Virtuous activity is identical with happiness.
—Aristotle
The weight curves represented above are to be found in actual hospital (name on request) records of 75 consecutive infants fed on Similac for six months or longer. Not once in this entire series of 75 cases was it necessary to change an infant's feeding because of gastrointestinal upset.

Similarly good uniform results are constantly being obtained in the practice of many physicians who prescribe Similac routinely for infants deprived, either wholly or in part, of mother's milk.

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ANTISTINE IS ALSO AVAILABLE IN TABLET FORM for systemic treatment of other general allergic symptoms. This new drug has been found effective in patients where another antihistaminic has failed or where side effects have precluded discontinuation of therapy. Dosage is usually 3 to 4 tablets daily. Available as 100 mg scored tablets.

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ANTISTINE (sodium of phenazolate hydrochloride) — E. C. Reg. 10. I. P. 98.
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ANTISTINE IS ALSO AVAILABLE IN TABLET FORM for the systemic treatment of other general allergic symptoms. This new drug has been found effective in patients where antihistaminic has failed or where side effects have necessitated discontinuance of therapy. Dosage is usually 3 to 4 tablets daily. Available as 100 mg scored tablets.

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'Surfacaine' (Cyclohexethane, Lilly) produces an unusually powerful surface anesthesia on damaged or disordered skin and on rectal, vaginal, urethral, and bladder mucous membranes within a few minutes after application. Anesthesia usually persists for from six to eight hours and may be made continuous with regular applications. Systemic toxicity has not been observed in extensive clinical usage, even when the drug is applied to burns covering a large part of the body surface. Allergy to 'Surfacaine' is rare. The following preparations, for every indication, are provided on the physician's specification:

Cream: 'Surfacaine,' 0.5 percent, in 1-oz. tubes, and in 1-lb. and 5-lb. packages.

Jelly: 'Surfacaine,' 0.25 percent, in 1-oz. tubes.

Ointment: 'Surfacaine,' 1 percent, in 1-oz. tubes with removable metal tips, and in 1-lb. and 5-lb. packages.

Suppositories: 'Surfacaine,' 10 mg., in packages of 12.

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COMING MEETINGS
American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.
American Public Health Association, Boston, Mass., Nov. 8-12.
Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 3.
Sixth Councilor District Post Graduate Assembly, Akron, Oct. 13.
International College of Surgeons, St. Louis, November 15-20.
the unique surface anesthetic

'Surfacaine' (Cyclomethylaine, Lilly) produces an unusually powerful surface anesthesia on damaged or normal skin and on rectal, vaginal, urethral, and bladder mucous membranes within a few minutes after application. Anesthesia usually persists for four to eight hours and may be made continuous with regular applications. Systemic toxicity has not been observed in extensive clinical usage, even when the drug is applied to burns covering a large part of the body surface. Allergy to 'Surfacaine' is rare. The following pharmaceutical forms, for every indication, are provided on the physician's specification:

Ointment 'Surfacaine,' 1 percent, in 1-oz. tubes with removable rectal tips, and in 4-oz. and 5-lb. packages.

Jelly 'Surfacaine,' 0.25 percent, in 1-oz. tubes.

Cream 'Surfacaine,' 0.5 percent, in 1-oz. tubes.

Injection 'Surfacaine,' 10 mg., in packages of 12.

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To read—what and when—is often a fond wish of every doctor and as often is difficult to accomplish. Our libraries are stocked with Books and Journals but actual perusal of all the material is impossible. This self-education which is so necessary to keep up to date is an art which requires time, correct material, perfecting of reading technique and much practice. Many of our members set aside a certain period each week for study of the current medical literature and so by sheer will power the time element is solved. The tremendous volume of scientific publications requires everyone to choose only those Books and Journals which give the most straightforward and thought-provoking value to the chooser. This is naturally very individualistic and often is by trial and error. Medical College and Hospital Residency has trained us for the many daily mental and physical gymnastics of our profession but one phase has not been stressed in the average curriculum. This is the training to choose correct professional publications. Journal Clubs with required reading and review of modern medical literature furnish a good foundation for such experience. Perhaps our hospital training should activate such clubs among our staffs.

We learn the art of reading in elementary school but rarely try to improve it later. The fast reader is the lucky one but most of us are not so blessed. One can read the title and the summary with study of the whole article if interest is aroused. An excellent experienced internist reports that he reads the first and last sentence of each paragraph and thereby digest many modern advances in medicine.

Then there is the storing of the knowledge—card indexes?—too cumbersome and time consuming—scrap-book filing?—rarely for the same reason—most of the time it requires extra shelving in our memories and thereby practice makes perfect but practice must exist.

July and August are vacation months and some of the spare time may be allotted to reading medical publications—or so think one at the moment!

JOHN NOLL, M. D.
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JOHN NOLL, M. D.
CONSERVATISM

Press reports concerning the Palomar telescope are to the effect that the project of making and assembling the superior instrument has every indication that it will be a complete success. We will be in touch with inconceivable distances which can be recorded only in terms of light-years. We will have new bases for marveling at the vastness and the interrelation of the forces of the universe. We will have new reasons for marveling at man's ingenuity in bringing these into human understanding.

We will have additional tangible evidence that will make more real to us the immateriality which man recognized even in the days of his savagery. We arrive scientifically to what was once intuitional. We may demonstrate conclusively what has been an hypothesis. Primal man was satisfied to sense this relationship between causative factors and remote effects without attempting to analyze the process. He allowed his wonder to become transcendent and gave it forms of worship. Sometimes the forms gave satisfactions that otherwise would not be his.

While the ancients lifted up their eyes unto the hills,” we tend to cease looking for help from extraneous sources, and try to develop within ourselves an adequate response to the forces already available. This, we feel, makes for progress that can be sustained. While it keeps us aware of our limitations, it encourages the establishment of planes from which we may project our thought.

It is not easy, in these days of constant change, to hold fast to what we consider to be unchangeable. Most people look at the conservative as a hindrance to advancement. Yet he has been in good company throughout the history of mankind. The Greeks, who anticipated us in much of our thinking, thought well of the immutable; and extended the concept of stability into their ideas of government, as they would build it into their temples.

The best of Hebrew thinkers, in seeking foundation for religious convictions and social practices, kept going back to the origin of light “with whom is no variableness, neither shadow of turning.” In this, they were not at variance with the Persians, whose search for stability had taken them to the sun.

Copernicus was not without a concept of stability that permeated mutable things. In contemplating the increasing immensity of the heavens with the incessant change of relations that resulted from endless expansion, he saw also persistence of the centrifugal force on which this constant motion depended.

Newton saw, inherent in matter, properties which could be extended indefinitely throughout the universe, and which were applicable within the concept of change, properties which were changeless. Leibniz could see continuity, even in implied force that persisted and could be revived after motion had ceased. He could see conservation of power through persistence in the effects; and thought that nature would retrograde if it were not so preserved. Our modern concept of radiant energy supports his view.

However, it may be contended that reference to these basic inanimate forces has little or nothing to do with man's conscious, self-determining power, which has so much to do with shaping his course and in determining his end. Indeed, Emerson would ask. To which the genial Holmes would add that “the fluent, self-determining power of human beings is a very strictly limited agency in the universe.”
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Relief of the physical and mental distress so often associated with declining ovaries serves to bestow a positive outlook on life.

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While natural estrogen sulfate is the primary estrogen in "Premarin," other estrogens, such as estrone, equilenin, hippogen, are probably also present in varying amounts as water soluble conjugates.

PREMARIN

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While odorous estrone sulfate is the principal estrogen in "Premarin," other estradiol estrogens...estrithol, estradiol, estronol, are probably also present in varying amounts as water-soluble estrogens.

PREMARIN

ESTROGENIC SUBSTANCES (WATER SOLUBLE)
also known as CONJUGATED ESTROGENS (bovine)

Ayerst, McKenna & Harrison Limited
22 East 40th Street, New York 16, N. Y.

We like to appreciate man's audacity and his increasing efficiency; but we cannot feel that his social affairs are entirely separated from natural phenomena. We may not be able to discern laws that are identical in the material and the immaterial aspects of the universe; for man, who presents both these aspects, finds himself to be the least understandable of all things of which he would have knowledge.

The skepticism which was distinctive of the eighteenth century has continued unabated into the middle of the present century. Where it has applied to physical phenomena and their interpretation, the result has been greater accuracy in observation, more careful deductions, and synthesis which excites the wonder of the age.

Where this skepticism has pertained to intellectual and ethical matters, the influence has been destructive. Through misstep and neglect, old fancies, upon which character had been built, no longer give adequate support. Insincerity and exhibitionism are to be seen in much of our aesthetic, social, economic and political affairs. That which is extreme, the questionable, even the false, and sometimes the obscene, are presented as if they were legitimate successors to a decadent conservatism. These are altering our standards of judgment, and are making us less discriminating in our intellectual and moral problems. This is in contrast with our scientific insight and accomplishments.

This striking difference between our scientific and our cultural interests, tends to produce the impression that man has penetrated the universe, both near and far, and has found only mechanism. However, this attitude is not prevalent among the scientists themselves. They have found continuity and persistence of force operative in ways that are indicative of intelligence, conservative as well as constructive. To them, doubts have not become the insincerity and exhibitionism are to be seen in much of our aesthetic, social, economic, and political affairs. That which is extreme, the questionable, even the false, and sometimes the obscene, are presented as if they were legitimate successors to a decadent conservatism. These are altering our standards of judgment, and are making us less discriminating in our intellectual and moral problems. This is in contrast with our scientific insight and accomplishments.

In this age of enlightenment and of undoubted progress, we need re-visualization of the ancient idea of holding fast to the good until that which seems to be better has been scrutinized, established and incorporated. We may hope for reaction from this debilitating unrestraint. Then conservatism may come into its own.

W. D. C.

THE MEDICAL CRIER

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

Italy in the year 1500 was at the height of the second or greater Renaissance and very near its decline. Filled with brilliant scholars and artists, dominated by rich and powerful lords, populated by an industrious and pleasure loving people, the land had no national unity nor, indeed, felt any need of any. While the rest of Europe with the exception of a few cities was still comparatively poor, the wealth of Italy was incredible. Her merchants had prosperous manufactures and extensive foreign trade; her bankers were the financiers of the world; Italian silks and gold were exported to all parts of Europe, although Venice still retained the greater part of the carrying trade of the world in her ships.

Florence and Rome vied with each other in patronizing the arts and sciences. Eustachius was professor at the Collegio della Sapienza at Rome, and Falloplius was studying the anatomy of the choroid spring, the semi-
HERE, doctor, is a good, practical food that will furnish your patients with some of every food factor they need, including 400 U.S.P. units of added Vita·min D in every quart. It is delicious-packed with outstanding nutrition—and costs only a few cents per pound. If you are interested in your patients getting the bone-and-tooth-protecting benefits of milk enriched with Vitamin D, Isaly Dairy’s Vitamin D Homogenized Milk is your answer.

Isaly’s DAIRY SPECIALISTS
HERE, doctor, is a good, practical food that will furnish your patients with some of every food factor they need, including 400 U.S.P. units of added Vitamin D in every quart. It is delicious—packed with outstanding nutrition—and costs only a few cents per pound. If you are interested in your patients getting the bone-and-tooth-protecting benefits of milk enriched with Vitamin D, Isaly Dairy’s Vitamin D Homogenized Milk is your answer.

Isaly’s DAIRY SPECIALISTS

BUBONIC PLAGUE was the great scourge which marched with solemn tread all over Europe in the Middle Ages, and it is not surprising that Cellini describes it, for he was a victim at the age of twenty-three, at a time when thousands were dying every day in Rome. He describes his illness thus:

"I rose upon the hour of breaking fast, and felt tired, for I had travelled many miles that night, and was wanting to take food when a crushing headache seized me, several boils appeared on my left arm, together with a carbuncle which showed itself just beyond the palm of the left hand where it joins the wrist. Everybody in the house was in a panic; my friends all fled. Left alone there with my poor little prentice, who refused to abandon me, I felt stifled at the heart, and made up my mind for certain I was a dead man."

"Just then the father of the lad went by, who was physician to the Cardinal Iacoacci, and lived as a member of that prelate’s household. The boy called out: 'Come, father, and see Benvenuto; he is in bed with some trifling indisposition.' Without thinking what my complaint might be, the doctor came up at once, and when he had felt my pulse, he saw and felt what was very contrary to his own wishes. Turning around to his son, he cried: 'Oh, traitor of a child, you've ruined me; how can I venture now into the Cardinal’s presence?' Then the doctor turned to me and said: ‘Since I am here, I will consent to treat you. Considering the sores are so new and have not yet begun to stink, and that the remedies will be taken in time, you need not be too much afraid, for I have good hopes of curing you.’ And so we went on by the help of God: and the admirable remedies which I had used began to work a great improvement, and I soon came well out of the dreadful sickness.'"

Cellini does not say what the admirable remedies were, but his recovery was probably due to the waning virulence of the epidemic and his own robust physique. Today although the cause and mode of transmission is well known, treatment of laboratory animals with streptomycin and sulfonamides has proved disappointing. The Pasteurella Pestis yielded to the Public Health worker long before antibiotics were known.

J. L. P.
DR. ALEXANDER: This is the case of a 29 year old colored girl who had never been pregnant before and who came into the hospital with a history of having her last normal menstural period on the 22nd of September. She was admitted on the 24th of February. She claimed that between the 22nd and approximately the 20th of December she "spotted" and had several episodes of lower abdominal cramps with a slight brownish vaginal discharge all the time until the 20th of December at which time she had an episode of very severe abdominal cramps with moderately severe vaginal bleeding. This episode quieted down and after that the additional bleeding of the uterine bleeding; she had no more abdominal cramps, but her lower abdomen was very tender to the touch. It was so tender that she was unable to wear a tight belt. She had persistent vomiting and she vomited at least once a day between the 20th of December and the time of her admission. Her lower abdomen became progressively larger. On the morning of February 24th she had a severe vomiting spell which left her feeling dizzy and weak until she was unable to stand and she was sent into the hospital.

Examination on admission showed a well developed, well nourished, pale, washed out negress. Her pulse was 120, respiration 30, blood and general physical examination was negative, except for the abdomen. Her abdomen was soft and slightly distended. There was a mass in the lower abdomen, which gave the impression of being the uterus enlarged to approximately 2½ fingerbreadths below the umbilicus at the mid line. There was another mass which could be delineated from the smaller mass extending up the left of the umbilicus to approximately 1½ fingerbreadths above the umbilicus. Both of these masses were extremely tender. Pelvic examination showed the cervix to be pushed anteriorly quite some distance. The cervix was very soft and dilated. It was confirmed by pelvic examination that the smaller of the masses was the fundus of the uterus. There was a large fluctuant mass which filled the entire posterior cul-de-sac and was exquisitely tender so that rubbing your fingers over lightly gave her quite a bit of pain. You couldn’t make out what this large abdominal mass was due to the fact that she was so extremely tender, but a diagnosis was made at the time of an extra-uterine hemorrhage, with extra-uterine pregnancy with intra-abdominal hemorrhage. Her red blood count upon admission was 3,000,000, urinalysis showed nothing of any note. Her white count on admission was 48,750 with 94% polys, of which 9% were stab cells. She was given a blood transfusion and was taken to surgery.

Upon opening the abdomen a large amount of both bright red blood and old clotted blood was encountered. The smaller of the masses was confirmed to be the uterus. The left tube was finally identified as the larger of the abdominal masses. The left tube was pulled down posteriorly into the cul-de-sac to which the placenta was attached. Within this tube there was a fetus which approximately was 5 months gestation which incidentally was alive because it made 2 or 3 respiratory efforts after it had been delivered. The head was pointing downward, the buttocks upward. The head was markedly deformed, with bilateral club hands and club feet, and there was a gross deformity of the right humerus so that there was quite a bit of bowing.
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MAHONING COUNTY MEDICAL SOCIETY

DR. ALEXANDER: This is the case of a 29 year old colored girl who had never been pregnant before and who came into the hospital with a history of missing her last normal menstrual period on the 22nd of September. She was admitted on the 26th of February. She claimed that between the 22nd and approximately the 25th of December she "sensed" and had several episodes of lower abdominal cramps with a slight brownish vaginal discharge all the time until the 20th of December at which time she had an episode of very severe abdominal cramps with moderately severe vaginal bleeding. This episode subsided down and after that she had no more vaginal bleeding, she had no more abdominal cramps, but her lower abdomen was very tender to the touch. It was so tender that she was unable to wear a tight belt. She had persistent vomiting and she vomited at least once a day between the 20th of December and the time of her admission. Her lower abdomen became progressively larger. On the morning of February 26th she had a severe vomiting spell which left her feeling dizzy and weak until she was unable to stand and she was sent into the hospital.

Examination on admission showed a well developed, well nourished, pale, washed out negro. Her pulse was 120, respiration 30, blood and general physical examination was negative, except for the abdomen. Her abdomen was soft and slightly distended. There was a mass in the lower abdomen, which gave the impression of being the uterus enlarged to approximately 2½ fingerbreadths below the umbilicus at the midline. There was another mass which could be delineated from the smaller mass extending up the left of the umbilicus to approximately 1½ fingerbreadths above the umbilicus. Both of these masses were extremely tender. Pelvic examination showed the cervix to be pushed anteriorly quite some distance. The cervix was very soft and distended. It was confirmed by pelvic examination that the smaller of the two masses was the fundus of the uterus. There was a large fluctuant mass which filled the entire posterior cul-de-sac and was exquisitely tender so that rubbing your fingers over lightly gave her quite a bit of pain. You couldn't make out what this large abdominal mass was due to the fact that she was so extremely tender, but a diagnosis was made at the time of an extra-uterine hemorrhage, with extra-uterine pregnancy with intra-abdominal hemorrhage. Her red blood count upon admission was 3,000,000, urinalysis showed nothing of any note. Her white count on admission was 48,750 with 94% polys. of which 9% were stab cells. She was given a blood transfusion and was taken to surgery.

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Laboratory Park

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JULY 1948
A salpingectomy was done and it was necessary to do a hysterectomy in order to get out all the bleeding surface. She did have a fibroid uterus, incidentally. There was considerable bleeding from the placental site so it was necessary to shell out the placenta and pack the cavity with gauze pack. There was tremendous decidual reaction within the uterus.

The woman had had an uneventful post-operative course. She suffered the first few days with a little abdominal distention, but when the pack was removed, the distention disappeared. Her temperature varied from 101.8 to normal.

DISCUSSION

DR. ALTDOERFFER: As a rule the placenta is not removed but left alone. But in this case, the placenta was loose and there was considerable bleeding from the site. We had a good anesthesia and before we were through she had 6 pints of blood and 2 pints of plasma so we did have lots of blood.

Last summer I had a case of abdominal pregnancy in which the placenta was not removed. As the woman advanced in pregnancy, the placenta stayed very high in the abdomen until 2 months ago when this mass had dropped from the right upper quadrant to the lower left quadrant. It felt very cystic and hard and I thought she had some kind of dermoid or embryonal cyst. It didn’t get any smaller so I brought her in and the laboratory said it was a placenta. It looked very much like a dermoid cyst, except for the area of discoloration.

DR. ANDERSON: I’ve looked over some of the literature in abdominal pregnancy and also in the relation to what happens in the placenta. About 1/2% of all pregnancies are extra-uterine and most of these fall in the tubular variety. There was a series of 300 cases reported in Chicago. They reported that only one of these was abdominal, so that makes the abdominal pregnancy pretty rare, and then to come to a full term pregnancy makes it even rarer. There are a few cases reported in the literature of primary abdominal pregnancy and the diagnosis is made when no pathology or any suggestion of pathology is found in either tube and there is no evidence of the fistula connecting the uterus to the peritoneal cavity. The literature generally advised that the placenta in abdominal pregnancies be left alone, especially if they are attached to any organs such as the rectum or vascular organs, because implanted in the abdomen, there’s no chance of decidual reaction to occur. Thus, the placenta cannot be stripped off. To remove the placenta in the abdominal pregnancy is to tear it off and this can cause a lot of damage.

DR. NELSON: I think last year we had a case, in which the diagnosis was not completely made. She jaundiced, so, we didn’t do anything except give her a lot of blood and she finally, after 4 or 5 weeks went out west and she was operated on and we got word that she was obviously a tubule abortion with bleeding.

I think the idea of having to leave the placenta in should certainly be modified because when the placental site is bleeding, you have to take it out and pack it.
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A salpingectomy was done and it was necessary to do a hysterectomy in order to get out all the bleeding surfaces. She did have a fibroid uterus, incidentally. There was considerable bleeding from the placental site so it was necessary to shell out the placenta and pack the cavity with gauze pack. There was tremendous decidual reaction within the uterus

The woman had had an uneventful post-operative course. She suffered the first few days with a little abdominal distention but when the pack was removed, the distention disappeared. Her temperature varied from 101.8 to normal.

DISCUSSION

DR. ALTDORFFER: As a rule the placenta is not removed but left alone. But in this case, the placenta was loose and there was considerable bleeding from the site. We had a good anesthesia and before we were through she had 6 pints of blood and 3 pints of plasma so we did have lots of blood.

Last summer I had a case of abdominal pregnancy in which the placenta was not removed. As the woman advanced in pregnancy, the placenta stayed very high in the abdomen until 2 months ago when this mass had dropped from the right upper quadrant to the lower left quadrant. It fell very cystic and hard and I thought she had some kind of dermoid or embryonal cyst. It didn’t get any smaller so I brought her in and the laboratory said it was a placenta. It looked very much like a dermoid cyst, except for the area of discoloration.

DR. ANDERSON: I've looked over some of the literature in abdominal pregnancy and also in the relation to what happens in the placenta.

About 11% of all pregnancies are extra-uterine and most of these fall in the tubular variety. There was a series of 300 cases reported in Chicago. They reported that only one of these was abdominal, so that makes the abdominal pregnancy pretty rare, and then to come to a full term pregnancy makes it even rarer. There are a few cases reported in the literature of primary abdominal pregnancy and the diagnosis is made when no pathology or any suggestion of pathology is found in either tube and there is no evidence of the fistula connecting the uterus to the peritoneal cavity. The literature generally advised that the placenta in abdominal pregnancies be left alone especially if they are attached to any organs such as the rectum or vascular organs, because implanted in the abdomen, there’s no chance of decidual reaction to occur. Thus, the placenta cannot be stripped off. To remove the placenta in the abdominal pregnancy is to tear it off and this can cause a lot of damage.

DR. NELSON: I think last year we had a case, in which the diagnosis was not completely made. She jaundiced, so, we didn’t do anything except give her a lot of blood and she finally, after 4 or 5 weeks went out west and she was operated on and we got word that she was obviously a tubule abortion with bleeding.

I think the idea of having to leave the placenta in should certainly be modifed because when the placental site is bleeding, you have to take it out and pack it.
Health Department Bulletin

REPORT FOR MAY, 1948

Deaths Recorded: 186 121 65 158
Births Recorded: 461 253 208 320 272 246

CONTAGIOUS DISEASES:

VENEREAL

Total Patients: 121 0 0
Total visits to clinic (Patients): 208 0 0

UNCLE DUDLEY

The number of years we waste in our life is of no more importance than are those years in which we are 'extremely busy without extracting wisdom from our experience.' The busy years, we usually think of as being constructive; but they may be barren of thought that lives beyond the day.

What would the world have done if men had never become ambitious? What the world has suffered because of it? Could the idea be true that whatever is, is right?

In our quest for certainty, we may be assured that the idea is rather difficult to define the helping process which deals relatively tangentially with physical disability or well being. This is especially true since the most general concept of rehabilitation includes everything which makes a sick person feel better and the most limited concept speak of it as getting the handicapped individual a job, and for the sake of statistics, seeing that he keeps it. Various agencies have been set up in the former or latter philosophy and, each type of agency, can in terms of statistics, show successful figures.

Consonant with this service, the Bureau should be able to provide counseling, and psychometric tests which aid in vocational guidance and training. Unfortunately the State of Ohio has never seen fit to appropriate sufficient funds to match potential Federal assistance so that all of these services may be offered. The legislature of the State of Ohio consistently maintains that it is not the function of the Bureau of Vocational Rehabilitation to provide room and board, while studying, to a promising candidate for rehabilitation. They ever it is some other agency's function to assume this responsibility. Let us see how that works out in actual practice.

We have, at the sanatorium, an eighteen year old patient who will soon be discharged. He is finishing high school during hospitalization. Pre-discharge investigation reveals the fact that his home environment would be extremely detrimental to the maintenance of good health. This means that a more adequate outside situation must somehow be found before the patient can conscientiously be discharged. Our logical channel for seeking this aid is the Bureau of Vocational Rehabilitation. We are told that the Bureau can

JULY 1948
Health Department Bulletin

REPORT FOR MAY 1948

<table>
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<th>1947 Male</th>
<th>1948 Female</th>
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CONTAGIOUS DISEASES:

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<td>Measles</td>
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VENERAL DISEASES:

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<tr>
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What would the world have done if men had never become ambitious? What the world has suffered because of it? Could the idea be true that whatever is set with a figurative pat on the head, covered veritably by the shibboleth that an aspergillum can offset to be without it. We generally support, with varying proportions of fanaticism and enthusiasm, the invention of a program to bring rehabilitation to the handicapped and institutionalized. Yet our concern for the program itself usually stops there. Moreover, when the term rehabilitation is mentioned the immediate identification is somewhere away from our own lives, and frequently "umbred by the walls of the institution or by some psychological appertainances which shuns us off from knowing realistically what is happening in that other province." Efforts should be made to overcome this attitude.

It is rather difficult to define the helping process which deals relatively tangentially with physical disability or well being. This is especially true since the most general concept of rehabilitation includes everything which makes a sick person feel better and the most limited concept speak of it as getting the handicapped individual a job, and for the sake of statistics, seeing that he keeps it. Various agencies have been set up in the former or latter philosophy and, each type of agency, can in terms of results, show successful figures.

The Federal Security Agency, for example, supports and gives impetus in each State to a Department of Education, which in turn activates and staffs a Bureau of Vocational Rehabilitation. This Bureau is set up to offer, under Public Law 113, five services:

1. Vocational training.
2. Room and Board, where necessary, during training.
3. Medical care which will render the person employable.
4. Psychiatric care which will render the person employable.
5. Job placement.

Concurrent with this service, the Bureau should be able to provide counseling and psychometric tests which aid in vocational guidance and training. Unfortunately the State of Ohio has never seen fit to appropriate sufficient funds to match potential Federal assistance so that all of these services may be offered. The legislature of the State of Ohio consistently maintains that it is the function of the Bureau of Vocational Rehabilitation to provide room and board, while studying, to a promising candidate for rehabilitation. They over that it is some other agency's function to assume this responsibility. Let us see how this works out in actual practice.

We have at the sanatorium, an eighteen year old patient who will soon be well. He is finishing high school during hospitalization. Pre-discharge investigation reveals the fact that his home environment would be extremely detrimental to the maintenance of good health. This means that a more adequate outside situation must somehow be found before the patient can conscientiously be discharged. Our logical channel for seeking this aid is the Bureau of Vocational Rehabilitation. We are told that the Bureau can...
only accept the case for vocational training—someone else must provide
the funds for living costs. This means that the patient faces discharge with
more concern than that to which he should normally be subjected. He will
worry anyway, to worry about his disease which he knows can reactivates.
He worries about reintegrating himself into a new strange and often terrifying
society. We know that all tuberculosis patients contemplate discharge with
a combination of anticipation and dread. This patient has even greater
conflict because, not only is he torn between wanting to be with his family
and wanting to do what is most advantageous to his health, but he is beset
with the insecurity of having to use the help of two agencies, and frequently
more than that, when he is not even sure that one agency will be dependable
in what he views as, an untrustworthy, real situation. He must submit to a
division of his depleted resources for making relationships, when we know
that for good mental health, and, hence, for a consolidation of the gains
made in the hospital, he should learn to rebuild the structure of his inter-
personal relationships around a satisfying contact with one representative
of the professions set up in the goal of giving him this opportunity. This is not an isolated case.

Other types of rehabilitation agencies and programs are the sheltered
workshop, the physical medicine programs of the Veterans Administration
and some intramural programs taking place in scattered institutions throughout
the country. Examination of a good many of these reveals the fact that careful
planning which looked satisfactory on paper has not worked out too well in
actual practice. This is sometimes true because areas of function are so
overlapping that there is rivalry among members of the ancillary staff. This
rivalry tends to undermine the concept of teamwork making it nothing more
than a tidy abstraction. In such instances, the highly advertised versions
of revolutionary rehabilitation methods, and their results, hold true for only a
handful of cases. The others are the expensive recidivists which we find
so alarming, primarily in terms of wasted human material, but which should
trouble us, too, as taxpayers.

Rehabilitation should not invariably be offered as soon as the patient
has been pronounced medically feasible nor is it, at that moment, a reliable
safeguard against morbid interspection. The patient demonstrably cannot
be exposed to such a program before the more challenging and painstaking
process of helping him use all of the services designed to get him well is
undertaken. There are some basic principles which, if followed conscientiously,
may result in more than lip service and which are rewarding both to patients
and personnel. For the sake of professional standards, of spending community
funds wisely and for long range gains in salvaging our handicapped, they
are the fundamental criteria.

1. A steady and continuous effort should be made to define positively
and, yet, exclusively, the peculiar function of each member of the ancillary
staff. This is only accomplished where there is willingness to participate in
the dynamic exchange which should take place in regular, periodic, case
conferences presided over by the medical head of the program and implies
mutual respect for the skills and training of those participating.

2. Function may become sharpened and more clearly defined through
an integrated, in-service training program including lectures by appropriate
personnel and through supervision which involves ascertainment of competences
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areas of activity. This may be utilized to highlight function and again to foster growth in the understanding of and belief in the service which the other person offers. Value of each service must be emphasized, by the supervisor, strongly and unselfishly.

3. A continuing study should be kept regarding points of referral of patients' problems and in-sanatorium education should, from time to time, center around peak channels of referral, so that problems may be handled expeditiously and before techniques for solution are used by those not skilled to use them.

4. A patient should be urged to share in a vocational-rehabilitation plan which be in psychologically ready to do so. Stealing of this readiness must be left to conference decision rather than to individual determination. Some patients have been so fearful regarding premature vocational discussion that they have retrogressed medicinally. It appears that this phenomenon is, in effect, an unconscious desire to prolong residence in the protecting environment since vocational planning symbolizes the fact that the time to give up such dependency is drawing near. Adequate and intensive preparation must take place before the patient can be expected to think outside the engrossing problem of his illness per se.

5. Efforts should be bent towards leaving as much responsibility as possible to the hands of the patient for effective rehabilitation planning. However, along with this there is a need for skillful use of the helping process in motivating or offsetting this sense of responsibility which is frequently diminished or nullified in the demands which the illness makes upon him.

6. Rehabilitation projects should be designed in a graduated plan, becoming more and more complicated as the patient demonstrates greater and greater ability to absorb. This tends to give a sense of achievement and ego satisfaction which are so necessary in the struggle to emerge from the trappings of dependency.

7. Rehabilitation setting should strive for more and more to duplicate community situations so that the patient may have ample opportunity for reality testing and so that the gap between institutional and community living may be bridged.

8. Every case must be examined and re-examined not for crowing over purposes in those which have been successful, but for augmenting skills in those which yield slowly or not at all.

Parenthetically, every medically hopeless patient who leaves a hospital prematurely against advice represents a breakdown in one of the segments of the rehabilitation framework. Every patient discharged with a good prognosis who returns to the hospital in a worsened condition represents a failure in the total structure of rehabilitation, including the resources of outside agencies whose work is dispensably essential throughout the course of treatment.

We are attempting to incorporate all of the above thinking in our rehabilitation plans and the Mahoning County Tuberculosis Sanatorium. These concepts are an integral part of the structure of specific rehabilitation courses which includes instruction in shorthand, typing, bookkeeping, accounting, sewing, homemaking, and all grade and high school subjects.

Your interest in our program and in the total objective of rehabilitation is needed and wanted.

H. K. G.

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5. Efforts should be bent towards leaving as much responsibility as possible to the hands of the patient for effective rehabilitation planning. However, along with this there is a need for skillful use of the helping process in revitalizing or creating this sense of responsibility which is frequently diminished or nullified in the demands which the illness makes upon him.

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DIABETES 1926—1948
MORRIS DEITCHMAN, M.D.; F. A. C. P.

In a busy lifetime one has little leisure to sit, think, and just digest one's impressions. Given such leisure it is natural that one does a certain amount of arm chair exploring—a permissible amount of reminiscing—and by combining the two one may presume to make some inductive predictions. This is ultra-unscientific, of course, in the sense that the predictions are based on observation or hunches rather than on experiment or facts based on research.

More than twenty years of experience with diabetics of all ages; and of various degrees of intelligence, cooperation and self control, has convinced me that there is not much question as to the truth of the statement that "70% of diabetics of 15 years duration develop arterial disease regardless of method or the degree of regulation." (Wilder) Others say the arterial disease is near 100%. This then presumes that the reason retinopathy and Kimmelstiel-Wilson's disease are so prevalent, is because we have been able, with insulin and diet, to keep diabetics alive at least the necessary 15 years for the development of this pathology. Hagedorn, the discoverer of protamine insulin, states it thus: "If we venture to imagine that a vascular disease is the common cause of diabetes—retinitis, nephropathy and other complications, even the complete compensation of the diabetic symptoms cannot prevent the complications, while poor treatment may permit early death of diabetics so that complications do not develop."

After twenty years it is possible to say that any diabetic diet will presumptively achieve the same result. The only exception is the obese diabetic who can apparently escape the arterial changes by reducing weight. Adequate diet can be anything, but in general one can say that it approximates the normal diet of 200 carbohydrate, 100 protein and 100 fat. No attempt must be made to restrict the diet to avoid the use of insulin. Starvation diets were all the rage in 1914, and were a distinct addition to the armamentarium of the physician treating diabetics when Frederick Allen first introduced this method of treatment. However, there is no necessity for any such primitive treatment today.

In twenty years I have seen the prejudice among physicians, against insulin almost entirely disappear. The resistance of patients to insulin can be readily overcome by an intelligent but simple explanation of the general metabolic benefit derived from its use.

Adequate control is as difficult to define as adequate diet. Frank Allen of the Lohey Clinic summarizes his objectives as follows: (1) "Aim for complete control of hyperglycemia and glycosuria in early diabetes, in juvenile cases, and in the obese cases. (2) Less complete control may be satisfactory if glycosuria cannot be controlled without hypoglycemia or when patients are over 60 years old."

Many "diabetic specialists" insist on absolute control, i.e., no hyperglycemia or glycosuria at any time. I do not believe this is either necessary or desirable. Experience has led me to develop a great respect for hypoglycemic reactions, especially in patients with arterial disease. The manifestations are very bizarre and even an expert may not recognize some of them.

Treatment in diabetic coma is still fought over at each meeting of the American Diabetes Association by those who advocate and those who oppose the use of glucose. I believe that the experimental work of Cori, Soskin, Rabinowitch, and many others has proved that glucose given intravenously...
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THE MATHONING COUNTY MEDICAL SOCIETY

is more available than the glucose already in the blood hyperglycemia. Adequate dosage of insulin must be administered to cover. The insulin dosage need not be excessive if available carbohydrates is present. Acidosis and coma are evidence per se of loss of homeostasis in the liver. Hyperglycemia with its resulting glycogen inevitably induces liver glycogen exhaustion. With glucose and insulin the homeostatic mechanism can be restored. There is no disagreement about the use of salt and fluid, but these too can be given to excess, and produce edema and left ventricular failure in a strained organism.

With understanding of the etiology of acidosis it seems evident that the mortality from diabetic coma must drop sharply if our hospitals can be organized so that a definite program could be followed. Too often the diabetic in coma is under the care of a physician whose orders are being carried out by an intern who is too busy or too tired; and nurses who cannot tell hyperglycemia from coma due to other causes. Diabetes is the 5th cause of death in the U.S.A. Fewer of these deaths should be due to coma. Perhaps the answer is a missionary lay organization similar to "Alcoholics Anonymous."

Everyone treating diabetics is intrigued by the excessive arterial disease of a rather specialized type occurring in the diabetics who have survived long enough. I have been intrigued by a possible endocrine explanation of this condition which is based on well known experimental work, up to a certain point. One must reach on from that point, into the realm of probabilities.
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**WHEN IT IS DIFFICULT TO CATEGORIZE THE ANEMIA**

Four Therapeutic Essentials

* * *

<table>
<thead>
<tr>
<th>Desiccated Liver</th>
<th>Ferrous Sulphate</th>
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<tr>
<td>Ascorbic Acid</td>
<td>Folico-Acid</td>
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Dosage—One or Two Daily

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**THE RENAL FACTOR IN THE GENESIS OF EDEMA**

By Dr. J. G. BORST

In normal man the kidney reacts promptly to the drinking of 1 liter of water; within 3 hours the whole amount is excreted. The sodium chloride concentration in the urine is low and the amount of it excreted is not significantly higher than in a control period.

When 1 liter of 0.9 percent saline is taken, its excretion takes more time, but within 24 hours the extra amounts of water and sodium chloride are excreted in their entirety.

Verney demonstrated that after the drinking of water the following sequence occurs:

Fall in the sodium chloride concentration of the blood

Decrease in secretion of anti-diuretic hormone by the neuro-hypophysis (posterior pituitary) into the blood of Physiologic "diabetes insipidus."

A similar increase in the water excretion can be produced by the injection of a small amount of hypertonic solution of sodium chloride into the carotid artery. On the other hand, injection of hypertonic saline causes a reduction in the volume of the urine and a considerable rise of its sodium chlor-
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Dehydrated Liver Ferrous Sulphate

Ascorbic Acid Folic Acid

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ANNUAL GOLF MEET

PHYSICIANS DENTISTS

The Annual Golf Meet will be held in conjunction with the Corydon Palmer Dental Society at the Youngstown Country Club

Thursday, August 19, 1948

Fun Starts at 1:30 P. M.

GOLF ---- DINNER ---- PRIZES

No Dinners Served Without Reservations

(Return reply postals at once)

THE MAHONING COUNTY MEDICAL SOCIETY

ide concentration. This highly important mechanism is essential to the maintenance of a normal osmotic pressure of the body fluids.

The mechanism of the increase in the output of water and sodium chloride following the intake of 0.9 percent saline solution is unknown; certainly there is no detectable increase or decrease in the concentration of sodium chloride in the blood.

Patients with nephrosis and with heart failure have no such increased excretion of water and sodium chloride following the oral ingestion of saline solution. It has been assumed that in such cases sodium chloride is retained by the tissues and is not "available" to the kidneys. This explanation is unsatisfactory, as more than 100 liters of glomerular filtrate are formed each day. Normally approximately 98% of the water and sodium chloride of this filtrate is reabsorbed by the tubules, but in nephrosis and in heart failure the reabsorption is more nearly 100%.

Observations on patients with bleeding from a peptic ulcer shed a new light on this problem. Following gross hemorrhage into the gastro-intestinal tract the urinary output of water and sodium chloride is markedly reduced. The urine, quite often, is nearly free of sodium chloride, while at the same time there exists an increased sodium and chloride concentration in the blood plasma. The urinary output of potassium, urea and creatinine, consistently, is quite high, indicating satisfactory secretory powers of the kidney in respects other than those pertaining to salt and water.

Such retention of water and sodium chloride occurs as the volume of the circulating blood begins to reach more normal levels—whether this occurs following a blood transfusion, or spontaneously. This points to the existence of a mechanism for the regulation of the blood volume, as follows:

reduced blood volume
retention of sodium chloride and water
increase in plasma volume.

When, during the period of post-hemorrhagic blood dilution, 0.9 percent saline is administered, part of the water is lost by perspiration and (a minimal) urinary excretion; sodium chloride is retained and the level of sodium and chloride in the blood plasma rises. A rise to more than 150 percent of normal has been observed to occur when the intake of plain water is prevented and physiologic loss of water is met by repeated infusions of normal saline. In restricting the fluid intake and promoting the urinary output of water by the administration of urea, a similar retention of sodium and chloride in the presence of their high levels in the blood plasma, has also been produced in patients with edema due to nephrosis, heart failure, and cirrhosis of the liver with ascites. This suggests the existence of a more complicated mechanism, viz:

low blood volume
low venous pressure
(Starling's law of the heart)
low cardiac output
retention of water and sodium chloride
increased plasma volume.

After hemorrhage and in patients with nephrosis the blood volume is small. In Lennern's cirrhosis of the liver, part of the circulating blood is in the portal system and a decreased venous pressure, in the rest of the circulation, results. In heart failure, the damaged heart fails to respond (with increased cardiac output) to the increased venous pressure. Transfusion of 3 liters of blood, in patients with nephrosis, increased the venous pressure from a
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ANNUAL MEETING OF MEDICAL-DENTAL BUREAU

The 14th Annual Dinner Meeting of the Medical-Dental Bureau was held on Tuesday, June 29th, at the Youngstown Country Club. The meeting was the largest in the history of the Bureau, which indicates the wide interest of its members. Many important activities and services of the Bureau were discussed and a good time and mutual understanding prevailed.


PENSION EXAMINATIONS

Any physician who is interested in doing pension examinations for the Veterans Administration either on a part-time or fee basis should contact Dr. Sidney Franklin, local Chief Medical Officer, 512 Union National Bank Bldg., Telephone 4-5161.

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TB STAFF MEETING

The staff meeting of the Mahoning County Tuberculosis Hospital will be held in the evening of July 27th, at the auditorium of St. Elizabeth's Hospital, at which time there will be a talk by Dr. M. M. Yarmy on "Cure of Diastasis." This talk was originally scheduled for the June meeting but due to the A. M. A. meeting, was postponed.

PENNY BITTEN
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Among those who request them from Mead Johnson are dentists and physicians in old established locations.

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