . . . A great change has come over doctors. They are learning more about human and public relations, as well as their own professional pursuits. It is not uncommon now to see physicians taking the lead in every community movement. . . ."

LAWMAKERS RATE FOUR MEDICAL BILLS IMPORTANT NEXT SESSION

In the opinion of a representative group of Senators and Representatives, four issues of significance to the medical profession will be among the more important questions to come before the next session of the 83rd Congress.

Social Security. The question is this: Shall an additional 10.5 million persons, including physicians, be brought under social security coverage? President Eisenhower asked for this legislation.

Tax Legislation. While the House Ways and Means Committee is working on a complete revamping of tax laws, the Jenkins-Keogh plan is of paramount importance to physicians. It would allow physicians and other self-employed persons to defer income tax payments on a portion of their income which would be put into restricted annuity programs. Corporation employees now have this privilege. This plan has the strong support of AMA.

Aid to Schools, Hospitals. It would include aid to hospitals and clinics under a national health plan as well as support for the Hill-Burton hospital construction program.

Veteran's Services. The question of whether Congress should expand or restrict care of non-service connected cases. AMA is proposing that care be restricted to (a) service-connected cases, and (b) certain long-term non-service cases where the veteran himself cannot pay. All other non-service cases would be the responsibility of the individual himself or the community.

CORRECT STATEMENT ON LUMPING OF HOSPITAL BILLS

The American Hospital Association met in San Francisco. One erroneous Press Association story clouded the atmosphere considerably and set off a chain reaction that was heard across the country.

The United Press story said that the American Hospital Association had adopted a resolution advocating the lumping of all hospital expenses so patients would have only one bill to pay.

"In other words," the story said, "patients will no longer have to pay a separate amount to the doctor, anesthetist and hospital."

This story was erroneous and misleading in every way.

Several conferences were held with United Press officials, but the press steadfastly refused to carry a corrective story on its wires according to American Hospital Association people.

An official statement was prepared giving the true facts. It was signed jointly by Dr. Edwin L. Crosby, president of the AHA, and Dr. Edward J. McCormick, president of the AMA.

"This (United Press) interpretation of the report on hospital-physician relationships by the Joint Committee of the Boards of Trustees of the AMA and the AHA would, if allowed to stand uncorrected, largely nullify the intent of the resolution. This resolution was not designed to alter billing practices. It was designed to establish mutual understanding between physicians and hospitals."

THE CHICAGO TRIBUNE SUPPORTS AMA POSITION: Upheld the AMA's position on veteran's medical care.

"Dr. Edward J. McCormick, president of the AMA, is on firm ground in calling for re-examination of the extent of free medical care to be dispensed by the Veteran's Administration.

"No one denies the right of a man incapacitated in his country's service to receive all medical attention which can benefit him, but the VA, thanks to a Congress most sensitive to pressure of the veterans' lobby, does not confine itself to that.

"A racket has sprung up in the provision for extending medical care to non-service connected disabilities when VA facilities are available to handle such cases. A year ago 65% of the patients in VA hospitals fell into this category. During the year, September 1, 1951 to August 31, 1952, 85% of the 500,000 veterans treated were patients with non-service connected disabilities.

"Dr. McCormick reports that there are now 20 million veterans in civilian life and the number is increasing by a million annually. If a vast and proliferating VA empire is to keep pace with this enormous demand, it is hard to see how the process can be brought to a stop short of a completely nationalized medical profession and system of hospitals. The expense of any such operation would be staggering and the loss of liberty apparent.

"It is time to call a halt to this progression and to impress upon Americans that while they may be veterans they are citizens first, that their responsibility is to take care of their own requirements instead of trying to shunt them off on their fellow citizens and that in the long run there can be no benefit even if they seem to be ahead of the game in getting something from the 'government'. The government is themselves and they pay for it. The pay will increase in proportion, if these exactions continue, precisely as we approach the point where this becomes a nation of veterans."

PHS DETERMINING COST OF FREE MEDICAL CARE FOR U. S. PERSONNEL

As an outgrowth of a budget dispute over the free care of merchant seamen in Public Health Service hospitals, a study is being made to determine what it costs PHS each year to care for patients turned over to it by other government departments. The issue arose after the Budget Bureau told the Department of Health, Education, and Welfare to prepare its next budget excluding the care of merchant seamen, which has been considered a federal responsibility for about 150 years.

Secretary Hobby informed the Bureau she would comply, but that she

would also have to determine the costs to PHS of caring for thousands of other patients for whom the federal government has assumed responsibility; also whether her department should not be reimbursed by the other federal departments for this hospital care.

Mrs. Hobby noted that the Treasury Department's Coast Guard personnel are also treated free in PHS marine hospitals, as are employee compensation cases of all departments under a program handled by the Labor Department. Because merchant seamen make up about 40% of all cases in the 16 marine hospitals, PHS plans to close up all these hospitals if it is denied funds to care for the sailors. This would require the government to make other arrangements for the care of hospital and dispensary patients from other government departments, who average about 10,000 a day. Where the seamen would receive care probably would be determined by the unions and the shipping lines.

AMA WITNESSES TO TESTIFY AT HOUSE HEARINGS ON DISEASE

AMA will testify before the House Interstate and Foreign Commerce committee, starting October 1. The committee handles all health bills, with the exception of those applying to the military services and VA. Subjects to be taken up include; heart diseases, cancer, arthritis, rheumatism, muscular distrophy, mental conditions, poliomyelitis, multiple sclerosis, tuberculosis, cerebral palsy, and blindness. Chairman Wolverton commented in the announcement: "It now seems appropriate to find out just where we are, where we are going and what additional assistance through legislation or otherwise may be necessary to hasten the amelioration of these dreadful diseases."

DR. MELVIN A. CASBERG'S DUTIES ARE DETAILED FOR THE FIRST TIME as Assistant secretary of Defense (Health and Medical). The Assistant Secretary's job includes the following: 1. Development of policies and standards for the department in the board fields of health and sanitation, medical care and treatment of patients and administration of hospitals and related facilities; 2. Administration of the doctor draft law; 3. Development of policies and standards for construction of hospitals and other health installations; and 4. Providing for close cooperation and mutual understanding between the department and the civilian health and medical professions.

HOUSE HEARINGS ON DISEASES BROADENED TO TAKE IN HEALTH PLANS

Scope of the House Interstate and Foreign Commerce Committee hearings on cause and control of diseases has been widened to take in an examination of voluntary health insurance. Chairman Wolverton said, October 13-16, has been set aside to hear witnesses from Blue Cross, insurance companies, and possibly labor unions and employers operating health plans. Dr. Edward J. McCormick, president of AMA and Dr. Paul L. Wermer, secretary of the AMA Council on Research are scheduled to testify early in the hearings. The same diseases as listed above will be discussed by the officers.

AMA WITNESSES TESTIFY ON DISEASE CONTROL AT HOUSE HEARINGS

Dr. Edward J. McCormick, president of AMA, informed the House of Interstate and Foreign Commerce Committee on opening day of its hearing on diseases and health insurance that the AMA spent over 80% of its $10 million budget for 1952 on scientific activities. The remainder was spent in the socio-economic field of medicine, which includes ethics, laws and legislation, medical service, economic research, rural health and health education.

Dr. McCormick declared that "all of their work is extremely important in advancing the science of medicine."

Dr. Paul Wermer, secretary of the Committee on Research of the Council on Pharmacy and Chemistry, said that the AMA for over half a century has shown "bold leadership" in opposing "those who seek commercial gains by foisting false hopes and cures on the cancer patient and his family." The Bureau of Investigation has cooperated closely with the various federal and state agencies charged with enforcing the drug laws and with state licensing agencies. "In turning the searchlight of truth upon these cancer quacks we have frequently become the defendant in a court of law. AMA has been obliged to spend large sums of money in the defense of such legal actions. It is significant, however, to note that although we have been sued for more than $40 million dollars over the years, we have been obliged to pay for one judgment and that in the nominal sum of one penny."

MEDICAL FRANKENSTEIN OF THE FUTURE

The future of social security plans the world over is of prime concern to American physicians because the schemes are constantly being expanded to include all kinds of medical care provisions.

At its recent meeting in The Hague, the World Medical Association representing doctors from 46 nations, took the initiative in opposing medical care under government controlled social security schemes. The association contended that physicians should not be forced to work on a full time salaried medical service under a government plan because it would leave the doctor no incentive.

Applauding the World Medical Association's position, one newspaper said, editorially, that "the only incentive in socialism is to socialists," and then added: "If an industry is nationalized it and its workers and managers are put at the service of the socialists in government. If medicine is socialized, the benefit to the doctors and the patients will be less. But the benefit to the bureaucrat is tremendous.

"If there then should be something less than enthusiasm among the younger generation for entering the medical profession, the bureaucrat will rectify that by subsidizing the medical education of aspirants with the right political preferences. And that gives him a hold on something else—education. Once started, the thing snowballs, and if no one else is particularly happy, the omniscient planner is sure to be. (*Note: This follows that we should and must support our medical schools through the A. M. E. F. Send your check.)*

EXPLOITATION OF HEARTBREAK CASES A SHAM

Lately, all of us have been seeing more and more exploitation of heartbreak cases by TV, radio and newspapers. The subject of medically-needy cases, especially those that are tearfully pictured before TV audiences, came in for a good share of discussion recently at a pulbic relations conference sponsored by the Medical Society of the State of New York and attended by representatives from most of the 61 county medical societies comprising the state organization.

A "heartbreak case" was defined as an appeal for funds through TV, press or radio to pay for extensive medical care or an operation, the cost of which is overwhelming to the person involved.

The concensus at the meeting was that exploitation of these unfortunate cases must stop.

Dr. James D. Tyner, Newark, told the conference that investigators of many heartbreak cases showed that patients did not consult with hospital authorities or ask their county medical societies what could be done. "Instead," he declared, "they chose to glamorize their plight."

"The patient must be informed that regardless of ability to pay he need only ask to receive the services of a doctor or hospital care. In these cases, the county medical society, state welfare department and voluntary health organizations are ready to help every deserving person."

How many people know that doctors in wards and clinics of hospitals throughout America give their services daily without charge? The average doctor spends 12% of his working hours doing charity work. The dollar value of the time given to charity patients by the average M.D. is more than $3,000 annually and his donation of time from 1947 to 1951 increased 15%.

"Physicians are already giving service to thousands of potential heartbreak cases in their everyday duties. We must let the people know this fact, and try to prevent the few cases that are dramatized from damaging the good name of American medicine."

CLINICAL SESSION PLANNED FOR GENERAL PRACTITIONER

Have you made your plans to attend the seventh annual Clinical Session of the American Medical Association in St. Louis, December 1-4? More than 3,500 physicians will be there.

A program has been designed to give the general practitioner an opportunity to see and hear the latest developments in medicine. More than 150 papers by outstanding physicians will cover such topics as internal medicine, surgery, pediatrics, obstetrics and gynecology, tuberculosis and other diseases of the chest, caridovascular diseases, arthritis, dermatology, gastrointestinal diseases and neuropsychiatry.

One outstanding feature will be an exhibit symposium on the prevention of traffic accidents. This will include discussion of the responsibilities of the physician in telling his patient when not to drive and what other precautions the physician should take in such special situations as the testing of the drinking driver and the care of the injured after an accident. Physicians and representatives from the National Safety Council and several police departments will participate in the symposium.

Other special features will include fracture demonstrations; problems of delivery, with manikin demonstrations by leading obstetricians, and a diabetes exhibit and question-and-answer conference.

All scientific activities will be held in the Kiel Auditorium, where there are ample facilities for the lecture program. The Scientific Exhibit of about 80 displays will be correlated as far as possible with the clinical presentations. The Technical Exposition will consist of about 160 exhibits covering all types of office and medical practice needs.

Arrangements have been made for color television to be presented through the cooperation of Smith, Kline and French Laboratories. A motion picture program covering all the important problems which the general practitioner faces also will be presented. These will be shown continuously, with the authors present, whenever possible, to discuss their work.

The House of Delegates will meet in the Jefferson Hotel. Every physician should make an effort to attend one or more of these sessions.

helps control cough and clear congestion

BENYLIN® EXPECTORANT

BENYLIN EXPECTORANT relieves distressing cough and uncomfortable congestion because it combines Benadryl® hydrochloride, highly effective antihistaminic, with other proven remedial agents. A palatable raspberry-flavored and raspberry-colored syrup—free from narcotic drugs—its antispasmodic, decongestant, and mucolytic action helps assure prompt relief whether the cough is due to cold or allergy.

BENYLIN EXPECTORANT

RELAXES bronchial musculature
LOOSENS cough
LIQUEFIES mucous secretions
SOOTHES irritated mucosae
CLEARS congestion

BENYLIN EXPECTORANT contains in each fluidounce:

Benadryl hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.	Chloroform	2 gr.
Ammonium chloride	12 gr.	Menthol	1/10 gr.
Sodium citrate	5 gr.	Alcohol	5 %

DOSAGE: One or two teaspoonfuls every two to three hours. Children, one-half to one teaspoonful every three hours. Supplied in 16-ounce and 1-gallon bottles.

MEDICAMENTA VERA · PD Co.

Parke, Davis + Company
DETROIT, MICHIGAN

PROCEEDINGS OF COUNCIL

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at the office of the Society, 202 Schween-Wagner Building, Monday, October 12, 1953.

The following doctors were present: V. L. Goodwin, president, presiding; W. M. Skipp, M. W. Neidus, S. W. Ondash, G. E. DeCicco, J. D. Brown and I. C. Smith.

Dr. Skipp discussed problems concerning the Board of Health set-up.

Bulletin problems were discussed.

A motion was made, seconded, and duly passed instructing the Executive Secretary to ask for bids on the Bulletin from several reputable printers and submit to the editor and Council.

Downtown parking on Monday nights was discussed.

A motion was made, seconded, and duly passed to hold the next Council meeting at Dr. Neidus Office, 318 Fifth Avenue where there is ample parking.

The following applications were presented.

ACTIVE MEMBERSHIP

Dr. James R. Gillis, Youngstown Hospital Ass'n, Youngstown, Ohio
Dr. Robert R. Fisher, 224 N. Phelps Street, Youngstown, Ohio

JUNIOR ACTIVE MEMBERSHIP

Dr. Robert E. Glasgow, 2218 Market Street, Youngstown, Ohio
Dr. Frank K. Inui, 305 Home Sav. and Loan Bldg., Youngstown, Ohio
Dr. Robert V. Bruchs, 413 Dollar Bank Bldg., Youngstown,Ohio
Dr. Robert L. Jenkins, Jr., 312 Home Sav. and Loan Bldg.
Youngstown, Ohio

NON-RESIDENT MEMBERSHIP

Dr. Wm. H. Gross, 362 Liberty Street, Hubbard, Ohio

INTERNE MEMBERSHIP

Dr. Fred H. Landeen, Youngstown Hospital Ass'n, Youngstown, Ohio
Dr. Herman L. Allen, Youngstown Hospital Ass'n, Youngstown, Ohio
Dr. Jos. J. Campolito, Youngstown Hospital Ass'n, Youngstown, Ohio
Dr. James G. Eason, Youngstown Hospital Ass'n, Youngstown, Ohio
Dr. Henry R. Light, Jr., Youngstown Hospital Ass'n, Youngstown, Ohio

G. E. DeCICCO, M.D.
Secretary

ST. ELIZABETH HOSPITAL STAFF MEETING

The regular monthly staff meeting of the St. Elizabeth Hospital was held on Tuesday, October 6, 1953. Meeting was called to order at 8:40 p.m. In the absence of Dr. W. H. Evans, Chief of Staff, and Dr. T. K. Golden, Vice-Chief of Staff, Dr. H. J. Reese, Secretary presided.

The medical section consisted of the following clinical case presentations:

a. Stab Wounds of the Abdomen—presented by Dr. R. E. Hancock; discussed by Dr. A. K. Phillips.

b. Dr. B. I. Firestone reported that the case of paroxysmal ventricular tachycardia discussed at the last meeting has had a thyroidectomy, had a post-

operative recurrence of cardiac pathology, but responded in twelve hours to intravenous Pronestyl.

Minutes of the last meeting were read and approved.

Committee reports:

a. Dr. J. LoCricchio, chairman of the Tissue Committee gave a summation of first six months of 1953.

The minutes of the Executive Committee meeting were read.

The Treasurer's report was read.

In the absence of further business, meeting was adjourned at 9:00 p.m.

H. J. Reese, M.D.
Secretary

FROM THE MEDICAL ADVANCE OF NATIONAL FUND FOR MEDICAL EDUCATION

Doctors in industry, playing a mounting role in keeping America's workers healthy and productive, depend on the medical schools for both their basic and their refresher training. Industry and the schools, therefore, have an equal stake in the quality of medical education.

Dean George Packer Berry of the Harvard Medical School, called for a thorough overhauling of medical education to prepare future doctors for the practice of "comprehensive" medicine, instead of the narrower "scientific" medicine that prevails today. Scientific medicine, he pointed out, stresses mainly the biological, chemical and physical factors in disease. Comprehensive medicine, on the other hand, "accents the preventive features of medical practice, striking hard at the circumstances—physical, genetic, environmental, and psychological—which give rise to disease, striving to cut down illness at the earliest possible link."

Dr. Robert Collier Page, medical director, Standard Oil Co. (N. J.), outlined the advantages of closer cooperation between industry and schools. He said, "More teaching time should be devoted to the socio-economic aspects (of industrial medicine) and the relationship between the private practitioner, the industrial patient, and industry."

Dean Joseph C. Hinsey, of the Cornell University College of Medicine, reported that under graduate medical training does not seek to teach "techniques required for the successful practice of the various specialties. It seeks, among other things, to provide "the setting in which the student can learn the fundamental principles applicable to the whole body of medical knowledge."

Dr. Earl C. Bonnett, medical director, Metropolitan Life Insurance Company, pointed out that, with the trend toward "treating the whole man", the job of the industrial physician in the future may not differ much from that of the general practitioner. The big job of the doctor in industry is prevention and health conservation—which requires that his activities and interests be extended to the worker's home where "a lot of the industrial physician's problems are initiated."

Note: when these statements are read and reread, and then taken to heart, it means that we, as physicians, have a given task to perform. Let's all give to our medical school, or to the American Medical Education Foundation, which is a part of the National Medical Education.

Before you pass this by, *"STOP, LOOK, AND LISTEN"!* The time is today as tomorrow may be too late. Send your check to your Alumni Fund or the American Medical Education Foundation.

DEFENSE DEPARTMENT ISSUES DIRECTIVE ON REVISED DOCTOR DRAFT

With the issuance October 8 of Defense Department's directive to implement the revised doctor draft act, the three military services are prepared to put into effect all changes called for by the new law. The directive has been more than three months in preparation. Pending its official release, Army, Navy and Air Force have delayed acting on a number of things, including the upward adjustment in grade for certain officers.

The directive restates much policy that has been in effect for some time, but also makes the following new points:

GRADE: The law requires appointment, reappointment, or promotion to a grade "commensurate with professional education, experience or ability." The directive retains the present scale of grades, based on years of experience, and states promotions must be given "at the earliest practicable date" to men now on active duty who qualify for higher grades. In effect, this means that a physician's experience alone will determine the grade in which he serves, whether he is on active duty now or is commissioned or recalled in the future. Eliminated are such limit-commissioning of Priority I and II men on the basis of cutoff dates, and delays pending action of officers' boards. (The following scale is used to determine grades: if less than four years' professional experience since graduation, first lieutenant; four but less than 11 years, captain; 11 but less than 18, major; 18 or more, lieutenant colonel; comparable grades in the Navy).

NATIONAL GUARD: The regulations spell out more clearly the policy now in effect regarding the call up of medical officers in a National Guard or Air National Guard unit. If the physicians joined the unit prior to June 25, 1950, they are not subject to call unless the unit is called; otherwise they are now subject to call as individuals.

REGULAR AND SPECIAL REGISTRANTS: Physicians registered under the regular draft as well as the doctor draft now may accept a medical commission in the reserves and await their call the same as any other doctor draft registrant. Until issuance of the directive the physicians registered in both drafts found their situations complicated. They had to volunteer for immediate active duty as a reserve officer or, technically at least, face the prospect of induction as an enlisted man through the regular draft channels. One reason for the change was the fact the services have no need for more doctor volunteers at this time.

PHYSICAL STANDARDS: There is some change of wording regarding physical requirements, but the principle is the same. The directive declares: "All physicians . . . are considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces. . . . No person with limited physical capabilities will be assigned by the military departments to duties which are beyond the limitations imposed by their physical capabilities."

NOTE: In September the Defense Department said the drafting of physicians would be suspended indefinitely; the prospect is that no more calls will be made at least until well into next year.

A.M.A. Washington Letter No. 41
October 9, 1953

DIABETIC DETECTION WEEK

HELP FIND THE UNKNOWN DIABETIC

Diabetic Detection Week . . . November 16 - 21, 1953

Exhibit at North Side Unit, Youngstown Hospital Association
Wednesday, Thursday and Friday, November 18, 19, 20
7 P. M. to 9 P. M.

Dietician and Physician in attendance. Movies on diabetes will be shown.

Free urine tests will be taken in all Doctors' offices. Kindly tabulate all tests and follow positive urine tests with Blood Sugar Determinations. Clinitest and Galatest material will be supplied to all Physicians, free of charge.

All Physicians are asked to aid in this program not only for detection but also for public benefaction to the individual.

Health Department Bulletin

CITY OF YOUNGSTOWN

REPORT FOR SEPTEMBER, 1953

	1953	Male	Female	1952	Male	Female
Deaths Recorded	218	121	97	195	109	86
Births Recorded	595	287	308	578	331	247

CONTAGIOUS DISEASES	1953 Cases	Deaths	1952 Cases	Deaths
Chicken Pox	4	0	2	0
Measles	1	0	3	0
Polio	8	3 (non-res.)	11	0
Tuberculosis	10	2	4	3
Whooping Cough	9	0	4	0
Gonorrhea	24	0	30	0
Syphilis	15	0	14	0
Mumps	4	0	0	0
Scarlet Fever	1	0	0	0

VENERAL DISEASES

New Cases	Male	Female
Syphilis	2	5
Gonorrhea	22	2

Total Patients 31
Total Visits (Patients) to Clinic 202

CANFIELD FAIR DISPLAY

The Medical Education Exhibit at the Canfield Fair was attended by some 92,000 Fair visitors and without a doubt, was the outstanding display of the 107th Canfield Fair. There was a constant stream of people through the portals of the tent during the entire five days of the Fair and the people showed a great deal of enthusiasm and interest as evidenced by their facial expressions and the questions they asked those in attendance at each of the displays.

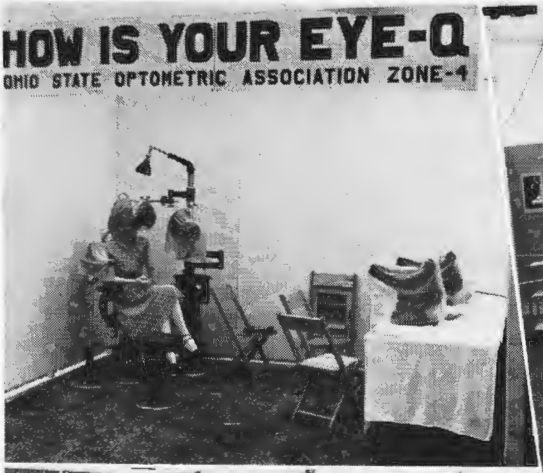
Those, who took an active part in exhibiting, deserve special commendation for their untiring efforts to make the exhibit such a success. As so often happens, many are delegated but few respond. Those who did make their services available did a heroic job and our Society owes them a vote of thanks for a job well done.

Fifteen organizations took part in the display this year and each one of them presented to the public, worthwhile and educational subjects. Some of course, were more elaborate than others to look upon while those performing simple clinical tests and demonstrations enjoyed equal success. The Heart Association's Cardiac Audiometer had an unending line of people. The visual analysis tests were also popular, and the Youngstown Hearing Society's testing equipment was taxed to the limit, having done over 1100 hearing tests during the five day period.

Awarded to St. Elizabeth's Hospital was a large trophy for the best attended exhibit, and to Youngstown Hospital Association a similar trophy for the most original exhibit. Special awards also were given to each of the following exhibitors: Youngstown Society for the Blind; Youngstown Area Heart Association; Youngstown Hearing Society; Youngstown Hospital Association; Mahoning Chapter Academy of General Practice; Corydon Palmer Dental Society; Mahoning Red Cross; Visiting Nurses Association; District 3, Ohio State Nurses Association; Ohio State Optometric Association; Mahoning Valley Chiropodists Society; Eastern Ohio Pharmaceutical Association; American Cancer Society; Arthritis and Rheumatism Foundation, Mahoning Valley Chapter; Ninth Ohio District of Osteopathic Medicine.

At a special dinner meeting at the Youngstown Club, September 24, Attorney E. R. Zieger, Executive Secretary of the Fair Board presented, in its behalf, to our President Dr. Vernon L. Goodwin, a trophy "for bringing to the public a health education exhibit of value to all who saw it". He went on to say, "Five other Fair Boards in other Ohio counties have asked us for information on the Medical Health Exhibit, one of the best we have ever had".

As far as can be determined, this is one of the first if not the first Health Education Exhibits of its kind, where in all the members of the allied profession were invited to combine their efforts in a single project and the results speak for themselves. This was made possible through our Society who appointed Dr. M. M. Szucs as chairman of this project. Due to his untiring efforts and direction, our Society has received a great deal of favorable comment and praise from many organizations and people of this area. Our Council voted Dr. Szucs a special appreciation for his work and each of us should throw in a hearty thanks.


HOW IS YOUR EYE-Q
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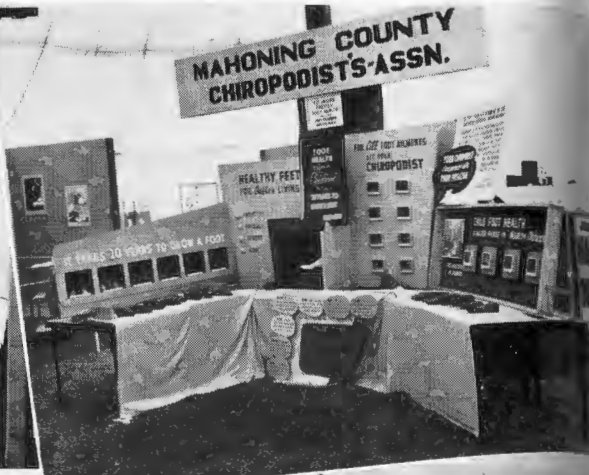
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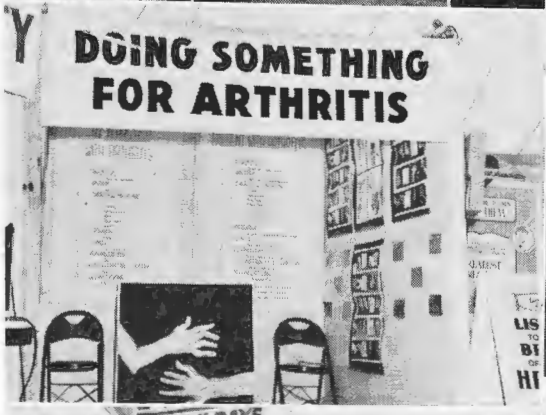
DOING SOMETHING
FOR ARTHRITIS


LISTEN TO THE BEAT OF YOUR HEART
LISTEN
TO THE
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DENTAL X-RAYS
FOR CHILDREN
6 TO 15 YEARS
ORYDON PALMER DENTAL SOCIETY


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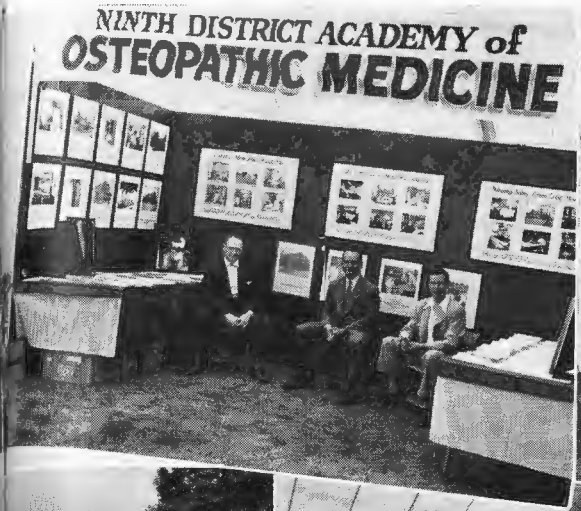

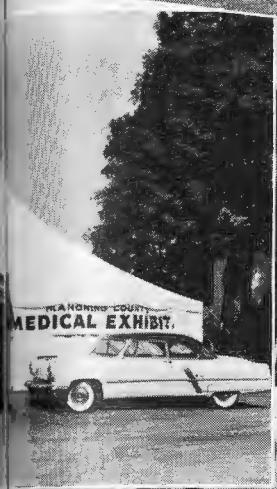

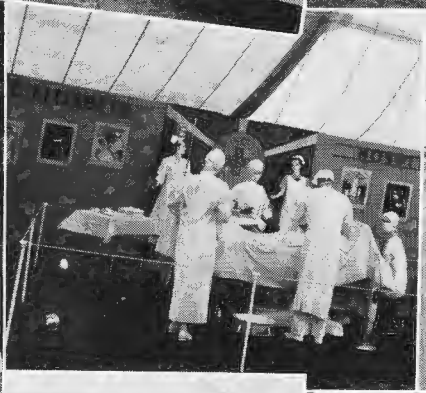

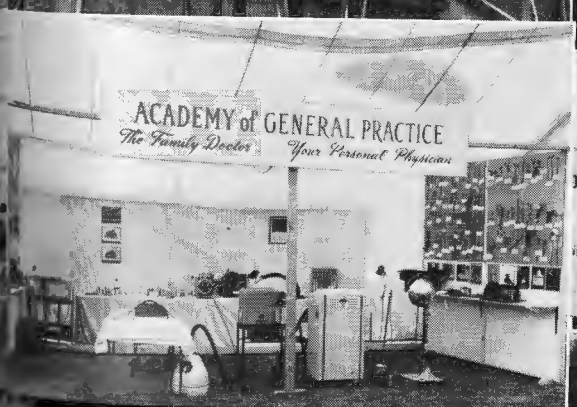

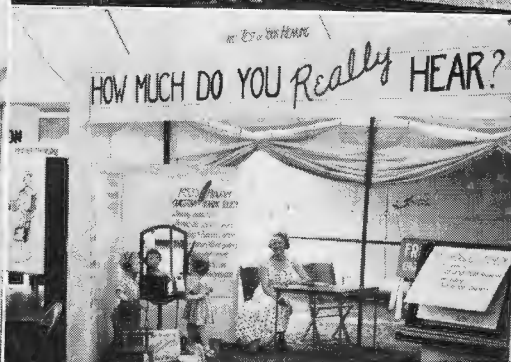

George J. Hamwi, M.D.

NOVEMBER MEETING

TIME:

TUESDAY, NOVEMBER 17, 1953
6:30 P. M.

PLACE:

ELKS CLUB, 220 W. Boardman Street

SPEAKER:

DR. GEORGE J. HAMWI

Associate Professor of Medicine; Head of Section of Endocrinology and Metabolism, Department of Medicine, College of Medicine, Ohio State University.

SUBJECT:

"General Clinical Endocrinology in Practice"

The November meeting will be a combined meeting of the Mahoning County Medical Society, Mahoning Academy of General Practice, and Mahoning Diabetic Association. The meeting will highlight Diabetic Week.

PLAN TO ATTEND!

CANCER PROGRAM

BY

COLUMBIA UNIVERSITY
COLLEGE OF PHYSICIANS AND SURGEONS

All Day Program--December 3, 1953

PICK-OHIO HOTEL

9:00 A.M. Registration

Morning Session

10:00 - 10:45 A.M.	Carcinoma of the Prostate	Dr. Perry Hudson Dr. Maurice Lenz Dr. Arthur Purdy Stout
10:45 - 11:30 A.M.	Carcinoma of the Lung	Dr. Richard Moore Dr. Maurice Lenz Dr. Arthur Purdy Stout
11:30 - 12:15 P.M.	Carcinoma of the Head and Neck	Dr. Maurice Lenz Dr. Arthur Purdy Stout

Afternoon Session

2:15 - 3:00 P.M.	Carcinoma of the Uterus	Dr. Howard C. Taylor, Jr. Dr. Arthur Purdy Stout
3:00 - 3:45 P.M.	Carcinoma of the Breast	Dr. C. D. Haagensen Dr. Arthur Purdy Stout Dr. Maurice Lenz
3:45 - 4:30 P.M.	Lymphoblastoma and Leukemia	Dr. Alfred Gellhorn Dr. Maurice Lenz Dr. Arthur Purdy Stout

Dinner Meeting

The Role of the General Practitioner in the Diagnosis and Treatment of Cancer---Dr. Maurice Root

BLOOD PRESSURE STUDY IN PERSONS 65 AND OVER

Arthur M. Master, M.D., Director and Associate
New York Heart Association, Inc.

Dr. Arthur M. Master, N. Y., Mr. Herbert H. Marks of the Metropolitan Life Insurance Co., N. Y., and Dr. Harry L. Jaffe, N. Y., have undertaken a statistical study of the blood pressure in people who are 65 years of age and over. The investigation is sponsored by The New York Heart Association, New York, The Mount Sinai Hospital, New York, and The Metropolitan Life Insurance Company, New York. The American Medical Association has given aid to the project.

Since hypertension is so common and may lead to heart disease, the correct interpretation of blood pressure readings is of great importance, particularly because of the increasing number of people who undergo routine health examinations in the physician's office, in industrial plants and in public health studies.

Although previous blood pressure studies had indicated that the incidence of hypertension increased with age, the important influence of age by decade and sex on the normal blood pressure was not taken into account. As a result, an arbitrary figure, usually 150/90, was used as the upper limit of normal for all adults over 40. This resulted in an excessive incidence of hypertension. Therefore, the blood pressure in 74,000 gainfully employed persons up to the age of 64 was studied. The ranges of normal blood pressure for each decade and by sex were published in 1950. The upper limit of normal was higher for each age group than that previously used.

The evaluation of blood pressure in old age has become a major problem because of the growing number of older people in the United States and the paucity of data on these age groups. Millions of Americans are now 65 years of age or older. With the increasing life span, many more millions will be added within several decades. It is essential to know (1) the normal range of blood pressure as well as the lower limit of hypertension, for each age group over 65 for both sexes, (2) whether the blood pressure continues to increase with age and to vary with sex in those who are more than 65 years old, (3) whether the blood pressure is related to weight, or (4) to surface area or (5) to height.

The relationship of hypertension to coronary sclerosis and occlusion, cardiac enlargement, valvular disease, calcification of the aorta, electrocardiographic abnormalities, hypercholesteremia and diabetes may have to be re-investigated in people over 65, as was recently done up to that age. It had generally been accepted that an etiologic relationship between hypertension and coronary occlusion exists in both sexes. However, using the limits of normal blood pressure newly established for those under 65, it was shown that such a casual relationship exists only in women; in men, no important relationship between hypertension and coronary occlusion was found. Using the new limits of normal blood pressure, it was also found that enlargement of the heart occurred not uncommonly in men with coronary occlusion when their blood pressure had been normal. It was concluded that coronary artery disease alone could produce cardiac enlargement in men. Women with coronary occlusion, on the contrary, rarely developed cardiac enlargement if their blood pressure was normal. Hypertension,

therefore, appeared to be a very important factor in the production of enlargement of the heart in women.

For the previous study of people 16 through 64 years of age an excellent source of material was found among the larger *industrial concerns.* Therefore, for the study of the normal blood pressure in people 65 years of age and older, in 1951-2 a pilot study was conducted in such concerns to determine their availability for data in these age groups. It was found that industry was not a suitable source because (1) relatively few persons 65 or older were employed. Most concerns retire their employees at 65. (2) Half of these companies discharged workers whose blood pressures were beyond an arbitrary, fixed limit which varied from 140/90 to 230/130. (3) The techniques employed in obtaining blood presssure readings varied tremendously.

Old age homes also proved unsuitable for the study because only scanty blood pressure data were available. It was therefore decided to seek the aid of doctors, between the ages of 30 and 60 years, geographically distributed throughout the country, in order to obtain the data required. General practitioners, part time specialists, i.e., practitioners with a specialty, full time specialists in internal medicine and cardiovascular diseases, were to be asked to cooperate in the investigation. The number of doctors to be contacted in each state was determined in accordance with the number of its inhabitants over 65.

In the hope of obtaining the cooperation of the American Medical Association in this study, Dr. Frank G. Dickinson, Chief of Medical Economic Research of that organization was approached. The American Medical Association was able to obtain from its records, the required number of names of physicians in each state. Dr. George Lull, the General Manager, brought this request to the attention of the Board of Trustees of the American Medical Association, who decided to help. Thus were obtained the names of 17,000 physicians to whom printed questionnaires were recently sent.

The questionnaire card was made as simple and clear as possible. It can easily be completed by the insertion of the figures requested, and by check marks in the "yes" and "no" columns. The data on the cards will lend themselves to facile transfer to "punch" cards, and to subsequent statistical analysis on International Business Machines.

Each of the 17,000 physicians was requested to fill out the questionnaires for six newly examined persons: 2 in the 65 to 69 year group, 2 in the 70 to 74 year group, and 2 above the age of 75. It was suggested that one of the latter be 80 years old or over, if possible. The subjects were all to be in fairly good health and not bed ridden, although they might have some chronic illness. Those able to do part or full time work were particularly desired. If they were well at the time the blood pressure was obtained, people with rheumatic heart disease, chronic coronary disease or hypertension could be included. The most suitable subjects, therefore, were patients coming for routine examination and relatives or friends in the desired age group.

Two blood pressure readings on each subject, 10 minutes apart, were requested, taken in either the reclining position or sitting. The diastolic pressure was to be recorded in both the fourth phase (a definite diminution in the sound) and in the fifth phase (complete disappearance of the

sound). If, however, only the fourth or the fifth phase diastolic reading could be obtained, it was to be entered in the appropriate place on the card. The need for accurate readings, to the nearest even digit, was stressed.

The weight of the subject, without shoes or clothing, was to be entered on the questionnaire. Women might wear a slip and stockings, and men their shorts. If the subject was more fully clothed, the estimated weight of the clothes was to be subtracted.

The height of the patient was to be taken with the shoes off. If shod, the heel height was to be subtracted from the total.

The questionnaires were sent by first-class mail. Each letter contained a self-addressed return enevelope with postage affixed.

The persons whose blood pressures will be recorded and analyzed are geographically distributed throughout the country, in accordance with the distribution of those who are 65 and older. This is important, since the blood pressure level seems to vary with *race and geographic location*. Thus, people in tropical and subtropical climates appear to have lower blood pressures, and the incidence of hypertension among them is low.

In earlier studies of gainfully employed persons, between the ages of 16 and 64, the absolute and relative variations in blood pressures, as measured by the standard deviation and the coefficient of variation, were found to increase with *weight*, particularly after the age of 40 years. The greatest contrast in the mean pressures was found in the older age groups. It will be of interest, then, to study the weight of even older people, i.e., those over 64 years of age.

In analyzing the measurements of such a variable physiologic function as the pressure of the blood, difficulties are encountered because exact figures cannot often be obtained. However, all precautions possible have been taken to round out the blood pressure readings, which will be recorded with care, to the nearest even digit. Physicians in this country usually record readings with terminal zeros and eights, but this was guarded against. In previous studies in each age group of both sexes, the frequency distribution of the blood pressure levels yielded a fairly normal curve. It is hoped to obtain results at least as good, in this newly undertaken research project.

The range of normal blood pressure will be based upon the distribution of blood pressure readings around the mean, according to age and sex. The standard deviation, σ, will be used to measure the amount of deviation from the mean. In the normal distribution, roughly two-thirds (68.27 per cent) of all the observations are found to be within one standard deviation from the mean (mean $\pm$ σ); and approximately 95 per cent of all the observations are found to be within two times the standard deviation from the mean (mean $\pm$ σ). Since there is no definition of what constitutes physiological normality, the statistical determination of the normal blood pressure range must, of necessity, be an arbitrary one. Statistically speaking, one may assume that any reading within one standard deviation ($\pm$ σ) from the mean is within the normal range. Indeed, the normal range may reasonably be extended to include 80 per cent of all observations — 40 per cent on either side of the mean ($\pm$ 1.282 σ). All blood pressure readings found to be higher than two

times the standard deviation from the mean (about 5 per cent) will be called "abnormal." These will include 2.5 per cent of all the observations, at either extreme. The area between the upper limit of the normal and the lower limit of the probably abnormal will constitute a narrow borderline range. Frequency distribution curves will be constructed for each five year age group and for each sex, and the calculated arithmetical mean, the "normal", the "borderline", and the abnormal ranges, according to the definitions just given, will be indicated.

Blood pressure readings which are higher than two times the standard deviation from the mean ($\pm$ 2 σ) will be considered hypertensive. Those which are lower than 2 times the standard deviation from the mean ($-$ 2 σ) will be considered hypotensive.

Definitions of "hypertension" among the older age groups will, of course, be established. In addition the incidence of "hypertension" in these age groups according to various old criteria will be computed. It must be emphasized that the new limits of hypertension will have to be correlated with the entire clinical picture.

Editor's Note: The above group of physicians is extremely anxious to collect data from other physicians throughout the nation. If any of the members of the Mahoning County Medical Society are willing to contribute their findings, please write to "BLOOD PRESSURE STUDY", 11 East 100th Street, New York 29, N. Y. Questionnaires will then be forwarded to them.

HOW TO DEFINE SYSTEMS OF GOVERNMENT

During the recent A.M.A. Public Relations Institute held at Chicago's Drake Hotel, a number of speakers touched on everything from vitriolic excoriations in politics to the changing connotation of words. One speaker—and I can't remember who—burst forth with a delightful definition of the systems of government. It went something like this:

Idealism. If you have two cows, you milk them both, use all the milk you need, and have enough left for your neighbors.

Socialism. If you have two cows, you keep one and give the other to the man next door.

Communism. If you have two cows, you give both to the government; then the government gives you back a little milk.

Imperialism. If you have two cows, you steal somebody's bull.

Capitalism. If you have two cows, you sell one and buy a bull.

New Dealism. If you have two cows, the government shoots one; you milk the other, then dump half the milk down the sink.

Nazism. If you have two cows, the government shoots you and takes the cows.

Realism. If you have two cows, they're both dry.

Secretary's Letter, A.M.A. No. 269

THE HENRY FORD HOSPITAL MEDICAL SOCIETY
PROGRAM FOR 1953-1954

October 22, 1953 - Thursday, 8:45 p.m. - Grand Ballroom - Hotel Statler
(Meeting in conjunction with International Virus Symposium)

Problems of Diagnosis in Virus Diseases

Frank L. Horsfall, M.D., The Hospital of the Rockefeller Institute for Medical Research, New York, N. Y.

November 10, 1953-Tuesday, 8:15 p.m.-Henry Ford Hospital Auditorium

Tissue Culture Techniques in Investigative Dermatology

Clarence S. Livingood, M.D., Physician-in-Charge, Division of Dermatology, Henry Ford Hospital, and Funan Hu, M.D., Research Associate, Division of Dermatology, Henry Ford Hospital.

December 8, 1953-Tuesday, 8:15 p.m.-Henry Ford Hospital Auditorium

Some Results of the Application of Electron Microscopy to Medicine

The Edsel B. Ford Lecture. James Hillier, Ph.D., Research Physicist, R.C.A. Laboratories, Princeton, N. J.

February 9, 1954 - 8:15 p.m. - Henry Ford Hospital Auditorium

Roentgen Manifestations of Acute Abdominal Disease

William R. Eyler, M.D., Associate Physician, Department of Radiology, Henry Ford Hospital.

March 9, 1954 - 8:15 p.m. - Henry Ford Hospital Auditorium

Some Problems of Biliary Tract Disease

I. S. Ravdin, M.D., Professor of Surgery, University of Pennsylvania, Philadelphia, Pennsylvania.

April 13, 1954 - 8:15 p.m. - Henry Ford Hospital Auditorium

The Certified Chaplain and the Modern Hospital

Russell L. Dicks, Ph.D., Litt. D., Professor of Pastoral Care, Divinity School, Chaplain of Duke Hospital, Durham, N. C.

April 30, 1954 - 8:15 p.m. - Henry Ford Hospital Auditorium

The Expanding Scope of Cardiovascular Surgery

The Roy D. McClure Memorial Lecture
Alfred Blalock, M.D., Surgeon-in-Chief, John Hopkins Hospital, Baltimore, Maryland.

To All Members of the Society:

The American Medical Education Foundation is appealing to you as a physician and an alumnus of some medical school to make your annual donation to either your school or to American Medical Education Foundation directly. If you are going to give to your school, fine; if not, send a check to the Foundation earmarking it for your school, or just send a check to the open fund of the Foundation and your school will get its share.

Medical Education needs your support. Just think — last year only 265 in Ohio gave directly, and 1,657 to their schools — which means a lot of us here in this county did not give. When you think there are over 9,000 of us in the state.

Fill out the card that comes to your desk and put an amount you feel you can give each year. Deduct it from your gross income, it is not taxable. Don't forget, you still owe for your education, and we cannot let "George do it".

Some one of your local committee will contact you. Please do not put him off, give him the check, or keep your promise and mail it to 535 North Dearborn Street, Chicago, Illinois.

Do you want the government to take over or curtail the high quality of medical education? If so, there is no need for your donation.

Mahoning County Committee
AMERICAN MEDICAL EDUCATION FOUNDATION

HAZARDS IN THE TREATMENT OF CARDIAC DECOMPENSATION

Mark D. Altschule, M.D.
Boston, Massachusetts

One aspect of the treatment of congestive heart failure that deserves repeated emphasis is the harm that may be caused by therapy injudiciously or erroneously applied.

DIGITALIS

The common manifestations of digitalis intoxication—that is, nausea and vomiting, bigemini and heart block—are well known. The possible occurrence of less common symptoms, such as diarrhea and visual disturbances, should be remembered. Some rare cardiac disorders caused by administration of excessive amounts of digitalis must also be borne in mind. Digitalis has strong vagal effects, one of which may be the production of auricular fibrillation. In other cases the vagal action may cause slowing of the heart rate to below 50 per minute, with the resultant precipitation of Stokes-Adams attacks. This phenomenon is rare, but is most likely to occur in patients who are unable to increase the cardiac stroke output markedly, owing to severe myocardial disease or valvular stenosis. Another aspect of digitalis therapy that might be mentioned in passing is an error of omission rather than of commission: many physicians forget that some patients become de-digitalized gradually, unless re-digitalized (cautiously) three or four times a year.

BED REST

There is conflict among authorities concerning the value and harm of bed rest for patients with congestive heart failure. The purpose of rest should be understood as avoidance of exertion, and not the maintenance of complete immobility or of any specific position. Few, if any cardiologic authorities ever recommend rigid restriction of patient to bed; a comfortable reclining chair serves as well. However, clinical experience shows that unduly prolonged rest causes muscular flabbiness and often psychologic changes that may be disabling.

If these limitations are accepted, there is no reason to derogate traditional ideas about rest in the treatment of cardiac decompensation. The belief that bed rest of itself causes deep femoral phlebitis and subsequent pulmonary infarction is not securely founded in controlled observation. Other known factors that should be considered as favoring the development of this condition are extreme degrees of stasis associated with excessive use of barbiturate drugs, hemoconcentration during overenthusiastic diuretic therapy and changes in blood clotting caused by barbiturate drugs or by severe physical or emotional shock or discomfort. The problem of femoral phlebitis in the bedridden requires much study, and statements that the bed alone is to blame are as yet unproved. In this connection it is important to bear in mind that bed rest in the waking state may have markedly different effects from best rest during sleep or stupor.

MORPHINE

The immediate and strikingly beneficial effect of morphine on cardiac dyspnea is well known. This action is presumably due to amelioration of

discomfort in general and also to diminution in respiratory activity in some cases. Untoward effects are also well known; these include excessive—in some cases, fatal—depression of respiration in chronic cor pulmonale, vomiting or cutaneous itching in sensitive persons and impairment of bladder function in patients with enlarged prostate glands.

Other undesirable consequences of the action of morphine include inhibiting mercurial diuresis, and a hypotensive effect. Morphine in doses of about 15 mg. has no effect on the ciculation in recumbent patients; however, when subjects given morphine are tilted up with feet dependent, a hypotensive syncopal attack may occur. This same effect may cause collapse in patients with myocardial infarction or pulmonary edema who are placed with the head up and feet hanging.

OXYGEN

The use of oxygen in the treatment of cardiovascular disease is usually beneficial but occasionally may have harmful effects. Mixtures containing 90 to 100 percent of oxygen may cause a decrease in vital capacity when administered continuously for twenty-four to thirty-six hours. The gas in high concentration is also irritating to the respiratory mucosa. In occasional cases it may favor the development of atelectasis. This phenomenon is apparently owing to the washing out of the nitrogen in the pulmonary alveoli —a process that requires less than seven minutes in the normal lung and less than fifteen, as a rule, in the abnormal lung. Alveoli containing no nitrogen will, if temporarily blocked by secretion, collapse markedly when the oxygen in them is rapidly absorbed. The presence of less readily absorbable nitrogen in alveoli normally permits only a slight amount of immediate alveolar collapse when the small bronchi are temporarily plugged. A rare complication of the prolonged use of high concentrations of oxygen is the vasomotor collapse that may occur when the patient suddenly resumes breathing room air. Oxygen in high concentration has a systemic vasoconstrictor effect (of unknown mechanism), and during its action normal vasomotor mechanisms may be depressed, leaving the patient without protection against hypotension when the oxygen is removed.

The harmful effects of oxygen therapy in cor pulmonale are also worthy of comment; they may be precipitated in this condition by concentrations as low as 40 percent. Chronic anoxia and carbon dioxide retention of severe degree are present in cor pulmonale. The respiratory center becomes accustomed to this degree of hypercarbia in only a few days, and the excess carbon dioxide in the blood ceases to act as an effective respiratory stimulant; respiration is maintained largely by the stimulus of anoxia. Relieving the anoxia by means of oxygen therapy depresses respiration to such a degree that carbon dioxide retention increases markedly. The resulting acidosis (or possibly the carbon dioxide itself, which in high concentration is a narcotic) causes coma, or in some cases confusional psychoses. Another acidotic mechanism—one causing tissue acidosis—acts in patients given excessive amounts of oxygen. The transport of carbon dioxide away from the tissues depends in large measure on the development of basic properties in hemoglobin when it is changed from acid oxyhemoglobin to reduced hemoglobin. The therapeutic use of oxygen in high concentrations may cause so much of the gas to dissolve in the plasma that venous blood

contains a decreased amount of the basic reduced hemoglobin; tissue carbon dioxide retention results. All the acidosis-producing effects of oxygen administration are rapidly reversed when room air is breathed.

AMINOPHYLLINE

The action of aminophylline in causing gastric irritation needs no comment here. In addition, it is a potent relaxer of smooth muscle. It greatly relaxes constricted bronchi and has a less striking effect on the smooth muscles of blood vessels. Its effects on other smooth muscle are negligible in doses used clinically. The drug must be given intravenously if a rapid dilatation of constricted bronchi is desired, as in cardiac asthma. The aim is to obtain a circulating concentraton of the drug large enough to relax bronchial muscle but not enough to dilate vascular muscle. Rapid injection of aminophylline may cause so much vasodilatation as to precipitate collapse or even death. Slower but still excessively rapid injection may cause lesser degrees of peripheral arteriolar dilatation, resulting in an increase in cardiac output (and work) and the development of cardiac pain in patients with rigid coronary arteries. This reaction may at first seem paradoxical, since aminophylline is used for the treatment of anginal pain, being given by mouth, however, in doses far too small to cause generalized vasodilatation.

AMMONIUM CHLORIDE

Ammonium chloride may cause gastric irritation, the manifestations of which may confuse the picture in a patient in the process of digitalization. This effect may be obviated by the use of enteric-coated tablets of the drug, but it must be remembered that in occasional cases this coating may not dissolve in the intestinal tract. A simple way to test this is to measure the urinary chloride output after the drug has been given.

The action of ammonium chloride as a diuretic given alone is largely based on the transformation of ammonium ion to urea, with the resulting liberation of chloride ion that carries sodium with it as it is excreted. This mechanism ceases to act after a few days and the drug is excreted unchanged; the diuretic effect of ammonium chloride, never great, is only of short duration. However, the use of the drug is important in patients given mercurial injections, in that it prevents the development of excessively low blood chloride levels, thereby augmenting diuresis and reducing the tendency to refractoriness. When ammonium chloride is given to patients with impaired renal function, a signifcant rise in blood urea level occurs. It is not established that this is harmful. However, the giving of very large doses of the drug, such as 15 gm. a day to normal subjects or small amounts for long periods to patients with renal insufficiency, leads to the accumulation in the blood of ammonium ion in concentrations toxic to brain tissue; psychosis or coma may result.

The prolonged use of ammonium chloride in patients with renal insufficiency may also cause sufficiently severe acidosis to produce coma. Even the mild acidosis that regularly develops in patients given 8 to 10 gm. of ammonium chloride a day may have undesirable effects; cardiac output is increased, and a strain thereby imposed on the heart. The acidosis may

aggravate dyspnea. In addition, acidosis has a metabolic effect, not well understood at present, consisting in a depression of carbohydrate utilization. This phenomenon may complicate the regulation of some diabetic patients and in all patients increase protein wastage. The occurrence of protein deficiency in many patients with congestive heart failure is well known. It might be aggravated by the long-continued use of moderately large doses of ammonium chloride.

MERCURIAL DIURETICS

The action of mercurial diuretics depends on their effect in inhibiting the reabsorption of chloride in the renal tubules; the increased output of chloride carries off base—chiefly sodium—and water. Frequent mercurial diureses may so markedly deplete the body of chloride as to prevent subsequent mercurial diuresis even though the patient is still edematous. The situation is easily remedied by the administration of ammonium chloride, 7 or 8 gm. of that substance being required to prevent a fall of blood chloride level during mercurial diuresis.

More serious is the development of the low-sodium syndrome, which is the result of frequent mercurial injections in a patient whose sodium intake is markedly restricted. Some patients with a lowered blood sodium concentration may become unresponsive to mercurial injections whereas others may continue to have fairly large diuresis. In the latter a variety of syndromes develop—muscle cramps, confusion, stupor or a shock-like state usually unaccompanied by tachycardia. The treatment is to give a 5 percent solution of sodium chloride intravenously, despite which an occasional patient may go on to die. Prevention of the syndrome merely involves limitation of excessively rigid salt restriction to cardiac patients who can be kept free of edema by this degree of restriction alone, without mercurial diuresis.

The loss of chloride that occurs during mercurial diuresis carries off basic ions other than sodium. The loss of potassium and calcium is increased in patients depleted of sodium. The loss of calcium rarely reaches degrees sufficient to cause hypocalcemic tetany, but the depletion of body stores of potassium may be marked. Some patients actually excrete more potassium than sodium during diuresis induced while they are in a state of sodium depletion. It has been known for decades that skeletal muscle of patients with congestive heart failure contains abnormally low concentrations of potassium; whether the profound skeletal-muscle weakness of cardiac decompensation is related to this chemical change is at present a matter for conjecture. There is some evidence that potassium loss accentuates digitalis intoxication. The loss of potassium during mercurial diuresis can be minimized by administration of generous amounts of fruit juices, which contain a good deal of potassium and little sodium.

The possibility of mercury poisoning need be mentioned only briefly. It occurs only—and usually in a mild form—in patients given mercurial diuretics by mouth.

LOW-SALT DIETS

Some patients in whom edema develops during congestive heart failure may be kept free of edema by means of rigid restriction of sodium intake without the use of mercurial diuretics. Skill is needed in the planning of these

diets, to make them attractive and to insure that the patients receive required amounts of animal protein and components of the vitamin B complex. Use of the Karell diet imposes additional deficiencies of calories, thiamine, vitamins A and C and iron.

Severe restriction of sodium intake combined with repeated injections of mercurial diuretics can be expected to lead to the low-sodium syndrome. Patients who require frequent mercurial diuresis should be advised not to restrict their salt intake excessively; extreme restriction is best reserved for patients who can be kept free of edema without mercurial diureses.

ION-EXCHANGE RESINS

The use of ion-exchange resins is not wide-spread at present but may become so. In addition to gastrointestinal upset and the acidosis caused by the ammonium chloride contained in some resins, the chief hazard is sodium depletion.

ABNORMAL WATER INTAKE

Marked restriction of water intake was once practiced in the treatment of edema in cardiac disease. It is now known that this was of little help in preventing edema and might even favor its persistence owing to stimulation of the posterior lobe of the pituitary gland. In recent years forcing of fluids by mouth has been recommended by some, with the aim of obtaining the diuretic effect of water. However, it has long been known that water diuresis cannot be induced in edematous cardiac patients. Excessive intake of water may produce vomiting and signs of water intoxication.

ANTICOAGULANTS

The use of anticoagulant drugs to counteract the tendency to the development of femoral phlebitis in congestive heart failure is not without hazard. The dangers of anticoagulant therapy are increased in the presence of hepatic disease. Dosages should accordingly be smaller than usual in patients with engorged livers.

TOURNIQUETS, VENESECTION AND POSITIVE-PRESSURE RESPIRATION

Decreasing the venous return from the limbs by means of tourniquets helps to relieve pulmonary congestion and edema. However, the diminution in blood flow through the lungs is accompanied by a corresponding fall in the output of the left ventricle; in addition, the blood volume decreases as a result of increased filtration into the tissues of the extremities. Shock is sometimes precipitated by the use of tourniquets. Tourniquets also cause a marked reduction in cutaneous blood flow in the extremities and thereby impair heart dispersal. The use of tourniquets for several hours may induce a fever that may be misinterpreted. Another effect that may be misleading is a sudden increase in respiratory activity that occurs shortly after the tourniquets are released; this phenomenon is due to the entry into the circulation of blood containing large amounts of lactic acid and carbon dioxode accumulated during a period of stasis in the extremities. This brief period of hyperpnea should not be considered an indication for the reapplication of tourniquets.

Tourniquets commonly cause the development of edema in the extremities, owing to increased filtration from the obstructed vessels. In addition,

some mechanism that causes over-all water retention apparently operates; this mechanism has not yet been defined. It is evident that prolonged use of tourniquets enhances peripheral edema and might theoretically favor the accumulation of pulmonary edema in one way while diminishing it in others.

Venesection and positive-pressure respiration decrease cardiac output and blood volume and thereby may precipitate or aggravate shock. The difficulty of performing venesection in patients in incipient or mild shock has saved many lives. Prolonged standing or sitting with legs dependent cause a decrease in blood volume (owing to increased filtration into the tissues of the legs) and in cardiac output and accordingly affords all the hazards as well as all the benefits of the application of tourniquets.

DISCUSSION

In some localities cardiac patients are under-treated with digitalis and overtreated with the other measures used in congestive heart failure. It is evident that adequate treatment with digitalis minimizes the need for some of the procedures discussed here. It must be borne in mind that, except for digitalis, all therapy for cardiac decompensation is symptomatic and does not improve cardiac function except, indirectly, by relief of anoxia in some cases. These treatments impose abnormalities that are different from but only partly opposite to those of the disease. It is not surprising, therefore, that use of the therapeutic agents discussed above may do harm at times. On the other hand, any harm done is usually the result of excessive or injudicious use of these agents. The well informed, alert physician can prevent these hazards or counteract them quickly when they occur.

FROM THE BULLETIN

James L. Fisher, M.D.

TWENTY YEARS AGO — NOVEMBER, 1933

From President Harvey's page: "For the past few years, Mahoning County has been using the county jail for housing mental cases . . . because there is no other place to handle these cases. It is a shameful situation which reminds one of the middle ages. Probate Judge Woodside has . . . offered a simple solution . . . that the city turn over the present municipal hospital to the county to be used as a mental hospital. At present the municipal hospital . . . is not kept up in repair so that it is not habitable as a hospital. At the request of Judge Woodside, Dr. Arthur G. Hyde, superintendent of the State Hospital for the Insane at Massillon, examined the municipal hospital. Dr. Hyde's opinion is that with some minor alterations, it would be excellent for a psychopathic hospital and mental clinic.

Excerpts from Dr. Patrick's "Biographies of the Living": Dr. R. D. Gibson was born in 1855 in the old stone house, still standing at the corner of East Dewey and Homestead Avenues. After graduating from Cleveland Medical College and Bellvue Medical College, his office was established at

No. 3 West Federal Street in 1881. Just a few years previously Koch had opened the field of bacteriology. In the early years of his practice Lister was applying Pasteur's discoveries to surgery. The surgery of those days was that of necessity, very little being done for the relief of conditions that did not threaten life. Dr. Gibson was the first in this city to limit his practice to eye, ear, nose and throat diseases. He brought to Youngstown many outstanding doctors some of whom are well known or remembered: F. F. Piercy, Harold Baird and W. H. Evans.

Dr. John Noll published an article on Rabies, which was on the increase. He outlined the procedure to be followed in case of dog bite, and the methods of diagnosing rabies in animals and man.

Dr. B. J. Dreiling had an article in the Ohio State Medical Journal on "Penetrating Wound of the Heart and Lung with Successful Removal of Foreign Body."

Hematology lectures were being held every Friday night. Over 120 were enrolled for the course.

TEN YEARS AGO — NOVEMBER, 1943

Excerpts from Dr. F. F. Piercy's article on "Maintaining Public Good Will in a War Crisis": Fifty percent of our profession here at home must try to do for the public what a hundred percent did before . . . Every dissatisfied patient is a possible booster for socialized medicine . . . Nothing pays a doctor bigger dividends than showing a sympathetic interest in the case and in the family. When a diagnosis is made the patient has a right to know three things: first, can he be cured, second, can much or little be done, third, can nothing be done . . . Be kind, be sympathetic but truthful. Send the patient away not in despair but with the determination to fight and win.

Not many letters this month from doctors in the service. Most of them were in far distant places where the censorship was strict or they were so pen weary from paper work that writing to the Bulletin was too great a chore. Dr. John Keyes wrote from Brigham in Utah. Stan Myers was heard from in the South Pacific. Gordon Nelson was at Oran where the Arabs never heard of soap and water being used together. The Bulletin was going out to everyone whose address was known and they were reading about how tough it was at home and who was taking vacations in New York, Florida and Hot Springs, Virginia.

You could still buy white shirts at Strouss's for $1.75 with your monogram on at a small extra charge. The Women's Auxiliary were hosts to 1000 service men from Camp Reynolds. Coach Wilce from Columbus didn't show up for the November meeting but Dr. E. E. Baird of Cleveland filled in on 24 hours notice and talked on "Recent Contributions to Endocrinology." Speakers were hard to get those days. Gasoline was, too.

FALL SERIES OF "MARCH OF MEDICINE"

A better look at the nation's leading health problems is in store for the American TV-viewer when the popular "March of Medicine" television series is resumed this fall over the NBC network. Actual live demonstrations from leading medical centers will be telecast to create greater public awareness of the extensive research being carried out by the medical profession. Sponsored by Smith, Kline & French Laboratories and the American Medical Association, the series features one telecast a month—in October, November and December—over 70 NBC network stations in the United States and also in Ottawa, Toronto and Montreal.

A report on the extent of research being carried out in various parts of the country on cancer—the nation's second major health problem—will be aired at 10 p.m., EST, Thursday, November 5, replacing the US Tobacco Company's "Martin Kane, Private Eye." Highlights of the A.M.A.'s annual clinical session in St. Louis will be covered in the third program December 3.

The first telecast, broadcast October 8, featured a progress report on research and treatment of some types of heart disease—the nation's number one health problem.

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