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Vol. XV No. 8
August 1945

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CONTENTS

PRESIDENT'S PAGE - - - - - - - - 232

SURGICAL TREATMENT OF HYPERTENSION - - 233

A RARE TYPE OF ANOMALOUS OPHTHALMIC ARTERY IN A NEGRO - - - - - - - 247

SPECIAL CLASSES IN THE YO. PUBLIC SCHOOLS - 249

NEWS - - - - - - - - - - 255

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Beil-Rempes Drugs, Inc. 227
Blair's 227
Central Square Garage 226
Ciba Pharmaceutical Prod., Inc. ....cover
Crookes Laboratories, Inc. 253
Cross Drug Stores 228
Endo Products, Inc. 127
Fair Oaks Villa 252
Isaly's 234
Lyon's Physician's Supply Co. 226-254
Lester's 256
Massengill, The S. E. Co. 231
McKelvey's 252
Mead Johnson Co. ....cover
Mercer Sanitarium 228
Renner's Brewing Co. 226
Scott Co. 230
Similac ....cover
Spencer 229
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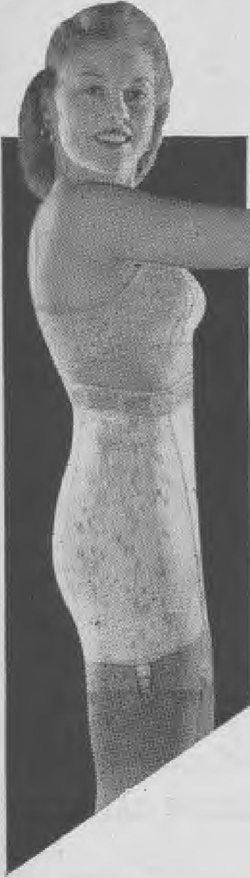

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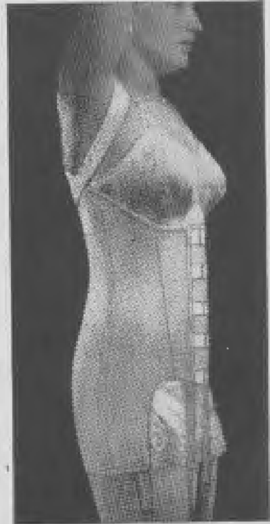

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PRESIDENT'S PAGE

It has become increasingly apparent that there is a lag between modern knowledge in the field of public health and its application to health conditions in Youngstown. This is a situation largely due to the fact that the position of health commissioner is a political appointment with a guaranteed tenure of office of not more than four years. No graduate of a school of public health or a physician especially trained in this field can afford to accept a position with such an uncertain future. Members of the Mahoning County Medical Society appointed as health commissioner are working under a distinct handicap. Regardless of how willing or well intentioned these men may be, they are not adequately trained and must spend months or years "catching up" before becoming efficient.

We are trying to arrange for a survey of our public health needs in Youngstown. When this is completed, we will be able to inform the public just what is lacking in health supervision, how much money will have to be spent to modernize the department of public health and what alterations in the charter will be necessary to permit such changes.

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

BULLETIN of the Mahoning County Medical Society

AUGUST 1945

THE SURGICAL TREATMENT OF HYPERTENSION

Some Circumstances Under Which Lumbodorsal Splanchnicectomy Appears to Be Inadvisable in Hypertensive Patients

By R. H. SMITHWICK, M. D., Boston

(*When considering hypertension from a surgical approach the following is an excellent paper for study. —Ed.*)

For the past eleven years, a clinical investigation of hypertension in man has been in progress at the Massachusetts General Hospital. Various departments—medical, pathologic, research, and surgical—have participated in this study.

A number of recent communications dealing with different aspects of this complicated problem have been written by White *et al.*,[1–4] Castleman *et al.*,[5–6] Talbot *et al.*[7] and Smithwick.[8–10]

Various operations were performed upon the sympathetic nervous system which were designed to interrupt the vasomotor supply to the arterioles of the abdominal (splanchnic) viscera. During the first five years, small groups of patients were operated upon by various technics, including multiple-stage operations in some cases. At the end of this time, it was felt that an operation could be performed which would result in physiologic evidence that this portion of the arteriolar bed has been thoroughly or completely sympathectomized. This evidence was the appearance of postural hypotension in the acutely denervated state. The technic for this procedure, which we have come to call lumbodorsal splanchnicectomy, was published in 1940.[11] It has been used continually for the past six years, since the latter part of 1938. In the first few years, it was employed in small groups of hypertensive patients, but more recently, during the past two years in particular, the series has been increased to over 500 cases.

The two stages of the operation are performed about ten days apart. The great splanchnic nerves are removed from the celiac ganglia to the midthoracic level and the sympathetic trunks are excised from at least the ninth dorsal to the first lumbar to at most the sixth dorsal to the third lumbar, inclusive. The operative mortality has been less than 3 per cent, which is low considering the severity of the hypertensive disease in many of the cases. A further discussion of surgical technic will be published in the near future.

In recent publications,[8–10] it was noted that a significant and persistent lowering of the diastolic pressure followed operations of the above order of magnitude in the majority of a series of 156 cases. This was associated with favorable changes in eyegrounds, electrocardiograms, and cardiac and renal functions as judged by ordinary tests, as well as in symptoms. The lowering of blood pressure was thought to be due to a decrease in the tone of arteriolar smooth muscle. It was noted that the effect of operation in certain cases did not appear to be very significant, and in some cases the blood pressure when studied one to five years afterwards was found to be higher.

The results were divided into five groups. In the first four, the diastolic pressure was lowered 30 mm. or more, 20-29 mm., 10-19 mm., and up to 9 mm., respectively.

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In the fifth group, the level was higher. It was also noted that, in general, women did better than men. Also, the results varied according to the type of hypertension. This refers to the width of the pulse pressure, which varies considerably in these patients. The cases were divided into three types: narrow, intermediate, and wide pulse pressure, and were called Types 1, 2, and 3, respectively. In general, it was found that the wider the pulse presser the higher the percentage of poorer results.

The purpose of this communication is to discuss the results of a slightly larger series of 179 living patients, followed one to five years, who had elevation of the diastolic level to 100-170 mm. before operation. In addition, the 36 known deaths which have occurred during the past six years will be reviewed. This makes a total of 215 cases.

It is advisable to perfect the selection of cases for surgical treatment as far as possible. The complexity of the hypertensive state in man, which appears to be the result of a number of different factors joining together in an infinite variety of combinations makes it necessary to divide cases into many groups, holding constant as many of the various factors as possible. This requires a large series of cases and the data available at this time permit only a preliminary and tentative discussion of this matter. By dividing the 215 cases into groups according to the two sexes, the three types, and five levels of preoperative diastolic pressure, a total of thirty groups, it is possible to suggest four rules, which, had they been available at the beginning of this investigation and followed closely, would have been extremely helpful in reducing the total mortality and the number of poorer (Group 5) results. These four suggestions have been given considerable thought, as it is realized that it is just as important to be able to state that a hypertensive patient cannot be helped as to indicate that he can be benefited by a particular form of treatment. As our experience increases, these suggestions will be modified, amplified, and corrected if found to be in error, with the ultimate goal in mind the ability to select only those patients who will derive worthwhile results from operation.

Furthermore, during the past year in particular, we have operated upon a number of patients in the earlier stages of the hypertensive state, some with resting diastolic levels of 90-99 mm., and even a few who had levels below 90 when studied in the horizontal position after several days of rest and hospitalization, but who when up and active ordinarily had well-elevated levels, often severe, with associated cardiovascular changes. The follow-up of such cases may conceivably disclose that operation may be even more helpful when performed in the earliest instead of later stages of the disorder.

The preoperative data upon which the diastolic level and type of hypertension is based has been obtained in these cases as part of a routine of study. The patients have hospitalized and the following studies carried out: fasting non-protein nitrogen, sugar, Hinton test, hematocrit, serum protein, cholesterol, hemoglobin, and smear. Description of eyegrounds with fully dilated pupils has been furnished by an opththalmologist, and a 7-foot heart plate, electrocardiogram, and clinical evaluation of cardiac status have been made by an experienced cardiologist or internist. Several urinalyses, urine concentration test

(twelve-hour), intravenous phenolsulfonephthalein test (fifteen-, thirty-, and sixty-minute and two-hour), and intravenous pyelogram have been done. Admission blood pressure was taken by a physician and a four-hourly blood pressure chart kept by nurses.

A postural and cold blood-pressure test is performed. This test is employed to study the reactivity of the vascular bed and to determine the approximate severity and type of hypertension of the particular individual. It is best performed after two or three days of hospitalization, most of which time should be spent in bed. To perform this test it is desirable that the environment be quiet and that the patient be lying on a comfortable bed or couch. A special room is recommended so that ward conditions of study can be avoided. The patient should rest for fifteen to twenty minutes. Readings of pulse and blood pressure are taken every minute for five minutes, first with the patient lying and then with the patient sitting and then with the patient standing. The patient then lies down again and pulse and blood pressure are again taken every minute, for five minutes, following which the hand opposite the side on which the blood pressure is taken is placed in ice water (4-5 C.) up to the wrist for exactly one minute, readings of pulse and blood pressure being taken when it has been in the water for thirty seconds and again when the hand is removed at exactly the end of a minute. Following this, readings of pulse and blood pressure are taken every minute for an additional five minutes. The patient then assumes the standing position again and the cold test is repeated in the upright position exactly as it was performed in the horizontal position, five readings of pulse and blood pressure preceding and following the one-minute period of stimulation by cold. It is advisable to use a mercury manometer. The systolic level is the first audible sound, which is generally heard just above the level at which the radial pulse can first be felt to come through. The diastolic level is taken as the fading point just above the disappearing point. There is no objection to recording both diastolic levels. The readings may be taken by a physician, but preferably by a trained technician, in order to avoid the pressor effect of the presence of a physician. Every attempt is made to study the hypertensive state at its basal level.

A sedative test is performed as follows: After a light

supper the patient is given 3 grains of sodium amytal p.o., at 7:00, 8:00, and 9:00 P. M. (a total of 9 grains) and an hourly blood-pressure and pulse chart is kept from 7:00 P.M. to 7:00 A.M., stating whether the patient is asleep, drowsy, or awake at each reading.

Following operation, many of these tests have been repeated, first at the end of one year, and at annual or biennial periods thereafter. It was originally intended that the patients be rehospitalized for postoperative study. However, the shortage of beds resulting from the war has made it necessary to study the cases in an ambulatory fashion. Consequently, the postural and cold blood-pressure test has been repeated fifteen to twenty minutes after entrance to the hospital. The post-operative blood-pressure data are therefore not strictly comparable to the preoperative. Other blood-pressure data are available, but none obtained in as near a standard and comparable fashion as this.

The preoperative diastolic level is the average of the five readings in the resting horizontal position. The systolic level is the average of the five comparable readings. The pulse pressure is the difference between the two. The types are determined as follows. In Type 1, the pulse pressure is less than one half the diastolic pressure. In Type 2, the pulse pressure is equal to or up to 19 mm. more than one half the diastolic level. In Type 3, the pulse pressure is 20 mm. or more greater than one half the diastolic level. The result of operation has been judged by the difference in the average of the five diastolic blood pressure readings in the first portion of the test, the lying level before and after operation.

In the rules to be suggested, some reference to eyeground changes is made. So far a very simple classification has been used which will be amplified later. Grade 0 eyes are normal and Grade 1 eyes have changes other than arteriovenous compression, hemorrhage, or exudate, or measurable elevation of the disks, or papilledema. Grade 2 eyes are those with arteriovenous compression but without hemorrhage, exudate, or papilledema. Patients with Grade 3 eyes have hemorrhages and/or exudate without papilledema. Grade 4 eyes have papilledema, generally with hemorrhage and/or exudate with any or all types of arterial change.

The 36 known deaths which have followed the surgical treatment of over 500 patients during the past six years have been divided into three groups — operative deaths, deaths within one year, and deaths over one year following operation. The number of cases in each group was approximately the same—13, 12, and 11, respectively. All but 4 were the result of complications of the disorder—cardiac, cerebral, or renal. All of the unrelated causes of death occurred in female patients, of which 2 were operative deaths due to pneumonia and bilateral pneumo-thorax, and 2 occurred within one year, because of meningitis and peritonitis. Of the 32 remaining deaths, 29 were in male patients and 3 in females, a striking sex predominance, particularly since female patients exceeded males in the series as a whole 56 per cent to 44 per cent.

Of the 179 living patients, the number of cases in each of the five groups of results as judged by the change in the diastolic pressure following operation was 75, 32, 35, 21, and 16, respectively.

These results as well as the 36 deaths have been critically reviewed when divided into the previously mentioned thirty groups according to the two sexes, three types, and five levels of preoperative diastolic pressure. With reference to the latter, the five levels contain cases with preop-

erative diastolic pressures of 100-109, 110-119, 120-129, 130-139, and 140 and over respectively. There are thus thirty possible combinations of type, sex, and diastolic blood pressure level. Examples of all of these exist except Type 3 men, 130-139, and type 3 men, 140 or over. The number of cases in each combination varies from 2 to 15. Such a division places the patients in roughly comparable groups for study. These, however, must eventually be further subdivided according to the many other variables such as age, the state of the brain, eyes, heart, and kidneys, as well as arteriolar disease as judged by biopsy material.

The cases in these thirty subdivisions have been studied with a view toward reducing the mortality and the Group 5 results in particular. It appears that most of the deaths and poorest results following lumbodorsal splanchnicectomy have occurred under certain circumstances. The most obvious of these are as follows and might be tentatively considered as contraindications to surgery:

1. In the presence of congestive heart failure and impaired kidney function as indicated by an elevated nonprotein nitrogen or a reduction in the intravenous phenolsulfonephthalein output to below 15 per cent in the first fifteen minutes.

2. In male patients with resting diastolic levels of 140 or more, operation does not appear to be advisable unless there have been no cerebral vascular accidents or episodes of encephalopathy, *and* there is no evidence of actual or impending cardiac failure, *and* the kidney function is normal or near normal as indicated by an intravenous phenolsulfonephthalein output of 20 per cent or more in the first fifteen minutes.

3. In women patients with resting diastolic levels of 140 or more, the same rule as for men should be observed with the exception that operation may be performed in the presence of impaired renal function providing the intravenous phenolsulfonephthalein output is 10 per cent or more in the first fifteen minutes.

4. For patients with lower diastolic levels the following tentative suggestions are made:

(a) Type 3 males with Grade 3 eyes, levels 100-109 and 110-119, have so far done poorly almost regardless of any other factor. The same applies to type 3 women with Grade 3 eyes, level 110-119, except those with a normal kidney function (phenolsulfonephthalein output of 25 per cent or more in the first fifteen minutes) and a good response to sedation (a diastolic fall to 90 or less).

(b) Men and women with levels 100-109 and 110-119, of any type, ages 48-57, with previous cerebral accidents *and* Grade 3 eyes *and* a poor response to sedation did poorly. Under the same conditions, those with lesser eyeground changes *and* congestive failure *or* poor kidney function (phenolsulfonephthalein output 10-15 per cent in fifteen minutes) also did poorly.

(c) Type 1 and 2 males, level 120-129, aged 38 or more, with Grade 3 and 4 eyeground changes, have not done well unless the kidney function was normal (phenolsulonephthalein output of 25 per cent or more in fifteen minutes). Similar cases without retinitis or papilledema but with a marked reduction in kidney function (phenosulfonephthalein output of 5-10 per cent in fifteen minutes) have not done well.

(d) Type 1 females, level 120-129, have so far done poorly when the diastolic level did not fall to 100 or less on sedation.

(e) Type 2 males, level 130-139, with Grade 4 eyes have done poorly when the kidney function was below 25 per cent in fifteen minutes.

TABLE 1.—MORTALITY FOLLOWING LUMBODORSAL SPLANCHNICECTOMY

No. Affected by	No. Deaths	Operative	Within 1 Yr.	1 Yr. or More
	36	13	12	11
Rule 1	7	3	4	0
Rule 2	9	3	3	3
Rule 3	3	2	1	0
Rule 4	13	5	3	5
No. after applying rules	4	0	1	3

(f) Of type 3 females, level 130-139—2 patients with Grade 3 eyes did poorly, one with normal kidney functions *and* a poor response to sedation (see (a)); and the other with a previous cerebral accident *and* a poor response to sedation (see (b)).

The effect of these four rules upon the mortality and the results in the living patients, when applied to the 215 cases under discussion, is shown in Tables 1 and 2, respectively.

It should be noted that a marked reduction in the deaths and in the Group 5 results has occurred at the expense, however, of one Group 1 result and two Group 4 results. In all three instances, these particular cases have been clinically worth while. It would seem, however, that this is not too great a price to pay for the marked reduction in total mortality and the poorer results. All of these rules should at this time be regarded as tentative suggestions to be amplified and modified as our experience increases. There still is considerable room for improvement so far as the accurate selection of patients for operation is concerned. These suggestions may, perhaps, be of some help to those who are concerned with the surgical approach to this complicated problem.

SUMMARY

Certain suggestions are made regarding the selection of hypertensive patients for surgical treatment. These are based upon a review of the data available concerning 215 patients who have been treated by lumbodorsal splanchnicectomy. These suggestions are directed primarily at reducing the mortality and the poorer results.

TABLE 2.—RESULTS FOLLOWING LUMBODORSAL SPLANCHNICECTOMY

No. Living Patients Followed 1-5 Yrs.	Effect Upon Blood Pressure GROUP 1	2	3	4	5
No. 179	75	32	35	21	16
Affected by rules 16	1	0	0	2	13
No. after applying rules 163	74	32	35	19	3

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A RARE TYPE OF ANOMALOUS OPHTHALMIC ARTERY IN A NEGRO

By J. C. HARVEY and L. M. HOWARD
Department of Anatomy, Johns Hopkins University, Baltimore, Maryland

According to the standard anatomical textbooks, the ophthalmic artery normally arises from the internal carotid immediately below the anterior clinoid process, passes through the optic foramen, and provides the main blood supply to the contents of the orbit. It is well known, however, that the orbit and its contents not infrequently can be supplied with blood by branches from the anterior division of the middle meningeal artery rather than by the internal carotid via its ophthalmic division. Yet in such instances one commonly finds some of the intraorbital branches (usually the central artery of the retina) arising, as normally, from the internal carotid artery. Instances where the blood supply of the orbital contents is derived wholly from a branch of the middle meningeal artery apparently are exceedingly rare. The present communication deals with such an example.

On the left side of the head of an adult male Negro we found the ophthalmic artery arising from the middle meningeal and not at all from the internal carotid artery (fig. 1). The course of the middle meningeal artery along the floor of the middle cranial fossa was normal. The anomalous ophthalmic artery arose from its anterior branch not far from the foramen spinosum. Curving medialward, it entered the orbit through the superior orbital fissure, passing along the course of the not infrequent anastomosis between the middle meningeal and lacrimal arteries. Within the orbital cavity the vessel assumed the path and distribution of a normal ophthalmic artery, excepting only the central artery of the retina. The latter arose from the very beginning of the lacrimal artery and passed deep to the optic nerve to enter its sheath on the inferomedial aspect.

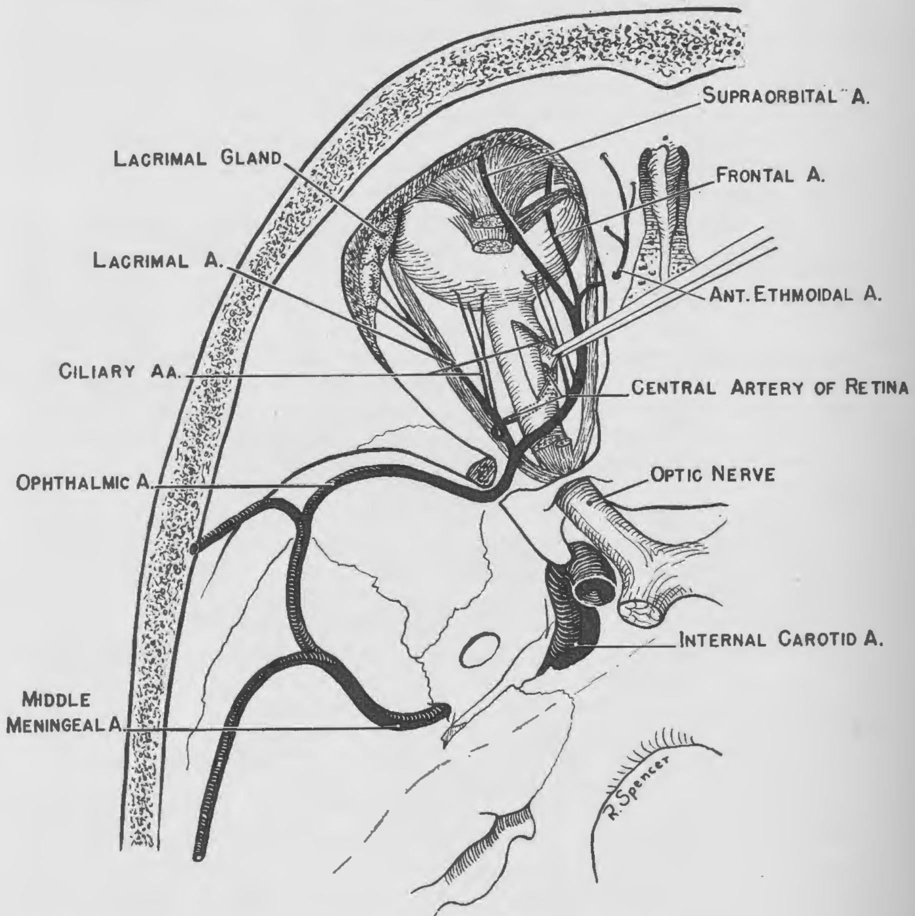
On the right side of the head there was found no evidence of any vessel arising from the internal carotid save its terminal branches, but as the middle meningeal artery was destroyed during dissection we were unable to confirm a duplication of the anomaly. There is reason to believe, however, that the condition was essentially similar to that found on the left side.

In a search of the literature, the writers have found only three instances of the occurrence of this particular anomaly. Dubrueil (1847) recorded two of these cases. In these the ophthalmic artery arose from the anterior branch of the middle meningeal artery and passed into the orbit via the supraorbital fissure. Its distribution in the orbit was normal. Adachi ('28) in a study of 142 heads, found one case in which the ophthalmic artery arose from the middle meningeal. He makes no reference to the origin of the central artery of the retina. This case, therefor, must necessarily remain as a doubtful example of the anomaly under discussion.

There are other investigators (as Blandin, Chanmugam, Curnow, Krause, Tiedemann) who have described variations of this anomalous ophthalmic artery; but in every instance some portion of the blood supply to the orbit, notably the central artery of the retina, arose from the internal carotid artery.

Meyer (1887) described and reviewed anomalies of the blood vessels supplying the orbit. In this work he used Krause's axiom that anomalies result from abnormal development of normal embryonic anastomoses. This led him to believe that if the root of

the ophthalmic artery degenerated it would be possible that all the blood could come from the middle meningeal artery through persistence of an embryonic anastomosis. Padget, in work as yet unpublished, finds that in the human embryo the ocular branches (ciliary and central artery of the retina) arise, after a complicated series of secondary anastomoses, from the internal carotid and that the orbital branches of the adult opthalmic artery arise from the primitive stapedial (a large component of which forms the middle meningeal artery). Her study further reveals that an anastomosis between these primitive orbital and ocular branches later takes place. This then explains the not infrequent finding of large branches of the ophthalmic artery arising from the middle meningeal artery. Normally the primitive arterial connection between the middle meningeal and the definite ophthalmic artery is lost. In the case herein described one would assume that there was disappearance of the most proximal portion of the ocular branch (stem of the definitive ophthalmic artery) of the internal carotid with persistence and further development of the primitive arterial connection between the middle meningeal artery and the definitive opththalmic artery.



We are greatly indebted to Dr.

W. L. Straus, Jr., for aid and criticism given us in the preparation of this paper, to Mrs. D. H. Padget for help and for permission to refer to her unpublished study of the development of the cranial arteries, and to Miss Rowena Spencer for the accompanying illustration.

SUMMARY

A case is reported wherein the ophthalmic artery arises wholly from the anterior branch of the middle meningeal artery. This anomaly appears to be exceedingly rare. A possible embryological explanation is offered.

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Special Classes in the Youngstown Public Schools

Some of the most difficult educational problems in the public school work have to do with children who vary greatly from the usual child or who have some serious handicap. Many such children are unable to secure proper education or to make the proper growth unless the schools make special provision for them. For example, a child who has a high degree of hearing loss will be at a distinct disadvantage as long as he is treated just the same as other children. He may be judged as being slow or stubborn when his difficulty is merely that he cannot hear.

Included in these groups of distinctly atypical children are the hard of hearing, the deaf, the partially sighted, the blind, the crippled, the speech defective, the mentally retarded, and the highly nervous. Special segregated classes with trained teachers giving full time to small groups are now provided in Youngstown for the hard of hearing, the deaf, the partially sighted, the blind, the crippled, and the mentally retarded. The class for the blind is at Chaney. The classes for the hard of hearing, the deaf, and the crippled are at Bennett. The class for the spastic crippled is in a building adjoining the South Side Hospital. Classes for the partially sighted, commonly called the sight-saving classes, are at Princeton and Monroe. Classes for the mentally retarded are in Madison, Cleveland, Lincoln, Bennett, Covington, East, Hillman, Tod, and Washington.

Because this work must be done in small classes, it is much more expensive per pupil than is regular instruction. The local school system receives financial assistance from the state in partial support of the sight-saving classes, the classes for the blind, the crippled, and the hard of hearing. Legislation has passed the Senate this session providing state assistance to the local school system for work with the mentally retarded, those with speech difficulties, and other difficulties.

There are classes at Hayes Jr. High School in speech correction. A speech correction person will be employed for full time city-wide work

beginning September, 1945, but much of her work during the first year or two must be in the field of in-service training of teachers. Extensive speech correction classes are not planned for the immediate future.

To be admitted to the classes for physically handicapped, candidates must be examined by the school physician and by the school psychologist. To be entered a candidate needs to secure an intelligence quotient above 70. Candidates for the retarded classes must have individual psychological examinations. The classes for the mentally retarded in general do their best work with children whose intelligence quotients are between 50-70. Roughly this includes those who will have adult mental ages from 7 to 10 years. Children whose I. Q.'s are below 50 and whose adult mental ages will be below 6 years do not belong in the classes for mentally retarded. These children usually need institutional care.

The usual procedure in having a child placed in one of these special classes for the physically handicapped is for the request to come to the principal from the teacher, the nurse, the parents, or the physician. Admission to the classes for the mentally retarded will be arranged by the principal, who will request an individual psychological examination if one has not already been given.

One distressing group for which inadequate provision is now made is the emotionally disturbed or highly nervous children. It seems that some extremely sensitive or high strung children simply cannot adjust themselves to the required routines of school procedure. Frequently they are highly intelligent. Many more things need to be done for these and other handicapped children. However, a great amount of excellent work by well-equipped persons is being done in Youngstown. Much special equipment has been secured; constant effort is made by nurses, teachers, and principals to locate children needing special types of service. Many physicians are very helpful in referring children who need to be in these special classes.

Several elementary schools have had remedial classes especially for children of average ability who have not learned to read as well as capacities allow. By individual and small group instruction, many children can be helped. This work, as well as the work with the mentally retarded, cannot be safely or adequately performed without competent individual child study.

Dwight L. Arnold

September Meeting

Speaker:

ROGER E. HERRING, M.D., M.P.H.

Department of Health, State of Ohio,
Columbus, Ohio

Subject:

"MEDICINE IN PUBLIC HEALTH"

Tuesday, September 18th, 1945

YOUNGSTOWN CLUB

OUR DOCTORS IN SERVICE

29 June 1945

"It occurred to me today that the Mahoning County Medical Society published a journal which I have not seen a copy of for some time. I wish you would put my name on the mailing list, I often wonder about the medicine in the Mahoning Valley and about the men I used to work with. I regretted not being able to meet my former instructors from Marquette when they visited Youngstown.

At this time I am at sea underway to a rear area after having been at sea for six months straight. In these six months I have been to the Marshalls, the Marianas, the Philippines, among the Volcano Islands and lastly around the Rynkyn Rhetto where our unit took part in the invasion of Okinawa Easter morning, April 1st. During this time many things have happened here and at home. My son is nearly three months old and I can only speculate about when I will see him for the first time, I am becoming terribly anxious to meet Tommy.

The invasion of Okinawa again proved the efficacy of one close in fine support units which are made up of rocket ships and mortar ships. The H-Hour scene on D-Day was a spectacular one. All hell broke loose as we escorted the soldiers and marines into the beaches. We had to shout into each others ears to be heard above the din created by gunfire of all dimensions. During the assault on the beaches I was bouncing all over the ship with two cameras slung around my neck and taking pictures at a furious pace. I wanted to have many pictures taken just in case I had to stop and care for any casualty that occurred.

The plans called for the other units on both sides of us to retire leaving our unit alone to carry on the bombardment of an air field. It is a wonderful feeling of apprehension to be alone with both flanks exposed but when I recalled that the large fleet units were covering us from behind I felt a bit better. It was wonderful to see our troops get ashore with very little difficulty.

It was quite a contrast to the scenes of Iwo Jima where I had seen boat loads of marines hit before they got to the beaches. A few minutes before H-Hour a Jap plane suddenly shot out from the clouds. The terrific anti-aircraft barrage brought him down immediately."

Lt. A. A. Detesco

U. S. S. Gosper
July 29, 1945
At Sea

I have received with a great deal of pleasure my copies of the Bulletin in almost all corners of the world, and it is a link with home that I look forward to with keen anticipation; I am truly grateful. Its newsy contents keep us posted on the "doings" at home and also the fellows in the service. Despite the fact that I have neglected to keep you informed of my proper address, it finds me eventually and is always most welcome. For my neglect I beg your forgiveness. It also tells us that you men at home are doing a noble job under tough conditions, and we in the service are proud to say we come from Youngstown. One thing we in the service have found time and again is that the medical profession of Youngstown need not take a back seat for any of them. The people of Mahoning County are indeed fortunate to be the recipients of so high a standard of medical practice.

At the present I am permanently attached to Fleet Hospital One Eleven, but haven't been in "my office" much lately. I was ordered to it two years ago when we formed it back in the "old country," and came out to the Pacific. It has a capacity of 5000 beds and we have been filled many times. However, being attached to a Fleet Hospital does not assure one that he will stay there all the time, as I can well testify. This is my third "clambake" with invasion forces in the past year—Saipan, tail end of the Guam affair, and now we are returning from Okinawa, where we attended the full performance. I thought I had a pretty rough time of it a year ago on the beach at Saipan, but "Suicide Joe" at Okinawa grabs off all the orchids. He is a most terrifying fellow and it is difficult for us who believe in Life, Liberty, and the Pursuit of Happiness to fathom his fanatical mind. He respects no rules and certainly contributes nothing to the above beliefs. When he hits, the casualties are appalling, and there is no end of work. Only in the work were we able to keep out of our minds what was happening all around us day after day. Afraid is not the word for it—many times we were paralyzed with fear. We learned to pray in all denominations and languages. In a mix-up during one of the many raids one of our "hard-shelled Southern Baptist" doctors ended up with my rosary beads, and now he refuses to give them up, claims they saved his skin and that he intends to keep them. I guess religion is religion in times like that. Going to take it easy on the praying

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*

Aboard the U.S.S. Gage, June 28, 1945

"Here we are in another stopping place and no mail, no nothing. It has been seven weeks since I had any mail and there is nothing anyone can do about it.

This place was formerly a big active base and now many of the areas are deserted and others inhabited but dilapidated. It extends for many miles up and down the coast, a dirty scar on a beautiful landscape; testimony of the ugly effects of American industrialization, and the hurry of war.

These islands have almost no coastal plain, many of them being the tops of mountains sticking up out of the sea. Not being able to build far back from the sea they get space by extending the bases up and down the narrow beachhead. This one is about thirteen miles long and was formerly a Jap base. There is still fighting going on up in the hills, but it is no longer our objective and we are leaving it to some of our Allies.

This afternoon I went ashore to visit the hospital and see if there were any doctors I know. Ran into a Cleveland outfit, the Lakeside Hospital Unit. Met Col. Glover, Donald M. Glover who was editor of the Cleveland Bulletin when I was editing our Bulletin. Also Col. Toomey a dental officer and brother of John Toomey the Cleveland pediatrician. I invited them aboard the Gage tomorrow for dinner, and more about them later."

At Sea July 1, 1945.

"We are on our way again. Never stay any place very long. Enjoyed getting ashore the last stop, and met some interesting doctors. Col. Glover and Major Weir were on board for dinner and seemed impressed with our medical set-up and way of living. Their hospital is rather run down and very tattered looking. The buildings looked old, rusty and weather beaten. It is very damp down here and rains much of the time. They are scraping the bottom of the barrel on food, but they seem to be in the best of spirits. Everyone is yellow from atabrine. I am taking it too but don't look yellow yet."

Lt. Comm. J. L. Fisher

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SINCE LAST MONTH—

The following doctors have recently returned from Active Military Service and are located as follows:

C. W. Sears, M. D.
Medical Arts Bldg., 3031 Market St.

P. R. McConnell, M. D.
19 Lincoln Avenue

Major Walter J. Tims is home on leave after having spent 23 months abroad.

Major Tims, with the 10th Air Depot Group was the first air service group to arrive in England and the first group to reach Normandy after D-Day. He was assigned over-seas in August, 1942, and spent 36 months in England, France, Belgium, Holland, Luxembourg and Germany. He has four battle stars and a group citation.

Dr. Tims says: 'For two weeks heavy trucks and tractors rumbled through the main gate of the newly-won Villa Coubla airfield near Paris, headquarters of the 10th Air Depot Group. Then a German captain, prisoner of the French Forces of the Interior was loaned to the Americans to finish the job of neutralizing the hidden mines which covered the field. Bomb disposal squads had worked for two weeks to make the area safe, but the work was not finished. The German captain revealed that a half-ton of dynamite had been placed under the main gate. The area was blocked off until the German ordnance officer could make sure it would not blow up. He removed the fuse without difficulty because the field had been mined under his direction. He spent the next two weeks removing more explosives from the airfield."

A pleasant surprise awaiting Major Tims when he arrived at the station in Indianapolis, was his wife, Ellen, and their 32-month-old son, Walter Jay. He had never seen his son.

Major Tims will report to Camp Atterbury, Indiana, and then to Macon, Georgia.

ANNOUNCEMENT

Of much importance to both Dental and Medical professions is the appointment of Mary B. Herald as Bureau Manager. "Mary," as known to most of us, has served our Society as Business Manager, Assistant Secretary and is now our Executive Secretary, a position she will continue to hold. Everyone of us, appreciating her efforts and wishing her success in her new undertaking, pledge our loyal support.

Captain Richard Goldcamp, Regimental Surgeon, returned to the States June 28, 1945, from Germany, having served twelve months overseas. After a thirty-one day leave he reported August 1, to Camp Shelby, Mississippi, for redeployment.

Dr. E. C. Baker is a patient in the South Side Hospital. He has been ill several weeks with pneumonia.

Dr. John Thomas and family spent their vacations with relatives in Youngstown. Dr. Thomas is taking a three year post-graduate course at the Boston Eye and Ear Infirmary.

Capt. G. E. DeCicco is spending a forty-five day leave with his family at the end of which he will return to the Philippines. Capt. DeCicco has served twenty-nine months overseas.

Dr. and Mrs. Armin Elsaesser celebrated their 34th wedding anniversary recently.

Dr. and Mrs. F. W. McNamara have returned from a vacation at Timagami, Canada.

Dr. and Mrs. Dean Nesbit visited Dr. and Mrs. O. J. Walker at their summer home, Conneaut Lake, Pa., recently.

Dr. and Mrs. J. D. Brown and their daughters, Joan and Betty have returned from a two week stay at Lake Chautauqua, N. Y.

Dr. H. E. McClenahan went a hunting? It is reported that while in Ontario, he SHOT a Bear, Not captured him just SHOT him.

Mrs. W. O. Mermis and son, Walter, Jr., have returned from a three-week holiday in the East. They visited in New York City, Jones' Beach, Lakewood, N. J., and Bennington, Vt.

Dr. and Mrs. James B. Birch are visiting Judge and Mrs. Robert Nevin at their cottage at Conneaut on Lake Erie.

Dr. R. E. Odom spent a 30 day leave with his family returning to Atlantic City, N. J., July 16th, where he will be stationed for two weeks. Mrs. Odom accompanied him to Atlantic City.

Maj. Samuel D. Goldberg, 285 Benita Ave., was chief of anesthesia at the 135th General Hospital in Leominster, England. After treating 7,786 wounded soldiers, that United States Army general hospital has completed its mission in the United Kingdom, a release from overseas says.

The Youngstown major joined the hospital May 5, 1944, and arrived at Gourock, Scotland, in July, 1944. On July 13, the first battle casualty, a soldier wounded on the Normandy beaches, arrived for care and treatment. The last patient left the hospital for the United States July 6.

Major Brack Bowman, recently returned from England, has concluded a thirty day leave and expects soon to be redeployed to the Pacific Area. While on leave Major Bowman gave freely of his time to act as consultant on some of our urological problems. We deeply appreciate the "lift" he gave us.

Dr. Samuel Klatman, formerly Captain, has opened offices at 409 City Bank Bldg., and is practicing General Surgery.

May 15, 1942, to July 31, 1945, Aleutians; May 20, 1942, to June, 1943, Hawaii; Dec., 1943, to February, 1944, South Pacific; April, 1944, to June, 1944, served in the Aleutian Campaign; Bronze Star for enemy action at sea in Aleutian, Asiatic, Pacific and American Theatres, ribbons with two battle stars.

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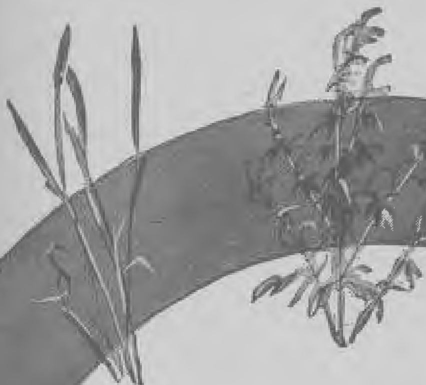

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