

# BULLETIN

of the

Mahoning County  
Medical Society



"What is true, simple and sincere  
is most congenial to man's nature."

—Cicero

October, 1935

Volume 5

Number 10

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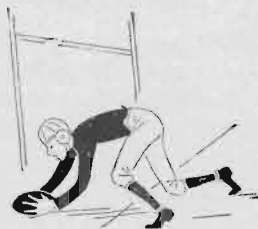
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	68.0	Caloric Value per 100 cc. . . . .	68.0	
	20.0	Caloric Value per ounce . . . . .	20.0	

\* Average percent according to Holt, "American Journal Diseases of Children", Vol. 10, page 239, 1915.

† Friedenthal, H. -- Ueber die Eigenschaften kuenstlicher Milchsera und ueber die Herstellung eines kuenstlichen Menschenmilchersatzes. Zentrabl. f. Physiol., Vol. 24, 1910, page 687.

‡ Davidsohn, H. -- Ueber die Reaktion, der Frauenmilch. Zeitsch. für Kinderh. Vol. 9, 1913, page 13.



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## PRESIDENT'S PAGE

Last month we had the enjoyable privilege of hearing Dr. Plass of the University of Iowa talk on "The Simplification of Obstetric Care." It seemed to me that the trend of his thought might be enlarged beyond the field of his specialty and applied to other fields of medical practice with benefit to our patients' health as well as their pocket books. Assuming that the maxim is true that simplest methods are the best, it follows that by eliminating unnecessary *fol de rol*, we can be of greater service.

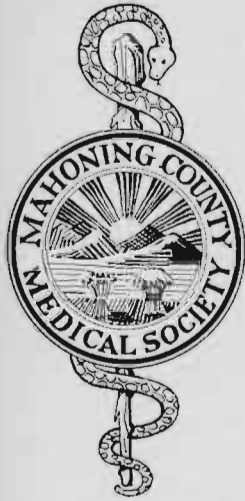
Take for instance infant feeding—leading pediatricians have demonstrated that simple formulas are best tolerated and least expensive. In treating diabetes, diets which are not too complicated are more easily made up and more likely to be followed. The multiplicity of vitamin preparations which have been manufactured to be stuffed into the anorexic, debilitated, hypocalcemic child or adult is amazing. New ones come out every month until we are lost in a maze of strange names and new formulae. So it is with the proprietary remedies from Atophan to Zorostrast with names and claims glibly propounded by the ebullient detail man. In spite of his catch phrases, there are better preparations in the U. S. P. and N. N. R., which cost less.

In the field of diagnosis, better training of and more reliance on the eyes, hands and ears make less indiscriminate ordering of costly and complicated laboratory procedures. A carefully taken history, a thorough examination and laboratory work which is to the point are worth more than a sheaf of reports filled with decimals and graphs.

What is to be gained by subcutaneous, intramuscular or intravenous injection of drugs whose effect can be obtained by simple ingestion? Yet countless ampoules have been filled with salicylates, iron and methenamine which might better never have been. And the antiseptics—what vivid hues and what beautiful names! Bacteria must be proud to die in such splendor.

But in the field of the administration of medical care, the acme of confusion has been reached in some of the proposed schemes for changing the method of supplying this necessary service. Pannels, insurance practice, state medicine, group clinics, hospital plans all tend to insert interfering lay supervision between the direct relationship of physician and patient. Benevolent foundations seeking to lower the cost of medical care complicate the picture with social service agencies, welfare workers and administrators so that the real issue of caring for sick people is liable to be be-clouded by the economic phase to the detriment of good practice. There has never been a better plan of medical care devised than to have a patient place his health in the hands of the doctor of his choice and pay what he is able for the service. Today we are farther away from complicated plans of social medicine than at any time in the last three years. Let us give thanks that medicine too can have a breathing spell, and in the meantime let us try to keep down the cost of medical care by using methods that are simple and direct.

JAMES L. FISHER.



# BULLETIN

of the

## MAHONING COUNTY MEDICAL SOCIETY

O C T O B E R 1 9 3 5

### SIMPLICITY

Dr. Plass' address before our Society on the evening of September 17, conveyed to us much that is useful in the practice of obstetrics. But it did more than simply that. As those of his large audience reflect over his delightful presentation they perforce must see in it a deeper and wider philosophical significance.

Using as a preface to his discourse a reference to the large new Sheet and Tube Mill, which he had just seen, and in which a vast sum of money had been spent "to simplify operations" to increase efficiency, Dr. Plass' logical mind carried that concept over into the technique of obstetrics. And in that field he made simplicity seem synonymous with obvious common sense.

One is led thence to speculate as to the real value of many other elaborations that this ultra-scientific age has incubated. Not alone in obstetrics but in every branch of medicine, is it not just possible that there has developed the tendency, as the old folks used to say, "to put on dog"? How much of these injections for this and that are necessary or more helpful than oral administration, and how much of it is really harmless? How many of the procedures rest upon the basis only that Doctor "Big-Wig" always did them? And who pays the bill? Some-

body does, that's sure! And here again Dr. Plass made the use of simple methods, where possible, seem synonymous with plain common honesty.

Again, why draw water for the horses out of a deep well by using a frosty, hand-freezing iron chain to hoist small buckets-full, when a perfect sleuce may be had comfortably with an electrified pump? Dr. Plass revealed that patient coöperation with nature and natural law prevents injury and gives copious good results without harrowing regrets afterwards.

By eliminating those things which really have no basis other than that "they're done" by thus and so, or have long been taught—there creeps in another element: "The job isn't so messy"! In other words, there is beauty in simplicity. Walt Whitman puts it well: "The art of art, the glory of expression, and the sunshine of the light of beauty, is simplicity."

These considerations by no means imply that needed things, sensible precautions, are not to be maintained. To carry the idea that far was not in Dr. Plass' mind. That would be the work of a simpleton, which is hardly of the same sort as the work of the keen observer whose effective artistry is expressed in rational simplicity.

## SECRETARY'S REPORT

Council met September 10, 1935. The Government has requested that we furnish a list of members qualified to care for injured P. W. A. workers. The medical attendant is to be paid through the Federal Compensation and the rate to be paid is that prevailing in this County.

After considerable discussion as to the proper procedure to follow the Council, with the Society as a whole, empowered the Medical-Economics Committee, plus the new Committee appointed from the Economics Committee, to contact the director of the Medical P. W. A. in our County and make all necessary arrangements as to fees to be paid. The free choice of physician is to be maintained at all times. Also, the foreman on the project shall not be responsible for the choice of the physician attending the injured P. W. A. employee.

The Committee has mailed a return card, on request of Council, to each practicing physician in the County asking that he indicate whether he desires to attend this type of patient. If you have not returned your card, please do so. From these returned cards the list to be submitted to the director will be compiled.

The Council urged the Committee to make contact with all officials who have to do with unemployables, Widow Pension Board, Old Age Pension Board, etc., in regard to setting up a workable and just fee schedule for the care of these individuals. Each physician of the County will be notified as to these fees. Also the Council urges that contracts for the care of the indigent of any political subdivision be not entered into until such a time as the Committee has made a report.

The Council instructed our delegates to bring to the attention of the House of Delegates at the State Meeting in Cincinnati, the matter of having a State lien law passed for the protection of the medical fees in all

automobile accident cases that are covered by insurance.

The regular monthly meeting of the Society was held at the Youngstown Club, September 17th, 1935. One hundred and twenty-five members and guests were present. We appreciate having our friends and neighbors with us at our meetings and extend to them a hearty welcome to all of our meetings. We are rather disappointed that so few of our members are turning out to our regular meetings. What is wrong, fellows? Do not forget these are your meetings and we need every one of you at every meeting. Please come out so our speakers will not be disappointed in us. Your committee cannot hope to get speakers if we do not do our part.

The Speaker of the evening was Dr. Edward Plass, Professor of Obstetrics, University of Iowa. He delivered one of the most common sense addresses that we have had in many days in regard to methods of doing Obstetrics. All absent physicians interested in this type of work certainly missed a treat. Dr. Plass is a jolly, good natured, polished gentleman, knows his subject, and puts it out with vigor. We are much indebted to the Professor for coming so far, and giving us such a worthwhile and enlightening paper.

Please, we beg you, keep the dates of the coming meetings in mind and then come out and make your presence swell our audience.

---

### More Picnic More Rain

Jupiter Pluvius simply won't tolerate our medical picnics! The golf play-off on Thursday, September 19, to even up on the "drowning" of last month, got soaked, too. Anyway several of the members enjoyed a pretty good game at the Youngstown Country Club and dinner afterwards.

*October*

**DR. KARL W. ALLISON**

1885-1935

By LELAND E. PHIPPS, M. D.

A little more than 50 years ago there was born a boy destined to be a prominent member of our medical fraternity. Now he has gone from us leaving memories of his deeds that will not soon be forgotten.

He would not have wished for an eulogy. Idle words of praise were never part of him. Rather would he have desired the genuine appreciation and sincere affection of his many friends.

He always had a deep desire to help others. In the medical profession, particularly, there are many who can attribute at least a portion of their success to his helpfulness. And the only compensation he wanted was friendship, reasonable appreciation, and ethical conduct of his brothers in medicine.

His patients were to him friends, friends who, by coming to him, had expressed what to him was a sacred confidence. He accepted the responsibility thus imposed as a command which was his highest joy to obey,—not to the letter only—but beyond that,—up to the complete fulfilment of his exalted idealism. For idealist he was, with a sense of the harmony of things rightly related one to another. And he was more than simply a conscientious and well-informed medical man.

He was a man of many hobbies. He loved flowers and his garden was a real show place. Blooms of rare types were there, many that he himself had

transplanted from surrounding towns and countryside. Even the lowly wild flowers and shrubs were not forgotten in his collection. He rarely took a motor trip without bringing back some beautiful horticultural specimen for his garden. Golf was a recreation with him seemingly more for the association with good fellows than for the game itself. He was an expert with the rifle or pistol, enjoyed fishing and motoring, but in all of his hours of leisure he wanted companions. He made friends and kept them. He was never daunted by a seemingly impassable obstacle. He formed his opinions and unswervingly followed the path he had determined upon.

Those who knew him will remember his indomitable will

power, his courage, his ability, and his loyalty to his family and close associates. Courage and perseverance led to the success which was his. Friendship and loyalty have made his memory imperishable.

Grief and loneliness fill our hearts that he who only a few short days ago shared our joys and sorrows has gone forever. No more beautiful or appropriate sentiment can be expressed concerning him than to quote Ingemsol: "He added to the sum of human joy and were everyone to whom he did some loving service to bring a blossom to his grave he would sleep tonight beneath a wilderness of flowers."



Dr. Karl W. Allison

## MEDICAL FACTS

By J. G. B.

In discussing a case of a 51-year old nurse who died of agranulocytosis, Mallory says, "an overwhelming proportion, more than three-fourths of the cases, have been in nurses, doctors and doctors' families." It was known that this patient took six Allonal tablets (which contain Amidopyrin) the evening before entering the hospital, and she was probably in the habit of taking them.

Ether anaesthesia should never be used on patients with hyperthyroidism, according to Lahey. Neither should local anaesthesia. Nitrous oxide is better, but still not perfect, because it contains only about 9% of oxygen. Ethylene has an oxygen mixture of about 15%, and hence is preferable. But Cyclopropane, with an oxygen mixture of 85%, is the one to be used in severe cases. The inflammable nature of the last two should, of course, be borne in mind.

In reporting his experience in the surgery of the biliary passages, from the date of opening of the Peter Bent Brigham Hospital to the present, a period of about 22 years, Cheever of Harvard gives the following résumé: (1) There are no harmless gall stones. (2) An inflamed gall bladder, or one with gall stones, is likely to give trouble if treated by evacuation and drainage only. (3) The gall bladder is a "dispensable organ." (4) In the absence of severe complications the removal of the calculous gall bladder is, in competent hands, a very safe procedure. (5) Stones in the hepatic and common ducts will sooner or later cause pain, jaundice, cholangitis and a fatal termination. (6) The history, physical examination, x-rays, laboratory tests, or even inspection and palpation of the viscera cannot give positive evidence of the presence or absence of stones in the ducts. (7) Incision, exploration and drainage of the common duct with dilatation of the

papilla, afford the only approximately reliable means of diagnosis and relief.

Alvarez and his associates made a study of the food dislikes and food sensitiveness of one hundred college women. The foods most commonly blamed for indigestion were cabbage, tomatoes, peppers, onions, fats, peanuts, strawberries, cucumbers and chocolate. The list of foods disliked was headed by cauliflower, onions, coffee, cabbage, cucumbers, "sour foods," milk, pickles, peppers, radishes, and pork. Dr. Alvarez points out the advisability of not forcing on hospital patients these disliked foods.

A case of orthostatic hypotension was reported from the Mayo Clinic about a month ago. In all, only 17 cases have been described, and of these patients, three were women, two of whom had passed the menopause. Most patients show: (1) a sharp drop in systolic and diastolic blood pressure, with syncope, when they stand; (2) a failure of the pulse rate to increase so as to compensate for the drop in pressure; (3) deficient sweating with inability to stand hot weather; (4) a tendency to secrete a larger volume of urine at night than in the daytime. There may also be (1) an appearance of youthfulness not in accordance with the calendar age; (2) a slight lowering of the basal metabolic rate; (3) signs of slight changes in the nervous system; (4) loss of sexual desire, perhaps with impotency; (5) a concentration of blood urea around the upper limit of normal. The disease responds best to the oral administration of ephedrine sulphate.

Frazer and Walsh of London are treating patients with pneumonia, septicemia, erysipelas and rheumatic fever with intravenous injections of olive oil. In patients with pneumonia, septicemia, and erysipelas the temperatures returned to normal a few hours after the injection of the olive oil.

## PATHOLOGICAL CONFERENCE --- YOUNGSTOWN HOSPITAL

By C. A. GUSTAFSON, M. D.

The regular Friday noon Pathological Conference was resumed on September 6, 1935, with about 25 doctors in attendance. Last year special attention was paid to Kidney Pathology; this year a special study of Tuberculosis will be made. Dr. H. E. Patrick was in charge of the Conference and 2 very interesting and unusual cases were presented.

The first case was that of a white male about 60 years of age who had been ill for about one year. On admission to the hospital a diagnosis of superior sulcus tumor was made. The physical findings upon which this was based were: Involvement of the cervical sympathetic on the right side, swollen glands on the right side of the neck, pain in the right arm with partial paralysis, and dullness in the right apex. X-ray showed a mass in the right apex with involvement of the ribs and also a general reaction of all the bones, especially of the long bones. On post-mortem examination the right clavicular space was found to be filled with a tumor mass and the right apex contained a mass about 8 cm. in diameter. The first, second and third ribs were involved on the right side, and in the location of the thymus was a mass about 5 cm. in diameter of the same growth. The peribronchial lymph nodes and the cervical lymph nodes were involved, by direct extension probably. Dr. Kramer, in discussing this case, says that Pancost has described cases of this sort as a pathological entity, known as a superior sulcus tumor. Hare of England, in 1837, first described this tumor, giving as his symptoms pain in the arm and clavicle with shooting pains to the arm and heart, contracted pupil on the same side, and on post-mortem examination there was a tumor mass found in the apex. There had been no other cases described until 1924 and at that time Pancost described 5 cases as patho-

logical entities, Horner's syndrome which includes contracted pupil, pain in the arm and paralysis of the arm, always being present. In 1932 he described 3 more cases, and he was of the impression that they were embryonic tumors arising from the branchial cleft on that side. All pathologists, however, do not agree with Pancost. Broder says that this is not a clinical entity because Horner's syndrome will appear where this definite anatomical location is involved,—that is, the brachial plexus and cervical sympathetic. He says that carcinoma of the apex of the lung will cause all of these physical findings. Microscopic examination of the tissue showed a squamous cell carcinoma and not a branchial cleft tumor.

The second case was that of a white male 49 years of age who had been in the hospital on 4 occasions since his first admission in 1931. At that time he complained of fainting spells, followed by weakness, which had been quite severe in childhood and less severe as he grew older. Within the last 8 weeks he had had 2 attacks accompanied by abdominal cramps and diarrhea. The physical findings were negative. The spinal fluid was 220 mm. Hg. There was no free hydrochloric acid in the gastric contents. A diagnosis of early combined sclerosis was made. In 1932 he again entered the hospital with the complaints of feeling of pressure in the abdomen, fainting attacks, and diarrhea. No hydrochloric acid was found in the stomach contents. Temperature showed a slight afternoon rise. A diagnosis at that time of acute gastritis was made. In March of 1935 he was again re-admitted to the hospital. He had had influenza 6 weeks previously, following which he felt tired and listless, with a fever rising as high as 104 degrees in the afternoon. The skin had been slightly



copper-colored since one week before admission. There was no rhythm to the fever. The physical examination was negative except for the copper tinge to the face and sclerae. The chest x-ray was negative. Icteric index was 16. The blood findings were normal; temperature was still irregular. A diagnosis of Addison's disease was made. In April of 1935 he was admitted to the hospital for the fourth time. He still had a fever and chills of an unexplained origin, his temperature frequently going to 104. He perspired at night, especially about the head and neck. He had an occasional cough and expectorated a great deal of green mucus; he had lost 25 pounds in the last six months. His skin was a little more copper-colored. Blood pressure was 118/80. The temperature in the afternoon was elevated but not with any regularity. All laboratory findings were negative. This included the massive blood culture. Undulant fever was thought of and test was negative. Von Pirquet was positive but this is to be expected for a man of his age. There were no changes in the physical findings. On May 10th there was a change in the x-ray findings; there was a generalized infiltration of both lungs which showed markings characteristic of tuberculosis. After several weeks in the hospital he was sent home in a rather weakened condition. His temperature continued to be irregular and he had occasional attacks of weakness, sometimes being semi-conscious. Temperature rose as high as 104.5 degrees. In one of these attacks he died. Smears of the blood had been sent to Drs. Doane and Wiseman of Columbus and their opinion was that there was tuberculosis somewhere. On post-mortem examination there was tuberculous involvement of the peritoneal surfaces of the liver, the spleen was large and mushy, and there was a large amount of green pus in the stomach and small bowel. Both lungs showed dense

involvement of miliary tuberculosis. Microscopic examination showed tuberculous involvement of both lungs, miliary tuberculosis of the spleen, and tuberculosis and fatty degeneration of the liver.

This case illustrates the difficulty in diagnosis. In this case the x-ray showed a positive diagnosis only a short time before death. In differential diagnosis we considered Hodgkin's disease or some glandular involvement and also subacute bacterial endocarditis, but no organisms were found in the blood even with massive culture. X-ray in a period of 20 days showed that from somewhere there was a tremendous shower of tubercular bacilli of the lungs. This case illustrates in a very striking manner, especially to the younger physicians, that not every case can be diagnosed before post-mortem.

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#### Announcements

Dr. Paul R. McConnell announces the removal of his offices to 19 Lincoln Avenue, where he will continue in his specialty, Urology.

Dr. Carl Arthur Gustafson, who succeeds Dr. Fred S. Coombs as Reporter for the Youngstown Hospital, has opened his office at 101 Lincoln Avenue, for the practice of medicine.

Dr. William H. Evans presents as his new associates as specialists in Eye, Ear, Nose and Throat, Dr. Robert E. Odom and Dr. E. J. Wenaas.

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#### Beware, the Addict!

Have you been called to see a family in which somebody claimed to be in great pain—requiring immediate relief—by morphine? There is such an outfit, masquerading under various highly respected names, such as Bailey, Jones, Williams, etc., and they live not far South of Spring Common. Several doctors have been called, and some have been "hooked." Mr. Smith, of the Medical-Dental Bureau, has the facts, and will be glad to tell them to you.



### DR. VAN BUREN D. VEITS

On August 22, 1935, DR. VAN BUREN D. VEITS died. Dr. Veits had ministered to the sick as "the old family physician" in this community for more than thirty years.

### TO A BIRTHDAY

*(Seven and Five)*

By B. W. SCHAFFNER, M. D.

HAIL! HAIL! Brother John—Greetings! I say,  
 For you'r' Seven and Five years young today!  
 It is plain that with "figgers" we may do as we please,  
 Jot them down in a row, add them up at our ease,  
 Make them answer our purpose (be it lesser or bigger),  
 Though figgers don't lie (yet liars may figger).  
 But nevertheless it matters not now, what with numbers we do,  
 Nor the why, nor the how.  
 For the thing that to me most truly appeals,  
 Is the fact that a man is as young as he feels.

Now Seven and Five in the hands of a sage,  
 May make a man more, or less than of age;  
 Depending of course upon what is befitting,  
 Do you wish him to stand, or prefer he be sitting.  
 Should you wish to recall when in mischief he'd delve,  
 Then, Seven and Five surely make him but Twelve.  
 Yet again, should your fancy create an estate  
 From the boy to the man, with looks more sedate,  
 Observe how like magic, from One plus Eleven  
 You can make of the boy a man Fifty-Seven.

But Hold! I now see, while in numbers I'm Dealing  
 A shift of the figgers that's still most appealing.  
 All Hail! to the man (who at Seventy-Five)  
 Is still going strong and glad he's alive.  
 What secret is this, that fills life with such joy?  
 'Tis the man in the man, 'tis the man in the boy.  
 Yes, 'tis the mingling of these along through the years  
 That heightens our joys and softens our tears,  
 And the thing that to me most truly appeals  
 Is the fact that a man is as young as he feels.

*This Month*

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**DR. CHAS. GORDON HEYD**

Professor of Surgery, Columbia University

SUBJECT:

“The Role Occupied by the Liver  
in Abdominal Surgery”

Tuesday, October 15th, 1935

8:30 P. M.

**YOUNGSTOWN CLUB**

*In November*

The Mahoning County Medical Society

Has the Honor

TO ACT AS HOSTS

For

**The Sixth Counselor's District**

AFTERNOON: AT 2:00

*Program to be presented by Local Members*

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Dinner: at 6:30

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Evening Session: at 8:30

SPEAKER

**DR. H. L. BACKUS**

Professor of Medicine, University of Pennsylvania

Tuesday, November 19th

**YOUNGSTOWN CLUB**

## *Coming Events*

December

ANNUAL MEETING

January

ANNUAL BANQUET

SPEAKER

DR. JOHN L. DAVIS

February

DR. ELLIOTT P. JOSLIN

Professor of Medicine, Harvard University

April

POSTGRADUATE DAY

Group from Columbia University

May

DR. WILLIAM F. MANGES

Professor of Roentgenology, Jefferson Medical College

June

DR. CHAS. P. WALFERTH

Associate Professor of Medicine, Jefferson Medical College

## PEPTIC ULCER

By J. PAUL HARVEY, M. D.

*(Continued from last month)***Diagnosis**

Realizing that it would be impossible to diagnose accurately many lesions of the G. I. tract, one must not neglect the fact that simple clinical methods, careful history, and intelligent scrutiny of other data from physical examination are all we can depend upon in the other 60% or 65% of ulcers of stomach and duodenum. (Smithies).

In those individuals exhibiting atypical symptoms stool examinations may be depended upon. Atypical symptoms requiring these procedures are: 1. Pain independent of ingestion of food and often severe. 2. Absence of pain except vague, indefinite discomfort. 3. Epigastric discomfort, fullness and pressure after meals, vomiting of food or mucus.

In a large percentage of cases, duodenal and gastric ulcer can be diagnosed with absolute certainty. First, the periodicity of attacks especially when ulcer is duodenal. Pain with coarse and highly seasoned food relieved by restricted bland diet. The usual rhythm of food, comfort and pain is characteristic of typical duodenal ulcer. To these should be added hypersecretion, localized tenderness, transient weight loss, x-ray findings of spasm or deformity. In addition we may have melena or hematemesis. All these point to a positive duodenal lesion.

On the other hand, the same periodicity and experience with highly seasoned food but with the quadruple rhythm of food, comfort, pain and comfort, hyperacidity or hypersecretion, occult blood, tender point, possible other signs and characteristic x-ray changes, should clinch the diagnosis of gastric ulcer.

A tentative diagnosis of ulcer may be based on the punctuality and periodicity of symptoms. Those symptoms are very suggestive. The disap-

pearance of occult blood when the diet is bland is also very suggestive.

Some of these typical symptoms are often seen in diseases of gall bladder, appendix, kidney, ureter, malignancy, diaphragmatic, and epigastric herniae, ptosis, syphilitic adhesions and other conditions; but further studies and x-rays serve to differentiate a large per cent. of these lesions.

Chronic lesions of the gall bladder tend to cause subacidity and usually give some hint of their presence in the dye test, or an old history of jaundice, or the character of the stools. Appendicitis at times produces epigastric symptoms and may prove a difficult diagnostic problem.

In gastric neuroses the psychic instability, lack of punctuality and periodicity aid in differentiation. In such states the most indigestible foods can often be eaten with impunity while the simplest foods cause violent symptoms. Adhesions of stomach and gall bladder may distort the x-ray picture.

Carcinoma of the stomach frequently shows a persistence of bleeding, low acidity, loss of appetite, asthenia and characteristic x-ray shadows. A large per cent. are found at the middle and distal end of stomach. It may show obstruction or rapid emptying. It shows on the plate a sinister pitting and on fluoroscopy the absence of peristalsis in the cancer region, but the peristalsis reappears below the indurated area. Butler says, "A deformity of greater curvature is always cancer, and if the amount of indentation is greater than a 50-cent piece it is purely cancer."

Syphilis may simulate ulcer or carcinoma of the stomach but x-ray and Wassermann should differentiate it. Epigastric hernia with an adherent omentum is an obvious entity which simulates the ulcer pain. Gastropnoia, with atony and tension of the rela-

tively fixed duodenum, is a frequent complicating feature which may simulate organic lesions but can be differentiated by x-ray easily.

#### Complications

1. Perforation is seen in 5% of duodenal ulcers and 2% of gastric ulcers. This may lead to general peritonitis or a localized abscess. Of our series here there were 8 perforating ulcers, or 16%.

In perforation the onset of agonizing pain is the usual thing. There are usually shock symptoms and the ulcer history to aid in the diagnosis.

The perforation is small as a rule and the usual treatment is early operation. As a result of Singer's work there is a conservative attitude on this subject of small perforations. X-ray in 24 hours may show a bubble of air under the diaphragm. These cases often improve in several weeks without intervention. The mortality is small (Forme Fruste perforations). Forty to 50% of perforations of this type will heal themselves (Keefer).

#### Classical Types of Perforation

In violent intolerable epigastric pain frequently collapse may or may not be followed by remission. Diffuse peritonitis soon appears and rapidly progresses. Death with or without operation occurs in 95% of cases. Another group shows overwhelming pain at the onset, following rapidly by progressive collapse and death in a few hours. A third variety is ushered in by symptoms of peritonitis but peritonitis fails to develop. Evidence of diffusely progressive peritonitis instead, produces rather mild symptoms which quickly abate. (Forme Fruste).

Symptoms of Forme Fruste perforations are periodic attacks of chronic ulcer distress for 1 or 2 years. One or several days prior to actual perforation there are prodromal symptoms consisting of pain, vomiting and epigastric tenderness; pain is more severe and less responsive to alkalis than in ordinary ulcer distress. Vomiting is more persistent than usual

and often fails to relieve pain. There is a point of tenderness elicited by a slight touch, practically always. Onset is abrupt and sudden but less intense than the doubling-up pain of graver perforation. Prostration is less. There is board-like rigidity. In 2 to 10 hours the patient is in comparative comfort. Hiccough may be the sign of localizing air in the sub-diaphragmatic area, and one must get the history of acute sudden pain experienced a day or so previously.

Hemorrhage is seen in 3% to 7% of gastric ulcer cases but is not so dangerous as in duodenal ulcer. Between 10% and 20% of hemorrhages are fatal. The proximity of duodenal ulcer on the posterior wall to large vessels or to the pancreas seems to explain the gravity of hemorrhages from such an origin.

Perigastric adhesions with deformity of the stomach, pyloric, or duodenal stenosis from contractions, etc., are relatively common in long-standing cases. When the clean cut syndrome begins to be blurred and symptoms become irregular with retention, complications are generally developing.

#### Treatment

Each case is a law unto itself. The pendulum is swinging back toward medical treatment more than was the case a decade ago.

Surgical indications of necessity are: 1. Obstruction. 2. Perforations. 3. Doubtful cases, often watching them for sufficient time. 4. Repeated hemorrhages. 5. If repeated medical trials fail surgery is indicated.

The aim of medical treatment is to provide rest for the stomach by eliminating physical and mental strain, calling for absolute rest for 4 to 6 weeks if possible. Foci of infection should be removed. To regulate the diet suitably, give small repeated feedings of low residue, smooth foods. Pylorospasm and gastric irritability should be relieved and hypersecretion should be corrected if present.

Diet: In regulation of diet one

must stress these requirements: first, give no food that is irritating mechanically or otherwise; second, include foods which hold acid in combination and those which stimulate a minimum of gastric juice; and third, provide material to build up the patient and facilitate healing.

Low gastric-stimulant foods are egg white, olive oil, salt-free butter, and gelatine, and is theoretically ideal for the initial stage; but where impractical the milk and cream and cereal mixture may be more satisfactory. The Sippy diet has been a standard procedure for a great many years, but feeding less frequently is productive of more rapid improvement. For many patients 6 feedings a day are more satisfactory. The diet will consist of milk, cream, gruel, eggs, zwieback, toast and butter, for a week or two. Later add boiled rice, custard, pureed vegetables, and in 2 or 3 weeks add rare beef, chicken, lamb and fish, at the usual meal time. Lenhartz diet, higher in protein, is oftener the choice for hemorrhage. Fruit juices may cause discomfort in many of these cases.

Four to 6 weeks or less of a bland diet combined with partial or complete rest and proper medication usually relieves symptoms. For cure the diet, increased to caloric requirements, must be followed for years. Good results require a permanent regime of regular hours, leisure at meals, slow eating, avoidance of irritants, such as condiments and alcohol and hot or cold drinks. In many cases coffee, tobacco, and salt must be denied.

Drugs: Alkalis have played a large role. Those most frequently used are: bismuth, calcinated magnesia, calcium carbonate, and sodium bicarbonate. These, of course, find their best use an hour or so after feeding, and at night. Magnesia is valuable in constipation and bismuth or calcium in diarrheas. Barium sulphate, 2 to 4 ounces, is one of the most effective agents to relieve ulcer pain. Intra-

venous therapy at the present time in the treatment of ulcer finds its greatest advocates in the representatives of drug manufacturers. Mucin has some theoretical value but most of it is subject to decomposition and putrefaction. Besides, the expense is too great for the average patient to bear. Okrin, a vegetable substance rich in mucilagenous material, and containing glyconuronic acid which appears to be necessary for the formation of mucus in the stomach, is a valuable demulcent in peptic ulcer.

In Germany "short wave" x-rays have been recommended and used by some clinics. At present, however, for ambulant or hospital cases, diet and management are the greatest factors in therapy.

#### Treatment of Hemorrhage

The treatment of hemorrhage is fortunately not frequently required. But hemorrhage is a formidable complication when it does occur, and it taxes the ingenuity and resources of the physician.

Immediate therapy: If copious, with retching and vomiting, morphine sulphate in large doses,  $\frac{1}{2}$  gr., q 3 H, if necessary, even if respirations are slowed to 10. In shock, where subcutaneous absorption is poor, intravenous morphine or codein is best. Atrophine is not an aid here, due to diminished urine output and it dries the mucus surfaces and skin when given in frequent doses. Rest with the head and shoulders low; elevate the foot of the bed to favor cerebral circulation, and to permit vomiting without effort. Regurgitation is prevented if the head is low and the patient is inclined to the left. Lavage with normal saline at 110 deg. F., with a large tube is efficacious in stopping a hemorrhage and putting the stomach at rest. Smithies, who has had large experience in lavage of gastric hemorrhage, says he has never observed any harmful effects. Cold applications to the stomach are not used, unless in cases of perforation

in an effort to lessen peritoneal engorgement. Hot applications with a tight binder limiting abdominal motion and peristalsis is an aid. The heat assists in preventing shock.

Mouth feeding is completely stopped. An empty stomach soon becomes aperistaltic and secretion-free, and after 12 hours the muscles contract mechanically closing the bleeding capillaries or arterioles. Give nothing by mouth unless it be sips of hot water for 2 days after hemorrhage has stopped. The fluid content of the body must be maintained during this time by the intravenous or the subcutaneous routes or per rectum. Ordinarily sufficient fluid can be given by rectum to supply the needs and the loss from hemorrhage (Smithies).

Nutrient enemata are valuable during the days of food prohibition. One good nutrient enema consists of 8oz. of normal saline, 30 cc. of glucose syrup, and 30 cc. of 50% alcohol. This is administered by Murphy drip at body temperature.

Where clotting time is long and bleeding profuse, an intravenous infusion is useful. It should consist of 200 cc. of 1% sod. bicarb. and 20 cc. of 5% calcium chloride. Glucose and calcium chloride are also valuable, as also, are transfusions.

Later: Mouth feeding is begun only when hemorrhage has stopped and has not recurred. Indications are: increasing blood pressure; lowered pulse rate and improved quality; and increasing red count and hemoglobin. All these are evidence that hemorrhage has stopped, especially if there are a feeling of well being, freedom from symptoms, and a flat soft epigastrium.

When food is begun, small quantities frequently are advisable. Warm foods are necessary, and those which do not stimulate acidity. Carbohydrates are preferable—fruit, vegetable juices, and broths. Thin suspensions of yeast and haliver oil in soups or

gruels are the best. Milk should be heated to minimize the casein clots. Routine is 2-4 oz. water gruel every hour, and at alternate hours, an ounce of sweet fruit juice. After 24 hours, add to the gruels, thin custard, strained soups, or vegetable purees. The colonic intake can be built up with these additions. Later add vegetables and chopped meat. For 2 weeks a feeding a day is advisable in addition to the above, but the calories should be kept below 3,000.

If bleeding does not stop with infusion of calcium chloride (5%), 20 cc. in saline q. 2 H. for 6 doses, or prompt transfusion of large volumes of whole blood, surgical intervention must be considered. In 3 to 48 hours or sooner one should decide on the advisability of exploration.

Indications for surgery, by all means are: Increasing pulse rate; falling blood pressure; and falling blood count and hemoglobin.

X-ray examination should not be done for several weeks after cessation of a severe hemorrhage.

*(The End)*

#### **Committee of Allied Professions**

Dr. O. J. Walker, Chairman of the Committee of the Allied Professions, called that committee together on the evening of September 27th. Those present, besides Dr. Walker, were Misses Emma Modeland and Sarah Evans, Mr. Tom Hewett, and Drs. W. H. Hayden, C. H. Clark, and C. H. Tidd.

The committee considered the various aspects of the problems presented by the New Relief Policies to be established November 1st. They decided to bring together the councilmanic candidates and the candidates for Mayor in groups, in a series of meetings to review with them the matters of especial interest to the Allied Professions. The Allied Professions are the physicians of Mahoning County, the pharmacists, the hospitals, and the nurses, representing some 3000 voters in their membership.

*October*



## OPINIONS OF OTHERS

By P. J. F.

### Heart Deaths

From a paper by O. F. HEDLEY, U. S. P. H. S.  
SUMMARY AND CONCLUSIONS

The etiological factors in 450 deaths from heart disease occurring in Washington (D. C.), hospitals during 1932 have been studied. Arterio-sclerotic-hypertensive diseases resulted in 61.4 per cent., rheumatic heart disease in 13.3 per cent., syphilitic aortitis with its extensions and complications (syphilitic heart disease) in 12.0 per cent., bacterial endocarditides and pericarditis in 4.7 per cent., congenital cardiac malformations in 2.0 per cent., thyrotoxic heart disease in 1.3 per cent., other conditions in 0.6 per cent., and in 4.7 per cent. the etiological factor was undetermined.

There were considerable variations according to sex and color. Rheumatic heart disease is more common in the white race, particularly among females, than in the colored race. The degenerative diseases, particularly hypertensive heart disease, are common to all races and both sexes. Hypertension is especially fatal in the colored race, more so among females than among males. Coronary arterio-sclerosis and thrombosis are uncommon among Negroes. Syphilis of the aorta and heart is a very common cause of death among colored males, but not so common among colored females.

The importance of arterial hypertension in causing deaths in middle age can hardly be overstressed. In the degenerative forms of heart disease in persons under 50 years of age hypertension was evident in nearly all cases.

Heart disease results in death considerably earlier in the colored race than in the white. This is due in part to the greater prevalence of cardiovascular syphilis and to the greater frequency of arterial hypertension and to the more rapid progression of the degenerative diseases.

### Malpractice Cases

Editor, *Public Forum*:

What I have to say in this letter with respect to malpractice actions is, of course, not susceptible of definite proof, but my conclusions are based upon 15 years of actual experience in this work. I should roughly divide malpractice cases into three classes:

(1) Those that may properly be called "strike" suits. (2) Those where liability is doubtful and depend to some extent upon a determination of issues of veracity between the patient and the physician. (3) Cases where the liability of the defendant is clear.

I would not attempt to allot percentages to the classification above enumerated, although it seems to me that within the last five years there has been an increase in meritorious claims on the part of the plaintiff.

So far as causes for malpractice actions are concerned, I believe that a great many result from careless, critical remarks on the part of some physician. Time and again the plaintiff's lawyers have told me that their clients never would have started the action but for the criticism of some other doctor. *The State Journal* attempted to bring this fact home to our membership in an editorial published in the July 15, 1934, issue.

The economic depression is to my way of thinking also responsible for many of our cases. This has a two-fold effect: (a) Patients hard pressed for money will begin an action when they would not have done so in prosperous times; (b) some physicians are undertaking to do work for which they are not fitted and which in prosperous times they would have referred to competent doctors.

Lack of tact on the part of the physician in his relations with his patient is also an inciting cause for malpractice actions. There are occasions where the doctor knows that

trouble is in the offing and if at that time patience and tact are exercised by the physician he would, in my opinion, often avoid a lawsuit. It is true, of course, that in some situations no matter what the physician does, a malpractice action will result. It is also a fact that cases of liability will happen to the most competent men.

Some years ago we collected from our experience advices on how to avoid a malpractice action. These suggestions are embodied in the book which Mr. Stryker has written, entitled "Courts and Doctors," and will be found in Chapter 12 of that book, under the heading "Suggestions on Avoiding Being Sued." These suggestions are based on practical experience and if followed by physicians would, in my opinion, materially cut down the number of malpractice actions.

In the chapter to which reference has already been made, you will find that the advice is directed against many things which, in our opinion, have been responsible for malpractice actions in the past.

There has been another result of the economic depression which is true not only so far as malpractice actions are concerned, but affects all phases of personal injury actions. The depression has filled the jury box with the unemployed. These men are often disgruntled and bitter and come into the jury box with the desire to take it out on somebody.

It is also true that there has been a noticeable change in the attitude of juries toward the medical profession. Neither the professions of law nor medicine occupy in the public mind the position that they once did, and this attitude is, of course, reflected in the jury box.

It is most important to point out that we must be extremely careful to avoid making public the shortcomings of the medical profession. It is impossible to keep publicity of this char-

acter within the profession. The plaintiffs' lawyers are quick to seize upon any unfavorable publicity and use it to our great disadvantage.

Perhaps you will recall that some time ago a committee (I believe it was a committee of the Academy of Medicine) made public its findings on obstetrical fatalities. In a large percentage of these cases obstetrical deaths were laid to the incompetence of the doctor. This report was given great publicity in all the papers in this State. I am not in a position to pass upon the correctness of the findings of the committee, but I do know that the report was widely read among others by lawyers, judges, and prospective jurors, and naturally this did not help us.

It must also be recognized that in all professions there are a certain percentage of men who lack those qualities of honesty and integrity which are so essential to the proper practice of any profession. Whether competent or incompetent they present a hazard which must always be recognized. This, of course, has always been true and always will be true.

(Signed) LORENZ J. BROSNAN  
Counselor at Law, in *N. Y. Medical Week*.

### Speakers' Bureau

During the month of September the following radio talks were made:

September 3, Dr. P. H. Kennedy, on "First Aid".

September 10, Dr. C. M. Askue, on "A Romance of Vaccination".

September 17, Dr. E. H. Jones, on "Allergy in Childhood—Part I".

September 24, Dr. J. M. Kavanaugh, on "Allergy in Childhood—Part II".

September 24, Dr. W. M. Skipp, on "Obesity"; and September 25, Dr. C. B. Norris, on "How One May Have a Beautiful Skin". These two addresses were given under the sponsorship of the Young Women's Christian Association of Youngstown.

### In Our Hospital Libraries

There is no doubt that the wise physician continues to study throughout his entire life. He budgets his time for reading, for the stimulation resulting from medical society meetings, for the investigation of puzzling problems and the writing of essays. Unless these four are combined, some side of his professional fullness of life will be neglected and he will in some way restrict his field of usefulness. —*Pittsburgh Medical Bulletin*.

This month your attention is called to a few articles to be found in various medical periodicals in the hospital libraries. These articles seem well worth reading.

In the June issue of *American Journal of Medical Sciences*: "Macrocytic Anemia following the Use of Hair Dye," by C. W. Balbridge, page 759.

In the May *Lancet* is a most interesting article on "Staphylococcic Pneumonia Among Infants," by C. M. Smith,—page 1204.

The *American Journal of Roentgenology and Radium Therapy* for June, presents "Roentgenologic Diagnosis of Tumors in Sellar Region" by Dr. Nichols of Cleveland,—page 733. To those who are interested in the progress of x-ray diagnosis this would appear to be a valuable contribution.

Two papers in *Annals of Internal Medicine* for June are good. The first is "Diabetes Mellitus and Pulmonary Tuberculosis," by McKean and Myers, p. 1591; the second is "Atopic Annoyances in Course of Pulmonary Tuberculosis," by Phillips, page 1649.

The work being carried on these days with the various endocrinal substances promises to bring great and beneficial changes. In *Surgery, Gynecology and Obstetrics*, July, G. Van S. Smith and O. W. Smith, page 27, have an article "Further Quantitative Determinations of Prolan and Estrin in Pregnancy."

For an interesting discussion of

Ménière's disease as to its similarity in pathogenesis to epilepsy, eclampsia, migraine, the allergic diseases, angina pectoris, gout, and bronchial asthma, read "New Concept of Ménière's Disease," by Foldes, page 243 of *American Journal of Diseases of Nutrition*, June issue.

*Annals of Surgery*, July, page 22, carries a paper on "Splanchnic Nerve Section in Juvenile Diabetes," by G. de Takáts. The operation is described. It was done in only a few cases, but may prove to be of value if selectively used.

### Gleanings

By C. A. G.

Drs. O. J. Walker, Wm. Evans and E. C. Goldcamp attended the American Otolaryngological Association convention in Cincinnati the week of September 16.

Drs. Allsop, Gross, and Sedwitz have just returned from a two-weeks camping and fishing trip in Canada.

Dr. Malcolm Hawk, Resident at the North Side, is vacationing for two weeks with his parents in Mansfield, Ohio.

Dr. J. C. Kemp, of Kewanee, Illinois, Northwestern graduate, who interned in Akron last year, has been appointed Assistant Resident at the North Unit of Youngstown Hospital.

Dr. Clarence Sears, who was resident at the Youngstown Hospital two years ago, has returned to be assistant to Dr. McClenahan. Dr. Sears spent a year in general practice in Iowa. He expects to do postgraduate work in obstetrics and gynecology soon.

Dr. and Mrs. Herman A. Kling have returned from their honeymoon in New York and are at home at 2033 Elm Street. Mrs. Kling was Miss Leona Newberry of New York.

Dr. R. H. Middleton was recently married to Miss Helen Hick of Youngstown. They have just returned from honeymooning in Canada.

## HEALTH NEWS

By H. A. K.

**Blindness and Tetanus**

Although much has been done to prevent blindness due to gonorrhoeal infection of the eyes at birth, we still must pay for the education of too many children so unfortunately blinded. Success in treatment depends upon very early care, every minute counts. The state realizes the cost of caring for the blind, and so provides payment of nurses to children under two weeks of age through the local health officer to reduce the chances of blindness. A marked reduction in case incidence is shown by figures of 27% of child blindness in 1908 due to G. C. ophthalmia neonatorum, as compared with 7% at the present. This figure is still too high and means lack of vigilance on the part of physicians. Let us diagnose, report, and begin treatment early with adequate trained nursing care so that this preventable thing may be wiped out in this day of gonorrhoeal flourish.

Another preventable but rapidly fatal scavenger of public health is the tetanus bacillus. The fact of its being anaerobic may be the deciding point of its development. Three cases in one month died of tetanus here with lacerations easily thus infected from the history with no rational treatment for prevention. These lacerations had been tightly sutured. When in doubt and no antitetanus serum is available it is best to leave the wound wide open so that anaerobic conditions are eliminated. The board of health supplies the serum upon request to persons unable to pay.

**Diphtheria**

1. *Recognition of the disease.*—An acute febrile infection, generally of the air passages, especially of tonsils, throat, and nose, marked by a patch or patches of dirty white and grayish membrane, from which cultures of the diphtheria bacillus may be ob-

tained. Cases of diphtheritic infection in infants are often missed because of the lack of definite local symptoms.

2. *Etiological agent.*—Diphtheria bacillus, *Corynebacterium diphtheriae*, the Klebs-Loeffler bacillus.

3. *Source of Infection.*—Discharges from diphtheritic lesions of nose, throat, conjunctiva, vagina, and wound surfaces. Secretions from the nose and throat of carriers of the bacillus.

4. *Mode of transmission.*—Directly by personal contact, indirectly by articles freshly soiled with discharges, or through infected milk or milk products.

5. *Incubation period.*—Usually 2 to 5 days, occasionally longer if the carrier state precedes the development of clinical symptoms.

6. *Period of communicability.*—Variable, until virulent bacilli have disappeared from the secretions and the lesions. Usually 2 weeks or less, seldom over 4 weeks. In exceptional cases virulent bacilli remain in the throat and discharges from 2 to 6 months.

7. *Susceptibility and immunity.*—Infants born of mothers with an established immunity are relatively immune for the first 6 months of life. By the ninth month of life this passive congenital immunity has been lost in a high percentage of infants. Subsequently children and adults develop immunity apparently in approximate proportion to their contact with associates who carry the diphtheria bacillus with or without exposure to persons with recognized attacks of the disease. It is usual to find about half of the children of school age and three-quarters of adults in large cities immune. Such accidental immunity is less frequent among rural and small town populations. Passive temporary  
(Continued on Page 336)

**Our Nurses**

Miss Mary Scully, St. Elizabeth's Hospital Class of 1930, was married on August 31st to Dr. H. B. Thomas. Dr. and Mrs. Thomas will live in Gallipolis, Ohio.

Miss Anastasia Ryan, St. Elizabeth's Hospital Class of 1926, is taking a postgraduate course in Physiotherapy in Chicago.

Miss Isabelle C. Connor, Youngstown Hospital Class of 1930, entered the Novitiate of the Benedictine Order at St. Mary's, Pennsylvania, on September 8th.

Miss Alice Port, Youngstown Hospital Class of 1931, was married on September 2nd to Dr. Martin C. Lindman. Mrs. Lindman has been Superintendent of the Chicago Maternity Center for the past three and one-half years. Dr. and Mrs. Lindman will reside in Chicago where the former is chief resident in St. Luke's Hospital.

Miss Mary Ann Moore, Youngstown Hospital Class of 1934, was married on September 11th to Mr. Lester H. Smith. Mr. Smith is associated with the engineering department of the Youngstown Sheet and Tube Company.

Miss Ruth Renstrom was married to Mr. Howard Wickerly of Struthers, Ohio, on September 10th. Mrs. Wickerly has been a member of the staff of the North Side Unit of the Youngstown Hospital since May, 1932.

The marriage of Miss Lucille Fisher to Mr. Russell L. Vaughn took place on September 14th. Mrs. Vaughn is a graduate of Youngstown Hospital class of 1933 and has been a staff nurse at the North Side Unit of Youngstown Hospital. Mr. Vaughn is associated with Butler, Wick and Company.

Miss Helen Rein has been appointed to the position of Practical

Instructor at the South Side Unit, Youngstown Hospital. Miss Rein, who is a graduate of the University of Cincinnati and the School of Nursing and Health of the same University, was for several years a member of the Navy Nurse Corps and has had much experience in both the teaching and administrative fields.

Miss Luella N. McComas, for the past 5 years Practical Instructor at the South Side Unit of the Youngstown Hospital, has been appointed Second Assistant Directress of Nurses at the same unit.

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**HEALTH** (From p. 334)  
immunity (10 days to 3 weeks) and active immunity of commonly permanent duration can be developed artificially. Recovery from attack of the disease, especially if with the aid of therapeutic diphtheria antitoxin, is not necessarily followed by active immunity.

8. *Prevalence*.—Endemic and epidemic. Two-thirds or more of the cases are in children under 10 years of age and two-thirds or more of the deaths occur in children under 5 years of age. More common in temperate zone than elsewhere, and in fall and winter months. Local increased prevalence may occur in irregular cycles of 4-to-8-year intervals. Reductions in incidence, death rate, and case fatality rate has been progressive and marked in the past 30 years.

9. *Methods of control*:

A. The infected individual, contacts, and environment:

1. Recognition of the disease and

reporting. By clinical symptoms with confirmation by bacteriological examination of discharges.


2. *Isolation*: Until 2 cultures from the throat and 2 from the nose, taken not less than 24 hours apart, fail to show the presence of diphtheria bacilli. Isolation may be terminated if the micro-organism reported as morphologically "positive", although persistently present, proves to be an avirulent form. Where termination by culture is impracticable, cases may be terminated with fair safety as a rule 16 days after onset of the disease. A virulence test should be made in any case where positive throat cultures are reported 3 weeks or longer after onset of the disease.

3. *Concurrent disinfection of all articles which have been in contact with the patient, and all articles soiled by discharges of the patient.*

4. *Terminal disinfection*: At the end of the illness, thorough airing and sunning of the sick room, with cleaning or renovation.

(Continued on Page 337)

## ARTHRITIS

 IN his care of the arthritic patient, the physician encounters many cases that are stubbornly unyielding to treatment. But in spite of their resistance, much can be done to relieve suffering and check further inroads of the disease.

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## HEALTH (From Page 336)

5. *Quarantine*: All intimate contacts until shown by bacteriological examination not to be carriers.

6. *Immunization*: Passive immunization with antitoxin is rarely necessary for exposed persons over 5 years of age, for whose protection daily examination by a physician or nurse suffices. Infants and young children exposed to diphtheria in the family should receive a prophylactic dose of antitoxin without prior Schick testing, unless they are already known to the physician to be immune.

7. *Investigation of source of infections*: In unreported cases, in carriers and milk.

## B. General measures:

1. *Active immunization of all children, without prior Schick testing, at the age of 6 months, with a diphtheria toxoid. This same procedure should be applied to all children at or below 6 years of age if immunization has been neglected in infancy.*

2. Older children, and adults especially exposed, including teachers, nurses, and physicians found to be Schick-positive should be actively immunized. In order to minimize local and constitutional reactions in members of these groups, it is desirable to carry out a preliminary "toxoid reaction test", nonreactors to receive toxoid, and reactors toxin-antitoxin

(goat) in 2 or 3 inoculations or suitably diluted toxoid.

3. Pasteurization of milk supply.

4. Educational measures to inform the public, and particularly the parents of little children of the advantages of toxoid immunization in infancy.

(From *Public Health Reports* of the U. S. Public Health Service.)

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\*Morris, R. S. and Dorst, S. E.: *Am. J. Med. Sci.* 178:631-632 (1929)

Burger, G. N.: *J. Lab. & Clin. Med.* 19:234-243 (1933).

