

WITH BOUND PERIODICALS

BULLETIN

of the
MAHONING COUNTY
MEDICAL SOCIETY

Volume LII

FEBRUARY, 1982

Number 2

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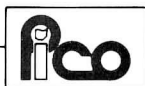
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1982 - MAHONING COUNTY MEDICAL SOCIETY MEETINGS - 1982

Tuesday	Tuesday	Tuesday	Tuesday	Tuesday	Tuesday
Jan. 19	Mar. 16	May 18	Sept. 21	Nov. 16	Dec. 21

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From the Desk of the President



SOCIAL SECURITY

As physicians, we are at a special vantage point from which to observe the use and abuse of Federal and State Funds such as Social Security, Welfare and Workman's Compensation. As the years have rolled on since 1936, I have been progressively more inclined to remind my patients that they are really talking about social *insecurity*, because the contributions that were supposed to be confined in a special trust were utilized by Congress for some other purposes. Unlike a contractual agreement established as an insurance policy, the Social Security System is subject to changes in the rules and benefits, leading to further insecurity.

The ultimate damage may lie in the "double standard" of this so-called insurance. One double standard is the FICA system for the majority and a second, separate and superior, system for our congressmen and government workers. As the number of government employees approaches the fifty percent mark, it weakens the FICA System, thereby further increasing the insecurity.

Mr. Average American is captive in paying for his own contributions and also for a part of the government workers special system by way of taxes. It is my suspicion there would be better accountability and improved handling of the FICA funds if the Congress had a personal involvement and dependence on this system. President Reagan recently said we must make our Social Security System secure. Both he and Congress can expedite this improvement by decisively destroying the double standard and by placing all U.S. citizens under the same Social Security System on an totally equal basis. The willingness of each congressman to bring about this type of equity would be a measure of his own personal integrity.

I bring this subject to your attention because I think the time is right to insist on this kind of change, and to include pressure to keep all contributions intact in a Social Security Trust Fund. It must be free and clear of the general operating fund. In the last month, President Reagan has indicated some interest in part of this concept and we need to encourage his definitive action. Sit down now and write one sentence about this to your favorite congressman and to President Reagan.

R. M. Kiskaddon, M.D.
President



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The opinions and conclusions expressed herein do not necessarily represent the views of the Editorial staff nor the official views of the Mahoning County Medical Society.

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Editorial

THE PRACTITIONER AND INTENSIVE CARE

Two recent articles in J.A.M.A. (Nov. 6, 1981) on medical intensive care of the elderly bring into focus concepts which are of importance to all physicians.

Frequently, enough personal physicians of patients bow out voluntarily or feel "eased out" of a difficult situation, or patients of families may not wish to pay too many doctors.

The personal physician has much more knowledge of both the patient and the family which can have impact on effective therapy. Should extreme measures be used? Should decisions be made in consultation only with those who do not know all circumstances? What are the real feelings of all members of the family? What may be the long-term effect on family members where outcome is less than satisfactory? What does the patient really want?

Patients and families complain, at times, that their physician or physician have all but abandoned them. They do not know whose advice to accept when there is no clear-cut delineation of responsibility for overall versus specialized care. In those hopefully infrequent, instances when these occur, later problems may be avoided by direct definitions.

There is an elusive something about some patients that, if it can be tapped, can signal for the health care team an approach which will be acceptable to the ailing persons. We all know many examples of patients who are irascible and non-cooperative with a wall built around them. The personal physician is in the best position, usually, to discover the keys which will open cooperative doors.

There has been a great push in recent years for informed consent and also for sharing with our patients. It used to be taught that you did not inform and share very often because what the patient did not know would not hurt him. It would be interesting to know how many hypochondriacs this unenlightened attitude produced. Experience suggests that patients who are not given the truth develop concepts which may be totally wrong.

This does not mean that all patients should be told everything in all circumstances. The personal physician is in the best position to determine when and how this should be done.

Our old concept of the "crock" needs revision, too, since newer discoveries are showing us that many areas which were not understood by us may really be pathologically endowed and can be treated successfully. The newer findings on some mental diseases, for example, are suggestive of this. As the physiologists and biochemists progress in their research, we can expect more mysteries to be solved.

The roles of various physicians are changing with all these discoveries. The personal or primary physician is no longer all things to all people. He/she must have broad knowledge and understanding, while, as Will Durant suggested, he/she turns to resource material and specially-trained individuals for unique problems. Yet, he/she must maintain the role of bringing things together — the captain of the ship, so to speak.

The advancing knowledge in nutrition, alcoholism, geriatricist—to name a few—can be overwhelming to those of us who had little exposure to them. But it is important that we acquaint ourselves with them and utilize all resources which will help us give better care to our patients.

Medicine is unique. It is personal and it employs specific techniques while involving impersonal attitudes and methodologies.

This blending of the personal and impersonal is the province of the personal physician. He can do it best!

—Richard W. Juvancic, M.D.

IS THERE A NEED FOR THIRD GENERATION CEPHALOSPORINS?

Chatrchai Watanakunakorn, M.D., F.A.C.P.
St. Elizabeth Hospital Medical Center

Since the original licensure of cephalothin, there has been a proliferation of cephalosporins and cephalosporin-like antibiotics available for clinical use. There are now three generations of cephalosporins.

There are many third generation cephalosporins currently undergoing clinical investigations. Two of these have been released for clinical use, namely, cefotaxime (Claforan) and moxalactam (Moxam) (1, 2). Strictly speaking, moxalactam is a 1-oxa-lactam compound, structurally slightly different from that of the cephalosporins. However, since moxalactam is very similar to other third generation cephalosporins in all other aspects, it is considered a cephalosporin for practical purposes.

The third generation cephalosporins have an expanded antimicrobial spectrum. They are active against many gram-negative bacilli including some strains of *Pseudomonas aeruginosa*, though the activity against *P. aeruginosa* is much less than other gram-negative bacilli. They are also active against many anaerobes. A given strain of bacterium may be resistant to cefotaxime but susceptible to moxalactam and vice versa. Though cefotaxime and moxalactam are active against gram-positive cocci such as *Staphylococcus aureus* and *Streptococcus pneumoniae*, their activity is much less in comparison with cephalothin (Keflin) and cefazolin (Kefzol, Ancel), the first generation cephalosporins.

Cefotaxime and moxalactam should be used parenterally only. The half-life of cefotaxime is much shorter than that of moxalactam. In serious infection cefotaxime should be given every 4 hours, while moxalactam can be given every 8 hours.

The major problems of the third generation cephalosporins are development of antibiotic resistance and acquisition of superinfection during therapy (2, 3). Another important side effect of moxalactam is the development of prolonged prothrombin time and even bleeding due to the decrease of vitamin K dependent clotting factor. This is probably the result of decrease of normal colonic flora responsible for vitamin K production. Another drawback is the cost of these drugs. The costs of cefotaxime and moxalactam are 400%

higher than those of cephalothin and cefazolin and 200% higher than those of the second generation cephalosporins (Cefoxitin, Cefamandole).

The only clear-cut indication for the use of moxalactam (and perhaps cefotaxime) is in the treatment of meningitis caused by enteric gram-negative bacilli (excluding *P. aeruginosa*) (4, 5). Moxalactam and cefotaxime should not be used to treat infections caused by gram-positive cocci. Moxalactam and cefotaxime alone should not be used as empirical therapy of patients with sepsis. The efficacy of moxalactam and cefotaxime alone in the therapy of *Pseudomonas* infection is not proven. As a general rule, with the exception of gram-negative bacillary meningitis, there is no reason to use cefotaxime or moxalactam to treat infections caused by organisms susceptible to other cephalosporins and penicillins.

In summary, third generation cephalosporins are rarely needed. They should not be used routinely or frequently, because of the potential for emergence of resistant organisms, acquisition of superinfection and because of the high cost (1).

REFERENCES

1. Cefotaxime. Medical Letter. 1981; 23:61-62.
2. Platt R, Ehrlich SL, Afarin J, et al. Moxalactam therapy of infections caused by cephalothin-resistant bacteria: Influence of serum inhibitory activity on clinical response and acquisition of antibiotic resistance during therapy. *Antimicrob Ag Chemother.* 1981; 20:351-355.
3. Yu VL. Enterococcal superinfection and colonization after surgery with moxalactam, a new broad-spectrum antibiotic. *Ann Intern Med.* 1981; 94:794-785.
4. New drugs for enteric gram-negative bacillary meningitis in adults. *Medical Letter.* 1981; 23:73-74.
5. Sande MA. Antibiotic therapy of bacterial meningitis: Lessons we've learned. *Am J Med.* 1981; 71:507-510.

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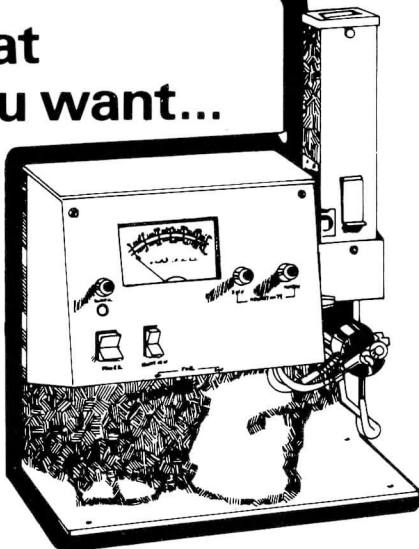
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PROCEEDINGS OF COUNCIL

January 12, 1982

The regular meeting of Council of the Mahoning County Medical Society was held on Tuesday, January 12, 1982 at the Youngstown Club.

The treasurer's report included a recapitulation of the total income for 1981, including dues, miscellaneous income and interest. The report also noted two members did not pay dues for 1981 and were suspended from membership.

The following applications were presented by the censors:

ASSOCIATES:

Stanley Goldstein, M.D.
Athanasios Kasamias, M.D.
Joseph P. Myers, M.D.

ACTIVE:

Steven Grossman, M.D.
Nicola B. Nicoloff, M.D.
John Politis, M.D.

The applications were approved. The applicants will become members of the Mahoning County Medical Society in the voted category 15 days after the publication of the names in the *Bulletin*, unless objection is filed in writing with the executive director before that time.

A note of appreciation for being included on the mailing list of the *Bulletin* was received from Mrs. Alma Coy of Escondido, California.

It was noted that schedules for the MASHEN approved CME programs are in the Society office and the list of American College of Physicians CME meetings is also in the Society office.

A questionnaire from OSMA was presented to the Council and members were asked to complete the survey form and return it to the Society office.

A report of the OSMA Delegation actions at the AMA Interim meeting in Las Vegas was presented.

A special emergency treatment form to allow treatment of minors when parents are not available to authorize treatment was presented and held in abeyance until the hospital attorneys have an opportunity to evaluate it. It was reported some parents accomplish the same purpose by writing the name of the family physician or pediatrician on a sheet of paper and authorizing them to provide needed treatment.

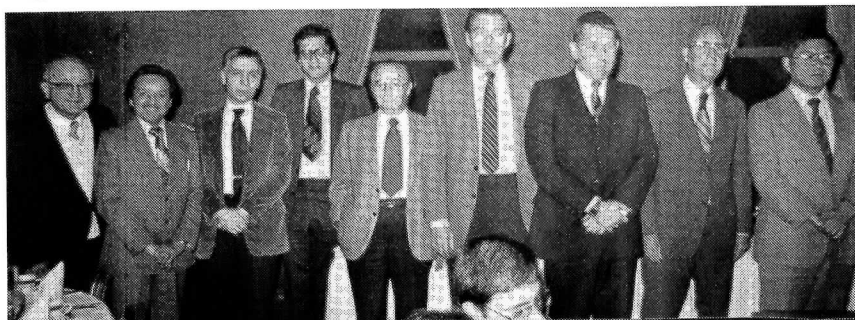
A report on the status of the lawsuit revealed everything still hinges on the submission of his particulars by the Attorney General. It was reported there is apparently some disagreement between other parties to the lawsuit and the AG.

Dr. Kiskaddon presented a rundown on what he hopes to accomplish in 1982 as president, noting that he wants to utilize practical ideas and hear the things members see as problems. He stated he will try to put meat into the Society meetings by providing academic topics with CME credits. Dr. Kiskaddon noted the May meeting will be at the Youngstown Country Club with a suitable program to go with the locale. The September meeting is planned to be a combined staff meeting for both hospitals, followed by dinner and a meeting of all persons and a CME-valued program to follow the dinner. The new president noted he wants to offer things to the committees that are in their areas of responsibility and have the committees report to the Society.

There was a suggestion from a Council member that each committee meet at least once a year, if only to become acquainted with the members of the committee and explore its area of responsibility.

There was a suggestion made that each new member of the Society be asked to attend a Council meeting (at his own expense) to get a first-hand look at the workings of Council and be made aware that Council members pay for their privilege of serving.

A motion was made, seconded and passed that the executive director join the American Association of Medical Society Executives and the Society pay the membership fee.

1
9
8
2

Photos 1, 2, 3, 4—members of Council and officers who received the oath of office from Dr. Dallis at the January 19 meeting of the Society. Photo 5—Mrs. Dallis and daughter, Kelly, respond to a gift of a volume of the *Bulletin*. Photo bottom left—Dr. Dallis received appreciation plaque from Dr. Kiskaddon. Photo bottom right—Dr. Kiskaddon expressed his appreciation for the gavel, made by Dr. Patrick Cestone, and presented by Dr. Dallis.

FEBRUARY

INSTALLATION WAS JANUARY HIGHLIGHT

Dr. D. J. Dallis was honored as the retiring president and Dr. Robert W. Kiskaddon was installed as the new president at the January 19 installation banquet of the Mahoning County Medical Society.

An appreciation plaque was presented to Dr. Dallis for his work as the 1981 president of the Society, and Dr. Dallis presented a new gavel to Dr. Kiskaddon that was made by Dr. Patrick Cestone. Dr. Dallis also received a president's pin and a bound volume of the 1981 *Bulletin*.

Dr. Kiskaddon presented a gift of golf balls to Dr. Dallis and to Robert Blake, the executive director, together with instructions on how they were to be used.

The meeting was opened with a moment of silence for those physicians who died last year: Dr. Carl H. Weidenmeir, Dr. Elmer J. Wenaas, Dr. Elsa Shapira-Bloomberg, Dr. Joseph J. Sofranec, Dr. Charles A. McReynolds, Dr. Nicholas G. Kastellorios, Dr. Fred G. Schlecht, Dr. Richard J. Jarvis, and Dr. H. Bryan Hutt.

Three active, two associate and two intern/resident applications were read and the officers of the society were installed by Dr. Dallis.

A proposal was read that would rescind the regulation requiring the payment of accrued assessments by persons reinstated to membership in the Society.

Entertainment was provided by the Harmonica Hi-Fi's of Struthers and, following announcements concerning coming events, the meeting was adjourned.

(The list of those installed is on the "contents page" of the *Bulletin*.)

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 Gelbman
 Giannini
 Laird, A. T.
 Pappas
 Saint-Julien
 Renner

Athletic Injury

Vuksta—*Chairman*
 Adornato
 Bernat
 Brocker
 J. Brucoli
 Cuttica
 Dockry
 Gonzalez
 Guthikonda
 Jaffer
 Panozzo
 Raghavan
 Werning
 Wieneke

Blood Bank

Pass—*Chairman*
 Deppisch
 Garg, S. K.
 Fry
 Squicquero
 Taylor
 Wiltsie

Budget

Kiskaddon—*Chairman*
 Bunn
 Juvancic
 Mahar
 Rabinowitz
 Wang

Cancer

Lupse—*Co-Chairman*
 Wieneke—*Co-Chairman*
 Adornato
 Altman
 Amorn
 Bhatti
 Bitonte
 Carbonell
 Crans
 Deppisch
 Detesco, A. A.
 Fok
 Garcia
 Garg, S. K.
 Goldberg
 Mehta
 Pass
 Roth
 Vuksta

Canfield Fair

Schreiber—*Chairman*
 Friedrich
 Melnick
 Resch
 Sinsenheimer

Child Learning

Brucoli, P.—*Chairman*
 Abram
 Brandmiller
 Cinelli
 Grajo
 Kalavsky
 Klahr
 Klodell
 Mahar, Jr.
 Mirvis
 Sethi, V.
 Wegner

Civil Defense & Disaster

Squicquero—*Co-Chairman*
 Wiltsie—*Co-Chairman*
 Cossette
 Finley
 Gonzalez
 Jenkins
 Might
 Phillips
 Vuksta

Constitution

Pichette, C. E.—
Co-Chairman
 Tandatnick—*Co-Chairman*
 Crawford
 Friedrich
 McConnell
 Ondash
 Szauter
 Warnock
 Watanakunakorn
 Weiss

Continuing Med. Ed.

Caccamo—*Co-Chairman*
 Juvancic—*Co-Chairman*
 Afrooz
 Amorn
 Boulis
 Conte
 Garg, A. G.
 Guthikonda
 Hoffmaster
 Iqbal
 Kessler
 Mishr
 Oh
 Rabinowitz
 Squicquero
 Speck
 Wang
 Wiltsie

Diabetes

Cleary—*Co-Chairman*
 Mishr—*Co-Chairman*
 Gaylord
 Hong
 Jung
 Kiskaddon
 Lakhani
 Latorre
 McGowen
 Pedraza
 Rabinowitz
 Rosenblum
 Yarmy

Drug Abuse

Gelbman—*Chairman*
 Galose
 Nalluri
 Prochnow
 Renner
 Sethi, V.
 Saint-Julien

Geriatrics

Boniface—*Chairman*
 Banninga
 Fok
 Hyland
 Jones, E.
 Jones, P.
 Lakhani
 McConnell
 Panozzo
 Rabinowitz
 Randell

Governmental**Medical Care**

Anderson—*Chairman*
 Barton
 Boening
 Deramo
 Fogarty
 Fry
 Galose
 Mahar, Jr.
 Rashid
 Riberi
 Ruth
 Whittaker

Grievance

Dallis—*Chairman*
 Baumblatt
 Gregori
 Kiskaddon
 Levy
 Lin
 Lupse
 Mahar, Jr.
 Slusher
 Sovik

Wang
Wasilko
White

Health Screening

Deramo—*Chairman*
Conte
Detesco, T. N.
Garg, A. G.
Guju
Grossman
Raghavan
Tandatnick

History

Melnick—*Chairman*
Beynon
Brandmiller
DiCicco
Fisher, R. R.
Fogarty
Gordon

Hospital Relations

Ondash—*Chairman*
Detesco, A. A.
Fogarty
Green
Hassell
Hritz
Ellison
McConnell
Phillips
Shorten
Sovik
Squicquero
Turner, J. J.
Wiltsie

Indoctrination

Pichette, C. E.—
Chairman
Cinelli
Gregori
McConnell
Pichette, D. E.
Pugh
Ondash

Industrial Health

Boeing—*Chairman*
Catoline
Dockry
Fagnano
Fry
Juvancic
Klodell
Kravec
Lin
Pugh
Shorten

Insurance

Abdu—*Co-Chairman*
Ruth—*Co-Chairman*
Barton

Deramo
Detesco, T. N.
Melnick
Nalluri
Shorten

Legislative

Pichette, C. E.—
Chairman
Anderson
Chiasson
Hernandez
Holden
Ruth
Solyn
White

Maternal Health

Bernstine—*Chairman*
Alexander
Bruchs
Buckley
Colla
Chiasson
Fogarty
Hazelbaker
Huang
Lenhart
Lepore
Moskalik
Roth
Saint-Julien
Solyn

Medical Assistants

Evans—*Chairman*
Brandmiller
Galose
Ruiz
Sethi
Sofranec
Sovik

Med. Emergency Serv.

Finley—*Chairman*
Campolito
Jenkins
Martin
McIver
Pappas
Parry
Ruth
Sarantopoulos
Squicquero
Wales
Wiltsie

Medical Legal

Reed—*Chairman*
Bennett
Brocker
Brown, R. A.
Detesco, T. N.
Laird, A. T.

McConnell
Sevachko
Solyn

Medical School

Caccamo—*Chairman*
Abdu
Brown, D. B.
Bunn, W. H.
Chiasson
Crans
Finch
Ghani
Guthikonda
Kessler
Kohli
Mishr
Pass
Squicquero
Wiltsie

Medicine & Religion

Rosenblum—*Chairman*
Brocker
Chiasson
DeCicco
Detesco, A.
Gilliland
Kohli
Resch

Mental Health

Waltner—*Co-Chairman*
Gelbman—*Co-Chairman*
Boniface
Giannini
Kachmer
Prochnow
Solana

Prisons & Jails

Levy—*Chairman*
Belinky
Bernat
Catoline
Gordon
Hayek
Hunt
Johnson
Wasilko

Public Health

Goldberg—*Chairman*
Fulks
LaManna, Jr.
Nath
Mikolich
Rich, F. A.

Public Relations

Dietz—*Chairman*
Adornato
Banez
Brown, D. B.
Bitonte

(continued
next page)

"THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

A number of studies show that the more physicians *know* about costs, the more they try to *reduce* them.* And this reduction can be done without reducing the quality of care to the patient.

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What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977: "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of right internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976): 594-600.

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THE YELLOW FUZZBALL WARS

Every afternoon and evening, throughout the city of Youngstown, one finds gladiators in short pants training for competitive warfare. These gladiators are the soldiers of the "Yellow Fuzzball Wars", thought by non-combatants to be a form of recreational athletics. Those of us who participate in the "Yellow Fuzzball Wars" know this is a form of hand-to-hand combat and that the most ferocious determined warriors emerge victorious. Combat with "Yellow Fuzzballs" can be held indoors or outdoors and is very popular among our area physicians and some have become so skilled that their activities deserve special mention.

Some physicians can be found engaging in a much more docile sport that is held outdoors, usually in good weather, and completely non-competitive. The instruments of that game are some rather dangerous-looking clubs and a small, white, wrinkled ball that gets clubbed from one field to another in a frenzy of chopping and hacking. It obviously requires a little skill and is not of great interest to true gladiators. The wrinkled white ball sport is called "Golf" and the Yellow Fuzzball" warrior games are true athletic endeavor requiring great agility and only played by young athletic physicians and are called "Tennis". The origin of the word "tennis" is obscure, but all physicians who play the game understand the true meaning and attach great honor to being skillful at tennis contests.

Some physicians have earned great reputations in the fuzzball courts and it brings to mind one of the great leaders of the fuzzball contests, P. D. Bunn. He is among the most skillful of all fuzzball warriors but he is so ill-tempered on the court that he is usually found by himself whacking the fuzzball against the practice wall. He has been engaged in this activity for several months. The contest is as yet undecided, but never once has P. D. Bunn been able to beat the wall. WHACK, WHACK, WHACK, WHACK. He hits the ball with an elegance and grace that a wild-life photographer would envy, but the wall, unimpressed, always gets the ball back. Eventually, P. D. Bunn misses. More frustration, more determination. There will come a day when P. D. Bunn CAN beat the wall!

On the court is the longest established floating fuzzball war game in the history of fuzzball wars. The teams line up: Hugh Bennett and Bruce Lipton, two of the baldest gladiators in the history of athletic warfare. Across the net, Larry Pass and Barry Sheridan, the tallest tennis players in the world and the fattest tennis players in the world. The contest begins. The conclusion of the fans watching the contest: "This is certainly not the most skillful tennis game we have ever watched, but it is the noisiest!" At the end, two sets for each team. They will have to play the contest again next week. The game began in 1969. A conclusion has not yet been reached. Something will have to be done soon. Hugh Bennett is not getting any younger.

In the next court, are stacks of broken tennis rackets, a torn net, the tennis carpet is in shreds. What could have caused such a disaster??? It was William Bunn, mutilating the court once again after missing an easy shot.

In the next court, another war game ensues. Harold Chevlin is playing with Helen. She is whipping him badly. But, what can you expect from a gladiator with the thinnest legs this side of Flamingo Island??? The teams leave. Another group enters the court. The dust and smoke rises. The fuzzballs are worn out and thrown out of play. A group of brand new fuzzballs are put in use.

The big boys are playing. The true Class 'A' handicapped gladiators, Renny Goldberg and Nazim Jaffer. WHACK! WHACK! The ball flies faster than the eye can see. This is a true jousting match! Who will be the superior warrior?? The contest continues. Dusk begins to fall. The lights are turned on with spectators seated, gladiators panting and sweating. The glistening beads of perspiration are falling on the carpet. The score is 6-6. Time for a

sudden death overtime. But neither player can get up! The strain has been so great that they both agree to quit. They both go home losers again!

The "Yellow Fuzzball" wars will always continue. Great athletes come and go, and each physician takes his turn on the court to test his skill against the "Yellow Fuzzball", the net, and the little white line that drives everybody to distraction! Ronnie Roth examines the line with a magnifying glass. His ball hits close to the line. Was it in or was it out?? "It was in!" shouts Roth. "It was out!" shouts David Brody. This is a problem that never becomes resolved. Both players stomp off the court. Another day of "Yellow Fuzzball Wars" has ended. The court closes and the sun rises again the next day. New gladiators in short pants arrive to test their skill. Come and see the "Yellow Fuzzball Wars". You'll die laughing!

LARRY PASS, M.D.

In Memoriam

MYRON H. STEINBERG 1909 - 1982

Dr. Myron H. Steinberg, 73, died Friday, January 22, in North Side Hospital of complications. He was a vascular surgeon.

Dr. Steinberg was born in Alliance, Ohio, graduated from Rayen High School, received his undergraduate degree at Ohio State University and his medical degree at Ohio State University Medical School. He served his internship at St. Francis Hospital in Columbus, Ohio.

He was a past president of the Ohio State Alumni Association, and a member of the Mahoning County Medical Society, Ohio State Medical Association, American Medical Association and the American Angiology Association. In 1970, he was elected a vice regent in the Great Lake Zone of the Peripheral Vascular Society of America. He served in the U.S. Army Medical Corps in World War II.

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From the Bulletin

FIFTY YEARS AGO — FEBRUARY 1932

Dr. Harry Patrick had a leading article on the MAL ARIA of Rome. It told how the disease got its name from the popular belief that it came from the bad air exhaled at night from the Pontine marsh.

In order to give prominence to the coming meeting, the announcement was given a two-page spread in the center of the *Bulletin* on pink paper.

New members were W. Stanley Curtis, E. C. Mylott and John P. Kenney. You remember them?

The South Side Hospital reported that in 1931 the amount collected from patients was only 55% of the operating expense. The North Side Unit stood silent and only partially filled. The new Warner Theater was packing them in.

FORTY YEARS AGO — FEBRUARY 1942

The temper of the times was for immediate and positive action. News from Bataan and Corregidor was bad and many could not wait. Raymond Cafaro, Sidney Davidow, Samuel Epstein, S. D. Goldberg, J. S. Goldcamp, Joseph Keogh, Herman Ipp, O. M. Lawton, Stanley Myers, Thomas Patton, Asher Randall, J. A. Renner and Henry Sisek were in uniform and off to camp.

The Medical-Dental Bureau sponsored a symposium on Civil Defense. The entire membership of the Society was invited to lunch at the Tod House to hear Colonel Donald Lynn tell about plans for the defense of this area. Dr. O. J. Walker spoke for the physicians and W. J. McCarthy for the dentists. The attack on Pearl Harbor had the west coast in a bad state of invasion jitters and even in the Mahoning Valley we were having air raid drills. 150 doctors attended the luncheon and listened solemnly to instructions on what to do if we were attacked. The lucky people, there were no ICBM's then!

Henry Schmid, chief of the Venereal Clinic, reported 578 cases of syphilis and 268 cases of gonorrhoea treated during the past year. Syphilis was treated with arsenic and bismuth, gonorrhoea with Argyrol. It took two years to cure an average case of syphilis and three weeks for gonorrhoea.

The hospitals reported a great increase in admissions. The new O.M.I. was the reason.

Dr. B. B. McElhaney died after being struck by a car on Market St. He was our first orthopedist.

THIRTY YEARS AGO — FEBRUARY 1952

President Gustafson said: "The public is made up of many individuals. The attitude of the public is the sum total of the opinions of those individuals. If enough of those persons like us and approve of what we do, the public will think well of us and 'public relations' will cease to be a problem."

Editor McNeal invited letters to the Editor with comments, criticism or if possible, praise of the *Bulletin*. He hoped he would not need to write them himself.

The banquet at the Youngstown Country Club celebrated the 80th birthday of the Medical Society. W. D. Coy, S. G. Patton, H. E. Blott and C. R. Clark were there. Dr. Clark told about his early days in the Society when meetings were held in the doctor's offices and the most important medical problem was typhoid fever. "Pancho from the Rancho" was the entertainer.

The Venereal Clinic treated 430 cases of syphilis and 294 of gonorrhoea the past year. Penicillin had superseded other forms of treatment for both diseases.

New members that month were Edward Henry Jones, Jr., Sam Amil Lerro, Hugh Norman Bennett, Donn Farrar Covert, Paul Easton Ruth, William Watts Parmenter, Charles M. Geiring and Paul A. Dobson.

Ben Brown had a very informative article on "Operative Cholangiography" and recommended the adoption of the procedure as an essential part of gall bladder surgery.

Henry L. Shorr and A. J. Telego opened their offices for general practice. W. J. Flynn returned after two years at the Memorial Hospital in New York. James Calvin reported for active duty with the U.S. Army at Camp Lee, Va.

TWENTY YEARS AGO — FEBRUARY 1962

The annual banquet was no longer a stag affair. One hundred seventy doctors and their dates attended for dining and dancing in the Mural Room. Sam Goldberg was chairman and M.C.

Statistics published by the Department of Labor revealed that from 1939 to 1969 physician fees were up 90%. Clothing was up 106% and food was up 151%. Per capita income rose 289.6%.

TEN YEARS AGO — FEBRUARY 1972

The Centennial year celebration of the Mahoning County Medical Society was entering its second month. Editor John Melnick had a lengthy and interesting article about Dr. Timothy Woodbridge, the Society's first president. Dr. Melnick also urged Council to seek some way that a street in Youngstown could be named after Dr. Dutton, Youngstown's first physician.

Venereal Disease was still on the minds of the members of the Society. Dr. Walter Greissinger, Health Commissioner, estimated that the case load for gonorrhea at the VD Clinic had almost doubled in the past five years and the case-load of syphilis had doubled in the past year. "We are part of a national epidemic", he stated, and he asked for help from the Society members to man the V.D. Clinic.

Two staunch members of the medical community passed away that month: Dr. Richard Middleton and Dr. Walter B. Turner, father of Dr. John J. "Jake" Turner. Dr. Middleton was a husky, square-jawed, cigar-smoking pediatrician whose favorite prescription for sick kids was an enema. He was loved by everyone.

Dr. Walter Turner was an excellent surgeon from the old school. He was short but very erect and always impeccably dressed. He made rounds with grace and dignity and always with a group of white-coated interns close behind.

New members that month were: Ernest V. Hidvegi, M.D. and Marcio Soares, M.D.

Robert R. Fisher, M.D.

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F. C. Lin

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H. L. Queen

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C. C. Albarran

March 6
D. Chung

March 9
A. N. Pannozzo

March 10
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M. Szauter

March 12
S. F. Petraglia

March 14
J. R. Madison

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CANCER SYMPOSIUM

"Adjuvant Chemotherapy Update" is the title of the Cancer Symposium being held March 10 from 9:00 a.m. through 3:30 p.m. at Stouffer's Inn on the Square in Cleveland. Registration starts at 8:00 a.m.

The purpose of the symposium is to provide an educational update concerning the status of adjuvant chemotherapy for multiple cancers.

For further information and registration blanks, contact Dr. Samuel G. Adornato. Registration deadline is March 3.

CME AT YHA

February 18, 8:00 a.m. Hitchcock Auditorium. William Bunn Memorial Lecture. "Nuclear Imaging and Cardiac Diagnosis" - Richard Leighton, M.D., Medical College of Ohio at Toledo.

March 2, 7:30 a.m. Tod Classroom II. EKG Advanced Course. "Rhythms and tachycardias of Ventricular Origin" - R. Houston, M.D.

March 4, 8:00 a.m. Hitchcock Auditorium. All-Divisions Visiting Professor. "Antibiotics in Gynecology" - Michael Spence, M.D.

March 6, 9:00 a.m. Hitchcock Auditorium. "Breast carcinoma" - Charles Hubay, M.D.

March 11, 8:00 a.m. Hitchcock Auditorium. Quarterly Review. "The Eye in Diabetes" - YHA Ophthalmology Service.

March 11, 8:00 a.m. Tod Classroom I. "Kartegener's Syndrome" - Kurt Wegner, M.D.

March 13, 9:00 a.m. Hitchcock Auditorium. Surgical Visiting Professor. "Topic to be Announced" - Eberhard F. Mammen, M.D., Professor of Physiology and Pathology, Wayne State University.

March 16, 7:30 a.m. Tod Classroom II. Advanced EKG Course "Atrial Tachycardia and Abberation" - W. H. Bunn, M.D.

NON-RESIDENT MEMBERS

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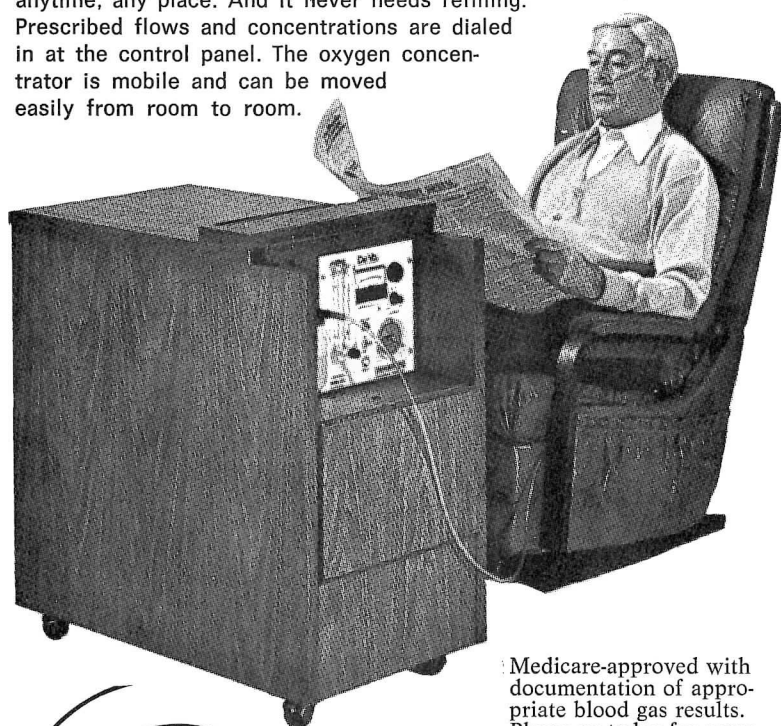
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NEW DEVELOPMENT IN ANTIFUNGAL THERAPY

Ketoconazole is a new antifungal agent which is administered orally, which has recently been marketed under the trade name Nizoral by Janssen Pharmaceuticals. Ketoconazole is one of the imadazole family and is closely related to the previously marketed drug Miconazole (Monistat IV). It is effective in vitro against many fungi and there are many studies which are ongoing to evaluate its efficacy in the treatment of fungal diseases in man. At the present time, Ketoconazole is given in a dose of 200 to 400 mg. daily, administered as a single dose, usually with meals. It is well absorbed from the gastrointestinal tract provided the pH is low in the stomach. Antacid and Cimetidine may impair absorption. Thus far, the drug appears to be relatively nontoxic with the most common side effects being nausea and vomiting.

Exact data is not yet available in regard to the clinical use of this drug. However, as stated before, many studies are ongoing. From the data that is presently available, Ketoconazole now appears to be the drug of choice in the treatment of chronic mucocutaneous candidiasis and in the treatment of paracoccidioidomycosis. It also appears to be effective in the treatment of many dermatophyte infections. Drug trials are ongoing comparing Ketoconazole to Griseofulvin. Ketoconazole may also be of value in the treatment of mucosal Candida infections, especially Candida esophagitis, which do not respond to the administration of Nystatin. Blastomycosis, noncerebral cryptococcosis, histoplasmosis, and coccidioidomycosis may also respond to the administration of Ketoconazole in certain instances. Aspergilliosis and sporotrichosis have not responded well to the administration of Ketoconazole. Any type of central nervous system fungal infections probably should not be treated with Ketoconazole since the drug has poor penetration into the cerebrospinal fluid. There is presently an ongoing drug trial to evaluate the use of Ketoconazole in the treatment of cryptococcal meningitis, which is the most frequently seen central nervous system fungal infection.

Besides the trials already mentioned, future studies will evaluate the use of Ketoconazole in combination with Amphotericin-B and other antifungal agents, as well as the evaluation of Ketoconazole used prophylactically in neutropenic, immunosuppressed patients. Despite the apparent promise of this new oral antifungal agent, any severe, life-threatening, systemic fungal infection, especially aspergillosis, candidiasis, and cryptococcosis, should continue to be treated with Amphotericin-B. Amphotericin-B is still the "gold standard" in most systemic fungal infections and any new drugs must be carefully evaluated with this in mind.

Director, Infectious Disease Service Y.H.A.
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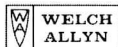


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