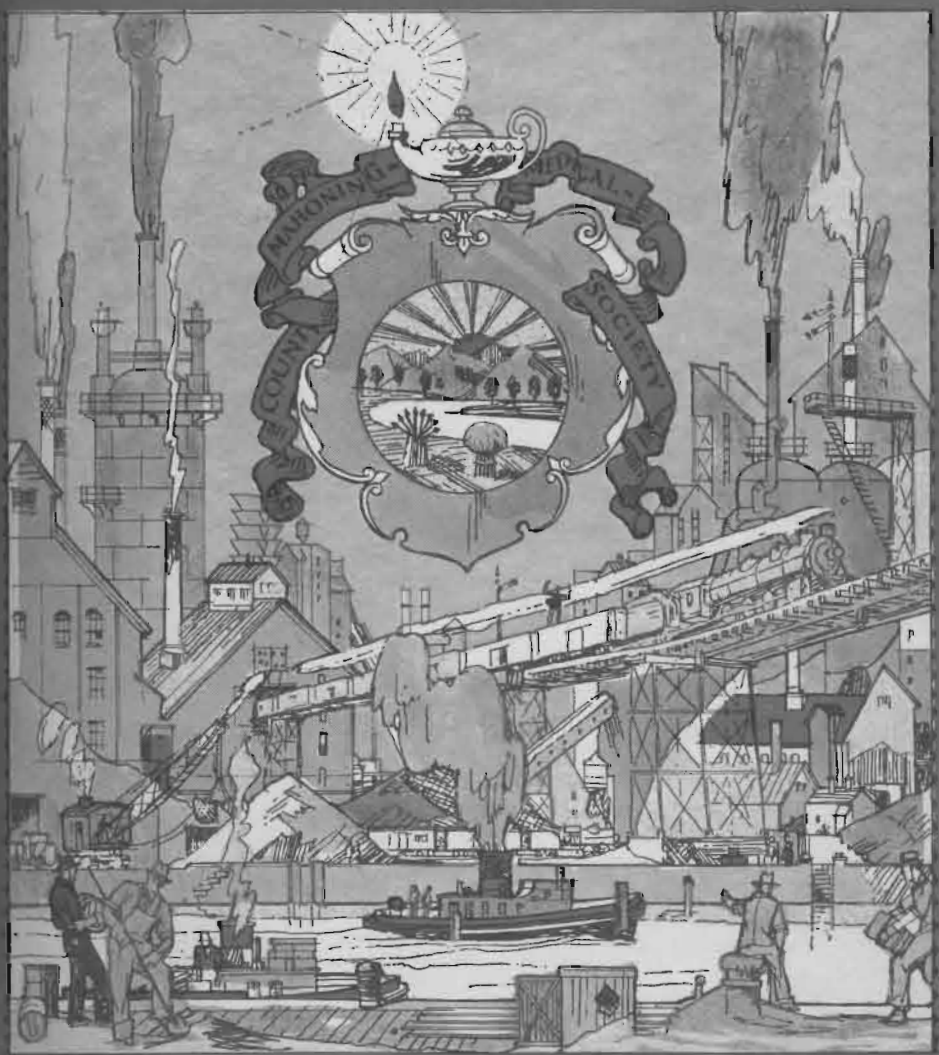
# POST GRADUATE NUMBER

## *Bulletin*

## MAHONING COUNTY MEDICAL SOCIETY

*Volume One* JUNE 1931 *No. Six*



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Our invalid coach is, as its favorite title implies, a varitable "Hospital on Wheels."

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# CORRECTING AN ERROR

In the Journal of the A. M. A., March 28th, 1931, page 30, we inadvertently stated the iron content of Mead's Cereal to be 68 milligrams per hundred grams. (This figure was confused with .0068 gms. iron per ounce.)

The correct content is 24 mgs. iron per 100 gms. But even so, Mead's Cereal contains —

**26% more food iron than kidney**
**73% more food iron than spleen**
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**179% more food iron than egg yolk**

These five foods are compared because they are considered highest in food iron.

(Mead's Cereal contains 100 times as much iron as whole milk.)

A well-known pediatrician has drawn attention to the fact that in practice, Mead's Cereal is more palatable and more readily taken by children than other iron-containing foods, some of which are quite unappetizing and even repellent, especially after long-continued use.

Mead Johnson & Co. SPECIALISTS IN INFANT DIET MATERIALS Evansville, Ind.

Mead's Cereal also is rich in copper, calcium, phosphorus and in other essential minerals.

# The Mahoning County Medical Society
# BULLETIN

Published Monthly at Youngstown, Ohio, by the Editorial Committee

JAMES L. FISHER, M. D.....Editor — WM. M. SKIPP, M. D.....Advertising Mgr.
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## Our New Dress

We are proud of our new cover design which is the gift of Dr. Armin Elsaesser. This beautiful example of the engraver's art, requires four separate plates for its printing and has been in preparation for months. We are indebted to the donor not only for the actual expense involved, but also for the expenditure of a great deal of time in the personal supervision of its design and manufacture.

It has been suggested that copies be made on paper suitable for framing, with the caption "Member of the Mahoning County Medical Society" suitably displayed; and that these copies be distributed to the members for hanging in their offices, similar to emblems used by certain service clubs. These emblems would serve to show affiliation with an organization which is active for the good of the community and to which it is an honor to belong. If this idea meets with your approval, please communicate your views to a member of the Executive Committee.

The Editorial Committee takes this opportunity to thank Dr. Elsaesser for his generosity to and interest in The Bulletin.

## The Pre-School Roundup

For a number of years it has been customary for children in the first year of school to be examined for the purpose of correcting physical defects, to be vaccinated against smallpox, and to be given toxin-antitoxin for diphtheria. Recently we have been interested in extending the benefits of these disease-preventing methods to the pre-school child as well. Children should not have to wait until school age to receive this service. Smallpox and diphtheria, spinal curvature and strabismus will not wait until then to develop — in fact the resistance to diphtheria is lowest shortly after the baby is weaned.

Now the school authorities have begun to realize that much sickness and consequent absenteeism can be avoided if such measures are adopted before the child enters school. With this idea in mind, other cities have conducted campaigns each spring during which children about to enter school are urged to take advantage of these methods of disease prevention. Such a roundup is now proposed for Youngstown.

We are heartily in accord with this proposal, and after careful study of the manner in which these campaigns are conducted in New York, Pittsburgh, and Cleveland, we have certain ideas on the way in which they should be carried out.

For the purpose of brevity, let us put down certain principles which we believe to be fundamental and under each one state the details which each principle naturally suggests:

1. *Examinations should be done in a thorough and painstaking manner by an interested person.* It naturally follows that they should be done by the *family physician* in his private office with the child *undressed* and a parent present to discuss the problems which the case may present.

2. *Mere examination is of no value unless followed by correction of abnormalities which may be found.* The presence of the parent and the opportunity to discuss these problems will result in more efficient measures being taken subsequent to the examination.

3. *Proper records should be made in triplicate.* Thus one copy can be kept by the physician, one by the parent, and one by the school.

4. *The prevention of sickness is as valuable as the curing of sickness.* Physicians should be paid for this service the same as other professional services. The cost should be kept low enough to avoid imposing a burden on the family in average circumstances. Those unable to pay should have the same benefits and this can easily be arranged through existing agencies.

5. *The expense should be borne by those who derive the benefit.* This avoids adding to the school budget which is already severely strained. Blank forms and other materials can be supplied by the physicians.

6. *Co-operation is essential.* Parent-teachers Clubs and other organizations should cooperate by reaching the families and arranging for the service. Physicians should cooperate by giving special attention to children.

J. L. F.

# The Secretary's Report

Two men were elected to membership in the Medical Society at the meeting held May 18:
Dr. John McCann, 2724 Mahoning Avenue
Dr. T. A. Lander, 279 East Federal Street

The following applications were read for the first time and passed to the Board of Censors and will be voted on at the next meeting:
Dr. Julia March Baird, 526 Elm Street
Dr. Samuel Klatman, 338 Lincoln Avenue

May 25, 1931, the Council of the Medical Society held a meeting and endorsed the Community Fund Campaign.

NOTICE

There is a section in the City Ordinance, Chapter 29, Section 386, which is as follows: "Treatment of gun shot wouuds, etc., must be reported. Every physician or surgeon duly admitted to the practice of medicine or surgery in the State of Ohio, whenever he shall treat any person in the City of Youngstown for a gun shot wound or wounds, or for any other wound or wounds which have been inflicted by a deadly weapon of whatsoever kind, shall notify the Police Department of the City of Youngstown within one (1) hour of the time he rendered such professional service or is called upon to render the case."

Born to Dr. and Mrs. Paul Kaufman, a son, June 2, 1931.

Born to Dr. and Mrs. Skipp, a daughter, Betty Ann, April 11, 1931.

Born to Dr. and Mrs. Gordon Nelson, a daughter, Phyllis Jean, May 20, 1931.

Dr. Chester Askue has been a patient in the South Side Hospital with appendicitis.

Dr. H. E. McClenahan, for the past three weeks, has been a patient in the North Side Unit of the Youngstown Hospital.

Dr. Goldstein had a very interesting article in the May 16 number of the American Journal, "Dermatitis Venenata Due to Chrysanthemum Leaves."

The medical profession of the city lost a true friend when Dewitt Morrow passed away on May 26, 1931. More than once he has been of service to the doctors individually and many times he whole-heartedly assisted the profession in the interest of science.

At the last Council meeting, June 1, 1931, the suggestion of the Public Health Committee was adopted that cards be printed of a suitable size to hang in Doctor's waiting rooms and be furnished to each member of the Society. These cards will call attention to Toxin-Anti-Toxin, Smallpox Vaccine and Typhoid Innoculation.

Physicians are urged to file their narcotic inventories and applications before July first. J. P. HARVEY, M. D.

# Hospital Notes

At a recent meeting of the Staff of St. Elizabeth's Hospital officers were elected as follows:

Emeritus Chief of Staff....Dr. R. E. Whelan
Chief of Staff.....Dr. Chas. D. Hauser
Vice Chief of Staff.....Dr. Arthur P. Smith
Secretary - Treasurer....Dr. James B. Birch

Also an Executive Committee, whose personnel is as follows: Chas. D. Hauser, Arthur P. Smyth, J. E. Hardman, E. W. Coe, F. W. McNamara.

These appointments have been confirmed by the Hospital Management and by the Bishop of the Diocese.

Monthly Staff meetings will be held the second Tuesday of each month (except during the months of July and August) at 8:15 P. M.

Weekly Clinical conferences will be held each Friday morning at 11:00 o'clock.

The Bishop of the Cleveland Diocese made a personal donation to the hospital as a contribution to the Medical Library Fund.

Commencement exercises for the Graduating Class of the Youngstown Hospital were held in the Stambaugh Auditorium, May 8th. There were forty nurses in the class. Dr. Robert Vinson, President of Western Reserve, was the speaker. A reception and dance was held for the nurses and their friends.

Six hundred and sixty patients were admitted to the Youngstown Hospital last month.

Three hundred and twenty-four new patients were treated in the Out-patient Department, and there were 1,346 re-visits, making a total of 1,670 treatments.

# The President's Page

The American Medical Association and the State Medical Associations fill a definite need in our country, through the publishing of their journals and through annual meetings; but to the man who is practicing medicine, his local County Society is much more important. Perhaps this is because this Society is not as remote as the others, and because he feels that he is among his personal friends, and that he has more to say about the conduct of the group than he has about the State or National Societies. This appears to be the situation, and it will not soon change. And for this reason, it occurs to me that each County Society should be developed to its full possibilities. So many Medical Societies have but one interest,— that of having a monthly meeting and being addressed by a scientific speaker. That is the extent of their activity and it is indeed an important one, but why stop at that? It is true that financial limitation precludes expansion of the smaller societies, but there are many which could have a broader usefulness if they were not bound down and gagged by too strict adherence to precedent and tradition and by a most ridiculous catatonic pose on the part of some of the membership, which they think of as being "professional dignity."

In Youngstown, we appear to have a Society of enough members to anticipate bigger things. In ten years we have grown thirty per cent. We have been less timid and have learned to take a few hesitating steps and these steps seem to have been in the right direction. We have, through a most active Editorial Committee, published a monthly Bulletin which compares very favorably with any in the country and which has renewed the interest of its readers. And through an equally energetic Program Committee the meetings have attracted an attendance that has been an incentive and stimulus to the speakers who have addressed us. How many Societies in the country present a program such as the one offered for June 18? And, in their different activities, each committee has responded and has cooperated to its fullest measure. It is to the combined efforts of these committees and of each of the officers that we must attribute what success we are enjoying. But we must not be content to only toddle on our newly-found legs. We must walk with firm stride, and at times, perchance we must run. But instead of running away from disturbing problems, as the medical profession has too often done, we must run *at* them and attack them when attack is necessary.

Ideally, and many ideal things are also practical, we should have our own building, owned and operated by ourselves. I feel certain that this could be financed and that it could be so constructed as to be self-supporting. It should include an auditorium of generous size and of comfort and quietness and good acoustic quality; a library where standard volumes would be available and which would attract members to the pursuit of scientific information; a banquet hall and kitchen, possibly serving noon-day lunch; lounging rooms and club rooms which would conduce to better acquaintance and deeper friendships; and a central office which should include secretarial service, telephone exchange service (replacing the present two exchanges) and our own collection service.

In other words, the Medical Society should have three functions — the presentation of regular, high-grade scientific programs, the furtherance of better business methods, and the provision of club facilities. With these, we should be a more closely-knit unit; the practice of medicine would be so much more enjoyable, we would be in a position to better direct the influence which we are led to believe is at last about to be recognized, and the community would profit in having an even better medical service than we offer it in 1931.

We must not, without much consideration, discard these dreams as being impractical or impossible, for many towns no larger than ours have proved the value of similar experiments.

Let us give much thought to medical affairs, and may our slogan be: *"It can be done."*

A. W. THOMAS, M. D.

# Officers and Committees

## For Mahoning County Medical Society for Year 1931

President .....Dr. A. W. Thomas
Vice President.....Dr. A. E. Brant
Secretary .....Dr. J. P. Harvey
Treasurer .....Dr. W. X. Taylor

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Dr. C. R. Clark
Dr. J. E. Hardman

# The Acute Abdomen In Childhood

*by Dr. Joseph Brenneman of Chicago*

*An abstract of the lecture given before the Society on May 19th, 1931*

The thing which strikes one first, of great interest in the acute abdomen of children, is that a child is a very different thing from an adult. Not only does a child not have the same pathology, but our approach to it is entirely different. We do not have to think about kidney stones; gastric crisis is rare; bladder stones are rare; there are a lot of things that a child does not have that one does not have to think about.

One of the things that is commonly thought by those who do not practice with children, is that the child cannot talk, and that it is difficult to get at. However, this is not true. A child has straight symptoms only. When a child has something, we know it has it. Not only that, in a baby, we can tell from the way the child lies and we can tell a lot of things by the expression of the child's face. You can tell by gentle pressure as to whether there is tenderness by simply watching the expression on the child's face, rather than asking the child where it hurts. I never ask a child up to five or seven years whether it hurts or not; I just look at its face and see whether it screws-up its face, draws up its leg, or twitches a little bit. That gives a truer statement of actual tenderness than if one asks the child.

From a practical standpoint I want to talk about — 1. Obstruction, in the intestinal tract chiefly; 2. Hemorrhage, and, 3. Inflammatory conditions.

Whenever any hollow viscus of any sort, whether it is the Circulatory System, whether in the Urinary tract, gall bladder region, or whether it is in the intestinal tract — whenever any hollow viscus with a propulsive mechanism is obstructed, a certain series of things happen. If the obstruction is incomplete, there will be hypertrophy, ultimately succeeded by dilatation above the point of obstruction.

Now, the first thing I want to say, which is very interesting from a diagnostic standpoint, is Congenital Atresia of the Esophagus. I mean complete atresia, not stenosis. They all act alike — they all die, but there is a certain satisfaction in being able to make an accurate diagnosis. Everyone I have seen is exactly alike, because one of the esophagus ends has a blind pouch and there is an obstruction of the blind end with hypertrophy. X-ray would show the upper end of the esophagus to be as big as my finger. The baby lies on one side with a string of mucus hanging from its mouth. The child is not able to pass the mucus down into the intestinal tract and therefore it runs out. Then if you give a child of that sort a drink of water, the child takes one swallow and gets away with it, then a second and sort of hesitates. After taking the third swallow the water comes back through the nose and mouth, the child chokes, turns blue and looks like it is going to die. In other words, the first swallow causes a dilatation of the upper part of the esophagus, the next tries to get out the lower part of the esophagus, floods the lungs, and the child nearly drowns. Commonly the abdomen is rather flat, except the upper part is rather distended due to air going through the upper part of the stomach. It does no good to do anything for these cases. Jejunostomy and Gastro-Enterostomy have been done but do no good.

Pyloric Obstruction — It is rather different from what it was a few years ago. Some get well without operation and some get well with operation. We feel that every case should be treated medically until we know it is not going to get along. We should try to find that out as quickly as we can so as to give the surgical men some kind of a case. Projectile vomiting is a common symptom of pyloric spasm.

Whether they are different or not pathologically, Pyloric Spasm and Pyloric Ste-

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# THE FOURTH ANNUAL

## Thursday, June 18, 1931

## A Course of Lectures by a Faculty Group from

## PROGRAM

### MORNING SESSION
8:30 A. M., Hotel Ohio

DR. EMIL NOVAK — Associate Professor of Clinical Gynecology
*"The Treatment of Chronic Endocervicitis"*

DR. THOMAS B. FUTCHER — Associate Professor of Clinical Medicine
*"The Problem of Arthritis in General Practice"*

DR. WILLIAM E. REINHOFF, JR. — Instructor in Clinical Surgery
*"The Surgical Status and Treatment of Chronic Peptic Ulcer With Some Experimental Observations"*

DR. LOUIS HAMMAN — Associate Professor of Clinical Medicine
*"The Diagnosis of Obscure Fevers"*

### AFTERNOON SESSION
1:30 P. M., Hotel Ohio

DR. EMIL NOVAK —
*"Recent Developments in the Physiology of Menstruation"*

DR. THOMAS B. FUTCHER —
*"Manifestations of Hyperfunction and Hypofunction of the Endocrine Glands Seen in General Practice"*

# POST-GRADUATE DAY

## Youngstown, Ohio

## The Johns Hopkins University School of Medicine

## PROGRAM

### AFTERNOON SESSION
Continued

DR. WM. E. REINHOFF, JR.—
*"Clinical Observations Before and After Operation in Cases of Hyperthyroidism"*

DR. WALTER E. DANDY — Associate Professor of Clinical Surgery
*"Diagnosis and Treatment of Injuries of the Head"*

DR. LOUIS HAMMAN —
*"Diagnosis of Coronary Occlusion"*

Banquet at 6:30 P. M.— The Youngstown Club
First National Bank Building

### EVENING SESSION
Youngstown Club

DR. WALTER E. DANDY —
*"Diagnosis and Treatment of Lesions of the Cranial Nerves"*

DR. THOMAS B. FUTCHER —
*"Diagnosis and Treatment of Diabetes Insipidus"*

DR. EMIL NOVAK —
*"Endocrinology and Organotherapy in Gynecology"*

Telephone Numbers — At the Hotel 4-1131, at the Club 4-2177
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nosis are different clinically. Pyloric Spasm can begin vomiting at any time. Hypertrophic Pyloric Stenosis never has vomiting in the beginning — they begin to vomit at two, four, or five weeks, but never later than that. Projectile vomiting is present in true Pyloric Spasm. The gastric waves start in the upper left quadrant, like a half golf ball, go across and another one starts in the left side, and by the time the first one gets to the right — a little above the umbilicus, there can be three balls standing out. There is very little bowel movement, very scanty urine, and always projectile vomiting. In all cases, always try medical treatment first — Atropine or Luminal, and frequent feedings of a reasonable food such as mother's milk or condensed milk with one drop of 1 to 1000 solution of atropine. Occasionally 2 or 3 drops can be given. One is always given sufficient warning when getting up to a point of giving enough Atropine; the child gets red all over, gets a temperature and the abdomen becomes slightly distended. In one case, the child was getting Atropine before each feeding and when two drops had been given, the child had a temperature of 109, the abdomen was distended, and it is thought to have Peritonitis. However, they get over it and it never does any harm

Apparently, the thymus is not generally the cause of Pyloric Spasm. In some cases we have cured Pyloric Spasm with treatment of the Thymus. If a child does not get well promptly, stops vomiting within 24 to 48 hours, then we ought to think the child has a true Hypertrophic Pyloric Stenosis, especially if beginning in the third or fourth week and persisting. In true Hypertrophic Pyloric Stenosis, almost without exception, one can feel a tumor. That is the enlarged pyloric muscle, and has sort of a smooth feeling. Whenever you examine a child with Hypertrophic Stenosis, if you find the tumor you should refer the case to a surgeon quickly. Whenever seeing a child having Pyloric Stenosis, give the baby sugar water, and a small amount of this getting into the stomach will start the peristaltic waves. That alone never means operation because there are just as big waves in Pyloric Spasm as in Pyloric Stenosis. The child will shoot the water out, and this is the moment that you can feel the pyloric tumor. The place to feel the tumor is just outside of the rectus muscle on the right side, a little below where the liver is, and if you feel around long enough you can find that tumor. And if you find the tumor, that usually turns the scale in favor of the surgeons so quickly that you must not wait. Whether true Hypertrophic Pyloric Stenosis ever gets well with Atropine, Luminal, etc., I do not know. I have not seen it. Sometimes they make X-rays. X-ray, to determine as to whether there is an obstruction to the pylorus, is not only harmful but a pernicious procedure. It is best to know just as soon as possible whether the case is a true Hypertrophic Pyloric Stenosis, and turn it over to the surgeons quickly so that he may have the case in fairly good condition.

Duodenal obstruction very closely resembles Pyloric Stenosis, in that there is the same peristaltic wave but the child vomits a quanity of bile, egg-yolk in color. In true Pyloric Senosis they do not vomit bile.

Intestinal Obstruction is the real dramatic thing in medicine. Intussusception is sometimes muffed more than it should be. It is not ordinarily difficult to diagnose. Intestinal Obstruction, usually ileocecal, is usually ushered in with the child suddenly crying, and after crying may vomit for a time. After a few hours the child does not keep on crying By the time the doctor gets there — eight or ten hours afterwards, the child is apt to be rather quiet and not crying but they have a very peculiar facial expression. They get just enough distress that they never smile and keep their eyes open, and every so often make a turn or twitch, or throw themselves on to their side. They change their position, and at other times seem to be having gall stones. They do not make any marked disturbance. We had one case that we could not find the obstruction, could not find a tumor, child was having

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bowel movements, but the child had this peculiar expression. The obstruction was about one inch from the ileo-cecal valve.

However, the diagnosis is ordinarily not difficult because Intussusception has blood in the stools. This is different from any other blood. It is mixed blood and mucus, like apple-jelly. It may not appear on the outside but after one makes a rectal examination, after drawing out the finger, it is covered with bloody mucus. I have never seen a case when this was not Intussusception. I always like to find the tumor, and in most cases can find it — in the ileo-cecal region.

As soon as the diagnosis is made, go after a surgeon. If you get them early the prognosis is good, otherwise it is not.

Sometimes we have obstruction due to Meckel's Diverticulum. Meckel's Diverticulum does several things, and can cause obstruction very easily. This is mostly in the right lower quadrant. There is never any blood in the stools and it can be distinguished from Intususception. If a child has obstruction without any blood in the stools it is probably a Meckel's Diverticulum. Volvulus is a rare thing. I have only seen one genuine volvulus in a new-born baby. That one had symptoms of Pyloric Stenosis except the waves were a little low. You cannot do an Enterostomy on a new-born baby and make an artificial anus because you cannot nourish a new-born baby this way.

The next thing is the rectal canal. This is a type of obstruction that is interesting. I have seen three such cases. The first one was 18 years ago. This child was four or five days of age, had an enormously distended abdomen, occasionally would scream with pain, and I could feel big coils of intestines going from the left side to the right. Occasionally the child would pass gas. I passed a catheter into the rectum to relieve the child and the intestine collapsed. I tried to get my finger into the rectum but could not. I pushed my finger hard and gradually got my finger in, following which the child was relieved and has never had any trouble since — not even with constipation. The last time I saw this patient was when he was 16 years old. It looks like Hirschsprung's disease and will often be diagnosed as Hirschsprung's Disease. When the obstruction in the rectum is relieved, this is what relieves the child. All you need to do after you have made your diagnosis in a young child, is to dilate the rectum with your finger and it will get entirely well. Everyone that I have seen is just above the sphincter, not higher.

Hemorrhage from the bowel makes a lot of difference if you know what the blood looks like. If it is bright red blood, it comes from low-down. Hemorrhoids are very rare in babies and children. Polyps are rare. If the blood is dark or black, then it comes from high-up. If it is bright red, and sometimes fairly dark, that is a very important diagnostic point. One of the common hemorrhages of children is Melena of new borns, where the child has blood on bowel movements. If this is accompanied by other hemorrhage from the eyes, ears, nose or mouth, then it is a hemorrhagic disease of new borns. Gastric and duodenal ulcers are very rare in children.

When you find blood coming from the bowels, you must always think of a perforation, and you must think of the possibility of a foreign body. There was one case in which the child had a rather profuse hemorrhage from the bowel. I put my finger in the rectum and pulled out a tin soldier.

There is one hemorrhage that I want to especially talk about. The suspicion of a diagnosis is so simple that you can make it over the telephone. One Sunday morning, about three weeks ago, the hospital called and said they had a child that had had two rather severe hemorrhages from the bowel, passing big clots. The second bowel movement contained clots as big as a duck egg. The house surgeon talked over the phone and he did not think it was Intususception, although it acted like it.

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However, it was suggested that it might be a Meckel's Diverticulum. The child was operated and it was found that there was an ulcer in Meckel's Diverticulum. The child got well. This condition can cause three things — can produce obstruction, can produce profuse abdominal hemorrhage, and can porduce a perforation — secondary to that, Peritonitis. In this particular case there was an ulcer in Meckel's Diverticulum and the ulcer had gone clear through and produced local peritonitis. In a Meckel's Diverticulum, ulcers occur that are almost identical with a duodenal or gastric ulcer. There are tissues in Meckel's Diverticulum that look like pancreatic glands. When you get a serious hemorrhage from the bowel, if it is black, and if there are clots, then think of Meckel's Diverticulum, and never take any chances.

The appendix is an interesting sort of institution. The appendix is a relatively small affair. If it were on the outside, on the arm, or leg, we would not think anything more of it than a boil. It is the location of the appendix that makes it serious. Because it is so little one does not expect much reaction. One does not ordinarily with Appendicitis get a high temperature. The fever in appendicitis rarely ever goes over 101. The important thing in Appendicitis is the location of the point of tenderness. The pain usually starts in the middle of the abdomen and later localizes in the right lower quadrant. The pain may be referred but the tenderness is not referred. The tenderness is at the point where the inflammatory- condition occurs. Therefore, you can have tenderness along McBurney's point, but if the appendix is longer than usual with an inflamed tip, it is not going to hurt where the normal appendix is, but where the inflammation really is in that particular case. The important thing is the tender point. It is customary to make a rectal examination but I do not stress this test. If you can feel a mass inside you can feel a mass outside. The important thing is the tender point.

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However, it was suggested that it might be a Meckel's Diverticulum. The child was operated and it was found that there was an ulcer in Meckel's Diverticulum. The child got well. This condition can cause three things — can produce obstruction, can produce profuse abdominal hemorrhage, and can porduce a perforation — secondary to that, Peritonitis. In this particular case there was an ulcer in Meckel's Diverticulum and the ulcer had gone clear through and produced local peritonitis. In a Meckel's Diverticulum, ulcers occur that are almost identical with a duodenal or gastric ulcer. There are tissues in Meckel's Diverticulum that look like pancreatic glands. When you get a serious hemorrhage from the bowel, if it is black, and if there are clots, then think of Meckel's Diverticulum, and never take any chances.

The appendix is an interesting sort of institution. The appendix is a relatively small affair. If it were on the outside, on the arm, or leg, we would not think anything more of it than a boil. It is the location of the appendix that makes it serious. Because it is so little one does not expect much reaction. One does not ordinarily with Appendicitis get a high temperature. The fever in appendicitis rarely ever goes over 101. The important thing in Appendicitis is the location of the point of tenderness. The pain usually starts in the middle of the abdomen and later localizes in the right lower quadrant. The pain may be referred but the tenderness is not referred. The tenderness is at the point where the inflammatory- condition occurs. Therefore, you can have tenderness along McBurney's point, but if the appendix is longer than usual with an inflamed tip, it is not going to hurt where the normal appendix is, but where the inflammation really is in that particular case. The important thing is the tender point. It is customary to make a rectal examination but I do not stress this test. If you can feel a mass inside you can feel a mass outside. The important thing is the tender point.

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Pneumonia in a child is as often below the diaphragm as above. When you have a lower lobe Pneumonia in a child, if you feel over the upper part of the abdomen on both sides, you can get a certain amount of rigidity on the side that the Pneumonia is on. Right lower lobe Pneumonia can simulate Appendicitis. Upper respiratory tract infections commonly produce pain in the abdomen. Appendicitis is a frequent complication of throat infection. Evans, from the University of Wisconsin, states that during a period of 226 days, during which time they had an epidemic of upper respiratory tract infections, that there were 116 cases of Appendicitis; that is, an Appendicitis every other day. Whereas, when they had no epidemic they had an appendix every 15 days, or, Appendicitis cases were eight times as bad when they had an epidemic as when they had no epidemic.

Peritonitis, especially in babies, is relatively hard to diagnose because other things can simulate this. The important things in making a diagnosis of Peritonitis are pain, rigidity, and tenderness all over the belly, or you can have localized tenderness with Peritonitis. If you have board-like pain and rigidity you usually think of Peritonitis. Another thing about Peritonitis which helps from a diagnostic standpoint is that you can tell the difference between the way the child looks, because it looks sick and the eyes are not clear. There may be a pinched and anxious expression — the Hippocratic facies. Usually in a child, Peritonitis is due to a systemic condition, a throat condition, or something else. If due to appendicitis it is better to operate. If caused by the pneumococcus it is better to wait.

I have seen two pedunculated ovarian cysts that I thought were Appendicitis at the time. I remember so well, that at the time I did not know what it was, but thought it was Appendicitis. One of our Internes who saw the case, thought it was a twisted pedicle of an ovarian cyst because of the high Leukocytosis. I had one case when a child had a 60,000 Leukocytosis and another case when the child had a 90,000 Leukocyte count. These do not occur in Appendicitis and one has to think about that.

# Report of Communicable Diseases for June, 1931

| Diseases | Youngstown Cases | Struthers Cases | Campbell Cases | County Cases | Total Cases |
|---|---|---|---|---|---|
| Scarlet Fever | 95 | 16 | 15 | 33 | 159 |
| Influenza | 4 | | 1 | 2 | 7 |
| Chickenpox | 14 | 14 | 5 | 32 | 65 |
| Tuberculosis | 30 | | 3 | 2 | 35 |
| Measles | 103 | 3 | | 5 | 111 |
| Pertussis | 16 | | | | 16 |
| Diphtheria | 5 | 4 | | 5 | 14 |
| Syphilis | 4 | | | | 4 |
| Pneumonia | 2 | | | 9 | 11 |
| C. S. Menigitis | | | | | |
| Erysipelas | | | | 1 | 1 |
| Opthalmia Neonatorum | | | | | |
| Septic Sore Throat | 3 | | 1 | | 4 |
| Pahomyelitis | | | | | |
| Typhoid | 1 | | | | 1 |
| Smallpox | | | | 1 | 1 |
| Mumps | | | | 9 | 9 |

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