No man should so act to take advantage of another's folly.

—Cicero

BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

Youngstown, Ohio
VOL. XX No. 1
ANUARY • 1950

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	G. M. McKELVEY	W. M. SKIPP	

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Vol. XX—No. 1 **January, 1950**

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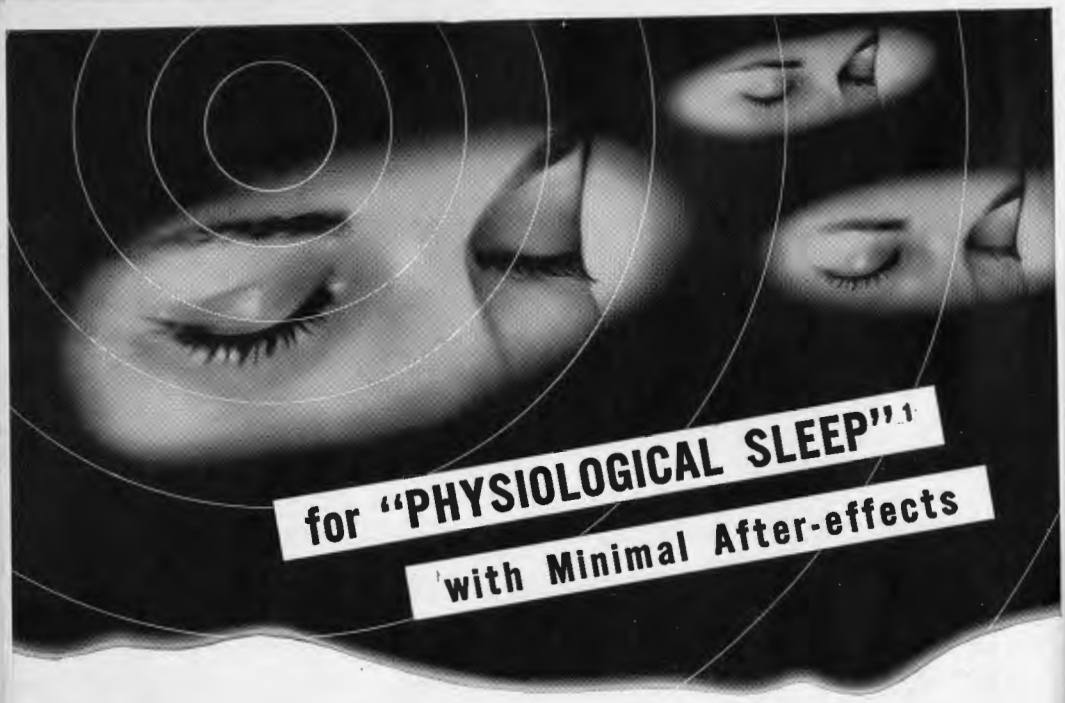

Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has ". . . caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."[2]

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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles.

Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.

FELLO-SED

FORMULA: Each fluidram (4 cc.) contains, in a palatable aromatic vehicle: Chloral Hydrate, 0.5 Gm. (7½ gr.); Calcium Bromide, 0.5 Gm. (7½ gr.); Atropine Sulfate, (1/480 gr.).

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MEDICAL CALENDAR

1st Tuesday	Monthly Staff Meeting, Youngstown Hospital, Auditorium—Nurses' Home
8:30 p. m.	Monthly Staff Meeting, St. Elizabeth's Hospital, St. Elizabeth's School of Nursing
Sunday following 1st Tuesday 11:00 a. m.	Monthly Surgical Conference, St. Elizabeth's Hospital Library
2nd Monday 9:00 p. m.	Council Meeting—Mahoning County Medical Society—Office of the Society—Schween-Wagner Bldg.
2nd Tuesday 11:30 a. m.	Monthly Medical Conference, Youngstown Hospital, Auditorium—Nurses' Home
8:30 p. m.	American Academy of General Practice, Youngstown Hospital Auditorium—Nurses' Home
3rd Tuesday 8:30 p. m.	Monthly Meeting—Mahoning County Medical Society—Elks Club, 220 W. Boardman St.
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.	Clinical-Pathological Conference, St. Elizabeth's Hospital Library
Every Friday 11:30 a. m.	Clinical-Pathological Conference, Auditorium Nurses' Home, South Side Unit Youngstown Hospital
Every Friday 2:00 p. m.	Conference—X-ray Dept., St. Elizabeth's Hospital
11:00 a. m. Alt. Saturdays	Obstetrical Section—North Side Unit of Youngstown Hospital

COMING MEETINGS

Annual Congress on Medical Education and Licensure, Chicago, Feb. 5-7.

American Academy of Orthopedic Surgeons, New York, Feb. 11-16.

American College of Physicians, Boston, April 17-21.

PRESIDENT'S PAGE

★ ★ ★

The coming year promises to be one of importance for the medical profession. Our friend Mr. Ewing returns from Europe with his enthusiasm for socializing medicine dampened not one bit. He states that the cost of free wigs, teeth and crutches doesn't amount to a "hill of beans." Certainly, each doctor in this country should do his part to see that our profession is not hampered by the monstrous evil whose influence has swept thru all the world and is now threatening the shores of the only free nation on earth. It is not amiss to mention here the work which the A. M. A. is doing, and the only sad thing about it is that it should have been started years ago. I believe that thru the medium of lay education this organization has started, the public at large has, to a certain extent, been made conscious of the contributions which an unfettered medical profession has made toward the health and welfare of our people. However, it is only a dent, and there must be no let up in our support. The dues have been increased by the A. M. A. because the cost of everything has gone up and the added expense of the new program must be borne by each doctor. The fate of medical practice as we know it is at stake. Mr. Ewing and others of his ilk at Washington have unlimited funds supplied by taxes which we pay, and if those individuals succeed in their plans we will have higher taxes and in addition we will have lost one of our prized possessions, the keystone in the arch of democracy, the right to be an individual. Let us give our support one hundred percent.

GORDON G. NELSON,
President

BULLETIN of the Mahoning County Medical Society

Published monthly at Youngstown, Ohio — Annual Subscription, $2.00

VOLUME 20 — JANUARY, 1950 — NUMBER 1

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

F. S. COOMBS, *Editor*
275 W. Federal St.

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DR. SKIPP REPORTS ON A. M. A. CONVENTION

With the report in newspapers that the American Medical Association at its December meeting in Washington, D. C., had voted to collect dues of $25 per year per member, the Editors of the *Bulletin* asked Dr. W. M. Skipp, delegate to the A. M. A. to comment on the meeting.

Dr. Skipp reports that payment of the $25 will be made through the county and state organizations upon notification by county secretaries. He went on to point out that the resolution establishing the system of annual dues was adopted unanimously by the House of Delegates.

Some of the interpretations of payment are as follows:

Payment of the $25 will not make a doctor a Fellow of the A. M. A., but is simply a requirement for membership. Fellowship will be granted on separate application only.

Non-payment will not affect county or state membership, providing those dues have been paid. Thus non-payment will not affect hospital appointments as the lay press erroneously pointed out. Non-payment of dues after notice of delinquency (13 months) will result in forfeiture of membership. Possible consequences of loss of membership in the A. M. A. may result in connection with other special societies and specialty boards who require membership or Fellowship in the A. M. A.

Dues will not be assessed physicians who are not active members of their county societies or physicians who are certified as being financially unable to pay.

Dr. Skipp further noted that 80 percent of the doctors who were eligible to pay the assessment last year did so.

Short comments by Dr. Skipp on resolutions and reports of general interest to the profession follows:

Internships in general practice are being established in many hospitals.

Resolution that hospitals set up a section on General Practice was approved.

Resolution that each state organization set up a Patients' Grievance Committee was approved.

two simple twists . . . 5 seconds

Time saving is made easy with the newly designed disposable syringe for **'Duracillin'** (Crystalline Procaine Penicillin—G, Lilly). Just two simple twists of the wrist, and it's ready to use. Because it is presterilized and the dosage premeasured, it eliminates needless bother—saves precious time. Take this less pressing moment to order a supply for the daily occasions when every second counts. Complete literature on disposable syringes for **'Duracillin'** is available from your Lilly medical service representative or will be forwarded upon request.

Resolution that 1,500 blood banks in U. S. A. adopt standardized equipment so it can be interchanged was approved.

Resolution that A. M. A. approve full-time health commissioners wherever possible was approved.

Resolution disapproving Senate Bill 1453 was adopted. This bill has to do with federal grants to medical schools. The money would be apportioned on the authority of the surgeon general of the Public Health Service.

JANUARY MEETING AT ELK'S CLUB

The Mahoning County Medical Society will have a new home for its monthly meetings at the Elk's Club, 220 W. Boardman St.

The first gathering at the Elk's Club will be for the January 17 meeting at which time Dr. George Crile Jr., surgeon at the Cleveland Clinic, will talk on "Some Problems in the Treatment of Peptic Ulcer." Dr. Crile's father was a frequent visitor to Youngstown for talks and medical consultations, but this is the first time that the Younger Crile has appeared before our society.

The meeting at the Elk's Club will be at the usual time at 8:30 p. m. and will be held in the large lodge room. The usual telephone accommodations will be available during the meeting. The telephone number at the Club is 4-5011.

Members of the Society will be extended the privileges of the Club on meeting nights.

Present plans call for holding the annual banquet in March at the Elk's Club.

NEW OFFICERS ELECTED

With the start of 1950 Dr. Gordon G. Nelson assumed office as president of the Mahoning County Medical Society. The new president-elect is Dr. Elmer J. Wenaas who was named to the position at the Society's annual election of officers December 20 in the Pick-Ohio Hotel.

Dr. G. E. DeCicco was elected secretary and Dr. L. H. Getty was re-elected treasurer. Dr. Vernon L. Goodwin, the retiring secretary was elected to a three-year term as delegate to the Ohio State Medical Association. The other two delegates whose terms are still in force are Dr. W. M. Skipp and Dr. Ivan C. Smith.

Alternate delegates to the Ohio State Medical Association for one year terms are Drs. R. E. Odom, J. C. Vance, and C. A. Gustafson. Dr. H. E. Patrick was re-elected as the Society's representative on the board of directors of the Associated Hospital Service.

Dr. John N. McCann, the retiring president, thanked the members of the Society and committee chairmen for their co-operation during the past year. He cited the work of Dr. C. A. Gustafson, who retires as editor of the *Bulletin*, during the last five years.

Mrs. Mary Herald, executive secretary of the Society, reported that the Mahoning Medical Service Foundation was ready to function and that the Mahoning County Commissioners, through the efforts of Attorney Franklin B. Powers, legal counsel for the Foundation, were to arrange for payment for services of hospitalized cases, beginning early in 1950.

A buffet luncheon was served to the more than 100 members who turned out for the election.

Evidence that Pyribenzamine aborts the Common Cold

Of three antihistaminics tested in the common cold, Gordon[1] found Pyribenzamine "equally or superiorly effective in controlling symptoms and producing fewer and less severe side reactions."

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Results of Treatment of the Common Cold with Pyribenzamine

Investigator	Number Treated	Benefited	%
Gordon[1]	252*	224	89
Murray[2]	494	397	80
Brewster[3]	466*	348	75

*Includes patients treated with other antihistaminics

1. Gordon, J. S.: Laryngoscope, 58:1265, Dec. 1948
2. Murray, H. C.: Indus. Med. 18:215, May 1949
3. Brewster, J. M.: U. S. Nav. M. Bull. 49:1, Jan.-Feb. 1949

THREE THERAPEUTIC APPROACHES

1. Pyribenzamine-Ephedrine for systemic treatment

Each tablet contains 25 mg. of Pyribenzamine hydrochloride and 12 mg. of ephedrine sulfate. This combination synergistically promotes decongestion of the entire respiratory tract including the nasopharyngeal mucosa.

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Immediate relief of allergic symptoms with no systemic side effects. Pocket-size nebulizer distributes a mist of minute droplets of Pyribenzamine hydrochloride Nasal Solution 0.5% throughout nasal passages.

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CARCINOMA OF THE LARGE BOWEL

By Paul J. Fuzy, M.D.

This evening it is my aim to review carcinoma of the large bowel. I will try to hold your interest for awhile to show the advances made in Proctology.

Sulfa and the antibiotics have really revolutionized the treatment of the large bowel lesion. Before the use of sulfa and the antibiotics, the simple handling of the colon, seemingly caused germs to "ooze" through its wall and contaminate the peritoneum, the wound and the operator's gloves. The result was that practically all wounds were infected and peritonitis was always feared. I had adopted the method of closing the wound up to the skin, which was left open for secondary closure, because closed wounds almost always were infected. Then came sulfa, later penicillin and streptomycin. Today, we not only handle the colon, but open it up widely, and anastomose it end to end, contaminating the wound with the contents of the colon. The wound is closed. Peritonitis and wound infection is the exception. This is truly a remarkable advance.

At a recent surgical conference on "the spastic colon", the question was asked, "how do we know what symptoms to look for in a patient with a 'spastic bowel'?" That was a good question. Along the same line, how do we know what to look for when a patient with a lesion of the large bowel comes in to see us? It might seem elementary for me to tell you that the contents of the right colon is liquid, therefore a carcinoma in the ascending colon will give no obstructive symptoms because the liquid will pass through a small opening. Obstructive symptomatology will not develop until the obstruction is complete. That does happen occasionally. An unexplained secondary anemia is often all we find at first. You may feel a mass. In an unexplained secondary anemia, consider three things.

1. Carcinoma of the right colon.
2. Bleeding hemorrhoids.
3. Meckle's diverticulum.

A carcinoma of the transverse colon presents practically the same symptomatology as the right colon, because the liquid stool has not yet become dehydrated, it's still semi-liquid and will pass through a decreased lumen. The lesion on the left will show bowel changes. An individual who has been normal in bowel habits, develops constipation. A carcinoma in the rectum presents symptoms of "diarrhea." It is not a true diarrhea. The patient passes feces usually once a day, but he goes to the toilet anywhere from four to ten times a day and passes mucus and gas. He thinks it's diarrhea, but it isn't. It is a muccorrhea. An adenocarcinoma is a glandular carcinoma, the mucous glands of which are increased in number and pour out mucus in large quantities. The center of the mass becomes ulcerated, and forms an ideal medium for the gas forming organisms. This excess of mucus and gas is the "diarrhea" that is so distressing. Bleeding may or may not be present.

Seventy percent of carcinomas of the large bowel are within the reach of the examining finger or the sigmoidoscope. The inverted position or Simm's position should be used for digital examination of the rectum. If a patient deserves a barium colon x-ray, he deserves first a digital examination, if not a sigmoidoscopic, especially in diarrheas. The x-ray occasionally fails to show a lesion in the bowel, but if symptoms persist, repeat the x-ray study.

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Each Teaspoonful (4 cc.) contains:

Thiamine Hydrochloride	2.5 mg.
Riboflavin	3.5 mg.
Niacinamide	25.0 mg.
Pyridoxine (B_6)	0.056 mg.
Calcium Pantothenate	2.5 mg.

plus Choline, and other factors of the B-Complex present in the natural base. The Riboflavin content is derived entirely from natural sources.

BASE: Rice Bran, Corn, Liver Concentrate

SUPPLIED: in 4-oz. Rx size.

formula:

Each Capsule Contains:

Thiamine Hydrochloride	10 mg.
Riboflavin	15 mg.
Niacinamide	100 mg.
Pyridoxine	1 mg.
Calcium Pantothenate	10 mg.
Choline Dihydrogen Citrate	20 mg.
Inositol	20 mg.
Folic Acid	0.25 mg.
Liver Extract (secondary)	100 mg.
Brewers' Yeast Extract	100 mg.

plus other factors of the B-Complex present in Whole Liver.

BASE: Liver and Yeast.

SUPPLIED: in 50's and 1000's.

1. Jolliffe, N., Special Article, Council on Foods and Nutrition: The Preventive and Therapeutic Use of Vitamins, J.A.M.A., 129:61 Oct. 27, 1945.
2. Lewey and Shay, Dietotherapy, Philadelphia, W. B. Saunders Co., 1945, p. 850.

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It has been shown that carcinoma of the large bowel extends laterally in the wall of the bowel 2 cm. This is important in resections. One must divide the bowel at least 2.5 cm. to 3 cm. on each side of the lesion to prevent local recurrence at the suture line.

Types of Operations

1. Resection of caecum: The ascending colon is divided about 6 cm. distal to the lesion, the terminal ileum is divided about 6 cm. proximal to the ileo-caecal valve. The proximal ascending colon is closed and the proximal ileum anastomosed into the side of the ascending colon. The anastomosis is done with the lumen of both bowels open.

2. Carcinoma of ascending colon or hepatic flexure of the colon: The ileum is divided 6 or 8 cm. proximal to the ileo-caecal valve. The entire ascending colon and right half of transverse colon is removed. The open end of the transverse colon is closed. The ileum is anastomosed to the transverse colon. The procedure is known as a right hemi-colectomy with ileo-transverse colostomy.

3. Lesions of the transverse, descending and sigmoid colon. The lesion bearing area can be excised and the cut ends anastomosed, end to end.

4. Lesions in the rectum: Abdomino-perineal resection consists of complete removal of the rectum and lower sigmoid, with the establishment of a permanent colostomy. Today, no bag is worn by a colostomized individual. It is controlled by diet, and regular irrigations. In fact, many require a mild laxative after a year or so. They wear a piece of gauze over the colostomy stoma.

5. Anterior resection: For a lesion in the upper rectum. Years ago it was thought that it was necessary to preserve the superior hemorrhoidal artery to the rectum, if one wished to anastomose it to the sigmoid. We know that this is not necessary. The superior hemorrhoidal artery can be divided, as in abdomino-perineal resection. Collateral circulation from the middle hemorrhoidal artery will supply the suture line from below. In this operation we proceed as in combined abdomino-perineal resection, dividing the superior hemorrhoidal artery about 1½ inches below the bifurcation of the aorta. The rectum is separated from the hollow of the sacrum posteriorly, and from the bladder or vagina anteriorly, depending on the sex of the patient. The lateral attachments of the rectum are also divided. This mobilization allows the rectum to be drawn up into the wound and if it can be divided 3 cm. below the lesion, it can be anastomosed to the sigmoid. The cut ends of the rectum and the sigmoid are opened and inspected. They are then anastomosed end to end.

Before we had sulfa and the antibiotics we could not safely do this procedure, which allows us to save rectums, that formerly were sacrificed. A word of caution here. One must feel that there is no retrograde lymphatic spread to the nodes along the superior surface of the levator ani muscles.

I wish to compliment Dr. Tims for his paper on polyps. In my opinion one hundred percent of carcinomas of the large bowel originate as polyps. Multiple polyposis is a condition in which the rectum and the sigmoid and the rest of the colon is involved with multiple polyps anywhere from five to hundreds. This is usually a familial inherited disease. Practically all become cancerous. All of those individuals must or should have their colons removed. In such an individual if the polyps in the rectum can be fulgerated, desiccated or otherwise destroyed, the rectum can be saved and later when the colon is removed, the ileum can be anastomosed to the top of the rectum, or ileo-proctostomy.

Patients admitted to the hospital with a large bowel lesion causing complete obstruction, present a different problem. We have not the time to prepare them with sulfa. We've got to relieve their obstruction. If the complete obstruction is distal to the left half of the transverse colon, we do a loop transverse colostomy. Years ago we used to do a caecostomy with a catheter. I think that is inadequate. It does not adequately decompress, but a transverse colostomy does. Then, later we can do whatever type of resection that is indicated when the patient has had rest, and has been adequately prepared for major surgery. We recently had a case of complete obstruction in a patient who had a right hemicolectomy with an ileo-transverse colostomy, nine years ago for carcinoma of the ascending colon. He had complete intestinal obstruction involving all of his small bowel. A catheter ileostomy was performed. About two weeks later I resected a large carcinoma at the site of his former ileo-transverse colostomy and made him a new ileo-transverse colostomy. This patient is being prepared for a resection of another carcinoma of the rectosigmoid.

Carcinoma of the large bowel causes changes in metabolism. These patients have hypoproteinemia, anorexia, weight loss and anemia. They are in a state if vitamin deficiency too. If one sees a very large carcinoma in the rectum with metastatic involvement of the liver and marked enlargement of the liver, surgery is contraindicated. However, if, on opening the abdomen, you find metastatic involvement of the liver, but the carcinoma is resectable, the patient still deserves a resection. With a metastatic liver, after resection, he will gain weight, gain in his red count and feel better. Of course, he will die of carcinoma of the liver, but usually there is much less pain. If we cannot cure him of his carcinoma but can prevent him from having the terrible pains of a rectal carcinoma death, I believe it is our duty to do so.

I want to tell you how we prepare these patients on our service. We take seven days if possible to prepare them for surgery. We get a blood chemistry, consisting of N-PN, serum protein, serum chloride, cell volume and if necessary an AG ratio, CBC, urine daily, times four. The reason for the urine times four is that we can get an average of their specific gravity. If they need transfusions, it is given. We give them an adequate amount of blood. We give them betalin complex, 5 cc., 500 mg. vitamin C., 100 mg. nicotinamide by vein daily for seven days. They are given sulfathalidine, 3 to 4 grams four times a day. They get saline laxatives to empty the bowel. You'd be surprised, even with saline laxatives, how these lesions in the colon will not allow the bowel to empty completely. They seem to retain a large amount of stool. So, repeated saline laxatives are often indicated and we use daily enemata. We get a pre-operative x-ray of the chest. One or two days preceding operation, they get a gram of streptomycin by mouth in divided doses. We make free use of consultations, medical, urological, or whatever is necessary. They are allowed up and around, encouraged to drink water, and eat hard candy to increase their energy. At operation we use three pints of blood. Post-operatively, patients are given an adequate amount of opiate to keep them comfortable. The morning after operation a blood chemistry is taken to determine the patient's need for salt or protein. Peritonitis is rare. Atelectasis happens rather infrequently. Wound infections are not as common as formerly. Infarction and embolism occur in my patients as they do in general surgeon's patients. We try to control that with heparin, dicumarol and watching their pro-thrombin time. All patients are ambulated early, out of bed on the first post-operative day.

Summary

The Proctology Service of Youngstown Hospital reports to the Staff, the progress that has been made in large bowel surgery in the last ten years.

We emphasize the necessity of adequate pre-operative preparation, and have outlined our post-operative management of the surgical colon. We stress the fact that nutritional and chemical balance is essential to intelligent treatment.

We have tried to show how sulfa, antibiotics, and better understanding of anatomy, have made it possible for the proctologist to safely do types of operations on the large bowel today that formerly could not be done.

It has made it possible for us to save rectums, which formerly had to be removed.

The Youngstown Hospital has the only approved Residency in Proctology in Ohio. There are only eleven approved Residencies in the United States. May I, in closing, say that I feel that the Practice of Proctology in your Hospital is abreast of the times.

ST. ELIZABETH'S HOSPITAL STAFF MEETING

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

In the short scientific program prior to the business meeting, a movie film on "The Role of Gastroscopy in the Diagnosis and Treatment of Gastric Pathology" was exhibited.

The secretary-treasurer presented an analysis of hospital service for the month of November and the status of the staff treasury as of December 6, 1949.

The president lauded the work of the Record Committee headed by Dr. Harold J. Reese. The number of incomplete charts is at an all time low. Dr. Poling also thanked staff men for their co-operation in expediting the completion of charts.

The annual election of officers for 1950 then took place. Results of balloting are as follows:

President	Dr. R. B. Poling
Vice-President	Dr. R. E. Odom
Secretary-Treasurer	Dr. S. W. Ondash
Director of Department of Surgery	Dr. L. G. Coe
Director of Department of Medicine	Dr. M. W. Neidus
Director of Department of Obstetrics-Gynecology	Dr. P. L. Boyle
Director of Department of Eye, Ear, Nose and Throat	Dr. W. H. Evans
Additional members to the Executive Committee	Dr. R. V. Clifford
	Dr. I. C. Smith

Representative to the Associated Hospital Service Board, Dr. C. D. Hauser

Dr. Poling thanked the staff for its vote of confidence and for the splendid support given him by the general staff and all the committees. He stated that many constructive plans have been instituted during the year and that many others are being projected for the coming year.

The secretary presented a brief report of the Executive Committee meeting.

Stephen W. Ondash, M. D.
Secretary

• PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN •

SIXTH COUNCILOR DISTRICT

The Mahoning County Medical Society was host to the other physicians of the Sixth Councilor District of Ohio Wednesday, November 30, 1949 at an all-day Post Graduate Meeting in the Pick-Ohio Hotel in Youngstown. Three hundred nineteen physicians from the district were registered for the meeting and over 200 attended the banquet which climaxed the activities for the day.

The scientific program started at 9:30 a. m. and was presented by the following physicians who are members of the staff of the Lahey Clinic, Boston, Mass.: Dr. Sara M. Jordan, Dr. Samuel F. Marshall, Dr. Carlton R. Souders, and Dr. James W. Toumey.

Dr. Paul A. Davis, Akron, sixth district councilor, presided at the banquet. The day's activities were in charge of a committee headed by Dr. Alexander K. Phillips, of the Mahoning County Society.

UNCLE DUDLEY

We remember the advice of our teachers in our youth not to imitate but to strive to be original. We have noticed, however, that imitation may lead to original and independent thinking. Quality isn't contagious, but through contact, something enters one's soul.

★ ★ ★

The desire to have others think well of us continues to be a constructive power in our lives as long as it does not force us into superficiality.

★ ★ ★

Strictly speaking, there is no present. But that infinitesimal line between what was and what will be has been responsible for the eternity that has gone without recall and will give form to the eternity yet unborn. Yet there it is, and in these successive evanescences we must shape our course.

FORMS CIVIC SYMPHONY

Members of the medical profession who play musical instruments are invited to become members of the Community Civic Symphony Orchestra which is being formed under the directorship of Michael Ficocelli.

Mr. Ficocelli has announced that rehearsals will be held at eight p. m. on each Tuesday night at the Strouss-Hirshberg Music Center, Wick Ave., beginning in January. He is especially interested in obtaining drummers, brass and wood-wind instrumentalists, though a few more string instrumentalists can be used.

The director has announced that a picture of the group will be taken shortly after organization. He has urged as many interested musicians as possible join the orchestra early so that they will be included in the picture.

This orchestra will be for adults, another group being formed for children under the same direction.

It is planned to arrange for a series of broadcasts through local radio stations after organization and sufficient rehearsals.

JANUARY MEETING

Speaker:

DR. GEORGE W. CRILE, JR.

Attending Surgeon, Cleveland Clinic

Subject:

"Some Problems in the Treatment of Peptic Ulcer"

Time:

TUESDAY, JANUARY 17, 1950 — 8:30 P. M.

Place:

ELKS CLUB, 220 W. Boardman St.

Note the Change of Meeting Place

Roster of Mahoning County Medical Society

ACTIVE

Alden, A. H.
Allgood, John Evans
Allsop, W. K.
Altdoerffer, J. A.
Askue, C. M.
Autenreith, W. C.

Badal, S. S.
Baker, E. C.
Baker, W. Z.
Banninga, H. S.
Basile, J. M.
Bayuk, A. J.
Beede, R. W.
Belinky, D. A.
Belinky, N. D.
Benko, J. M.
Bennett, W. H.
Berkson, M. I.
Bierkamp, F. J.
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McCune, E. L.
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Young, W. P.

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Zeve, H. S.
Zlotnick, Sam
Zoss, S. R.

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Gambrel, F. J.
Goldcamp, R. R.
Kelley, W. J.
McNeal, E. R.
Shorten, E. A.

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PERIARTERITIS NODOSA

By D. F. Covert, M. D.

Periarteritis nodosa is in reality a misnomer in this disease since arterial and venous systems and all layers of the blood vessels may be involved. In the majority of cases there are no nodules present. Irving Wright suggests that essential vasculitis would be preferable, but essential polyarteritis would be the most acceptable.

About four to five hundred cases of this disease have been reported since it was first described in 1852. It has been found that it may occur at any age, from 10 days to 77 years old, but approximately 50 percent of the cases will occur in the fourth and fifth decades. Mortality rate in the past has been found to be rather high, about 90 to 95 percent, but as mild cases are recognized more commonly in the future, rates will have to be revised.

Various entities have been described in the past as the cause of periarteritis nodosa. Among these are syphilis, virus infections, and toxemia. Recently several cases have been reported associated with serum sickness following sulfonamide therapy and one author describes a series of nine cases in which bronchial asthma was associated with the disease. The presence of eosinophilia in a high percentage of the cases is suggestive of an allergic factor. Typical lesions of this disease have been produced in rabbits by the injection of various forms of foreign proteins and varied antigens. Wright states that hypersensitivity may ultimately be found to be the fundamental mechanism in a large percentage of cases and eventually will be proven to be present in all cases.

The pathogenesis of the disease may be divided into four phases:

1. Acute state in which necrosis occurs in the media of the large and small arteries.
2. Subacute phase in which there is inflammation with exudate.
3. Chronic phase characterized by the appearance of granulation tissue around the arteries and the beginning of healing.
4. Fourth phase in which the lumen is greatly reduced or obliterated and the wall is replaced by scar tissue and periarterial fibrosis.

The above classifications should be clarified by the statement that only a small segment of any artery may be involved; the other portion may not show pathological change; and that each of these processes may be present at the same time and blend into each other.

Since the blood vessels are involved in the suggested allergic reaction of the disease, any organ of the body may become the shock tissue if the vessels supplying it are involved. The percentage of organs involved, as determined by autopsy, has been found to be as in the following:

Kidneys—74%
Heart—66%
Liver—61%
Stomach—46%
Mesentery—38%
Muscles—30%

It has been found that secondary renal and cardiac insufficiency are common causes of death. Many deaths have followed profuse hemorrhage from ruptured arterial aneurysms in vital sites of the body.

(Editor's Note: The above was presented at a Clinical-Pathological Conference at South Unit, Youngstown Hospital, recently.)

The fundamental clinical observation regarding essential polyarteritis is its bizarre picture which may resemble almost innumerable diseases. The duration may be a few weeks to five months. The syndrome appears as a fairly acute or chronic sepsis with varied local manifestations. It is characterized by initial languor marked and progressive weakness, rapid emaciation, chills, fever, insomnia, and headaches. The signs of the disease may include fever, loss of weight, albuminuria, cylinduria, leukocytosis, anemia, tachycardia, abdominal symptoms, polyneuritis, polymyositis, edema, various cutaneous lesions, cardiac symptoms and signs, hepatomegaly and respiratory symptoms.

Four symptom syndromes have been described by Myer. These may include:

1. Chlorotic marasmus of Kussmaul and Maier.
2. Polymyositis and polyneuritis.
3. Gastro-intestinal disturbances resulting in surgery.
4. The nephritic syndrome.

Three types of skin and subcutaneous tissue changes have been noted in this disease. They are rash, edma, and subcutaneous nodules and any varied form of these manifestations.

As to the diagnosis of the disease, the most important factor in the recognition of essential polyarteritis is the physician's awareness of the existence of the disease and its vagaries. The extent of potential organic involvement has resulted in its confusion with a great number of diseases and a provisional diagnosis made in the beginning of this disease has included any of a great and a varied number of general infectious diseases, cutaneous conditions, and abdominal disorders.

One of the significant laboratory findings is a high white count which is often characterized by an eosinophilia in 30 to 50 percent of the cases. Marked atrophy and tenderness of muscles is often noted. The final diagnosis often is not made until the case has reached post mortem examination and can be substantiated in the clinical cases only by biopsy with microscopic examination.

Prognosis is generally fatal and the disease may last from a number of days to several years progressing in either an acute, subacute, or chronic form. Symptomatic treatment is about the only kind available. It has been found that sulfa drugs and penicillin therapy are of no value in the disease.

— BIBLIOGRAPHY —

1. Allen, Barker, Hines: Peripheral Vascular Diseases, P. 475. 1946
2. Cecil: Textbook of Medicine, P. 1189. 1944
3. Gelfand, M., and Aronoff, W: Periarteritis Nodosa—Possible Relation to Increased Usage of Sulfonamides, Annals of Internal Medicine 30: 919—May, 1949
4. Wright, I.: Vascular Diseases in Clinical Practice, Page 238. 1948.

DR. ALLSOP AGAIN HEADS YOUNGSTOWN STAFF

Dr. W. K. Allsop was re-elected to his fourth term as president of the staff of the Youngstown Hospital Association following the tallying of votes in balloting conducted by mail.

Dr. G. G. Nelson was re-elected vice-president, and Dr. E. C. Baker will continue as secretary-treasurer. Dr. W. H. Bennett will again represent the staff on the board of directors of the Associated Hospital Service.

COUNCIL MEETING

December 12, 1949

The regular monthly meeting of the Council of the Mahoning County Medical Society was held at the office of the Society on Monday, December 12, 1949. The following doctors were present: G. G. Nelson, V. L. Goodwin, E. J. Reilly, L. H. Getty, C. A. Gustafson, W. M. Skipp, E. J. Wenaas, I. C. Smith, J. Noll, R. E. Odom, W. J. Tims and Dr. F. S. Coombs, editor for the coming year was also present. Dr. G. G. Nelson presided in the absence of Dr. McCann.

Mr. Lamar Donahey and Mr. Lloyd Stillson, representatives of the Loyalty Group Disability Plan Insurance, presented some very interesting facts and figures about operations for a 34 month period from February 25, 1947 to December 2, 1949 and advised they would, with approval, re-open enrollment.

A motion was made seconded and duly passed approving the re-opening of enrollment plan conducted along the lines they followed in February 1947 and that the members be so notified by Donahey and Stillson.

The following applications were presented to Council.

FOR ACTIVE MEMBERSHIP

Dr. Elmore Rice McNeal, 36 Elva Ave., Youngstown, Ohio

Dr. Jerome B. Steckschulte, 701 Himrod Ave., Youngstown, Ohio

FOR ASSOCIATE MEMBERSHIP

Dr. Fred Ruhl Tingwald, 2218 Market St., Youngstown, Ohio

FOR INTERNE MEMBERSHIP

Dr. Irving H. Chevlin, 2004 Elm St., Youngstown, Ohio

Dr. George W. Cook, 3716 Market St., Youngstown, Ohio

Dr. Robert S. Donely, Jr., 1007 Central Tower, Youngstown, Ohio

Dr. Frank Gelbman, 250 N. Heights Ave., Youngstown, Ohio

Dr. Dean E. Stillson, 2914 Market St., Youngstown, Ohio

Dr. Edward M. Thomas, Home Savings & Loan Bldg., Youngstown, Ohio

Dr. Joseph Edward Tomayko, St. Elizabeth's Hospital, Youngstown, Ohio.

Dr. Wm. Breesmen, St. Eizabeth's Hospital, Youngstown, Ohio

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

The Secretary read a letter from Dr. E. C. Goldcamp in which he stated he was retiring from practice.

A motion was made seconded and duly passed to accept Dr. Goldcamp's application for honorary membership and present it at the next meeting of the membership for approval.

The Secretary read a letter from Dr. J. A. Patrick in which he asked the status of his dues inasmuch as he will be away for approximately two years taking a postgraduate course.

The Secretary was instructed to notify Dr. Patrick to pay only his state dues during the time he is doing Postgraduate work.

The Secretary read a letter from Dr. S. Schwebel in which he stated he would be away for approximately 2 years taking a postgraduate course and asked the status of his dues.

The Secretary was instructed to notify Dr. Schwebel to pay only his state dues during the time he is doing Postgraduate work.

The Secretary reported the results of the voting on the Postgraduate Day.

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Should Mahoning County Medical Society continue holding Postgraduate each year?

53 Yes 95 No

If so, should it be held on Wednesday or Thursday?

12 Wednesday 27 Thursday

Combine with 6th Councilor District?

112 Yes 29 No

A new meeting place was discussed.

It was moved seconded and unamiously approved by Council to make the suggested change to the Elks Club, but that it be put to a vote of the membership at the meeting December 20 for approval.

V. L. Goodwin, M. D.
Secretary

INFECTIOUS MONONUCLEOSIS

(Editorial The American Journal of Medicine December, 1949)

For the third time in this century Infectious Mononucleosis is enjoying a new peak of attention. The history of Infectious Mononucleosis can be divided into four periods:

1. Clinical description in 1885 ending in 1920 with discovery of the blood changes.
2. Hematological changes 1920-1932. During this period the disease became a clinical entity.
3. Serologic phase 1932-1944 dominated by Paul and Bunnells' discovery of the agglutination test.
4. Pathological description 1944 to present by Ziegler, Allen and Kellner, and Cluster and Smith.

The pathology of infectious mononucleosis is now clear and the basic lesion is a perivascular infiltration of both normal and abnormal lymphocytes found in all tissues, but bone marrow. It is one of the acute reticulo-endothelioses, almost certainly infectious and hardly bacterial in nature.

Many alarming symptoms and other clinical pictures occur depending upon the organ involved, such as: (1.) Guillan-Barre syndrome, encephalitis, or benign lymphocytic meningitis when the central nervous system is involved; (2.) Primary atypical pneumonia when lungs are involved; (3.) Infectious hepatitis when liver is involved; and, (4.) Splenic rupture usually in the third week.

The disease has been understimated both in regard to its total effect upon young population groups and in its potential harm to the individual patient. The incidence seems to be increasing not only in this country, but in England as it did following World War I. A carrier state is possible and there are many subclinical cases found in epidemics.

The treatment of infectious mononucleosis remains symptomatic and unsatisfactory. A new method of treatment that will probably receive study is the use of gamma globulin.

Infectious Mononucleosis is no longer properly regarded as a diagnostic curiosity or as a benign and unimportant disorder. The disease always impairs vital organs, frequently incapacitates, and occasionally kills.

E. R. McNeal, M. D.

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CHRONIC LEAD POISONING

By
H. S. GIBBS, M. D.
In Charge of Industrial Medicine
Carnegie-Illinois Steel Corporation

Chronic lead poisoning, one of the oldest known occupational diseases, is a diagnosis that is too frequently assumed and more frequently missed. It is a potential hazard of all occupations entailing an exposure to lead fumes resulting from the application of heat to lead coated or lead containing substances or from lead-containing dusts or mists arising from such occupations as enameling, spray painting, battery manufacture, etc. Many cases of non-occupational origin have arisen from drinking water which has stood in lead pipes overnight, thereby permitting a solution of a portion of the pipe by its contents.

In industrial cases the principal route of absorption into the body is by way of the respiratory tract whence it gains entrance into the blood stream by way of the pulmonary circulation. Having entered the blood stream, it is then stored in the various organs of the body and is excreted principally by way of the kidneys. Tetra-ethyl lead is absorbed through the skin and reaches the general circulation from that organ.

From a pathological standpoint the principal damage in lead poisoning is to the red blood cells; the membranes of which become brittle, with ultimate destruction of the cell and a consequent increase in hematoporphyrinuria, hemosiderin, and bilirubin. It is believed by some authorities that the increased porphyrin resulting from the disturbed hemoglobin metabolism is the basic cause of the symptoms seen in the so-called cases of "lead colic" and also accounts for the presence of the basophilic stippling found in the red blood cells of patients having an advanced form of this disease. Chronic lead poisoning may manifest itself in one or more of the three following forms, namely: (1) the alimentary type characterized by the predominance of abdominal signs and symptoms; (2) the neuromuscular type characterized by weakness of the extensor muscles and consequent "wrist drop" or "foot drop"; and (3) the central nervous system type, or lead encephalitis, in which the lead attacks the meninges of the brain, resulting in the production of cerebral edema and increased intracranial pressure.

The symptoms commonly associated with lead poisoning, namely, sweetish taste, malaise, loss of appetite, nausea, constipation alternating with diarrhea, "lead colic," headache, dizziness, tremor, wrist drop, foot drop, "lead line" on the gums, and secondary anemia are all frequently associated with non-occupational illnesses and are in reality late manifestations of frank lead poisoning rather than an early indication of over-exposure. There are no signs or symptoms pathognomonic of lead poisoning alone, and the diagnosis of over-exposure to this substance by the previously accepted criteria is frequently not possible to make with any degree of accuracy. This statement applies particularly to the stippled cell count; in that many authorities have shown that entirely too much confidence has been placed upon this test in the diagnosis of the disease, whereas many cases of chronic lead poisoning fail to show any increase in basophilic stippled cells whatever. In view of the fact that basophilic stippling is seen in such conditions as benzene, xylene, or toluene poisoning, arsenic poisoning, aniline poisoning,

(Editor's Note—The above is a resume of an address presented before the Academy of General Practice, Sept. 13, 1949 in the Nurses' Auditorium, South Unit, Youngstown Hospital).

gold or copper poisoning, pernicious anemia, secondary anemias, porphyria, poisoning by chlorinated hydrocarbons, hemolytic jaundice, polycythemia, leukemia, malignant toxemia, cachexia following malaria and neoplasms, and change to high altitude, it becomes readily apparent that the absence or presence of basophilic stippling contributes precisely nothing either on the negative or positive side of the diagnostic picture of chronic lead absorption or lead intoxication. However, because a definite relative amount of absorbed lead is excreted through the kidneys under both normal and abnormal circumstances, the determination of the urinary lead content of suspected cases of chronic lead poisoning furnishes a reliable diagnostic criterion in any final determination. The photometric dithizone method of urinalysis has been made specific for lead and is recognized as the most reliable method of detecting minute quantities of this substance in body fluids. Determinations are made on either "spot check" or 24-hour specimens, the latter being preferred. Concentrations in excess of 100 micrograms of lead per liter of urine are indicative of excessive lead absorption by the individual, and concentrations of 200 micrograms of lead per liter of urine warrant a diagnosis of chronic lead poisoning, whether or not the signs or symptoms of this condition are present.

In the differential diagnosis of lead poisoning one must consider the various conditions associated with the acute surgical abdomen, renal colic, gastric or duodenal ulcer, acute gastroenteritis, acute pancreatitis, coronary occlusion, and acute toxic porphyria due to other substances such as the barbiturates. However, if the physician will bear in mind that the so-called "lead colic" cases are in reality a form of acute porphyria and keep in mind Guenther's triad of symptoms associated with this latter condition, namely, nausea and vomiting, constipation, and severe abdominal pain with SOFT abdomen, he will not often be mistaken in his differentiation of this illness from the other conditions noted above. In the encephalitis type, of course, one must rule out brain tumor, infection, syphilis of the central nervous system, uremia, and the effect of other intoxications or poisons.

Treatment of chronic lead poisoning consists in removal of the patient from all further exposure to lead. Those cases in which the signs or symptoms warrant it are hospitalized. Abdominal pain is treated by the administration of 10 cc. of 10 percent calcium Gluconate intravenously every four hours continuing for two days after the cessation of the colic. Morphine or atropine are contra-indicated in these cases. Alcohols or barbiturates should be countermanded since they magnify the symptoms. Constipation is best corrected by the daily administration of ½ ounce of Epsom salts. Ferrous sulfate is given in sufficient quantities to correct the accompanying anemia. Experience has shown that large doses of a high potency Vitamin B complex formula supplemented with 100 milligrams of ascorbic acid daily will do much to rectify the neurological aspects of this condition. Rapid deleading of the patient is in our opinion unsound, as it entails the additional hazard of producing lead encephalitis by the sudden mobilization of excessive amounts of this material in the blood stream. The wrist drop or foot drop seen in cases of lead palsy are best treated by means of a cock-up splint supplemented by hydrotherapy, galvanic therapy and gentle massage. Lead encephalopathy is best treated by means of lumbar puncture, sedation, and the intramuscular injection of 25% magnesium sulphate solution every four to six hours.

Howard Mathey, M. D.

COURSES AT MICHIGAN

The University of Michigan Medical School has recently announced the following post-graduate courses to be given at Ann Arbor, Michigan, during the Spring and Summer 1950:

Internal Medicine

Diseases of the Gastro-Intestinal Tract	March 13-17
Diseases of the Heart	March 20-24
Rheumatic Disease	March 27-29
Recent Advances in Therapeutics	March 30-April 1
Endocrinology and Metabolism	April 3- 7
Diseases of the Blood and Blood-Forming Organs	April 10-14
Allergy	April 17-21
Electrocardiographic Diagnosis	August 28-September 2

Neurology	May 8-11
Ophthalmology	April 24-26
Pediatrics	April 12-14
Roentgenology, Diagnostic	April 17-21

For further information write to Howard H. Cummings, M. D., Chairman, Department of Postgraduate Medicine, Room 2040, University Hospital, Ann Arbor, Michigan.

CYNICAL SAM

The habit of having pleasant thoughts and looking on the bright side of everything does produce a marked effect on one's personality. When the doctor tells you that there is no good reason for your being elated because the pain in your belly has ceased, your looking on the bright side is going to be profitable for the mortician.

★ ★ ★

The cynical fellow who said agreeable people were people who agree with you, probably got tired of flattering himself and wanted some flattery to mix with his own.

★ ★ ★

Those who can look into reality must be content to be less companionable as their ability increases. Penetration into the reality enabled Mohammed to see that idols were nothing but waxed wood with flies sticking on them. His people didn't like that. Neither do ours!

SHEET & TUBE MALE CHORUS TO APPEAR WITH SYMPHONY

The next concert of the Youngstown Symphony Orchestra, Thursday, January 26, 1950, in Stambaugh Auditorium will feature the Youngstown Sheet & Tube Male Chorus under the direction of W. Gwynne Jenkins.

Guest soloists on the same program will be Alice T. McMichael, contralto, and Father Mathew Quaranta, baritone. Carmine Ficocelli will conduct the orchestra for the concert which will start at 8:30 p. m.

YOUNGSTOWN HOSPITAL ASSOCIATION STAFF MEETING

Dr. C. W. Sears presented two cases of "Hydatidiform Mole" at the monthly meeting of the Youngstown Hospital Association staff meeting Tuesday, December 6, 1949. Dr. Sears' talk was illustrated with lantern slides to show the pathological features of the lesion. Dr. Rollis R. Miller discussed the paper. Dr. W. K. Allsop presided at the meeting.

DR. KEOGH HEADS T. B. STAFF

Dr. Joseph P. Keogh was re-elected president of the staff of the Mahoning Tuberculosis Sanitarium in the recently conducted mail ballot. One hundred eight members of the staff cast ballots. Dr. M. W. Neidus was re-elected vice-president, while Dr. John Renner was chosen as secretary-treasurer. Drs. John Stotler and F. S. Coombs were elected to the executive committee.

Dr. Oscar O. Turner will speak on "Tuberculous Lesions of the Central Nervous System" at the next monthly meeting to be held Tuesday, January 24, 1950, in the auditorium of the Nurses Home, South Side Unit, Youngstown Hospital.

NEWS

Dr. J. P. Harvey was elected a Fellow of the American College of Physicians on November 14, 1949.

Dr. R. S. Lupse was recently elected to membership in the Cleveland Society of Obstetrics and Gynecology.

Health Department Bulletin

REPORT FOR NOVEMBER, 1949

	1949	Male	Female	1948	Male	Female
Deaths Recorded	159	102	57	177	111	66
Births Recorded	466	253	213	560	299	261

CONTAGIOUS DISEASES:	1949		1948	
	Cases	Deaths	Cases	Deaths
Chicken Pox	53	0	22	0
Measles	12	0	3	0
German Measles	1	0	1	0
Scarlet Fever	3	0	3	0
Whooping Cough	62	0	14	0
Mumps	10	0	1	0
Tuberculosis	11	0	1	3
Syphilis	30	0	31	0
Gonorrhea	40	0	18	0

VENEREAL DISEASES:

New Cases:	Male	Female
Syphilis	3	8
Gonorrhea	17	18

Total Patients 46
Total Visits to Clinic (Patients) 463

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

LIVER EXTRACT IN CIRRHOSIS OF THE LIVER

The course of cirrhosis of the liver has been observed in a group of 112 patients. 44 of these patients were treated in the conventional manner, i.e., a nutritious diet, large doses of vitamin B complex, and in many cases liver extract intramuscularly in doses of 5-10 cc. weekly. In the other 68 patients the same diet and vitamin therapy were used and in addition the liver extract was given in much larger doses intravenously. In the early part of the work the doses averaged 30 cc. weekly, but after the first year this was increased to 45 cc. weekly, then to 60 cc., and in the past year and a half to 100 or 120 cc. weekly.

The distribution of patients as to age, sex and nutritional state was similar to both groups. Jaundice was present in 61% of the conventionally treated patients (group 1) and in 52% receiving the liver extract intravenously (group 2). 39% of the patients in group 1 and 41% of the patients in group 2 had angiomata. Ascites was present in 77% of the patients in the conventionally treated group (group 1) and 96% of the patients receiving liver extract intravenously (group 2). The ascites was more severe in the latter group and 74% of the patients required paracentesis. Of this 74%, ascites was finally controlled in 70%

Of the conventionally treated patients (group 1) only 29% were alive at the end of the first year as compared to 65% surviving in group 2, who received the liver extract intravenously. At the end of 3 years, 12% of group 1 had survived and 48% of group 2 had survived. At the end of 5 years, 41% of the patients in group 2 were surviving. This survival is better than reported heretofore by other observers for groups followed for as long a period of time. Patek et al. (30) reported 32% survival at the end of 5 years. The patients in group 2 (liver extract intravenously) withstood an unusual number of paracenteses and the removal of very large amounts of ascitic fluid.

The serum albumin level in the majority of the patients did not rise until ascitic fluid reaccumulation was slowed or controlled. In the patients in whom ascites was never controlled, the serum albumin level remained low. In several cases, in spite of control of ascitic fluid reaccumulation, the serum albumin remained at a low level. The first laboratory finding to reflect or suggest any improvement was the ratio of free to total cholesterol.

Treatment with liver extract was continued in some patients for as long as 3½ years, and the total amounts of liver extract administered varied from 100 to 5000 cc. per patient. Increasing the amounts of liver extract given intravenously in the initial period of therapy, has seemed to control ascitic fluid reaccumulation more effectively and this has been associated with a more rapid increase in serum albumin. *Medicine*, September, 1949.

J. D. M.

THE INTERNSHIP

The transition to the residency system by the majority of our hospitals has placed greater emphasis on the resident staff of each individual hospital and to some extent a lesser emphasis on the intern. It goes without saying that the internship is—or should be—the time when the groundwork is laid for future success in a physician's chosen field. This is ideally accomplished by the usual manifold duties of the intern, plus daily contact with the attending staff and a certain amount of systematic teaching by the latter group.

It is imperative that in the care and teaching of the resident staff, all of whom are receiving specialized training, the intern is not slighted or overlooked. There is a tendency for the attending staffs to concentrate on the resident staff, which policy in some instances leaves the intern to fend for himself, and pick up the crumbs, so to speak. It is the duty of every hospital to see to it that the intern receives adequate instruction, in each and every service to which he is assigned. While it is true that the internship would not aim to produce a specialist in any given field, for this is the domain of the residency system, it should aim at the development of character, at teaching the intern to put into practice what he has learned of the uses as well as the limitations of instruments, of precision, learning to care sincerely and honestly for the sick, and at implanting and developing responsibility. This can only be accomplished by the attending staff of each hospital taking a decided personal interest in the intern and his future career.

It is well to remember that all interns do not automatically go on to residency training, and not every intern wishes to be a specialist—at least not at first—although after his period of training is up he may have a decided change of mind and for good reason.

Many of the internships today are of one year's duration. At the end of that time many interns manage to obtain a residency. Some do not. These men are in a precarious plight. Obtaining additional training is extremely difficult, competition being what it is today. In many instances an individual is forced to repeat the one year internship at another institution. If, in this repetition, they do not receive adequate teaching and instruction, of what value is the training?

A one year rotating internship, which is in vogue at many institutions, may be a good stepping stone for a residency, but it is not for general practice. Perhaps the shortage of general practitioners may be in part attributed to the fact that in meeting the various Board requirements in the training of specialists, our hospitals have neglected the training of well rounded general men.

In any event, this a good time to closely scrutinize the problems of the intern, and make careful evaluation of just what constitutes a good internship.

—*New York Medicine*

G.P. ACADEMY ELECTS OFFICERS

Dr. E. J. Reilly was elected president of the Mahoning Academy of General Practitioners at the annual meeting December 13, 1949, in the Nurses' Auditorium, South Unit, Youngstown Hospital.

Dr. H. E. Mathay was made president-elect, and Dr. D. H. Levy, secretary-treasurer.

Dr. H. K. Hellerstein, research fellow in medicine of Western Reserve University, presented an analysis of 2,000 cases of coronary thrombosis at the meeting. Members of the Youngstown Area Heart Association also attended the meeting.

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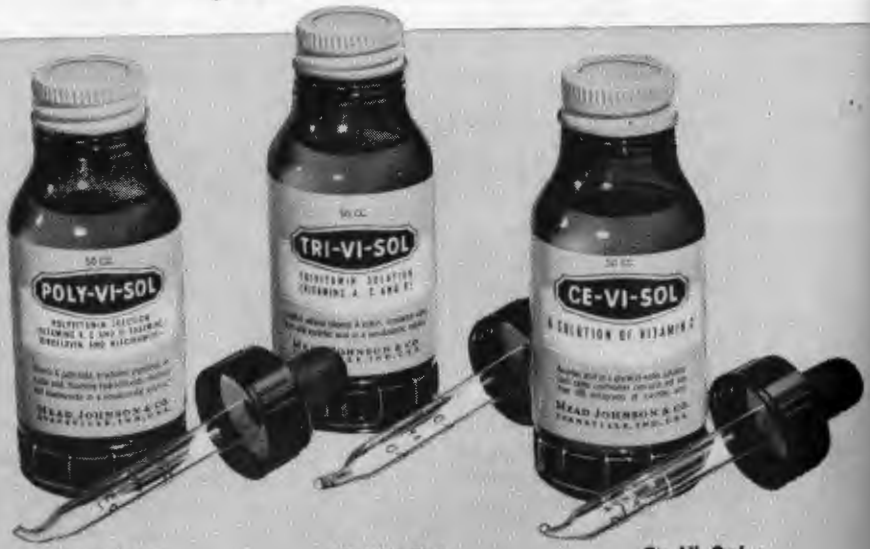

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