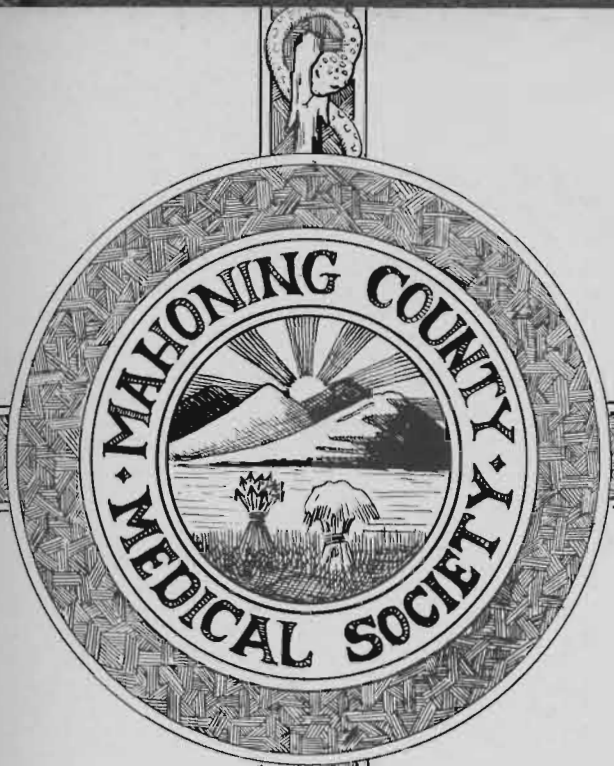

"I dressed their wounds,—
God healed them."
—*Ambrose Paré.*

BULLETIN

of the

Mahoning
County
Medical
Society

Vol. VIII No. 9
September 1938

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Corrective Management of CONSTIPATION

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Please send me professional literature and clinical sample BASSORAN (both types).

Dr._____

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RADIO TALKS

Sept. 2—Relation of Health of Mother to Welfare of Child - - - - - - - - - - - - - - - - Dr. A. J. Brandt
Sept. 9—Mothers of America - - - - - - - - - - - Dr. C. W. Sears
Sept. 16—Pipes and a Pump - - - - - - - - - - - - Dr. E. Nagel
Sept. 23—Coronary Sclerosis - - - - - - - - - - Dr. M. W. Neidus
Sept. 30—War on Heart Disease - - - - - - - - - - Dr. W. H. Bunn
Oct. 7—High Blood Pressure - - - - - - - - - - - Dr. L. K. Reed
Oct. 14—Flat Feet - - - - - - - - - - - - - - - Dr. T. K. Golden

MEDICAL CALENDAR

Sept. 20—Dr. Perrin H. Long, Johns Hopkins University—Sulfanilamide.
Oct. 18—Dr. Bradley M. Patten, University of Michigan—Movies on Embryology.
Nov. 15—Dr. John Talbot, Massachusetts General Hospital—General Use of the Chemical Laboratory in the Diagnosis and Practice of Medicine.
Dec. 20—Annual Business Meeting.

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September, 1938

ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

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PRESIDENT'S PAGE

COME AND GET IT!

From our first autumn meeting to the end of the year, not one unimportant affair is scheduled.

We begin with Dr. Long, master of his subject, "Sulfanilamide," on September 20th. Then the next night, the 21st, begins the weekly Wednesday evening series, which continues eight weeks, closing November 9th. Meanwhile, October 18th, we shall have the really great privilege of hearing Dr. Patten, and of seeing his most interesting movies, on "Embryology." Then comes that eminent investigator, Dr. Talbott, whose work here on the use of sodium chloride to prevent heat-damage, is so well known. Dr. Talbott is to discuss "The Use of the Chemical Laboratory in the Diagnosis and Practice of Medicine."

Your especial attention is solicited to the eight-weeks series. Diagnosis is always important, but treatment is equally so. The patient wants you to "do something." His yearning is to be relieved of pain, loss of time, and possible death. Doing those things is "Treatment." Everyone knows that Drs. Haden, Ernstene, and Collins are not to be excelled in experience, imagination, resourcefulness, and practical skill in therapy. What more constant problems confront us than those of heart disease, hypertension, the anemias, peptic ulcer, and arthritis? Nor are hemorrhagic disease and leukemia by any means rare. What these gentlemen will teach us as to the treatment of these very maladies will represent the last word in scientific discovery artistically—and most effectively—applied.

After all, no other function of our Society is as important as its scientific work. You have paid for everything. Be on hand to get the full benefits.

CLAUDE B. NORRIS, M. D.

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BULLETIN of the . . . . . .
Mahoning County Medical Society
SEPTEMBER 1938

FROM THE STATE SECRETARY

Special Extra Bulletin

Special Session, House of Delegates, American Medical Association, Called to Consider Emergency Situation at Washington

1.

A special session of the House of Delegates of the American Medical Association for the purpose of considering the National Health Program, discussed at the recent National Health Conference at Washington, and which in all probability will be the basis for proposed legislation at the next regular session of the Congress, will be held in Chicago starting Friday, September 16.

The call for the special session was issued on August 26 by Dr. H. H. Shoulders, speaker for the House of Delegates of the A. M. A.

This matter is brought to your attention so that you can inform the members of your county medical society that the governing body of the A. M. A. fully realizes the acuteness of the situation at Washington, and intends to take necessary steps to meet it. Please make every possible effort to relay this important announcement to the members of your society at the earliest possible date.

2.

Acute problems ahead; every County Medical Society must get ready for action.

Serious situations confront the medical profession as summer vacations end and county medical societies resume activities. *Is your society ready for action—and lots of it?* Now, if ever, physicians must stick together and meet the crisis ahead with organized activity. You can do much to keep your society keyed up; get members to attend meetings; get members to work; and see that important impending questions are discussed.

Here are a few suggestions for immediate action and consideration as your society resumes activities:

Study of Medical Care and Facilities should be completed immediately — Whoever is handling the A. M. A. medical survey in your county, should put on the pressure for completion of that important study at the earliest possible date. That is: *You should get in No. 1 Blanks from physicians and dentists and assemble the data sought by the other blanks of the series.* Within the next few weeks *Summary Blanks* will be sent to all county medical societies for compilation of the data obtained on the individual blanks. You won't be able to make out the Summary Blank unless the individual blanks have been gathered. Information obtained from this study will be of indispensable value in meeting the critical situation at Washington.

Speaking of the Situation at Washington—Those who want up-to-date information regarding recent events and developments at Washington of vital concern to the medical profession *should refer to the September 1 issue of The Ohio State Medical Journal* which will reach all members shortly. Urge all your members to read that issue of The Journal —the special articles regarding the National Health Conference, pro-

posed National Health Program, action of The Council in naming a Special Committee to devise ways and means of meeting this crisis, etc. Uninformed members will be of little value in the battle which may be anticipated.

Alert Legislative Committee Imperative—Is your Legislative Committee or Committeeman on the job? *Between now and the General Election in November, nominees to the State Legislature should be contacted and interrogated;* and the information obtained disseminated to all your members. Some county societies haven't picked a Legislative Committeeman. Every county society must have one. Does your society? Is he working? Now is the time to prepare for the legislative session next January. Your society is the one to make known the view points of the medical profession to your representatives in the General Assembly.

Regional Postgraduate Lectures — Three series of Regional Postgraduate Lectures, sponsored by the State Association, will open early in September at Mansfield, Zanesville and Dayton-Springfield. See the September issue of The Journal for details. Members from about 50 counties have received personal invitations to attend these lectures. *All members of the State Association are eligible to attend regardless of residence.*

Let the Speakers' Bureau Help You—Don't forget the State Association has a Speakers' Bureau which is at the service of all county medical societies. It has a list of more than 300 physicians who may be used by societies for local scientific programs. *If the Bureau can help you or your Program Committee, drop us a line.*

Malpractice Problems — Part of an early meeting of your society should be devoted to a discussion of malpractice problems. Causes of malpractice suits should be aired and means of preventing threats and suits reviewed. The enclosed report, compiled by a committee of the State Association, has a lot of valuable data on this subject. Turn it over to your program committee and suggest that it arrange a symposium on malpractice questions, using the committee's report as a basis. If this is not feasible, at least have the report read to your members.

All-Time Membership Record Possible—With the help of all secretaries, the State Association can set an all-time membership record by the end of the year. Present membership is 5,935. Previous record (end of 1937) was 5,045. Needed for 6,000 and new record—65. Are there any eligible physicians in your county who are not but should be members? Get them interested. *State Association dues for new members between now and September* 30 *amount to* $3.00. *Members joining between October* 1 *and December* 31 *must pay* $2.00. Dues for former members renewing their affiliation are $5.00.

3.

Special Committee on Poor Relief at Work: It Wants Your Assistance

Dr. Walter K. Stewart, Youngstown, chairman of the Special Committee on Poor Relief of the State Association, has requested me to communicate with all county society secretaries respectfully requesting them to coöperate with his committee members on a most important piece of work which the committee is undertaking.

Briefly, this committee is working on a series of proposals for revising and modernizing those sections of the laws of Ohio which relate to medical care of the poor. These propositions will be whipped into shape and consolidated into a constructive program which can be presented at the next regular session of the Ohio General Assembly, opening in January.

Facts, figures and suggestions must be obtained by the committee from

all counties. *This is where you enter the picture.*

The counties of the state have been divided up among members of the committee. Each member will get in touch with the secretaries of the county medical societies assigned to him. Secretaries will be requested to supply certain information. Don't get scared—there will be no red tape; you will not be required to make a "survey"; the questions asked will be comparatively simple and you will be able to answer them easily.

HERE IS THE POINT OF THIS SPECIAL BULLETIN:

WHEN A MEMBER OF THE SPECIAL COMMITTEE ON POOR RELIEF GETS IN TOUCH WITH YOU, PLEASE GIVE HIM YOUR FULLEST COOPERATION AND ASSIST HIM IN EVERY POSSIBLE WAY.

The committee cannot handle this gigantic job unassisted. It needs help and advice from all members.

Physicians all over the state have been complaining about the present poor relief statutes and administrative methods. Here is a chance for them to do some constructive work, thereby helping themselves and the entire profession. It is impossible for the committee to contact all members. It has done the next best thing—decided to ask the secretaries for help. They can ask individual members to assist them in getting the information the committee is after.

WILL YOU HELP? Dr. Stewart and his committee are counting heavily on you for help and promises something which will be a real contribution toward eliminating the chaotic condition of medical relief in Ohio.

Sincerely yours,

CHARLES S. NELSON,
Executive Secretary.

Whenever Walter King Stewart accepts a job he does that job, no matter what self-sacrifice is required. For years he has served our Society effectively in matters of great importance to the men who practise medicine. The Mahoning County Medical Society is proud that the State Association has so signally recognized Dr. Stewart's value.

TECHNICIANS' PROGRAM

The meeting of September 15th at the Tod Nurses' Home opens the second year of the Youngstown Society of Medical Technicians. The organization, this year, presents the following program:

September 15th, 1938

Speaker: Dr. C. R. Clark.

Subject: "Some Relations of Laboratory Work to Clinical Problems."

October 6th, 1938

Speaker: Dr. B. S. Kline, Pathologist, Mount Sinai, Cleveland.

Subject: "The Slide Test for Syphilis."

November 3rd, 1938

Speaker: Miss Rose Ketteringham, Tech. University Hospital, Cleveland.

Subject: "Malaria from the Viewpoint of Ohio Technicians."

December 1st, 1938

Speaker: Miss Bess Deitchman.

Subject: Neufeld Pneumonia Typing.

In addition to our regular program, we are having a course in Hematology extending ten weeks to be given by Miss Smith, Assistant to Dr. Haden in the Cleveland Clinic.

We sincerely hope that the interest shown the past year will continue throughout the forthcoming season.

Submitted by HELEN BUEHRLE.

ALLERGY IN OTOLARYNGOLOGY*

By R. E. ODOM, M. D.
Youngstown, Ohio

Allergy implies a bodily tissue reaction to extrinsic or intrinsic stimuli. Of course, the individual has been previously sensitized to a particular excitant. One writer contrasts allergy and vaccination; that in the former there is brought about greater sensitiveness whereas in the latter there is established less sensitiveness to the offending excitant, as the case may be. Allergy is rightly a specialty in medicine and at the same time, as Faulkner says, the study of each individual case demands a comprehensive understanding of the whole science of medicine.

Constant and steady advance in allergy is being made and simplification of this broad field in medicine will no doubt take place as it has in other branches of medicine. Etiological and clinical allergy will probably never lend themselves to satisfactory division in respect to anatomical systems. A sinusitis in an individual with asthma may reflect an associated allergic manifestation rather than be the cause. Foci of infection are removed at times with melodramatic results in the treatment of allergic conditions while again it brings only disappointment to both patient and physician. Nevertheless, the existing sinusitis may aggravate the asthma and so should be treated.

Recent literature deals with certain aspects of allergy in general that have a bearing on the ear, nose, and throat manifestations. In a statistical study of pathogenesis of allergy Ratner observed that only rarely is there a so-called allergic family in which a large proportion of the members are allergic. In contrast Kunkel's study of 62 members of an allergic family representing six generations residing in six different states observed that 7 or 13% had hay fever and 3+ or 6+% had asthma. The latter observations would tend to show the hereditary factor behaved as a dominant factor.

Goltman reports a case as an explanation of the mechanism of migraine. A young woman suffering from migraine had her brain explored through an opening over the left frontal region of the skull. With a typical attack, vasomotor spasm, as evidenced by blanching of the face and a depression in the region in the opening in the skull, was noted as the first stage. Secondary vascular dilation followed with a resulting edema of the brain, indicated by bulging in the region of the depression. The swelling receded with termination of the attack.

The allergic individual is theoretically subject to one or more of a wide variety of excitants which may be grouped as foods, pollens, bacteria, house dust, molds, chemical, and physical stimuli. We are more or less familiar with these stimuli and are necessarily prevented from speaking of the almost limitless components of each group. Likewise the diagnostic methods and the mechanics of testing belongs in the field of the allergist.

Allergic conditions as seen by the otolaryngologists will be considered in respect to system. As mentioned before the field of allergy is broad in extent and does not lend itself well to such a means of division. More or less, important phases will be omitted for the sake of brevity. An attempt will be made to review the more practical manifestations of allergy recognizable in general examination.

Of chief interest to us here are the following varieties of allergy:

(1) Nasal allergy, vasomotor rhinitis or allergic coryza.

*Presented June 13, 1938, Symposium of Allergy St. Elizabeth's Hospital Staff Meeting.

(2) Hay fever.
(3) Bronchial asthma.

Vasomotor rhinitis has a greater incidence among women in the second and third decades of life. Unlike hay fever it is non-seasonal in incidence. Etiologically, it is caused by stimuli other than pollens such as thermal causes, foods, chemicals, etc. Like hay fever, though possibly not to the same extent, it is associated often with asthma in the same individual.

The symptoms are principally sudden attacks of sneezing, watery nasal discharge and a feeling of nasal obstruction.

The appearance of the nose during an attack of vasomotor rhinitis is a source of argument that will usually provoke discussion. It is usually described as a nose whose mucous membrane is pale and sodden in appearance pitting on pressure—the color sometimes referred to as "oyster-like." The inferior turbinates are swollen to give the sensation of nasal obstruction. I have observed in the same individual gradations from the so-called typical appearance to a turgid red with essentially the same symptoms from day to day. This probably would also be true at different times during the day. This variability may find explanation in the degree of autonomic instability of nervous control of the nasal vascular bed supplying the mucosa and the extent of vascular stasis at a given time of observation.

There also seems to be a difference of opinion among observers as to the extent of eosinophils in the nasal secretion. Some observers qualify their occurrence by stating there *may* be shown numerous eosinophils on nasal smear.

Hay fever differs etiologically from vasomotor rhinitis in the kind of excitant. It is seasonal in character, the excitants being pollens of certain plants, trees and grasses.

Added to the symptoms of vasomotor rhinitis are sensations of burning or itching of the nose and eyes.

Bronchial asthma is a large subject in its own right. The accepted clinical pathology consists of spasmodic contraction of the bronchial muscle producing dyspnea. Some authors add to this mechanism edema of the bronchial mucosa plus hypersecretion from the mucosa made tenacious and dried to crusts by the more rapid respiratory effort.

Of more immediate interest to us is the nasal relationship to asthma. Conservatism in prognosis should be the by-word of the nasal surgeon. As mentioned before abnormal nasal conditions can and do exist in the otherwise normal patient as in the asthmatic. A definitely causal relationship of nasal pathology in the asthmatic cannot be foretold. It is as advisable to treat and correct infection and gross nasal abnormalities as is indicated for local or general disease elsewhere. However, prognosis as to the result on the asthmatic condition per se should be guarded.

The most frequent associated nasal conditions with asthma are edematous polypi and infected sinuses. Both may be results of the allergic state as is the asthma. I believe that they are, however, sources of aggravation of the asthmatic state, and should be treated as such and no more. That their correction considerably alleviates the asthmatic sufferer is an added indication for establishing a good functioning nose, i. e., to establish nasal drainage and produce free airway.

The treatment of allergic states can be divided into two divisions. First, determining where possible the specific excitant and by elimination through change of environment and/or desensitization correct the etiological factors. Secondly, alleviate the symptomatology.

In the first division suffice to say, success in cure depends on the ability of the allergist to determine through his armanentarium of sensitivity tests the specific or specifics and then to

desensitize the patient by means of the necessary extracts.

In the second division, more in the field of the otolaryngologists there are constantly being added new forms of therapy.

First will be considered the more tried methods of alleviating symptoms and later some of the more recent additions in therapy. Like other medical problems where the final answer has not been found there are many methods used in an attempt to solve this problem.

Regarding local treatment of nasal allergy we have already mentioned the desirability of correcting deformities and pathology present through treatment and surgery. Another procedure is the cauterization of so-called hypersensitive spots on the septum in nasal allergy and in the ethmoid region in bronchial asthma. Nasal drops or sprays containing shrinkage agents such as adrenalin, ephederine and neosynephrine are necessary for the comfort of the patient to improve nasal aeration and drainage, as well as preventives to, or control of secondary infection in the nose and paranasal sinuses.

Zinc ionization of the nasal mucosa in the allergic nose still has adherents and believers in its benefits. The more recent literature cautions against undue enthusiasm concerning this form of treatment. House and Gay observing results in 15 cases of allergy found the condition unimproved in 47%, and made worse in 33%. Added to these uncertain results, great local discomfort accompanies the procedure.

In the line of general treatment many non-specific allergic injections have been tried such as peptone, milk, blood serum, vaccines, etc., with questionable success.

One form of general treatment is definitely supportive in treating the chronic allergic with frequent acute attacks. This is the ephederine sedative combination in capsule form. They frequently also contain aspirin to which the patient may be sensitive, however. Methods for removing air borne irritants from the inspired air range from mechanical applications to fit over or in the nostrils; air-conditioning and filtering equipment to air cleaners which depend on attraction of air borne particles to electrically charged plates through which the air is directed.

In the treatment of hay fever with reported good results are included escharotics such as pure phenol painted over the nasal mucosa. Such a procedure is obviously drastic.

Caution is advised in the use of zinc sulphate spray for poliomyelitis in the allergic patient. In normal persons where the reaction is limited to severe headache and anosmia, in the nasal allergic patient a marked increase in allergic symptoms may be developed secondary to its use.

Vander Veer and Clark in writing on the permanency of the result following pollen treatment for pollen asthma and hay fever conclude that permanent relief may be expected from injections of specific pollen extracts in well over 50% of patients so treated.

As in nasal allergy there is a wide choice of non-specific adjuncts in treatment. Maytum and Leddy found some relief in over 50% in 23 cases of severe asthma following roentgen treatment. Clerf believe that bronchoscopy is of definite value as an adjunct in treatment of bronchial asthmatics, especially in those with tracheobronchitis, excessive secretions or bronchial obstruction.

Anderson in a report of 200 persons with uncomplicated asthma states that 180 patients were completely relieved from one to eight years after treatment with iodized oil. The average length of time under treatment was 10 months.

Parlato believes that at room temperature of 70° F. with a relative humidity maintained between 40 and

55% is the best environment for the asthmatic individual.

Insulin shock has been proposed, in what seems to be a rather drastic form of treatment, to check asthmatic attacks.

Barach advises the use of a helium 80%, oxygen 20%, mixture in the treatment of asthma (⅓ wt. per same vol. of air). He noted a decrease in pulmonary ventilation, a decrease in pulmonary pressure, relative and absolute diminution in length of expiration and an increase period of rest between respiratory cycles. The therapy is not without danger.

Kahn reports in the treatment of 16 patients with status asthmaticus, after repeated hypodermics of epinephrine had failed, the use of intravenous epinephrine. With failure of response to the later he advocates the use of ether and olive oil rectal anaesthesia. He found that further therapeutic measures were seldom required.

Fuchs advocates the use of avertin to relieve the bronchospasm in asthmatic crises.

Graeser and Rowe advocate the use of 1:100 epinephrine solution inhalations administered with a nebulizer in intractable asthma.

Dean, Agar and Linton of St. Louis report the following list of symptoms in the effects of allergic conditions associated with the ear:

Stuffiness or fulness of the ear or ears.

Subjective loss of hearing.

Shooting or dull pain in the ears.

Itching or a sensation of something crawling deep in the ear.

Continuous high pitched tinnitus.

Vertigo.

Nausea.

Extreme nervousness or irritability.

Hyperacusis.

Syncope.

The above symptoms were subjectively noted during the leukopenia index test. This is a test which finds its basis in certain observations by Vaughn. He noted if white cell counts are taken at one-half hour intervals for four hours, a drop of one to two or more thousand cells in patients who ingest foods which cause them asthma, eczema, or other manifestations of allergy.

Dean et al. divided allergic patients with aural symptoms into four groups:

(1) Those with a severe labyrinthine type of vertigo.

(2) Those with the Meniere symptom complex (acute vertigo, tinnitus and loss of hearing) associated with unconsciousness.

(3) Those having decrease in hearing, a sensation of fulness in the ear, itching, earache, tinnitus and sometime vertigo or nausea or both. This is the largest group.

(4) Those with migraine and aural symptoms.

Diagnosis of acute allergic middle ear conditions are discussed. Essentially the only distinguishing feature from other clinical O. M. P. A. is the presence of more or less numerous eosinophils in the aural discharge on myringotomy.

Allergic dermatitis of the external ear and canal are discussed. This is diagnosed and treated as allergic dermatitis elsewhere.

Bibliography

Duke: Advances in the Field of Allergy as Related to Otolaryngology During the Years 1936-37. Arch. of Otolaryngology. 26:6-1937.

Hansel: Allergy of the Nose and Paranasal Sinuses. Mosby Company. 1936.

Dean, Agar and Linton: Allergic Diseases of the Ear. Laryngoscope. 47:10-1937.

SPEAKER AT THE FIRST REGULAR FALL MEETING
Tuesday Evening, September 20th—8:30 P. M.
Youngstown Club
Subject "Sulfanilamide"

Dr. Long was born in Bryan, Ohio, attended University of Michigan College and Medical School, was a resident at the Thorndike Memorial Laboratory in Boston, interned on the fourth medical service, Boston City Hospital; spent a year in Germany where he worked in the Hygienic Institute in Fredburg; spent two years in the Rockefeller Institute in New York, and since 1929 has been in the Department of Medicine at the Johns Hopkins Medical School, where he is now Associate Professor of Medicine and assistant physician to the Johns Hopkins Hospital.

PERRIN H. LONG, M. D.

REVISED SCHEDULE
For Lectures to be given at the First Christian Church, Wick Avenue

September 21—
Treatment of Hemorrhagic Disease - - Russell L. Haden

September 28—
Drug Treatment of Heart Disease - A. Carlton Ernstene

October 5—
Management of Hypertension - - A. Carlton Ernstene

October 12—
Treatment of Anemia - - - - - - Russell L. Haden

October 19—
Treatment of Leukemia - - - - - - Russell L. Haden

October 26—
Treatment of Peptic Ulcer - - - - - - - E. N. Collins

November 2—
Management of Disorders of the Colon - - E. N. Collins

November 9—
Treatment of Arthritis - - - - - - Russell L. Haden

HADEN, RUSSELL L., Graduate of the University of Virginia in arts and of the Johns Hopkins Medical School in medicine. Resident house officer, Johns Hopkins Hospital, 1915-16; associate in medicine, Henry Ford Hospital, Detroit, 1916-17; director of laboratories, same place, 1917-18 and 1919-21; assistant chief of medical service, Base Hospital, Camp Lee, Va., 1918-1919; associate professor of medicine, University of Kansas, 1921-23, professor of experimental medicine, same place, 1923-30, since 1930 head of division of medicine, Cleveland Clinic.

Member of Assn. of American Physicians, American Society for Clinical Investigation, American Assn. of Pathologists and Bacteriologists, American Clinical and Climatological Assn., Central Society for Clinical Research; fellow of American College of Physicians.

Special interests have been focal infection, intestinal obstruction, diseases of the blood and arthritis.

Author of Clinical Laboratory Methods, Dental Infection and Systemic Disease and Principles of Hematology.

•

COLLINS, E. N., Graduate of the University of Chicago in arts and the Rush Medical College in medicine. Interne, Presbyterian Hospital, Chicago, in service of Dr. B. W. Sippy. Formerly in charge of gastro-intestinal radiology, Cleveland Clinic. Since 1935 in charge of section on gastro-intestinal diseases, Cleveland Clinic.

Member of Radiological Society of North America.

•

ERNSTENE, A. CARLTON, A. B., University of Iowa; M. D., University of Iowa. Interne Henry Ford Hospital, Detroit, 1925-26; Assistant Resident Physician, Thorndike Memorial Laboratory, Boston City Hospital, 1926-27; Resident Physician, Thorndike Memorial Laboratory, Boston City Hospital, 1927-28; Assistant in Medicine, Harvard Medical School, 1927-30; Instructor in Medicine, Harvard Medical School, 1930-32; since 1932 in charge of section on cardio-respiratory diseases, Cleveland Clinic.

Member of American Society for Clinical Investigation; American Clinical and Climatological Association; Central Society for Clinical Research.

LEGISLATIVE BULLETIN

By O. J. WALKER, Chairman Legislative Committee

Now that the primaries are over it is time to size up the candidates coming up for election in November.

Perhaps never before in this country has the Medical Profession been faced by a more critical situation in pending State and Federal legislation. Now, as never before, is it imperative that physicians take an active interest in government affairs, not only as physicians, but as public spirited private citizens.

It may be necessary as physicians to ignore party politics and support only those candidates who are thinking right in medical matters.

Your Legislative Committee is busy gathering data about each candidate, which will be passed on to you before November. In the meantime the committee offers the following suggestions for your IMMEDIATE ACTION:

1) Study the list of candidates, National, State and Local, published below.

2) Analyze the list. Do you know the candidates? What kind of a record have they? Are they qualified for public office? How do they stand on medical and public health questions? Will they listen to the advice of the medical profession on medical and health matters?

3) Get acquainted with all candidates as soon as possible. Ask your friends and acquaintances about them. Check all possible sources of information. Express an interest in their candidacies. Offer to keep them informed on questions in which the medical profession is interested. Sound them out—diplomatically, of course. Make no promises. Do not ask candidates to make promises. Nevertheless, let them know the medical profession asks the right to confer with them from time to time on questions in which it is interested.

4) Pass on to members of your society and your patients information which you obtain regarding candidates. Ask members to vote and work for candidates who are dependable, have the correct viewpoint on medical and health questions, and will listen to the advice of their physician-constituents. Request members to oppose and work against candidates whose record is bad and who are antagonistic to the policies of the medical profession. Get all members to talking politics and working in the interests of qualified candidates.

5) Relay to the Legislative Committee any information obtained about candidates.

6) *Right now is the time for the Medical Profession of Ohio to lay the ground work for its battles before the Ninety-third General Assembly and the National Congress. Preparedness and action now will go far toward preventing disappointments and defeat in 1939.* If physicians are apathetic now they will have to face the music later. Unless the medical profession stands by its friends among the candidates it can expect headaches during the next two years.

Candidates

GOVERNOR	
Charles Sawyer	John W. Bricker
SENATORS	
Robt. J. Bulkley	Robert Taft
CONGRESSMEN-AT-LARGE	
John McSweeney	Geo. Bender
Stephen Young	L. L. Marshall
CONGRESS	
Michael J. Kirwin	Wm. P. Barnum
STATE SENATORS	
(Two to elect)	
Maurice W. Lipscher	Frank H. Mills Jr.
Eugene Callan	James P. Griffith
STATE REPRESENTATIVES	
(Four to elect)	
William Glass	William Bacon
John J. Buckley, Jr.	Wade C. Christy
Thomas J. Barrett	Earl D. Haefner
Dan E. Conway	Decker R. Fithian
COMMISSIONER	
Thos. R. Bees	Lewis J. Kindler
AUDITOR	
John W. Lyden	George W. Jones Jr.
COURT OF APPEALS	
James Cannon	Elmer Phillips

PATHOLOGICAL CONFERENCE

Case I—North Side

Mrs. S. S.; American, white, female, age 31. Case No. 20599.

Chief complaint: Abdominal pain of one month's duration.

Present illness: One month ago patient first had a severe attack of low abdominal pain which was so severe she fainted. Pain was sharp in character and did not radiate down legs, or to back. She was examined and a mass found in the pelvis, which was thought to be the right ovary or a tumor in the broad ligament. Until the present acute attack, patient just had a feeling of heaviness in the pelvis.

Six years ago patient suddenly ceased menstruating and developed masculine characteristics such as deeper voice and masculine hair distribution. She has taken many hormonal injections without relief. General health has been good. Her menstrual history was normal except for some irregularity in time.

Marital history: Married 9 years; 1 daughter living and well, age 7; no miscarriages.

Past history: Tonsillectomy 15 years ago. Health good.

Head—Infrequent headaches. Some tinnitus past 2 months.

Physical examination: Well developed and nourished white woman showing masculine hair distribution, complains of severe pain in right lower quadrant and in the pelvis.

Head, eyes, ears, nose and mouth —Negative.

Neck—Thyroid isthmus palpable, not markedly enlarged.

Lungs and Heart—Nothing remarkable.

Abdomen—Hair is of masculine distribution. Moderate muscle rigidity on right side; definite tenderness to deep palpation in the right lower quadrant. Rebound tenderness present. Solid organs not felt.

Course during stay in hospital:

Aug. 10, 1937 — Admitted with symptoms of acute abdomen; surgery done, large right ovarian cyst (techacell) was found on a twisted pedicle; right salpingo-oophorectomy and appendectomy done. Post-operative course satisfactory.

Aug. 11, 1937—Fluids by vein; some gas, but looks fine, reacted well.

Aug. 12, 1937 — Drainage from Penrose drain is less; temperature still up, but falling.

Aug. 14, 1937—Penrose removed with marked discomfort; rubber dam inserted; course satisfactory.

Aug. 16, 1937—Clips and rubber dam removed; feeling much better. Course during rest of stay in hospital was uneventful, and she was discharged in good condition August 25, 1937.

Conducted by Dr. G. Nelson.

SECRETARY'S REPORT

The Annual Picnic held Thursday, September 1st, at Milliken's Farm, ended the summer activities and was a huge success. A good time was had by all.

A council meeting has been called for September 12th at which time a complete report will be given on the A. M. A. Survey.

The regular monthly meeting of the Society to be held September 20th, will be addressed by Dr. Perrin H. Long. A most ambitious program of scientific work is scheduled to start Wednesday, September 21st. These lectures are conducted by Dr. Russell L. Haden of the Cleveland Clinic and two of his associates, Dr. E. N. Collins and Dr. A. Carlton Ernstene, and will continue every Wednesday evening ending November 16th.

ROBERT B. POLING.
Secretary.

AN OPEN LETTER

Mr. President and Gentlemen of the Mahoning County Medical Society:

Our Society progresses by virtue of mutual help and participation among and by its members. As a somewhat sad commentary on the above theorem, permit me to recite to you the woes of your entertainment committee in putting on the recent picnic. Then judge for yourself if you are doing all that you might do to lighten the not inconsiderable burden on those groups of your members whom you have intrusted with the management of your affairs.

Returnable postal cards were put in your hands one week in advance of the day of the picnic, asking you to indicate whether or *not* you would be present. Our membership is over two hundred. The response, by postal card, indicating yes or no, was one hundred.

Sixty indicated their intention of being present. However, to be on the safe side, your committee obligated itself to the caterer for seventy-five dinners. When we sat down to dinner, there were present, seventy-two active members and ten internes. Five men, four of whom had expressed their intention of being present by returning their cards, found it necessary to go to town for their dinner. (Needless to say their money was refunded.) Of the sixty-seven active members who found places at the tables, *twenty-four had not troubled to return their cards.*

Mr. President: This is not alone my protestation against the lack of coöperation on the part of our members. It comes from every committeeman entrusted with the activities of the Society. Dr. Noll can pour such woes into your ears by the hour. I present this data with the hope—is it hoping too much?—that in the future each member will lend his coöperation.

H. E. PATRICK, M. D.

NON-PENETRATING FOREIGN BODIES OF THE EYE

By WM. F. HATCHER, M. D.

In industrial areas, injuries by foreign bodies probably constitute more than one-half of all eye injuries. Penetrating wounds of the eye due to foreign bodies will not be discussed in this article, inasmuch as such injuries are seldom treated by the family physician. It should be borne in mind, however, that in rendering first aid in a case of a penetrating wound of the eye, the injured eye should be closed by a patch and bandage.

Persons with foreign bodies in the palpebral or bulbar conjunctiva, or in the cornea, frequently seek relief from laymen and physicians. The subjective symptoms may be helpful or misleading. A foreign body imbedded in the center of the cornea may produce intermittent symptoms and very little reaction in the eye. A foreign body under the upper lid gives immediate and constant evidence of its presence. In many instances, patients complain of a sensation of a foreign body when none is present. In these cases, there is sometimes a history of a foreign body having entered the eye, but it is no longer there on examination. In other cases, there has been an inflammatory reaction in the palpebral conjunctiva of the upper lid. The resulting roughness of the conjunctiva produces an intermittent sensation of one or several small foreign bodies. In all cases of redness or discomfort of the eyes, the presence of a foreign substance should be suspected.

The conjunctiva, a vascular membrane, reacts in a classical manner to the irritation of a foreign body. The conjunctiva immediately around the irritating substance, as well as the portion of conjunctiva over which the substance passes during active wink-

ing, becomes engorged. Nature endeavors to alleviate the situation by flushing the eye with tears and removing the irritation of light and movement by photophobia and blepharospasm. These symptoms combined with pain greatly reduce the usefulness of the eye. The intensity of the conjunctival reaction depends largely upon the type of foreign body, the location of the foreign body, and the length of time it is present. Conversely, the rapidity and completeness of recovery after removal of the foreign body depends upon the above conditions, together with the presence or absence of infection.

The cornea, an avascular transparent structure, reacts in its own peculiar way to the presence of a foreign body. There is a local zone of edema and ulceration with a peripheral zone of congestion at the conjunctivo corneal junction (limbus conjunctivae). Frequently, the pain and discomfort caused by a corneal foreign body is referred under the upper lid. The presence or absence of a scar of the cornea following an imbedded foreign body will depend upon the penetration of the foreign body ar any resultant ulceration. Non-complicated foreign bodies removed from the corneal epithelium do not leave scars. If, however, the foreign body or associated ulceration causes a solution of continuity of Bowman's anterior glass membrane, a corneal scar results. Fortunately, Bowman's membrane is very resistant and may be curretted quite readily with a dull spud. The corneal epithelium regenerates very rapidly under favorable circumstances.

The substances found as foreign bodies in the eyes are innumerable. A few merit special mention: Particles of iron, emery, cinders, and gun powder stain the surrounding tissue. Particles of glass, paint scales and fish scales are particularly difficult to see. In the summer, insects and plant material frequently act as transitory foreign bodies. The irritating action of inturned eye lashes must also be borne in mind.

To discover foreign bodies on the conjunctiva or in the cornea, normal near vision is essential. Good illumination, a condensing lens, and a monocular or binocular loupe are necessary adjuncts.

A dilute solution of the sodium salt of fluorescein instilled in the eye will frequently outline by a green stain a foreign body otherwise undetected. This dye also temporarily stains denuded corneal areas.

The removal of a foreign body from the lower culdesac is very simple, provided the patient turns the eye well upward. A foreign body under the upper lid is easily removed, provided the patient looks constantly downward while the upper lid is everted. Eversion of the upper lid is readily accomplished by pressing any small rod-like object, such as an applicator or a wooden match, firmly on the eyelid immediately above the upper margin of the tarsal cartilage while the eye lid is turned upward by the firmly grasped cilia. A sterile applicator wrapped with moist cotton is suitable for removing superficial substances.

To remove imbedded foreign bodies, particularly in the cornea, a metallic spud is required. It is also necessary to anesthetise the eye. For this purpose, solutions are employed of holocaine 2%, butyn 2%, pantocaine ½%, or if the intraocular tension is normal, cocaine 2%. A drop of anesthetic solution instilled in the eye at one minute intervals for two or three doses produces excellent superficial anesthesia.

Incidental conjunctivitis must be treated, free drainage being allowed by leaving the eye open. Following the removal of a foreign body from the cornea, antiseptic ointment, such as bichloride of mercury, is instilled and the eye closed by a patch until the epithelium regenerates. Yellow oxide of mercury is an irritant and

not suitable for treatment of an irritated or inflamed eye.

When the corneal epithelium has been abraded and the sensory nerve endings are exposed, patients frequently complain of a sensation of a foreign body in the eye. Products of explosion, such as gun powder, are well borne by the external eye. Frequently, it is inadvisable to attempt complete removal of all such foreign bodies at first treatment. After a few hours or days, the foreign particles work nearer the surface and are more easily and safely removed.

THE MEDICAL CRIER

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

• Now that the summer vacations as well as the August Primaries are over, we can begin to pick up the loose threads — read those neglected medical journals, start our Medical Society and Staff meetings and get ourselves ready for the long winter grind. The warm months have been exceptionally pleasant and it is with a tinge of regret that we see them fading into autumn. Settling down to business again may not seem easy, but let us do so with good grace and with determination to make this coming season a very active and successful one for our Medical Society and for our profession.

• In 1815 the second war with England had been going badly with us for three years. The New England Convention sat in the State House at Hartford with old George Cabot in the chair. They were sick of the war and were ready to end it —on any terms. They were furious that our peace commissioners at Ghent had refused to cede the Northwest territory to England and there was talk of secession from the Union. Happily they were stopped by Jackson's brilliant victory at New Orleans.

Now we see another Cabot turning against his associates of the medical profession in their struggle to maintain their independence. He advises us to sell out our birthright of freedom to become political servants as the price of peace. Let us repudiate him just as Monroe and Andrew Jackson repudiated that other one. Let us fight to the last ditch to maintain our tradition of personal service to the people of this country. The American Medical Association is our own organization and it is our only hope in this fight. Let us support it with all our loyalty.

• Medical men of letters have been very successful recently in reaching the top rank in the realm of biography and fiction. Among the best sellers may be found Carrell's "Man The Unknown," Cronin's "The Citadel," Heiser's "An American Doctor's Odyssey," and Hertzler's "The Horse and Buggy Doctor." They are all well worth reading and should be in every well stocked library. We do suspect Heiser and Hertzler of drawing the long bow occasionally in telling of their exploits but their books are an inspiration nevertheless. We enjoyed Hertzler's tale about how he called his dead-beat patient out of bed at midnight to come over and see him. When the man arrived Dr. Hertzler calmly said he had decided he would like to have that load of hay that had been promised so long ago. Well, he finally got the hay but it was mostly weeds. How true! Did you ever have a patient work out a bill for you?

• In Detroit they are choosing their speakers this year by ballot. Early this summer a long list of prominent speakers with their subjects was published in The Detroit Medical News and members were invited to vote on the ones they would like to hear. The balloting is about finished now and the programs will be made up accordingly.

• The best medical story we have

heard this month was about the fellow applying for a job working for a wealthy widow who was very particular. She wanted a good strong man to be general handy-man about the place. At her request he obligingly displayed his biceps, then his calf muscles. Then she asked to see his testimonials. If the poor fellow had been possessed of more book learning, he would have got the job!

J. L. F.

TREATMENT OF POISONING*

By E. H. YOUNG, M. D.

The importance of the early recognition and proper emergency treatment of acute poisoning has not been sufficiently stressed. Many subclinical and chronic poisonings are never diagnosed. Some acute, dramatic poisonings have received improper immediate care because all phases of the clinical picture of acute poisoning were not recognized. Shock and anoxemia are two symptoms which must not be disregarded.

The clinical course of poisoning depends on the dose, the method of administration, the tissue involved, and the resistance of the patient as well as the type of poison. Death may occur from poisoning before any appreciable amount of pathology can be demonstrated, and in a great number of instances death may be prevented by the emergency application of the same medical principles which are used daily in other medical and surgical emergencies but too often are omitted in poisonings.

Profound shock, coma and death are three terms often applied to acute poison cases. Most patients in shock will die if the shock is disregarded, and the treatment is confined to emesis and the usual antidotes. Emetics and especially apomorphine should not be given to patients in shock. All of us have heard the expression, "I gave him a tenth of apomorphine; waited 15 minutes, gave the second tenth, but he died before it could work." When present, shock should be treated before or along with the specific symptoms.

The treatment of shock due to poisoning is the same as that for surgical or medical shock. Such a simple procedure as applying warm water bottles and blankets may be life saving. Intravenous fluids definitely influence shock. The addition of acacia to a solution tends to hold the fluid in the vascular bed and tends to reduce the amount of fluid required. Some authors advise 50% glucose, some 25% glucose, others 10% glucose in saline or even normal saline. Whether the hypertonic solutions favor the absorption of the poison from the intestinal tract is a moot question. In severe shock the circulation immediately needs extra volume in the form of fluids. This may be followed by transfusion with or without partial exanguination. Caffeine, adrenalin, digalen, and morphine each has its place in shock associated with emergencies in poisoning. The recognition and treatment of shock in acute poisoning is of primary importance. The more profound the shock, the less important the direct attack on the poison.

Anoxemia is a second serious emergency complication of poisoning. It is recognized easily when the poison is inhaled or excreted through the lungs, but when present due to depression of the respiratory center, as in morphine poisoning, it is often overlooked. The lack of oxygenation of the blood may be manifest by cyanosis, cherry redness (as in CO poisoning), an ashy greyness of the skin and mucous membranes or by a change in the respiratory cycle. Pure oxygen and oxygen with carbon dioxide are routinely used for gas poisonings. Their

*Read at the regular meeting of the Staff of St. Elizabeth's Hospital, May 24, 1938.

use should be extended to all types of poisonings when anoxemia is present.

In conjunction with the measures to relieve shock and anoxemia, it is important to remove the source of local irritation and to prevent the absorption of the poison into the general system. Emmolients, local anesthetics, mild disinfectants and soothing lotions are useful external remedies. Poisons may be removed from the gastrointestinal tract by purgation, emesis or gastric lavage and their effects reduced by demulcents or non-specific antidotes such as milk and egg-whites.

Obviously, when a specific antidote is known it should be given. Alkalies are treated with weak acids, depressants with stimulants, tetany of strychnine with sodium amytal, morphinism with atropine and so on. Certain chemicals have a definite reaction on specific poisons. Ferric hydroxide with magnesium oxide for arsenic, methylene blue for cyanide, dilute hydrochloric acid for lead acetate, are a few examples.

It is necessary to understand the pathology of the various types of poisoning to carry out the proper treatment. The prevention of liver damage in chloroform, phosphorus, arsenic, and benzene ring poisoning; the protection of the kidney in bichloride poisoning; the treatment of esophageal stenosis in phenol poisoning, each must follow the emergency treatment of that poison. These things must be kept in mind and used when indicated, but the more serious, killing symptoms, shock and anoxemia, must be treated and relieved first.

Due to laxity in the drug laws, to self-medication by the patients, to inadequate control of the period of treatment by physicians, and due to the early use of new and unproved remedies chronic and subclinical poisonings are very frequent. Colitis is often the result of frequent purgation, many skin rashes are dermititis medicamentosa or allergic manifestations of ingested drugs. It has been estimated that at least one-fourth of the adult population of the United States is exposed to toxic agents each year. All of us see such patients every day.

The following brief case reports are given to illustrate a few of the usual rather than the unusual findings in general practice.

Mrs. F., a married nurse, was first seen in February, 1938. Following the death of her mother one year previously, she began to take veronal. One month later she developed asthma for which she gave herself 1-1000 adrenalin by hypodermic and 1-100 adrenalin by spray. She had also been on a low carbohydrate diet because a nurse friend told her that starches often cause asthma. When seen she was semi-comatose, had a dry coated tongue and pharynx. Her skin was dry; her breath had the odor of acetone; her urine contained acetone and diacetic acid; her blood sugar was 55 milligrams. Glucose, water, withdrawal of veronal and adrenalin, relieved all of her symptoms.

T. B., 12 years old, had generalized erythematous blotches and hematuria. One week previously he had developed acute tonsilitis for which his mother had been giving him 5 grains of aspirin every two hours.

Miss A. M., age 19, weight 92 lbs., took dinitrophenol on a dare. Her temperature was 104.8; pulse 140. She was very nervous and apprehensive, and had difficulty in breathing. Her skin was hot and dry, and her lips extremely swollen. Her urine contained albumen and casts.

Mrs. J. was refused insurance because of obesity. The insurance examiner gave her a sample of Nitraphen (dinitrophenol) and advised her to take it. She developed jaundice, abdominal pain, weakness, and vertigo.

Mrs. Z., aged 62, when first seen complained of palpitation, yellow vision and the sensation of seeing yellow snow falling when she looked out her

window. For six weeks she had been taking a mixture of medicines as a heart tonic, the chief ingredient of which was digitalis. The withdrawal of this relieved her symptoms completely.

J. R., 35, had been treated in Pennsylvania with bismuth and neoarsphenamine. Following the sixth intravenous injection of neoarsphenamine he developed a severe skin eruption with jaundice, malaise, and weakness. He was hospitalized for two weeks. One year later one injection of 0.45 grams of neoarsphenamine produced an acute, generalized, exfoliative dermititis.

J. J., 35, had cyanosis, dyspnea, anorexia, diarrhea, and jaundice from 200 five-grain sulphanilamid tablets advised by a druggist.

L. R., 27, also advised by a druggist, had been taking sulphanilamid. He had marked swelling of the lips and eyelids with a thick yellow discharge from his eyes. On all exposed sunburned areas of the skin he had a red papular eruption which ended abruptly at the line made by his bathing suit.

Rashes from bromides, changes in personality from barbiturates, cyanosis from coal tar products, and other mild manifestations of drug poisoning are more frequent than is generally suspected. Most drugs are capable of producing definite symptomatology when their administration is prolonged. These symptoms may not be as dramatic as agranulocytosis, aplastic anemia, sulphemoglobinemia or other sever intoxications but should be kept in mind.

Summary

In acute poisoning the recognition and early treatment of shock and anoxemia are of primary importance.

The use of specific and non-specific antidotes should accompany or follow the treatment for shock and anoxemia.

Emetics and purges may be used following the treatment for shock.

Better control of drugs is necessary to prevent chronic poisoning.

NEWS ITEMS

Doctors Morris Deitchman and M. M. Szucs are at Michael Reese Hospital in Chicago for a two weeks special course in Cardiology.

Doctors Cafaro, Clifford, Kupec, Marinelli, Osborne and J. M. Ranz have returned from the wilds of Canada where they allegedly caught innumerable large fish. They missed the companionship and knowledge of that champion fisherman of the Staff of St. Elizabeth's Hospital, Dr. B. B. McElhaney, who was to have been with them. Unfortunately, just before train time Dr. McElhaney's appendix flared up on him and it had to be removed stat. He is now convalescing at his home.

Dr. S. Jay Goldblatt has returned from the University of Chicago where he took a three weeks postgraduate course in Obstetrics and Gynecology.

The annual Ex-Internes reunion of St. Elizabeth's Hospital was held on Thursday, August 11th. The day's events began with a scientific program consisting of a series of papers on the Acute Abdomen. These papers were presented by Drs. Herald, Marinelli and Wasilko. Dr. Saul Tamarkin showed a number of x-ray films illustrating the Acute Abdomen as diagnosed by the Radiologist. Dr. Dean Lewis was present at the meeting as a special invited guest. He gave a short talk on Cystic Disease of the Breast. At 12 o'clock noon the Sisters of St. Elizabeth's Hospital entertained the Staff at a luncheon in the nurses' dining room. The members then adjourned to the Mahoning Country Club where a number of golf enthusiasts had considerable difficulty breaking par. After the usual refreshment at the 19th hole about 60 members partook of the steak dinner. Dr. R. V. Clifford as Master of Ceremonies succeeded in unearthing a number of very fine duets and quartets among the usually reticent M. D.'s. Community singing was also participated in with much gusto to the strains of a fine hill billy band. The day ended with bridge and poker.

Dr. W. K. Allsop is doing a little fishing with Drs. Sedwitz and Gross in Canada.

Dr. S. W. Weaver has been fishing in Canada about 150 miles south of St. Marie. He says it was very cold up there, very wild, but *lots* of fish. His camp was the last outpost below the Arctic circle.

Dr. Fred Coombs, who has spent three years at Massachusetts General Hospital, is home for a month's vacation. He addressed the Staff of the Youngstown Hospital on "Value of Chemistry in Medicine."

Dr. J. P. Harvey will spend the month of September at the Massachusetts General Hospital. He is studying heart with Dr. Paul White.

Dr. W. H. Bunn has returned from a vacation in Yellowstone Park and other points west.

Doctors L. W. Weller and Charles Warnock attended the "Fellowship" reunion of the Cleveland Clinic Friday and Saturday of last week. Dr. Weller also attended the Fellowship Interne Reunion of the Henry Ford Hospital last Monday and Tuesday.

Dr. Barclay Brandmiller has returned from a three weeks period as "Camp" Doctor at Camp Fitch.

Personal Knowledge

Being a public school physician, I often run across amusing incidents. A school nurse one day sent a boy home with a note asking his mother to give him a bath, because he smelled bad. The next day the boy returned to the nurse with the following note:

"Johnny smells just like his father. The trouble with you old maids is that you don't know what a real he-man should smell like."

—(Submitted by Hermina Hartig, M. D., Minneapolis, Minn.)

His First Solid Food

PABLUM is now being fed to infants as early as the third or fourth month because it gets the baby accustomed to taking food from a spoon, but, most important, Pablum early adds essential accessory food substances to the diet. Among these are vitamins B_1 and G and calcium and, perhaps most necessary, iron. Soon after a child is born its early store of iron rapidly diminishes and, as milk is poor in iron, the loss is not replenished by the usual bottle-formula. Pablum, therefore, fills a long-felt need, for it is so well tolerated that it can be fed even to the three-weeks'-old infant with pyloric stenosis, and yet is richer than fruits, eggs, meats, and vegetables in iron. Even more significant, Pablum has succeeded in raising the hemoglobin of infants in certain cases where an iron-rich vegetable failed. Pablum is an ideal "first solid food." ***Mothers appreciate the convenience of Pablum as it needs no cooking. Even a tablespoonful can be prepared simply by adding milk or water of any temperature.***

Pablum consists of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, iron salt, and sodium chloride.

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The baby's first solid food always excites the parents' interest. Will he cry? Will he spit it up? Will he try to swallow the spoon? Far more important than the child's "cute" reactions is the fact that figuratively and physiologically this little fellow is just beginning to eat like a man.

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The physician finds S. M. A. simple to prescribe and the mother gratefully finds it simple to prepare. • The busy physician is relieved of exacting detail because he has only to increase the amount of S. M. A. (as with breast milk) when in his judgment it becomes necessary. • The physician's time is also saved because chances are good for excellent results under his skilled supervision. • Samples to physicians on request.

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S. M. A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is *essentially similar to human milk* in percentages of protein, fat, carbohydrates and salts in chemical constants of the fat and in physical properties.

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