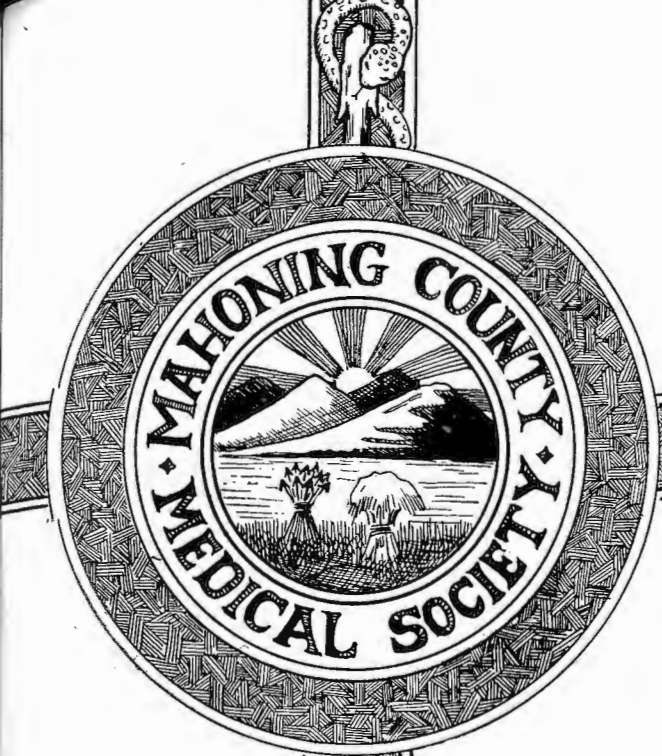

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

OCTOBER • 1955
Vol. XXV • No. 10
Youngstown • Ohio

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ADVERTISERS' LIST

Our President Speaks

In many respects, physicians have to be more careful in their relationships than members of any other profession or business. Many of the principles of medical ethics are concerned with our behavior towards one another. Most of us are meticulous in our observation of all these ethical principles.

For a long time I have been bothered by something which seems to me involves the matter of common courtesy. Suppose that Doctors Jones and Brown are working in their respective offices, both presumably equally busy. Doctor Jones has occasion to call Doctor Brown on the telephone. He has his secretary get Doctor Brown's secretary on the phone and tell her that Doctor Jones is calling. Doctor Brown drops what he is doing on the assumption that Doctor Jones is waiting. Instead, Doctor Jones' secretary informs Doctor Brown that she will get Doctor Jones. In the meantime, Doctor Jones has started something which he cannot stop immediately, so Doctor Brown waits and waits until Doctor Jones is able to get to the phone. Whose time is more valuable? After all, Doctor Jones was the one who wanted to talk to Doctor Brown, not the other way around.

Putting myself in the place of Doctor Brown, I have frequently meditated on ways to stop this discourteous practice — especially when the delay becomes unreasonably long. As the wait grows, my ideas become more radical. One way would be in instructing my secretary to tell Doctor Jones' secretary that she would call me to the phone as soon as Doctor Jones was able to get on the line. This could result in a stalemate. Suppose Doctor Jones' secretary insisted that she would not interrupt Doctor Jones until I was on the line? We would get nowhere. My most drastic idea has been to wait until Doctor Jones finally gets on the line, then to hang up just as he is swinging into his greeting. This is a little impractical, however, because after all, Doctor Jones is probably a very close, if somewhat thoughtless, friend.

My solution ultimately was to put these few remarks in *The Bulletin*. I really intended to make the wording stronger because twice within the last few days, an interne has had the nurse call me and tell me to wait until the interne got to the phone. However, moderation in language, as in all things, is supposed to be a virtue.

Ivan C. Smith, M.D., Pres.

BULLETIN of the Mahoning County Medical Society

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

EDITORIAL

THE INDOCTRINATION DINNER

On September 20th, prior to the September Meeting of the Mahoning County Medical Society, along with other sponsors of incoming members, I attended the Indoctrination Dinner.

The purpose of this affair is to acquaint the new members of the functions of organized medical eschelons at all levels and to stress the need for vitality and strength at the grassroots; to instruct the new members of their obligations to their patients, confreres, and themselves; to offer the new members the advice and council of seasoned veterans of our ranks.

The program included a superb repast, good fellowship, and a series of short but most informative talks given by members of our society on subjects of vital interest to new members. The speakers and their subjects were . . . Dr. Vern Goodwin on medical ethics; Dr. Ivan Smith on the Constitution of the Mahoning County Medical Society; Dr. James D. Brown on hospital relations; Dr. Joseph Wasilko on insurance and the doctor; Dr. C. A. Gustafson on the function of Ohio State Medical Society; Dr. William Skipp on the function of the American Medical Society.

It seems to me that this program is of such merit that it should be included annually in the schedule of the meetings of the Mahoning County Medical Society so that the entire membership might benefit from it.

Robert L. Tornello, M.D.
Editor

THE COUNCILOR'S PAGE

And suddenly it is Autumn! I saw this sign in a store window on State Street, Chicago, a few days ago. They were trying to sell winter wardrobes, with the temperature outside above 100°.

I have had good intentions of writing a councilor's page for several weeks, but it has just been too hot, (even with air conditioning,) to do much about it. But now that hot weather, vacations, hurricanes, are over, it is really time to resume our medical activities.

We hope you have all had a good vacation this summer, in preparation for a busy year ahead.

The annual Sixth Councilor District Post-graduate Day, our major medical event, will be held on Wednesday, October 26, at Warren, in the new Packard Municipal Auditorium. Trumbull and Portage Counties will be hosts this year. They began to plan this meeting a year ago and have left nothing undone to make this an outstanding medical meeting worthy of your wholehearted support.

On other pages of this *Bulletin*, you will find our program. As Councilor, I am pleased to extend an invitation to you. I am sure you will find this meeting of great value and interest. The Committies have secured outstanding teachers for all parts of the program. As you will note, a wide variety of material will be presented, all on subjects of great concern to busy practitioners. No matter what branch of medicine you are especially interested in, you will find something on this program that will help you. The Sixth District has always had good programs. We hope you will plan to participate in this Post-graduate Day and through your presence provide the speakers with the type of audience which has made our Post-graduate Days so outstanding in the past.

I hope you read carefully, President Hudson's letter of August 20th. The American Medical Association has endorsed the recommendation that current priority in administration of Polio Vaccine be given to the age group of 5 through 9 years. Also keep a record showing the name, residence and age of each patient vaccinated for polio by you in your office; the site and date of the innoculation; the lot number of the vaccine; and the manufacturer's name. You may find this data valuable for reference.

Recently you received a legislative message from your American Medical Association. We hope you have kept it for ready reference. It helps you know your members of Congress, and contains a map showing the Ohio Congressional Districts. Keep it for ready reference.

Did you read "The President's Page" in the August 27th issue of the A.M.A. Journal? If you did — fine! If you didn't, I urge you to read it. Dr. Hess is not crying "Wolf." The issues are vital to our welfare, and we must know about them and then get concerted action.

Congress reconvenes in January, and will take up where the first session left off. The polio-vaccine controversy (three months) was responsible for the postponement of conclusive action upon a number of health bills which seemed well on their way to enactment. These health bills are discussed in your state and A.M.A. journal. Take time to read them and know what is going on. Many members of Congress are in their home districts. I want to suggest that you get in touch with them. Let them know how the profession feels about certain legislation — and why.

Are you registered for the November election? Dr. Hess, in his monthly message (August) says only about 20% of our physicians and their wives and children of voting age were registered.

And, finally, a word about grievance cases. Some have been coming up in the Sixth District. As always, the usual cause of the misunderstanding is from two sources:

(1) The fee has not been discussed with the patient, before the service was rendered and —

(2) A second doctor has made some remark about the care which led the patient to think that proper service had not been rendered.

We can correct both, and this will do much to lessen the number of grievance cases.

C. A. Gustafson, M.D.

THE STORY BEHIND THE WORD

Some Interesting Origins of Medical Terms

Placenta — This Latin word literally means a cake and is derived from the Greek word "plakous," a flat cake, which in turn comes from the Greek "plox" meaning a flat surface. While the placenta or after-birth was known to the ancients and was noted by Aristotle and Galen, the term "placenta" was apparently first applied to this structure by Fallopius in the sixteenth century.

Placenta Praevia — This condition was first described in the sixteenth century by Jacques Guillemean, but the name was first applied about a century later by Hendrik van Deventer.

Pinna — The Latin word "pinna or penna" was used to designate a feather and also a wing. Because the external ear projects from the side of the head like a feather or wing, it was named the "pinna" by Rufus of Ephesus in about the first century A.D.

Pill — A simple descriptive term applied to a small solid globular or ball-like body of medicine which is to be swallowed whole. This term is derived from the diminutive Latin word "pilula," meaning a little ball and which comes from the Latin "pila," or ball.

Phenol — Friedlieb Ferdinand Runge, a German chemist, first prepared "phenol" from coal tar in 1834. The French chemist Laurent in 1841 named it "acid phenique" or phenic acid from the Greek word "phaino," — "I show," or "I shine," because it was brought to light or shown to be a coal tar product. Later the hybrid name "phenol" composed of the Greek word "phaino" plus the Latin "oleum," or oil, was given to this substance.

Petri Dish — These shallow, cylindrical, covered glass dishes for bacterial cultures were introduced in 1887 by Julius Petri, a German bacteriologist who was one of Robert Koch's assistants.

Affliction — When illness or adversity "afflicts" you, a wave of misfortune has literally been "dashed upon" you. This term comes from the Latin word "affligere," meaning to distress. This in turn comes from the Latin "af or ad," meaning "to" or "upon," plus, "fligere" or "flict" meaning to dash. Thus to "dash upon" someone is to afflict him.

Alcohol — The word alcohol is of Arabic origin, being derived from the particle "al" and the word "kohl," an impalpable powder used in the East for painting the eyebrows. For many centuries the word was used to designate any fine powder. During the tenth or eleventh century, a transition of meaning occurred from a fine powder to a spirituous substance, such as the "spirit of wine."

—Harry Wain, M.D., Mansfield, Ohio

FROM THE BULLETIN

TWENTY YEARS AGO — OCTOBER 1935

Last month the Society members were concerned about the termination of FERA responsibility for medical care of the indigent. As reported this month our Economics Committee was busy contacting the PWA, the Widows Pension Board, the Old Age Pension Board and other agencies to establish a system to replace the old one. Members were warned not to make private contracts with any agency to care for their wards.

Dr. Everett Plass of the University of Iowa addressed the Society on "The Simplification Of Obstetric Care." His ready wit and common sense brought down the house and his lecture was talked about long afterward.

The golf day on September 19th, postponed because of rain on July 25th, was rained out. Guests consoled themselves by sitting around holding hands and exercising elbows.

Dr. Karl Allison died, we still miss him. Dr. Carl Gustafson opened his office at 101 Lincoln Ave. Dr. E. J. Wenaas returned from post-graduate study and resumed practice in diseases of the eyes. Dr. Paul Harvey had an excellent article in this issue on "Peptic Ulcer." Dr. R. H. Middleton and Helen Hick were married.

Scott's were featuring the new Knox hat with a tapered crown and narrow curling brim.

TEN YEARS AGO — OCTOBER 1945

"Welcome Home Service Members" was the title of the leading article that month and the slogan of the day. Every service doctor was counting his points for all the good that did). Dr. Allsop's committee was busy checking office space, arranging for telephone service and offering financial aid. Some of the returnees had no office, no car and very little money. Servicemen were assured they would be given their former hospital appointments and their industrial and insurance jobs. The Home Savings and Loan Building had kept every doctor's office just as he left it and it was ready for him all cleaned and no charge for rent or storage.

John Keyes, Sears, McConnell, Klatman, DeCicco, Goldberg, Epstein and Kaufman were home and ready to work. Bowman, Firestone, Tims, McElroy, Boyle and Lawton were back in the country but not out yet.

Brandmiller was in Manila for V-J day where he found Denny Thomas and Kenneth Camp. Weller was still sweating it out in San Antonio. John Rogers was convalescing at Sorrento from a streptococcic throat infection. Last minute promotions: A. Detesco to Lieutenant U.S.N.R.; Fisher, Evans and Goldstein to Commander U.S.N.R.

The Ohio Medical Indemnity was organized at Columbus. Dr. Wm. Skipp and Mr. David Endres were elected to the Board of Directors.

James L. Fisher, M.D.

All prizes, like all titles, are dangerous. The seekers for prizes tend to labor not for inherent excellence but for alien rewards; they tend to write this, or timorously to avoid writing that, in order to tickle the prejudices of a haphazard committee.

—*Sinclair Lewis*

UNITED STATES BECOMES 'MEDICAL MAGNET'

The United States has become a "medical magnet" for physicians in Europe, Asia, Africa, and Latin America.

More than 5,000 foreign physicians came to this country during the year 1954-55 for study, according to a survey by the Institute of International Education and the American Medical Association.

They came from 83 different countries for internship and residency training at hospitals in 42 states, the District of Columbia, Hawaii, Puerto Rico, and the Canal Zone.

The survey of 1,177 hospitals, among those approved for internships and residencies by the A.M.A. Council on Medical Education and Hospitals, indicated that there were at least 5,036 alien physicians in training. Not included in the study were immigrants and displaced persons.

Individual countries sending the most physicians were the Philippines, Canada, Mexico, Germany, and Turkey. Of the major geographical areas, the Middle, Near, and Far East had the largest representation.

Of the total, 620 or 12.3 per cent were women. In comparison, women made up only 5.2 to 5.7 per cent of American medical school graduating classes in the years 1952 through 1954. Over half of the women came from the Near, Far, and Middle East, with the Philippines sending the most.

More than 2,000 of the physicians were in the United States on their own resources. Others were sponsored by at least 67 different agencies, including their own or the Untied States government, the United Nations, and religious, educational or philanthropic organizations. Many were sponsored by the hospitals in which they were training.

In addition to the large number of physicians in hospital internship - residency training, others visited this country as observers, professors, or guest participants in research. They represented 21.5 per cent of all foreign educators who visited the country during the year.

In comparison, only 3.6 per cent of all American educators visiting other parts of the world in 1954-55 were listed under medicine.

The survey was reported in the current (Aug. 13) Journal of the American Medical Association by Dr. James E. McCormack, associate dean of graduate studies at Columbia University College of Physicians and Surgeons and Arthur Feraru, head of the Central Index and Census Division, Institute of International Education, both of New York.

Revenue Bureau Summarizes Medical Expenses Under Tax Law

Deductible and non-deductible medical expenses for income tax purposes have been summarized by the Bureau of Internal Revenue in a series of rulings that combine new interpretations with a clarification of old rulings. Some examples:

Travel expenses to and from a location where daily visits to a medical clinic are required are deductible but (since 1954) cost of food and lodging are not, except as part of a hospital bill. *On education and training*, special instruction in speech and lip reading for a deaf child are deductible expenses, but not a course of ordinary instruction. Psychiatric care and therapy at specially equipped treatment schools for alleviating mental illness are deductible items, but where cost of instruction at a psychiatric school doesn't represent medical care, it is not deductible. *On health and accident indemnity insurance*, if a policy covers both injury indemnity and medical expense reimbursement, premium cost for latter is deductible but not for former. On *other points*, ordinary exercise rubdown, air conditioner, oxygen equipment, iron lung, special bed board, all are deductible items when prescribed by a physician for an illness, but not food for ulcer patient, maternity clothing, diaper service, wigs or toothpaste.

KEEPING UP WITH A.M.A.

By Wm. M. Skipp, M.D.
Ohio Delegate to A.M.A.

COMPULSORY DISABILITY INSURANCE. The House passed H.R. 7225 without hearings. The Senate did set up just one day for hearings on this socialistic scheme. No action was taken in the Senate Finance Committee. Senator Byrd states no action will be taken until full public hearings are held. Of necessity, this will be held over until the next session of Congress.

Secretary George F. Lull, in a recent letter, points to the extremely dangerous position in which American medicine finds itself after passage of a bill which makes sweeping changes in the Social Security Act.

"The bill, which would amend the law to provide cash benefits to certain beneficiaries who are permanently and totally disabled . . .

"I urge every freedom-loving physician to read the special message from the A.M.A. Board of Trustees which appears on page 1032 of the July 23 issue of the Journal.

"The action of our representatives in Washington is nothing more than a piecemeal approach to the socialization of medicine.

"As the Board's statement said: "The distance between our present medical freedom and complete government regimentation has narrowed considerably. The remaining gap will be closed completely unless physicians throughout the nation take constructive action to educate themselves, the public, and their congressmen and senators during the next few months."

"The Board of Trustees held a long meeting in Chicago. When the sessions ended, I seemed to recall a phrase attributed to Benjamin Franklin. Ben warned his fellow patriots in the daring venture that made us an independent people: "We must all hang together, or, assuredly, we shall all hang separately. Another bit of advice . . . this from Eddie Canton . . . Eddie was advising a group of his troubled friends to learn the story of the banana. "As soon as it leaves the bunch," he said, "it is skinned."

TAX POSTPONEMENT FOR SELF-EMPLOYED. The House Ways and Means Committee reported on the "Individual Retirement Act of 1955." 1. The bill's application is limited to those defined as self-employed in the social security law, plus physicians and Christian Science practitioners; 2. The alternative forms of investment were amended to provide three choices instead of two under the bill. These alternative forms are . . . a. A restricted retirement annuity fund; b. A restricted annuity contract; and c. A life-insurance annuity contract to the extent that the premium is allocated to the annuity. Provision is made for creation of custodian accounts. The maximum amount that could be excluded in any taxable year was reduced from $7,500 to $5,000 and the maximum lifetime exclusion was reduced from $150,000 to $100,000.

COMMITTEE TO REVIEW THE FUNCTIONS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS. The Committee has been appointed by Dr. E. Vincent Askey, Speaker of the A.M.A. House of Delegates. The Committee is to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals or the Joint Commission on Accreditation of Hospitals. The special committee shall be instructed to make an independent study or survey and report its findings and recommendations to the House at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on Accreditation of Hospitals.

FOLSOM URGES SOCIAL SECURITY FOR PROFESSIONAL GROUPS. Marion B. Folsom, Secretary of Health, Education and Welfare, in a 20th anniversary observance of enactment of the Social Security Act, declared that the act cannot remain static but must change "with changing economic and social conditions." He then advocated the inclusion of professional groups and all federal employees, and forecast congressional action next session on bringing in federal workers. He did not elaborate on what professional groups he had in mind.

SEARS-ROEBUCK FOUNDATION ANNOUNCES NEW ASSISTANCE PLAN. The Sears-Roebuck Foundation, in cooperation with A.M.A., has announced a new plan for assistance in establishing medical practice units with loans of up to $25,000, beginning in 1955. The unsecured, low-cost, 10-year loans will be available to physicians seeking to establish new practices but unable to arrange full local financing.

Details will be in the September 3 issue of the Journal.

The plan requiries that the physician first exhaust all local possibilities for financing, that his application indicate a need for a practice in the proposed locality and good possibilities for success and public service, and that he give evidence of effort and thought in planning a well-organized, effective practice unit.

The foundation states that its plan is intended to "realize the principles of opportunity, incentive, mutual help, and self reliance, to give the American people the best possible medical care, and to help the American physician build for himself the most effective, the most rewarding and the most satisfying life as a professional man." The plan relies on individual initiative and enterprise, requires that assistance be given only where it will generate independence, and is sustained entirely by those who benefit from it.

HIPPOCRATES ON OPHTHALMOLOGY

Editor's Note: How much have our powers of observation improved? Over 2,000 years ago Hippocrates recorded his observations regarding the eye.

"It is a sign of the crisis when the eyes and their whites, having been dark or livid, become clear. To become clear quickly denotes a quick crisis; slowly, a tardy one.

"For the eyes to become misty, or for the whites to become red or livid or to show a marked venous congestion, is not a pretty sign; it is also a poor sign when there is photophobia, or lachrymation, or strabismus, or if one pupil becomes smaller than the other. It is also bad if the eyes move restlessly, or if there are small styes, or if they show a thin skin over them, or if the pupil is hidden by the upper eyelid. Bad signs too are enophthalmos, a severe degree of exophthalmos, lack of their lustre so that the pupil fails to dilate, irregularity of the eyelids, fixity of the eyes, continuous blinking and changes of colour. For the eyes not to close in sleep is a fatal sign. Squint is also bad.

"Redness of the eyes occurring during the course of a fever denotes protracted stomach trouble.

"Swellings by the eyes in convalescence indicate violent diarrhoea.

"A rigor supervening on strabismus of the eyes, with lassitude and fever, is a fatal sign. To be comatose when these signs are present is bad also.

"Fever supervening on ophthalmia ends the latter; if it does not, there is risk of losing one's sight, or one's life, or both.

"When headache develops in cases of ophthalmia and accompanies it for a long time, there is a risk of blindness."

—*J. International College of Surgeons, June, 1955*

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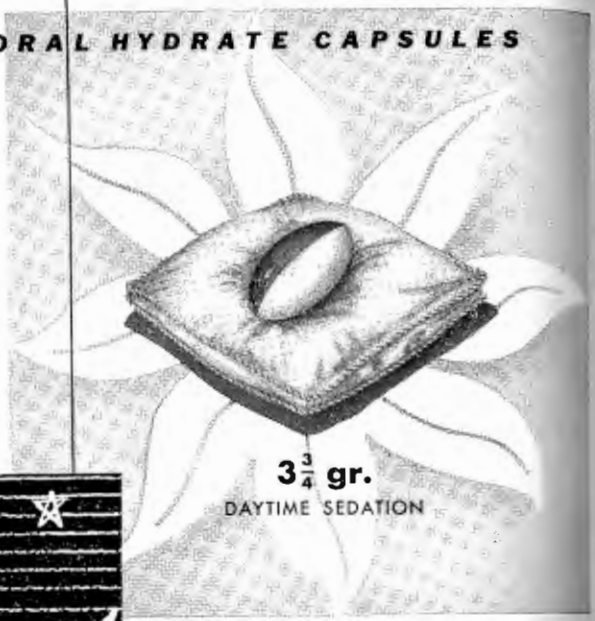

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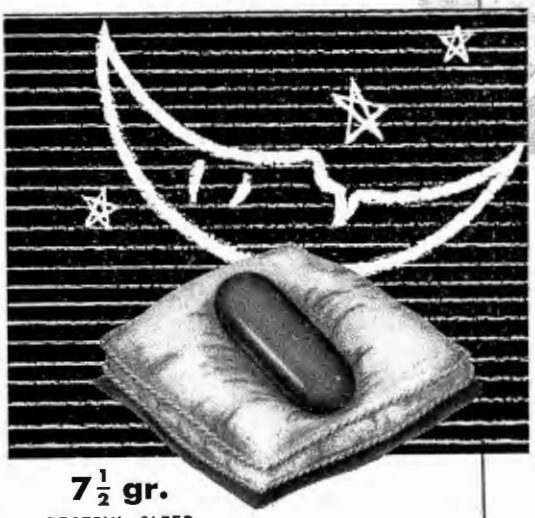

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HAVE YOU HEARD . . . .

. . . . . that Dr. Morris S. Rosenblum has announced the association of Dr. David B. Brown for the practice of internal medicine and gastroenterology at 406-407 Home Savings and Loan Building?

. . . . . that Dr. Arnoldus Goudsmit announces the association of Dr. Norman E. Sharrer for a practice limited to internal medicine at 2218 Market Street?

. . . . . that Dr. Leonard P. Caccamo announces the opening of his offices at 419 Catalina Ave. for a practice limited to internal medicine?

. . . . . that Dr. Wayne B. Hardin announces his association with Dr. John Storer for the practice of cardiovascular surgery at 2921 Glenwood Avenue? Dr. Storer, who was trained by Dr. Charles Bailey, is the chief of vascular and thoracic surgery at Huron Road Hospital. He will hold consultations in Dr. Hardin's office and has obtained operative privileges at the Youngstown Hospital Association.

. . . THE HUMBLEST OF MY PATIENTS TODAY

I noted a cartoon dealing with the cost of medicine. My thoughts wandered to the father and mother looking at the small figure so still in the big bed. It all seemed to have happened very quickly. The small boy coming in from the drenching rain. Next day the sore throat. Then the horrible cough, high fever, nurses, doctors, never-ending vigil, hope and despair, and finally, death. Death entered the White House as devastatingly as though it had been a hovel. Eight dollars worth of antibiotics would have had Willie Lincoln well within a week or less.

Not so remote in time, Calvin Coolidge, Jr. blistered his heel on the tennis court. Infection and septicemia followed. Once again death eluded every barrier to invade the White House and carry away the President's son. Five to $10 worth of sulfonamide or broad spectrum antibiotic tablets would have saved a life — a precious child.

William McKinley was struck down by an assassin's bullet. It took him nine days to die. The wound in itself would be considered trifling today. But the President died of the peritonitis that followed.

Warren Harding died of pneumonia, another disease which is rapidly taking its place among the diseases of the past.

What does all this mean to us today? It means that the humblest of my patients today is infinitely better off than were the most powerful in the world just a few years ago. For half a day's pay the laborer of today can buy these precious medicaments which the Lincolns, the Coolidges, the McKinleys, the Hardings, and untold others could not obtain at any price.

Tremendous sums are spent in reserach. Superhuman effort is spent by countless dedicated men and women so that for a few insignificant dollars all boys and girls filled with promise for life and loved by their parents, the wives and husbands, the fathers and the mothers, yes, the grandfathers and the grandmothers in my reception room, may live with the least physical and emotional agony. I'm humbly thankful.

Herman B. Kipnis, M.D.
Chicago Sun-Times
May 17, 1955

PULMONARY COIN LESIONS

ROBERT E. CARR, M.D., F.A.C.S.

The solitary circumscribed pulmonary lesions or coin lesions, include a variety of conditions with similar roentgenographic appearance. Although coin lesion may not be the ideal term, it has become acceptable because of common usage. To be included in this group a lesion should meet certain criteria, including. solitary lesion, round or oval shaped with well circumscribed borders, five centimeters or less in diameter, surrounded on all sides by normal appearing lung tissue, more or less homogenous in density but may contain calcium. Most of these lesions are asymptomatic and are found on routine chest roentgenograms.

Graham and Singer[1] in 1936 reported the removal of rounded pulmonary lesions, which proved to be tuberculous in origin. In 1942 Alexander[2] pointed out that benign and malignant lesions may present the same picture roentgenographically and a diagnosis can seldom be made preoperatively. Surgical excision and microscopic examination is the only reliable method of diagnosis.

The incidence of malignancy has been reported by various authors from 15 per cent[3] to 55 per cent.[4] A review by Jones and Cleve[5] of 714 cases collected from the literature, revealed 40 per cent inflammatory, 35 per cent malignant, 12.5 per cent benign tumors, and 12.5 per cent heterogenous group of lesions.

The value of chest roentgenogram in revealing asymptomatic pulmonary lesions is well known, but it has not proved to be of great value in determining the pathologic nature of most lesions. Although calcium is seen more frequently in benign lesions, calcification in malignant lesions has been reported. If one suspects that a lesion is a metastatic tumor, x-ray survey of other body systems is indicated.

The largest group of coin lesions is composed of the various types of granulomas. A negative skin test suggests that the lesion may be a tumor. A positive reaction, while being evidence in favor of a benign granulomatous lesion of tuberculous or fungus origin, cannot be considered assurance that the mass is not tumor.

Most of the coin lesions are peripherally located and beyond the limits of bronchoscopic visualization. Rarely is a positive bronchial biopsy obtained. Examination of the sputum and bronchial washings for tumor cells seldom reveals the nature of the lesion. Smear and culture of sputum and gastric washings do not aid in diagnosis frequently enough to justify waiting several weeks for the results of cultures. Scalene or supraclavicular lymph node biopsy, which is a valuable aid in the diagnosis of many mediastinal and pulmonary lesions, has not been helpful in the diagnosis of most coin lesions.

Exploratory thoracotomy carries a risk no greater than exploratory laparotomy. Since the possibility of malignancy is ever present, surgical excision is the treatment of choice. In bronchogenic carcinoma the resectability rate is highest in the group explored on suspicion of cancer and declines rapidly in the group in which the diagnosis is proven preoperatively.

The granulomatous lesions comprise the largest group of coin lesions. Tuberculosis, histoplasmosis and coccidioidomycosis are the most common etiologic agents.[6,7] The importance of microscopic and complete bacteriologic study of these lesions should be emphasized. Recent reports have shown that the use of the periodic acid-Schiff (PAS) stain has made it possible to

identify histoplasma in some of the granulomatous lesions previously classified as tuberculous or non-specific granulomas.[8] About 40 to 50 per cent [9 10] of the large tuberculomas may show evidence of progression in size, cavitation or parenchymal spreads. There are reports that granulomatous lesions due to fungi may act similar to tuberculomas, and are best treated by resection.

Benign tumors of the lung seldom become malignant but it is clinically impossible to differentiate malignant from benign tumors without excision. Malignant lesions have appeared stable by x-ray for years before sudden increase in size and widespread metastases occurred. Bronchial adenomas should be considered as malignant tumors and treated as such, since distant metastases occur in about 10 per cent.

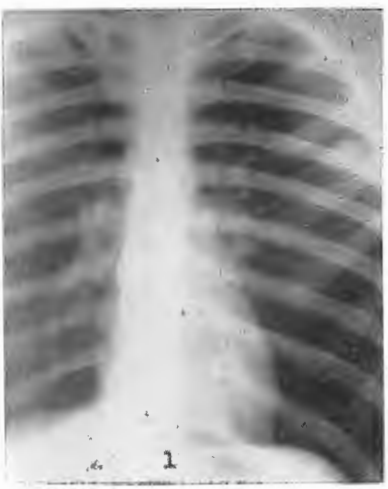
Solitary metastatic tumors of the lung comprise only a small percentage of pulmonary malignancies. History of previous removal of a malignancy or evidence of existing malignancy in other organs suggests that the pulmonary lesion in question may be metastatic, but does not confirm it. Following the report of Alexander and Haight[11] on the resection of solitary metastatic pulmonary lesions, other reports with encouraging results have appeared. The best results occur in those patients with a long interval between the removal of the primary and the appearance of the metastatic pulmonary lesion.

This leaves a small group of lesions which include: Non-specific granulomas, localized areas of pneumonitis, congenital cyst or blocked cavities, residuals of lung abscesses and occasional pulmonary infarction. These lesions present no diagnostic characteristics and their true nature is not known until examined microscopically.

The 21 coin lesions in this report were resected during an 18 month period on the Thoracic Surgical Service of one hospital. All cases in which the diagnosis had been proven preoperatively were excluded. The diagnosis in this series is shown in table 1.

TABLE #1

PATHOLOGIC DIAGNOSIS	NUMBER OF PATIENTS	PERCENTAGE
Bronchogenic carcinoma	7	33.3
Granuloma (Tuberculous and fungi)	10	47.6
Benign tumors	2	9.5
Non-specific infectious granulomas	2	9.5
Total	21	99.9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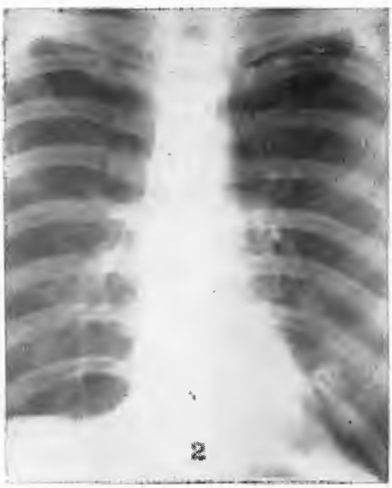
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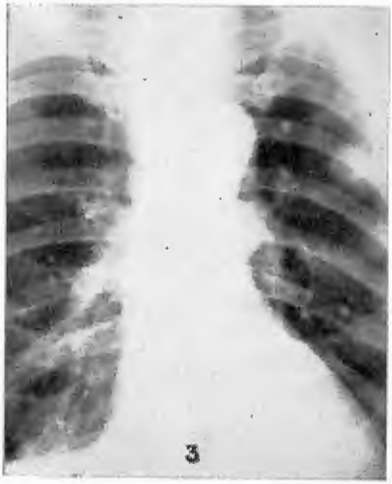
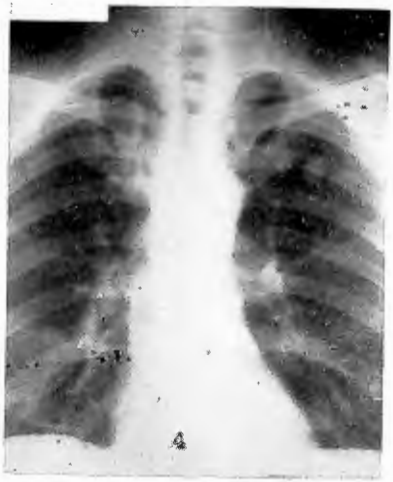
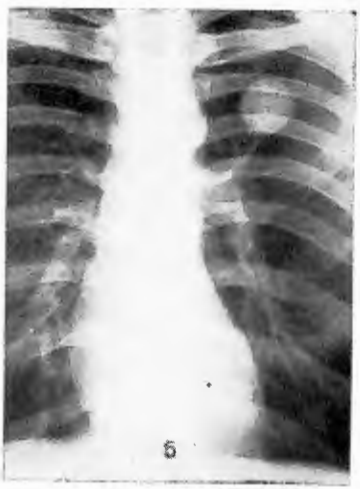
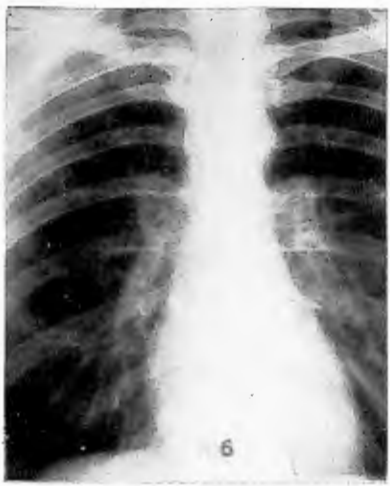






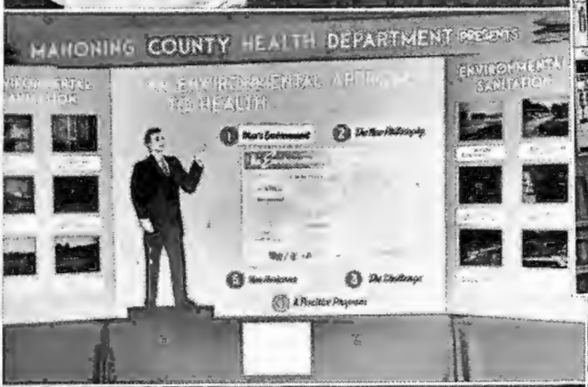


The difficulty in diagnosis is demonstrated by the preoperative roentgenograms of 6 cases shown, figures 1-6.

Summary:

The coin lesions include a variety of pathologic entities and surgical excision is usually required to establish a diagnosis. The incidence of malignancy is high and most of the lesions confused with malignancy are best treated by excision. This procedure is accepted in the management of breast tumor and should be applied more frequently to undiagnosed pulmonary lesions. The risk of thoracotomy is extremely low and the period of incapacity is short. Early excision of undiagnosed coin lesions appears to offer the best chance of increasing resectability rate and long time survival in bronchogenic carcinoma.

THE CANFIELD



FAIR EXHIBIT

DECREASE IN SURGICAL MORTALITY RATES

Every physician should have at his fingertips modern statistics relative to surgical mortality rates. Patients about to undergo major operations are quite naturally concerned with their "chances," and it is most reassuring for them to be given the latest information, especially since the data shows an ever decreasing mortality from major surgical procedures. Too many patients are still saddled with older concepts of the risks of major operations and are not aware of the progress which has been made since the days of their parents or grandparents.

One of the major insurance companies recently issued a bulletin of statistics garnered from the country's leading clinics. In it they give comparative figures of the surgical mortality in specified major operations prior to 1940 and at the present time. Formerly, an amputation for diabetic gangrene carried a rate of 13.7 per cent; today this has been reduced to 5.5 per cent (New England Deaconess Hospital, Boston). At the Lahey Clinic total gastrectomy (1927-1943) showed a 34.6 per cent mortality; from 1944 to 1950 the rate has been reduced to 9.4 per cent. Recent figures from the Cook County Hospital, Chicago, show hysterectomy with a rate of 1.1 per cent; before 1930 this figure was 9.4 per cent.

Such illustrative figures could be cited for many other major surgical operations. The improved outlook for surgical patients is strikingly illustrated by the rapid decline in the mortality from appendicitis. In the past decade the mortality from uncomplicated cases has decreased by three-fourths; in two decades it has fallen by nine-tenths.

The record of improved mortality rates is all the more remarkable when one realizes that the age of the patient being operated is also steadily rising. In recent years persons at ages 50 and over constituted somewhat over half the total number of patients undergoing radical surgery of the stomach and duodenum in three Chicago hospitals.

We are all familiar with the factors responsible for the improved outlook for surgical patients. Among them are (1) Better trained surgeons (2) Advances in surgical techniques, and the wide use of the newer chemo-therapeutic and antibiotic agents to control infection (3) Improved anesthesia plus better preoperative preparation and post-operative care (4) Easy availability of blood for transfusion when necessary (5) Early ambulation, reducing the chances of pulmonary embolism.

Today we can unhesitatingly recommend and perform major surgical operations which a few decades ago carried prohibitive mortality rates.

TO THE MEMBERS OF THE MAHONING COUNTY MEDICAL SOCIETY

The time has come again when the American Medical Education Foundation asks that you make a donation either directly to your medical alumni or the A.M.E.F.

When a member of the county committee contacts you, do not turn him down but give so that our medical schools can remain free of federal subsidy.

We have increased the amount of money given, and the number of subscribers, every year in the county, state, and national, but we need more, in fact ten million is our goal and we are far from that.

If you give to your alumni fund, request that A.M.E.F. be notified. If you give directly to A.M.E.F., your school will get credit if you so request, if not amount will be pro-rated to all medical schools.

Please send your check soon, for as much as you can afford, we need your help.

W. M. Skipp, M.D.
A.M.E.F. County and State Chairman

Program of the

POST GRADUATE DAY

Sixth Councilor District, O.S.M.A.
Wednesday, October 26, 1955
New Packard Music Hall
Warren, Ohio

8:30		Registration
9:00-9:15		Surgery Cineclinic
9:15-9:30		Surgery Cineclinic
9:45-10:50		*Diebetic Acidosis, Panel Discussion*
Medical	(M)	Dr. Max Miller, Ass. Prof. Medicine, Western Reserve U
		Dr. A. Cantarow, Clinical Prof. Biochemistry, Jefferson
Surgical		*Trauma of Upper Extremity, Panel Discussion*
	(M)	Dr. Ralph F. Bowers, Chief of Surgery, Kennedy Vet Adm., Memphis
		Dr. Gordon W. Batman, Ass. Prof. Orthopedic Surgery, Indiana U
		Dr. J. W. Littler, Prof. Hand Surgery, Columbia
		Dr. H. Alvin Jones, Visiting Surgeon, Johns Hopkins
Pediatrics		*Current Trends in Pediatrics*
		Dr. R. Mercer, Pediatrician-in-Chief, Cleveland Clinic
Ob-Gyn		*Vaginal Discharge & Vaginitis, Panel Discussion*
	(M)	Dr. Allan Barnes, Prof. of Ob-Gyn, Western Reserve U
		Dr. A. E. Rakoff, Ass. Prof. of Gyn, Jefferson
		Dr. P. R. Zeit, Ass. in Gyn, Western Reserve U
11:10-12:30		*Jaundice, Panel Discussion*
Medical &	(M)	Dr. Ralph F. Bowers, Memphis
Surgical		Dr. Argyle Beams, Clinical Prof. of Medicine, Western Reserve U
		Dr. A. Cantarow, Jefferson
		Dr. J. E. Dunphy, Prof. of Surgery, Harvard
Pediatrics		*Pediatric Emergency Surgery, Panel Discussion*
	(M)	Dr. E. Gerich, Asst. Prof. of Pediatrics, Western Reserve U
		Dr. E. A. Mortimer, Asst. Prof. of Pediatrics, Western Reserve U
		Dr. Foldes, Ass. Prof. of Anesthesia, Pittsburgh
Ob-Gyn		*Pelvic Carcinoma, Panel Discussion*
	(M)	Dr. A. Barnes, Western Reserve U
		Dr. A. Rakoff, Jefferson
		Dr. P. R. Zeit, Western Reserve U

11:10-12:30		*Fracture Panel*
Orthopedic	(M)	Dr. Gordon W. Batman, Indiana U
		Dr. H. Alvin Jones, Johns Hopkins
12:30-2:00		LUNCHEON
1:15-1:45		*PR Panel*
		Leo Brown, Public Relations, A.M.A.
1:45-2:00		Surgery Cineclinic
2:00-2:45		*Rehabilitation of the Hand*
		Dr. J. W. Littler, Columbia
2:00-2:45		*Diagnosis and Management of Severe Anemia*
		Dr. Richard W. Vilter, Ass. Prof. of Medicine, U of Cincy
2:00-3:30		*Geriatric Surgery (Carcinoma in Aged), Panel Discussion*
	(M)	Dr. J. E. Dunphy, Prof. of Surgery, Harvard
		Dr. Ralph F. Bowers, Memphis
		Dr. Foldes, Pittsburgh
Pediatrics		*Collagen Diseases, Panel Discussion*
	(M)	Dr. E. A. Mortimer, Western Reserve U
		Dr. Haserick, Ass. Dermatologist, Cleveland Clinic
		Dr. E. Gall, Prof. of Pathology, U of Cincy
Ob-Gyn		*Obstetricians Contribution to Fetal Salvage*
	(M)	Dr. A. Barnes, Western Reserve U
		Dr. R. A. Hingson, Prof. of Anesthesia, Western Reserve U
		Dr. R. Mercer, Cleveland Clinic
2:50-3:45		*Non-TB Lesions of Chest*
Medical	(M)	Dr. Van Ordstrand, Chief, Section Chest Disease, Cleveland Clinic
		Dr. Julian Johnson, Clinical Prof. of Surgery, U of Penna.
		Dr. R. N. Westcott, Charge of Respiratory Function, Cleveland Clinic
3:30-4:00		Exhibits
4:00-5:15		*Clinical Pathological Conference*
	(M)	Dr. E. Gall
		Dr. R. F. Bowers
		Dr. J. Johnson
		Dr. R. W. Vilter
		Dr. J. E. Dunphy
5:30-6:30		Reception with the Auxiliary
6:45		BANQUET
		Speaker: Dr. Wm. Alexander, Lecturer — Gen. Motors Oklahoma City, Okla.

REGISTRATION $8.00 INCLUDING LUNCHEON AND BANQUET

• PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN •

Cardiac Asthma

The word asthma was first used by Hippocrates to denote "hurried breathing," and for some time it was considered synonymous with shortness of breath. In 1819 Laennec, the discoverer of auscultation, originated the concept that asthma is distinct from shortness of breath and represents a definite entity characterized by paroxysmal dyspnea without demonstrable associated organic lesions. In 1832, however, Hope called attention to the fact that there are several varieties of asthma, of which organic disease of the heart constitutes one, and that in all instances bronchospasm exists. He recognized the difficulty of distinguishing the asthma produced by disease of the lungs from that due to heart ailments and coined the term cardiac asthma for the latter. Subsequently, cardiac asthma became known as a distinct clinical state. In 1897 Osler described this syndrome so clearly that to date all writers on the subject quote him verbatim.

—Maxwell Gelfand, M.D., International Record of Medicine and General Practice Clinics, October 1953

Sex Education Pamphlets Available Soon

A new series of sex education pamphlets is in the final production stages by the Joint Committee on Health Problems in Education of the National Education Association and the A.M.A. Designed primarily for parents, teachers and youth leaders, some of the pamphlets also are suitable for youngsters, and doctors may want to include them in patient education programs.

The five booklets are: (1) "Parents Privilege"—for parents of pre-school and early school age children; (2) "A Story About You"—for children, ages nine to 12; (3) "Finding Yourself"—for boys and girls, ages 12-15; (4) "Learning About Love"—for both sexes, ages 16-20, and (5) "Facts Aren't Enough" —for adults who have responsibility for children or youths which may create a need for an understanding of sex education.

The booklets are scheduled for release about May 15 and may be obtained from either A.M.A.'s Order Department or the NEA headquarters in Washington, D. C. Prices available on request. The Joint Committee is composed of five physicians and five educators representing the sponsoring organizations.

What Is A Virus?

Asking "What is a Virus?" Dr. K. M. Smith, F.R.S., begins by outlining 2 theories *(Nature, 1955, 175: 12)*. First, they may be parasitic organisms that have developed their parasitism to the highest possible degree. Alternatively, viruses, or at least some of them, may have no external origin; they may be derived from the cell proteins of one organism and become viruses only when introduced into the cells of another organism. Some support for this 2nd theory may be obtained from a study of certain plant viruses. The potato King Edward, Dr. Smith points out, is invariably infected with a virus, yet the infection is entirely symptomless. The virus can be detected by transferring the sap to other plants, when they show signs of virus infection. Such a wholly latent virus which causes no symptoms at all in its normal host, Dr. Smith compares with the partially latent virus of herpes simplex, which causes symptoms only when activated by some stimulus, emotional or infective, as during an attack of the common cold. Dr. Smith also discusses the use of viruses to exterminate insect pests, a method already used with some success in Canada and the U.S.A.

British Medical Journal, January 1955

Fiske Fund Prize Dissertation

1955

The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following subject for the Prize Dissertation of 1955:

"Use of Radio-Active Isotope in the Treatment and Investigation of Disease"

For the best dissertation on this subject worthy of a premium they offer the sum of three hundred fifty dollars ($350.00). The dissertation will be particularly graded on the basis of original work by the author. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the Trustees on or before the second day of February, 1956, free of all expense, a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto, inscribed on the outside, with his name and address within.

Previously to receiving the premium awarded, the author of the successful dissertation must transfer to the Trustees all his right, title and interest in and to the same, for the use, benefit, and advantage of the Fiske Fund.

Dissertations, other than the successful one, will be returned to the authors.

The dissertations must be typewritten, double spaced on standard typewriter paper, and should not exceed 10,000 words.

SECRETARY to the TRUSTEES
John E. Farrell, Sc.D.
106 Francis Street
Providence 3, Rhode Island

Frank B. Cutts, M.D.
John G. Walsh, M.D.
Charles L. Farrell, M.D.
TRUSTEES

PROCEEDINGS OF COUNCIL
September 12, 1955

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at 9:00 P.M. on Monday, September 12, 1955 at the offices of Dr. M. W. Neidus, 318 Fifth Ave., Youngstown, Ohio.

The following doctors were present: I. C. Smith, president, presiding, G. E. DeCicco, J. D. Brown, A. A. Detesco, W. M. Skipp, F. G. Schlecht, A. K. Phillips, M. W. Neidus, Robt. Tornello, S. W. Ondash, C. A. Gustafson and A. Randell.

Council discussed the 6th District Post-graduate meeting to be held in Warren, Ohio, October 26, 1955. Last year there were 640 in attendance. Through the efforts of the Membership and Attendance Committee we hope to have a good representation from our Society at Warren this year.

Council discussed the United Cerebral Palsey Association drive that is now getting underway.

The following applications were read:

Active Membership

Chas. N. Giering, 402 Oak Hill Ave., Youngstown, Ohio

Jr. Active Membership

Dr. H. L. Allen, S. S. Hospital, Youngstown, Ohio
Jas. W. Barnes, 2724 Mahoning Ave., Youngstown, Ohio
D. B. Brown, 407 Home Sav. & Loan Bldg., Youngstown, Ohio
Alex. Calder, 1612 Mahoning Ave., Youngstown, Ohio
L. P. Caccamo, 419 Catalina Ave., Youngstown, Ohio
D. J. Cox, S. S. Hospital, Youngstown, Ohio
G. H. Davies, Sebring, Ohio
G. B. McAleese, 701 Home Sav. & Loan Bldg., Youngstown, Ohio
G. B. Pugh, 707 Dollar Bank Bldg., Youngstown, Ohio
J. Schreiber, 312 Home Sav. & Loan Bldg., Youngstown, Ohio

Associate Membership

R. E. Carr, 243 Lincoln Ave., Youngstown, Ohio
R. D. Murray, 220 Lincoln Ave., Youngstown, Ohio
N. E. Sharrer, 2218 Market St., Youngstown, Ohio

Interne

John Burke, St. Elizabeth Hospital, Youngstown, Ohio
Jas. Medley, St. Elizabeth Hospital, Youngstown, Ohio
R. J. Paul, Youngstown Hospital, Youngstown, Ohio
K. H. White, Jr., Youngstown Hospital, Youngstown, Ohio

A. A. Detesco, M.D.
Secretary

If no objection is filed with the secretary in writing within 15 days, the above become members of the society.

The earliest written references to the physician are the hieroglyphs "SWN," represented by an arrow having a broken shaft. When translated, these also indicate the word for wisdom or knowledge. Apparently the Egyptian word for arrow was phonetically nearest that for physician, and such meaning was retained by this word; for later the Ionian word for physician, which Homer used in the *Iliad* (written about 850 B.C.), originally meant an extractor of arrows. The word for medicine is derived from the hieroglyphs "MEDH," which mean "to be wise" or "a doctor for the teacher."

—J. L. Schwartz

I Am a Newspaperman—But if I Were a Doctor*

If I were a doctor, I'd be concerned about the fact that no profession has lost as much prestige in recent years as my own.

I'd concede—as a doctor friend of mine told me recently—that "My patients still seem to love me, but they certainly don't love my profession."

I'd realize that medicine is in danger of degenerating into a bureaucratic State service in my country as it has done in others, if I don't help to alert the public to the evils of such a system.

I'd ask myself what's happened to the old, intimate doctor-patient relationship, and why so many of the young fellows shun the hard road of the honored old G. P. in favor of the plush salons of the society doctor and the specialist.

I'd admit that some of my colleagues have grown too worldly; that too many are thinking in terms of Cadillacs, Chris-Crafts, and Cointreau rather than carcinomas, cataracts, and chicken pox.

I'd recognize that I'm not a businessman, but a community servant; and that Dr. Norman Bethune was right when he said the term "public health" was redundant: *all* health is public.

I'd remember that the little old lady I wheeled into the operating room was not a "case" but a patient; that the black bag I carry with me is a case.

I'd recall that the true definition of profession is "a willingness to serve" and that I should be humble before the axiom that "in no other act does man approach so near the gods as when he is restoring the sick to the blessing of health."

And having thought deeply about these things, I would resolve:

That in future I would bear in mind Sir William Osler's injunction to ask myself not only "What kind of sickness has this man?" but "What kind of *man* has this sickness?"

I Am a Doctor—But If I Were a Newspaperman*

If I were a newspaper man . . . I would try to keep it forever in mind that I am dealing with one of the most powerful forces known to mankind, that I have a singular opportunity to influence public opinion, to create goodwill or bad, to elevate or depress the moral tone of the community, and to promote world understanding and peace.

I would try to produce the perfect newspaper, knowing well that the wants and demands of my readers would have some bearing on my achievement of that Utopian goal. The measuring stick of a newspaper's success is it circulation, we are told. I would reexamine that belief. For can it be fairly argued that the newspapers with the largest circulation are the best and those with the fewest readers the poorest? I do not think so.

If I were a newspaper publisher, here is the creed I would hang over my desk as a guide for me and all my associates in the conduct of my paper:

1. *I shall print all the news that is fit to print.* But I reserve the right to determine what is news, what useful purpose can be served by its publication, its relative importance to other news, and its possible effect upon my readers.

No flaming front-page headlines garnished with sordid details shall be used to report a murder, or a sex crime, or somebody's malfeasance. Deviations of personal behavior, in their important aspects, shall be told without resort to sensationalism and repulsive details. I shall never inflame or offend the sensibilities of readers I hope to reach.

2. *I shall not stir up strife* frivolously or mischievously. I shall try to remember the ease with which a well-conducted propaganda campaign in the press can influence the emotions of the readers and the Goebbels dictum that a story repeated suffici-

That, when I was called at 3 a.m., I would refrain from mumbling into the telephone, "Give her a sedative—I'll see her in the morning." I'd get dressed and see what I could do to help.

That I would never, never, never, stand at the foot of a patient's bed, whispering to my colleague while casting dark glances at the sick; that my approach to him would always be cheerful, honest, and as gentle as medical candor permits.

That I would try to keep pace with new techniques and new research by attending at least one convention a year, or visiting a metropolitan hospital for postgraduate study when I felt myself getting insular or "rusty."

That I would hire the smartest nurse available to restore some routine to the chaos of my waiting room, so that each patient is examined and none left waiting when I go home.

That my fee would be determined not by my estimate of *his* ability to pay but by *my* ability, period.

That I have responsibilities as a citizen as well as a doctor; that I could make a worth-while contribution to Community Chest, to Rotary, to the Symphony Society, or to politics.

That I owe it to my family, my patients, and my profession to keep in good health; and that I could best restore my perspective by scheduling myself a certain number of hours each week for golf, fishing, gardening, or reading.

And finally, to underline the aphorism "Physician, heal thyself," I'd hang on my office wall, where I could read it every day, the ancient Oath of Hippcorates:

I do solemnly swear by that which I hold most sacred:

That I will be loyal to the profession of medicine and just and generous to its members;

That I will lead my life and practice my art in uprightness and honor;

That into whatsoever house I shall enter it shall be for the good of the ently often and with sufficient effrontery ends by being believed by man. I shall therefore try to be objective in reporting news and resist the tendency to emotional interpretation of events.

3. *I shall try to be tolerant* in the firm belief that St. Paul's citation of the greatest of the virtues is true. I shall try to show my readers why people are behaving as they are rather than abuse them.

4. *I shall try to keep this newspaper free from the shackles of a political party.* I have a political creed, but I shall never identify it publicly with that of a party. To do so could be to bring me and this paper under party discipline and subject it to the vicissitudes of party strategy and tactics. I thus reserve the right to criticize or to approve party measures.

5. *I shall let no advertiser compromise my honesty.* I welcome advertising. I count most of it truthful and its presentation in my pages a service to the reader. Yet I reserve the right to express disapproval of any commodity advertised if in my opinion the public will be thus best served.

6. *I shall try to maintain a sense of fairness and the application of the Golden Rule in every reference to people appearing in my columns.* This paper shall never subject any individual to vilification and abuse. It shall expose villainy and evil where they exist, and it shall always deal with the good citizen as we would have him deal with us.

7. *I shall try always to make this newspaper speak plain English.* Obscure or slovenly writing is an act of discourtesy to the reader. Windy nonsense is a cloak under which a dishonest man may conceal the truth from his readers. I shall not tolerate any departure from the rule that writers for this paper shall say what they mean, and say it simply, clearly, unpedantically, without ambiguity.

sick to the utmost of my power, I holding myself aloof from wrong, from corruption, and from the temptation of others to vice;

That I will exercise my art solely for the cure of my patients, and will give no drug, perform no operation for a criminal purpose, even if solicited, far less suggest it.

That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken, I will keep unviolably secret.

These things I do promise, and in proportion as I am faithful to this my oath may happiness and good repute be ever mine—the opposite if I shall be forsworn.

In short, I would recognize—as a wise old doctor once observed—that the best public relations of all is to do good and be good!

*Stuart Keatte***

*Reprinted from the Rotarian, April 1955, with permission of the editor.

**Publisher of the Victoria, B. C. Daily Times.

8. *I shall constantly strive to operate this newspaper on the principles of the Rotary mottoes: "Service above Self—He Profits Most Who Serves Best."* I shall undertake most diligently to follow my creed, working to raise the standard of public thinking, and hoping meanwhile that the southeast corner of my balance sheet will show a profit.

I am not a newspaperman and never will be. Yet this brief excursion into the world of the newsman confirms my long belief that the newspaper profession is a truly great one. I would therefore leave the fraternity, which by and large is striving to make its contribution to world enlightenment in a spirit of wholesome cooperation with its fellowship, with my sincere and respectful compliments.

*T. Clarence Routley, M.D.***

*Reprinted from the Rotarian, April 1955, with permission of the editor.

**President-elect, British Medical Association and the Canadian Medical Association.

WHAT'S NEW THIS MONTH

Dr. Henri Schmid attended the 24th Annual Venereal Disease Conference, September 26 to 30 at Chicago. The meeting was presented through the cooperation of the U. S. Public Health Service and sponsored by the School of Medicine of the University of Chicago.

39 States Ready For 'Waiver of Premium' Program

A total of 39 states, plus the District of Columbia, Hawaii, and Puerto Rico, have entered into agreements with the U. S. Department of Health, Education, and Welfare to carry out the "disability freeze" program of the social security act. Under this plan, enacted last year, the pension a disabled worker would receive at age 65 is "frozen" or not reduced because of the years he is unemployed. Most states have selected their vocational rehabilitation agencies to operate this program. State officials are in immediate charge of administering the program, but subject to federal review and investigation.

The same machinery being used for administering medical examinations under the new "disability freeze" law will be used to handle the compulsory disability insurance program if that plan is enacted next year. Under the proposed legislation the disabled worker would get his pension at age 50, rather than waiting until age 65. Federal disability insurance is opposed by the A.M.A. because (a) machinery at the federal level to supervise the certification of disability would project the government into the medical practice picture, (b) cash disability benefits would be a threat to the rehabilitation program, and (c) physicians would be under pressure from patients to make certifications of disability.

IS APPENDICITIS STILL DANGEROUS?

The death rate from appendicitis in 1952 was one-seventh what it had been in 1900.[1,2] This drop looks like, and is, a considerable accomplishment. However, analysis of the data raises the question as to whether the mortality is still higher than need be.

Curiously, from 1900 to 1930, the incidence of deaths from appendicitis in this country increased from 9.7 to 15.3 per 100,000. Some of this apparent increase was undoubtedly due to greater awareness of the disease and more complete reporting. By 1940, the mortality rate had again declined to 9.8. This decline was slow but steady. It was variously attributed to better post-operative care, public education (to seek early care and avoid cathartics), and the use of sulfonamides. After 1940, the figure dropped precipitously. In 1951, it was 1.7 per 100,000, and a repetition of this figure in 1952 lent credence to the belief that the irreducible minimum had been reached.[1,2] Anti-infective agents seemed to account for the achievement.

Although the dramatic change in outlook made appendicitis appear relatively innocuous, the fact is that 2,600 persons died in 1952 from this cause. Thus, each week, fifty persons lost their lives from a disease considered to have a specific remedy. From this standpoint, a search for the explanation seems worth while. An inquiry into the mortality by age groups is pertinent, and a look at the frequency of specific complications may focus attention upon a few that are particularly dangerous.

The difficulties of diagnosis in the very young and the very old are well known. At both extremes of life, patients can be expected to present atypical signs and symptoms that often mask the underlying pathology.

That appendicitis in childhood should carry an inordinately high risk is not difficult to understand. Frequently these patients can give little or no history, and suitable treatment may be delayed—particularly if no vomiting occurs. Purgation is common and the incidence of peritonitis high. In a series of sixty-nine patients less than five years of age, for example, peritonitis (local or diffuse) was observed at operation in forty-one (60 percent).[3] The frequent occurrence of generalized peritonitis in young children is believed to be enhanced by their incompletely developed omentum. Although the total white blood count is a definite aid in patients over four years of age, it fails as a diagnostic sign in younger children, who have higher normal white blood counts and may not respond to infection in the characteristic manner. Also, the presence of diarrhea is sometimes mistakenly thought to rule out appendicitis, and the differential diagnosis between appendicitis and pneumonia or right-sided pyelitis may require precious hours. To complicate matters further, two diseases do sometimes coexist. Boyce reminds us that "the child with pneumonia is likely to sleep for long periods, while the child with acute appendicitis does not sleep himself or let anybody else sleep."[4]

Variations from a classical disease picture are also common among older people, and the absence of the typical symptoms and signs of appendicitis in the elderly patient results in a high mortality rate. Fifty-six persons of the seventy-seven who died of appendicitis in Indiana in 1953 were over forty years of age.[5] In this age group, the incidence of gross perforation of the appendix has been variously estimated at 54 to 77 percent and that of fatalities at 4.5 to 12 percent of the total number of cases.[4,6] According to the 1952 Bureau of the Census tabulations, more than 1,500 of the 2,600 deaths from appendicitis were in persons over fifty-four years of age.[1]

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The onset of this disease in the aged is likely to be insidious, and the patient may fail to seek help promptly, sometimes because of fear and sometimes because he is used to discomfort. He may appear to have a chronic illness with presenting complaints of vague abdominal distress and often diarrhea. Furthermore, an unimpressive sequence of events which lack the note of urgency of the same disease earlier in life can lull both patient and physician into a false sense of security during the critical time for decisions.

Physical findings may be minimal or even absent in the aged. Obesity and poor muscular tone of the abdominal wall lead to the absence of rigidity over inflamed tissues. Occasionally, abdominal distention or a mass in the lower right quadrant may be noted. However, signs of chronic degenerative disease can easily divert attention to unrelated or coincidental illness. Nevertheless, Wolff and Hindman[6] find that pain and localized tenderness upon rectal examination are still fairly consistent positive features in older patients.

It is generally agreed that once a diagnosis of acute appendicitis is made, operation should follow immediately unless major contraindications (such as cardiac decompensation, diabetic acidosis, or shock) take precedence.[7] Then the delay should be only long enough to prepare the patient for surgery. Since operative technic is well developed and rather standardized, further refinements can hardly be expected to decrease the higher mortality associated with aging. Naturally, the complicated cases require different management from those with simple acute appendicitis. The modern trend seems to be away from expectant treatment and toward prompt surgery, the use of anti-infective agents, and carefully regulated fluid and electrolyte balance. Specific surgical approaches to problems of abscess formation and intestinal obstruction may prove helpful.[8]

Several investigators have pointed out the decline in mortality from appendicitis that has followed the introduction of the anti-infective agents.[3 9-11] However, persons in different age groups and with different types of pathology have not benefited equally. Although appendectomy for simple acute appendicitis is now attended by the lowest possible risk (about 0.3 percent mortality), Boyce found that patients over forty years of age (12 percent died) made up only 13 percent of his cases but contributed 35 percent of the total deaths in his series.[4]

When cases are divided into those with simple acute appendicitis, those with local peritonitis or abscess or both, and those with diffuse peritonitis (Table 1), the over-sixty-year age group is seen to show a high frequency of complications. In recent years, a substantial decrease of fatalities in cases complicated by local or diffuse peritonitis has been observed.[3 9 10 12] When abscess formation occurs, the evidence for an improving outlook is less clear-cut.[10]

A remarkable decline in the over-all rate of mortality from acute appendicitis has occurred coincidently with the introduction of anti-infective agents. Nevertheless, the atypical response to disease in young children and in older people together with an increasing incidence of degenerative diseases as the average span of life lengthens makes the diagnosis and treatment of appendicitis a continual challenge.

TABLE 1

Types of pathology found at operation for appendicitis, in percentage of totals

	CHILDREN UNDER 5 YEARS[3]	CHILDREN UNDER 16 YEARS[3 13]	ADULTS 20 TO 40 YEARS[6]	ADULTS OVER 60 YEARS[6]
Simple acute appendicitis	40%	59%	76%	42%
Abscess and/or local peritonitis	45	33	21	42
Diffuse peritonitis	15	8	3	16
Total number of cases	69	1,118	274	88

GOLF . . . is the Great Mystery. Like some capricious goddess, it bestows its favours with what would appear an almost fat-headed lack of method and discrimination. On every side we see big two-fisted he-men floundering round in three figures, stopping every few minutes to let through little shrimps with knock knees and hollow cheeks, who are tearing off snappy seventy-fours. Giants of finance have to accept a stroke per from their junior clerks. Men capable of governing empires fail to control a small, white ball, which presents no difficulties whatever to others with one ounce more brain than a cuckoo-clock. Mysterious, but there it is.

—*P. G. Wodehouse*

The Rectal Examination

Since the majority of malignancies of the intestinal tract are within reach of an examining finger, and since the necessity for doing digital examination of the rectum has been emphasized so strongly, it is rather surprising to find so many rectal lesions being missed. It then becomes apparent that while emphasis on the digital examination has been made, the method of doing it properly has been neglected, since the surgeons see so many late cases of CA of the rectum.

It is important to put an examining finger in the rectum intelligently and seriously and remember, at all times, that the pathology of the rectum is attached to the rectal wall. Therefore, if you put your finger in the lumen of the rectum and wave it around, you will miss pathology. It is important to sweep the finger against the lining of the rectum. It is good procedure, during digital examination, to have the patient strain to bring down any tumors or polyps which otherwise might be beyond the tip of the examining finger.

The most important features of the anoscopic examination is to (1) have an anoscope; (2) use an anoscope. Hermorrhoids are not diagnosed by the examining finger but by visual inspection, using the anoscope when necessary. Because of the collapsible nature of most hemorrhoids it is easy to miss them on digital examination whereas if an anoscope is used, gradual withdrawal and rotation of the anoscope will result in the hemorrhoids appearing in it. Gauze on the examining finger, slowly withdrawn, will assist the demonstration of hemorrhoids.

I have made it a policy to examine, for occult blood, stool of all patients at the time I do a rectal examination. The examining finger is withdrawn and the amount of feces on the glove is sufficient to perform this test. It is simple and accurate and, in some cases, may enable the examining physician to make an early diagnosis of cancer or bleeding from the G.I. tract.

The test is sensitive when bleeding is present but false positives may occur when meats or soups containing red cells have been ingested. Recto-vaginal examination, if desired, should be performed first.

Edwin Matlin, M.D.

If you want to be a self-made man, don't leave out any of the working parts.

AN EPITOME OF EPONYMS

Here is an opportunity for refreshing (and frustrating) relaxation.

Can you define the following, sometimes and unfortunately known by the name of an early describer?

(We, too, deplore the use of eponyms to describe medical entities; but we fear that, for the present, they are very much with us.)

A score of 60 percent makes you erudite.

what is . . .

TAKATA-ARA TEST?

TALLQVIST'S SCALE?

TAY-SACHS DISEASE?

THEBESIAN VEINS?

THOMAS SPLINT?

TISELIUS APPARATUS?

TOPFER'S REAGENT?

TRAUBE'S SEMILUNAR SPACE?

TREITZ, LIGAMENT OF?

TRENDELENBURG TEST?

(Answers on next page)

ANSWERS TO EPONYMS

TAKATA-ARA TEST: A test of hepatic function based on an elevated serum globulin and devised by two Japanese pathologists, Maki Takata and Kiyoshi Ara.

TALLQVIST'S SCALE: The widely used but crude color-comparison scale for hemoglobin determination devised by the Finnish doctor Theodor W. Tallqvist.

TAY-SACHS DISEASE: The English physician Warren Ta yand the American neurologist Bernard Sachs helped to clarify the rare amaurotic familial idiocy.

THEBESIAN VEINS: About 250 years ago, Adam Christian Thebesius described the small intramyocardial vessels which open directly into the heart chambers.

THOMAS SPLINT: One of the great British orthopedists, Hugh Owen Thomas (1834-1891), invented the popular iron splint used in various fractures of the lower extremity.

TISELIUS APPARATUS: The contemporary Swedish chemist Arne Tiselius greatly advanced biochemical research by his electrophoretic method for the separation of proteins.

TOPFER'S REAGENT: An alcoholic solution of an indicator which provides a simple means of testing for the presence of free hydrochloric acid in gastric contents, first used by Alfred Edouard Topfer.

TRAUBE'S SEMILUNAR SPACE: Ludwig Traube, a nineteenth-century German physician, described an area overlying the air bubble of the stomach over which a tympanic sound is heard on percussion.

TREITZ, LIGAMENT OF: A fold of peritoneum extending from the duodenojejunal junction to the left crus of the diaphragm was described by Wenzel Treitz, of Austria, about one hundred years ago.

TRENDELENBURG TEST: A simple procedure for testing the competency of the saphenous and communicating veins was devised by the German surgeon Friedrich Trendelenburg about sixty years ago.

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POLY-VI-SOL 6 Essential Vitamins					6	0.8	1	50	1000	5000
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