BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

JULY • 1956
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Youngstown • Ohio

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ADVERTISERS' LIST

Our President Speaks

For many, many times we as physicians are confronted with a most difficult problem. In Medical Diagnosis have we the right as physicians to withhold the truth from our patients?" Do we have an obligation to tell the truth? Disraeli once said, "a gentleman is one who knows when to tell the truth and when not to." Can we be "gentlemen" and still meet our obligations to our patients?

Sometimes the results of our discoveries about the physical conditions of our patients are very discouraging. As gentlemen we dislike to upset our patients feelings. In some cases it is cruel and even harmful to tell the truth. However if the patient is not told the truth about a serious condition he may be deprived of his God given responsibility and moral status. Have we a right to so deceive our patients about their condition that they slip out of life without realizing that they are dying?

I have in mind two patients with fatal diseases. Both asked to be told the entire truth, one had carcinoma of the sigmoid the other aplastic anaemia. Both have been told and both are living to the fullest and doing their daily tasks with all possible vigor. I have also seen patients with mild, non-disabling heart disease who have "given up" because they knew they had heart trouble.

I do not propose to say that all patients should be told the truth neither do I say that we should always withold the truth. Each patient is a different individual and presents a different problem and should be treated accordingly. Osler once said "We should treat the patient and not the disease." This problem does not have an easy solution, in many cases the solution may be a "white-lie" in the others the truth. As mortals it is a difficult decision for us to make and we must ask for divine guidance.

G. E. DeCicco, M.D.

BULLETIN of the Mahoning County Medical Society

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WOMAN'S AUXILIARY NEWS

Although the regular monthly meetings of the Women's Auxiliary to the Mahoning County Medical Society end with the annual dinner meeting in May, certain committees of the Auxiliary continue to function throughout the summer. One of these committees is Radio and Visual Education, headed by its chairman, Mrs. Edward A. Shorten, and her co-chairman, Mrs. C. W. Stertzbach.

This committee arranges for representatives of the Mahoning County Medical Society to speak on various subjects every Friday on the Adelaide Snyder Show. However, on a recent program, Mrs. W. H. Evans, State president of the Women's Auxiliary to the Ohio State Medical Association was interviewed, and presented some interesting facts about the Medical Auxiliaries throughout the nation.

The organization has branches in all forty-eight states, and also in Alaska, Hawaii, and Puerto Rico.

National membership totals 70,416, while the membership in Ohio includes 4,814. There are 208 members in Mahoning County.

The purpose of these Auxiliaries is to promote active leadership in community health, in service and in health projects.

To accomplish these aims, the Auxiliaries promote the sale of *Today's Health*, provide scholarships for nurses, raise money for the American Medical Education Fundation, and grant aid to graduate nurses who wish to take post-graduate work in the field of nursing-education.

Other activities in which members of the local Auxiliary participate are the drives for Cancer, Diabetes, Heart, and Polio. Included also in their program are meetings devoted to Civil Defense, Mental Health, Legislation and Public Relations.

—MRS. SAM SCHWEBEL

THE COUNCILOR'S PAGE

Your Council met at OSMA headquarters office, Columbus, on June 2 and 3. Your next issue of the Journal will tell you what we did. Be sure to read it.

The membership of OSMA, as of June 1, is 8478 and the number of OSMA members of affiliated with AMA is 7489. So you can see that there are 1000 of our members who have not joined the AMA. The AMA is our organization; let's sell it to our fellows. A strong AMA is our only hope for survival in this highly organized age.

Did you like our state meeting at Cleveland? Do you want anything changed for next year? This meeting is for you. We try to give what the membership wants. Won't you sit down *now* and drop "Chuck" Nelson a line? If you liked the program tell him so. If you want something different for next year, or if you have a suggestion jot it down and send it to headquarters. This is important. Plans are in the making now for the 1957 meeting which will be held in Columbus on May 14, 15, 16.

At the Cleveland meeting, we had more resolutions submitted than ever before. There was not enough time to adequately study and consider them. We didn't get through until 6:30 of the last day. By that time many of the delegates had gone home. We suggest that whenever possible, these resolutions be submitted to Council and not to the House of Delegates. The Council can then give adequate time and thought to these Resolutions and if necessary, refer them to the proper committees. These committees then, after due consideration, refer them back to Council. The Council can, if necessary, bring the resolutions with all the pros and cons before the House of Delegates. This is not in any way intended to take away any jurisdiction or authority from the House of Delegates, but is intended to submit the resolution with thorough study and suggestions. As it works out now, several resolutions were submitted to Council after discussion in the House of Delegates. The course should be reversed.

Only eight counties have sent in reports on mal-practice suits. This is not a very good response. You should send in a report whether or not there has been a mal-practice suit filed in your county. This is our only way of knowing that you are on the job and reading the legal news. Let's have a hundred per cent response. It is an important job.

As you all know, more polio vaccine is available now. If you have too much make it available to another doctor. Don't let it pass the expiration date unused in your possession. You will be advised of new regulations very soon. At this writing it may be given to children 1 to 15 years of age and to pregnant women.

A hearing on proposed changes in regulations governing maternity hospitals is scheduled for June 23, at Columbus. This is important. Your president, chairman of Maternal Health and your hospital has been given a complete copy of the proposed changes. If you are interested in Maternal Health ask to see a copy and after careful study, give your representative your opinions. Then see that he attends the hearing and presents your views.

The next meeting of your council will be held in Granville on September 14, 15 and 16.

The following articles by McDermitt in the Plain Dealer, bring forcibly to our attention one of the gross iniquities in income taxes of professional men, as compared with business men.

I quote: "A high school student graduating in June enters medical school

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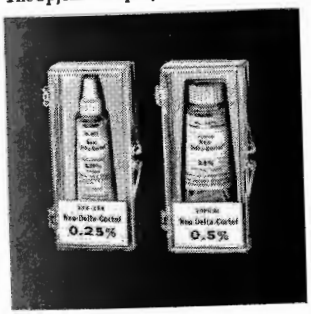


FROM THE BULLETIN

Twenty Years Ago — July, 1936

The pattern of a doctor's personal, professional and public life twenty years ago was much the same as it is now. There were no Society meetings those hot summer months but many other activities of a lighter nature enlivened the humdrum of the daily grind. Golf days, picnics, vacations, class reunions and visits to medical centers gave recreation to mind and body. New internes fresh from the frenzy of commencement exercises poured into the hospitals creating chaos for the first month. Last years internes and residents hopefully signed notes for new equipment and opened offices partially stocked with generous though involuntary donations from the hospitals they served and with samples from the drug house.

Night calls were promptly and gratefully answered by those eager young men not yet disillusioned by the inveterate dead beats, the alcoholics and the dope addicts. There was some difference in the diseases they met and they way they were treated. Instead of penicillin, diphtheria antitoxin and culture tubes were kept in readiness. Every GP carried an obstetrics bag in his car, stocked with forceps, cord ties and fluidextract of ergot for home deliveries. Hospitalization insurance was unknown and surgical benefits unheard of. Hospitals were for the desperately ill, the seriously injured and the abnormal parturient. Most hospitalized patients were cared for in open wards lined with rows of white iron beds around which screens were laboriously rolled for bedpan activities, intimate examinations and last rites.

In the Youngstown Hospital, John Renner and John Rogers stayed on as residents. New interns were Barclay Brandmiller and Gabriel DeCicco from Jefferson Medical College, Rollis Miller from Western Reserve and Milton Yarmy from Wayne University. At St. Elizabeth's Dr. Murrill Szucs was appointed medical resident and James K. Herald surgical resident. Dr. Michael Sunday, Stephen Ondash and Andanto D'Amore were new interns. S. D. Goldberg, J. J. Wasilko and L. S. Shensa finished their interneships and opened offices for private practice.

Dr. J. B. Kupec, R. W. Rummell, E. J. Wenaas and V. A. Neel became new members of the Society. Council met and heard a report from E. J. Reilly that the Mahoning County Relief had paid the doctors $2,516.75 for treating 4,102 indigent patients in May. President Coe and M. J. Kocialek of the attendance committee were worried about the attendance at the meetings.

Ten Years Ago — July 1946

Life for the doctors, at least for the returned veterans, was pretty confusing ten years ago. All of them who wished to or were able to, had come home by then although the Bulletin was still printing a list of returned veterans and their service records. Back from the routine of military life they were trying to catch up with the changes in civil practice and get adjusted to the competition, the unusual demands on time and energy and the new interests of the post-war social scene.

There were new faces, new names and new drugs to learn and remember. Hospitals had blood banks which made transfusions much simpler, but getting patients admitted was not so simple and they learned about waiting lists. Every doctor's mail was flooded with brochures on new drugs with fancy names with which everyone else seemed to be familiar.

(Continued on Page 285)

KEEPING UP WITH THE A.M.A.

(C. A. GUSTAFSON, M.D.)

(I plan to attend the House of Delegates of the A.M.A. at Chicago next week. In the next issue of the Bulletin I shall give you the high-lights of this meeting).

The new military dependent medical care program sets up the financial machinery for furnishing private medical care to hundreds of thousands of wives and children of servicemen. Naturally there will be a concentration of these families around the big military posts where generally there are large military medical facilities. But many thousands of others will be found scattered throughout the country, separated from the serviceman because he is overseas, because housing is unavailable near his post, or for other reasons.

The Defense Department, which has asked the views of the American Medical Association and of other medical, hospital and insurance organizations, now is attempting to draft regulations to implement the new law. The task will take weeks and perhaps months. The main problem facing the Department of Defense is that of choosing a workable method of contracting for private medical and hospital care. There are several possibilities: Blue Cross, Blue Shield, arrangements with state medical societies, commercial insurance or home town care with the government paying according to fee schedules.

The new military dependent medical care plan — awaiting only the President's signature to become law — makes medical care a statutory right, defines dependents, and provides uniform benefits for Army, Navy, Air Force, Marine Corps, Cost Guard, and Commissioned Corps of Coast and Geodetic Survey and U. S. Public Health Service. This protection for dependents is designed to make military careers more attractive and thus help to reduce personnel turnover.

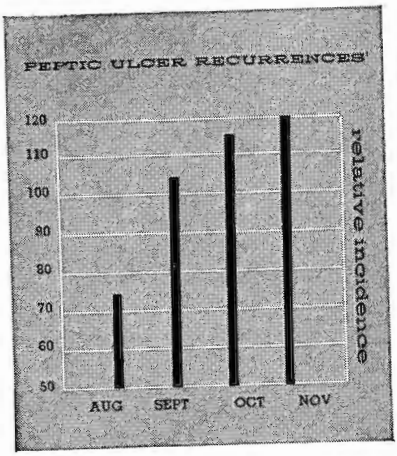
ALL DEPENDENTS may be treated in military facilities "subject to availability of space, facilities, and capabilities of staff," with the medical officer in charge making the conclusive determination as to whether the particular facility is able to handle the particular dependent.

ONLY SPOUSES AND CHILDREN of active duty personnel are eligible for medical care from private physicians and in private facilities "under such insurance, medical service or health plan or plans" as the Secretary of Defense may contract for, after consulting Secretary of Health, Education, and Welfare.

FREEDOM OF CHOICE for spouses and children between military and private facilities is restricted by the following provision: The Secretary of Defense may limit or prohibit the use of private facilities in any area where in his opinion military facilities are adequate to care for the service families.

OTHER BENEFICIARIES, all restricted to care in military facilities on a "space available" basis, include parents and parents-in-law residing in the home of the service member and for whom he pays at least half the support, retired members and dependents and dependents of persons who died while on active duty or retired. Limitation: Regardless of age, non-career retired reserves with less than eight years' active service and dependents not eligible.

CHARGES TO DEPENDENTS: While in military facilities, dependents will pay subsistence and in-hospital charges (currently totaling $1.75 per day); as a restraint on excessive demands, "uniform, minimal" charges may be made for outpatient care in military facilities. In private facilities, the charges will



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(1) Ivy, A.C.; Grossman, M. I., and Bachrach, W. H.: Peptic Ulcer, Philadelphia, The Blakiston Company, 1950, p. 626. (2) Steigmann, F., and Dolehide, R. A.: Am. J. Digest. Dis. *22*:37, 1955. (3) Riese, J. A.: Am. J. Gastroenterol. *23*:223, 1955.

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1956

be at the same rate or the first $25, whichever is the larger. All other medical care costs will be met by the federal government, through absorption of charges in military facilities and payment for insurance or other costs in private facilities. The Bureau of the Budget has approved $76 million to meet the first year's costs of private care; no estimate has been announced of the cost of the program in military facilities. The Secretary of Defense will establish the subsistence and in-hospital charges, described in the bill as "fair charges."

ADMINISTRATION: Secretary of Defense to administer for Army, Navy, Air Force, and Marine Corps and Cost Guard when it is a part of the Navy; Secretary of Health, Education, and Welfare to administer for Coast and Geodetic Survey and Public Health Service, and the coast Guard when not a part of the Navy. In writing regulations, etc., except those applying only to the military, the Secretary of Defense required to consult the Secretary of Health, Education, and Welfare. Secretary of Defense authorized to set up advisory committees on insurance, medical service, and health plans.

BENEFITS PROVIDED BY PROGRAM IN MILITARY AND IN CIVILIAN FACILITIES

(Only spouses and children of active-duty personnel eligible for private care)

I

Military Medical Facilities Will Provide:

1. Diagnosis, treatment of acute medical and surgical conditions, treatment of "contagious diseases," immunization and maternity and infant care.

2. Hospitalization for nervous and mental disorders, chronic diseases or elective medical and surgical treatments *but only in "special and unusual cases"* and for not more than 12 months. This would be provided at the discretion of the Secretary of Defense.

Military Facilities Will Not Provide:

1. Domiciliary care.

2. Prosthetic devices, hearing aids, orthopedic footwear and spectacles, ambulance service (except in acute emergency), home calls (except in special cases where medically necessary) or dental care.

Exceptions: Dental care authorized as necessary adjunct to medical or surgical treatment or to relieve pain and suffering but not to include any permanent restorative work or dental prosthesis. Also, outside the U. S. and at remote stations in the U. S. where private facilities are not available, dependents eligible for dental care and — at cost — prosthetic devices, hearing aids, orthopedic footwear and spectacles.

II

The Private Care Program Will Provide:

1. Hospitalization in semiprivate accommodations up to one year for each admission, including all necessary services and supplies furnished by hospital.

2. Medical and surgical care incident to hospitalization.

3. Complete obstetrical and maternity service, including prenatal and postnatal care.

4. Physician or surgeon's services prior to and following hospitalization for bodily injury or surgery.

5. Diagnostic tests and procedures, including laboratory and X-ray examinations accomplished or recommended by the physician incident to hospitalization.

(Continued on Page 287)

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A THUMB-NAIL SKETCH OF IMMUNO-HEMATOLOGY

by

Paul D. Jackson, B.S.; M.S. M.T. (ASCP)—Head, Division of Blood Banks

and

Arthur E. Rappoport, M.D. — Director of Laboratories, Youngstown Hospital Assn. Representative for State of Ohio, American Association of Blood Banks.

In spite of the complexity of the genetic combinations of the various Rh factors, present methods of Blood Banking and treatment of immuno-hematologic problems require a familiarity with these principles.

1. The genetic relationship of the three Rh factors, D (Rh_0), C (Rh'), E (Rh"), and their corresponding Hr factors, d (Hr_0), c (Hr'), e (Hr") is given below. The simplest explanation of their occurrence is linkage on three closely adjacent loci in a certain pair of chromosomes.

Rh Genes	Hr Genes
D (Rh_0)	d (Hr_0)
C (Rh')	c (Hr')
E (Rh")	e (Hr")

2. The relationship of D to d (C to c or E to e) is analogous to that of red and white roses. These two characteristics are homozygous, but their combination arises from the heterozygous pink variety. This relationship is shown below in connection with the Rh factors:

Genotype		Incidence Percent		Results of Testing with Anti-D Serum	Anti-d Serum
DD Homozygous	Rh†	37	85%	†	0
Dd Heterozygous	Rh†	48		†	†
dd Homozygous	Rh-	15		0	†

Since anti-d serum is not available, anti-c (anti-Hr') is used to determine the genotype along with Anti-C, Anti-D, and Anti-E. The method of establishing a presumptive diagnosis of homo - or heterozygosity in Rh positive individuals (D) is illustrated below:

Genotype	Incidence Percent	Anti-D (Anti-Rh_0)	Anti-C (Anti-Rh')	Anti-E (Anti-Rh")	Anti-c (Anti-Hr')
DCe/DCe Homozygous	20	†	†	0	0
DCe/dce Heterozygous	34	†	†	0	†
DCe/DcE Homozygous	14	†	†	†	†
DcE/dce Most frequently	15	†	0	†	†
Dce/dce Heterozygous	2	†	0	0	†
Total	85				

In studying other situations where isoimmunization is suspected such as in hemolytic transfusion reactions, or in the serum of an Rh positive female with a history suggestive of isoimmunization, a panel of cells should be used which are known to contain all six Rh-Hr factors. A person who is negative for an Rh factor, will carry the corresponding Hr factor, i.e., d (Hr_0), c (Hr'), e (Hr"); however, individuals who are positive for a given Rh factor may or

may not carry the corresponding Hr factor depending on whether they are heterozygous or homozygous for the particular factor concerned.

In the case of the Rh positive female, the husband's cells if group compatible (A B O) should always be included in the panel of test cells. Comparison of Rh-Hr mosaics will frequently reveal a factor present in the husband but absent in the mother. This may serve as a clue to the specificity of the antibody which has been produced by the mother.

In transfusion reactions, similar studies are made to determine which factor or factors the recipient lacks; this also serves as a clue to the specificity of the antibody or antibodies which may have caused the reaction. Cells of the previous donors should be included in the test panel.

Differences within the Rh positive group are very common in pregnancy and transfusions, but fortunately these seldom result in antibody formation. When immunization of an Rh positive person does occur, it is very likely to be against the E (Rh'') or c (Hr') factor or both. The patient is usually of the genotype DCe/DCe or R^1 R^1. Table 1 will demonstrate the patterns.

Table 1

Possible Findings in the Immunized Rh Positive Patient

Probable Genotype Determined by Tests with Available Sera	Testing with following serum				Antibodies which patient may have produced as a result of exposure to the different cell types*
	Anti-D (Rh_0)	Anti-C (Rh')	Anti-E (Rh'')	Anti-c (Hr'')	
Patient DCe/DCe (R^1 R^1)	†	†	-	-	
Husband DCE/Dce or Previous DcE/dce	†	†	†	†	Anti-E, Anti-c or both
	†	-	†	†	Anti E, Anti-c or both
Donors DCe/dce	†	†	-	†	Anti-c
dce/dce	-	-	-	†	Anti-c

*A study of the genotypes will indicate also the possibility of anti-d antibody formation in three of the four cases. It should be remembered that the genotype shows the individual genes inherited from each parent. Since none of the Rh-Hr factors are recessive, a person's genotype can be determined by doing a complete Rh-Hr typing.

When, as a part of the prenatal examination, a woman has been found to be Rh negative; i.e. negative when tested with the Anti-D (Anti-Rh_0) 85% serum, and her husband is Rh positive, serologic tests should be performed during the pregnancy to detect the formation of Rh antibodies. Transplacental immunization usually becomes evident during the last three months; however, antibodies may be found much earlier when there is a history of prior blood transfusion, intramuscular injection of blood, or fetal death.

The presence of Rh antibodies in the patient's serum is easily detected by performing *each* of the following *four* qualitative tests:

1. A test with a saline suspension of Rh positive and Rh negative cells patient's serum.
2. A test with Rh positive and Rh negative cells suspended in bovine or human albumin and patient's serum.

3. A test with Rh positive and Rh negative trypsinized cells and patient's serum.
4. The indirect Coombs test, with Anti-Human Serum. This is performed on the cells which have been exposed to the patient's serum in test #1 and will detect antibodies which "coat", but do not agglutinate saline suspended cells.

The four tests above are based on the observation that immunized individuals form antibodies, identical in specificity, which differ in their method of reaction with the specific antigen. These antbodies have been given many names — but based on their method of detection, they may be divided into two groups.

1. *Saline agglutinins;* Antibodies which agglutinate saline suspended cells, — also known as complete or early immune antibodies;
2. *Blocking antibodies:* Antibodies which coat but do not agglutinate saline suspended cells — also called albumin agglutinins, cryptagglutinoids, hyper-immune, incompete, conglutinating antibodies, etc.

Table 2 summarizes the possible findings when using the battery of tests now available for the detection of the Rh-Hr and other antibodies.

Table 2

Detection of Antibodies by the Various Technics

Type of Antibody	Saline Suspended Cells	Albumin Suspended Cells	Indirect Coombs on Saline Suspension	Trypsin Treated Cells
Saline Agglutinin	†	†	N.T.	†
Albumin (Blocking) Agglutinin	0	†	†	†
Prozone-Containing Albumin Agglutinin*	0	0	†	† 0
Atypical (Anti-Duffy, etc.)	0	0	†	0

† Agglutination
0 No visible reaction
†/0 Not always clearcut agglutination
N.T. Not test necessary
*Prozone containing sera, give negative or weak reactions when tested undiluted or in low dilution, but show strong agglutination in higher dilutions upon titration.

General Considerations:

In 93% of all cases of erythroblastosis, the mother is Rh negative. In the remaining 7%, The Rh positive mother is immunized by any one of at least 11 other blood factors:

1	Rh factor C
2	Rh factor E
3	Hr factor d
4	Hr factor c
5	Hh factor e
6, 7	Kell-Cellano factors (K, k)
8	Duffy (Fy)
9	Kidd
10	Blood group factors A
11	Blood group factor B

Progress has been made in the methods for the demonstration of Rh and other antibodies.

The description of the pathogenesis of hemolytic disease has stimulated research which has resulted in the recent discovery of many new human blood factors, their hereditary nature, and their role in clinical medicine.

SUGGESTIONS:

1. In all cases of erythroblastosis, both mother and father should have an Rh profile made.
2. In all cases of hemolytic disease with or without jaundice, some or all of these procedures should be carried out.
3. In cases of obscure anemia or jaundice, the presence of circulating antibodies should be investigated in search of evidence of a hemolytic etiology.

NEWS NOTES

Dr. and Mrs. William H. Evans spent a week in Chicago last month, where they attended the meetings of the American Medical Association and Woman's Auxiliary to the American Medical Association.

Dr. Louis Scharf, Staff Physician at Woodside Receiving Hospital was recently notified by the A.P.A. that he successfully passed the examination in Neurology and Psychiatry.

Dr. M. H. Steinburg has recently been elected a Fellow of the American College of Angiology.

Dr. Paul J. Fuzy, Jr. presented a paper entitled "Experience with the Optical Density Cancer Detection Test" at the meeting of The American Proctologic Society in Detroit, June 5th through 9th. It won an award given biannually by the Ohio Valley Proctologic Society to an affiliate member of The American Proctologic Society for the best paper on a proctologic subject.

Dr. J. D. Brown is convalescing in University Hospital, Ann Arbor, Michigan. Hurry back, Jim! !

Dr. Henri Schmid attended the First International Symposium on Venereal Diseases and Treponematoses. This Conference was sponsored by the World Health Organization, the U. S. Dept. of Health, Education and Welfare and the U. S. Public Health Service. This meeting took place in Washington; May 27 through June 1, the working languages were English, French and Spanish. Simultaneous translation was provided.

Dr. Sidney Franklin attended the annual meeting of the American Medical Association in Chicago and addressed the American Board of Legal Medicine on the subject "The Medicolegal Aspects of Public Health" at the Edgewater Beach Hotel. He was elected Second Vice President of the Board.

ST. ELIZABETH'S EX-INTERN REUNION

More than 100 physicians, residents, interns and medical students attended the St. Elizabeth's annual ex-intern resident day, Thursday, June 21, 1956.

The day's activities began with a scientific session, the guest speaker of which was Dr. A. Seymour Parker, Jr., a former intern and resident and now an associate physician in the department of internal medicine at Lahey Clinic, Boston. He spoke on "Practical Aspects of Endocrinology," a subject on which he has written a book in collaboration with Dr. Lewis Hurxthal of Lahey Clinic.

This was followed by a tour of the new addition to the hospital and a luncheon given by the sisters who operate St. Elizabeths.

A golf party and banquet at Youngstown Country Club brought the day of reunion and celebration to an end.

Dr. L. C. Zellers was elected President of St. Elizabeth Hospital Ex-Intern-Resident Association and Dr. William Sovik, vice president. Dr. Francis Gambrel is the new secretary-treasurer.

—CWS

YOUNGSTOWN HOSPITAL ASSOCIATION
Ex-Intern Reunion

The annual Ex-intern Reunion of the Youngstown Hospital Association was held Thursday June 21st under the direction of Drs. Wendell Bennett, President; Fred Schlect, Secretary-treasurer; J. L. Fisher and J. D. Brown.

The morning scientific program was held at the South Side Auditorium sans air conditioning and following this a very tasty southern fried chicken luncheon was served in the doctors dining room by the dietary staff.

The afternoon was spent in the "rough" at Tippecanoe Country Club by most of us. John Rogers, of course, played only in the fairways and won the low gross prize. Blind Bogie winners were Chevlen, Phillips, Ipp, Hardin, McNeal, Segal, Tornello, Schlecht and Giber.

A dinner featuring steak was served following which choir master Gene Fry led the singing. Door prize winners were Rollie Miller, Dean Stillson and Chuck Giering.

New officers for next year were elected, namely, Dr. Gene Fry, President; and Wayne Hardin, Secretary-Treasurer.

Mrs. Wright, the hospital photographer took time off from her vacation to make the pictures of this event available to our bulletin, for which I am duly grateful to her.

—C. W. S.

CLEVELAND DERMATOLOGICAL SOCIETY HOLDS MAY MEETING IN YOUNGSTOWN

The Cleveland Dermatological Society held its May meeting on Thursday, May 24th at the South Side Unit of the Youngstown Hospital. Interesting and unusual cases were presented by the Youngstown members of the Society. This was followed by a clinical meeting and discussion of the cases. In the evening cocktails and dinner was served at the Mural Room.

MEDICAL SERVICE FUNCTIONS OF UNITED CEREBRAL PALSY ASSOCIATION, INC.

Two of the service functions of United Cerebral Palsy Associations, Inc. are of particular interest to the medical profession.

Medical Supervision and Program Coordination. This includes development of medical information for use by physicians caring for the cerebral palsied, collection and evaluation of data relative to various forms of treatment, cooperation with medical organizations, national health agencies and professional groups in their activities relating to cerebral palsy, publication and distribution of professional articles dealing with medical and other aspects of the disorder. The national budget for the fiscal year 10/1/55 — 9/30/56 sets aside $121,000 for this service.

Research and Training of Medical and Teaching Personnel. The national office of UCP carries on an extensive program of grants-in-aid for research and training. The national budgets calls for $617,000 to be spent on this function. This money is dispersed under the direction of the Research Advisory Board and the Educational and Clinical Advisory Boards. Emphasis during this fiscal year has been placed on basic neurological research designed to develop further knowledge of the human central nervous system and on basic research in the broad field of causation of cerebral palsy. The fields in which training is given are medicine, dentistry, occupational and physical therapy and education.

This year a far reaching service function has been the part played in the Arden House Conference. In 1954 Jack Hausman, then national president of UCP, suggested holding a National Cerebral Palsy Conference. In an effort to accelerate help to some 10,000 Americans suffering from brain damage of various kinds, the scope of the conference was broadened to include all neurological disabilities.

The National Health Council, of which UCP is a member, sponsored the first National Conference on Neurological Disability as a National Problem. It was held at Arden House, Harriman, N. Y. early in December 1955. The cost of this conference was underwritten by UCP.

Subjects realistically discussed were what is now being done for individuals whose nervous systems have been impaired, the costs and effect on communities. Consideration was given to current programs of reseacrh now being conducted under government or voluntary sponsorship and the possibility of broadening and expanding scientific studies. A total program of help will be formulated and will be presented to the American people with the cost and benefits which would accrue. The proceedings of the Arden House meeting will be available after publication.

The Board of Directors of the National Health Council resolved the committee which planned the Arden House meeting be continued as a permanent group appointed by the president of the Council, Dr. Hugh R. Leaveall, of the Harvard School of Public Health. Dr. Glidden L. Brooks, Medical Director of UCP heads this committee.

On the state level, in May, 1956, the National organization of UCP underwrote a Symposium on Cerebral Palsy and Other Neurological Disorders which was held at Columbus, Ohio. All phases of the problem of neurological disorders were presented and discussed by specialists in their field.

Sponsors of the symposium were the Ohio State affiliations of the Medical Association, Psychiatric Association, Neuropsychiatric Society, Dental Association, American Academy of Pediatrics, American Congress of Physical Medicine and Rehabilitation, the Columbus Academy of Medicine and Dental Society, and Ohio State University, College of Medicine.

CHRISTINE K. KLINE, *Technical Director*
UNITED CEREBRAL PALSY CENTER

(Continued from Page 264)

Patients were demanding to go to the hospital to be X-rayed "from top to bottom." "After all, I have the insurance and I paid for it and I want my money's worth."

"Have you read about the new treatment for arthritis with prostigmine, Doctor? It was in the Reader's Digest."

The Medical Society was interested in Public Relations. There was to be a big exhibit at the Canfield Fair. Doctors were urged to tell the story of American Medicine to their patients. They were asked to work with Rehabilitation Centers. They put their names on the list with the Veteran's Bureau with its forms in quadruplicate.

It was very confusing. Some of them thought with nostalgia about the good days on Leyte Gulf.

—J. L. F.

EIGHT YEARS

Eight years is a long time to wait. And yet the average person with a serious eye handicap waits eight years from the time he knows of his eye problem to the time he contacts the social service agency which can help him. The statistics are given to us by the National Labor Statistics Bureau in Washington.

An estimated fifty people lose their sight in Mahoning County each year. Multiply that by eight and you have four hundred years. Seems like a long time to wait doesn't it? Especially when the Youngstown Society for the Blind has such a variety of helpful activities available to the person with a visual handicap.

They range all the way from convincing sixteen-year-old Susan that she can still part her hair, put on lipstick, and distinguish the powder blue sweater from all the others in her drawer to helping Grandpa Carson utilize new gardening techniques so that he can continue to raise the prize dahlias he has always been so proud of. From showing Mrs. Italiano how to measure liquid vitamins for her new-born baby to training mill-worker Bill Stevens to operate his punch-press without sight.

They include instruction in Braille, use of the Talking Book, writing, sewing, cooking, handicrafts, and independent travel.

All these services and many others are available at the Youngstown Society for the Blind.

We know now that the sooner a disease is recognized the greater the chances of cure. In the same way, the sooner a person with a potentially serious visual handicap begins to plan for the day when he will have less sight or the person who has already lost his sight begins to learn the techniques and devices that will enable him to lead a normal life, the greater his chances of maintaining his place in the community.

Eight years is a long time to wait. All of us can help shorten it by referring cases of visual limitation that come to our attention to the Youngstown Society for the Blind.

—ROBERT LANGFORD
Director, Society for Blind
Youngstown, Ohio.

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Note: Also included under private care may be surgery in a physician's office, X-rays or laboratory tests outside the hospitals, but not "what is normally conceived to be outpatient care." "Reasonable" limitations, additions, exclusions and definitions could be authorized by the Secretary of Defense. Scope of private care may not exceed that furnished in military facilities. If hospitalization is required beyond one year, patients may be transferred to military facilities, or the federal government will assume cost in private facility.

HOW ACT DEFINES MILITARY DEPENDENTS ENTITLED TO MEDICAL CARE

(Private care restricted to spouses and children of Members on active duty)

"The term 'dependent' means any person who bears to a member or retired member of a uniformed service, or to a person who died while a member or retired member of a uniformed service, any of the following relationships:

(a) the lawful wife;

(b) the unremarried widow;

(c) the lawful husband, if he is in fact dependent on the member or retired member for over one-half of his support;

(d) the unremarried widower, if he was in fact dependent upon the member or retired member at the time of her death for over one-half of his support because of a mental or physical incapacity;

(e) an unmarried legitimate child (including an adopted child or stepchid), if such child has not passed his twenty-first birthday;

(f) a parent or parent-in-law, if the said parent or parent-in-law is, or was at the time of the member's or retired member's death, in fact dependent on the said member or retired member for over one-half of his support and is, or was at the time of the member's or retired member's death, actually residing in the household of the said member or retired member; or

(g) an unmarried legitimate child (including an adopted child or stepchild) who (i) has passed his twenty-first birthday, if the child is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching the age of twenty-one and is, or was at the time of the member's or retired member's death, in fact dependent on him for over one-half of his support, or (ii) has not passed his twenty-third birthday and is enrolled in a full-time course of study in an institution of higher learning as approved by the Secretary of Defense or the Secretary of Health, Education, and Welfare and is, or was at the time of the member's or the retired member's death, in fact dependent on him for over one-half of his support."

A Bill filed by Rep. Francis E. Dorn (R., NY) calls for Congressionally sponsored investigation of this country's medical manpower by a Commission on the Doctor Shortage in the United States. Its 12 members would be composed of two Senators, two Representatives, two officials from government's executive branch and six persons from private life. Group would be charged with task of ascerting why thousands of foreign medical graduates come to U. S. for internship and residency training, extent to which the states grant licenses to physicians trained abroad, enrollment policies of American medical schools and adequacy of output.

ANNUAL GOLF MEET
THURSDAY, AUGUST 23, 1956

Youngstown Country Club

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

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

NO dinner tickets sold at Club
NO dinners served without reservations

Reservations MUST be received not later than AUGUST 13

SEPTEMBER MEETING

Tuesday, September 18, 1956

The regular monthly meetings of the Society will be held at the ELKS CLUB, starting with September.

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Dorn bill (HR 11518) is result of May 8 address by Dr. Dominick F. Maurillo, chairman of license committee of New York State Board of Regents, in which he attributed hospitals' increasing dependence on foreign graduates to fill internship and residency billets to insufficiency of the domestic increment.

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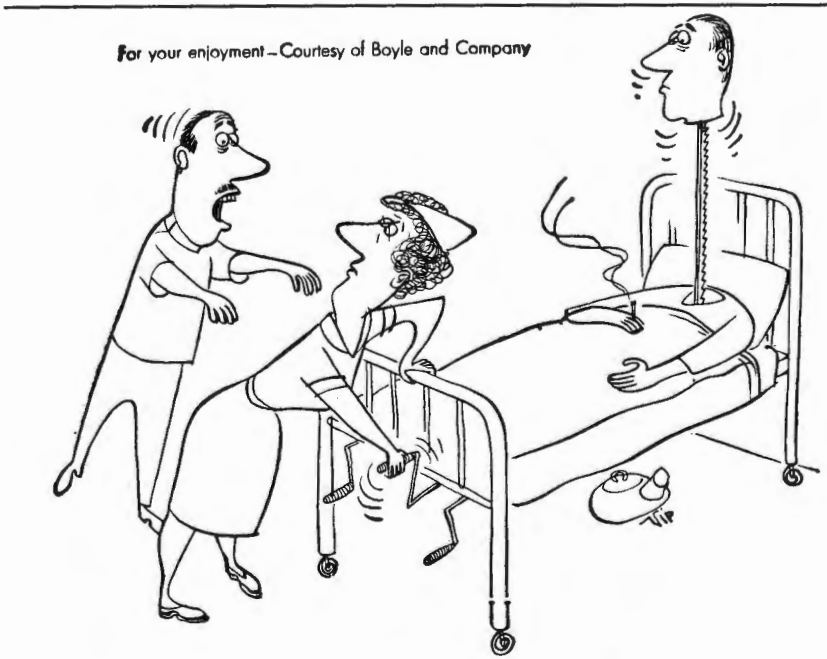
in September. He faces eight years in college, two years of internship, and two years in the Army. His family and himself will make an investment of at least $20,000 in his profession (or business) during that time. Not a penny can be deducted for depreciation on this 10-year term of preparation.

"Another student graduating at the same time is set up in a $20,000 gas station business. Right away he starts earning an income. The first year he deducts 50% of this investment, and the balance is written off in four years. His investment is fully depreciated in five years. But the medical student has just started the last four years of medical instruction, and has not yet earned his first fee.

"When is an investment in business not an investment? When you are a professional man—doctor, lawyer, dentist, preacher, teacher. After practicing 10 years the medical student attends a clinic for six weeks to equip himself for a specific feature of his business. The filling station operator likewise puts in the same amount of money in another pump. He can write off his additional investment in his business, but the doctor cannot write off the additional investment in his business."

Food for thought!

—C. A. GUSTAFSON, M.D.



"Not that crank, O'Brien!"

EDWARD C. GOLDCAMP
1889 — 1956

Dr. Edward Goldcamp, "Goldie," as he was known to most of the profession, passed away June 2nd, 1956, at the age of 67. He had been in poor health since 1949, and had not practiced since that time. A graduate of Jefferson Medical School, class of 1914, he interned at Rhode Island General Hospital, and took his Otolaryngology training at Massachusetts Eye and Ear Hospital in Boston. He served in World War I as a Major in the Medical Corps and worked in France in various hospitals while in the Army. After the war he practiced in Warren, Ohio until 1925 when he joined the Youngstown group of Hartzells, Bierkamp and Goldcamp.

Early, he became interested in Bronchoscopy and trained with Jackson, Clerf, and others, and initiated this work at the Youngstown Hospital where a clinic was opened in the early 30's. At this time all the foreign bodies in the lungs and bronchi were sent to Pittsburgh for treatment. Following the inception of this clinic, these cases were treated here at the Youngstown Hospital. Bronchogenic carcinoma and other similar cases were at this time becoming recognized and Dr. Goldcamp pioneered in this field along with the Roentgenologists.

Bronchoscopic diagnosis of disease is the particular niche where "Goldie" inscribed his name in the 'March of Time in Youngstown'. He was a most able Laryngologist but Bronchoscopy was his particular forte in the practice of medicine.

He was always a friend of the internes and served on that committee for years. He loved music, boxing and sports. The latter resulted in his sponsoring "Caddies Welfare", also tournaments, banquets and he will be long remembered by many of the boys for his kindly interest, advice, and financial help over the years.

He was active in the local Medical Society for years and served on many committees and offices. He was president of the Pittsburgh Otological Society and active in state and national medical society affairs.

He was a good supporter of civic affairs, his church, and anyone in need. Dr. Goldcamp is survived by three brothers, Dr. S. W. Goldcamp, Dr. John Goldcamp of Youngstown and C. F. Goldcamp of Pittsburgh, a sister, Mrs. E. M. Wenfurtner of Florida.

In parting let us who knew him say, he came, he saw, he conquered, in his field as well as his community.

—J. P. HARVEY, M.D.

(ED. NOTE: The following article was written by request of the editor. Next month, Dr. McDonough will submit an article on his foreign visit.)

FAR HORIZONS

Regarding your request for information concerning our recent trip to Europe and the Near East, I seriously doubt the interest such a report would arouse among the members, but I will be glad to acceed to your request.

We flew from Idlewild Airport to Rome, where we stopped two days in order to break the trip, and we then went on by air to Istanbul. This proved to be, in our estimation, the most interesting city that it has ever been our pleasure to visit. The new Hilton Hotel is modern in every respect, with all the up-to-date accomodations found in any first class hotel in this country, with the added attraction of some Turkish atmosphere and a beautiful location which overlooks the Bosphorus and the Golden Horn, which afforded very interesting views. You can see across to Asia Minor, which we visited, as we did the Black Sea.

We took occasion to visit the University Medical School Hospital in Istanbul which we found, much to our surprise, to be quite modern. The Professor of Medicine was just going into the classroom to lecture on leukemia with a copy of Wintrobe's Hematology under his arm. He discussed very clearly the diagnosis and modern treatment. He called in the Associate Professor of Medicine, who had studied with George Burch at Tulane, and he asked me to conduct ward rounds. This was a very interesting experience. Most of the students and ward physicians understood English. The hospital was clean, and in general, less crowded than many of our hospitals. The equipment is modern, even to cardiac catheterization facilities, and the atmosphere quite stimulating from an academic standpoint.

We then visited Cairo and saw the Pyramids, as most tourists do, by camel back. We went up the Nile to Luxor where we visited the Temple of Karnak by full moonlight. We went across the Nile in a felucca and visited the Valley of the Kings and the Tomb of Tut en Kamen. Most of the materials have been removed from the tomb and are in the Cairo Museum. They are fabulous. One of the three caskets in which King Tut was buried was of solid gold and weighs 224 pounds. The workmanship on the casket and the jewelry and alabaster boxes makes one realize that the handicrafts then were equal to ours. I had a letter to the United States Navy Research Center in Cairo, and found that they are spending most of their time on schistosomiasis, which they feel is likely to be a world problem, as 200 million people at least have this disease.

In Greece, we visited the usual: The Acropolis in Athens, the Delphian Oracle, the Mycenian civilization, and Corinth. I had the good fortune to have a letter to a young physician who was with the United States Navy, caring for the personnel of the American Mission in Athens, which number about 4,000. They have an outpatient department and a 25 bed section of the large hospital. These young men are hungry for contacts with physicians from the States, and anyone visiting them will, I am sure, be quizzed on modern medical subjects, as I was. I spent a day making rounds and consulting on various patients in the wards.

We next flew to Amsterdam in order to see the tulips in full bloom, and we were fortunate in having good weather to see this glorious display of color, which I believe is not duplicated anywhere in the world. We attended the dedication of a Memorial to the Underground and saw the Queen of

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NEW BOOK FOR PHYSICIANS "GIRL FRIDAY"

A 350-page manual for the modern physicians "Girl Friday" is available in medical book stores throughout the country.

Entitled "The Office Assistant," the book contains suggestions for more efficient procedures and methods of handling nearly every phase of medical office work. Its contents are valuable to anyone employed in a doctors office — secretary, receptionist, nurse, bookkeeper, technician. The book was planned to save the doctor time, money and a vast amount of explanation in the training of an efficient office aide.

Authors are: Portia M. Frederick, Instructor in Medical Office Assisting, Long Beach College, California, and Carol Towner, director of special services, A.M.A. Public Relations Dept.

The book will sell for $5.75 and orders should be sent direct to the publisher, W. B. Sanders Company, West Washington Square, Philadelphia 5, Pa.

PEARLS AT RANDOM

Vascular surgery has taken great strides in the last 5-10 years. Ten years ago repair of traumatized vessels (accidental or from disease) was a rare procedure. Today it is a common place occurence. Aneurysmal dilatation of any of the major vessels can be amenable to repair or replacement by artificial prothesis or a homograft. Segmental occulusions or emboli of major arteries can also be recannulated surgically or the area excised and repaired or replaced.

The loss of extremities from injury of its major arterial supply has been decreased from 90% - 100% loss in the case of popliteal or common femoral arteries to less than 10% in the hand of experienced vascular surgeons. These figures should make us all sit up and cogitate before ligation of a major artery is performed. These extremities were not only salvaged but were fully active without signs of vascular insufficiency.

Splenorenal and portacaval shunts are adding to the life expectancy and comfort of patients with portal obstruction.

These procedures are no longer limited to medical school centers but can and are being performed in smaller hospitals throughout the country.

—FRANK K. INUI, M.D.

—o—

The following test has been used successfully in Great Britain.

Adults. Sodium bromide orally, one gram T.I.D. for three days. Then allow two full days before the test.

Children. Sodium bromide 0.25 gm. — 0.5 gm. T.I.D., Then as above.

Take venous blood, 5 cc. and CSF. 3 cc. (Duplicate tests)

The clotted blood is centrifuged and the bromide contents of the serum and the CSF are estimated.

Bromide ratio — $\frac{\text{serum bromide}}{\text{CSF bromide}}$

In the absence of detectable organic disease, the serum contains 2 to 3 times as much bromide as the SSF.

The ratio falls in TB Meningitis. Values of 1 or less are common. As the patient responds to treatment, the ratio returns to normal.

—H. H. TEITELBAUM, M. D.

ST. ELIZABETH HOSPITAL ORIGIN AND DEVELOPMENT

St. Elizabeth Hospital is a non-profit institution dedicated to serving the physical needs of peoples residing in the Mahoning Valley District. The services of the Hospital are available to all who need them, and admissions are not restricted because of race, color, creed, financial status or place of residence.

The Hospital had its origin in 1911 when residential-type buildings were converted for care of the sick. Shortly thereafter, a city-wide building drive, supported by Youngstown citizens of all creeds, made possible construction of what is now the North Wing, and this building had its opening in January 1915.

Similarly, the center structure and South Wing was financed in 1926 by public subscription, and these expanded facilities were opened to the public in 1928.

In 1945, another limited appeal for funds permitted construction of a substantial 2-story addition to the St. Elizabeth Hospital School of Nursing which is located on a 6½ acre plot of land at Belmont and Caroline Avenues. The original 3 story structure, acquired by the Hospital in 1927, was one of Youngstown's fine residential mansions and it lends itself well to its present use. Overall, the present buildings afford 19,725 sq. ft. of floor space used for classrooms and student nurse residence. There are sleeping accomodations for 150 students as well as visitor's parlor, recreation rooms and outside tennis and picnic facilities. The School is fully approved by the National Nursing Accrediting Service.

NEW CONSTRUCTION AND MODERNIZATION

That enlarged and modernized facilities were needed for St. Elizabeth Hospital are evident from the following facts:

The two original hospital buildings had accomodations for but 250 patients. But, in recent years, to approximate the service demanded of it, 340 patient beds and 60 bassinets for newborn babies have been in use. This is 90 beds more than rated capacity.

Despite this overcrowding, St. Elizabeth has had an average daily waiting list of 35 individuals who have been unable to secure necessary accommodations. Likewise, diagnostic, therapeutic, surgical and service facilities have been equally overcrowded and have functioned substantially beyond reasonable capacity. A comparison of the Hospital's vital statistics, 1940 vs. 1955 shows:

Patients Served	Births	Operations	Lab. Tests	X-ray Procedures
1940— 8,000	1500	4000	12,300	12,970
1955—15,940	2260	6609	131,244	23,723

The new West Wing addition to St. Elizabeth Hospital came under construction in August, 1953, and is presently nearing completion. Currently, the North Wing section is undergoing extensive remodeling and it is estimated that all work will be completed by the latter part of this year.

The overall building and remodeling project is being accomplished at a cost of $4,500,000. Two million dollars of this amount has already been raised through public subscription with an additional sum allocated by the Federal government under terms of the Hill-Burton Act.

The project adds 195 new beds and other patient-visitor facilities to the previous capacity, for a present total of 470 beds, with 70 available bassinets.

Architects for the project are Schmidt, Garden and Erickson, Chicago, Illinois with Mellon-Stuart Co. of Pittsburgh, Pa. as General Contractor.

With completion of the building and remodeling program, St. Elizabeth will rank among the finest institutional facilities in this section of the country.

SALK VACCINE

Acceptance and use of the Salk vaccine for the prevention of paralytic poliomyelitis is in direct proportion to the interest and enthusiasm of local physicians concerning its use, Dr. Hart E. Van Riper, medical director of the National Foundation for Infantile Paralysis, pointed out to physicians in a "Letter from the Editor" appearing in Number 3, June, 1956, of "New Information for Physicians on the Salk Polionyelitis Vaccine." This new 32-page publication, issued by the National Foundation as a service to the medical profession, has now reached 200,000 physicians in the United States.

Where local physicians are enthusiastic about the vaccine, a high proportion of "acceptance" is obtained with the public, Dr. Van Riper's letter reveals. In one North Carolina county, Dr. Van Riper said, where one local physician had been strongly convinced of the value and need of providing against the unpredictable threat of paralytic poliomyelitis, and had spearheaded a campaign for vaccination, nearly 95 per cent of the eligible population has already received one or more injections of Salk vaccine.

Vaccinate now and throughout the summer is the essence of a statement by Leonard A. Scheele, M. D., Surgeon General of the U. S. Public Health Service, which appears in the new issue of "Information for Physicians on the Salk Poliomyelitis Vaccine." Dr. Scheele's statement in full says:

"Physicians and health officers should begin immediate planning for expanded poliomyelitis vaccination programs during the next few months.

"Vaccine should be used as promptly as it becomes available, even during periods of rising incidence of poliomyelitis, to assure maximum protection.

"To provide some protection in higher priority groups as soon as possible, vaccination programs should not only be continued but expanded as more vaccine becomes available throughout the summer months, which are periods of rising incidence.

"The total preventive effect of the vaccine is much greater than any slight hazard of provocation. Evidence accumulated during 1955 supports this conclusion."

The changing picture of poliomyelitis in the United States with the advent of the Salk vaccine is described at length in the new edition of information for physicians. The summary and conclusions of this article declare:

"The ideal dosage schedule for the Salk poliomyelitis vaccine, as presently constituted, is two 1-cc. doses, intramuscularly, spaced two to six weeks apart, with a booster dose of 1 cc. given at least seven months to one year later. The schedule of injections should ideally start during the second six months of life.

"Because of possibly limited vaccine supplies, a compromise or emergency dosage schedule may have to be used in 1956. All available vaccine supplies should be used immediately. Booster doses should be postponed until vaccine supplies are fully utilized for primary immunization.

"Properly processed and tested Salk vaccine is safe—as safe as any biological product can possibly be. The question of vaccine safety is now largely historical.

"Contraindications for administration of the Salk poliomyelitis vaccine have been slightly revised. The vaccine should not be given (1) during major acute illness; (2) during the poliomyelitis season to persons exhibiting symptoms of minor illness, especially fever, sore throat and gastrointestinal upset;

and (3) to those in intimate household or institutional contact with an index case of poliomyelitis.

"The risk of provoking paralysis by a first injection of Salk vaccine is minimal. If primary sensitization has occurred, the risk in subsequent vaccine injections is probably nil.

"The best hope of aborting an epidemic of poliomyelitis is to give one injection of the Salk vaccine immediately to the entire unvaccinated population in the community up to age 35 or 40. Households with index cases should be excepted.

"The demonstrated effectiveness of the Salk vaccine, under conditions of use in 1955, was approximately 80 per cent. It was somewhat less effective against type 1 poliovirus infections and epidemics.

"Detailed records of the past incidence of poliomyelitis, paralytic and nonparalytic, with an entirely unvaccinated population in the United States, are provided. These may serve as a base line for determining the long-range effects of programs of vaccination against paralytic poliomyelitis.

"The statistical and epidemiologic picture of poliomyelitis in the United States is rapidly changing as the result of the increasingly widespread use of all available supplies of the Salk vaccine. The World Health Organization has recommended that all countries 'with a high incidence of paralytic poliomyelitis should plan to bring vaccination into routine use at an early date.'

"If efforts are successful to vaccinate a high proportion of the most susceptible age groups in the American population — children aged six months through 19 years and pregnant women — before the advent of the 1956 poliomyelitis season, a reduction by 50 per cent in the number of paralytic cases that might otherwise have occurred in the epidemic season of 1956 is well within reason. This would represent a most dramatic reduction in a single year. The cooperation of the medical profession is essential to this possible result."

A new statistical analysis of age-specific admission rates of paralytic polio patients to hospitals reporting to the National Foundation reveals that the incidence of paralytic polio is likely to be as high among pre-school and nursery school children as among those in the first and second grades in school.

—National Foundation for Infantile Paralysis

PROCEDINGS OF COUNCIL
June 11, 1956

The following applications were presented by the Censors:

Active Membership

Joseph Vincent Newsome, 2722 Mahoning Ave., Youngstown, Ohio

Jr. Active Membership

James Medley, 5532 Mahoning Ave., Youngstown, Ohio
Irving Berke, 1005 Belmont Ave., Youngstown, Ohio
Robert A. Wiltsie, 21 N. Wickliffe Circle, Youngstown, Ohio
Bertram Katz, 517 Home Sav. & Loan Bldg., Youngstown, Ohio

Interne Membership

Aurora P. Reyes, Yo. Hospital Ass'n., Youngstown, Ohio

Unless objection is filed with the Secretary in writing within 15 days, the above become members of the Society.

—A. A. DETESCO, M.D.
Secretary

(Continued from Page 291)

Holland, The Prince, and two of their children, which provided an interesting interlude in our Holland trip. Following this we went to Coblenz, Germany, which still shows a tremendous result of the bombing.

We took a trip on the Rhine to Bingen, then by car to Heidelberg and down through the Black Forest, visiting the old city of Rothenberg, which was a high spot in our trip. We then went on to Munich, and Vienna in Austria, and spent some time in Innsbruch, a lovely Tyrolean city. From there we went through Zurich to Zermatt, and up the Gornergraut to the Matterhorn. We were again favored with beautiful weather. This is a glorious spectacle and should be a must on anyone's trip to Switzerland. I spent a day at the World Health Organization in Geneva, and came away impressed with the value of this assembly. It is, as you know, one of the agencies of the United Nations. We went through southern France, Avignon, Neims Arles, Lebaux, Carcassonne, and back up to Paris by car, where we visited the Rheumatic Fever Hospital, and found the doctors who came to see our rheumatic fever program here to be extremely cordial. They invited me to return in the fall to relate our experiences in the prevention of first attacks of rheumatic fever to a seminar which is to be held in September. The Children's Hospital is very modern, and all the wards have glass cubicles. The instructions to students I found to be very good.

We came home from Cherbourg on the Queen Mary and I enjoyed the restful atmosphere of this lovely ship.

—WILLIAM H. BUNN, M.D.