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MARCH • 1954
Vol. XXIV ■ No. 3

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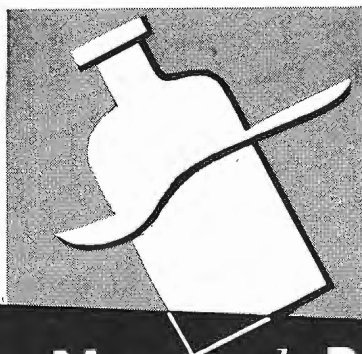

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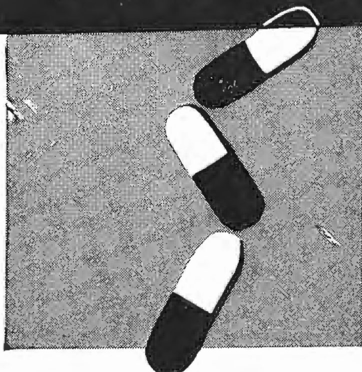

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BASE: Liver and Yeast.

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.

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TABLE OF CONTENTS

Volume XXIV—No. 3 **March, 1954**

President's Page - 104
Editorial - 105
Councilor's Page - 109
Polio Vaccine Evaluation - 115
The Patient Examines the Doctor (Guest Editorial) - 107
Schistosomiasis - 117
Errors in Diagnosis - 125
Periodical Pearls - 129
Medicolegal Responsibilities of the Marital State - 136
Control is Spelled Co-operation - 138
Notes on Cervico-Sympathetic Surgery - 140
Keeping up with the A.M.A. - 143
Summary, Congress on Medical Education and Licensure - 146
Personal Patter - 149
Current Methods in Treatment of Hypertension - 150
Donald M. Glover, M.D. - 153
From the *Bulletin* 20 Years Ago — 10 Years Ago - 156
Proceedings of Council - 163
The Physician in the Care of the Indigent - 162

ADVERTISERS' LIST

Beil-Rempes Drug 122
Blair Dry Cleaning Co. 124
Borcherdt Malt Extract Co. 124
Ciba 120-126
Cross Drugs 118-120
Endo Products 130
Fellows 103
Geigy Pharmaceuticals 112
James & Weaver 122
Laeri's Pharmacy 132
Lakeside Laboratories 110
Lester's Pharmacy 130
Lilly, Eli & Co. 114
Lyons Physician Supply Co. 128-132
O'Linn's Drugs 126
Park, Davis & Co. 118
Pfizer Lab., Division of Chas. Pfizer & Co., Inc. ..... Cover
Renner's 132
Scott Co. 130
Squibb 171
Stillson & Donahay 128
Strouss-Hirshberg Co. 122
Thornton Dry Cleaning Co. 120
Upjohn Co. 116
Yo. Com. for Education on Alcoholics 124
Zemmer Company 167

Our President Speaks

SERVICE

According to Funk and Wagnalls dictionary, service is described as the act of serving in the interest of others, or, any work performed for the benefit of others whether the service is performed for an individual or in general.

There are many things in this life that people value. Some possessions are more valuable than others due to what they represent to their owner and what may be of extreme value to one may be of no value to another. But one thing that we can all agree upon, that possibly outranks anything else, is unselfish service to one's fellowman whether to a small group, a community or a nation. Somehow it seems to me that in no other profession does the above hold true so much as in the medical profession.

Often times we are tempted by a feeling that our patients are unreasonable, therefore we are apt to be remiss in giving the best service of which we are capable. In this mechanized world we live in today I sincerely feel that we should never lose sight of the human side of our daily problems. The past history of the medical profession has been magnificent in its service rendered to the people of this country. I feel that it is our duty and privilege as members of this high-calling to carry on in such a manner that the future of the practice of medicine will be secure.

James D. Brown, M.D.
President

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

The opinions and conclusions expressed herein do not necessarily represent the views of the Editorial Staff or the official views of the Mahoning County Medical Society.

VOLUME 24 **MARCH, 1954** **NUMBER 3**

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

EDITOR
A. A. DETESCO
2921 Glenwood Ave.

ASSOCIATE EDITORS

P. B. Cestone
J. L. Fisher
R. A. Jenkins
E. R. McNeal
F. W. Morrison
S. W. Ondash
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EDITORIAL

"A physician is a person who puts drugs of which he knows little into a body he knows less."

Voltaire

Before a drug is prescribed or administered, every physician should make certain that he is not the type to whom Voltaire referred. After the choice of a drug is made, it might be well to recall the following words.

"Be not the first by whom the new is tried nor yet the last to lay the old aside."

Alexander Pope

Andrew A. Detesco, M.D.
Editor

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2. Kesten[2] observed that Pyribenzamine afforded complete relief or suppression of postpenicillin urticarial symptoms in 88% of cases and concluded that Pyribenzamine is a "most useful therapeutic agent in allergic symptoms which follow the administration of antitoxin or penicillin."

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Literature available on request. Write Medical Service Division, Ciba Pharmaceutical Products, Inc., Summit, N.J.

1. SIMON, S. W.: ANN. ALLERGY 11:218, 1953. 2. KESTEN, B. M.: ANN. ALLERGY 6:408, 1948. 3. LOEW, E. R.: MED. CLIN. N AM. 34:351, 1950.

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GUEST EDITORIAL

THE PATIENT EXAMINES THE DOCTOR

By Howard C. Aley

(Editor's Note—Howard C. Aley, a life-long resident of Youngstown, Ohio, is a widely recognized author of educational text books. He is one of the most sought-after speakers in northeastern Ohio, and has his own television show, "TELERAMA" which is presented weekly over WFMJ-TV. Mr. Aley is at present on the faculty of Woodrow Wilson High School.)

While not equipped with such scientifically valid instruments as the stethescope, the sphygmonometer, and the electrocardiograph, it is nevertheless a fact that every time the physician examines the patient, the patient is in his own way examining the physician. While equipped with different instruments of examination, both are equally determined to find the particular syndrome upon which each can make his own diagnosis. In the instance of the physician, he with scientifically perfected devices is searching for evidences of malfunction or disease in the hope that with the wonders of his science at his command, he can improve the patient's condition, or can preserve the patient's health at an optimal degree.

H. C. Aley

The patient, on the other hand, is examining his physician with less scientifically valid instruments, but with nevertheless highly significant emotional equipment, looking for evidences of humane qualities that elevate the physician above the level of a scientific machine, and which strengthen the patient's confidence in his physician and in himself.

Much has been said and written in recent years about the so-called "inhumanity" of the medical profession. Some proponents of socialized medicine submit that the doctors themselves have nourished this threat against American principles and against themselves, by attitudes of callousness and material greed. These would further insist that doctors are more pre-occupied with making money than in serving their patients. It has never been this writer's ill fortune to come upon such a practitioner. Whether these charges are well-founded or not, cannot be decided upon evidence submitted by any individual or even by any group of individuals, and certainly no attempt will be made to answer it here. The issue does, nevertheless, give rise to another question that is of major importance in the life of the patient and in the success of the practitioner, and that is, "What does the patient hope to find in his doctor?"

Well, certainly it may be fairly assumed that the patient has every right to expect a warm friendliness on the part of his physician, even though the latter may have grave misgivings concerning the danger of "coddling" or "babying" his patients. Certainly, even if the physician discovers that he is dealing with an immature personality, he should be willing to make some effort to reach the patient's emotional level. All that present day psychiatry and psychosomatic medicine tell us would indicate that an emotional rapport between the physician and his patient is imperative to the healing process. Certainly the doctor would be the first to admit that the patient has every

right to be treated as a human being, not looked over with the disdain of an automobile dealer looking over an old model in an off-season for trade. There is always some danger in suggesting something in the past as having been the ultimate, for it is said that one of the five indications of senility is a pre-occupation with the past. Nevertheless, the old "country doctor" idea insofar as doctor-patient relationships are concerned, seems to be the kind of relationship most people think of as a desirable one. Whether this concept of the country doctor is based upon personal experience or is the evidence of nostalgic fancies—certainly the basic characteristics of warmth, friendliness, and interest were woven into the pill and powder practice of the old days. This is not to say that these qualities are not in evidence today; it is only to say that they are the qualities patients seek in addition to the specialized skills of modern doctors.

The patient in examing his physician looks for simple statements concerning the nature of the treatment that has been prescribed. He usually prefers, too, to have some indication from the doctor as to what lies ahead. Whether or not the patient should be told the facts in instances of what are likely to be fatal illnesses, is an issue which is widely debated among the doctors themselves. But the patient is almost certain to feel more satisfied if the doctor makes some explanation as to the diagnosis and his approach through treatment, than if he merely sets forth in an unintelligible language, a prescription for an unpronouncable ailment.

The oft-repeated statement, "The doctors won't tell you anything," may justify a reconsideration of this practice, if it is as widespread as some claim. Surely, the last thing the doctor would want to do would be to add to the patient's difficulties by frightening him. Yet, a grave non-commital attitude is to the patient often most disturbing, for it may stimulate the patient's imagination to deplorable heights. What all this means is that because patients are human creatures, they want to be treated as such. And physicians, being human creatures, should not find their role too difficult. A warm, personal attitude on the part of the physician undergirds the patient with courage and confidence. If the physician finds that his patient is leaning upon him to a degree that hampers the curative process, or that monopolizes the physician's time, it would be at that point that the physician might well counsel with the patient in these matters. In a world of human relationships, it should not be asking too much to be treated humanely. To the extent that this is being done, or is not being done is again, not for anyone to answer, except in terms of his own relationships with his own physician.

It is undoubtedly one of the great satisfactions of life to be examined by a physician and be pronounced whole. The good physician undoubtedly finds an equal satisfaction in having won the respect and admiration of those who have entrusted their health, if not their very lives to him.

Finally then, while the doctor is looking for something *wrong* with the patient, the patient is looking for something *right* with the doctor. When both have found that for which they are looking, a happy professional relationship at a friendly level, should bring optimal results. In all of this, there is certainly nothing new, but it is possible that in doctor-patient relationships, as in so many other areas of living, the problem is not one of finding a new solution, but rather of applying the solutions we already have at hand. This being so, while it is encouraging to find that we have at times done better than we knew; it is never good to have known better than we did.

COUNCILOR'S PAGE

C. A. Gustafson, M.D.

The opinions and conclusions expressed herein are those of the author and do not necessarily represent the views of the Editorial Staff or the official views of the Mahoning County Medical Society. — Editor.

The political system which we have in America may be defined as a constitutional republic. We should keep in mind that at the time when this republic was established there was not in the whole world a single republic functioning on a national scale. It is true that there had been a number of experiments with both democracies and republics but none of them had endured and our founding fathers, familiar with these past failures, sought to create here in America a democracy which would escape the pitfalls which had proven the ruin of every predecessor. They undertook to do this through the provisions of a national constitution, the purposes of which were set forth in its preamble in the following phraseology:

> "We, the people of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the Blessings of Liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America."

By this constitution, it was sought to create a form of government in which the people would be protected not only from oppression by their rulers, but as far as possible, from their own hasty or ill-advised acts.

Throughout the document and the first ten amendments, known as the Bill of Rights, the protection and preservation of human rights and property rights go hand in hand. As a matter of fact, one of the greatest human rights guaranteed is the right to acquire and to own property and to be protected in the possession and ownership thereof. It is largely that right which has set us apart from the nations of the Old World *and has made possible the wonderful growth and development which has* taken place here in America since our constitution — unique in all history — was adopted.

For almost two centuries, Americans have been proud of their economic and political independence and of the right to govern themselves. By the same token, and in direct ratio, they are envied by millions of people in other lands. It is well to remember that because of this envy it is well that every American be ever on the alert to preserve, protect and cherish the advantages he enjoys under the invigorating atmosphere of our American Way of Life.

Since the establishment of our government under the principles set forth in the Constitution, Americans, through the congress and the various state legislatures, have made their own laws without foreign direction or interference. Now, however, our right to self-government and the very integrity of our free America are threatened by the program of "treaty law" contemplated by the so-called International Bill of Rights program of the United Nations.

Ordinarily and until the organization of the United Nations, the average citizen — and in fact most lawyers — took comparatively little interest in treaties between the United States and foreign countries. This lack of interest

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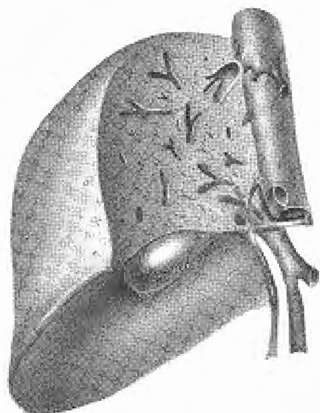

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was understandable because usually a treaty dealt only with some specific subject of interest to two or three nations, such as questions of boundaries, trade agreements, and like matters.

We were inclined to believe that treaty-making was the sole business of the State Department, the President and the Senate. Or possibly we assumed that these international engagements did not affect the basic rights of the average citizen and could not result in any substantial infringement of our individual rights as citizens whether we be workers, industrialists, business men or professional men. Certainly we did not believe that treaties could possibly result in changing or destroying the American form of government or its system of free enterprise.

Now we come to the real heart of this discourse. Permit me to quote Article VI, Clause II, of the Constitution of our United States of America:

> "This constitution and the laws of the United States which shall be made in pursuance thereof, and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land, and the judges in every state shall be bound thereby, anything in the Constitution or laws of any state notwithstanding."

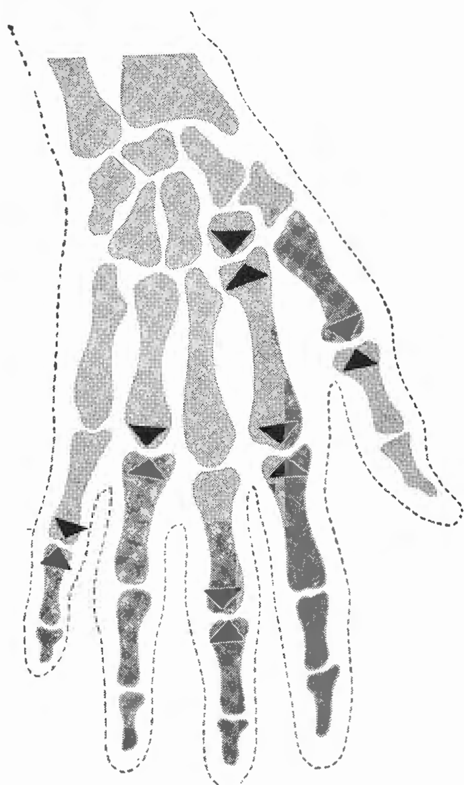
Several court decisions have confirmed the fact that we are fast approaching a new development in lawmaking. By means of "treaty law," the normal legislative processes of the Congress and of the state legislatures are to be by-passed by international agreements ratified as treaties. Through such treaties, the established law in the United States and in every state for that matter might and could be changed or nullified without the people generally knowing anything about it.

The outstanding and most alarming example of the effect of treaties on our domestic law, on our own United States Constitution, and on the thinking of our judges is to be found in the opinion of the Chief Justice of the United States in the 1952 decision dealing with the President's seizure of private property in the steel industry. In his dissent in the steel seizure case, the Chief Justice of the United States advanced the shocking doctrine that the United Nations Charter and other international commitments gave the President of the United States authority — nowhere granted him either by the Constitution or by the laws of our country — to seize private property.

In other words, acting under the doctrine of internationalism, the President was supposed to have powers not only NOT granted to him by the Constitution but moreover even denied to him by the Constitution.

The Chief Justice succeeded in getting two other members of the Supreme Court to join him in this extraordinary doctrine whereby the United Nations Charter and commitments in connection therewith would be superior to the Constitution of the United States. If he could have succeeded in getting two additional members of the Supreme Court to concur in this decision, the United States would in effect then and there have ceased to be an independent Republic.

We would have to be obligated and bound by whatever the United Nations does or directs us to do. We would have had a full-fledged world government overnight. This is exactly what may happen under so-called "treaty-law" unless a constitutional amendment is passed which will protect



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American rights, American law and American independence against the effects of United Nations treaties.

Article VI of the Constitution, as we have seen, unequivocally provides that a treaty when ratified becomes "the Supreme law of the Land — any thing in the Constitutions or Laws of any State to the Contrary, notwithstanding." It is self-evident that where our international agreement like the United Nations Charter or the Genocide Convention or the Covenant of Human Rights is ratified as a treaty, it supersedes every city ordinance, *every county ordinance, every state law, every state constitution,* and every federal statute on the same subject throughout every state of the union.

Americans in their great desire for safety and peace should not be fooled into sacrificing either their individual freedoms or *their integrity as a nation. We can easily lose our rights and freedoms* in the entanglements of international commitments and agreements if we permit our basic rights under the Constitution and the Bill of Rights to be rewritten, levelled out, compromised, and confused by nebulons and ambiguous United Nations Treaties.

There are some who will say: "Well! but what has all this to do with the Medical Profession?" The answer to that question is an elemental one. In the event we lose our rights as free Americans the first innovation we can expect is nationalization of business, industry and services. The nice word "nationalization" is used. The word which should have been used is "socialization." Needless to say that one of the first services to be "nationalized" would be medicine.

Many of us believe that proper consideration should be given to an appropriate constitutional amendment. Whether it be the Bricker amendment in its original form or a suitable revised version, this proposal deserves thoughtful consideration of all Americans.

You will be told by some that such an amendment is not necessary. You will be told by others that such an amendment would interfere with the functioning of the United Nations as an international organization for peace. A study of this subject, however, *should* convince any one that a constitutional amendment is necessary and that such an amendment will not interfere with the functioning of the United Nations in its announced role as an international organization to plan, discuss, and attempt to maintain world peace.

But whatever we do in world affairs, our first consideration must be to preservation of this country's integrity as a free, solvent and independent nation — the preservation of the rights and liberties of its citizens as free men and free women.

I am not an isolationist. Nor is such a policy as I have outlined here isolationism. We most certainly have an interest and a stake in the well-being of the rest of the world. But America will perform its role in world affairs better if, instead of being Santa Claus to all nations, it first of all protects the rights and liberties of its own citizens, conserves its own strength, and encourages other nations to stand on their own feet.

In all the world, we are the last hope and last stronghold of individual liberty. When the great problem of world peace is examined from all sides, the necessity for preserving America's identity, integrity and strength becomes more apparent. A strong, independent and free America is not only

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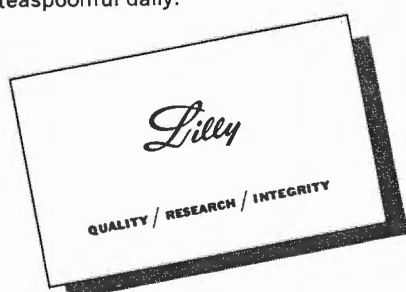

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best for its own citizens, but is also the best guarantee of world peace and world order.

Our best guarantee of this enviable condition is the adoption of either the Bricker amendment or an amendment of similar character.

P.S. The Bricker amendment was recently defeated.

POLIO VACCINE EVALUATION

Dr. Thomas Francis Jr., chairman of the Department of Epidemiology in the University of Michigan School of Public Health and one of the nation's leading authorities on epidemics, has agreed to direct an evaluation of the polio vaccine tests which will be conducted this spring, it was announced today by Basil O'Connor, president of the National Foundation for Infantile Paralysis.

Dr. Francis will organize and direct a staff which will make an independent study of the vaccine's effectiveness. No results of the evaluation will be available before 1955.

Dr. Francis made clear that while the National Foundation will finance the evaluation with a grant, the study will be completely independent. An evaluation center will be established at the University of Michigan and the University's Survey Research Center will assist in collecting data and preparing statistical analyses.

The actual field trials and inoculations will be conducted by state, county and community health officials for the National Foundation in areas determined by recommendations of State Health Officers. University researchers and scientists will record and evaluate the results of the test vaccine after it has been administered by designated agencies of the National Foundation. The tests will begin in late March or early April.

"I am impressed by the number of people who have expressed their willingness to support and collaborate in an integrated effort to conduct an objective, independent and adequately controlled evaluation," Dr. Francis said.

Although the trial vaccine will be triple-checked for safety before use, Dr. Francis pointed out that the vaccine's effect in controlling polio is not yet proved.

"It is not known at present," he said, "whether the vaccine to be used will be highly effective, moderately effective or ineffective in protection of human subjects against paralytic poliomyelitis."

Dr. Francis continued: "In an independent study of the results of the test, we will attempt to insure an adequate measurement of the vaccine's influence through the collection and analysis of good and unbiased data."

Chairman of the University of Michigan Department of Epidemiology since 1941, Dr. Francis became the University's Henry Sewall Professor of Epidemiology in 1947. At that time he also was given the Lasker award for "distinguished contributions to our knowledge of influenza."

He has been consultant to the Secretary of War and the director of the Influenza Commission of the U. S. Army Epidemiological Board since 1941. He is also a member of the Committee on Growth of the Virus Panel of the National Research Council, is past president of the Society of American Bacteriologists, of the American Society of Clinical Investigation and of the American Association of Immunologists.

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Nicotinamide	10.0 mg.
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SCHISTOSOMIASIS (CLINICAL ASPECTS)

In the last issue of the Bulletin the subject of Schistosomiasis was discussed in a general way, covering the importance of the problem, the geographical distribution of the disease and the life cycle of the parasite. In this issue the clinical aspects of the disease will be discussed.

Schistosomiasis Mansoni (Intestinal Schistosomiasis or Bilhariasis). This form of the disease is caused by Schistosoma mansoni. It was originally an African disease, which was brought into the West Indies and South America by the slave trade. Penetration of the skin by the cercariae causes erythema and intense pruritus, and frequently a papular dermatitis. During the migration of the metacercariae, the patient develops fever, leukocytosis with an increase in eosinophiles, nausea, anorexia, cough and various abdominal and intestinal symptoms. In about six to eight weeks ova are produced, and lodge in various tissues. The ova cause an intense inflammatory reaction (of the granulomatous variety), especially in the intestinal wall, the liver and the lung. Fever and eosinophilic leukocytosis are constant features in this stage. Dysentery, enlargement of the liver, and bronchopneumonia are observed. Loeffler's syndrome may occur. As this stage subsides, usually only the manifestations of a chronic colitis persist. The colon is the only part of the intestinal tract that is ordinarily involved. Ulcers of the mucosa, thickening of the intestinal wall or polyp formation may develop. The polyps may subsequently undergo carcinomatous change. If the original infection was massive or repeated infection occurs — as it does in endemic areas — cirrhosis of the liver may develop. This is thought to depend both on the inflammatory changes set up by the ova and parasites and also on the malnutrition from which the patient usually suffers. If the cirrhosis becomes progressive, splenomegaly, esophageal varices and ascites may develop. The clinical course is milder and more chronic than in the other types. Prognosis is relatively good, if the disease has not progressed to the late stages.

Schistosomiasis Japonica (Oriental Schistosomiasis). This form of the disease is endemic to the Orient, and is caused by the fluke, Schistosoma japonica. Lesions of the intestine and liver, and also of the central nervous system may be found. The penetration of the skin and the migration of the parasites cause essentially the same symptoms as described under S. mansoni. With the liberation of ova, a period of several months' duration begins in which fever and dysentery are the main symptoms. Anorexia, weight loss, abdominal pain, and enlargement of the liver and spleen are usually present. These symptoms ordinarily subside in a few months but tend to recur periodically. In some cases ova may be found in the brain and meninges. In acute cases symptoms of cerebral involvement consist of drowsiness, coma, incontinence and signs of pyramidal tract involvement; in chronic cases, of Jacksonian seizures and hemiplegias. In the later stages of the disease, cirrhosis of the liver, splenomegaly, ascites, anemia and chronic dysentery are frequently seen. Japonica infections are the most severe of the schistosome infections. Unless treated early and adequately, the prognosis is poor.

Schistosomiasis Hematobia (Vesical Schistosomaisis or Bilhariasis). The etiologic agent is Schistosoma hematobium. The penetration of the cercariae causes only a mild dermatitis. This is followed by urticarial rash fevér, head-

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ache and generalized aching. These symptoms subside and then after a period of variable duration hematuria appears. Signs of urinary bladder involvement may not occur until many years after the initial infection. With the hematuria, frequency, nocturia, dysuria and perineal pain are usually present. There are both hypertrophic and atrophic changes in the bladder wall. Polyps may form. The incidence of carcinoma of the bladder is high and may appear relatively early in endemic areas. The prostrate, seminal vesicles, urethra and ureters are also sometimes involved. In the female, the vagina and cervix may be involved. Rarely there are lesions in the rectum and colon. The ova can best be demonstrated in the terminal, blood-tinged portion of urine. Involvement of the lungs, brain or liver may occur, but this is rare. If treatment is instituted early, prognosis is good. When chronic urinary tract infection and severe tissue changes are present, treatment does not accomplish very much.

As can readily be seen from the above discussion Schistosomiasis usually involves multiple organ systems and may present itself as a variety of clinical syndromes. It may represent quite a diagnostic problem, especially if the patient is no longer in an endemic area. A positive diagnosis is based on finding the characteristic ova in feces, urine or biopsied tissues.

Various Antimony compounds are used in treating Schistosomiasis. If treatment is begun early, the prognosis is usually good. However, in the later stages, when extensive tissue alterations are present, treatment is not of much value.

In endemic regions the prevention of infection becomes the most important problem in the control of this disease. As noted in the first part of this discussion, the disease is contracted from polluted waterways which are inhabited by a suitable species of freshwater snail that acts as the intermediate host. Prevention of the disease therefore resolves itself either to prevention of pollution of waterways or to eradication of snails. In endemic regions it seems almost impossible to prevent pollution without bringing about vast changes in the life habits of the natives, so most of the efforts have been concentrated on eradication of snails. Copper compounds and hexachlorocyclohexane have proved to be good molluscicides.

A NOTE ON THE HISTORY OF ENDOMETRIOSIS

The report of the first case of aberrant ovarian endometrium by Russell in 1899 didn't cause a ripple of general interest, and the case was complacently accepted as representing an interesting but rare instance of misplaced muellerian rests. Following this an occasional instance of this sort was encountered in laboratories of gynecological pathology, but no one appreciated its significance until 1921, when Sampson published his first paper on the subject. I well recall that for a year or two before this I had gotten letters from him asking me to send him sections or blocks of any available hemorrhagic lesions of the ovary, and I wondered what he had in the back of his head. We all found out when he published his first classical paper in 1921, establishing the frequency and importance of endometriosis as both a pathological and clinical entity.

—*Emil Novak, M.D.*

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TRENDS AND EVENTS

December 23, 1953

The Honorable Dwight D. Eisenhower
The White House
Washington 25, D. C.

My dear President Eisenhower:

Doctors, Martin, Murray, Wilson and myself are very grateful for the time which you gave us at the White House, December 23, 1953. May I reiterate once again that the facilities of the American Medical Association and its research findings in the fields of chronic illness, indigent care, insurance coverage, and all medical problems are available to you and your department heads at all times. After more than one hundred years of study of these problems, we feel that we can offer you a worthwhile consulting service in the medical field.

You were so hospitable and friendly that we did not have time to discuss many of our problems with you, and I should like to refer to them now.

First: The House of Delegates of the American Medical Association is opposed to compulsory social security coverage of physicians.

Second: There are many reasons why the continued care of non-service-connected disabilities is not in accord with American philosophy. It imposes an unjustifiable and ever-increasing tax burden on the American people.

Third: We have no objection to the care of the dependents of career personnel in defense installations. We question, however, the advisability of extending this program over the entire country for the dependents of draftees. This may necessitate the building of additional hospitals and dispensaries. The extension of the dependent care program and the enlargement of the veterans program puts the government in competition with all private institutions for physicians' services and technical personnel of all kinds.

Fourth: We are in favor of the Bricker Amendment because many of the socialized proposals which we have faced in our country have been conceived and born in the International Labor Organization and, as loyal Americans, we are fearful of the suggestions made by representatives of other countries, and proposed as universal law.

Once again, thank you for the consideration extended to us and we offer our help and advice in the solution of the many bills and proposals which are presented from time to time having direct implication in the medical field.

With every sincere good wish, I am

Very truly yours,
Edward J. McCormick, M.D.
President,
American Medical Association

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Dear Doctor McCormick:

This is just a note to thank you for your letter of December 23rd and your generous offer of assistance in connection with medical problems.

I am sorry that time did not permit more extensive discussion when you and your associates were here last week. However, I have read with interest your comments on the several matters about which you are concerned, and I shall also see that they are brought to the attention of the appropriate authorities.

With best wishes,

Sincerely yours,
(signed)
Dwight D. Eisenhower

to Edward J. McCormick, M.D.
President
The American Medical Association

IN DEFENSE OF HOSPITALS

Recently, several magazines and newspapers have published articles criticizing hospitals for alleged high charges to patients. Much of the material in these published criticisms was presented in an unfair and misleading manner. Hardly any of it was typical.

As a result of these articles, every hospital in America has been challenged to initiate an alert community relations program aimed at publicizing the local fact and figure truth.

For example, a recently completed survey of 57 metropolitan hospitals located in one of the nation's most costly hospitalization areas revealed the following:

> Last year, these 57 hospitals served 70,516 in-patients. In all, confinements totaled 374,027 patient days, or 8,976,648 patient hours. For all hospital facilities and services these patients paid a total of $10,300,042 or an average of $1.11 per patient hour of hospitalization.

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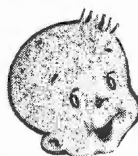

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ERRORS IN DIAGNOSIS

For more than fifty years the clinicopathologic conference has been a stimulating and important part of medical education. In addition to providing an immediate challenge to make correct diagnoses from given sets of facts, these conferences may also serve to indicate common errors in diagnosis.

Hunter has recently reviewed 2,600 cases discussed at clinicopathologic conferences held at the Massachusetts General Hospital and published in the *New England Journal of Medicine*. In this series he found that one hundred anatomic diagnoses made at autopsy had been overlooked during life with sufficient frequency to be considered significant. Of the hundred conditions sometimes missed, eleven were unrecognized ten or more times (Table I.)

Carcinoma of the Pancreas

Carcinoma of the body of the pancreas was diagnosed correctly during life only once in twenty-five years. Among the diseases which were considered, in patients who subsequently were found to have carcinoma of the body of the pancreas, were such varied clinical states as acute pancreatitis, mediastinal lymphoma, carcinoma of the rectosigmoid, pernicious anemia plus cerebrovascular accident, abscess of the brain secondary to middle-ear disease, gallstones, and perinephric abscess.

The predominant symptom of eleven patients with carcinoma of the body of the pancreas was back pain. The distinctive feature of this back

TABLE I

Autopsy Findings	*Number of Times Missed*
Aortic and mesenteric vessel disease	22
Carcinoma of the pancreas	22
Carcinoma of the colon	19
Lymphoma	17
Bacterial endocarditis	17
Bronchogenic carcinoma	16
Carcinoma of the stomach	13
Myocardial infarcts	13
Appendiceal disease	11
Lung infarcts	10
Carcinoma of the gall bladder	10

pain was that its severity was related to posture. For example, pain was accentuated by the supine position in three patients, by the prone position in one, by standing in another, by movement in four, and by all positions except sitting in one. Bizarre radiation of pain was common and was apparently related to retroperitoneal extension of the malignancy, sometimes to the diaphragm or sciatic nerve. In four patients the first symptoms were cough or dyspnea or both from metastases to the mediastinum and pulmonary lymphatics. Thromboses occurred in seven of the patients with carcinoma of the body or tail of the pancreas.

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Bacterial Endocarditis

Difficulty in diagnosing bacterial endocarditis was especially great in older people. The presenting symptom was usually due to embolism or infarction, and the most common diagnostic error was the tendency to build the diagnosis around only the organ subjected to embolism, the cardiac murmurs being attributed to fever, anemia, or inactive valvular disease. In many of the older patients, rheumatic heart disease had not been diagnosed before the onset of the endocarditis.

Among the incorrect diagnoses in patients with bacterial endocarditis were nephritis, pneumonia, brain disease, and nonbacterial aortic-valve disease. Despite the rarity of acute glomerulonephritis in patients over fifty, this diagnosis was made in six patients who had the renal lesions associated with bacterial endocarditis.

Lymphoma

Lymphoma, presenting itself as an abdominal mass, was frequently thought to be a malignancy in one of the pelvic organs. Thus, of nine cases in which lymphoma of the abdomen was found at autopsy, the erroneous diagnoses were carcinoma of the ovary in four patients and carcinoma of the uterus in one.

Diagnostic Hints

This retrospective survey affords certain diagnostic hints. Carcinoma of the body of the pancreas should be suspected if the patient presents severe back pain, particularly when aggravated by changing position. The pain may also show unusual radiations, such as to the shoulder or down the sciatic nerve.

Bacterial endocarditis should be suspected more frequently in patients over fifty, especially when cardiac murmurs are present along with "nephritis," "cerebrovascular accidents," or "pneumonia."

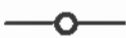
The clinician should also keep in mind the frequent similarity between abdominal lymphoma and ovarian tumor.

From a study of the 2,600 case histories, Hunter gained the impression that the average physician is inadequately familiar with the anatomy and clinical disorders of the retroperitoneal space and mediastinum.

Physicians' Bulletin

Diabetes originally had nothing to do with sugar. It is a pure Greek word simply meaning a "going through," and hence a siphon. It was applied to the disease because of the way in which water passed through the sufferer — a human siphon. There are two forms of diabetes: one in which the victim passes large quantities of urine containing much sugar; and one in which even larger quantities of extremely dilute urine containing no sugar are passed. In the 17th century the only way to distinguish them was to taste the urine; so one was called *diabetes mellitus* (sweet; *mel, mellis,* is Latin for honey), and the other *diabetes insipidus* (tasteless).

H. L. Marriott, M.D.
"Medical Milestones" Williams & Wilkins Co., Baltimore



Quote of the month: Good public relations is something like making love — you have to be willing to participate in it if you expect to get much satisfaction out of it . . . Source: Leo Brown, public relations director, American Medical Association.

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The gastric hypersecretion that causes duodenal ulcer is dependent on two factors: (1) vagal stimulation from higher centers and (2) hormonal stimulation from the mucosa of the antrum. Operations for duodenal ulcer are based on control of one, the other, or both of these stimulatory mechanisms.

The conventional surgical attack, partial gastrectomy, is not a satisfactory answer to the problem of duodenal ulcer. Although resection of the antrum removes one of the factors that causes hypersecretion of acid, the remnant of the fundus remains connected to the central nervous system by the vagus nerves, and hypersecretion frequently continues. This results in a high incidence of recurrent ulceration unless 70 per cent or more of the stomach is removed.

In extensive resections of over 70 per cent of the stomach, sound physiologic principles have been abandoned, and the surgeon resorts to mere removal of the major part of an important and undiseased organ. Unfortunately these radical gastrectomies are often followed by side effects just as incapacitating as the original ulcer.

Vagotomy has not given any better answer to the problem of duodenal ulcer than has partial resection, because in vagotomy the stimulatory mechanism of the antrum is not removed and the incidence of recurrent ulceration is unacceptably high. Gastric retention, moreover, frequently occurs, unless a drainage operation, such as gastroenterostomy, is simultaneously performed.

Vagotomy with gastroenterostomy has been utilized extensively as a substitute for gastric resection, but here again the results are far from perfect. The original report of the National Committee on Peptic Ulcer published in the November 1952 issue of *Gastroenterology* indicated that gastric resection was attended by better results than vagotomy and gastroenterostomy. But a revised report, published in the June 1953 issue of the same journal, admitted that a transposition of figures had occurred and concluded that there was no statistical difference between the results of the two operations unless, in the resected cases, over 70 per cent of the stomach were removed. Since it is not always technically easy to remove over 70 per cent of the stomach, this is like saying that gastric resection is the best operation when it is technically easy to do it or, conversely, that vagotomy is the best operation when it is complete. The fact remains that, despite the arbitrary nature of the Committee's criteria of evaluating results, there was no statistical difference between the results of gastric resection and of vagotomy with gastroenterostomy. The Committee's criteria, moreover, take no account of the relatively high mortality of radical subtotal resection, of the nutritional disturbances that frequently follow it, and of the high incidence of the dumping syndrome that occurs when most of the stomach is removed.

Although the mortality rate of vagotomy and gastroenterostomy, in experienced hands, need not be over 0.5 per cent, and although the side effects are minimal if the gastroenterostomy is properly placed, clinical evidence of recurrent ulceration in a careful 5 year follow-up will be approximately the same as that following a conventional two-thirds gastrectomy, between 5 and 8 per cent. In order to avoid this high recurrence rate and at the same

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time to avoid the morbidity of radical gastrectomy, Johnson and Orr of London have performed vagotomy associated with a two-thirds gastric resection in 236 patients, and have employed vagotomy and gastroenterostomy when the risk of resection seemed too high. In gastric ulcer, when the factor of hypersecretion did not play a part, they removed two-thirds of the stomach without resection of the vagi.

The mortality rate in Johnson and Orr's "policy group" (i.e., the group in which they did the operation best suited to the individual case) was only 1.1 per cent, as compared to a 4 per cent mortality in radical resections. The results were highly satisfactory, no recurrences of ulceration having taken place in the 5 year period studied. The "policy group" also showed a lower incidence of every side effect and a higher proportion of satisfactory results.

Although in the beginning of the controversy there were strong prejudices in some quarters against vagotomy and, in others, against resection, more and more surgeons now realize that the compromise operation, vagotomy with resection of the antrum, is based on sound physiologic principles. It is now apparent that the combination of these two physiologic methods controls the ulcer diathesis more completely than even a very radical gastrectomy and does so with less risk and with fewer side effects. When this operation can be employed safely, it approaches the ideal treatment of duodenal ulcer. When increased risk is involved, vagotomy with gastroenterostomy gives safe and satisfactory results.

George Crile, Jr.

November 1953
Postgraduate Medicine

MEDICAL PROGRESS, 1953

Early in 1953 Dr. Jonas E. Salk of the Virus Research Laboratory in the University of Pittsburgh School of Medicine reported that antibodies against poliomyelitis could be stimulated by inoculating intramuscularly a vaccine prepared with tissue culture fluid. Before the meeting of the American Academy of Pediatrics in Miami, Florida, October 9, 1953, he showed that it is possible to stimulate antibody formation in human subjects against the three types of poliomyelitis virus. Children and adults, who do not have antibodies to any of the poliomyelitis viruses, can form antibodies to the three virus types. Another observation reported by Dr. Salk is the extraordinary height to which antibody level can be raised in persons who have some antibody initially. When antibody is present before vaccination, a rise occurs, as if the inoculation has a booster effect. Moreover, he is able to state unequivocally that the results are due to the antigenic substance in the inoculum and not due to any particles of living virus that may be postulated to be present.

Conclusions cannot yet be drawn concerning the total persistence of antibodies until sufficient time has elapsed and a sufficient number of serums have been tested. The next step is a large scale inoculation of hundreds of thousands of children to be undertaken next spring. It will probably be a controlled study involving the injection of alternate children with another vaccine.

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New Operation for Parkinsonism

A new artery-crushing operation is reported to have brought relief to some cases of tremor such as occurs in Parkinson's disease. The operation, reported by Dr. Irving S. Cooper of New York, was announced at a meeting of the American Neurological Association. In this procedure the anterior choroidal artery, a branch of the internal carotid artery, is blocked. Dr. Cooper reported trial in 10 cases of Parkinson's disease with 1 death and also in 5 cases with other motion disorders.

Adrenal Hormones

In September Dr. Tadeus Reichstein, who shared the Nobel Prize for cortisone and hydrocortisone with E. C. Kendall and Philip S. Hench, announced the isolation of another hormone from the adrenal cortex. Several British and Swiss scientists participated. The product was isolated in pure crystalline form from beef adrenal glands. Twenty-two milligrams were extracted from 500 kg. of beef adrenal glands. Provisionally the hormone is called electro cortin; it is concerned with utilization by the body of minerals such as sodium and potassium and is said by Dr Reichstein to be 50 to 100 times as potent as desoxycorticosterone acetate, called DCA.

The adrenal hormones and ACTH from the pituitary continued to be used in a wide variety of conditions, such as intractable asthma and other allergic conditions; rheumatoid arthritis and rheumatic fever in which striking improvements may occur; inflammatory eye diseases; such skin conditions as angioneurotic edema and exfoliative dermatitis including cases resulting from allergy to drugs. Some conditions of the skin, formerly nearly uncontrollable, in which cortisone has yielded amazing results are pemphigus, scleroderma and dermatomyositis. Cortisone is also the first medicament to have some beneficial effect on disseminated lupus erythematosus. Cortisone has also been helpful when injected into bursae and joints, in endocrine disorders, in inflammatory conditions like coidosis, and in periateritis nodosa. Cortisone was said to be helpful in Bell's palsy by diminishing swelling around the nerve where it passes through a bony canal near the ear. Benefit has been reported in many cases of idiopathic thrombocytopenia in which easy bruising and bleeding occurs along with a deficiency in blood platelets. Another blood disorder with reported benefit from cortisone is erythroblastosis in which there is destruction of red blood cells as a result of different reactions of the Rh factor in the parents.

Antibiotics

Several new antibiotics are now under investigation including Fumagillin used to advantage in amebic dysentery; Neomycin against tuberculosis; Tetracycline which is effective in pneumonia, dysentery and typhoid; Erythromycin which resembles penicillin; Magnamycin and Amicetin which also prevent growth of a variety of germs.

Among the other amazing observations was the reported action of hyaluronidase in preventing the formation of kindney stones; the action of ATABRINE[R] dihydrochloride against lupus erythematosus; ammus majus, an Egyptian plant remedy said to be useful in vitiligo; rauwolfia serpentina, a plant remedy from India, said to have been used on Mahatma Ghandi for control of high blood pressure; and a solution of 30 percent euphorbium in 95 percent alcohol used in treating warts on the soles of the feet.

Cholesterol Research

A vast amount of research is now centered on hypertension and arteriosclerosis. Drugs based on hexamethonium have gained increasing support. The chief interest, however, has been in testing the nutritional factors said to underlie arteriosclerosis. Large molecules of fat combined with proteins have been observed in the lining of blood vessels. Another test determines the amount of cholesterol circulating in the blood. Dr. Frederick Stare and his associates at Harvard University have developed a technic for the production of atherosclerosis in the Cebus monkey. The atherosclerosis is produced in the short period of 18 to 20 weeks in adolescent monkeys on a diet low in the sulfur amino acids and with added cholesterol. Neither the lack of sulfur amino acids nor the added cholesterol will by itself produce the disease in the length of time these monkeys were studied.

Dietary restriction of cholesterol and fats, both animal and vegetable, does not necessarily influence lipoprotein molecules or serum cholesterol unless the diet is almost completely devoid of these materials. Such restriction is impractical in treatment. From a practical point of view, the best diet for the person with atherosclerosis is one which provides good nutrition, preferably one that is high in protein, and with calores to reach or maintain desirable weight.

Swank has said that a high fat diet is a factor in multiple sclerosis. Another investigator found that administration of female sex hormones to men with abnormally high cholesterol restored the blood to normal. Irradiating rabbits produced resistance against action of cholesterol in causing hardening of arteries. Some substance in brain tissue was found by University of Chicago investigators to diminish high cholesterol in the blood.

New Drugs

A hormone of the anterior pituitary called oxytocin was synthesized. Several new drugs such as 6-Mercaptopurine and Triethylene Thiophosphoromide (called Thio-tepa) were able to destroy excess white blood cells in leukemia. In addition to heparin, *Dicumarol* and tromexan, a new anticoagulant used in coronary and other thromboses, is 2-phenyl-1, 3-indanedione.

Celiac Disease

An extraordinary discovery was the observation that wheat, barley and rye are related to the development of celiac disease in which infants are unable to digest fats. When these substances are removed from the diet, the patients recover.

Surgery

Tremendous progress has resulted in surgery from advances in physiology, preoperative and postoperative nutrition, use of new anesthetics, blood transfusion and antibiotics. Of the first thousand "blue babies" operated on in Johns Hopkins, 843 survived, and the condition of 674 of them showed good results. New operations on the heart are correcting narrowing of the mitral valve and of the aorta. In hypertension, due to difficulty in passing blood through the liver, a shunt operation is proving successful.

Studies on Smoking

A great furor is developing over the concept that smoking of cigarettes is definitely related to an increased incidence of primary cancer of the lung.

Surgeons warn against it. The use of filter-tip cigarettes has increased many hundreds of times. Studies are under way by the American Cancer Society, the National Cancer Institute, the Medical Research Council in Great Britain and many other agencies. Research has shown that an adequate filter removes much of the irritating tars and lowers nicotine content of cigarette smoke. The exact mechanism of this process is not yet understood. Pipe smokers, as shown by British and Danish studies, were not similarly affected as cigarette smokers.

Rehabilitation

Rehabilitation centers are springing up rapidly in the United States. The injured and handicapped are often restored to functional competence.

Medical Insurance

More than 91,000,000 Americans are now voluntarily insured against the costs of hospital care, and many millions carry insurance to cover costs of surgery. As the year ended, the Commission on Financing of Hospital Care was preparing to publish its studies and recommendations for lowering costs and for enabling all, including those with low income and the indigent, to receive hospital care whenever needed.

Morris Fishbein

PERSONAL PATTER

Born to Dr. and Mrs. C. E. Pichette, a boy, James Michael, February 14, St. Elizabeth Hospital.

Born to Dr. and Mrs. J. J. Sofranec, a boy, Joseph James, February 15, St. Elizabeth Hospital.

Born to Dr. and Mrs. Robert B. Bruchs, a boy, James Michael, February 14, St. Elizabeth Hospital.

MEDICOLEGAL RESPONSIBILITIES OF THE MARITAL STATE

Prenatal Serological Test

The Revised Code of Ohio, Section 3701.50, provides:

"Every physician who attends any pregnant woman for conditions relating to pregnancy during the period of gestation shall take a sample of blood of such woman at the time of first examination or within ten days thereof, and shall submit such sample to an approved laboratory for a standard serological test for syphilis. If, in the opinion of the physician attending such woman, her condition does not permit the taking of a blood sample for submission to an approved laboratory, then no sample shall be taken prior to delivery. If no sample shall be taken prior to delivery because of the woman's condition, then such blood sample shall be taken as soon after delivery as the physician deems it advisable."

The Revised Code, Section 3701.46, states:

"In reporting every birth and stillbirth, physicians and others required to make such reports shall state on the birth or stillbirth certificate, as the case may be, whether a serological test for syphilis has been made in an approved laboratory upon a specimen of blood taken from the woman who bore the child for which such certificate is filed, and the approximate date when the specimen was taken. If such a test was not made, the physician or other person shall state the reasons why such test was not made. In no event shall the result of the test be stated on the birth or stillbirth certificate."

The Revised Code, Section 3701.99, provides:

"(C) Whoever willfully violates section 3701.46 to 3701.50 inclusive, of the Revised Code shall, upon conviction in a summary proceeding in the county wherein such offense was committed, be fined not less than twenty nor more than one hundred dollars to be paid into the general fund of the county, and, upon failure to pay such fine and the costs of the prosecution, shall be imprisoned not less than ten nor more than thirty days."

Attempt to Procure Abortion

The Revised Code, Section 2901.16, provides:

"No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose.

Whoever violates this section, if the woman either miscarries or dies in consequence thereof, shall be imprisoned not less than one nor more than seven years."

Disciplinary action by the Ohio State Medical Board in the form of revocation of authorization to practice Medicine and Surgery usually follows conviction.

The crime is not complete unless the woman either miscarries or dies. It is apparent that the crime may be committed although the woman was not actually pregnant, and the parties acted under a mistaken opinion to the contrary.

Medical Grounds for Divorce

The Revised Code, Section 3105.01, provides:

"The court of common pleas may grant divorce for the following causes: D. Impotency
H. Habitual drunkeness"

Impotency

If, by reason of malformation or organic defect existing at the time of marriage, there cannot be natural and perfect coition — vera copula — between the parties, the case comes within the legal definition of impotency. The origin of the incapacity is immaterial.

Impotency to be a ground for divorce must be incurable. If there is a probability of capacity for the parties to accomplish the sexual act no decree will be granted.

Thorough clinical investigation and competent evaluation are necessary for the physician to form an opinion if an individual man or woman is impotent and if the specific condition present is curable. Consultation may frequently be advisable.

Habitual Drunkeness

Since early times in Ohio, if a person had formed a habit of drinking intoxicating liquor in excess and of becoming intoxicated, whether daily and continuously, or periodically, such a person would be an habitual drunkard. An 1876 lower court decision allowed divorce for habitual drunkeness for three years.

An occasional drunken spree does not, however, constitute habitual drunkeness as a ground for divorce. But it is not necessary to the existence of intemperate habits, that the excessive use of intoxicating liquor should be continuous and daily.

It requires sound clinical judgment for the physician to form an opinion regarding habitual drunkeness, in the case of a problem drinker, who finds it increasingly difficult to control his drinking.

The final decision as to impotency or habitual drunkeness as a ground for divorce in any case is a legal one and does not rest with the physician.

Prophylaxis Against Ophthalmia Neonatorum

The choice of a prophylactic must be made with care and serious consideration. A new and experimental drug should not be used. The procedure should conform to the usual standard of medical practice of the community.

Sidney Franklin, M.D., LL.B.

A MAN OF MANY TALENTS

Richard Bright (1789-1858) was not the first to make observations on kidney disease, but his was the original observation that dropsy, with albuminous urine, was the result of renal disease. It was Bright's correlations of clinical studies with postmortem findings that established the syndrome of the condition to which his name was given.

Before receiving his M.D. degree in Edinburgh in 1813, Bright and a friend, who was later to become Sir Henry Holland, accompanied Sir George Mackenzie on an expedition to Iceland. Mackenzie's account of the trip, "Travels in Iceland," was illustrated by Bright who also added notes on botany and zoology. When he returned, Bright completed his medical studies at Guy's Hospital and in Edinburgh and then toured for a while in Europe. An account of this trip was published in "Travels Through Lower Hungary," which was also illustrated by the author. Settling in London, Bright entered medical practice and became Physician to Guy's Hospital in 1824.

In addition to his work on renal diseases, Bright also published studies on such other conditions as jaundice, tumors, nervous disorders and diabetes.

CONTROL IS SPELLED CO-OPERATION

Charles Scofield, M.D.
Chairman
Public Health Committee

The problem of tuberculosis control in Mahoning County is essentially one of cooperation between the several interested parties, namely the members of the Mahoning County Medical Society, the four Health Departments, the Tuberculosis Sanatorium, the Tuberculosis Association, and last, but not least, the public which has to foot the bill.

One of the major responsibilities of the Health Departments in Tuberculosis Control is to record known cases of tuberculosis on diagnosis. Tuberculosis by state law in Ohio is a reportable disease. Last year out of 33 deaths from tuberculosis, one third, or eleven persons were not known to have tuberculosis until their death certificate was filed. While it is perfectly possible for this large percentage, one of the largest in the state, to be unknown to the medical profession, it is no particular credit to the profession when free chest X-Rays are available to all. It is also possible that some of the members may have overlooked the reporting of newly diagnosed cases of tuberculosis, which fact may have contributed to the fact that Mahoning County has one of the highest rates of unknown cases of tuberculosis until time of death in both the state and the nation. New cases of tuberculosis on diagnosis should be reported to the health department having jurisdiction over the patient.

The four health departments in Mahoning County have cooperated with the Tuberculosis Sanatorium and the Tuberculosis Association in establishing the Tuberculosis and Chest X-Ray Center in the Dollar Bank Building. A central case registry for all four health departments is maintained at the center. All cases of tuberculosis reported to the Health Departments are reported to the Center and vice versa. The only way that the central case registry can function effectively is through the reporting of new cases promptly and periodical reporting on the status of known cases on report forms supplied by the center. The Central Case Registry is under the cooperative supervision of the four Health Commissioners and is operated by the Medical Director of the Sanatorium, acting for the Health Commissioners as Controller of Tuberculosis for Mahoning County.

The status of a number of persons now registered in the Central Case Registry is unknown because repeated inquiry to the private physician has gone unanswered in some cases for as long as several years. We believe that most physicians prefer to refer their patients on diagnosis or suspicion of tuberculosis to the Tuberculosis Center for consultation, examination and treatment. However, there are, we realize many patients with tuberculosis who are under the care of their personal physician whose progress should be reported periodically to the Central Case Registry.

Tuberculosis, as a public health problem of controlling communicable disease, is yielding to the combined forces of organized medicine. Tuberculosis can be controlled and ultimately eradicated through the cooperation of the private physician and the public health authorities. TB cannot be intelligently controlled until all known cases are registered and periodic prog-

ress reports are filed. The primary responsibility for this of course lies with the individual attending physician.

The medical and public health authorities in Mahoning County can perfect a tuberculosis control program only as strong as the weakest link in the control program. The Public Health Committee appeals to the members of the Mahoning County Medical Society to cooperate willingly with their Health Departments in this effort to control and eradicate tuberculosis.

EDITORIAL EXPLAINS WHY WE ARE BEING DAMNED

An excellent editorial in the January issue of Arizona Medicine, the journal of the Arizona State Medical Association, explains in part why the medical profession is being damned today.

The editorial is lengthy and we cannot quote it in full, but there are a few points I would like to pass along.

"Before 1953," the article said, "we blamed the socialistic planners for most of the derogatory outbursts in our press but even now that the planners have been 'subdued' we find that the tirades of the press are more numerous and more vitriolic. Recently in one week our newsstands contained four magazines all featuring articles exaggerating our shortcomings and by implication condemning the whole medical profession. . . .

"Some place, somewhere, we as a profession must be guilty of failing to offset these most salable stories because the public determines the salability of feature articles. The public is being told that we are mercenary money-grabbers without interest or sympathy for our patients and that we have discarded our Hippocratic oath for one based on commercial selfishness. It is the belief of some that our guilt lies chiefly in our failure to disseminate pertinent information. . . .

"You may try to shift the blame onto your A.M.A. for our poor public relations but they can only be blamed insofar as they have failed to devise ways and means to instill the proper information, of which they have much, into us for dissemination to the public.

"Let me ask you — Have you seen or read the publication, 'Your Money's Worth in Health,' an A.M.A. publication? This same question was asked recently at a meeting of those whom you elected to run your state medical society and not a single man could say that he had ever even heard of this booklet. Let me assure you that this pamphlet is a most excellent presentation and, if properly disseminated, would do much to improve and offset heretofore false impressions.

"If we as physicians are not informed, how can the public formulate balanced opinions and attitudes? There are many hidden facts of which the public is entirely unaware. As long as they do not know the whole truth, they will continue to base their opinion on partial truths and lies.

"So the question is, 'Are you guilty of failing to inform yourself and your clients, not only about medical economics, but about our training, our services, the gains they have obtained in health and longevity and, yes, even about our trials and tribulations?' If we do not trouble ourselves to do these things, we will continue to be damned."

George F. Lull, M.D.—Sec.-Gen. Mgr. A.M.A.

NOTES ON CERVICO-SYMPATHETIC SURGERY: SOME PERSONAL EXPERIENCES

Leon L. Bernstein, M.D.

Twenty years ago, when I was second assistant to Professor N. M. Dott, Neurological Surgeon, Royal Infirmary, Edinburgh, Scotland, we had a patient who was a Scottish sea-captain, about 80 years old. He had, several years previously, a resection of the entire trigeminal nerve on the right side, all three divisions, for pain in the right side of his face. The patient returned to us because of the development of several ulcers of the right side of the face that failed to heal. In addition, he had a trophic ulcer of the right cornea which failed to heal. A right cervical sympathectomy was done as well as a periarterial carotid sympathectomy, to improve the blood supply of the face and thus stimulate healing of the indolent ulcers of the face. The latter anticipated desire, in fact, did occur; but, what was even more gratifying was very unexpected — the ulcer of the cornea also healed. The exact neuro-physiological mechanism to explain this unanticipated result in that case is not entirely clear even today. However, my subsequent interest in autonomic neural mechanisms was greatly stimulated by that experience. The following short commentary will, of necessity, be confined to only a tiny fragment of the potential surgical possibilities within the field of the Autonomic.

Within most recent years impetus has been given toward the improvement of certain cerebro-vascular disturbances by cervical sympathectomy. The rationale for this, in simple terms, may be looked upon as a removal of vasocontrictor function mediated through the cervical sympathetics on the intracranial cerebral arteries. There are some who do not believe that cerebral vasospasm plays an important role in the total physiological deficits found in cases of cerebral thrombosis or cerebral embolus. Personally, it is my impression that cerebral vasospasm is an invariable concomitant in each case of cerebral thrombosis and embolism, but the degree of vasospasm and its direct proportion to the physiological deficit present, in each patient, may vary tremendously. A blockade with chemicals on the cervical sympathetic is one of several means available for attempted evaluation of the degree of vasospasm within the broad gradient of any clinical case.

Following are several excerpts of cases recently treated that may be of pertinent interest, and favorable examples.

Case 1.

Mrs. L. N., age 29, 7 months pregnant, with sudden onset of left hemiplegia with short episodes of Jacksonian movements of hand. No loss of consciousness. No clinical signs of meningeal irritation of free blood in the cerebro-spinal fluid. Lumbar puncture showed the fluid to be clear and colorless. Diagnosis: Cerebral embolus. Right stellate block gave good physiological response but no evidence of clinical improvement immediately. Second stellate block showed some suggestive improvement in sensation on the left side. The following day, 48 hours after onset, cervical sympathectomy was done. Three weeks later Caeserian section was done and a healthy baby delivered. Able to move left lower extremity very well and left upper

to a lesser degree. Three months later able to look after the child and good use on left side, still spastic left lower extremity with some ankle clonus.

Case 2.

Mr. A. S., age 56, with history of two weeks' duration with episodes occurring several times each day of sudden onset of difficulty in speaking with weakness and sensory disturbance in right arm and right leg. Patient was right handed. Entire neurological examination showed striking absence of many positive findings between the hemiplegic episodes. Clinical diagnosis of recurrent cerebral thrombosis. Left cervical sympathemtomy done. Six months after surgery never had a recurrence of hemiplegic episodes which occurred several times each day for two weeks prior to surgery.

Case 3.

Mrs. A. K., age 29, with history of difficulty in speech nine days previously with gradual onset and progression of right hemiplegia. Patient right handed. Neurologic examination showed a very striking right hemiparesis with no evidence of any sensory disturbance. Diagnosis of cerebral thrombosis. Left carotid arteriography showed inadequate filling of the left anterior cerebral artery, compatible with cerebral vasospasm. Left periarterial sympathectomy and cervical sympathectomy done. Within 24 hours the patient noted a 90% improvement in her previous physiological deficit. One month later no abnormalities found on clinical examination other than the residual Horner's.

Case 4.

Mr. G. P., age 15, onset of weakness, right arm and right leg, slowly, several weeks after mild upper respiratory infection. Patient left handed. Pertinent findings showed a hypesthesia effecting the right half of the body and a right hemiparesis, more marked in the upper than in the lower with a strongly positive Babinski on that side. Clinical impression here was a possible space occupying lesion in the left hemisphere. Pneumoencephalogram showed excellent filling of the left middle cerebral, but not the anterior cerebral. A left cervical sympathectomy and periarterial sympathectomy performed. Two months later the only complaint was slight tiredness of right leg, earlier than the left one.

Case 5.

Miss M. B., age 10, sudden onset one morning of weakness in the right leg and also numbness and tingling for a short time in the right lower extremity. In retrospect, she appeared to have on two previous occasions a similar episode which lasted one day, in which she had difficulty in using the right upper and lower extremities. The pertinent findings showed a very definite right hemiparesis of moderate severity, more marked in the upper than in the lower extremity. Strongly positive right Babinski. No sensory loss. Clinical impression that of a vascular lesion, left cerebral hemisphere, perhaps angiomatous or mal-formation. Pneumoencephalogram showed no evidence for any space occupying intracranial pathology. Arteriography, left carotid, showed good visualization of internal carotid and anterior middle cerebral. Tendency for angulation and spasm of vessels. No other focal pathology demonstrable on cerebro-vascular tree. Periarterial sympathec-

tomy and cervical sympathectomy performed. Good convalesence. Subjective stiffness pre-operative in right upper extremity absent. Re-examination 11 days later showed no abnormal neurological findings other than post-operative Horner's.

Spasm of cerebral vessels may be an important factor in the persistant clinical residue, not only of cerebral thrombosis and cerebral embolus, but also in all forms of cerebral trauma, regardless of cause.

RECORD FUND RAISING FOR MEDICAL EDUCATION

Here is a year-end financial picture of the two fund-raising organizations for the nation's 79 medical schools—the American Medical Education Foundation, founded by the A.M.A., and its cooperating agency, the National Fund for Medical Education with offices in New York.

As of December 31, the American Medical Education Foundation, working through its 53 state and metropolitan committees, recorded a gross return of $1,089,962.93 from 18,176 individual physicians, organizations and laymen. This is the first time that the foundation's annual income has passed the million dollar mark. The number of contributors in 1953 increased 149 percent over the previous year.

The National Fund for Medical Education, which seeks its funds primarily from business and industry, has just announced that during the past year 994 corporations contributed $1,367,979. This represents an increase over 1952 of 74 percent in contributions and 193 percent in the number of participating firms. This record is a tribute to the leadership of 1,000 corporation executives who make up the 47 industry divisions and 17 local sponsoring committees of the Committee of American Industry.

The two fund-raising organizations jointly have distributed nearly $5,000,000 to the nation's medical schools since 1951. Fifty percent of this money has been contributed by the medical profession and others in the medical field.

POSTOPERATIVE PUNSTER

Oh, doctor, though you're quite a card,
You'd sometimes best forget it.
Don't make your patients laugh too hard—
You may, indeed, regret it.

Withhold those salty tales for men,
Those puns a bit outrageous;
It ill becomes a doctor when
His laughter is contagious.

Lay off the funny jokes that tend
To give them giggling twitches,
Lest patients laugh themselves, my friend,
Not in but out of stitches.

KEEPING UP WITH A.M.A.

by William M. Skipp, M.D.

The Hoover Commission Medical Task Force

This task force has set up four divisions with separate chairmen to consider all medical problems:

1. Medical Services of the Armed Forces — E. D. Churchill, Chairman
2. Medical Services of the V. A. — Basil C. MacLean, Chairman
3. Medical Services of the U. S. Public Health and other Federal Services — Theo Klumpp, Chairman
4. Medical Services in Time of War — Paul Hawley, Chairman, Dr. James P. Dixon will be Secretary.

House Committee On Insurance

Hearings will look into all phases of prepay plans, including catastrophic illnesses. Representatives of A.M.A., cooperative plans, Blue Cross and Blue Shield, health information foundations, and economic security.

The President commended physicians for their war time service; he said the nation is indebted to each of you; for your loyalty and devotion to duty and to your country during a time of grave crisis.

Federal Support Of Health Plans

President Eisenhower's special message: the President proposes to re-insurance costs of private and non-profit organizations so that there will be better insurance protection to meet the public need. Spokesman for the administration said the program would not involve subsidies. He said he is opposed to socialized medicine, but is his plan of paying just coming in the back door of socialism? The message covered *Rehabilitation* wherein he wants the States with federal aid to set up research, specialized training of personnel, clinics, and special workshops for the handicapped. Covered *construction of medical facilities:* wherein he wants more hospitals constructed but this is only part of the need — non-profit hospitals for chronically ill, medically supervised nursing and convalescent homes, rehabilitation facilities for the disabled, diagnostic and treatment centers for ambulatory patients, special funds for these needs be made available for surveys.

Bills have already been introduced to cover these requirements, which would be in addition to the Hill-Burton requests.

New Approach: This grant-in-aid would give the states more say in the programs and have them take more responsibility.

Sees No Relief In Hospital Costs

The A.H.A. found little evidence to show that there would be a leveling-off of hospital costs during 1954.

The major factors which would contribute to a continuation of increased operating costs were payrolls and cost of supplies. The gradual reduction in hospitals from a 48-hour and a 44-hour work week to a 40-hour schedule would be reflected in higher operational costs.

TV Guide Takes the Doctor's Viewpoint

A recent TV Guide magazine editorial tore into the CBS-TV Strike It Rich programs and upheld the viewpoint long held by the medical profession.

"It must be a cinch to write for the Daily Worker, Pravda and other Communist sheets as long as TV press agents dish out publicity releases like this one:

"Even though she failed to win the top cash prize on the CBS-TV Strike It Rich program, Mrs. ____, of Philadelphia, "struck it rich" . . . when she appeared as a recent contestant. In desperate need of medical aid, Mrs. ____ won $115 toward it, but through the show's heart line telephone, she received an additional $100, plus free medical treatment as long as she may need it."

The magazine's editorial continued: "Can't you just hear the Red propagandists citing that as proof that the poor in America must bare their misery on television shows in the hope of winning medical treatment?"

Thousands Of German Doctors Are Idle

Germany has an army of 30,000 jobless or partially jobless doctors.

There are 4,543 West German doctors unemployed or dependent on odd jobs outside their profession. Doctors are working as construction laborers, jazz musicians and circus roustabouts.

An additional 18,000 German doctors have all but deserted the medical field for other careers . . . Finally there are 8,000 postgraduate medical students working without pay as internes.

Why don't these doctors try their luck and take the risk of starting the life of a private practitioner?

The answer is the traditional German system of public health insurance, a system which has existed since Bismarck. Today, four out of five families are insured under the system.

East Germany, ironically, is critically short of doctors, there being only one doctor for every 2,000 inhabitants. Food shortages and long working hours decreed by the East-zone Communist regime have brought a serious increase in illness.

Campaign Hits Unnecessary Government Spending

In the promotion of our inter-association relations program, the A.M.A. is participating in a new organization known as the Farm-City Conference Board.

The board is made up of the following: National Grange Foundation for American Agriculture, General Electric, International Harvester, Avco Corporation, the Quaker Oats Company, The General Federation of Women's Clubs, Kiwanis International and others.

The first major project of the Farm-City Conference Board is a "Crusade Against Unnecessary Government Spending."

The 15,000 General Federation of Women's Clubs throughout the United States have assumed the responsibility for stimulating group action at the community level. We are asking county medical societies to cooperate with them. This non-partisan crusade certainly warrants the support of the medical profession.

This crusade is aimed at a reduction through the elimination of wasteful and unnecessary government spending.

Mr. Herbert Hoover will launch this crusade nationally before the end of January.

House Commerce Committee On Federal Aid To Health Plans

Henry J. Kaiser, president of the Kaiser Foundation Health Plan: Investment of one billion dollars in private funds, backed by federally insured

mortgage loans could finance the building of medical centers, with provisions for hospitalization for 30 million persons and their care by 30,000 physicians. The Kaiser Foundation now operates 35 hospitals, clinics, and rehabilitation centers and has a ten million dollar expansion program. Both physicians and patients are compelled to do as directed.

Dr. Paul B. Magnuson: The next decade will witness a tremendous growth in the writing of catastrophic illness insurance because of insistent public demand. Government reinsurance "will give Blue Cross, Blue Shield, and commercial companies the needed shot in the arm to experiment and develop sound premiums and policies.

Dr. Russel V. Lee: (has always been a little to the left in House of A.M.A. delegates). More money, not less, should be spent for health. Such devices as group practice provide higher quality care and decrease costs.

Dr. George Baehr, president and medical director, Health Insurance Plan of Greater New York: To facilitate growth of health plans like HIP, two things are necessary, 1. "elimination of interference by local professional societies with prepaid group practice," and 2. government loans to comprehensive health plans under local sponsorship.

Dr. H. Clifford Loos, Ross-Loss Clinic of Los Angeles: Some type of federal assistance to the aged for their medical bills would be helpful.

TODAY'S HEALTH

Each year the members of the Woman's Auxiliary to the Mahoning County Medical Society do a number of things to help bridge the gap between the physician and his patient. One such effort is the promotion and sale of subscriptions to the journal, *Today's Health.* This informative magazine, which was formerly called *Hygeia,* is published by the American Medical Association to get health information of all kinds to the public in terms which the public can understand. In that way it saves time for the physician by answering some of the questions which his patients might otherwise ask him, and it saves time for the patient, who would otherwise have to call his doctor.

The cost is small. Physicians can obtain subscriptions at the following rates which are only 50% of the usual price: one year, $1.50; two years, $2.50; three years, $3.25; four years, $4.00.

The ladies are spending a great deal of time and effort in contacting each member of our medical society who is not already a subscriber. Say "Yes" when you are asked to subscribe. Make your subscription checks payable to "Today's Health, A.M.A." and mail them to Mrs. C. S. Lowendorf, 284 Granada Avenue, Youngstown.

SUMMARY, CONGRESS ON MEDICAL EDUCATION AND LICENSURE

CHICAGO—Licensure and medical care problems created by the heavy influx of foreign-trained doctors commanded a great deal of attention at the 50th annual Congress on Medical Education and Licensure here, February 7-9.

The three-day meeting attracted an unexpectedly heavy attendance of more than 600 medical educators and licensing and specialty board officials. The congress was sponsored by the American Medical Association's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, dean of Columbia University College of Physicians and Surgeons, told the meeting.

"The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government, in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of 40 years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of 50 years ago.

Dr. Stiles D. Ezell, Albany, secretary of the New York Board of Medical Examiners, also called attention to the inadequacy of the medical training of most of the foreign doctors seeking to practice in the United States.

Dr. Ezell said that except for Great Britain and the Scandinavian countries the last war brought destruction and degeneration to European medical education.

"Even before the elimination of the last of the unapproved medical schools in this country, there had begun a migration of physicians to this country which has now reached a total of more than 20,000," he stated. "The challenge in this fact is that the profession has not been prepared to understand what is involved in such a massive movement, nor has it realized the numerous deficiencies involved in the collective educational background of this group."

He pointed out that large numbers of foreign graduates have completed specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure.

Dr. Edward L. Turner, Chicago, secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign-trained doctors.

Such a uniform procedure, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Turner reported that the Council on Medical Education and Hospitals and the executive council of the Association of American Medical Colleges have compiled a list of 39 foreign schools which provide basic medical education on a par with that of approved schools in the United States, but said there are more than 550 medical schools in the world.

He said that while the council has endeavored to indicate that the adsence of a school from this current listing does not indicate either approval or disapproval, but means primarily lack of adequate information, the absence of listing frequently serves to deny a graduate the right to examination before a state board.

"It seems advisable that there should be a careful analysis of state medical practice acts with serious consideration being given to the cooperative development of some commonly acceptable yardstick or screening mechanism to evaluate competence of the foreign graduate," Dr. Turner stated.

He suggested that the National Board of Medical Examiners could become a highly effective aid to state boards in determining whether foreign-trained physicians were eligible for further state board consideration for licensure. The National Board, at the request of the state board, could conduct the examination for professional competency, and the state board could then determine if the candidate met other requirements for licensure, he added.

Dr. Edward J. McCormick, Toledo, president of the A.M.A., told the meeting that it was the responsibility of medical educators to instill a proper sense of moral values into the minds of medical students.

The financing of medical education was touched upon by two speakers. William C. Stolk, New York, president of the American Can Company and a trustee of the National Fund for Medical Education, reported that management is becoming alert to the vital significance of the 79 medical schools. Mr. Stolk said that business is accepting increased responsibility in helping to maintain high health standards and it realizes that financially solvent medical schools are a necessity.

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Dr. H. G. Weiskotten, Skaneateles, N. Y., chairman of the Council on Medical Education and Hospitals, reviewed the 50 years' history of the council. Dr. Weiskotten cited the progress in medical education and said that a new era was being entered — experimentation in undergraduate, graduate and postgraduate training of physicians without losing any of the gains already made.

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A fast-growing interest in postgraduate education was reported by Dr. Douglas D. Vollan, Chicago, a staff member of the Council on Medical Education and Hospitals. Presenting a preliminary report of a survey of postgraduate education by the council, Dr. Vollan said that responses from about 5,000 physicians out of 17,000 chosen at random indicated that they spent an average of 83.3 eight-hour days a year in keeping themselves up to date.

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Speaking on medical legislation, Dr. John N. McCann, Youngstown, O., retiring president of the Federation of State Medical Boards of the United States, said physicians must be brought to realize that a basic license to practice issued by a responsible state board is the sole guarantee of legal practice, not the examination given by a specialty board.

Dr. Frank B. Berry, Washington, assistant secretary of defense (health and medical), reported that the armed services need about twice as many medical officers as they now have, and that they hope to persuade graduates to take up such service as a career. Dr. Berry also said that "the chances are that from August to October, 1954, there will be a considerable number of doctors called into the armed services."

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A panel on professional orientation brought out general agreement that most medical school graduates enter active practice with inadequate preparation and training in ethics, medical economics, doctor-patient relationships and social problems. Medical schools have the primary responsibility of providing such teaching, the panel members concluded, but they should have the help of medical societies and physicians in active practice.

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Medical societies have a definite responsibility to sponsor and advance postgraduate education in order to improve the caliber of medical service to the public, it was emphasized by one panel member. Another urged that teachers of postgraduate courses should have adequate previous experience to appreciate the needs of active practitioners. A third participant suggested that there is a rich area for experimentation in the field of home-study courses. There was general agreement on the need and value of participative courses which enable postgraduate students to work closely with teachers and patients in the demonstration of clinical problems.

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State medical practice acts show a wide variance, it was reported by George E. Hall, Chicago, staff associate of the A.M.A.'s Bureau of Legal Medicine and Legislation. Differences exist, Mr. Hall said, in such matters as the method of appointment of licensing boards, the membership of such agencies, the type of examinations, the requirements of professional skill, the reasons for revoking of licenses, the exemptions from the acts, and reciprocity.

A committee headed by Dr. Bruce Underwood, Louisville, secretary of the Kentucky State Board of Health, suggested that a uniform Medical Practice Act be developed and be submitted next year.

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Dr. George W. Covey, Lincoln, Neb., a former member of the Nebraska Board of Medical Examiners, reviewed recent developments involving a possible recognition of osteopathy and *concluded that the practice was still a cult.*

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The president of the Advisory Board for Medical Specialties, Dr. Robert A. Moore, St. Louis, called upon specialty boards to assume a greater leadership in the improvement of medical practice.

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At the annual meeting of the Federation of State Medical Boards, Dr. Elmer W. Schnoor, Grand Rapids, Mich., was installed as president to succeed *Dr. McCann.* Dr. M. H. Crabb, Fort Worth, was elected president-elect; Dr. K. D. Graves, Roanoke, Va., vice-president, and Dr. Walter L. Bierring, Des Moines, secretary-treasurer for the 40th year.

The executive committee chosen consists of *Dr. McCann;* Dr. Joseph J. Combs, Raleigh, N. C.; Dr. C. J. Glaspel, Grafton, N. D.; and Dr. Gerald D. Murphy, Jr., El Dorado, Ark.

PERSONAL PATTER

HAVE YOU MET . . .

Dr. John LoCricchio, the pathologist of St. Elizabeth Hospital, who, though soon to become an active member of the Mahoning County Medical Society, has been a vital and interesting member of our medical family since his arrival in 1950. Born in Italy, John arrived in the States with his parents in 1914 at the age of 10. The LoCricchio family settled in Detroit, Michigan, and here his preliminary schooling was obtained. It was a short hop to Ann Arbor where, between cheering the All-American classmate, Benny Osterbaun, and exchanging leather on the boxing team, Dr. LoCricchio completed his premedical work in 1927 and graduated from the University of Michigan School of Medicine in 1931. After completing his internship at Henry Ford Hospital in Detroit, a four year residency in pathology followed at the same hospital. The last two years of this residency, from 1934 to 1936, were taken in Brazil where he directed the laboratory of the Ford Rubber Plantation. Here he received incomparable training in tropical disease and a boost to his long interest in horticulture. In 1938, Dr. LoCricchio returned home to become pathologist in Lima, Ohio, for both the Lima Memorial and St. Rita's Hospitals. Here his enthusiasm for horticulture became infectious and soon, along with other physicians, a greenhouse was rented to form a Hobby Greenhouse.

In 1941, Dr. John LoCricchio was certified by The American Board of Pathology in both anatomical and clinical pathology.

From 1944 to 1946, Dr. LoCricchio was the pathologist for the Sharon General Hospital, and here he elected to enter general practice, but in 1948, he returned to pathology for health reasons at St. Vincent's Hospital in Bridgeport, Conn. When Dr. Collier died in 1950, Dr. LoCricchio was invited to become the pathologist at St. Elizabeth Hospital in Youngstown, Ohio.

Dr. John LoCricchio

Dr. LoCricchio is an energetic, inquisitive, sensitive member of our profession. The latitude of his experiences and knowledge, both professional and cultural bespeak the intensity of his interesting life. He is at home in the laboratory, the greenhouse, before the easel, or at the modeling bench with his clay, or in the darkroom with his photography regalia.

The LoCricchio home at 246 Broadway is easily recognized by the full-scale, honest-to-goodness greenhouse erected behind it. It is now nearing completion after having been transported from the Bridgeport, Conn. home. It has a separate intricate heating system complete with row on row of steam pipes to heat the beds. There is an individual orchid room which promises to be a thing of beauty. The plan calls for flagstone walks and wrought iron porch furniture along the walks to complete the picture. Dr. and Mrs. LoCricchio have three children. Proving that medicine is in their blood, one daughter is a doctor's wife, and the son is a last year premedic, at Western Reserve University.

Welcome, Dr. John LoCricchio!

CURRENT METHODS OF TREATMENT OF HYPERTENSION

By Robert W. Wilkins, M.D.
Associate Professor of Medicine, Boston University

The scientific knowledge, wit and charm of Dr. Robert Wilkins were very cordially received by all who met and heard him. The entire Society is looking forward to a return visit.—Editor.

Hypertension is a disease resulting from narrowed arteries and more especially arterioles. Most common is the arteriolar etiology.

Treatment in the past has consisted of a limited number of medical remedies of an unproven value, surgical approach which, except for cases of coarctation of the aorta, does not appear to be of more than a very limited advantage.

Drugs are by far the most efficacious and most universally utilized:

1. Sodium nitrate has long been used but results in a postural hypotension.

2. KCNS (potassium thiocyanate) in 1934 was a slight improvement.

Direct approach to the sympathetic nervous system control of arterioles spasm and constriction resulting in *"medical"* sympathectomy by use of drugs had been the next advance. Although many drugs have been used for this specific purpose the results are of little advantage in general over surgical sympathectomy.

More satisfactory results have been achieved by the following drugs:

1. Rawolfia Serpentina, whose action seems to be of a central neurogonic type.
2. Dehydrogenated ergot.
3. Veratrum, whose action appears to be a central nervous system general and a specific vasodilatation.
4. Hydralazine, whose action is apparently central resulting in a renal vasodilatation.
5. Dibenozylone, a peripheral adrenergic block.
6. Hexamethonium, a total ganglionic block resulting in postural hypotension.
7. Pyrogens which result in a general vasodilation.

The general report of recent trends in anti-hypertensive therapy in Dr. Wilkins' group has resulted from the use of Rawolfia Serpentina and its alkaloid active component, Reserpine, or as it is also known, Serpasil.

This drug, old in Hindu practice, is relatively new in modern medicine.

Selections of patients was as follows, in the order of importance for evaluation of efficacy:

1. Severe organic Cardiac Vascular disease:
   A. Renal impairment (uremia).
   B. Congestive failure.
   C. Coronary insufficiency.
   D. Cardiac enlargement.
2. Age—over 50:
   Weight: obese.
   Sex: males predominated.
3. Level of blood pressure—diastolic above 140.
4. Fixation of pressure.

Effects of Rawolfia and the alkaloid seem to be:

1. Can cause sedation, relaxation, tranquility.
2. Relieve neurotic symptoms of HCVD.
3. Can cause Bradycardia and moderate hypotension (postural).
4. Nasal congestion and miosis with aver dosage.
5. Weight gain and increased appetite.
6. Can cause nightmares and a depressed anxiety state.
7. Can cause diarrhea.
8. Does not cause tolerance or addiction.

Rawolfia and Reserpine was evaluated in controlled series of patients both alone and in combination with other recognized antihypertensive drugs as well as placebos.

Evaluation of the results suggest that Rawolfia and Serpasil are of definite value in antihypertensive therapy. Statistics presented indicate that the Rawolfia and alkaloid derivative work best only in conjunction with concomittent administration of apresoline and veratrum. This combination is shown by Dr. Wilkins' statistics to be of more efficacious than any of these three medications alone.

No evaluation with use of the nitrates alone or in combination with the preceding three drugs was made.

Frank W. Morrison, M.D.

Health Department Bulletin

REPORT FOR JANUARY, 1954

Deaths Recorded	208	116	92	260	155	150
Births Recorded	356	171	185	336	157	179
Chicken Pox			107	0	274	0
Measles			5	0	82	0
German Measles			1	0	0	0
Mumps			11	0	97	0
Scarlet Fever			12	0	7	0
Tuberculosis			1	2	28	5
Typhoid			1	0	1	0
Whooping Cough			11	0	6	0
Gonorrhea			28	0	31	0
Syphilis			20	0	12	0
Chancre			0	0	1	0
Inf. Hepatitis			1	0	0	0
Syphilis		7	3			
Gonorrhea		17	12			
Total Patients				39		
Total Visits (Patients) to Clinic				249		

ADMINISTRATION'S BUDGET FOR HEALTH AND WELFARE

The following table lists major programs of HEW and medical items of other agencies, but does not include proposed armed forces spending for medical care. The following is presented to demonstrate the contribution of the government to the health of the nation.—Editor.

	ESTIMATED FISCAL 1954	REQUESTED FISCAL 1955
Dept. Health, Education and Welfare	$2,521,897,175	$2,321,591,988
Public Assistance (grants to states)	1,340,000,000	1,200,000,000
Food & Drug Administration	6,280,200	6,245,000
Office of Vocational Rehabilitation	23,658,100	27,625,000*
Children's Bureau (grants to states)	30,000,000	30,000,000
Public Health Service	232,830,950	191,463,000
assistance to states, general	13,525,000	15,039,000
venereal disease control	5,000,000	2,300,000
tuberculosis control	6,000,000	3,500,000
communicable disease control	5,009,000	4,397,000
Hill-Burton hospital program	65,000,000	55,600,000**
hospitals & medical care	33,117,500	33,040,000
National Institutes of Health (operating expenses)	4,680,250	4,675,000
National Cancer Institute	20,104,775	19,730,000
mental health activities	12,039,575	12,460,000
National Heart Institute	15,169,750	14,570,000
arthritis & metabolic diseases	6,985,150	7,270,000
microbiology activities	5,721,300	5,930,000
neurology and blindness activities	4,501,750	4,763,000
Veterans Administration		
hospital & medical care	693,000,000	694,000,000
hospital construction	84,000,000	60,000,000
Atomic Energy Commission	26,000,000	27,000,000
Civil Defense Administration	22,500,000	60,000,000
National Science Foundation	8,000,000	14,000,000
Bureau of Indian Affairs	52,000,000	54,105,320

*Includes a $7,800,000 item for President's program of expanded vocational rehabilitation for the disabled.

**Includes a $5,600,000 item for start of expanded program for clinics, nursing homes.

Note: President also requested a $1,100,000 item to start proposed reinsurance of health programs.

THE STEPS TO SUCCESS

- *Planning*
- *Initiative*
- *Imagination*
- *Self-Confidence*
- *Perseverance*
- *Personality*
- *Common Sense*
- *Character*
- *Appearance*

PERSONALITY OF THE MONTH

DONALD M. GLOVER, M.D.

The visiting personality for the March meeting of our Society will be Dr. Donald Glover who comes from a neighboring city, Cleveland, Ohio. Shortly after our meeting, he will address Sessions of the American Academy of General Practice to be held in his home city.

A graduate of Harvard Medical School, 1920, Dr. Glover interned at Children's Hospital, Boston, 1920-21 and Massachusetts General Hospital, 1921-22. He then went to St. Luke's Hospital, Cleveland, Ohio, where he completed his surgical residency in 1924.

Dr. Glover's wife, Leona, is also a physician. She is a graduate of Western Reserve University School of Medicine, 1924. While in active practice she specialized in pediatrics. She is not in active practice at the present time.

An indefatigable work, Dr. Glover has made numerous contributions to the surgical literature chiefly on general and plastic surgery. He is Assistant Clinical Professor of Surgery at Western Reserve University and is Director of Surgery at St. Luke's Hospital. He is also Assistant Surgeon at Lakeside Hospital and on the visiting staff of City Hospital in Cleveland. His practice is limited to general and plastic surgery.

Dr. Glover holds membership in the Ohio State and American Medical Association, is a member of the American Surgical Association, is a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, member of the Central Surgical Association, member of the American Association for Surgery of Trauma, Diplomate of the American Board of Plastic Surgery and member of the Societe Internationale de Chirurgie.

Dr. Glover saw service in World War II from 1942-46, and was retired as Colonel in the Medical Corps. He spent the greatest portion of his time in the Southwest Pacific.

Dr. Glover will speak on "EMERGENCY SURGERY IN INFANTS AND CHILDREN," a subject which will prove of interest to every Society member. He will bring along a short movie which will be shown following his talk.

COMBINED MEETING

MAHONING COUNTY MEDICAL SOCIETY

And

MAHONING ACADEMY OF GENERAL PRACTICE

TIME:

Tuesday, March 16, 1954
8:30 P.M.

PLACE:

YOUNGSTOWN COLLEGE LIBRARY BUILDING
(Third Floor — use elevator)

This is a trial meeting at the Youngstown College Library. We urge that as many attend as possible so that its desirability as a meeting place can be evaluated by each Society member.

SPEAKER:

DR. DONALD M. GLOVER

Director of Surgery, St. Luke's Hospital, Cleveland, Ohio; Asst. Clinical Professor of Surgery, Western Reserve University School of Medicine.

SUBJECT:

"EMERGENCY SURGERY IN INFANTS AND CHILDREN"

A short movie featuring the highlights of Dr. Glover's remarks will be presented immediately after his talk.

APRIL MEETING

Combined Meeting

of the

MAHONING COUNTY MEDICAL SOCIETY

and

MAHONING ACADEMY OF GENERAL PRACTICE

TIME:

Tuesday, April 20 ,1954

8:30 P.M.

PLACE:

To Be Announced

SPEAKER:

DR. MURRAY M. COPELAND

Professor of Oncology, Georgetown University Medical Center, Washington, D. C.

SUBJECT:

"LUMPS IN THE BREAST - - -
THEIR SIGNIFICANCE"

FROM THE BULLETIN

TWENTY YEARS AGO—MARCH, 1934

From the President's Page: "There are many who believe that the leaders in organized medicine have adopted the defensive position too long. A strong offensive movement in Ohio would never have permitted the present plan for the care of the indigent. It now becomes necessary to know the opinion of the majority of the members of our Society with regard to the pursuit of a future aggressive policy. With this in mind some of the committees are submitting questionnaires to all members. These should be answered carefully and returned at once."

From an editorial: "It is quite apparent that the financial situation of the physician is the same all over the nation. There is loud grumbling, much complaining and a definite tendency toward demanding that something be done for him who has hitherto accepted the crumbs in silence."

The March scientific program was presented by Drs. Wm. E. Lower and Wm. J. Engel of the Cleveland Clinic who spoke on genito-urinary surgery. The Society mourned the passing of Dr. M. P. Jones who was loved and respected by all. He was revealed as the author of a column in the Bulletin under the name of "Breetus."

St. Elizabeth's Hospital and the Youngstown Hospital announced the opening of their medical libraries. Council approved the action of the nurses registry in changing from 12 hour to 8 hour duty. Fred Coombs and Carl Gustafson were appointed Resident Physicians at Youngstown Hospital. T. K. Golden was appointed to the staff of St. Elizabeth's Hospital on the orthopedic service. Dr. W. W. Ryall was in the hospital recovering from an illness. Twenty years later we find him recovering from fractured ribs received in an automobile accident. Dr. E. Henry Jones was appointed chairman of the Centennial Celebration of Ohio State University.

Jim Brown and Sam Tamarkin were busy with preparations for Post-Graduate Day next month when a group of speakers would be coming from McGill University in Montreal.

TEN YEARS AGO—MARCH, 1944

Plans for Post-Graduate Day were going forward in spite of war time restrictions. Speakers were coming from Georgetown University and in addition Dr. E. C. Baker and the late W. D. Collier were on the program. On the committee were A. J. Brandt, E. J. Wenaas, J. D. Brown and V. L. Goodwin.

Dr. Emil Novak of Johns Hopkins was here in February to speak on "Endocrinology." Dr. John Wilce of Ohio State University spoke in March on "Physical Fitness." Dr. Novak said that only a small proportion of menopausal women need any organotherapy and the use of estrogenic therapy has been greatly abused. He stressed the value of thyroid substance in amenorrhea sterility and habitual abortion.

Capt. H. E. Hathhorn was transferred from Oregon to a port of embarkation in the east. O. M. Lawton was promoted to Commander. Bill Bunn was elected to the Board of Directors of the American Heart Association. Capt. D. E. Beynon was heard from but his address could not be given. Al Cukerbaum came home from Great Lakes on leave and married Beatrice Sandler of New Castle. Capt. Sam Epstein was in the Hawaiian Islands. Barclay Brandmiller was on a transport en route to an unknown destination.

M. M. Szucs was at the U. S. Marine Hospital in Brooklyn. Harold Reese was working in a Merchant Marine Medical Center and said he had been entirely separated from the stethescope. Dick Middleton was home on leave to see his new daughter born Jan. 25th.

Bill Skipp was pretty excited about his son Thomas Jackson born February 13th.

J. L. Fisher, M.D.

M. D.'s TOO CONSERVATIVE

Doctors have come to expect harsh criticism from labor leaders; but it's news when an *industrial* leader rakes them over the coals. So here's news:

Speaking in his capacity as head of Detroit's Henry Ford Hospital, automobile magnate Benson Ford recently told a Blue Cross meeting that doctors "tend to be a little on the conservative side, a little suspicious of modern gimcracks and ways of doing things." And he intimated that, as a result, medical men are square wheels on the car of health progress.

"I think that inclusive health care should provide to every American citizen, at a cost that he can reasonably meet, all the services necessary to keep him healthy and productive," said Ford. "Ultimately, it must involve preventive and diagnostic care as well as curative."

He conceded that the march toward such a health system "must be evolutionary." But, he added, "it must evolute visibly—at something more than a snail's pace."

How can it be speeded along.

Ford's answer: "The burden of leadership in this effort must come mainly from those business men and professional men who are experienced in hospital and health matters." Presumably, from men like Benson Ford.

Medical Economics

Our most urgent effort should now be directed to the solution of the problem of the medically indigent and the chronically ill. We believe that this objective can be reached without major change in our existing mechanism.

W. B. Martin, M.D.

VACATION TRIPPED

The merchant takes a little trip,
A week or two or more;
The business runs as usual,
There's profit at the store.

The banker basks on sunny sands,
The landlord's pleasure-bent;
Depositors deposit still,
And tenants pay their rent.

The doctor's income ceases, though,
Upon departure day,
And that's what takes the rest from rest
And takes the fun from play.

SCALENE NODE BIOPSY

[1]Daniels in 1949 suggested a diagnostic method that consists of a biopsy past decade by the introduction of improved roentgenographic methods, of cytological study of the sputum, bronchoscopy, bronchoscopic biopsy, thoracoscopy, and exploratory thoracotomy.

Daniels in 1949 suggested a diagnostic method that consists of a biopsy of scalene lymph nodes. These nodes are a part of the chain of the deep mediastinal lymph nodes and therefore are quite likely to be involved in the same pathological process. The method involves a rather simple operation that can be performed with the patient under local anesthesia. A short incision is made just above and parallel to the clavicle and lateral to the external border of the sternocleidomastoid muscle. The clavicular portion of the sternocleidomastoid may be divided if necessary. This muscle is then retracted medially, and the fat filled space underlying the anterior scalenus muscle is exposed. Several lymph nodes are usually found in this fat pad; these are removed for microscopic study. It is possible to follow the subclavian and internal jugular veins down into the upper mediastinum to remove any nodes that may be encountered. The procedure is essentially that used for phrenic nerve crush. When the operation is done on the left side, care should be taken not to injure the thoracic duct.

In the five cases reported by Daniels, diagnosis of Boeck's sarcoid was established in two cases; the finding of a metastic carcinoma in three cases prevented a major surgical exploration of the chest. In the fourth case there was an inoperable carcinoma of the lung with metastasis in the scalene lymph nodes. The major procedure could have been avoided if scalene node biopsy had been first performed. The fifth case revealed a combination of silicosis and sarcoidosis.

Weiss and co-workers[2] observed a man 48 years old with mild subjective pulmonary symptoms but with extensive roentgenographic evidence of involvement of both lungs. Sputum cultures and tuberculin tests were negative on repeated examinations. Microscopic examination of a scalene node established the diagnosis of Boecks sarcoid. Johnson and MacCurdy[3] studied the case of a young adult who had no subjective symptoms but who presented on roentgenographic chest examination lung fields studded with calcific densities measuring 1 to 3 mm. in diameter, with soft nodular prominence of both hilar shadows. Lymph nodes obtained from the fat pad lying over the anterior scalenus muscle and cultured on Sabouraud's medium and on blood cystine plates revealed an organism with the morphological characteristics of Histoplasma capsulatum. Storey and Reynolds[4], in a discussion of the various biopsy techniques for diagnosis of intrathoracic lesions, cite three cases in which the use of the scalene lymph node biopsy established the diagnosis of Hodgkins disease, Boeck's sarcoidosis, and carcinoma respectively.

Shefts and co-workers[5] report in a recent communication on a series of 187 patients in whom the Daniels' procedure was performed. In 67 of the patients biopsy material presented evidence of the identity of associated intrathoracic disease that had previously been undiagnosed despite application of the generally used nonsurgical diagnostic methods. There were 38 instances of Boeck's sarcoid, 13 of bronchogenic carcinoma (9 undifferentiated carcinoma and 4 adenocarcinoma), 8 of tuberculosis, 2 of lymphosarcoma, 2 of Hodgkin''s disease, 1 of histoplasma, and 3 of metastases of tumor to the lung. Complications were mainly limited to involvement of the thoracic ducts. The left thoracic duct was torn once and the right twice.

Scalene node biopsy should prove to be particularly valuable in instances of hilar and mediastinal roentgenographic enlargement, particularly when the diagnosis is difficult to establish by other laboratory means. The histological and cultural study of scalene nodes should reveal many cases of Boeck's sarcoid, tuberculosis, lymphosarcoma, and Hodgkin's disease. Such biopsy may also establish the microscopic type of tumor, thus enabling the clinician to detect the primary site of the neoplasm.—*J.A.M.A.*

NEW A.M.A. COMMITTEE APPOINTED

At the A.M.A. Clinical Session in St. Louis, the House of Delegates adopted a resolution calling for the appointment by the Board of Trustees of "a special committee with broad representation throughout the profession" to study "all aspects of the problems of public relations created by recent adverse publicity."

The resolution, introduced by Dr. John F. Burton of Oklahoma, referred specifically to "published statements of certain medical spokesmen concerning alleged unethical practices by members of the medical profession" which have "tended to destroy the confidence of patients in their physicians, without solving the basic problems involved."

The Board appointed the following five physicians to the committee and there is a possibility that two more will be appointed before the first meeting, which is scheduled to be held sometime this month:

Drs. Stanley R. Truman, chairman, Oakland, Calif.; John S. DeTar, Milan, Mich.; Leland S. McKittrick, Brookline, Mass.; James Q. Graves, Monroe, La., and Felix L. Butte, Dallas.

The committee has been instructed to report its findings and make whatever recommendations it deems necessary to the House when it meets in San Francisco in June.

The traditional concept that painless jaundice is the initial sign of cancer of the head of the pancreas has been disproved. Actually, pain is the earliest symptom in over half of these patients. This pain may be extreme, and characteristically radiates to the back.

PERIODICAL PEARLS

HYPERGLYCEMIC GLYCOGENOLYTIC FACTOR OF THE PANCREAS

For years physiologists have puzzled over many peculiar things about diabetes and insulin. For instance, total removal of the pancreas in man does not produce as severe a diabetes as often comes spontaneously. Also, there is something in ordinary insulin preparations which causes a preliminary rise in blood sugar. When Abel first crystallized insulin he found that this stimulating factor was gone; later, when Scott crystallized insulin with another technic, he found that his crystals contained the stimulating factor.

Dr. Chr. de Duve of Belgium has written a fine summary of our present-day knowledge in regard to this other hormone, which in the last five years has been isolated and to some extent purified by several workers. There is good evidence to indicate that it is the secretion of the alpha cells of the islands of Langerhans. The beta cells produce insulin.

Glucagon is a polypeptide similar to insulin, but in some ways different. It counteracts the effects of insulin much as adrenaline does, but in chemical structure it differs greatly from adrenaline. Its production is stimulated by a growth hormone in the pituitary gland, and this throws additional light on the long-known relation between the pituitary and diabetes. As one might expect, alloxan, which destroys the beta cells, does not destroy the alpha cells and hence does not affect the secretion of glucagon. The giving of cobalt will, to some extent, knock out the alpha cells but does not destroy them entirely.

The question now arises as to whether there is a disease due to the failure of development of the alpha cells. Apparently, there is. In 1950, McQuarrie and his colleagues at the University of Minnesota described the occurrence in children of certain families of a peculiar type of hyperglycemia during the first month of life. This condition responded to treatment with ACTH and was found to be associated with a total or almost total absence of the alpha cells in the pancreatic islands.

Evidently, then, physicians must now recognize a new gland of internal secretion with a new disease due to the failure of development of the gland. We can now suggest why a man who has to part with all of his pancreas will not have as severe diabetes as has a man who has lost only his beta cells. With a pancreatectomy the man loses both his insulin and his glucagon.—*Walter C. Alvarez, M.D.*

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Glucagon, a pancreatic extract, appears to have no extrahepatic influence upon the tolerance of rats for intravenous glucose. However, the agent may have extrahepatic effects upon metabolism, report Dr. Dwight J. Ingle and associates of Kalamazoo, Mich. Glucagon induced hyperglycemia in normal but not in eviscerated rats. After intravenous administration of glucose and glucagon, blood glucose levels in normal rodents rose rapidly, whereas the blood glucose levels in the eviscerated animals were unaffected. —*Proc. Soc. Exper. Biol. & Med. 84:232-233, 1953.*

MD's NEVER STOP STUDYING

In these busy times the average practicing physician still manages to devote the equivalent of 83.3 eight-hour days a year to keeping abreast of current developments in the field of medicine. This striking figure is one of many brought out in a preliminary report by the AMA's Council on Medical Education and Hospitals on its recent survey of postgraduate medical education. Survey findings are based on data compiled on personal visits to more than 220 institutions engaged in postgraduate medical education as well as 5,000 questionnaires received from a random sample of 17,000 practicing physicians throughout the country.

Not only are more opportunities for postgraduate medical education being offered today than ever before, but more doctors are taking advantage of these opportunities, the report indicates. Over 41,000 practicing physicians took some form of postgraduate medical course last year (this figure excludes all "graduate" courses formerly considered "postgraduate").

Ways in which the doctor keeps up-to-date on medical matters are divided into five categories: (1) Medical reading; (2) professional contacts with colleagues, consultants, etc.; (3) hospital staff meetings; (4) attendance and participation in medical society and specialty group meetings at the local, state and national level, and (5) postgraduate courses conducted by some 26 different types of organizations such as medical schools, health departments, medical societies, hospitals, etc. Physicians responding to the questionnaire indicated that about one-third of the time spent in continuing their education is devoted to medical reading, another one-third to professional contacts and the remaining one-third divided among the other three forms.

Other highlights of the preliminary report: Some form—though varied—of organized postgraduate medical course is being offered in every state in the country . . . Ninety per cent of these postgraduate courses are offered in the larger cities . . . Chief reasons noted for not taking postgraduate courses is lack of someone to care for patients while the doctor is away and the multiplicity of medical society and hospital staff meetings . . . More than 93 per cent of the responding physicians felt that the maximum amount of time they could be away from practice was under 15 days . . . It cost the average physician surveyed in this study approximately $350 per year to attend postgraduate courses alone, without including the other four forms mentioned above. . . .

PALLIATION IN LIVER CANCER

The first palliative treatment in patients with advanced liver cancer, previously regarded as "hopeless," has been reported from the Memorial Center for Cancer in New York. A group of physicians, using large amounts of x-ray delivered directly to the liver, have reported improvement in liver function, temporary relief of pain, abdominal distention, nausea, weakness, fever, and loss of appetite. In some instances, abnormally large livers were reduced in size and the patients showed a gain in weight. Improvements lasted from two to seven months. Since no evidence of damage to normal liver tissue resulted from even the highest dose of x-rays, these studies may prove that patients with advanced cancer involving the liver may now be regarded as amenable to palliative therapy.

THE PHYSICIAN AND THE CARE OF THE INDIGENT

One of the major responsibilities of the active members of the Hospital Staff is the care of indigent patients on the house services. Few persons realize the amount of effort this involves. Everyone is aware that the house officers spend long hours with these very sick people, but in addition, the active staff member assumes the ultimate responsibility for their care.

As each new patient is admitted to the hospital, the history, physical and indicated laboratory procedure are subject to review on medical rounds. Diagnosis is established, treatment instituted and a regimen planned with the hope of relieving the situation. Follow up study is required thereafter until the patient is discharged.

To be more concrete let us examine some statistics gathered from the charts of a single house service for a *2 month period.* Fifty-six patients were discharged from the service in sixty days. Forty-five of these patients were discharged as improved. Eleven died. The fifty-six were hospitalized a total of 1214 days. The shortest stay was three days, the longest 131 days, with an average of 21 days. These figures indicate a minimum of 1214 visits by the staff member.

The bulk of these patients were over 60 years of age and of course manifested the diseases of degeneration, malignancy and infection. None had a single diagnosis. Most had 3 or more separate disease entities present at one time. Yet it should be noted again that 45 patients were made well enough to leave the hospital and return to their homes.

The story does not end here because through the O.P.D. these patients are followed and further helped. Many clinics are held each week and at each the active staff member is present to supervise and give guidance.

It is hoped that this will serve to remind the membership that staff privileges are earned by the conscientious fulfillment of staff obligations which are never easy and are usually difficult.

Robert A. Jenkins, M.D.

WITNESSES COOL TO REINSURANCE PLAN AT HOUSE HEARINGS

E. A. Van Steenwyk of Philadelphia, speaking for the *Blue Cross Commission,* said that while "it is difficult to see" how a reinsurance corporation under government auspices would be of much help, it might be a good idea to set up a corporation on a limited, experimental basis. Working with voluntary plans, it might inquire into such areas as (1) accepting local responsibility for hospital needs of the aged, (2) providing hospital care for subscribers during unemployment, and (3) granting extended coverage in catastrophic medical insurance.

Dr. Charles G. Hayden of Boston, representing *Blue Shield Commission,* stated: "An outstanding characteristic of Blue Shield Plans is their ability to stand on their own feet financially. It is partly for this reason that they do not look with favor upon any suggestion that their benefit structure or method of operation be subsidized."

William S. McNary of *American Hospital Association:* "The association believes that if local and state governments extend their appropriations to the limit of their capacities for financing such care, there will be limited need for assistance from federal government."

PROCEEDINGS OF COUNCIL

February 8, 1954

The regular monthly meeting of the Council of the Mahoning County Medical Society was held on Monday, February 8, 1954, at the offices of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following doctors were present: J. D. Brown, president, presiding, M. W. Neidus, A. Randell, S. W. Ondash, A. A. Detesco, A. K. Phillips, E. J. Wenaas, E. R .McNeal, F. G. Schlecht comprising the Council also doctors J. M. Ranz, E. A. Shorten and R. S. Lupse.

Dr. Lupse outlined a program for the rehabilitation of handicapped children with muscular dystrophy. Included in the program is an article to be run in Look Magazine, which will explain the vibrating machine used in treatment. Council's chief concern was that none of our members get into a field that will be classed as advertising on a commercial set-up.

Dr. McNeal, Chairman of the Arthritis Committee reported a meeting with Mr. Perry Beatty, Dollar Savings & Trust Company, in which Mr. Beatty asked approval of the Council before starting a campaign to raise funds. There should be a survey or some means of knowing how many arthritic patients there are in this area. Dr. Neidus will contact the clinic at St. E's Hospital and get full information.

Dr. Brown advised that he had been talking to Mr. Ross Packard, Secretary of the Youngstown Chamber of Commerce with reference to the appointment of a committee to work out problems where drives are conducted to raise funds for the care and treatment of the people in general. He is making a study of the problems involved and Dr. Brown will hear from him later.

Dr. Ondash announced that the March meeting would be held at the Youngstown College and that we should try to get a good attendance in order to decide on our meeting place in the future. The following application was read:

Dr. James L. Smeltzer, 243 Lincoln Ave., Youngstown, Ohio

Unless objection is filed in writing with the secretary within 15 days, the above applicant becomes a member of the Society.

G. E .DeCicco, M.D.
Secretary

AURICULAR FIBRILLATION

Though usually considered a serious complication of mitral stenosis, auricular fibrillation has 3 definite advantages: (1) Digitalis retards tachycardia with fibrillation but is relatively useless for sinus rhythm. (2) As cardiac output falls, pulmonary pressure and edema of the lungs are also reduced, declare Dr. Murray Rabinowitz and associates of Peter Bent Brigham Hospital and Harvard University, Boston. (3) At a particular pulse rate, systole is shorter and diastole longer with fibrillation than with sinus rhythm. Since blood flows through the mitral valve only in diastole, fibrillation may allow a liter of blood per minute to pass the valve at a determined pressure, or a decrease in pressure amounting to 20 mm. of mercury in pulmonary capillaries for a specific blood flow.—*Federation Proc. 12:111, 1953.*

A PROMPT ANSWER TURNETH AWAY WRATH

The second the telephone rings, the caller is beginning to form an impression of your office. Answering promptly is the best way to get off to a good start. Women in the telephone company business offices are trained to answer on the first ring. Though this may not be possible all the time in your office, the telephone should be answered as soon as possible.

The caller should receive a gracious and friendly greeting. It doesn't have to be long and involved — friendliness is what counts. This tone should be maintained throughout the conversation. Try to be helpful, and don't make the caller ask for answers to obvious questions. To show what we mean, let's contrast these two conversations:

(Telephone rings—several times)

"Hello."

"Hello, is this Dr. Brown's office?"

"Yes."

"May I speak to Dr. Brown, please?"

"Who's calling?"

"This is Mrs. Smith."

Here are some other tips on good telephone usage:

1. Speak directly into the transmitter in a normal voice. Your lips should be half an inch from the mouthpiece. A pencil, cigar, cigarette, or gum in your mouth will make it more difficult to understand you.

2. Try to visualize the other person. Many people speak mechanically over the telephone. Speak to the person and not to the telephone.

3. Say "Thank you" and "You're welcome." This is one way to smile over the telephone.

4. Be attentive. Your caller will appreciate your listening politely and not interrupting what he is saying.

5. Use the patient's name. To him, there's no sweeter sound.

6. Be sure of the number before you call. A wrong number irritates you and the person you have called by mistake.

7. Hang up gently. Slamming down the receiver when you've finished talking is as discourteous as slamming the door when you leave a house.

Every physician's office is different, and every office has developed its own way of handling calls. Any system will work, as long as there is a sincere desire to use the telephone courteously. The telephone system is a modern miracle — mechanically the best in the world. The manner in which it's used is up to you.

ERYTHROMYCIN ABSORPTION

Erythromycin has been shown to be very sensitive to acid. It decomposes within a few minutes at a pH of 3 or less. However, absorption of oral doses of 300 to 500 mg. in fasting healthy patients was found to provide a blood level of more than 1 microgram per cc. in most cases. It was found that persons who had eaten shortly before taking the antibiotic showed poor absorption. The use of an acid-insoluble and an alkali-soluble coating on the capsules provided somewhat greater absorption and, therefore, appeared to be an advantage. However, food still reduced the amount of absorption.

IS THERE A DOCTOR SHORTAGE?

A serious shortage of doctors has been alleged. Actually, we have more doctors than any other nation, and we have more in proportion to population than any country except Israel, which has an abnormal influx of refugee physicians from Europe. For more than twenty years the supply of doctors has been increasing at a faster rate than the general population. It is estimated that the period of 1950-1960 will bring another 30 per cent increase in the supply of physicians.

Today we have a total of 220,104 physicians — the largest in our history. Of this number 159,120 are in active practice. All the rest, except for about 9,700 who are retired or not in practice, are serving American health needs in research, teaching, hospitals and government service. On the basis of an estimated population of 160,000,000 in 1953, we now have one physician for every 727 persons, or approximately one physician actually engaged in the practice of medicine for every 1,000 persons.

For the fifth consecutive year, the total number of students enrolled in approved medical schools has established a new record. The number of students graduated constitutes the largest group ever graduated in one academic year. Enrollments in the country's 72 medical and seven basic science schools during 1952-1953 totalled 27,688, or 2.3 per cent more than the 27,076 enrolled during 1951-1952. The estimated number of graduates for 1953-1954 based on enrollments reported for senior classes in schools, is even greater — 6,831 — than last year (6,668) which exceeded by 279, or 4.4 per cent, the previous record established in 1947, when at the termination of the wartime accelerated program several schools graduated more than one class.

It is obvious that in the areas of medical progress, medical cost and doctor supply the picture is far brighter than some would have you believe. We hope that we have clarified some of these misconceptions.

Walter B. Martin, M.D.—Pres.-Elect A.M.A.

THERAPY FOR LUPUS

Amelioration in lesions of chronic discoid lupus erythematosus may be obtained by administration of Atabrine or Aralen (chloroquine phosphate). Induration and erythema may decrease, scales disappear, and a pronounced resolution of plaques occur. Drs. Eugene M. Farber and Irina E. Driver of Stanford University, San Francisco, noted objective improvement for all but 1 of 14 patients after three weeks of such treatment. After decrease in dosage or cessation of treatment, 6 of 10 patients receiving Atabrine were definitely improved, and 1 of 4 given chloroquine was slightly better. Little or no benefit was noted by the others. Lesions progressed in 1 case of Atabrine therapy. Biopsies of healed lesions frequently showed a peculiar edema and proliferation of the basal layer. Atabrine dosage consisted of courses of 300 mg. daily for the first week, 200 mg. daily for the second, 100 mg. daily for the third week, continued until the lesions had been favorably affected. Chloroquine was given in an initial dose of 300 mg., with 300-mg. doses six hours later and twelve hours after the second dose, and then 150 mg. three times a week. Both drugs are relatively harmless, though occasionally lichen planus-like eruptions or leukopenia appear during therapy. *Stanford M. Bull. 11:157-158, 1953.*

LOCAL NEWSPAPER PRAISES A LOCAL DOCTOR

I have never used the overworked adjective "cute," but the word aptly describes how the Decatur, Ill., Herald-Review got into the heart of an editorial which praised a local physician for the fine job he did as president of his local medical society.

"This newspaper," said the editorial, "may be guilty of violating the medical code of ethics by saying a good word for a physician while he is alive to read it, even before he is honored for rounding out 50 years of practice.

"We hope Dinger Bell doesn't get in Dutch with his professional brethren because of this piece. He didn't know it was being written.

"Seriously, and formally, we want to take note of the fact that Dr. C. Elliot Bell is completing a term as president of the Macon County (Illinois) Medical Society."

Then, after this cute introduction, the editorial went on for five paragraphs praising Dr. Bell and his committees for a job well done from the standpoint of both the profession and the public. In conclusion the newspaper said:

"Under Dr. Bell's leadership the medical profession in Macon County has answered the challenge proposed by the advocates of socialized medicine, not by tight-lipped denunciation, but by enlightened efforts to abolish conditions and situations that were to blame for criticism of the medical profession."

Certainly a fine tribute to a local doctor by his home-town newspaper!

George F. Lull, M.D.
Secretary-General Manager, A.M.A.

The above is presented to call attention to a problem that is most confusing to a great number of doctors. Is it wrong to receive public acclaim for doing a good job in community affairs or in the workings of the medical Society?

ONE KIND OF IMMORALITY

Thoughtful surgeons are concerned with the fact that our hospitals and medical schools are accumulating mounting deficits. We frequently record the fact that the rich and near-rich no longer give frequently to these institutions so necessary to our modern society. And yet, a few surgeons are constantly alienating such people from providing the help which we have a right to expect that they give. The truth is that some surgeons' fees are higher than they ought to be. This is true now, and it was true in Rome in the Fourth Century, for it was recorded then that "where there is a question of fees, the medical officer must take as a standard not what men fearing death will agree to pay, but what men recovered from illness will offer."

In medicine the adage of charging all the traffic will bear is immoral, and the surgeon who does this is doing a great disservice to his profession and the institution in which he works. Our profession is expected to be more sensitive to such immoralities, and we should be. — Dr. I. S. Ravdin, before the Section on Surgery at the 100th Annual Session of the A.M.A.

MISCELLANY

A Veterans Administration report estimates that since 1944 some 180,000 veterans have studied medicine or related courses under the GI bill of rights; about 300,000 veterans are still in training under the broad program which expires in 1956 . . . An Office of Defense Mobilization manpower study states that in event of full mobilization greatest personnel shortages would occur in health, scientific and technical fields; raising the nation's physical and mental level is perhaps the greatest potential addition to military manpower resources, the report adds . . . Atomic Energy Commission has announced in its semiannual report to Congress the completion at Los Alamos, N. Mex., of the only health laboratory exclusively for research in hazard aspects of atomic weapon development . . . Brig. Gen. Alvin L. Gorby, senior medical advisor to the Assistant Secretary of Defense (health and medical), has been appointed deputy commander of Walter Reed Army Medical Center . . . Effective July 1, Army Medical Service residency program in anesthesiology will be increased from two to three years . . . VA reports an urgent need for social workers, dietitians, biochemists, X-ray and medical technicians, and therapists for VA hospitals.

The overall narcotic addiction situation in this country is said to be improving, despite an eight-fold increase in seizures of raw opium last year. Deputy Customs Commissioner Chester A. Emerick says the increase in seizures was caused by a bumper crop in parts of Mexico . . . Although a swimming pool or elevator may be built for medical reasons, its cost can't be deducted as medical expense, Internal Revenue Bureau rules, because both constitute permanent improvements and increase the value of the home

. . . Dr. William F. Windle, former scientific director of Baxter Laboratories, has been named chief of the Laboratory of Neuroanatomical Sciences, National Institute of Neurological Diseases and Blindness. He will contine his investigations into the problems of nerve regeneration . . . Dr. Frank B. Brewer, a VA medical officer since 1921, is the new assistant chief medical officer, responsible for operation of all VA hospitals, domiciliary homes and clinics. Dr. Brewer succeeds Dr. Robert C. Cook, who is retiring . . . Examinations for appointment to Regular (Medical Corps of U. S. Public Health Service are scheduled for June 1-3 at various points throughout the country.

A New Approach in the Treatment of Rheumatic Arthritis
Tablets
SALI-ZEM NO. 2
Keratin Coated Light Blue

Colchicine ....1/200 gr. (0.3 mg.)
Sodium Salicylate ....2 1/2 gr. (0.15 Gm.)
Para-Aminobenzoic Acid ....2 1/2 gr. (0.15 Gm.)
(as the sodium salt)
Thiamine Hydrochloride ....1 mg. (1/60 gr.)
(Vitamin B_1, 333 I.U.)
Riboflavin ....1 mg. (1/60 gr.)
(Vitamin B_2, 340 Sherman Units)

This formula will be found of great value in the treatment of rheumatic fever, myalgias (pain in a muscle or muscles) and joint pains, inflammations, immobility, and other arthritic states submitting to salicylate therapy.

THE ZEMMER COMPANY
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AUDIO-DIGEST FOUNDATION

The California Medical Association, through its recently-formed subsidiary, Audio-Digest Foundation, is promoting a new means of communication for medical learning, and it has announced that profits from the project will go to the American Medical Education Foundation.

A.M.E.F. Secretary Hiram W. Jones estimates that if 20,000 subscribers sign up, nationally, the medical education foundation can reap approximately $1,000,000 annually.

Using tape recorded material, the Audio-Digest Foundation makes available to doctors three "postgraduate services" designed to save their time while increasing the scope of their knowledge.

The basic service is the weekly issuance of a one-hour tape for general practitioners, on which are recorded from 20 to 30 abstracts of the best in current medical literature embracing all fields. These articles are screened by a board of medical editors. As a corollary service, Audio-Digest offers semi-monthly digests in the fields of surgery, internal medicine and OB-Gyn. The third service is tape-recorded lectures and panel discussions on one-hour reels for individual or group purchase. Many of these lectures are illustrated by film strips made from the speaker's own slides and cued by him in the recording.

One of the most appealing factors about these services is that they are of definite, practical value to the physician. Much of the literature digested ordinarily would not come to the busy practitioner's attention. To the physician, the advantages of hearing world-renowned authorities in medicine and surgery at his own hospital staff meetings or in his own living room are obvious.

THE MEDICAL - DENTAL BUREAU and its affiliation with THE CREDIT BUREAU OF YOUNGSTOWN

by Carl M. Wolter

As managing director of the Credit Bureau of Youngstown, with its 476 members, I feel it my duty to express appreciation to the Medical-Dental Bureau for its cooperation and efficient handling of our collection problems.

The recording of claims affords members of both the Credit Bureau and the Medical-Dental Bureau a true picture of individuals in our community seeking credit.

Out-of-town claims are forwarded to members of the American Collectors Association, who operate all over the United States, the Ohio Collectors Association and many other agencies.

Investigations and tracings which have always been one of the costly operations of any collection agency, are very efficiently handled by this collection department.

We are also fortunate in having as a member of the collection department, Merle Baumgartner, with thirty three years experience in the collection business.

All in all, the combined efforts of both organizations have proven to be a worthwhile service to this community.

THERAPY OF PANCREATITIS

Pain from acute pancreatitis may be relieved by 1 intravenous infusion of novocain; chronic forms of the inflammation respond more slowly.

Dr. A. Lauterbach of the Rudolf Foundation Hospital, Vienna, administers 4 cc. per kilogram of body weight of a 0.25% solution of novocain daily by slow intravenous drip. General improvement was noted in 30 patients with pancreatitis secondary to diseases of the extrahepatic biliary tract within twenty-four to seventy-two hours. Serum diastase and blood sugar levels also fell during the period.

Because of the analgesic action of novocain, morphine is unnecessary. Surgery may be done as soon as pancreatitis subsides.

This method is apparently as effective as a novocain splanchnic block and is simpler.

NEUROLOGICAL PROCEDURES

Neurosurgical procedures—such as rhizotomy, chordotomy, and lobotomy —are sometimes avoided because the physician may believe that they are too radical a step. Actually, if the patient is not emaciated, they are well tolerated and produce results which are often worth the slight risk involved. Their disadvantages include a resultant mental, physical, and financial strain, and the operations are often accompanied by complications. However, if neurosurgery is the best procedure to relieve pain in a particular patient, then neurosurgery should become the treatment of choice. And the operation should be carried out at an early time, while the patient is still in good physical condition with a life expectancy of three to six months.

The methods employed to relieve pain should be pursued with the aggressiveness attendant upon curative therapy. An air of confidence and optimism on the part of the physician can do much, because "a healthy mental attitude raises the threshold for pain."

THERAPY OF PERITONITIS

Terramycin is more effective when given intraperitoneally than intravenously to dogs with peritonitis. The survival rate for 17 dogs with appendiceal peritonitis increased to 47.1% when Terramycin was given intraperitoneally as compared to a mortality rate of 100% in a control group of animals given equal doses of Terramycin intravenously, report Drs. William E. Schatten and William E. Abbott of Western Reserve University, Cleveland. The intravenously treated animals lived about fifty-five and a half hours after peritonitis was produced, whereas 10 of the intraperitoneally treated dogs lived at least seven days and the other 7 animals lived about one hundred and a half hours. Cultures of peritoneal fluid from animals that survived the twenty-one-day experimental period repeatedly contained organisms of *Escherichia coli, Proteus vulgaris,* and *Clostridium welchii.* Only 3 of 78 cultures from dogs given the intraperitoneal therapy contained other organisms. However the peritoneal fluid of 14 of 17 dogs given intravenous Terramycin contained additional bacterial strains. Regardless of the method of therapy, all dogs that had gram-positive cocci in the peritoneal fluid after initiation of therapy died within ninety-six hours. — *Surg., Gynec. & Obst. 97:445-455, 1953.*

THERAPY OF SARCOIDOSIS

Symptoms of cutaneous sarcoidosis are alleviated after oral administration of isoniazid. The initial daily dose of 1 mg. per kilogram of body weight is gradually increased for one or more weeks until 3 mg. is tolerated, reports Dr. Edmond Edelson of the Newark Board of Health Clinics, N. J . Of 6 patients so treated, the 4 receiving medication five and a half months or longer improved. Tubercles decreased in size, swelling diminished, and no new lesions appeared during treatment. However, biopsy specimens of regressing lesions did not have the histopathologic alterations often seen in the involution of sarcoidosis. Shorter terms of treatment in 2 cases produced no benefit. *J. Invest. Dermat. 21:71-74, 1953.*

CAPSULETTES

Careful, painstaking, and if necessary repeated radiographic examination is far and away the most important diagnostic procedure in the problem of gastric cancer. If x-ray signs are present but equivocal, surgical exploration should be done.

Gastric ulcer is a surgical problem.

Cancer of the digestive tract constitutes 23.0 percent of total cancer in both the male and female population. This percentage of occurence is about equally divided between cancer of the upper digestive tract and cancer of the lower digestive tract. Cancer of the upper digestive tract occurs as follows:

1 Esophagus, 1.0 percent; 2 Stomach, 6.6 percent; 3 Liver and biliary passages, 1.8 percent; 4 Pancreas, 1.8 percent; and 5 Small intestine, 0.2 percent.

The differential diagnosis of aseptic meningitis. These include the following:

Non paralytic poliomyelitis; Lymphocytic choriomeningitis; Silent brain abscess; Virus encephalitides; Encephalitis lethargica (Von Economo's disease); St. Louis encephalitis; Eastern and Western equine encephalomyelitis; Herpes simplex meningoencephalitis; Infectious mononucleosis; Infectious hepatitis; Acute syphilitic meningitis; Leptospiral meningitis; Cases due to agents not yet identified.

THERAPY RHEUMATIC CARDITIS

Active rheumatic carditis may be terminated before the onset of irreversible cardiac damage by early administration of corticotropin. When the drug is given intramuscularly every six hours for about seven days in daily dosage of 1 to 5 mg. per kilogram of body weight, May G. Wilson, M.D., and associates of Cornell University, New York City, find that the process may be arrested by the second day and patients become ambulatory within one to three weeks after completion of treatment. Chamber enlargement was reversed in 13 to 15 subjects with acute inflammation of short duration, and in 7 of 9 individuals ill for ten to nineteen days. A circulating eosinophil count of 0 to 10 per cubic millimeter was arbitrarily considered a measure of adequate therapy.—*Am. J. Dis. Child. 86:131-146, 1953.*

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- Raudixin contains the standardized *whole root* of Rauwolfia serpentina. There is no definite evidence that any alkaloid or fraction has all the beneficial actions of the whole crude root.
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50 and 100 mg. tablets, bottles of 100

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in the treatment of a wide range of infections due to gram-positive and gram-negative bacteria, spirochetes, rickettsiae, certain large viruses and protozoa.

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excellent toleration[5,6]

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