Excellence does no depend upon greatness, but greatness upon excellence.
—Zeno, The Stoic

BULLETIN

of the
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MEDICAL
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Youngstown, Ohio
OCTOBER • 1947
VOL. XVII No. 10

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THE MAHONING COUNTY MEDICAL SOCIETY

Vol. XVII—No. 10 CONTENTS October, 1947

Officers and Committees 389

Medical Calendar 391

September Meeting 393

Fluid Therapy in Extensive Burns . . . 399

Youngstown Receiving Hospital 413

News 415

ADVERTISERS' LIST

PATRONIZE THEM—THEY MAKE THE BULLETIN POSSIBLE

Beil-Rempes Drugs 388
Blair Dry Cleaning Co. . . . 396
Bowman Bros. 396
Breon & Co. 398
Buffington's 390
Cassaday Pharmacy 390
Central Square Garage . . . 388
Ciba 404-416
Connecticut Mutual Life Ins. Co. 419
Cross Drugs 408
Endo Products 388
Isaly's 394
James & Weaver 390
Laeri's Pharmacy 419
Lester's Pharmacy 396
Eli Lilly & Co. 414
Lincoln Ave. Hospital 398
Lyons Physician Supply. . 410-412
McKelvey's 412
Mead Johnson & Co. . . . Cover
Mercer Sanitarium 392
Merrell 388
Professional Pharmacy . . . 403
Renner's 408
Scott Co. 418
Similac 386
Spencer Supports 417
Stillson, Lloyd T. & Asso. . . 410
Strouss-Hirshberg Co. 408
Thornton's 390
Treudley, H. H. & Co. . . . 417
White Drug Stores 392
Zemmer Co. 396

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MEDICAL CALENDAR

1st Tuesday 8:30 p. m.	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
1st Tuesday 8:30 p. m.	Monthly Staff meeting, St. Elizabeth's Hospital, St. Elizabeth's School of Nursing
Sunday following 1st Tuesday 11:00 a. m.	Monthly Surgical Conference, St. Elizabeth's Hospital Library
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
8:30 p. m.	Monthly Staff Meeting—Youngstown Receiving Hospital Auditorium
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
Every Tuesday 8:00 a. m.	Weekly Medical Conference, St. Elizabeth's Hospital Solarium
Every Friday 11:00 a. m.	Weekly Surgical Conference, Youngstown Hospital—Nurses' Home
Every Thursday 12:30 p. m.	Orthopedic Section, Library—South Side Unit, Youngstown Hospital
Every Friday 11:00 a. m.	Urological Section, Library—S. 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
Alt. Saturdays 11:00 a. m.	Obstetrical Section—North Side Unit of Youngstown Hospital

COMING MEETINGS

Interstate Postgraduate Medical Association of North America, St. Louis, October 14, 1947.

American Society of Clinical Pathologists, Chicago, October 28-30, 1947.

American Society for the Study of Arterioscherosis, Chicago, November 2-3, 1947.

Sixth Councilor District Postgraduate Assembly, Canton, Ohio, November 5, 1947.

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BULLETIN of the **Mahoning County Medical Society**

Published monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 17 OCTOBER, 1947 NUMBER 10

Published for and by the members of the Mahoning County Medical Society

C. A. GUSTAFSON, Editor
101 Lincoln Avenue

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SEPTEMBER MEETING

On the 16th of September the Society was privileged to hear an encyclopedic review of the recent progress in neuropsychiatry, delivered by Dr. Howard D. Fabing, of Cincinnati.

Following the classification of Stanley Cobb, attention was called to the fact that roughly one-tenth of our population suffers from disabling illness of neuropsychiatric nature, thereby stressing the problem with which we are faced and highlighting the disproportion between the critical importance of the problem and our actual attempts to find solutions for it.

In the field of amentias it was noted that classification and study of the various groups of mental defectives had begun to yield some results. Recent use of Glutamic acid therapy is hailed as the first successful attempt to treat this great group of unfortunates.

In the group of dementias, which in this classification includes all individuals who have made some sort of satisfactory adjustment and then becomes unable to continue, particular emphasis was placed on shock therapies. Attention was called to the fact that 60 to 70%. of schizophrenics were made "better" if gotten to treatment early. Discription of electro shock was more detailed since that has come to replace the other shock therapies in practice. Attention was called to such modifications as unipolar current, the "sweep" method of gradually inducing the maximum current into the patient, modification by drugs, such as curare, to soften the physical effects of the fit, modification by other drugs such as coramine for increased effectiveness in particular psychiatric syndromes, especially the acute manias, and lastly, the recently introduced electronarcosis which consists of using a very much smaller dose of electricity over a very much longer period of time and is not accompanied by the violent physical manifestations of the ordinary electrically induced fit. In evaluating the results of shock therapy, Dr. Fabing called attention to the fact that in the affective disorders the duration of illness is dramatically shortened, the risk of suicide, wasting from exhaustion, is markedly diminished and that the results are uniform enough that we can predict as high as 90% successful treatments. The results in schizophrenia as stated above provided improvement in

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60 to 70% of the patients which is many fold the number of improvements obtained by previous treatments or mere custodial care. Some time was devoted to pre-frontal leukotomy which apparently found favor with the society because of the discussion it provoked. The results of interrupting the associative pathways between the frontal lobes and the remainder of the brain were described as preponderantly constructive in the cases of intractable melancholia, incapacitating obsessional states and continuously aggressive schizophrenics. Although mortality of 3% and the possibility in some 6 to 10% of the occurrences of convulsions were noted, the use of this therapy after all other forms of therapy had failed to show any effect was enthusiastically endorsed. Attention was called in passing to the treatment of luetic brain disease originally by malaria and then by malaria and chemotherapy and at present usually by artificial pyrexia and penicillin.

The enthusiasm of the Speaker shown in the preceding parts of this paper was dampened by his frank admission of our failure to be able to offer constructive treatment of that large segment of neuropsychiatric disorders induced by senile and arteriosclerotic brain diseases. It was felt that this was as much a problem for the general practitioner and other specialists since it was merely one phase of the process of aging and that much more basic work must be done in geriatrics before advance in particular phases of the problem can be expected.

In calling attention to recent advances in the treatment of epileptics Dr. Fabing again became hopeful. He described in particular, five anti-convulsants out of the over 700 that have been intensively studied in recent years. Dilatin and phenobarbital continue to be the basic weapons against fits. Tridione, Mesantoin and a fifth drug designated at present as A-N23 are useful for the cases in which dilatin and phenobarbital failed. Dr. Fabing feels that the advances in this field which have been great in the past ten years will continue.

In the borderline group of Cobb's classification are listed stammerers and alcoholics. Dr. Fabing has failed to find any medical advances in the treatment of these conditions, although he has been favorably impressed by the results accomplished by Alcoholics Anonymous.

Also included in Cobb's borderline classification are the psychoneurotics. In discussing this group Dr. Fabing drew upon his wide clinical experience with military psychiatric casualties most of whom fell into this grouping. He drew attention to the fact that one of the most successful treatments of true combat fatigue, that is rest continuously under hypnotics and feeding was a reintroduction of a treatment recommended by Weir Mitchell who used it extensively under similar circumstances in the Civil War. Specific modifications of the Weir Mitchell regime of rest and feeding were discussed. Rest was most promptly assured with large and continuous doses of hypnotics. Feeding and weight gain were induced by the use of insulin. A nod was made to the Freudian theory of the development of neuroses and attention was called to the successful use in war time of short cuts in making repressed

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experiences available by means of group psychotherapy and by chemically induced hypnotic states and the hope was expressed that these measures could be successfully translated to civil practice.

Pessimism was again the key note in discussing the psychopathic personalities but it was felt that investigations stimulated by the large group observed during war time will lead to more successful therapeutic possibilities.

The organic neurological syndromes have shown response to increased study. Specific, palliative measures are available in the case of myasthenia gravis with prostigmin, neurological changes of pernicious anemia have responded to liver therapy and narcolepsy can be successfully controlled with amphetamine. Meniere's disease can be alleviated in most cases by potassium chloride. Some cases of birth palsies are responding to the use of curare. Although no progress has been made in multiple sclerosis, in myopathies, or neuropathies it was felt that the intensive research going on would yield results in the near future.

In closing Dr. Fabing called attention to the fact that until recently neuropsychiatry has been the black sheep among the provinces of medicine and that therefore it has attracted less than its share of attention by physicians in general and by the best minds in medicine in particular. He called attention to the lack of facilities for modern treatment both in the way of personnel and hospital facilities, the lack of training available to men who are interested in this speciality, and he predicted that the intense need and the awakened interest on the part of the public would force within the near future recognition by every general hospital of the necessity of maintaining psychiatric facilities of comparable efficiency and completeness to the facilities maintained for other types of illness. Then with these increased facilities, with this quickening of interest on the part of our best doctors, problems of neuropsychiatry will begin to yield more quickly and our therapeutic efforts will be more fruitful and successful.

Robert Olson, M. D.

NOVEMBER MEETING

WOMEN'S AUXILIARY

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FLUID THERAPY IN EXTENSIVE BURNS

RICHARD V. CLIFFORD, M. D.

Following damage to the skin by a burn there is a loss of extracellular fluid, including salts and plasma proteins, both into the burned area itself and as a discharge from any denuded surface. With this fluid loss there will be dehydration, a decrease in the circulating plasma volume and hemoconcentration.

In mild burns, spontaneous ingestion of fluids and food according to the desires of the patient is usually adequate but in more severe injuries special methods of therapy are necessary to aid convalescence and to save lives. It is generally agreed that in burns which involve less than 10 percent of the body surface there is not sufficient loss of extracellular fluid to warrant intensive fluid therapy. Hence this discussion is directed to those patients with more than 10 percent of the body surface involved by second degree (blistered) or third degree (coagulated or charred) burns. Roughly, then, this outline would be followed in patients with a severe burn of at least one of the following areas:

1. face and neck.
2. dorsal or ventral surface of chest.
3. dorsal or ventral surface of abdomen.
4. one upper extremity.
5. dorsal or ventral surface of one lower extremity.

If there is any question as to whether the patient should be included in this category, he should be. Patients with burns involving less than 10 percent of the body surface and with, in addition, any other injury, particularly wounds or fractures, should be treated as though they were in this category. Exceptions to this statement are:

1. head injuries
2. perforating wounds of the chest
3. burns of the pharynx, larynx or lower air passages (a face burn should make one suspicious of such respiratory involvement). In these instances excessive fluid administration may bring on pulmonary edema.

If many burn casualties are seen, it is often advisable to treat energetically those patients with a large surface area involved (30 to 40 percent) and then treat the less seriously burned patients as time is allowed. Further, in patients with burns weeping much plasma, it must be remembered that they will need infusions more regularly than will those patients with burns showing little or no seepage.

The course of the severe and inadequately treated burn patient can be divided into three dangerous phases:

1. **The Period of Shock:** (Onset 48 hours after the burn).
2. **The Period of Toxemia:** (From 48 hours to 120 hours, occasionally as late as the third week).

3. **The Period of Burn Anemia and Hypoproteinemia:** The anemia and hypoproteinemia develop first during the initial 72 hours but are usually not evident until the signs of toxicity have largely disappeared.

Fluid therapy in burns should be directed toward two major objectives: (1) rapid replacement of acute deficits and (2) maintenance of daily needs.

1. **Rapid replacement of acute deficits:**
   a. Restoration and maintenance of a normal blood volume.
   b. Restoration and maintenance of an adequate hemoglobin concentration (13 to 16 Gm. per hundred cubic centimeters.
   c. Restoration and maintenance of plasma protein concentration above 6.0 Gm. per hundred cubic centimeters.
   d. Restoration and maintenance of a satisfactory urinary output, usually 100 cc. per hour during the first 48 hours.
   e. Prevention of dehydration and acidosis. (Determination of plasma bicarbonate concentration by the method of Van Slyke is a useful index of acidosis).
   f. Prevention of salt depletion. (Determination of plasma chloride concentration by the method of Van Slyke may be used to determine approximate salt depletion).
   g. Avoidance of overadministration of electrolyte (non-colloid) solutions by the parenteral route.
2. Maintenance of daily normal fluid and nutritional requirements of water, salt, carbohydrate, protein and other substances.

A suggested outline for fluid therapy in burns is as follows:

1. **Early Acute Burns (Up to 48 Hours).** The prevention and treatment of burn shock. Fluids are given in this phase for 3 purposes: (1) to restore blood volume and to treat shock, (2) to provide extra fluid to compensate for loss from burned surfaces and as edema of injured tissues (plasma and salt solutions) and (3) to provide additional fluid for adequate urinary excretion (water and salt solutions or dilute salt solutions).

A. Intravenous therapy: Whole plasma is the colloid solution of choice since it supplies fluid and electrolyte as well. The dosage of plasma is best gauged by previously suggested formulas which depend on hemoconcentration, size of burn and, of especial importance, the clinical response of the patient. The depth of the burn is of little practical value as a guide for this purpose. It is best not to give all of the indicated amount of plasma at one time. Even if clinical shock is severe, usually one-third of the complete dose is sufficient at first, other equal doses being given over the succeeding four or five hours. When acute collapse occurs, the first dose of plasma should be given rapidly. Since in these circumstances there

is an acute failure of venous return to the heart, the fluid introduced must to a considerable extent supply this venous return. An initial introduction of 200 to 300 cc. in the first 2 minutes is not too rapid. The administration should then be continued up to 1,000 cc. or more until a satisfactory clinical response is obtained. Subsequent amounts should be given more slowly. In shock, time is extremely important. If plasma or whole blood is not immediately available give intravenous electrolyte solution (physiologic electrolyte solution or isotonic solution of sodium chloride if the former is not available) rapidly until plasma and whole blood are secured.

Plasma is of little value beyond the third day and is seldom needed after the first 24 hours if the treatment during that period has been adequate. Its chief role is in large surface area burns (over 10 percent of the body surface) and during the first 48 hours.

Representative formulas for quantity of plasma infusion are as follows:

a. Formulas dependent on extent of hemoconcentration:

(1) Give 150 cc. of plasma for each specific gravity increase of 0.001 above the normal whole blood specific gravity of 1.060 (i. e. if the specific gravity of whole blood is 1.070, give 1.500 cc. of plasma):

(2) or give 100 cc. of plasma for each point the hematocrit exceeds the normal of 45 (i. e. if the hematocrit is 60, give 1,500 cc. of plasma):

(3) or 50 cc. of plasma for each point the hemoglobin exceeds the normal of 100, or 300 cc. of plasma for each gram the hemoglobin is 130 percent or 20 Gm. per hundred cubic centimeter give 1,500 cc. of plasma:

(4) or 100 cc. of plasma for each 100,000 the red cell count exceeds the normal of 5,000,000 cc. per cubic millimeter (i. e. if the red cell count is 6,500,000 give 1,500 cc. of plasma).

All formulas based on blood concentration-hematocrit and so on may at times be in serious error. For example, in the first hour or so after the injury the hematocrit may still be normal, plasma loss having just started. In such a case the hematocrit repeated at the third and sixth hours gives a truer picture of the condition. Other patients may be anemic at the time of injury or may show anemia because of associated wounds. It should be remembered that formulas dependent on hemoconcentration show only the needs of the patient at the time of testing and certainly not all his requirements during the entire course of the burn.

b. Formula dependent on the area of the burn: Give 50 cc. of plasma for each percent of the body surface involved by a deep blistering burn during the first twelve hours. Often more plasma must be given later. Burns of the face, groin or buttocks usually cause more plasma loss than the surface

OCTOBER MEETING

Tuesday, October 21, 1947

YOUNGSTOWN CLUB

THREE well known doctors from Ohio State University will present the program.

SPEAKERS:

Robert Zollinger, M. D. Bruce K. Wiseman, M. D.
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SIXTH COUNCILOR DISTRICT POST GRADUATE DAY

The following program has been arranged for the Sixth Councilor District Post Graduate Day, to be held at the Hotel Onesto in Canton, on November 5.

Dr. Henry W. Brosin, Professor of Neurology:

(1) "Emotional Aspects of Organic Illness"
(2) "Recognition of Mild Depressions"

Dr. Walter L. Palmer, Professor of Medicine:

(1) "Medical Management of Peptic Ulcer"
(2) "Functional Disturbances of the Digestive Tract"

Dr. Lester R. Dragstedt, Professor of Surgery:

(1) "The Pathogenesis of Peptic Ulcer"
(2) (Evening) "New Methods of Protein Nutrition"

Dr. M. Edward Davis,
Professor of Obstretrics and Gynecology:

(1) "The Role of the Gonadal Hormones in Human Reproduction"
(2) "The Modern Concept of the Prevention and Treatment of Postpartum Hemorrhage"

Additional information concerning the program will be sent to you in the near future.

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involvement indicates and more plasma should be given accordingly. Very few persons with less than 10 to 15 percent of the body surface burned will require plasma transfusions.

Iso-osmotic human albumin solution is a satisfactory substitute for blood plasma in comparable dosages of protein. With concentrated albumin solutions, saline solution should be given in addition.

Whole blood transfusions are often indicated in early burns. In patients with a hematocrit below 60, give 500 cc. of compatible whole blood for every thousand cubic centimeters of plasma administered. In any case in which plasma is not available, whole blood is better than intravenous electrolyte solutions. Rh typing is mandatory in all burn cases which show transfusion reactions on repeated transfusion. It is desirable in all cases of deep burns of more than 20 percent of the body surface in which repeated transfusions may be needed. The use of Rh negative blood for females under 40 years of age is advisable.

Electrolyte solutions are included in initial fluid therapy in burns of less than 10 percent of the body surface. In such cases give 2,000 cc. of physiologic electrolyte solution each 24 hours, perferably by mouth; if not, by vein. In burns of more than 10 percent of the body surface, chief reliance for prevention or relief of shock is placed on plasma (or albumin or whole blood) as indicated.

However, additional amounts of saline and glucose solutions should also be given parenterally to patients unable to take adequate amounts by mouth or to extensively burned patients in whom the required intake by mouth may be excessive, i.e. more than 8 liters in any 24-hour period. The physiologic electrolyte solution or its equivalent should be used. Some of this fluid should also contain glucose, about 100 to 200 Gm. daily. To give average figures, the volume of electrolyte solution given intravenously will be roughly the same as the volume of plasma in the first two days. It will be larger or smaller, depending on the success of oral therapy, but should not exceed 4,000 cc. in any 24-hour period.

B. Oral Therapy: As already indicated, oral therapy with crystalloid solutions is used chiefly to provide fluid for surface loss and local edema and for adequate urine volume. Water and non-salt containing fluids, such as milk and ginger ale, can be given up to 2,000 cc. a day to aid renal function; no more than this quantity should be given until all of the required electrolyte solution has been swallowed and retained. After this has been accomplished, water can be given as tolerated in controlled and reasonable amounts. The following suggestions are made for the administration of oral fluids in the first 48 hours:

   a. Burns of less than 10 percent of the body surface: Give 2,000 cc. of physiologic electrolyte solution each of the first two days.

   b. Burns of more than 10 percent of the body surface: Give

3,000 to 8,000 cc. of physiologic electrolyte solution the first day depending on the extent of the burn. Give 3,000 of physiologic electrolyte solution the second day.

Such oral therapy should be started immediately on admission before local treatment is begun and while waiting for parenteral therapy. However, in severe shock oral fluids should be started cautiously, as absorption may be slow and there is danger of vomiting and aspiration. In such cases, as already indicated, parenteral therapy must be begun at the earliest possible moment, while oral administration should not be pushed until the patient is out of shock. If, after recovery from acute shock, the patient vomits, a quantity of physiologic electrolyte solution equal to the vomitus should be given again. If this happens repeatedly, oral fluid should be temporarily discontinued, but an attempt should be made to give electrolyte solutions again after a 2 to 3-hour rest period. In cases in which the stomach is loaded with food or lack of veins make oral administration obligatory, preliminary washing out of the stomach to prevent aspiration of solid food, followed by Levine tube fluid administration by steady drip, may be advisable.

A definite schedule of oral fluid administration in terms of cubic centimeters per hour should be set up and closely followed to avoid overloading the stomach in an attempt to catch up, if enough fluid is not given in the first 6 hours. In severe burns, 200 to 400 cc. of fluid should be given regularly on the hour during the first 18 to 24 hours. Usually very large volumes of fluid are tolerated in the first 2 days after injury. Contraindications are (a) the presence of thermal burns of the throat, larynx or lower air passages, (a face burn should make one suspicious of such involvement), (b) presence of the casualty in a conflagration in an enclosed space where inhalation of toxic gases may have occurred and (c) in the aged or cardiac patient, when too vigorous fluid administration may increase the tendency to pulmonary edema. A reduced intake of electrolyte solutions and plasma and the substitution in part of whole blood is considered preferable therapy in such cases.

The urinary output is one important indication of the adequacy of fluid therapy. An attempt should be made to maintain the urinary output above 100 cc. per hour during the first 48 hours. Obviously at the beginning of treatment fluids administered will pass into dehydrated and injured tissues, and anuria for a matter of hours is not uncommon. With the schedule of treatment already described, however, urine output should start up at least after 4 or 5 hours and increase to the 100 cc. per hour level shortly thereafter. An inlying catheter may be useful to follow this more closely.

Treatment of acidosis, once present, must be promptly instituted. If the severely burned patient has received no fluid therapy for several hours after the time of injury, acidosis is not infrequent. This is particularly likely if the patient has been in shock

for any length of time. For each volume percent the plasma carbon dioxide is less than 55 volumes percent in a 60 Kg man give one of the following:

a. 40 cc. of a 4 percent sodium bicarbonate intravenously.

b. 125 cc. of 1.3 percent (isotonic) (one-sixth) molar sodium bicarbonate orally or intravenously.

c. 125 cc. of 1.75 percent (isotonic) (one-sixth molar) sodium lactate orally or intravenously.

d. 375 cc. of physiologic electrolyte solution (the larger dosage is necessary since to prevent alkalosis when administered in large quantities, this solution is purposely made with only one-third of the antiacidotic power—as is contained in the one-sixth molar solutions).

2. **Late Burns (After 48 Hours):** The prevention and treatment of burn toxemia, anemia, and hypoproteinemia. Toxemia may be present early and cause fatalities as late as the third week. Anemia and hypoproteinemia may exist from the first few days and are troublesome until granulating surfaces are covered with epithelium. Electrolytes as well as protein are lost from granulating surfaces and should be replaced by an adequate intake of salt in the diet.

One must be aware of the danger of giving too much fluid in later stages of burns. There is a strong tendency in both the adema-absorption stage and in the toxemia-infection stage for plasma and blood volume to increase above normal when excessive fluid is given, with resultant cardiac strain, general edema formation, decreased renal function and pulmonary edema. The chief aims of fluid treatment at this stage are as follows:

a. Maintenance of fluid balance and of normal electrolyte balance. After 48 hours, some resorption of the local edema may be expected and it may be unwise to force fluids and electrolyte as vigorously as during the period of local edema formation. If the therapy in the first 48 hours has been adequate, a normal intake of fluid with supplemental fluid and salt to cover continued loss from the wound should prove adequate.

b. Control of anemia.

c. Maintenance of body protein.

These aforegoing aims are accomplished by the following means:

a. Intravenous therapy. Plasma or albumin is seldom necessary after the second day. A 500 cc. plasma transfusion usually contains less than 30 Gm. of plasma protein; a severely burned patient needs 150 to 200 Gm. of protein every day. Hence while plasma transfusions are helpful in combating hypoproteinemia, they are quantitatively insufficient to accomplish much in this regard.

b. Amino acid solutions, as now available, can usually be tolerated intravenously in amounts up to 100 to 150 Gm. of

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amino acids in a 10 percent solution if administered slowly. They are helpful during the first week or longer (after shock has been relieved) in sustaining and restoring the patient's state of nutrition but are indicated only if the patient cannot take adequate proteins by mouth.

c. Whole blood transfusions are of especial value at this stage. Most open burns are accompanied by a continued red cell loss (loss from bleeding, from increased red cell degeneration). Plasma protein is also lost from open burn surfaces in large amounts. Whole blood in large amounts and at frequent intervals combats anemia and hypoproteinemia and is one of the best means of maintaining resistance to infection.

The following rules are of help in blood administration:

a. Give enough whole blood to raise the hemoglobin to 85 (hematocrit to 40, red count to 4.7 million) and to keep it above this level. As much as 1,500 cc. of whole blood daily for several days may be necessary to correct severe anemia in burns.

b. Five hundred cc. of whole blood every three to four days as long as the rectal temperature is above 102 F. or the plasma proteins are below 6.0 Gm. per hundred cubic centimeters.

Electrolyte solutions by vein are seldom necessary in the later stages of burns because the patient usually can take sufficient fluids by mouth. However, when this is not possible, adequate fluid balance should be maintained by the use of intravenous physiologic electrolyte solution in sufficient but not excessive amounts. Glucose in saline solution may be substituted for the physiologic electrolyte solution, and at all times a high carbohydrate intake (100 to 200 Gm. a day) is advisable. In the late stages of burns, with infection and low plasma protein, urine volume may diminish, with edema of the body tissues. Strenuous forcing of electrolyte solution then may only increase edema, without diuresis. Moderate fluid intake, with feeding and whole blood tranfusions, constitutes the logical treatment.

B. Oral Therapy. The immensely important problem of feeding during the often protracted period of infection and anemia cannot be adequately covered in this memorandum. Each case is an individual problem of dietetics and nursing. A full food intake, including calories, vitamins and especially protein, is essential. A few notes may be useful:

1. Total fluid intake should be sufficient to keep the urine 1,500 cc. or higher daily. If salt intake has been adequate, body proteins not too much depleted and heart and kidney function competent, this usually means an intake of between 3,000 and 4,000 cc. daily.

2. Salt (sodium chloride) intake should be maintained around 10 Gm. daily; a little higher if the burn is exten-

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sive with much exudate. Too much salt, however, promotes general tissue edema. Blood carbon dioxide tends to run somewhat low, and some alkaline salt is advisable. Try to keep the urine about neutral to litmus. The physiologic electrolyte solution 1,000 to 1,500 cc. daily will often be useful during the first 5 to 10 days. Water can be given ad libitum after the fourth day.

3. Diet should be high in protein, carbohydrates, calories and vitamins. The protein intake should be added to with increasing areas of third degree burns as early as possible after the injury and probably by the end of the first week. Such protein intake should be of the following magnitudes: 5 to 10 percent body surface burned, 125 Gm. of protein per day; 10 to 20 percent of body surface burned, 125 to 200 Gm. of protein per day; more than 20 percent of body surface burned, more than 200 to 300 Gm. of protein per day, provided the patient's gastrointestinal tract can tolerate the large amounts. The corresponding calorie intake should be approximately 3,000 to 4,000 or 5,000 calories per day.

   a. Amino acids by mouth, 100 to 200 Gm. per day are an effective form of protein intake but difficult to tolerate because of the bad taste. Few patients can take them for more than three or four days.

   b. An example of an adequate diet is the diet used by Evans, which is palatable by mouth but also can be given by tube, as follows: 150 Gm. of dehydrated meat powder, 150 Gm. of powdered whole milk, 50 Gm. of corn oil, 150 Gm. of sucrose, 150 Gm. of dextromaltose, 35 Gm. of chocolate and 1,000 cc. of water (plus vitamins and especially A, B, C, D and iron).

   c. Adequate vitamins and iron are essential in all unhealed burns. A suggested daily dosage is as follows for burns of 20 percent area of third degree. Correspondingly smaller doses should be used for less severe burns: vitamin A, 20,000 units; vitamin B, thiamine hydrochloride, 40 mg.; riboflavin, 20 mg.; niacin amide, 50 mg. vitamin C, 1 Gm.; vitamin D, 2,000 units, vitamin K, 1 mg.; ferrous sulfate, 1.5 Gm.

In conclusion it must be reiterated that the role of adequate fluid therapy in burns cannot be over-emphasized. Such therapy should be instituted promptly and maintained to meet the demands of altered and changing physiological states. Inadequacy of therapy will result either in early death or an unnecessarily prolonged convalescence.

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General Plans for the Operation and Progress of
The Youngstown Receiving Hospital

Funds have been appropriated for the purpose of constructing a new receiving hospital on the site of the present structure which will remain as at present. Legislative approval is required but this seems certain. The new institution will have private and semi-private rooms and all departments will be complete. This is a state hospital and it operates under existing laws. Every patient in a state hospital is a ward of the superintendent who is responsible for him or her. There cannot be divided authority. A plan is in the making and under the auspices of a twelve-man commission which may bring about the alteration of existing laws. After this, private physicians may be able to follow their patients into the institution to care for their physical ills. At present that cannot be done legally. However, consultations by private physicians are in order. The receiving hospital patient's private physician has the legal right to visit the patient but he cannot treat.

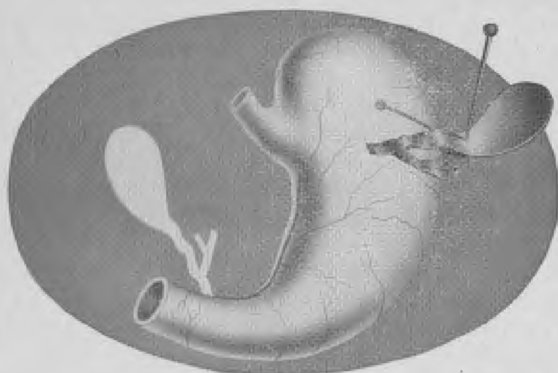
It is the desire of the state commission of mental hygiene to make the Youngstown Receiving Hospital a pattern, both as to its operation and the function of the visiting staff for the country over. Dr. Tallman suggests the visiting staff arrange a program of regular visitation to the Receiving Hospital without awaiting a definite call from the intra-mural staff. He does not wish visitation to depend solely on the discretion of the intra-mural physicians but this will be done between regular visitations as deemed necessary by them. Visitations by physicians will remove the fallacious opinion by family and others that some patients may be brutally handled. Each department on service at a given interval of time shall be responsible for the welfare of the patient in that particular department of medicine or surgery. The various departments that are required to make regular visitations are: medicine, general surgery, gynecology, obstetrics, eye, ear, nose and throat. The authorities of the Youngstown Receiving Hospital at present wish to prepare for and conduct master ward rounds at regular intervals for the benefit of as many physicians as wish to attend them. The physicians of this community should take advantage of it. It is a fertile field for this type of activity.

Dr. Tallman suggested that the Mahoning County Medical Society have a committee of Mental Hygiene. All matters regarding the Receiving Hospital should go through it.

The state commissioner of mental hygiene considers The Youngstown Receiving Hospital the most important unit of receiving hospitals in the country today. It is being observed by interested psychiatrists all over the country. This hospital must continue to succeed as it has already. The procedures followed in this hospital represent a departure from the usual psychiatric hospitals and treatment philosophy in psychiatric therapy as obtainable in no other place.

R. B. Poling, M. D.

Bile in the Stomach?



This illustration has purposely been made to show the common duct opening into the stomach. Had nature intended the bile to be excreted in the stomach, she would have placed the opening there herself. Instead, nature releases bile in the small intestine, in which it carries out its function most efficiently.

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NEWS ITEMS

Dr. and Mrs. H. E. McClenahan have returned from a much enjoyed western trip. Dr. McClenahan has retired from medical practice after 32 years.

Dr. and Mrs. E. J. Wenaas have returned from a few days' trip to Loughboro Lodge, Battersea, Ont.

Dr. and Mrs. G. M. McKelvey have returned from New York where Dr. McKelvey attended the meeting of the American College of Surgeons.

Dr. and Mrs. Myron Wilkoff have returned to Denver, Colorado, to make their future home.

Dr. W. B. Turner and Dr. F. W. McNamara are among the local members of the American College of Surgeons who attended the clinical congress held at the Waldorf-Astoria, New York.

Dr. W. H. Evans attended the annual three-day alumni conference of the New York Eye and Ear Infirmary in New York.

Dr. and Mrs. R. G. Mossman have returned from their summer home at Washagami, Ontario.

A group including Dr. John S. Goldcamp, Dr. E. J. Wenaas, Dr. E. L. Boye and Dr. Donald Gross spent a few days at Hotel Hershey, Hershey, Pa.

Dr. and Mrs. J. J. Wasilko and Dr. and Mrs. T. K. Golden have returned from a sojourn at Cape May, N. J.

Dr. Paul M. Kaufman has been granted a fellowship by the American College of Surgeons it was announced recently.

Dr. and Mrs. J. L. Scarnecchia recently enjoyed a 10-day eastern motor trip. While in New York Dr. Scarnecchia attended the American College of Surgeons convention and from there went to Boston for a few days.

Dr. and Mrs. H. E. Mathay enjoyed a visit in Montreal while on a motor tour through Canada and the New England states.

Mrs. Mary Wick Miles of the Department of Photography and Illustration of Youngstown Hospital Association has an entry of six Kodachrome tranparencies showing variations in the appearance of the liver in the International Exhibition of Biological Photography being held in Rochester, N. Y., September 10-27. This exhibition is the first of its kind to be presented to the scientific photographer and the laity. It is sponsored by the Biological Photographic Association which held its 17th Annual Convention in Rochester, September 10-13.

Mrs. Miles and Dr. E. C. Baker attended sessions of the convention. High spots on the program were a symposium on medical photography sponsored by Rochester General Hospital and trips through Bausch and Lomb Optical Co. and Kodak Park. Papers of particular interest were presented on The Use of the Phase Microscope for the Examination of Fresh Tissue, The Western Union Concentrated Arc Lamp for Photomicrography, and An Infra-Red Photographic Study of the Superficial Veins of the Thorax in Relation to Breast Tumors.

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Dr. John J. McDonough has returned from the Homestead at Hot Springs, Va., where the American Association of Obstetricians, Gynecologists and Abdominal Surgeons held their 58th annual meeting from September 4th through September 6th. Dr. McDonough attended as the guest of Dr. Joe V. Meigs of Boston, professor of gynecology at Harvard University.

Dr. and Mrs. B. J. Dreiling returned from a fishing trip at Burleigh Falls, Ontario, Canada, where they spent ten days angling for the big ones.

Dr. and Mrs. J. B. Birch and children, Tony and Katie, have returned from a month's sojourn at Salter's Point, Massachuetts.

Dr. Ivan C. Smith attended the Congress of Physical Medicine at Minneapolis, Minn., from September 2nd through September 4th. He also attended sessions on Arthritis at the Mayo Clinic for a week prior to the Physical Medicine meeting.

Dr. and Mrs. W. L. Mermis and daughter Gwendolyn have returned from Culver, Indiana, where they visited with their son William, Jr., who attended the summer session at the Culver Military Academy.

DR. SCHEETZ JOINS ST. ELIZABETH'S RADIOLOGY STAFF

Dr. Raymond J. Scheetz recently joined the Department of Radiology at St. Elizabeth's Hospital. He is an associate to Dr. Saul J. Tamarkin. Dr. John Heberding acts as consultant in the Department.

Dr. Scheetz is a graduate of the Ohio State University School of Medicine, class of 1940 and interned at St. Elizabeth's Hospital. He served a fellowship in Radiology at the Mayo Clinic, Rochester, Minnesota, from June 1941 to January 1945. He then spent 33 months in the Medical Department of the United States Army where his work was confined to Radiology. He is a fellow of the American Board of Radiologists.

Dr. Scheetz is married, has three children and resides at 153 Halleck Street.

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ST. ELIZABETH'S HOSPITAL STAFF MEETING

The regular monthly Staff meeting of St. Elizabeth's Hospital was held on Tuesday, September 2, 1947, at 8:30 p. m.

Dr. William L. Mermis presented a paper entitled "Medical Emergencies in Allergy and the Many Important Methods Used in Status Asthmaticus." Dr. Mermis discussed the etiological factors, incidence and treatment of various allergy states. The importance of adequate control of allergy was emphasized when he pointed out that thirteen million working days are lost annually as a result of the affliction. Aids to early recognition and treatment were brought out in the very timely discussion.

Dr. Mermis presented a brief review of "Isuprel" the new potent bronchodilator agent which is identical with a compound known as "Aludrin" which is in use in Europe. Following complete and thorough experimental investigation in which confirmatory evidence was obtained of the European findings, Isuprel was distributed for clinical trial and study and it has been said to be equal or superior to products in use at present. The management of Status Asthmaticus was presented.

WEDDINGS

Dr. Samuel Zlotnick and Marjorie Rose, daughter of Mr. and Mrs. Saul C. Rose, were married August 3 in Rodef Sholom Temple. Dr. Zlotnick just recently returned from military service.

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BOWLING LEAGUE PLANS RENEWAL

The Medical Bowling League plans to resume play on the first Thursday of November at 2:00 p. m. Arrangements are now being made for reservation of alleys so as to accommodate all keglers who are registered for the league. A census is being taken of all those interested in participating.

In addition to competing for seasonal high averages, high games, etc., efforts are being made to secure at least two teams from each of the local hospitals for some inter-hospital competition. Members of the Youngstown Hospital Association are to contact Dr. Robert Piercy, Jr., relative to registration and St. Elizabeth's Hospital Staff Men are to contact Dr. Harold J. Reese.

The fine turnout in last year's play should stimulate added interest and make for even greater representation this Fall. Those anticipating play should notify hospital representatives at the earliest practicable time. Let's have enough so that reservations can be made for six alleys! Prizes will be awarded to individuals with highest averages, highest single game and team winners.

The most significant feature in the history of an epoch is the manner it has of welcoming a great man.—Carlyle

To die for the truth is not to die for one's country, but to die for the world. —Jean Paul Richter

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