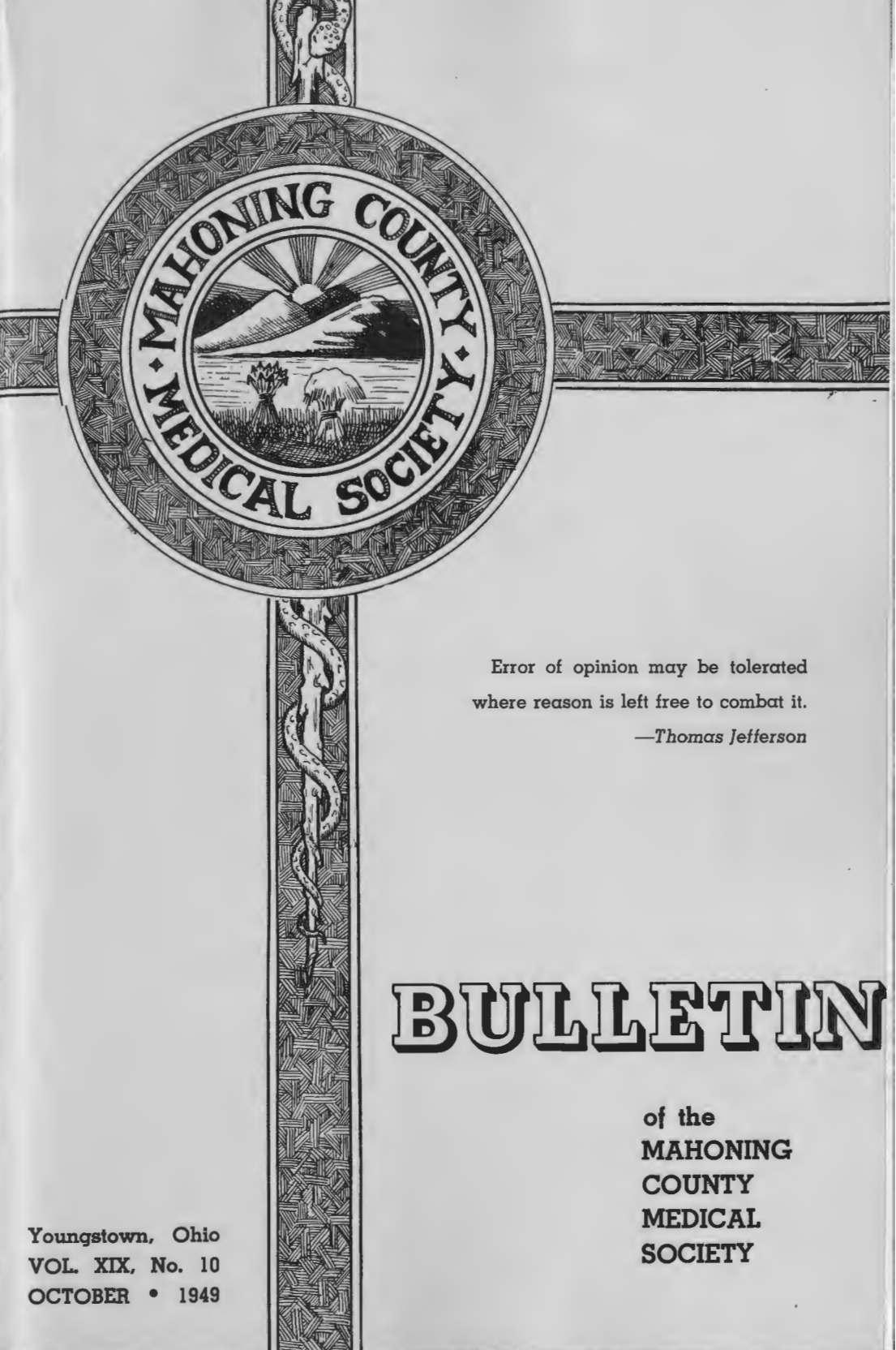

Error of opinion may be tolerated
where reason is left free to combat it.
—*Thomas Jefferson*

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XIX, No. 10
OCTOBER • 1949

if she is one of your patients...

The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.

***"Premarin"** offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen becouse...*

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2. *Untoward side-effects are seldom noted.*
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TABLE OF CONTENTS

Vol. XIX—No. 10 **October, 1949**

ADVERTISERS' LIST

MEDICAL CALENDAR

1st Tuesday	Monthly Staff meeting, Youngstown Hospital Auditorium—Nurses' Home
8:30 p. m.	Monthly Staff meeting, St. Elizabeth's Hospital, St. Elizabeth's School of Nursing
Sunday following 1st Tuesday 11:00 a. m.	Monthly Surgical Conference, St. Elizabeth's Hospital Library
2nd Monday 9:00 p. m.	Council Meeting—Mahoning County Medical Society—Office of the Society—Schween-Wagner Bldg.
2nd Tuesday 11:30 a. m.	Monthly Medical Conference, Youngstown Hospital Auditorium—Nurses' Home
8:30 p. m.	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
Every Friday 2:00 P. M.	Conference—X-ray Dept., St. Elizabeth's Hospital.
Alt. Saturdays 11:00 a. m.	Obstetrical Section—North Side Unit of Youngstown Hospital

COMING MEETINGS

American Academy of Pediatrics, San Francisco, Nov. 14-17.

Central Society for Clinical Research, Chicago, Nov. 4-5.

International College of Surgeons, Atlantic City, Nov. 7-12.

Inter-State Post Graduate Medical Association of North America, Philadelphia, Oct. 31-Nov. 3.

PRESIDENT'S PAGE

★ ★ ★

DIABETES

Diabetes is an inherited disease which may make its appearance at any time during life. Its recognition in a classical case may be considered simple, providing the patient presents himself to a physician. Many persons with diabetes dread having the diagnosis established because of an unwarranted fear of the possibility of having to take insulin.

The number of lay persons with this fear who are potential diabetics is fortunately a minority. They are, however, sufficiently great numerically to justify renewed efforts to recognize their undiagnosed diabetes.

During the coming week the American Diabetic Association is sponsoring a nation-wide campaign to try to find these persons. The medical profession has been asked to co-operate. A committee has been appointed from your medical society to direct this detection drive in this community. Already the committee has solicited your support by mail asking for co-operation in performing urine tests gratis during the week, October 10-16.

This is just one example of the efforts being made by the present type of private practice of medicine in this country to improve the health of the nation and to maintain America's world leadership in medicine.

JOHN N. McCANN, 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

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THE "UNPROVEN DIABETIC"

BY ARNOLDUS GOUDSMIT, M. D.

As will have become abundantly clear by the time this Bulletin is distributed, Mahoning County is participating wholeheartedly in the nation wide Diabetes Detection Drive, culminating in Diabetes Week, October 10-16, 1949. Aided by appropriate radio and newspaper publicity, and through the mass distribution of self-testing equipment, patients will come to their physicians asking for urine tests, or saying: "Doctor, I have sugar in the urine. Now what?"

By way of explanation, self testing equipment is being distributed throughout the community under the auspices of the American Diabetic Association through a local committee of the Mahoning County Medical Society. Each self tester has a reply envelope in it for the tester to send the report of the urine test, whether negative or positive, to the national headquarters of the American Diabetic Association. Patients with positive tests may consult their local physicians immediately, otherwise the Diabetic Association may notify family physicians of the results.

On the basis of the time-honored practice of considering everybody who spills reducing substances in the urine a possible diabetic, every such case then automatically becomes a diagnostic challenge and a therapeutic opportunity. If as much testing material is made available for our community as is hoped for, these newly discovered "unproven diabetics" may well number considerably over 1,000.

No single method of arriving at the correct diagnosis in any given case of "unproven diabetes" will be found suitable to every physician and every patient concerned. However adherence to a few basic principles would seem applicable to all situations:

(1) No number of positive urine specimens ever makes a diagnosis of diabetes mellitus, and no number of negative urines refutes it.

(2) A fasting blood sugar (venous) above 120 mg. per 100 cc. in the absence of complicating conditions, is quite presumptive of diabetes; a fasting sugar over 140 mg., for all practical purposes, conclusive proof.

(3) A fasting blood sugar below 120 mg. per cent is quite compatible with the presence of a bona fide, unquestionable case of diabetes.

(4) Blood sugars, 90 minutes to two hours after a meal moderately rich in carbohydrates, below 160 mg. practically exclude the existence of diabetes mellitus, whereas one above 200 mg. is highly suggestive of the presence of this disease. Thus, from the point of view of diabetes detection, A SINGLE BLOOD SUGAR DETERMINATION AFTER A MEAL IS MORE INFORMATIVE THAN ONE TAKEN IN THE FASTING STATE.

(5) In doubtful cases some form of sugar tolerance test will be indicated. If such a test is ambiguous in its result, the case would appear to call for continued observation of the patient.

The fallacy of dismissing the presence of sugar in the urine on the basis of a normal fasting blood sugar is well illustrated by a case report quoted from Dr. Garfield G. Duncan (Diseases of Metabolism, W. B. Saunders Company, 1942; page 740): "P. B., a male, aged 60 years, was treated in January, 1929, for an acute pharyngitis and heart disease. A trace of sugar was found in the urine on one occasion. A normal blood sugar value served, but falsely, to exclude diabetes. The patient was admitted in June of the same year in diabetic coma with a blood sugar concentration of 1280 mg. per 100 cc."

Thus the "unproven diabetic" will be promoted to either one of the following classes:

(a) the proven diabetic, infinitely better protected from complications than his "undetected" brother;

(b) the proven non-diabetic, grateful, and satisfied with the knowledge that he does not have the disease;

(c) the person under continued observation.

MAHONING COUNTY HOST TO SIXTH COUNCILOR DISTRICT

The Mahoning County Medical Society will be host to the Sixth Councilor District of Ohio at its annual Post Graduate Assembly in the Pick-Ohio Hotel all day Wednesday, November 30, 1949.

A group from the Lahey Clinic, Boston, Mass., has been secured to present the program for the day. Arrangements were made by a committee headed by Dr. Alexander K. Phillips. The essayists for the day are Dr. Sara M. Jordan, Dr. Samuel F. Marshall, Dr. James W. Toumey, and Dr. Carleton R. Souders. The general subjects covered with be gastro-intestinal disease, pulmonary disease, and orthopedic lesions, with a special panel discussion during the afternoon session on medical and surgical problems. All of the visiting speakers will participate in the panel discussion.

The program will start at nine a. m. with registration and the first paper presented at 9:30 a. m. Luncheon will be informally arranged, but reservations for dinner at the hotel will be received at a later date. The after dinner program promises a surprise with a prominent political leader as the guest speaker.

This meeting will take the place of the November monthly meeting of the Society.

The Sixth Councilor District includes most of the counties of Northeastern Ohio so that a large group of out-of-town physicians are expected to attend the meetings. Dr. Paul A. Davis, Akron, is councilor for the district.

WHAT'S WRONG WITH THE NURSING PROFESSION TODAY?

So something is wrong with the nursing profession? What can it be? Surely these young women who enter nursing as a life work today enter with the idea of giving service, as did we who entered 20 years ago. What happens to these young women between their high school days and the year in which they pass their state board? Are they alone the cause of the great change?

Surely the supervisory heads know what is going on, or don't they realize that their students are not learning that there is more to nursing than administering drugs? No amount of medication can compensate for an aloof manner in the sick room, yet the actions of the average senior student in the average hospital today demonstrate that coldness and lack of sympathy are firmly ingrained as important attributes of their professional attitude. Twenty years ago this old-fashioned attribute was called "bed side manner."

Too much emphasis is placed upon high scholastic attainment, thus discouraging the average student from a life of service. Many fine girls with high ideals, but average ability scholastically, would make superior nurses were they given the chance for training. A degree in nursing is fine for those who desire advanced training, but more emphasis should be placed upon the care of the patient, rather than the class standing of the student nurse.

One of many deterents to entering the profession today is the high tuition. While it is true that the other professions have high entrance fees in the form of tuition and special fees, the nursing profession should not use the same methods. To begin with the student nurse gives of her own strength through serving in many capacities. That alone, over the period of training, should more than compensate for monetary contributions at the outset of training.

Every one of us doubtless knows more than one fine girl, often intellectually brilliant, who desires to enter nursing, but due to family circumstances is deterred by the prohibitive amount of tuition required. And another fault of present day training is that in spite of all the emphasis upon mental health throughout the country today, every probationer lives with the always present fear of "flunking out." Can this be one of the reasons sensitive sympathetic girls, who would become kindly nurses, end up in offices and department stores?

Might another fault of present day methods be that the student is kept too long at class work before practical experience begins? Of course we do not recommend that the beginning student jeopardize the life of a seriously ill patient, but she could do much of the work now delegated to nurses' aids. This would give the new student a feeling of belonging to the one group whose primary purpose is to give aid and comfort to others. Here could be developed a desirable bedside approach, along with a sense of responsibility and a feeling of growing experience, instead of a feeling of being frustrated through not getting into active service.

When kindness and consideration for the patient is again stressed, and cheerfulness in the sick room is brought back as an important factor in being a successful nurse, then the profession will begin to improve.

(Editor's Note:—The above article was submitted by a graduate nurse to present one view of the present status of nursing education. The name of the author has been withheld).

DR. McKHANN DESCRIBES NEW OPERATION

BY H. B. HUTT, M. D.

At the regular monthly meeting of the Mahoning County Medical Society held September 20, 1949, in the Pick-Ohio Hotel, Dr. Charles F. McKhann, professor of pediatrics in the Western Reserve University School of Medicine, described a "New Approach to the Treatment of Convulsive Disorders and Mental Retardation in Children." A resume of his talk follows.

Mental retardation, cerebral spasticity, and convulsive disorders in children present distressing problems to the parents of the individual child and to the pediatrician who must rationalize the situation to the parents and encourage them to adjust to their misfortune. Therapy in these conditions has been directed toward training the child in the use of his physiologic nervous residue in retarded or spastic children, and in the use of drugs to suppress and control convulsive disorders.

By observing the increased growth in the affected leg of children with femoral arteriovenous aneurysms, the idea occurred to Dr. McKhann of an operative procedure to increase the arterial blood supply to the cerebral cortex through establishment of a cervical arteriovenous fistula. It was hoped to increase the nutriment and oxygen available to cortical cells and thus improve function of existing cells, perhaps rendered abnormal through injury or inflammatory reaction. This procedure has been carried out by Dr. Claude S. Beck.

The operation consists of a surgical anastomosis of the common carotid artery with the right internal jugular vein. The first attempt on a human subject was made on a microcephalic baby. This resulted in such a definite increase in head size that the roentgenologist, who was purposely not informed of the operative procedure between serial films, reported that the child appeared to have an expanding brain lesion.

In general, however, the operation has not been carried out on patients with developmental defects (e.g., mongols), but has been confined to those who originally have had a normal brain, (e.g. birth injuries, spastics, thromboses, etc.)

To date the anastomosis has been performed on 85 patients. The house staff refer to the procedure as the "buzz" operation because of the characteristic sound heard in the right side of the neck post-operatively. In the young infants who were operated, the anastomosis closed off. Now no patients are operated under one year old. There is in almost all cases a temporary increase in intracranial pressure, but this has not persisted.

Extensive studies were made of each child before the procedure was recommended. Careful follow-up observations are now being made. While the procedure has been employed only since November, 1948, some indications as to its results begin to appear. As of July 1, 1949, eight children with severe convulsive disorders had been subjected to the operation and had been followed long enough to permit some appraisal. In four of the eight children cessation of episodes followed the operation; in two children the number and severity of convulsions were reduced; while in two, the procedure seemed ineffective. The cessation of convulsive episodes for variable periods following procedures such as general anesthesia or air injection into the cerebral ventricles, dampens undue enthusiasm for the apparently good results in the cases undergoing the new operation.

Nine children with cerebral spasticity have been similarly observed. In seven, definite improvement occurred, while in two no benefit has been derived from the procedure.

Eighteen children with severe degrees of mental retardation due to birth injuries or to encophalitic process had been subjected to the operation. In eleven, distinct improvement was demonstrable, apparently out of proportion to the pre-operative rate of development. In seven children, no benefit was apparent. The difficulty of interpreting improvement in mental retardation without the lapse of much longer periods of time is recognized.

The procedure, which on first inspection seems to hold promise, must be recognized as a new type of approach to the problem. It will require extensive trial and particularly a prolonged follow-up period to determine degree of benefit and type of patient for whom benefit may be expected. A procedure offering any likelihood of improving the lot of these children merits thorough but dispassionate appraisal.

DR. RIENHOFF TO TALK AT DINNER MEETING

Dr. William F. Rienhoff Jr., Associate Professor of Surgery in the Johns Hopkins Medical School, will be the guest speaker at the monthly meeting of the staff of the Mahoning County Tuberculosis Sanatorium October 25, 1949. The affair will be a dinner meeting to which all physicians in the county will be invited.

Dr. Rienhoff, a prominent thoracic surgeon, will talk on "The Present Status of the Surgical Treatment of Malignant Tumors of the Lungs." His talk will be illustrated with lantern slides and movies.

Dr. Rienhoff comes to the "San" at the invitation of Dr. William Newcomer, medical director and chairman of the program committee of the staff. It is planned to have an open dinner meeting once a year. Last year Dr. George Curtis, professor of Surgery in Ohio State University Medical School, was the guest speaker at a similar meeting.

Dr. Newcomer announced that the entire medical profession will be invited by postal cards with return reservations for the dinner which will be served at six p. m. in the dining room at the Sanatorium.

THE INTANGIBLES OF MEDICINE

A mother's labor pains, the cardiac's anxiety, and the child's newly-found fear seem not assuaged entirely by last month's "security taxes." Neither does a doctor's value to society and the individual seem adequately measured by the anatomy covered within his specialty; nor is it fully determined by an unusual skill with a stethoscope, a scalpel, or a microscope.

The intangibles in medicine—the infinite reactions of both mind and soul of the patient, as brought out in impending death, births, prolonged suffering, and the everyday struggle with disease. Next in turn, there is the inspiring word, the sympathetic ear, and the deep understanding of human frailties, as evidenced in the really good physician.

One can state categorically, the patient and physician intangibles can never be governmentally blueprinted, nor strait-jacketed with rigid departmental regulations. Bureaucracy does not change human nature.

— Detroit Medical News

ST. ELIZABETH'S HOSPITAL HAS NEW SUPERINTENDENT

Sister M. Adelaide H. H. M., Superintendent of St. Joseph's Hospital in Lorain for the past six years, has been announced as the new Superintendent at St. Elizabeth's Hospital, Youngstown, Ohio. She succeeds Sister M. Germaine who had been Hospital Superintendent for the past twelve years.

Sister Germaine recently was made Directress of the three hospitals and a Home for Crippled Children operated by the Sisters of the Holy Humility of Mary. Hospitals in her charge include St. Elizabeth's Hospital in Youngstown, St. Joseph's Hospital in Lorain, St. Joseph's Hospital in Warren and the Rosemary Home for Crippled Children in Cleveland, Ohio.

Prior to assuming the superintendency of St. Joseph's Hospital in Lorain Sister Adelaide was in charge of the Hospital Pharmacy at St. Elizabeth's Hospital, this city.

ST. ELIZABETH'S HOSPITAL STAFF MEETING

The regular monthly staff meeting of St. Elizabeth's Hospital was held on September 6, 1949. Dr. R. B. Poling, President of Staff, presided.

In the scientific program, brief case abstracts of recently hospitalized cases were first presented by members of the resident staff. Presenting case histories were Drs. A. Bax and J. Tomayko of the surgical service; Drs. L. Strutner and W. Breeseman of the medical service and Drs. V. Cafaro and F. Lamprich of the ob-gyn service.

Dr. J. A. Renner presented a paper on the Cooney-Crosby Button. In reviewing the medical treatment of cirrhosis he cited the discouraging results in the management of the ascites in advanced cases and discussed the use of the Cooney-Crosby Button as a palliative measure especially in such instances. He reviewed 15 consecutive cases in which the button has been used in the Hospital and indicated that the use of the peritoneal button operation was a useful adjunct in the management of ascites.

He discussed the rationale underlying the procedure and pointed out that it is usually simply and rapidly performed and prevents loss of proteins, fluids and electrolytes from the ascitic fluid and returns them to the general circulation. He pointed out the main reason for the failure of peritoneal button to work in many instances is due to formation of fibrous-walled, mesothelial-lined subcutaneous pouch from which absorption is minimal. He suggested that the subcutaneous pouch formation may be avoided by the use of a stab wound so that tissue planes are not opened up to permit formation of a pouch. His interesting discussion was highlighted by presentation of a case which demonstrated the formation of a subcutaneous pouch. Despite the presence of a pouch the patient alleged to being quite comfortable for a number of months following the procedure.

The president lauded the work of the Therapeutic Evaluation Committee in the preparation of a brochure which will be used as a guide in the treatment of medical and surgical emergencies and used principally in the training of the interne-resident personnel. He also commended the Ex-Interne Association Committee for the success achieved in their reunion meeting of August 18.

Dr. M. W. Neidus reported an autopsy average of 52% for July and 32% for August and an overall average to date, of 42%.

STEPHEN W. ONDASH, M. D.
Secretary

YOUNGSTOWN HOSPITAL HOUSE STAFF IS ANNOUNCED

The House Staff of the Youngstown Hospital, South Side and North Side Units, for the year 1949-50 has been announced by Dr. R. W. Rummell, medical director of the Hospital. The group includes 25 residents, one fellow, and five internes. They are as follows:

INTERNES

Dr. David J. Cox, Jr., from St. Louis University School of Medicine.

Dr. Raymond N. Catoline, from Northwestern University School of Medicine.

Dr. Clifton E. McParland, from Western Reserve University School of Medicine.

Dr. Robert L. Jenkins, from Georgetown University School of Medicine.

Dr. L. D. Cushing, from Western Reserve University School of Dentistry.

RESIDENTS

Medicine: Drs. D. C. Miller, F. A. Friedrich, and C. A. Haefner, third year; Drs. D. F. Covert, R. A. Brown, and J. L. Calvin, second year; Drs J. J. Campolito, L. W. Grossman, and R. R. Fisher, first year.

General Surgery: Drs. J. L. Alexander, J. G. Rogers, and J. R. Willoughby, fourth year; Drs. S. A. Lerro and W. B. Hardin, third year; Dr. F. K. Inui, second year; Drs. J. M. Snelling, A. Dow, J. W. Barrett (neuro-surgery), and I. Zeavin, first year.

Anesthesia: Dr. F. E. Shaw, second year; Dr. P. A. Dobson, first year.

Pathology: Dr. R. G. Thomas, third year; and Dr. J. R. Gillis, second year.

Dr. E. E. Brant is second year resident in Radiology.

Dr. L. A. Loria is resident in Orthopedics.

Dr. J. L. Finley is fellow in obstetrics.

Health Department Bulletin

REPORT FOR AUGUST, 1949

	1949	Male	Female	1948	Male	Female
Deaths Recorded	180	97	83	182	109	73
Births Recorded	578	294	284	500	257	243

CONTAGIOUS DISEASES:	1949		1948	
	Cases	Deaths	Cases	Deaths
Chicken Pox	3	0	4	0
Measles	3	0	1	0
Poliomyelitis	8	0	0	0
Whooping Cough	32	0	3	0
Mumps	3	0	0	0
Tuberculosis	2	0	4	2
Gonorrhea	39	0	12	0
Syphilis	35	0	36	0

VENEREAL DISEASES:

New Cases:	Male	Female
Syphilis	4	5
Gonorrhea	25	4

Total Patients 38
Total Visits to Clinic (Patients) 434

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

HELP FIND SOME OF THE 1,000,000 UNKNOWN DIABETICS

Delay in Diagnosis is Diabetic Enemy No. 1

Proper Use of Diet and Insulin (if Needed) Will Improve the Health and Protect the Future of the Diabetic

Check the Urine of Your Patients.

Guard Their Health!

Symptoms of Diabetes are:

Loss of Weight and Strength

Thirst

Frequent Urination

Positive Urine Test

Unusual Pain or Fatigue

Blurred Vision

DIABETIC DETECTION WEEK

OCTOBER 10-16, 1949

Committee on Diabetes,
Mahoning County Medical Society

THE MANAGEMENT OF THE BLOOD BANK

BY PAULINE M. TWEEDDALE, R. N.

A blood bank may be defined as an establishment for the storage and exchange of human blood to be used for transfusions. The deposits and withdrawals of blood in the bank, are credited and debited in much the same manner as transactions are recorded in a monetary bank.

The accumulated experience of many hospital blood banks has demonstrated that there are many advantages which accrue, by keeping a stock of blood of the various types or groups, which is readily available for immediate transfusion. When a bank is available, whole blood of the proper group and proper RH can be transfused into a patient within a very short time, after the need arises. This is in marked contrast to the number of procedures required before fresh blood can be employed as:

1. Obtain donor
2. Determine blood type
3. Do Kahn
4. Cross-match with patient
5. Collect blood from donor
6. Transfuse into patient

The first one-procurement may take considerable time especially if we are looking for an unusual type. In the days before there was a blood bank, we have been told that as many as 20 people, potential donors, have been typed before finding the right type and one that was compatible with the patient's blood. In any event much time would elapse after the need arose.

In using blood from the bank the time element is greatly reduced. If the physician or surgeon knows he may need blood it can be ordered ahead of time and will be cross-matched and labeled with the patients name and kept in refrigerator until called for. If transfusion is found unnecessary the blood is kept for 36 to 48 hours and then converted to stock. The stock in a bank permits transfusion of large volumes of blood in cases of exsanguination. Under such circumstances it occasionally has been necessary to transfuse the patient with four to six liters of blood in 24 hours. Such a problem as you know, would be extremely difficult without a blood bank. I would like to show you how our bank has grown in the past 4½ years at the North Side and South Side Units.

The percent of transfusions per 100 admissions:

1st year	3%
2nd year	9%
3rd year	11%
4th year	14%

The increase from 3%—9% during the first and second years reflects the return of the doctors who were in service.

Our stock of blood should be sufficiently large to permit an adequate supply of all four groups and proper proportions of RH negative and positive blood of each group. Theoretically the proportion of each group should approximate the same as is encountered in the general population. Actually, however, this incidence seldom will be found in stock. The percent will hold true in a sufficiently large series, and the incidence of blood donors belonging to a certain group will equal the number of recipients of the same group. But the number of units kept in stock is not large enough to satisfy the law of probabilities. Furthermore one or two patients may be in the hospital simultaneously who require large amounts of the same type. Weeks may pass before the drain on that group is compensated for. We have had two patients who used 10 to 15 pints of group "O" blood in one

week. This depletes the stock of that particular group. Then if and when donors come in for these patients, invariably we will find they are mostly "A" or "B" and maybe only a few "O's". These results do disturb the proportion of the groups in the bank sometimes for weeks.

We have on hand a supply of Witesbky A & B specific substance for use with type "O" blood when we do not have the required type. This neutralizes anti-A and anti-B isoagglutinins. As a general thing about 80 per cent of our stock is used in the first 8-10 days of storage. This is true of the common O or A groups especially. In general the rare types remain much longer. We have found that when we have one patient of the rare types two more patients turn up and we quickly deplete our stock of rare types or RH negative.

No exact figure can be given for the optimal stock to be carried in a hospital of our size. If an average of 100 transfusions a week are given, we like to have about 70 to 80 units in stock. We are averaging around 80 units in both banks at this writing. We can use the blood up to 21 days, after which time the plasma is aspirated off into a plasma pool. We use about 9 or 10 units to make a pool.

A large number of our units of blood are given to house cases. We attempt to contact their families or friends in an effort to get replacement donors on these cases, but have a minimum of success. We send out a card showing the indebtedness of the patient which is to go to his family, but feel that the doctor on the case can do a great deal more by talking to them and explaining the necessity of sending in donors. However, in some cases there are neither family nor friends as we know. In these cases we use credit from hypertensive or altruistic persons who have given to the bank to be used where needed. The latter however are far from adequate to supply the existing demand.

The average patient has a limited number of friends and relatives who can qualify as blood donors and are willing to donate blood. You would be amused at the number who are perfectly able to donate, but who are afraid. We feel we are gradually educating them, but it takes such a long time to do it.

The story of not being the same type is a thing of the past, inasmuch as we take any type when it is a matter of replacing blood used. At times we run out of the type required and then only do we call for the family to come in and be typed, hoping to pick up a donor or the type required from his blood relatives. The fact that the patient can replace with any type is of advantage to him, particularly if he is of a rare type. Due to this fact, we require two donors for each transfusion given for the first three transfusions and one for one thereafter. When the patient has a great many donors, we pay him $12.50 for any over and above what is needed to clear his account. Patients pay the $10.00 service charge in this manner.

The professional donor who used to receive $50.00 for each donation of blood, is about a thing of the past. We now have a large donor file, from which we can usually contact a donor or donors of the type needed, who are happy to sell at $12.50 per pint. We make no difference in this set price for rare or RH negative blood. As a matter of fact, we seldom have to buy it. Usually an O or A is most in demand.

We have a few physicians who, knowing in advance that the patient is going to need considerable blood, tell him to send in donors in readiness. He calls and makes appointments for six to eight donors. These are taken and credited to his account. If the blood is not used, he still has his blood

credits to his account. The physician who sees that his patient knows about replacing the blood while he is still sick and in the hospital, is doing him a great favor, because the chance of getting donors decreases daily as he improves in health. If the patient expires, the chances of having it replaced are practically nil.

We are open from 8 a. m. to 4:30 p. m. every day, Sundays and holidays, and 4 days a week until 7 p. m. These hours satisfy the requirements of our potential donors. They may drop in after work, give blood, and then go home. We allow about 15 minutes to take blood pressure, test hemaglobin, take a history and a similar time for venipuncture and recovery afterwards. We give them some refreshment when we are finished. Our greatest number of donors in any one day at one Unit has been 26.

We have arranged with the Mahoning County Tuberculosis Sanatarium to accept units of blood from them, when they have extra units and send them units as they need it. We do no laboratory work on blood received; it has been done. They usually have a credit of four or five units. We also have an arrangement with the Crittenden Home to do a typing and RH on each patient. We get one donor for each, which is credited to the Home. Should a pint of blood be needed for any one, it is furnished without monetary charge. To date we have credited 10 pints and supplied one.

We have a pre-natal service also. The physician on obstetrics advises the patient to make an appointment for herself and husband. She has a typing, RH and Kahn done. Her husband gives a unit of blood and has his type, RH and Kahn. There is no charge for this. We have the blood. If she needs a pint of blood or more when she delivers she receives it. She pays service charge and is not reqired to obtain more donors. This year we have had 243 pre-natals and have used 46 units of blood on 31 patients.

We also have an out-patient department for transfusions at North Unit. After 10 a. m. the patient is taken to one of the basal metabolism rooms, given his transfusion, allowed to rest a while afterwards, and dismissed. The patient must arrange for his donors. We have had 19 this year using 43 pints of blood.

We have an affiliation with about 20 industries and organizations, in the way of donor banks. The largest of these are the Youngstown Sheet and Tube Benefit Association and the Post Office employees. Most of the industries in Youngstown and surrounding towns have organized donor clubs. Members come in by appointment to replace blood used by other members or their dependents.

The blood bank laboratory has been in operation since the Spring of 1947. It is a branch of the main laboratory. All typings, RH determinations and cross-matchings are done in this laboratory. A great many of the intravenous infusions and blood transfusions are started by our technician. The main laboratory does all the serology tests. I have been asked what we do about a positive Kahn. The laboratory reports to the blood bank that a Wassermann is being done. If this report is also positive a form letter is sent to the donor stating that when he gave blood the laboratory tests were equivocal, and he is advised to consult his physician for further tests. The physician can obtain the reports from the laboratory. The donor is not given any reports.

In conclusion, I would like to thank Mrs. Miles for the excellent slides, Dr. Patrick and Dr. Rogers for their help in making our blood bank one of the finest small blood banks in the country, and Dr. Giffen and Dr. Rappaport for their help and advice on our many problems.

OCTOBER MEETING

Speaker:

DR. DONALD KERR, D.D.S.

Assistant Professor of Pathology,
School of Dentistry,
University of Michigan

Subject:

"PERIDONTAL DISEASE"

Time:

8:30 P. M., October 18, 1949

Place:

Cascade Room, Hotel Pick-Ohio

This will be a joint meeting with the
Corydon-Palmer Dental Society

MANAGEMENT OF INFANTILE PARALYSIS IN ST. ELIZABETH HOSPITAL

St. Elizabeth's Hospital Staff recently announced its program for the management of infantile paralysis cases confined within the Hospital. It is as follows:

1. All acute Infantile Paralysis patients who are admitted to the Hospital shall be placed under the care of a "Polio" team consisting of at least a pediatrician, physiotherapist and an orthopedist.
2. Upon admittance, the patient's name shall be given to the County officer of the State Crippled Childrens' Service for investigation as to financial status. Those patients, child or adult, which would be classified as indigent by the Department of Public Welfare of Ohio shall be treated by a "Polio" team that is designated by the Hospital medical staff. Members of the team shall send fee bills separately and in accordance to the prevailing Crippled Childrens' Service schedule for non-operative Hosiptal cases (see below). These bills are to be sent to the county chapter of the National Foundation for Infantile Paralysis.
3. In the indigent cases it is also recommended that the family physician receive $25.00 for the diagnosis and other efforts he has made to get the patient to the "Polio" team.
4. Those cases which would not ordinarily be idigent cases under the standards mentioned above shall be considered private cases. A similarly composed "polio" team shall manage the care of such patients. However, the patient or parents and the private physician shall have a choice of the members of the team. The members of such teams shall send fee bills to the parent, as a private patient, and at prevailing private practice standards. Whether the Foundation Chapter aids in the payment of these bills is of no concern to the physicians but a matter of concern pertaining only between the patient, parent, and the Foundation. The private physicians on the team do not wish the Foundation to set or approve of the private fee schedules.
5. A patient receiving treatment by a "Polio" team shall have a pediatrician in charge of the case during the contagious, acute stage of three weeks or longer if the individual condition warrants it.
6. After the fever has ceased and further paralysis has stopped an orthopedist shall be in charge of the patient.
7. It shall be the duty of the physician in charge to have the rest of the team in attendance, as is required, in the management of the case.
8. The following fee schedule for the "Polio" team to be sent by each member of the team to the County Chapter of the National Foundation of the Infantile Paralysis on Indigent Cases is outlined below:

   (a) For the first three months or a fraction thereof $50.00.

   (b) Subsequent three months or a fraction thereof $30.00.

The above principles of management have been approved by those physicians most vitally concerned with the care of Infantile Paralysis Cases and bear the approval of the Executive Committee of St. Elizabeth's Hospital.

AGNOGENIC MYELOID METAPLASIA

Clinico-Pathology Conference

Youngstown Hospital Association

Clinical History: The patient, a 64 year old white male, was first admitted to the Youngstown Hospital on December 2nd, 1946, with the chief complaint of weakness. The present illness began one year previously, at which time there was a transitory loss of consciousness with complete recovery. During the year he noticed a progressive weakness wtih a loss in weight of approximately 10 pounds. There were espisodes of bradycardia associated with dizziness. During the seven weeks prior to admission, he developed extreme constipation and shortly before admission a mass was noted in the left upper quadrant. There was no dyspnea, edema or any complaints as to the gastro-intestinal tract. No history of any excessive bleeding tendency could be elicited. There was no history of chills or fever and no complaint of pain of any type.

Physical Examination: Blood pressure 140/70. Temperature 98.6. Pulse 94. Respiration 26. He was a well developed, well nourished white male appearing to be about the stated age. There was pallor of the skin and mucous membranes but no jaundice. Heart and lungs were normal to examination. Within the abdomen the liver could not be palpated. A mass was palpated in the left upper quadrant extending three fingers below the left costal margin. It was firm, non-tender and moved with respiration.

Laboratory Examination: Urinalysis: specific gravity 1.015; albumin and sugar negative; microscopic 3 to 4 white blood cells. Red blood count 2,360,000; hemoglobin 41% or 6.4 grams; color index minus 1. White blood count 10,800; differential: polys 65%, with 1 eosinophile, 20 stabs, 44 segs; lymphs 34%, monos 1%, 3 nucleated red cells. There was anisocytosis, poikilocytosis, polychromatophilia, hypochromia. Icterus Index 8 units. Fragility test 0.44% to 0.34%

Hospital Course: X-rays of the chest and gastro-intestinal tract were negative except for a displacement of the colon by the large mass in the left upper quadrant. Several bone marrow aspirations were performed. These showed a preponderance of the erythroid elements with an M/E Ratio computed to be 1-to-1 or 1-to-2. Erythroblasts and orthochromic normoblasts were present in large numbers. There was a good distribution of the myeloid series. An adrenalin test was performed and showed an increase in all cellular elements within the peripheral blood. He received several transfusions of whole blood and was discharged on the 15th of December 1946 with a diagnosis of "chronic anemia, due to hyperplastic splenomegaly."

Following this admission the patient was seen in one of the university centers and a diagnosis of "myelogenous leukemia" was made. He was started on a course of radio-active phosphorus.

Second Admission: January 9th, 1947. Symptoms and physical findings remained the same as on the first admission.

Laboratory Examination: Red blood count 2,120,000; hemoglobin 39% or 6 grams; color index minus 1. White blood count 11,950; differential: 81% polys with 1 basophile, 3 eosinophiles, 12 myelocytes, 15 stabs, 50 segs; lymphs 19%, normoblasts 15.

During his hospital stay he received four transfusions of whole blood. Following this admission the patient was seen numerous times at the university, and treatment with radio-active phosphaus was continued. His red count remained depressed and his white count remained slightly elevated.

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Normoblasts were always present and on several occasions myeloblasts and promyelocytes were detected in the peripheral blood. He received large numbers of transfusions with only transitory improvement in his symptoms.

Final Admission: September 30, 1947. He complainted at this time of anorexia, extreme thirst and constipation.

Physical Examination: revealed the patient to be poorly nourished, weak and pale. Temperature 101.2. Pulse 100. Respiration 32. Blood pressure 90/60 mm. No lymphadenopathy was found. Some dullness was detected in the right chest. The heart was slightly enlarged but not otherwise remarkable. There was a visible mass in the upper abdomen which moved with respiration.

Laboratory Examination: Red blood count 2,680,000; hemoglobin 36% or 5.5 grams. White blood count 11,650; differential: 92% polys with 1 basophile, 18 stabs, 73 segs; lymphs 6%, monos 2% and 4 nucleated red blood cells.

Hospital Course: Temperature and pulse remained elevated. He went rapidly downhill and expired October 6, 1947.

AUTOPSY FINDINGS

Gross: Inspection revealed a sallow color to the skin with small petechial hemorrhages over the anterior chest and in the mucous membranes of the lips. On section, 4,000 cc's of dark amber fluid was found in the right pleural cavity and 300 cc's of yellowish-green turbid fluid was seen in the peritoneal cavity. The pleura of the right chest was covered by a grayish-pink fibrinous exudate. The right lung was firm but some crepitus was noted thru-out. Grayish-yellow nodules measuring up to 1 mm. in diameter were seen beneath the serosa of the terminal ileum, appendix, cecum and recto-sigmoid. The liver weighed 2,710 grams. The cut section revealed irregularly defined grayish-yellow areas measuring up to 3 mm. The spleen weighed 2,000 grams. Cut section revealed the same grayish-yellow areas.

Microscopic: The pleural exudate was tuberculous. Very little of a tuberculous nature was seen within the lung parenchyma. The small nodules described on the serosal surface of the bowel also proved to be tubercles. Within the liver sinusoids were somewhat dilated and there were focal areas of extramedullary hematopoiesis in which all components of the bone marrow could be distinguished. The myeloid series predominated but erythroid series was also represented. Numerous large megakaryocytes were seen thru-out the sections. Within the spleen the follicles were preserved but they were not as prominent as usual. Areas of extramedullary hematopiesis resembling those in the liver were found.

The discussion was opened by Dr. A. E. Rappoport who pointed out that altho the diagnosis of leukemia was not made in this hospital, this laboratory and all concerned with the case readily accepted it. In retrospect, however, on the first admission the bone marrow findings were not those of leukemia and through-out the course numerous nucleated red blood cells in the peripheral blood was an almost constant finding. He stated that he believed this to be a case of a rather rare and little publicized condition known under many names, but probably best known as a *"agnogenic myeloid metaplasia."* Reference was made to an article by Jackson, Parker and Lemon of Boston which appeared in the New England Journal of Medicine of June 13, 1940. The authors reported 10 cases proved by histologic examination

to have this condition. All had an insidious onset and a slow course. In nine, the clinical and hematological picture simulated myelogenous leukemia. One was erroneously dignosed as "hemolytic jaundice." In their group the prominent symptoms were weakness, joint pain, anorexia, abdominal pain, epistaxis and loss of weight. In this condition, the spleen is enlarged, and the liver is frequently increased in size. Generalized lymphadenopathy does not occur but slight jaundice is common. The bone marrow picture varies greatly. It may be normal, aplastic, hyperplastic or fibrotic, but in no instances are changes of leukemia found. The spleen shows a varying degree of fibrosis and there are isolated foci of hematopoietic cells of various types representing both the granulocytic and erythroid series. As a rule, megakaryocytes are found and are often present in large numbers. Malpighian corpuscles are preserved. The spleen of leukemia, however, has a marked diffuse infiltration by immature cells of the granulocytic series. Malpighian corpuscles are completely obliterated as a rule, altho fibrosis may be present from irradiation. In the liver of agnogenic metaplasia the infiltration is focal but in leukemia it is diffuse. Leukemia infiltrates a large number of organs, whereas in the myeloid metaplasia usually only the liver and spleen are involved. The white count varies, but is usually moderately increased. Anemia may be normacytic, microcytic, or macrocytic and varies in degree. Nucleated red cells and more rarely normablasts are found almost constantly in the peripheral blood stream. Removal of the spleen or irradiation of the spleen is contra-indicated in this condition, and is usually followed by death within a short period of time.

JAMES R. GILLIS, M. D.

YOUNGSTOWN HOSPITAL STAFF MEETING

The regular monthly meeting of the Youngstown Hospital Association staff was held in the South Side Nurses Home September 6, 1949. The scientific program for the evening was presented by Mrs. Pauline M. Tweeddale, R.N., who reported on the operation of the Blood Bank.

Dr. R. W. Rummell, Medical Director of the Hospital, discussed the problem of obtaining internes for the coming year.

Plans were discussed for furnishing television sets for the House Staff quarters in both units.

Dr. O. A. Turner reported on the progress which has been made in attempting to establish a formulary for the hospital.

Dr. W. K. Allsop, president, presided at the meeting.

ACADEMY OF GENERAL PRACTICE MEETS

The regular monthly meeting of the Mahoning County Chapter of the American Academy of General Practice was held at the Stambaugh Nurses' Home Auditorium, Youngstown Hospital, September 13, 1949.

Dr. Harley S. Gibbs, Director of Industrial Medicine of the Carnegie-Illinois Steel Corporation, Pittsburgh, Penna., and a former Research Fellow in industrial medicine and hygiene in the University of Pittsburgh, presented a paper on "Chronic Lead Poisoning." An abstract of this paper will appear in a later issue of the Bulletin.

H. E. MATHAY, M. D., Secretary

FLUORESCEIN: AN ADJUNCT IN SURGERY OF EXTRAHEPATIC BILIARY PASSAGES

(Extracted from an article by G. J. Menaker and M. L. Parker in J. A. M. A., Dec. 4, 1948)

In surgical treatment of the biliary tract the surgeon is often faced with three major problems: first anatomic anomalies which occur rather frequently in this system, affecting particularly the cystic duct; second, distortion of the external biliary passages by inflammatory processes and adhesions, causing poor visualization of the ducts, and, finally, the absence or atresia of the extrahepatic biliary ducts, which is the most difficult and presents the most distressing problem of all.

Immediate cholangiography and dissection are the only aids which the surgeon possesses in the operating room. Dissection may be unsuccessful and dangerous, while cholangiography requires special equipment, is time consuming and is often of little assistance because of the difficulty in application and lack of information as to the third dimension.

The authors believe that they have found a method which obviates these difficulties and have established a procedure which may be an invaluable adjunct in this type of surgical procedure.

They have been able to demonstrate clinically and experimentally that fluorescein is excreted and concentrated in the bile to such an extent that under ultraviolet rays the hepatic and extrahepatic bile ducts appears in striking and contrasting yellow. Also, on section of the liver, large bile channels can be seen. These, they believe, can be cannulated, and this may prove to be the method of choice in surgical treatment for agenesis or stricture of the bile ducts. The timing of injection and observation is important and has been experimentally and clinically established. Chemical studies confirm the extreme usefulness of the concentrating power of the liver with respect to fluorescein. The solution used is 5 per cent solution of fluorescein in 5 per cent sodium bicarbonate. Various dosages are being experimented with, and quantitative determinations are being made on liver bile in both dogs and human beings. The authors have been able to visualize clearly the biliary passages in human beings in the operating room.

The use of fluorescein diluted by the blood stream has been described by Lange and his associates, and Crismon in a series of articles published since 1942. However, its application to its concentration in bile has not been described. In the Department of Surgery and Gastrointestinal Research of the Medical Research Institute of Michael Reese Hospital it has also been shown by urologists that it may be possible to use fluorescein for visualization of the ureter in view of the fact that fluorescein is also excreted in the urine.

It is the authors' impression that on completion of this work they will have a valuable adjunct in surgical treatment of the biliary system and possibly also the ureters, a procedure which is innocuous and simple in application.

E. R. McNEAL, M. D.

The American Academy of General Practice of Wayne County (Detroit, Mich.,) will hold its Third Annual Post Graduate Lectures on October 26-27, 1949, in the auditorium of the Henry Ford Hospital, Detroit, Mich. The program will be presented by the staff of the Henry Ford Hospital. No registration will be charged members of the American Academy of General Practice, while non-members will be assessed $5.00. Information and hotel reservations may be obtained from Dr. Karl L. Swift, 869 Fisher Bldg., Detroit 2, Mich.

COUNCIL MEETING

The regular monthly Council meeting of the Mahoning County Medical Society was held at the office of the Society, 125 W. Commerce St., on Monday, September 12, 1949 at 9:00 P. M. The following doctors were present: J. N. McCann, V. L. Goodwin, L. H. Getty, I. C. Smith, R. E. Odom, G. G. Nelson, E. J. Wenaas, C. A. Gustafson, W. M. Skipp, John Noll and G. M. McKelvey, comprising a quorum of the Council. Also present were Dr. F. S. Coombs, Dr. M. S. Rosenblum and Dr. A. Goudsmit.

Doctors Rosenblum, Coombs and Goudsmit are members of the Committee on Diabetes of Mahoning County Medical Society. They outlined the work being done in other parts of the country and asked Council's opinion on matters of importance. The campaign will be conducted from October 10, 1949 to October 16, 1949.

The Council, appreciating the good judgment of the committee, instructed them to carry on the campaign as they see fit, and report back to Council. The committee consists of the following doctors: M. S. Rosenblum, Chairman, S. Goursmit, F. S. Coombs, W. S. Curtis, H. H. Ipp, Robert Kiskaddon, M. M. Yarmy, H. J. Reese, W. J. Tims, E. J. Wenaas, H. E. Mathay, P. H. Kennedy, J. R. Buchanan, and G. E. DeCicco.

Dr. James Patrick, now taking a three year Postgraduate course, asked the status of his dues during that time.

A motion was made, seconded and duly passed to notify Dr. Patrick that during the course of his Postgraduate work he is to pay state dues only.

V. L. GOODWIN, M. D.
Secretary

SIXTH COUNCILOR DISTRICT
POST GRADUATE ASSEMBLY
PICK-OHIO HOTEL, WEDNESDAY, NOVEMBER 30, 1949

	9:00 to 9:30	Registration
1.	9:30 to 11:30	Discussion of Lesions of the Stomach and Duodenum
		(a) Medical Approach and Management — Dr. Sara M. Jordan
		(b) Surgical Therapy — Dr. Samuel F. Marshall
2.	11:20-12:00	The Painful Shoulder with Particular Reference to Subacromial Bursitis — Dr. James W. Toumey
		Visit Exhibits between sessions
3.	1:30- 2:00	Panel-Complications of Chronic Ulcerative Colitis — Dr. Sara M. Jordan, Dr. Samuel F. Marshall
4.	2:00- 2:45	Diagnosis and Management of Bronchiectasis — Dr. Carlton R. Souders
5.	2:45- 3:30	Cicatrizing Enteritis — Dr. Samuel F. Marshall
	3:30- 3:40	Intermission
6.	3:40- 4:25	Pulmonary Carcinoma—Clinical Features — Dr. Carlton R. Souders
7.	4:30- 5:00	Panel—Combined Medical and Surgical Problems — Dr. Sara M. Jordan, Dr. Samuel F. Marshall, Dr. Carlton R. Souders, Dr. James W. Toumey
8.	5:00- 5:40	Diagnosis and Treatment of Low Back and Sciatic Pain — Dr. James W. Toumey
	6:15	Dinner
9.	7:30- 8:30	Diagnosis and Management of Functional Disorders of the Digestive Tract — Dr. Sara M. Jordan

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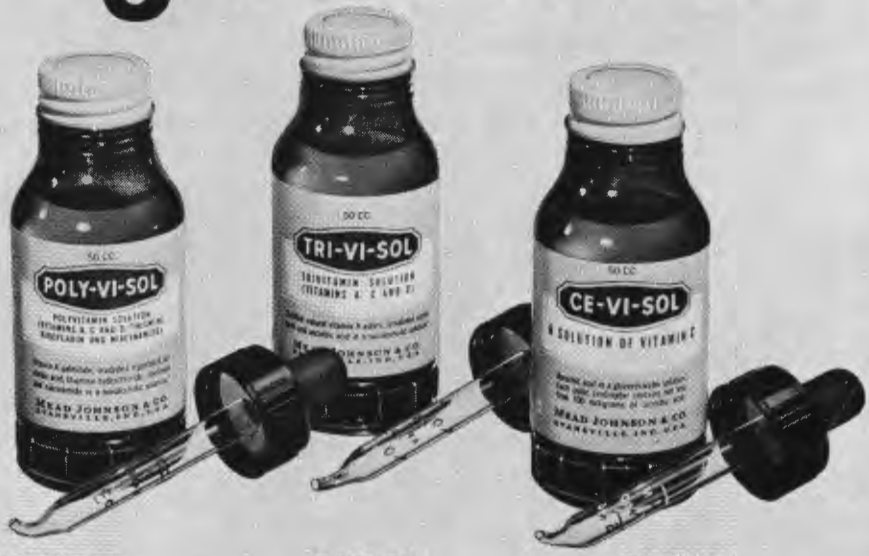

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