Think wrongly if you please,
but think for yourself.

—Lessing

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XVIII No. 11
NOVEMBER • 1948

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THE MAHONING COUNTY MEDICAL SOCIETY

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403 Central Tower

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SUB COMMITTEE ON ECONOMICS—Ivan C. Smith, Chairman; J. C. Hall, W. P. Young, Szucs, S. H. Davidow, Raupple.

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MEDICAL CALENDAR

1st Tuesday 8:30 p. m.	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
	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.	American Academy of General Practice, Youngstown Hospital Auditorium—Nurses' Home.
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

Trumbull County Post-graduate Day—Nov. 17.

American Medical Association Interim Session, St. Louis, Nov. 30-Dec. 3.

American Academy of General Practice, Cincinnati, March 7-8-9, 1949.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

PRESIDENT'S PAGE

★ ★ ★

A recent statement entitled "The Medical Profession's Role in School Health Programs" was sent to each County Medical Society by the Committee on School Health of the Ohio State Medical Association. The following quotations from that report are self explanatory: "Health is one of the cardinal objectives of modern education. Every school, big or little, is offered great opportunities to promote the health of its pupils—in fact, of its community. Realizing this, the Ohio State Medical Association has created a Committee on School Health through which the medical profession of Ohio can provide leadership in the development of sound school health policies and beneficial school health programs in all communities. The degree of leadership attained by the medical profession in Ohio will depend on two things: (1) Active and intelligent participation by all physicians; (2) organized action and participation on the part of each County Medical Society. Realizing that participation and action by members of the medical profession in all areas is of paramount importance, the Ohio State Medical Association is requesting each county medical society to establish a local Committee on School Health." After discussion with the President-Elect the following Committee on School Health for Mahoning County Medical Society was appointed and will serve through the coming year: Dr. O. J. Walker, Chairman; Dr. E. R. Thomas, Dr. E. C. Mylott, Dr. S. G. Patton, and Dr. W. J. Tims.

JOHN NOLL, M. D.

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

THE MEDICAL SERVICE FOUNDATION OF MAHONING COUNTY

James L. Fisher, M. D.

The formation of The Medical Service Foundation is liable to be one of the greatest things the Mahoning County Medical Society has ever done. For a long time two problems have existed without any of us realizing that an acceptable solution of the minor one would effectively solve the major one.

The major problem has been the need for a progressive Medical Society like ours to expand its facilities for education of the medical and allied professions, for medical research, and for active participation in matters that affect the public health. To assume active leadership in such an ambitious program requires the hiring of expert help on a full time basis, the establishment of a good library and headquarters, the provision for grants in aid for medical research and public health projects. In other words, it requires a great deal more money than the Medical Society can raise from its members and friends. There has been much said in the meetings about the need and many proposals have been considered for financing the project, but until now the society has had to do the best it could with its limited budget.

What it has done has been considerable. Our Society has pioneered the Post-Graduate Day meetings which have contributed to the education of many hundreds of physicians of this and nearby communities. The Speakers Bureau has supplied thousands of lectures for any civic group which applied. The committees have conducted campaigns in public education on such vital health matters as cancer, poliomyelitis, and heart disease. The individual members have given freely of their time in cooperating with other health agencies and in treating the indigent sick.

The minor problem has been the administration of welfare funds in treating indigent patients in the hospitals. The establishment of the National Emergency Relief Act and the subsequent transfer of its activities to the Mahoning County Welfare Department is well known history. During the depression, the work of our relief committee in supervising the treatment of the indigent sick was a model for the nation. Ever since that time, it has been known that legal provision

has existed to pay physicians on a fee basis for treating indigent patients in the hospitals as well as in their homes. The funds were there, the machinery was set up but the doctors were never paid.

The reason they never asked for payment was that to do so might upset the long established training programs of the hospitals. The ultimate result would be bad. Teaching and training of internes and younger doctors in the hospitals is important. To disrupt the established services of the specialty groups would stop ward rounds and clinics, would interfere with the elaborate diagnostic and clinical facilities which are provided for indigent cases without thought of cost. The pathologist and radiologist, the interne and clinician give their services freely and in turn the patients give them broad experience. Experience and study make better doctors to give the public better medical care. In order to maintain the system, the doctors were willing to forego payment for those hospital cases. Although legally entitled to it, they preferred to maintain the charity status.

Twelve years ago Dr. E. J. Reilly began to talk about an idea he had whereby the doctors could put those funds to good use. No individual would profit, and the hospital services would remain unchanged. Here was the money the Medical Society needed to start its program. If the doctors did not wish to take payment for their charitable service, why not use it for the Medical Society?

For years Dr. Reilly thought and talked about the idea until a plan crystallized in his mind. A Foundation could be formed to receive and administer the funds. In December of 1947, he presented his plan to the Medical Society in the form of a resolution which was passed without a dissenting vote. Attorney Franklin Powers was called in to iron out the legal technicalities and under his guidance a constitution for the Foundation was drawn up. Prominent leaders in educational, religious and civic affairs were asked for help, and in October an organization was formed and officers elected as follows: Dr. Reilly, president; Mr. Howard W. Jones, first vice president; Dr. I. C. Smith, second vice president; Dr. Elmer Nagel, secretary; Dr. George McKelvey, treasurer; Mrs. Mary Herald, executive secretary.

What is left to do now is to meet with the budget committee of the county commissioners to set up the expense account for next year. It is planned that the money paid for care of indigent cases in the hospitals will be turned over to the Foundation for the purposes outlined above. By the first of the year, it is hoped that the plan will be in full operation. Not much can be expected at first until the Foundation can accumulate funds to finance its projects. In a year or two, we should begin to see great things.

1948 HANDBOOK AVAILABLE

Copies of the 1948 Handbook of the American Medical Association are still available to physicians upon request. This 60-page booklet gives a brief description of the various Councils and Bureaus of the A. M. A. and contains a complete index to sources of information at the Association headquarters. Address requests to the Council on Medical Service, 539 North Dearborn Street, Chicago 10, Illinois.

RETRODISPLACEMENTS OF THE UTERUS AND THEIR TREATMENT

John L. Scarnecchia, M. D.

The relation between retroflexion, retroversion and retrocession is sufficiently intimate to make it desirable to consider all under one heading of retrodisplacement. Frequency of retrodisplacement is sufficiently great to make this condition almost normal—unless accompanied by notable symptoms or associated with pathologic disturbances. At least one woman out of every six has a uterus which is definitely out of its natural position. Among the contributing factors responsible for retrodisplacement are frequent maldevelopment of the supporting muscles, fascial structures and bony pelvis, either from debilitated conditions and lack of physical exercise or protracted illnesses during childhood. Among the acquired etiological factors responsible: injuries incident to childbirth are of outstanding importance. In many of these cases the displacement of the uterus is only part of a relatively widespread traumatism of the pelvic tissues. Other factors include inflammatory conditions and pelvic tumors. Our most important concern in a given case is frequently the causative lesion rather than the displacement itself.

The normal position of the uterus is practically horizontal in a woman in the erect position. The cervix points downwards and backwards and the fundus is bent with a wide obtuse angle on the cervix. One of the commonest findings in making routine pelvic examinations is retrodisplacement of the uterus in women who are completely free of symptoms and treatment of any sort is usually unnecessary.

The symptoms attributed to retrodisplacement are many and varied, for example:

1. Heaviness or a bearing-down pressure in the pelvis.
2. Low back pain.
3. Increased menstruation and dysmenorrhea.
4. Delayed conception.
5. Spontaneous abortion.
6. Leukorrhea.
7. Constipation.
8. Urinary disturbances.

In order to evaluate the symptoms with reference to treatment a consideration of individual symptoms and treatment will follow. For many years the relation of retrodisplacement of the uterus to backaches has been a controversial one. It is true that innumerable retrodisplaced uteri have been suspended because of backaches for which they were not responsible and the correction of which, to the chagrin of the surgeon and distress of the patient, did not relieve the symptoms. This led some gynecologist to take the dogmatic view that uncomplicated retrodisplacement cannot cause backaches. Others do not support this extreme decision. The gratifying results obtained from uterine suspension in certain selected cases strongly opposes such a view. The backache and abdominal discomfort usually occur together and are dull in character and increase as the day goes on usually becoming more severe with the approach of the menses and during the menstrual flow. If the patient complains of backache before she rises in the morning and particularly if she gets relief on becoming

active, one can be sure that the position of the uterus is not responsible and it is probably due to an arthritic condition. When one is doubtful about the etiologic relationship of the uterus and the back, a therapeutic test with the pessary is invaluable. If the uterus is held up with the pessary and the backache is relieved only to return when the pessary is removed in 4 to 6 weeks and the uterus falls back, there is reason to believe that surgical intervention will bring permanent relief. It should be remembered that the operation is never an emergency and one can afford to observe the patient for a time before making a final decision. It is advised that this procedure be tried on several occasions since many of these cases will show permanent correction of the retrodisplacement with the pessary alone making surgery unnecessary. If the use of the pessary is accompanied by douches, adequate exercises to re-establish tone of the supporting ligaments and abdominal wall, together with improvement of the circulation and drainage of the uterus, a better percent of good results in shorter time will be obtained.

In general, it may be said that an uncomplicated retroposed uterus is less apt to be responsible for symptoms than one complicated by other intrapelvic diseases. Among the conditions commonly associated with and frequently a factor in the cause of retrodisplacement are: salpingitis, endometriosis, ovarian tumors, myomata and childbirth injuries. Often these conditions are responsible for symptoms which in themselves necessitate surgery but frequently complete relief will not be obtained without a proper suspension together with the correction of the other pelvic lesion. It should not be lost sight of, however, that even the complicated retrodisplaced uterus may be asymptomatic and requires no treatment:

Menstrual Disturbances:

The second most common disturbance attributed to malposition of the uterus are menstrual disorders. Any type of menstrual dysfunction may be present with retrodisplacement of the uterus but in most instances the position of the uterus has no etiological relationship to the disturbance. For example, amenorrhea, polymenorrhea, hypomenorrhea and oligomenorrhea of an endocrine origin occur with the retroverted uterus as well as with the anteverted uterus. A correction of the uterine malposition will have no curative effect on these menstrual disorders and certainly not on intermenstrual bleeding. However, menorrhagia or hypomenorrhea, though more frequently due to other causes, can be explained by malposition of the uterus; the passive venous congestion of the uterus lying in the cul-de-sac may cause increased bleeding from the denuded menstrual endometrium, or hyperfunction of the displaced congested ovaries may be a causative factor in hypermenorrhea. The literature does report many incidents where the excess of menstrual flow was corrected following a uterine suspension or correction of malposition by pessary. This has been also my experience in repeated cases. **Dysmenorrhea:** is another symptom frequently attributed to retrodisplacement. Marked retroflexion of the uterus affording poor drainage of the menstrual flow is apt to be a favorable factor in dysmenorrhea more so than when retroversion exists alone. Surgical suspension is not indicated in either menorrhagia or dysmenorrhea without the definite knowledge

that the malposition of the uterus per se is the sole cause of the symptoms. This knowledge can be obtained by the therapeutic test with the pessary.

Sterility:

Permanent sterility is apparently a rare complication. However, delayed conception is considered a fairly common occurrence in retrodisplacement. This is explained by the fact that retrodisplacement of the fundus causes marked tipping of the cervix anteriorly, thus displacing the cervical opening out of reach of the vaginal pool of spermatozoa. Also another explanation has been advanced; such as the edema of the endometrium of a large boggy retroposed uterus may not afford suitable soil for implantation of the fertilized ovum. As a rule, patients with retrodisplacement rarely fail to become pregnant if displacement is uncomplicated but pregnancy may be long delayed. With the presence of this condition in a patient complaining of infertility, one must consider its existence as one of the probable causes, and during the time that the husband's semen is being studied and existing cervicitis is being treated, the uterus should be replaced and held in place with a pessary. Further studies can then follow such as: Basal Body Temperature, The Huhner test, salpingography or Rubin's insufflation. One is seldom, if ever, justified in undertaking a uterine suspension for relief of sterility alone.

Abortion:

Concerning the tendency to spontaneous abortion in patients with retrodisplacement, the consensus is that a displaced uterus is a factor of some importance in the etiology of this condition. When abortions occur repeatedly at about the 3rd month and are associated with retroposition, one may fairly assume that the position of the uterus is the cause. This is particularly true when the uterus is acutely retroflexed so that its rise above the sacral promontory is difficult. If the patient is seen during pregnancy replacement of the uterus with pessary support is the best treatment. The pessary should remain in place until the first trimester is past and the uterus has become an abdominal organ.

Constipation:

Some symptoms which have been and still are by some attributed to retrodisplacement have no relation to this condition whatsoever. Constipation which is extremely common in parous women most times co-exists with retrodisplacement. Most authorities state that this symptom is never relieved by suspension or pessary.

Leukorrhea:

Leukorrhea is also attributed by some to malposition but an understanding of the underlying lesion behind this symptom scarcely permits one to explain it on the basis of uterine position. The cervicitis or vaginitis causing the discharge may be cleared up by appropriate treatment regardless of the position of the corpus.

Frequency and Dysuria:

One of the commonest misconceptions is that frequency and dysuria may result from retrodisplacement. These symptoms have been ascribed to the abnormal position of the cervix which presses upon the

trigone. Many uteri have been suspended for these bladder symptoms without relief. When there is descensus and particularly when there is associated a urethrocoele or cystocele, bladder symptoms may be dependent upon the gynecological condition but never upon a simple retrodisplacement.

Pessaries:

A word about pessaries which was very much in vogue years ago. Their popularity waned as surgical technique improved and frequent resorts to operation advanced. With the statistical ill results obtained from unnecessary suspension, the pessary has again assumed a prominent place if only as a temporary device or for therapeutic test. Many types of pessaries are on the market today and each has its advocate probably depending on type of training he has had and the adaptability of the instrument to his technique. However, the Hodge, Smith, Thomas and Findley pessary can be interchanged with minor variations in shape. They come in four sizes and are very pliable after heating.

TYPE OF OPERATION

No operation for retrodisplacement has found universal acceptance as evidenced by the fact that about 150 operations have been described to correct this condition and most gynecologists report some failures with their pet procedure. The best suspension of the uterus at the menopause or after the menopause is a total hysterectomy. In young women in whom future pregnancies are expected, the group at McDonald House and other prominent Gynecology Clinics in the country found the modified Gilliam suspension to be the most satisfactory. It is not detrimental to pregnancy and pregnancy does little harm to a properly performed suspension of this kind. Many gynecologists have reported satisfactory results with other types and I have no doubt that their results justify their claim. Among the most used in this country are the Baldy-Webster, Coffey, Olshausen and angleworm reefing. I prefer the modified Gilliam, not because of mere academic reasons, but by shortening the round ligaments through the internal ring there is no opening left lateral to the point of attachment to the abdominal wall as there is in the unmodified Gilliam or Olshausen, and therefore less chance of strangulation of the bowel. Again in the modified Gilliam the distal weak part of the round ligament is reefed-in allowing the proximal strong portion to serve in bringing the uterus forward which the Baldy-Webster or Coffey operation do not do. Regardless of the type of round ligament suspension employed, there are cases in which simple round ligament shortening will not hold the uterus in place. In those cases additional procedures are necessary. One of the more essential of these is shortening of the uterosacral ligaments; this is especially valuable in cases in which some prolapse is present or the cervix is markedly anterior. Another valuable procedure is the suturing of the bladder peritoneum higher on the anterior uterine wall. This is done following the round ligament operation when the fundus still tends to sag backwards.

In conclusion:

1. We should differentiate co-existing pathology and treat it first, for example, a healed cervix may entirely relieve a patient's sideache and backache and obviate the need for suspension of the uterus.

2. Laparotomy is indicated without prior trial with pessary when there is need for appendectomy, myomectomy, salpingectomy, oophorectomy or associated pelvic adhesions.

3. Suspension of the uterus is justifiable when preliminary trial with a pessary effects complete relief of symptoms and return of symptoms with removal of the pessary.

Reference:

Donnreuther, W. T., J.A.M.A. 113; 1609; 1939.
Vegt, Boedecker, Lopez, A.J.O.G. 55; 1044; 1948.

WARNING FROM FOOD AND DRUG ADMINISTRATION

Washington, D. C.

The Federal Security Agency's Food and Drug Administration warn physicians and dentists that certain codes of procaine hydrochloride solution manufactured by C. B. Kendall Company, Indianapolis, Indiana, caused severe necrotic damage upon injection.

This code was placed in distribution in February 1948. C. B. Kendall Company determined, following reports of untoward reactions, that the solution is highly acid, possessing a pH of about 1.

The Food and Drug Administration has just learned that another batch of the firm's procaine hydrochloride solution, coded 64712, has caused several alleged necrotic reactions. The pH of a vial of this lot was found to be 2.9.

Pharmacological work being performed by the Administration indicates that these two products are dangerous and should not be used.

The C. B. Kendall Company has distributed several other lots of injection drugs which possess a pH of 3.0 or less. Of these the firm has voluntarily recalled the following products on which complaints have been received:

Vitamin B Complex Stronger—Lot No. 54843
Vitamin B Complex—Lot No. 44832
Pentabexin—Lot Nos. 44823 and 54837
Thiadoxin—Lot Nos. 34808, 44817, and 64842.

Also, the following injection products of C. B. Kendall Company have shown low pH values as indicated:

Product	Lot Number	pH
Vitamin B Complex Stronger	64844	2.9
Vitamin B Complex	54811	2.8
Thiamine Hydrochloride	34817	2.6
Thiamine Hydrochloride	74806	2.9
Pyridoxine Hydrochloride	74725	2.7
Pentobexin	64812	3.0
Procaine Hydrochloride	74871	3.0

The Council on Pharmacy and Chemistry of the American Medical Association is assisting in the distribution of this notice through its facilities for communicating to hospitals and physicians.

NOVEMBER MEETING

Douglas Bond, M. D.

Professor of Psychiatry, Western Reserve University

Subject: The Relationship of Doctor and Patient

Dr. Bond received his medical degree from Harvard Medical School in 1938, following which he had a Rotating Internship at Bryn Mawr Hospital, 1938-39, Resident in Psychiatry at Butler Hospital, Providence, R. I., 1939-40, Teaching Fellow in Physiology at Harvard Medical School, 1941-42, Candidate in Training at Boston Psychoanalytic Institute, 1941-42. During the war he was Chief, Laboratory of Psychiatry, School of Aviation Medicine, Randolph Field, Texas, Dec. 1942-Oct. 1943, Director of Psychiatry, 1st C.M.E., 8th Air Force, Dec. 1943-June 1945, Consultant in Psychiatry, Headquarters, Army Air Forces, Washington, D. C., June 1945-October 1945.

He has been Professor of Psychiatry, Western Reserve University Medical School and Physician in Charge, Division of Psychiatry, University Hospitals of Cleveland since November 1, 1945.

He is a member of numerous Medical and Psychiatry organizations.

***Tuesday, November 30, 1948 — 8:30 P. M.**

Cascade Room — Pick-Ohio Hotel

***Note Change of Regular Meeting Date**

ANNUAL MEETING

Election of Officers

TUESDAY, DECEMBER 21, 1948

Hotel Pick-Ohio — 8:30 P. M.

Officers to be elected:

President-Elect
Secretary
Treasurer
Delegate (Three-Year Term)
Three Alternate Delegates (One-Year Term)
Representative on the Associated Hospital Board

Health Department Bulletin

REPORT FOR SEPTEMBER, 1948

	1948	Male	Female	1947	Male	Female
Deaths Recorded	161	97	64	165	98	67
Births Recorded	600	333	267	574	291	283

CONTAGIOUS DISEASES:

	1948		1947	
	Cases	Deaths	Cases	Deaths
Chicken pox	5	0	4	0
Measles	0	0	2	0
Mumps	1	0	1	0
Polio	1	0	7	0
Scarlet Fever	1	0	1	0
Tuberculosis	18	0	10	0
Whooping Cough	7	0	57	0
Gonorrhea	27	0	21	0
Syphilis	34	0	51	0

VENEREAL DISEASES:

	Male	Female
New Cases:		
Syphilis	4	3
Gonorrhea	16	1

Total Patients 24
Total visits to clinic (patients) 433

W. J. TIMS, M. D.
Commissioner of Health

In Memoriam

CHARLES H. SLOSSON, M. D.

Dr. Slosson was the son of Dr. Henry and Sarah Harvey Slosson. He was born in Youngstown, Ohio, June 6, 1866. He attended the old Front Street School, and later was graduated from Rayen School. His medical career began with his graduation from the Cleveland Homeopathic Medical College.

After internship at Ward's Island Hospital, New York, he began to practice in Youngstown in the Davis Block on West Federal Street. This was in 1890. Ten years later, he was married to Alice Bertha Webb, who was the daughter of Mr. E. Webb, the Realtor. Mrs. Slosson died in August 1942.

Dr. Slosson was afterward located at the corner of Wood and Phelps Streets, and then later at the corner of Arlington and Bryson Streets. After his retirement, he removed to Miami, Florida, where he died September 30, 1948. His passing was the first of our recently designated Half-Century Club.

Dr. Slosson's interest was in general medical practice, during the early part of which he gave special attention to obstetrics. His suavity and his quiet efficiency secured the respect of many influential residents of Youngstown, and they remained friends as well as patients.

Chas. D. Hauser, M. D.

GROWING OLD

It is true that most "men shut their doors against a setting sun," and this is because there are few who know how to grow old. Those who have learned what can make the closing years a worthy culmination, have found the preparation necessary for it to be an interesting process, each part of which makes its contribution.

Throughout the lives of these men, the quest for knowledge has been continuous, the power of discernment and discrimination increasing with the years. This leads to correlation, to postulation, and teaching becomes inevitable. Experience being continuously subjected to analysis, there develops the judgment that is necessary to sustain character.

Eager men with less experience and younger ones with vision share the fruits of these labors. So the world becomes better through there having lived some men who had learned how to grow old.

Though Browning invited us to grow old because "the best was yet to be", he seemed to think that most of that best was originated outside the man himself. And we are apt to take for granted these attainments without recognizing the effort that made them possible. Phenomena do not yield their secrets to those who do not examine themselves as well, the intrinsic precedes the extrinsic.

Discovering one's capabilities, developing, directing and limiting them, becomes an obligation, the fulfillment of which necessitates also the careful study of other men's capacities and purposes. This was characteristic of Confucius and it accounts in part for his permanent influence on our thinking: "When I walk along with two others, they may serve me as my teachers. I will select their good qualities and follow them, their bad qualities and avoid them."

This sense of obligation which has long been integral with the consciousness of those men who have learned how to grow old, was itself a development, a process of intelligence being conditioned by circumstance. Its intrinsic origin not only permits of modifying the response, but makes it also an obligation to change the environment. The way to glory is not merely to assist mankind; but, as well, to alter mankind.

W. D. C.

1948

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

BREAST CANCER
CLINICO-PATHOLOGY CONFERENCE

October 8, 1948, S. S. Hospital

The meeting was called to order at 11:30 a.m. October 8, 1948 by Dr. H. K. Giffen. The clinical history for the day's case was given by Dr. W. W. Ryall, who had taken care of the patient for several years.

The case was that of a 35 year old white female who entered the hospital complaining of pain in her lower left chest and vomiting. Four years previously she had had a radical mastectomy at another hospital for cancer of the breast. Following the mastectomy she had received post-operative x-ray treatment, the quantity of which was unknown. For the next 3½ years she considered herself to be in good health and was without complaints. Six months prior to her admission at the South Side Hospital a tonsillectomy was performed and following that she was bothered by continuous loss of weight, nausea and occasional vomiting. During the few weeks prior to admission she had received x-ray therapy to the chest and supra-clavicular region on the left.

Physical examination on admission revealed her to be a well developed, well nourished 35 year old white female lying in bed and appearing slightly dyspneic. There was a subcutaneous nodule on the left forehead measuring 3 x 3 cm. This was hard, slightly tender and not movable. The conjunctiva and sclerae were clear. The pupils were round, equal and reacted to light and accommodation. The ears, nose and throat were not remarkable. Lymphadenopathy was noted posteriorly on the left side of the neck. There was some tenderness in the left supra-clavicular area and some induration here. On the chest the scar of the previous mastectomy was seen. There was induration, discoloration and tenderness of the chest wall in this area. No axillary nodes were felt. Examination of the lungs revealed some dullness of the lower left lung field. There were markedly decreased breath sounds in this area. The heart had a regular sinus rhythm but the rate was rapid. There were no murmurs. There was voluntary rigidity of the abdominal muscles and some peri-umbilical tenderness. No organs were palpable in the abdomen and no inguinal lymph nodes were palpable. There was no edema or other abnormality of the extremities.

Laboratory examinations on the day following admission revealed the urine to be orange with a reaction of 5; sp.gr. 1.015; albumin and sugar were negative; there were a few epithelial cells. The red count was 3,820,000; the white count 5,500; Hg. 11.6 gms. or 75%. The differential showed 74% polys of which 8 were stabs and 66 segs. There were 24% lymphs and 2% monos.

The patient remained in the hospital approximately one month, receiving symptomatic treatment and grew progressively worse. At the end of that period she was allowed to return home for several weeks and then was re-admitted in poor condition. Her physical examination and laboratory work following the second admission were essentially the same as following the first. She died on her 8th hospital day. This was approximately four years following the radical mastectomy.

Following the case presentation Dr. R. G. Thomas described the gross findings of the autopsy. These consisted of a generalized carcinomatosis as had been predicted clinically. There was massive involvement of both lungs by metastatic carcinoma and large tumor masses at the hilus of each lung. There was a hydrothorax on the left consisting of 1500 cc. of an amber fluid. Numerous metastases occurred in the liver and the perihepatic lymph nodes. There was extensive tumor involvement of the head of the pancreas and the nodes in that vicinity. A metastatic tumor nodule was found within the substance of the spleen. This measured approximately 1 cm. in diameter. A comment was made concerning the rarity of this type of metastasis. Lymph nodes containing metastatic tumor were found in the mediastinum, the hilus of the lung, peri-aortic region, the perihepatic region, peripancreatic, perirenal, axillary, supra-clavicular and cervical. A metastatic tumor nodule was present in the right adrenal and there were metastases to the skull, ribs, sternum, lumbar spine and pelvis. Unexpected metastases were found within the dura, in the falx cerebri lying between the two cerebral hemispheres. These consisted of two large tumor nodules 4-5 cm. in diameter growing within the dura and compressing the brain tissue on either side but not invading it.

Lantern slides were shown to illustrate these metastases. Following this, Dr. Giffen described the microscopic features of the tumor which was a fairly well differentiated adenocarcinoma.

Following the case presentation, Dr. Baker discussed the uses of x-ray in the treatment of carcinoma of the breast. He pointed out that this woman's life had been considerably prolonged and made more comfortable by the post-operative treatment. For these reasons x-ray therapy is nearly always indicated as an adjunct to surgery and in many cases affords the only effective means of palliation for surgically hopeless cases.

There was some discussion concerning the use of hormones. Experiences with them differed widely and instances were cited in which incorrect use had produced considerable harm.

Drs. Nelson and Baker recalled a case of an elderly woman, however, who had had a far advanced carcinoma of the breast with numerous bony metastases in whom the use of testosterone had produced striking and prolonged improvement.

Carcinoma of the breast is still a major medical problem even though many are cured today.

R. G. Thomas, M. D.

THE YOUNGSTOWN HEART ASSOCIATION

The October meeting was held in the Lecture room at the N. S. Hospital on the 5th of October, 1948. The constitution for the organization was adopted and the following officers were elected:

President—Dr. W. H. Bunn
Vice-Pres.—Dr. R. B. Poling
Secretary—Mr. W. J. Brown
Treasurer—Mr. H. R. Hooper

Following the business meeting two cases of juvenile H.D. were presented by Drs. Kinney and Covert. J. D. M.

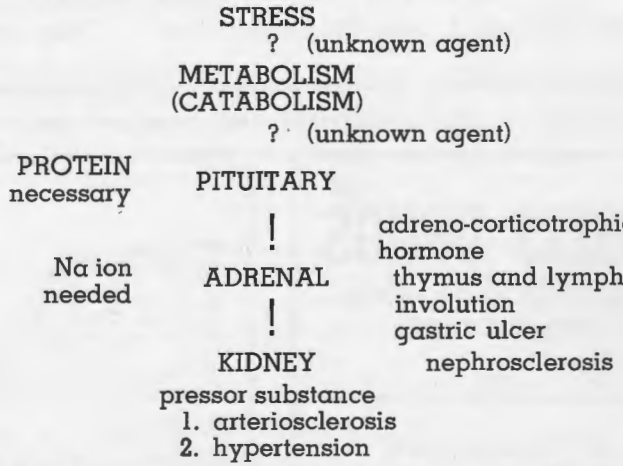
"Adaptation Syndrome"

Dr. Hans Selye, Professor of Medicine and Director of the Institute of Experimental Medicine at University of Montreal, gave a very thought provoking and interesting discussion on the "Adaptation Syndrome" before the October 12th meeting of the Mahoning County Medical Society.

Dr. Selye first became interested in this work while studying ovarian hormones with Dr. Collup at McGill University in 1936. They noted that a syndrome of thymus involution, gastric ulcer and hypertrophy of adrenal cortex developed in many of their laboratory animals following the use of ovarian extracts. Dr. Selye gives his poor chemical techniques the credit for their early discoveries as his ovarian extracts caused the most profound changes in animals. As a result of the studies they considered the "Adaptation Syndrome" to be due to constant systemic stress such as emotion, burns, cold temperatures, etc., and to consist of three stages as follows:

1. "Alarm" reaction—medical or surgical shock.
2. Stage of Resistance—adaptation.
3. Stage of Exhaustion—final stage.

Dr. Selye then presented a brief outline of the pathways and agents necessary for the development of the syndrome.



Lantern slides of animal experimentation were then shown proving the above chart by:

1. Negative proof—remove pituitary and even in presence of great systemic stress the chain below the pituitary is broken and no changes occur.
2. Positive proof — give large doses of corticoids, even in absence of stress, with or without pituitary gland present, and in the final effects in thymus, lymph nodes and kidneys are seen.

Also demonstrated were some of the diseases of "Adaptation", proven pathologically in animals, to be (1) rheumatic pericarditis, (2) periarteritis nodosa, (3) nephrosclerosis, and (4) although not constant, arthritis resembling that occurring in acute rheumatic fever. The

agents used to produce the above lesions were desoxycorticosterone with sodium chloride and anterior pituitary extract.

Of particular interest were Dr. Selye's remarks on the "Endocrine" kidney, prepared by reducing the blood flow to one kidney to that point where urine was no longer formed, yet not destroying the kidney cells. This kidney then became smaller, all glomeruli disappeared and cells changed to endocrine cells showing mitotic figures and other evidences of growth. This is followed by rapid and profound arteriosclerotic changes in the opposite kidney and the rest of the circulatory system.

Most encouraging were Dr. Selye's final remarks, "although this subject is thought provoking and interesting, do not take it too seriously as the whole theory may be wrong. Much further work is needed to establish the 'adaptation syndrome' as pictured tonight."

E. R. McNeal, M. D.

UNCLE DUDLEY

After all of our experiences and psychic forays, we return to Descartes' starting-point, and make it our own. We realize, however, that even this point is as relative as are material objects in space.

* * *

There are children who, after many explanations, encouragements and admonitions will learn to keep themselves out of danger; there are others who respond to a whack on the seat of the pants. If you are looking for strength of character and self-reliance, think this out.

* * *

Do not be too critical of the old man when he occasionally gets emphatic over the laxity and indiscretions of modern youth, or even if he becomes condemnatory. He may be fighting again within himself the battle he had won long years ago.

BLEEDING PEPTIC ULCER

Hemorrhage from peptic ulceration may take place at any age but it occurs more frequently in the fourth and fifth decades. The author strongly advocates that patients with bleeding from the upper G. I. tract not be x-rayed until at least two weeks have elapsed after the onset of hemorrhage. Factors precipitating hemorrhage are: 1. Upper respiratory infections. 2. Alcoholic beverages. 3. Emotional disturbances. 4. Dietary indiscretions. 5. Physical exertion and overwork. Most hemorrhages occurred in the calendar season from October to March. The biochemical changes noted after G I bleeding are: 1. Alimentary hyperazotemia. 2. Hyperazotemia as a result of functional renal impairment. 3. Increase in plasma chlorides. 4. Hypoalbuminemia. 5. Urobilinogenuria. 6. Hyperbilirubinemia. R. L. Fisher and M. Zukerman—Am. Journal Med. Oct. '48.

J. D. M.

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TUMORS OF THE BONE

(Presented by Dr. Bradley Coley at our September Meeting)

Doctor Coley made a plea for early diagnosis of all tumors of the bone. He emphasized the importance of early, thorough investigation of all deep seated bone pain. A complete history and physical examination, plus adequate roentgenograms are necessary for early diagnosis and this is necessary to make progress in treatment. Biopsy is a diagnostic aid. Aspiration biopsy in skilled and experienced hands is satisfactory in a high percentage of cases, but surgical biopsy is more certain in accurate diagnosis.

Treatment depends on the type of lesion present.

1. Certain benign bone tumors may be beginning malignancies and should always be removed. Condroma is one of these and treatment is immediate excision. Irradiation of these tumors is dangerous and may cause degeneration with subsequent development of sarcoma.
2. Osteogenic sarcoma requires radical treatment which is usually amputation. Irradiation is dangerous because sufficient quantities of x-ray to destroy the sarcoma causes permanent destruction of normal tissue.
3. Conservative surgical measures, such as resection of a single bone, such as the scapula may suffice in selective cases when there has been no soft tissue extension.
4. Certain radical surgery, such as hemi-pelvectomy is indicated in selective cases of sarcoma involving such bones as the head and the neck of the femur and the ilium. The mortality in selective cases has been low.
5. Estrogenic substance are of value in bone metastasis of breast and prostate carcinoma but such treatment is palliative only.
6. Doctor Coley discussed their frozen bone bank and demonstrated several cases where such bone grafts had been used to fill in the defects caused by local resection of tumors.

J. R. Buchanan, M. D.

CYNICAL SAM

It has been said that the custom of shaking hands when people meet, grew out of the primitive showing of hands to let each other know they held no concealed weapons. Why wouldn't showing the tongue answer the same purpose?

* * *

When considering the advantage of civilization over savagery, we are compelled to balance the effects of being loused up by insects or by dictators.

* * *

There is a compensation for being a poor old man. The rich old fellow, who once looked upon you as a competitor, has quit saying mean things about you. It is possible that he doesn't know that you exist.

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL POSTGRADUATE COURSES

1949

Urology Conference, January 19-20. A two-day postgraduate program in urology and related sciences is being offered by the Postgraduate Department of the University of Michigan under sponsorship of the Detroit Urological Society. The lectures and clinics have been selected to interest the specialists in both practice and basic knowledge of urology.

Registration will be open at 9:00 a.m., January 19, 1949, in the Rackham Building. A limited number of rooms have been made available at the Michigan Union.

Requests for information should be addressed to Howard H. Cummings, M. D., Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

PENNSYLVANIA TELLS THE STORY

The Medical Society of the State of Pennsylvania is making an effort to reach more than 1,000 service clubs throughout Pennsylvania and tell them the centennial story of the society. Each county medical society has been asked to assign a physician from its membership to appear before his own service club and outline to his fellow Rotarians, Kiwanians, or others "100 Years of Medical Progress in Pennsylvania."

By this medium over 60,000 influential business men and women can be told the historical facts and organizational accomplishments of the Society.

While this type of project is merely one of a number of informative programs sponsored by medical societies, it seems that the idea could be explored even further as a means of presenting many of the profession's viewpoints to civic leaders and through them to the general public.—Pa. M. J., Aug. 1948.

NEWS

Dr. Bryan H. Hutt passed successfully the examination for the American Board of Pediatrics, in Seattle, Washington, on Sept. 12, 1948.

Dr. E. R. McNeal announces the opening of his office at 3718 Market Street.

Dr. John L. Scarnecchia received his fellowship in the American College of Surgeons at Los Angeles, on Oct. 22.

COUNCIL MEETING

The regular monthly meeting of Council was held on October 11, 1948 at the office of the Society, 125 W. Commerce St. The following doctors were present: John Noll, G. G. Nelson, I. C. Smith, W. H. Bunn, W. M. Skipp, C. A. Gustafson, W. J. Tims, E. J. Wenaas, E. J. Reilly, J. N. McCann, V. L. Goodwin, and L. H. Getty, Chairman of the Indigent Relief Committee, was a guest.

In compliance with a request from A. A. Brindley, M.D., President of The Ohio State Medical Association, that each County Medical Society create as soon as possible, a Committee on School Health, Dr. Noll has appointed the following committee: Dr. O. J. Walker, Chairman; Dr. W. J. Tims, Dr. S. G. Patton, Dr. E. C. Mylott and Dr. E. R. Thomas.

The following report was submitted by the committee appointed by Dr. Noll to study the problems involved in the Mahoning Chapter Infantile Paralysis Committee's function.

The Special Committee met in the library of St. Elizabeth's Hospital on September 21, 1948.

After discussing the problems from all angles, the following two motions were made: 1) Council to appoint a committee to advise on the standardization of treatment. 2) Council to appoint a committee to meet with the Medical Advisor of Polio Foundation Chapter, whenever he feels that any charge is worthy of dispute. The doctor whose charges are in dispute to be at the meeting.

Dr. Noll appointed Dr. I. C. Smith to handle the standardization of treatment in the hospitals and Dr. L. H. Getty to handle any question of fees.

Dr. Noll announced that in compliance with a suggestion from the Ohio State Medical Association, he had appointed the following doctors to serve as medical advisors to the draft boards so named: Dr. R. V. Clifford, Draft Board No. 78; Dr. C. A. Gustafson, Draft Board No. 79; and Dr. J. C. Hall, Draft Board No. 80.

The following applications were returned by the censors:

FOR ACTIVE MEMBERSHIP

Dr. William J. Flynn, 138 Lincoln Ave., Youngstown, Ohio
Dr. Albert J. Fisher, 5929 Glenwood Ave., Youngstown, Ohio

FOR INTERNE MEMBERSHIP

Dr. Lloyd W. Barnes, North Market St., Petersburg, Ohio

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

V. L. Goodwin, M. D.
Secretary.

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.