We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness.

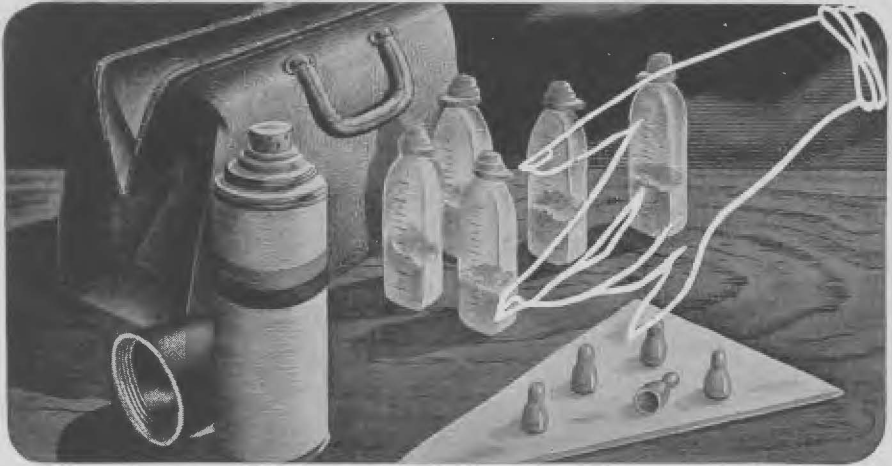
—Declaration of Independence—Thomas Jefferson

BULLETIN

of the

Mahoning County Medical Society

Vol. XIV No. 7
July 1944



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PRESIDENT'S PAGE

Vacation time is here again. It is the time of the year when all organization functions are curtailed. To a great extent, this is only apparent, while our monthly meetings are discontinued during July and August, there remains much to be done to keep our Society functioning, so that it can carry on its usual activities for the coming year. Officers and Committees are active, despite no monthly meetings. There is some increased incentive to more and longer vacations, compared to last year. Train travel conditions are somewhat improved and the "thick juicy steaks" at the end of the journey seem to be a bit more plentiful.

While we believe it to be a patriotic duty to decrease our social activities, it is becoming increasingly apparent that it is necessary to continue a part of this social life as a hypodermic stimulant to practice of good medicine and is the cement that holds our individual members together and molds them into one great group, interested in the general welfare and health for the common good of all.

Of much importance is the forthcoming Golf Meet. Dr. E. J. Wenaas and his social committee, as usual, are intent on making this day a big success. It is to be hoped that combined Medico-Druggist golf meet, will develop into a reality, and through its social influence unite these two great organizations with ties that are of great importance to each and everyone of us.

Don't forget the date. Thursday, August 3rd, Youngstown Country Club.

ELMER H. NAGEL, M. D.,
President.

BULLETIN of the Mahoning County Medical Society

JULY 1944

CLINICAL PROBLEMS CONCERNED WITH BLOOD INCOMPATABILITIES

By W. D. Collier, M. D., Pathologist, St. Elizabeth's Hospital, Youngstown, Ohio

It is a pleasure for one in the field of laboratory medicine to have the opportunity to explain the reason for the detailed and time consuming technics which have been instituted for the study of blood incompatibilities, particularly in relation to transfusions and to the hemorrhagic diseases of the newborn. While the necessity for these procedures have become a measurable reality to the physicians in laboratory medicine, they are often only vague causes of expense and delay in the minds of many physicians in the other fields of medicine.

Near the beginning of the present century, it was thought that all human bloods could be classified into four groups and that bloods belonging to the same group could be exchanged without fear of unfortunate results. It was further thought that one group, International O (Moss IV), had red cells which were free of agglutinogens and could not be agglutinated by the serum of the other three types and could be used as universal donors. It was also thought that the blood of another group, International AB (Moss I), had serum that was free of agglutinins and could be universal recipients. Almost immediately, exceptions were found to these rules. We learned that it was unsafe to administer any blood in a transfusion unless cross matchings of the bloods were made immediately before each transfusion. We learned that certain titres of blood incompatibility could be considered safe. Then, it was found that the agglutinogen A was capable of analysis into three measurably different varieties; and, that a given type of agglutinogen A contained red cell might be bathed in a serum containing antibodies which would produce agglutination of red cells containing a different variety of A agglutinogen. These findings gave us an explanation for some of the rather common intra group incompatabilities found in crossmatchings. No longer could group AB (Moss I) be considered free of anti A agglutinins because it might contain anti A agglutinins for the varieties of A not found in its particular red cells. It was also demonstrated that some typing sera did not contain all varieties of anti A in sufficient quantities. A blood might type out B with deficient sera and AB with totipotential sera or might type out O with deficient sera and A with potent sera. Also, it was demonstrated that some varieties of anti A agglutinated some type O bloods. Only cross matching done carefully could prevent the reactions that would have occurred from these mistakes of typing. We take no previous typing for granted unless it is from our own laboratory within the last five years. We certainly hope that the armed forces use some technic of pretransfusion cross matching since we have found several service men with the incorrect blood type stamped upon their identification tags.

With the growing popularity of the blood bank came new problems of cold agglutinins. Some show a high titre at or near room temperature and many show strong agglutination in the ice box. Some reactions have been reported due to these cold agglutinins so we are forced to measure their presence, particularly if

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banked blood is used. The common use of the sulfonomides has increased the confusing problem of autoagglutinins which was always a possible problem in typing and cross matching. Before we realized the necessity of using fresh cells and serum for cross matching, we not only had to keep in mind the confusion of pseudoagglutinins in cold blood but also the panagglutinins of blood contaminated by certain bacteria.

We have also learned to be particularly careful in the crossmatching of infants. An infant is born with little or no antibody content of its own making. It does contain many kinds of antibodies but these are almost entirely of maternal origin. There is ready passage of maternal antibodies to the fetus unless the placenta or amniotic fluid has the capacity of absorbing these antibodies as is the case of secretor infants who absorb the anti A and anti B agglutinins of the mother. Red cell agglutinogens are very poorly developed in the infant at birth and isoagglutinins of fetal origin are practically nil. The red cell agglutinogens develop more rapidly than the agglutinins. The latter are not well developed before the end of the first year. Because of the weak agglutinogens, cross matchings often do not show up incompatibilities of appreciable degree until after forty-five minutes to an hour. Likewise, the poor agglutinogen content of the cells often gives unreliable typing data and careful cross matching is particularly desirable.

All these facts have caused the laboratory to employ more and time consuming technics. Its utilization of new technics has decreased the number and severity of transfusion reactions but it has brought much misunderstanding with other members of the profession in regard to increased charges, increased time required for cross matching and its refusal to predict the length of time necessary to solve a blood incompatibility problem.

Within the last few years, a number of hematologists have been hunting for new agglutinogens in human blood cells. They wished for a further classification of bloods which might be useful in genetic problems in particular. They have identified the M, N, P, Q, T, X, etc., and most recently the very important Rh and Hr agglutinogens. Fortunately, most of these agglutinogens do not have spontaneous isoagglutinin formation and produce isoagglutinins under such rare conditions that they can apparently be disregarded in routine studies. The Rh agglutinogen cannot be so dismissed. It has been found to present one of the commonest transfusion problems and is the basis for the majority of the hemolytic diseases of the newborn and a common cause of still birth.

The Rh agglutinogen gained its name because of its similarity to an agglutinogen found in the red cells of the rhesus monkey and it was first identified by the antisera produced against rhesus monkey red blood cells. It has since been proven that the human Rh agglutinogen is not identical with that of the rhesus monkey and that only antisera produced against human Rh agglutinogen containing red cells are useful for human Rh typing. It has also been demonstrated that all human Rh agglutinogens are not alike and that only some anti Rh agglutinins demonstrate the presence of the group of the Rh's while other antisera demonstrate the presence of only some of the Rh agglutinogens. An average of 85 per cent of the white population contain some kind of Rh agglutinogen in their red cells while it occurs in a greater percentage of the colored population. The 15 per cent of the white population which are Rh negative, alone have the capacity of developing an anti Rh agglutinin in their blood serum. This capacity is only initiated by the administration of or introduction of Rh agglutinogen containing blood into one who

is free of this factor in his blood cells. Such an introduction of Rh positive blood into an Rh negative individual is accomplished by transfusion or by the development of an Rh positive fetus within the uterus of an Rh negative mother. In the latter case, some fetal Rh positive blood cells must escape into the maternal circulation and act as an antigen in exciting her to the production of anti Rh agglutinins. The ability of the Rh negative individual to produce anti Rh isoagglutinins is exceedingly variable in different individuals. Possibly the size of the dose of antigen is a factor since an Rh incompatible blood transfusion appears to excite a higher titre of anti Rh agglutinins than the presence of an Rh incompatible pregnancy as a rule. Usually, a first, second or third pregnancy is normal since the mother has an insufficient titre of anti Rh agglutinins to produce disease in her incompatible Rh positive fetus. It has been said that a greater number of normal pregnancies will occur before the disease becomes manifested in the instances in which the father is heterozygous for the Rh factor. This might be expected since only half of the pregnancies would have been associated with an incompatibility of mother and fetus.

The genetic problem has a decided influence upon the incidence of the disease, particularly after the disease has once made its appearance in a family. The factor is a dominant one so that an Rh negative mother must be homozygous for the absence of the factor. She has 15 percent chance to select a homozygous negative mate and 85 percent chance to select either a heterozygous or homozygous Rh positive mate. Therefore, about 12 percent of matings will be incompatible in relation to the Rh factor. The actual statistical incidence of the disease resulting from incompatibility of the Rh factor is only 1 in about 500 deliveries. Obviously, most Rh factor incompatibilities occur in mothers who do not produce sufficient anti Rh agglutinins to materially interfere with the well being of her Rh incompatible offspring. However, once high titres of anti Rh isoagglutinins have been produced, they may exist for years and affect subsequent pregnancies. The subsequent outcome of pregnancies will largely depend upon the genetic constitution of the fetuses in regard to the Rh factor. If the father is homozygous for the Rh factor, there is little chance for a subsequent normal pregnancy. If the father is heterozygous, there is about fifty-fifty chance for a normal fetus. It must be remembered that the mother might have been sensitized by a previous transfusion in which Rh positive blood was used and that the anti Rh titre might be so high that she will have no normal children.

The manifestations of this blood incompatible disease will be those of blood hemolysis; anemia, jaundice, purpura, anasarca or hydrops, etc. In the milder cases, only anemia may be apparent while in the more severe complex pictures of blood destruction may be present. If there is a good attempt at blood regeneration, erythroblastic feactures may be found. It seems surprising that so many infants show no manifestation of the disease at birth but show a rapid onset and progression after birth. Even more surprising are those cases which have a late onset after three or four days of apparently normal life during which time the hemolytic factor must have been fixed and inert. And, most surprising are those anemias which have refused to respond to liver and iron that are permanently cured by a single transfusion sufficient to elevate the blood to normal.

The treatment of these blood incompatibility diseases demands the cooperation between laboratory medicine and the other clinical branches. The laboratory must define the disease by its special methods and it must select the proper therapeutic

agents. Usually, the proper therapeutic agent is transfusion. The transfusion must be given intravenously or into the bone marrow and nowhere else. It must be fresh so that it will contain other substances than simple red cells in those cases in which clot forming substances are needed to control hemorrhagic disease. The blood must be compatible. The blood must be given in sufficient quantities to obtain the desired results.

In the case of transfusion of Rh positive adults, any fresh compatible blood in sufficient quanity should be used. The Rh negative adult should be transfused only with Rh negative type compatible blood to guard against sensatization and anti Rh agglutinin formation. It may be argued that the sensitization of the male is of little importance and that if he does become sensitized, Rh negative blood can be given him thereafter. The fallacy lies in the fact that it is not easy to demonstrate the presence óf lesser titres of anti Rh agglutinins and the failure to recognize that he is Rh sensitized. There is no excuse of failing to take into account the sequence of events that may occur in the female if she is sensitized by incompatible Rh factor blood. There are instances in which it seems justified to give Rh positive blood to the Rh negative female but the more examples that one encounters of the problems which arise from such incompatible transfusions, the fewer are the accepted instances that seem to justify it until after the childbearing period is passed.

In infants with hemolytic disease, the treatment is still transfusion. It must be repeated for emphasis that the transfusion must be intravenous or into the bonemarrow and nowhere else. If the hemolytic disease is due to Rh factor incompatibility, the treatment of choice is the administration of Rh negative, type compatible blood in sufficient quantities. And, Rh negative blood should not be accepted if the history of the prospective donor gives any suggestion of possible circumstances which might have sensitized the donor against Rh positive blood. One can use a type compatitible Rh negative blood containing anti Rh agglutinins in the serum or the mother's blood which would contain anti Rh agglutinins *provided* the cells are washed and resuspended in saline or a type compatible serum from an Rh positive individual which would be free of course of any anti Rh agglutinins. Obviously, the father's red cells or any other Rh positive red cells should not be given for at least 10 days after birth. After 10 days to 2 weeks, the maternal anti Rh agglutinins are thought to have been absorbed so that it will have no further effect on Rh positive cells. Many advocate the use of Rh negative group O (Moss type IV) blood because they feel that the infant's red cell agglutinogens are so poorly developed that any agglutinins in the serum of Type O would have no effect. We are still using type specific Rh negative blood and we fear the effect of replacing almost completely type A blood with O blood. Reports of this practice in the literature make me feel that some of the A blood cells were destroyed by the serum from O blood and that the infant lived in spite of the treatment.

The dosage of blood should not be arbitrary. Our present problem is to replace destroyed blood cells. Our practice should be to return the red blood count to normal. Certain circumstances might dictate the rate at which the blood should be administered but the object of therapy is to return the blood to normal levels as soon as is feasible. Our formula to determine the size of the transfusion based upon the blood count of the patient, the weight of the patient and the coefficient of blood to body weight at different weight levels. The latter factor is clearly shown by the fact that the normal 7 lb.

(Continued on Page 205)

GOLF MEET

PHYSICIANS — DRUGGISTS

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VALE, ALMA MATER

(Address delivered by Louis J. Karnosh, M. D., to the Graduating Class of Western Reserve University Medical School, Oct. 27, 1943)

"The years in measured tread have come and gone,
Each hopeful day has brought its golden dawn,
And now deep surgings flood the heart
A glorious transition comes—it's time to part."

Transitions are those few but significant mileposts that chart the path through life, of which birth and death are the terminals. It is the irrevocable law that all such transitions be admixtures of pleasure and pain, that they shall call forth from us our most extreme emotions of joy, grief, pain, exultation and humiliation. There shall always be feeling and antifeeling, and it is the nature of pleasure that it shall never be undiluted with strain and despair.

Yours is a glorious transition today! Has ever a world in the past and will ever a world of the future await with bated breath this very hour and this particular occasion? It has been the custom to gently gibe at the young graduate, to make light of his self-evaluation, his callow awkwardness and his juvenile earnestness. No such ridicule can be directed toward you who enter upon your working days after these exercises today, whatever your own inner misgivings may be.

Yours is a transition which will not find you academically bookish and inept in the immediate application of your art, even if your very first professional assignment comes to you as soon as tomorrow morning —and, in these times, that is scarcely soon enough. In the arduous months which have just passed, you may have felt imposed upon, you may have oftten sensed that you were dragooned into duties which dampered your dignity. But these indignities shall now pay dividends in feelings of greater self-security, in an enlarged capacity to know what to do and how to do it. At once, you have learned to filter fact from theory and to translate fact into deed. No training and education can be freer of neurotic didactics, of sickly sentimentalities and mawkishness. Be forever proud of your job because it is the expression of a true and healthy instinct rather than of an intellectual artifice. Be forever proud that in your profession the hand is just as sublime an instrument as is the mind, and be consoled again and again by the fact that it takes more brain cells to perform a complicated manual feat than it does to think a fine but fatuous thought. Your work in smelly laboratories, the bended back over ailing and whining patients, the dull lectures which you have had to absorb from people like me, constitute an unwritten saga in which you should record no regrets. That you are badly wanted at this hour, that your training shall be a boon to humanity and that you have a crystal-clear idea of your life's work—these are the pleasure-giving principles in this glorious transition today.

But as in all glorious things, there is an element of discomfort. From this day on, you can no longer call yourselves common men or women. Tradition, training, and the unique position of the man of medicine in the community have necessarily made the doctor an uncommon person. Whether you are up to the job or not, you will be asked to assume the position of leading and guiding the common man.

And yet, there is inchoate in the contemporary atmosphere a scheme to make the physician and his art a standardized commodity like baked beans and salted peanuts. For the social planners are again upon the

land to regulate things, to distribute happiness and to assign six morning glories to every front porch. Again there is inchoate a scheme to make life more happy and secure for the "common man" and to make it economically nice and comfortable for the mass. We hear them talk grandiloquently of the "Century of the Common Man."

What an incongruity! At the same time that the Utopians are groping for a synthetic universal happiness, there exists the dire necessity for desperate national defense, for mass destruction of our enemies, for appalling material waste and wild political disorder. In the din and destruction of bombing, the social engineers are protecting themselves with one hand and with the other they are blithely busy planning a stereotyped happiness and a "rational" regulation of society.

What a paradox! There is a drive to regulate the practice of organized, legitimate medicine while hundreds of commercial enterprises are free to sell their headache tablets and carminatives over the radio without stint or economic hindrance. The four freedoms to the dispensers of vitamins, but a sharp regimentation of the physician, of the hospital, and of the cost of legitimate medical care!

There are certain sound and fundamental reasons for the instinctual distrust of the social planner by the physician—the least of which is his concern over his own economic security. By reason of his knowledge of organic life, the doctor of medicine knows that the social rationalists are anything but rational. The doctor knows that the more significant the culture, and the more natural and sound the social structure, the more it resembles the anatomy of a noble animal or vegetable body and the greater are the differences between its constituent elements.

More than anybody else, the doctor knows that society rests upon the inequality of men just as the organic body of men functions smoothly with tissues of different duties and different levels of refinement. There is no teleologic absurdity in the question as to what would happen to human efficiency if the connective tissue cell demanded the same protection and choice office as is enjoyed by the upper neuron. What would happen if the red cells went on a strike and demanded the same privileges and duties of a leucocyte?

Least of all, can the physician be accused of hating the common man, for in his life work he cares for him and is far more intimate with him than is the autocrat living up on the hill. Where the social planner leads the common man to overreach his capacities, his doctor must ever remind him of his limitations and spare him thereby from an overcompensation neurosis.

Every doctor in his daily practice is confronted by the hard-bitten fact that there are strong and weak natures in men, and, quoting Spengler, "there are natures born to lead or not to lead, creative and untalented, honorable, lazy and placid natures. Each has its place in the general order of things." Let the rationalist rave and rant against this as he will.

Lest I be accused of being too Spenglerian and therefore tinged with a pro-Nazi philosophy, let me quote an individual whose views are definitely an antithesis to everything that smacks of Hitlerian dogma. When Einstein was asked to record for the remote generations to come the choicest commentary he could make on contemporary civilization, he naturally paused to do some concerted thinking. His comments were to be preserved in the "Time Capsule." This was to be planted at the New York World's Fair, many hundred feet below the ground level, for the information of archeologists five thousand years hence, who, guided by a divine intuition, are supposed

to discover and dig it up. Among other items such as a zipper, a piece of cellophane and a child's funny magazine, concerning man circa 1940, a letter was thus deposited to posterity from the foremost scientist of our day. It says:

"In this year of our Lord, 1940, people living in different countries kill each other at irregular time intervals so that also for this reason anyone who thinks about the future must live in fear and terror. This is due to the fact that the intelligence and character of the masses are incomparably lower than the intelligence and character of the few who produce something valuable for the community."

That all men are entitled to the same opportunities, no sane person can deny; but that all men can utilize these opportunities to equal advantage defies the law of organic inequality. Athletic contests, quiz programs and final examinations are implicit with the idea of biologic variation in capacity. As teachers, we examine and grade you A, B, and C to determine the level of your abilities. It would be far easier on us to give you all an A and let it go at that. And despite the social engineers, who would like to stereotype and standardize you in the practice of medicine, the world shall continue to go on grading you A, B, and C, and in a few sad instances the mark will be a D.

The common man will readily lend himself to socializing schemes, for in such programs, he dissolves his inferiority sense in the mob. Oliver Wendell Holmes commented crisply after visiting one of the Utopian schemes of his age, "Everything was common there but common sense."

The uncommon man will instinctively rebel against socialization, for its sole purpose is to reduce him to the colorlessness of the crowd. Socializing and stylizing medical practice will serve to make it a dull job and against this, it is your destiny as uncommon men to fight with all your soul and spirit. If the day ever comes when medicine is trimmed down to a cheap and prosaic commodity, it will not be necessarily very poor, but by no means will it be very good. It will certainly be very common, and commonness is the one poisonous ingredient which will certainly destroy it as an art.

I feel certain that I do not stand alone in lamenting the "Century of the Common Man." Loud praise and glorification of commonness are precisely as suspicious as scorn of riches; the psychologists know full well that it is a cloak for anger at one's own ability to put an end to it. Many of the brain trusters who planned our present Utopian Paradise were young men who were badly scotched and infuriated by their own personality tensions over the drabness and the poverties of the depression years. At Cambridge University, in the Rede Lecture given by old Sir Max Beerbohm, he says: "We are all to go down on our knees and worship the common man." "I like to think," he adds, "that on the morning of January 1, 2000, mankind will be free to unclasp its hands, rise from its knees and look about it for some more rational form of faith."

Winston Churchill had the same misgivings in mind when he stated, "I hope to heaven that we are not fighting this war to remake a world dedicated to the cause of commonness."

Security against want and sickness, say the social engineers, will make man a happier and more efficient being. As if happiness were a synthetic commodity which could be regimented like canned peaches or predicated like the wheat crop under government restrictive control! "No," says Dr. Dodds of Princeton, in his new book "Out of This Nettle, Danger," "For society, concentration upon se-

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VALE, ALMA MATER

(Continued from Page 195)

curity as a goal is suicidal, doomed to practical as well as spiritual failure. Happiness and security at best is but a by-product recovered in the process of living. When we make the mistake of placing our hope in measures of security rather than in a willingness to venture toward larger growth, decay has begun."

As students of human nature, we physicians have a right to pose the question: Does man really want security, does he want the torpid calm that goes with it; does he want such a political soporific? Or does he want excitement attended with an element of risk and does he actually require the exercise of striving, contending and of endangering life and limb as a necessary instinctual expression of life?

In a recent play by Thornton Wilder, a character answers this question in these words: "Every good thing in the world stands on the razor-edge of danger."

Man races toward security, stops short of its attainment and deliberately deflects his course to endure stress, strain and emotional exercise. For it is the one best manifestation of life that hazards be thrust upon him, and only by accepting this destiny, can man know freedom. It resolves itself into the axiom that man cannot have security and freedom at the same time. That he inherently values freedom more than he does security is attested to by the historical fact that he will quickly abandon the latter for the former—rarely the reverse.

Social planners naturally disagree on how to become secure, because at a given moment the word "security" does not mean the same thing to two people even though they find themselves in the same economic situation. Some call social security "merely a slice of today's surplus for tomorrow's deficit." Security certainly offers no freedom from fear and particularly fear of pain, of disease and of the unpredictable and the unknown.

"Freedom from fear," says Dr. Wriston, President of Brown University, "cannot be achieved even by putting an end to the things of which men are afraid. The record of human experiences show that men fear the figments of their imaginations with a terror as profound as that induced by the realities of life. Many a miser has died in dread of the poorhouse on a dirty mattress stuffed with currency. Freedom from fear is therefore an utterly individual spiritual triumph and the bold social engineers with all their devices cannot confer it."

With all the logical foresight which can be mustered, with all the beautiful paper plans to put medicine on the assembly line, the human emotional experiences of pain, fear of disease and all the sorrows epitomized in "Ol' Man River" will continue to torment man and to defy regimentation and bureaucratic control.

Even the best of rational social planners, when he is personally beset by that most irrational and nonregimentable thing called fear, cannot fail to realize that the practice of medicine is no stereotyped and standardized commodity. If he finds himself fearful that he has a brain tumor, will he be enrolling to go to his panelized central clinic for routine treatment? No, I think not; you will more likely spot him in a few days within earshot of the carillons pealing their chimes from the top of the Plummer Building in the medical shrine at Rochester, Minnesota, or sitting in the waiting room of the sages of intracranial physiology at Baltimore. If, in his morbid apprehension, the chimes at Rochester happen by coincidence to be playing the evening anthem, "Nearer, My God, to Thee," his pains will irrationally increase. He soon finds that his un-

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regimentable emotions are more ultimately wise in directing him than are his rational and sociological notions. Unerringly, he shall recognize there are and always shall be good, bad and indifferent types of medical services, that there are grades of A, B, C, and D, as there are good, bad, and indifferent apples in his orchard. He shall be smitten by the omnipresent, emotional, organic element in medical practice. And he will then discover that the emotions of men cannot be socialized and regulated by bureaucratic edict.

The sociologist will harass medicine. Of this there is no doubt, and it is your divine duty to protect it from such inane manipulation. The social idealist will gnaw at its periphery, as he is already doing. He will regiment everything he can, but because the soul of medicine rests on an organic evolution, he will ultimately fail. Only when a painting by Rembrandt will bring the same price as a finger daub done by a Greenwich Village neurotic, only when pain, fear and mortal ills can be levelled to a standard scale, will medicine become an article of commerce and you will become spiritless automatons and dispensers of pills and surgical incisions.

From this day, you are destined to be uncommon men whose training and whose education are inseparably bound up with high culture and high responsibility. And high culture is implicit with the tradition of enjoyment which knows how to make much of little. It is no mere coincidence that in my perigrinations as a neurologic consultant through small towns of northern Ohio, I find the family doctor always domiciled in one of the most striking, if not the best house in the community. Somehow or other, there is a unique something in the atmosphere of the doctor's home—and it is not the smell of iodine—which I do not find in the house of the town's rich and retired plumber.

Should you be fortunate to acquire wealth beyond your immediate wants, as uncommon men, remember it is a result and expression of your culture and not a mere background of your superior position. "Let it for once be said outright," says Spengler, "though it is a slap in the face of the vulgarity of the age: property is not a vice, but a gift and a gift such as few men possess."

This class of 1943 is in a sense the consummation of 100 years of medical teaching in this University. You are a centennial monument of Western Reserve. In you we see a new age which our pessimistic spirit contemplates with some misgivings and fear as all older men frequently do. We exhort you to keep all avenues to medical progress and to scientific wisdom freely and naturally open. We pray that you will keep the art of medicine liberated from all schemes to make it an unnatural device to enslave the human spirit.

"The years in measured tread have come and gone,
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Every Physician in the Armed Forces Should Vote; How Those In Service from Ohio Can Get Ballot Described

(From June Issue of Ohio State Medical Journal)

Every Ohio physician serving with the armed forces, at home or abroad, should consider it his duty to vote in the November election.

Under the provisions of a bill passed by the Ohio General Assembly in special session April 27, absentee voting by persons in the service is greatly facilitated.

A physician, who is a legal resident of Ohio, may make written application for an absentee ballot to his county board of elections, or a relative may make the application.

Under the law, applications may be made by "the spouse, father, mother, grandparent, father-in-law, mother-in-law, brother or sister of the whole blood or half blood, son, daughter, adopting parent, adopted child, step-parent, step-child, uncle, aunt, nephew or niece" of the voter.

The application need not be in any particular form. It should merely request an absentee ballot; state the branch of the service in which the applicant is serving, and specify the location of his legal residence in Ohio so that the clerk of the county board of elections can determine the precinct in which he is located.

Applications for "war ballots" can be made now. The ballots will be ready for mailing by the clerk of each county board of elections to the absentee voter on or after August 9. Such ballots must be received by the board by 12:00 noon on election day, November 7.

The Ohio law provides that the absentee voter in the service will have an opportunity to vote for national, state and local candidates. The federal absentee voting law recently passed by the Congress permits the voter to write-in his choice only for federal offices. It is not legal in Ohio and therefore any votes cast under the Federal law will not be counted in Ohio.

Never has there been an election in this country of such vital importance to physicians not only as citizens but as doctors. Issues are at stake which will affect the future course of their lives and those of their families. Ohio physicians with the armed forces can and should express their views through the ballot by using this simple method of absentee voting.

Ballots will be sent to applicants via air mail, so there will be ample time for them to be marked and returned by election day, November 7.

CLINICAL PROBLEMS

(Continued from Page 191)

infant at birth has about 350 cc. of blood or a 1:50 relation while the 150 lb. adult has about 6000 cc. of blood or a 1:40 relation. The formula is: 5,000,000 minus the patient's R.B.C. count divided by 1,000,000 multiplied by the coefficient per pound of body weight times the body weight. The coefficients are 10 cc. up to 10 pounds of body weight; 9 cc, from 10 pounds to 25 pounds of body weight; 8 cc. from 25 pounds to 50 pounds of body weight and 7 cc. for all over 50 pounds. For example: An infant with a count of 3,000,000 R.B.C. that weighs 7 pounds should have: 5 million minus 3 million is 2 million. Divided by 1 million gives 2. 2 multiplied by the coefficient for 1 to 10 lbs. which is 10 gives 20. 20 times the body weight of 7 lbs. gives 140. This figure gives the number of cubic centimeters of normal blood required to bring this infant's blood count to about normal.

The only conclusion that I have to make to this paper is that many problems in medicine require the combined efforts of various diagnostic and therapeutic proceedures. A large problem has been identified, we in the laboratory hope that you will bring us more of these problems to study with you.

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Alleviation of Hypertensive Symptoms

S. H. May, New York City
(Med. Annals, D. C.)

The author presents a study of nine cases of severe hypertension previously treated by sedation, xanthines, iodide and vitamins, and individually for obesity, menopausal disorders, heart complications, etc., in which he tried the effect of calcibronat. The remedy was injected intravenously on the average of two to three times a week for a period of 12 months in 7 cases and 6 months in two cases. Occasionally an additional dose was given orally in the form of granules or effervescent tablets. In most cases 4 to 6 successive injections of calcium gluconate were given as a control. An intermission in the course of injections for the vacation period of 4 weeks served also as a control of the effectiveness of treatment. The patient's renal and cardiac functions were carefully checked at the beginning and end of treatment.

Blood pressure was measured at frequent intervals by different observers. The changes in the degree of blood pressure were not appreciable, but a drop in the average pressure was noted in 8 of the 9 cases. The average lowering of the systolic figures was 12, and of the diastolic figures 13.3 points. No untoward results were noted. The improvement in general condition was impressive. Symptoms and complaints were diminished; greater contentment with mental and physical relaxation was noted. Two patients were able to resume work while under observation. During a control period of injections of calcium gluconate, the general condition was only slightly worse. The benefit obtained in this series of cases from treatment with calcibronat surpassed that previously obtained with the customary sedatives and hypnotics.

1944

Vitamin A in the Treatment of Arterial Hypertension

Manuel Villaverde, Havana, Cuba
(Med. Record)

Following a review of the literature in the treatment of hypertension with vitamin A, the author mentions the various theories as to the mode of action of the vitamin in this disease. He believes that in some instances essential hypertension is the result of chronic hypovitaminosis A. He had administered vitamin A both orally and parenterally. One hundred thousand units in olive oil, intramuscularly or subcutaneously, are usually rather painful, but no suppurations have been encountered. By mouth 200,000 units a day may occasionally cause a slight regurgitation which usually disappears with continued treatment. In some cases 300,000 international units a day have been administered for 3 or 4 months without ill effects. When the desired fall in blood pressure has been obtained, the daily dosage of vitamin A is reduced to that amount which permits maintenance of the optimal blood pressure for the patient. This maintenance dosage has varied between 25,000 and 100,000 units per day. Although some cases show immediate results, others have needed several weeks treatment before improvement is noted. In some cases treatment could be discontinued without recurrence, but others required continuous vitamin A therapy. It is reasonable that other hygienic, mental and medicinal measures should be used, although these have not been employed in the present series. Some cases with renal sclerosis have responded favorably to the treatment. The injection of 100,000 international units of vitamin A reduces the pressure by 10 to 30 mm. Hg. in from one to three hours.

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FROM OUR DOCTORS IN THE SERVICE

Doctors are earnestly requested to write the Bulletin of their activities and by all means CHANGE OF ADDRESS. Let's help keep the good work up.

Jan. 26th, 1944

My only mail today in this God forsaken country was the Bulletin of August, 1943. No matter when it arrives it is always welcome. I've read it from cover to cover, not only because it was interesting but because it is purely American, and quite different after Aussie biased news.

After seven months in El Paso, Texas, enjoying Juarez, Mexico, and such moist spots we embarked for Australia. There we built a National Park 1st Cavalry Style in the middle of which we ran a 200 bed hospital. I was fortunate enough to be chief surgeon. We were loaded with surgical and medical cases. We completed about 250 major and minor operations while there. At last they thought we were ready so now we are in New Guinea constructing National Park II Cavalry Style! Oh! It is a great life. Our hospital will be open again in about two weeks.

Being among Fuzzy Wuzzies is a new thrill but competing with the entire zoological world is another. Ants, mosquitoes, scorpions, lizards, and bugs is simply mentioning a few of them. Rain in torrents daily with a bare 110° during the day adds to the pleasure.

As you may have noted I am no longer with the 3rd Rec. Sq., but in the 1st Med. Sq. My A.P.O. number is given and I would appreciate having the bulletin sent to me at that address.

Capt. J. M. Gledhill

*

Feb. 11, 1944

I received the Bulletin of the Mahoning County Medical Society. Since I am in the service I enjoyed the Bulletin a lot.

I have been to New Zealand, New Caledonia, Guadalcanal, Russell Islands and Munda, since I left the States. Could be that I would like to see them again soon —at least for a short time. Do you have any further information about Dr. Bartz? The November issue said that he was a prisoner of the Japs.

I'm looking forward to more copies of the Bulletin.

Lt. Benj. Green

*

April 22, 1944

Just a short note to let you know of two changes. I have been transferred and also promoted. My new mailing address is 2006-D N. Porter Court, Mobile, Ala., and my rank is now Passed Ass't Surgeon.

Even in the sunny South, we Youngstown doctors see each other. The first day I was in Mobile I stepped out of the elevator into the lobby of the hotel where we are staying and ran right into Dr. Morrison Belmont, who has just been transferred to Brookley Field here, too. Small world, isn't it?

Thanks for the Bulletin.

Passed Ass't Surgeon Harold Reese

*

May 27, 1944

Just a note to inform you of my change in address. I am on detached service at the Station Hospital at Fort Jackson, near Columbia, S. C., waiting for further orders. Maj. Selkovits who was out at the T.B. Sanitorium for sometime is doing very good work here in chest and contagion. I don't see his name listed in the Bulletin. It possibly should be.

The family are anxious to have my proper rank listed in the Bulletin. It doesn't make any difference to me, just being in the army is enough. I take great pride in the fact that I was able to keep up better than some of the younger men on hikes, etc., at Carlisle, Pa.

Thanks for Bulletin, especially since it lists the men in service and we can always find some one here from home.

Sincerely,

Capt. C. M. Askue, M.C., A.U.S.

*

May 19th, 1944

Just received the March Bulletin which followed me here. Please note my new address.

I would suggest that your list of the men and women in the service be revised and brought to date. There are a good many of us here now and we can get in touch with one another if we know the A.P.O. numbers. Needless to say, we are always glad to see the boys from home.

You may be interested to know that Tingwald is here for a while, also saw Hap Hathhorn and Weaver at their respective hospitals.

My first patient in the E. T. O. (European Theatre of Operations) was a boy who lived within a block of my house in Youngstown. Quite a thrilling coincidence.

Major L. S. Deitchman

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SINCE LAST MONTH—

Eugene Laurisin, M. D., announces the opening of his office for the practice of proctology, 27 Ludlow Street, Yonkers, N. Y.

Major C. W. Sears has returned to the States from England. He is ill in a hospital in New York but hopes to be placed in an Army Hospital nearer his home soon.

Dr. W. Z. Baker is expected home Monday from Long Beach, Calif., where he went to see his son, Ph. M. 3/c Waldo Z. Baker, Jr., U. S. N., who is stationed at the San Pedro Naval Frontier Base.

Dr. and Mrs. E. J. Wenaas left July 1 for a fishing trip to Georgian Bay, Canada.

Dr. S. W. Weaver, chief of neurosurgery at the station hospital at Santa Ana, Calif., has been promoted to major. Major Weaver was with the station hospital in Chicago before going to Santa Ana 10 months ago. A graduate of the University of Colorado, he took post-graduate work in brain surgery in New York and Boston hospital and came to Youngstown in 1935. His wife and three children live in Westminster, Calif.

Capt. Laura R. Clark, A.N.C., recently spent a short leave with her parents, Dr. and Mrs. C. R. Clark and has returned to duty at Nichols Hospital in Louisville, Ky. Her promotion to the rank of captain awaited her upon her return.

Dr. W. D. McElroy, serving with a hospital unit in the Peninsular Base section in Italy, was recently promoted to Lieutenant Colonel. In the service 22 months, Colonel McElroy has been overseas 17 months. A graduate of University of Cincinnati, he served his internship at South Side unit of Youngstown Hospital and was resident physician there two years. Before entering the army he was associated with Dr. R. R. Morrall. He is the son of Mr. and Mrs. C. L. McElroy, 3103 Hudson Drive. His wife and son live at 4455 Oak Knoll Drive.

"IF AT FIRST—"

The sergeant was giving the rookies bayonet drill. They were practicing charging a dummy. One awkward fellow stumbled, missed the dummy with his bayonet, but flattened his nose against it.

"That's the stuff!" encouraged the sergeant. "If you can't stick 'im, bite 'im!"

*

REVENGE

Jones—"Your office sent me a cook last week."

Employment Office Manager—"Yes, that's right."

Jones—"Well, it will give me the greatest pleasure if you will dine with me tonight."

*

HANDY LEG

Bishop: But how on earth did you manage to keep the cannibals from eating you?

Returned missionary: It was easy. You see, I have a cork leg. As soon as I landed I pulled up my trousers, cut off a slice and gave it to the chief. He decided I wasn't worth cooking.

*

HIGH QUALITY

Jeweler: Here's a nice little diamond for a dollar.

Prospective: Well, it's O. K., but haven't you got imitation ones cheaper?

*

OUTRAGEOUS TREATMENT

Two friends met and in the course of their conversation discussed their ailments and the treatment they had received.

"Have you ever been x-rayed?"

"No," came the reply, "but I've been ultra-violated!"

Fair Warning

A bulletin board outside a church announced Sunday's sermon: "Do you know what hell is?" Underneath was printed in small letters: "Come and hear our new organist."

*

GOOD BUSINESS

Mrs. Nuwed said to her husband: "Darling, will you lend me twenty dollars, and only give me ten of them? Then you'll owe me ten, and I'll owe you ten, and we'll be straight."

A LONG SIT!

Policeman (to tramp sitting on top of an oak tree): "Hey! What are you doing up there?"

Tramp: "I don't know; I must have sat on an acorn."

*

PERMANENT JOB

Lady (at employment agency): I want a good cook for my country place.

Manager: Miss Jones, have we anybody here would like to spend a day or two in the country?

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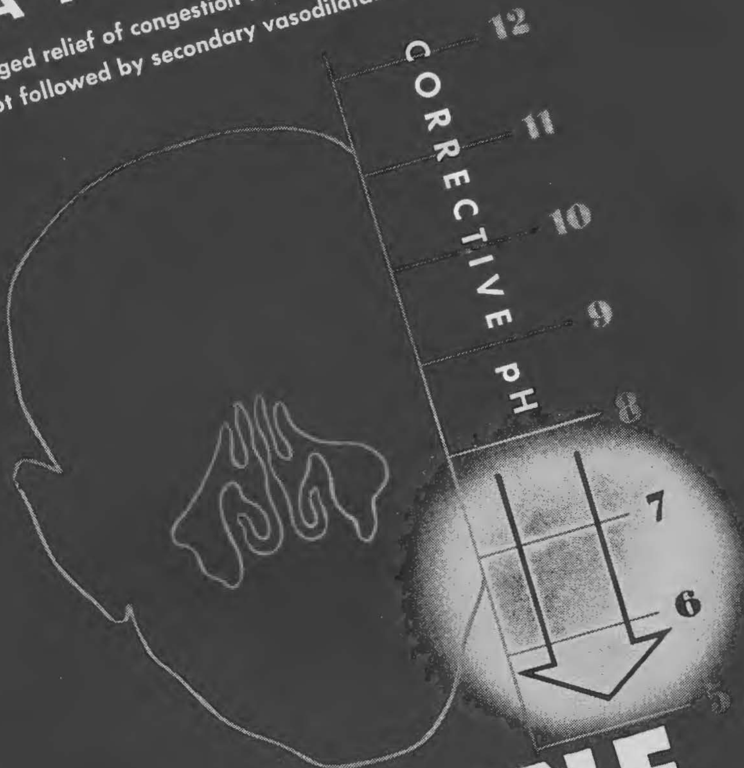

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