The worst dangers to the human race are not atomic bombs, but slavery, parasitism, and chicks that cheep but do not scratch.

—Anton J. Carlson

BULLETIN

of the MAHONING COUNTY MEDICAL SOCIETY

Vol. XVI No. 6
JUNE . . 1946

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.*

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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CONTENTS

President's Page . . . 186
Individualized Medication . . . 187
Management of Edema . . . 189
Study and Cause of Prevention of Deafness . . . 191
From the Nurses' Viewpoint . . . 197
News — Service Record . . . 199
Auxiliary . . . 201
Still Fighting . . . 201
Our American Way of Life . . . 202
Pathological Conference . . . 203
Civilian Rehabilitation Centers . . . 204
Conference on Poliomyelitis . . . 205

ADVERTISER'S LIST

PATRONIZE THEM — THEY MAKE THE BULLETIN POSSIBLE

Beil-Rempes . . . 181
Blair's . . . 181
Buffington's . . . 181
Cassaday Drugs . . . 192
Central Square Garage . . . 182
Ciba Pharmaceutical Products, Inc. . . 190
Cross Drug Stores . . . 183
Fair Oaks Villa . . . 194
Isaly's . . . 185
James & Weaver . . . 181
Laeri Apothocaries . . . 184
Lyons Physicians Supply Co. . . 196 - 198
Lester's . . . 192
McKelvey's . . . 198
Massengill . . . 200
Mead Johnson Company . . . 208
Mercer Sanitarium . . . 183
Overlook Sanitarium . . . 205
Pitman-Moore Company . . . 182
Professional Pharmacy . . . 184
Renner Brewing Company . . . 182
Scott Company . . . 180
Similac . . . 178
Spencer . . . 188
Lloyd Stillson & Associates . . . 194
Strouss-Hirshberg's . . . 192
Thornton's . . . 196
H. H. Treudley & Co. . . . 184
White's Drug Stores . . . 180
Zemmer Company . . . 196

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*Minimum daily requirement (F.D.A.)
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ISALY'S

Dairy Specialists

PRESIDENT'S PAGE

•

Mahoning County Medical Society was well represented at the Ohio State Medical Association meeting on May 7th, 8th and 9th, as twenty-two of our members were in attendance. Dr. Rogers kept up the reputation of our society's golf players by walking away with the first prize.

At the Centenary of the Canfield Fair, to be held this year from August 24th to September 2nd inclusive, the Society, represented by a committee headed by Dr. S. G. Patton will offer a display that will do justice to the medical profession. An exhibit of old instruments as well as new ones will be an interesting attraction. These exhibits will be under the protection of our own members, and I urge all who possibly can serve to get in touch with Dr. Patton for assignment, thus enabling him to formulate his plans and help make this a huge success.

Don't fail to attend the June meeting as proposed changes in the Constitution are to be read after the scientific meeting.

EDWARD J. REILLY, M. D., *President*

INDIVIDUALIZED MEDICATION

Good afternoon, Doctor. May I take a few minutes of your time? I am a detail man. I represent no particular manufacturer nor do I wish to describe some particular product. I am speaking for the Pharmacists of the Mahoning Valley Pharmaceutical Association. We pharmacists have been trained to make properly solutions, mixtures, capsules, powders, ointments, and to compound prescriptions as per your order.

In a survey of twenty drug stores in this city only 28% of two thousand prescriptions filled were required to be compounded. In other surveys across the nation similar ratios have been reported where physician-pharmacist co-operation was not practiced. In localities where this co-operation has been practiced, the percentage has been decidedly higher. Modern medicine now suffers from a tablet and proprietary epidemic. Many physicians and pharmacists are to be blamed for this undesirable condition. Even the psychic potency of the prescription written and compounded for an individual is greater as the patient has more faith in a remedy prescribed and prepared especially for him than one machine-made by the millions.

Let's take specific examples whereby you, as an individual physician, can help immeasurably to make some pharmacist a compounding pharmacist and give the patient individual medicine. Assume that your very next patient is one that you deem advisable to prescribe an astringent douche powder. In that case you write for "Pulvis Zinci Sulfatis Compositum N. F." Your next patient needs a mouth wash; you write for "Sodii Perboras Aromaticus N. F." Yes, both prescriptions require compounding. Your next patient apparently, after examination, needs ephedrine. You have used this drug in as many forms as there are pharmaceutical firms. You desire to be different; then write for "Syrupus Ephedrine Sulfatis N. F." Finally, you wish to write for a patient a cough mixture, using your favorite proprietary. In that case you can fortify with additional Codeine or add several drams of Potassium Citrate or Ammonium Chloride.

We as pharmacists can often judge the professional ability of the physician and his interest in the welfare of the patient from the type of prescription and the manner in which it is written. In satire, it might also be mentioned that the pharmacist is able to tell what detail men have been visiting the physicians' offices in their localities.

Let's take a quick glance into the vitamin therapy. You no doubt write many prescriptions for B-Complex using some proprietary, but did you ever realize that you can adjust your own potency by writing a prescription to be compounded with the desirable quantities of thiamin chloride, riboflavin, calcium pantothenate or yeast extract as you so desire. Yes, in capsules of color, too. Assuming that you prefer liquid medication, then write for your favorite Elixir or Syrup of B-Complex but add another ingredient; fortify with thiamin chloride or riboflavin or even add ascorbic acid.

We, as graduate pharmacists, invite you to make use of our knowledge in incompatibilities and idiosyncrasies of drugs and chemicals. May I suggest that you stop in to see your favorite pharmacist and discuss with him various ways whereby you can write prescriptions that will give your patient individualized medication. I dare say that he won't be able to give you the desired in-

Have you patients with any of these conditions ?

Nephrotosis or Visceroptosis with Symptoms—Low-Back Pain—Spinal Fractures, Deformities or Disease—Inoperable Hernia—Prenatal, Post-partum, Postoperative Conditions—Breast Disorders or Breast Removal—Certain Cardiac Syndromes?

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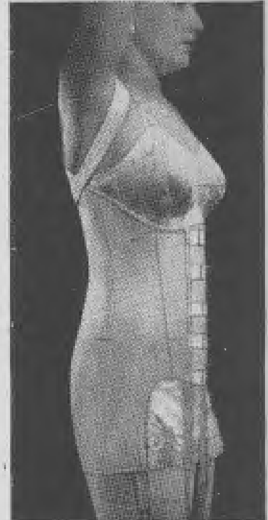

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formation immediately, but give him time to work out suitable bases and vehicles for your specific medications.

Thank you very much for the privilege of visiting with you, and I hope that I can be invited again to discuss various other means of tailor-made medications. Your comments and criticisms will be most welcome.

GEORGE W. BROWN,
Past President Mahoning Valley Pharmaceutical Association.

Management of Edema

RICHARD HUGH LYONS, M. D.*

A. General measures.
- I. Decrease hydrostatic pressure.
  1. Bed rest.
  2. Elevation of extremity.
  3. Increase tissue tone.
- II. Decrease intake of sodium chloride.
- III. No need to decrease water intake if sodium is sufficiently low.

B. Specific measures.
- I. To increase colloid osmotic pressure.
  1. Hypertonic glucose.
  2. Hypertonic sucrose.
  3. Acacia and other foreign solutions.
  4. Human serum. (Protein deficit in tissues.)
- II. To increase glomerular filtration.
  1. Digitalis. (In heart failure only.)
  2. Xanthines.
- III. To decrease tubular resorption.
  - (a) Acid producing salts.
    1. Ammonium chloride, 9 gms. T I D for 3 days.
    2. Ammonium nitrate.
    3. Calcium chloride.
  - (b) Potassium salts, 5-15 gms. T I D.
  - (c) Urea, 40-120 gms.
  - (d) Mercurial diuretics.
    - Intravenous.
    - Suppositories.
    - Oral.

Primary Factors Favoring the Production of Edema

Increased Filtration Pressure, greater than normal, 22-25 mm. Hg.

Arterial: 1. Local (a) nerve injury, (b) tissue injury, (c) local heat. 2. General (a) hyperthyroidism, (b) hot weather.

Venous: 1. Local obstruction. 2 General — back pressure from heart.

Decreased Osmotic Pressure, Low Serum, Protein Concentration Less than Normal, 22 mm. Hg.

Excessive protein loss: 1. Bleeding, 2. Capillary damage. 3. Nephritis.

Inadequate replacement: 1. Impaired manufacture (a) liver disease. 2. Inadequate protein intake (a) starvation edema.

Capillary Damage, Loss of Protein through Capillary Wall.
1. Trauma.
2. Burns.
3. Allergic.
4. Nephritis.
   Anemia.
5. Anoxia.
   Poor circulation.
6. Inflammation.

Obstruction to Lymph Flow.
1. High venous pressure.
2. Traumatic.
3. Inflammatory.

Low Tissue Pressure, Less than 1 mm. Hg.

* Outline of an address given before the Mahoning County Medical Society on March 19, 1946.

Take the burn out of SUNBURN

Recommend and prescribe Ciba's sooth-
ing unguent containing 1% Nupercai

NUPERCAINAL

Nupercainal gives the sunburned patien
relief from torturing pain...relief that
long-lasting.

Extremely effective in burns, Nuper-
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of hemorrhoids, dermal pain and itchin
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applicator and in jars of 1 pound.

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In Canada: **Ciba Company Ltd., Montre**

Developmental, weight loss, previous edema.

Secondary Factors.
High sodium intake.
Endocrine.
Immobility.
Diet deficiency—beri beri.

Low Salt Diet

The low salt diet is essentially a normal diet with the exception of salt. None is used in preparing any of the foods. It contains approximately 3 grams sodium chloride. If more than 70 grams of protein is desired it will increase the sodium chloride content accordingly.

Include each day foods selected from the basic requirements:

1. One serving of meat, unsalted cottage cheese, fresh water fish, fowl, or eggs.
2. One pint of milk.
3. Two servings of fruit, one to be citrus.
4. Two or three servings of vegetables, one should be green leafy or yellow.
   Exclude—all commercially canned vegetables, relishes, and salad dressings, unless prepared without salt.
5. Two or three servings of whole grain cereal or enriched bread, prepared without salt.

   Exclude—prepared cereals except shredded wheat, puffed wheat, and puffed rice.
6. Two tablespoons unsalted butter. No salt shaker is to be used.

Sodium Restricted to .290 GMS.

CONSTANT DIET

Food	*Wt. Gms.*	*Sodium Gms.*
1 egg		0.065
Bread, salt free	60	0.020
Beef	150	0.078
Potato	100	0.002
Carrots	50	0.008
Orange	100	0.006
Jelly	45	0.005
Butter, salt free	40	0.000
Peanuts	50	0.005
Grapefruit juice	200	0.001
Milk	200	0.100
Salad Dressing Corn oil 5% acetic acid as desired Paprika		0.000
		0.290

STUDY AND CAUSE OF PREVENTION OF DEAFNESS

(As outlined by DR. L. M. POLVOGT, Johns Hopkins University)

In 1924 at the Johns Hopkins University investigative work of the study and cause of prevention of deafness was started. The plan of the investigation was based on the correlation of impaired hearing as determined by clinical tests with the location and nature of the casual lesion. During this period we have made, in the sound-proof room of the Johns Hopkins Hospital, audiometer and tuning fork tests on more than 25,000 hospital patients. These tests were made primarily for research purposes and were not limited to those complaining of any ear trouble.

From these studies, there are seven points I wish to stress:

1. "Impaired hearing for high tones with good hearing for low tones" is the

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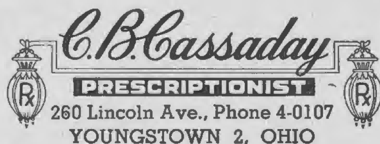

SURGICAL DRESSINGS SICK ROOM SUPPLIES

earliest symptom of middle ear as well as inner ear deafness in children. We have abundant proof to support this statement.

2. Adenoids always recur to a greater or less extent in children. This is not due to an incomplete operation, but to the fact that lymphoid tissue is an integral part of the mucous membrane in the nasopharynx and pharynx.

3. Recurring adenoids usually cause a condition in the nasopharynx similar to the "granular pharyngitis" so often seen in the oropharynx after removal of the tonsils and adenoids in children.

4. Every type of deafness seen in adults is also found in children. In most types the earliest symptom is a loss for high tones, and for their early recognition the tones above 8,000 d. v. must be tested.
   The two common causes of deafness that can be prevented are: first, suppurations in the middle ear, which are usually secondary to infected lymphoid tissue, and second, long contained partial obstruction of the eustachian tubes by hypertrophic lymphoid tissue in the nasopharynx.

5. In order to have good hearing the eustachian tubes must function normally. Impaired function of the eustacian tubes in children is caused by an overgrowth of lymphoid tissue in the nasopharynx. In order to see this the nasopharynx must be examined with a nasopharyngoscope.

6. Early recognition of impaired hearing for high tones—and radiation of the nasopharynx to restore the patency of the eustachian tubes, is the only method for the prevention of a progressive deafness.
   It is a comparatively simple matter to radiate the nasopharynx with X-ray and do this to such an extent that shrinkage of adenoids can be accomplished. This necessitates the employment of a number of small portals, and utilizing the principle of cross-firing. With little children, it is difficult to maintain them in a position for the duration of the treatment, even when they are accurately placed; furthermore, it takes much longer and is more expensive. The greatest disadvantage, I should say, of X-ray, is the danger of injuring normal structures, particularly the growing bones of the face and head. X-ray treatments should not be carried out by anyone except an experienced X-ray technician or radiologist. In contrast, the radon nasal applicator permits easy and convenient carrying out of the treatment by the otolaryngologist, who has charge of the child, who is responsible for the study of the nasopharynx before and after treatment, and who also makes the hearing tests.

7. If we are to learn more about the causes, treatment and prevention of deafness we must concentrate our studies more and more on children. The only hope is early recognition and treatment, before irreparable damage to the mucous membrane of the middle ear and ossicular chain has occured. These changes begin in childhood. In the treatment of deafness, as in the treatment of cancer, the best results depend on early recognition, and in both the best results are the least spectacular.

V. L. G.

IS HOUSE-CONFINEMENT REQUIRED?

Be on guard against Accident and Health policies requiring house-confinement, including the provision for drastic reduction of indemnity and limitation of the period of coverage for the subsequent non-confining disability.

You will need just as much money for living expenses while convalescing as while you are one of the "shut-ins".

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Fair Oaks Villa Sanitarium is a member of the American Hospital Association and Central Neuropsychiatric Hospital Association

June Meeting

Speaker:
GEORGE T. PACK, M. D.

Subject:
"The Extension of Radical Surgery in the Treatment of Cancer"

Dr. Pack is attending surgeon in charge of two services at the Memorial Hospital for Cancer and Allied Diseases and also a Professor of Clinical Surgery at the New York Medical College.

YOUNGSTOWN CLUB

Tuesday, June 18th 8:30 P. M.

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100 YEARS *of* MEDICINE

The Mahoning County Medical Society
will have a display at the

CANFIELD CENTENNIAL
August 24th to September 2nd, 1946
Canfield, Ohio

For this display we need old instruments, medical books or any other articles that will help to make an interesting display. Our tent will be 30 x 60 feet, and all display articles will be fully protected from fire and theft.

If you have "display material" or know where we might be able to pick some up, call
DR. SKIPP — 42996.

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Glycerine

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An Isotonic Solution for the treatment of congested nasal passages.
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Oakland Station Pittsburgh (13), Pa.

FROM THE NURSES' VIEWPOINT

In military tactics a defensive position is not generally considered the most strategic. This, however, seems to be the position of the medical and nursing profession in relation to the current National Health Act—The Wagner-Murray-Dingell Bill—under consideration. Medical care as practiced under the urgency of war has given large numbers of persons a keener concept of complete health service and stimulated an understandable demand for a more comprehensive health plan. This has added impetus to the proposed legislation. Nevertheless it is disquieting to overhear so much favorable comment by people who seem to think a Federally sponsored and controlled health act would insure everyone adequate and satisfactory medical care at reduced or no cost to the individual. This popular though fallacious philosophy is practiced by too many people in relation to all phases of life today. However, that there is something lacking in efficiency in health care any observant, unprejudiced person must admit. What convincing argument can you offer to a distraught family that have vainly tried for fourteen hours (probably Thursday afternoon) to get a doctor for an acutely ill member? Or to the family desperately needing special nursing care when no such service can be made available while they know a chronic invalid luxuriates under the care of three specials?

Since neither the medical profession, nor the nursing profession, nor the hospital administrations alone can satisfy the public demand for sick care, is it naive to think that in coordinating resources, understanding peculiar problems of each other and the will, we should be able to better meet the increased demands for medical service on the local level without Federal controls? To this end District No. 3, O. S. N. A., has initiated a "Professional Relationship Committee" on which representatives from the allied professions have been invited to sit. We hope that together we can anticipate medical demands and make practical suggestions to improve and satisfy community health needs.

It would seem to us the most logical argument against a National Health Act would be to provide acceptable, available care on a local level and encourage personal responsibility through some plan, possibly through more comprehensive voluntary prepaid insurance. Human needs should and will be served and if the professions dedicated to the highest service of humanity do not voluntarily meet the needs then it is inevitable that state demands will be arbitrary.

Nurses, individually and collectively, either justly or unjustly, have called forth some vitriolic criticism in the recent past, so it is with pride we eulogize an ideal nurse, Miss Mary Drohan. For thirty years she has epitomized the pattern of nursing. In charge of O. B. service at St. Elizabeth's Hospital, through example and precept she has inspired and guided student nurses through all these years. Her relationship with the hospital and the medical profession has been exemplary and multiple mothers, fathers and babies remember her with love and admiration. The orchids presented on her anniversary and received in true humility were indeed appropriate and becoming. Congratulations Miss Drohan, may you be granted many more years contribution to the nursing profession.

E. W. V., District No. 3, O. S. N. A.

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NEWS

Dr. Sam Weaver, now in Santa Ana, Calif., hit the front pages during the railroad strike, caring for Richard Rice, 13-year-old Douglas, Arizona, lad, as he was rushed by army bomber to a California Hospital for an emergency operation after the strike-bound Southern Pacific stranded him in Tucson.

Dr. and Mrs. John S. Goldcamp are in Philadelphia where Dr. Goldcamp is taking a few weeks' postgraduate course at Wells Eye Hospital.

Dr. John Rogers attended the meeting of the Association of American Physicians at Atlantic City recently.

Dr. J. P. Harvey and Dr. Donald A. Gross have returned from Philadelphia where they attended a meeting of the college of Physicians.

Dr. and Mrs. R. Lupse have returned from a trip to Chicago, where they were guests at the Palmer House.

Dr. M. M. Kendall has returned home from New York where he was called by the death of his father, Dr. Henry Kendall.

Dr. and Mrs. O. W. Haulman have returned from a visit with Mrs. Haulman's parents, Dr. and Mrs. Edwin A. Murbach.

Lt. (j.g.) Dave H. Smeltzer, U. S. N. R., arrived home recently after three years in the service, 22 months of which he spent in the South Pacific. He is now on terminal leave. Lt. Smeltzer is a son of Dr. and Mrs. D. H. Smeltzer.

The following doctors attended the Ohio State Meeting held on the 7th, 8th and 9th of May. G. A. Parillo, E. J. Reilly, O. J. Walker, E. J. Wenaas, E. E. Kirkwood, W. J. Tims, W. M. Skipp, E. H. Nagel, J. N. McCann, F. F. Monroe, W. D. Collier, R. R. Morrall, G. G. Nelson, D. H. Levy, M. H. Steinberg, J. H. Fisher, P. H. Leimbach, H. S. Banninga, C. C. Wales, D. Nesbit, G. E. Decicco and Saul Tamarkin.

Dr. and Mrs. V. C. Hart, 1357 Fifth Avenue, announce the birth of a son, William Vernon, at North Side Unit.

Dr. and Mrs. A. M. Rosenblum have arrived home from Sarasota, Fla., where they have been spending the winter. Their son, Lt. Alex Rosenblum, Jr., who has been stationed at Percy Jones General Hospital, Battle Creek, Mich., spent a few days with his parents before going to Ft. Sam Houston, Texas, where he has been transferred.

Dr. and Mrs. Stanley A. Myers have moved into their new home at 146 N. Cadillac Drive, Boardman.

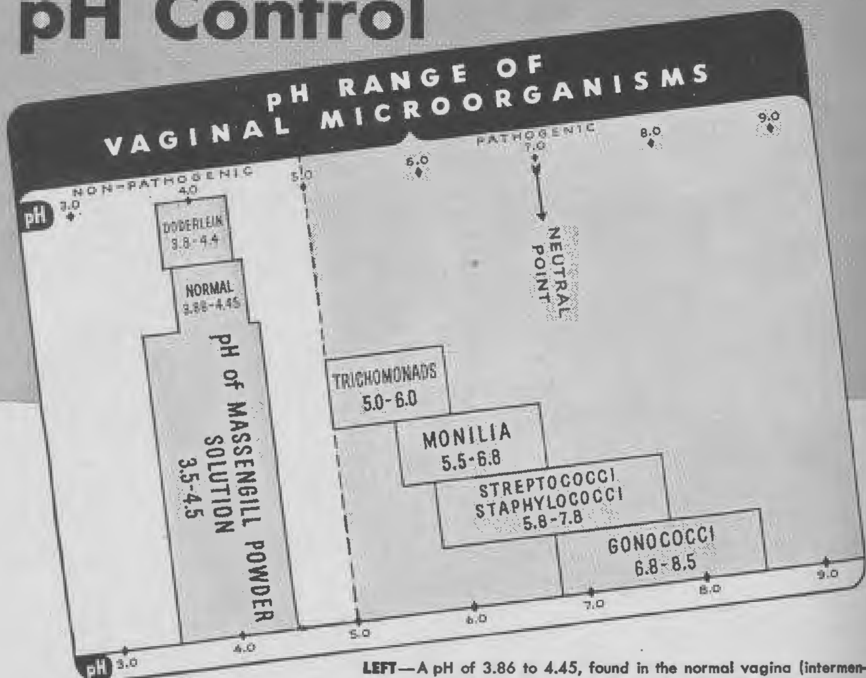
Dr. W. R. Hubler is taking a few weeks Postgraduate course in Dermatology at New York Postgraduate Hospital.

SERVICE RECORD

LT. COLONEL LOUIS K. REED

Dr. Reed entered the army in October, 1942, and was discharged March 20, 1946, to terminal leave. Dr. Reed's first assignment was at Miami Beach, OTS; then twenty-two months at Muroc, California, with the AAB as Chief of Medical Service. He served as Base Surgeon at Ephrator, Washington, and had assignments at Crile General Hospital, Cleveland, and Ashford, W. Virginia. Then with the 337th General Hospital he went to the Philippines. He spent from September, 1945, to March, 1946, at Osaka, Japan, as Chief of the General Medical Sections.

pH Control



LEFT—A pH of 3.86 to 4.45, found in the normal vagina (intermenstrual period), favors the growth of harmless Döderlein bacilli, normal inhabitants of the vaginal tract. Massengill Powder solution presents a pH of 3.5 to 4.5.

RIGHT—The pH range, 5.0 to 9.0, most favorable to the development of pathogenic organisms.

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WOMEN'S AUXILIARY OF THE MAHONING COUNTY MEDICAL SOCIETY

Mrs. L. George Coe, President
Mrs. W. K. Allsop, President-Elect **Mrs. John Rogers,** Secretary
Mrs. C. A. Gustafson, Vice President **Mrs. M. M. Kendall,** Treasurer

The Women's Auxiliary to the Mahoning County Medical Society held the last meeting of this season Tuesday afternoon, April 29th, at the residence of Mrs. Paul Fuzy.

Mrs. F. F. Piercy gave a delightful review of Anne Morrow Lindbergh's book, *The Steep Ascent,* which was followed by an informal tea and social hour.

The wives of internes at the local hospitals were special guests.

During the business meeting final plans were made for the Dinner Dance which will be held at Tippecanoe Country Club, Thursday, June 6th.

The first Fall meeting will be held at the Birch Hill Cabin in Mill Creek Park, when a picnic is being planned, September 23rd.

CHARLOTTE R. GOLDBLATT.

STILL FIGHTING!!

Anchorage, Alaska

I want to tell you how much I appreciate receiving the *Bulletin* of the Mahoning County Medical Society, which I read from cover to cover within twenty-four hours after its arrival. I believe that I have seen practically all issues since I have been here at the Ft. Richardson Hospital (over fourteen months), having received some directly from the society, others from Dr. Monroe, and until last November when Dr. Chalker left I had read his on occasions. "Chalk" was here from the time I arrived till this past Fall, and it was amusing the way we watched to see who would be the first to receive a new issue, and be able to pass it on to the other.

At the present time this hospital, the 183rd Station Hospital, is functioning as well as the Station Hospital for the Ft. Richardson Post. I was fortunate in being assigned to it when I first arrived in December, 1944, and following a two month assignment as dispensary officer and Alaskan Department Replacement Battalion Surgeon, I was given the choice assignment of Chief of the Orthopedic Section which I have retained to date. The "fracture service" is very brisk here with the presence of icy weather eight-and-a-half months out of the year, the large Arctic Ski Bowl and the Recruit Training Detachment for the whole of Alaska on the post. The Surgical Service, in addition to orthopedics and general surgery, has taken over the new maternity section and the three of us on the Service will also "get the feel of delivering babies again." We had our first delivery on the 27th of February and proudly received a meritorious service award and plaque on the afternoon of the same day.

In addition to the duties in the hospital I have managed to find time for some interesting outdoor activities, chiefly ice skating and flying. Last summer when the days were 24 hours long I began instruction at the Anchorage airport. Was just able to get in a couple of solo flights before the long nights set in, then had to discontinue this sport till two weeks ago when I again began to fly, this time with the plane on skiis. Ski planes are extremely popular here in Alaska, and I truthfully believe I much favor ski landings and takeoffs to those on wheels, seem much smoother and buoyant.

In this section of Alaska the dog sled is used chiefly in rescue work since roads penetrate to the areas which are populated. Further north and away from the urban areas dog teams are common as are the picturesque trails which they follow. I feel myself fortunate to have been able to take a ten mile dog sled ride over these trails on the day before Christmas, and looking back I certainly would not have wanted to miss this experience for the world.

The weather conditions here are extremely variable. Since a year ago this past December we have had temperatures as low as twenty-five degrees below zero on occasions, and also have had the thermometer register ninety-two above. The Spring and Fall seasons do not amount to much, although this past Fall the tree leaves were colored for several weeks. The post sponsors a summer recreation program at one of the numerous lakes where they have built a Post Exchange, several tennis and badminton courts, archery ranges, an outdoor dance pavilion, canoe and row-boat facilities, and an attractive bathing beach (there is approximately two months of swimming weather).

Please convey my best regards to all of the physicians now practicing in the "valley" . . . I hope to be back to join them in the not too distant future.

Sincerely,

CAPT. C. W. MATHIAS

OUR AMERICAN WAY OF LIFE

By DeWITT EMERY, *Evanston, Illinois*

Our American way of life is made up of many things,, bathtubs and automobiles; big cities and small towns; farms and victory gardens; mammoth steel mills and village machine shops; colossal educational institutions and the little red schoool beside the road; churches and hospitals; railroads and air lines;! chewing gum and ice cream; pool rooms and race tracks; Hollywood, Broadway and the High School play; laughter and sorrow; eagerness and despair and people—millions of all kinds of people—gathered together from all over the world, drawn by the magnet of Freedom, Opportunity and Justice.

Our American way of life provides each individual an opportunity to go as far and climb as high as his willingness to work, his skill, ingenuity and integrity will carry him.

Our American way of life recognizes that the individual has the right to work when and where he wishes, the right to worship as he pleases, to speak his mind on any subject, to meet with his fellow men for any peaceful purpose, to be secure in his possessions and to have his day in a free court. It also recognizes that the individual is superior to the State, that our public officials are servants of the people and that they derive their just powers from the consent of the people.

These things taken together created an atmosphere of freedom and an economic climate which made possible in the United States the greatest production and diffusion of wealth in the history of the world, and the establishment, for even the lowest paid workers, of the highest living standard the world has ever known.

Why? Because for more than one hundred fifty years, free men in a free country have been working together to provide this better way of life. Let us hold what they have given us and go forward in the sure faith that the American way of life is the greatest blessing known to mankind any place on the face of God's earth.

ABSTRACT OF CLINICO-PATHOLOGICAL CONFERENCE OF MAY 17, 1946

Case history by Dr. Segal. This patient, a 42 year old white male, first was seen in Dr. Segal's office in January of 1946. His complaint at that time was pain in the left hip region. Dr. Segal's examination showed tenderness over the left sciatic notch but no other positive findings were evident. He was placed on sodium salicylate therapy without much improvement. One week later he was sent into the hospital for a checkup. Upon admission on February 12, 1946, the patient's chief complaint was severe pain in the back of his left leg which had been present for the past three weeks. The pain radiated down the back of his left leg and terminated in the second toe of the left foot. No change in position affected the pain.

The past history disclosed that the patient had had a poor appetite and weight loss of 30 lbs. since the fall of 1945. The systemic review revealed nothing striking.

Physical examination: T. 102°F., P. 86, R. 20, B. P. 145/80. Patient was a well developed, muscular male in no acute pain at the time of examination. The only positive finding was an area of tenderness over the left greater trochanter. The range of motion was unlimited in both legs. Reflexes were bilaterally equal with no accentuation of the pain when performing the test. The impression upon admission was 1. Sciatica 2. Anorexia, secondary to an undetermined cause.

Admission Laboratory work: Erythrocytes—4,810,000; Hemoglobin—84% (13 gms. per 100 cc.) ; Leucocytes - 7,550; Polymorphonuclear - 73% Small lymphocytes—27%. Urinalysis: Sp. gr.—1007; Albumin—negative; Sugar—negative; Microscopic: 2 to 3 wbc's per hpf.

On the day of admission a lumbar puncture was performed. The pressure was 170 mm. of water, the fluid clear. Globulin 1 plus, WBC'S 3, K&K negative. X-Ray of the chest, pelvis and dorsal-lumbar spine revealed the following: A minimal osteo-arthritic change about both sacro-iliac joints and both hip joints. There were numerous calcifications in the right hilus and scattered calcifications in both lung fields. There was an increase in trunkal markings and fine infiltration in both lung fields. No pathosis could be found in either dorsal or lumbar spines.

During his hospital stay, the patient's temperature remained elevated between 100, 101 and 102°F. He received penicillin with hope that some non-specific infection would be controlled. However, the temperature remained elevated. The patient was continued on sodium salicylate and physio-therapy without improvement. He was discharged on March 8, 1946, in the same condition.

The patient, followed by Dr. Segal in his office, progressively grew worse. He was re-admitted to the hospital on March 30, 1946, with acute urinary retention and mental disorientation. On the day after admission Dr. Bowman saw the patient and found the following: The bladder was markedly distended, the prostate moderately enlarged, somewhat irregular and quite hard. He was catheterized and 1500 cc. of concentrated urine was removed. Diagnosis was not definite, but malignancy of the prostate was considered. Dr. Bowman thought that some neurologic lesion giving a neurologic bladder had to be ruled out. The NPN was 30 mgm. per

100 cc., the K&K was again negative. X-Ray of the skull, lumbar spine and K. U. B. film added nothing new. Other admission laboratory work: Urinalysis — Sp. gr.—1.010, Albumin—1 plus, Sugar—negative, Microscopic — Few coarsely granular casts, 1 to 2 wbc's per hpf. Blood Count: Erythrocytes—4,070,-000, Hemoglobin—78% (12 gms.), Leucocytes—6,700, Polymorphonuclear—70%, Small lymphocytes — 27%, Monocytes—3%.

Cystoscopy on April 5, 1946, revealed a prostatic gland that neither gave the appearance of malignancy nor obstruction. There was moderate injection of the bladder mucosa.

Dr. Oscar Turner found the following neurologic signs: Bilateral weakness of both lower extremeties, and sustained ankle clonus; poor coordination on finger to nose test, especially on the right; Romberg strongly positive, tended to fall to the right; marked confusion, disorientation and negativism. A lumbar puncture showed the following: Pressure 140 mm. of water, Queckenstedt normal. Fluid was xanthochromic with 15 cells per cu. mm., all lymphocytes; and 4 plus globulin. Smears showed no acid fast organisms, Quantitative Sugar was 46 mgm.%. By this time the patient had developed a deviation of the tongue to the right and a marked psychosis, with slurring of speech.

Dr. Turner's impression at this time was frontal lobe neoplasm with possible bulbar involvement.

On April 8, a ventriculogram was done. This showed that the lateral ventricles did not appear displaced, but appeared larger than normal.

The condition became worse, temperature remained between 102 to 103°F., pulse 120 to 130 per min. and respirations rose 30 to 40. On April 10, a craniotomy revealed an arachnoiditis with multiple adhesions. The cerebellum extended posteriorly to the foramen magnum and showed evidence of pressure. Three days after the operation the patient lapsed into coma, and died on April 14, 1946.

Dr. Bowman stated that the prostate manifested a chronic infection but no diagnosis of specific type could be made. He was fairly certain that the gland was not cancerous.

Dr. Turner after operation felt the arachnoiditis was not sufficiently significant to warrant a diagnosis of tuberculous meningitis. The normal sugar values did not support this diagnosis.

Dr. H. K. Giffen discussed the post-mortem findings, and demonstrated brain displaying tuberculoma and tuberculous leptomeningitis, lungs in which old foci of tubercul[illegible] were present. Sections exhibiting [illegible]liary tuberculosis of the kidne[illegible] spleen, liver, prostate and brain were projected.

CIVILIAN REHABILITATION CENTERS

The need for additional rehabilitation services and centers where the disabled and handicapped can receive post-hospital physical rehabilitation, psycho-social adjustment and vocational guidance and re-training is stressed in the final report of the sub-committee on civilian rehabilitation centers issued recently by the Baruch Committee on Physical Medicine.

The report, prepared by a group of six authorities with military and civilian rehabilitation experience, blue-

EPIDEMIC PREPAREDNESS CONFERENCE ON POLIOMYELITIS

In anticipation of a possible infantile paralysis outbreak in Ohio this summer, the State Department of Health and the National Foundation for Infantile Paralysis are sponsoring an Epidemic Preparedness Conference to be held Thursday and Friday, June 13 and 14, at the Neil House, Columbus.

One of a series being held in various parts of the country in May and June, the meeting will hear national and state authorities on epidemiology, progress in research, pediatrics, treatment and care, hospitalization and public health problems.

Invited to the opening sessions beginning at 1:30 P. M. Thursday, are physicians, public health commissioners, hospital administrators, nurses and physical therapists.

Second day sessions, beginning at 9:00 A. M. and continuing through a luncheon, will be devoted to National Foundation chapter representatives and lay groups interested in public health.

Thursday's sessions will be presided over by Dr. Charles Doan, Dean, School of Medicine, Ohio State University, Columbus.

Dr. Roger E. Heering, State Director of Health, and Daniel W. DeHayes, the National Foundation's Ohio Representative, 1100 Beggs Building, Columbus, Ohio, are in charge of arrangements.

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Elizabeth McLaughry, M. D. **Elizabeth Veach, M. D.**

prints the organization and operation of model community rehabilitation centers. Emphasizing that such centers should integrate rather than duplicate the work of existing agencies, it outlines the organization and operation of proposed centers which would offer physical medicine (physical therapy, occupational therapy, physical rehabilitation), psycho-social adjustment, vocational guidance, social service, vocational education, special education for the handicapped, a sheltered workshop, brace and limb shop, research in rehabilitation, and an industrial program for the homebound.

The centers would not provide definitive medical treatment, but would bridge the gap between the bed and the job by following preventive and curative medicine and surgery with what the Committee terms "the third phase of medical care."

The report suggests that the envisioned centers might be established by communities as "living war memorials" by the action of local governments, civic groups, social agencies, or medical schools and hospitals. They point out that both the construction and operating costs of such centers would be considerably less than for hospitals and would release needed hospital beds for sick patients.

They estimate the average patient stay at two months, which would result in a case load of 1500 patients per year. Total program costs for physical therapy, occupational therapy, medical services, vocational testing, guidance and retraining, and psychosocial adjustment are estimated at $125 per patient, exclusive of dormitory care and food services. Such centers, once established, the Committee believes, would be relatively self-supporting as fees would be received from private patients, the Veterans Administration, state rehabilitation programs, industry and insurance companies.

In considering community plans the facilities, personnel and problems of the community must be given prime consideration, and the basic plan modified to meet the specific needs of the community.

In issuing the report, Dr. Frank H. Krusen, Director of the Baruch Committee on Physical Medicine, said, "It was recognized early in 1945 that much had been learned in the rehabilitation programs of the armed forces which would be of value to physically and emotionally disabled civilians. The armed forces through their comprehensive rehabilitation programs offered services to disabled servicemen which are available to the civilian handicapped in but a few highly specialized centers in the country. It is the hope of the Committee that this report will stimulate interest in the establishment of such centers and services throughout the nation in order that our civilian disabled may receive the same splendid care that was afforded our disabled servicemen."

The report was prepared by a special committee under the chairmanship of Dr. Howard A. Rusk, Consultant in Physical Rehabilitation of the Baruch Committee on Physical Medicine and Associate Editor of The New York Times; Dr. George G. Deaver, New York University College of Medicine and Medical Director of the Institute for the Crippled and Disabled; Mr. Lawrence J. Linck, Executive Secretary of the National Society for Crippled Children and Adults; Dr. Carl M. Peterson, Secretary of the Council on Industrial Health of the American Medical Association; Mr. Michael J. Shortley, Director of the Office of Vocational Rehabilitation; and Dr. Alfred R. Shands, Jr., Medical Director of the Alfred I. du Pont Institute.

MEMBERS RETURNED FROM SERVICE

Name	Address	Phone
W. H. Atkinson, M. D.	3370 Wilson Avenue	
O. A. Axelson, M. D.	Medical Arts Bldg.	84118
B. M. Bowman, M. D.	604 Home Savings & Loan Bldg.	41396
Peter L. Boyle, M. D.	413 Mahoning Bank Building	42633
B. M. Brandmiller, M. D.	2020 Market St.	29114
John R. Buchanan, M. D.	608 City Bank Building	41432
R. V. Clifford, M. D.	19 Lincoln Avenue	77322
Joseph Colla, M. D.	518 Dollar Bank Bldg.	32256
C. H. Cronick, M. D.	244 Lincoln Avenue	70415
A. R. Cukerbaum, M. D.	408 Home Savings & Loan Building	73211
Sidney L. Davidow, M. D.	338 Lincoln Avenue	77093
G. E. DeCicco, M. D.	1008 Market Street	31215
Samuel Epstein, M. D.	2004 Elm Street	32625
W. H. Evans, M. D.	Dollar Bank Bldg.	42147
B. I. Firestone, M. D.	508 Home Savings & Loan Bldg.	36722
J. L. Fisher, M. D.	224 N. Phelps Street	77713
S. D. Goldberg, M. D.	506 City Trust & Savings Bldg.	31223
John Goldcamp, M. D.	810 Dollar Bank Bldg.	34168
M. B. Goldstein, M. D.	Stambaugh Bldg.	32554
R. A. Hall, M. D.	Home Savings & Loan Bldg.	36656
Harold E. Hathhorn, M. D.	2547 Glenwood Ave.	21821
H. H. Ipp, M. D.	306 Home Savings & Loan Bldg.	79351
P. M. Kaufman, M. D.	304-5 Home Savings & Loan Bldg.	45121
M. M. Kendall, M. D.	Home Savings & Loan Bldg.	36762
J. P. Keogh, M. D.	812 Home Savings & Loan Bldg.	79217
J. E. L. Keyes, M. D.	617 Home Savings & Loan Bldg.	73643
Samuel Klatman, M. D.	409 City Bank Bldg.	31422
Herman Kling, M. D.	317 So. Solan St., Albuquerque, New Mexico	
O. M. Lawton, M. D.	Mahoning Bank Bldg.	33314
A. Marinelli, M. D.	1204 Central Tower	32726
P. R. McConnell, M. D.	19 Lincoln Avenue	38112
W. D. McElroy, M. D.	1006 Central Tower Bldg.	41677
R. H. Middleton, M. D.	Medical Arts Bldg.	21211
A. W. Miglets, M. D.	61 E. Florida Avenue	41764
Stanley Myers, M. D.	810 Dollar Bank Bldg.	34168
M. W. Neidus, M. D.	Home Savings and Loan Bldg.	36722
G. G. Nelson, M. D.	138 Lincoln Avenue	77650
John Noll, Jr., M. D.	101 Lincoln Avenue	30916
R. E. Odom, M. D.	510 Dollar Bank Bldg.	42147
S. W. Ondash, M. D.	2514 Mahoning Avenue	95358
A. K. Phillips, M. D.	250 Lincoln Ave.	33608
Robert L. Piercy, M. D.	613 Home Savings & Loan Bldg.	34189
Asher Randall, M. D.	5th Floor, Schween-Wagner Bldg.	78611
Lewis K. Reed, M. D.	634 Market Street	78634
H. J. Reese, M. D.	2714 Market Street	23413
John Renner, M. D.	Dollar Bank Bldg.	34168
John A. Rogers, M. D.	603 Home Savings & Loan Bldg.	41944
M. S. Rosenblum, M. D.	406 Home Savings & Loan Bldg.	31912
J. M. Russell, M. D.	2726 Market Street	29113
S. Schwebel, M. D.	Schween-Wagner Bldg.	
C. W. Sears, M. D.	3031 Market Street	24617
L. S. Shensa, M. D.	Dollar Bank Bldg.	75125
Henry Sisek, M. D.	317 Home Savings & Loan Bldg.	37141
Ivan C. Smith, M. D.	210 Home Savings & Loan Bldg.	73257
J. J. Sofranec, Jr., M. D.	1007 City Bank Bldg.	79249
William E. Sovik, M. D.	20 Twelfth Street, Campbell, Ohio	55012
M. M. Szucs, M. D.	608 Dollar Bank Bldg.	47315
S. Tamarkin, M. D.	Schween-Wagner Building	72612
W. J. Tims, M. D.	19 Lincoln Avenue	37698
L. W. Weller, M. D.	1006 City Bank Building	30127
John Welter, M. D.	19 Lincoln Avenue	34464
Herman Zeve, M. D.	228 Lincoln Avenue	43359

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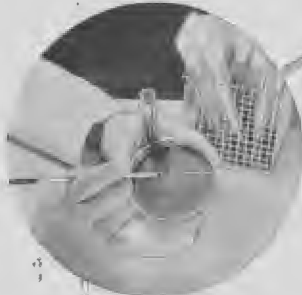

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