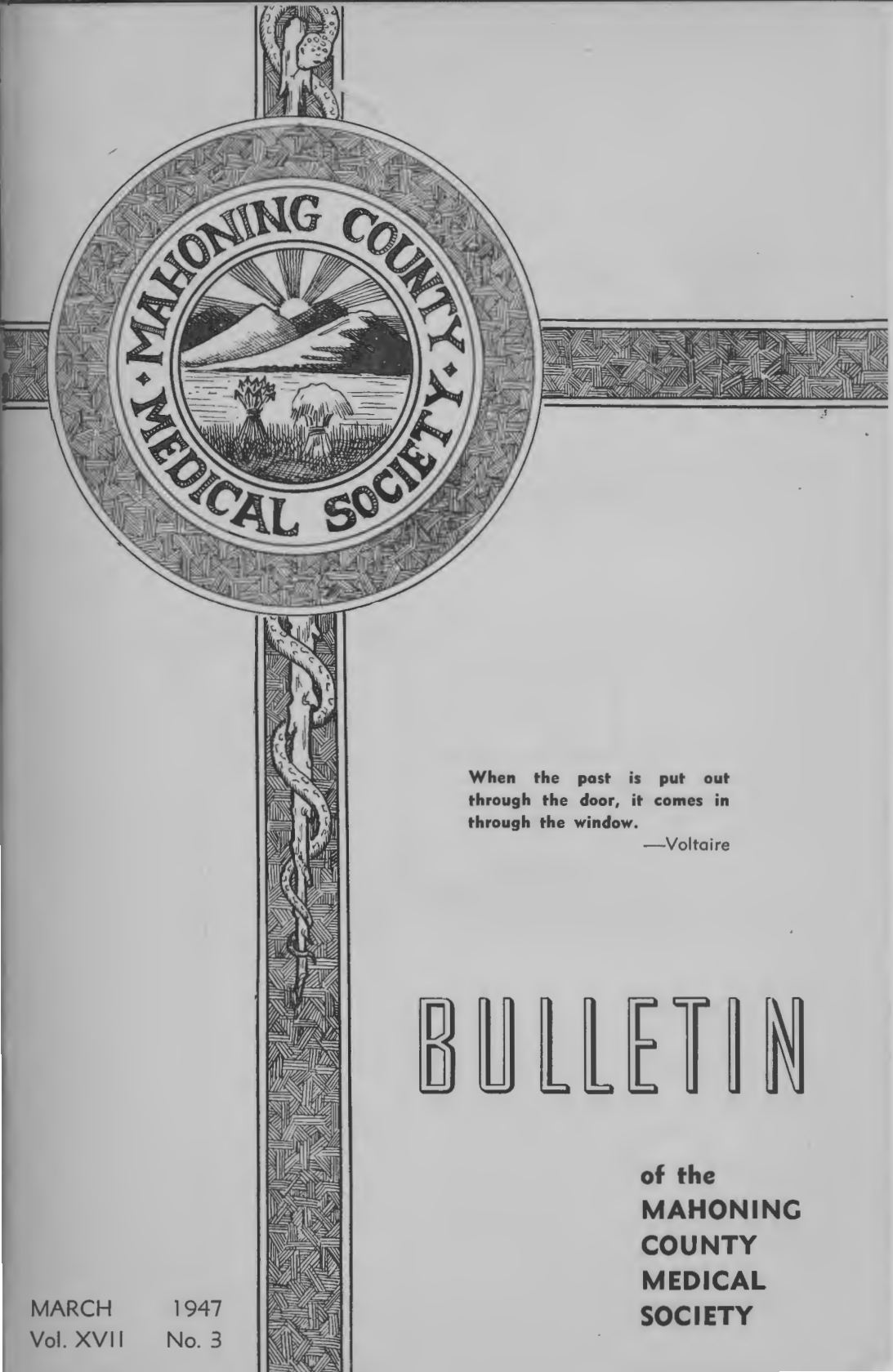

When the past is put out through the door, it comes in through the window.

—Voltaire

BULLETIN

of the MAHONING COUNTY MEDICAL SOCIETY

MARCH 1947
Vol. XVII No. 3

MEDICAL CALENDAR

1st Tuesday 8:30 p. m.	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
2nd Monday 9:00 p. m.	Council Meeting—Mahoning County Medical Society—Office of the Secretary
2nd Tuesday 11:30 a. m.	Monthly Medical Conference, Youngstown Hospital. Auditorium—Nurses' Home
2nd Tuesday 8:30 p. m.	Monthly Staff Meeting—St. Elizabeth's Hospital Auditorium—Nurses' Home
3rd Tuesday 8:30 p. m.	Monthly Meeting—Mahoning County Medical Society—Youngstown Club
4th Tuesday 8:30 p. m.	Monthly Staff Meeting — Youngstown Receiving Hospital Auditorium—Indianola Ave.
Every Thursday 11:30 A. M.	Weekly Surgical Conference Youngstown Hospital—Stewart House
Every Friday 11:00 a. m.	Clinic—St. Elizabeth's Hospital Library
Every Friday 11:30 a. m.	Clinic—Pathology Conference Auditorium Nurses' Home South Side Unit Youngstown Hospital
4th Thursday 8:30 p. m.	Trumbull County—Monthly Meeting Warner Hotel—Warren, Ohio

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8.
American Medical Association, Atlantic City, June 9-13.
American College of Physicians, Chicago, April 28 - May 2.
American Congress on Obstetrics and Gynecology, St. Louis, Sept. 8-12.
Mississippi Valley Medical Society, Burlington, Iowa, October 1-3.
Twelfth Assembly, United States Chapter, International College of Surgeons, Chicago, September 29 - October 2.

THE MAHONING COUNTY MEDICAL SOCIETY

Vol. XVII—No. 3

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March, 1947

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STATE COMMITTEE ON MEDICAL SERVICE PLANS—W. M. Skipp.

STATE DELEGATE TO AMERICAN MEDICAL ASSOCIATION—W. M. Skipp.

PRESIDENT'S PAGE

Elaborate plans are being made for the celebration of the Centennial of the American Medical Association at Atlantic City on June 9th. May I again call your attention to the fact that only Fellows and invited guests are eligible to attend. If you are not a Fellow and plan to attend the Atlantic Session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering if you will write now to the A.M.A., 535 N. Dearborn St., Chicago 10, Illinois, and ask if you are eligible to become a Fellow. We hope Mahoning County will be well represented at this meeting.

I am pleased to report that all the committees are getting down to work and producing good results. The program committee is to be congratulated on the very excellent program presented at the February meeting. The address by Dr. Paul R. Cannon was one of the best that we have had in many years, and the attendance was the largest since postwar days.

In looking forward to coming activities of the society, I would like to call your attention to the Annual Banquet, which is scheduled for March 20th, Youngstown Country Club. This is really our first post-war reunion, so let's have a good attendance.

For about a year since the return home, the veteran has been gradually assuming the strenuous but, nevertheless pleasant, responsibility of practice, which has brought him the joy which he sought and usually missed in service.

Many have found time too short and occasion too infrequent for moving around in the circles of professional friendships. The only common ground for many members to have seen each other has been at the monthly scientific meetings. During the past few months, bowling has become a very popular Thursday afternoon activity. We note that some of our advertisers have promised some good prizes for the champions or near champions, so let's turn out and give the boys some competition. We owe it to ourselves to relax and become acquainted again.

Plans are well under way for the 19th Annual Postgraduate Assembly. We are unable to get the program in detail, due to the absence of Dean Parkinson from Temple University, but a copy of the program will be mailed to you as soon as it is available.

An added attraction this year will be the revival of the 6th Councillor District Postgraduate Day, which will be held in Canton some time in October.

The Public Health Committee, under the chairmanship of Dr. Barclay Brandmiller, is working on the final details of a proposed amendment to the City Charter to be placed on the ballot at the November election which will provide Youngstown with a full time Health Director. It is our duty to acquaint our patients with just what this means to them, as we all realize the need for a full time Public Health Commissioner.

G. M. McKELVEY

BULLETIN of the Mahoning County Medical Society

Published monthly at Youngstown, Ohio — Annual Subscription, $2.00
VOLUME 17 — MARCH, 1947 — NUMBER 3

Published for and by the members of the Mahoning County Medical Society
C. A. GUSTAFSON, Editor
101 Lincoln Avenue

ASSOCIATE EDITORS

F. S. Coombs — J. L. Fisher — S. W. Ondash
W. D. Coy — S. Klatman — H. J. Reese

CALL TO VETERANS

The great representation of our members in World War II is only too well known. Little known, however, are the varied and interesting experiences encountered by the medical officers during such service.

Not only would such items be of interest to members at large but to other veterans who would like to know what their fellow servicemen experienced. Actual combat experience, side visits to interesting places, observations on civilian practice in other countries, new techniques, etc., or all matters of general interest.

Undoubtedly many of you have compiled interesting medical data, devised or used new techniques, etc, while in various installations throughout the world. Short papers on such subjects would hold tremendous interest and value. What were your experiences with front line casualties? What were your experiences with resuscitatory measures, with blood, plasma, the sulfones, etc.? Did you compile general statistics of any type? What, for example, was your treatment of burns; your experiences with plastic surgery and with other types of reconstructive surgery? Any of the foregoing would be of interest to us as civilians since traumatic surgery still has to be reckoned with in civilian practice.

Let us hear from you and let others profit by timely suggestions on techniques, new devices, medications, etc.!

This is your *Bulletin*. Let's add to fraternal feeling and voice ourselves through our publication. Your editor and his staff will add any technical assistance they can. Let us hear from you! S. W. O.

CONSENT OF THE GOVERNED

Having become imbued with the idea that consent gives validity to government, we are not able to accept the present-day European idea of free elections. We resent being compelled to deal on equality basis with countries in which the sanction for government rests upon the will of a militant minority. In our zeal for spreading abroad our ideas of liberty, our heritage may be jeopardized through our neglect.

Edmund Burke was right when he thought that trial by jury was the soul of government. This we have, and it is inconceivable that we would surrender it. It pertains not alone to individuals accused of crime; but extends in principle until government itself must be tried by a jury of the whole. This we insist upon doing at regular intervals. It has been our salvation and re-

mains our hope of continued freedom; but it becomes a gesture if it be not a deliberate and intelligent choice. It must be more than an occasional protest against injustice and inadequacy. These reactions are not sufficient to insure its maintenance. Only the sustained interest of enlightened people furnishes the basis of good government.

We insist so much that the people are the source of authority for the government and that it is of their creation for their needs, that we cannot reconcile this with secret meetings of a few individuals, partitioning peoples and lands, with nothing to restrain them but their own suspicions and jealousies. Theoretically, people do not belong to the state; but there are millions of people alive today who could not be persuaded that this is true. They could not be made to believe that they are not owned and controlled in every detail of their lives by the militant minority that holds complete power over the territory in which they are compelled to remain, or from which they must move without any reason connected with their wishes or their welfare.

How we can become and remain a party to this and still keep our own thinking clear with respect to citizenship, is a problem which has not been solved by those who have been trying to untangle our unholy alliances. The responsibility which became ours through the exigencies of war cannot be terminated at will; nor will it have been met through relief of physical distress alone. What we shall be able to do and how far we should go in the affairs of other peoples is not yet clear to us who are not able to see our own short-comings.

When we speak of self-governing peoples, we use this term relatively. Representative government is ours, and we should make the most of it. It is ours to improve and maintain, else we will lose what has been gained with so much effort. Justice under law will not be for us unless we choose the most competent men from those who are available and put this kind into positions of authority. We have not been doing this. Capacity to think clearly and logically on many subjects, executive ability, honesty and impartiality are not qualities that have much vote-appeal. We are influenced in our choice by trivialities which we are ashamed to acknowledge.

If we remain indifferent to the quality of men to whom we show deference, we cannot escape being imposed upon and exploited. When we give importance to opportunists at home, we not only become embroiled in internal affairs; but we encourage and strengthen the forces, both here and abroad, which are trying to make self-government a thing of the past.

The men whom we select to govern us, both locally and nationally, should be those who know that government itself, as well as they who are to administer it, must obey its own laws. There should not be two standards of ethics to be chosen and exercised at will by those whom we have chosen to conduct our public affairs. When we become aware that this state of affairs has developed, the blame is also our own if we do not rectify it.

An obvious conclusion from this is that people should not expect to be well governed before they are fit to govern themselves. During his incumbency, William Howard Taft told us that, though representative government was ours, we were not fit to govern ourselves. We did not like it. We did not believe him. We wonder if equally clear-thinking men today can find reasons for a different opinion.

We might use our national debt as an index of our capacities, a debt so

large that we are threatened with insolvency. We like to view this debt as having been incurred alone by the necessities of war. We do not like to think of it as having been increased and maintained by extravagances, emoluments and subsidies which exhibit to ourselves the kind of make-shifts, artificialities and vanities that we condone and for which we are being made to pay.

It may be that we do not know this. It may be that we would rather adapt ourselves to it than to try to alter it. It may be that we have not the quality, as individuals, which would enable us to readjust to sensible living conditions, both psychic and material. It may be that it is not only the treasury which is facing insolvency.

The consent of the governed is to be thought of as a definite support to law and law enforcement. It becomes destructive if this consent be predicated upon security of person and of property without adequate effort of the individual to get this for himself. It becomes parasitism, either in part or in whole. It is destructive to character and consequently to legitimate government. Higher pay and shorter hours with diminished output belongs in this category. Inferior workmanship belongs with the idea of something for nothing which has possessed our people, sporadically. Now it is epidemic.

Economists are able to estimate the loss to our country in goods which should and could have been produced through the times of intentional slowing and of idleness. No one can estimate the loss and permanent damage to the individual in self-respect and trustworthiness. The physical part is much easier to replace, or substitution might suffice; but not so with the psychic factor involved. These scars may never be effaced.

Food, clothing and shelter, being our principle needs, will continue to be the incentive to labor; but it is possible that many of us have let these real needs sink so far into the background that only remotely do they motivate. We are concerned more with the unreasonable things which have developed out of them. We call it a standard of living. Perhaps it is; but not necessarily a high standard because of its extravagance. High standard in thinking, in behavior does not require luxurious environment, though it may persist even under such unfavorable circumstances.

We have a direct interest in these matters for we are in daily contact with them in both our personal and our professional relations. As physicians, we can determine not to yield to the wave, not of the future but the present engulfing one, of little effort and large returns, of small or inadequate contribution and large recompense. Then we will not be embarrassed when we hold that our contribution has been adequate, is continuing to meet the needs of the public, and is progressing toward greater efficiency through our own initiative.

We must give more thought to ourselves as citizens, and to our influence in other than professional matters. For we may be sure that government, though deriving its power from the consent of the ignorant, would yet not be without power to impede that progress which should be reason for pride and not for calumny. So we are led to conclude that, though government justly derives its power from the consent of the governed, the personal excellence of the governed is the ultimate factor in good government. It is out of this, nourished by the toil of men and watered by women's tears, that the precious tree of liberty has grown. W. D. C.

1947

DR. SHELDON DISCUSSES FOOD ALLERGY AT SOCIETY MEETING

The problem of food allergy, its diagnosis and treatment, was discussed by Dr. John M. Sheldon, associate professor of Internal Medicine at The University of Michigan, Ann Arbor, Michigan, at the regular monthly meeting of the Mahoning County Medical Society, held on January 21, 1947.

Food sensitization is one of the most common causes of allergic manifestation and second only to house dust and pollen in clinical importance. Food allergy may be the cause of a wide variety of clinical entities and is of sufficient numerical incidence that its possibility must be kept in mind in the routine examination of patients.

There are five primary points in the history which lead one to suspect food as the cause of symptoms in a known allergic patient. They are: (1) onset of allergic symptoms early in life, (usually before the age of three); (2) known intolerance to easily digestible food; (3) symptoms that are of perennial occurrence; (4) relationship of symptoms to ingestion of food; (5) absence of other obvious causes for the disturbance.

Once an ingestant is suspected the first approach to the specific excitant is by a detailed history. This should enumerate the average weekly intake of the common food allergens with particular emphasis upon suspects. (It is often observed that the patient knows of a food that causes symptoms but does not realize that the food is present in the dietary mixture). Food dislikes may be of clnical importance especially in children and food taken in frequent, excessive quantities is often known to be the allergen.

The usual diagnostic procedures of skin tests, ingestion tests and leucopenic index in certain instances of food allergy are of value. In the main, however, they are disappointing and unreliable procedures.

A reliable method for rapid determination of the presence or absence of food sensitivity is the use of synthetic diets. They are indicated for those hospitalized patients in whom the severity and chronicity of symptoms justify a temporary restricted dietary intake.

Dr. Sheldon covered the field of aids in making diagnosis. He made a very strong plea for the doctor to make a careful, detailed history, for this might be the most important aid to solving the problem. He suggested that in a great many cases the patient will make the diagnosis for the doctor if the latter will permit the patient to discuss his suspects, dislikes, cravings, etc.

The formal presentation was concluded with a discussion of the usual complete diagnostic aids. It was pointed out that a very useful form of basic elimination diet is the synthetic diet and the means of preparing such a diet was clearly set forth.

Dr. Sheldon concluded by answering questions on the use of the Polypetans and also Benadryl and related compounds in the symptomatic relief of the manifestations of food allergy.

H. J. R.

NEW BECOTIN WITH VITAMIN C

(Vitamin B Complex with Vitamin C, Lilly)

HIGH-POTENCY VITAMIN B COMPLEX AND VITAMIN C

'BECOTIN WITH VITAMIN C' (Vitamin B Complex with Vitamin C, Lilly) furnishes all the known water-soluble vitamins. In addition to the entire vitamin B complex, this product provides a therapeutic dose of the synthesized B vitamins and ascorbic acid.

General debility, lassitude, easy fatigability, anorexia, and belching and fullness after meals are commonly encountered symptoms of vitamin B complex and vitamin C deficiencies.

One Pulvule 'Becotin with Vitamin C' daily is adequate for the treatment of mild deficiencies; two or more pulvules a day are recommended for the more severe cases.

Available at prescription drug stores everywhere.

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HEMOLYLTIC STREPTOCOCCAL DISEASE

By F. S. Coombs, M. D.

The role of the streptococcus in producing disease has been tossed about so much that it may be well to review the current concepts of diseases produced by or related to the streptococcus.

In 1918 Brown applied a classification to streptococci which is still accepted today. He divided them into three groups:

(1) Alpha, slightly hemolytic organisms producing the green pigment of methemoglobin. The commonest of these is streptococcus viridans.

(2) Beta, hemolytic organisms.

(3) Gamma, non-hemolytic organisms. (Probably not pathogenic.)

Alpha, or streptococcus viridans is often found in throat cultures. It is generally without pathogenic significance. However, when this same organism is found growing in a blood culture it is of tremendous pathological significance. It is probably the commonest etiological agent in subacute bacterial endocarditis.

Beta or hemolytic streptococci have a number of varieties. During the past ten years a group of American investigators, notably Lancefield, Swift, Hobby and Dawson, have done much to classify this organism. At the present time this organism is broken up into groups numbered from A through L. Little is known of many of these groups, but considerable work has been done on Group A which seems to be the outstanding human pathogen. Group A has been further broken up into types ranging from 1 to 47, though several of the types have now been found to belong to other groups.

So far it would seem that any one of these types may cause the same clinical picture in humans. Apparently different types are prevalent in different years and during epidemics of streptococcal disease one or two types may be the offending organisms in the vast majority of cases. During the war, epidemics of streptococcal disease in this country were caused by Type 17 or Type 19.

This organism, Group A, may cause streptococcal sore throat, follicular tonsillitis, or scarlet fever. However the clinical picture in throat infections may be the same regardless of whether group A streptococci are found. This is suggestive that some infections may be due to a "virus". Thus a very practical point in favor of routine throat cultures on patients with upper respiratory infections is raised. First: streptococcal sore throat cannot be diagnosed by its appearance; second, the presence of group A hemolytic streptococci should warn the physician of the possibility of sequelae as Rheumatic Fever, Nephritis, or possibly Rheumatoid Arthritis; and third, the absence of such organisms throws serious doubt on the need for chemotherapy or anti-biotics.

The relationship of Group A hemolytic Streptococci to Scarlet Fever cannot be too strongly emphasized. Commercial preparations of Scarlet Fever Anti-toxin are probably insufficient since they are made from one Type (#10) of Group A streptococci. Since each of the various types—(1 to 47) contain different antigens and presumably produce different antibodies, such an anti-toxin from one type obviously could not protect. This Anti-toxin, however, must not be confused with human convalescent serum whose status is still undetermined.

Streptococcus Scarletinae thus is composed of all of the various types of group A hemolytic streptococci.

In this respect it is important that our quarantine regulations on Scarlet

Fever be revised. Proven group A hemolytic streptococci sore throat is just as contagious as Scarlet Fever. In fact they are the same disease, except that one patient gets an "allergic" rash to the toxin produced by the streptococcus. The "peelings" of Scarlet Fever are not infectious.

Group A hemolytic streptococci may be a cause of broncho-pneumonia. Early X-Rays of the chest in such a case may not be diagnostic; in fact there may be some doubt as to the etiology. "Virus" pneumonia might be considered, for both conditions are somewhat alike in the early stages. A positive sputum for hemolytic streptococci indicates the need for specific therapy. Indeed a correct bacteriological diagnosis is imperative because streptococcal pneumonia, in the writer's experience, is insidious of onset but often explodes into fulminating disease with massive pleural effusion.

Thus throat and sputum cultures for hemolytic streptococci may be of invaluable aid to the physician in treating the immediate disease or in understanding subsequent complications of diseases.

DOCTORS TO VIE FOR BOWLING PRIZES

Medical keglers have shown increased interest in the score columns by the announcement of prizes for leaders at season's end. Prizes will be offered for highest three game score—for best season's average and for highest single game score. A time limit will be set as will a minimum number of frames bowled in order to qualify for awards.

Top average still rests with Dr. Wenaas, but more significant averages are sported by Drs. Herman and Clifford, who have been rolling more frequently. Dr. F. F. Piercy is crowding the leaders by his consistency on the lines. Averages to date are as follows:

Name	*No. Games*	*Total*	*Average*
E. J. Wenaas	10	1590	159
V. Herman	37	5721	155
P. McOwen	18	2779	154
J. Goldcamp	12	1832	153
R. Clifford	28	4261	152
F. F. Piercy	26	3882	149
J. Renner	16	2361	148
E. H. Young	8	1166	146
H. J. Reese	41	5960	145
S. Goldberg	7	1013	145
R. Piercy	18	2608	144
S. W. Ondash	42	5982	142
D. Levy	17	2412	142
E. DiIorio	8	1070	136
H. Hathorn	9	1180	131
A. K. Phillips	24	3180	132
I. C. Smith	39	5085	130
J. Brown	5	629	126
H. Ipp	25	3058	122
S. Davidow	8	909	114
G. DeCicco	18	2028	113
J. Scarnecchia	4	443	111

S. W. O.

Sent your check in?

ALL CHECKS SHOULD HAVE BEEN IN LONG BEFORE THIS . . .

ANNUAL BANQUET

MAGIC, MUSIC, MEMORY and GAIETY

GEORGE BAILEY

Memorimusagician

THURSDAY, MARCH 20th, 1947

6:30 P. M. — YOUNGSTOWN COUNTRY CLUB

"A THREE-RING CIRCUS IN VAUDEVILLE"—That is what George Bailey will give us—Fun, Music and Magic. He has rare talent in a number of directions as a musician, for he knows his way about with a violin and harmonica, singly or simultaneously, and gives masterful renditions of well known tunes upon ordinary water goblets filled to varying degrees.

19th ANNUAL

POSTGRADUATE ASSEMBLY

WEDNESDAY, APRIL 16th, 1947

PICK-OHIO HOTEL

PROGRAM BY

GROUP FROM

TEMPLE UNIVERSITY SCHOOL OF MEDICINE

MORNING SESSIONS

10:00 A. M. Clinical Pathological Conference
At St. Elizabeth's Hospital

10:00 A. M. Surgical Clinic at Stambaugh Nurses' Home, South Unit

12:30 - 1:30 P. M. Registration, Ballroom Pick-Ohio Hotel

AFTERNOON SESSIONS

1:30 to 4:30 at Ballroom Pick-Ohio Hotel

Dinner — 6:30 P. M.

EVENING SESSION — 8:00 P. M.

FULL DETAILS IN THE APRIL ISSUE OF THE BULLETIN

WHAT DO VARIOUS HOSPITALIZATION PLANS OFFER?

Many physicians have made inquiry relative to benefits entitled to the patient from the many hospitalization plans in effect. Oftentimes the patient asks the doctor whether X-ray fees, operating room fees, etc., are covered by their particular insurance. Submitted herewith are the various types of plans and what they offer to the patient. The data can be used as a ready reference and will prove of value in answering hospitalization insurance inquiries.

Republic and Truscon mills carry Metropolitan Hospitalization and will pay benefits to the hospital if patient signs assignment. All others carrying Metropolitan Hospitalization collect their own benefits and in turn reimburse the hospital of selection. Policies vary according to premium, etc.

Republic and Truscon Only As Follows:

Employees: 31 days at $7.00 per day toward room rate.
Maximum extra benefits for one whole contract year $35.00
Wives and Children: 31 days at $5.00 per day toward room rate.
Maximum extra benefits for one whole contract year $35.00
Maximum Maternity Benefits Complete 50.00
Green forms are to be signed by the doctor; white forms by the patient.

Carnegie Mills Hospitalization

Ohio Works:

$4.50 per day up to 28 days.
$25.00 toward the extra charges for one year.
Extras include: Operating Room, Anesthesia, Laboratory, X-ray and Delivery Room.

WILL NOT PAY FOR Drugs, Oxygen, Physio, Nursery, Plasma, etc.

McDonald Mill:

$4.75 per day toward ward rate.
$5.00 per day toward semi-private or private.
$15.00 Maximum for Operating Room and Anesthesia.
$5.00 Maximum for routine Laboratory.
$10.00 Maximum for X-ray.
Benefits not used up for one service cannot be applied to another, e. g. a medical patient may NOT use the $15.00 allowed for Operating Room toward drugs, physio, etc.

Union Works Mill

No Maternity Benefits. NO Children covered for Benefits.
$4.50 per day. $10.00 Operating Room. $5.00 Anesthesia.
$10.00 Laboratory. $12.50 X-ray.
Dependent wife entitled to partial benefits.

Pioneer Mutual Hospitalization, also known as Youngstown Hospital Agency

$6.00 per day for 42 days.
$10.00 for all operating room, oxygen, physio, metabolism.
$5.00 for all anesthesia, laboratory and drug charges.
$10.00 for X-ray.

(*Continued on page* 109)

(*Continued from page* 107)

Maximum of $50.00 for Gyn or Maternity cases. Policy must be 18 months old before it will be eligible for these benefits.

Policy is not definitely approved at time of admission in most cases. It must be proved from case records that the condition was not pre-existing to date of policy.

Only one $50.00 benefit allowed during each 18 month period for Gyn or Maternity benefits.

White form is to be signed by the doctor, patient and hospital.

Sheet & Tube Hospitalization

$4.50 per day for 31 days toward bed and board rate.

Complete coverage for extras EXCEPT X-ray, Blood and Plasma.

Chart of patient must be completed before the Company will consider the bill because a final diagnosis is required.

Members of the Sheet & Tube Benefit Association, their wives and dependent children up TO 19 years, are covered under this policy.

Miscellaneous Hospitalizations

The aforegoing represent the majority of insurance plans in effect. There are numerous other companies whose plans have their own features but they are not in great variance to the ones submitted. Generally speaking, however, all hospitalization companies except Associated of Youngstown require a diagnosis.

The majority of out-of-town companies pay benefits directly to the one insured. The patient is expected to take care of his own hospital expenses and make arrangements accordingly at time of admission. S. W. O.

COMMUNICABLE DISEASES REPORTED IN MAHONING COUNTY TO BOARD OF HEALTH

	1945	1946	Jan. 1946	Jan. 1947
Chickenpox	80	123	16	19
Diphtheria	0	3	0	2
Measles	7	556	5	0
Meningitis	4	1	0	0
Mumps	37	88	0	0
Polio	8	5	0	0
Scarlet Fever	120	212	13	17
Undulant Fever	0	5	0	0
Whooping Cough	80	97	31	8
Malaria	1	0	0	1
Venereal Diseases	58	56	11	8

S. G. P.

NEWS

Dr. and Mrs. Anthony J. Bayuk announce the arrival of a son, Dennis John, at St. Elizabeth's Hospital on January 20, 1947. Mrs. Bayuk is the former Miss Ann Kmetz, of Farrell, Pa. Dr. Bayuk is the Director of the Department of Anesthesia at St. Elizabeth's Hospital.

Commander Martin E. Conti, U. S. N. Medical Department, was home on an emergency leave from January 19 to January 29, 1947. His visit was occasioned by a serious illness of his mother. Commander Conti is Assistant Chief of Surgery at the Aiea Naval Hospital, Pearl Harbor, T. H. Mrs. Conti and daughters, Suzette and Mary Elizabeth, are making their temporary home at Pearl Harbor.

Dr. Ivan C. Smith and Dr. Chester S. Lowendorf attended the meeting of the American Academy of Orthopedic Surgeons held at the Palmer House, Chicago, Illinois, from January 25 through January 27, 1947. Dr. Smith also took a brief instruction course in Poliomyelitis and Hand Surgery during this meeting.

Dr. and Mrs. Joseph J. Sofranec, Jr., announce the birth of a daughter, Kathryn Lynn, at St. Elizabeth's Hospital on February 14, 1947.

Dr. and Mrs. James S. Mariner, Loveland Road, motored to Athens recently to be present at the graduation of their son, James S., Jr., from Ohio University.

Dr. James E. Miller has returned from New York City where he spent some time taking postgraduate work in internal medicine and arthritis.

About 75 local doctors and their wives were guests at a dinner party at the Hotel Pick-Ohio at which members of the Women's Auxiliary to the Mahoning County Medical Society were hostesses. Bridge was the evening's diversion, prizes going to Mrs. J. B. Birch, Mrs. Samuel Zoss, Mrs. V. C. Hart, Dr. R. B. Poling, Dr. Lawrence Weller and Dr. Elmer Nagel. Mrs. L. George Coe, Auxiliary president, gave an informal greeting to the guests.

Mrs. Louis S. Deitchman, widow of the late Dr. Deitchman, has returned to Oakland, California.

Dr. and Mrs. Stanley A. Myers have returned from a vacation in Florida.

Dr. and Mrs. W. O. Mermis are vacationing in Mexico City.

Dave H. Smeltzer, medical student at Duke University, son of Dr. and Mrs. D. H. Smeltzer, has concluded a 10-day vacation with his parents.

Dr. Paul M. McConnell has returned from a vacation in Florida.

Dr. and Mrs. O. J. Walker have returned home from a five-day vacation in Florida. They spent a week at Miami where Dr. Walker attended a series of lectures sponsored by the University of Miami at the Floridian Hotel, and were at Fort Lauderdale for the remainder of the time.

Dr. O. J. Walker, Jr., vacationed with his parents recently. He is a student at Ohio State University.

Dr. and Mrs. Robert L. Piercy, announce the birth of a daughter, Carolyn Eve, at North Side Unit Youngstown Hospital, February 12.

Dr. and Mrs. Orrin W. Haulman have arrived home after a month's vacation at their winter home in Eau Gallie, Florida.

Cancer Detection Clinic Opens

St. Elizabeth's Hospital and Youngstown Hospital have opened a cancer detection clinic and examinations are now available for persons

who believe they may have some cancer symptoms. Fred B. King, Jr., is Commander of the Youngstown Branch of the American Cancer Society.

Appointments for examinations may be made by calling St. Elizabeth's Hospital, Sister Germaine, superintendent, or Mrs. Helen O'Hora, South Side Unit Youngstown Hospital.

Dr. F. F. Piercy was recently elected president of the newly organized Youngstown, Eye, Ear, Nose and Throat Society, at a meeting in North Side Unit of Youngstown Hospital.

The Society's membership will include medical men whose practice is limited to eye, ear, nose and throat. Specialists in Youngstown district cities will be invited to join the group which plans to hold regular meetings at which nationally known specialists in these fields will speak.

Other officers are Dr. W. H. Evans, vice president, and Dr. V. C. Hart, secretary-treasurer.

Weddings

Dr. Paul J. Fuzy, Jr., and Miss Susan Evans were married February 7, in Poland Presbyterian Church. Dr. Fuzy is the son of Dr. and Mrs. Paul J. Fuzy and Miss Evans is the daughter of Mr. and Mrs. G. Taylor Evans.

Dr. Sidney L. Davidow and Miss Lois Carolyn Friedman were married February 6th, in the Cascade Room of the Hotel Pick-Ohio. The bride is the daughter of Mr. and Mrs. Martin Friedman and Dr. Davidow is the son of Mrs. Rebecca Davidow.

COUNCIL MEETING

The regular monthly Council Meeting was held at the office of the Secretary on February 10, 1947.

The following applications were presented favorably by the Censors:

FOR INTERNE MEMBERSHIP:

DR. CHAS. WALTNER
Youngstown Receiving Hospital

DR. LOUIS BLOOMBERG
Central Tower

DR. JOHN R. LaMANNA
2912 South Avenue

DR. STEWART G. PATTON, JR.
36 Potomac Avenue

FOR NON-RESIDENT MEMBERSHIP:

DR. MARIE BURKEY KRUPKO
624 Washington Avenue
McDonald, Ohio

Unless objection is filed in writing within 15 days, the above applicants become members of the Society.

V. L. Goodwin, M. D., *Sec'y.*

PRESCRIPTION THOUGHT OF THE MONTH

Although there are many expectorant proprietary preparations for the physician to prescribe, the formula printed below is a very good example for a tailor-made cough mixture requiring the pharmacist to use his skill in compounding.

Tr Opii Camph . . . 30.0
Amm Carb 6.0
Syr Ipecac 6.0
Syr Tolu . . . . . .
Sol Glycyrrizha Comp AA
Q S 180.00
Met Fiat Sol
SIG. 4 cc Q 3 HRS IN AQUA

Rapid Relief in Peptic Ulcer Without the Danger of Systemic Alkalinization

It is generally conceded that prolonged and continuous administration of alkalis for chemical neutralization of gastric hydrochloric acid inaugurates detrimental sequelae . . . Yet, hyperchlorhydria in peptic ulcer and chronic gastritis requires positive correction, both for the comfort of the patient and healing of the underlying lesion.

Kamadrox produces the required relief without the undesirable sequelae. Acid neutralization is accomplished, in part, by the physical property of adsorption; the chemical action is of a nature which does not cause acid rebound; an excess of Kamadrox cannot result in alkalosis.

Kamadrox consists of magnesium trisilicate—an insoluble and neutral powder—which produces continuous and prolonged acid neutralization without alkalinization; aluminum hydroxide—insoluble, neutral, and astringent—which neutralizes acid by adsorption of the hydrogen ions, uncomplicated by a secondary acid rise; and colloidal kaolin—an inert silicate—which coats the mucosa with a protective layer, and adsorbs bacteria and toxins.

A rational compound, constructed on sound therapeutic principles, Kamadrox is a remedy of choice in the management of peptic ulcer, gastric hyperacidity, chronic gastritis and gastroenteritis.

THE S. E. MASSENGILL COMPANY, Bristol, Tenn.-Va.
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SEMCO

50th ANNIVERSARY

Kamadrox

MARCH

St. Elizabeth Hospital Shows Increased Activity in 1946

Statistics recently released by the office of the Superintendent, St. Elizabeth Hospital ,indicate a distinct increase in hospital activity for 1946 as compared to 1945.

In view of shortages of unskilled labor, lack of adequate nursing and professional help, the 1946 yearly report takes on an added significance. More patients have been served in spite of fewer trained personnel.

13,722 patients, representing 124,966 days of care, were cared for during the year. The average number of days per patient was 8.1, the lowest since 1942; the average number of days for 1945 was 9.5. The average number of patients per day was 342.4 —Christmas eve having the lowest census—and December 6th ,the highest, 402. October was the highest month, having 1,329 patients discharged and February the lowest, when 910 patients were discharged from the hospital. Bed occupancy for 1946 was 114.1%. 85 to 87% represents a normal occupancy.

The increased activity was reflected in every department. There were 2,000 newborns in 1946 as compared to 1931 in 1945; 162 patients in the contagious section as compared to 111. A total of 2,166 patients were cared for in the pediatric section. The physiotherapy department gave 15,419 treatments, an increase of 400. There were 75,983 laboratory and pathological procedures— an increase of 8,000 over 1945.

There were 4,812 operative procedures in the surgical section as compared to 4,329 the year prior. The X-ray department processed 13,193 patients and made 42,037 films, examinations and treatments. 4,403 patients were processed through the emergency room section — as compared to 3,655 patients in 1945.

The out patient department had 10,539 patients. This department embodies the health clinic for employees, the municipal venereal disease clinic and the clinic for cancer detection. The clinic for cancer detection is held once weekly and is manned by representatives of the o.b.-gyn., surgical and medical sections.

S. W. O.

SERVICE RECORD—Capt. Herman A. Kling

Dr. Kling was inducted July 27, 1942, with the rank of Captain. His first assignment was to the 197th Sta. Hospital, Camp Breckenridge, Ky., where he remained until July, 1943. He was then transferred to the 228th Sta. Hospital in England in the Surgical Service. He returned to the States and was with the Station Hospital at Camp Reynolds, Pa. He was then sent to the Dispensary at Indiantown Gap Military Reservation. He developed Marie-Strumpell Arthritis in England and was returned to the States where he had a desk job from then on. He had no chance for promotion after his disability. He was separated from service Sept. 9, 1945, at the Newton D. Baker General Hospital where he was a patient. He resumed his practice February, 1946, and specialized in Gynecology and Proctology. He is practicing in Albuquerque, New Mexico.

Major Richard H. Middleton

Dr. Middleton was inducted Sept. 15, 1942, with the rank of Captain. His first assignment was to the Induction Board No. 9, at Evansville, Indiana. He was then transferred to Camp Breckenridge as the A. & O. officer at the Station Hospital. From there, he went to Fort Knox, Kentucky, as the A. & O. officer at the Station Hospital. He was later sent to the 304th General Hospital as Acting Chief of Medicine and Chief of Communicable Diseases. On June 22, 1945, he was promoted to the rank of Major. He served overseas in the South Pacific area. He was separated from service December 1, 1945, at Atterbury. He resumed his specialty, diseases of children, on March 1, 1946, in Youngstown.

Commander Joseph P. Keogh

Dr. Keogh was called to Active Duty on June 16, 1941, with the rank of Lieut. (j. g.). His first assignment was to the Great Lakes Naval Hospital at Great Lakes, Ill., from June 16, 1941, to March, 1942.. From March, 1942, to November, 1942, he was at the U. S. Naval Hospital, Pearl Harbor, T. H., with the Surgical Service. From November, 1942, to April, 1944, he was at the Aiea Heights Naval Hospital at Pearl Harbor, T. H. as Thoracic Surgeon. Then in April, 1944, he was sent to the U. S. Naval Hospital at Seattle, Washington as General and Thoracic Surgeon. He remained there until May, 1945, when he was sent to the U. S. Naval Hospital at Sampson, New York, as Chief Thoracic Surgeon. He was there until December, 1945. In 1942 he was promoted to Lieut. (s. g.) and in 1944, to Lieut. Comdr., then in 1945 was again promoted to Comdr. He was separated from service Dec., 1945, at New York, and resumed his practice of General Surgery with special attention to Thoracic Surgery, in January, 1946.

Captain Samuel Klatman

Dr. Klatman was inducted April 30, 1942, with the rank of First Lieut. His first assignment was to San Francisco, Port of Embarkation. On arrival in San Francisco, he was immediately assigned as Transport Surgeon aboard the U. S. A. T. *President Fillmore*. On May 20, 1942, they set sail for Alaska and the Aleutian Islands. He remained in that Theater of Operations until March 23, 1943. Following the Aleutian Campaign, he served in Central and South Pacific Theaters. On March 20, 1944, he was promoted to the rank of Captain. His decorations include the Aleutian Campaign Ribbon and two Bronze Stars for enemy action. He served overseas from May 20, 1942, to August, 1944. He was then reassigned to Camp Claiborne, La. He was separated from service Aug., 1945, at Camp Atterbury, and resumed practice of General Surgery at 409 City Bank Bldg., in November, 1945.

TINEA CAPITIS

EDWIN R. BRODY, M. D.

Tinea capitis, or ringworm of the scalp, was first noted in epidemic proportions along the Eastern seaboard in 1943. Since that time it has been seen in increasing numbers in all sections of the United States. It is a contagious disease of children and cures spontaneously at puberty.

Tinea capitis can be caused by numerous fungi belonging either to the Genus Microsporon or Genus Trichophytin. Approximately 85% of the cases reported in this epidemic are infections caused by M. Audouini and M. Lanosum. M. Fulvum, T. Gypseum, T. Violaceum, T. Crateriforme and Achorion Schonleinii are largely responsible for the remaining 15% of all cases.

M. Audouini is a parasite of human origin, and is transmitted from child to child by means of direct contacts at home, at school, in barber shops, and by the common use of hats, combs, and brushes. The infected hairs, containing thousands of parasites, break off easily and fall onto hat linings, and remain on brushes and combs.

Clinically, when this parasite is the etiologic agent, we see one or more non-inflammatory placques of partial alopecia. The placques are variously sized, and the surface is covered with a thin layer of grayish scales. Throughout these areas are numerous short, broken hairs. The disease begins rather slowly, with the first sign often being an area of slight scaling in the scalp resembling seborrhea. The eyebrows, eyelashes and skin may also be involved.

M. Lanosum is a parasite of animal origin, and is transmitted to children from animals. These parasites may be found on cats, dogs, and horses. Once the child is infected, it is readily transmitted from child to child. Clinically, this type of ringworm usually presents inflammatory areas of alopeca, with a tendency toward more extensive involvement of the scalp and surrounding glabrous skin.

M. Fulvum infections closely simulate that produced by M. Lanosum and can only be differentiated culturally.

Infections due to the Genus Trichophytin usually present a large number of small pea sized placques. T. Violaceum and T. Crateriforme produce practically no inflammatory reaction of the scalp, whereas, T. Gypseum is productive of lesions varying from a mild folliculitis to an extensive perifolliculitis which is called Kerion. The kerion form of scalp ringworm is not necessarily caused by any one special fungus. It is, however, most frequently seen in those types wherein inflammatory changes are a characteristic feature.

Rarely seen, is Favus, which is produced by the Achorion Schonleinii, another member of the Trichophytin group of fungi. Here the pathognomonic sign is the presence of scutuli, or favus cups, containing both spores and mycelial threads. This disease does not cure spontaneously at puberty and frequently produces permanent alopecia with scarring.

Diagnosis of tinea capitis should not be made on the clinical appearance of the lesions alone. All suspected cases should be examined under a Wood's filter. This light filters ultra violet radiation through a cobalt and nickel oxide glass, and all rays are filtered out except those around 3650 Angstroms. This light produces a fluorescence of infected hairs. All Microsporon infections fluoresce under the Wood's filter. Each infected hair can thus easily be

detected. It is most important, however, to remember that other fungi producing scalp ringworm do not fluoresce, and therefore a negative examination under a Wood's light is not sufficient to rule out the presence of tinea capitis. Microscopic and cultural examinations must also be done.

In examining suspected hairs, the short, broken hairs should be selected and examined under the microscope. Long hairs at the edge of the lesions seldom reveal the parasite. Since treatment is dependent upon the knowledge of the exact mycologic agent in each case, cultural examinations in all cases of ringworm of the scalp, are most desirable. Only by such means can we be sure of the exact pathogen present.

Diseases often confused with tinea capitis are alopecia areata, syphilitic alopecia, seborrheic dermatitis, folliculitis decalvans and trichorrhexis nodosa.

Treatment depends largely upon the etiologic parasite present. Inflammatory types produced by animal fungi usually respond favorably to local medications. The inflammation itself helps in the expulsion of infected hairs. Clipping the hair close, wet dressings, and fungicidal ointments are productive of early cures.

In the non-inflammatory types, the infected hairs are firmly attached, and in order to achieve a cure, these hairs must either be epilated or treated with a fungicide which will penetrate the hair follicle which is also infected. A considerable amount of research has been done in the past several years to effect cures by the latter process. Numerous new fungicidal agents in various penetrating bases, called wetting agents, have been tried with generally disappointing results to date. The fungicides employed have included salicylanilide, copper undecylenate, pentachlorphenol, di-nitrocyclohexyl phenol, sodium proprionate, and trimethyl cetyl ammonium pentachlorphenate.

Epilation achieved by the use of thallium acetate, while effective, is to be avoided because of the high toxicity of the drug.

X-ray epilation gives the largest percentage of cures, and at this time is deemed more efficacious than other methods. This procedure, however, is not entirely devoid of danger, is not always successful and requires a most exacting technique. After defluvium produced by roentgen rays, the patient should be inspected weekly under the Wood's filter, and manual epilation of any remaining fluorescent hairs must be done. The scalp should also be treated daily with topical fungicidal preparations.

Manual epilation may be tried if the child is near puberty. This requires the greatest patience on the part of both the patient and the family. It must be done thoroughly over long periods of time, and even then, newly infected areas are frequently seen.

Estrogens, androgens and vaccines have also been tried, but have not been found effective.

The prognosis in the majority of all cases of tinea capitis is good providing proper treatment has been instituted. In this regard, it should be remembered that the application of medicaments which are too strong frequently produces deep inflammation resulting in scarring and permanent alopecia upon healing. This may also occur when there has been kerion involvement.

Prophylactic measures to reduce the incidence of this disease should include:

1. Examination under the Wood's filter of all children prior to admittance to school.
2. Compulsory treatment of all infected cases as a public health measure.
3. Exclusion from school or the wearing of a stocking cap while at school. Some communities hold special classes for infected children.
4. Instruction of parents concerning prompt burning of epilated hair, and sterilization of combs and brushes.
5. Immediate shampoo and application of fungicides following each haircut.
6. Examination of house pets for the presence of fungi.
7. Proper sterilization of barber's combs, brushes, and scissors.
8. Restriction of activity of infected children. Nothing is to be gained by keeping a child home from school, and allowing him to infect playmates at home.

125 East 50th Street, New York City

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6th Councillor District Postgraduate Day

The 6th Councillor District of the Ohio State Medical Society will hold its First Postgraduate Day in Canton, Ohio. The tentative date is October 8th, and the meeting will probably be held at the Hotel Onesto. Further details will be given in a later issue. Plan to keep that date open.

G. E. D.

Bowling Tournament Prizes

The Professional Pharmacy has announced that they will donate three prizes to the bowlers with the highest scores and a bogy to the bowler with the lowest score. The prizes will be given on the average of total scores up to and including games played on April 10th. G. E. D.

LINCOLN AVENUE HOSPITAL

Barclay Brandmiller, Chairman o fthe Public Relations Committee and myself as Chairman of the Hospital Relations Committee were asked by Council of the Society to inspect the Lincoln Avenue Hospital. This report was made to the Council.

This hospital and the splendid work it is doing so impressed me that I thought all members of the Societey should be familiar with it.

The building is in good condition. The sanitary conditions are splendid. The kitchens, toilets, etc., would pass inspection of any regular Army C. O. The building throughout is very clean. The rooms are comfortable and not as crowded as our regular hospitals. Beds are good and linen is spotless.

The hospital has a competent staff. It has a business manager who attends to the office work, interviews patients, etc. The management of the hospital proper, that is the care of the building, feeding patients and general hospital problems are handled by a man and wife. There are three practical female nurses on duty and one male attendant.

Dr. Tarnapowicz is the physician. He is on call at all times and spends much time at the hospital. He serves without pay.

In the eleven months it has been in operation, 700 patients have been attended, 415 of these were admitted to the hospital. Their average stay was five days and the average cost was $55.00. Many of these patients were admitted from neighboring states. Three hundred of the patients admitted and treated have joined Alcoholics Anonymous and are useful citizens. A patient ready for discharge, who has no gainful occupation is referred to the Salvation Army or other Social Agencies, who have been very co-operative in securing jobs, providing a home, etc., until the man or woman is established in a gainful occupation.

Alcoholic patients are admitted at any time, regardless of degree of Alcoholism or their ability to pay. Their treatment is simple. Some patients are given whiskey for one or two doses if it is indicated. Then they are given sufficient paraldehyde or a milder sedative until they have sobered up. From then on it is a question if or not the person wants to quit drinking. No persuasion or abusive arguments are used. Ex-patients visit these people and tell them how they have been cured. They are encouraged in every way possible. They are invited to join Alcoholics Anonymous. This organization has eight separate groups in the county who meet regularly. Every Sunday evening the entire group meets. These meetings are the real inspiration to the member. They serve a social as well as a moral purpose.

The Hospital seeks the support of the Medical Society. They deserve our support for many reasons. What doctor has not had alcoholic patients who were problems? The local hospitals are not equipped to take care of these patients. The family cannot handle them. They are patients and do not deserve the stigma of being sent to jail. Now the doctor can send his patient to a reliable hospital and if he so desires may visit his patient and help him to recovery.

Many Alcoholics do not need to be hospitalized to be cured. Some of them need medical treatment but blame all their ailments on alcohol. At New

Haven an elaborate study is being made of these people.

At present a small clinic is desirous here. They ask for a psychiatrist only at present. An ambulatory patient will then be examined by Dr. Tarnapowicz and the psychiatrist. A Wasserman test will be made and a complete physical examination given. If he needs treatment, he will be referred to his family physician. If he is a psychiatric patient or a syphilitic, this group can do him no good.

If the patient has a relapse and should for some reason begin to drink he is treated again with the same kindness and consideration as long as there is hope for his recovery. As they explained to us, "It is like a Diabetic who slips on his diet or use of insulin. If he comes to your hospital in a coma, you treat him again and advise him what to do to avoid a recurrence of the coma."

No patient is refused treatment. If he has no money the members pay his bill. Some of this money is returned when the patient returns to work.

The true facts should be known and people would gladly support this hospital, financially and otherwise.

From the standpoint of the Alcoholic patient, his family and the community, the relief of these patients from the local general hospitals and the aid to the local physicians I know of no other institution that is doing more real good than the Lincoln Avenue Hospital.

W. K. Allsop, M. D.

HEADACHES OF OCULAR ORIGIN

John S. Goldcamp, M. D.

I have chosen the subject, Headaches of Ocular Origin, for two reasons. First in the hope that it may be of some interest to a general group, more so I am sure than most eye subjects, and second because headache is the symptom most frequently complained of by the patients consulting an opthalmologist.

First, let us consider the mechanism of pain of ocular origin. The sensory nerve supply of the eye is the ophthalmic branch of the fifth cranial nerve. It supplies branches to the cornea, ciliary body, iris, lacrymal gland, conjunctiva, and the skin of the eyelids and forehead and communicates with the oculomotor, trochlear and abducens nerves. The receptive mechanism for pain is contained in free nerve endings with a plexiform arrangement of nerve fibers. These are very abundant within the epidermis, the cornea and conjunctiva. Pain from the iris and extrinsic muscles of the eyes is produced by traction. Pinching, sticking or cutting the extraocular muscles does not cause pain but traction on them produces immediate pain localized deep within the orbit. The origin of the afferent fibers for these muscles is not known although they are present in the oculomotor, trochlear and abducens nerves. Pain from the iris is referred to the eyeball itself but if of sufficient intensity will spread over the ophthalmic division of the trigeminal nerve. The afferent fibers of the opthalmic division of the fifth cranial nerve have their cells of origin in the semilunar ganglion. Within the pons many of them divide into short ascending and long descending branches, the former terminating in the main sensory nucleus and the latter in the spinal tract nucleus of the trigeminal nerve.

As a rule it is very easy to arrive at a diagnosis of headache of ocular origin because of the fairly large number of accompanying eye symptoms or

signs. Of those patients we see complaining of headaches without some ocular symptom, we have found less than five per cent resulting from ocular pathology or derangement. On the other hand, the patients who complain, in addition to headache, of symptoms referable to the eyes we have found in almost every case some ocular condition which might well be the cause of the head pain. These accompanying symptoms and signs can be elicited by a few simple questions and a short external examination. In examination of the eyes, look for strabismus, excessive tearing, squinting, localized or generalized swelling of the lids, redness or scaliness of the lid margins, exophthamos, inflammation or follicles of the conjunctiva, exudate in the lower culdesacs, haziness of the cornea, blood vessels in the cornea, foreign bodies, and irregular, fixed or sluggish pupils. One or more of these findings are present in a great many ocular conditions that may cause headaches.

I will now enumerate and enlarge on the most important questions to be asked of the patient, the answers to which will give the examiner a lead as to whether or not his patient's headache is ocular in origin.

Question No. 1. Where is the location of the headache? Most ocular headaches are either frontal or located within or behind the eyes. Many are occipital. I feel that the majority of headaches in the region of the occiput associated with frontal pain are ocular in origin, whereas frontal pain alone is a common symptom in a much greater variety of conditions. Generalized head pain and localized temporal headaches are infrequently of ocular origin.

Question No. 2. What time of the day or night does the headache usually begin? If the answer is that it is present almost every morning on awakening then one can fairly well eliminate an ocular cause, particularly so if the headache lessens in severity as the morning passes. If a middle aged or elderly patient is awakened during the night by eye or frontal pain then one must bear in mind the possibility of glaucoma. Headaches that begin in the morning after the patient has been up and about for a short time and which increase in severity may well be of ocular origin; late afternoon and evening headaches frequently are.

Question No. 3. What seems to cause the headache or increase its severity? The patient may attribute the pain to bright light, movies, blurring of vision for either distance or near, or to concentration on some type of close work as reading, typing, clerical work, or any kind of fine work that requires constant ocular use. In such cases one may be almost certain one is dealing with pain of ocular origin. Do not ask leading questions at this point because headaches of other than ocular origin are frequently increased in severity by prolonged ocular concentration.

Question No. 4. Do you have any eye difficulties along with or separate from the headaches? The patient may give a history of burning of the eyes, excessive tearing, blurring of vision, jumping or doubling of print when reading, heaviness of the lids, inflammation of the lid margins, sties, transient double vision, photophobia, tender eyeballs, redness of the eyes, or drowsiness when doing close work. Any one or combination of these symptoms leads one to strongly suspect the eyes as the seat of the trouble.

Question No. 5. What, if anything, tends to relieve the headache? If the answer is that reclining with the eyes closed lessens the pain then an ocular cause is a definite possibility. Many headaches due to refractive errors are relieved by aspirin but those due to ocular infections and muscle imbalances

usually are not.

From the answers received to these questions and from the finding of an examination of the eyes externally the physician can decide whether to send the patient to the ophthalmologist or whether a search should first be made for other causes.

The ocular conditions that cause head pain are numerous, most common of these being a derangement of the refractive media of the eye. Of these errors of refraction, hyperopic astigmatism and hyperopia or so called far sightedness are the most frequent offenders. Next in line are presbyopia or old age sightedness, myopic astigmatism, and myopia or so called near sightedness, in that order. The latter two conditions rarely give rise to headaches. In uncorrected hyperopia and hyperopic astigmatism the increased amount of accommodation necessary to focus the images on the retina results in overaction of the ciliary body of the eye. This increased traction on the ciliary muscle gives rise to the eye pains and head pains that frequently occur in these two conditions. The headaches of presbyopia are a result of ciliary muscle fatigue. This fatigue in return is due to the prolonged action of the ciliary body against a sclerosing lens in which the loss of elasticity prevents proper accommodation. In myopic conditions there is no over-action of the ciliary muscle, hence, headaches are a rare symptom except where the myopia is over corrected by a too strong concave optical lens, thus inducing an artificial hyperopia. Under the heading of refractive errors there are anisometropia which is a marked difference in the refractive error of the two eyes, and anisoconia, which is a difference in the size of the images on the two retinae. These conditions are comparatively rare but invariably cause headaches.

Extraocular muscle imbalances or phorias are the next most common ocular causes of headaches. These imbalances tend to defeat single binocular vision and tend to cause diplopia. The prolonged abnormal effort of the extrinsic muscles of the eyes to maintain single binocular vision results in the symptoms. Vertical imbalances or hyperphoria of even small degrees cause almost daily headaches whereas lateral muscle imbalances, esophoria and exophoria, do so only if of comparatively larger degrees. However, esophoria and exophoria are a great deal more common than hyperphoria.

Extraocular muscle paralysis causes headaches if diplopia is present just as a phoria that develops into a squint does until suppression of the image develops in one eye.

The two groups just discussed, namely refractive errors and muscle imbalances, cause the majority of headaches of ocular origin. Since these conditions, particularly the refractive errors, reveal few or no ocular signs the history given by the patient is of the utmost importance to the examiner who has not had special eye training. On the other hand, the following ophalmological conditions that cause headaches and at the same time reveal ocular signs are easily recognized for the most part by the general practitioner. These conditions which usually produce localized pain over the area supplied by the ophthalmic division of the trigeminal nerve are numerous and need only be mentioned here. They are acute purulent dacryocystitis, horedeolum, stray foreign bodies, traumas of the conjunctiva and cornea, ulcerations of the conjunctiva and cornea, superficial and deep keratitis, iridocyclitis, acute congestive glaucoma, periostitis and osteomyelitis of the orbit, orbital cellulitis, scleritis, suppurative endophthalmitis, panophthalmitis, secondary glaucoma and exophthalmos. Those conditions which may produce a pro-

dromal ocular pain without early evidence of ocular involvement are herpes zoster ophthalmicus, marginal periostitis of the orbit, actinic conjunctivitis, iritis, and sympathetic ophthalmia. All these pathological conditions are for the most part inflammatory diseases and their mechanisms of producing headaches are by causing traction, displacement, distention, or inflammation of structures supplied by the ophthalmic division of the fifth cranial nerve. H. G. Wolff has shown that all the tissues covering the cranium are more or less sensitive to pain, the arteries being especially so. He, therefore, feels that the traction, displacement, distension and inflammation of the cranial vascular structures are chiefly responsible for headaches.

In conclusion, it can be safely stated that the majority of headaches caused by pathology of the eye or its adnexa can be traced to their source by a short external eye examination and by a short but careful inquiry into the history of the patient's complaint; that the headaches without accompanying ocular signs or symptoms are infrequently of ocular origin and lastly that any lesion which can produce traction, displacement, distension, or inflammation of any of the structures supplied by the ophthalmic division of the trigeminal nerve has the potentiality of producing pain, varying in degree from a slight uneasiness to extreme distress.

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1928

It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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