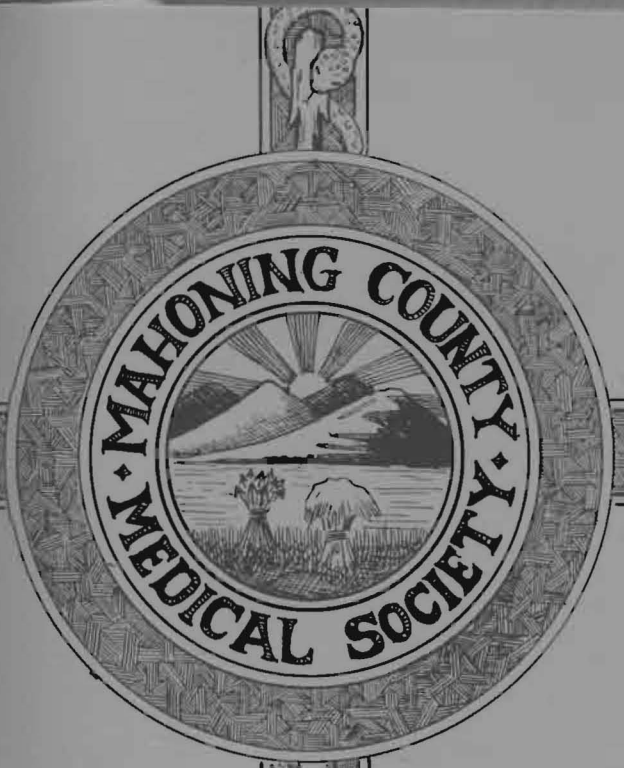

He who would surrender liberty
for security is likely to lose both.

George Washington

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
FEBRUARY • 1948
VOL. XVIII NO. 2

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Vol. VXIII—No. 2 **February, 1948**

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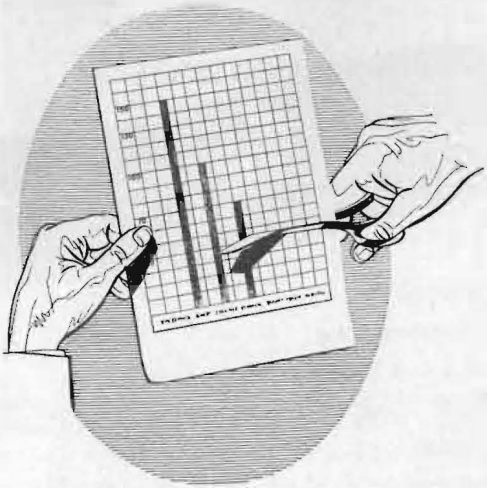

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MEDICAL CALENDAR

1st Tuesday	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
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 Society—Schween-Wagner Bldg.
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—Hotel Pick-Ohio.
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 Tuesday 11:00 a. m.	Orthopedic Conference, St. Elizabeth's Hospital Library
Every Thursday 12:30 p. m.	Orthopedic Section, Library—South Side Unit, Youngstown Hospital
Every Friday 11:00 a. m.	Weekly Surgical Conference, Youngstown Hospital—Nurses' Home
	Urological Section, Library—S. Side Unit, Youngstown Hospital
	Clinico-Pathological Conference, 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

Ohio State Medical Association, Cincinnati, March 30—April 1, 1948.

American Medical Association Annual Meeting, Chicago, June 21-25, 1948.

American Association for the Study of Goiter, Toronto, Canada, May 6-8, 1948.

American Urological Association, Boston, May 17-20, 1948.

Mahoning County Medical Society, 19th Annual Postgraduate Assembly, Youngstown, April 14, 1948.

Northern Tri-State Medical Association, Findlay, April 13.

PRESIDENT'S PAGE

The Second National Conference of County Medical Society Officers was held at the Statler Hotel, Cleveland, Ohio, on Tuesday evening, January 6, 1948. The three main speakers discussed the general practitioner and all agreed that of all types of medical practice the field of general practice must and still include the greatest number of doctors. There was a lively and representative discussion period after each paper. Doctors from every section of our country seemed glad of the opportunity to air their views on the subject. The picture painted by this type of discussion was truly a cross section of our nation and certainly presented information vital to all doctors of medicine.

Three points were stressed above all others and they seemed of sufficient importance to repeat here. First, our interne training should be at least two years and the general practitioners on the staffs must take an active part in this training. We stress too frequently the unusual and highly specialized phases of medicine and surgery in our ward rounds and forget the good common sense facts necessary for general practice. The hospitals in our county are not excluding the general practitioner, as some seem to be doing in other sections of our nation, but we are not paying enough attention to the training of internes in a broad basic knowledge of the practice of medicine. A definite program of interne training commensurate with the needs of a general practitioner are necessary, not only in the medical schools but in our own hospitals.

The second point which was stressed many times during the conference, was that 75%—80% of all patients can be handled by the general practitioner and from an economic point of view no good general practitioner who has practiced two or more years, is short of either patients or financial return. At the present time our economy is on the upgrade but with the inevitable leveling off, which is bound to come, the well trained general practitioner will have more economic security than the average specialist. Instances were cited of the specializing following World War I and the final score following the depression. Warnings were given that when this leveling off occurs the medical profession must have sufficient well trained general practitioners or the public in desperation will solve the problem with socialized medicine.

The third, and certainly a most important point, was that all doctors of medicine and especially the general practitioner who is the family doctor, have not taken sufficient part in the civic, health and economic problems of their respective communities. This is a responsibility which is expected of each of us by our patients and our opinions are thoughtfully discussed if they are only expressed. Many of our members are active on school boards, special civic appointments, civic clubs, etc., but it is essential that each and every member of our Society take an active interest in these phases of our civic and national life.

It is impossible here to convey all of the material presented at this three and one-half hour conference. A detailed report will appear in one or more of the future issues of the Journal of the American Medical Association and each doctor should carefully read it. The conference presented a national problem and it is vital that each physician realize its importance in the modern practice of medicine.

JOHN NOLL, M. D.

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THE PAPANICALOAU METHOD

By HORACE K. GIFFEN, M. D.

Medical literature reveals that the lay public has made greater strides in the last few years toward coming to the doctor with early carcinoma than the medical men have reduced the mortality from cancer. The problem resolves itself into getting patients early for treatment. It is therefore very important to study and try out the method developed by Dr. Papanicaloau for the cytologic search for cancer in the accessible tissues of the body. Pathologists have insisted on histologic methods in determining the presence or absence of cancer. To us the deeper tissues are more instructive and more helpful in clear-cut cancer diagnosis than the superficial cells. However, Dr. Papanicaloau has demonstrated that in these superficial cells there are changes which occur even before the changes in the deeper cells. With experience it has been shown that these superficial changes, particularly in the nuclei of the cells, are dependable as a method of finding carcinoma. Obviously this method is limited in its use, but it does offer definite possibilities for detecting early cancer in several important parts of the body.

Its first application was in carcinoma of the female genital tract where vaginal smears have been found very helpful in detecting cancer in the lower and even the upper part of the uterus. Recently the application of this method has been extended to the urinary tract, the sputum, gastric juice, bronchial secretions, and in fluids collected from body cavities. The real advance made by this method is in staining technique. It has been necessary to modify the stain in such a way that the cytoplasm of the cell does not mask the early changes detected in the nuclei. In the exfoliated cells into any of the body cavities there are rarely mitoses, but the relative size of the nucleus, the size of the nucleolus and the staining reaction of the nuclei are all helpful in showing the changes of carcinoma. Several stains are possible in this method. Some prefer the Papanicaloau stain, others use hematoxylin and eosin which is more familiar to most doctors. Both can be used provided the stain is modified in such a way that the muclear details are apparent.

To pathologists this cytologic study is a problem. It requires more actual professional time for proper study than the study of biopsy material. However, the challenge is thrown out to our medical profession to try to make our

diagnosis of cancer earlier than is possible from biopsy material. It is necessary to train technicians to screen the slides carefully and spot the areas under suspicion for the pathologists. To examine adequately a single slide requires 20 to 30 minutes, and when several slides are made it is obvious that the time of the pathologist does not permit his examining every field in the smear. To train technicians for this task is distinctly a new field but it is being attempted in a few centers of the country. The Youngstown Hospital Association is setting up this service which should prove helpful to the physicians of this vicinity and to their patients. The smear method should not replace biopsy material but it should supplement such examination and in many cases it has proved to be diagnostic even before the lesion is visible. The value of the method promises to increase as the experience of the pathologists and technicians grows.

PHOSPHATASE AS A DIAGNOSTIC TEST

By F. S. COOMBS, M. D.

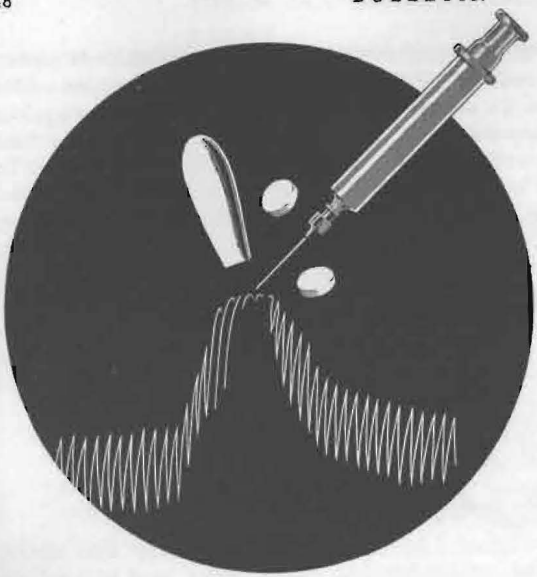
The enzyme Phosphatase is found in the body in two phases: that which acts in an alkaline medium and called Alkaline Phosphatase, and that which acts in an acid medium and called Acid Phosphatase.

To date Alkaline Phosphatase seems to be more widespread and has more uses, though this may indicate its lack of specificity. Alkaline Phosphatase is found in increased amounts when new bone is being formed and in jaundice of hepatic origin. Thus increases in Alkaline Phosphates may be found in the growing child, osteitis fibrosa cystica (Hyperparathyroidism) Padget's disease of bone, osteogenic sarcoma, and osteoblastic metastases from prostatic cancer.

Normal values for Alkaline Phosphatase levels depend upon the method that is used. The method of Bodansky has been used widely for this determination and is the one in use in the chemical laboratories of the Youngstown Hospital. By this method the normal value is considered to be 4.0 units per 100 cc. of serum. Values of 5.0 or 6.0 units are not usually considered diagnostic, but occasionally when combined with other findings may be considered as suggestively elevated. The growing child (with normal calcium and phosphorus values) may have Alkaline Phosphatase levels between 10.0 and 15.0 units. Osteitis fibrosa cystica in addition to having an elevated calcium and lowered phosphorus will show an elevation of Alkaline Phosphatase somewhat in proportion to the amount of involvement of bone. In Padget's disease of bone, calcium and phosphorus values are normal, and the Alkaline Phosphatase is generally moderately elevated (8.0 to 15.0 units). The same condition prevails in osteogenic sarcoma, the roentgenogram being the basis of distinguishing between the two, which is not difficult.

In jaundice of hepatic origin, Alkaline Phosphatase is generally elevated, but the degree of elevation is now fairly well established as being an aid in differentiating between infectious hepatitis and obstructive (surgical) jaundice. When the Alkaline Phosphatase is under 10.0 units the jaundice is thought to be that associated with infectious hepatitis; over 10.0 units indicates surgical jaundice.

Metastatic prostatic cancer may show an elevation of both Alkaline and Acid Phosphatase, though most often only the Acid Phosphatase is elevated and is the test to be preferred since no other disease has been shown to affect



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the level of Acid Phosphatase. The method most widely used for the Acid fraction is that of King-Armstrong. It is a bit more complicated than the Bodansky method, but the King-Armstrong is more reliable for this test. The normal values are about the same by this method as for the Alkaline fraction done by the Bodansky method and this saves confusion. In metastatic prostatic cancer Acid Phosphatase values between 5.0 and 10.0 units are considered presumptive (Huggins). Acid Phosphatase is increased *only when prostatic cancer has metastasized,* though the metastases do not have to be confined to bone since the enzyme will be liberated from metastatic lymph nodes.

THE CLERGYMAN IN THE SICKROOM

By REV. ROLAND A. LUHMAN, D. D.
First Reformed Church
Youngstown, Ohio

The function of the clergyman in the sickroom should be that of implementing rather than impeding the function of the medical man in charge of the patient.

It is generally recognized that there is a wide divergence of opinion on the part of laity and physicians as to the efficacy of the clergyman's visit in the sickroom, varying from that of a genuine warm welcome, to passive tolerance of his presence, to a polite and cold refusal of admittance. The physician's attitude toward the clergyman's visit to the patient is based largely upon the type of experience his patients have enjoyed or suffered, or are likely to enjoy or suffer at the hands of the visiting clergyman.

However, though there are and always will be a number of "quacks" who, like barnacles attaching themselves to the hull of the ship, will attach themselves to these two professions under discussion is no reason to completely discount the usefulness of either or both, inasmuch as both do perform a beneficial service to mankind.

To fully treat in proper manner the clergyman's function in the sickroom requires considerably more space than can be allocated in a single article such as this. Hence, the only phase that will be touched upon here will be that of the clergyman's responsibility to awaken within the patient the desire to cooperate with his doctor by carefully observing all instructions.

No doubt the greatest point of contention centers around the type of conversation carried on and the formal prayer if offered, in the sickroom by the visiting clergyman. Formal prayers if used, as well as general conversation should always be elevating and encouraging to the patient, rather than depressing and despairing.

It is well to remember the words of a certain medical practitioner of primitive days, when he said, as he seared a head wound with a heated iron, "In the practice of pure science, God often lends a hand." When we consider those primitive methods employed in the practice of medicine, it is a fortunate thing that God did lend a hand.

It should also be remembered by the clergyman that as he enters the sickroom he and the medical man in charge are actually seeking the same end for the patient— restoration to physical and mental health. The physician

will be ministering to the physical needs of the patient, preparing the body for physical rehabilitation. The clergyman is present to assist that endeavor by seeking to adjust the mental attitude and thought processes of the patient into a spirit of cooperation with the physician, so that the patient appropriates for himself all the available resources supplied by man and God.

To secure this cooperation on the part of the patient, a mighty responsibility falls heavily upon the clergyman. And this is it. His conversation and his prayer if one is offered, shall not at anytime dwell unduly upon the physical condition of the patient or the anxiety felt by his family. This does not mean that the clergyman shall show no interest in the seriousness of the case at hand. What it does mean is that it is most important that he shall not DWELL upon it, talking loosely and loudly as if he were speaking authoritatively about the percentage of failures in treating similar cases, the danger involved, and much other small talk not based on fact, all of which is most upsetting and distressing and does more harm to the patient than good.

Unfortunately, much that passes for prayer at the bedside of the sick is not prayer at all in the best sense of the word. For it has as its basis the paganistic idea that man is able to coerce or cajole God into performing an act in behalf of the patient contrary to all human and divine wisdom. The clergyman should always bear in mind that central in all his contact with the sick should be the aim of getting the patient's mind off of himself and his illness. The more he dwells upon the patient's ills, his fears, grounded and ungrounded, and his anxieties, the more upsetting will be the visit. Years of visiting the sick have convinced the writer that such conversation and prayer in the sickroom spells utter defeat for the clergyman, is detrimental to the welfare of the patient, and thwarts the purpose of the medical man.

It must always be the function of the clergy to guide the thoughts and to lift up the spirit of the patient, so that he will be thinking less of his ills and misfortune and more of reaching out into the great reservoir of ability and knowledge possessed by his doctor and beyond that into the inexhaustible resourcefulness of Providence.

If the clergyman succeeds in doing this, then the value of his service and presence in the sickroom will never be questioned by anyone with any sense, and he will be welcomed by both patient and physician, because the contribution he makes to the well-being of the patient will be a tonic to his mind and the soul. Then the clergyman will have succeeded in adjusting the patient's life around a certain sustaining faith in his physician and his God. He will have justified his claim of usefulness both to patient and Physician, and will be appreciated by both.

ATRESIA OF THE TERMINAL ILEUM: A CASE REPORT

ALFRED L. COLLEY, M. D.*

Ladd and Gross report a series of fifty-two cases of congenital atresia of the intestinal tract. In this series the most common site of the atresia was the proximal and mid-portion of the ileum accounting for thirty-four of the cases. The least common site for the presence of atresia was found to be the terminal ileum in the region of the ileo-colic valve accounting for but two of the series.[1]

The intestinal tract is derived from an internal tract of entoderm covered by a layer of splanchnic mesoderm that later develops into the muscular layers of the gut and the peritoneum. At the end of nine weeks the normal

intestinal tract is patent throughout, the cloacal membrane has broken down, the rectum formed and the proctodeum broken down to form the anal canal.[2]

The purpose of this account is to report one more case of the relatively rare atresia of the terminal ileum and to mention several errors in diagnosis and management that might be of volue to others encountering similar problems.

CASE REPORT:

The case is one of a four-day old colored male infant. The mother had a normal labor and the infant, weighing nine pounds and three ounces at birth, was apparently a normal healthy infant. During the first two days of life the baby took glucose water and formula when offered to it. On the third day the infant refused anything by mouth and began to vomit. On the fourth day it vomited frequently and in large amounts and the weight was one and one-half pounds under the birth weight. The infant passed meconium on the first two days of life but nothing on the third or fourth days. Progressive abdominal distention was noted from the second day of life accompanied by progressive dehydration. On the fourth day of life, surgical consultation was sought.

At this time the child presented a picture of extreme dehydration and lethargy. The child could be made to cry only with great difficulty. Respirations were shallow and rapid. The lungs were clear and the heart grossly normal. The abdomen was greatly distended and tympanitic. No peristalsis was audible. On recital examination it was possible to insert the little finger about four cms. into the rectal-anal pouch at which level there appeared to be a uniform constriction of the lumen to such caliber that it barely admitted the tip of the little finger but still seemed to be patent. No bulge could be felt toward the promintory that would represent a dilated blind pouch of descending colon or sigmoid.

Fluids were given immediately by hypodermoclysis and the infant X-rayed. The X-rays were taken after the method of Wangensteen and Rice, supporting the infant by the feet in the inverted position in an effort to demonstrate gas in the distended terminal pouch of the undescended colon.[3] The X-ray revealed many distended gas filled loops of bowel but did not show the level of the terminal pouch.

Surgical intervention was advised and carried out after moderate improvement in the state of hydration occurred. Due to the poor condition of the infant surgery was performed under local anesthesia. The pre-operative diagnosis was arrested descent and rotation of the large bowel with complete bowel obstruction and the anticipated operative procedure was a loop colostomy for decompresses with establishment of continuity with the anal pouch at a later date.

A left lower gridiron incision was made and several distended loops of bowel bulged through when the peritoneum was opened. This bowel did not proved to be colon as it first appeared but many coils of small bowel attached to each other by numerous fibrinous adhesions. These were liberated and the bowel replaced. An attempt to demonstrate the descending colon or sigmoid revealed a cord of tissue about the size of a lead pencil. This structure had a mesentery and could be traced distally and found to be continuous with the rectal-anal pouch. Proximally it could be traced to what would correspond to the mid-transverse colon. Further examination through the incision revealed a distended portion of bowel in the right lower quadrant in the normal loca-

tion of the cecum. The left incision was closed and a right gridiron incision made and a cecostomy performed. A catheter was tied into the cecostomy and approximately two hundred cubic centimeters of meconium-like material removed. This markedly relieved the abdominal distension and the infant was returned to its crib in fair condition. Our pre-operative diagnosis had been arrested descent and rotation of the large bowel with complete bowel obstruction. Our post-operative diagnosis was atresia of the transverse, descending and sigmoid colon.

The infant was started on glucose in water by mouth immediately upon return from the operating room. The child took the glucose eagerly and after twenty-four hours was started on a weak milk formula. The child continued to take its formula well but in spite of supportive therapy consisting of vitamins, plasma and hypodermoclysis of glucose, saline, and parenteral amino acid preparations the child, though active, continued to lose weight. The cecostomy continued to function well. The child was sent to X-ray for insertion of barium into the cecostomy to determine the extent of patent large bowel but due to a misunderstanding the barium enema was attempted in the usual manner. To our surprise, the distal two-thirds of the colon filled with barium and, although the bowel was very narrow, a lumen of about one-fourth inch in diameter could be demonstrated. The proximal colon could not be visualized but was thought to be gas filled.

In spite of all efforts the weight of the child decreased from a little over nine pounds at birth to about six and one-half pounds and the baby expired in two and one-half months after progressive inanition.

The autopsy examination revealed an extremely dehydrated male infant. The terminal three centimeters of ileum consisted of a mere strand of tissue and had no lumen whatever. The entire colon was completely collapsed but, although very small in diameter, did have a lumen The ileum just proximal to the obstruction was dilated to about two inches in diameter for a length of about six inches. A functioning ileostomy rather than a cecostomy was present. No other congenital anomalies were noted.

There are several lessons to be learned from this case:

1. The fact that the infant passed some meconium for two days, even if not great in amount, should have told us that the obstruction was higher than the anal pouch as believed.
2. We should not assume when we find a loop of hypogenetic bowel that we are dealing with atresia. This is the normal picture found in bowel distal to a congenital atresia.
3. The original barium enema revealing a blind ano-rectal pouch does not rule out the possibility of continuity with the lumen of the large bowel. One can speculate as to the reasons for the failure in demonstrating the lumen at the first examination. The most likely reasons are the marked increase in the intra-abdominal pressure coupled with the under-developed bowel which never had the normal stimulus to dilate due to absence of meconium. After the decrease in pressure it was possible to readily demonstrate the lumen.
4. In spite of the poor condition of the patient good general anesthesia, adequate exposure in questionable cases and immediate definitive surgery in cases of small bowel obstruction are of paramount importance. (In one series of twenty cases in which ileostomy was performed the mortality was 100%.)[1]

February Meeting

Speaker—PAUL G. BOVARD
Roentgenologist of Allegheny Valley Hospital
Tarentum, Pa.

Subject—"Some Observations on the Medical, Roentgen and Legal Aspects of Silicosis"

Dr. Bovard was graduated from Washington & Jefferson College in 1920—A. B., from Northwestern University Medical School in 1926—M. D., Internship at Allegheny General Hospital, Pittsburgh, Pa., 1926, American College of Radiology, 1938, F. A. C. R., Consultant in Silicosis for the makers of silica brick throughout the U. S. A.

Date—Tuesday, February 17, 1948—8:30 P. M.
Cascades Room, Hotel Pick-Ohio

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to the
MAHONING COUNTY MEDICAL SOCIETY

MONDAY, FEBRUARY TWENTY-THIRD
1:00 P. M.

DESSERT LUNCHEON

BUTLER ART INSTITUTE

Textile Display and Lecture.....Mr. Jos. G. Butler III

Chairman .....Mrs. J. D. Brown
Co-Chairman .....Mrs. O. M. Lawton

—COMMITTEE—

Mrs. J. B. Nelson
Mrs. J. J. McDonough
Mrs. John Brenner

This display and talk will deal with printed silks, screen designed, and suitable for garments and interior decoration.

ETHEL M. FISHER

20th ANNUAL POSTGRADUATE ASSEMBLY

By a Group Led by
DR. WILLARD O. THOMPSON
Chicago, Illinois

ALL-DAY SESSION -:- PICK-OHIO HOTEL
WEDNESDAY, APRIL 14, 1948

5. This case re-affirms the importance of early complete physical examination of the new-born including the insertion of the gloved finger into the rectum and careful supervision of the infant for the first few days of its independent existence.

*Chief Surgical Resident—St. Elizabeth's Hospital

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2. Arey, L. B. "Developmental Anatomy." W. B. Saunders Company 3rd. ed. 201, 1934.

3. Wangensteen, O. H. and Rice, C. O.: Imperforate Anus-a Method of Determining the Surgical Approach. Ann. Surg., 77, 1930.

4. Ladd, W. E. and Gross, R. E. "Abdominal Surgery of Infancy and Childhood." W. B. Saunders Company 38, 1941.

THE ANTIHISTAMINE DRUGS

By ALFRED R. CUKERBAUM, M. D.

The demonstration of the phenomena of anaphylaxis, which had its impetus at the turn of the century was largely responsible for the progress in the development of an understanding of the allergic diseases. No sooner had specific desensitization been demonstrated than experimenters began to turn their energies to find a method which would desensitize or inhibit anaphylaxis without the employment of a specific antigen.

Up to 1932, at least 165 substances or methods aiming at non-specific inhibition of anaphylaxis had been reported. Several of the most common methods and substances used was that of substituting Potassium Chloride for Sodium Chloride, high doses of Vitamin C and Histaminase known by the trade name of Torantil. The first of the antihistamine drugs to be reported on was Antergan and Neoantergan. Results with these two drugs first began to appear in the European literature in 1942.

The most commonly used antihistamine drugs in this country are Benadryl Hydrochloride and Pyribenzamine. To the best of our knowledge the antihistamine drugs operate by competing with the liberated histamine in their attachment to the receptor cell. Benadryl and Pyribenzamine are synthetic chemical compounds. These drugs possess both anti-allergic and antispasmodic effect on smooth muscle. They are non-narcotic, possess a wide range of tolerance and there is no evidence to prove that they are habit forming. They were first introduced early in 1946.

These drugs have been used effectively in: Urticaria, Serum Reactions, Dermographism, Contact Dermatitis, Erythema Multiforme, Drug Sensitization, Hay Fever, Vasomotor Rhinitis. They are used in these diseases as an antiallergic drug. They have been reported to have use as an antispasmodic in Dysmenorrhea.

They have had some usefulness in conditions of: Angioneurotic Edema, Asthma, Cardiospasm, Eczema, Food Sensitization, Hiccough, Migraine, Pruritus (associated with dermatosis), Spastic Colitis, Tinnitus (menieres), Vesicourethral Spasm.

Extreme caution should be used in administering hypnotics and sedatives to patients taking the antihistamine drugs. There are numerous side reactions which may develop in patients taking the antihistamine drugs. The most frequent complaint is that of drowsiness and mental sluggishness. This occurred in 61% of the patients taking Benadryl and in 20% of the patients taking Pyribenzamine.

The next most frequent complaint in the use of antihistamine drugs was that of gastro-intestinal disturbances ranging from nausea, anorexia, epigastric distress to vomiting, diarrhea and abdominal colic. The gastro-intestinal complaints were more frequent in patients taking Pyribenzamine than in those patients taking Benadryl.

Sense of exhaustion and weakness occurred in 8% of the patients taking Benadryl against 3% of the patients taking Pyribenzamine. Muscle twitching, tenderness, difficulty in phonation and in co-ordinating movements of the extra orbital muscles are occasionally observed with the antihistamine drugs. Dryness of the mouth is a common complaint.

As we have shown, there are important differences in the types and incidences of the side reactions that follow the two drugs. Although Benadryl produced sedation in 60% of patients, this fact may be turned to advantage when fatigue, anxiety, or insomnia complicates the allergic disorder. The sedative effect is also highly desirable for Pruritus. Benadryl should be deliberately selected in these cases. This effect can also be controlled to some extent by having the patient take the drug after meals, having them drink black coffee, or having the patient take caffeine or ephedrine.

On the other hand, patients whose efficiency and judgment may be impaired by sedation should be given Pyribenzamine for daytime use. Some patients prefer one drug and some patients prefer the other drug. They may receive more relief from one drug than the other drug. Thus, if relief is not experienced from one drug, it is worth while to change to the other.

There might also be a sensitivity to the drug. We have several patients whose allergic disease became more severe after taking the drugs. The antihistamine drugs should be used as an adjunct in the management of an allergic case, since they only exert a symptomatic effect and are only palliative.

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1. Feinberg, Samuel H.: Histamine and antihistamine agents, J. A. M. A. 132: 703-713 Nov. 23, 1946.
2. Loveless and Brown: A comparison between the clinical effects of Pyribenzamine and those of Benadryl, The New England Journal of Medicine 237: 14 October 2, 1947.
3. Parke, Davis & Company, Clinical Resume.

THE EFFECTS OF GERMAN MEASLES DURING PREGNANCY

The most frequent abnormalities noted were congenital heart disease, cataracts, deafness and mental deficiencies. Eighty-seven percent of the babies born of mothers having German Measles during the first trimester of pregnancy were abnormal. Forty-two percent of the babies whose mother contracted German Measles during the second trimester were abnormal while if the disease occurred during the final trimester of pregnancy none of the babies were abnormal.

STUART ABEL and T. R. VAN DILLEN
Presented before Central Society for Clinical Research at the Twentieth Annual Meeting

Submitted by Dr. J. D. Miller

THE MEDICAL CRIER

A Page of Sidelights, News and Views in the Medical Field

Up in Cleveland last month at the interim session of the A. M. A., the general practitioners gave voice to their growing discontent. They said that they were being put upon, restricted, and coerced by the specialists; that they get the drudgery and grief while the specialists reap the glory and the rewards; that the family doctor has just become a reference bureau to distribute his patients to the various specialists.

Now this seems exaggerated to me, but there must be some truth in it or there would not be so much complaint and protest coming from all over the country. Here is an unique situation. The medical profession while being attacked from without by those who would damage its prestige in order to change the system under which it operates, now finds itself divided within, with the largest and strongest element of the profession crying that it faces extinction. The threat of extinction is very real, too, for the young interne of today looks over the situation with an appraising eye and decides for himself that a couple more years of resident training will pay off in the long run. That is why all the approved hospitals have more applications for specialist residencies than they can handle. That is why the old family doctors as they die off are not being replaced.

The worst thing about this situation is that the doctors have no one to blame but doctors. They can't blame the New Deal or the Wagner-Murray-Dingell bill or even the President. Some try to blame the people because they by-pass the G. P. and go directly to the specialist, but that is not a decisive factor. The things that really hurt are the restrictions put on the G. P. in the hospitals. As time goes on they are shut off from more and more things: first it was major surgery, then tonsils, then obstetrics and so forth. Where it will end nobody knows. But who wants to be a G. P. if he can't take care of his patients in the hospital?

Remember that the Executive Committees of the hospitals are concerned with keeping up high standards. They have to meet the requirements of the College of Surgeons and the A. M. A. When the inspectors come around, they are interested in records and morbidity and mortality statistics and the quality of the work that is done and the teaching of internes and residents. If the doctors have been too busy to keep up with those things, then the hospital doesn't qualify. So the hospital is very particular about who does what, and it would rather have specialists doing special things because they do them better. But when you go right up to the top, you have the doctors in the College and the Specialty Boards dictating what shall be done in hospitals all over the country. Now this must be a good thing because it is a system which has evolved over a great many years, and it corrects a great many evils such as incompetent doctors doing things they are not qualified to do. It is much better to have doctors bossing the system than to have laymen or politicians doing it.

What is the answer to the dilemma of the general practitioner? That is a hard question, but it surely has an answer. I do not believe that the family physician is going to disappear. He fills a definite need, and that which serves will endure. The medical schools are now filled with men who are years behind in education because of the war. They are anxious to get out and go to work. They don't all want to be neuro-surgeons. They just want to be

doctors in small towns where they can have large practices and "be somebody." They want to grow in skill and experience and maybe later on limit their work to some field in which they have attained eminence. That's the way it used to be. It was called "earning" your specialty. They want the hospitals to set their standards on the basis of individual ability rather than classification and labeling. It is not in the interest of economy or the public welfare to cut a patient up into little sections and portion out each to a different specialist. When a man is sick, the whole body is sick.

There should be no conflict between the G. P. and the specialist. They need and supplement each other. The family doctor should be glad to turn over the cases he can't handle to the specialist. He should welcome consultation and advice and can do so without loss of prestige. Let him not envy the specialist who dominates the scene for a while, for his is the "long pull." He sees the patients first, last, and in between. They will depend on him for advice in all things medical and many things moral. His professional life is longer than that of the specialist, and if he loves his work, his rewards are much greater. If he studies constantly and keeps improving, he will be permitted to do the things he is able. When he feels his activities are being restricted, he should do just what he is doing now—form a group and do something about it. But don't take the grumbling of the G. P. too seriously. He is not going to quit.

J. L. F.

COUNCIL MEETING

January 12, 1948

The regular monthly Council meeting was held at the office of the Secretary on January 12, 1948. The following doctors were present: John Noll, J. N. McCann, W. M. Skipp, G. G. Nelson, C. A. Gustafson, R. E. Odom, V. L. Goodwin, I. C. Smith, E. J. Reilly, J. K. Herald, W. J. Tims, Morris Rosenblum, Chairman of Publicity Committee, H. E. Hathhorn, Chairman, Public Health Committee and G. E. DeCicco, Chairman, Lay Education and Speakers' Committee.

Meeting was called to order at 9:00 by President John Noll. Minutes of the previous meeting were read and approved.

Dr. E. J. Reilly, Chairman, Public Relations and Economics Committee discussed progress of fees for medical service to hospitalized indigent paid by the State of Ohio according to law.

Motion was made, seconded and duly passed that Dr. E. J. Reilly, Dr. I. C. Smith and Mary B. Herald contact a law firm dealing with corporate laws such as Manchester-Bennett-Powers & Ullman or Harrington-Huxley & Smith for legal advice and report back to Council.

Council turned over to Dr. Hathhorn, Chairman, Public Health a brochure submitted by the Ohio State Medical Association dealing with set-up and recommendations for a local health council.

Dr. Noll suggested that the Health Survey conducted by Dr. Gregg be turned over to Dr. Hathhorn together with the ordinance and anything in connection therewith that would be of help to him and Dr. G. E. DeCicco, Chairman, Lay Education and Speaker Bureau, in conducting a Health Educational Program.

Dr. Skipp called attention to the Allied Professions Committee Group and suggested that the entire committee be carried in the Bulletin.

Dr. L. H. Getty submitted a report on the new indigent hospitalization set-up.

Dr. Getty's report appears on page 69 of this Bulletin.

A motion was made seconded and duly passed to accept Dr. Getty's report and publish same in the Bulletin. His report appears as a separate article in this issue.

Dr. Gustafson read the following letter which was sent out to the members who have practiced medicine 50 years or more. Drs. Coyt Horace Beight, Harmon E. Blott, Warren Deweese Coy, Charles David Hauser, Milton Emerson Hayes, Adin Vincent Hinman, Henry Manning Osborne, Wallace Wilberforce Ryall, Charles Henry Slosson, Raymond Edward Whelan, David Richard Williams.

LETTER

Dear Doctor:

At the December meeting of the Mahoning County Medical Society, it was suggested that those of our members who have practiced medicine for a half century be given special honor at our Annual Banquet to be held in March, also that they be given special recognition in the March issue of the Bulletin.

The plan would be something like this: Publish the names, together with the Medical School from which they were graduated (the year of graduation will be omitted.) Following this there will be a special article as a tribute to those who have spent fifty years or more in medicine. The recognition at the banquet will depend upon the plans of the social chairman, but we are sure that you will not be required to give any speech unless you especially desire to do so. The Council appointed me a committee of one to see whether or not you are willing to cooperate in this plan.

Will you please reply by letter, telephone or personal communication whether or not you are in favor of this tribute to our men who have spent so many years in the practice of medicine.

Enclosed is a List of those whom we would like to honor.

Fraternally yours,

C. A. GUSTAFSON, M. D.

Motion was made seconded and duly passed that honoring the Half Century Club be part of our Annual Banquet and the Social Chairman be so notified.

Dr. M. S. Rosenblum, Chairman Publicity Committee, presented for approval, a new sign to be posted in the hospitals advising members of meetings.

A motion was made seconded and duly passed accepting Dr. Rosenblum's recommendations and authorizing him to get suggested signs for the three hospitals.

Council reviewed the Financial Report as inserted in the January issue of the Bulletin and reported that due to illness Mr. Fisher, C. P. A., was unable to attend the meeting but would be glad to be present at the next meeting and explained the report in detail and answer any questions.

A motion was made seconded and duly passed to accept Mr. Fisher's report as presented.

FOR ACTIVE MEMBERSHIP

Clyde Kenneth Walter, M. D., Canfield, Ohio.

Dr. Kenneth E. Camp, M. D., 18 W. Wood St., Lowellville, Ohio.

Dr. Rollis R. Miller, M. D., 3031 Market St., Youngstown, Ohio.

Anthony J. Bayuk, M. D., 511 Parmalee Ave., Youngstown, Ohio.

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

The radio program was discussed. It was suggested to Dr. DeCicco that he work out a plan and report back to Council.

A more comfortable place for Council to meet was discussed.

It was moved seconded and duly passed that Council Meetings in the future be held at the Council Room of the Medical-Dental Bureau, second floor Schween-Wagner Bldg.

Meeting adjourned at 10:45 p. m.

V. L. GOODWIN, M. D.
Secretary

HEALTH COMMISSIONER SPEAKS

The duties of Health Commissioner are many and varied. The best definition would be, "coordinator of any and all functions pertaining to health of community." The commissioner is the medical man on the mayor's cabinet. He represents the doctor, and aids in determining the policy in regards to public health and welfare of the city, cooperating with doctors.

With winter well on its way, diseases peculiar to it are increasing in number. A widespread outbreak of upper respiratory infection, with 20% school absenteeism occurred in California. According to reports type A influenza virus has been identified. Texas has a marked increase in incidence of influenza. Locally there has been no marked increase in any communicable disease.

Having spent only a short time in the health department there are many problems I have not yet encountered. As questions come up I will try to handle them to the best of my ability.

Suggestions will be welcome at any time from anyone interested. In the morning I can be reached at the health department. I can also be reached at my Lincoln Ave. office during my regular afternoon and evening office hours.

W. J. TIMS, M. D.

NEW INDIGENT HOSPITALIZATION SET-UP

Many physicians have been asking questions about the new set-up for hospitalization of indigent patients, now handled for Youngstown by the Mahoning County Welfare Department.

The new arrangement went into effect October 1, 1947, under amended Senate bill 178 to Section 3391 of the Ohio General Code. This bill makes hospitalization of indigents a part of the general relief program to be administered by local welfare departments.

Since Youngstown relief, under contract, is handled by the Mahoning County Welfare Department, hospitalization also comes into the hands of the same department.

In taking over the investigation of indigents for hospitalization Mr. I. L. Feuer, Mahoning County Welfare director, asks that the medical profession give full co-operation.

"Please," he pleads, "don't swamp us with unlikely cases. We have the facilities for handling those cases which are reasonable. But if we should have to check a great number of improbable cases, the whole program might break down."

Here are the steps which a physician should take when he has a patient he believes to be unable to pay a hospital bill.

1. All patients who are already on Welfare care can be referred to the hospitals and can inform the hospital that he is now under Mahoning County Welfare care.
2. Within three days after the admission of a welfare or supposedly welfare patient the hospital will notify the Welfare Department. They, in turn, will make an investigation to determine if the patient is eligible for welfare care.
3. All emergency cases should be referred directly to the hospitals which will then refer the case to the Mahoning County Welfare Department if the person states he is unable to pay the bill.
4. The County Welfare Department will pay only such hospital bills as fall within their legal responsibility.
5. The County Welfare Department will pay hospital bills for patients who because of lack of funds or prepaid hospitalization are unable any longer to pay their hospital bill and are otherwise indigent. Cases, assuming this status, if reported promptly by the attending physician, will be investigated as any regular indigent case and will facilitate payment for the hospital.

Here again Mr. Feuer urges discretion on the Medical Profession in referring cases to the hospitals. Be sure that they come under the Welfare Agency.

The fees paid for house and office calls are the same as those paid by private patients. The fees for x-rays and surgical cases outside of the hospital are paid according to the rates paid by the State Industrial Compensation Commission of Ohio.

L. H. GETTY, M. D.

NEWS ITEMS

At a meeting of the American Academy of General Practitioners in Cleveland held during the A. M. A. Session, Dr. G. E. DeCicco was appointed chairman of the membership committee for the state of Ohio. Will all local members please contact Dr. DeCicco so that a local organization can be started. It is the desire of the national headquarters that a local organization be started by March 1, 1948.

Dr. Edwin R. Brody recently addressed the Columbiana County Medical Society on "The Treatment and Management of Skin Diseases Seen in General Practice."

Dr. Wm. Newcomer of the Mahoning County Tuberculosis Hospital talked to the P.-T. A. group at Market St. Grade School, January 15, 1948.

ST. ELIZABETH'S HOSPITAL STAFF MEETING

The first 1948 regular monthly meeting of the St. Elizabeth's Hospital Staff was held Tuesday, January 6. Dr. R. B. Poling, newly elected President of Staff, presided.

Dr. J. K. Herald presented an excellent paper on "Diagnostic Problems in Colo-Proctology." He presented a concise statistical analysis of the incidence of colon, rectal and anal carcinoma and pleaded not only for fuller evaluation of the patient's symptomatology but for added completeness in the physical examination of patients suggesting lower bowel lesions. He emphasized that the burden of early diagnosis still rests with the physician and that any intestinal symptomatology should make complete examination and proctosigmoidoscopic survey mandatory. If anything, he emphasized "the physician should make religious application of the examination which will carry him to within reach of the greatest percentage of carcinomata in the colon-proctological tract, the *digital examination.*"

Dr. Herald made a summation of predominant symptoms of the pathology of the colon, rectum and anus, and gave a systematic review of the significane of each. He warned that early diagnosis can only be achieved by careful attention to what may appear to be insignificant details. The search, he emphasized, is for the early carcinoma with obscure symptoms and not so much for the pathological entity that is obvious, if any significant progress is to be made in morbidity and mortality statistics.

The paper elicited a great deal of healthy comment and discussion.

DR. REESE TOPS MEDICAL PINMEN

Firing a sizzling 263, Dr. H. J. Reese set a torrid pace for high game honors at the January 8th session of the medical keglers at Champion Alleys. He veritably ate his words when he said "local physician blows top on alleys" as he fired strike after strike in his dazzling performance. His 263 replaces a previous high of 210 set by Dr. V. G. Herman in earlier sessions. While averages are far from spectacular the keglars have been enjoying good sport and fellowship during dreary winter days. Averages of the pinmen as of January 8 are as follows:

Name	*No. Games*	*Total*	*Average*
R. Piercy	16	2614	163
H. Reese	25	4023	161
N. Belinky	18	2897	161
R. Clifford	7	1120	160
P. J. McOwen	3	470	157
V. Herman	35	5444	156
M. Conti	14	2155	154
E. H. Young	17	2592	152
J. Brown	16	2364	148
S. W. Ondash	26	3796	146
J. Renner	6	878	146
F. F. Piercy	19	2740	144
H. Ipp	4	558	140
S. Goldberg	4	545	136
I. C. Smith	19	2521	133
W. O. Tims	8	1065	133
A. Phillips	15	1953	130
J. Clair Vance	4	512	128
B. J. Dreiling	8	1005	126
J. Colla	8	981	123

HEALTH DEPARTMENT REPORTS

Communicable Diseases

	Year 1946	Year 1947
Malaria	4	0
Chicken Pox	375	804
Diphteria	6	1
Influenza	0	2
Measles	1507	127
Germ. Measles	7	2
Mumps	148	75
Epidemic Men.	4	1
Poliomyelitis	1	11
Scarlet Fever	157	90
Small Pox	0	1
Tbc.	92	73
Typhoid	1	1
Whooping Cough	151	329
Syphilis	593	461
Gonorrhea	111	91
Amoebic Dep.	1	1
Pneumonia	2	

VITAL STATISTICS

Principle Causes of Death

	Dec. 1946	Dec. 1947
Diseases of heart	51	37
Cancer	24	17
Cerebral Hemorrhage	20	13
Nephritis	3	3
Tbc.—all forms	2	1
Accidents (other than auto)	10	11
Pneumonia	14	8
Arterio Sclerosis	4	6
Diabetis Mellitus	3	1
Premature Births	6	7

Communicable Disease Report December, 1947

	Cases	Deaths
Chicken Pox	75	0
Measles	33	0
Germ. Measles	1	0
Mumps	1	0
Scarlet Fever	8	0
Tbc.	9	2
Whooping Cough	38	0
Syphilis	30	0
Gonorrhea	16	0
Pneumonia	0	14

REPORT OF SOCIAL WORKER FOR 1947

Total patients seen in home visits	329
Total visits made in the homes	568
Classification of patients for whom home visits were made	
Syphilis found in Army examinations	3
Pre-natal with positive serology	1
Pre-maritals with positive serology	60
Discharged from the armed services with doubtful serology	28
Contacts of active cases of venereal disease	64
Referred from local hospitals	4
Clinic positives (These failed to report for their blood or smear reports	17
Referred from local doctors	13
Referred by social agencies	2
Referred by out of town health departments	5
Special request visits	4
Referred from Veterans administration	1
Delinquent registered clinic patients	127
TOTAL	329
Disposition of patients, other than registered clinic patients	
Referred to local physicians	38
Records transferred out of town	25
Still under observation	28
Treatment found not necessary	26
Refused to submit to necessary tests	7
Unable to locate	25
Admitted to the V. D. Clinic	53
TOTAL	202
Delinquent clinic patients	127
Total number of individuals investigated	329

In addition to home visits many individuals were reached by phone calls and form letters. Additional contacts were referred to the clinic by the Board of Health. Thirty-eight home calls were made by various members of the visiting nurse staff.

The part time social worker has endeavored to interview all patients when admitted to the V. D. Clinic. Some clinic periods were devoted entirely to encouraging eligible patients to undergo penicillin therapy at the Columbus Rapid Treatment Center.

In the coming year it is hoped that eligible patients (this list includes cases of early syphilis, all pre-natals with syphilis, and those with congenital lues) will accept therapy at the State Treatment Center. This will reduce our delinquency thus enabling

the social worker to devote more time for contact investigations.

It is hoped, too, that local agencies and physicians will feel free to refer venereal patients or suspects in whom they find delinquency so far as treatments are concerned or other problems.

The social worker is in attendance at all clinic periods and may be reached daily in the visiting nurse office 108 Dollar Bank Building.

N. GRANT, R. N.
Visiting Nurse
Part time social worker
V. D. Clinic

VENEREAL CLINIC, REPORT FOR 1947

SYPHILIS

No. of cases treated this year			353
Carried over from 1946		172	
Admitted this year		181	
Primary			
Sero negative	6		
Sero positive	21	27	
Early			
Secondary	28		
Other	51	79	
Late		22	
Neuro		15	
Latent		30	
Congenital		8	
		181	
Males		94	
Females		87	
Discharged as cured or arrested		100	
Transferred		36	
Delinquents		38	
Remaining		174	
Died		5	
Total			353
No. of blood tests taken		986	
Positive	445		
Negative	541		
No. of spinal punctures		30	
Positive	6		
Negative	24		
No. of Intravenous injections administered		2528	
No. of intramuscular injections administered		3833	
No. of chest and eye exams.		340	
No. of patients treated with penicillin at Columbus Rapid Treatment Center		47	
No. of Clinic visits			6588

GONORRHEA

No. of cases treated this year			171
Carried over from 1946 and re-admitted		25	
Admitted this year		146	
Acute	107		
Male	103		
Female	4		
Chronic	30		
Male	12		
Female	18		
Post Gonorrheal and non specific	9		
Discharged as cured		55	
Transferred		2	
Delinquents*		89	
Remaining		25	
No. of Clinic visits			558
No. of patients treated with penicillin		126	
No. of penicillin injections given		137	
NUMBER OF VISITS MADE BY PEOPLE SEEKING ADVICE OR REQUESTING EXAMINATIONS NOT ADMITTED AS PATIENTS			128

*Of these 89 patients, 68 received penicillin treatment, they can be considered as probably cured thus making the total of cured cases as 123.

CHANCROIDS

No. of cases treated this year			3
Carried over from 1946		1	
Admitted this year		2	
Discharged as cured		3	
Transferred		0	
Delinquent		0	
Remaining		0	
No. of clinic visits			12
GRAND TOTAL			
No. of patients treated at clinic during 1947			527
No. of visits			7286

HENRI SCHMID, M. D.
M. E. HAYES, M. D.

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.