BULLETIN

of the

Mahoning County Medical Society

Organized 1872

When you talk you only repeat what you know, but if you listen, you may learn something. *Anon.*

July, 1936

Volume 6 Number 7

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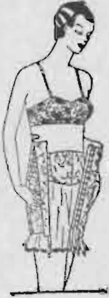

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PRESIDENT'S PAGE

A la McIntyre

A nostalgia for wood smoke and smell of stables—sound of horses' hoofs and wagon wheels amid the downtown traffic cacyphony brings a twang of heart strings. A picture with ruffles and a burnt wood frame—art of a period past makes one feel suddenly gray, and bent, and stooped, for it was a living vital art when we were vitally young. 'Twas then that we were all curious as to what lay beyond the next big river bend; eager to see the other side of the next hill. Our gang built a raft (did yours?). A sudden spring freshet no doubt saved some from drowning by whisking the collection of bailing wire and lumber down stream.

Those gay fellows of the village who were of age—they went downtown most every night in the week; did just as they pleased. Nobody told them when to go to bed. If I ever live to reach that age and freedom my life will have been quite full and complete, thot I. At twenty-one we feel that a person past thirty-five is growing old. Now, at forty, I have concluded one is not old until sixty. At sixty perhaps it will be "One is only as old as one feels."

I wonder how many read these ramblings? Not many methinks (and hope!). Just something for ye editor to use as space filler—in between the paid ads.

Certainly glad I don't have to do this every day for a living, like that slave of the eyeshade and typewriter, Odd McIntyre. Guess I'll stick to the practice of medicine.

L. GEO. COE.

BULLETIN

of the

MAHONING COUNTY
MEDICAL SOCIETY

J U L Y 1 9 3 6

CLINICAL MANIFESTATIONS OF DYSFUNCTION OF THE ANTERIOR PITUITARY

(This Article and others to follow are abstracts of a series which appeared in the *Journal of the American Medical Association* over a period from February to August, 1935. Upon the haze which surrounds the whole field of endocrinology and organotherapy, these articles shed a penetrating and orienting light. These articles are now available in book form and it is hoped that this resume will stimulate its readers to avail themselves of the source of this material, and acquaint themselves with a sane and proper perspective.)

The anterior lobe of the pituitary gland elaborates five distinct and well recognized internal secretions or hormones.

(1) The Somatotropic or Growth Hormone.

(2) The Gonadotropic Hormone.

(3) The Thyrotropic Hormone.

(4) The Mammotropic Hormone or Prolactin.

(5) The Adrenotropic Hormone.

1. Dysfunction of Somatotropic or Growth Hormone.

The hypofunctions attributable to this hormone when manifested in infancy or adolescence, result in dwarfism and cretinism. At first hand, we are inclined to disagree with the inclusion of cretinism, as a dysfunction of the growth hormone, feeling that it is a failure of thyroid function. Quite true, but the failure also involves a failure of thyroid stimulation to the production of the growth hormone; for once thyroid medication is instituted, growth takes place. With the above mentioned conditions, there is an associated infantilism, manifested by sexual immaturity and general failure of body growth.

When the hypofunction of the growth hormone occurs in adult life, there may be produced a condition of pituitary cachexia. However, there appears to be something lacking besides the growth hormone, because feeding of the hormone will bring about improvement in growth, but fails to relieve the cachexia.

A second condition has been ascribed to the failure of the growth hormone during adult life which is a counter part of acromegaly. The condition is termed akromikric, and is characterized by thinning of the acral parts, subnormal growth of hair, thirst, amenorrhia and acrocyanosis.

Hyperfunction of the growth hormone as is well known, results in gigantism and acromegaly. Autopsy has shown an eosinophilia in the enlarged gland.

The anterior lobe is apparently the sole source of the growth hormone, and from a consideration of skeletonal changes in adult life as described above, it is evident that it functions throughout life.

2. Dysfunction of Gonadotropic Hormone.

In 1926 Zondek & Aschheim demonstrated that implants of anterior pituitary tissue into immature rats or mice induced development of the ovaries and sexual precocity in four days. The changes brought about in the ovaries were first, a typical follicle growth, ovalation and formation of the corpora lutea and second, luteinization transformation of the walls of many ovum containing follicles. In the first instance, the effect is attributed to a follicle stimulating hormone and in the second, to a luteinizing hormone.

Interestingly enough, this gonadotropic hormone is also found in the urine of pregnant women and in body fluids and tissues. During the menopause, the urine contains the follicle stimulating hormone only; both hormones are present in pregnancy urine.

There is evidence to show that the gonad stimulating substance of pregnancy urine is not exactly similar in its action to the anterior pituitary substance, apparently being less efficacious than pituitary implants. The effects of the two principles varies in the following manner.

(1) The gonad stimulating substance of pregnancy urine fails to produce any change in the ovary of a hypophysectomized animal.

(2) There is no effect upon the development of immature avian testicle.

(3) There is but a slight effect on monkey ovary.

(4) In immature rats it fails to produce as great enlargement of the ovaries as does pituitary implants.

However, by adding an extract of anterior pituitary to pregnancy urine, the characteristic changes of pituitary implants are produced, even in hypophysectomized animals. This principle is called "Synergist."

The gonadotropic substance of pregnancy urine probably arises from chorionic tissue. This is substantiated by the following facts.

(1) Chorionic tissue contains large quantities of the substance, even in cases dying during pregnancy, the anterior lobes of which contained little or none.

(2) It is present in all types of chorionic tissue such as hydatiform mole and chorionepithelioma.

(3) The hormone content of pregnancy urine is high in chorionic tissue before the hypophysis shows the characteristic hisological changes of pregnancy. Hence this gonad stimulating substance in pregnancy urine is best designated the chorionic gonadotropic hormone.

The gonad stimulating substance seems also to be present in urine, in the presence of underfunction of the ovary; in the menopause and following castration. In these instances, it seems certain that the substance is produced by the basophil cells of the anterior pituitary, because the anterior lobe in castrated rats shows enlarged signetring basophils or "castration cells," and because such pituitaries contain an increased amount of gonadotropic hormone.

Inadequacy of Gonadotropic Hormone.

The classical example of an inadequate action or amount of gonadotropic hormone is sexual infantilism. While Mazer and Goldstein say that 80 percent of such cases are due to inadequate hormone, the failure of sexual secondary development may in certain instances be due to a failure of gonad to respond to an adequate hormone stimulation. This has a clinical significance in women. Since the estrogenic and gonadotropic hormones can be recognized as being present or absent in the blood by analysis, the type of amenorrhea can thus be determined. However, in those cases of amenorrhea due to inadequate gonad-

otropic stimulation, therapy has been notoriously inadequate, because preparations from pregnancy urine, which as has been pointed out above, lack the pituitary factor.

Occasionally menorrhagia occurs due to failure of lutenizing hormone. The unopposed estrogenic factor causes endometrial hyperplasia and profuse hemorrhage.

Overabundance of Gonadotropic Hormone

PREGNANCY

The pregnant state is characterized, hormonally, by an abundance of estrogenic and gonadotropic hormone in the blood and urine, both probably derived from the chorion. The estrogenic substance appears somewhat later than the gonadotropic hormone, though it lasts until parturition, when it abruptly diminishes. The gonadotropic hormone is abundant by the first missed period and it is upon its presence in the blood and urine that the Aschheim-Zondek reaction is based. It reaches its maximum between the fourth and fifth month.

PARTURITION AND PUERPERIUM

At parturition or during the early days of puerperium, the gonadotrophic and esterogenic substances disappear from the blood stream. Continued high titre during the puerperium indicates a retention of the membranes. There is also a titre present in retained abortion.

HYDATIFORM MOLE AND CHORION EPITHELIOMA

Both conditions give very high titres, but the titre disappears on complete removal. Persistance of titre is probably due to metastastasis. These may later regress. Continuously positive titre over three months after removal of uterus indicates malignant metastases.

TESTICULAR TUMORS

Teratoid tumors of the testicle, containing embryonal cells, give a very high titre.

Castration, Hypogonadism and Menopause.

The loss of ovarian function for any reason results in the excretion of considerable amounts of gonatropic substance.

3.

THE LACTOGENIC HORMONE (PROLACTIN)

The close relationship of lactation and the termination of pregnancy led to the belief, on clinical grounds, that the ovarian hormone (progestin) was responsible for breast function. While the ovarian hormone does seem to have some growth stimulating effect upon the duct system, it is quite proven that the stimulus for the physiological activity of the mammary gland is supplied by the lactogenic hormone (prolactin), derived from the pituitary. Experimental biology has quite definitely established:

1. The necessity of estrogenic substance to provide the growth stimulus to the mammary gland.

2. The fact that the estrogenic factor is limited in its effects — it causes an unfolding of the duct system but not the development of secretory alveoli.

3. The non-necessity of progestin in mammary physiology.

4. The invariable dependence of the mammary gland for functional development of prolactin.

5. The inhibition of prolactin secretion by estrogenic substance.

The foregoing conceptions of the interraltion of estrogenic substance and prolactin explain some of the anomalies of lactation. The infant in utero, early subjected to estrogenic influence, develops ducts in the mammary. The sudden withdrawal of this influence at birth, coupled with a temporary prolaction secretion, probably explains the phenomenon of witch's milk. The cyclic enlargement of the breasts at menstruation, often with secretion is best explained by a cyclic secretion of prolactin.

That estrogenic substance is not essential to mammary function is confirmed by the facts that cows and

women lactate long after ovariectomy. Further, many women show parenchymal breast hypertrophy following the menopause. Conversely, hypophysectomy during pregnancy results in the loss of the breast function. Furthermore, pregnant animals can be caused to lactate in those instances where ovariectomy has been done during the pregnancy. The interplay of these two hormones in the condition of gynondromorphism is interesting but not well understood. Then further, in disorders of the pituitary alone, which not infrequently involves the production or lack of production of not one but several of its hormones, precocious mammary development may be observed, as in gigantism and acromegalia in both sexes.

The implied use of prolactin clinically, as an aid to lactation in the recently delivered woman, is intriguing, yet a word of caution is in order. The over stimulus to alveolar development could possibly lead to malignant conditions. One will do well to leave this interesting bit of speculation to be answered by the experimental biologist. Much will be learned when a suitable test for prolactin in the blood has been perfected.

4.

THYROTROPIC HORMONE

In 1929 Loeb and Aron, independently discovered a derivative of the anterior lobe of the pituitary which had a specific stimulating effect upon the thyroid. This hormone exerts its action only in the presence of an intact thyroid, complete thyroidectomy obliterating all of its specific effects.

Under-Production of Thyrotropic Hormone.

Removal of pituitary invariably produces hypothyroidism; hence it may be justifiable to assume that cretinism and myxedema are, primarily, evidences of pituitary disorder and only secondarily attributable to thyroid hypofunction.

Over-Production of Thyrotropic Hormone

It does not seem that the condition of hyperthyroidism is dependent upon an overproduction of thyrotropic hormone. An interesting but confusing contribution has been made by Collip in the discovery of an anti-thyrotropic hormone. Its use in the treatment of exophthalium goitre is being investigated.

5.

INTERRENOTROPIC HORME (ADRENATROPIC)

Experimental clinical evidences supports the idea of an interrelation between the anterior pituitary and the cortical tissue of the adrenal gland. This interrelationship expresses itself in four ways—

1. Hypopituitary states — following hypophysectomy there is atrophy of adrenal cortex; controllable by pituitary implant. Following unilateral adrenalectomy, there is hypertrophy of the remaining adrenal, unless the animal has been hypophysectomized.

2. Hypocortial states—Adrenalectomized rats can be made to grow by use of cortical hormone if the pituitary is intact.

3. Hyperpituitary states—Implants or injections of anterior pituitary in normal animals bring about growth of the adrenals.

4. Hypercortical states—The adrenal cortex is intimately related to the reproductive and integumentary system. Cushing pointed out that basophilic adenoma were frequently behind the picture of hypercortical activity.

6.

METABOLIC HORMONES

There is evidence accumulating to indicate that the anterior pituitary is intimately concerned with water balance, carbohydrate, fat and protein metabolism.

COMMENCEMENT ADDRESS

St. Elizabeth's Hospital School of Nursing, June 1, 1936

By DR. A. M. ROSENBLUM

It is with a keen sense of appreciation of the trials, tribulations and labors of the last three years that I welcome you here this evening, the night of your graduation. It must, indeed, be a satisfaction to each and every one of you to realize that you are now on the threshold of entering life in its fullest meaning. You will now have an opportunity to serve humanity. How graciously and well you will do it will label you as a success or a parasitic hanger on.

In order for you to live up to the traditions of your noble profession, it will be necessary for you to remember certain duties and obligations. I would like for each of you, in your mind's eye, to picture the work done by your Patron Saint, Florence Nightingale. She ministered to the sick, the wounded, the forlorn and the helpless under such adverse conditions and circumstances and yet left such a beautiful picture for those who follow her, that she is well worth emulating. If you, too, wish to follow the noblest and the best that is in your profession there are certain requisites that I believe are absolute necessities.

I realize that many of the ideals that I hold in my own mind as necessary for nurses are only my own opinions and as this subject is a little heart-to-heart talk between ourselves, the doctor and his nurses, maybe my private opinion may help you and your patients.

First is cleanliness. To bring before you the subject of cleanliness after the intensive training you have received here may seem superfluous but if you will follow me you will see just what cleanliness really means. Naturally cleanliness means asepsis; you have all learned that. In addition, cleanliness means an immaculate nurse. Her uniform spotless, her hands asceptically clean, her face beaming, the entire picture being one of "I will not and can not contaminate." You can see how easily it is for enlightened people to think, and I am not sure but that they have right to think, that a nurse who wears a dirty uniform, whose hands are dirty, can not practice asepsis.

Under cleanliness, the patient should always be spotless and clean; this is not only necessary for the patient's health and welfare, which at all times should come first in your mind, but also for the confidence that it creates in your doctor and in the patient's family.

Next to cleanliness I would classify patience and kindness. The greatest satisfaction that your profession has is its abundance of kindness to all and a no-ending patience. A nurse or a doctor who loses his or her temper cannot be true to his or her obligations. A kind word, a careful explanation of what you are trying to do, the truth about whether it will hurt or not and how much it will hurt, will soon establish a confidence between the patient and yourself and duties that may be distasteful and hard become pleasant acts of kindness. Likewise, if you are sufficiently patient you will not be aroused to anger with your patient; words will not pass between you. The patient is always right, but the nurse in her kind way sees that the orders for the patient's welfare are carried out. Frequently this is the only way they can be carried out, and frequently the possession of these attributes distinguishes between the successful and the unsuccessful nurse.

I call my next necessity intelligence because it requires intelligence to realize that in order to remain at the top of one's profession one must constantly study all things pertaining to the nursing profession or to the

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I call my next necessity intelligence because it requires intelligence to realize that in order to remain at the top of one's profession one must constantly study all things pertaining to the nursing profession or to the

part of the nursing profession which you are following. You must read your magazines and books, attend your meetings, and not infrequently take a postgraduate course; then and only then, can you display the intelligence that we so desire our nurses from St. Elizabeth's to have. I would urge those of you who have a love for more learning and greater amelioration of suffering, to prepare yourself in the near future for supervision and group nurse service so that many patients may be benefited by your special talents instead of a few. I am a thorough believer that no doctor can be successful in attaining the greatest height in his profession who doesn't have a group of intelligent nurses to administer his orders to the sick.

After intelligence I want you to consider duty. Like a sentinel who stands at guard and dares not go to sleep or be off duty for a moment without proper relief, so it is my belief that a nurse in charge of a patient is on a duty that should be a sacred duty that is not to be sidestepped for a moment. I have no use for a nurse who spends her time talking in the halls, gallivanting here, there, and everywhere, when her duty is with her patient. To achieve the perfect satisfaction in nursing, your conscience, your patient, and your doctor must all feel that you have done your duty and done it well.

I would next like to consider silence. Silence is an attribute that only the wisest possess, therefore Be Ye Wise. Many times the innermost secrets of one's life will be opened to you. I know the temptation of telling it to your friend or friends but I know of no quicker way a nurse can commit suicide than to hear and speak what she hears. Silence is a virtue. When you are asked to prescribe for a patient, I know the temptation that will exist for you, when you have seen a certain drug act marvelously in a certain case, to prescribe the same thing for a friend whom you think has the same disease as this drug was used for, but remember that you are not a physician, neither a diagnostician, though frequently you may be right, many times you will be wrong and so to prescribe you may do injury.

All these things that I am calling to your attention are for your welfare, for your happiness, and for your success, as well as your patients.

I should next like you to consider dignity. A nurse should always remember that she belongs to a noble and dignified profession. All of her acts are judged and as they are judged so is the nurse's profession judged. Be loyal to your Alma Mater, be loyal to your profession and so conduct yourselves at all times so that no shame shall come to those who have sponsored you.

It has been my pleasure to watch you for the period of your training and without flattery, I do not believe that I have ever seen a finer group of nurses. I am certain that success and happiness awaits all of you who will seek to attain it and my most fervent hope is that St. Elizabeth's Hospital will always be proud of each and every one of you. This can only happen if you will remember those things that make for the best in nursing.

May happiness pursue you and may you bring health and happiness to all those that you serve.

Report of the Speakers' Bureau

Radio talks were given during June as follows:

June 15, 1936, at 11 o'clock—Dr. C. A. Gustafson. Title: "The Price of Worry."

June 22, 1936, at 11 o'clock—Dr. S. W. Weaver. Title: "Head Injuries and Their Danger Signs."

June 29, 1936, at 11 o'clock—Dr. J. D. Brown. Title: "Diet and Health."

JOHN NOLL.

July 30, 1936

YOUNGSTOWN COUNTRY CLUB

1:30 P. M.

GOLF

6:30 P. M.

DINNER

8:30 P. M.

EDDIE and O. W. L.

What Have You?

A STUDY OF DIPHTHERIA IMMUNIZATION IN THE YOUNGSTOWN PUBLIC SCHOOLS

Showing a Comparison of Results Obtained from the Use of:

(1) Toxin-antitoxin
(2) Toxoid (Anatoxin Ramon)
(3) Alum Precipitated Toxoid

Diphtheria immunization was started in the Youngstown Public Schools in 1924 as a matter of economy. Diphtheria quarantines were causing thousands of days of absence each year and many children were failing promotion because of absence. It was therefore decided that it was cheaper to pay for immunization than to pay for repeated grades.

In the early days we assumed that once a child had given a negative Schick reaction, our troubles would be over so far as he was concerned. We were soon disillusioned. While the incidence of diphtheria dropped very satisfactorily, we were greatly disturbed to find that many of the cases which did develop were among children who were recorded as Schick negative. Our first thought was of clerical error in recording and every precaution was taken to overcome this possibility. However, our Schick negatives continued to have diphtheria and we began to wonder if our test material was as potent as it should be. To eliminate the possibility of an occasional vial of test material being poor and to check further on clerical error, we decided to retest each year until we obtained two consecutive negative Schick reactions one year or more apart, giving additional treatment whenever a positive reaction occurred. We immediately began to get information as well as better results. It became apparent that a portion of our children were adequately protected for one year, but lost their immunity before the end of the second year after treatment. A few of these children consistently alternated a negative reaction one year with a positive reaction the next year throughout their entire school life. Another small group was Schick positive year after year, and a fairly large group remained constantly Schick negative.

During the years 1924-1936, we have given 95,276 Schick tests and 49,936 complete treatments. Individual records have been kept from the beginning, and the data given in the following tables is a tabulation of the 1930-1936 cards.

Table A

A comparison of immunity obtained with (1) three injections of toxin-antitoxin, one week intervals, (2) two injections of plain toxoid, four weeks interval, (3) one injection of alum precipitated toxoid. All tests were made one year after treatment.

	Number in group	Schick Positive	Schick Negative	Percent Immunized
Toxin-antitoxin	5787	1805	3982	69
Plain Toxoid	1636	249	1387	84.8
A. P. Toxoid	2231	283	1948	87.3

Table B

The loss of immunity during the second year after treatment with (1) three injections of toxin-antitoxin, (2) two injections of plain toxoid, (3) one injection of alum precipitated toxoid. These children, all Schick negative one year after treatment, were re-Schicked at the end of the second year.

	Number in group	Schick Positive	Schick Negative	Percent Losing Immunity
Toxin-antitoxin......	2674	162	2512	6
Plain Toxoid........	950	30	920	3.1
A. P. Toxoid........	952	64	888	6.7

Table C

In this table, we have applied the percentages shown in Tables A and B to three groups of 1,000 each, thus giving a graphic comparison of the relative efficiency of three immunizing agents at the end of two years.

	Toxin-antitoxin	Plain Toxoid	A. P. Toxoid
Schick Negative at end of first year	69% of 1,000 or 690	84.8% of 1,000 or 848	87.3% of 1,000 or 873
Number losing immunity during second year.......	6% of 690 or 41	3.1% of 848 or 26	6.7% of 873 or 58
Schick Negative at end of second year	649	822	815

This seems to leave the choice definitely between plain toxoid and alum precipitated toxoid. Subtracting 815 from 822, we find that 7 or 0.7% more children are protected with plain toxoid at the end of two years.

However, from an administrative standpoint, this small advantage is more than offset by the saving in labor and the fewer disruptions of regular school work obtained through the use of the one dose toxoid. This is especially true with our present method of retesting each year until two consecutive negatives are secured. We will, therefore, continue to use alum precipitated toxoid in the Youngstown Schools until something better develops.

W. E. HAWTHORNE,
Director of Health Department
Youngstown Public Schools.

REACTIONS

With Special Reference to the Teaching of Nurses

By L. N. M.

It has been said that we do not educate people unless we change them, and nursing education is no different from any other in this respect. What these changes should be and how to bring them about is the problem of nursing education and psychology combined. We do know that in every form of education we must utilize inborn tendencies; we must know how to form habits that will be a help not a hindrance in our day's work; and we must develop an interest which will be an incentive to the formation of the highest ideals in whatever we are doing.

It is wise to consider some of the specific stimuli and the responses made to these stimuli. A teacher's word, gestures, facial expressions and posture act very definitely as stimuli toward either a desirable or an undesirable reaction. Of course, other factors must be taken into consideration, but if the teacher fails to arouse any mental zest in a class, or if she fails to lift a class out of a pathetic, dull, behavior, then that teacher as a stimulus is a failure.

An even more important criterion of successful stimulation on the part of a teacher, and this seems particularly true in nursing education where the issues at stake are so vital, is the failure to arouse an interest which will be enduring and creative for the future and not just for the short time during which the subject is taught. Since it is not possible to tell the effect of every stimulus and the course of every possible response, all the instincts which have proved effective for good should be utilized.

Expression as well as impression should be considered. Not what we think we give the student but what she takes from us is important. What "we get across" to her is the evidence for or against a real teacher. That is the student's expression of the impression made upon her by the teaching. Expression on her part is necessary to prove that we "get it over" to her. We must be sure that there is in the student's mind a link which connects what she has gotten theoretically with what she is most vitally concerned—her work.

A practical psychology aims to influence behavior so that only desirable reactions result. Every reaction must take a definite form in order to increase the values of better living. A student's psychology, if it is to be of value, must not only give her an insight into the management of such things as the daily routine of the wards, but she must, in some way, find a like insight as to her conduct with her co-workers. Self-reliance, sympathy, precision, originality are a mere handful of the desirable qualities which will be of value in the practical application to her work as a nurse. If every teacher realized that it is her special task to teach two great lessons the task of the control of behavior might be less difficult. These lessons are: first, to teach the nurse to judge not by feelings but by facts; and second, to utilize every noble sentiment by making it an incentive to the formation of good habits. There must be a coördination of these habit patterns which will fit the student to meet the unexpected problems of her work.

When the student realizes that self-control is the aim and purpose of education, then she knows that the only method by which this objective can be gained is by practicing self-control today, tomorrow, and the day after, just as accuracy and thoroughness can be gained by looking for accuracy in every situation.

Our students enter training with high ideals of serving humanity and

they have found that their duties consist very largely of doing over and over again certain humdrum tasks. They know that these tasks are to be done, but they fail very often to grasp the real reason why they must spend so much time and effort upon them and why the instructors insist that one particular way of doing things shall always be used. If they knew more about the force and value of habit, much of their discontent would vanish. They would see that during this "grind" habits are being formed and made automatic, not as ends in themselves, but so that the student's very high ideals of service may later be fulfilled.

Action forms habits; interest lies back of action. In action lies the seed of habit, ahead of action lies behavior, behavior grows into conduct. Conduct grows into character and character into destiny—thus is life.

ECONOMICS COMMITTEE REPORT

Dr. L. G. Coe,
President, Mahoning County
Medical Society.

The Medical Economics Committee composed of Drs. W. M. Skipp, J. B. Nelson, W. K. Stewart, H. Schmit, W. X. Taylor, and E. J. Reilly, submits its report for the first half of 1936.

During January much energy was expended in formulating an administrative plan for the care of the indigent sick, which was submitted to the Commissioners of Mahoning County and agreed upon and approved by them when they assumed responsibility for all Relief in the County early in February. This agreement has become known as the "Mahoning County Plan" and has been published in our own *Bulletin*, in the *Ohio State Medical Journal*, and in the *Journal of the American Medical Association*, along with some very kind comment particularly in the last named publication. Our Sixth District Councillor, Dr. W. M. Skipp informs us that it is also being used as a model by other County medical groups in their dealings with Relief.

While we appreciate that the Mahoning County plan is far from ideal, still the medical care of the indigent is still under the guidance of the Mahoning County Medical Society and this same indigent continues to enjoy free choice of physician. We as the complaint takers have had no notification by the relief clients that the medical care is not adequate, although this satisfaction is not shared by some members of our Medical Society, and lastly some $12,000.00 has accrued to physicians. It is true that bills have been slow of payment but through no fault of our County Commissioners.

February and March bills have been paid; April bills will have been paid before this appears in print, and May and June bills will be cleared up during the month of July.

Month	Doctors	Drugs	Case Load
February	$2,581.00	$602.50	4,526
March	3,665.00	765.57	4,344
April	2,919.00	699.36	3,988
May	2,516.75	643.66	4 102

Three members of this committee were in attendance at the Mid-Year Organization Conference of the Ohio State Medical Association held in Columbus, April 26th. One member, Dr. Walter King Stewart, presented a paper on "Free Choice of Physician for Indigents." While we came away with few or no new ideas regarding our own special problem, still the time was well spent if for no other reason than to have heard Dr. J. L. Van Horn, chief, Bureau of Child Hygiene, and Dr. Walter H. Hartung, State Director of Health, both declare emphatically that their aim is to correct practices that have grown common in some communities, where-

by the local Health Officials engage in competition with private practitioners. They outlined a plan of instruction and education for Health Commissioners and Public Health Nurses which was comprehensive although rather vague in the light of the fact that the money for it was to come to Ohio under the Social Security Act, the future of which legislation has yet to meet the test of Supreme Court scrutiny.

Little or no work has been done on any other economic problem confronting the Society because such time as could be spared from the ever-present necessity of earning a livelihood has been consumed by the administration of medical relief. While it can be distinctly recalled by some of us that the Economics Committee was created for this express purpose, time has proven that many other pressing questions should receive its attention. If the volume of detail handled by other standing committies is as great, and in some instances we are convinced it is even greater, then in order to maintain our hard won prestige as a County Society, our leadership in the State Association, and our usefulness to each other and the community where we serve, this Society must have the services of a full-time executive secretary, because it becomes increasingly apparent to this committee that the burden can no longer be efficiently and satisfactorily carried by volunteers.

EDWARD J. REILLY,
Chairman.

Circulation of Our Bulletin

It has come time to revise our mailing lists, and, incidentally, to ask ourselves just to whom should the *Bulletin* be mailed each month. Primarily it is a news organ, created for the purpose of informing our membership of the activities of the Society, and of the members themselves.

Because of the success of our successive program committees, in securing interesting men and instructive programs and postgraduate groups, a large request for the privilege of receiving the *Bulletin* sprang up, until at present we mail out, each month, close to one thousand copies. All this is costly, but if the *Bulletin* serves those who receive it, we are willing to continue to make the effort just so long as our advertisers make it possible.

That we may know to just what an extent the *Bulletin* is appreciated and desired, we are announcing that this is the last month that the old mailing lists will be in use. New ones are being made up, which comprise the local society membership, Presidents and Secretaries of each county society in the State, officers and councillors of the State Association, certain hospitals, libraries, local newspapers and exchanges with other such publications. All other addresses will be discontinued, excepting those of the out-of-town visitors to our last Postgraduate day. If it is desired to receive further copies, or to be retained on our mailing list, it will be necessary so to inform the Editor.

Summer Activities

There will be no scientific meeting during the months of July and August. However, the Entertainment Committee has arranged an event for each of the months, to maintain interest in the society and promote sociability and good fellowship. Won't everyone endeavor to be present on one of these days at least; better, of course, on both?

You will receive reservation cards later in the month. Please give prompt attention to these, that the committee may make proper arrangements. For details of the events, you are referred to the program as given each month in the *Bulletin*.

Youngstown News Flashes

By C. A. GUSTAFSON

Dr. Collin Reed has moved his office from Bryson St. to 787 Wick Ave., in the Youngstown Printing Company building.

Dr. Charles Warnock will occupy Dr. Reed's former office at 415 Bryson Street.

Dr. A. E. Brant has left for a three weeks' vacation in the Georgian Bay.

Dr. and Mrs. Rhinehart recently left for a two months' tour of Europe. They will meet their daughter who has been studying there.

Dr. and Mrs. Turner accompanied the Rhineharts as far as New York.

Many of us were fortunate in seeing Dr. Neel, a recent visitor in Youngstown.

Dr. D. H. Levy has recently been a patient at St. Elizabeth's Hospital. Glad you're better, doctor.

Dr. J. T. Kemp, former Assistant Resident at North Side Unit, has charge of a camp in Pennsylvania for the summer. Beginning September 1 Dr. Kemp takes up his practice in Texas.

Dr. J. A. Renner was best man at his brother George's wedding recently.

Dr. J. J. Welter and Miss Esther Huxley were recently united in holy matrimony. Dr. Welter will have his office at 19 Lincoln Ave., and Dr. and Mrs. Welter will reside at the Parkway Tower.

All the new internes are in and have started on their year's work.

Dr. Hamilton, who interned at the Youngstown Hospital this year, will remain four months doing special laboratory work at South Unit.

Publicity Committee Report

President Mahoning County
Medical Society.

Dear Sir:

I wish to report that the Publicity Committee made and posted placards on all hospital bulletin boards, announcing the monthly meetings.

A series of three articles was submitted to both newspapers during the Diphtheria Campaign, and these articles were run in the daily papers during the drive. Both newspapers have been very kind and coöperative in every way possible to assist us in publicising every event so far this year.

Respectfully submitted,

J. ROSENFELD, M. D., *Chairman.*

Membership Committee Report

The following men were taken into the Society from January, 1936, to date:

Dr. Morris H. Belinky, 2004 Elm Street.

Dr. J. R. Buchanan, Central Tower.

Dr. J. B. Kupec, Central Tower.

Dr. R. E. Odom, Dollar Bank Bldg.

Dr. R. W. Rummell, 1506 Market Street.

Dr. E. J. Wenaas, Dollar Bank Bldg.

The following men were admitted to Associate Membership:

Dr. E. G. Caskey.

Dr. V. A. Neel.

Dr. S. R. Proudfit, 66 Warren Avenue, Honorary Member, expired during the year.

The following men were suspended:

Dr. D. H. Hauser.

Dr. Joseph F. McGowan.

Respectfully submitted,

LAWRENCE SEGAL,
Chairman.

SECRETARY'S REPORT

The fifth meeting of Council met June 12, 1936.

Dr. E. J. Reilly was in attendance to inform Council on the "status praesens" of the medical economic and the plans for the near future. The medical relief plan is in the process of being revamped to take care of the relief situation after July 1, 1936. They are not ready for release at this time.

Dr. Louis Deitchman presented a report of the Postgraduate Day. It was satisfactory to Council and all bills were paid and a balance remains.

The Old Age Pension Board made a request for Council to suggest the name of a doctor to fill the vacancy created by the resignation of its doctor member. This was done as requested.

The regular meeting of Mahoning County Medical Society was held at the Youngstown Club June 16, 1936. Dr. Charles C. Wolferth was the essayist of the evening. The subject for the essay was "Coronary Arteriosclerosis."

The speaker is a master of his subject and presented his data in a distinct manner. He was at one time pathologist at the Youngstown Hospital.

Interest is now alive in the Ohio State Medical Society, relative to the political situation. It is always an important feature that candidates for offices in legislature have a proper attitude towards medical legislation. It is each one's duty to use influence when possible to advise legislators along proper medical ideas.

ROBERT B. POLING, *Secretary*

COMING EVENTS

August 27, 1936—Annual picnic and corn roast. Squaw Creek Country Club.

September 15, 1936—Dr. R. C. McKay, Attending Physician, City Hospital, Cleveland. Tuberculosis.

The Youngstown Sheet & Tube Company has extended a cordial invitation to the members of the Mahoning County Medical Society, for luncheon and an inspection of its steel mills. The Entertainment Committee acknowledges gratefully this kind invitation and will arrange a day in September.

October 20, 1936 — Dr. L. C. Kress, Buffalo, N. Y. "Treatment of Malignancy."

November 17, 1936—Dr. A. J. Lanza of The Metropolitan Life Insurance Co., N. Y. "Trends in Medicine."

There will be a meeting either in October or November, featuring home talent, offering the following program:

Dr. Armin Elsaesser — Some Aspects of Goitre Surgery.

Dr. S. H. Sedwitz — Peripheral Vascular Disease.

Drs. Brant and McNamara—Certain Aspects of Abdominal Surgery.

Then, too, we are to have a course of lectures in October by Drs. Perry and McCullough of the Cleveland Clinic on Endocrinology.

"Isn't that a dainty dish to set before the King?"

Vital Statistics and Communicable Disease Report

Youngstown, O., June, 1936.

Chicken Pox	9
Diphtheria	1
Measles	3
Scarlet Fever	36
Whooping Cough	18
Tuberculosis	11
Erysipelas	1
Pneumonia	1
Syphilis	8
Total Births	240
Deaths	120

R. MELLON, *Registrar.*

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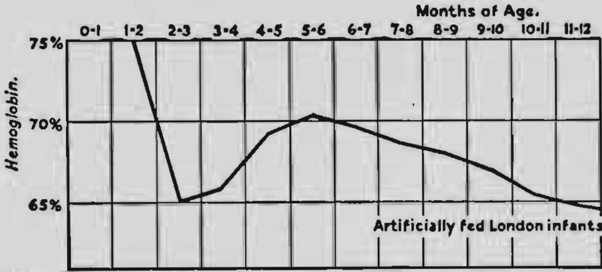
7 8 7 . W I C K . A V E N U E

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.

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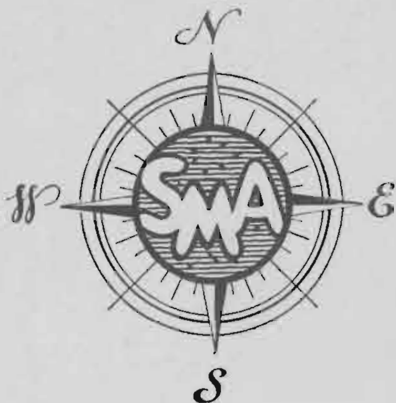

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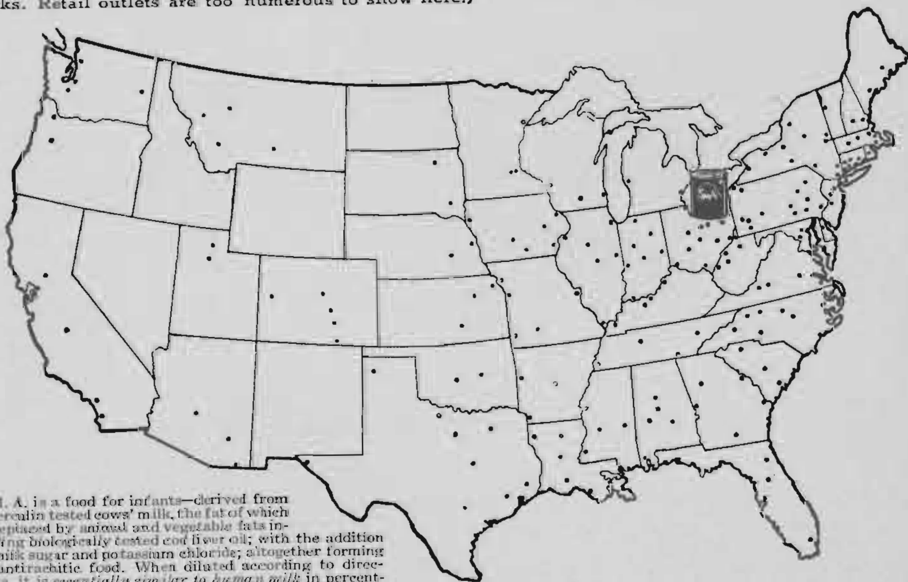
From Maine to California, practically every wholesale drug house in the country carries stocks of S.M.A., and most of the 50,000 retail druggists stock it. In the cities, any retailer who runs out of S. M. A. can get it overnight, and druggists even in the remote rural districts can get S. M. A. quickly 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.

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