BULLETIN

of the

Mahoning County Medical Society

Organized 1872

February 1937

Volume 7 Number 2

ΑΣΚΛΗΠΙΟΣ ΑΣΚΛΗΠΙΟΣ

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

Inquiries and remittances for advertising or subscriptions should be addressed to Dr. Lawrence Segal, 701 Himrod Avenue, Youngstown, Ohio.
Published Monthly at 2218 Market St., Youngstown, Ohio.
Annual Subscription, $2.00.

VOL. VII—NO. 2 — February, 1937

CONTENTS

PRESIDENT'S PAGE

THE SECRETARY

We must not fail to take into consideration the "multitude of duties" that our secretary has to perform. The routine work of transcribing the activities of council and the Society is but a minor function.

The bookkeeping system of the secretary's office must balance with the treasurer's. It is the secretary's work to send statements, and collect dues, to write all communications pertaining to council and society work. To write many letters for committees, to set type for, and mail notices of banquets, picnics, meetings, etc. When he has done these, he can devote what time is left to the practice of his profession.

We have grown rapidly, as a Society, and have reached a point where it is an imposition upon any of our members to expect any of them to assume the arduous duties of the office of secretary.

We must either cut down our activities to our member's ability to devote his personal time to his office, or if we are to continue to progress, we must provide paid assistance, with unlimited time, to do the necessary detail of the work.

Dr. Poling can formulate policy as heretofore, except that card mailing, letter writing, etc., can be done by such paid assistance.

The Medical-Dental Bureau can and is willing to act in this capacity. The Bureau has the facilities and personnel to carry out this program.

I pledge myself to work for some method of coöperation with the Bureau, so that our secretary can have more time to direct the affairs of his office and still practice his profession.

PAUL J. FUZY, M. D.

BULLETIN
of the
MAHONING COUNTY MEDICAL SOCIETY
FEBRUARY 1937

TO THE MEMBERSHIP OF THE MAHONING COUNTY MEDICAL SOCIETY

Our Society is exceedingly active and to be a member of this Society is a privilege and we are honored by being members. There is too few of the membership that take an active part in the activities of the Society. Too many of us sit on the side lines and even then we do not "root" for the members that are trying to make a place for the Society. These members are not looking for self-praise, but for the Society alone.

All medical men should be members of organized medicine, but the membership should be selected with care. The old saying, "We can handle a man better in the Society than we can out of it" does not always work. It is then the duty of the local Society to see that its members are ethical and if they step away from the "straight and narrow path" they should be called before the Society for accounting. In other words, it is the duty of the Society to police its members.

The medical profession is facing many problems at the present which cannot be solved by a committee chairman of the society or a committee chairman of the state organization. These problems are the task of the entire profession, and we will all have to do our part in aiding the officers and committeemen if we are to win. The new Legislature going into session will have bills of all description which will deal with all types of medical practice, fostered by cults. Remember, they will leave no stone unturned to gain a point or to break down the health laws of this State. Our medical practice laws are adequate and are giving the public protection. Our profession will foster measures for the improvement of these laws, and for the protection of the rights of the profession. Go to your committee. Volunteer your aid; they will be able to use you. They will also direct your activities so they will be more effective.

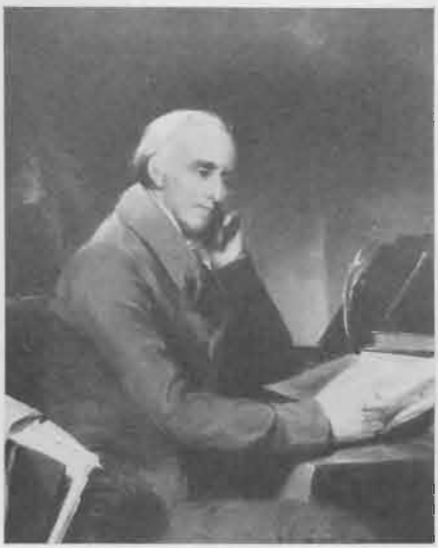
The State Medical Association is not made up of a group of medical men that have no interest in the members of the County Societies. They are continuously working, giving their time for your benefit. Your problems and complaints will always be heard. Remember, the State Association is your association as much as the county Society is yours. The State needs your support, which can be given through the County Society.

WM. M. SKIPP, M. D.,
Councilor Sixth District.

THE HIPPOCRATES OF PENNSYLVANIA

By LOUIS S. DEITCHMAN, M. D.

One of the favourite aphorisms of the late and much lamented Doctor Benjamin Rush, the learned and candid man, the gentleman and Christian, was: "In every age and country theories have been numberless, accurate observers few." This saying, often repeated, strongly impressed itself on my youthful mind. I have therefore, assiduously cultivated this art of observation and have strengthened and augmented it, from my student days on, by writing everything down on paper, in journals and notebooks. For how can a man spend a life-time in the practice of physic without cultivating observation, the keystone of that art. Is he not called upon in his daily rounds, to observe the operations of natural forces, in both healthy and morbific states? Or of his fellowmen, their stratagems and foibles and the working of both their bodies and minds? And now that I have reached the age of contemplation and reminiscence, it is a pleasaunt and profitable pastime to rummage through these writings and thus bring forth events and faces, important and trivial, which have, through the operation of time, become blurred or forgotten.



Doctor Benjamin Rush

I am of a strong opinion that it has been my exceeding good fortune to have lived in what will be considered, by historian and philosopher, as one of the most interesting and important periods in the world annals. For I have witnessed the emergence of our American colonies from the part of a subservient appendage to our Mother Country, Britain, into a novel and independent form of government. I have seen, and with mine own eyes, the birth of a state based on the principles of justice, liberty and equality, and in the depth of my heart I am thankful to the Author of Creation for this privilege.

I also deem it my exceeding good fortune to have had as my contemporaries and compatriots men of great caliber and mental stature, in all ranks of life, and in various pursuits; a plentitude of statesmen, scholars, patriots, scientists, humanitarians, &c., &c., the equal of which few generations, I am persuaded, will boast. To mention but a few, General Washington, Benjamin Franklin, Thomas Jefferson, the Adamses, John Hamilton, Madison, and many others, and in my own calling, men of illustrious achievement as Benjamin Rush, Casper Wistar, Adam Kuhn, Morgan, Shippen, Physic, &c. &c.

I have spent many an hour in the idle conjecture and speculation, and I regretfully state without reaching any conclusion, whether the exigencies of the time produced these great and worthy men, or whether the generation rose to the opportunity of the historic moment; perhaps, it was a combination of both, be that as it

may, the growing country has provided a sett of men, who will leave an indelible mark upon the history of this growing nation.

In this historical period the city of Philadelphia played a particularly important role, being the capitol of the nation as well as the seat of scientific endeavour and culture. Many of our great men sprang thence; and perhaps in no field has this city nurtured and developed a finer group of leaders as in the field of medicine, so that as I write this, Philadelphia has already become a center for medical and scientific learning, and holds the promise of being the Athens of the New World for generations to come.

Not the least among these celebrated men was the late lamented Doctor Benjamin Rush, the scientist, medical philosopher and teacher, humanitarian and generally great and good man. I deem it no small privilege that it has been my happy lot to be associated with him, first in the capacity of apprentice in his shop, later as a student in the University of Pennsylvania (the erstwhile College of Philadelphia), where he was, for many years, professor of Institutes of Medicine and the occupant of several other chairs, also through a long and uninterrupted correspondence. I followed his many fold activities and voluminous writings for personal reasons as well as from a deep conviction that his life was of great historic value, having had so many points of contact with important events of his and my days so that a chronicle of the life of Benjamin Rush, which I am about to record (to the best of my ability), constitutes a good record of our time.

There is now, as I presume there will always be, a deal of controversy about Doctor Rush. By some, he is most extravagantly praised. He has been called the Hippocrates of Pennsylvania and the Sydenham of America, &c. &c. By others he has been just as roundly abused. It remains for posterity to decide on the true stature of the man. But whatever the verdict of future generations (and may they treat us with charity) upon his claims to fame, no one who is acquainted with the facts of his life will deny that he has led a most dramatic and interesting life, as I shall, in my imperfect way, attempt to shew.

In doing this I fully apprehend my shortcomings. I make no claim to florid stile or special felicity of expression; for a life spent in a busy practice of medicine does not engender many ornamental frills or a facility in what the Frenchman might call *Belles Lettres*, and being of the older generation I fear that the stile of my day is no longer accepted as modish; they accuse our way of writing as redolent of superfluous ornamentation and circum-locution. The younger writers are wishful of a more direct road. Our ways and our tempo (to borrow a term from musick) are too slow for them. And that, I regret, is also true of the general mode of living. Try as I may to accept this accelerated life, I fail to see that this change is a laudable one. This is no place to attempt to re-produce the virtues and charms, the stateliness and gentility of my generation, which I apprehend is vanishing. But there is something to be said for the leisurely traveller of yore. He was more apt to observe the beauties of the road-side land-scape which, I fear, is missed by those of the younger generation who are bent on reaching their destination at a break-neck pace.

I must, however, confess to a garrulity among those of my day, against which I must guard in this writing, noting that I am apt to go off into observations not entirely relevant to the matter in hand, which is to sett down the life of Benjamin Rush, in my imperfect way, and hope that the future may produce some one, with a pen more graceful and facile, to write a life history worthy of the man, and that these rough notes, which, I

trust, will not be consigned to oblivion, may be of some assistance to the future biographical efforts.

My close association with Doctor Rush enabled me to gather some fragmentary information about his early life. He was born on Christmas Eve, 1745 (old stile), on a farm near Philadelphia, and came of English Quaker stock. His father, who was a farmer, blacksmith, and gunsmith, was apparently a man of limited learning, though well known for his honesty and God-fearing life. He died when Benjamin was but 6 years old. His mother, the parent who most inspired his life, had been educated in a Philadelphia boarding school and was a woman of high intellect and principles.

His early education was received in a school conducted by his uncle, the Reverend Samuel Finley, a schoolmaster and Presbyterian clergyman. At 14 he was admitted to the Junior class of the College of New Jersey. Because of some oratorical ability, he intended to study law, but was dissuaded from pursuing a legal career by his uncle and school mentor, who thought, and with reason, that the practice of law was then full of temptation, which I regret is still true. Medicine was suggested as an alternative and was soon decided on. In 1760, at the age of 15, Rush was granted the Bachelor of Arts degree by the College of New Jersey.

Having definitely embarked on a medical career he began to look for an apprenticeship—the customary procedure for a young man about to enter the profession—, and in February, 1761, he apprenticed himself to the distinguished and busy practitioner, Dr. John Redman of Philadelphia.

Medical apprenticeship in those days was not an easy nor pleasaunt occupation. The apprentice had to perform a great variety of menial chores inherent in the practice of medicine. He had to act as nurse to the sick, run errands, administer glisters (lately known as clysters), help with purging, bleeding, cupping and leeching and perform many duties of a servant. At first young Rush was dissatisfied with his lot, but as the months passed he became interested in the work and the study of medicine. He applied himself so diligently that he gained Dr. Redman's complete confidence so that only after one year's observation and practice, 16-year old Rush was frequently placed in full charge of patients. To those of the present generation this may appear implausible, but in my younger days we matured rapidly.

A few words about Philadelphia of that day. It was then the Metropolis of the colonies, and growing steadily. It was laying foundations for the progressive and humane institutions which were later to come into full fruition. The Pennsylvania Hospital, America's first public hospital, had been opened in 1749. The Academy, later the University of Pennsylvania, was attracting young men from all parts of the country, eager after learning. A fire insurance company had been organized and, since 1753, under Deputy Postmaster General Franklin, there had been a daily delivery of letters. There was a rapid Stage-coach line, operating weekly between Philadelphia and New York City, which reduced the time for that journey, hitherto made on horseback, to but three days. The shops were well stocked with all manner of domestick and imported wares and all carried on a busy trade. There were many fine publick buildings as well as private mansion-houses and the general mode of living was not unlike that found in the capital cities of the Old World.

Dr. Redman had a high position in the community and enjoyed a wide practice, which provided young Rush opportunity for experience, and a well stocked library, which was utilized in spare hours to improve himself by study. Dr. Redman was on the staff of the Pennsylvania Hospital, a con-

nection which meant a great deal to Rush, since it permitted him to see the work of all the other members of medical staff. Therefore, while the work was arduous, it was interesting and engrossing, so that Rush was happy and contented, while he remained in Dr. Redman's shop and was a member of his household for five and a half years. At the end of this period, Dr. Redman, recognizing the aptitude and industry of young Rush and his zeal for medicinal studies, advised him to go abroad, and accordingly, in 1766, he enrolled in Edinburgh University .

It is easily seen how seriously Rush was taking his preparations for the practice of his profession. For although his apprenticeship was sufficient to qualify him for practice, since this was the usual preparation requisite of most of the practitioners of that day—much as I myself did as apprentice to Doctor Rush—he wanted to go further. Generally, the qualifications for practicing physicians were altogether vague, some taking medical courses abroad, others serving as apprentices, and still others practiced without qualifications whatsoever. The country was, as it still is, quack ridden, and perhaps no city worse than our capital city Philadelphia. Sure cures were promised for every conceivable malady by medical charlatans, to the detriment of both patients and honest practitioners. The news-papers were filled with advertisements of quacks, who immodestly and unscrupulously extolled their own nostrums and surprising and miraculous cures, which, under God, had been performed by them. It was difficult for an upright practitioner to compete with these hawkers; I wonder how long the human race will permit these vultures to prey upon its misfortune, ignorance and gullibility!

I offer an example extolling Dr. Ryan's "incomparable worm destroying sugar plumbs; one of the best purges in the world, for gross bodied children that are apt to breed worms, and have large bellies; their operation is mild, safe and pleasaunt; they wonderfully cleanse the bowels of all stiff and clammy humours which stop up the parts and prevent the juice of food being conveyed to the liver and make blood, which is often the case with children and is attended with a hard belly, stinking breath, frequent fevers, rickets and a decay of strength in the lower parts. Likewise, settled aches and pains in the head, swellings, old sores, scabs, tetters or breakings out, will be perfectly cured; they purge by urine and bring away the gravel and effectually cure ulcers in the kidnies and all scorbutic humours and effects, &c. &c."

One Thomas Anderton, a glazier, is augmenting his trade by promising in the columns of *The Pennsylvania Gazette* sure and infallible cures for the Pox and Gleet by Saxary's medicines, "the first ever offered in the world that will effectually and radically cure every symptom of the venereal disease, without pain or sickness or any confinement whatever. Salivation is wholly rendered by them unnecessary. They may be taken by the most delicate of both sexes, at all seasons of the year, and by fishermen in water, without any hurt to the constitution, for they improve and invigorate the whole nervous system."

Another: "Gleets and seminal weaknesses in both sexes, impotency, fistulas and obstructions of the urinary passages, cured at moderate terms." For a dollar, cash, one may buy bottles and boxes of infallible cures for the worst of fevers, agues, rheumatism, &c. &c., ad nauseam.

I express it as a matter of regret that our otherwise admirable newspapers open their pages, for pecuniary remuneration, to the advertisements of shady quacks and dubious nostrums, thus aiding in the perpetration of these frauds. It renders it difficult of acceptance, their editorial claims to

liberality and zeal for the dissemination of truth.

"It is melancholy to reflect that amidst the imperfection and feebleness of the healing art, the success of it should still further be curtailed by ignorance, negligence, prejudice, follies and vices of the sick themselves, or of those who undertake their management" (vide: Rush lectures). How true this is, only we practitioners of physic know, and it has been my regretful observation that most of these self-stiled practitioners prey upon the unfortunates who are afflicted with the venereal maladies. Discussing it in my own mind, I have reached a firm conviction that the condemnation for this deplorable state may be laid at our own door-steps; viz., for generations the notion has been impressed upon the publick mind that venereal disease is a shameful malady, which stamps its possessor as an outcast and pariah, on a footing with criminals, to be shunned as contaminated as poisoned individuals. This, together with the foolish and sinister mystery which surrounds the disease, cause these unfortunates to secrete their affliction, to their own detriment, and to the detriment of others to whom they transfer the contagion. So that instead of seeking competent advice at the first appearance of symptomata, the stage when the malady is most amenable to cure, the victims are suffered to go on to the later stages and manifestations when they are already past human and medical aid. All this time they continue to innoculate others with the contagion and to re-produce tainted offspring. And, finally, when they do decide to seek relief, they are more likely to knock at the door of a quack, who, with smiling affability, beckons and caters to them and fleeces them unmercifully, without affecting a cure, rather than at the door of the honest practitioner. And this because prejudice, ignorance, and superstition have made these diseases loathsome and unmentionable. In the name of reason, why are these sufferers neglected, despised and kicked about? We extend our sympathy (which takes away the keenest edge from affliction) and aid to the inebriate, who in his cups fractures a leg. We kow-tow to the glutton, who through his own dietary sins has become a sufferer of the gout. My mind is fully settled that the victim of Lues Venerea, whether the entirely innocent sufferer of the inherited type, or the unwittingly acquired type, should have the same claim to our sympathy and ministrations as the victim of a scirrhus, a dropsy, hypochondria, iliac passion, phrenitis, hooping-cough or any other disease; and this change in the viewpoint must extend to the publick in general. So let us bring the entire matter into the open and strip it of all mysterious and sanctimonious mummery. For not until such time when syphilis and gonorrhea become words fit for polite conversation and sensible discussion, will we make any progress in the controul and eradication of these two dreadful diseases. Men only require to be made acquainted with the distress and true facts of the matter for their compassion and their charity to be awakened. But here I am again letting my verbosity divert me from my subject.

The University of Edinburgh was the outstanding school in the British Isles. Here Rush studied under Cullen, Monro and the other medical celebrities on the faculty, and in June, 1768, he received the degree of Doctor of Medicine after having presented the faculty with an inaugural dissertation on the digestion of food in the stomach, *"De coctione ciborum in ventriculo,"* done into classical Latin.

This study, conducted upon his own person, was to ascertain whether fermentation had any agency in digestion. For this purpose he took 5 grains of an alkaline salt, to destroy any acid that may accidentally be in the viscus (sic!), this followed by

ingestion of food. Three hours later he took 2 grains of an emetic (cremor tartar) and examined the digested stomach contents after it was puked up. The conclusion was, in his own words: "From these facts, thrice repeated, inference was drawn, that the aliment in the human stomach, in the course of three hours after deglutition, underwent acetetous fermentation." Discussing this in my mind, I consider these experiments only worthy of note as bearing testimony to the zeal and heroick determination of the candidate, rather than as a scientific contribution.

After receiving the degree of Doctor of Medicine from this school, he stayed on for another summer, working at the infirmary. Besides the contacts with local leaders of medical thought, he was in frequent intercourse with the educators, philosophers and sociologists of that city. It is at this time that the seeds were sown for his liberal views on education, government, penology, slavery, temperance, &c. &c.

From Edinburgh he went to London, where he studied at several hospitals and attended Dr. William Hunter's lectures. Benjamin Franklin, the friend of every American in England, was then in London as Colonial Secretary. As was his customary habit, he took the young doctor under his wing and made him acquainted with most of the important Englishmen of that day. Among them were Doctor Samuel Johnson and Oliver Goldsmith, the men of letters, Sir Joshua Reynolds, the portrait painter, Doctor John Fothergill, and many others.

Doctor Rush was now ready to return home, but Franklin suggested that he visit Paris first. So armed with letters from Franklin, he went to France. But finding that there was but little chance to study medicine there, and apparently unimpressed with the gay life and the splendours of that city, he stayed there but a few weeks, returning to London to embark for home. After a voyage of six weeks he arrived in New York in 1769, and at once proceeded to Philadelphia, well prepared, strongly purposed and eager to sett out in practice.

The peregrinations of Doctor Rush were typical of the course pursued by most American practitioners who were desirous of obtaining a sound medical education. It was a laborious, costly and difficult road, and it is to the credit of the medical educators and leaders of this land that our youths are now spared these difficulties. For we can now boast of several medical schools where one can obtain an adequate training in the science and art of practice, equal to that given by most of the Continental schools, from the same text books, and under the guiding hand of our own teaching staffs and medical talent, so that we might proudly say that we have now achieved independence in medical education, just as we have politically.

To be sure, there is still a deal of traveling among our students, but that (save for the serious scholar who is wishful of perfecting himself in special medical problems or to sit at the feet of some outstanding master physician or chirurgeon), I consider, and with good reason, as almost entirely superfluous, since, for general purposes of practice, our medical course of instruction is entirely adequate.

I do not wish to be uncharitable, but I am painfully impressed with the pretensions of some of our recent European graduates who affect haughty airs and dandified fashions in their cloathes and generally make a show of themselves in the deceitful notion that the mere residency in a foreign school gives them the right to superiority over their honest home spun colleagues. These airs fool no one but their own selves, for, thank Heaven, it is our custom, in harmony with our republican principles, to accept men for their true worth, and no grandiose

(*Turn to Page* 46)

February Meeting

W. W. G. MACLACHLAN, M. D.

Pittsburgh, Pa.

SOME CHEMICAL PROBLEMS OF PNEUMOCCIC PNEUMONIA

YOUNGSTOWN CLUB
February 16, 1937
8:30 P. M.

Dr. Maclachlan's interest in the understanding and treatment of pneumonia extends back over a period of 15 years. He will have some interesting and instructive ideas to present.

March Meeting
DR. J. SHELTON HORSLEY
Richmond, Virginia

●

APRIL 20, 1937—POSTGRADUATE DAY

1937 • SOCIETY MEETINGS • 1937

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS
Quebec, second week of June. (Secy.—Dr. Henry L. Sanford, 1622 Keith Building, Cleveland)

AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS
Hot Springs, Va., September. (Secy.—Dr. James R. Bloss, 418—11th Street, Huntington, W. Va.)

AMERICAN COLLEGE OF SURGEONS
Chicago, October 25-29. (Chairman, Board of Regents—Dr. George Crile, 40 E. Erie Street, Chicago)

AMERICAN GYNECOLOGICAL SOCIETY
Swampscott, Mass., May 31-June 2. (Secy.—Dr. Richard W. TeLinde, 1201 N. Calvert Street, Baltimore)

AMERICAN MEDICAL ASSOCIATION
Atlantic City, June 7-11. (Secy.—Dr. Olin West, 535 N. Dearborn St., Chicago)

AMERICAN ORTHOPAEDIC ASSOCIATION
(Secy.—Dr. Ralph K. Ghormley, The Mayo Clinic, Rochester, Minn.)

AMERICAN RADIUM SOCIETY
Atlantic City, June. (Secy.—Dr. Wm. P. Healy, 121 E. 60th St., New York)

AMERICAN ROENTGEN RAY SOCIETY
Chicago, September 13-17. (Secy.—Dr. Eugene P. Pendergrass, 3400 Spruce Street, Philadelphia)

THE AMERICAN SOCIETY OF ANESTHETISTS, Inc.
New York, second Thursday of February and April. (Secy.—Dr. Paul M. Wood, 131 Riverside Drive, New York)

AMERICAN SOCIETY OF REGIONAL ANESTHESIA
Stated Meetings in February, April, October and December (Secy.—Dr. Paul M. Wood, 131 Riverside Drive, New York)

AMERICAN SURGICAL ASSOCIATION
New York, May or June. (Secy.—Dr. Charles G. Mixter, 319 Longwood Avenue, Boston)

ASSOCIATED ANESTHETISTS OF THE U. S. AND CANADA
Atlantic City, June 7-11. (Secy.—Dr. F. Hoeffer McMechan, Westlake Hotel, Rocky River, Ohio)

CONGRESS OF ANESTHETISTS
Chicago, October 25-29. (Secy.—Dr. F. Hoeffer McMechan, Westlake Hotel, Rocky River, Ohio)

INTER-STATE POST-GRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA
St. Louis, October 18-23. (Secy.—Dr. Tom B. Throckmorton, 406 Sixth Avenue, Des Moines)

NEW ENGLAND OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Hartford, April. (Secy.—Dr. Thomas Almy, 140 Rock St., Fall River, Mass.)

NEW ENGLAND SURGICAL SOCIETY
Providence, R. I., September 24-25. (Secy.—Dr. John M. Birnie, 14 Chestnut Street, Springfield, Mass.)

PACIFIC COAST SOCIETY OF OBSTETRICS AND GYNECOLOGY
(Secy.—Dr. T. Floyd Bell, 400—29th Street, Oakland, Calif.)

PACIFIC COAST SURGICAL ASSOCIATION
Seattle, February 18-20. (Secy.—Dr. Glen H. Bell, University of California Hospital, San Francisco)

RADIOLOGICAL SOCIETY OF NORTH AMERICA
Chicago, September 13-17. (Secy.—Dr. Donald S. Childs, 607 Medical Arts Building, Syracuse, N. Y.)

SOUTHERN SURGICAL ASSOCIATION
(Secy.—Dr. E. W. Alton Ochsner, 1430 Tulane Avenue, New Orleans)

WESTERN SURGICAL ASSOCIATION
(Secy.—Dr. Albert H. Montgomery, 122 S. Michigan Blvd., Chicago)

(*Continued from Page 43*)

miens or outlandish frippery deceive us. An overdressed macaroni with a fancy foreign diploma may yet be an ignoramus unsurpassed by our own country bumpkins. These affectations may be partly condoned in the real foreigners, on the ground that they are unacquainted with our ways. But those of our own stock, who go to foreign parts, for variable periods, may become obnoxious through these affectations. I cannot reflect upon this matter without some rancour, which I know to be wrong, but which I cannot subdue.

It is at this time that I made the acquaintance of Doctor Rush and, as I recollect him at this age, i. e. 23, he was a vigorous, well-built, attractive and dignified young man whose appearance and manner seemed to inspire confidence. He was, however, I must regretfully note, entirely lacking in gayety, exhuberance and carefree spirit of youth, and devoid of a sense of humour. This character of Doctor Rush is essentially true for the rest of his busy and turbulent life.

Editor's Note—Further installments of the life of Benjamin Rush will appear in subsequent issues.

SECRETARY'S REPORT

The business of Society activities has begun. The president, Dr. Paul Fuzy, held a dinner meeting January 7, 1937, for committee chairmen and the other officers.

The purpose of this meeting was to instruct the committee chairmen relative to their duties and what will be expected of them.

The annual banquet replaced the regular meeting for the month of January. One hundred and forty-four regular attendants were served and nineteen guests. The entertainment was excellent. The entire group enjoyed themselves and there was cheerfulness throughout the evening. During the dinner hour Dr. Patrick lauded a number of the older and honorable members of the group and called them to take a bow.

The after dinner speaker was Dr. Ellis Manning of the Research Laboratories of the General Electric Company. The title of his address was "The House of Magic." His address was well delivered and he was a master of his subject. It was highly scientific and revealed some of the secrets of the science of physics.

The subject "Syphilis" has finally been released from its dark niche. Information relative to this subject is well received by the general public. People are very enthusiastic to learn more. There is a distinct clamor from lay-group organizations for speakers on this subject. Many calls have come to the secretary's office to provide speakers for them.

It seems quite certain that the public will demand a housecleaning to rid the great populous of this plague.

"The Chiropractic Bill, asking for a separate board and special rights and privileges for these limited practitioners, was introduced late Thursday afternoon by representative John B. Curtin of Lucas County. It will be known as "House Bill 172."

One can readily see that the cultists are again active in the state legislature. It is highly important for members of the County Medical Societies, officers and especially the Legislative Committee to meet with the representatives in order to provide correct information to them. These legislators depend upon the Medical Profession to guide them correctly. The members of the State Legislature usually return to their homes over weekends. This is the opportune time to confer with them on legislative matters.

The Medical Profession for Ohio maintains a membership of between 8000 and 9000 members. This is quite a force and the potential influence is great. There are 350 to

400 osteopaths and about 500 to 600 chiropractors. The numerical difference is great. The personal differences should also be great.

It is suggested by the State Executive Secretary, Charles Nelson, that each member read carefully the article on the legislative situation published on page 189 of the February, 1937, issue of the *Ohio State Medical Journal*.

The members of the County Medical Society regret the passing of Dr. Colin M. Reed. He has been a successful physician for many years in this city and was noted for his admirable characteristics.

ROBERT B. POLING,
Secretary.

WORTHWHILE KNOWLEDGE

By M. W. NEIDUS, M. D.

Pericarditis with effusion is frequently diagnosed lobar pneumonia, particularly of the left lower lobe of the lung. In both conditions we find dullness to percussion and tubular breathing. Fever and leucocytosis may be present in both. Bloody sputum may be present, especially if the pericarditis is associated with failure of the lesser circulation as a result of advanced rheumatic mitral valvulitis. Dyspnoea is usually obvious in both. The onset is more sudden in lobar pneumonia. Since pericarditis with effusion is most commonly due to rheumatic fever a good history may be of diagnostic aid. Occasionally rheumatic fever is ushered in by a pericarditis with effusion. The lung findings in lobar pneumonia are due to inflammation within the lung tissue, while in pericarditis with effusion the lung is being compressed by the distending fluid-filled pericardial sac. This explains the dullness in pericarditis. An x-ray of the chest further aids in the differential diagnosis.

According to C. H. Smith, pediatrician, New York City, broncho-pneumonia occurs mainly in young infants and is rare over three years of age. The belief that a child with pneumonia must have broncho-pneumonia is erroneous. The death rate from lobar pneumonia is so low that they rarely come to autopsy. This view is based on the fact that broncho-pneumonia is much the most common variety found at necropsy. Clinically, lobar pneumonia is the most common at all ages, even in the first year and is almost the only type seen after three years in New York City. Otitis media is the most frequent complication of lobar pneumonia and the younger patients rarely escape it. The prognosis is excellent except in small infants. Pneumococcus meningitis is always fatal.

In treatment, he urges grouping of medication so that the child may be let alone to rest as much as possible. Transfusions are of value in these protracted cases. If possible blood should be used from a member of the family when there has been a family epidemic with the same organism causing the pneumonia in the child. Types 1 and 2 sera should be used where indicated. Serum will have a larger part in the treatment in the future as more specific sera are developed.

According to Henry T. Chickering, Columbia University, it is not wise to use amidopyrine and barbiturates in influenza because there is already a tendency to leucopenia and in rare instances agranulocytosis may develop. Type 1 and 2 pneumococcus infections are rare in the secondary pneumonias following influenza, though they are occasionally seen, because these types are found infrequently in normal noses and throats.

OUR ANNUAL BANQUET

The annual banquet of the Mahoning County Medical Society, held Tuesday evening, January 19, 1937, at the Youngstown Club, was one of the best of the long line of such oc-

casions. The crowd assembled from 6:30 P. M. on, and, thanks to the efforts of Geo. Cadman and his assistant, were brought to just the right "pitch," when dinner was announced. Manager Jim McGoogan served an excellent turkey dinner in his usual, inimitable manner, during the course of which, Impresario Sam Sedwitz kept us entertained with his world-famed floor show.

The guest speaker of the evening, Mr. Ellis Manning of the Research Laboratories of the General Electric, then took us for a tour through the field of recent discoveries in the field of physics. Dr. Fuzy, in introducing the speaker, had considerable difficulty in distinguishing between physic and physics, but in the long run, no particular harm was done, due to his faultless technique in the handling of a somewhat delicate problem.

Mr. Manning proved a delightful speaker and while much of his subject matter was as much over our heads as is some of our shop talk to the laity, yet everyone experienced a sense of elation, as they heard the wonders of pure science unfolded.

The aftermath continued far into the wee, small hours and beyond, to the enrichment of some and the impoverishment of others. Thank you, Dr. Evans and Dr. Baker and committeemen, from all of us.

POSTGRADUATE DAY APPROACHES

The first postgraduate assembly of the Mahoning County Medical Society was held in the fall, 1914. Through the coöperation of Mr. Fred Bunn, then Superintendent of the Youngstown Hospital Association, the facilities of the institution were put at our disposal, and "A" ward was converted into a lecture room for the day-time meetings.

The speakers on that occasion were a group of clinicians from the University of Michigan, made up of Dr. Ruben Peterson, Professor of Obstetrics and Diseases of Women; Dr. Hugh Cabot, Professor of Surgery; Dr. Van Zwaluenberg, Professor of Roentgenology; Dr. Fuerstenberger, Assistant Professor of Otolaryngology, and Dr. Newburgh, Assistant Professor of Medicine. How that group labored to give us a day of outstanding clinical instruction!

And now, the tenth anniversary of that occasion will be held on April 20, 1937, and a group from that same institution will be our guest speakers. How interesting to note that the "cub" of that earlier group, now risen to full professorship and Dean of the School of Medicine will be one of the speakers. Dr. Fuerstenberger, in his capacity as Dean, has assured us a fine group and a program of great worth.

Keep the date open.

Tuesday, April 20, 1937.

SPEAKERS' BUREAU

January 4—Dr. A. J. Brant, "What is Prenatal Care."

January 11—Radio—E. H. Nagel, "Pneumonia."

January 13—Boardman School—Dr. C. A. Gustafson, "Venereals."

January 13—Kiwanis Club, Salem, Ohio—Dr. Wm. Skipp, "Endocrinology."

January 14—Hillman School—Dr. P. J. McOwen, "Venereals."

January 18—Radio—Dr. J. P. Harvey, "Rheumatic Infections in Childhood."

January 19—Garfield School—Dr. C. A. Gustafson, "Venereals."

January 21—Board of Education—Dr. C. A. Gustafson, "Venereals."

January 25—Radio—Dr. O. A. Axelson, "White Collar Hazards."

January 28—Federation of Women's Club, Butler Art Gallery—Dr. Claude B. Norris.

SOME PHASES OF PARIETAL PAIN DIAGNOSIS AND TREATMENT

(Paper read at Youngstown Hospital Association Staff Meeting January 5, 1937, by the staff of W. B. Turner, Sedwitz, Weller and Gustafson)

J. B. Carnett, Professor of Surgery in the Graduate School of Medicine of the University of Pennsylvania, has been one of the foremost advocates to emphasize the role played by the spinal nerves in producing neuralgias. These neuralgias when involving the abdominal wall are often diagnosed as due to visceral conditions.

As a rule one realizes the part played by Pott's disease and pneumonia producing abdominal pain, and much has been written about these. The late Carnett, followed by Wm. Bates, stressed the necessity of examining the back before operating on the abdomen. They do not agree with Head's theory of visceral pathology causing parietal pain. Carnett made two statements—never to operate on an abdomen before examining a back and the other in effect, that if the pain the patient complains of overlaps the confines of the cavity containing the organ supposed to be the seat of the pain—reconsider the diagnosis.

Verification of the truth of these statements can readily be made when we consider the frequency of patients complaining of the same symptoms even after surgical intervention to remove viscera supposedly causing the trouble.

The causes of these pains are many. Bates and Carnett stressed body mechanics and poor posture. Judovich and Bates claim the common back sprains produce neuralgias, which are diagnosed as "sacro-iliac," "lumbo-sacral sprain," "lumbago," and "malingering."

A. *Anatomical and Mechanical Considerations*—We quote Judovich and Bates:

Anatomical and mechanical considerations of the lumbodorsal spine establishing its greater susceptibility to sprain than any other portion of the spine:

1. The thoracic and pelvic curves are primary, developing before birth, forming part of the walls of the thorax and pelvis, and are due chiefly to the shape of the vertebral bodies. The lumbar curve, however, is secondary, developing after birth, and depends mainly on the shape of the intervertebral discs. Under these circumstances it is natural to expect greater mobility.

2. Areas of the spine where fixed and movable portions join each other are the areas most subject to sprain, fracture, dislocation, etc. This applies more to the lumbodorsal region than to any other part of the spine below the cervical region. The segments above and below the lumbodorsal region are comparatively fixed.

3. The vertebrae of the lumbodorsal region bear almost as much weight as the lumbar spine and yet they are smaller and weaker.

4. In this region the transverse processes are short, while the longer ones below, together with the crest of the ileum and the ribs above, give a powerful leverage to the muscles that move the lumbodorsal region.

5. The nearness of the lumbodorsal area to the middle of the spine enables a greater length of leverage to be brought to bear against it than any other part of the spine.

6. The lumbodorsal segment bears the weight of the body superstructure at angles more variable than any other part of the spine, often with the addition of lifting load.

7. The lumbar enlargement of the spinal cord in this region makes the vertebral housing relatively smaller.

8. If, in addition, we consider the further predisposing causes of scolio-

sis, lordosis, and off-balance lifting, twisting, and bending, the picture of lumbodorsal sprain becomes less difficult to comprehend.

It is the belief of Bates and Judovich that little attention has been paid to this condition of lumbodorsal sprain because of the fact that the pain associated with it is referred to another area.

Again quoting Judovich and Bates: "Lumbodorsal sprain may be acute or chronic. It is a clinical entity, with its diagnosis resting upon a definite outline of pain and tenderness not to be confused with any other condition. When the sprain occurs, it involves the deep paraspinal muscles and intervertebral ligaments with irritation of the trunks of the twelfth dorsal and first lumbar nerves, only occasionally the eleventh dorsal and second lumbar nerves. Involvement of the first lumbar nerve is the cause of the pain in the sacroiliac and lumbosacral regions; the intense pain in this region causing the examiner to erroneously focus his attention upon it as the point of injury. This is the area supplied by the terminal sensory endings of the gluteal branches of the first lumbar nerve. Treatment is focused upon this area of referred pain with little relief. Usually a diagnosis of sacroiliac or lumbosacral sprain is made and erroneously so. In younger groups of patients x-ray studies are negative; whereas in older groups of patients where the x-ray studies show some evidence of bony changes, a diagnosis of sacroiliac arthritis is made and accepted as the basis of pain—another erroneous conclusion.

This condition cannot be diagnosed merely by inspection and by consideration of the patient's complaints. An active effort must be made to outline the area of tenderness. The anterior distribution, although not actively painful as is the posterior distribution, is tender as compared with the unaffected side."

"The area of pain and tenderness is as follows: Posteriorly, an area over the gluteal region limited above by the crest of the ileum, below by the intertrochanteric line, mesially by the sacroiliac line and laterally by the posterior margin of the great trochanter. Anteriorly: Parietal tenderness over McBurney's point over an area parallel to Poupart's ligament; a small area one finger breadth wide parallel to and below Poupart's ligament, and by a triangular area high up on the inner aspect of the thigh. Lastly, there will be found definite tenderness over the first lumbar nerve trunk paravertebrally. Pressure at a point about two and one-half inches from the midspinous line and immediately below the last rib on the affected side will elicit this tenderness. It is well to apply equal pressure to a corresponding area on the unaffected side. This will serve as the control area."

"In acute lumbodorsal sprain or strain, some muscular spasm is usually present in the paraspinal group at the injured area. This may be absent in a goodly percentage of cases, however, and along with the absence of other definite objective signs, there is a strong tendency to relegate this type to the malingering group, literally adding insult to injury."

Parietal Neuralgia

Symptoms: The predominant symptoms of the parietal neuralgia syndrome are pain and tenderness. The spontaneous pain may be roughly classified into four groups:

1. In its severest form, which fortunately is relatively rare, the pain may be as distressing as any colic or strangulation requiring large doses of morphine for its control and yet patients seem to find difficulty in describing its characteristics. They may use such terms as "tearing apart," "tearing of flesh," "stabbing," "grinding," or they may describe either one of two types of extreme tension. In

the compression type of pain the abdomen feels as though it were being viciously squeezed in a vise, whereas in the distention type of pain the sensation is comparable to a distended balloon situated inside the abdomen.

2. A less agonizing but fairly common and distressing form of pain is described as "shooting," "knife-like," "lightening-like," "stabbing," "jumping," "pounding," "cutting," "colicky," "cramp-like," or in similar terms indicative of lancinating pains.

3. A milder form of pain that is the most frequent and that is usually tolerable except for its long duration or the fear of its being indicative of an intra-abdominal lesion is described as "drawing," "pulling," "dragging," "throbbing," "pressing," "aching," "cutting," "sickening," "burning," or "bloated" pain.

4. In its mildest form the pain may resemble an "ache" or "soreness" or may consist of "burning," "pins and needles" or other mild parasthesias.

These four types merge into one another and a few patients may exhibit each of the four types at different times. This holds true especially of the patients who have had the severest as with improvement they frequently pass through the lesser grades before full recovery from pain. On the other hand the majority of patients continue to complain indefinitely of the one type of pain when the latter is chronic.

When asked to describe the character of abdominal pains the average patient seems content to state that they are either "gas pains" or "indigestion pains" and he needs to be prodded into giving a more precise description. Often the term "gas," "indigestion" or "colitis" pains has been suggested by the physician.

Intercostal neuralgia of the abdominal wall can be quickly and easily diagnosed by a few special tests that should be carried out at the bedside examination of every patient having abdominal pain or tenderness. Palpation over relaxed muscles fails to indicate the parietal location of the tenderness which is then wrongly ascribed to an intra-abdominal lesion.

To detect parietal tenderness, Carnett devised the test of having the patient hold his abdominal muscles as tense as possible during palpation. His tensed muscles protect the abdominal viscera from palpation pressure and any tenderness which is elicited thus must be parietal in location.

Carnett had supposed this test was an original suggestion but in looking up the literature for this paper we found a recent article with earlier references by Franke in which he describes palpation of the abdomen while the patient is in the act of rising from a lying to a sitting position. He utilizes the principle of palpation while the muscles are actively tensed, but the method is less satisfactory than having the patient voluntarily tense the abdominal muscles while lying in a supine position. Tension of the abdominal muscles may be secured in any one of three ways. Voluntary forcible elevation of the diaphragm or active contraction of the abdominal muscles tends to produce the scaphoid type of abdomen which permits the examiner's fingers to come in too close contact with the viscera. The best method of tensing the abdominal muscles is by having the patient make a straining effort downward with the diaphragm thereby ballooning out the abdominal muscles to their maximum capacity. With children or with adults who do not readily understand how to contract the diaphragm the same result can be obtained by having them keep their knees extended while they actively raise and hold their feet about six to twelve inches above the level of the bed.

Palpation tenderness that is present over relaxed muscles and entirely absent over tensed muscles is subparietal

in location, being tenderness due to a lesion either of an abdominal viscus or of the lumbar vertebrae and sacroiliac joints. Palpation tenderness which is found both when the abdominal muscles are tensed and when they are relaxed is located in the anterior parietes and is due to intercostal neuralgia except in rare instances of local trauma or inflammation of the parietal tissues.

The best way to apply the pinching test after grasping a fold of skin and fat over the spontaneous pain area is to apply gradually increasing pressure until the patient manifests distress; then the examiner should register in his own brain the exact amount of force used; then pick up another fold of skin preferably at the corresponding area on the opposite side of the midline and reapply as great or even three or four times as great pressure when it will be found, if the neuralgia is not bilateral, that the second pinch does not produce nearly as much pain as the first pinch. If the neuralgia is bilateral in the abdomen some one quadrant is often found free from hypersensitiveness and it can be used as a control for the other three quadrants. If the whole abdomen is hypersensitive, control can be made by pinching over the ulnar border of the forearm as the latter region is only rarely involved. It is very important for the examiner to pinch the fold of skin with increasing force until one of two results occurs—either (1) the patient exhibits evidence of distress or (2) the examiner has exerted his maximum pinch without causing distress. If the examiner's pinching muscles are weak he needs to substitute or to add a twisting effect on the uplifted fold of skin and fat. With the average patient prompter and usually more reliable information is obtained by watching their facial expression than by asking them questions as to the amount of pain caused by varying degrees of pinching pressure. All these details are given because the great majority of clinicians have found it impossible to recognize parietal neuralgia from the descriptions of tests given in earlier papers. Almost invariably the cause of their failure is using insufficient force.

Pinching tenderness may be limited to the anterior abdominal wall but not infrequently, especially in hyperacute cases, it may extend from the scalp to the ankles and involve both upper extremities.

The tenderness thus far described has all been in the terminal distribution of the affected nerves. This tenderness may be encountered in routine examinations of patients with scoliosis, excessive lumbar lordosis or spinal arthritis who have never had any previous spontaneous pain but who are likely to develop it in the near future. This tenderness is also found in subsiding cases of acute toxic neuralgia for a variable length of time after complete disappearance of the spontaneous pain.

Tenderness in the trunks of the intercostal nerves is demonstrated by making upward pressure against the lower edge of the rib while moving the examining finger back and forth for a distance of about one and one-half inches in the interspace. This sliding movement is necessary as often the nerves are sensitive only at certain "points" and pressure over a limited area might miss the hypersensitive "point."

Localized tenderness encountered at or near the transverse vertebral processes may be due to an irritative lesion of the joint between them or may represent Valliex's apophyseal "tender point" of the nerve trunk.

Tests

Tests to differentiate between parietal and visceral pain were devised by Dr. Carnett which is believed will eventually stand as a monument to his name. Although the pinching and poking tests of the abdominal wall have received most notoriety because they are painful, the outstanding test

was what he called the A-B test. This consists of examining the abdomen with muscles relaxed (A) and then with muscles rigid (B). The presence or absence of tenderness on the second part of the test is so important in all abdominal cases, that Bates feels that when it is in common use, it will be recognized as a most valuable differential test.

In detail, with patient lying relaxed, pressure on the abdominal wall may yield tenderness—this means that the tenderness may be in the abdominal wall or in the viscera immediately underlying it. The patient is then instructed to tighten the abdominal muscles (straining—raise head or raise heels with knees straight). Pressure is again applied and if tenderness is absent, the source of trouble is considered visceral. If tenderness is present with abdomen tense, then it surely is in the abdominal wall but there may also be some in the underlying tender viscera, such as the appendix or the gall bladder. We then inject two percent solution of novocain into the abdominal wall and repeat the tests. When pressure is applied with muscles relaxed and the overlying abdominal wall desensitized, if tenderness results we have visceral trouble, otherwise it is in the abdominal wall. With abdomen tense—if properly injected—no tenderness results when pressure is applied. As the injection of novocain does not decrease the tenderness of acute or inflammatory visceral disease, this test is used by us routinely in acute abdominal pain.

As we examine the back of almost every patient standing before having them recline, we get an opportunity to observe the anteroposterior curves of the spine and the corresponding curvatures of the anterior surface of the body in profile. These studies have led us to some interesting findings and have been helpful for proper therapeutics. As an example of these findings a lordosis means visceroptosis. True, we may have no lordosis and some visceroptosis, but it is rare and is usually due to relaxation of the anterior abdominal wall by some such factor as pregnancy or chronic infection. To help these lordotic patients with visceroptosis, correction of the lordosis is absolutely essential. As lordosis becomes more marked, compensating kyphosis of the dorsal spine occurs which allows the chest to sag, the diaphragm to become lower, the heart to change position and the lungs to be improperly aerated.

As a result of this sequence we get circulatory disturbances of venous stasis leading to constipation, dysmenorrhea, hemorrhoids, varicose veins, orthopedic defects of all the weight-bearing joints, and chronic pulmonary changes.

Treatment

Strapping—Physiotherapy—Infrared—Diathermy—Shortwave, etc., all to the region of twelfth dorsal and first lumbar nerve trunks.

Posture

Frequently one sees cases in which the condition responds slowly to treatment or has lapsed into a chronic backache. Careful examination will often reveal a slight shortening of one lower extremity which tilts the pelvis and lumbar spine and produces a compensatory scoliosis resulting in chronic lumbodorsal strain. A simple heel lift to provide equalization greatly hastens recovery, often of itself giving complete relief by removing the lumbodorsal strain. Scolosis, lordosis, ptotic postures, etc., should receive attention as soon as symptomatic relief is obtained.

Heat, rest, constitutional treatment, removal of foci of infection, etc., are merely mentioned as acceptable standard forms of treatment. Massage over the painful area usually causes an aggravation of symptoms. When applied to the spine in the lumbodorsal region, some relief is obtained, probably by increasing the circulation in the injured area.

Injection of the first lumbar nerve trunk: This method we have found to be the most efficacious, providing rapid relief even in severely painful cases, usually in five or ten minutes, allowing many cases to be comfortably ambulatory. Occasionally patients are completely and permanently relieved by a single treatment. The average case requires four to six treatments which are administered on alternating days. Thus cases ordinarily requiring weeks or months for recovery are relieved in a period ranging from one to twelve days, which greatly reduces the time of pain, disability and treatment.

The fluid injected at the first treatment consists of a mixture of novocaine solution and extract of pitcher plant, the former providing immediate relief and proof of diagnosis by blocking off the entire area of pain, and the latter producing a more lasting effect in cutting down subsequent pain. Injections thereafter are given with the plant extract alone.

The day after treatment the patient is given a mecholyl by iontopherisis over the area injected. This removes the local pain, relaxes the muscles and increases the local circulation.

Technique of Injection

The patient lies prone with the shoulder on the affected side raised, thus bringing the last rib into greater prominence. The point of injection is a quarter of an inch below the last rib and from two to two and one-half inches from the midspinous line, at which point a tender area will be found on palpation. The needle is advanced (through a wheal previously made with novocaine) at right angles to the midline and at an angle of 40 to 45 degrees to the sagittal plane of the body. Paresthesias will be induced through the painful area in the majority of cases at a depth of four to seven centimeters (1.5 to 2.75 inches).

Typical cases of dorsal-lumbar involvement show the most startling results. To date about 30 cases have been treated, including classical conditions, chronic osteo-arthritis, neuralgias of the occipital nerve and cases of inoperable "Ca."

The injection was employed for the purpose of ruling out malingerers of back pain from injury. In these cases surface temperature readings are made by thermacouple before and after in the areas of complaint. If the readings are increased it is direct (objective) evidence that the nerve has been "hit." Should the patients persist in their claim of pain they are definitely branded as malingerers.

In cases of abdominal pain as in a vague suspected appendix the following has been the routine to rule out neuralgia. McBurney's point is injected with 2% novocain going through the skin fascia and muscle. If superficial pressure after few minutes does not produce pain it is neuralgic in origin. If now deep pressure continues to produce the pain complained of it must come from the involvement of the viscus as the superficial or parietal pain has been eliminated.

This test is especially useful in cases of vague, unexplainable pain in the lower quadrants of the abdomen. Many cases of appendectomy, oophorectomy, and even uretral stone, operated on without relief of symptoms can be cleared up by this test. It is harmless, quick and very simple to perform.

It is hoped that none believe that this simple procedure does away with the services of the orthopedist. In fact it only means that many more cases have to seek their aid for correction of postures, braces, etc. These patients do not seek the services of the orthopedist at the onset as their complaints are too vague and generally run the gamut of physician, surgeon and then chiropractor or bonesetter.

It is the hope of this staff that we place before you much food for

thought and some simple tests for practice to aid in establishing more positive diagnosis in cases that we all have missed, many such deserting the doctors for quacks and adopting cults.

Nervous Anatomical Drawings and Demonstrations were prepared by Dr. Gustafson.

Typical cases were demonstrated by a movie film made by Dr. B. Judovich and loaned to us by him. Thanks is hereby acknowledged.

Bibliography

1. Common Back Sprain—B. D. Judovich and Wm. Bates, Med. Rec. 2/5/36.
2. Carnett, J. B. and Bates, Wm.—Railway Spine, Surgical Clinics, N. A., Dec., 1932.
3. Goldwaithe—Body Mechanics—J. B. Lippincott Co.
4. Judovich, B. J.—Med. Rec. 6/18/35.
5. Lovett, R. W.—Lateral Curvature Spine and Round Shoulders—Blakiston's Son and Co., 1931.
6. Antonomic Nervous System—J. C. White—MacMillan Co., 1935.

NEWS ITEMS

Doctors Whelan, McElhaney, E. W. Coe, H. M. Osborne, W. E. Ranz, and J. G. Brody have been placed on the emeritus and consulting staffs of Saint Elizabeth's Hospital.

Doctor Alice Elliott has been placed on the associate staff of Saint Elizabeth's Hospital. Dr. Elliott is engaged in general practice with her office at 2004 Elm Street.

The smoker held at the tap room of the Youngstown Brewery Co. for the benefit of the Saint Elizabeth's Hospital Staff library was both a social and financial success. About 65 attended the stag. The staff is very grateful to Mr. Weaver and his associates for their fine hospitality. Dr. Samuel Tamarkin was chairman of the smoker committee.

Drs. E. C. Mylott, R. E. Odom, and S. R. Cafaro presented a series of papers on Sinusitis at the January meeting of the Staff of Saint Elizabeth's Hospital.

Dr. J. G. Brody, convalescing from his recent serious illness, has moved to Cleveland.

The play, "Past 30," presented by the graduate nurses and staff doctors of Saint Elizabeth's Hospital on the evening of January 21, at South High School Auditorium, was very well performed and enjoyed by a large and enthusiastic audience.

Members of the cast were: Dorothy Burke, Mrs. A. C. Marinelli, Rebecca Rosensteel, Donna Millard, and Doctors L. G. Coe, L. Shensa, S. Goldberg, H. Marsico, and S. Ondash. Dr. W. O. Mermis became ill a day before the performance and was put to bed by his physician. His part as Station Agent was taken by Joseph Michaels. Dr. Mermis is now improved and is up and about. The play was under the direction of Miss Teresa Scarnecchia and produced by Miss Helen Brislane, R. N., and associates. Michael Ficocelli's Orchestra furnished the music for the play.

Dr. and Mrs. Homer Thomas announce the birth of a baby boy, James William, January 6th, 1937. Dr. Thomas was resident interne at St. Elizabeth's Hosptial in 1935. Mrs. Thomas was the former Mary Scully, R. N.

Dr. A. M. Rosenblum is on an 18-day cruise to the South Seas.

Dr. Samuel Zoss has opened his office at the Home Savings & Loan Bldg. He is confining his practice to Allergy. He has just completed a course with Dr. Milton Cohen of Cleveland.

We regret the passing of another member of our Society

DR. COLIN M. REED

Died January 23, 1937.

POSTGRADUATE DAY — APRIL 30TH

POSTGRADUATE DAY — APRIL 30TH

Old Way . . .

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923

It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

New Way . . .

Preventing and Curing Rickets *with* OLEUM PERCOMORPHUM

NOWADAYS, the physician has at his command, Mead's Oleum Percomorphum, a natural vitamin D product which actually prevents and cures rickets, when given in proper dosage.

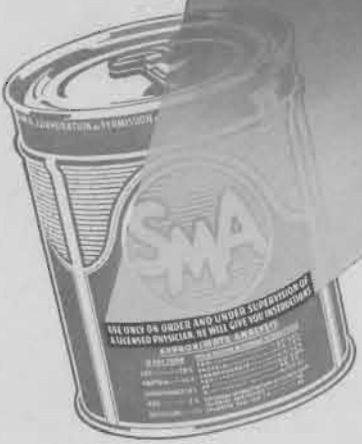
Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets, regardless of degree and duration.

Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

Mead's Oleum Percomorphum is not advertised to the public and is now obtainable at drug stores at a new economical price in 10 c.c. and 50 c.c. bottles and 10-drop capsules.

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

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons.



. . from the very beginning

EVERY PACKAGE OF S.M.A. HAS BORNE THIS INJUNCTION

thus putting S.M.A. irrevocably on the side of ethical medicine

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.

WHEN S. M. A. was first offered, there were many abuses in the field of infant feeding. Some firms, it is true, refrained from giving formulas and feeding directions to the laity, but the producers of S. M. A. voluntarily went further and put the above injunction right on the label. How big a forward step this was may be judged from the fact that few manufacturers have any comparable injunction, even now.

S. M. A. was developed by physicians, under hospital auspices, was first offered in response to demand by physicians, and has always been a physicians' product. Every one of the many millions of packages of S. M. A. has carried this injunction which directs patients, in their own best interests, to the physician.

S. M. A. is offered on the basis of the results it produces under the guidance and supervision of the physician. If you are one of the relatively few physicians unacquainted with S. M. A. may we suggest that you send for samples of S. M. A. and compare the results with whatever you are now using.

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