BULLETIN

of the

Mahoning County Medical Society

Organized 1872

"All That Is Beautiful Dies In Man,
But Not In Art."
—*Leonardo da Vinci.*

June, 1936

Volume 6 Number 6

ΑΣΚΛΗΠΙΟΣ ΑΣΚΛΗΠΙΟΣ

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THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

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Vol. VI, No. 6. June, 1936

PRESIDENT'S PAGE

June 1936

The first half of the year 1936 is nearly at an end. It seems to me rather significant that ideas and material for this page seem more difficult to assemble than heretofore. Is it an early summer let-down in medical activities, in society work; is it due to an easing off of medical-economic stresses and strains; or is it entirely a personal factor? If the latter, we sincerely hope it is not progressive.

Routine society work is being carried on very smoothly by the various committees. The program committee hopes for a particularly good attendance at our next meeting, June 16th. Dr. Wolferth is well known personally to many of our members, he having been at one time pathologist at City Hospital. He is a man of wide clinical experience and will have, without doubt, a message both practical and applicable for all of us.

There will be no scientific meetings during July and August, these months being assigned to Dr. McNamara and his entertainment committee. They have assured us of some good times to come, with an innovation or two. May we all be there and participate with vim and vigor, with hilarity, but seemly restraint.

L. GEO. COE, M. D.

BULLETIN
of the
MAHONING COUNTY MEDICAL SOCIETY
JUNE 1936

THE PANEL SYSTEM

May 25th, 1936.

Dr. H. E. Patrick
138 Lincoln Avenue
Youngstown, Ohio

Dear Doctor Patrick:—

Because much of the argument concerning the various forms of social medicine is presented with obvious intention to support a viewpoint, I wrote to a friend of mine, Doctor Ramsay, in London, and received from him the information which follows my letter. My own opinion is that we shall hear more about this question from time to time, and in what Doctor Ramsay says I am convinced that we have exactly the reactions of the physicians of England to the panel system.

Sincerely yours,
CLAUDE B. NORRIS, M. D.

March, 2nd, 1936.

Dr. Hugh Ramsay
Victoria Cross Hospital
London, England

Dear Doctor Ramsay:—

In forty-five of our forty-eight States the subject of the Socialization of Medicine is being debated by high school students and in many of the schools of higher learning. Of course, we of the Medical Profession are apprehensive as to the dangers of State Medicine. In the negative arguments the experiences of Germany and Russia with State Medicine, and of England with the Panel System are cited to show the inefficiency of such systems. Our Medical leaders tell us that the practitioners of England are very much dissatisfied with the Panel System and that the results so far as the public service is concerned are not as good as under our system of practice.

Would you mind to give me your own views? If you desire it I shall treat what you say in confidence. Specifically, is the Profession satisfied with your system? Do you feel that the Doctors are as well off as before? Is the Public as well served as under the old system of private practice?

Sincerely yours,
CLAUDE B. NORRIS, M. D.

May 7th., 1936.

Dear Doctor Norris:

I am afraid this is a most belated reply to your letter. I fear it will be too late to serve any useful purpose. My attempts to meet your request have been attended by considerable misfortune. I wished to obtain an opinion on our "panel system" a little more authoritative than mine,

and so asked one of the medical referees to prepare something. He took rather longer than I anticipated, and by that time I had very stupidly mislaid your letter. I have just obtained your address from Mother.

I enclose a short resume of the scheme, supplied by my friend. He has not expressed any opinions about the success of the scheme, but I think what I propose to say myself more or less covers the professional attitude to the question.

It depends how one looks at it. A good many physicians were placed on a much improved financial basis when the scheme was started. A regular income which is guaranteed is much better than huge outstanding debts which are very difficult to collect. Consequently, the average general practitioner has without doubt been benefited in this way.

Again, it has meant the provision of medical attention easily attainable by the large mass of the "working class" population. They need no longer remain away from the surgery (I think you call it "the office") because they cannot afford to pay the fee. There are also available a few specialist services which augment the usual attention. So far so good, but there is a strong debt side.

Ease of access to the doctor is of course inclined to be taken advantage of by the usual crowd of those who suffer from minor ailments or perhaps only imaginary ones. The evening surgery frequently is filled with dull and uninteresting cases which absorb far too much of the physicians energies, to the detriment of his work in general. Many patients seem far more interested in obtaining the necessary certificates allowing financial benefits, than in the doctors efforts to help them medically. Many forms have to be filled up in a short space of time, and the whole process produces a good deal of irritation in all but the most stolid. No doubt it is part of our duty to deal with a goodly number of stupid people who pay little attention to us, but our National scheme rather tends to encourage this attitude. Also it necessitates the presence within the scheme of a large number of laymen of the "clerk" type, who are concerned only with records and statistics and do not seem to realize how "elastic" one's attitude to medicine must be, and what an inexact science it still is in many ways. A good deal of friction is the result. As you can see, with overcrowded surgeries, frequent home visiting, and much work of the clerical type which is uncongenial, the quality of the work done must inevitably suffer. This is of course true of any busy practice, but under our scheme there seems to be much more that is exacting and unpleasing than there ought to be.

It is difficult to see, however, what could take its place. I am not personally averse to "State Medicine". I don't mind what the method or organization is, so long as it provides adequate facilities for good quality work, with proper remuneration and freedom from interference by the layman. Whether we could obtain such a state of affairs under State control is of course very doubtful—may we be preserved from the "organizing" State official!

Whatever may be the solution, I feel that a greater degree of "institutionalization" will be necessary, with provision of assistance to take the clerical work out of our hands, without undue interference. To sum up, I may say that our scheme is better than nothing, but that there must be several better ways of doing things. So far the whole effort seems to be directed towards providing "sick-pay" for the patient, no doubt very important, but practically no thought has been given to making it easier for the Profession to do efficient work. In fact, I do not see how good work can possibly be done within the scheme as it stands.

I hope this very inexpert presentation of the position may be of some

little help, if not too late. I myself am fortunately released from the worries of general practice. I have specialized in diseases of the chest and have a clinic and sanatorium of my own under our County Tuberculosis Scheme, with x-ray plant and good clerical and nursing staff of my own. The routine dull work is done for me and I have little to complain of. This of course makes my suggestions about our National Scheme somewhat "second-hand" and perhaps not very reliable, but what I have said is I think fairly representative of the ideas of those who work within it.

Please accept the best wishes of myself and my people for Mrs. Norris and yourself.

Yours sincerely,
HUGH RAMSAY, M. D.

National Insurance Acts

These acts apply with certain exceptions, to all persons employed in manual labour and to all other employed persons whose rate of pay is under £250 per year.

Funds

These are raised by weekly contributions from:

(a). Employer; (b). Employed person; (c). Grant from the State.

These contributions are distributed by *Approved Societies*. These societies are special departments of existing Industrial Insurance Societies, Sick Clubs, Tontine and yearly Dividing Societies.

Benefits

These consist of the following:

(a). Medical Benefits; (b). Sick and Disablement Benefits; (c). Special and Additional Benefits.

These benefits are not always available, and do not concern us here.

Medical Benefits

These consist of medicine and treatment by the Doctors on the Panel. They commence immediately on insurance, at 16 years of age. The Act entitles the insured to adequate treatment by a qualified general practitioner, and to proper and sufficient medicine.

For administrative purposes the country is divided into areas, controlled by an Insurance Committee. The Insurance Committee is the local responsible Authority, but there are also the

1. The Local Medical Committee, representing all the Doctors in the area, whether working under the National Health Acts or not. This Committee should be consulted about the Terms of Service and all matters concerning the interests of the Profession as a whole.

2. The Panel Committee, representing the Panel Doctors in the area, is consulted by the Insurance Committee, on such occasions as required by the act, to learn the opinions or the wishes of the Panel Practitioners. Complaints by one doctor against another may be considered by either of these Committees.

3. Medical Service Sub-Committee of the Insurance Committee. This Committee consists of six to ten members, half appointed by the Insurance Committee, the other half consisting of doctors appointed by the Local Medical Committee and the Panel Committee. Its duties are to consider complaints by: (a). An Insured person; (b). A Doctor; (c). An Approved Society; (d). An investigation called for by the Insurance Committee or by the Panel Committee.

Panel

The list consists of doctors available under the Act. It must be posted up in the Post Offices in the area. Any qualified practitioner may apply for admission to this list in any given area, notice being given three (3) months before the intended time of commencement.

Terms of Service

These relate to:

(a). Fees. Fees are: (1). Ordinary fees payable for the daily work. (2). Special fees where allowed.

(b). Medical Attendance. (1). At

the patient's home or at the surgery. (2). Emergency: any place in the area.

(c). Medicines. Proper and sufficient medicine for adequate treatment, with due regard to economy. Prescribing is well supervised.

(d). Certificates.

These are required: (1). First, at the beginning of every illness, on the first occasion on which the patient is seen by the doctor, either at the surgery or at the patient's home. (2). Final, to be given on the last visit or attendance of the illness. (3). Intermediate, to be given every eighth day, between the first and final certificates. (4). Special intermediate certificates, for convalescence or monthly for long illnesses.

(e). Records. To keep records of the illnesses of the patients in the official form as may be required from time to time by the Minister. To afford to the regional medical officer or his representative access to these records at all reasonable times.

(f). Regional Medical Service. This is conducted by Medical Officers of the Ministry of Health, who (1). Inspect records from time to time; (2). Interview panel practitioners on matters relating to records, prescribing, certificates or other matters as required by the Minister. (3). Examine cases refered to them by the Approved Societies, or by the Doctors.

The Societies have the power to refer for examination by the Ministry any patients receiving sick or disablement benefit, during the illness.

BACTERIOPHAGE, WITH SPECIAL ATTENTION TO ITS THERAPEUTIC VALUE

By ALBERTA NELSON, A B., M. S.

(Continued from May issue)

Water Purification

It has been suggested, further, that since rivers, lakes, and surface waters invariably contain one or more transmissible lysins for some bacterial species, that such widely distributed "bacteriophages" must play a significant part in natural water purification. Having noted the vibriocidal properties of certain Indian rivers and the bactericidal property of at least one European stream, certain enthusiasts have suggested that bacteriophages should be added to swimming pools and used in the routine disposal of sewage. Bacteriophage has even been suggested as a possible food preservative, as a plant spray, and as a means of conserving or enhancing the fertility of the soil. Many criticisms can be offered immediately to these suggestion. It has not been proven that the lytic agent is a self-propagating vital unit. Multiplication takes place apparently only in the presence of rapidly proliferating homologous bacterial strains. If for any reason bacterial proliferation is inhibited, little or no increase takes place in the accompanying "phage titer." This in itself would seem to rule out the possibility of any appreciable quasimultiplication of bacteriophage under the usual low temperature of surface waters, at least for bacteriophages of the gastro-intestinal group. It is further emphasized that, even under most favorable temperature and nutritional test tube conditions, bacteriolysis does not occur until the phage concentration of the culture medium has been raised to approximately a billion "lytic units" per cc. (14). A mere dilution of the culture medium might thus delay or even prevent bacteriophage lysis. Moreover, the lytic factor is known to be absorbed on proteins, nonprotein colloids, kaolin, clay and other suspended particles and thus rendered temporarily inactive. Under such conditions, the exposed micro-organisms may change to bacteriophage-resistant strains, which can't be lysed even under favorable test tube conditions.

Beard (46) has studied this problem, simulating conditions of natural water supplies, etc., as nearly as possible, and in none of his tests, did bacteriophage show the least effect on the corresponding bacteria. There was no significant difference in the number of specific micro-organisms developing or remaining in any fluid or chamber to which bacteriophage was added, when compared with control counts under bacteriophage free conditions. Moreover, none of the exposed bacteria became phage resistant. In the presence of clay or of suspended organic particles, 99% of the phage was absorbed. Beard concludes that it does not seem possible that phage is likely to participate significantly in the reduction of bacterial numbers in polluted water or in sewage.

Conclusion

In conclusion we can only say that the evidence concerning bacteriophage is at best inconclusive. There are too many conflicting statements with regard to its nature and its use to permit anyone to make a definite assertion concerning its value. Each writer who bas used phage extensively has his own pet theory and technique in administration, thus making it impossible for others to repeat the startling clinical experiments reported by some. Indeed, most phage enthusiasts insist with Lampert (49), that his or her own technique must be followed in detail for success — and these techniques seldom agree to the extent that no loophole be left to explain failure. We can, in general, say that bacteriophages have been isolated for very varied species such as Eberthella coli; Salmonella schotmülleri, pullora, suipestifer and typhi-murium; Proteus vulgaris; Vibrio comma; Pasteurella pestis and bovis; Corynbacterium diptheriae, and B. subtilis; staphylococcus, streptococcus, pneumococcus, Rbizodium radicicolum, B. tumefaciens and B. carotovoms.

Attempts have been made to use bacteriophage therapeutically in treatment of such things as: Asiatic cholera, dysentery, typhoid fever, boils and carbuncles and furuncles, abscesses, cellulitis, peritonitis, puerperal sepsis, fecal fistulæ, cystitis, infected wounds, bed sores, leg ulcers, sinusitis, staphylococcus septicemia, impetigo, acne, streptococcic infections, osteomyelitis, pyelitis, bubonic plague and chronic bronchitis. Most success has been evidenced apparently in the use of phage among the group of enteric disorders and the staphylococci infections, although complete success has not been attained even here. We do not know if the agent produces actual lysis in vivo, or causes bacterial variation, or if it has an immunizing effect or even, as is claimed by certain workers (47), that phagocytosis is increased as a result of its action. Although there are several references made to the fact that the injection of bacteriophage might be harmful to the individual, it is generally agreed that the stuff is harmless. However, while commercial phage preparations have been available to the medical profession for 15 years, the American Medical Association has not given them a stamp of approval (48).

The nature of the lytic principle and its mode of action is certainly attended with uncertainty at the present time, and since the preparations used in therapy contain in addition to the phage, proteins and bacterial metabolic products, they must be used with care and discretion. The results produced might in cases be induced by plain broth filtrates. This is a great objection to the past efforts of those who have experimented with the agent—they have in most instances neglected or have been unable to provide suitable controls for their experiments so that the spectacular results secured by some cannot be properly compared with the dismal failures of others.

N. B.—An extensive Bibliography was submitted by the author, but from considerations of space, the editor has refrained from publishing it.

COLLAPSE THERAPY IN PULMONARY TUBERCULOSIS

By CHARLES H. WARNOCK, M. D.

Not many years ago, the treatment of pulmonary tuberculosis was a dull, weary and often discouraging routine of bed rest, fresh air and food. With the introduction of various procedures designed to collapse diseased lungs, it has changed to a vital, active, extremely encouraging matter, as interesting as any other field of modern therapy.

The medical profession, especially in this country, was slow to recognize the benefits of collapse therapy. In these days of bold, almost reckless thoracic surgery, it is difficult to understand the timid, fearful manner in which physicians approached the possibility of therapeutically collapsing the lungs.

The first measure attempted on any scale was artificial pneumothorax—the introduction of air or other gas into the pleural cavity. The measure was independently and almost simultaneously introduced by Forlanini in Italy in 1894, and by Murphy in this country in 1898. Murphy's announcement created immediate and widespread interest, but he soon turned the work over to his assistants, particularly Lembke. With the untimely death of Lembke, interest lagged, so that within four years after Murphy's paper, pneumothorax in this country was almost completely dropped. However, from 1904 to 1912 the treatment was making rapid strides on the continent, chiefly through the efforts of Brauer. Reports of the work abroad began to filter back to this country, then suddenly, about 1912, American physicians again took up the treatment with great enthusiasm and within three years it was being used by every sanatorium and phthisiologist in the country.

In the twenty years that have since elapsed, it has become an established proceedure. Waring states without exaggeration that it has unquestionably saved hundreds of thousands of lives, and as long as mankind suffers from tuberculosis will remain a most valuable method of treatment. Other proceedures, some more radical, have been developed and are now being widely used. These are intra-pleural pneumolysis, phrenic nerve paralysis, and thoracoplasty.

Some idea of the extent to which collapse proceedures are being used at the present time may be gained from the report published in the Tuberculosis Number of the Journal of the American Medical Association for December 7, 1935, covering tuberculosis institutions in this country. During a twelve months period 1933-1934, over half a million pneumothorax treatments were administered. 929 pneumolysis operations, 7695 phrenic nerve operations and 2935 thoracoplasties.

Artificial Pneumothorax

By far the most valuable and most widely used of these various measures is artificial pneumothorax. It is a comparatively simple proceedure, rather than a drastic one, as it was first thought to be. It requires no special technical skill, although considerable experience is necessary in determining how much air should be injected each time and how often injections should be given. When the initial injection is made, a trochar is inserted through the chest wall into the pleural space, as determined by the oscillations of a water manometer as the patient breathes. From 200 to 400 c.c. of filtered air are then allowed to enter the pleural space. Subsequent injections, or "refills," are given on the second or third day and thereafter twice or once a week. After a lung has been collapsed for some time, refills need not be given more often than once in two weeks, once a month, or even once in three months, depending on the rapidity with which the air is ab-

sorbed and the degree of collapse it is desired to maintain.

Contrary to what one would think from viewing tuberculous lungs on the autopsy table, diseased areas in the lungs collapse more readily than normal areas, due to the fact that in such diseased areas there is little or no diminution of contractility, but marked impairment of expansibility. Thus, on allowing a quantity of air to flow into the pleural space, one frequently sees the disease portion of the lung shrink, while the healthy lung tissue remains expanded and carries on respiratory function. This phenomenon is termed "selective collapse". If the negative intra-pleural pressure is still further lowered by the introduction of more air, a more or less complete collapse of an entire lung can be secured, and this degree of collapse is usually desired when the disease is limited to one lung.

The object of the treatment is to put the diseased lung at rest in order to favor healing. Strict bed rest alone reduces the activities of the lungs very slightly. They continue to expand at the rate of approximately 25,000 times a day. Therapeutic collapse of the lungs serves to squeeze tuberculous sputum and debris out of the air containing tissue opening into a bronchus, much as water is squeezed from a sponge. Venous stasis and blocking of lymph circulation occur, which prevent resorption of toxins from the diseased areas and also stimulate the growth of connective tissue which aids healing. There is also a definite inhibitory action on the growth of tubercle bacilli. Relief from symptoms, such as fever, cough, expectoration and hemoptysis is often immediate.

Formerly the indications for therapeutic pneumothorax were hemorrhage, cavity formation and disease limited to one lung. Greater experience has shown the wisdom of wider application. A small area of disease in the opposite lung was at one time considered a contraindication and the impression still persists in the minds of many physicians that pneumothorax is applicable only in cases of unilateral disease. Paradoxical as it may seem, collapse of one lung is often accompanied by improvement in the opposite lung. Such improvement may be explained on the basis of the following factors: The patient's general condition is improved by the reduction of toxemia, the sputum is rendered negative for tubercle bacilli, thus cutting off the chief source of spread to the contralateral lung, and pneumothorax on one side has a slight immobilizing effect on the opposite lung, particularly if the mediastinum is movable.

Partial bilateral pneumothorax is frequently employed, providing the disease in the better lung is not too extensive or of a rapidly advancing character. If, during the course of unilateral pneumothorax, disease appears in the sound lung, bilateral pneumothorax may be employed to control the process on both sides. In maintaining bilateral pneumothorax the degree of collapse on either side is balanced by injecting air in one side, then the other, usually with more collapse being maintained on the worse side. The lungs possess sufficient reserve capacity so that approximately half of each lung may be collapsed without producing dyspnea.

Conditions once considered to contraindicate pneumothorax no longer do so. Patients having tuberculous laryngitis and enteritis are now treated by collapse; frequently this is what is needed most. Diabetic patients with tuberculosis are treated as are other diabetics, with their tuberculosis controlled by pneumothorax. Pregnancies are allowed to proceed to full term while the patient receives pneumothorax, with no greater difficulty in delivery than if the lung were not collapsed, and the tuberculous disease remains under control. Pneumothorax may be employed in children of al-

most any age, providing the disease is of the adult or reinfection type.

Statistical studies of the end results in any form of treatment of tuberculosis are difficult to compare because of the difference in the types of cases included. Among the most reliable statistics available is a group[1] of 492 patients treated by pneumothorax. Of these, a satisfactory collapse was obtained in 211, partial collapse in 183 and no collapse in 98. Of the group in whom satisfactory collapse was obtained, 48 per cent were clinically well, 20 per cent arrested and 21 per cent were dead. Of those in whom partial collapse was obtained, 13 per cent were clinically well, 13 per cent arrested and 50 per cent dead. Of those in whom no collapse was obtained, only 7 per cent were clinically well, 23 per cent arrested and 55 per cent dead. The value of a satisfactory collapse is more strikingly illustrated when the results are considered in this way: Of 133 patients who were clinically well, 76 per cent had a satisfactory collapse, 18 per cent had a partial collapse and 5 per cent had no collapse.

Intrapleural Pneumolysis

The operation of closed intrapleural pneumolysis, or the severing of pleural adhesions, is being widely used at the present time. In many cases, when pneumothorax is attempted, pleural adhesions are encountered, stretching from the parietal pleura to the surface of the lung. Some are thin strands which became sufficiently stretched so that collapse of the lung is secured. Others, however, are strong thick bands that, in effect, exert traction on the lung at their point of attachment and prevent complete collapse of the lung. They may be attached to the lung surface overlying a cavity and prevent the approximation of the cavity walls and subsequent healing.

Their presence is probably the greatest cause of failure of artificial pneumothorax. In fact, the successful use of pneumothorax is limited to less than half the cases in which it is indicated because of pleural adhesions which permit either no collapse or insufficient collapse. The continuation of an unsuccessful and useless pneumothorax over months and even years is not justified. When pneumolysis is performed, adhesions are cauterized near their attachment to the parietal pleura, following which the lung readily collapses.

The operation is a minor one but requires considerable skill. A lighted thorascope, resembling a cystoscope, is inserted through the chest wall, giving the operator a good view of the interior of the thoracic cage. A cautery is then inserted into the pleural cavity at another point and the adhesions carefully severed. In this way, many cases of incomplete and ineffective pneumothorax are converted into successful ones.

Matson[2] found in 249 operations among 1700 cases of artificial pneumothorax that pneumolysis will convert approximately 70 per cent of unsatisfactory cases of pneumothorax into satisfactory ones. There was only one operative mortality.

Phrenic Nerve Operations

Phrenic nerve paralysis is the simplest proceedure in collapse therapy. When used alone it probably is the least effective, but when used to supplement pneumothorax, it frequently adds sufficient immobilization of the lungs to bring a tuberculous process under control. The diaphragm on the side paralized rises and may diminish the thoracic capacity by from 400 to 800 c.c. The decrease in volume and relaxation of the base of the lung due to elimination of the pumping action of the diaphragm, are factors which rest not only the base of the lung but also the upper portions. It is considered particularly applicable in basal lesions. It is also frequently tried in minimal lesions as the least drastic of the surgical proceedures available.

(Continued on page 178)

June Meeting

DR. CHAS. C. WOLFERTH

Associate Professor of Medicine
University of Pennsylvania

◂●▸

Subject:

CARDIO VASCULAR DISEASE

◂●▸

TUESDAY, JUNE 16, 1936

◂●▸

YOUNGSTOWN CLUB
8:30 P. M.

Two operations are in vogue. Evulsion, or the removal of a section of the nerve approximately two inches in length, results in permanent paralysis of the diaphragm on the side employed. The other type of operation is simple crushing of the nerve, the so-called "temporary phrenic", which produces paralysis for a variable period of time, usually six months, after which the nerve regenerates and the diaphragm again begins to move.

Thoracoplasty

The operation of thoracoplasty consists in the removal of all or portions of a variable number of ribs, depending on the extent and location of the disease. It is done in two or more stages. The type of patient most suitable for operation is one with chronic disease, limited chiefly to one side, in whom there is ample evidence of resistance to the disease as shown by the presence of fibrosis, and in whom there is no evidence of progressive tuberculosis in other organs or any other serious illness. Usually there is cavitation as well as fibrosis.

Although thoracoplasty is usually employed when a satisfactory collapse cannot be secured by pneumothorax or other collapse measures it should not be witheld until the case is hopeless. On the contrary, cases must be very carefully selected for operation. Archibald[3] believes that for patients suitable for pneumothorax but in whom it has failed, a thoracoplasty should be advised without further delay. More recently, some workers advocate primary thoracoplasty in certain types of cases, without first trying pneumothorax. A considerable number of cases of bilateral thoracoplasty have been done.

Among 1159 cases collected by Alexander[4], 61 per cent were either cured or sufficiently improved to make the operation worth while. It carries an operative mortality of from 1.5 to 5 per cent.

Application of Collapse Measures

In determining whether a given case of pulmonary tuberculosis requires collapse therapy and if so what collapse measure is most suitable, several factors must be considered: Whether the disease is in the white or negro race, whether in a minimal, moderately advanced or far advanced stage, whether the predominating lesion is of the exudative or proliferative type and finally whether the disease is retrogressing, stationary or advancing. Brown and Sampson[5] have formulated a working classification, based on these considerations, with a plan of treatment that may be considered fairly conservative. In the treatment of minimal cases, they point to the fact that at Trudeau Sanatorium 92 per cent of patients with minimal disease are alive at the end of fifteen years and they justifiably question whether these results could be improved by any other form of treatment. Their plan in minimal cases is to place patients on strict bed rest, watch carefully and refilm from time to time. If the disease is found to be progressing, surgical interference is considered, especially when time or finances are pressing. Occassionally simple phrenic nerve crushing may be sufficient to bring about recovery. If not, artificial pneumothorax is considered. Patients in the moderately and far-advanced group are treated according to the type of lesion, its behavior and extent, and whether or not cavitation is present.

When the disease extends below the third rib it becomes more serious and indicates collapse treatment earlier and upon slighter symptoms. Patients with retrogressing disease may safely be watched for a longer period without resort to surgical treatment. Cavitation usually is an indication for collapse treatment, since a cavity can practically never heal until its walls are approximated. An open cavity constitutes one of the greatest hazards to the tuberculous patient,

being a prolific source of tubercle bacilli which are aspirated into the bronchi and thus spread to other parts of the same lung and to the opposite lung, as well as to the gastro-intestinal tract and larynx.

The exudative type of disease is more acute, more rapidly changing; cavities frequently appear with startling rapidity. Hence, collapse treatment is indicated earlier than in the proliferative type. Because of the rapid changes that often occur in patients between the ages of twelve and nineteen, especially in girls, they should be placed in this group. The same is true for negroes. This group of patients requires close watching and early application of collapse therapy.

The general principles of treatment just enumerated, as has been stated, are fairly representative of a conservative attitude. In any field of therapy in which rapid strides are being made, it is to be expected that there will be wide differences of opinion. Thus we have groups who reluctantly give up the older methods of treatment, and those who boldly employ surgery in all cases of tuberculosis. So rapid has been development in the field of tuberculosis therapy that the literature of only a few years ago is already out of date.

Unfortunately, most of the reports available deal with patients who had moderately or far advanced disease when the treatment was begun. Myers[6] believes that pneumothorax should be attempted in all unilateral cases, no matter how minimal or how advanced, as soon as the disease is known to be progressing. If the lesions are minimal when the treatment is begun, strict bed rest is necessary for only a short time. Myers concludes, therefore, that the earlier in the course of the disease collapse therapy is begun, the better. There can be no doubt that the present trend in the treatment of pulmonary tuberculosis is toward the application of collapse measures in earlier cases.

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SPEAKERS' BUREAU

Radio Talks

Dr. P. J. Fuzy, April 14, 1936—"Minerals in the Diet."

Dr. F. F. Piercy, April 21, 1936—"What is a Mastoid?"

Dr. S. J. Klatman, April 27, 1936—"The Battle of Children."

Dr. A. M. Rosenblum, May 4, 1936—"Blood Building Foods."

Dr. Wm. A. Skipp, May 11, 1936—"Goiter—Enlargement of the Thyroid Gland."

Dr. C. H. Warnock, May 18, 1936—"The Present Status of Health Examinations."

Dr. W. M. Neidus, May 25, 1936—"What About Your Blood Pressure."

Dr. R. H. Middleton, June 1, 1936—"Childhood Diseases."

Dr. J. P. Harvey, June 8, 1936—"Too Much Sugar."

*

Dr. L. G. Coe gave a talk to the P. T. A. at St. Dominic's, March 24, 1936. The title, "Immunization Against Diphtheria and Small-Pox."

Dr. S. W. Weaver gave a talk to the boys at the Memorial High School in Campbell, Ohio, April 29, 1936. The title, "Social Hygiene."

WHY A VENEREAL CLINIC

By W. W. RYALL
Commissioner of Health
Youngstown, Ohio

A report made in 1931 by the Public Health Service showed that in the area of the United States in which syphilis has been reportable since 1920, 35,000 more cases of syphilis had been reported than of scarlet fever; 79,000 more than all forms of tuberculosis; 500,000 more than diphtheria; three times as much syphilis as smallpox; five times as much as typhoid.

A one-day survey covering 31,837 sources serving a population of 24,498,000, to determine the number of cases actually under treatment at any one time, found that there were 99,333—which means 4.05 per thousand constantly under treatment. The Health Service estimates that there are 425,000 fresh infections yearly in the United States.

In Youngstown cases of syphilis have been reported as follows: 62 in 1931, 44 in 1932, 59 in 1933, 162 in 1934, 303 in 1935. It is well known that doctors do not report all their cases; in pneumonia, for instance, we had 132 deaths in 1935, yet only nine cases were reported. The rise in the syphilis figures is due largely to the changed relief setup in the more recent years; all the cases are not being reported, but the 1935 figures are enough to indicate how serious the local situation is.

If we do not do something about this public menace, our hospitalization cost will be greatly increased and our Massillons will have to be greatly enlarged. Then again, think of the chances to you and yours in allowing these untreated cases to run at will. There is some control of these few reported cases, but think of the hundreds of unreported cases over which we have no control, disseminating their wares through the community.

We have the weapons at hand to treat this public health problem in an intelligent manner. In Dayton, Ohio, the Clinic for Venereal Diseases was reopened Dec. 2, 1935, after having been closed for 19 months on account of the City's lack of funds. The Montgomery County Medical Society endorsed it. A clerk and a social investigator take registrations. A 50-cent maximum donation is asked of the patient. This is the only clinic in operation in Dayton. No one who is able to pay above the 50 cents for treatment is accepted. Others are sent to their physicians.

Such a clinic along ethical lines is needed badly in Youngstown. At the beginning of my term as Health Commissioner there were 24 children barred from school on account of congenital syphilis. I finally had 17 of these children treated by their physicians so as to get them back to school. The others could not get any aid from the Relief, could not afford to go to a doctor, so the City Physician and myself are treating them to get them back in school.

The city, in the present state of its finances, cannot afford a clinic—but there is a way. Dr. Thomas Parran, our new Surgeon General of the U. S. Public Health Service, is heading a drive to see that all who have syphilis shall have treatment. If they are unable to pay, then they should be sent to a clinic. Dr. W. H. Hartung, our state director, said in several talks with the writer that he wants a clinic for venereal diseases established in every county, with two or more in large counties.

The Social Security Act appropriated $10,000,000 for public health, part of which is to be used to fight venereal disease. We have a good chance, if we stand united, to get funds from this source for the establishment of a clinic.

The need is great. The different settlement centers in Youngstown are asking, "How long before we will have a clinic?" Strangers stop you on the street and say they are backing you in the project. The clinic would not take a dollar out of any doctor's pocket. The idea is for the indigent only. The Relief setup helped for a time, but it soon closed up that angle. There is no way except the clinic to clear up this mess we are headed for.

"Am I my brother's keeper?" Surely with such a picture confronting the wise medical man, there can but be the answer "YES." Let us all get back of this vast humanitarian cause and show that we will aid and assist in helping stamp out the so-called "social diseases."

Public Relations Committee

The public relations committee has carried out several tasks this year. A rather voluminous report of the Central Curriculum Committee of New York was studied and a report rendered. The curriculum committee is seeking to improve nursing education throughout the country by making changes in the curriculum which will raise the standards of nursing.

The committee was instrumental in obtaining concessions from the traffic department in the matter of parking on downtown streets. The final ruling is that doctors' cars displaying the insignia may park longer than usual if in front of a drug store or some other building where a call is being made.

The third task was one of bringing before the Medical Society the fact that there exists in Youngstown a Better Business Bureau, and that this organization has built for itself a definite place in the civic and business life of this city. What is the Better Business Bureau? It originated 25 years ago in the city of Minneapolis when a group of business men organized in an attempt to purge business in general of some of the pernicious practices which existed then. There are at present 53 cities in the United States each having a Better Business Bureau and coöperating with each other in ferreting out irregular practices in business. Youngstown is the fifty-third city to join and just this month has received its charter. Already the bureau in this city has succeeded in running out of town several rackets and exposing others and so discouraging the promoters, that even now Youngstown is becoming known as a hot place for chiselers and the shady propositions. Formerly, it was called the racket city where the suckers were quite thick. In view of all this it seems that any organization which has for its purpose, the betterment of Youngstown, should have the support of the local Medical Association. Mr. Paul Bolton, who is secretary of the Youngstown Better Business Bureau, informs me that in Toledo and Columbus, the medical groups there coöperate with the Better Business Bureau of those cities in combating medical frauds. The public relations committee feels that the Youngstown Better Business Bureau deserves the support of the Medical Society and every member of the Society should give the idea serious thought.

PUBLIC RELATIONS COMMITTEE
G. G. Nelson, *Chairman*
R. Fenton — J. B. Birch
J. C. Vance — P. R. McConnell

Communicable Diseases

April, 1936

Chickenpox	12
Measles	4
Diphtheria	3
Scarlet fever	70
Whooping cough	20
Influenza	3
Epidemic cerebro-spinal meningitis	2
Tuberculosis	21
Septic sore throat	1
Syphilis	7
Pneumonia	5

W. W. RYALL.

RECENT MEDICAL BOOKS

By DR. A. J. BRANDT

The medical profession is never at a loss for reading material embracing all of the components of each specialty, in detail. The statement that the contributions to medical literature far exceeds the additions to medical knowledge is perhaps only too true. In the past few months there have come to my desk three books that are well worthy of the consideration of any of the brethren who are interested in the field of gynecology and obstetrics.

"Puerperal Gynecology" is a small book of 186 pages written by Dr. J. L. Bubis of Cleveland. In it he recounts his experiences over the past 20 years since he first advocated the immediate gynoplastic repair of the genital tract of the female after childbirth. The chapter starts with the anatomy and prenatal care, continue on through delivery with detailed technique of repair of parts, and ends with puerperal care. By doing all the necessary repair work on the cervix, vagina, and perineum at the time of delivery, the length of time of hospitalization is shortened considerably, which amounts to a considerable saving in money and time to patients and the community.

"Gynecological and Obstetrical Tuberculosis" is by Dr. E. M. Jameson of the Trudeau Foundation. It is most carefully written, with excellent illustrations of pathological material available at the large institution at Saranac. Part III of the book deals in detail with the problems of pregnancy and tuberculosis. Many of the perplexing problems of this complication are answered clearly and authoritatively in this book. The question of the effect of maternal tuberculosis on the offspring is also given consideration.

The third book is by Dr. Frederick Taussig of St. Louis, and answers a long felt need in medical literature for the complete and adequate discussion of the problems of abortion in all its myriad ramifications. "Abortion Spontaneous and Induced, Medical and Social Aspect" is the title, which describes the contents of this volume. Everyone is familiar with the writings of Taussig and there can be no doubt as to the knowledge and experience that he brings to the elucidation of such an important subject. The subject matter is well knit together and sums up all the information concerning the historical aspect, technique, therapy, pathology, ethical, religious and legal aspects of the problems.

These are only three of the recent books and all deal with one specialty. Each one of us has a particular field wherein his interest is most keen, and it is there that he should do his browsing and contemplative study. A new book every month or two is an excellent way to build up a library as well as the best way to sharpen the mind that slips back when new material is not added periodically to keep the interest keen.

St. Elizabeth's Commencement

The Twenty-fifth Annual Commencement of the Saint Elizabeth's Hospital School of Nursing was held on Tuesday, June 2, at 7 P. M., on the campus. Rev. Charles McDonough presided. Dr. A. M. Rosenblum gave the opening address. The Rt. Rev. Monsignor William A. Kane also gave an address. After the nurses' pledge, Dr. C. D. Hauser presented diplomas to the following members of the class:

Margaret Lucille Belco, Eleanor Cassidy, Catherine Louise Kennedy, Alberta Louise Lamb, Margaret Jane Hartman, Margaret Dolores Maletic, Isabelle Beatrice Murray, Carmel Rose Salpietra, Ethel Mae Shrum.

HOSPITAL ACTIVITIES

The regular staff meeting of the Youngstown Hospital Association was held at the South Side Unit on June 2, 1936, at 8:30 P. M., with Dr. H. E. Patrick presiding.

The program of the evening with Dr. O. J. Walker, Dr. L. S. Deitchman, and Staff participating was received with spontaneous enthusiasm.

Dr. Walker's "Routes of Infection from Middle Ear and Mastoid" was a lengthy and very interesting discussion cleverly illustrated with numerous lantern slides.

"The Hippocrates of Pennsylvania" in which Dr. Deitchman brought out the highlights of the career of a pioneer practitioner with Benjamin Rush as a model example, was a little off the scientific line but unanimously enjoyed.

The Youngstown Hospital Staff of Residents and Internes for the year 1936-37 are the following:

Residents—Dr. John A. Renner, Dr. John A. Rogers, Dr. Louis Hall, Surgical Resident, North Unit.

Internes—Barclay M. Brandmiller, Youngstown, Ohio—Jefferson.

Gabriel DeCiccio, Youngstown, Ohio—Jefferson.

Charles H. Cronick, Youngstown, Ohio—University of Pennsylvania.

David G. Sauer—Cincinnati College of Medicine.

James J. Redmond—State University of Iowa.

William Albert Clark III—New Wilmington, Pa.—Ohio State University College of Medicine.

David M. McKenna—University of Colorado.

Royald James Westcott—University of Wisconsin.

Rollis Ray Miller—Western Reserve University.

Robert P. Harvey—University of Colorado.

Milton M. Yarmy, Youngstown, Ohio—Wayne University College of Medicine, Detroit, Mich.

Francis L. Browning—Western Reserve University.

St. Elizabeths' Hospital announces the appointment of the following residents and internes for the coming year: Dr. Murrill M. Szucs, Cleveland, as Medical Resident; Dr. James K. Herald, Youngstown, as Surgical Resident; Dr. Henry C. Marsico, Lorain; Dr. Michael J. Sunday, Wauwatosa, Wisconsin; Dr. Benedict Raymond Walske, Galesville, Wisconsin; Dr. Stephen W. Ondash, Youngstown; Dr. Sylvester Joseph Raetz, Racine, Wisconsin, and Dr. Adanto D'Amore, Youngstown.

Of the present interne staff of St. Elizabeth's Hospital, Dr. F. R. Harrison is entering a CCC Camp for one year; Dr. P. A. Mankovich is to go into general practice in Punxsutawney, Pa.; Dr. S. D. Goldberg is to go in general practice in Youngstown; Dr. J. J. Wasilko in general practice in Youngstown with his office with Dr. B. B. McElhaney in the Home Savings & Loan Bldg.; Dr. L. S. Shensa in general practice in Youngstown with his office in the Dollar Bank Bldg., with Dr. J. M. Ranz.

Harrowing.

Farmer: "Just look at my field of oats—more weeds than there is grain. What the Sam Hill am I going to do with all those weeds?"

Farm Advisor: "Weed 'em and reap."

NEWS ITEMS

Dr. McClenahan was in Philadelphia recently, attending the joint meeting of the Obstetrical and Gynecological Societies of Philadelphia, New York, Boston, Washington, Pittsburgh, the Philadelphia Society acting as host.

Dr. Morris Deitchman who is doing postgraduate work in New York, expects to return to Youngstown about August 1, to resume his practice of medicine.

Dr. Fred Coombs will arrive in Youngstown on June 12 for a two-weeks' vacation with his parents. He will return to Boston for another year's work with Dr. Talbot.

Drs. Brant and McNamara are at Jefferson Medical College attending class reunions.

Dr. Goodwin expects to study in New York this coming year.

Dr. L. L. Hall has been appointed assistant resident of the north side unit of the Youngstown Hospital.

Dr. J. P. Keogh expects to do postgraduate work in New York during the coming year.

Dr. A. A. Baldwin will locate at Wellington, Ohio.

Dr. Herald will become resident at St. Elizabeth Hospital on July 1.

Dr. A. J. Ernie will practice medicine at Millersburgh, Ohio, following the completion of his interneship on July 1.

Dr. Bookwalter will do postgraduate work in pediatrics at the Children's Hospital in Chicago.

Dr. Malcolm Hawk will be camp physician for the Y. M. C. A. boys this summer.

Dr. J. J. Welter, who finishes his interneship at the Youngstown Hospital in July, will locate at 19 Lincoln Ave., and do general practice.

Drs. Renner and Rogers will remain at the Youngstown Hospital as residents for the coming year.

Mrs. C. D. Hauser is at home convalescing after a recent appendectomy at St. Elizabeth's Hospital.

Doctors J. Heberding and S. J. Tamarkin presented a program consisting of a lantern slide demonstration of lesions of the gastro-intestinal tract at the May meeting of the staff of St. Elizabeth's Hospital.

Our congratulations and best wishes to Doctor and Mrs. J. L. Scarnecchia on their recent marriage.

Scarlet Fever Immunization at the Youngstown Hospital

By C. A. GUSTAFSON, M. D.

During the year, 28 preliminary students of our training school were given the Dick Test for scarlet fever. Out of this number six had positive reactions.

For five weeks at one-week intervals Scarlet Fever Toxin was given in graduated doses with the following results: Two of the students complained of muscular soreness after each innoculation; two had muscular soreness, vomiting and slight headache; one had a slight headache after first three innoculations; one had slight headache and backache after the second, fourth, and fifth innoculations. None of these students were incapacitated for duty longer than one day. The temperature at no time was higher than 99.8.

Two weeks following the last injection all six students showed a negative reaction to the Dick test.

MEDICAL FACTS

By J. C. B.

Excerpts From a Recent Article Entitled: "Primary Carcinoma of the Lung: Early Diagnosis and Treatment by Pneumonectomy."

By Richard H. Overholt, Department of Thoracic Surgery, Lahey Clinic.

"It has now been demonstrated that one lobe of a lung or the entire lung on one side can be successfully removed. It has also been shown that the procedure does not limit the patient's ability to enjoy the ordinary activities of life.

"The recent advances in the surgical treatment of primary carcinoma of the lung demand that the general medical profession be more concerned with early symptoms and differential diagnosis.

"1. A warning symptom, a persistent cough, appears early. 2. A large majority of the growths originate in a stem bronchus and therefore can be actually visualized (with the aid of the bronchoscope). 3 The stem bronchus lesion is limited by cartilaginous rings and apparently grows slowly over a period of months until the infiltrating process breaks through these bounds.

"That surgery promises some help for patients doomed on account of primary malignancy of the lung is more welcome since it is generally admitted that irradiation in any form fails to cure and frequently does not even influence, for the better, the progress of the disease.

"Bronchoscopic removal of a very small bronchial neoplasm must always be considered as a possible form of treatment. Kernan has reported at least temporary improvement in a limited number of cases followed two and three years. Jackson and Konzelmann, however, in a series of twenty-nine cases, found no lesions small enough to treat in this way. All of the cases in their group who had been followed had died of the disease, except the three most recent ones.

"Efforts on the part of thoracic surgeons to cure primary malignant disease of the lung have been stimulated by successfull experiences with lobectomy for bronchiectasis.

"Thoracic surgeons now feel that in most cases of malignant disease the entire lung should be removed and the bronchus divided as high as possible.

Within the past four years, it has been demonstrated that the resection of one entire lung (Pneumonectomy) can be done with survival of the patient and without subsequent disability.

"In 1933 the author removed the entire right lung for carcinoma and in the following year had four additional successful resections of the lung, two for cancer and two for pulmonary suppuration.

"The success of our attempts to salvage such patients will depend upon two factors: first, early diagnosis and early operation before the lesion has spread beyond the lung; and secondly, careful management before, during, and after operation to minimize operative morbidity and mortality.

"It is now generally conceded that the great majority of primary lung tumors arise from cells in the bronchial epithelium or from the bronchial mucous glands. Origin in the cells of the pulmonary alveoli possibly never occurs or is so rare that it can well be dismissed.

"It is the opinion of Geschickter and Denison that the hilar lesions are usually carcinomata of the epidermoid form whereas the peripheral lesions are usually adenocarcinomata.

"A peripheral growth (pneumonic form) would obviously produce an area of density in the roentgenogram

early in its development. The lesion casts a homogeneous shadow and is fairly well circumscribed. Cough is one of the early symptoms and may be the only symptom. Hemoptysis at this time is not so likely as in the stem bronchus lesion.

"Edwards reports that ten per cent of pulmonary absesses, so diagnosed, are primary neoplastic lesions which have broken down.

"All patients of middle age or past middle age who develop a chronic and persistent unexplained cough should be studied bronchoscopically."

JULY FIRST

On or before this date it is obligatory for every physician to have renewed his registration with the Bureau of Narcotics. Shortly now, you will receive from the Collector of Internal Revenue in Cleveland a manila envelope containing signature and inventory card. Don't delay in returning this, properly filled out, together with one dollar, the registration fee. Failure to do this may be calamitous.

Considerable laxity on the part of physicians, in the past, has been courteously overlooked by the Bureau upon payment of a 25c fine. However, the Bureau now serves notice that more drastic measures are being adopted. The penalty for failure to register can be a fine of $5,000.00 and six months of jail life. Several recent instances are known wherein the Bureau has comprised this harsh punishment but the settlement has cost the physicians several hundreds of dollars.

Another proviso of the Harrison Narcotic law not usually complied with is in the matter of supplying incurables or addicts with narcotics. The law specifically states that on each prescription in the first instance it should be stated that the drug is intended for use in an incurable condition, and in the second instance that the individual is aged or infirm and that withdrawal would threaten life. If it is preferred to do so, the first exception to the continuous prescribing of narcotics for one individual may be indicated on the prescription by the words: "Exception (1), article 85"; the second exception, "Exception (2), article 85."

Attention to these pertinent facts of the Harrison Narcotic Law will save us needless worry, and possible costly defense of prosecution.

OUR NURSES

The Youngstown Hospital Association School of Nursing held its thirty-ninth graduating exercises at Stambaugh Auditorium, the evening of May 15, 1936. The address of the evening was given by Rev. Herbert B. Hudnut of Pittsburgh, Pa.; the diplomas were presented by Mr. John Tod, and the class pins by Miss Dorothy Windley, Directress of Nurses.

Members of the graduating class:

Jean Anderson, Youngstown, O.; Helen Bryce, Youngstown, O.; Jessie Crumbacher, North Lima, O.; Frances Findley, Youngstown, O.; Hattie Godd, Ravenna, O.; Mary Hoovler, Mercer, Pa.; Irene Janceski, Youngstown, O.; Dorothy Johnson, Youngstown, O.; Margaret Keenan, Sebring, O.; Irma Kreuzwieser, Youngstown, O.; Martha Kron, Youngstown, O.; Virginia Lyle, Diamond, O.; Florence Miller, Youngstown, O.; Hazel McConnell, Hubbard, O.; Virginia Morrall, Girard, O.; Helen Nash, Hubbard, O.; Leona Naughton, Struthers, O.; Phyllis Purnell, Canfield, O.; Helen Reeves, Niles, O.; Hazel Simons, Youngstown, O.; Helen Sittig, Youngstown, O.; Mary Stephens, Hubbard, O.; Irene Stephenson, Andover, O.; Elizabeth Takach, Canfield, O.; Ruth Taylor, Youngstown, O.; Mary Thorne, Youngstown, O.; Gladys Vasbinder, Warren, O.; Margaret Williams, New Castle, Pa.; Mary Ann Wilson, Struthers, O.

SECRETARY'S REPORT

Our postgraduate day on April 30, 1936, was again a definite success. The number in attendance still remains an incentive to the local Society to carry on.

During the several years that the Society has fostered this institutional-like day annually a continued desire for its repetition is felt by all members.

The program this year as previously was well selected, timely and given by men eminent in the profession.

Dr. Willis F. Manges of Philadelphia, was the essayist for the Society May 19, 1936. His subject was "X-Ray Therapy in Acute Inflammations." His exposition of the subject was excellent and no doubt the type of therapy received a stimulus in our local community not to the detriment of the x-ray therapeutists. Many lesions can be treated according to Dr. Manges and abort serious consequences. Many case reports were given and the results of treatments depicted.

Governor Landon's stand against State Medicine as presented to the assembly at the American Medical Association meeting in Kansas City, has attracted a considerable degree of interest. He is not in favor of politicians attempting to operate the practice of medicine.

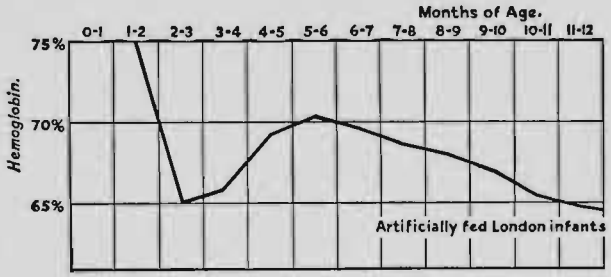
General business of the Society has not been abundant during the past month.

ROBERT B. POLING,
Secretary.

Our Bulletin Honored

Dr. R. G. Tuck, Medical Director of the Oakland County Emergency Welfare Relief Commission, Pontiac, Michigan, has expressed his pleasure and interest in our Bulletin, and has requested an exchange with the Bulletin of the Oakland County Society. We are pleased to enter into this mutually beneficial exchange.

Nutritional Anemia in Infants



Hemoglobin level in the blood of infants of various ages. Note fall in hemoglobin, which is closely parallel to that of diminishing iron reserve in liver of average infant. Chart adapted from Mackay. It is possible to increase significantly the iron intake of the bottle-fed from birth by feeding Dextri-Maltose With Vitamin B in the milk formula. After the third month Pablum offers substantial amounts of iron for both breast- and bottle-fed babies.

Reasons for Early Pablum Feedings

1. The iron stored in the infant's liver at birth is rapidly depleted during the first months of life. (Mackay,[1] Elvehjem.[2])

2. During this period the infant's diet contains very little iron—1.44 mg. per day from the average bottle formulae of 20 ounces, or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt.[3])

For these reasons, and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Coons,[4] Galloway[5]), the pediatric trend is constantly toward the addition of iron-containing foods at an earlier age, as early as the third or fourth month. (Blatt,[6] Glazier,[7] Lynch[8]).

The Choice of the Iron-Containing Food

1. Many foods reputed to be high in iron actually add very few milligrams to the diet because much of the iron is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 gm. (Bridges.[9])

2. To be effective, food iron should be in soluble form. Some foods fairly high in total iron are low in soluble iron. (Summerfeldt.[10])

3. **Pablum is high both in total iron (30 mg. per 100 gm.) and soluble iron (7.8 mg. per 100 gm.) and can be fed in significant amounts without digestive upsets as early as the third month, before the initial store of iron in the liver is depleted. Pablum also forms an iron-valuable addition to the diet of pregnant and nursing mothers.**

Pablum (Mead's Cereal thoroughly cooked and dried) consists of wheatmeal, oatmeal, cornmeal, wheat embryo, brewers' yeast, alfalfa leaf, beef bone, iron salt and sodium chloride.

1-10 Bibliography on request.

MEAD JOHNSON & COMPANY, Evansville, Indiana, U. S. A.

VACATION TIME

S.M.A. is obtainable wherever vacations take parents in the United States.*

In addition to producing excellent nutritional results more simply and more quickly, S. M. A. has the advantage of availability in all parts of this country.

Parents need take only small quantities of S.M.A. with them when they travel, replenishing their supply as they go. *S.M.A. is also available in Canada and many foreign countries. Details upon request.

S.M.A. babies are independent of local milk supplies. Wherever their parents may travel, they are assured of safe milk. S. M. A. and boiled water provide them a breast milk adaptation anywhere.

From Maine to California, practically every wholesale drug house in the country carries stocks of S.M.A., and most of the 50,000 retail druggists stock it. In the cities, any retailer who runs out of S. M. A. can get it overnight, and druggists even in the remote rural districts can get S. M. A. quickly when their supply is exhausted. (The map shows locations of wholesale stocks. Retail outlets are too numerous to show here.)

S. M. A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is *essentially similar to human milk* in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

S. M. A. CORPORATION - - CLEVELAND, OHIO