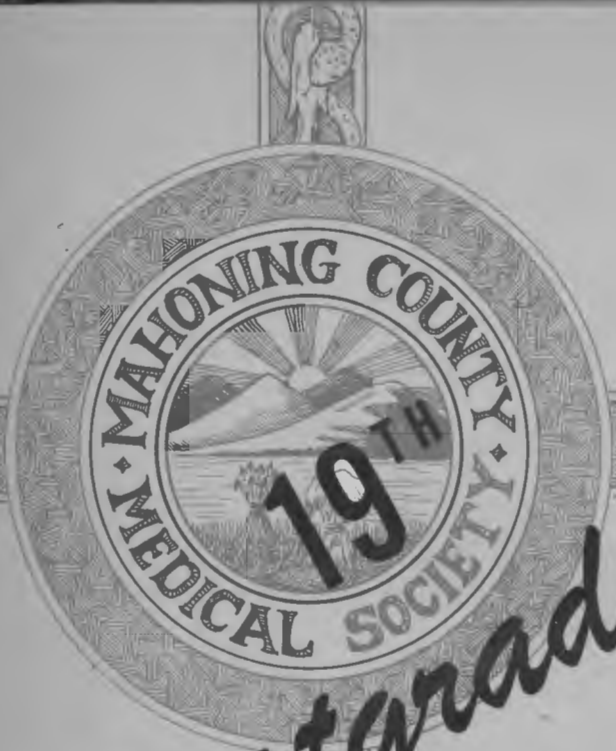

Postgraduate Assembly

We must make the best use that we can of the things which are in our power, and use the rest according to their nature.
Epictetus

APRIL 16, 1947

BULLETIN

of the
MAHONING
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THE MAHONING COUNTY MEDICAL SOCIETY

Vol. XVII—No. 4

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April, 1947

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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 Tuberculosis Sanitarium, Kirk Road Monthly Staff Meeting — Youngstown Receiving Hospital Auditorium—Indianola Ave.
Every Thursday 11:30 A. M.	Weekly Surgical Conference Youngstown Hospital—Stewart House
Every Thursday 12:30 p. m.	Orthopedic Section Library—South Side Unit Youngstown Hospital
Every Friday 11:00 a. m.	Urological Section Library—South Side Unit, Youngstown Hospital Clinic—St. Elizabeth's Hospital Library
Every Friday 11:30 a. m.	Clinic—Pathology Conference Auditorium Nurses' Home South Side Unit Youngstown Hospital
Alternate Saturdays 11:00 a. m.	Obstetrical Section North Side Unit of Youngstown Hospital

COMING MEETINGS

Northern Tri-State Medical Association, Detroit, April 8.

Nineteenth Annual Mahoning County Postgraduate Assembly, Youngstown, April 16.

American College of Physicians, Chicago, April 28 - May 2.

Ohio State Medical Association, Cleveland, May 6-8.

American Society for the Study of Sterility, Atlantic City, June 7 - 8.

American Medical Association, Atlantic City, June 9-13.

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.

PRESIDENT'S PAGE

The trend of medical literature during the last year has indicated that we have entered a new epoch during which we must re-interpret our civilian experience and correlate it with the mass of material which war produced. It also shows that we must properly evaluate our military experience and extract from it all that will prove applicable, immediately and remotely.

To this end we are continuing our interest in our annual Post-graduate Day, and are welcoming, as usual, those who in the past supported us in our effort to make available to them the leading investigators and clinicians from clinics and teaching institutions.

We feel assured that these yearly meetings not only afford us contacts with men of experience and of mature judgment to broaden our own concept of disease conditions, but also furnish material for discussion subsequently. We will be looking for our neighboring medical friends who have been regular in their support previously.

May we ask you to bring along another, perhaps a young man, that he may also become interested?

GEORGE M. McKELVEY

BULLETIN of the Mahoning County Medical Society

Published monthly at Youngstown, Ohio — Annual Subscription, $2.00
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Published for and by the members of the Mahoning County Medical Society
C. A. GUSTAFSON, Editor
101 Lincoln Avenue

ISHTAR, a Meditation

Again comes the season of regeneration, of earth's awakening. All around us may be seen the evidence of that all-pervading, irrepressible element which keeps pushing itself through the inanimate into our consciousness. Look where we will, and we find no place where it is not, has not been or will not be. It sometimes seems to us like a universal solvent that would take all things into itself, transform them into an harmonious whole, that they might separate and begin again.

That this ageless process should be recognized by early man to be akin to his primitive impulses, and that these should be exalted into a motif for his festivals, is in keeping with the gradual unfolding of his understanding of a world of cause and effect. And so it seems that our rites and observances, like many of our best thoughts, have always existed; that they have come down to us from antiquity, wearing garments which, though weather-stained and torn, are redolent of spices from where they had rested in their course.

As we stand beside our flower-beds and watch this unfolding, meditating upon its significance, the alchemy of the ages, we think we can hear cathedral chimes echoing among the seven hills. The Aegean with its innumerable isles, the Nile and the flower-carpeted banks of the Jordan, seem to entice us onward to the Euphrates where once was Babylon.

So as we meditate about this process of redistribution of energy, wondering if it be continuous or intermittent, we are convinced that such thoughts are for him who does not suffer when he discovers uncertainty, for him who is not discouraged when he may not be able to demonstrate purpose in all that he sees. It is for him who can view this process as both a challenge and as an enticement.

It is not for the seeker after simplicity; for he will find little to give him comfort in the yielding as he advances into what he recognizes as a vaster and more intricate whole. But there is comfort for him who can yield his own permanencies, replacing these with each advance, modifying his conceptions as he proceeds. And he may remain comforted though he may not be able to separate fortuity from much of what must be true.

So this season for regeneration and meditation comes again, myriad in its manifestations, abounding in promise, alluring to our concepts, and inclusive even in its unfolding. And we are not only grateful recipients of its bounty and its beauty, but are also eager participants in its processes.

W. D. C.

FEBRUARY MEETING

The importance of the nine essential amino acids in maintaining health were outlined by Dr. Paul R. Cannon, professor and chairman of the department of Pathology in the University of Chicago, at the regular meeting of the Society February 18, 1947, at the Youngstown Club. Dr. Cannon spoke on "Recent Advances in Protein Nutrition."

The speaker pointed out that these essential amino acids were more entitled to be called vitamins than the present chemicals recognized as such, since the lack of any one of the nine essential amino acids resulted in a negative nitrogen balance.

He listed the essential amino acids as follows:

Histidine	Phenylalanine	Leucine
Lysine	Methionine	Isoleucine
Tryptophane	Threonine	Valine

He pointed out that sick patients with ulcers or neoplasms may suffer from protein deficiency because some of the essential amino acids may be destroyed by toxic products of the disease.

Dr. Cannon went on to illustrate his lecture with graphs of animal feeding experiments. He showed how the withdrawal of one essential amino acid, as lysine or tryptophane, caused immediate loss of appetite, loss of weight and a change in the animal's coat. He pointed out that humans require a minimum of 150 mg. of tryptophane a day. The other essential amino acids are required in greater quantities than tryptophane, leucine being required in the largest amount, roughly six times that of tryptophane.

Dr. Cannon also showed graphs of animal experiments in which all the essential amino acids were fed during a day, but not at the same time. His charts showed that animals failed to thrive. He pointed out that in animals the power to retain the function of one acid for as little as one hour until the other essential acids are fed is lacking.

Practically, Dr. Cannon pointed out that white flour lacks lysine and that many breakfast foods are lacking in lysine since it is destroyed in the processing.

He analyzed the composition of protein split products now being offered to the medical profession for parenteral and oral administration. He emphasized that such products must contain all the nine essential amino acids to be of any value. Unfortunately, he said, some products are not complete and should be avoided. F. S. C.

BACKGROUND FOR SEPARATE NATIONAL HEALTH DEPARTMENT

An examination of the minutes of the House of Delegates of the American Medical Association shows that considerable thought was given over a period of years to the formulation of a separate federal health agency. References and records of action taken appear repeatedly in the minutes. As early as 1884 at the annual session it was urged that a separate Department of Health be established under a Cabinet officer. In 1891, a committee of twenty-three members was appointed to petition Congress on this matter. Further references appear in the minutes of the annual sessions each year from 1891 up to and including 1902. The subject apparently was not discussed during the three succeeding years, but reappears annually from 1906 to 1913, and from 1917 to 1930. After five years, a resolution was introduced into the Special Session of the House held in Chicago in 1935 urging the President of

the United States to establish a separate Department of Health. At the session of the House of Delegates in San Francisco in 1938, the House adopted the following recommendation of the Reference Committee on Legislation and Public Relations: ". . . your committee recommends that this House of Delegates reiterate its demand for a federal executive department to be designated as the Department of Health, with a Doctor of Medicine at its head who shall have general supervision and direction of the affairs of the federal government pertaining to the health of the people." From the foregoing it will be seen that the American Medical Association has repeatedly gone on record as being desirous of seeing legislation passed leading to the formulation of a separate National Health Department. Current opinion in the Association at the present time is to the effect that this department should be an agency separated from other activities of the government.

Congress in 1879 passed legislation authorizing a National Board of Health. The functions and relations of this unit with other departments were very poorly defined in the law and no money was appropriated for its activities. The legislation remained on the statute books without any action until 1893 at which time it was repealed.

It has been estimated that educators are concerned in some manner with approximately twenty-eight million members of the population. Social Security has contact with about fifty-one million people including recipients as as well as taxpayers. Medicine, on the other hand, has a much broader contact and in fact, enters into the lives of all of our people.

An examination of proposals to group all health activities of the federal government under one head may be accomplished in a number of ways. The most commonly considered conceptions are:

1.—A separate Department of Health whose head has Cabinet status.
2.—Combining all health activities of the federal government in a separate agency not of Cabinet status.
3.—Combining health activities with other activities of the federal government in one department.

While the American Medical Association is still of the opinion that the health of the nation warrants a separate Department of Health with a Cabinet officer at its head, it realizes that it may be impractical to develop this at the present time.

Furthermore it is its opinion that if a separate department of health is not feasible it is possible to group activities in a separate bureau. The Association is opposed to having health activities grouped with other activities in a department with Cabinet status.

It might be well for you to *discuss with your senator* the *provisions of these two bills, S.* 140 *and S.* 545 within the next few weeks.

SPEAKERS BUREAU

Members of the Society have recently received a questionnaire asking them to indicate medical subjects they would be willing to discuss before lay groups. These questionnaires are to help the committee on Lay Education furnish speakers for various meetings in this community. Prompt return of the questionnaires is urged.

The committee announces that it will be glad to furnish qualified speakers on medical subjects to any lay group. Inquiries should be directed to Dr. F. S. Coombs, chairman or any member of the committee. F. S. C.

COLITIS

By B. I. FIRESTONE, M. D.

Colitis is a subject which covers a very large field of medicine. I prefer to spend the predominant portion of the discussion on the enigma of the colitides "Ulcerative Colitis". In the differential diagnosis, I shall bring in the other forms of colitis briefly and then briefly discuss the subject of "Nervous Diarrhea".

Bockus defines "Ulcerative Colitis" as a clinical syndrome ushered in with a suppurative, ulcerative inflammation of the colonic mucosa with or without a recognizable initial specific infection but associated with a bacterial or toxic invasion of the bowel wall conditoned by varying immunologic, allergic, nutritional and nervous phenomena. The disease has variously been called chronic suppurative colitis, idiopathic ulcerative colitis, non specific ulcerative colitis, thrombo-ulcerative colitis and by Bargen, streptococcal ulcerative colitis.

Much acrimonious debate centers about the etiology of ulcerative colitis. When Bargen discusses the disease he refers to it as streptococcal ulcerative colitis; but there are many reports at present to refute his original idea that a specific streptococcic organism is responsible for the train of events seen in this devastating disease.

In 1936 Felsen called attention to the role of chronic bacillary dysentery as an etiological agent in ulcerative colitis and allied lesions. World War II has served to substantiate Felson's idea. A number of American soldiers returning from the Orient have developed chronic bacillary dysentery and present a picture indistinguishable from ulcerative colitis and in whom a diagnosis of ulcerative colitis is ultimately justified. The same might be said of many cases of chronic amebic dysentery. Whether or not these chronic dysenteries so debilitate the bowel that another form of ulcerative colitis supervenes is a moot question. The importance of a correct etiological diagnosis in a colitis originating from either of these sources is self evident. The response in the amebic type to specific therapy is incomparably better than noted in all the other varities of ulcerative colitis.

Viruses and specific fungi have been traced through and found to bear no relationship to the actual etiology of the disease. It has also been projected by certain investigators that lymphatic obstruction with resultant edema and anoxemia accounting for cellular necrosis may possibly open the pathway to secondary invaders.

Andresen has been a rabid proponent of the allergic character of the disease. He presented 33 of 50 consecutive cases in which he believed allergy to be the principal factor. Elimination of the offending items resulted in the cure of these cases. He found milk, egg, wheat, potato, orange and tomato to be the offenders in 84% of his cases; and milk alone in 40%. Bockus' group believe that the allergic phenomena may be a factor in aggravating the disease after the tissues have become sensitized as a result of the original disease but they place little emphasis on allergy as a specific cause of ulcerative colitis.

The psychogenic factor in the etiologic theories of ulcerative colitis is tremendous. I do not believe there is any consistent psychiatric pattern but psychiatrists agree that the individual with ulcerative colitis is apt to be self-centered and dependent, the dependency usually falling upon a mother or sister. The patient is emotionally and sexually immature and is one who does

not bear responsibility well. Mental depression is a frequent finding and one should not be misled into believing that this is a legitimate secondary reaction to a disagreeable uncomfortable disease. Hysterical conversion and anxiety states are common. The role of precipitating factors, such as severe emotional disturbances or conflicts, is frequently noted and the physician even without psychiatric training can usually note the item which sets off the trend of events either in the original attack or in a recurrence. There are numerous investigators who discount the psychogenic factor but it suffices to say that the percentage of abnormal personality patterns is definitely higher in this group than that found in the normal population. An abnormal personality pattern in a person having diarrhea does not rule out carcinoma of the bowel.

An imbalance of the autonomic nervous innervation of the bowel may set up mucosal conditions which are associated with edema, necrosis and secondary invasion with the resultant picture of ulcerative colitis. The role of mucous or spastic colitis progressing to ulcerative colitis is disputed. However, I personally am not convinced that there is no relation.

In summary even though acute inflammatory conditions of the bowel can be produced by one or more of the above factors, a condition such as is seen in chronic ulcerative colitis, cannot be reproduced experimentally. The primary barrier of defense of the colon could be overcome by any of the aforementioned factors; then it is not difficult to assign to secondary bacterial invaders the role of bringing about further inflammatory changes and finally a state of chronic ulcerative colitis.

The incidence of ulcerative colitis is not great but the number of cases seems to be on the increase; and if there is much to the idea that bacillary dysentery and amebic dysentery are forerunners of this disease, then we should see a lot more in the next few years in veterans of World War II. Crohn reported 9 cases of ulcerative colitis in 2500 cases of digestive disturbance. It usually occurs before the age of 40 and is found in both sexes with equal frequency. There seems to be no familial predisposition to the disease.

A good past medical history is essential, particularly as to previous intestinal upsets; diarrhea, gastro-enteritis, amebiasis, pulmonary Tbc. A good past medical history may be very revealing as to a possible specific etiological factor. A psychiatric anamnesis is important; not a so called specialist affair, just good common horse sense psychiatry; such as the relationship of the acute onset to pregnancy, to a financial worry, a marital tiff, physical fatigue, etc. Also the question of "does the patient have any allergic manifestations" should arise.

The onset of the disease may be insidious or an abrupt fulminating affair. There may be no diarrhea at first, merely a bit of blood and mucus on the outside of the stool; slowly progressing until the bloody diarrhea is paramount. Most cases begin with a severe diarrhea associated with the passage of large amounts of bloody mucus. In the acute fulminating variety the patient has almost continuous liquid evacuations containing little fecal material and composed almost entirely of blood, pus, and mucus. If the lower rectum is not involved the patient may only manifest the disease with 3 - 5 mushy stools per day as the initiating symptom. Abdominal pain is present in almost all cases and is colicky in type, usually in the left lower quadrant, but may be generalized. The pain is usually relieved somewhat on defecation. Rectal tenesmus is one of the most annoying complaints. Low back ache may be a distressing symptom in some patients. Reflex symptoms such as

nausea, distension, and even vomiting may be present. Loss of weight, strength and general nutrition is dependent on the severity of the disease. Temperature increase may or may not be present.

The disease may be classified as to its severity and tendency to recur.

1.—*Acute Forms*:

A. Insidious or mild type. This type presents few symptoms except for some mucus and blood in the stools. It may become acute fulminating but usually runs a course of a few weeks or months and recurs at intervals.

B. Fulminating. This type is severe; it may last for weeks or months; but usually reaches its peak at 2 - 3 weeks. It may terminate fatally or pass into a chronic stage or a remission.

C. Continuous. This type is usually of moderate severity and shows no evidence of remission. After 5 - 6 months of continuous difficulty it passes into the chronic stage.

2.—*Chronic types* exist in two forms, one in which the patient is never free from symptoms, and the other in which the patient displays a persistence of bowel lesions without appreciable symptoms except during relapses.

A. Continuous. This type includes that group of patients who never have actual relief from the disease although there is a wide variation in intensity. Sometimes severe bouts with marked toxemia, other times mild bouts with relatively little toxemia. These patients are usually semi-invalids. Their bowels are likely to show extreme roentgenologic and sidmoidoscopic changes. They may at any time develop a fulminating attack which will produce an exitus; but a good proportion continue to live for many years with a narrow fibrotic colon and die of some unrelated disease.

B. Relapsing. In this group falls the greatest number of cases. This type usually is the one which begins as the acute continuous type; but after a few months of an insidious affair the patient clears up with residual bowel changes and a recurrent attack makes clear the chronicity of the condition. These cases may have remissions of one year or longer but usually have one to two bouts a year, ordinarily seasonal in recurrence.

Recurrences are usually preceded by an upper respiratory infection, an emotional upset, dietetic indiscretions, nutritional deficiencies, trauma from an enema, excessive fatigue, or worry. Pregnancy may aggravate a case but in some cases the patient is improved during pregnancy. Any of a number of other factors may set off a mild to a fulminating relapse.

Physical examination of the patient should be complete, providing he or she is not too ill. Inspection of the skin will give an idea as to the water balance and tissue elasticity of the patient. Evidence of nutritional disease may be noted. Tongue, mouth, eyes should be studied for evidence of avitaminosis or allergy. Abdominal examination usually reveals some tenderness in the lower left quadrant, and frequently the left colon can be palpated as a rigid tube. Abdominal distension which remains persistent is considered a bad sign. The liver or spleen may be palpable. Rectal examination is usually not too revealing but the educated finger may be able to note granular changes in the rectal mucosa. Occasionally there are fistulous tracts between the rectum and the vagina or bladder.

Sigmoidoscopic examination is the means of diagnosis in 90% of the cases.

Factors of time, virulence, and the differences of individual reaction modify greatly what may be seen. Not every acute involvement of the recto-sigmoid is to be considered ulcerative colitis. Early in the disease the colitis presents a red friable mucosa which traumatizes easily. Later the application of a cotton swab reveals a granular mucosa with multiple pinpoint hemorrhages. A well developed case presents a diffuse granular mucosa; the pinpoint granular areas subsequently undergo hyperplastic changes which may progress to diffuse polypoid hyperplasia. The degree of bleeding is an index to the activity. Granular mucosa free from bleeding may be seen in chronic cases during a remission. Discrete ulcerations are not the usual finding. The surface of the bowel is usually covered with a thick muco-purulent discharge and in fulminating cases a diphtheritic like membrane is seen. A smear and culture should be taken during every examination; and a specimen examined for evidence of pathogenic ameba or the infection. Cultures should be studied for the typhoid dysentery group.

X-ray examination of the colon by barium enema outlines areas not reached with the sigmoidoscope. Certain important features are noted, namely; the fuzzy character of the acutely involved areas, the polypoid changes of chronic cases, the generalized irritability of the colon with loss of haustral markings, the shortening and narrowing of the lumen and finally some estimation of the extent of the process.

Laboratory procedures of value in a case of ulcerative colitis, and which may help in controlling an acute fulminating colitis, are: routine blood studies, blood urea, nitrogen blood chlorides, calcium determination and carbon dioxide combining power. The last procedure is of value both to detect the presence of complications and to act as a gauge of therapy for acidosis, alkalosis or other chemical abnormality. The albumen-globulin ratio must be watched as a marked hypoprotenemia may result from the increased plasma loss through the bowel, deficient protein intake and poor absorption from the bowel.

A prothrombin time determination is very important. Hypoprothrombinemia is frequently found with gross hemorrhage due to general malnutrition, avitaminosis and possible liver disease. Bargen believes that a marked shift to the left with many toxic white cells is of prognostic significance as to the severity and possible fatal outcome. Repeated sedimentation rates are of value in determining the activity of the disease. A gastric analysis to determine the degree of acidity is indicated. About 15% of the cases are achlorhydric.

In the differential diagnosis one must consider bacillary dysentary, amebic dysentary, colonic neurosis, colonic diverticula, or factitial proctosigmoiditis.

Other less common forms of ulcerative colitis are due to tuberculosis, the virus of lymphogranuloma and non-specific regional enteritis. Isolated T. B. of the large bowel is rare and is almost always secondary to small bowel involvement. The colitis due to lymphogranuloma presents a characteristic picture. Recently we have been confronted with a new entity called regional colitis; probably related in some way to the etiologic factor of regional ileitis Regional colitis presents localized areas of chronic, stenosing, granulomatous lesions which usually begin closer to the right side of the colon and progress caudad; in contradistinction to the idiopathic ulcerative colitis which begins at the distal colon and progresses orad. Clinically and pathologically the disease does not appear to be similar, nevertheless there is sufficient similarity

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of the diseases to warrant an open mind as to whether or not they are variants of the same process.

Complications:

1.—Polyposis occurs in 10% of the cases. These polyps are potential sources of malignant change.
2.—Stricture of the bowel.
3.—Free perforation is rare.
4.—Abscess and fistula formation, recto-vesical and recto-vaginal.
5.—Carcinomatous change should be entertained if the patient develops a palpable mass, stricture or obstruction.
6.—Massive hemorrhage is alarming and dangerous.

In addition to these local complications, patients who have a chronic continuous or an acute continuous colitis, are apt to develop systemic complications usually found in other severe dibilitating diseases, I. C. nutritional deficiencies, toxic bone marrow, skin lesions (pyodermia) and arthritis.

Medical, Management: Diet is preferablye a low residue one containing at least 120 gms. of protein daily. Most of this is given in gelatin, albumin, amigen if tolerated, milk, eggs and cheese. High carbohydrate intake is recommended. In the acute stage if diarrhea is too severe, food by mouth is best held to a minimum, the fluid balance and protein balance can be maintained parenterally. Vitamins, especially the water soluble one, are maintained in the intravenous feedings. If steatorrhea is present, the calcium excretion may be high and this should be compensated for by calcium IV or by mouth if tolerated. Plasma or amino acids may be given parenterally to maintain the A/G ratio and total protein, 500 cc. of blood daily plus 1000 cc. of plasma will supply the patient with approximately 100 gms. of protein a day. If there is not too marked an anemia, I believe that frequent small transfusions of 250 cc. are more advantageous than an occasional large transfusion.

Vaccines, sera and bacteriophage, I believe, have no place in the therapeutic armamentarium of ulcerative colitis.

Penicillin in very large doses has proven of some benefit in acute fulminating cases which were rapidly deteriorating. It has no effect on the chronic cases of ulcerative colitis. Streptomycin has been of no value in a limited number of cases.

The chemotherapeutic attack has been the most encouraging of any of the specific methods. The most effective in commercial production at the present time are sulfadiazine, sulfasuxidine, sulfathalidine, sulfathiazole, and sulfaquanidine. A more recent preparation used by Bargen and not released to my knowledge is sulfacarizole.

Sulfaquanidine and sulfasuxidine are sparingly absorbed from the intestinal tract and may be given in large doses, that is 12 - 16 gms. daily in divided doses for 10 days. Streicher has found that as much as one gm. every eight hours of sulfasuxidine gave relief in acute cases. Frequently one can give one of the readily absorbed sulfa, such as sulfadiazine, 1 gm. every four hours plus 2 gms. of a poorly absorbed sulfa, such as sulfasuxidine, every four hours.

A course of sulfa given occasionally to a patient in a remission is also an accepted practice. Some men prefer to use the drug ten days, then rest for ten days. If there are no untoward reactions, I see no reason to give any rest periods until the patient is in a remission. These drugs do not cure the

(*Continued on Page* 157)

19th ANNUAL POSTGRADUATE PROGRAM

by

GROUP FROM TEMPLE UNIVERSITY
SCHOOL OF MEDICINE AND HOSPITAL
PHILADELPHIA, PENNSYLVANIA

•

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Professor and Head of the Department of Obstetrics and Gynecology
C. L. JACKSON, M. D.
Professor and Head of the Department of Broncho-esophology and Laryngology

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MORNING SESSIONS

10:00 A. M. Surgical Clinic at St. Elizabeth's Hospital
Dr. W. E. Burnett

10:00 A. M. Clinical Pathological Conference at Stambaugh Nurses' Home, South Unit . . . . Dr. John Lansbury

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

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AFTERNOON SESSION

1:30 P. M. Contribution of Broncho-esophology to General Practice
Dr. C. L. Jackson

2:30 P. M. Treatment in Psychosomatic Conditions
Dr. O. Spurgeon English

3:30 P. M. The latest Developments in Eclampsia and the Treatment of Menorrhagia
Dr. Robert J. Willson

4:30 P. M. Obesity
Dr. John Lansbury

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DINNER—6:30 P. M.

8:00 P. M. The Widening Scope of Thoracic Surgery
Dr. W. Emory Burnett

POSTGRADUATE

W. E. Burnett, M. D.

BURNETT, WILBUR EMORY, Professor and Head of the Department of Surgery, Temple University School of Medicine; born February 20, 1898, Spartanburg, South Carolina; son of Wilbur Emory and Gertrude (Du Pre) Burnett; educated at Wofford College, AB. 1918; Jefferson Medical College, M. D. 1923; married Peyton Bolling Jones, May 20, 1938; a son, Livingston Emory. Dr. Burnett was Chief Surgeon of Florida East Coast Railroad 1929-30; Professor of Clinical Surgery at Temple University 1941-43; Professor of Surgery 1944. He is Surgeon to Temple University Hospital and Philadelphia General Hospital; Consulting Surgeon to Shriners Hospital for Crippled Children; active in Civilian Air Patrol and Medical Defense Organization of Philadelphia. He is a member of Franklin Institute; American Association of Thoracic Surgeons; American College of Surgeons; American Medical Association; Academy of Surgeons of Philadelphia; Philadelphia College of Physicians, and Philadelphia Country Club. Hobbies: Flying, golf. He served as 2nd Lieut. in C. A. C., 1918-1919.

O. S. English, M. D.

ENGLISH, OLIVER SPURGEON, Professor and Head of the Department of Psychiatry, Temple University School of Medicine; born Sept. 27, 1901, Presque Isle, Me.; son of George Wesley and Annie Louise (Hemphill) English; educated at University of Minnesota 1918-20; Jefferson Medical College 1920-24. On February 28, 1933, he married Ellen Mary Brown; three children, Wesley Joh, Oliver Spurgeon, Jr., and Carroll Allen. Dr. English was resident physician at Jefferson Medical College Hospital 1924-27; Interne at Boston Psychopathic Hospital 1927-28, and from 1928-29 held residency at Neurol. Div. of Montefiore Hospital, N. Y. He was Commonwealth Fellow 1929-32, and Instructor in Psychiatry 1929-32 at Harvard; volunteer in Psychiatry at Charite Hospital, Berlin, Germany, 1929-30. He was Clinical Professor of Psychiatry at Temple University School of Medicine 1933-38, and has since been Professor and Head of the Department of Psychiatry at Temple University School of Medicine. He has served as physician to Psychopathic Department, Philadelphia General Hospital. He is a member of Adv. Council of International Inst., Member of Philadelphia County Medical Society; Philadelphia Psych. Soc.; American Medical Association; American Psychoanalytical Soc., and Philadelphia Country Club. Dr. English is co-author of Common Neuroses of Children and Adults (W. W. Norton), 1936 Psychosomatic Medicine (Saunders), 1943.

FACULTY

C. L. Jackson, M. D.

JACKSON, CHEVALIER L., Professor and Head of the Department of Broncho-Esophagology, Temple University; born August 19, 1900, Pittsburgh, Pennsylvania; son of Chevalier and Alice (White) Jackson; educated at University of Pennsylvania, M. D. 1926, M. Sc. 1930; married Hilda Cowling; a daughter, Joan Louise. Dr. Jackson began his career as Laryngol. and Broncho-esophagol. 1930. He became Clinical Professor of Broncho-Esophagology 1935 and Professor of Broncho-Esophagology, Temple University 1938. He gave post-graduated courses in Paris, 1937-39, and in Mexico, 1942. He is Trustee of International House of Philadelphia, and Member of Executive Com. of Philadelphia Regional Inter-American Center. He is a member, Pan-American Association of Philadelphia (Pres., 1943); American Medical Association; American College of Surgeons; International College of Surgeons; College of Physicians of Philadelphia; Pan-American Medical Association; (Secretary of Philadelphia Chapter, Inter-National Secretary) Clubs: University, Rotary, Foreign Policy Association, Alliance Francaise, France Forever. His hobby is photography. Publications: Numerous contributions to medical journals.

John Lansbury, M. D.

LANSBURY, JOHN, Associate Professor of Medicine, Temple University School of Medicine and Hospital; Graduated from Queens University (Canada) 1926 M. D.; M. S. (med.) Mayo Foundation 1933; Interned Montreal General Hospital Canada 1926-27; Mayo Clinic Staff 1930-33; Temple University School of Medicine and Hospital Staff as Associate Professor of Medicine 1935. Member of the American Medical Association.

J. R. Willson, M. D.

WILLSON, J. ROBERT, Professor and Head of the Department of Obstetrics and Gynecology, Temple University School of Medicine and Hospital; Graduated from the University of Michigan, M. D. 1937; M. Sci. Degree, University of Michigan 1941; Interned, University of Michigan 1937-38; Residency in Obstetrics and Gynecology, 1938-41 at the University of Michigan; Instructor at the University of Michigan, 1942; Assistant Professor of Obstetrics and Gynecology at the University of Chicago 1943; Professor and Head of the Department of Obstetrics and Gynecology, Temple University School of Medicine and Hospital, 1946.

(*Continued from Page* 151)

pathology, or change the emotional status; they merely control the symptoms due to active infection.

The question of whether to give antiamebic therapy should depend upon the demonstration of amebic cysts or motile protozoa. It is not an easy diagnosis to make in a laboratory whose technicians are not specifically trained in coprology and who do not see sufficient specimens to maintain their efficiency.

Psychotherapy, last but not least, if well handled, will go a long way towards bringing about an early remission. The earlier all the above therapy is instituted, the less likely we are of having a person with a chronic relapsing ulcerative colitis with a permanently damaged colon.

Surgery has little to offer, except in severe complications such as perforation or carcinomatous change. In some cases of regional colitis gratifying results are sometimes obtained by resection. Ileostomy for an acute fulminating colitis is of no value and may produce a mortality. In the chronic continuous cases, surgery occasionally appears as the only hope. Ninety percent of these so called "intractable" cases will calm down on good intensive medical management.

In estimating the prognosis, the type of onset of the disease is of import. Those cases which begin as fulminating colitis have a 30% chance of dying from the disease; those cases with an insidious onset have a good chance for long survival. The extent of involvement as demonstrated by X-ray has little prognostic value, although those cases which have the disease limited to the recto-sigmoid have a much better chance of recovery than those cases in which the entire colon is involved. Those cases in which the right side of the colon is involved are more susceptible to perforation and the prognosis is poor. Cases with the narrow, fibrotic, shortened type of colon, have little chance of cure, but may live a normal span of life with the disease. Prognosis is definitely worse in those cases which develop mental depression, hysterias, or despondency. There are two facts to be borne in mind; (1) that recovery in ulcerative colitis is invariably slow and rarely complete and (2) that there are few diseases in which a patient can reach such emaciation and exhaustion and yet recover. Patience is a requisite and hope is justifiable in quite a number of cases.

It is appropos at this time to devote a few remarks to mucous colitis colonic neurosis, irritable colon, unstable colon, or whatever else you may wish to call it. This is a disease occurring in a nervous, anxious appearing patient with all the stigmata of a neurogenic imbalance such as flushing of the face, sweaty hands and tachycardia; and who has not been cured by an appendectomy. The disease is characterized by a disturbance of the colon, manifested by generalized abdominal pain, a long history of recurring attacks of diarrhea alternating with constipation. The patient usually clears the diagnosis with his or her description of the stool; characteristically a thin mushy stool with a lot of mucus. A bowel movement, which usually occurs shortly after eating, relieves the crampy colicky pain they may have. The diagnosis is substantiated by a barium enema and endoscopic examination of the colon. The former shows areas of spasm in the colon; the latter shows a normal appearing mucosa with many highlights due to the glare of tenacious mucus; and at times may even show a dry mucosa. Never is bleeding produced by swabbing with a cotton swab. Hyperthyroidism, achlorhydria, and allergy should be ruled out.

. . . and for gentle bowel regulation without bloating, take . . .

BASSORAN

Brand of Sterculia Gum and Magnesium Trisilicate

Low residue diets and inactivity seem to conspire to add "constipation" to the symptomatology of many post-surgical, pregnant, and convalescent patients.

Bassoran is ideally suited to the management of such cases.

Bulk without Bloat

This unique combination of sterculia gum and magnesium trisilicate has been commended by a number of physicians because it does not seem to produce a feeling of "fullness" or "bloating." Taken with sufficient water, Bassoran adds soft, nonirritating bulk and gently stimulates peristalsis, facilitating normal evacuation.

Two pleasant, easy-to-take forms:

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In the treatment, psychotherapy is of the greatest importance. Atropinization of the patient and administration of small doses of phenobarbital before meals and at bedtime are usually helpful. During such periods of constipation, a hydrophilic colloid such as metamucil, mucilose or konsyl is in order. I occasionally use a powder recommended by Bockus.

Rx	Extract of Belladona	grs. 2
	Phenobarbital	grs. 2
	Bismuth subnitrate	drs. 6
	Kaolin	oz. 2
	Peppermint to taste	

Take a level teaspoonful after each bowel movement.

As to prognosis, this is a disease which in itself never kills a patient but makes many of them very uncomfortable and at times strains the knowledge of the physician in an endeavor to combat the psychogenic factors. In many of these cases it is merely the physician's attempt to plug up the outlet the patient has chosen for his conflicts.

(Read at the monthly Staff Meeting at St. Elizabeth's Hospital.)

A GRECIAN EVOLUTIONIST

Anaximander of Miletus, who lived about the middle of the sixth century B. C., had some very definite ideas which we are not apt to attribute to such an early time. His concept of there being an infinite first cause of all things and of this being in eternal motion, is quite modern; and needs not much alteration to be used in conveying our idea of matter.

That he had ideas of evolution which anticipated those of the middle of the nineteenth century may not be as well known. Translations from various ancient manuscripts by John Burnet gives such interesting extracts as these:

> Living creatures arose from the moist element as it was evaporated by the sun. Man was like another animal, namely, a fish, in the beginning.
>
> Further, he says that in the beginning man was born from animals of a different species. His reason is, that, while other animals quickly find food for themselves, man alone requires a prolonged period of sucking. Hence, had he been originally such as he is now, he could never have survived.
>
> The first living creatures were produced in the moist element, and were covered with prickly integuments. As time went on they came out upon the drier part, and, the integument soon breaking off, they changed their manner of life.

Thomas H. Huxley, whose observations three quarters of a century ago had inseparably connected him with the modern development of the idea of evolution, had found that the Chinese historians of the Han dynasty, writing in the third century B. C., had their idea of the descent of some yellow-haired barbarians of whom they were writing. They thought these barbarians were "just like the apes from whom they are descended." However, there was no elaboration of the idea and this was three centuries after Anaximander had made his observation and presented it in detail. How much of our knowledge is rediscovery; and how rediscovery tends to establish validity!

W. D. C.

THE RABIES PROBLEM

R. W. BEEDE, M. D.

The existence of rabies as a prevalent disease in any community that has the means to control it, is an indefensible outrage.

Effective methods of control are known. It has been controlled and is now controlled in certain other countries, and also in certain areas of our own country. It has been held in check in Great Britain since the year 1902. Forty-five years ago! And no deaths in that country from this disease during that time.

The efficacy of the single injection method of canine vaccination for the control of rabies was acceptably established in the year 1942. Since that time, it has been usual to include this method of control in any revision of rabies control regulations. Some of the States in our Union and a few counties in our own State have made revisions of their control regulations that incorporate the advantages of current knowledge on the subject. The adjacent County of Summit was the first health district in Ohio to require this vaccination of dogs. The results obtained there have been highly effective and have remarkably reduced the incidence of rabies in that area, considering the fact that quarantine of dogs has not been required. The most effective control procedure should include quarantine, as well as vaccination and the elimination of strays, in any event at least, until the entire dog population has been immunized. However, quarantine may not be applicable from a practical standpoint in some communities because of certain and obvious difficulties. It is probably generally conceded that the effectiveness of the enforcement of any law is, to a great extent, influenced by the degree of public acceptance of that law. The instant point I wish to impress, in this respect, is that the widespread lack of knowledge concerning rabies, and the reluctance of dog owners to keep their dogs confined, preclude effective enforcement of quarantine except by methods that might be considered unfeasible. With this situation existent, it would presumably in this locality, by using present enforcement procedures, require no less than the services of an army to even approach an adequate and effective quarantine enforcement.

Any serious exploration of the rabies problem, however, should verify with sufficient clarity, that its main roots lie far deeper than would be superficially apparent, and originate in common with those of many other and similar problems of the day. The essential basis of our conception of governmental function presupposes certain qualifications. As to rabies, it presumes a proper regard for this disease on the part of the public, including those more directly concerned with the formation of our laws. A sufficiently informed and responsible body politic is, and would have been, a most desirable factor in rabies control. These remarks are not intended, however, to contain the implication that any deficiency in this respect is due to any particular fault on the part of the public, unless it could be said, that a failure to properly provide for an assurance of desirable qualification might fundamentally be due to a dereliction on its part. What, then, has made it possible for this vicious disease to be tolerated, and to persist as it has, in a supposedly enlightened society in this day and age?

Now, as has been evident in other unfortunate matters, if the rabies emergency should become sufficiently great, which could esaily occur at any time, there would be a pronounced change in regard for this disease overnight.

There would be much ado made, and many demands made, that something be done about the situation and at once. But when the ferocity of the epidemic subsides, and the concern abates, there is a tendency toward reversion to the old order of things.

The solution of the rabies problem requires a long range and farsighted program. Satisfactory control of this disease is within the limits of present possibilities, but a hope for its complete eradication is probably idealistic. However, a degree of control would be possible that would eventually approach eradication, if the scope of the control program were on a national basis or equivalent to such. Of what permanent avail is it to eradicate the weeds from one's own yard and have the seeds blow in from the neighbor's?

Laws more consistent with present knowledge of rabies control and more conducive to effective control are needed. Inasmuch as local health districts in our State have the authority to require canine vaccination against rabies, this procedure should be given consideration. As has been mentioned, the larger the control area, the more satisfactory should be the results. Measures have been recently introduced in our own State Legislature requiring the yearly vaccination of dogs against this disease. These measures should be actively supported. It can be expected, of course, that objections might be raised to these measures but they probably would not emanate from enlightened sources.

Regardless of the nature of any revised methods of control, the essence of the solution of the problem is education and, as has been indicated, it should not be limited in its focus. The rampant incidence of this disease in our society, demands that a concerted action against it be initiated immediately and without further delay. But, as is customarily necessary in other embarkations of this nature, someone will have to do an immense amount of work, devote considerable time and thought—and make a lot of noise.

• **PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN** •

TONSILLECTOMY AND POLIOMYELITIS

By RAY HALL, M. D.

Poliomyelitis has been recognized as a disease for a hundred years. Tonsillectomy is an operation that has been, for over 30 years, routinely deferred to the summer months when it was convenient to do it. It was not generally considered that any intimate relationship existed between tonsillectomy and poliomyelitis although poliomyelitis is epidemic during the same time. Recently some writers have claimed a cause and effect relationship between them and these claims have been widely reverberated.

There have been a total of 274 cases of poliomyelitis reported as having followed a recent tonsillectomy during the past 35 years. It is estimated that there have been 70,000,000 tonsillectomies done during this same period.

All of these 274 cases, of poliomyelitis that have been reported as following tonsillectomies, have been patients who were under 18 years of age. It is estimated that about 75 per cent of the tonsillectomies are done on patients under 18 years of age, the most susceptible age. Likewise it is estimated that approximately 24,000,000 tonsillectomies were performed during the poliomyelitis months. If these 274 cases of poliomyelitis had all occurred during the poliomyelitis months (which they did not) the incidence would be one case of poliomyelitis to approximately 100,000 recent tonsillectomies.

It is estimated that the average annual incidence of polimyelitis in everyday life is one to 3,250 of population. These statistics do not show any conclusive relationship between poliomyelitis and tonsillectomy.

Recently, Dr. John R. Page surveyed the incidence of poliomyelitis following tonsillectomies performed at the Manhattan Eye, Ear, and Throat Hospital during the years 1937, 1939 and 1941 when the disease in New York City was above normal expectations. During the three year period, 27,849 tonsillectomies were performed. Cards were mailed to these individuals requesting detailed information on subsequent illnesses. Replies were received from 8,915 patients. There was but one case of poliomyelitis reported in the replies.

An extension of this same survey was attempted by Dr. Daniel S. Cunning for the months of July, August and September of 1942, 1943 and 1944 and 1945. For the year 1944, when New York suffered the most severe epidemic in recent years, the months of October and November were added to the statistical survey. Cards were sent to 5,470 patients (in the 3-16 year age group) who underwent tonsillectomy at the height of the epidemics and replies were received from 2,289. There were three cases of poliomyelitis in this group. None of them were of the bulbar type and all three reported as mild cases.

The Connecticut State Board of Health compiled the following figures for the year 1945 in that state: 10,000 tonsillectomies, 214 cases of poliomyelitis reported, 12 of the bulbar type, none of the patients having the bulbar type had had a recent tonsillectomy, three cases of mild poliomyelitis following the removal of tonsils just prior to the onset of illness.

Dr. Morely T. Smith, of Grasslands Hospital in Westchester County, reports on the number of acute poliomyelitis admitted to that institution during the severe epidemic of 1944. There were 104 cases admitted (in the 3 to 16 year age group). In this group there were 13 cases of the bulbar type. None of these patients had had tonsillectomies within two months of the onset of the disease.

Dr. Ben Shapiro, Chief Pediatrician at Mary Immaculate Hospital, Jamaica, New York, reports for that institution for the year 1944. There were 39 cases of poliomyelitis admitted, two of the bulbar type. One case, which was of the spinal type, followed the removal of tonsils.

Reports regarding experimental work on the portal of entry of poliomyelitis have been inconclusive. Sabin attempted to produce poliomyelitis in monkeys by painting the virus over the operated areas of recently removed tonsils, she was unable to produce the infection. Two other investigators, Toomey and Krill, removed the tonsils of six monkeys and then flooded the operated regions with ten per cent virus suspension for five days. Again these monkeys resisted experimental infection.

However, the mode of transmission and the portal of entry of the virus of poliomyelitis remain unknown. Without this knowledge we are forced to theorize on the relationship between tonsillectomy and poliomyelitis. Most statistics of the local and state boards of health have no information regarding any operative procedures, hence their statistics are of little value. Therefore, a concerted effort is to be made to collect the proper statistics containing pertinent information. It has been suggested that such a nation-wide survey be carried out by the American Laryngological, Rhinological and Otological Society. These would be more instructive than any now available.

The following is taken from an editorial in "The Bridgeport Telegram" June 1944:

POLIO IS OVERPLAYED

In some ways it is the most over-advertised disease because it is far less prevalent and far less injurious than some other diseases which hardly get any attention at all.

For one child crippled by Infantile Paralysis, for instance, at least a half a dozen will be crippled by rheumatic fever, which is hardly known to the general public, but is far more prevalent.

Neither experiments nor statistics up to the present time have proven any true relationship between poliomyelitis and tonsillectomy. Hence the widespread alarm on the part of the public, and shared by doctors in some communities, is unfounded.

This is essentially an abstract of two papers, on this same subject, in the ANNALS of OTOLOGY, RHINOLOGY and LARYNGOLOGY for September, 1946. The authors are Daniel S. Cunning, M. D. of New York City and Edward Russell Roberts, M. D. of Bridgeport, Connecticut.

BOWLING LEAGUE NEARS FINALE

Medical keglers are nearing the close of an interesting season. The Thursday afternoon sessions have seen brisk activity and have provoked keen competitive spirit and good fun for all the participants.

The final session will be held on Thursday, April 10. The Professional Pharmacy has announced the donation of three prizes, one for the highest and second highest season's averages and a third for a blind bogey for the bowlers in the lower scoring bracket. Bowlers must have at least 30 games during the season in order to eligible for any prize.

Drs. V. Herman and A. Marinelli lead with averages of 160 but their margin is far from secure inasmuch as seven others are pressing them for honors. Dr. P. McOwen scored a neat 237 to show the way for the highest single game. He displaced a 215 posted by Dr. V. Herman some time ago. Averages to and including March 13 are as follows:

Name	*No. Games*	*Total*	*Average*
V. Herman	67	10737	160
A. Marinelli	18	2877	160
P. McOwen	39	6171	158
E. J. Wenaas	16	2486	155
J. Goldcamp	12	1832	153
R. Clifford	56	8512	152
R. Piercy	34	5145	151
F. F. Piercy	42	6287	150
J. Renner	34	5090	150
E. H. Young	8	1166	146
H. J. Reese	64	9287	145
S. Goldberg	15	2161	144
D. Levy	17	2412	142
S. W. Ondash	68	9593	141
A. K. Phillips	30	4004	133
I. C. Smith	54	7092	131
H. Hathorne	9	1180	131
E. DiIorio	16	2060	129
J. Brown	14	1800	129
H. Ipp	25	3058	122
G. DeCicco	20	2279	114
S. Davidow	8	909	114
J. Scarnecchia	4	443	111

S. W. O.

NEWS

St. Elizabeth's Hospital Woman's Auxiliary held a bridge tea recently for its hospital fund and Mrs. Robert H. Coffey was guest speaker, reviewing a book. Mrs. Charles E. O'Linn is president, Mrs. John N. McCann, vice president, Mrs. John P. Dillon, treasurer and Mrs. W. O. Mermis, secretary. Organized for many years, the Auxiliary provides needed equipment for the hospital, and its funds are earned through public card parties and teas. Alternating parties, members make bandages for the hospital. Non-sectarian, the Auxiliary is composed of women throughout the community who cooperate in its service. New members are always welcome.

Mrs O. M. Lawton was hostess at the Friday Bridge Club's fortnightly luncheon. Bridge honors went to Mrs. Arthur H. Zabel and Mrs. Lawton.

Dr. and Mrs. John Scarnecchia have returned from Buffalo, where they were guests of Dr. and Mrs. Norman Heilburn. While there Dr. Scarnecchia visited Filmore Hospital and Dr. Potter's Clinic.

Dr. and Mrs. George M. McKelvey have returned from a few weeks vacation at Cat Key Island, Florida.

Dr. and Mrs. D. H. Smeltzer and Mrs. Coltaire J. Buehrle are spending several weeks at Miami, Florida.

Dr. and Mrs. James D. Brown have returned from a week's vacation in New York City, where they were guests at the Taft Hotel.

Dr. Morris Rosenblum is taking a postgraduate course in medicine at the Mayo Clinic at Rochester, Minn.

Mrs. Armin Elsaesser has returned after a 10-day visit in New York during which she saw her son, Armin Elsaesser, Jr.

Mrs. Joseph P. Keogh is recuperating from a recent illness of pneumonia.

Dr. and Mrs. M. J. Kocialek have arrived home after a month's stay at Miami Beach, Florida, where they were guests at the Flamingo.

Dr. Milton M. Yarmy has returned from two week's study at the New York Postgraduate Medical School.

Dr. and Mrs. J. J. McDonough recently returned from a sojurn in Nassau on New Providence Island of the Bahamas. While there they were guests at the British Colonial Hotel.

Dr. McDonough reports good fishing and tells of one that didn't get away—a 42 pound amberjack that gave him good sport in the catch.

Dr. James K. Herald is in New York City where he is enrolled in a three month postgraduate course in Proctology at the New York Polyclinic. He will commence his study on April 1.

Dr. and Mrs. Francis W. McNamara are vacationing at Phoenix, Arizona.

Drs. Gabriel DeCicco and S. W. Ondash attended a meeting of the program committee for the First Postgraduate day of the sixth Councillor District, at the Congress Lake Country Club, Akron, Ohio, on Sunday, March 16. Appropriately enough, Dr. DeCicco arranged for the entire committee, numbering some fifteen men, to hold its next meeting at the Ohio Hotel on the Postgraduate Day of the Mahoning County Medical Society on April 16.

Births

Dr. and Mrs. Andrew A. DeTesco announce the birth of a son, Andrew A. Jr., at the North Side Unit, Youngstown Hospital.

Dr. and Mrs. Sidney E. Keyes announce the birth of a son Monday, March 3rd, North Side Unit, Youngstown Hospital.

HOSPITAL NEWS

Youngstown Hospital

The following program was presented at the staff meeting of the Youngstown Hospital Association on March 4, 1947:

1.—Multiple Primary Malignancies, Drs. Brown, Nelson, Sisek and Neel.
2.—Vote and adoption of Constitution of the medical staff.
3.—Report of Library and Laboratory Committees.

Receiving Hospital

The staff meeting was held at the auditorium of the nurses home of St. Elizabeth Hospital on the evening of February 25. Mrs. Corinne F. Baker spoke on the subject, "The use of psychological tests in clinical work."

St. Elizabeth's Hospital

The regular monthly meeting of the staff of St. Elizabeth's Hospital was held on Tuesday, March 11, 1947, at 8:30 P. M. Dr. F. W. McNamara, president of staff presided.

After a review of hospital statistics was made the meeting was turned over to the clinical discussion. Drs. John Heberding and S. J. Tamarkin, radiologists, presented papers on "Irradiation Therapy." The discussion was divided into two sections. Dr. Heberding discussed irradiation of the breast in breast carcinoma. He cited efficacy of radiation therapy pre and post operatively in carcinomata with and without glandular metastasis.

Dr. S. J. Tamarkin discussed radioactive isotopes and their application to therapy in various diseases. He gave a concise explanation of the transmutation of elements and reviewed the significance of imparting radioactivity to elements for treatment of disease. The role of radioactive iodine in treatment of thyroid was particularly stressed. The use of nitrogen mustard and isotopic phosphorus in various leukemias, sarcomata and polycythemia rubra vera was also emphasized. S. W. O.

Tuberculosis Sanatorium

The monthly meeting of the staff of the Mahoning County Tuberculosis Sanatorium was held February 25, at Dollar Bank branch offices.

The president, Dr. Keogh, read the names of the staff members who were placed on the various standing committees and stated that the use of streptomycein would be regulated by the Drug Committee. This committee will be composed of the medical director, the chief of the clinical laboratory service, the chief of medicine and the chief of X-ray on service at the time.

Dr. Mahar outlined plans for programs to be held during the year.

The beginning of a regular library was announced when funds were made available for that use by the Board of Trustees. Members of the staff were urged to contribute medical texts or journals to this worthy cause.

The medical program consisted of a paper "Radical Surgical Treatment of Bronchiectosis and Tuberculosis" read by Dr. Stotler. A lively discussion by the entire group followed.

J. F. S.

Announcements

Dr. E. E. Kirkwood announces the opening of his office for the practice of diseases of the chest at corner of Indianola Ave. and Hillman Street.

Dr. E. J. Wenaas announces that Dr. C. W. Stertzbach is associated with him in the practice of general ophthalmology.

Dr. Louis Bloomberg announces the opening of his office for the practice of ophthalmology, 604 Central Tower Building.

Dr. John L. Scarnecchia has resumed his practice after separation from the military service and completion of a residency in obstetrics and gynecology at Lakeside Hospital in Cleveland. Dr. Scarnecchia has his office in the Central Tower. His work is limited to the obstetrical and gynecological specialties.

THE LOCAL VETERANS ADMINISTRATION PROGRAM

By SIDNEY FRANKLIN, M. D., M. S. P. H.

Chief Medical Officer, Veterans Administration Sub-Regional Office
Youngstown, Ohio

In order to assist the Participating Physicians, the procedure of the local medical care program for veterans is reviewed. Compliance with the requirements outlined will greatly facilitate the smooth operation of the program. The cooperation of all is earnestly solicited.

Out-Patient Treatment

On the occasion of the first visit, the Participating Physician should advise the veteran to seek authorization for treatment from the Veterans Administration office on the 9th floor of the Union National Bank Building, Youngstown. In the event that he is too sick to travel, the credentials of a veteran may be submitted for inspection by a relative or friend. If the veteran is found eligible, the Chief Medical Officer will give prompt authorization. The Participating Physician is advised not to render treatment before authorization, except in emergency. In an exigency, a request for authorization by telephone, prescription blank or letter, is acceptable.

The fact that veteran is referred for an examination or had received treatment in a government hosptial does not mean that he is eligible for out-patient treatment. We can only authorize out-patient treatment for conditions due to or probably due to military service. Public Law 16 (disabled) trainees are entitled to treatment for any condition interfering with their training. This does not apply to other GI trainees (Public Law 346).

If the veteran has never filed a claim or if it has not already been adjudicated, service data and some information are needed to determine if his condition developed during or was aggravated by military service. Your assistance in this matter may be requested by the Veterans Administration. However, if the veteran wishes a medical statement to support a claim for a review of a rating, he has to pay the physician himself.

For an initial request for treatment, the Participating Physician should continue to complete only Section I of Form 2690. This request should be specific as to what disability requires treatment. It should also state definitely the nature of the proposed therapy and the date of the first treatment. It should estimate how many house and office calls will be required during the current month, and also during the following month if the request is submitted near the end of the month.

All treatment authorities automatically terminate at the end of the calendar month, unless otherwise specifically indicated. They must be renewed if treatment is to be continued. For later requests for treatment, only Section II of Form 2690 should be completed. The Participating Physician is to anticipate the treatment required for the following month and submit renewal requests, as well as bills for treatment rendered, to the Veterans Administration office, 910 Union National Bank Building, Youngstown,

between the 23rd and the last day of the current treatment month. All veterans being treated may be listed on one form.

Out-patient treatment requests must be submitted within fifteen (15) days following the date treatment is begun. If the authority received by the physician is inadequate, the Veterans Administration should be advised promptly, at least within fifteen (15) days or by the end of the month, and an additional authority will be issued.

Consultations

Consultations should be requested from the local Veterans Administration office. They may be granted only to a Participating Physician. We are instructed not to authorize a psychiatric or neurological consultation, examination or treatment until a general physical examination has been done and the report received. The Clinical Findings Column of the Report of Medical Treatments Rendered (Form 2690A) is not adequate for this purpose.

Dental

Each veteran applying for dental treatment at the Sub-Regional Office is given an appointment for a thorough examination, including X-ray. The Chief Dental Officer will then promptly authorize treatment for defects and conditions judged to be due to or probably due to military service.

Hospitalization

An authority to furnish out-patient treatment does not include authority to hospitalize the veteran. Authorization for hospital visits can be granted to the Participating Physician only if the care of the veteran in a contract or private hospital is authorized.

The Chief Medical Officer in the Sub-Regional Office has authority to authorize care in a contract or private hospital when government accommodations are not feasible, under the following conditions:

A.—For male veterans with emergent service-connected disabilities.

B.—For female veterans with emergent disabilities, regardless of service connection.

The Veterans Administration has contracts with the Youngstown Hospital, North Side and South Side Units, and with St. Elizabeth's Hospital in Youngstown. Requests regarding local hospitalization must be submitted within seventy-two (72) hours following admission. Later, local hospitalization may be authorized only from the time of notification.

Mahoning County does not possess a Veterans Administration Hospital. However, the following government hospitals are readily accessible for the general care of veterans:

1.—Crile Veterans Administration Hospital,
Cleveland, Ohio — Telephone number: Victory 9260.

2.—Deshon Veterans Administration Hospital,
Butler, Pennsylvania — Telephone number: Butler 4781

3.—Veterans Administration Hospital,
Aspinwall, Pennsylvania — Telephone number: Sterling 1800.

4.—Marine Hospital, U. S. Public Health Service,
Cleveland, Ohio — Telephone number: Garfield 2260.

Veterans with active tuberculosis are treated at the Brecksville General Hospital, Brecksville, Ohio, and the Deshon Veterans Administration Hospital, Butler, Pennsylvania. Veterans with mental disorders are treated at Crile Veterans Administration Hospital, Cleveland, Ohio, and at the Vet-

erans Administration Hospital, Chillicothe, Ohio.

For the transportation of veterans to hospitals, the Veterans Administration has a contract with the Lynn Ambulance Company, Youngstown — Telephone 7-6534.

Prosthetics

Requests for prosthetics should not be made on Form 2690, but should preferably be made separately on the physician's prescription blank or stationery. The Participating Physician is urged to submit measurements, when he orders braces, supporting belts, elastic stockings or stump socks. Thus, it will not be necessary to request the veteran to be called into Cleveland for measurement. All requests for eye glasses and other prosthetics should be submitted to the local Veterans Administration office for forwarding to the Regional Office. Whenever feasible, the final fitting and delivery of a prosthetic to a veteran will be done in the local Sub-Regional Office, instead of in Cleveland. It is planned to purchase prosthetics in Youngstown, if suitable arrangements can be made.

Reports and Billing

If an authority for treatment is received, payment is not automatically made. At the end of each month a brief report is required on Form 2690A. On this form should be listed the treatments, the date of each treatment, and the progress of the patient. This form is a report—not a treatment request. An itemized bill in duplicate should be attached to this form; only the original should be signed. On both copies the following certification is typed above the space for the signature:

> "I certify that this account covering my services in this case is correct and just and that payment therefor has not been received."

The billing should be in accordance with the Ohio State Medical Association Contract Fee Schedule. All reports and bills should be sent to the Veterans Administration Sub-Regional Office, Room 910, Union National Bank Building, Youngstown 3, Ohio.

Prescriptions

No additional fees for drugs dispensed by the Partcipating Physician can be authorized. He may prescribe drugs or the following medical requisites for the veteran:

1.—Insulin syringe and two (2) needles.
2.—Two (2) hypodermic (insulin type) needles.
3.—Atomizer.
4.—Nebulizer.
5.—Hot water bottle.
6.—Fountain syringe.
7.—Combination hot water bottle and syringe.
8.—Ice bag.
9.—Ice cap.
10.—Urinal.
11.—Bed pan.
12.—Enema can.
13.—Feeding tube.
14.—Ear and ulcer syringe.

A prescription for a medical requisite must be only for a single item. The statement "I am authorized to treat and prescribe for the above-named Vet-

erans Administration's patient," must appear above the physician's signature on each prescription.

The following Participating Pharmacists of Mahoning County can then fill such prescriptions for the veteran:

Borak's Pharmacy	20 — 12th Street	Campbell
Morris Drug	6 Broad	Canfield
Bittner's Pharmacy	329 Elm Street	Struthers
Bovee's Pharmacy	127 Bridge Street	"
McNeeley's Pharmacy	137 Bridge Street	"
Ashton's Drug Store	2724 Mahoning Avenue	Youngstown
Austintown Pharmacy	5527 Mahoning Avenue	"
Benita Drug Company	2002 Elm Street	"
Brown's Drug Store	1847 Oak Street	"
Burick Drug	1919 Hillman Street	"
C. B. Cassaday Prescription Phcy.	260 Lincoln Avenue	"
Colonna Pharmacy	3502 Hillman Street	"
Dobson's Pharmacy	100 East Midlothian Blvd.	"
Foster Pharmacy	2420 Glenwood Avenue	"
Gray Drug Store No. 19	12 West Federal Street	"
Gray Drug Store No. 20	129 West Federal Street	"
Gray Drug Store No. 32	100 East Federal Street	"
Gray Drug Store No. 42	2739 Market Street	"
Hasbrouck Drug	1625 Mahoning Avenue	"
Himrod Drug	1028 Himrod Avenue	"
Idora Pharmacy	2636 Glenwood Avenue	"
Jones Drugs	2702 Market Street	"
Kelley Drug Company	2250 Market Street	"
Laeri Apothecary	Home Savings & Loan Bldg.	"
Lester's Prescription Pharmacy	264 West Federal Street	"
Logan-Wick Drug Store	1109 Wick Avenue	"
McConnell & Schrag	1900 Market Street	"
Porembski Pharmacy	2316 South Avenue	"
Professional Pharmacy, Inc.	418 Dollar Bank Building	"
Rea's Pharmacy	4230 Market Street	"
Tragesser's Pharmacy	409 Madison Avenue	"
White Drug Company	259 West Federal Street	"
White Drug Company	283 East Federal Street	"
White Drug Company	1648 Mahoning Avenue	"
White Drug Company	1843 Hillman Street	"
Zeman Drug Company	1500 Market Street	"
Zimmerman Parkview Pharmacy	909 Elm Street	"

All medical communications and telephone calls should be addressed to the attention of the Chief Medical Officer and all dental to the attention of the Chief Dental Officer, Veterans Administration Sub-Regional Office, Room 910, Union National Bank Building, Youngstown 3, Ohio. The telephone number is 4-5161. Please be assured of our willingness to cooperate with the members of the Mahoning County Medical Society at all times. You are all cordially invited to visit the local Sub-Regional Office on the 9th floor of the Union National Bank Building during our office hours on Mondays through Fridays, from 8:30 A. M. to 5:00 P. M.

CLEVELAND MEETING

Varied to meet the interests of all members, and streamlined for effectiveness, the program of the 1947 Annual Meeting of the Ohio State Medical Association, scheduled for May 6 to 8 in Cleveland, promises to be one of the most outstanding medical meeting of the year.

From the opening sessions at 8 a. m., Tuesday, May 6, until the final adjournment, sometime Thursday afternoon, May 8, the meeting will be packed with interesting features, including papers by 13 top ranking out-of-state guest speakers; 21 instructional courses; sessions of nine specialty sections, including the new section on general practice; technical, educational, and scientific exhibits; and entertainment.

The registration desk will be located in the Main Arena, Cleveland Public Auditorium, and all scientific, clinical, and instructional sessions will be held in the various rooms of the Auditorium.

The House of Delegates will meet at the Hotel Cleveland, the headquarters hotel. A dinner will be held for the delegates at 6 p. m., Tuesday, and a luncheon at 12:15 p. m., Thursday, also at the Hotel Cleveland.

One of the new features of the Cleveland meeting will be the 21 instructional courses, which are practical demonstrations on problems arising most frequently in everyday practice.

Admission to the courses is by card only. Attendance at each course will be limited to 100, and cards will be allocated on a "first come, first served" basis. Reservation cards will accompany a formal printed announcement of the meeting which all members will receive from the headquarters office of the State Association.

Seven of the courses are scheduled each morning from 8 a. m. until 9:30 a. m. for each of the three days of the meeting. Course personnel, topics, and other details, will appear in the April issue of *The Ohio State Medical Journal*.

Another innovation of the 1947 meeting is the scheduling of the initial meeting of the new section on general practice from 10 a. m. until noon, Thursday, in place of the usual general session program. Topics to be discussed here are of general interest and were chosen because of their adaptation to the daily use of the general practitioner of medicine.

The annual banquet will be held Wednesday evening, May 7, in the Main Ballroom of the Hotel Cleveland. This year a program of music, floor show, and dancing has been arranged and there will be no speeches.

The technical exhibits, consisting of about 100 displays will occupy the Main Arena of the Public Auditorium, and will be open daily from 9 a. m. until 6 p. m., except Thursday, when closing time will be 12 noon.

COMMUNICABLE DISEASES FOR FEBRUARY 1947

Youngstown City and Mahoning County Health Commissioners.)

	City	*County*
Chicken Pox	141	83
Diphtheria	0	0
Measles	3	1
Meningitis	0	0
Mumps	17	2
Polio	0	0
Scarlet Fever	18	22
Undulant Fever	0	0
Whooping Cough	3	8
Malaria	0	0
Syphilis	34	4
Gonorrhea	11	0
Smallpox	0	0

S. G. PATTON, M. D.

PROPOSED "HEALTH" LEGISLATION

Christian Science Measure: The old-timer—the Christian Science Bill—went into the hopper early. Under the terms of House Bill 136, the so-called practice of Christian Science and practitioners of that church would be exempt from the definition of the practice of medicine contained in the Medical Practice Act. Representative Corlett, Cleveland, introduced this proposal.

Chiropractic Bill: Another old-timer, the chiropractic separate board bill, has been introduced in the Senate. It is Senate Bill 165 and was presented by Senator Brooks, Cincinnati.

In addition to the foregoing measures, there are a score or more bills having to do with Workmen's Compensation, public health and welfare activities, old age pensions, tax levies and bond issue for health, welfare, and hospital building purposes, etc.

Members should look to the legislative chairman of their county medical society for informaton, advice, and guidance on how and when to discuss these matters with members of the Legislature. Weekly legislative bulletins are sent from the Columbus office to presidents, secretaries, and legislative chairmen of all county medical societies, containing information and suggestions for action "back home" when legislators are home on weekends.

PRACTICAL NURSES

A change in the policy of nurse examining boards, which have discouraged employment of practical nurses in hospitals, may result from the current serious shortage of nurses. In the District of Columbia proposals to relieve the current nurse and auxiliary nurse shortage by training practical nurses are being studied by hospital superintendents . Only Doctors Hospital now offers practical nurse training, which was encouraged in a recommendation of the American College of Surgeons. Recently about 20 practical nurses were employed at Providence Hospital to meet the shortage. Some critics attribute the lack of graduate nurses to stiff requirements for training, time involved and low pay as compared with salaries paid business women.

SOON THERE WILL BE THREE

Early in 1944 at National Headquarters, the American Red Cross Home Nursing Program was reexamined with regard to its fundamental purposes and its place in the field of public health instruction—a 12 Hour Course, Unit I, Care of the Sick was brought into being, dealing only with the simple care of the sick at home. Meanwhile, requests were received for a second unit which would comprise much material not given in Unit I.

In consultation with members of the U. S. Children's Bureau and the U. S. Public Health Service staffs, the American Red Cross was assured that in many communities throughout the country there was inadequate instruction in the problems of mother and baby care, and that competent instruction given through local American Red Cross Chapters should be provided especially in communities where this type of instruction is not available through other channels.

As a result Unit II, Mother and Baby Care and Family Health was developed. It is, also, a 12-hour course. There are six 2-hour classes of lectures and demonstrations, followed by student practice. The classes are held weekly—afternoon or evening and open to all adults, male or female.

The class instructors are graduate nurses, especially trained for the pro-

gram with 108 hours of conferences, demonstrations under supervision, and teaching methods before they are authorized to teach by the American National Red Cross.

The wide appeal for these classes comes from the group of expectant mothers. From past experience the lack of reproductive knowledge among all levels of people is profound. At first apprehension and fear abound. Facts of pregnancy are little known. The instructor interprets the course and explains its purpose, and, thus helps to give an understanding of what constitutes good care in safeguarding mothers and babies; emotional and physical developments of the growing child; the effect of the community upon the health of the individual; and, the responsibility of the family for the maintenance of health in the community. The tension disappears, frank discussions of their problems reduce fears to a minimum.

The content of all of the six lessons are integrated so that the material in each lesson becomes a logical part of the whole. The titles of the six lessons are: Before Baby Comes; Baby is Born; After Baby is Born; Baby's First Year; The Child's Health in an Expanded Environment; Protection of the Family's Health.

The first lesson explains the female reproductive system, external and internal genitals, breasts, menstrual cycle, fertilization, signs and symptoms of pregnancy, changes that are normal during pregnancy, growth of the baby within the mother's body and planned care of the expectant mother. Thruout the lecture much illustrative material is used: the Birth Atlas, semi-diagrammatic charts from New York Maternity Center, charts of food needs for the expectant mother and nursing mother, form the basis of the material. Also, the instructor brings out an understanding of the discomforts of pregnancy and the awareness of unfavorable changes during pregnancy and the importance of early and continuous medical care.

The purpose of the second lesson is to explain the importance of choosing the place of delivery—reasons why an increasingly large number of babies are born in hospitals and the desirability especially for the first baby. If the choice is decided upon for a home delivery—detailed instructions are given for the necessary provisions —the fact that all such planning should be under the doctor's advice. Planning and preparing baby supplies creates much interest and wide discussion of price ranges from wearing apparel to bedroom furnishings. Other topics explained are: Determining the end of Pregnancy; Understanding Labor and Delivery of Baby and Placenta; Giving Immediate Care to the Mother; the pre-natal period and delivery safeguarded by good health supervision of the Mother; and, understanding of the problem of the premature baby.

The third lesson includes care of the young baby—how to hold, how to bathe, how to dress baby comfortably; to recognize any symptom requiring the attention of the doctor and to follow his recommendations.

The fourth lesson, The Baby's First Year, presents the factors which influence child development; rate of physical growth; explanation of why the doctor will want to see the baby every month; protection against communicable diseases—natural and acquired immunity; habits of feeding and sleeping.

The Child's Health in an Expanded Environment is considered in the fifth lesson. Helping the child become a well adjusted member of society requires poise, patience and understanding on the part of parents. Good Health, security, self-expression, congenial companionships are discuss-

ed. Further reading on child care is encouraged. Special childhood problems, like thumb-sucking, fear of the dark, temper, whining are explained with reasons for their development and methods to prevent or correct them. The responsibility of individuals to their community is stressed—need for cleanliness at all times, means by which communicable diseases are spread and means by which spread of disease is controlled. In turn, the students learn about official public health agencies and their responsibilities to the nation, state and local communities.

The sixth lesson is Protection of the Family's Health. The instructor clears with the local health department for advice regarding local needs, practices and emphasis regarding prevalence of disease, facilities for care and other items of interest before class meets. Generally, the assignment includes the definition, cause, prevention and symptoms of one infectious disease, one non-communicable disease from a suggested list of diseases—mindful, that all scientific information is subject to continual change as research broadens knowledge of the field.

At the beginning of each class a brief review is held to check on correct details, and discussion is urged about any problem.

The teaching of this course has proved of benefit to all of its students. Mahoning Chapter is ready to assist the doctors, within its jurisdiction, with the task of spreading this great need of information, that the community may be a more healthful place in which to live.

MARY PLANT HALL, *Chairman*
Public Information

Prescription Thought

For the "common cold", another "tailor-made" formula is presented this month:

Strychine Sulphate—grs. 1/60
Quinine Sulphate—grs. ii
Acid Acetylsalicylic—grs. iii
M et fiat tales dose # XII
Siq one capsule Q 3 hrs.

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.