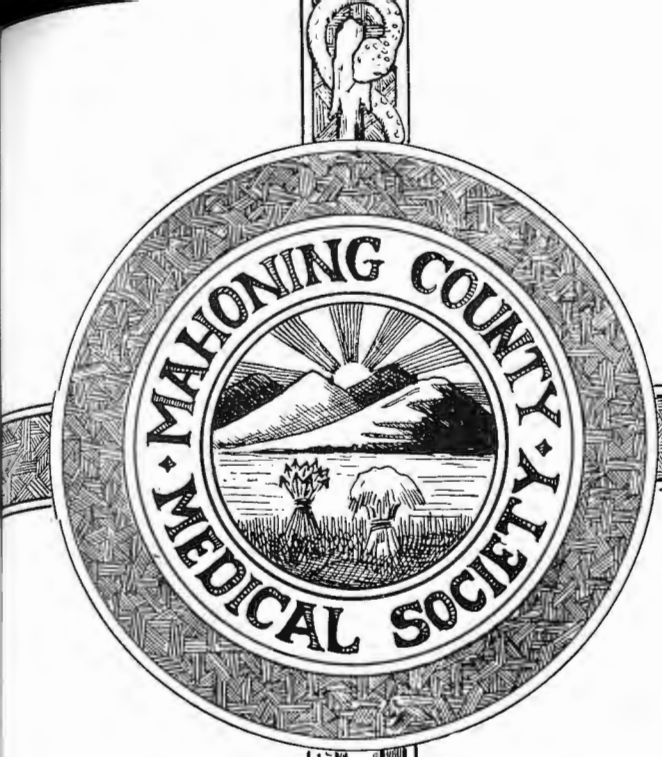

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

August • 1956
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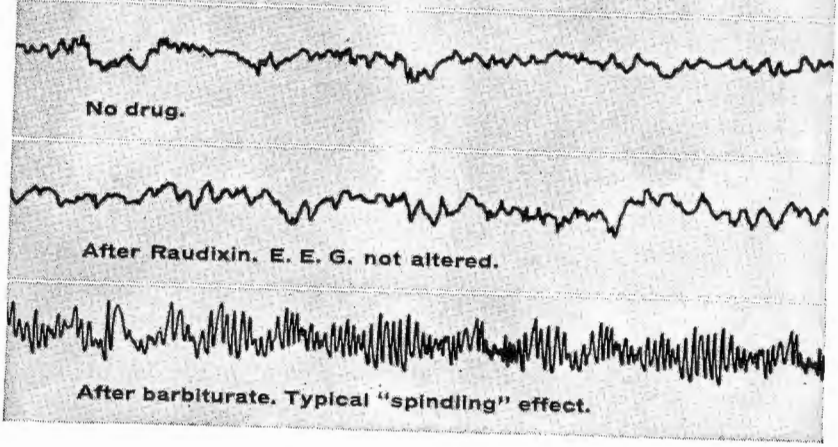
Youngstown • Ohio

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

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Our President Speaks

During the past several years medicine has made much progress. There is much more to be achieved. Youngstown has kept abreast of this progress. It was my privilege to attend the recent open house ceremonies at the new St. Elizabeth's Hospital. It is truly well equipped, up-to-the-minute, beautiful hospital. South Unit has completed its rebuilding and North Unit is contemplating an addition in the near future.

Despite the increase in hospital beds it still is often difficult to get a patient in the hospital. There are reasons for this predicament. Far to many individuals are using hospital beds simply because it is the only way to get insurance to pay for such services as X-rays. Often times patients desire to stay in the hospitals longer than necessary for various personal reasons of their own. Hospitals should be used for the diagnosis and treatment of patients and not as convalescent or rest homes. These unwarranted uses of beds leads to a shortage. The increased use of beds will eventually lead to an increase in the cost of hospitalization insurance.

What is the answer? There are several: (1) X-ray fees paid for by insurance for out-patients as well as in-patients, (2) Have deductible insurance much like automobile insurance, (3) Discharge patients when ready and not just to suit their convenience.

In addition to the general hospitals, Youngstown can boast of the Woodside Receiving Hospital. It is one of the first of its kind and has been copied throughout the country. It, too, has been recently enlarged.

The Mahoning County Tuberculosis Sanitarium and its staff have done such a wonderful job that there are not enough patients to keep it full. The treatment of tuberculosis has made tremendous progress. Yes, the Youngstown area has reason to be proud of its hospitals.

G. E. DeCicco, M.D.

BULLETIN of the Mahoning County Medical Society

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Bulletin Staff for 1956

TELL YOUR PATIENTS WHERE YOU ARE

Three state medical societies have made it easier for members to explain their absences from the office during state society scientific meetings. The societies provide doctors with printed signs for display on the office door. Each sign mentions the society meeting; one has a place for an emergency phone number and one is gummed for quick affixing to the door or window.

The South Dakota State Medical Association notice is titled "To My Patients." It says, in part: *"This is my opportunity to receive more scientific education so that I may better my services to you.* I regret any inconvenience this may cause you, but will see you soon." The orange sign is 7 by 11 inches.

The State Medical Society of Wisconsin supplies a red and white sign, perforated across the center. The top half, "Tell Your Patients," carries a message from the secretary about the importance of the meeting and tells how to arrange in advance for emergency calls during the program. The lower half, "To My Patients," carries the state society seal and explains the doctor's whereabouts. This half, 7 by 5½ inches, can be detached and posted.

The Medical Society of the State of North Carolina offers a gummed sticker, 6 by 4 inches. It reads, *"Doctor Is Out. He is attending the annual session of the Medical Society of the State of North Carolina,* where he is hearing scientific lectures by the leading scientists of the nation and viewing the latest medical and surgical techniques and equipment that he may better serve your medical needs. The Doctor is expected back in his office ——"

Most patients are reasonable about such absences if they understand why they happen. This method of explanation serves, too, to remind the doctor of his responsibility to take an active part in his society's scientific meetings.

THE ALLIED PROFESSIONS

By C. A. Gustafson, M.D.

The organization in Mahoning County known as the "Allied Professions" has been in existence and effectual operation for more than 25 years. The late Dr. William Skipp was one of the organizers and its most faithful workers. Since Bill is no longer with us, I am wondering about the future of this organization. Who will carry on? It will not run itself; it takes a lot of work.

With the thought that some of our newer members should know more about the "Allied Professions" and how it operates to make for better health, I am submitting a brief history. This history is an abstract of a paper, read by Dr. Skipp at a meeting of the AMA a few years ago. I helped him prepare the article and know how enthusiastically he worked for this organization, and how anxious he was that others might profit from our experience.

"Our improved relations with the Allied Professions began in about 1930. This was long before public relations of state and national organizations ever existed. Public relations were not good. Hospitals managed their own affairs as they pleased. Professions were back-biting. We were fighting with the pharmacists; we were fighting with the nurses. We had no good relations whatever with any of them, in any sense of the word.

"The BULLETIN of the Mahoning County Medical Society came into existence in January, 1931, and was instrumental in introducing public relations among our members first, and then among the members of the Allied Professions. Each profession seemed to be selfishly thinking of its own selfish welfare.

The Council of our medical society was organized in 1930. With the founding of council we tried to find ways and means of getting better relations with the other professions in the county. The nurses and dentists were contacted, and after a discussion in the Council, we formed what we called an Inter-Professional Committee. The nurses and dentists were invited to membership and accepted the invitation.

This committee began to function with three organizations: medical, dental, and nursing. Two years later the hospitals were invited to join. The druggists were the next group invited to join the Allied Professions Committee.

About this time a decision was made to have these groups function politically.

In 1948 we invited the Allied Professions of Trumbull County to join with us. This was because members of the Allied Professions extended into that county. In 1949 the veterinarians and the chiropodists were invited to join and accepted.

At the beginning of each year a meeting is called for the selection of a Chairman of the Committee and other officers, and to formulate plans for the year. If it be election year, we draw up a questionnaire after the candidates are nominated. We present that questionnaire to each candidate, we have a meeting with each candidate and go over the questionnaire with him and get his reaction to public health problems. These questions are submitted to every candidate from the governor down to the county commissioners. The results of these questionnaires and interviews are tabulated and sent to every member of the Allied Professions.

All candidates who are elected get a congratulatory letter from the Allied Professions, and as soon as possible after the election, a congratulatory dinner. We sit down again with them and go over these matters that we are interested in."

THE DIAGNOSTIC USE OF SERUM AMINO-PHERASE
(Glutamic Oxaloacetic Transaminase)

By Peter R. Cibula, M.D.

SGO-T levels were studied extensively by Cohen and Heckhuis in 1940 in various animal tissues with the highest concentration being present in heart muscle. LaDue, Wroblewski and Karmen making note of this observation in 1954 devised a spectrophotometric method of determination and tested the serum concentration of this enzyme following transmural myocardial infarction. This specific tissue engyme is found in heart muscle, sketetal muscle, brain, liver, kidney, testicle and lung, in decreasing order and is liberated only when the above tissues are injured. The SGO-T elevation then depends upon:

1—the specific tissue injured,
2—the extent and type of injury
3—the vascularity of the surrounding tissue.

Agress, LaDue, Wroblewski and Karmen have shown that injury to tissue results in a decreased concentration of the enzyme, with a concomitant increase in serum activity. Their studies have also shown the SGO-T activity to be within normal limits in the absence of damage to liver, heart or skeletal muscle in the diseases and conditions as shown on slide No. 1.

We have similarly obtained normal values in many of these conditions, as shown by our determinations on slide No. 2.

The transaminase activity may be measured either by quantitative paper chromotography or by spectrophotometric assay, the latter being more easily and rapidly determined. As seen on slide No. 3, the spectrophotometric assay depends upon the transfer of the alpha amino nitrogen of aspartic acid, to alpha ketoglutaric acid in the presence of the engyme with the formation of glutamic acid plus oxaloacetate. The oxaloacetate is then reduced by DPNH to malate in the presence of excessive malic dehydrogenase. The resulting decrease in optical density of the solution which results from the oxidation of DPNH to DPN is measured by ultraviolet absorption in a spectrophotometer. The machine which we have used is the Beckman DU-DK2 which has given excellent reproducible results. All of the chemicals are present in excess, with a phosphate buffer at p^H 7.4, the limiting factor, therefore, being the concentration of SGO-T. The normal range has been found to vary between 5 and 40 units. One unit is the change in optical density of 0.001 per milliliter per minute at 340 millimicrons.

This study is based on 491 determinations on 236 patients, run at the laboratories of the Youngstown Hospital Association, from September 1, 1955, through May 15, 1956, the purpose being to evaluate the usefulness of SGO-T activity in the diagnosis of myocardial infarction and liver disease.

It has been shown experimentally, that the height and duration of the elevation of SGO-T is roughly proportional to the amount of heart muscle damaged. Nydick, Agress and Ladue have shown that following graded myocardial infarction in dogs with coronary ligation or the injection of plastic microspheres into the coronary circulation, the elevation of SGO-T is roughly proportional to the amount of myocardium infarcted with as little as 10% of the myocardium producting abnormal levels. The intravenous injection of papain into rabbits produced similar results. The elevations were in the range of two to twenty times normal and it must be borne in mind that these all occurred during the acute phase of myocardial destruction.

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FROM THE BULLETIN

Twenty Years Ago — August, 1936

It was a rainy summer twenty years ago. The reunion and golf party of Youngstown Hospital Internes was rained out and had to move indoors at the Youngstown Country Club. The annual picnic and golf day of the Medical Society had to be postponed until September. The former internes from St. Elizabeth's Hospital evidently lived right for their reunion at the Squaw Creek Country Club was unspoiled. E. J. Wenaas won the golf prize with F. W. McNamara a close second. J. M. Ranz won the honors in trap shooting. It was a special celebration that year to commemorate the twenty-fifth Jubilee of the Hospital.

In line with the anniversary celebration, the Bulletin printed a leading article giving the history of the founding and development of St. Elizabeth's Hospital. Some excerpts would be appropriate here ~~in view of the present-day~~ ceremonies incident to the opening of the new addition.

Monsignor Mears in 1909 appointed a committee of laymen and clergy to solicit funds for the new hospital. By 1911 enough money had been raised to buy the Fitch property on Belmont Ave. consisting of a large lot with three frame houses. Remodeling of the buildings was started in August and the new institution opened its doors to receive patients in December, 1911. That was fast work. The largest building was capable of accommodating 30 patients, the second building was used as a home for the Sisters and the the third provided quarters for employes and the hospital laundry. Sister Genevieve was named the first Superintendent and proved to be a capable executive with a genius for organization.

In a month the hospital was taxed to its capacity and it became necessary to buy an adjacent property with two more buildings, one for a nurses home and one to house 25 more patients. These facilities soon became inadequate and two years later a public campaign raised more than $1,000,000 dollars to build a new brick hospital of six stories which is now the old north wing of the present hospital. It was opened in 1915.

Dr. R. E. Whelan was the first chief of staff and became the grand old man of St. Elizabeth's, devoting his life to the service of his fellow men and the Hospital he loved. Dr. C. D. Hauser succeeded him when his health failed but up to his last days Dr. Whelan could be seen in his wheel chair attending operations and supervising the work on the wards.

The rapid growth of the hospital soon necessitated expansion. The Stambaugh mansion across the street was acquired for a nurses home in 1927 and two years later the "A" unit was finished so that at the time of the Jubilee year the capacity of the hospital was raised to 300 patients. It was the last word in equipment for hospital care of the sick with all the adjunct services of X-ray, emergency rooms, physiotherapy, record keeping and a modern medical library.

Ten Years Ago — August, 1946

The summer of 1946 found things booming both in business and medical practice. The new hospitalization insurance had the hospitals crowded, with beds at a premium and waiting lists to contend with. A new situation of scarcity of nurses had arisen so that private duty nurses were hard to find and it was a problem to supply existing wards with personnel.

Preparations were under way for a big medical exhibit at the Canfield Fair. Dr. Skipp was desperate because there were only six volunteers to man the exhibit.

—*J. L. F.*

ANESTHETIC PROBLEMS IN THE AGED

Today, the average life expectancy of the male is 64.45 years and of the female 69.78 years. These figures are misleading for they classify the patient on the basis of chronological and not biological age. Thus, age is determined by organic functional capacity, mental capacity and response to stress and strain. This increase in longevity complicates anesthesia with pure aging and with the debilitating diseases of old age. The slight increase in mortality between the younger and older age group then can be attributed to the fact that the aged patient does not possess the reserve of the younger patient. The management of the geriatric patient as a result is a challenge to both the surgeon and the anesthesiologist.

The anatomic, physiologic, and pathologic changes peculiar to old age are responsible for the difficulties occurring in surgery and anesthesia. External changes are visible, but there are also internal changes, and both are due to the normal deterioration of old age. For example, the principle change in the bones is osteoporosis. Synovial sacs are stiff and hard. Fusion of the sternum produces a rigid thorax which in turn reduces pulmonary ventilation.

In the cardio-vascular system, physiologic changes occur in the heart due to dehydration and degeneration. Diseases such as hypertension result in hypertrophy, fibrosis, and less reserve. The geriatric patient shows some degree of coronary sclerosis. Blood vessels even superficially show atheromatous calcification and loss of elasticity. Hypertension resulting from these changes is of no importance unless the diastolic pressure is elevated. Patients with diastolic pressures over 130 are digitalized. Cardiac irregularities are common. Extrasysales in themselves are not significant unless they are ventricular in origin. Auricular prematures are precursors of auricular fibrillation. Ventricular tachycardia indicates severe cardiac disease and its occurrence during a surgical procedure demands immediate treatment with antifibrillatory drugs as I.V. Quinidine, Pronestyl, Procaine or Benadryl. Benadryl is used frequently because Benadryl prolongs both the Q.R.S. and Q.T. intervals as can quinidine. It is a successful drug for clinical fibrillation and is ever more effective in ventricular arrhythmias.

In the respiratory system, emphysematous changes and existing pulmonary disease cause tidal hypoxia. Realizing this, Orthoxine an Isopropyl Amine was investigated. This amine is a more effective bronchodilator than ephedrine, less effective than adrenalin, but it has no stimulating effect on blood pressure, no effect on pulse rate, and in only 50% of the patients investigated, it had a transient depressor effect. Spirometric studies on 20 patients with bronchial asthma indicated that orthoxine is an effective bronchodilator and antihistaminic. This amine group deserves further investigation because it overcomes the parasympathomimetic effects from both organs and drugs (such as Pentothal which is commonly used in the aged).

In the genito-urinary system, the kidneys show definite pathologic changes. The urea clearance tests indicates that the reserve capacity of the kidneys is reduced. Examination of the specific gravity will show many times a persistent 1010. This simple observation should prevent overhydration during the operative and postoperative periods.

The limitation of time makes it impossible to enumerate other changes which are present. However, it is evident from the above descriptions that the patient's general condition must be evaluated in the preoperative preparation. We know that the following conditions may be present—arteriosclerosis, hypertension, coronary disease, pulmonary fibrosis, emphysema, liver,

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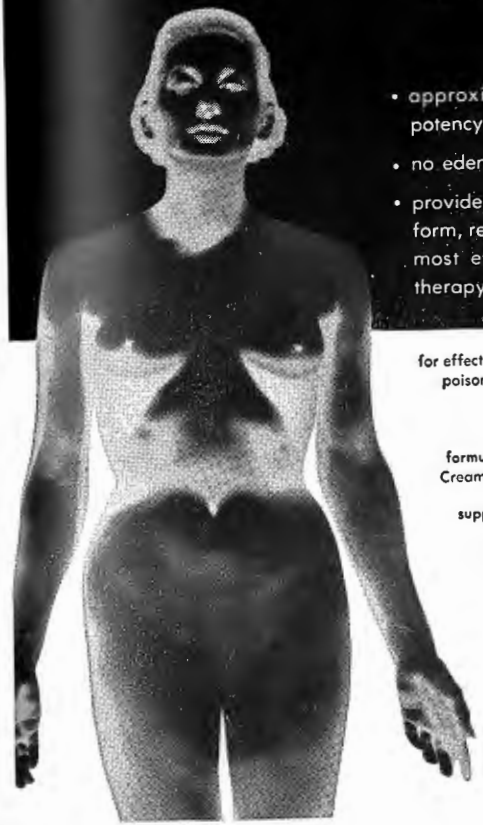

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kidney, or mental disease. We also should be aware that reversible pathologic states are present as anemia, hypoproteinemia, dehydration, diabetes, obesity, hypo-thyroidism, bronchitis and "chronic shock state"— a syndrome due to weight loss, reduced blood volume, decreased blood protein, and interstitial fluid. The conditions will respond to therapy and must be corrected in the preoperative period, otherwise perfect anesthesia and surgery will end in failure. The so-called "unexplainable deaths" in the aged are due to preexisting chronic shock states. Restoration of fluid and electrolyte balance prior to surgery is necessary because dehydration increase the incidence of venous thrombosis. Adequate fluid replacement will correct hemo-concentration and restore adequate urinary excretion.

Correction of anemia is as important as restorations of blood volume. The anemic patient is prone to the development of shock during surgery. Correction of the anemia improves the cardiac status of the patient and also elevates plasma protein. It is recommended that 500 cc of whole blood be given for every 7 point deficit in hemoglobin under 70%.

Restoration of protein deficits will protect the patient against edema and increase the resistance to infection. Protein therapy should be by the oral route. Under anesthesia, serum albumin is invaluable.

Vitamin deficiencies are common in the undernourished geriatric patient. Vitamin A is essential for normal liver function and should be given in the presence of hepatic damage. Vitamin C is essential for wound healing. Thiamine is necessary for carbohydrate metabolism. The administration of 1 gram of Vitamin "C"—30 mgm. of Thiamine, 100 mgm. of Niacin and 5 mgm. of Riboflavin for week prior to surgery will correct a vitamin deficiency. A higher death rate is associated with low levels of Vitamin A, Niacin and Ascorbic Acid. Another point to remember is to allow these elderly patients to use their tobacco and alcohol. Not permitting their use may effect them more than the surgical procedure.

Premedication must be considered next. The aged patient poorly tolerates the opiates, barbiturates and hyoscine. Large doses of morphine are not advised and may produce severe respiratory depression resulting in poor anesthesia and setting the stage for post-operative complications. Use morphine in doses of gr. 1/10-1/12. Demerol seems to be better tolerated. Chloral Hydrate is preferred to barbiturates which may produce pronounced respiratory and circulatory disturbances. However, prior to a local, spinal or regional black, a light dose of a barbiturate is necessary. Thorazine in judicious amounts is tolerable but in the recommended dosage it is dangerous because hypotension is not tolerated by the elderly cardiac. Phenargen and more recently Sparine are more promising.

The Belladonna group is used preoperatively to reduce secretions and depress vagal reflexes. Atropine is better tolerated than Scopolamine which has euphoric properties. Use small doses of Atrophine (gr. 1/300) to prevent cardiac acceleration and secondary myocardial hypoxia. Many times Benadryl alone is ordered because of its sedative, antisecretory and antifibrillatory effects. If a patient shows undue clinical changes from premedications as hypotension (barbiturates, thorazine), tachycardia (Atropine) or marked drowsiness, the case should be rescheduled.

As far as anesthesia is concerned, be conservative. It is very easy to overdose the geriatric patient. Avoid "Blitz inductions." Endotracheal Diethylether is still a very useful agent if it is kept above plane 3. Small amounts of intravenous dramamine eliminates nausea and vomiting and ade-

(Continued on Page 330)

KEEPING UP WITH THE A.M.A.

C. A. Gustafson, M.D.

The Senate has voted to include in the social security bill (H.R. 7225) a program of payments to the disabled at age 50. The House could accept the Senate version, but a conference to compromise differences is more likely. At any rate, because both Senate and House bills contain disability payment plans, the measure, when it reaches the White House, will be certain to carry this program to which we are so opposed.

In the Senate, the first roll call vote on disabiilty payments was 47 to 45 —a switch of one vote would have meant a tie and a victory. Doctors and their friends waged a vigorous and persistent fight against this program; had the vote on it been taken several months earlier, there is not much question but that the plan would then have carried by a far wider margin.

Because of all the time and effort you have put into this campaign, we believe you will be interested in the full story of what happened in the Senate when the disability payments plan came up for a vote. This gives you the abstracts from the arguments of those who took part in the debate. If you are pleased with the way your Senators conducted themselves when the pressure was on, I suggest you write them and express your appreciation.

There is no inclination on our part to minimize what has happened; a dangerous piece of legislation that can have far-reaching effect on the practice of medicine is very close to enactment. Only a presidential veto can stop it now.

Late in May the Senate Finance Committee completed its work on House-passed H.R. 7225 and reported out the bill with the disability payments section deleted. It was held off the floor while the Senate majority tried to work out a compromise. Early in July Senator George made public his idea of a compromise on disability payments: essentially it was the same as the original plan, except that OASI payroll taxes to finance the payments would be put in a special fund and disbursed from there. Transparent as this scheme was, it obviously had appeal for a few Senators who were worried that the new program, if an integral part of OASI, would endanger the OASI trust fund.

On Friday, July 13, H.R. 7225 was called up in the Senate, but not much debate took place that day. Agreement was reached for three hours' debate on the above George amendment, starting at 1:30 p.m. on Tuesday, July 17. The following abstract follows the course of the debate, leading up to passage of the amendment.

Chairman Byrd (D.,VA.) of the Senate Finance Committee led off by stating there were "pronounced differences of opinion" among experts on disability. "Many of them believe that a system of cash disability benefits would operate to discourage efforts toward rehabilitation at a time when important progress is being made in that field under the expanded Federal-State program of vocational rehabilitation." He said the question of adding cash disability payments to OASI was "complicated also by difficulty in estimating costs. Experience under the so-called disability freeze provision, which was added to the Old-Age and Survivors Insurance program by the amendments of 1954, is too brief to provide a firm basis for estimating the cost of cash disability payments."

In summary, Senator Byrd said the Finance Committee had concluded "from extensive hearings and study that the apparent disadvantages and uncertainties of the proposed system of cash disability payments are far too

great to warrant its recommendation to the Senate and to people, who would bear its cost." He explained also all of the provisions of the Senate Finance Committee's bill, including the program in which the Federal government would contribute 50% toward the cost of providing medical care for public assistance recipients on the basis of $8 per adult and $4 per child recipient.

Backing up Senator Byrd, Senator Bennett (R.,Utah), a Finance Committee member, warned the Senate that once it embarked on disability payments "there will be no turning back . . ."

Senator George, speaking on the point of a separate trust fund, admitted that the House would probably insist on retaining but one Social Security fund. He said, "it is not a thing we are going to avoid. Whether or not we do it this year we shall certainly do it in the next Congress. Make no mistake about that . . ."

Senator George claimed that disability determinations can be made by medical practitioners without difficulty and that they are being made satisfactorily in the disability freeze program and in many other government retirement programs. He argued that, while his proposal provides benefits for persons only between the ages of 50-65, ". . . there is as much justification for the payment of benefits to the disabled at age 48 or 49 as at 50 or 51."

Senator Aiken (R.,Vt.) asked if the George Amendment would give benefits to any of the 10,000,000 persons (including farmers), who were brought under social security two years ago. It was explained that they would not be eligible until they had been under the system for five years and that no persons now disabled who have not acquired eligibility could become eligible for disability benefits.

Senator Aiken said: "If the amendment will exclude the larger percentage of the persons who need the benefits the most, we had better wait until we can do a better job than apparently will be done by the amendment."

Senator Dirksen (R.,Ill.) then raised the question of eventual removal of the age 50 limitation to take care of the disabled man raising a family. But he added, "that suggests the real difficulty. What would be the cost if we were to remove the age limitation? . . . "To reduce this subject to its irreducible minimum would mean putting a compulsory tax on 70 million people in order to pay health benefits to some. In my judgment such an approach would put us well along the road to compulsory health insurance . . . it will be very easy to strike 'permanent' and make it 'temporary', and to strike 'total' and make it 'partial.' Then the hospital benefits would be built up, and we would be well along the road of compulsory health insurance. . . . It seems to me in view of the fact that the whole matter is so inconclusive today, the Senate would be warranted in sending the proposal back to the committee for some honest-to-goodness study."

Note—Senator Bricker voted on our side in both the first roll call and on the reconsideration roll call. Senator Bender did not vote. Why, I don't know. We shall give him opportunity to explain. The doctors think this is an important bill.

CANFIELD FAIR

Arrangements for the Medical Health Exhibit Tent at the Canfield Fair, August 30th through September 3rd, are rapidly nearing completion. Exhibitors this year will include the American Red Cross, Dentists, Optometrists, Chiropodists, Osteopaths, Druggists, Polio, St. Elizabeth's, Youngstown Hospital, Woodside Receiving, Tuberculosis and Health, Mahoning County Health, Cancer, and Hearing. We are also securing our own exhibit from the AMA entitled "Your Heart." A highlight of our tent this year, will be a film and slides on Prosthetics presented by Doctor Morgan W. Baker, in conjunction with the Corydon-Palmer Dental Society and Mahoning County Medical Society. With the time and effort put forth by our exhibitors this year, our "Tent" should be one of the best ever and a must on your agenda come Fair-Time.

H. P. McGregor, M.D.
Chairman, Canfield Fair Committee

NEWS NOTES

Dr. Ben Berg was in Salt Lake City June 20-24 to attend the meetings of the Society of Nuclear Medicine, to which he was recently elected into membership.

Dr. John R. LaManna has recently moved his office from 3714 Market to 3711 Market Street for the practice of general practice.

Dr. David B. Brown announced the removal of his office to 2921 Glenwood Avenue for the practice of internal medicine and gastroenterology.

Dr. Frances Miller went by air to Mexico City to attend the International Congress of Radiology which was in session from July 22 to 28th.

Dr. and Mrs. Arthur Rappoport are now touring Europe. Hope to have something about their sojourn in the next bulletin.

Dr. Robert Wiltsie has opened an office for the practice of pediatrics in the new Wickliffe Medical Center.

Dr. and Mrs. W. O. Mermis returned in July from an extensive tour of Europe.

The July edition of The Ohio State Medical Journal has an article entitled "Evaluation of Combined Prednisolne-Aspirin Therapy in the treatment of Arthritis" written by Drs. M. M. Szucs, Vitalij Holonko, K. M. Forster and Dario Nalagan.

Dr. Lester O. Gregg attended the course in rhinoplasty and otoplasty presented by Dr. Irving B. Goldman at Mount Siani Hospital, New York City during the last two weeks of July.

Dr. Edward Massullo who is now on active duty with the Air Force visited Youngstown during July while traveling to a new assignment in San Francisco.

Dr. Sidney L. Davidow announces association of Kurt J. Wegner, M.D. in his office for the practice of Pediatrics and Pediatric Cardiology.

Among the seventeen Ohio Physicians certified by the American Board of Obstetrics and Gynecology recently were Youngstowners Simon W. Chiasson and Kalman C. Kunin. Congratulations.

Our William Breesman tried the fairways in the Ohio Amateur Golf Tournament but without success this time. Better luck next time Bill.

HAVE YOU MET . . .

JAMES R. SOFRANEC, who practices otolaryngology at 208 Mahoning Bank Building, in association with Drs. Benko and Sovik? Dr. Sofranec was born in Youngstown, Ohio, February 26, 1923 and received his premedical education at Oberlin College. He was graduated from Loyola Medical School in 1950. His internship was at St. Elizabeth Hospital in Youngstown, from 1950 to 1951 and he also filled a surgical residency at St. Elizabeth from 1951 to 1952.

Two years of Army Medical Corp time in Korea and Japan, where he practiced eye, ear, nose and throat, occupied the years 1952 to 1954. On his return from service he had a residency from 1954 to 1956 in otolaryngology at Hines Veterans Administration Hospital, Hines, Illinois.

Dr. Sofranec is married to the former Margaret C. Dulard, who is from Chicago. They have four children: Lorraine, Janet Mary, Mary Elizabeth and Margaret Ann. Dr. and Mrs. Sofranec live at 452 Lora Avenue in Youngstown.

JACK MALKOFF, who quite recently became a father, July 6, this year to be exact? Dr. Malkoff practices at 1310 Central Tower, in Youngstown, Ohio and does ear, nose, and throat.

He was born in Youngstown, Ohio and attended Ohio State University for his premedical and medical work. His internship was at the Newark City Hospital, Newark, New Jersey. His ear, nose and throat residency was obtained at Veterans Hospital, Los Angeles and the Massachusetts Eye and Ear Infirmary. Total residency time was from July, 1952 to January 1956.

In 1954, he married Judy Sherman from Altoona, Penna. and their first child, Laurie, is just a few weeks old.

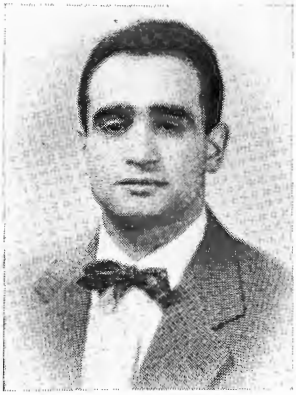
Dr. Malkoff served two years in the service from 1944 to 1946. His big interest at the moment are his family and his new practice.

ST. ELIZABETH'S HOSPITAL

The official opening of the new wing of St. Elizabeth Hospital was ushered in with an open house on the evening of June 29, 1956 which was attended by many Youngstown physicians. A complete tour of the hospital facilities was made. Inspection by the general public was made on July 1, 1956.

Only the north wing of the hospital which is undergoing repairs now remains to be put in operation. The date of opening of the north wing facilities will be sometime this fall but the exact date has not as yet been announced.

Paul Ruth



RAYMOND S. BONIFACE. Dr. Boniface was born in Pittsburgh, August 6, 1924 and took his premedical work at Duquesne University, Pittsburgh, graduating in 1948. He received his M.D. from the University of Bologna, Italy and had a rotating internship from 1952 to 1953 at St. Elizabeth Hospital. From 1953 to 1954 he had a medical residency also at St. Elizabeth's. At the present time he is doing a general practice at 1938 E. Midlothian Ave., where he opened his office in December, 1954.

His military service consisted of three years with the infantry in France, Belgium, Holland, and Germany, from 1943 to 1946.

He married the former Jacqueline Clair of Boardman and they have one child two weeks old. His interests are fishing and sport cars. His interest in sport cars is intense to say the least.

PEARLS AT RANDOM

(Louis Bloomberg)

Most physicians frequently encounter the patient with chronic respiratory disease such as bronchial asthma or pulmonary emphyema.

The small portable vital capacity apparatus is a helpful aid in evaluating the extent of pulmonary disease. A rough estimate of pulmonary function can be determined quite quickly and easily with this simple volume recorder.

The course of bronchial asthma, pulmonary emphysema or other chronic respiratory conditions can be followed with a surprising degree of accuracy by recordings of the vital capacity.

Because of the simplicity of this test, it may well be included in standard office procedure.

Jack Schreiber, M.D.

—o—

One of the most frequent questions asked, both by patients and physicians, is "which cases of Varicose Veins can be satisfactorily treated by injections alone, and which ones should be treated surgically?"

While no specific rules for the treatment of all cases of Varicose Veins can be drawn up, certain general rules apply. When a competent saphenofemoral valve and communicating branch valves are present, accompanied by dilated veins, these can be adequately treated with local injections. This applies only to 8 to 15 per cent of our patients.

When the sapheno-femoral valve is incompetent, local injections will result in early recurrence. In this situation the preferred method of therapy is to resect the Saphenous Vein at the Femoral junction with all of its branches and strip the entire Saphenous Vein from the groin to the foot. Each incompetent communicating vein must also be widely resected.

In the presence of an ulcer, active therapy is best deferred until the ulcer is clean or preferably healed. Then the ligation, resection and stripping procedure should be done.

When acute thrombo-phlebitis is present, surgical therapy had best be deferred until the acute process is no longer active. At this time operation may be done, but is best delayed for a minimum time of six months after phlebitic activity.

M. H. Steinberg, M.D.

ANNUAL GOLF MEET

THURSDAY, AUGUST 23, 1956

Youngstown Country Club

Mahoning County Medical Society
Corydon Palmer Dental Society
Medical-Dental Bureau

GOLF 12:00 Noon
Dinner 7:00 P.M.

NO dinner tickets sold at Club
NO dinners served without reservations

Reservations MUST be received not later than AUGUST 13

POST GRADUATE DAY TO BE OCTOBER 24th

Plans for the Annual 6th Councilor District Meeting, to be held this year in Youngstown, are now entering the advanced stages, and all indications point to a highly successful event. The meeting is scheduled for Wednesday, October 24th in the Stambaugh Auditorium.

Selection of the Auditorium for this year's meeting will provide much more adequate facilities for both members and exhibitors, including larger parking area, modern sound and visual equipment, with lunch available on the premises. The banquet will be held in the evening at the Pick-Ohio Hotel.

An interesting and unusual selection of speakers has been obtained to make for a stimulating and informative meeting. This will include a special panel of experts from Loyola University for the Section of Obstetrics and Gynecology.

The Woman's Auxiliary will hold their 6th district meeting at the same time, with a luncheon at the Mural Room for members. All wives who are not active members are cordially invited and urged to attend. Interesting entertainment, as well as a cocktail party for the ladies, will be provided to make it an enjoyable day for the wives.

Highlighting the banquet in the evening, for members and their wives will be the speaker, Dr. Douglas Bond, of Western Reserve University, who will give his own refreshing views on how a psychiatrist sees the practicing physician.

EUROPEAN TRAVELOGUE

(Dr. John McDonough)

April 29th, 1956
New York
Weather Beautiful

I am writing this on the plane as we take off on the first leg of our flight to England.

At Idlewild Airport the Pan-Am counter clerk was reasonable and courteous and did not charge us for overweight. We were about ten pounds over but this included our two Pan-Am overnight bags which we are normally allowed.

The flight is supposed to take ten hours to London. At 9:00 P.M. all is well and we settle down to try and sleep.

It's now 3:30 A.M. We are awake. It's daylight, a bright clear day and I can smell—and now see— bacon frying. We are to the immediate rear of the galley which is located approximately two-thirds distance back from the cockpit. Breakfast consisted of orange juice, scrambled eggs, and ham, rolls and coffee. I had tea (no trouble at all). The Captain reported that our flight path last night took us north almost to Greenland. We had a tail wind of 98 knots and are now over Scotland. He estimates our arrival in London at 4:30 A.M. This trip so far has been remarkably smooth and except for the vibration of the plane, we could well be sitting in our living room. However, sleeping in a semi-sitting position was next to impossible—a few cat naps, perhaps, but no real rest. As in most of our previous air travels this crew appears to be very efficient and pleasingly courteous. Other carriers could take a lesson from the airlines.

April 30, 1956
London, England
Weather beautiful again

Our first day in London was very interesting despite the fact that we were tired after our all night flight.

The English people are typically "British" wherever you find them. London seemed clean, the streets, shop fronts, and taxicabs were shining. Nowhere in the world have I seen taxicabs so clean and well polished. The cab drivers are almost all uniformed and reveal a dignity not seen in the States.

Everywhere we noticed small gardens with flowers in bloom. No matter how small the patch of ground there was a fence, a hedge, (mostly boxwood, I believe) grass and flowers.

We had tea and crumpets in the "Buttery" off Bond Street and near our hotel. There were more men than women drinking tea and eating a "sweet." Why don't they get fat? Most of the Englishmen we see are lean and very fit in appearance. Men's clothes seem to be more tailored. At times the fit seems a bit tight and one gets the impression that some of these gentlemen must sleep in their clothes or else rarely get the garments pressed.

We ate dinner or supper, I'm not sure which, in a restaurant called "Francai's"—not so good. Thereafter, we saw the show "Summer Song." It was a fine musical and we enjoyed it. The cast was a mixed British and American troup and did a splendid job. The entire audience and cast rose to sing GOD SAVE THE QUEEN at the close.

Our tour continues in the A.M. early with a visit to the University Hospital and on with the study of "infertility."

May 2, 1956
London, England
Weather excellent

Two half day sessions have been devoted to the Study of Sterility. Dr. G. I. M. Swyer, National Secretary of the English Chapter of the International Fertility Association, conducted the clinics on female infertility. He is an excellent lecturer and that crisp English accent makes delightful listening. I had a private conversation with Dr. Swyer over a cup of tea (served incidentally at the mid-point of our morning sessions) regarding the problem of habitual abortion. He and his English colleagues believe the "incompetent cervix" responsible for a substantial number of habitual abortions. They have devised a surgical procedure to correct the incompetency with good results. The habitual aborter remains a thorny problem for the gynecologist.

Two rugged days of sightseeing—The City of London yesterday, the British countryside, Warwick Castle and Oxford today.

We have seen so much, so fast, I am literally in an English fog. Our guide, who is a wonder, has traced the history of Briton from 33 B.C. up to the present time. He is intensely interesting and I could listen to him by the hour, but absorbing facts as fast as he puts them out would require nothing less than Univac working at full speed.

I like England.

May 8, 1956
Germany
Weather excellent

The pace of the trip is fast and there is so much to see that little time is left to write down ones' observations. I write this on the train between Wiesbaden and Heidelberg. Holland was interesting. The country was clean and in the countryside much scrubbing was in evidence. There are no slum areas in Holland, but in general, living standards seemed very much lower than ours in the States. Our hotel was only fair and on about par with a third class hotel in the United States.

Our tour was so arranged that we would be able to take in the "Spring Bulb Festival." It is an important event in Holland and certainly for us a never to be forgotten sight. We viewed acres of gardens, tulips, daffodils, and early hyacinths. A new tulip called President Eisenhower was a beauty and, of course, we ordered some of the bulbs to be delivered in the fall.

The Rijksmuseum in Amsterdam is a treasure house of Dutch art. The collection of Rembrandts is the worlds' largest and finest. The masterpiece "Night Watch" was beautifuly displayed. It occupied one entire room.

Dr. L. I. Swaab, National Secretary of the International Fertility Association of Holland, conducted our morning scientific sessions. Infertility clinics are new to Holland and are supported and controlled by the State. Medicine in Holland is socialized for the most part but there is some private practice. Modified state medicine is an old system in Holland. The study of infertility is relatively new and they are feeling their way.

May 11, 1956
Austrian border
Weather cold and cloudy

Munchen (Munich) is a large busy metropolis showing many scars of the last war. However, building goes on at a furious pace and in a few years most of the old ruins will be gone and new buildings will have taken their place. It's a strange mixture of the old and the new. The architectural

blending is pleasant and the contrast which might at first seem an impossible mixture works out very well. The "Church of Our Lady" in Munich bears out this study in contrasts. This church was almost completely destroyed during the bombing of Munich. It is now restored except for the interior and is and will be magnificent. It is late Gothic in style. It will seat 6,000 and should be seen by anyone visiting Munich.

The cost of food, clothing, and shelter in Germany appears high—about on par with U. S. A.—but wage scales are lower and work hours longer. The industry of the German people is obvious everywhere. We enjoy Wiesbanden more than Munich. The city is smaller than Munich and in much better condition. It was an open city during part of the war and not too badly damaged. Our hotel, the Nasser-Hof, was the very best thus far. "Grand" room and bath, excellent service and good food. The shopping areas in Wiesbaden are sometimes on the lush side, as is true in Munich, but few bargains are available. The prices on cameras, optical equipment, etc. seem reasonable and fairly priced.

It was interesting and unusual to see people come in and purchase glasses on the spot. The refraction and lenses and frame are all prepared while you wait and at prices one-third or less charged by the optometrist in the States. We were told the ophthalmologist is so busy and it takes so long to get an appointment that the optometrist does most of the refracting in Germany.

Some porcelain pieces are reasonably priced. Others exorbitant.

I am writing this as we travel by train into Austria. The Austrian Alps are covered with snow and are very beautiful. The hillsides are covered with evergreens and the valley below appears green and fertile. The homes are somewhat different in architecture and have a chalet type appearance. We have run into our first bad weather. It's rainy and cold and I have a head cold making it worse.

Wiesbaden is an old and fashionable health resort. We inspected the facilities but question the health giving qualities of the "spas"—particularly with regard to improving one's fertility!

May 13, 1956
Vienna, Austria
Excellent weather

Vienna was a truly different city. It was busy, and much reconstruction and new building was in evidence. The city is a mixture of very old and not so old but no modern. Our hotel, the Park, was an "antique", not good, and a "million miles" from the shopping district. The completely renovated opera house was the highlight of our trip to Vienna. It is "really" something and has to be seen to be appreciated. The word beautiful seems inadequate to describe it. However, the seating in the boxes, aside from the front seats, is un satisfactory. The opera DON CARLOS was enjoyed by all and was executed with meticulous perfection. After that experience, I shall see more of the opera.

I attended an interesting clinic at the University of Vienna—good work done there. The instruments seemed a bit odd, but they were functional and I should like to copy a few of them. In general, we liked Vienna. The palace at Schoenbrun was magnificent. A special dinner at "Grinzing" was for the birds. It was cold and drafty, crowded, and the food was only fair. We met Dr. Tassilo Antoine (Professor and Head of the Department of Gynecology at the University of Vienna), his wife and daughter and son-in-law. They

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quate topical anesthesia of larynx and trachea permits a lighter plane of anesthesia.

Nitrous Oxide is safe and useful in the aged provided that a concentration of 30% or more oxygen is maintained. It has no effect on the heart or blood pressure.

Nitrous Oxide combined with Pentothal, proper topical anesthetization and small amounts of relaxants are excellent in selected cardiac cases.

Cyclopropane has been unjustly condemned. Of all the anesthetics, it does not disturb hepatic or renal function. It is indicated in the diabetic but not in the patient with coronary infarction.

Rectal Pentothal, Avertin, Evipal and Surital are not used. They are contraindicated in the aged not only because of pre-existing diseases but also because they produce severe circulatory and respiratory disturbances. Their effect is unpredictable and the aged patient should be awake as soon as possible.

Intravenous Pentothal, Nitrous Oxide and Oxygen are excellent for short procedures. The addition of Anectine, an ultra-short relaxant and bronchodilator has increased the usefulness of the above combination. Pentothal predisposes to laryngospasm which is serious in the hypertensive. Anectine and topical anesthetization prevent it. Patients dislike a topical spray but do not object to a tronohane gargle.

Local infiltration is the method of choice but it is not foolproof. Procaine is a myocardial depressant and in excess causes cardiac arrest. Procaine should be measured and the surgeon informed when he has used 50 cc of 2%; 100 cc of 1% or 200 cc of ½%.

Spinal anethesia is desirable for the aged patient in selected cases. Under spinal anesthesia, a physiologic balance is maintained. The only danger is blood pressure fall which can be prevented with an intravenous vasoconstrictor running during the administration of the anesthetic agent. All patients under spinal anesthesia should receive 100% oxygen by hook on face tent. Unless the geriatric patient is supplemented with 0.1%-drip Pentothal he objects to the usual face mask. (Most do not fit anyway.)

Syncurine and anectine are the Curariform drugs of choice. They produce no histamine—like reactions such as bronchospasm or fall in blood pressure. With their judicious used, a lighter plane of anesthesia may be maintained.

Refrigeration anesthesia is the method of choice in amputations of the lower extremities.

In summary, one may state that skill is required in the management of the anesthetic period. Avoid overdosage; keep the patient light. Prevent shock by immediate blood loss replacement with blood, serum albumen and drugs. Avoid overloading the circulation. Do not use normal saline. If digitalization is indicated use Cedilanid or Digoxin.

If corticoid therapy is indicated, use Solu-Cortef. In an emergency, where the specific objective is to correct or prevent operative shock from becoming irreversible the contraindications to its use as Diabetes, etc. are relative rather than absolute. Maintenance of a patient's airway is essenial. Permit the more frequent use of Endotracheal anesthesia.

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Studies of SGO-T in humans, following acute transmural myocardial infarction have produced similar results. That is, there has been an elevation of the enzyme activity two to twenty times normal. Studies by the aforementioned authors have shown that the SGO-T acivity was elevated in patients suffering from acute transmural myocardial infarction with the determinations beginning to exceed normal levels within four to six hours after the onset, with moderate levels eight to twelve hours, and the peak being reached between twelve and twenty-four hours, occasionally extending to 36 hours. Thereafter, there is a gradual decline to normal during the following two to five days. The curve thus formed is distinctive for patients with acute transmural myocardial infarction.

Slide No. 4 shows the values obtained in 36 patients with transmural myocardial infarctions, that is, those who have shown a definiate Q wave on the electrocardiogram.

Slide 4 — (A value of 4500 units was obtained in a 52 year old white male, 36 hours after onset and 8 hours before death. At autopsy, there was thrombosis of the right and left circumflex coronary arteries with recent infarction of the walls of the right and left ventricles. The left ventricle had ruptured in two places resulting in a hemopericardium.)

It will be seen that these values when compared with those having clinical infarctions substantiated by EKG changes consisting of only ST or T changes Slide No. 5, of which there were 21 cases, shows that the values are not as high. This, once again, suggests that the elevation of enzymatic activity is roughly proportional to the size of the infarction. The presence of the Q wave indicating more damage to myocardial tissue.

Slide No. 6 and No. 7 are illustrative of two cases.

Slide 6—(36 year old white male with onset one hour prior to admission. SGO-T obtained at 2 hours was 24 units; 26 hours, 430 units; 3 days, 123 units; 5 days, 83 units; and 19 days, 25 units. WBC-12.5, ESR- 11 mm/hr.)

Slide 7.—(62 year old white female. Initial SGO-T 6 hours after onset, 20 units with WBC 14,050. SGO-T at 24 hours, 276 units; at 48 hours, 206 units; at 72 hours, 92 units; at 96 hours, 97 units and at 5 days, 70 units. EKG - Q with antero- lateral myocardial infarction.)

There has been shown to be no correlation between SGO-T activity, white count, erythrocyte sedimentation rate and the C-Reactive protein. It must be kept in mind that the SGO-T elevation is based on the time following onset of the acute attack and should be obtained at proper intervals or the elevated values will not be obtained.

LaDue and others have shown that there is no elevation of the transaminase activity in patients suffering from angina pectoris or coronary insufficiency.

Slide No. 8 shows twelve patients suffering from coronary insufficiency with normal transaminase values. The value of 64 units at 18 hours was in a patient in whom only one EKG was obtained. It has likewise been shown that the presence of shock, congestive failure in the absence of myocardial infarction, digitalis, cortisone, and mercurial diuretics do not effect transaminase values.

Six of the patients suffering from myocardial infarctions, all with Q waves on the electrocardiogram were examined at autopsy and all six were found to have had infarctions.

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U. S. ARMY PATHOLOGIST ON LIST OF AUTHORS OF NEW JAPANESE TEXT

Col. Clara Raven, MC, now on duty at the U.S. Army Hospital, Army Aviation Center, Fort Rucker, Ala., has received a copy of the recently published Japanese textbook on histological pathology of which she is the only non-Japanese among its twelve contributors.

At the time Colonel Raven, one of the highest ranking women physicians in the Army Medical Corps, was assembling material for the book she was on duty in Washington, D.C. at the Armed Forces Institute of Pathology. Under the guidance of Brig. Gen. Elbert DeCoursey, MC, then director of the Institute, Colonel Raven was able to get many photographs from the institute files for use in the proposed volume.

The book contains 685 pages of text, 30 pages of index and more than 1,000 illustrations. Although it is published now only in the Japanese language it is expected that it will be translated into other languages because of its importance in the field of pathology.

Colonel Raven's work became known to the Japanese educators who projected the book while she was in the Far East on an Army duty tour during the Korean hostilities.

Colonel Raven formerly was a member of The Mahoning County Medical Society and practiced here in Youngstown.

WIDEN YOUR CIVIC INTERESTS

ORADELL, N. J.—American doctors should take a more active role in politics, says Rep. Walter Judd (R., Minn.), himself a physician. Many physicians work such long hours and pay such close attention to their patients, he says, that they sometimes fail "to take the longer view . . . They won't get into politics; they won't discuss issues with their patients; they won't even bother to vote; they just go ahead and work. They're good in their profession. But what makes them good specialists sometimes makes them poor citizens."

The Congressman's opinions of his former colleagues appear in the June issue of MEDICAL ECONOMICS. He finds evidence for his views in the small amount of mail he receives from physicians on nonmedical issues.

"Doctors seem to concentrate on their own interests more than most groups." he comments. "I don't say this critically; it occurs as a result of their specialization. But we get less mail from doctors on general issues—international policies, farm policies, education, etc.—than from practically any other group in our population."

As further proof of physicians' occasional "narrowness," Dr. Judd cites the fact that they "pretty largely have the same point of view. They have lived together through medical school, in the medical society and in the hospital staff rooms. They have a cup of coffee while they're in the OB room waiting for a baby. They're very much confined to their own group. They talk things over and little by little they come to think alike."

The antidote for such conformism? The doctor "ought to be more like the barber and talk to his own patients," the Congressman tells MEDICAL ECONOMICS readers. "The barber talks to you about everything. But the doctor only talks about your gall bladder or your toenail."

—Medical Economics

(Continued from Page 328)

were all charming and gracious people. There we met many of the University of Vienna Medical School faculty. Dr. Knauss was very interesting and spoke English very well. I am amazed at the number of people in Europe who speak English.

May 15th, 1956
Venice, Italy
Weather beautiful

Venice is a dream—not a city. Getting off a train and on to a gondola to be taxied to the hotel is an experience everyone should have. Our hotel, the Royal Danieli, was lovely and very satisfactory from every standpoint.

St. Mark's Square, the Palace of the Doges, the Bridge of Sighs, the Grand Canal, and the multitudinous canals and bridges that make up Venice are thrilling to the sight-seer. We traveled to Lido and enjoyed that small picturesque island. I must not fail to mention the "Frari" Church with its treasure house of "Titians".

May 19, 1956
Florence, Italy

Florence is a lovely city. Our hotel was the Excelsior and it was satisfactory. I was impressed with the prosperity of Florence. There were a million small shops and all of them were busy. We saw innumerable works of art. The works of Michelangelo, of course, stand out above all else.

May 26th, 1956
Naples, Italy
Weather warm

Naples is a busy, dirty, begging city, but we had a beautiful room at the Excelsior with a large balcony (where we ate our breakfast daily) overlooking the Bay of Naples. These were the most outstanding accommodations we had. Our view was unlimited. We could see Mt. Vesuvius, the Isle of Capri and Sorrento from our balcony. Moreover, the weather was perfect every day.

The meeting was organized extremely well. The lectures were given in the speaker's tongue and translated simultaneously into Italian, French, Spanish, German, and English. Much of the material was rehashed and well known information, but as always a few new and important points were brought out.

During our stay in Naples we made the customary trip to Pompei, Sorrento, Capri and Anna Capri. The Amalfi Drive was a thrill from beginning to end. Our bus driver was most competent and he made the trip enjoyable despite the narrowness of the road and the million and one curves. The day was perfectly clear and we could see for miles and miles. The scenery is breathtaking and from such great heights is everywhere beautiful.

Pompei is a profound study in antiquity. It is all one has read and more. The Greeks and Romans had a functioning fairly advanced civilization. Only "God" was left out of their lives.

Sorrento and Capri are small resort islands pretty much set up for the tourists and a bit on the "hurdy-gurdy" side. At Capri, we visited the beautiful villa of the late Dr. Axel Munthe, which is owned and operated as a museum by the Swedish government. Anna Capri—I liked better. It was higher in the mountains, less crowded and more beautiful. The Caesar Augustus Hotel where we had lunch was appealing. At the time, I felt like staying there a few days.

"Ischia" was another spot visited during our stay in Naples. It was less spoiled than the other cities mentioned above and appeared to be well suited to families and children. It was more wholesome than the other places we visited about Naples.

May 30th, 1956
Rome, Italy
Weather warm and sunny

Five days in Rome is too short. It's a beautiful city with a million treasures. It's busy, prosperous appearing and the shop windows are smart looking and fashionable. I can understand the high fashion of Italian women's clothes. Dress designing in Rome goes on at a feverish pitch we were told. New designers with firsts appear each year. Of course, our most interesting experience in Rome was our visit to St. Peter's Basilica and our semi- private audience with the Pope. St. Peter's is breathtakingly beautiful and beyond my power to describe. Although it is the world's largest church, it doesn't seem that large, the proportions are so deceptive. Even though it is one of the world's oldest churches, it looked like they finished it yesterday. It is in a remarkably good state of repair and we understand that it is maintained that way. While we were there, they were cleaning and restoring a part of the church.

We saw the Holy Father in a semi-private audience of about thirty-five people. He spoke to all of us in our own language. I told him I was a physician from Youngstown, Ohio. He said, "Yes, I know Ohio, my blessing to you and your family." After he had spoken to all of us he blessed us all again as a group and then posed for a picture with us. Alberta stood right next to the Holy Father in the picture. She looks pretty grim—as do most of us. The Pope is completely at ease and friendly, but the enormity of the occasion weighs on everyone. To me the Pope looked very fit. He might well have been in his 60's rather than his 80's.

Continuing our sightseeing outside Vatican City, we saw St. Paul's Outside-the-Walls, the Appian Way, Quo Vadis, Quirinal Palace, Borghese Gallery, Pincian Gardens, Pantheon, Victor Emmanuel Monument and the Seven Hills of Ancient Rome. Rome is 3000 years old and its history has endowed it with masterpieces of three periods: that of antiquity, that of the Middle Ages, and that of recent times.

DiCarlo Ballorio, Secretary of the Italian Chapter of the International Fertility Association, was our guest lecturer in Rome. He conducted the Clinic at the Medical School where we inspected the facilities for the Study of Infertility. The University of Rome has a fine medical school. It is expanding its facilities at the present time and it is, or hopes to be, the finest University in Italy. There is no dearth of teaching clinical material in Italy.

June 2, 1956
Milan, Italy
Weather warm and sunny

Milan is a booming industrial city. Buildings new and as modern as New York's Fifth Avenue are scattered throughout the business section of Milan. Some of these structures are ultra-modern in design and the contrast with some of the buildings of the Middle Ages makes for a fascinating study. The Milan Cathedral, the largest Gothic Cathedral in Italy is magnificent. The detail of the never ending spires make for one of the most imposing sights of our trip. Another must in Milan is of course, the "Last Supper" by Leonardo da Vinci. The fresco is in an old Dominican Convent. It has recently

been restored, but is very slowly disintegrating. The Dominican Convent housing this masterpiece was bombed during the last war and the entire wall containing the fresco was exposed to the elements for almost a year. This work of art has withstood every conceivable abuse and still it remains, although in ruins. It is about 450 years old and according to our guide it will remain as is for approximately another fifty years.

June 3rd, 1956
Lucerne, Switzerland
Weather cool with showers

Switzerland is a grand country, clean and beautiful. The people are friendly, honest, and are truly experts in taking care of the tourists. Our stay was short in Lucerne, but I can understand why people return to Switzerland. We took the cog-railway to the summit of Rigi mountain but could not see very much. It was foggy and raining slightly—too overcast to see well. Shopping is fun in Switzerland and, of course, watches can be purchased at about one-half or less than New York prices.

June 7, 1956
Paris
Weather rainy

Certainly Paris is the most beautiful city in the world, "A City of Parks". We saw the principle points of interest there but one would need at least a month to do Paris. I suppose the Louvre is the standout attraction. Certainly it must house one of the greatest all around collections of art in the world. Its size is staggering and one walks for miles and miles.

Saw some of the Parisian night life. We attended the Follies Bergere and the Lido. Fairly good shows although the neck lines were a bit low—sometimes disappeared altogether. The food at the Lindo was good (and very expensive).

However, it was not all fun in Paris. Our morning scientific seminars were conducted by Dr. Henry Boyle. The gynecological clinics of Paris are very old but excellent. The lectures in Paris were interesting and informative.

June 9, 1956
New York
Weather warm and sunny

A long trip by air to New York from Paris. 18 hrs. in all. We stopped at Shannon and Montreal. The Shannon Airport is a shopper's paradise. While their selection is limited, what you may buy is the very best and it's sold at bargain prices. Of course, Irish whiskey is their specialty. You can buy it for $1.25 per fifth. Old Crow cost $3.00 a fifth. Wrist watches sold for almost Swiss prices, cameras at approximately the same prices one would pay in Germany, and perfume sold at Paris rates. To shop, one need travel no farther than Shannon. Moreover, those Irish colleens will take your money painlessly. New York looks wonderful, and Youngstown will look even better.

Just for the record, the U. S. A. is the finest country in the world.

PR DOCTOR TIP OF THE MONTH—An Illinois Physician has established a "telephone hour" from 7:30 to 8:30 a.m. No charge is made for his services by phone and he contends that this method encourages patients to wait until then, except in emergencies. It also makes it easier for him to plan his working day and reduces the number of nonsense calls.

DON'T BE A $OFTIE

Patients whose accounts are delinquent—usually become ex-patients.

If you're like the majority of doctors, you let your delinquent accounts drift on for a year or more — uncollected and with no effort made to collect them. It may not be carelessness so much as compassion — the same compassion that moves you, perhaps, to hold back a few months before billing a new patient. You know he's hard up and you don't want to add to his burdens until you have to.

Actually you're making a mistake on both counts. And, instead of making friends, you're making enemies.

The reason is to be found in elementary psychology (and doctors, above anyone else, should know more than somewhat about psychology!).

People react perversly — but logically — to protracted obligation. Human nature being the mixed-up thing that it is, they become, first, uncomfortable, and then resentful. If the sympathetic doctor doesn't send the patient a bill for several months, the patient begins to hope that the doctor forgot about it. Then, when the bill comes, instead of feeling gratitude for the breathing spell, he feels only anger at having to pay after all.

Or if the debt is allowed to drag on, and the doctor doesn't press for payment, the patient commences to rationalize his failure to pay. "The doctor (he tells himself) must have a guilty conscience. He knows he did a pretty lousy job on that operation. So he's afraid to try to collect it. He's a butcher, that's what he is. Come to think of it, I still have a little pain from the operation. Next time I'll go to another doctor!"

What happened (to put it in psychological language) is that the continued sense of obligation has chipped away at the patient's ego. To relieve his sense of obligation, and thus restore his lost ego, he must contrive reasons for thinking that the doctor who did him a favor actually was doing him no favor at all. In short, he must rationalize the doctor into the role of enemy rather than friend.

Consider, for example, the case of Dr. Goodheart. (The name is spurious, of course, but the story is true.)

Being a sympathetic as well as an able and conscientious physician, he waited a few months before billing Mr. Smith for his operation. Mr. Smith, he knew, was a little hard up.

When three months passed without a statement from the doctor, the Smiths were on a pink cloud. What luck! The doctor's secretary must have lost their account.

Then came the bill. The Smiths were hopping mad. They had borrowed money from Aunt Flo to pay the doctor, and then, when the bill didn't come, had used the money to make a down payment on a new car.

So they didn't pay the doctor. But they kept the car. (Monthly payments: $72.50.)

Each month thereafter came the doctor's statement. And each month the Smiths got madder. Mrs. Smith (groping subconsciously for something to justify their resentment) remembered an incident that had taken place while Mr. Smith was in the hospital. She had tried to reach Dr. Goodheart to ask if she might take a cantaloupe to her husband. The doctor was in surgery and didn't call back for an hour or so. "Why, my husband might have been dying for all he cared," sulked Mrs. Smith.

Mr. Smith held up his end of the rationalizing process very nicely, too, helped along by a slight (and purely psychosomatic) pain at the site of the operation. That, he harrumphed, was certainly proof that the doctor had bungled.

And when the doctor's statement arrived one month with the word "please" inscribed across it by the doctor's secretary, Mrs. Smith found a new focus for her suspicions. "That one!" she snorted. "She with her blondined hair! Goodness knows what goes on between her and that robber she works for. I feel sorry for his wife."

And so on and on. Each month a bill. And each month a new reason for not paying it.

When a newcomer to the neighborhood asked Mrs. Smith if she could recommend Dr. Goodheart, she exploded, "That butcher! I wouldn't let him operate on my cat!" And when the Smiths were again in need of a doctor, guess whom they *didn't* go to. Right!

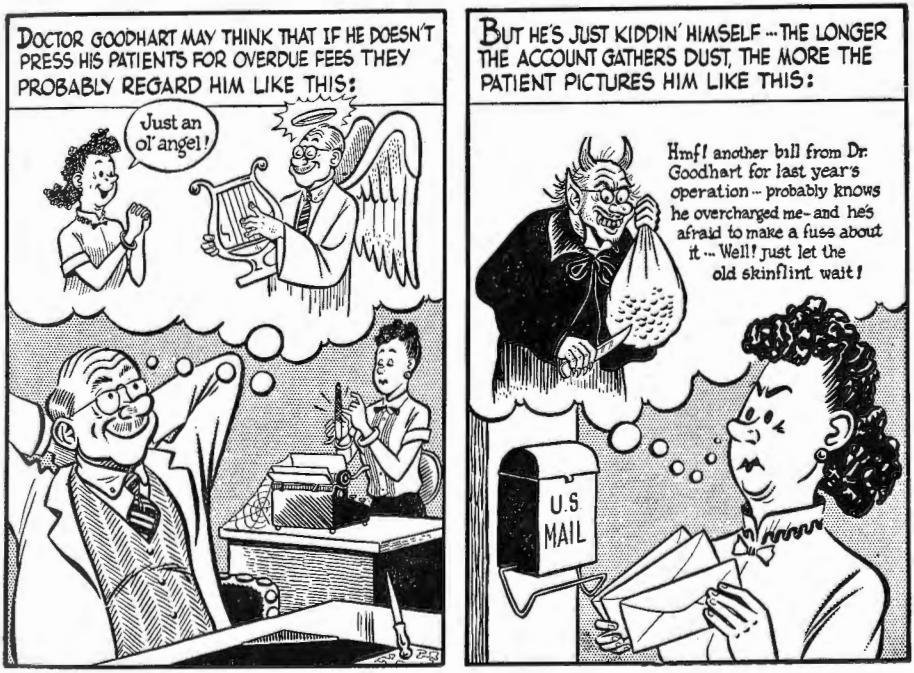
What should the good Dr. Goodheart have done?

1. Send the Smiths their bill promptly and on schedule. In case circumstances seemed to warrant it, the doctor might have written a note to this effect: "If immediate payment will be difficult, please call Miss Blondine, and she'll help work out a monthly payment plan."

2. If no payment by the fourth month, the account should have been assigned to the society's collection bureau or an approved commercial collector. They would have contacted the patient, discussed the matter diplomatically, helped the patient work out a payment schedule and/or a bank loan, emphasized the importance of regular payments, overcome any resentment on the part of the patient and repaired any damage to the patient-doctor relationship.

Department stores, filling stations — indeed, business men in general— know that a delinquent account, dragging on unattended, usually means a customer lost and a critic gained. They move expeditiously and systematically to collect the money that is owned them.

Doctors, please copy! Remember that a patient long in debt to you is not a grateful patient. Soon, in fact, he's likely not to be your patient at all but a potential detractor and a positive liability to you and your practice.



(Continued from Page 330)

Time does not permit a discussion of post-operative care. A well equipped and managed recovery room is essential.

In closing may I state that despite advances in anesthesia, mortality and morbidity in the geriatric patient is directly proportional to the duration of the anesthetic period. Mortality increases 25% if the operation is over one hour in duration and increases progressively with the duration.

Presented before the Ohio State Orthopedic Society
May 26, 1956, in Youngstown, Ohio
by:
Anthony J. Bayuk, M.D.
Anesthesiologist of St. Elizabeth Hospital

(Continued from Page 332)

We have studied 13 patients with liver disease, 7 being acute hepatitis, either infectious or homologous. In all of the cases the values have been markedly elevated, the highest values being obtained in patients with infections hepatitis.

Slide 9 shows the values obtained, whereas Slide 10 is illustrative of a case of acute infectious hepatitis.

Slide 10—(27 year old white male with onset symptoms 11 days and jaundice 3 days prior to admission. SGO-T on 11th day 2420 units; 13th day, 1340 units; and 16th day 336 units. Discharged after 5 days.)

LaDue and Wroblewski have reported two patients suffering from carbon tetrachloride intoxication with values of 12,340 and 27,840, 48 hours after exposure. These values returned to normal within one week and the patients subsequently recovered. Experimental work with rats has shown a close correlation between the amount of liver cell damage following exposure to carbon tetrachloride and a rise of transaminase activity. We have had no cases of toxic hepatitis.

Patients suffering from homologous serum hepatitis have values aproximating 2,000 units with a return to normal two weeks after onset whereas those with infectious hepatitis have a range between 800 and 1000 units with return to normal about the 4th week.

The values are roughly proportional to the severity of the disease and the amount of liver involved. In patients with serum hepatitis the liver function tests returned to normal approximately three months after transaminase values were reported as normal. Patients suffering from cirrhosis usually have about 100 units. This of course, depends upon the activity of the process and the extent to which the liver is involved.

Four cases which we have studied had essentially the same values.

Patients suffering from obstructive jaunidce have values ranging between 100 and 300 units, whereas, those with metastatic carcinoma of the liver have values approximating 100 to 200 units. From this, one may surmise that the determination of SGO-T may be of value in differentiating hepatitis from toxic or obstructive jaundice and that persistantly elevated SGO-T values are indicative of poor prognosis. It should also be pointed out that LaDue and Wroblewski noted that the SGO-T values were higher in patients suffering from metastatic carcinoma of the liver whereas, the other tests of liver function were normal.

Goldstein, et al., reported in the New England Journal of Medicine the value of the use of SGO-T levels in the differentiation of pulmonary embolism and myocardial infarction. They found the SGO T values to be normal in

11 patients studied who had clinical and laboratory evidence of pulmonary embolism. We have had the opportunity of studying only one case of pulmonary embolism with normal SGO T values.

At the recent meeting of the American Society of Clinical Investigation, Wacker of Boston reported a new, simple procedure for the diagnosis of acute myocardial infarction, based upon the elevation of serum lactic dehydrogenase, a zinc containing enyme which oxidizes lactic acid, following acute myocardial necrosis. It was found in 22 cases that the serum lactic dehydrogenase became elevated two to ten times normal, approximately 12 hours following infarction, with a peak value being reached in two days returning to normal within seven days. This enzyme is also affected by diseases of the liver, but normal in patients with pulmonary embolism. His group has also developed a special photometer that is portable and can be used at the patient's bedside. This means that soon an extremely simply test for the diagnosis of myocardial infarction will be available to all practicing physicians.

SUMMARY

Serum Glutamic Oxaloacetic Transaminase is an enzyme which has been found to have its highest concentration in heart and skeletal muscle and is liberated whenever myocardial necrosis occurs. Abnormal levels are detectable in the serum four to six hours after the acute onset of an infarction reaching moderate levels, eight to twelve hours, and peak levels 24-36 hours then gradually return to normal over a five to seven day period. The procedure is relatively simple with the use of a spectrophotometer. The time of obtaining the blood sample is extremely important. If the specimen is not obtained within the alloted intervals, values will be reported which may be misleading. SGO-T determinations shoud be done on all patients who are suspected clinically of having myocardial infarction, but who show no EKG changes. This test may also be of help in patients suspected of having hepatitis, but who do not show appreciable alteration in tests of liver function.

Over a nine month period in the Youngstown Hospital Association this procedure has proven of value in many instances. Two patients with elevated SGO-T levels developed EKG evidence two weeks after onset of symptoms of myocardial infarction.

I wish to thank Dr. Herbert Thompson for his work in setting up the procedure and the Laboratory Technicians who obtained the specimens and ran the determinations.

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OHIO ACADEMY OF GENERAL PRACTICE
SIXTH ANNUAL SCIENTIFIC ASSEMBLY

Wednesday, September 19, 1956

8:00 A.M. (EST)	Registration and Visit Exhibits
8:45	Opening Annual Scientific Assembly
9:00	HAZARDS IN ANESTHESIA—Jay Jacoby, M.D. Columbus
9:30	PRINCIPLES OF ELECTROLYTE THERAPY — Willard E. Hauser, M.D., Cleveland
10:00	TRENDS IN PEDIATRIC, ADULT AND GERIATRIC NUTRITION—Thaddeus D. Labecki, M.D., Jackson, Mississippi
10:30	Visits Exhibits
11:00	VENOUS THROMBOSIS AND TRYPSIN — Bert Seligman, M.D., Toledo
11:30	EVALUATION OF THE NEWER TYPES OF INSULIN — Thomas G. Skillman, M.D., Cincinnati
12:00	Informal Buffet Luncheon (South Exhibition Hall) Visit Exhibits
1:30 P.M.	HERNIATED LUMBAR INTERVERTEBRAL DISK PROBLEM—H. R. Oberhill, M.D., Chicago
2:00	ABNORMAL UTERINE BLEEDING—Frederick H. Falls, M.D., Chicago
2:30	OSTEOARTHRITIS—Joseph E. Levinson, M.D., Cincinnati
3:00	Visit Exhibits
3:30	MANAGEMENT OF CONGESTIVE HEART FAILURE—Hugh Luckey, M.D., New York City
4:00	CANCER DETECTION IN THE OFFICE OF THE GENERALIST—John S. DeTar, M.D., Milan, Michigan
4:30	Visit Exhibits
6:30	Social Hour and Banquet (Ball Room, Deshler-Hilton Hotel) THE WAY TO WIN—Major Norman Imrie, Columbus, Educator-Editor-Entertainer

Thursday, September 20, 1956

8:00 A.M.	Registration and Visit Exhibits
9:00	THE INVESTIGATION AND TREATMENT OF RECURRING URINARY INFECTIONS—William J. Engel, M.D., Cleveland
9:30	ULTRASONICS IN MEDICINE — Herman J. Bearzy, M.D., Dayton
10:30	Visit Exhibits
11:00	OFFICE MANAGEMENT OF LEUKORRHEAS — L. V. Dill, M.D., Washington, D.C.
11:30	TREATMENT AND PREVENTION OF LATERAL ROTATION OF LEGS AND FLATFEET IN SMALL CHILDREN—J. H. Kite, M.D., Atlanta, Ga.
12:00	Informal Buffet Luncheon (South Exhibition Hall) Visit Exhibits
1:30 P.M.	PSYCHOTHERAPY IN GENERAL PRACTICE — Vernon P. Williams, M.D., Boston
2:00	HYPNOSIS FOR THE GENERAL PRACTITIONER—Seymour Hershman, M.D., Chicago
3:00	Visit to Exhibits
3:30	INDICATIONS FOR AND ULTIMATE RESULTS OF SPLENECTOMY—A Twenty-five year Follow-up Study—Charles A. Doan, M.D., Columbus
4:00	PREMALIGNANT LESIONS OF THE RECTUM AND COLON —C. W. Mayo, M.D., Rochester, Minnesota
4:30	Adjournment.