BULLETIN

of the
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COUNTY
MEDICAL
SOCIETY

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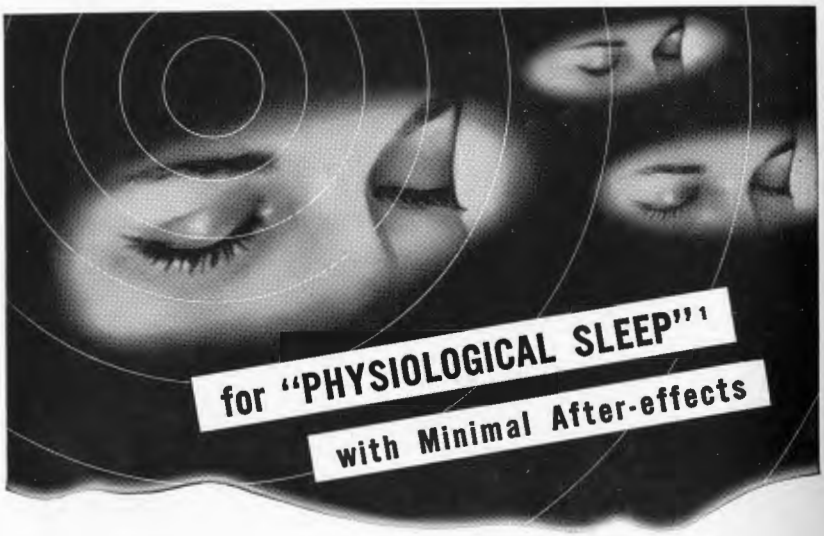

Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

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In FELLO-SED, supplementation with calcium bromide and atropine sulfate largely overcomes unwanted side-actions, enhances the sedative effect and provides valuable antispasmodic activity. It is presented in palatable liquid form.

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

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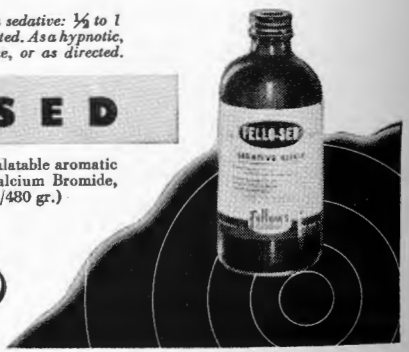

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OFFICERS AND COUNCIL

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Volume XXIII—No. 9 **September, 1953**

ADVERTISERS' LIST

Our President Speaks

Pessimism is easy but with us optimism is well justified. Nothing could be more inspiring than the wonderful unity and harmony between our Society and its Allied Professions. It is deeply satisfying to see the fine work done by our Canfield Fair Committee, headed by Dr. Szucs, Chairman, and Dr. Stertzbach in charge of Publicity.

In the interest of Public Health, it is gratifying to note that 92,250 people visited the exhibits.

Complimentary messages are pouring in, such as the following:

"The Mahoning County Medical Society and especially Dr. M. M. Szucs, are to be congratulated upon the splendid educational exhibit sponsored by the Mahoning County Medical Society at the Canfield Fair.

"The citizens of our community surely benefited from the screening services rendered and the educational information disseminated through the efforts of your Society and those related groups who helped with the project."

The above was expressed by Mr. Paul D. Keenan, Supervisor, Health Department, The Public Schools.

V. L. Goodwin, M.D.

BULLETIN of the Mahoning County Medical Society

Published Monthly at Youngstown, Ohio Annual Subscription, $2.00

VOLUME 23 SEPTEMBER, 1953 NUMBER 9

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

H. J. Reese
3720 Market Street

EDITORIAL

"LET'S ALL GO!"

Once again the membership of the Mahoning County Medical Society is beginning a new season of professional activity. All of us have heard the oft-repeated complaints that there are "too many meetings"; "they are too uninteresting"; "I don't go because I don't know the doctors." All of these complaints have been valid at one time or another. However, that time is now gone and a new era is facing us.

Cognizant of all of these complaints, and anxious to have our doctors come back to the Society meetings which once were so well attended, our Program Chairman, Dr. S. W. Ondash, and his energetic committee have spared no effort to answer all of the complaints. Fewer meetings will face us, because, wherever possible, the monthly Society meeting will be consolidated with other professional groups such as the Academy of General Practice, or the Heart Association, or the Diabetes Committee.

Meetings are uninteresting? Not any more! The program committee has really gone out to bring us only top-notch medical personalities who will speak on subjects of interest to all of us. For verification of this, a prospective program is printed elsewhere in this issue of the *Bulletin*.

You don't know the doctors? Come to the meetings and get acquainted. If you see someone you don't know, introduce yourself, he is a human being and will appreciate it. A *FREE* dinner with conviviality; and the opportunity to hear Dr. Melvin Casberg, the Assistant Secretary of Defense for Health and Medicine, speak on "Military Medicine." Those of us who have had the opportunity to hear Dr. Casberg, know his dynamic personality and forceful way of speaking. All of this is a combination which is unbeatable.

So, at 6:30 P.M. on Tuesday, September 15, let's all be at the Elks Club! With the success of this assured, we will all want to get to the October meeting which will be just as interesting, and thus, the Society meeting habit will be with us once more. Let's take advantage of the opportunity presented to us to hear nothing but the best.

H. J. Reese

KEEPING UP WITH AMA

By W. M. Skipp, M.D.

CANADIAN AND U. S. MEDICAL PROBLEMS ARE SIMILAR

The 84th annual meeting of the Canadian Medical Association was held in Winnipeg.

How similar the medical problems are between the two countries—nursing shortages, hospital construction, the place of the general practitioner in the medical care picture, public relations, and the fluoridation of water supplies were discussed during the session of the General Council, which corresponds with the House of Delegates of AMA.

LIFE EDITORIAL BRINGS COMMENT

The editorial was critical of the AMA and the House of Delegates in particular. *Life's* editor did not like the way the House acted on a resolution introduced by Dr. Cleon A. Nafe of Indiana, pertaining to "Section 200.9, of Part 12-4 of Regulations for Maternal and Child Health and Crippled Children's Programs, entitled: 'Crippled Children's Programs, Diagnostic Services.'

"State Plans for Crippled Children's Services shall provide that the diagnostic services under the plan will be made available within the area served by each diagnostic center to any child (A) without charge, (B) without restriction or requirement as to the economic status of such child's family or relatives, or their legal residence, (C) without any requirement for the referral of such child by any individual or agency."

The "resolved" paragraph of the resolution read: "That the Board of Trustees work through whatever channels may be necessary to eliminate this section of the regulations, same being a socialized regulation."

The Reference Committee on Hygiene and Public Health reported: "This resolution is required because of the fact that bureaucratic regulations from the Children's Bureau require that no means test be used and that a state which does not submit to these requirements can have no funds allocated to it."

Immediately after the Reference Committee made its report at the N. Y. Session, several newspapermen expressed more than usual interest in the resolution, some saying outright that the action was a clearcut indication that doctors, through the AMA, were "now picking on crippled children."

To give newspapermen the full and true story, Jim Waggener, executive secretary of the Indiana Health Association, was invited to hold an informal press conference.

The majority of newspapers and press associations treated the story honestly and fairly. *Life* magazine, however, chose to dish out a "souped up" version, giving interpretations that were never intended in the resolution. It was these interpretations that gave readers a false and derisive conclusion.

In addition to its reference to the resolution, *Life* made these comments: "During the convention week, newspapers throughout the U. S. ran accounts of the latest wonderful advances in the science of healing pain and prolonging life. Other news, however, that was not so wonderful—at least to the millions of us ordinary mortals who worry ourselves sick over the paying of our doctor and hospital bills . . ." "The ever-rising costs of medical care and how to lessen them, if possible, are problems of national concern. But the House of Delegates—The AMA's 185-member policy-making body—seems to be against almost anything that threatens the profits of a doctor's private practice . . ."

"Socialistic" and "social" seem to be synonyms to the House of Delegates, somebody should buy it a dictionary. If the 185 members could conceive of how utterly weary and cynical the American public has become from hearing the AMA snarl "socialism" at everything it doesn't completely approve of, they would hang up their stethoscopes (and their megaphones) and retire to the culture of petunias . . ." (NOTE: I wonder how the Editors of *Life* and the public would react if we would follow the above suggestion, just for 48 hours, no house, office or hospital visits?)

You should read this in the July 18, 1953, issue of the *Journal* of the AMA, which carries a reply to the "Watch It, Doc" editorial which appeared in *Life*.

The *Life* editorial gave a distorted picture of the action of the House of Delegates pertaining to the care of crippled children. "It is unfortunate that *Life's* editors took neither the time nor trouble to investigate the facts before sounding off on a subject so close to the hearts of millions of its readers."

The *Journal* quoted facts and figures from Indiana's Dept. of Public Welfare, showing professional contributions which Indiana doctors have been making for a long time in caring for crippled children—"Such services to crippled children are not given in Indiana alone. Every Shriner Hospital ward, orthopedic hospital, county hospital, and private hospital can certify to similar charitable services by physicians in every state in the Union. It has never been the intent of the medical profession to remove the availability of medical care from those who are in need of care and unable to pay."

The closing paragraphs of the *Journal* editorial said: *"Magazines and newspapers have ethics the same as the medical profession.* In reporting on the AMA action, *Life* threw the fundamental canons of journalism—sincerity, truthfulness and accuracy—out the window. In doing so, *Life* betrayed not only the physicians of this country, but also its big family of readers. Good faith with the reader is a paramount principle. By every consideration of good faith, a magazine is constrained to be truthful. It is not to be excused for lack of thoroughness or accuracy within its control. *So, in reply to Life's "Watch It, Doc," one can say, "Watch It, Life."*

The following is the action taken by the Committee on Legislation of the AMA:

S. 1495 (Murray, Senate); H. R. 4642 (Basch, House): To aid states in providing maternity and infant care for wives and infants of enlisted servicemen. The Committee is actively opposed.

S. 1748 (Taft, R., Ohio): To incorporate the national fund for medical education. No action taken by the Committee, but this was passed by the Senate.

S. 1154 (Ives and Flanders); H. R. 3583 (Hale); H. R. 3585 (Javits): Deduction of subscription charges to certain prepayment health service plans for purposes of Federal Income Tax. The Committee is actively opposed.

H. R. 4393 (Davis): To permit school teachers and other professional people to deduct as business expenses certain educational expenses. The Committee supports this bill because this covers the cost of postgraduate study of physicians.

H. R. 3487 (Lane); H. R. 3608 (Kean): To extend coverage of social security system. Active opposition, physicians dislike compulsory insurance.

H. R. 3204 (Yates): Authorizes Public Health Service hospitals to admit persons committed by state courts who are beneficiaries of the service or narcotic addicts. Reaffirm previous support.

H. R. 3930 (Radwan): To amend the Longshoremen's and Harbor Workers' Compensation Act. Approve principle of free choice of physician as outlined by this bill.

BROWNELL ATTEMPTS TO EFFECT BRICKER AMENDMENT COMPROMISE

Attorney General Brownell is continuing his efforts to work out a Bricker amendment compromise acceptable to the President and to the senators sponsoring the amendment. The administration has opposed the amendment in its present form as likely to hamper the executive in treaty-making. However, President Eisenhower has indicated he would support an amendment that would reassure the Bricker faction about abuse of treaty powers, if the amendment could be so worded that it would not disturb the balance between legislative and executive branches of the government.

The Bricker amendment has the strong support of the AMA.

UNIFORM MEDICAL CARE PROPOSED FOR ALL MILITARY DEPENDENTS

A civilian advisory commission has recommended extending medical care to all military dependents, using private physicians and hospitals where necessary, and charging dependents a token fee to discourage "running to the doctor for minor ailments, real or imaginary." Medical care is given dependents only at military installations where facilities are available on a "first come, first served" basis. It is estimated there are about 3,000,000 dependents. Approximately 60% receive some medical treatment; under the proposal all would be cared for either at military installations or by doctors and hospitals of their own choice.

The Citizens Advisory Committee has received testimony from representatives of the military services, veterans' organizations, and professional groups, including the AMA.

"The dependent medical care system which the Commission recommends should be regarded as an integrated whole. It is based on the principle that medical care for dependents—within prescribed limits—is sound national policy. It assumes that all dependents, wherever located, should be treated alike, and it holds the system should be uniform throughout all branches of the military organization."

HEPATITIS ON INCREASE

A sharp increase in infectious hepatitis is reported for the first six months of this year, and a sharp decrease is reported in measles. In the same period a significant decrease was noted in malaria in civilians, and a decrease of almost 90% among military personnel. About 25% more acute poliomyelitis cases were reported. The compilation was announced by National Office of Vital Statistics.

S. 2260 (Lehman, D., N. Y.) and 10 other Senators, July 1. Also at the same time a similar bill in the House introduced by Democrats headed by Dingell of Michigan. (NOTE: We know Mr. Dingell of Wagner-Murray-Dingell compulsory health insurance bills in the past.)

1. Extension of coverage to an estimated 8,000,000 persons, including members of the Armed Forces, farm owners, some professional groups

including lawyers, veterinarians, accountants, architects, funeral directors, and engineers, but not physicians or dentists. Also included would be farm workers, additional household workers, ministers, and certain groups of public employees.

2. Would increase from $3,600 to $6,000 that portion of wages subject to tax.

3. Monthly dollar benefits of various types would be increased.

4. Would increase from $75 to $100 the amount a retired person under the age of 75 could earn in a month without suspension of his benefit payment.

5. Would provide benefits equal to primary retirement benefits for permanently and totally disabled persons. To be eligible for permanent and total disability insurance the individual must have contributed for 5 of the 10 years preceding his disability and for a year and a half in the 3¼ years immediately preceding his disability. Disabled persons are required to submit to examination and re-examination from time to time under regulations. The Secretary of HEW could stop benefit payments if a disabled person refused rehabilitation, evaluation, and training.

6. A cash sickness insurance, with benefits limited to 26 weeks, would be established for persons temporarily disabled.

AMA STAND ON NON-SERVICE VA CARE OUTLINED TO HOUSE GROUP

AMA's opposition to further treatment in VA hospitals of veterans with non-service-connected disabilities, other than tuberculosis or neuropsychiatric disorders by a statement made by Dr. Walter B. Martin, President-elect, AMA. Dr. Martin made it clear that Congress should enact legislation limiting medical and hospital care for veterans in VA and other federal hospitals to:

1. Men with peacetime or wartime service whose disabilities or diseases are service-connected. 2. Within limits of existing facilities, to veterans with wartime service suffering from tuberculosis or neuropsychiatric disorders of non-service origin who are unable to pay for hospitalization. He further proposed that 1. Care for the remaining non-service veterans be discontinued and their responsibility revert to the individual or in the case of the indigent veteran, to the community; and 2. Congress reanalyze the entire question of whether the non-service chronically ill is a federal or local responsibility.

Acting VA Administrator H. V. Stirling argued, on the other hand, that to exclude veterans with acute non-service disorders who aren't eligible for compensation or pension would be a "substantial reversal of long-existing legislative policy." He said it would require the determination that "the government owes no obligation of this kind ot these veterans, however indigent."

National Medical Veterans Society (Dr. William B. Walsh): Should eligibility for hospitalization remain as broad as it is now, the burden on the public by 1970 will reach fantastic proportions.

American Dental Association (Francis J. Garvey): The Association opposes VA care for the non-service-connected tooth and "firmly believes that the obligation to care for one's health is primarily the obligation of the individual."

American Psychiatric Association (Dr. David J. Flicker): Under present

VA policy, it is becoming increasingly difficult to staff enough neuropsychiatric beds for non-service-connected veterans.

DR. CHESTER S. KEEFER was appointed and confirmed as special assistant to Secretary of HEW Oveta Culp Hobby—Dr. Keefer to be Secretary Hobby's right bower for health and medical affairs.

Dr. Keefer is taking the assistantship on a part-time basis. He will not sever professional connections in Boston, though it is problematical if he can continue as physician in chief of Massachusetts Memorial Hospital and Wade Professor of Medicine at Boston University.

DR. MELVIN A. CASBERG has been sworn in as Assistant Secretary of Defense for health and medical affairs. He will address the Society in September as our guest speaker. He is a personal friend of our own Steve Ondash.

DR. CASBERG'S OFFICE REASSURES DRAFT-ELIGIBLES

The office of Dr. Melvin Casberg, Assistant Secretary of Defense for Medical Matters, reassures those draft-eligible doctors alerted by Selective Service but not actually ordered to duty that they may have more time than they think. A spokesman for Dr. Casberg emphasized that there often is a long delay between receipt of individual letters informing the physicians they will be called and their actual orders carrying the date to report. Most of the men involved want to postpone closing out their practice or making other personal arrangements until they receive more definite word as to when they must leave civilian life. That definite word, according to the Assistant Secretary's office, comes with the orders which specify a particular date. A minimum of 30 days is provided between receipt of the order and the date for reporting for duty. In many cases, a much longer period is allowed.

AMA Washington Letter No. 35

ST. ELIZABETH HOSPITAL STAFF MEETING

The regular monthly staff meeting of the St. Elizabeth Hospital was called to order at 8:00 a.m. on Friday, August 7, 1953.

1. Clinical Pathological Conference was conducted by Dr. John LoCricchio. A case of primary melanosarcoma of the choroid layer of the eyeball was presented.
2. Business meeting opened at 8:55 a.m. Dr. W. H. Evans, Chief of Staff, presiding.
3. Dr. John LoCricchio moved that a staff picnic be held. This was seconded and passed.
4. Meeting adjourned at 9:00 a.m.

H. J. Reese, M.D.
Secretary

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OPHTHALMIC OINTMENT

TAY-SACHS DISEASE—"AMAUROTIC FAMILIAL IDIOCY"

*By Kenneth J. Hovanic, M.D., and Raymond Boniface, M.D.**

Tay-Sachs disease is considered a rare and unusual entity. For this reason a case recently seen at St. Elizabeth Hospital is being reported. With this report, sixty proved cases of Tay-Sachs disease can be found in the literature; thirty-two affecting females and twenty-six males. Thirty of the sixty were in the Jewish race and 32 per cent had a familial history.

This 13½-month-old female child was admitted to St. Elizabeth Hospital with a tentative entry diagnosis of "Fever Convulsions."

HISTORY:

Normal term child, uneventful delivery with all phases of growth and activities normal until approximately 5 months of age. At that time the parents noticed that the child was "slow" in response to stimuli, particularly to light. Hearing remained well but drowsiness was present constantly and the child would lie on its back unable to change from that position. The eyes would roll aimlessly about. This continued until 7 months of age when responses continued to lessen and movements became progressively less with bouts of extremity "stiffness." Mother also stated that gagging on food presented itself at that time. The child was sent to a clinic in another city where the family was informed that the child's "brain was not developing as it should."

PHYSICAL FINDINGS:

A 13½-month-old female white child lying quietly on its back. General appearance was one of a pale child, moderately dehydrated. Evident were signs of decerebrated type of rigidity. The arms were semiflexed the legs were hyperextended in the hip and knee joints with the feet in plantar flexion in a position of equinovarus. The eyes rolled listlessly in all directions, giving the impression of blindness. The child reacted well to sound. The neck was not rigid. Heart was normal. Lungs revealed rales at paravertebral area. Abdomen was pasty to touch and scaphoid in form. Temperature was 102.

Consultation by ophthalmologist reported "cherry spot" in the fundi of the eyes.

LABORATORY DATA:

Blood—RBC 4,200,000. Hb. 11.4. WBC 11,800. 5 Stabs. 82 Segs. 13 Lymphs.

CO_2 Comb. Power 24.

Spinal Tap—No cells. Sugar 40 mgm. Protein 19. Chlorides 695. Culture negative.

NPN 71.

DIAGNOSIS:

X-rays of chest—negative.

Tay-Sachs Disease—"Amaurotic Familial Idiocy."

Tay-Sachs disease or amaurotic familial idiocy is a well defined form of idiocy associated with blindness. It is an endogenous disease process, familial, steadily progressive and always fatal. Several forms of this morbid condition are recognized—infantile, late infantile, juvenile, and adult types. The most common and best studied form is the infantile type. The case history described here falls into this category.

SYMPTOMATOLOGY:

The child usually appears well developed after birth and shows no

abnormalities. Listlessness occurs early even after 2 or 3 months but usually at 7 to 8 months of age. The listlessness is evidenced by the child's not taking notice of anything. The child is not able to change its position. It lies on its back, rolls its eyes and exhibits great neuromuscular weakness or rigidity. The muscular weakness prevents the child from either holding its head straight or sitting upright. The child exhibits unusual acuteness of hearing. It is startled by the slightest noise, even when it is apparently drowsy and apathetic. In the terminal stages of the disease bulbar symptoms appear, drooling of saliva, choking spells and apnea, however the most remarkable feature on the part of the central nervous system is the visual disturbance characterized by the so-called "cherry red spot" in the fundi of the eyes. This classical "cherry red spot" in the fundi, together with a rapidly developing dementia, neuromuscular weakness or rigidity and blindness, hardly calls for a differential diagnosis.

ETIOLOGY:

The only specific etiological factor for the most common infantile type of Tay-Sachs disease is that it is racial and familial. Typical cases of this disease are known to occur almost exclusively in Hebrew children. The previously written case is the offspring of an Italian mother and Scotch-Irish father.

PATHOLOGY.

Tay-Sachs disease falls into the class of lipoid Storage disease or Reticulo-endotheliosis, the classical examples of which are Schuller-Cristian Syndrome (Cholesterolosis), Gaucher's Disease (Cerebrosidosis), and Neimann-Pick disease (Sphingomyelosis). The lipoid deposits found in Tay-Sachs disease are exclusively Lecithin.

* (Interne - St. Elizabeth Hospital)

A VOICE FROM THE PAST

By George Peck

How fitting this is in this day of governmental regulations

On August 16, 1809 (144 years ago), there appeared an editorial in the Hartford (Conn.) Courant, which it would be well for every present-day American to read. World War II ended around eight years ago, the Korean "police action," at least for the time being, has ended in a truce, and we have a new administration at Washington since January of this year. But, many an unnecessary bureau and tens of thousands of costly and useless bureaucrats linger on to plague us poor, oppressed taxpayers.

The Eisenhower administration is putting forth its best efforts to uproot these parasites—has succeeded in the face of great obstacles in "dehorsing" many of them—but has found that while it is easy to establish a bureau, it's awfully hard to abolish one. Now, please read what the discerning editor of the Hartford Courant wrote 144 years ago:

"A wise government is the people's guard and it takes effectual care that there should be none to molest or annoy, none to interrupt them in their lawful callings and pursuits. Thus guarded there is full scope and also

sufficient encouragement for industry and enterprise. Each individual employs himself as he finds it most for his own advantage, and each in advancing his own interest by honest industry, adds to the common stock."

Doesn't sound much like Newdealism or Fairdealism, does it? But, let's continue with the 1809 editorial:

"A nation resembles a swarm of bees. The bees must be well-hived, protected from external and internal annoyance and injury, and left free as air to make their combs, construct their cells, and labor in hive or field according to their own liking. Thus protected and thus free, they seldom fail to treasure up honey.

"But who makes the honey? Not the guarder of the hive but the bees themselves. So civil government (by government is meant the administration of government) however so wise and vigilant is not the direct and efficient cause of a nation's wealth, which is, in fact, produced by the Great Swarm, the People.

"On the other hand, should the keeper of the bees undertake to dabble in their private concerns, interrupt their labors or divert their wonted courses of enterprise into new channels—should he foolishly do this he would find little or no honey in the hive at the end of the year. And so again, whenever government is so imprudent as to obstruct or divert the enterprise and industry of the people by hampering them with unnecessary regulation, a decay of public prosperity follows as a natural consequence.

"Some men, however, seem to think that commercial industry and enterprise should come under the particular direction of government. But why? On the one hand, there are but few among the rulers and legislators of nations who possess extensive information in mercantile matters; whilst on the other, there are no people that know better how to manage their own concerns than experienced merchants. They best know how, when and where to put their property afloat; they can best calculate the risks and all the chances of loss or gain. It belongs to government to protect commerce, to guard it by a few general regulations and there leave it. The skill of the merchant will do the rest.

"All history testifies that trade flourishes most where it is most free, and that it soon leaves the nation that shackles it."

It is 144 years since the long-departed editor of the Courant penned that editorial. Much water has gone over the dam since then, but the fundamentals are exactly the same today. Today as then, government should confine its activities solely to protecting industry and trade—it should not direct, control, obstruct or enter into competition with private entrepreneurs. Consider the bee!

"Pulling Together"—Volume 16, Number 8

BOWLING

Doctors! If you are interested in forming a bowling group, call Dr. W. J. Tims at once. If enough are interested, we will arrange to get alleys on Thursday afternoons.

Phone ST 8-0715 (Office)

OCTOBER MEETING

DATE: Tuesday, October 20, 1953.

PLACE: Elks Club, 220 W. Boardman St., Youngstown, Ohio.

SPEAKER: Ned Shnayerson, M.D., Chief, Peripheral-Vascular Section, Poly Clinic Hospital, New York City, N. Y.

SUBJECT: "Recent Advances in Diagnosis and Therapy of Peripheral-Vascular Disease."

This will be a combined meeting of the Mahoning County Medical Society and the Mahoning Academy of General Practice.

PLAN TO ATTEND!

OCTOBER MEETING
6th Councilor District
ANNUAL POSTGRADUATE ASSEMBLY
St. Francis Hotel, Canton, Ohio
WEDNESDAY, OCTOBER 28, 1953

PANEL MEMBERS

Moderator

DR. ROBERT M. ZOLLINGER
Division of Surgery, Ohio State University
Columbus, Ohio

DR. JOHN BEACH HAZARD
Pathologist, The Cleveland Clinic
Cleveland, Ohio

DR. SARA JORDAN
Gastro Enterology, The Lahey Clinic
Boston, Mass.

DR. E. N. COLLINS
Gastro Enterology, The Cleveland Clinic
Cleveland, Ohio

DR. PHILIP F. PARTINGTON
Surgeon
Cleveland, Ohio

DR. KENNETH W. WARREN
Surgeon, The Lahey Clinic
Boston, Mass.

PROGRAM

●

8:30 to 9:15 Registration

9:25 Introduction ——— Dr. Clair B. King
President, Stark County Medical Society

9:30 "The Thyroid Nodule" ——— Dr. John Beach Hazard
Cleveland Clinic, Cleveland, Ohio

10:00 "Fibrosis of the Terminal Common Duct" ——— Dr. Philip F. Partington
Cleveland, Ohio

10:30 to 11:00 Intermission to View Exhibits

11:00 Panel—"Acute and Chronic Relapsing Pancreatitis"
Moderator—Dr. Robert M. Zollinger
Ohio State University, Columbus, Ohio

1:30 "Gastric Ulcer—Medical or Surgical Treatment?" ——— Dr. Sara M. Jordan
Lahey Clinic, Boston, Mass.

2:10 "The Most Detectable Internal Cancer" ——— Dr. Richard H. Overholt
Boston, Mass.

2:45 to 3:30 Intermission to View Exhibits

3:30 Panel—"Chronic Ulcerative Colitis and Regional Enteritis"—
Moderator—Dr. Robert M. Zollinger
Ohio State University, Columbus, Ohio

●

ANNUAL BANQUET

Onesto Hotel Ballroom

6:30 P. M.

Dr. C. A. Gustafson, Sixth District Councilor, Presiding

"The Fourth Dimension in Thoracic Surgery"

Dr. Richard H. Overholt, Boston, Mass.

PROGRAM COMMITTEE ANNOUNCES COMING MEETINGS

Your Program Committee has arranged the following schedule of meetings of the Society through February of 1954. Arrangements for the remaining meetings in the Spring of 1954 are still incomplete.

The Committee has attempted to consolidate as many of the meetings as possible. Meetings through December will be held at the Elks Club, 220 W. Boardman St., unless otherwise indicated in the *Bulletin* or your Newsletter.

September 15, 1953: A combined meeting of the Mahoning County Medical Society and the Mahoning Academy of General Practice. This is also a "Get-Acquainted" meeting of the membership and a kick-off of the Fall series of meetings. The Society is underwriting a free dinner to attract as many of the membership as possible.

Speaker ---------- Dr. Melvin A. Casberg, Assistant Secretary of Defense (Health and Medicine).

Subject ---------- "Military Medicine"—Dr. Casberg plans to cover all aspects of this general subject at the Department of Defense level.

October 20, 1953: A combined meeting of the Mahoning County Medical Society and the Mahoning Academy of General Practice.

Speaker ---------- Dr. Ned Shnayerson, Chief, Peripheral-Vascular Section, Poly Clinic Hospital, New York.
Poly Clinic Hospital, New York.

Subject ---------- "Recent Advances in Diagnosis and Therapy of Peripheral-Vascular Disease."
This should be a stimulating subject for all members of the Society. Dr. Shnayerson has many interesting slides on arterio and venograms and peripheral-vascular cases.

November 17, 1953: DIABETIC WEEK. This will be a combined meeting of the Youngstown Diabetic Association, Mahoning Academy of General Practice and the Mahoning County Medical Society.

Speaker ---------- Dr. George Hemwi, Director, Section of Endrocrinology and Metabolic Diseases, Ohio State University, School of Medicine, Columbus, Ohio.

Subject ---------- "General Clinical Endrocrinology in Practice."

December 3, 1953: Mahoning County Cancer Society.

Speakers ---------- Members of the Faculty of the Cancer Institute, Columbia University, New York. Details to be announced. Dr. A. J. Brandt is medical chairman in charge of the meeting.

December 15, 1953: Annual Meeting—election officers, buffet luncheon. This will be a combined meeting of the Mahoning County Medical Society and the Medical Service Foundation.

FROM THE BULLETIN

By J. L. Fisher, M.D.

TWENTY YEARS AGO — SEPTEMBER, 1933

There were eighteen cases of Poliomyelitis reported to the Health Department that month and much excitement about them although the twenty cases of typhoid fever passed almost unnoticed. Dr. E. R. Thomas contributed an article on polio in which he called attention to small percentage of cases with paralysis and the widespread acute generalized infections without signs of nervous system injury. A local newspaper on its editorial page urged the Medical Society to make an investigation as to the mode of transmission and possible common source of the infection, which brought forth comment from Dr. Charles Scofield as only he could comment. The Secretary (Dr. Skipp) was compiling a list of persons who had recovered from polio for the purpose of making convalescent serum available for use in acute cases. This treatment was popular then. The hospital laboratories would process the blood and the serum would be injected in 50 c.c. doses.

The late Dr. F. F. Monroe had a splendid article on "Medicine in Panama," in which he described how the isthmus was transformed from one of the worst pest holes in the world to a model of sanitation. Dr. Monroe worked for ten years with the Canal Sanitary Commission and was chief of the medical service of the Ancon Hospital in Panama City.

Dr. Patrick contributed a biographical sketch of Dr. Harry Welch who was then in his seventy-second year and had been health officer in Youngstown for thirty-nine years. He was a fine gentleman, one of the great men in Youngstown medicine, who headed the medical service and the obstetrical service at the Youngstown Hospital and handled the surgery for the Erie Railroad. This writer can remember assisting him at an operation where he scrubbed thoroughly, put on his gown and gloves, then his cap and mask and did a meticulous repair of a hernia which healed without incident.

We used to congregate in the Staff Room on Sunday morning those days for some good medical talk. Dr. Welch was the unofficial chairman; Buechner, Sherbondy, Booth, Patrick, Toby, Lindsay, Lewis, Elsaesser and Coy were usually there and what discussion there was! The unusual cases, the anecdotes, the latest treatments, the hospital gossip. That was the place to learn what was going on. The war ended those sessions but I have always missed them.

TEN YEARS AGO — SEPTEMBER, 1943

The doctors were very much concerned over two things, first the new plan of the Children's Bureau for providing maternity and infant care to the dependents of enlisted men; second, the new Social Security Bill called the Wagner-Murray-Dingle Bill. As to the first, the doctors grumbled but went along. As to the second, they have been fighting it ever since.

From the men in the Service: Fred Coombs reported he was having a great time at Madison, Wisconsin. John Goldcamp was at Ft. Sill, where the heat was terrific. Sam Klatman was overworked and happy at Ft. Lawton, Washington. M. M. Szucs was head cardiologist at Manhattan Beach, Brooklyn. Herman Ipp was at San Marcus Field, Texas.

The hospitals were protesting a poor deal from the Procurement and Assignment Service which had apportioned them 2 residents for Youngstown. In that year the hospitals in Youngstown averaged 1647 admissions per 1 house officer compared to 845 admissions in 1940. The average for the United States was 1 house officer for every 583 admissions. No wonder they were complaining! The number of practicing physicians had declined 31%. Internes and residents had decreased from 28 to 18 while the number of hospital beds had increased 15%.

ANNUAL GOLF DAY

On Thursday, August 13, 1953, the Annual Golf Day of the Mahoning County Medical Society was again held at the Youngstown Country Club. As has been the custom in recent years, the members of the Corydon-Palmer Dental Society and the Medical-Dental Bureau also participated.

When the golfing was completed, the champion was Dr. Frank "Chips" Bellino, who again demonstrated his prowess with his low gross score. Amongst the physicians Drs. Frank Morrision, Elmer Wenaas, Lester Gregg and W. B. Hardin were the best.

Your scribe has heard complaints that there were not enough prizes. Therefore, he heartily recommends to next year's chairman that suitable prizes be awarded for such events as the elbow closest to the bar, the longest putt made successfully while sitting down and telling about it, and the most likely recovery from an impossible lie-golfing, that is. There should be no dearth of candidates for the last event.

After dinner a short business meeting of the Medical-Dental Bureau membership was held and all of the officers were re-elected.

H. J. R.

Health Department Bulletin

CITY OF YOUNGSTOWN

REPORT FOR AUGUST, 1953

	1953	Male	Female	1952	Male	Female
Deaths Recorded	221	124	97	202	130	72
Births Recorded	732	375	357	639	331	308

CONTAGIOUS DISEASES	1953 Cases	Deaths	1952 Cases	Deaths
Chicken Pox	2	0	10	0
Measles	20	0	10	0
Polio	7	0	4	0
Scarlet Fever	0	0	1	0
Tuberculosis	7	1	6	1
Whooping Cough	0	0	2	0
Mumps	20	0	0	0
Infectious Hepatitis	1	0	0	0
Gonorrhea	25	0	31	0
Syphilis	15	0	20	0

VENERAL DISEASES New Cases	Male	Female
Syphilis	3	4
Gonorrhea	10	14

Total Patients 31

Total Visits (Patients) to Clinic 208

YOUR INSURANCE PROGRAM
(Article No. Two)

By Lloyd T. Stillson

In a previous article, we outlined the two financial problems facing a physician who becomes disabled for an extended period of time. First, he must have income with which to maintain his office expense, or else close his office. We suggested that the Mahoning County Medical Society Group Health and Accident insurance plan can and does underwrite the bulk of these expenses. Secondly, the physician must have income with which to maintain his personal and family expense. This income must necessarily come from one or more of three sources:

a. Savings painfully accumulated after paying stiff income taxes.

b. Borrowed money which must be paid back with interest out of taxable income.

c. Federal tax-free health and accident insurance income.

At the outset, we wish to make clear that we do not pose as experts in these matters. Times, conditions, and beliefs *constantly* change. We can speak only from over twenty years of experience in dealing with the health and accident insurance problems of approximately 500 physicians. We do feel that you can reach security in this field by following fundamental principles. You, as physicians, render a professional service to us laymen. In turn, we feel that you should expect and demand from us as insurance underwriters, a professional concept of your health and accident insurance problems.

With this thought uppermost in mind, let us approach the second financial problem facing a physician who is disabled—that of supplying certain and sufficient income to underwrite his own and his family's inevitable expenses.

We have established a need for this income. How much shall it be? This amount can be determined scientifically, in the same manner as you reach a solution to your life insurance needs.

We suggest that it would be just as pointless for you to purchase a health and accident policy just because it was a good thing to own, as it would be for you to prescribe certain medicines to healthy people just because they might need them sometime. You can be over-insured, or under-insured. Inflation, of course, has changed financial needs. However, your own special set of circumstances determines whether you are spending too much or too little for health and accident insurance. Below are listed six distinct sections designed to help you in determining the amount of monthly income you and your family will need if you are disabled for an extended period of time:

1. Cost of food, clothing, shelter (rent or mortgage payment, interest, taxes, repairs, etc.), insurance and utilities for family.

2. Family needs of a personal nature, such as necessary automobile expense, hair cuts, entertainment, etc. (Your family life goes on even though you are disabled.)

3. Your personal expenditures such as tobacco, shaving cream, etc. Case histories record many instances of undue worry over payment of small bills. Convalescence is retarded.

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4. Travel expense away from home. Our files indicate that 50% or more of our claimants in your society, in order to obtain normal recovery, need prescribed rest, relaxation, sunshine and diversion in climates found in Florida, California, Arizona or Canada. Funds for travel and hotel expenses must be available.

5. Extended hospital, nurse costs and drugs. Physicans with severe and prolonged illnesses often incur large hospital and/or "special nurses in hospital or home" bills.

6. College costs. If you have a child in, or contemplating college, it would be a tragedy if your disability destroyed these plans.

After you decide upon the amount of health and accident insurance income per month is required for your family and yourself, we turn to another important and difficult question. What kind of policy contract should you purchase? Or, if you are insurable, what guides can you use in replacing inadequate coverage? We suggest the use of certain rules as guides for selecting contracts which will give you the greatest possible security and peace of mind. The order in which these rules are set forth does not necessarily denote their relative importance.

1. Be certain the company you select is licensed in the state in which you reside. Otherwise you run the risk of heavy expense fighting an "out of state" company on a legitimate claim on which you may never collect. Furthermore, it is wise to select a company which maintains more than the "minimum reserves" required by state laws for "present and future disabled lives." Another great depression like that of the "thirties" could bring its accompanying heavy claim losses, which, in turn, would seriously affect those companies which had not built adequate reserves. When you become seriously disabled, you are *forced* to depend on the company you have chosen.

2. Select a contract which is truly non-cancellable and guaranteed renewable to a specified age, either 60, or 65. Avoid one which is non-cancellable only for the period premiums are paid, or which is guaranteed renewable at the option of the company. By following this rule, you "own" your policy, rather than "lease" it. Most disability insurance issued in conjuction with life insurance today does not protect you after age 55.

3. Practically all life insurance policies are incontestable after two years from date of issue. Select a health and accident policy containing the same provision. This means that your policy cannot be contested by the company because of any erroneous statements in your application, or because of any adverse physical condition at the time of your application.

4. Be certain the insuring clause in your contract covers disability resulting from "accidental bodily injury." If it covers disability resulting from "accidental means" you may not be covered if you are hurt while pushing a desk across the floor, or swinging a golf club. You intended to push the desk or swing the club, and the "means" was not accidental, but intentional. Innumerable cases are on record in our courts wherein companies have successfully denied claims where the "accidental means" clause was in the policy.

5. Watch for "escape" clauses. *Some policies do not pay if you leave your house while disabled, or else pay only one-half indemnity for a month or two.* Some policies do not pay if you become disabled while breaking some minor traffic law, or do not pay for mental infirmity, venereal disease, or for cancer or heart disease contracted within six months prior to date of policy. Look for a contract which does not have such exceptions or exclusions. In other words, demand the same sort of broad protection from your disability policies that you receive under your life insurance. It can be had.

6. Insist on a contract which will pay you a monthly income for a number of years, rather than a lump sum settlement in case of loss of an eye, hand, foot, both hands, etc. You will collect more this way when you need income while you need it.

7. Aim for long-term coverage paying income up to ten years. Insurance statistics disclose that 99% of disabilities are over in ten years, but the risk up to this point is very real.

8. Beware of policies paying for disabilities "in the aggregate." If you own a two-year aggregate coverage, for example, and you are sick for 15 months, you have only 9 months of *total* coverage left. At this time you no doubt an *impaired* risk, and you cannot replace an impaired policy.

9. Be certain you have a policy which guarantees that you can collect benefits regardless of the period of time which has elapsed between the date of your injury and the date when the results of that injury begin to appear. You cannot be certain when a bad fall on an icy pavement will produce a severe back injury.

10. Own a policy on which the premium payment is guaranteed, so that the company is prohibited from making any future assessments against you.

11. It is very helpful to a busy physician to have a "30-day grace period" in his contract, for payment of premiums, so that if he forgets to pay a premium, his policy will not lapse.

12. It is important to have included in your contract a "waiver of premium" clause, so that if your disability is extended, you will not be burdened with permium payments after the first 90 days or so while you are collecting benefits.

13. Look for a liberal definition of total disability. Good contract phraseology would be as follows: "Complete inability to engage in the insured's regular occupation."

14. Be certain that your benefits will not be reduced by reason of your changing your occupation, or by doing any act pertaining to any other occupation. If you decide to paint your house for the fun of it, on vacation, fall off a ladder, and are hurt, you still want to collect.

15. Be certain that a pyogenic infection incurred through a wound, is considered an accident, rather than a sickness. You will collect more.

16. It is wise to cover possible hospital costs with an additional coverage providing that if you are confined to your home, and have a registered nurse in attendance, you will be paid a monthly indemnity equal to that which you would have received if you were in the hospital.

17. Make use of a "surgical fee schedule" if one is available. This may sound silly to a physician who is offered professional courtesies from his own surgeon. Yet, we have often heard of a physician buying his surgeon a set of matched golf clubs, some fishing equipment, or some gift he thought the surgeon would appreciate after his operation. We understand that the physician in these cases, always wonders if he gave too much or too little. If the physician had available a surgical schedule calling for X dollars, he could then let the insurance company pay his surgeon a reasonable fee. Everybody all around feels better, and the cost for this additional coverage is very little.

18. If a physician applies for health and accident insurance, but, because of previous medical history is offered a policy excluding payment in event of tuberculosis, any accident to the sacrolumbar region, any kidney condition, or any one of dozens of other specific disabilities, he should accept the policy without question, unless the company has erred in its factual information. He should remember that in spite of the rider attached to his contract he has secured a policy on which he can still collect for any one of over 500 other disabilities which might occur to him. Also, in time, he might have the rider removed, provided he had no further recurrence of this specific disability, and provided that sufficient time had elapsed since his first attack. Far better that he own a policy excluding only one condition, if that policy ranks high in all the other essentials herein enumerated, for he should remember that never again can the company impose any additional riders; and, that if he obtained a concellable contract elsewhere, if the insuring company desired, it could cancel his policy at any time, or impose any number of riders in the future.

19. Remember that most reliable companies will offer not more than $300 per month coverage to one physician. If he needs more than this amount, there are available a number of companies who will entertain his application. However, most good companies will participate in an aggregate amount (including all non-cancellable coverage) of not more than $600 to $900 monthly indemnity for sickness and accident combined. The principle reasons for this are several: Disability Insurance Companies prior to 1932 had no effective total participation limits. The depression brought about such severe losses to everyone (some companies paid as much as $2,000 per month on one risk) that the rules were necessarily changed. Also, disability income proceeds are Federal Tax free. It is all net income.

20. Finally, the physician should remember that when he has made his selection of company, agent, and contract, according to a set of fundamental principles such as those outlined above, he should relax, secure in the knowledge that the company will use his contract only as a guide to performance; and that its performance undoubtedly will exceed its promises and guarantees. For, after all, if it is a good company, it will have charged the physician an adequate premium. Likewise, when the physician is in real trouble, on his back, needing a financial friend, we are there to help him get well. More than money is involved. The human heart, spirit, mind and body is at stake. We take justifiable pride in helping to restore our physician friend, on all counts, to his family, his friends, his society, his patients, and to himself.

1953

OHIO AND WESTERN PENNSYLVANIA REGIONAL MEETING AMERICAN RHEUMATISM ASSOCIATION ANNUAL MEETING

MAYFLOWER HOTEL AKRON, OHIO — NOVEMBER 11, 1953

9:20 A.M.	Robert M. Stecher, M.D.	Chief of Arthritis Clinic, Cleveland City Hospital—Past President American Rheumatism Association—President International Rheumatism Association.
9:30 A.M.	Currier McEwen, M.D.	Dean of University of New York Medical School—Past President of The American Rheumatism Association.
10:10 A.M.	Charles Ragan, M.D.	Professor of Medicine, Columbia University College of Physicians and Surgeons—President of The American Rheumatism Association.
11:00 A.M.	Richard H. Freyberg, M.D.	Internist-Associate Clinical Professor of The University of New York Medical School.
11:40 A.M.	Robert L. Preston, M.D.	Orthopedic Surgeon—Assistant Clinical Professor of Orthopedic Surgery of New York University Post Graduate Medical School.
1:20 P.M.	John H. Talbott, M.D.	Professor of Medicine, University of Buffalo College of Medicine, Buffalo, New York.
2:00 P.M.	Gordon M. Martin, M.D.	Consultant in Physical Medicine and Rehabilitation Mayo Clinic, Rochester, Minnesota—Assistant Professor of Physical Medicine and Rehabilitation, University of Minnesota Medical School.
2:50 P.M.	Joseph J. Bunim, M.D.	Chief, Arthritis and Rheumatism Branch National Institute of Arthritis and Metabolic Diseases—National Institutes of Health, Bethesda, Maryland—Associate Professor of Medicine, Johns Hopkins University.
3:40 P.M.	Panel Questions and Answers	
7:00 P.M.	Dinner	

REGISTRATION FEE $5.00 DINNER TICKETS $5.00

PROMINENT AFTER-DINNER SPEAKER

(Title of talks will be announced later)

CARDIAC PAIN

Dr. Hugh Hussey

(Continued from August Issue)

The compensability of myocardial infarction developing during working hours varies from state to state as do all things that are controlled by law and not by more exact sciences. In the District of Columbia, for example, myocardial infarction is rarely if ever compensable in a man who has developed it during work. Master statistics are quoted to the effect that thereare no provocative factors except shock in surgical operations. An exception was seen at Georgetown Hospital a few years ago when a man had previously been healthy and was testified as normal by his family physician developed chest pain while carrying a heavy load, an exertion to which he was not accustomed. He was brought to the hospital with chest pain, was found to have myocardial infarction by the next day and died on the seventh day of a cardiac rupture. In his case, the Compensation Board did rule it to be compensable and so far as I know that is the only one in our area. On the other hand, in New York State and other places they are much more lenient. There are many instances of compensation for myocardial infarction. I don't know how the situation is in Ohio. I hope that someone will enlighten me, because I like to find out about these things.

Patients who have had myocardial infarction, and who recover from it may be left quite well. They may resume activities and not suffer any discomforts. Some of them are left with angina pectoris or other incapacitating symptoms. I'd like to return for a moment to angina pectoris in connection with myocardial infarction and recall to your minds that sometimes angina pectoris is the only evidence that a patient has had myocardial infarction. Actually we are linking two terms at this point. I think this is most common in older patients having their first myocardial infarct. A man in his seventies, for example, who is still pretty active and vigorous, begins suddenly to have angina pectoris when he walks along the street—he stops and the pain goes away. Day after day the same thing is repeated but nothing worse—no long losting episode of pain. An electrocardiogram is made and as a part of his study and behold there are evidences of fresh myocardial infarction. He reports chest pain other than angina pectoris. In a man in this age group, anywhere from sixty on, in whom angina pectoris suddenly appears and it can be dated accurately in the history, you may assume one of two things. One, he has had myocardial infarction already, or two, he's on the brink of it—he'll soon have it.

Now I've spent most time on the pain of coronary insufficiency because that's the most important. What are the other types of cardiac and vascular problems that give chest pain? One of them is rheumatic carditis—unimportant, I'll pass it over with just this nod. The child who is having acute rheumatic fever with rheumtaic heart disease simultaneously and who develops a substernal or precordial aching as a part of the picture, has very severe rheumatic carditis. This is a bad case. That is the only point of clinical value I know.

Type III of cardiovascular pain is pericarditis. The pericardium, except at the very lowermost part of the parietal pericardium, has no sensory nerve supply which gives a sensation of pain. So it is that if the chest were laid open in an unanesthetized patient the pericardium could be trifled with without giving the patient any sensation of pain, except at its lowermost part.

Here it has sensory innervation that goes by way of the phrenic nerve, and when this part is involved in any inflammatory process, there is likely to be pain similar to that which you think of in connection with diaphragmatic pleurisy—a should pain often aggravated by respiration.

How do patients with acute pericarditis develop pain? Most of them don't. The commonest causes of acute pericarditis are uremia and such things as myocardial infarction, and in these conditions there is no chest pain referrable to the pericarditis itself. For pericarditis to provoke pain, there must be an extension of the inflammatory process from the parietal pericardium to involve the adjacent pleura. Then there will be chest pain due to the pleuritis. Of course, this chest pain is localized, unfortunately for diagnostic purposes, in the sternal area, because pleural pain is nearly always referred to the part of the chest wall immediately overlying the part of the pleura inflamed. Thus, when pericarditis provokes adjacent pleuritis there will be chest pain in the front of the chest, and by location and by duration it becomes difficult to distinguish from the pain of myocardial infarction. We make this differentiation by various means, but the most important again are certain qualities of pain and certain simple physical findings.

First of all, let us evaluate the quality of the pain. It is notable that in pericarditis the pain will be aggravated by breathing, or by turning the body or by some movement of the body, because these acts, of course, cause an additional irritation of the involved pleura. Sometimes swallowing is an important aggravating factor. The only other clue is a physical sign with reference to the development of friction rub. The pain of pericarditis begins abruptly, so does the pain of myocardial infarction. The friction rub of pericarditis appears early and lasts long. In myocardial infarction, on the other hand, the friction rub is rare before the second or third day, if it appears at all, and then it is quite transient. Unless you are fortunate you miss many of the friction rubs of the pericarditis that attends myocardial infarction. Finally, of course, there are electrocardiographic differences, but these become valuable only in retrospect. Initially, the best electrocardiographer cannot be sure that he is dealing with pericarditis as opposed to myocardial infarction. It takes some time for the changes to evolve and such retrospective appraisal is not too helpful in deciding about the therapeutic program.

The fourth type of cardiovascular pain is that which results from aortic aneurysm and this can be simply dismissed by showing one slide. In aortic aneurysm cough and dyspnea commonly compete with chest pain for attention by the physician. This is in contrast to the kinds of chest pain due to heart disease that I have described before. In these other causes for cardiac pain, cough and dyspnea are not likely to be chronic, important symptoms. The chest pain of an aortic aneurysm is a consequence of involvement of adjacent structures. So it was that in this patient who had a very large aneurysm involving the descending aorta, there was a growth of the vertebrae posteriorly and development of gurgling chest pain which was most intense in the front of the chest. Sometimes an aneurysm developing anteriorly will involve the sternum or other nerve-containing structures that will provoke chest pain. This is not difficult to distinguish ordinarily and not at all a common condition in these days. Once in a while an aneurysm is attended by coronary insufficiency, because syhpilitic aortitis, for example, will extend to involve coronary orifices.

The fifth type of chest pain is exemplified in the next type of case. This is a patient having an obvious abnormality of the mediastinal area and some cardiomegaly. Incidentally, this is a patient in whom violent chest pain began, was maximum at first, and in whom a chest film was made soon after the development of pain and showed an enormously enlarged and rather scalloped aorta. This is an instance of a dissection of the aorta. The pain of dissecting aneurysm usually is felt in front of the chest and may, therefore, be confused with myocardial infarction. Important differences are the fact that it is maximum from the start, that it tends to radiate toward the back and downward in some instances. Sometimes we are helped in making the diagnosis of dissecting aneurysm, because, although the patient looks "shocky," the blood pressure remains at a high level. Sometimes we become suspicious of this, because aortic regurgitation develops soon after the onset of pain. Now that's not an important thing physiologically, but from the point of view of diagnosis it is helpful. The dissection commonly begins just above the area of the aortic valve and goes onward usually in the aorta away from the valve. Beginning at that point, the media and intima are allowed to stretch a bit and the valve will drop down just far enough that aortic regurgitation may result; this may be a helpful physical sign in a patient who develops it acutely in the face of chest pain.

Arterial occlusions may be helpful as a diagnostic clue in this kind of case. The patient who suddenly acquires chest pain and in whom the pulse in one arm disappears soon after, usually the left arm, would be suspected of having a dissecting aneurysm that has gone on to dissect at the site of origin of the arteries to his left upper extremity. Finally, of course, not from the diagnostic point of view but from a prognostic point of view, this is the worst kind of chest pain to have in myocardial infarction. In myocardial infarction, or in coronary insufficiency of any kind, the odds for recovery are good. They are about ten to one in favor of the patient. In this kind of cardiac pain the odds are just the opposite—they are about ten to one against the patient, and those are bad odds when you are talking about an illness. Moreover, there is not much you can do about this. Thus far, the surgeons haven't attacked this kind of aneurysm very successfully.

The sixth kind of chest pain due to cardiovascular disease is one that has been described fairly recently. This is pain that is due to pulmonary hypertension of severe degree. What are the circumstances that form the background for this kind of chest pain? A disease like mitral stenosis in which the pulmonary artery pressure is constantly high; asthma or some comparable pulmonary disease in which pulmonary circulation is retarded and pulmonary artery pressure is high; pulmonary embolism in which there is an acute elevation of pulmonary artery pressure because of obstruction in the arterial bed and so on. In the face of such pulmonary hypertension, anything that suddenly increases it may provoke chest pain that is indistinguishable in all respects as to quality, location, duration, and so on, from the pain of coronary artery disease. The mechanism is different, for there is no coronary insufficiency—or so we believe. Rather, there is enough stretching of the pulmonary vessels that chest pain develops. Incidentally, these pulmonary vessels have precisely the same innervation from the point of view supplying the spinal cord with sensory impulses as does the heart. In differentiating this pain from that of coronary insufficiency, we must consider one, that it is not likely to be relieved by nitroglycerine but is

commonly relieved by the administration of aminophyllin; two, the existence of a background disease like neutral stenosis, bronchial asthma or some other pulmonary problem; three, the associaiton of cough as a prominent symptom because nearly always that will be so; and four, the clinical finding of right ventricular strain or hypertrophy on the electrocardiogram. Also, oxygen is likely to give relief from this kind of chest pain much more readily than it does in cases of myocardial infarction.

The seventh and last type of cardiovascular pain is that of neurocirculatory asthenia. More often than not this is seen in women. They have chest pain, they have a sense of beating of the heart, usually saying that it beats "fast," they have a strange kind of respiratory discomfort, they are short of breath but in the sense that they have difficulty getting a deep enough breath, they have an exaggerated siging if you will. They will show you this while you sit and talk to them.

I am reminded of a story told by Paul Williamson of a young woman who came into his office and was able to talk as I am talking now for a period that he timed by looking at the clock on his dask as lasting for a total of about 45 seconds before she took another breath. Yet, this woman complained of being short of breath. She was not short of breath in the sense that a cardiac is or any patient having an impaired vital capacity. No, she had the irregularity of breathing, the business of pulling, of not being able to get a breath in far enough, that typifies neurocirculatory asthenia. These people commonly are in poor physical training and they'll speak of getting dyspneic on exertion. However, this is nothing unusual, but they don't get any more dyspneic than a patient who leads a sedentary life. They are more aware of it and that makes for troubles in diagnosis. Finally, they have this sense of overpowering exhaustion. I'd like to dwell on that for a moment, because sometimes in a patient with coronary artery disease, instead of feeling pain or instead of having any other prominent manifestations of that kind, he just notices a sense of tiring or of exhaustion during exertion. It's not with him all the time. He says he feels fine except when he takes that walk up two flights of steps. He'll deny chest pain, dyspnea, intermittent claudication. He's just "worn out" when he gets to the top. You should suspect that he has heart disease and that this is his way of showing that his cardiac output is inadequate under the circumstances of exertion. On the other hand, the patient with neurocirculatory asthenia is just tired all the time. Exertion makes it worse sometimes in the opinion of the patient, sometimes not. If the patient is an honest narrator, it is sometimes possible to get the story that a pleasurable exertion gives no sense of exhaustion. The patient with neurocirculatory asthenia can do some things, if she likes to do them, without getting tired, but the housework and some other unpleasant things are provocative of an overpowering exhaustion. Frequency of these symptoms is about the same in a group of patients. They all run around 73 to 78 percent.

I overlooked chest pain in enumerating the symptoms. Chest pain is one of two types—either a dull ache, more often in the apical region than in the parasternal or substernal region. This alternates in some cases, or is totally replaced in other cases, by a sharper, stabbing chest pain which is felt in the region of the apex of the heart, and to which the patient will usually point. "Where is the pain," asks the doctor—"It's here," says the patient. He uses a few fingers. Mechanism for the pain is thought to be a sensitivity of the

chest wall, so that the beating of the heart against it, provokes this aching. What about the sharp pain with a bigger beat—the kind of beat that comes with extra systoles? This is an accompaniment that many of these patients have. It torments them because it implies something wrong with the heart.

Neurocirculatory asthenia is confused in the patient's mind, and sometimes unfortunately in the doctor's mind, with angina pectoris. Here are the differences. I mentioned the quality of the pain. The pain is not so definitely related to exertion in the sense of coming at a definite point in the course of exertion. Rather, it's likely to be noticed at a period after the exertion and lasting for some time after. The heart is normal, the electrocardiogram is normal—that's no help. As a matter of fact, sometimes it shows an insignificant abnormality, such as a transient change or positional changes in T_2 and T_3 and some of the chest leads. There are attendant signs of sympathetic overactivity. The prognosis is excellent, but you don't know that always in the beginning. That is a retrospective decision, so that's not much good either. Again we come to the fact that observation of the patient and careful history-taking are the chief reliances for this diagnosis. The principal importance of this diagnosis is the fact that usually you are reassured even if the patient isn't.

Now I would like to show you some of the conditions that mimic cardiovascular pain. Esophageal spasm is an important cause of chest pain that mimics angina. This is characterized by a dilation of the esophagus which can be detected by the X-ray. This kind of enormous dilatation of the esophagus, which is a consequence of severe cardiospasm, will give discomfort to the lower part of the sternum, but it's not a problem in differential diagnosis because these patients are so aware of their trouble in swallowing and you, therefore, quickly come to the point of ordering a barium swallow or getting a chest film and you've got the answer. There are minor forms of esophageal spasm that are extremely difficult to distinguish from angina pectoris except by the fact that the discomfort is not commonly present during the extertion. It is more likely to be felt at other odd times, especially during times of emotional stress. The discomfort is a sense of constriction or tightness or a vague aching and it's usually substernal in the lower part of the sternum, which makes it easily confused with angina. It is relieved by nitroglycerine, of course, because nitroglycerine is a relaxant for smooth muscles and the esophagus contains that kind of musculature. And how do you arrive at the diagnosis? Well, sometimes you don't, except that you feel reasonably sure the patient doesn't have coronary artery disease and you assume that there may be an element of some angiospasm. You can't prove it roentgenographically or by barium swallow for the simple reason that it is a transient thing and unless you are able to watch the barium swallow at a time that the patient is having the esophageal spasm you'll find no evidence for it.

Another common esophageal or similar lesion is the hiatal hernia. Hiatal hernia commonly provokes chest pain similar to angina or coronary failure. It is often seen in older people, without ever being symptomatic. Pain is more likely to come at times when angina is unusual; for instance, when the patient lies down—especially after a meal or when the patient increases intra-abdominal pressure by any mechanism like bending forward to lift weight and therefore putting the abdominal muscles on tension.

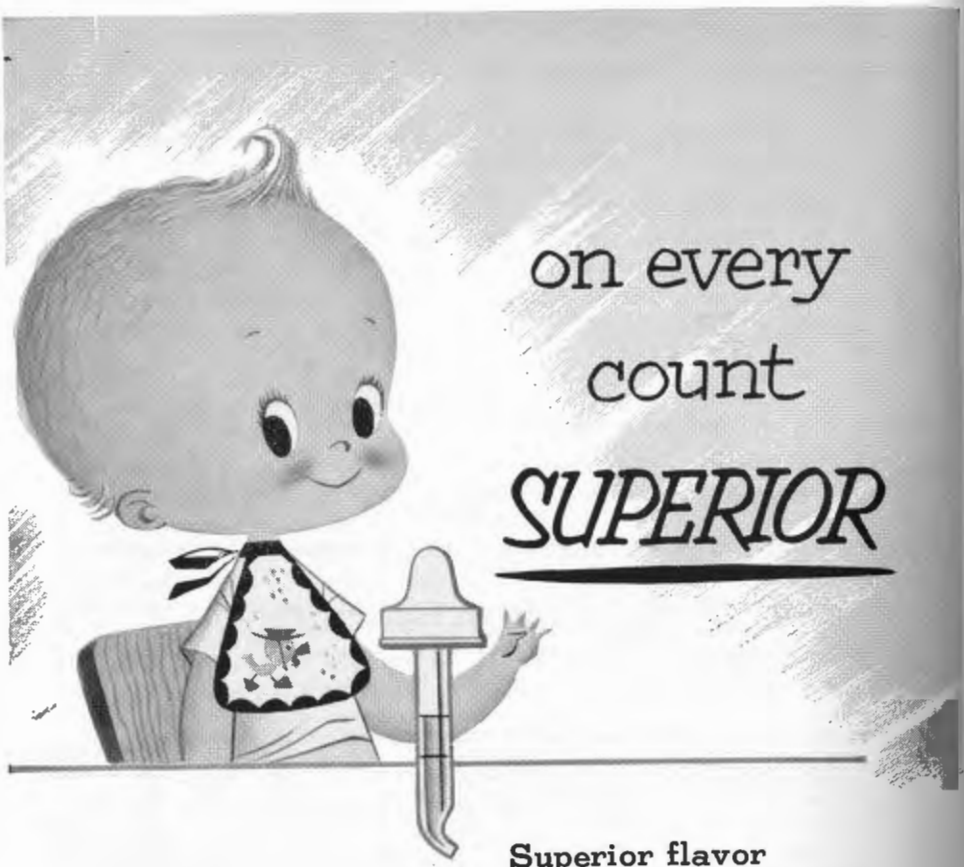
Several years ago Dr. Jeghers, who is a Professor of Medicine at Georgetown, was giving a lecture on chest pain due to heart disease. In

the middle of his lecture, one of the junior students who was busily taking notes and was listening to everything that Dr. Jeghers had to say, developed chest pain that to him was obviously representative of myocardial infarction. Now as it turned out this man soon thereafter also had dyspnea, but along with this dyspnea there persisted a sense of constricting, horrible anterior chest pain. The resident who examined him soon afterward found signs of massive pneumothorax which his chest film showed and the man was relieved quickly when some of the air was taken out. Now this kind of pneumothorax is easy to diagnose by physical signs and by X-ray examination. However, smaller collections of air in the pleural space do not give physical signs and may escape detection in a PA film of the chest. Under these circumstances when the diagnosis is suspected an oblique or a lateral film or both should be included in the examination.

Another kind of accumulation of air is spontaneous mediastinal emphysema. This is more often seen in patients who have had some kind of preexisting pulmonary disease, such as a pneumonia. They develop chest pain in the front of the chest and soon after an examination are found to have the peculiar crunching, crackling sounds that bears Dr. Hammond's name. Presumably what happens in these patients is that air breaks out of alveoli that have ruptured, dissects along the bronchovascular trunks until it reaches the hilar region and there enters the mediastinum and produces this kind of phenomenon. Sometimes the air accumulates under such pressure that the mediastinum is compressed and there may be evidence of obstruction of the vena cava with a florid face and distended neck veins.

Now commonest of all conditions that confuse our diagnosis of angina pectoris are musculoskeletal lesions. Most important as a source of confusion are those that involve the cervical region. Commonly, disc syndrome or cervical arthritis or involvement of the muscles of the neck will give chest pain that is felt in the front of the chest—a good location for angina—and will give no pain that is referred immediately to the neck. Sometimes, indeed, in addition to chest pain there may be head pain wtihout there being any neck pain. Fortunately, in such cases there may be a clue in the sense that the patient will notice a relationship of the pain to certain movements that he makes—turning his head, or putting it back, or sometimes pushing it forward, may bring him into a position that provokes the chest pain, and that's a clue.

When there is suspicion that cervical disease is the reason for pain of this sort, the physician has one good diagnostic test to employ and that, of course, is to treat the patient as though it were a cervical lesion, and that's not dangerous. It would entail using some mechanism for putting the neck on stretch—the kind of halter that you know about, or a wrapping of the neck with a wide gauze bandage in order to stretch the cervical vertebrae. Separating them a bit may relieve this kind of chest pain and keep it relieved. Return to the thought and worry about it as I do all the time, that 75 percent of patients with angina pectoris have some kind of other disorder—often a musculoskeletal thing of this sort that could be a cause for their chest pain. So you have troubles whether you know about the means of distinction or not.



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