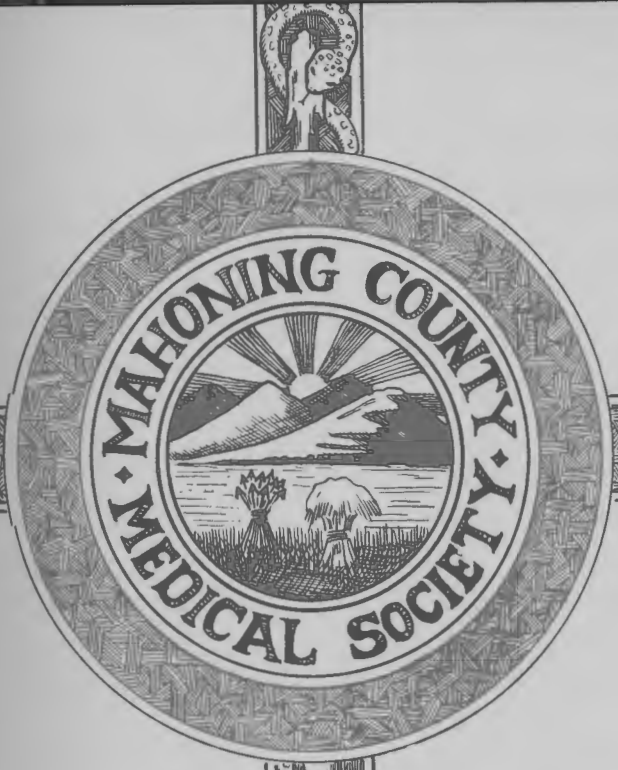

Our great problem of the new post-war age will be not how to produce, but how to use; not how to create, but how to cooperate; not how to maim and to kill, but how to live.

—Robert A. Millikan

BULLETIN

of the

Mahoning County Medical Society

Vol. XV No. 6
June 1945

S·I·M·I·L·A·C

Similar to human milk

★The name is never abbreviated; and the product is not like any other infant food — notwithstanding a confusing similarity of names.

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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Vol. XV—No. 6 — June, 1945

CONTENTS

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PRESIDENT'S PAGE

MEDICAL RESEARCH

It may well be that a new day is dawning in the field of Medical Research. As pointed out in discussing the Cancer Campaign, nationally known industrialists such as Mr. Eric Johnston are trying to set up a plan which will make a career in Medical Research attractive to younger scientists. Recently, Senator Claude Pepper, Chairman of the Senate Sub-Committee on Wartime Health and Education, has published an analysis of the great possibilities of Medical Research if properly financed. He shows by graphs that only about 5 million dollars was spent last year in this important field of human welfare while 275 million was the estimated amount allotted for industrial research. He describes the impetus given to the solution of medical problems when adequate funds are made available as has been the case during wartime. Senator Pepper feels certain American scientists if given the financial backing can, and do develop new ideas and improve old ones. He states that, "It took a World War of catastrophic dimensions to jar enough money out of the national pocket to enable medical research men to conduct their work on an adequate scale." He is as certain as physicians have been for years that the approximate 163,000 deaths from cancer, the 536,000 from heart disease, and the 107,000 from diseases of the kidney can be greatly reduced if the investigation of the cause and prevention of these killers can be thoroughly studied.

Now that high income and inheritance taxes have eliminated the chances of philanthropists financing adequate studies, Senator Pepper's idea of having Federal assistance for a research program appears to be a practical one. We trust that recommendations from Washington for a Medical Service Plan will be based on as thorough investigation. It should be made clear, however, that Federal funds not Federal supervision made possible the results obtained in war research medicine.

W. H. BUNN, M. D.,
President.

BULLETIN of the Mahoning County Medical Society

JUNE 1945

RECENT ADVANCES IN THE TREATMENT OF SYPHILIS

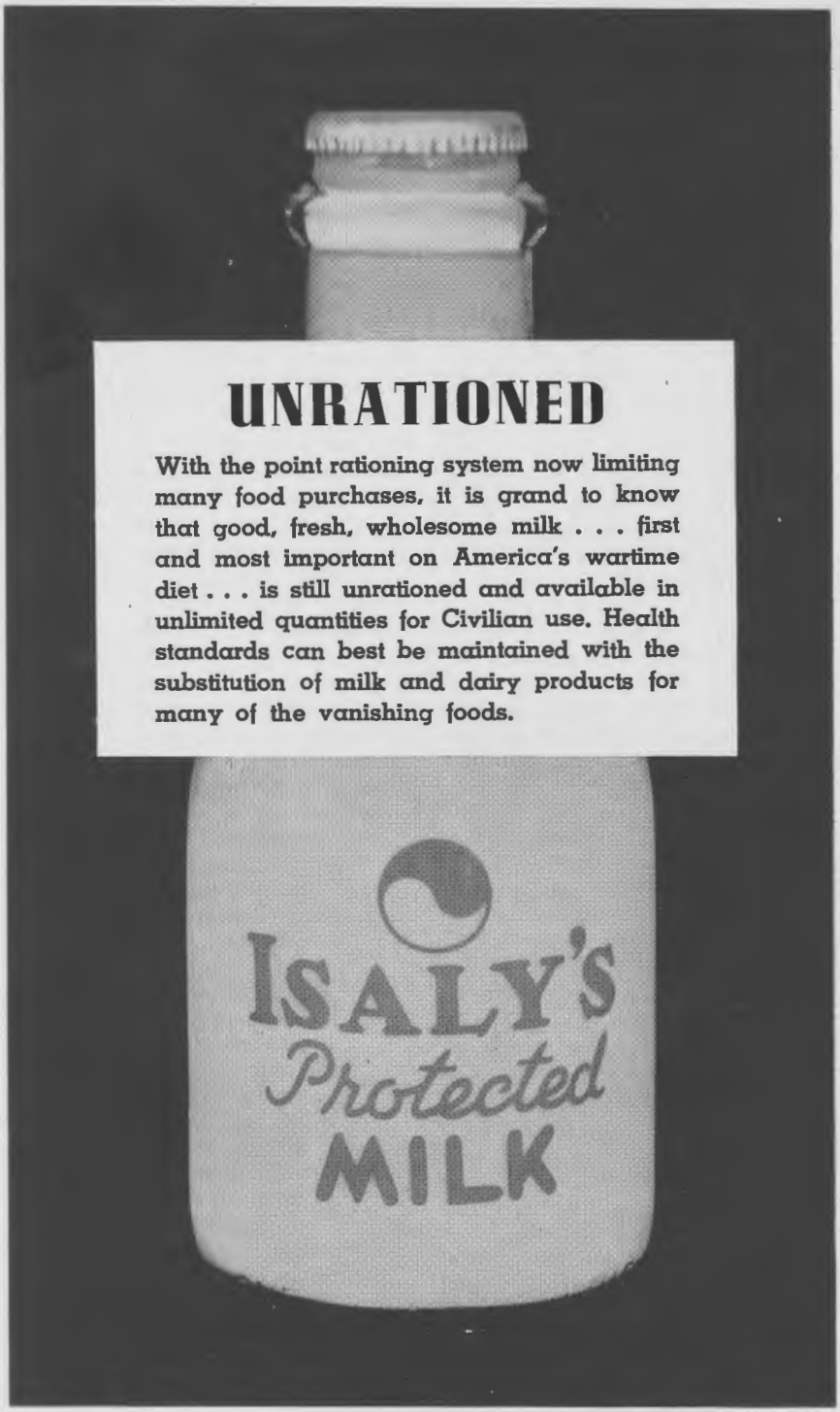
Dr. Harold N. Cole, the well-known dermatologist and syhpologist of Cleveland, and a man well known to all of us, was the speaker at our last medical meeting.

His talk very definitely brought us up to date on the methods of treating syphilis and on some of the newer work with penicillin in the treatment of syphilis. The start of the talk was given over to an outline of the previous treatment; starting with a historical resume of the different methods and bringing us up to date on some of the more advanced methods of treatment with heavy metals and arsenic. With some of the more recent methods a patient could be promised that in a year syphilis could be cured. Going back still further mercury took about four years to get the patient in a state of clinical cure; but at no time did mercury completely cure. Then bismuth came along and then the arsenicals. Regular treatment was definitely necessary. It took a long time to get the patient better and cure was usuallv not obtained. In any method of medical therapy it takes a long time to properly evaluate the different types of therapy. So it has only been recently that the previous methods of syphilitic treatment can be properly evaluated.

With the proper use of bismuth and arsenicals patients cured at the end of five years could expect to remain cured. Incidentally C.N.S. lues was two and one-half times as frequent in white as in the colored race; whereas, cardio-vascular syphilis was more common in the colored race. The best results were obtained with the use of bismuth and arsenical when the patient was treated following a positive Darkfield examination and before the blood became positive. With this method of treatment the C.N.S. involvement was six times as frequent in a patient who relapsed as in one who went steadily though with the treatment and became cured.

Forty arsenicals and forty doses of bismuth given in continuous fashion gave a high percentage of cures. As stated before it took many years to find this out. Following this various methods of intensive therapy were tried and recently penicillin has come into use. Some of the methods of intensive therapy mentioned were: a continuous grip with metharsen, this was followed by ten to twenty daily injections of metharsen. The early Army plan called for forty metharsen doses and sixteen bismuth injections in a period of twenty-six weeks. There were relapses from this form of treatment. Fever therapy was combined with arsenicals and bismuth with a definite percentage of cures. The fever therapy was given during a ten hour period and metharsen given hypodermically at the same time. This gave excellent results. Intensive treatment has shown what can be done if the patient is under control and can be observed carefully. Another method used with metharsen also combined typhoid fever shots in order to induce the fever. All the intensive forms of therapy have been more severe than the previous method of treatment. Intensive therapy was a transitional stage.

Mahoney introduced the use of penicillin. A number of experiments were carried on in different places to find out what dosage of penicillin


UNRATIONED
With the point rationing system now limiting many food purchases, it is grand to know that good, fresh, wholesome milk . . . first and most important on America's wartime diet . . . is still unrationed and available in unlimited quantities for Civilian use. Health standards can best be maintained with the substitution of milk and dairy products for many of the vanishing foods.
ISALY'S
Protected
MILK

was necessary in order to control the disease. With proper dosage of penicillin the spirochaeta pallidum disappears from the lesions; the skin lesions and the mucuous membrane lesions also disappear. The disappearances occurs in from ten to twelve to thirty-five hours. This is very much more rapid than with arsenical and bismuth. The lesions disappear with the arsenicals and bismuth in from ten days to three weeks. Serology should be titrated to evaluate therapy with penicillin. The response of the patient depends on the titer of the serum. With penicillin the serological curve is rather characteristic. Titer rises the first week then will drop slowly in three to four months; and the serology will become negative. If dosage is not high enough titer may not come down or there may be a relapse. Single dose of penicillin is worthless. A few days of therapy is not enough. The dose must be given oftener than four times a day. Therapy should be given every three to four hours; and not over four hours apart. Relapses occur in about one hundred per cent of the cases when sixty thousand units were used; with three hundred thousand units about seventy-five per cent relapses have occurred; with six hundred thousand units as a dose forty-five per cent relapses; with nine hundred thousand units about thirty per cent relapses have been seen. Relapses come on in from thirty to ninety days. The relapse can be predicted by the increase in the titer or the curve of the serological test. When the relapse occurs the dosage should be doubled. Dr. Cole carefully warned that penicillin is still in the experimental stage. It promises much but the final answer is not yet known.

In syphilis of pregnancy penicillin would be a tremendous advance and apparently it is working even late in pregnancy. One of the other possibilities is the combination of penicillin and metharsen or possibly even some other drug. Penicillin has proved disappointing in cardio-vascular syphilis and has been disappointing in taber and paresis. There are, however, few reactions from the use of penicillin and present indications are very promising.

To sum up, the methods of treatment which were in use prior to the intensive treatment of syphilis produced cure when properly administered in practically one hundred per cent of the cases. With the intensive methods of therapy the time of treatment could be shortened tremendously and the number of cures again was very high. Experimental work with penicillin promises to produce a high rate of cures provided proper dosage is given frequently enough.

Medical Art and Photography

The Youngstown Hospital Association is particularly fortunate to have the services of a splendid Medical Artist and medical photographer in the person of Mrs. Mary Wick Miles. She comes with excellent training, and has already made the budding department outstanding. Such photographic records add not only interest in medical meetings, but raise the quality of our medical records. Good illustrations are basic in medical presentations and publications elsewhere, and with the group spirit about Youngstown we all have the chance and responsibility to add to medical knowledge in varied fields. The medical Art and Photography department is housed in a dark, dingy room of the laboratory department of the South Unit. However, pending the day when it is where it belongs, you will hear from Mrs. Miles and her vital unit in a program for better medicine. H.K.G.

WHY NOT PREVENT RABIES?

The incidence of rabies, or hydrophobia is increasing throughout the United States. Because of its agonizing symptoms and hopeless prognosis, rabies causes widespread public fear. Unfortunately, the public becomes sufficiently alarmed to control its dogs only after a few people have been bitten or a death from rabies has occurred. It is time that we all take stock of the situation with a view toward doing something to improve it. It is quite apparent that Mahoning County could improve its "record."

	Deaths from Rabies		Positive Rabies Heads		Contacts Treated
	Ohio State	Mah. Co.	Ohio State	Mah. Co.	
1935	2				
1936	3				
1937	5	1			62
1938	3				136
1939	5	2			68
1940	5				51
1941	4		482	14	49
1942	4	1	156	32	138
1943	2	1	396	37	329
1944	2	2	379	13	302
1945 (until April)	0	0	197	1	0
Total	35	7	1610	97	1135
% of Total	100	20	100	5.4	

Statistics on dog bites in the United States are not available. However, Illinois may be considered an example of the occurrence of bites in a thickly populated state. In 1936, in Illinois, 18,466 persons were reported as having been bitten by dogs. Even if the disease were not a fatal one, the fact that so many people were subjected to the fear of rabies and the pain of treatment should arouse public interest in the control of dogs. Since 1937, 1135 persons in Mahoning County have been given anti-rabies vaccine. It is safe to assume that for each one treated at least nine other persons were bitten and not treated. If most of the 1135 persons were given the prescribed course of 14 treatments (some were given only 7) the cost to the taxpayers of the county would be approximately $24,350.00. The pain, worry and danger of treatment is immeasurable.

Over 90% of human rabies cases are caused by the bite of rabid dogs. Therefore, the proper control and disposition of this animal is paramount, not only in eradicating the disease, but in disposing of problems of human exposure. The responsibility for the control of dogs, and hence rabies, rest squarely upon the public. No real success will be seen until the people are sufficiently interested to insist upon and cooperate with a program which embraces the following measures: (1) the institution of an effective national and interstate quarantine period of observation for dogs not constantly caged or on leash; (2) the impounding and destruction of all stray dogs; (3) the rigid enforcement of statutes relating to licensing and to impounding as strays all dogs not licensed; (4) the requiring of anti-rabic inoculation of all dogs as a requisite to the issuance of a license and repetition of inoculations at six month intervals, and (5) the muzzling of all but working dogs when not on leash or on the owner's premises. When one sees packs of dogs, without any visible proof of licensing, roaming the streets of Youngstown, one can understand what an improvement such a program would be.

Because of the failure to control the canine population, increased reliance must be placed on secondary methods of prevention. Unfortunately, evidence concerning the value of anti-rabic vaccination of dogs is conflicting and indecisive. However, the concensus of opinion seems to be that a single inoculation of anti-rabic virus confers immunity beginning about two weeks after the immunization and lasting not longer than a year. There have been failures noted in shorter periods. The vaccination should be repeated, therefore, at yearly intervals or, better still, at six month intervals.

Once a person has been bitten, the problem becomes acute and serious. All bites should be reported immediately to the public health authorities so that the dog may be placed under veterinary observation for two weeks. As a rabid animal lives for five or six days after its saliva becomes infective, a dog which lives beyond that period and does not acquire the disease in two weeks of observation may be considered non-rabid. Strays should be destroyed after the period of observation. A cardinal rule is: "Do not kill the biting dog unless absolutely necessary." Approximately 11% of the brains of rabid dogs either killed or dying naturally fail to show any evidence of the disease. A second rule of equal importance is: "The biting dog must be placed in custody for observation." This should be impressed upon the policemen, sheriffs, dog wardens and the public. If the biting dog can not be observed for the full two weeks period, the lives of many persons may be jeopardized and the physician is given no choice but to subject the bitten person to a painful treatment that is not without danger.

The bitten person must report immediately to a physician for treatment. Complete reliance on anti-rabic vaccine is never justified. Every bite in which the skin is broken should be cauterized with fuming nitric acid. The acid should be used carefully and should not be neutralized. The sooner the cauterization is done the better the chance of preventing rabies. Experimentally, an interval of not longer than 30 minutes is ideal.

The decision as to whether anti-rabic treatment should be instituted immediately or whether it can be delayed depends on such factors as (1) the location and severity of the wounds; (2) the circumstances under which the biting occurred; and (3) the probability of the biting animal being rabid.

When there are multiple lacerations, or where the bite is upon the face, administration of the vaccine should be begun immediately but may be discontinued after three or four days if the animal remains normal but is kept under observation for the full two weeks period. (A negative report for Negri bodies on an animal killed before sufficient time has elapsed for the bodies to form is not an indication to discontinue treatment.) Obviously, treatment must be started immediately when the animal presents symptoms of rabies or where the bite is inflicted by a stray that can not be located. Deep puncture wounds, especially if multiple or badly lacerated, carry the most danger. When the bite is by a sick dog, or one that becomes sick during observation, injections must be given until the complete series is completed or until rabies has been ruled out.

Treatment of other exposures can usually be deferred pending observation of the animal or the receipt of the laboratory report. The Alabama State Department of Health reports that treatment is not indicated in the following "exposures": (1) contamination of old cuts; (2) "friction bruises" through clothing in which the skin is definitely broken but the clothing neither torn nor penetrated; (3) handling, eating af-

ter, or sleeping with rabid animals; (4) cleaning food or drinking vessels used by rabid animals; (5) drinking milk of rabid cows; (6) bites of any animal remaining normal seven days from the date of biting; (7) any exposure to a non-rabid animal just bitten by a rabid animal; (8) any exposure to a case of human rabies other than an actual bite, or direct contamination of fresh open wounds with fresh saliva; (9) handling bedding of a rabid animal; (10) treating wounds made by rabid animal; (11) handling chain or rope with which a rabid animal was tied; (12) getting saliva from rabid animal on hand, but either having no cuts or scratches, or having "scabbed over" sores; (13) getting blood on hands while decapitating rabid animal; (14) rat bites.

The Semple modification of the Pasteur treatment should be given twice daily for from twenty-one to twenty-eight doses for a suspicious bite upon the head or neck. For a mild bite in a region distant from the brain, fourteen daily doses are considered adequate. Local reactions which appear regularly on the seventh and eighth day and on the fifteenth and sixteenth days are usually not severe. The Pasteur Institute encountered severe treatment reactions in a proportion of 1:5,440 treatments with fatalities of 1:18,446. These occur usually from 11 to 30 days following the institution of treatment and are of three types: (1) an acute ascending paralysis; (2) a dorsolumbar myelitis; and (3) a peripheral neuritis.

When a definite re-exposure follows a series of rabies vaccine injections, three or four more doses should be given to bolster immunity. If a second exposure is severe and follows six months or more after the completion of treatment, repetition of the regular course of vaccine injections is indicated.

Rabies can occur within 10 days but may be delayed as long as 2 years following the bite. The average is 40 to 60 days. Once the symptoms of rabies have begun to develop in the human being, there is no effective treatment. The disease runs its course of terrible and terrifying agony until its fatal ending.

Thus the physician must pursue a conservative course—trying not to be swayed by the panic of the patient and his own horror of a fatal disease may be prevented but not cured, and yet trying to avoid the unnecessary use of a treatment which is far from innocuous. He can only hope that eventually the public and the officials responsible for maintaining the public health will waken to this ever-increasing menace. In a period where deaths by the thousands occur in other countries from starvation and torture, a few deaths from rabies in our own country may seem unimportant. But a picture of the pitiful agony and fear that precedes death by rabies would be just as terrible as the present atrocity films. The death of a starved child in Greece is no more pathetic than the death by rabies of a Youngstown child bitten by her neighbor's dog. Both should have been prevented!

Alcoholic Anonymous

Your president with representatives of the Clergy and the Bar Association attended the Fifth Anniversary Meeting of the Youngstown Group of A. A. It was an enlightening and pleasant experience. No method of attaining and maintaining sobriety heretofore tried has had the success which this movemet has enjoyed.

Physicians who have patients needing help to conquer the drink habit may be assured of intelligent and sympathetic aid by calling on this group.

Beriah Edwin Mossman, Jr., M. D.

Born Dec. 20, 1874 **Died May 3, 1945**

Dr. Beriah Edwin Mossman, Jr., city physician for two and one-half years, passed away May 3rd of a heart ailment at his home, 1352 Florencedale Ave.

Dr. Mossman was born in Greenville, Pa., a son of Dr. B. E. and Emma Hilands Mossman, and was a resident of Yougstown for 27 years. He was a graduate of Phillips-Andover Academy, Yale University and the Medical School of the University of Pennsylvania. In 1900 he graduated from the University of Pennsylvania, 1900-1901, interned at Allegheny General Hospital, Pittsburgh, Pa., 1901-1904 he was Assistant Physician at the Institution for Feeble Minded, Polk, Penna. 1906-1907, served on the surgical staff of Greenville Hospital, Medical Chief of Mercer County Draft Board 1917. At the start of World War I, he came to Youngstown to take over the practice of his brother, Dr. R. G. Mossman, who entered the service. He also served as chief surgeon for Sharon Steel Hoop Company, predecessor to Sharon Steel Corporation. He was a member of the First Presbyterian Church, and a man of sterling integrity with the interest of his patients always foremost in his mind. He served long and well, having been ill only a month. He always retained his membership in the Elks Club of Greenville, his birth place. A member of the Mahoning County Medical Society, the Ohio State Medical Association and the American Medical Association and a past president of Mercer County Medical Society, he will long be remembered by a host of friends.

Dr. Mossman leaves a daughter, Gloria, in Youngstown; a brother, Dr. R. G. Mossman, of Youngstown, and three sisters, Mrs. C. Burton Rouche of Kansas City, Mo., Mrs. James F. Fox of Encino, California, and Mrs. Charles S. Heath of Los Angeles. His wife Ruth Showalter Mossman, died in October, 1943.

Dr. J. N. McCann Appointed to State Medical Board

Dr. John N. McCann was appointed by Governor Frank J. Lausche to membership on the State Medical Board, for a seven-year term, ending March 18th, 1952. Dr. McCann succeeded Dr. J. H. Skavlem, Cincinnati, who was appointed last November to fill the unexpired term of the late Dr. Claude V. Davis, Pennsville.

Dr. McCann has practiced medicine in Youngstown for over 15 years. He is a graduate of the University of Georgetown, Washington, D. C., having received the Bachelor of Science and Doctor of Medicine degrees in 1927, and is on the Senior Medical Service and Cardiology Service of St. Elizabeth's Hospital. He is also a member of the Board of Trustees of the Mahoning County Tuberculosis Sanitarium, served as delegate from the Mahoning County Medical Society at the Annual Meetings of the State Association in 1942 and 1943, and is a fellow of the American Medical Association.

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Youngstown Hospitals' Internes

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1st Lt. James Delmar Miller, M.C., U.S. Army (0473617)—90th Field Hospital, Camp Gruber, Oklahoma.
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Walter B. Webb, Ass't. Sur. (R) Federal Penitentiary, Lewisburg, Pa.

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Maj. Geo. L. Armbrecht, M.C., (0357508) Med. Det. 8th Inf., A.P.O. 4, c/o Postmaster, New York City.
Capt. Nathan D. Belinky, M.C., American Prisoner of War, Interned in Philippine Islands, c/o Japanese Red Cross, Tokyo, Japan, Via New York, N. Y.
Dr. Donald J. Burmingham (P.H.S.) 210 Domer Ave., Takoma Park, Md.
Major David D. Colucci, 131st Gen. Hosp., Camp McCain, Miss.
Capt. C. J. Dudy, M.C., 0463233, 62nd Gen. Hospital, APO 887, Seine Section Comm. 2, c/o Postmaster, N. Y. City.
Lt. Francis J. Gambrel, M.C., (0475440), 362nd Inf., Med. Det., APO 91, c/o Postmaster, N. Y. City.
Maj. E. F. Hardman, Station Hosp., Morris Field, Charlotte, N.C.
Lt. Morris I. Heller (Address Wanted).
Lt. V. G. Herman, Public Health Dispensary, 4th and D. Street, Washington, D. C.
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Capt. Joseph Sofranec, (0489202) 110th Station Hospital, A.P.O. No. 3385, c/o Postmaster, New York, N. Y.
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Lt. John Veit, Southwest Pacific. (Correct address wanted).

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June Meeting

Speaker:

S. O. FREEDLANDER, M. D.

Associate Professor of Surgery, Western Reserve University; Chief Surgeon of Cleveland City Hospital; Chief of Department of Thoratic Surgery, Cleveland City Hospital and Sunny Acres Sanitarium; Associate Chief of Surgery, Mount Siani Hospital.

Subject:

"INDICATIONS FOR PULMONARY RESECTION"

Tuesday, June 19th—8:30 P .M.

Youngstown Club

CLINICAL PATHOLOGICAL PROGRAM

Presented at our 17th Postgraduate Assembly by Dr. Joseph F. Kuzma and Dr. Francis D. Murphy and Dr. Murphy's resident

The first case was presented by Dr. Murphy's resident. It was that of a twenty-five year old truck driver with weakness, weight loss, malaise fever and backache. Four weeks prior to his admission at the County Hospital he was admitted to a private hospital where he had a positive blood culture for an unknown organism. His past history was that he had had a congenital heart lesion. He had been operated on at Peter Bent Brigham Hospital in Boston for a patent ductus arteriosus which was not found. Physical examination disclosed a thrill at the level of the second and third interspace on the left. The heart was not enlarged, and there was no edema. The shite blood count was eleven thousand. The differential showed twenty-six per cent band forms. During the hospital course his temperature spiked; his blood cultures were positive for hemolytic streptococci. He was treated with penicillin and sulfa diazin and left the hospital, by his own request, after one month's treatment.

He returned three weeks later with a temperature that spiked each p. m. to 101 and 102. At this time the blood culture was positive for nonhemolytic streptococcus. This was a change in the character of the organism from the time of his first admission. One month after his second admission his spleen became palpable and he developed rales, albunimuria, edema, red blood cells in his urine and shortly a marked reduction in the urinary output; and then developed an ileus. Over his entire hospital course, including both admissions, this man received over twenty million units of penicillin.

Dr. Murphy pointed out that the

chief thing to learn from this case was that subacute bacterial endocarditis was brought under control with penicillin. The question was how long it could be kept under control. In some cases such all apparent control may be only a remission. One interesting thing in this case is the change in the nature of the streptococcus from hemolytic to non-hemolytic variety. However, this man went on and died of his heart disease.

Dr. Kuzma then presented the pathological report. At post this patient had a patent interventricular septum. Vegetation on the base of the pulmonic and mitral valves and along the edges of an interventricular septal defect. The interventricular septal defect is known as Rogers disease. In this case the murmur is heard best over the upper third interspace of the percardial murmur is loudest over the pulmonic area.

In 1944 penicillin was not considered to be of value in subacute bacterial endocarditis. In 1945 when they began to give two hundred thousand units per day it began to affect some cures or controls of this disease. At Marquette the doses have been two hundred thousand units of penicillin per day and treatment has been continued for one month after the fever has disappeared and the temperature is normal. Penicillin is administered intravenously and intramuscularly for the first few weeks; and then only intramuscularly.

The second case of the morning was presented by Dr. Mackey of the Youngstown Hospital Staff and the discussion was given by Dr. Fred Madison.

The patient was a sixty-seven year old female who was admitted to the hospital with profuse nasal hemorrhage. A few days previously she had noticed red blotches on the arm and leg and developed eccipital headache. Examination revealed a blood pressure of one hundred and ninety-four over one hundred. There were numerous petechia and purpuric spots below the knees and elbows. The review of the patient's diet revealed a birthday cake with colored frosting, having been ingested one week previously. In discussion Dr. Madison brought out the fact that the patient had a history of bruising easily; had noted hives at various times in her life and stated that she had an aspirin sensitivity. About the most important thing about the physical examination was the evidence of spontaneous hemorrhage. Significant findings in the laboratory work were moderately reduced plateley count. This was one hundred and two thousand. Coagulation time was two minutes and thirty seconds. Bleeding time was two minutes plus. The prothrombin time was normal and there was a moderate anemia. This was a story typical of hemorrhagic disease which is usually called purpura.

There has been great confusion and misunderstanding concerning purpura in late years. In his opinion it is not a complicated disease. Purpura is a vascular disease and not a hemolytic disease. It is a disease of blood vessels, characterized bv positive torniquet test, a long bleeding time and spontaneous hemorrhage. Bleeding time measures the contractilitv of the capiliaries and the ability of the clot to retract. Bleeding time is markedly increased in purpura and thrombocytopenia. The approach to diagnosis of purpura is to get the essential information at the outset. He listed seven things which were needed: (1) a complete blood count; (2) coagulation time; (3) bleeding time; (4) clot retraction time, which reflects the plateley level, (5) tourniquet test; (6) ascordic acid in the plasma, and (7) prothrombin time. Purpura and thrombocytopenia is, in his opinion, what this patient had.

With the above laboratory data the type of defect that the patient has

can be discovered. The positive tourniquet test indicates purpura. Increased coagulation time and increased clot retraction time plus some reduction of platets are also indicative of purpura. Etiology of purpura falls under one of the six following heads: allergy, toxins, either chemical or bacterial, malignancy, avitaminosis, endocrine disease and cachexia. Ninety eight percent of the cases of purpura fall in the first three classifications; in malignancy the process is not reversable. With a patient who has an aspirin sensitivity be very careful because such patients frequently have a wide range of sensitivity.

The third case of the morning was presented by Dr. Murphy and concerned the effect of sulfonamides on the kidney. At Marquette fourteen cases have died from the effect of sulfonamides on the kidney. Common complications are well known; some remote complications are not given much attention. Three different modes of attack on the kidney were shown in connection with sulfonamides. First, there was the chemical attack due to the sulfonamide concretions; next, there was definitely toxic damage of the distal and proximal convoluted tubules. In the kidney these drugs play a double role. Damage may appear to the kidney, but also certain diseases of the kidney may be cured.

The third method of damage is by means of allergic reaction. If there is any reaction or suggestion of this the drug should be stopped immediately. Dr. Murphy suggests alkalinization until the urine was between pH 4 and 5 to avoid crystal formation. In some of these patients the kidney damage would clear but months later the patient would show remote consequences.

Personal Communication

May 23, 1945

Horace Giffen, M. D.
Department of Laboratories
Youngstown Hospital Association
Youngstown, Ohio

Dear Horace:

I am trying to give you an answer to your request of the best media for resuspending red cells. I have asked Heinle about this and he feels that it is best to resuspend the red cells in normal saline within one to three hours after the cells have been separated from the plasma, either from fresh or banked blood. This means, of course, that the patient should be infused within two to three hours after the cells are separated.

Do not use corn-syrup as this is a good preservative except that it destroys the oxygen capacity of the cells and they circulate as inert "pickled erythrocytes." There will be fewer reactions if the cells are separated, resuspended and infused within a limit of two to three hours.

Very sincerely yours,

Walter H. Pritchard, M. D.

Since so many doctors have asked bout resuspension of red cells, we print the above letter.

For A Touchdown

Organized medicine has been on the defensive for too long. The American Medical Assn. should come forward immediately with its conception of a national health program. This program should include voluntary sickness insurance and diagnostic centers. It isn't enough to talk about the desirability of experimentation, to adopt platforms and principles. Our national organization must offer something tangible. Such a step will, to put it mildly, be welcomed by the rank and file of the medical profession, a great number of whom feel that it is long overdue.

Time is fast running out. We still have the ball. What are we going to do with it?—Medical Annals of the District of Columbia.

Clinico-Pathology Conferences

The noon conferences have been resumed each Friday in May at the Nurses' auditorium in the South Unit. Medical meetings are a nuisance to busy doctors. Yet they are a "must" to those who take their professional responsibilities seriously. Not only is medical information growing constantly but all of us forget many things we had known. In any community good quality of medical services depends on sharing with each other in studies, reviews and experiences.

The May 25th meeting began with a movie "short" on Rhinoscleroma. The disease is not common in this community yet with world travel bringing the ends of the earth near us, it may be seen by any of us. The film was made in Egypt where the disease is prevalent.

"Black market meat" seems to be contributing to clinical cases of trichinosis. A typical, proven case which was recently in the North Unit was used as an illustration. Review of the life cycle, incidence, clinical symptoms and pathologic findings followed. After the meeting two more acute cases turned up. The husband is in the South unit with diarrhea and fever. His wife shows the characteristic edematous face with marked muscle tenderness. Some of the remaining pork showed plenty of larvae. The pathologist called attention to the valuable blood test for trichinosis developed by Dr. Kline of Cleveland, yet in the interests of proving the diagnosis urges muscle biopsies on all cases.

The last parts of the conference were devoted to appendicitis. In spite of impressions given out by such writers as Paul de Kruif, we are still seeing too many deaths from appendicitis. The problems of diagnosis, especially in young and very old patients, were reviewed. Reference was made to the surgical and technical aspects of removal. Some aspects of the pathology were shown with a plea for greater gentility in handling the specimen, so that a truer picture of the basic changes can be gained microscopically. The last part of the discussion was on the prevalence of enterobius vermicularis or pin worms in the lumen of the appendix and occasionally in the mucosa. This is found more in females than males. This has not been satisfactorily proven as causing pathologic changes in many cases, yet eosinophiles are common in such mucosae.

The question was raised as to the possibility of trichina and enterobius contributing to the work of our allergists.

Via Crucis

Who follows Medicine, this truth must know:—
He will be called to bear the World-Heart's woe.
Is healing power to you by Nature willed?
Then yours the trust to keep her wish fulfilled.
For what price gain, where vision has been stilled.
When the Great Healer walked the earth rough-shod.
He chose, of all the arts that men applaud,
The touch that cures, to prove Him one with God.
Though treachery each day may dog your heel,
Your course is set ahead as knights who kneel,
And pledge their lives to test their tempered steel.
Who else could judge the recompense you'll feel?—
Transcendent joy each vict'ry will reveal,
And potency increased, all ills to heal.
But this I say:—this truth you first must know—
It is a rocky way that you must go.

—Agnes A. Foley.

June

OUR DOCTORS IN SERVICE

Regional Hospital, Camp Maxey, Texas
April 1, 1945

Just thought I'd drop you a line and let you know what a long time being a captain in Army and away from practicing means. Gus, I've never experienced it before and at my age it's totally unfair to us older doctors and dentists to be working along side of these new neophytes—just out of Medical school and Dental school. They have enough of them and will have more right along, so why hold us older doctors. I suppose I should consider myself fortunate in not having been sent overseas so far, do not know why, I've just done my job and kept plugging away at Army routine and red tape. I certainly appreciated your Xmas card, it means a lot to me.

At present I am at my third big camp in the 8th Service Command. Just transferred here from Camp Choffee, Arkansas, Feb. 23, 1945. My family is still at Fort Smith, Arkansas, where we lived at my last post, can't find a place down here yet in this small town of Paris, Texas. By way of news, Dr. McConnell has left Camp Bowie, Texas, for overseas again with an evacuation hospital. Dr. Buchanan is 95 miles from here at Ashburn General Hospital, McKinney, Texas, transferred from air forces around January 5, 1945, to Army Service Forces. That's all the news I know at present of interest to you.

Gee, for a family of four besides myself to live on Captain's pay these times is mighty hard—it seems elevation in rank is frozen for everyone in the higher brackets, second place it is all so unpredictable, unfair I call it, that I've given up hope—just waiting for the end, that's all.

Capt. Larry Weller

*

April 29, 1945

Dear Doctor:

Received your card today and am very pleased that you wrote to me.

I'm now in the Philippines. I've found this land to be the most interesting of any I've seen yet. The Philippine people are wonderful, although the peasant people are still rather primitive (nothing like the New Guinea Natives, however.) The urban Filippino seems to be almost typically American with the charm and graciousness of the Oriental added.

These people have suffered pitifully under the Japanese, and are still in dire straits, yet I've heard no word of complaint from any one of them. They seem to bear their hardships stoically and bravely, and are happy that the Americans have returned. The Japanese took everything away from them, and then what was left was levelled by the recent battles. All you have heard about Japanese atrocities toward the Filippinoes and toward American prisoners is true. My houseboy was an eye witness to the "Death March" of our soldiers from Corregidor and Bataan to Camp O'Donnell, where they were interned, and what he saw corresponds to the story of that war crime as you've heard it.

Best wishes,

Capt. F. L. Schellhase, M. C.

*

7 May 1945

It's been a long time since I have been home. I got the urge to drop a few lines and say that I appreciate getting the Bulletin. I have been at Ft. Meade for sometime, listening and ministering to artillery replacements in the regiments. The work is very interesting, at times, amusing and at times you feel lost. There is an ever changing population here and I listen to many tall tales from all over the country. If we eliminate most of the so-called psychiatric cases, the health of the American soldier is very good. He is a poor one to simulate disease. The soldiers are well fed here and they have more recreation such as shows and dances, than I have seen at other camps.

We live near Washington and see the historic sights once in a while. I am sorry I could not attend Postgraduate Day.

Major M. W. Neidus

*

March 20th, 1945

Hadn't received any Bulletin for several months, but this past week, three of them arrived. Now I feel as if I am caught up on the news again. At this particular base our station hospital is an active one, and has weekly discussions of interesting cases, which gives us some little cause to get professional for a change. Living in the jungles, without any evidence of civilization for 16 months is bad, in more ways than one. Well, it can't last forever, can it? Looks very encouraging lately.

Capt. B. M. Brandmiller

*

April, 1945

I have seen Paul Kling several times. At present am on 24 hour call. Have bought you a hat—bet I am the only one in the Army with nerve enough to buy his wife a hat. We are of course very busy.

Captain John Welter

May 12, 1945

My work is just the same as it always has been except that there are more men to see and treat. The work consists very much of O.P.D. style of the hospital, but I do not get to follow their treatment if I send them to the hospital. My work in the field is still first aid treatment of minor diseases that does not require hospitalization and the making of diagnosis on those I send to the hospital.

Today one of my friends gave me a bottle of coca-cola. It was my first in a long time. It sure would be good to be able to go to our Frigidaire and get a coke or a good cold glass of milk when I want it.

Most of the radio news seems to be about speculations as to movements of the forces from Europe to out here in the Pacific. I do hope and pray that soon the war will be over. There is, I am afraid, a long and rough road to victory.

Capt. G. E. DeCicco

From an Army Sergeant Who Was Interned in a Jap Prison Camp with Dr. Fred Bartz—(A Letter to Fred's Aunt)

I met Dr. Bartz when we were transferred to Davao in October, 1942. From then until June, 1944, we worked and lived together. I left him in Manila in July, 1944. When I returned in October, he had already been sent to Japan. I feel sure that he was sent before American planes became active in Philippine waters, therefore, he should now be safe in Japan.

As to his activities in Davao, it is unbelievable the untiring energy he possessed. On many occasions I have seen him sit up all night caring for a patient, then go on with his regular work the next day. His work there was entirely medical but he made his greatest contribution to camp welfare by his ability to bolster morale. I never saw him without a smile on his face and a cheery word for the sick. Through the darkest days, he never lost spirit or forgot the ideals for which the medical profession stands. He is my real hero of the War. A small obstacle like the Japanese can never swerve him from his aim in life—the helping of humanity.

I am sure you become discouraged at times but please have faith, I feel certain that he will come back to us and his experiences will make him an even greater doctor than he was in Davao.

What Every Woman Doesn't Know—How To Give Cod Liver Oil

What every woman doesn't know is that psychology is more important than flavoring in persuading children to take cod liver oil. Some mothers fail to realize, so great is their own distaste for cod liver oil, that most babies will not only take the oil if properly given, but will actually enjoy it. Proof of this is seen in orphanages and pediatric hospitals where cod liver oil is administered as a food in a matter of fact manner, with the result that refusals are rarely encountered.

The mother who wrinkles her nose and "makes a face" of disgust as she measures out cod liver oil is almost certain to set the pattern for similar behavior on the part of her baby.

Most babies can be taught to take the pure oil if, as Eliot points out, the mother looks on it with favor and no unpleasant associations are attached to it. If the mother herself takes some of the oil, the child is further encouraged.

The dose of cod liver oil may be followed by orange juice, but if administered at an early age, usually no vehicle is required. The oil should not be mixed with the milk or the cereal feeding unless allowance is made for the oil which clings to the bottle or the bowl.

SINCE LAST MONTH—

Dr. and Mrs. A. M. Rosenblum have returned home after spending the winter in Saratosa, Fla.

Dr. Armin Elsaesser has returned from Coral Gables, Fla., where he visited his son and daughter-in-law, Capt. and Mrs. Armin Elsaesser, Jr., and their young son, Armin Christopher.

Dr. and Mrs. E. J. Wenaas have returned from a vacation at the Homestead, Virginia Hot Springs.

Dr. and Mrs. A. J. Brandt spent a short vacation in New York.

Dr. and Mrs. W. K. Allsop have returned from a vacation in the Poconos. While in the East they visited their daughter, Maribeth, student at Edgewood Park, Briarcliff Manor, N. Y.

Dr. and Mrs. R. B. Poling spent 10 days with their daughter and son-in-law, Lt. and Mrs. Keith Watson, and little daughter, Diana Jane. Lt. Watson is stationed at Great Lakes.

Dr. E. H. Nagel and Dr. E. J. Reilly attended a meeting at Canton on May 6th, at which time the Stark County Medical Society was host to the Cleveland Neurological Society at the Mercy Hospital Auditorium.

Dr. V. L. Goodwin presented a paper on the diagnosis and treatment of several timely otolaryngylogical problems to the St. Elizabeth's staff at a recent meeting.

Major and Mrs. Edward Hardman were recently home on a short leave from Charlotte, N. C.

Captain L. S. Shensa, of Lawson General Hospital, Atlanta, Ga., spent a short furlough with his family in Youngstown.

Major P. R. McConnell was home recently on a short furlough. He has been transferred recently to Fitzsimmons General Hospital, Denver, Colo.

Promotions

Captain Samuel Tamarkin has recently been promoted to the rank of Major at MacDill Field, Florida.

Dr. Francis J. Gambrel, Battalion Surgeon of the 362nd Infantry medical detachment of the Fifth Army in Italy, has been promoted to captain. Capt. Gambrel interned at St. Elizabeth's Hospital, entering the Army in July, 1944.

Lt. Samuel Schwebel has been recently promoted to the rank of Lt. Commander at Pensacola, Fla.

Births

Dr. and Mrs. M. Yarmy announce the birth of a daughter, May 6th, N. S. Unit, Youngstown Hospital.

Dr. and Mrs. J. J. McDonough announce the birth of a girl at St. Elizabeth's Hospital on Thursday, May 10.


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