No man ever repented of having kept silence.

—Plutarch

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XIX, No. 6
JUNE • 1949

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TABLE OF CONTENTS

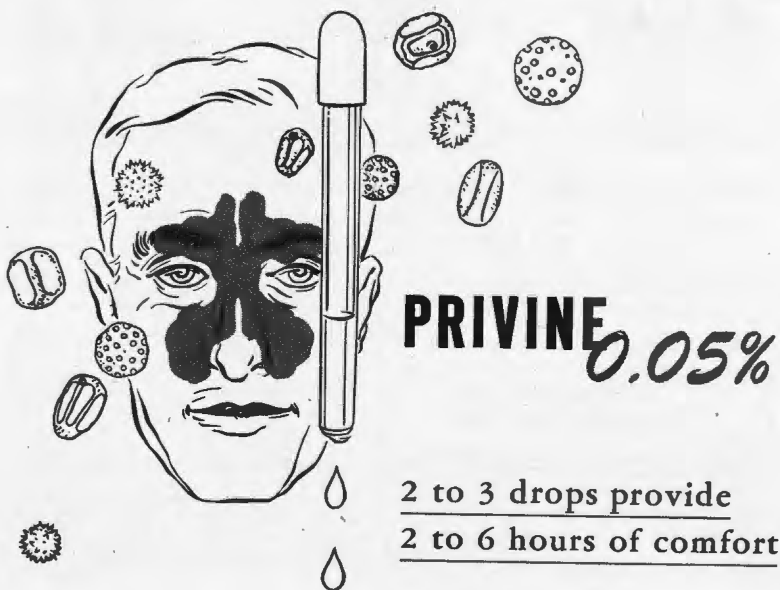
Vol. XIX—No. 6 **June, 1949**

Medical Calendar - - - - - - - - 209
President's Page - - - - - - - - 210
I'm for "Socialized Medicine" - - - - - - 211
The Diagnosis of Diabetes Mellitus - - - - - 215
The Medical Crier - - - - - - - - 219
June Meeting - - - - - - - - - 225
St. Elizabeth's Hospital Staff Meeting - - - - - 231
Youngstown Hospital Assn. Staff Meeting - - - - 233
General Practitioners Elect Officers - - - - - 235
The Diagnosis of Lesions of the Breast - - - - - 239

ADVERTISERS' LIST

Ayerst, McKenna & Harrison 214
Beil-Rempes Drugs 238
Blair Dry Cleaning Co. 243
Bowman Bros. 238
Buffington's 212
Burroughs Wellcome and Co. 228
Cassaday 226
Ciba 208
Cross Drugs 243
Fellows Medical Mfg. Co. 220
Healthaven 240
Isaly 224
James & Weaver 212
Laeri's Pharmacy 243
Lester's Pharmacy 238
Eli Lily & Co. 216
Lincoln Ave. Alcoholic Clinic 212
Lincoln Lab., Inc. 240
Lyons Physicians Supply 230-236
Maxwell Shoe Co. 226
Mead, Johnson & Co. ....Cover
Medical-Dental Bureau 241
Mercer Sanitarium 234
Merrell 238
O'Linn's 228
Overlook Sanitarium 242
Parke, Davis and Company 222
Professional Pharmacy 232
Renner's 228
Scott Co. 236
Stillson & Donahay 234
Strouss-Hirshberg's 230
Squibbs 243
Thornton's 242
Truedley, H. H. & Co. 241
Varick Pharmacal Co. 218
Vitaminerals Co. 206
White Drug Stores 206
Zemmer Co. 242

A distinguished nasal vasoconstrictor



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MEDICAL CALENDAR

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

COMING MEETINGS

American Medical Association, Atlantic City, June 6 - 10.

American Roentgen Ray Society, Cincinnati, Oct. 3 - 8.

PRESIDENT'S PAGE

The National Health Survey shows that 25,000,000 people have some chronic disease and that 1,500,000 of these are chronic invalids.

American medicine has created this problem which is still growing, by prolonging life thru control of infectious diseases, better surgery and health education. This presents a serious problem to the community, not only in the fields of prevention and research, but as concerns institutional and non-institutional care, and problems of providing necessities other than personal professional medical services to these unfortunate individuals.

There has now been established a Joint Committee on Chronic Illness spearheaded by the A.M.A.

Chronic illness requires a personalized type of service and the report of this committee should be of interest to us all, especially the work that is now going on in two hospitals in New York and one in Massachusetts. Also the home care program in Syracuse and Cleveland and the central services for the chronically ill in Chicago, Milwaukee and Philadelphia.

JOHN N. McCANN, M.D.

BULLETIN of the Mahoning County Medical Society

Published monthly at Youngstown, Ohio **Annual Subscription, $2.00**

VOLUME 19 **JUNE, 1949** **NUMBER 6**

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

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I'M FOR "SOCIALIZED MEDICINE"

There were two articles in the April 1949 Mahoning County Medical Bulletin which deserve emphasis. The first was written by Doctor Coy on the subject "Goals". The whole article is worth study but one paragraph stands out.

> "We hear much about doing something to make the world better. We shift the emphasis from ourselves where we can do much, and put it on the world where we can do little."

The other article is quoted from the Genesee County Bulletin which is called "Daytime Specialism". Three sentences from that give the idea.

> "No specialist nor specialty deserves to exist if it can actually confine its problems to the waking hours of a day . . . The foundations of medical practice are crumbling because too few of us remember that the bulwark of a profession is the service it renders. If service is to be regulated only by the financial need of the individual, we have gutted our professional standing and relegated medicine to the level of an unsavory business."

I am one of those specialists and I confess that the rubber tubing on my own stethoscope is hard, dry and useless. I must look at myself and see whether specialization has gone too far for the good of all concerned. Our medical profession should look in the mirror frequently and see whether there are things that each of us can do as individuals to sweeten our relationships with the public and restore any lost confidence. May each of us study his own individual practice to see whether we are doing all we can for the good of the public.

I am for "socialized medicine"; however, that term is not copyrighted and it means many things to many people. A great deal of loose thought and loose talk has occurred. Some people interpret "socialized medicine" as bureaucratic government control which no doctor really wants. However, there are many who interpret the term as meaning a chance to get some false teeth without paying money for them; others see a chance to get all of their medical bills shifted to someone else; at least they think that will

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occur. Most doctors see the probability of red tape and paper work under bureaucratic control shifting the emphasis of medical practice to filling out of forms more than on the service to a sick public. I am for "socialized medicine" in the sense that we doctors should never lose our sense of social consciousness. If we are not meeting the public need then we should question our own profession and see whether there are answers and especially whether each of us personally can do something to help supply the need. Many will retort that they are doing many things free for those who can not afford to pay. There is no question of the truth of the statement, for there are few doctors who do not have many free patients even though they do not publicize that fact. However, it has seemed to me that the fight of doctors against "socialized medicine" has received a very bad press. Most of us believe that government control of medicine would be to the detriment of the public as well as to the detriment of our profession. People do not seem to realize that our fighting it comes from a sincere belief that it would be harmful to them as well as disagreeable to us. The public is made up of individuals and individuals get their impression of our profession by very personal experiences. Let us look at ourselves and see whether we have kept our profession so clearly above reproach that we are not open to serious criticism.

Most doctors feel that specialization in medicine has been forced on us by the total inability of any one individual to master the whole field of medical knowledge today. Even within a given specialty it is extremely difficult and often impossible to exhaust the literature and advances in knowledge. Too many people, however, seem to believe that our specializing is purely for personal gain economically, and convenience, rather than for the professional and public good. Do we really believe that the specialization as it is today has been entirely for the better service of the sick in your community and mine? Is there anything lost in the idealism and the community responsibility which we personally may be able to improve? Perhaps we are so absorbed in our daily task that we have failed to keep people aware of the rapid strides in the medical field. The changes are not basically economic or mere convenience for the doctors, but somewhere along the line the emphasis has been shifted so that people are critical of our profession. That hurts you and me as well as others of our profession. We must socialize medicine in a true sense, which means that we must be more and more socially conscious of changing public needs as well as of our own professional progress.

My plea is that each one of us individually will look at his own practice, his own self, his own specialty, and see whether there is anything that has been lost in the professional attitudes, in human interest and in a constant spirit of service to a sick public. Let us "socialize medicine" in a true sense rather than the distorted sense that has grown up in our day.

H. K. G.

THE GALLUP POLL AGAIN

In the Washington *Post* for April 3, the Gallup Poll reported 56% of persons interviewed stated they had read or heard of the Truman Health Plan and they divided equally as to whether they favored it or not.

On further questioning, 47% of those who were familiar with the A.M.A. Plan as well as the Truman Plan, stated they preferred the A.M.A. Plan and 33% favored the Truman Plan.

if she is one of your patients... *The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.*

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THE DIAGNOSIS OF DIABETES MELLITUS

By Arnoldus Goudsmit, M. D.

The diagnosis of diabetes mellitus depends on objective proof of the body's diminished ability to utilize carbohydrate. In actual practice this amounts to the findings of dextrose in the urine and of its presence in increased concentration in the blood.

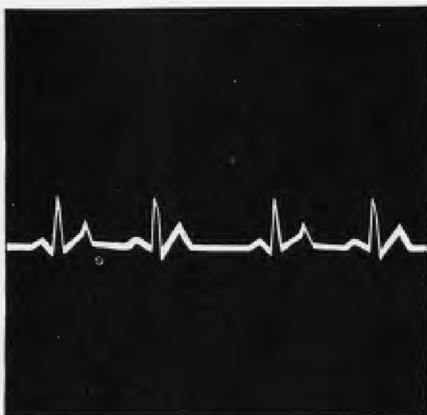
When the disturbance of carbohydrate metabolism is not severe, the body may have available enough endogenous insulin to take care of its needs outside of the periods associated with the ingestion of food; in other words, there are numerous diabetic individuals who do not have any sugar in their morning urine specimen and even have a normal fasting blood sugar level. They will readily give proof of their true condition, however, when urine and blood examinations are made after meals containing average amounts of carbohydrate. Using a more standardized procedure, a glucose tolerance test may be performed for this purpose.

In the actual practice of clinical medicine, performance of a glucose tolerance test is of the greatest value: (1) to rule out the existence of diabetes mellitus in cases of glycosuria (such as glycosurias of pregnancy and true renal glycosuria); (2) to establish a diagnosis of diabetes mellitus in a patient with a normal fasting blood sugar (e.g., when trying to establish the significance of the presence of reducing substances in a specimen of urine, while searching for undiagnosed diabetics among relatives of diabetic patients, or when attempting to establish the etiology behind conditions of retinitis, neuritis or arterial occlusive disease).

Once sugar is found in a urine specimen it appears a sound policy not to be satisfied until the absence of diabetes mellitus has been proven by a negative glucose tolerance test. Such a policy will undoubtedly increase the number of glucose tolerance tests to be performed, but a similar condition obtains in that the frequency of chest x-ray examinations has been increased markedly in the systematic search for cases of tuberculosis, and serological tests are being performed on great numbers of specimens of blood in order to discover a few cases of syphilis.

Conceding that the fasting blood sugar is well within normal limits in a considerable portion of proven diabetic individuals, and that there is no sugar present in their fasting urine specimens, it becomes obvious that there exists a great probability that many patients pass through physicians' offices and hospitals on which the diagnosis of diabetes fails to be made. There is no doubt that this situation will continue to exist as long as the "time-honored" tradition of examining fasting specimens as a routine measure is persevered in. Thus it appears obvious that unless the current methods of screening are changed, viz., urine and blood examinations are performed a few (e.g. two) hours after meals, rather than in the fasting state, a considerable proportion of diabetics will continue to go undetected. Their number, estimated from pilot screenings, is well over a million in this country.

It may be questioned what benefit is to be derived from making a diagnosis of diabetes in patients whose condition is so "mild" that most of them will probably need little care in terms of quantitative diets and insulin. The answer is that, strictly on the proven, practical, clinical level, a decreased mortality and morbidity may be predicted as a consequence of a more intensive search for diabetics on at least three counts:



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Complete literature on CRYSTODIGIN is available from your Lilly medical service representative or will be forwarded upon request.

(1) Prevention of death from diabetic acidosis and coma.

Once it is known that a person is a diabetic, even though a mild one, as to disturbance of carbohydrate metabolism, the physician will know to be on his guard for aggravation of the condition upon the occurrence of infection, trauma or vascular accidents. Under these circumstances, many signs and symptoms of impending coma, such as drowsiness, dyspnea, flushing of the face, vomiting, and abdominal pain, are much less likely to be misinterpreted as due to the infection, the trauma, or the vascular accident, or to be ascribed to any medications. Thus more prompt recognition will help toward the earlier institution of appropriate therapy with all its ensuing benefits.

(2) Prevention of peripheral vascular complications.

The significance of an ingrown toe nail, a small abrasion, or a superficial infection at the level of the foot, admittedly, is quite different in the diabetic than in the non-diabetic. This situation is all the more treacherous as many diabetics with occlusive vascular disease of the extremities are among the "milder" ones as far as the carbohydrate intolerance is concerned. Their knowledge of how to take care of their feet in a preventative manner, as well as of how to proceed with seemingly trivial lesions of the feet, may well spell the difference between an amputation or continued enjoyment of the use of two lower extremities.

(3) Prevention of aggravation from co-existent obesity.

Approximately three-quarters of the older diabetics are overweight. Both diabetes and obesity increase mortality rates, or: impair longevity. Obesity increases the severity of the diabetes. Hence the presence of diabetes becomes an added argument toward the institution of a weight reduction program in the obese person; its successful accomplishment should add materially to the longevity of these patients.

UNCLE DUDLEY

The bounteousness of Nature becomes so manifest as we notice these early awakenings in spring and then visualize the fullness of their promise, that we tend to forget that there is a parsimoniousness underlying all these bounties. Nature will develop an organ or a faculty for us; but will permit it to remain only on the condition of its proper and continued use. There isn't much that is permanently ours.

★ ★ ★

Before offering your criticism concerning something, be sure that you are thinking on the same plane as that in which it has been produced.

★ ★ ★

In holding with Bacon that usefulness is the end toward which science labors, we still recognize that the use has often been determined after the discovery. We are curious to see what we can do, what odd or interesting thing we can make, what molecular combinations we can produce. The usefulness of these, their human application, may be an additional invention. The progress of mankind is a pathway of indirections.

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THE MEDICAL CRIER

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

The constant barrage of propaganda in favor of compulsory health insurance has put the doctor on the spot. The people have been told so often that medical care is inadequate, poorly distributed and too expensive that a large section of the public believes it, or at least views the doctor with a critical eye seeking evidence of its truth.

Now the A.M.A. is spending large sums of money to combat the propaganda and achieve better public relations. All the doctors are contributing to the fund in the hope that public opinion will prevent the practice of medicine from becoming a chattel of the government. Public opinion is an ephemeral thing but in general the doctor has the public's good will; in fact, he is accorded a great deal of special privilege in deference to his prestige and long record of selfless service.

The doctor's prestige is maintained more by what he does than by what he says or what is said for him by any public relations expert. One act is worth a thousand words and when one doctor unhappily lapses from the standard of service expected of him by the public, not only is he condemned but every doctor's public relations suffer to a certain extent.

There is evidence that the public is getting increasingly difficult to handle. Take for instance the telephone service at the Bureau. When a doctor is out or away and has left no word, the impatient patient often says, "Wait until we get Socialized Medicine, then we'll be able to get a doctor!" When the patient can't get his doctor at night to make a call he immediately cries neglect. The specialist who won't make home calls day or night may be within his rights in limiting his work but he doesn't help public relations.

When the complaints are sifted most of them are unjustified, but a few have real basis for grievance. The Medical Society has given the question of night calls much thought and has established at the Bureau a list of physicians who are willing to make them. It can be said flatly that a patient can always get a doctor by calling the Medical-Dental Bureau. This does not mean drunks or pranksters but persons with true medical emergencies.

With the situation as it is, it behooves the doctor to be especially diligent in keeping the public good will. This goes beyond the observance of the code of ethics which the people in general don't understand anyway. It means responding promptly and cheerfully and giving full value for money received. It means giving something of himself along with his service. If the doctor can't or won't respond to a call he should say no and tell why. He should make some other satisfactory arrangement to handle the situation if he possibly can. He should remember that in time of grave emergency human need transcends all other considerations.

That is the application in medicine of the golden rule, which everybody understands. That is the very best kind of public relations. J. L. F.

EIGHT STATES NOW

Four more States have recently joined the parade of State Legislatures which have petitioned the United States Congress not to pass legislation providing for compulsory health insurance. This makes a total of eight States to date expressing objection from one or both houses to the federalization of medicine. The latest State Legislatures to act are Delaware, Michigan, Florida and Maryland.

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Thiamine Hydrochloride	2.5 mg.
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Calcium Pantothenate	2.5 mg.

plus Choline, and other factors of the B-Complex present in the natural base. The Riboflavin content is derived entirely from natural sources.

BASE: Rice Bran, Corn, Liver Concentrate.

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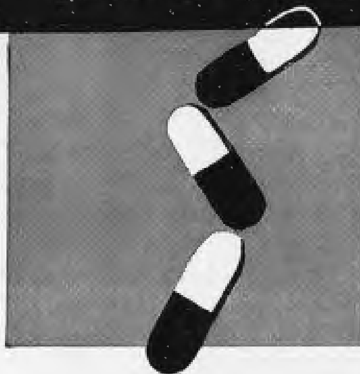
Natural Base



formula:

Each Capsule Contains:

Thiamine Hydrochloride	5.0 mg.
Riboflavin	3.5 mg.
Niacinamide	30.0 mg.
Calcium Pantothenate	10.0 mg.
Pyridoxine (B_6)	1.0 mg.
Choline (derived from Liver)	2.0 mg.
Desiccated Whole Liver	170.0 mg.
Brewer's Yeast Extract	170.0 mg.

plus other factors of the B-Complex present in Whole Liver.

BASE: Liver and Yeast.

SUPPLIED: in 50's and 1000's.

1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:613, Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

Samples on Request

26 CHRISTOPHER STREET NEW YORK 14, N. Y.

BLOOD BANKS

On a recent trip to New York City, Miss Monroe and I visited blood banks in a number of the large hospitals. I found that, essentially, we are conducting our bank activities in much the same manner that these hospitals are. One bank still continues to strain blood in an open filter before administering it, even though it is collected by the closed method.

The commercial banks visited were doing a land-office business—almost production line, much like a factory—we thought. These donors, and in fact all New York donors, are paid $5.00 per pint for blood, regardless of type—rare types and all. It is sold for $15.00 a pint and is shipped all over the country, F.O.B., N. Y.

St. Luke's Hospital has made an intensive study of Prothrombin activity in "Stored Human Blood". The results showed that the prothrombin activity of whole plasma is over 100% for first four (4) days following storage and 100% for the fifth day. After the fifth day, there is a gradual drop to 84.8% on the ninth day. Therefore, it is practical to use *Tanked* blood for Hypoproteinemia, or bleeding associated with it, as an agent containing normal hemostatic qualities, during the first week of storage.

I gathered from inspecting the various banks and conversing with the directors, that they are all in much the same predicament we are in—crowded quarters, due to the rapid growth of the blood transfusion service during the past five years. A few of the banks are doing considerable research, along with the daily business of drawing and dispensing blood. Notable among these is Dr. Katzin's Bank at Memorial, and, of course, Dr. Weiner at St. Luke's. The Katzin Bank supplies many of the New York and surrounding area's hospitals with blood. Many of these hospitals do not have blood banks which do an adequate business to supply the demand.

All in all, our conclusion is that the Blood Bank has grown from a new born babe to an enormous adult in the past three or four years, and surely deserves everything you, as doctors, and we, as technicians, and directors, can put into it.

PAULINE M. TWEEDDALE, R.N.
Director of the Blood Bank.

RABIES CONTROL

Month of May, 1949, the Second Annual Dog Inoculation Program for Youngstown is taking place. The mass inoculations are being carried out in the various fire stations in different areas each Sunday of the month of May.

First Sunday the response was very poor and few dogs were inoculated. After repeated appeals and publicity the public is responding excellently and our program is making full strides now.

Dog inoculation with anti-rabies serum was started in 1948. The ordinance states that every dog must be inoculated by June 1st of each year. Results of the inoculation program for the first year have been outstanding. The incidence of rabies in dogs and those transmitted to human beings have been reduced by around 95%. We are expecting to maintain this average and if possible to better it for the year 1949, if the public cooperation continues as it has.

W. J. TIMS, M.D.

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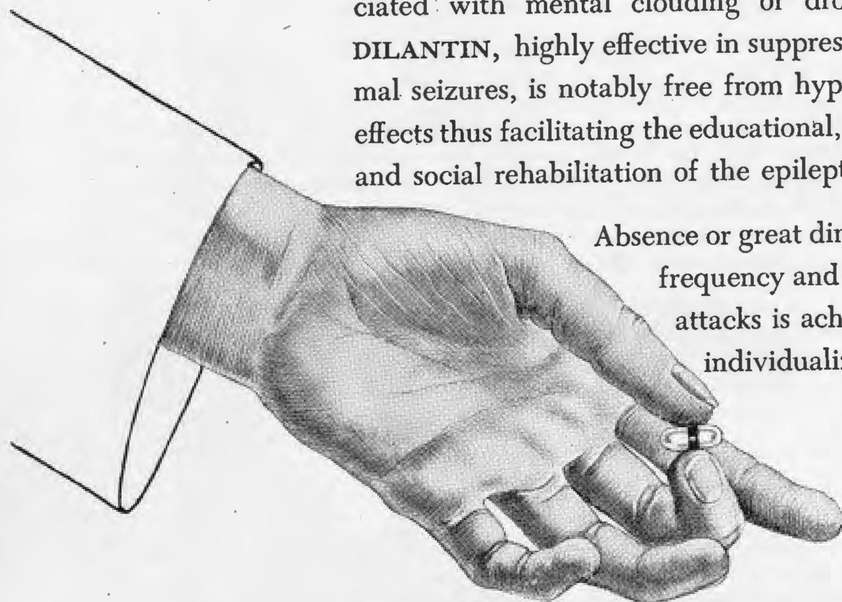

Absence or great diminution in frequency and severity of attacks is achieved with individualized dosage schedules.

DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is available in 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) Kapseals®, in bottles of 100 and 1000.

*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy. Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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NUTRITIONAL PROBLEMS OF THE HOSPITAL PATIENT

In a recent study done at Pennsylvania Hospital in Philadelphia, Dr. Garfield Duncan reports a widespread state of malnourishment on the part of a great many hospital patients. It is not pleasant to be reminded that in a great many patients admitted to general hospitals, all phases of malnutrition exist, and may still persist at the time of discharge.

All persons with a primary interest in the nutritional status of a patient, especially when faced with acute illnesses, pregnancy and its complications, and surgical hazards, are disturbed when full advantage is not taken of our present knowledge of nutrition. For a great many patients, for short periods, a state of undernutrition is unavoidable, but for the patient hospitalized for a long period, life itself may needlessly be threatened if the under-nutritional state persists. In every public, and a great many private wards throughout all hospitals, this hazard prevails. Susceptibility varies, but the wealthy patient may be the malnourished subject of a "fad" diet, while a patient with some organic disease, an infection, a toxemia of pregnancy, or an anemia victim, may all, on inadequate therapeutic diets, be subjects for later malnutrition.

The greatest single job for the professional dietary personnel, as well as those more closely allied with the patient, becomes that job of seeing that adequate amounts of nutrients reach the patient's stomach.

In the Pennsylvania Hospital studies, the results of 78 patients show that of the 105 grams of protein served daily, the mean total ingested was only 81 grams per day, while the mean total carbohydrate eaten was only 205 grams out of the 275 grams served. Even more startling was the total caloric value. Ten (13%) patients of the total 78 studied consumed less than 1,000 calories per day, 19 (24%) less than 1,500 calories, and 47 (60%) less than 2,000 calories.

Any campaign to insure adequate nutritional intake, as Dr. Garfield has pointed out, "must be continuous". Special attention must always be given to "salt-free" programs, where adequate food intake, especially protein and fat, is fundamentally low.

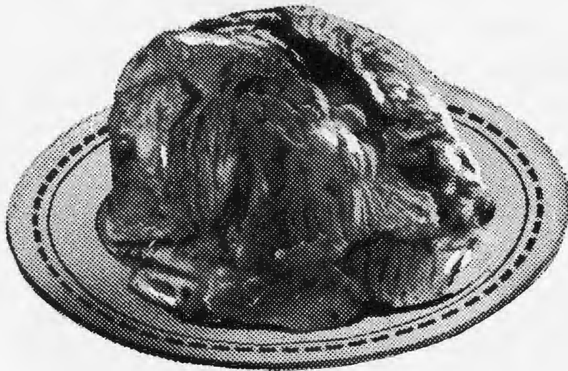
Protecting the hospital patient against unforseen, real or potential nutritional hazards, becomes the job of a whole retinue of people—the attending physician, the nurse, the interne, and the dietitian. It is not the real amount of food that the patient is subjected to in the form of a tray, but rather, how much of that food he will eat, and how much diligence goes into making him see the need for wanting to eat it, as a part of his getting well faster. It is often said in our own hospital, "There are no uncooperative patients," but rather, there is a lack of cooperativeness on the part of trained personnel in finding a way to make people want to eat, a feature which should be as much a part of clinical training, especially for professional dietary employees, as the learning of scores of calorie values, or the planning of well balanced meals.

R. WALTERS.

LAY EDUCATION AND SPEAKERS' CALENDAR

4/21/49 Dr. Paul J. Mahar addressed the Junior Seton Club; His subject: "Hypertension".

5/10/49 WFMJ; Dr. Raymond A. Hall; "Better Hearing for Life".



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DAIRY SPECIALISTS

JUNE MEETING

Speaker:

A. McGEHEE HARVEY, M.D.
Professor of Medicine,
Johns Hopkins Medical School

TUESDAY, JUNE 21, 1949

8:30 P. M.

Pick - Ohio Hotel

Subject:

"Some Recent Advances in Medical Therapy"

TRAINING COURSES IN POLIOMYELITIS

I wish to bring to your attention the training courses in poliomyelitis, which are offered here at City Hospital, Cleveland, to physicians, nurses, and physical therapists.

The material presented is of practical value. There is no tuition fee. The cost of traveling expenses, room and meals may be borne by the enrollee himself, the organization with which he is affiliated, or his local chapter of The National Foundation for Infantile Paralysis.

The physicians' courses are scheduled as follows:
July 18 to July 23, inclusive;
August 8 to August 13, inclusive;
August 28 to September 3, inclusive.

Please urge your members to enroll as soon as possible for the course of his preference, while classes are not as yet filled. A brochure giving the complete programs and details is enclosed.

Application blanks will be gladly sent upon request.

Sincerely yours,

JOHN A. TOOMEY, M.D.
Director, Poliomyelitis Teaching and Training Center
Department of Contagious Diseases

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MISSES, YOUTHS AND BIG BOYS

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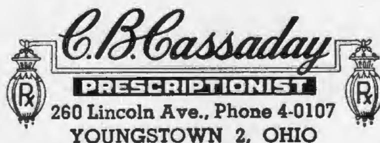


SURGICAL DRESSINGS SICK ROOM SUPPLIES

VALUABLE REGIONAL ANESTHETIC BLOCKS, INCLUDING EPIDURAL ANESTHESIA

Abstract of a paper presented by Dr. Edward B. Tuohy, Professor of Anesthesiology, Georgetown University, to the Mahoning County Medical Society, May 17, 1949.

Conditions frequently occur in which regional or epidural nerve block may be of great assistance in the diagnosis or treatment. The methods described are not advocated ahead of other accepted procedures, but are definite adjuncts to the field of anesthesia as well as many other branches of medicine.

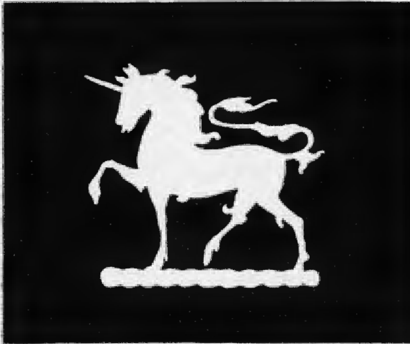
Although continuous epidural anesthesia does not offer quite as great motor relaxation as does subarachnoid injection it has certain factors of safety which must be considered in cases requiring protracted periods of pain relief. Frequently the severe pain of chronic pancreatitis is difficult to handle and a continuous epidural block proves much more specific and successful than a splanchnic block.

An indwelling epidural catheter offers less danger of infection than does one in the subarachnoid space, although a catheter has been left in the latter as long as 37 days without secondary infection in the treatment of tuberculous meningitis. Catheters in the epidural space have been left varying lengths of time up to 3 weeks without ill effects. Conditions such as anuria, vascular diseases and intractable pain are indications for epidural injections. Other than the lessened motor relaxation and the slower onset of anesthesia the results are essentially the same as with subarachnoid block.

Technically, the procedure is a little more difficult than a spinal tap, but anyone adept at entering the subarachnoid space can easily master the epidural block. In surgical anesthesia the contra-indications to continuous spinal or epidural block are the same as for a single dose spinal anesthetic. Debilitated and cachectic individuals are not good candidates. Patients showing signs of impending shock are poor spinal risks, as are those hypotensives who do not respond well to vasopressor drugs.

After entering either the epidural or subarachnoid space the foramen of the needle can be so directed that the catheter can be passed either cephalad or caudad depending upon the results desired. The level of anesthesia can also be reasonably well controlled by the volume of solution injected. A level below the umbilicus will allow painless labor while a level as high as the fifth thoracic segment will stop labor completely. This may be of definite value in a few instances. Doses as high as 2100 milligrams of procaine have been used in 6 hours without complications.

Aside from blocking the roots of the spinal nerves there are many other occasions when regional or field blocks are efficacious. One of momentary interest is the stellate ganglion block in the treatment of causalgias, traumatic arthritis, Reynaud's disease, cerebrovascular accidents and a number of other conditions. Current literature has provided pros and cons concerning the value of stellate ganglion blocks in cerebrovascular accidents, but it has been shown by actual vessel measurement that there is a release of sympathetic control on the ipsolateral side. The best results thus far have been in cases of cerebral thrombosis; however, it is generally felt that embolus, thrombosis and hemorrhage need not be differentiated before the block is done. Also, the classical signs of a Horner's syndrome need not all be present to consider the block successful.



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Sympathetic block at various levels varies with the anatomy of the sympathetic chain. In the cervical and lumbar regions it lies well anteriorly while in the thoracic region the chain is easily approached posterior to the body of the vertebrae. Hazards of this block are not great but do exist. Inadvertently entering the aorta, vena cava, kidney or other viscera should be avoided. Subarachnoid block occasionally occurs if aspiration is not practiced before injection.

Intercostal block can easily be accomplished and is of considerable value in the preferred surgical risk where abdominal relaxation is required. Light inhalation or intravenous anesthesia should be used as a supplement.

A new local anesthetic agent, xylocaine, has been studied and shows some promising characteristics. It is cocaine-like in nature acting as a mild vasoconstrictor when injected. The onset of anesthesia is rapid and the dose is comparatively small. Its relative toxicity is slightly greater than that of procaine.

D. W. METCALF, M.D.

COUNCIL MEETING

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, May 9, 1949, at the office of the society. The following doctors were present: J. N. McCann, V. L. Goodwin, J. C. Vance, W. J. Tims, W. M. Skipp, R. E. Odom, G. M. McKelvey, John Noll, G. G. Nelson, C. A. Gustafson, L. H. Getty, E. J. Reilly, and C. S. Lowendorf was a guest.

A motion that Dr. F. F. Monroe be made an honorary member of the society was received favorably and will be voted on at the next meeting of the Society.

The following applications were passed by council:

FOR ACTIVE MEMBERSHIP

Dr. William Newcomer, 4880 Kirk Rd., Youngstown, Ohio

Dr. Vincent G. Herman, 20 12th St., Campbell, Ohio

Unless objection is filed in writing with the secretary within fifteen days, the above applicants become members of the society.

V. L. GOODWIN, M.D.
Secretary

MEDICAL-DENTAL BUREAU ELECTS OFFICERS

The annual meeting of the Medical-Dental Bureau was held on Tuesday, May 31st, at the Council Rooms of The Credit Bureau of Youngstown, 2nd floor Schween-Wagner Bldg. The following officers were elected: Dr. W. H. Hayden was re-elected President; Dr. C. A. Gustafson, Vice President; Dr. G. E. DeCicco, Secretary; Dr. M. W. Neidus, Treasurer; Dr. Ray Hall, Asst Treasurer; and Mr. Carl M. Wolter, representing the Credit Bureau of Youngstown. Mrs. Mary Herald is Managing Director. Other members of the Board are Dr. G. M. McKelvey, Dr. H. E. Kerr, Dr. R. E. Odom, and Dr. E. C. Brown.

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ST. ELIZABETH'S HOSPITAL STAFF MEETING

The regular monthly staff meeting of St. Elizabeth's Hospital was held on May 3, 1949. Dr. R. B. Poling, President of Staff, presided.

The scientific program featuring the first portion of the meeting was divided into two sections. First, brief case abstracts and reviews of recently hospitalized cases were presented by members of the resident staff. Those presenting the case histories were Dr. H. Bannister and Dr. D. Dockry of the surgical service, Dr. W. Kelly, medical resident, Dr. B. Munson, obstetrics-gynecology service, and Dr. J. Tan, medical interne.

Dr. J. J. Wasilko presented a paper on "Varicose Veins and Ulcers: Their Diagnosis and Treatment". In his discussion he gave a graphic description of various clinical tests for determining the efficiency of the venous channels and the approach to treatment for various conditions encountered. The indication for saphenous ligation, venous stripping and segmental resection were described. Indications for use of sclerosing solutions were also given in the discussion of management.

Committee reports featured the report of Dr. H. J. Reese, Chairman of the Record Committee, who stated that the number of incomplete charts was the smallest that the hospital has had in a great number of years.

Dr. J. J. McDonough gave a statistical analysis of the cases examined in the Cancer Detection Clinic in the year 1948. The analysis included 118 cases and findings listed on the examinations indicated that operation of the clinic was productive of highly gratifying results in that many entities other than cancer were found and patients referred to their physicians for indicated attention.

Dr. R. V. Clifford announced plans for the annual reunion of the Ex-internes Association of the hospital. The reunion will be held sometime during the coming Summer and will highlight a clinical session to be conducted by an outstanding guest speaker, followed by luncheon, golf and a banquet in the evening. He stated that members of other Youngstown Hospital staffs and members of the Mahoning County Medical Society would be invited for the clinical session and luncheon at the hospital.

Dr. M. W. Neidus of the special committee on autopsy procurement, stated that the autopsy percentage for April was 41%, a slight decrease in the 50% or better average that efforts are being made to maintain.

In the absence of further business the meeting was adjourned at 10:30 p. m.

STEPHEN W. ONDASH, M.D.
Secretary

THOSE WHO HELP US

In the past several weeks scores of resolutions opposing compulsory health insurance have been mailed to the President of the United States and to members of Congress by organizations representing various interests. We have on file numerous copies of such resolutions so forwarded by Women's Auxiliaries to the Medical Societies, Lions Clubs, Rotary Clubs, Chambers of Commerce, and two Small Business organizations: the National Federation of Small Business and the American Association of Small Business. The former claims a national membership of 130,000. These business groups, champions of free enterprise, mailed questionnaires to their members on the subject of socialized medicine, to which 89% and 98% respectively were opposed.

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THE YOUNGSTOWN HOSPITAL ASSOCIATION STAFF MEETING

May 3, 1949

The regular monthly meeting of the Youngstown Hospital Association was called to order on May 3, 1949 by Dr. W. K. Allsop at 8:30 P. M. The minutes of the previous meeting were read and approved. The staff report for April was read and approved.

The program was in charge of Dr. Middleton who gave 4 case reports.

Dr. Segal asked what effect Parathormone had on blood phosphorous. This was not answered.

The commencement is on May 12th. Dr. Allsop asked the staff to turn out. Dr. Bennett asked support especially because of the smallness of the class.

Dr. McKelvey reported about the money raising campaign. $45,000 has been raised. About half of the pledge cards have been returned.

Dr. Rummell announced that the admitting office has been moved downstairs to the emergency floor.

Another case of tuberculosis in a student nurse has been found at the North Side. This makes 2 cases in 3 months. Any suspicious case is isolated.

Every day a staff member comes with a problem that is really a staff problem. Such problems should be presented to the staff for discussion and settlement.

Another interne's reunion should be started. This should be held at a country club so if rain occurs indoor sports could be followed. Social committee was asked to function for another interne's reunion.

Dr. Keogh remembers 11 nurses that he has seen with tuberculosis. There is a committee on tuberculosis and recommendations have been made. Dr. Delfs thinks isolation technique should be taught.

Dr. Allsop brought up the matter of the tremendous number of drugs in the drug room. Dr. Rummell said that Dr. J. R. Buchanan had ordered Duracillin and the patient had been receiving another form. Dr. Allsop felt that drugs could be standardized. Dr. Mathay said that Lakeside operates by means of a committee. There is a committee on Hospital facilities.

Dr. Yarmy says that insulin syringes are not used on any floor. The nurses have a problem every time insulin is given. Mrs. Aubrey did not feel that insulin syringes should be used. Dr. Bennett promised to look into this. Dr. James Fisher said that three official syringes have just been adopted by the Diabetic Association.

Dr. Gustafson reported that over 1,000 charts were unfinished. The narcotics are stumbling blocks. Dr. Altdoerffer complained about signing so many parts to the chart. The A.M.A. and College of Surgeons require the charts to be properly filled out.

Meeting adjourned at 9:45 P. M.

E. C. BAKER, M.D. Secretary.

CHAMBERS OF COMMERCE PETITION CONGRESS

The Florida State Chamber of Commerce petitioned Congress not to enact legislation in any form dealing with socialized medicine, compulsory health insurance—or by any other name. Copies of the Resolution were sent to all the Florida members of Congress.

The Chamber of Commerce of Columbus, Ohio, also petitioned Congress not to enact compulsory health insurance legislation.

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JANE E. DUNAWAY, M. D.

Medical Director
JOHN A. McKAY, M. D.

GENERAL PRACTITIONERS ELECT OFFICERS

At the second annual meeting of the Mahoning Chapter of the Ohio Academy of General Practice on May 10, the following officers were elected: President, J. L. Fisher; President-Elect, E. J. Reilly; Secretary-Treasurer, H. E. Mathay; Directors: J. C. Vance, C. A. Gustafson, E. H. Nagel, and D. M. Rothrock.

At the first meeting of the Board of Directors the following standing committees were named:

Membership: E. J. Reilly, D. M. Rothrock, and K. E. Camp.

Public Relations and Hospital: L. Segal, A. A. De Tesco, and L. H. Getty.

Education and Program: J. C. Vance, H. E. Mathay, and G. E. DeCicco.

Legislative and Constitution: C. A. Gustafson, E. H. Nagel, and Sidney Franklin.

The Mahoning Chapter now numbers forty-nine members and is receiving applications from doctors who do not limit themselves to any medical specialty. The purpose of the organization is to maintain a high quality of general practice and further its interests. Constant study and post-graduate work are encouraged to keep up with the advances of scientific medicine. Members are required to fulfill a minimum of 150 hours of post-graduate study in order to maintain their standing in the academy.

The first convention of the American Academy of General Practice at Cincinnati in April was attended by J. C. Vance, K. E. Camp, L. Segal, E. J. Reilly, W. P. Young, B. B. Burrowes, T. A. Lander, and C. A. Gustafson. They report an enthusiastic overflow meeting of 3,500 medical men, which far exceeded expectations. This growing organization will now be limited to six cities in the country with facilities to handle its annual meetings.

The next meeting of the Mahoning Chapter will be held on Tuesday evening, June 14th, at the South Side Unit. An out-of-town speaker is scheduled and plans will be discussed for an educational program. All members and any other interested doctors are urged to attend.

PITTSBURGH SOCIETY OF ANESTHESIOLOGY HOLDS REGIONAL MEETING

Members of the Pittsburgh Society of Anesthesiology held a dinner meeting at the Mahoning Country Club, Youngstown, Ohio prior to their group attendance as guests of the Mahoning County Medical Society to hear Dr. Edward B. Tuohy, Professor of Anesthesiology, Georgetown University School of Medicine and Past President of the American Society of Anesthesiology. Dr. Tuohy spoke on "Valuable Regional Anesthetic Blocks, Including Epidural Anesthesia".

Dr. Anthony J. Bayuk, Chief of the Department of Anesthesia at St. Elizabeth's Hospital, was host to the members of the Pittsburgh Society of Anesthesiologists at this meeting. Visiting anesthesiologists were Dr. George Thomas, St. Francis Hospital; Dr. Robert Patterson, Allegheny Hospital; Dr. Foldes, Mercy Hospital; Dr. Klein, West Penn Hospital; and Dr. Irene Shanks, Magee Hospital, all from Pittsburgh, Pennsylvania, and Dr. Ira Lamberg from Buhl Hospital, Sharon, Pennsylvania. Other guests included residents from the aforementioned hospitals.

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Health Department Bulletin

REPORT FOR APRIL, 1949

	1949	Male	Female	1948	Male	Female
Deaths Recorded	194	111	83	173	107	66
Births Recorded	524	274	250	480	240	240

CONTAGIOUS DISEASES:	1949		1948	
	Cases	Deaths	Cases	Deaths
Chicken Pox	191	0	127	0
Measles	125	0	257	0
German Measles	77	0	0	0
Mumps	24	0	5	0
Scarlet Fever	18	0	6	0
Tuberculosis	2	0	1	2
Whooping Cough	31	0	9	0
Gonorrhea	14	0	12	0
Syphilis	40	0	51	0
Oph. Neo	1	0	0	0

VENEREAL DISEASES:

New Cases:	Male	Female
Syphilis	8	4
Gonorrhea	16	1

Total Patients 29
Total Visits to Clinic (Patients) 423

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

RESOLUTION ON SOCIALIZED MEDICINE

Socialized medicine is not the answer to the country's health problems. Our medical and health problems will be better solved by enabling more qualified individuals to train for the medical profession, by lifting educational bars to racial minorities so that they may participate in medical and dental training and practice, by relaxation of Federal taxation so that the States may handle their responsibility in this connection, and by the spread of private health service plans.

CYNICAL SAM

Some of these old chronic talkers know that when they have a mental lapse, if they go back near the beginning they may jump the gap when they come to it and keep on going. The fellow who helped them to that knowledge was no friend of man.

★ ★ ★

It would not be agreeable to our sense of importance if we were made to recognize that civilization is being maintained through exploiting our vices and our vanities.

★ ★ ★

As modern man may meditate on the crude stone ax which his primitive ancestor probably had used to batter the head of some other half-human fellow, we wonder: When the human race has been succeeded by a different kind of being, what evidence will remain of the atrocious conflicts with which we have periodically entertained ourselves?

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THE DIAGNOSIS OF LESIONS OF THE BREAST

W. T. Fitts, Jr., and J. G. Donald in *Surgery*, March, 1949, present a a review of the records of 250 consecutive patients with breast lesions, not due to infection, referred to the senior surgeon of the Hospital of the University of Pennsylvania for surgical consultation.

Interesting highlights are that one fifth had carcinoma and more than one half had chronic cystic mastitis. The average age of the patients with fibro-adenoma was 30 years; with chronic cystic mastitis, 40 years; and with cancer, 50 years.

In formulating ideas about the diagnosis of breast lesions, the authors found the "dominant lump" helpful. Among the 250 patients, 170 dominant lumps were discovered and all were subjected to operation. A helpful diagnostic sign of the fibro-adenoma was its slipability, found in over one-half of the cases. Carcinomas and fibro-adenomas were characteristically non-tender. Sixty-five per cent of the malignant lesions were in the left breast, whereas the benign lesions were equally divided. The upper outer quadrants contained over one-half of both benign and malignant lesions. A bleeding nipple was encountered in 14 of the 250 patients and 5 (36 per cent) had carcinoma and 9 (64 per cent) had intraductal papillomas.

The authors do not advise the general routine use of aspiration for suspected cysts: first, because of failure of patient to return for further examination and, second, because of possibility of spreading an already existing carcinoma. It is often impossible to diagnose a small cancer of the breast on physical examination and if all "dominant lumps" are operated a mistaken preoperative diagnosis is not a serious one. Also it is often impossible to determine the presence of carcinoma in axillary nodes by physical examination unless they are extensively involved. Out of 48 carcinomas of the breast, 32 (47.9 per cent) were proven to have axillary metastases and only one half of these were recognized preoperatively; another one quarter only at operating table.

In the clinical examination of the breast the ability to recognize small and elusive "dominant lumps" is of much greater importance than the ability to diagnose the mass correctly. E. R. M.

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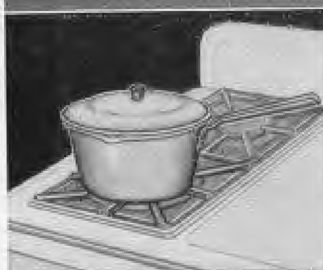

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