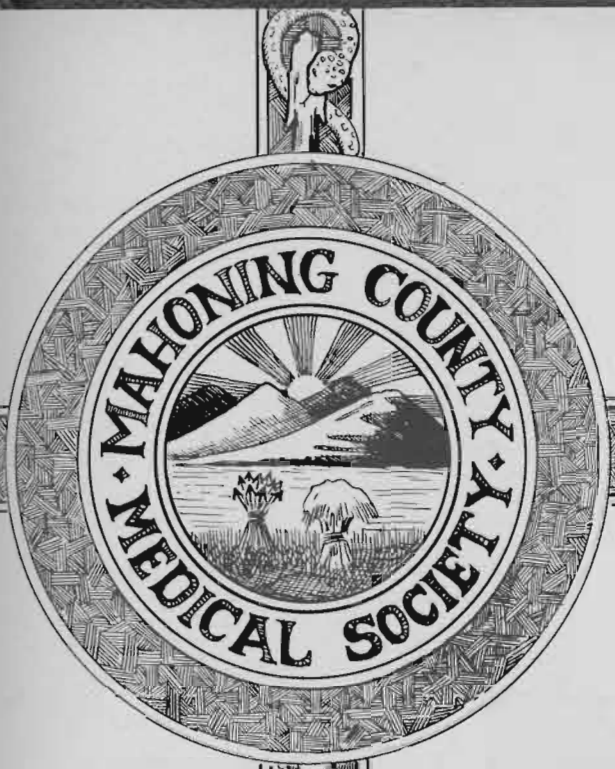


"The presumption is likely to exist that if only the diagnosis be correct, correct treatment will flow inevitably from it. Nothing could be further from the truth. Treatment is not a mere corollary of diagnosis. Treatment in itself demands the full employment of all one's powers of keen observation and clear, unbiased judgment, and it demands also a warm enthusiasm."—*William R. Houston.*

BULLETIN

of the

Mahoning County Medical Society

Vol. VIII No.11
November 1938

now . . .

YOU CAN GIVE SALICYLATES IN ADEQUATE DOSES

Gastric Disturbance Held to a Minimum

TODAY the trend is toward massive doses of salicylates in treating influenza, the common cold, rheumatic and arthritic conditions. Tolerance, then, becomes a most urgent consideration, for salicylates so often produce gastric disturbance when given in adequate doses.

ALYCIN-MERRELL assures maximum tolerance, for **only** Alycin combines these two elements:

1. **Natural Salicylates**—preferred for over 60 years for reliable salicylization with less gastric distress.
2. **Balanced Alkaline Base**—selected alkaline salts in proper proportion to act as a buffer against gastric irritation.

ELIXIR ALYCIN
(MERRELL)

One average teaspoonful Elixir Alycin contains approximately 5 gr. Natural Sodium Salicylate and 10 gr. alkaline salts (potassium bicarbonate, sodium citrate) in aromatized elixir containing 10 per cent alcohol. Supplied in four-ounce and sixteen-ounce bottles.

Alycin Powder and Alycin Effervescent Tablets are also available at the prescription pharmacy.

Write for literature and sample.

THE WM. S. MERRELL COMPANY

Established 1828

CINCINNATI, U.S.A.

RADIO TALKS

Nov. 11—Cancer Can Be Cured - - - - - - - Dr. G. M. McKelvey

Nov. 18—Cancer in Early Treatment - - - - - Dr. Joseph Nagle

Nov. 25—Cancer Is Curable - - - - - - - - - Dr. Herman Kling

Dec. 2—The Doctor of Tomorrow - - - - - - - Dr. E. H. Young

Dec. 9—Sickness Insurance or Your Own Family Physician - - - - - - - - - - - - - Dr. W. K. Stewart

Dec. 16—Your Doctor and You - - - - - - - Dr. J. L. Scarnecchia

Dec. 23—Have a Safe and Happy Christmas - - - Dr. L. K. Reed

MEDICAL CALENDAR

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.

Vol. VIII—No. 11 November, 1938

CONTENTS

ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

THE MAHONING COUNTY MEDICAL SOCIETY BULLETIN

Inquiries and remittances for advertising or subscription should be addressed to Dr. Morris S. Rosenblum, Home Savings and Loan Bldg., Youngstown, Ohio.

Published monthly at 787 Wick Avenue, Youngstown, Ohio.
Annual Subscription, $2.00.

COMMITTEE CHAIRMEN—1938

Name	Committee	Phone	Address
JAMES D. BROWN	Editorial	7-5126	Home Savings & Loan Bldg.
MORRIS S. ROSENBLUM	Business Manager	3-9113	Home Savings & Loan Bldg.
JOHN NOLL, JR.	Program	6-5119	101 Lincoln Avenue
WALTER K. STEWART	Public Relations & Economics	4-1974	Stambaugh Bldg.
EARL H. YOUNG	Sub-Committee on Economics	7-3245	1050 Wilson Avenue
F. F. PIERCY	Co-Chairman—Economics	3-4189	Home Savings & Loan Bldg.
D. E. MONTGOMERY	Sub-Com. on Indigent Relief	3-6510	Southside Bank Bldg.
DEAN NESBIT	Co-Chairman—Indigent Relief	6-6703	Home Savings & Loan Bldg.
WM. H. EVANS	Sub-Com. on Public Relations	4-2147	Dollar Bank Bldg.
G. B. KRAMER	Medico-Legal	4-2161	Southside Unit, City Hospital
JAMES B. BIRCH	Postgraduate Day	7-3127	127 Lincoln Avenue
O. J. WALKER	Legislative	7-6176	Home Savings & Loan Bldg.
CHAS. SCOFIELD	Public Health	5-2421	34 State St., Struthers, O.
LOUIS S. DEITCHMAN	Publicity	3-2620	Central Tower
EDWARD J. REILLY	State Correspondent	3-0631	247½ Robinson Road, Campbell, O.
ELMER H. NAGEL	Membership and Attendance	3-9618	1301 Market Street
H. E. PATRICK	Social	4-2661	138 Lincoln Avenue
L. G. COE	Co-Chairman—Social	4-2420	Home Savings & Loan Bldg.
W. M. SKIPP	Lay Education	4-2996	243 Lincoln Avenue
ADOLPH MARINELLI	Housing and Library	3-9553	Central Tower
WM. K. ALLSOP	Hospital Relations	6-6113	Home Savings & Loan Bldg.

PRESIDENT'S PAGE

That Hateful Old A. M. A.!

Influenced by a large section of the press, by articles in many popular magazines, by the propaganda of certain groups of very zealous, but short-sighted social theorists, a great section of our people have come to believe that organized medicine pursues only selfish and obstructive aims. Thousands believe that the American Medical Association (with its components, the State and County organizations) is a stand-pat, reactionary body, determined to maintain the *status quo*, no matter how many people suffer and die for want of medical service.

This state of affairs is as unfortunate to the people as it is unfair to the Medical Profession. That we should not jump into schemes that have already been tried and found unworkable or actually harmful, should be applauded, not condemned. Within limits that are reasonably practical, that retain some of the features with which we are familiar, and by our American experience, understand, we have shown our eagerness to be helpful and to coöperate for the public good. Somehow these things are not as glowingly portrayed to the public as are our allegedly stubborn resistance to change.

Do these people who condemn the A. M. A. know about our consistent insistence, generation after generation, in not simply maintaining the highest code of ethical conduct ever adopted by any group, professional or business, but in improving it, and, best of all, in requiring and practically securing faithful obedience to it? Mighty few doctors, and no wise ones, will risk the displeasure of their ethical brethren by flagrant violations of our ethical code. True enough, some crooks may be found everywhere—but they are not numerous. This self-discipline protects the public from fraud and injury that can not be computed.

Do these people know that the standards of medical education have risen solely because of the help, guidance, and determination of the A. M. A., so that today, in place of several hundred mere diploma mills, weak class B and class C medical schools, we have only the finest of medical schools, all of class A rank? These schools are thoroughly equipped, and are manned by the ablest teachers the world affords. Do the people know what this means? It means, of course, the saving of millions of human lives. Now the young man who wishes to become a doctor must learn the science and art of medicine under the supervision of devoted teachers, experts. Do the people know this?

Within the week, over the radio I have listened to a dozen programs offering to the public some quack nostrum or other, alleged to have marvelous properties for relief of everything, from acampsia to zoopsia. Pick up the dear old home paper, or your pet magazine, and you'll find "Keep John Alkaline"! or something for that "head." To our great surprise whisky, tobacco, and listerine are all wonderful remedies for what ails you. But why be surprised at all?

What have these to do with the A. M. A.? In your Journal, week after week, you find quacks exposed and nostrums analyzed. If the radio and the publications would painstakingly carry this information to the people—but—!! These are only a few of the many things we are doing.

And *we* are supposed to be selfish! A very sweet lady referred to our national organization as "That hateful old A. M. A." If only she really could be made to understand!

CLAUDE B. NORRIS, M. D.


REPORT OF VITAMIN D ASSAY

Products which contain Vitex produced by National Oil Products Company
Licensed by Columbia University under U. S. Pat. No. 1,678,454
Method of Assay - (Tentative A.O.A.C.)

Lab. Assay No. 3514 — Date August 3, 1938

Material Tested (Labeled) Vitamin D Milk (Vitex)
Produced by Isaly Dairy Company
Location Youngstown, Ohio
Date and hour when received 7/1/38 Western Union — Test Dates 7/8 to 15/38

RESULTS - Positive Control - 25 Mgs. U. S. P. Ref. Cod Liver Oil - 95 Units
Pat Nos. 31445,45,52,58,59,71,72,77000,99,101,31,48,49,54
Results 2 2 4 2 2 2

Experimental - 0.8 Average Degree of Healing
5006Mgs. 2504 4113
Pat Nos. 32140,41,46,47,51,80,86,87,91,00,
Results 2 1 4 2 2

1.2 Average Degree of Healing

PHOTOGRAPHS

Positive Control

Experimental

CONCLUSION: The Vitamin D Milk ... assayed at 1 unit 400 U.S.P. units of Vitamin D per ... quart.

Ohio Experiment Station
Wooster, Ohio

That each quart of Isaly's Vitamin D Milk contains, as claimed, the required anti-rachitic potency — 400 U. S. P. units of Vitamin D — is confirmed in this assay report from the Ohio Experiment Station at Wooster, Ohio.

THE ISALY DAIRY CO.

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

THE USE OF DRUGS IN THE TREATMENT OF HEART DISEASE*

Synopsis of Lectures given by
A. CARLTON ERNSTENE, M. D.
Cleveland, Ohio

(Number 1)

Digitalis is the most important drug used in the treatment of heart disease. The beneficial effects which follow its administration to patients who have congestive heart failure and normal heart rhythm are due to the direct action of the drug upon the myocardium. This results in increased amplitude of the cardiac contraction and more complete systolic emptying of the ventricles. When auricular fibrillation is present an additional mode of action comes into play and consists of depression of the auriculoventricular node. As a result, a certain degree of block is interposed between the auricles and ventricles, and the ventricular rate decreases. The diureses which so commonly results from the administration of digitalis in cases of congestive myocardial failure is not due to any effect of the drug on the kidneys but is a manifestation of the improved state of the circulation.

The most common toxic manifestations of digitalis are anorexia, nausea, vomiting, frequent premature beats, certain cerebral symptoms such as headache and mental confusion, and disturbances of vision.

Digitalis should be administered to all patients who have congestive myocardial failure, regardless of whether the heart rhythm is normal or is irregular due to auricular fibrillation or auricular flutter. In the presence of congestive failure, partial heart block does not contraindicate the use of the drug although it does call for caution and frequent electrocardiograms. Digitalis is also given to all individuals who have auricular fibrillation or auricular flutter with a rapid ventricular rate, even though there may be no evidence of myocardial failure. Persons who have had congestive failure are kept indefinitely upon maintenance amounts of the drug for it has been amply demonstrated that this, together with limitation of bodily activity, constitutes the most effective safeguard against recurrent attacks of failure. The drug is also administered as a therapeutic trial when it is uncertain whether or not a slight degree of myocardial failure is present, as in the case of elderly people who experience dyspnea on limited exertion and patients with emphysema of the lungs who have a higher degree of dyspnea than one can easily attribute to the lung condition alone. Individuals who have had one or more attacks of cardiac asthma are kept permanently upon suitable daily doses of digitalis. The drug also is useful at times in preventing recurrent attacks of auricular paroxysmal tachycardia. In persons who have numerous premature beats, digitalis must be used with caution; when the disturbance in rhythm is due to early myocardial failure, however, the drug often will diminish the number of extrasystoles.

In only a few cases is it necessary to administer digitalis in some other way than by mouth. Occasion-

*From the Cleveland Clinic.

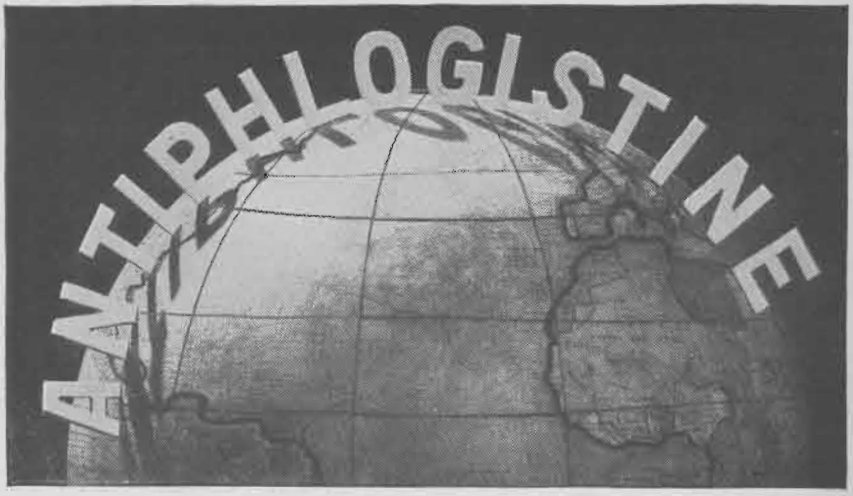
ally, however, because of nausea or vomiting or because of difficulty in swallowing after operations upon the thyroid gland, administration by intramuscular injection or per rectum is necessary. In emergencies only, the drug is given by intravenous injection.

The aim of digitalis therapy is to give the drug in amounts sufficient to produce and maintain the optimum therapeutic effect and yet to avoid toxic symptoms. For the average individual of 150 pounds, approximately 1.5 gms. (22½ grains) will be required to produce this optimum effect but there is considerable individual variation. The rate at which digitalis is introduced into the body must be determined in each case by the urgency of the situation. In well over one-half of all cases, the administration of 0.1 gm. (1½ grains) three times a day for five to seven days is the most suitable method. When the optimum amount of digitalis has been given, the dosage is reduced to a daily maintenance amount which usually ranges from 0.1 to 0.2 gms. A number of preparations suitable for intramuscular or intravenous administration are available on the market. It is advisable to become acquainted with one or two of these and confine one's self to their use. For rectal administration, the tincture of digitalis may be employed diluted with 30 to 50 volumes of water.

Quinidine sulphate is employed to reëstablish normal sinus rhythm in certain selected cases of auricular fibrillation or auricular flutter. Both of these arrhythmias are due to circus rhythm in the auricles and the drug, when used successfully, abolishes the circus movement by predominant prolongation of the refractory period of the auricular muscle. Patients to whom quinidine is given should be kept in bed, and if congestive failure is present this should be relieved first by the use of digitalis. Quinidine should not be given to patients who have badly damaged hearts or long-standing valvular heart disease, nor should it be used if rest in bed and the administration of digitalis have failed to control the symptoms and signs of congestive heart failure. A history of an earlier embolic accident or of idiosyncrasy to quinine or its derivatives also contraindicates the use of the drug. The most favorable group of cases in which quinidine is employed is that in which auricular fibrillation, which has developed during hyperthyroidism, persists for more than ten days after operation. Normal rhythm can be permanently restored in well over one-half of these cases. In patients who have paroxysmal auricular fibrillation, quinidine sulphate, in doses of 0.2 gms. (3 grains) two or three times a day, will often prevent recurrence of the paroxysms.

The persistence of edema due to congestive heart failure in spite of rest in bed and the suitable use of digitalis calls for the administration of a diuretic drug. The most effective diuretics belong to one of two classes, namely the xanthine group or the mercurial preparations. Theocin is the most useful member of the xanthine group and may be given in doses of 0.3 gm. (5grains) three times a day for three or four days followed by a rest period of at least ten days or in amounts of 0.1 gm. (1½ grains) three times a day for much longer periods. The most valuable mercurial diuretics are salyrgan and mercupurin. Both of these preparations are best given by intravenous injection. Usually the initial dose is 0.5 cc. or 1 cc., and subsequent doses of 2 cc. are given at intervals of three to seven days as necessary.

A few other preparations should be mentioned, and chief among these is morphine sulphate. This drug should be given immediately to every patient who has severe congestive failure and should be repeated in the evening of the first day to insure restful sleep. The degree of improvement that results from a good night's sleep is quite remarkable and always most



In all quarters of the globe

NOT only in countries of the Temperate Zone, but within the Arctic Circle, as well as in the Torrid Regions, Antiphlogistine is known and prescribed regularly by the Medical Profession.

Inflammation's antidote

Sample and literature on request

THE DENVER CHEMICAL MFG. COMPANY
163 Varick Street . . . . New York, N. Y.

gratifying. Morphine may be needed again on the following few nights but after that milder sedatives such as the bromides or one of the barbiturates usually suffices to control restlessness and secure sleep.

The Treatment of Coronary Artery Disease*

(Number 2)

The five chief manifestations of coronary artery disease are: (1) angina pectoris, (2) coronary thrombosis with infarction of the myocardium, (3) cardiac asthma (paroxysmal cardiac dyspnea), (4) the Adams-Stokes' syndrome, and (5) congestive myocardial failure. Each of these conditions gives rise to a well-differentiated clinical picture, and the management of each differs in important respects from that of the others. The diagnostic features and treatment of the various syndromes will be discussed in the present communication.

Angina Pectoris

Angina pectoris is a descriptive term applied to paroxysmal attacks of substernal pain which characteristically are precipitated by exertion or excitement and are relieved promptly by rest. The patient often experiences difficulty in describing the pain and frequently refers to it as a sensation of fullness, pressure, tightness or heaviness in the anterior chest. The distress is of such a nature as to enforce cessation of all activity and at times is accompanied by a sense of impending death. There may or may not be radiation of the discomfort to the neck, jaws or inner aspect of the arms. Glyceryl trinitrate and similar preparations give prompt relief from the symptoms. Death may occur instantaneously during an attack.

The most important measure in the treatment of angina pectoris consists of impressing upon the patient the imperative need for limitation of his activity in order to avoid, so far as possible, the induction of attacks. Hurry and unusual exertion of all kinds must be prohibited. Certain conditions exert an important effect upon the ease with which the pain is precipitated, and the patient must be instructed fully concerning these. The attacks come on with greater readiness during cold weather than during the warmer months. The patient therefore must be advised to reduce his gait during the fall and winter months and must be informed specifically of the greatly added load which walking against a wind or through snow places upon the heart. Residence in a warmer climate should be urged in all cases in which such a change is financially possible. Less exertion usually is required to induce the pain soon after eating than at other times, and occasionally an attack may result from the taking of a large meal without additional activity. Because of this it is important that overeating be avoided and that the patient rest for at least 30 minutes after each meal. Occasionally it is advisable to allow four or five small meals daily rather than three larger ones. The overweight individual should be placed upon a reducing diet, for the loss of excess weight will result in a proportionate diminution in the demands on the heart during physical activity. Coffee and tea should be allowed only in moderation, and the consumption of tobacco should be reduced to the lowest level the patient will accept. Because straining at stool may initiate an attack in certain persons, suitable measures must be taken to avoid constipation.

Many preparations have been recommended for use in patients with angina pectoris with the aim of increasing blood flow through the diseased coronary arteries, but the clinical effectiveness of most of these drugs remains doubtful. Although the administration of aminophylline and sim-

*From the Cleveland Clinic.

ilar preparations in sufficient amounts results in a certain degree of increase in the ability of the patient to do measured work without pain, the magnitude of this increase is seldom such as to be of appreciable help in the regular daily activities of the individual. Most patients appear to do quite as well without drugs of this nature as they do with them.

The two drugs of thoroughly established value in the management of angina pectoris are glyceryl trinitrate and amyl nitrite. Of the two, the former is to be preferred; it is just as effective as the latter, has a somewhat longer period of action, is less unpleasant to use and less expensive. Only fresh tablets should be employed, and these should be dissolved under the tongue or should be chewed thoroughly before swallowing. For many individuals a 1/200 grain tablet is as effective as a larger amount. The drug is employed not only for the relief of anginal pain but also as a means of preventing the development of attacks. Many patients are forced by the nature of their occupation to perform tasks which regularly precipitate anginal pain, and in these persons the attacks often can be prevented from developing by the use of glyceryl trinitrate shortly before undertaking the unavoidable exertion. In unusual circumstances from 12 to 20 tablets may be used in this manner each day. When attacks are liable to follow a meal, the drug may be given for its prophylactic effect either immediately before or soon after eating. The frequent use of nitroglycerine does no harm and often enables the patient to get along comfortably for a long time. It does not excuse him, however, from avoiding unnecessary types of activity that may bring on an attack.

In persons who are inclined to worry or in whom anginal pain is induced by emotional upsets, sedatives are indicated and may have a very beneficial effect. Occasionally an appreciable increase in exercise tolerance follows the use of whiskey or brandy in doses of one-half ounce or one ounce with each meal. Digitalis is employed in the patient who has angina pectoris only in the presence of such evidence of myocardial insufficiency as dyspnea on limited activity and edema of the lower extremities.

Of the various surgical measures that have been employed in the treatment of angina pectoris, alcohol injection of the upper four thoracic sympathetic ganglia on one or both sides appears to be the safest procedure and to be equal to any other in effectiveness. This method of treatment does not change the condition of the coronary vessels but it does afford the patient partial or complete relief from his attacks and may therefore enable him to remain self-supporting for a considerable length of time. There is no evidence that removal of the pain serves to shorten the individual's life. Neuritis of the infiltrated intercostal nerves is a rather common complication of the injections but is seldom a source of great complaint in those who have had severe anginal attacks. This method of treatment is worthy of wider application than at present but its use should be restricted to those cases in which the attacks can be controlled in no other way.

The work of Beck and his associates[1] in establishing a new blood supply to the heart by grafting a part of the pectoral muscle upon the myocardium constitutes a direct attack on the underlying coronary artery disease. The clinical results have been distinctly encouraging and the further progress of the work will be watched with great interest.

Coronary Thrombosis

The clinical picture of acute coronary thrombosis is too well known to warrant detailed description at this time. The pain is similar to that in angina pectoris but is more severe and of longer duration. Symptoms of shock of mild or severe degree appear soon after the onset, and fever and

leukocytosis usually develop within the first 24 hours. The erythrocyte sedimentation rate becomes elevated. A pericardial friction rub may appear at any time during the first few days after the attack and may last for only a few hours or for several days. The electrocardiogram will show characteristic changes in practically all cases of coronary thrombosis if records are made at daily intervals and if both standard and precordial leads are used.

The first aim in the treatment of acute coronary thrombosis is to relieve the pain. For this purpose, morphine sulphate should be administered as promptly as possible by hypodermic injection. The initial dose is usually one-fourth grain but whenever the pain is exceptionally severe one should not hesitate to administer one-half grain. Subsequent doses of one-fourth grain should be given at intervals of one-half hour or so if the distress continues unabated. At times, it may be necessary to administer as much as one grain within the first hour or two. The patient should be placed in bed as soon as possible after the onset of symptoms, and should not be disturbed by frequent examinations. Because of the shock and profuse perspiration which often are present, the body should be kept warm and, as soon as the patient is more comfortable and is free from nausea and vomiting, fluids should be offered in frequent small amounts. Stimulants, such as caffein sodium benzoate, are administered only if the systolic blood pressure falls below 80 mm. of mercury.

In the more severe attacks of coronary thrombosis which are accompanied by cyanosis and intense dyspnea, the administration of oxygen should be instituted as promptly as possible, preferably by means of an oxygen tent. Not only does this measure reduce the cyanosis and dyspnea but it may also lessen the intensity and shorten the duration of the pain.

After the pain and initial shock have been controlled, the majority of patients require little medication. It appears advisable, however, to administer quinidine sulphate in doses of 0.2 gm. (3 grains) two or three times a day as a possible prophylactic against the development of ventricular paroxysmal tachycardia and ventricular fibrillation. Aminophylline may be given in doses of 0.1 gm. (1½ grains) three times a day but its value is hard to estimate. Sedatives may be necessary in small divided doses during the day or at bedtime to control restlessness. Digitalis is employed only in the event of congestive myocardial failure or when there is auricular fibrillation with a rapid ventricular rate.

The diet should be simple and should be limited to a value of 800 or 1000 calories. If the bowels do not move spontaneously, enemas should not be administered until after the second or third day.

The emphasis in treatment should be placed on the necessity for absolute rest. The patient should be fed and should not be allowed to help in changing his position for at least two weeks, and the total period of rest in bed should be from six to eight weeks. The erythrocyte sedimentation rate is a helpful guide in this respect; rest is enforced until the rate has become stationary at a normal or nearly normal level. After the period in bed, the patient is permitted to be up for short and gradually increasing lengths of time daily but is not allowed to return to his business activities for 3 to 12 months, depending upon the severity of the attack.

The most important complications of coronary thrombosis are (1) sudden death due to rupture of the ventricle or to ventricular fibrillation, (2) ventricular paroxysmal tachycardia, (3) congestive heart failure and (4) embolic accidents. Sudden death and ventricular paroxysmal tachycardia occur most commonly during the first two weeks after the occlusion. Ventricular tachycardia may be a forerunner of ventricular fibrillation

NEXT REGULAR MEETING

Tuesday Evening, November 15th, 8:30 P. M.

YOUNGSTOWN CLUB

Subject:

General Use of the Chemical Laboratory in the Diagnosis and Practice of Medicine

BIOGRAPHY

DR. TALBOTT was graduated from the Harvard Medical School in 1929, his title now being Associate in Medicine. An interne on the Medical Service at the Presbyterian Hospital in New York until 1931. During the next two years was tutor in Biochemistry at Harvard College. In the summer of 1932 received appointment at the Massachusetts General Hospital where he is now Assistant Physician.

Since graduating from Medical School, Dr. Talbott has participated in four expeditions of the Harvard Fatigue Laboratory—first in 1929 to Colorado where the first high altitude studies were carried out: the next two were to Boulder Dam in 1932 and Youngstown in 1934, for the study of the ill effects of heat. In 1935 he was with the Harvard expedition to the Chilean Andes for further studies on the effects of high altitude. In 1933 carried on certain postgraduate studies at the University of Gottingen in Germany and again in 1937 did postgraduate work at the University of Innsbruck in Austria.

Annual Business Meeting

December 20th

ELECTION OF OFFICERS

FOR 1939

SOCIALIZED MEDICINE—TYRANNY

What may be expected if the people accept "Bureaucratic Medicine" is graphically shown in the following letter:

(FORM LETTER-WP-19)

UNITED STATES EMPLOYEES' COMPENSATION COMMISSION
Washington

October 19, 1938

In reply refer to File No. WP-683166
State No. 40547

Dr. J. C. Hall
243 Lincoln Avenue
Youngstown, Ohio.

Dear Sir:

In order that further consideration may be given the claim of Mr. Jack ....., Youngstown, Ohio, on account of an injury reported to have been sustained on May 31, 1938, while employed by Works Progress Administration, he is being referred elsewhere for a special examination and any necessary medical treatment.

Pending specific authorization from this office, the Commission will not be responsible for further medical expense under your supervision.

Your charges to date for treating this case should be submitted on Form 8-69 through the establishment which authorized the treatment. The "authorization for treatment" should accompany the Form S-69 in the event same was not previously submitted.

Yours very truly,

U. S. Employees' Compensation Commission
The State Administrator, W. P. A.,
Clinton Bldg., 8 E. Chestnut St.,

Official copy to: Columbus, Ohio
Attn.: Mr. Glen I. May.

Comment: If we take such as this lying down we deserve all we get.

This remarkable epistle is a "form" letter, and evidently, therefore, is the unblushing czaristic practice of the U. S. Employees' Compensation Commission. Firing a doctor is so insignificant a process with them as not to call for even a syllable of explanation. Is this Germany? The free choice of physician is nothing to them, apparently. Is this America?

This patient was sent to the Marine Hospital at Cleveland and there operated. *Back-door socialized medicine again!* This indecent flouting of every consideration for the rights and feelings of the Medical Profession, as well as of the doctor in charge, is worse than one would expect in dealing with criminals.

1938

★ PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN ★

or it may be directly responsible for the development of congestive heart failure. Its onset calls for the administration of increased amounts of quinidine sulphate. Congestive myocardial failure is treated by the usual measures, including the use of digitalis. After acute coronary thrombosis, a mural thrombus commonly forms on the endocardial surface of the infarcted myocardium. Embolic accidents, the result of dislodgment of portions of the thrombus, may occur at any time during the first six weeks after the attack but are most common during the earlier part of this period. The emboli may lodge in any part of the pulmonary or systemic circulation and their treatment usually is limited to symptomatic measures.

Cardiac Asthma

Coronary artery disease is a common cause of that form of paroxysmal dyspnea to which the term cardiac asthma is applied. The attacks of dyspnea are due to failure of a damaged left ventricle and usually occur at night although occasionally they are induced by exertion. Because of relative weakness of the left ventricle, an increased amount of blood accumulates gradually in the pulmonary vessels during sleep in the recumbent position. The vital capacity which is already diminished, is still further reduced as the degree of pulmonary congestion increases, and all that is now necessary to initiate the attack of cardiac asthma is some factor which acts as the trigger mechanism. Cough, Cheyne-Stokes respiration, noise, disturbing dreams and the urinary reflex most commonly supply this factor. The patient wakens with respiratory distress and is forced to sit up or stand in order to breath. Asthmatic breathing develops, with both inspiratory and expiratory difficulty, and as the attack progresses acute pulmonary edema may supervene.

The two most important measures in the treatment of attacks of cardiac asthma are morphine and the upright position. Morphine exerts its beneficial effect by depressing the respiratory and vasomotor centers in the medulla and by reducing the patient's apprehension and anxiety. The drug should be administered hypodermically as early in the attack as possible, usually in doses of one-fourth grain, and should be repeated if the patient does not appear to be improved within 15 or 20 minutes. The relief which the patient experiences in the upright position probably is due principally to the increase in the vital capacity which accompanies the change from the recumbent to the erect posture. There is evidence also that the minute volume output of the heart is decreased in the upright position and, of course, any reduction in cardiac work would lead to an improved state of the pulmonary circulation.

Morphine and the upright position at times may fail to relieve the patient sufficiently and other measures must be employed. Aminophylline may be given by intravenous injection in doses of 0.48 gm. diluted with physiologic solution of sodium chloride or 50 per cent dextrose solution and may result in prompt improvement. The beneficial effect of the preparation is attributed principally to its action on the coronary circulation[2] but the drug also causes a diminution in the degree of bronchial spasm.[3] In the absence of anemia, venesection should be carried out with the removal of 250 cc. to 500 cc. of blood. This may result in prompt and lasting relief, particularly in patients who present engorgement of the peripheral veins. Venesection reduces the circulating blood volume, and as a result the work of the heart is diminished and pulmonary congestion is lessened. An effect similar to that of venesection may be obtained by applying blood pressure cuffs to the four extremities and inflating them to a pressure just above diastolic blood pressure. The administration of oxygen by means of a tent or by nasal catheter is also a measure of great value and

should be instituted as promptly as possible.

In patients in whom cardiac asthma progresses to acute pulmonary edema in spite of the above measures, either strophanthin or digitalis should be given intravenously. It is, of course, essential to ascertain that these patients have not received digitalis earlier.

A patient who has experienced an attack of cardiac asthma due to failure of the left ventricle should be treated as any other individual who presents evidence of impaired myocardial reserve. Complete digitalization and the subsequent administration of daily maintenance amounts of the drug are indicated, and in subjects who have had but mild attacks, this measure alone may suffice to prevent the recurrence of paroxysms.

In those who have suffered more severe attacks, a period of absolute rest is advisable and should be followed by strict limitation of activity. Restriction of fluids and the administration of diuretic drugs also are valuable measures. At times, the intravenous injection of hypertonic glucose solution (50 to 100 cc. of a 25 or 50 per cent solution daily for several days) may be helpful in diminishing the frequency of attacks. Because cardiac asthma due to left ventricular failure usually occurs at night and the onset of the seizure is favored by the recumbent position, the patient should be instructed to sleep well propped up in bed. Sedatives also should be given to insure sound sleep since the attacks generally are precipitated by some factor which tends to waken the patient.

Heart Block

Coronary artery disease is the most common cause of auriculoventricular block. Simple prolongation of auriculoventricular conduction time is observed at times in individuals who have no symptoms referable to the cardiovascular system. More commonly, however, just as in the higher grades of heart block, the patient presents evidence of reduced myocardial reserve, and in such cases the cautious administration of digitalis is indicated. The treatment should be carried out with electrocardiographic control, and if the degree of block increases, the drug should be discontinued. In favorable cases, suitable amounts of digitalis not only relieve the symptoms of myocardial insufficiency but may also reduce the degree of block or abolish it entirely.

The higher grades of heart block, and particularly complete auriculoventricular disassociation, may be complicated by Adams-Stokes' attacks due to temporary standstill of the ventricles. The seizures are characterized by dizziness, syncope or convulsions, depending upon the duration of the ventricular asystole. Adams-Stokes' attacks are not common, but individuals in whom they occur are liable to have repeated seizures. The actual attacks seldom call for treatment, and therapy is directed toward preventing their recurrence. Occasionally, however, the standstill may be of such duration as to necessitate the intracardiac injection of epinephrine and this procedure may be directly responsible for the saving of life. The most effective drugs for preventing recurrent attacks are epinephrine (0.5 cc. to 1.0 cc. of the 1:1000 solution) by intramuscular injection every 3 or 4 hours and ephedrine sulphate (gr. ⅜ or gr. ½) by mouth 3 or 4 times in 24 hours.

Congestive Heart Failure

Coronary artery disease often results in the gradual development of symptoms and signs of congestive heart failure instead of the more dramatic episodes of angina pectoris, coronary thrombosis, cardiac asthma or Adams-Stokes' seizures. Treatment does not differ from that of myocardial failure due to other types of heart disease and consists principally of absolute rest in bed, the proper administration of digitalis, sedatives, and diuretic drugs, restriction of the fluid intake, and, less

★ PATRONIZE OUR ADVERTISERS AND MENTION THE BULLETIN ★

often, venesection and the mechanical removal of fluid from the thorax or abdomen.

Summary

The most common manifestations of coronary artery disease are angina pectoris, coronary thrombosis, cardiac asthma, the Adams-Stokes' syndrome, and congestive heart failure. The treatment of each of these conditions has been summarized.

References

[1]) Feil. H. and Beck. C. S.: Treatment of coronary sclerosis and angina pectoris by producing new blood supply to heart. J. A. M. A. 109:1781-1786 (November 27) 1937.

[2]) Smith. F. M.: Treatment of left ventricular failure. J. A. M. A. 109:646-648 (August 28) 1937.

[3]) Greene. J. A.. Paul. W. D. and Feller. A. E.: Action of theophylline with ethylenediamine. J. A. M. A. 109:1712-1715 (November 20) 1937.

NEWS ITEMS

BRANDT, Dr. and Mrs. A. J. announce the arrival of a daughter, Sunday, October 30, North Side.

FUZY, Dr. and Mrs. Paul spent 10 days in N. Y. attending the American College of Surgeons Convention.

DREILING, Dr. and Mrs. B. J. spent the week of October 10 in N. Y.

HATCHER, Dr. William F. attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology, October 9-14, Washington, D. C.

KEYES, Dr. John, gave two conferences at the course in graduate instruction sponsored by the American Academy of Ophthalmology and Otolaryngology, October 9-14, Washington, D. C.

NELSON, Dr. Gordon G. attended the Pitt-Fordham game Saturday the 29th.

PIERCY, Dr. and Mrs. F. F. spent a week in N. Y., attending the American College of Surgeons Convention, then going to New Haven, Conn., for the Yale-Michigan game.

RANZ, Dr. and Mrs. W. E. have returned from N. Y. where they attended the American College of Surgeons Convention.

REILLY, Dr. Edward J. spent the first week of November in Baltimore attending the Navy-Notre Dame game before returning.

RENNER, Dr. and Mrs. John A. announce the arrival of a son Saturday, October 8th.

ROSENFELD, Dr. Jos. attended the Interstate Postgraduate Assembly in Philadelphia.

ROSENBLUM, Dr. and Mrs. A. M. celebrated their Silver Wedding Anniversary Sunday, October 25th. Open house was observed.

SEDWITZ, Dr. Sam H. was in Washington, D. C., October 27th and spoke to the Medical Staff of the Veterans Bureau on Oscillating Beds and held a demonstration at Garfield Memorial Hospital.

SKIPP - ELSAESSER, Drs. Wm. M. Skipp and Armin Elsaesser attended the meeting of the International College of Surgeons, Philadelphia. Dr. Skipp was accepted as a fellow member.

WELTER, Dr. and Mrs. John A. have returned from a visit to N. Y.

Drs. Louis S. Deitchman, Raymond A. Hall, Stanley A. Myers have been notified by the American Board of Otolaryngology that they have successfully passed the examination recently held in Washington, D. C.

NON-PROFIT MEDICAL EXPENSE INSURANCE

Basically, the idea is to set up an administration which will serve the economic needs of the public and its profession of medicine. It will afford those of limited income or resources opportunity to receive indemnity for major medical care expense from a fund created by small annual "dues" or premiums.

The special meeting of the House of Delegates of the American Medical Association approved "medical expense insurance."

The Joint Legislative Committee on Recodification of the Insurance Law has prepared an act ready for introduction at the next session of the New York State Legislature, known by the title "Article IX-c," which will amend the Insurance Law to permit operation of "non-profit medical expense insurance" associations. This act must become law before the Associated Medical Service of New York can enroll "subscriber members," collect dues and pay indemnities on medical expense. The plan of operation of the Association has been designed to conform to the provisions of this act.

The parent legislative body of organized medicine having approved the principle of medical expense insurance (in which action the delegates of our State Medical Society participated), the enactment of this enabling law early in the legislative session becomes probable. This will be assured if the profession will make a united demand for it.

In order to determine the attitude of the medical profession toward the idea of medical expense insurance, the Association has recently canvassed the entire profession of Kings County. The letters of inquiry with reply postcards were mailed on the evening of Friday, September 23. Up to and inclusive of the first return of mail of Monday, October 3, 1,987 replies were received.

Excluding account of those who reported that they have retired from the active practice of medicine, only four physicians indicated "not interested" in the plan of development of medical expense insurance. All the others (1,983) indicated "interested" and expressed desire to receive forms for application for "participating physician membership" when the Association is ready to begin enrollment of such members.

The Association will make a similar canvass of the other 16 counties in which it proposes to operate.

The only question which should arise in the minds of the profession at large is, "Will this Association be conducted in a manner entirely fair and just to every physician and to the public which we all serve?"

Join with us in a demonstration to the public that the profession of medicine is capable of setting up a social mechanism which can solve a large part of the social-economic problem which is now the cause of public concern—a question which certain elements are endeavoring to emotionalize and capitalize in order to create a bureaucratic control and domination of medicine.

—Bulletin Medical Society County of Kings (N. Y.). October, 1938.

SECRETARY'S REPORT

November, 1938

Council of Mahoning County Medical Society met on October 10, 1938. The routine business was cared for as usual. The City Commissioner of Health, Dr. Ryall, was a guest of Council. He discussed the special ordinance passed by City Council in June, 1938, relative to the appropriation of money for public health services and explained that the health commissioner is responsible for its proper expenditure. In order to utilize this fund with wisdom he must investigate the source for which it is requested. Therefore, the Visiting

Nurses are acquired for part-time duty for this service. They may quaranteen homes, investigate clinics and hospitalization. By this investigation a more accurate knowledge of the real need of the ones requesting aid may be obtained.

A great deal of activity has been exercised by the Legislative Committee in order to secure data regarding the candidates for office. It is the customary thing for the "Legislative Committee" of the local and state medical societies to investigate the trend of thought of candidates for office relative to legislation affecting organized medicine. During the present campaign unusual efforts have been made by both of the committees mentioned above. They have, as a result, issued a joint report which has been sent to members of the medical society.

The great stir that has been made during the past year regarding socialized medicine has brought the existence of organized medicine closer to the general public than ever before. Candidates for office are stimulated to make a public statement which shows their general trend of thought regarding medical legislation.

The following applications were read at the last regular meeting of Mahoning County Medical Society:

Dr. Thomas E. Patton
Dr. Herman H. Ipp
Dr. Gabriel E. DeCicco
Dr. Herbert B. Hutt

The following applicants were accepted for active membership in The Mahoning County Medical Society:

Dr. John Renner
Dr. Barclay Brandmiller.

The following applicants were accepted to Class "D" Associate Membership in The Mahoning County Medical Society:

Dr. Joseph J. Sofranic
Dr. William E. Sovik
Dr. Paul W. Oakes
Dr. Alexander K. Phillips
Dr. Edward F. Hardman
Dr. John H. Thomas
Dr. Myron Stanley Owen
Dr. Arthur C. Litton
Dr. Albert L. Williamson
Dr. Waldemar R. Agricola
Dr. Arthur S. Parker, Jr.

Any objection to these applicants should be made in writing to the secretary within 15 days.

R. B. POLING, M. D., Secretary.

OUR ANNUAL DANCE

Through the *Bulletin* I would like to express the opinion of the majority of the doctors who attended the dinner-dance at the Youngstown Country Club last month when I state that it was a rousing success.

The program committee deserves considerable credit for its initial effort with such an affair in Mahoning County. I know it is the first function where the doctors' wives were invited in my eighteen years as a member of the Society. To Dr. Patrick and his committee should go unlimited praise for the fine manner in which the dinner and dance were conducted. The food was "par excellence," the music was very good, and the after-dinner refreshments were enjoyed by not a few of those present.

The outstanding feature of the dance was the youthful spirit displayed by so many of the wives who have been married ten years or more. It seemed more like a reunion of a large happy family.

To those of you who failed to attend for some reason or other, I can safely say that it would be to your advantage in every way to make it a point to attend the next one which we will surely have next year. The dinner-dance of the Mahoning County Medical Society will undoubtedly be an annual affair from now on and every member should see to it that he permits nothing to conflict with that particular date.

J. ROSENFELD, M. D.

THE MEDICAL CRIER

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

• We dined, we danced and they conquered us! Those lovely, bewitching, charming, intelligent, alluring wives of the doctors. In formal blacks, demure hoops, diaphanous flounces and gleaming silver they dazzled us, entranced us and transported us back to that land of youthful fantasy from which we had so far wandered.

More power to the entertainment committee who gave us such a party! The first annual Dinner Dance was not only a huge success, it was the outstanding social event of the season! May there be many more of them every year until at last the old Crier can only sit and gaze on the festivities with eyes dimmed by age, seeing visions floating past of that first gay assembly away back in 1938.

• The postgraduate course in football tactics held in Pittsburgh on October 29th was well attended by our members. The practical clinical demonstrations by the groups from Pitt and Fordham were very edifying and were received with loud cheers. The clinical amphitheatre was well filled and so were some of the spectators. It was remarkable to see seventy thousand people together, all with good hearts. They had to be good or they would never have gotten up that hill.

• In Spokane, the Medical Service Bureau is now offering medical care to the low wage employees of almost every large firm in the city and is taking care of the need which exists there by giving medical care on a prepayment plan. At the same time, it is maintaining the free choice of physician and independent relationship of patient and physician.

In Youngstown we have one of the best Medical Dental Bureaus in the country. Are they considering this service? We have a prepayment plan for hospitalization which is working successfully. Why not one for medical care operated by the doctors themselves?

• Well, Thanksgiving is rolling around again and we have many things to be thankful for. We can speak our opinions without being sent to a concentration camp. We can vote for whom we please. We don't have to make out lengthy reports to superiors who are laymen (yet). We can afford to take a little Postgraduate Study once in a while. And we are having excellent programs right here at home. What more do we want, anyway?

A German chemist has invented a candy made of coal-tar. Now the doctors in Hitler's realm will face the problem of how to treat a child with a macadamied stomach.—*Jackson (Miss.) News.*

THE COMPLEMENT FIXATION TEST IN GONORRHEA*

By HENRI SCHMID, M. D.

The interpretation of the C. F. T. in gonorrhea is simple if three things are remembered: (1) this serum-reaction demonstrates in the test-tube the presence or absence of gonococcal antibodies in the blood; (2) these antibodies in the blood owe their presence to the absorption of antigenic material or toxins from the tissues; (3) the absorption of toxins is usually proportional to the intensity of the inflammatory reaction that these toxins are able to call forth in the tissues.

Like in syphilis, a negative reaction is recorded in the first few days of the disease.

In the average case of gonorrhea where the infection is no longer confined to the anterior urethra, the reaction is positive about the 10th day, gradually becomes stronger and remains so for a varying period of time; then it slowly tends to revert to the negative, finally reaches that stage and remains negative if cure has been established. A positive test is to be expected and hoped for in the average case of gonorrhea; it indicates a good immunologic response.

If the patient comes in early, under ideal conditions of good drainage and good behavior, the disease may remain anterior until cured and the C. F. T. is likely to be negative throughout. A negative reaction may also be obtained even if a mild posterior urethritis develops provided it responds quickly to treatment.

When posterior urethritis has set in, however, a positive test is the rule. If complications arise, such as prostatitis or epididymitis, the reaction is intensified, becomes strongly positive because these complications occurred when the reaction was already positive.

The reversal of a positive reaction to the negative during treatment is pleasing; it indicates good treatment and adequate drainage. If this negative reaction remains negative at 6-8 weeks intervals in the presence of other negative findings it furnishes a strong evidence of cure; but if a negative reaction once obtained changes back to positive when treatment is discontinued it indicates a re-absorption of toxins and the presence of gonococci in the tissues.

A negative reaction is sometimes recorded in the presence of urethral discharge and positive smears. This occurs in the unfortunate patient whose immunologic function is deficient or, which amounts to the same thing, in the person infected by a strain of gonococci which is poorly antigenic. It has been shown that some strains of gonococci isolated from long-standing chronic gonorrhea are poor antigens both in vitro and in vivo. Be that as it may, in the patient who gives a negative reaction in the presence of active gonorrhea the disease runs a long clinical course with many ups and downs. Treatment, good or bad, has little effect.

A negative C. F. T. is also the rule if sulfanilamide fails to affect a cure when given at the start of the disease. We then have a patient who, though he may not develop severe complications, nevertheless suffers from a protracted disease with frequent relapses after periods of apparent great improvement. Carpenter of the University of Rochester has shown that sulfanilamide protects mice against gonococcal toxins. No one knows exactly how sulfanilamide acts in the human body. But when it fails, either openly or more often by hiding the disease, there remains behind a gonococcus which has lost its antigenic property; it seems unable to call forth a tissue-reaction of enough intensity to allow the tissues to produce the antibodies in question, namely the complement-fixing antibodies. For

*Presented October 10, 1938, at the Pittsburgh Urological Society.

that reason it would seem better not to use the drug at the start of the disease in acute gonorrhea but to wait till the serum reaction has had a good chance to become positive, that is not before the end of the second week. Perrin H. Long recently made the same recommendation thus reversing his stand from a year ago; he did not, however, give any tangible reason for his change of procedure.

A negative reaction may also be found in the presence of infected paraurethral channels or in chronic gonorrhea dependent upon an infected Gland of Littré. In the latter case the focus of infection is more or less walled off within fibrous tissue so that little or no toxic material can escape.

The administration of vaccines will produce a positive reaction lasting six weeks or longer.

It sometimes happens that a serum reaction once positive does not revert to the negative and remains positive long after clinical cure. In such cases the positive test does not necessarily mean the existence of gonococci in the tissues. This sero-resistance may be compared to Wasserman-fastness and "may result entirely from the persistence of a well established immunity." This occurs usually after a severe disease such as acute prostatitis or gonorrheal arthritis.

But we also find patients with a positive serum in whom the infection can no longer be discovered but who have some chronic post-gonorrheal lesions such as hard infiltration of the anterior urethra or chronic prostatitis. Such patients might, at first thought, be classified as serum-fast. If these people are treated and the chronic lesion eliminated the C. F. T. eventually becomes negative. It would seem that the chronically inflamed tissues were the seat of antibody formation.

In the management of gonorrhea the C. F. T. offers a number of useful clinical applications. If properly interpreted it can be just as helpful here as in syphilis. As a test of cure one negative is not sufficient but a series of negatives 6-8 weeks apart. A persistent positive reaction is highly suspicious of infectivity; a patient with such a reaction is considered infectious until proven otherwise.

PATHOLOGICAL CONFERENCE: A CASE REPORT

No. 171753.

Mr. M. B., age 54, Ukranian, White.

Chief complaint: Unconsciousness.

Present illness: This history is obtained from the immediate relatives of the patient who, however, were not in direct contact with the patient.

Four years ago this patient had his left kidney removed at St. Elizabeth's Hospital. He had been injured and passed blood in the urine so the kidney was removed. He has had kidney trouble for the past couple years. The presenting symptom has been frequency of urination. For the past several days the patient has not been feeling well. He has been complaining of pain in the back and abdomen, and has vomited on several occasions. This history of ill-feeling was present for a two-week period prior to admission. Patient's daughter was taken to the Tuberculosis Sanatorium because of Pulmonary Tuberculosis. The patient was taken there today. His lungs were examined and he was told that his chest was in good condition. On returning home from the Sanatorium he became sick and vomited several times. When the patient arrived home he had a severe chill and vomited again. Shortly after his arrival home he suddenly "went out of his head" and became irrational. He was immediately brought to the hospital.

Family history: Wife and one daughter have tuberculosis. His wife is home in bed with tuberculosis.

Past history: No further history obtainable.

Physical examination: Patient is a thin, fairly well developed white man 54 years of age, lying very restlessly in bed. His arms and feet are in restraints. This is necessary because the patient attempts to tear and remove bed-clothes and his bed-shirt, and it is not possible to keep him in bed without the use of these restraints. His breathing is deep and fairly rapid.

Head—Negative.

Eyes—Eyes are starey. Pupils react very slowly to light. There was no wink reflex present. Pupils were dilated. Conjunctiva not injected. Eyes fixed.

Ears & Nose—Negative. No blood or fluid noted.

Mouth — Considerable mucous in mouth and throat. Teeth poor.

Neck—Somewhat stiff but it can be flexed. The rigidity is not characteristic of a severe meningitis.

Chest—Respirations deep and labored, the extra respiratory muscles being brought into play with each respiration. Rate is about 35. Expansion equal and unlimited. Breath sounds slightly increased. No definite pathology in the lungs noted because there was considerable mucous in the patient's throat which was heard over the entire chest.

Heart—Heart sounds distant and not definitely heard due to the noise heard, produced by the mucous in the throat. Rate regular. No murmurs.

Abdomen—Flat and not distended. Abdominal muscles become firm with each inspiration. The bladder is about two fingers above the symphysis-pubis.

Extremities—Definite spasticity of both upper and lower extremities.

Reflexes—Patellars four plus; Biceps and Triceps three plus; Babinski negative.

Impression:

1. Cerebral Hemorrhage,
2. Subarachnoid Hemorrhage,
3. Possible Meningitis.

Laboratory findings:

5-11-1938 — Blood: RBC 2,720,000; Hgb. 53%; WBC 26,450; Polys 90; Filament 56; Non-filament 34; Mononuclears 5; L.L. 4; S.L. 1. Examination of spinal fluid: Smear is negative for organisms. Too bloody for routine examination, excepting Wassermann. Report of spinal fluid: Smear: no organisms seen; sterile after 48 hours incubation.

5-12-1938 — Urinalysis: (Stat) Spec. gr. 1.011—color cloudy—straw—alkaline—2 plus albumen—negative sugar. WBC innumerable per H.P.F. Report on exam. of spinal fluid: Color bloody; Volume 5 cc.—1,246 cells—Polys 95%—S. Lymphs 5%. Report of spinal fluid: Sugar 66.2 mgms. Report on spinal fluid examination: Smear shows many RBC, occasional WBC; no organisms. Sterile after 24 hours incubation.

5-14-1938—Wassermann (spinal) negative. (Blood) negative; Kahn negative.

Progress:

5-11-1938—Patient came in unconscious and with convulsions. Spinal tap was done. Bloody fluid was obtained under 320 mm. of water pressure. This did not coagulate in the monometer but did coagulate within 30 minutes in the test tube. In as much as we could not get a specimen of urine, catheterization was attempted but on using from size No. 12 to No. 16 catheters we were unable to get in. Later on the same night patient voided and urinalysis was done which was negative for albumen and sugar. However, many pus cells were seen. Patient was given 7½ grs. of Sodium Luminal intramuscularly which quieted him. Respirations were sterterous in type. Condition grave.

5-12-1938—Another spinal tap was done this morning and pressure was 100 mm. of water. Fluid was pink and coagulated after standing for ½ hour. Respirations still sterterous in type. There is a considerable amount of mucous in the trachea. Condition growing worse. Patient expired at 10:00 P. M.

Bulletin the Berries

We all look forward each month to the coming of the Bulletin. We read it from "kiver to kiver." We see reflected in its pages the wide range of constant activity in which our Society is engaged. We are justly proud of our Society. There may be other County Societies just as good, but none is better .

And we appreciate the vast amount of hard work it takes to line up this elegant Bulletin and get it to the printer.

Well, it means only one thing. The *advertisers* are loyal! Looking back through the file of Bulletins over the years I find that many business people have consistently given their support. For goodness sake, if we don't in turn give our support, our business, to these advertisers every time we possibly can do so, aren't we a "crumby" bunch of pikers, or aren't we? I. Q. S.

The doctor on opening the door of his reception room to summon the patient next in turn, was greeted by a boy of about seven years of age, who explained that his mamma had sent him over to be cured. Inquiry elicited the information that "Mamma" was one of the doctor's oldest patients.

"Well, my boy, what am I to cure you of?" he asked.

"Why," was the explanation, "bof of my eyes is rainin' and one of my noses won't go."

Damaged Enough Already

Lawyer (helping pedestrian up) — Come with me, my man. You can get damages.

Pedestrian (groggy)—H'vens man, I got all the damages I want. Get me some repairs.—*New Smyrna Breeze.*

"LET US HELP"

From the Cleveland Academy Bulletin we quote:

"Several Academy committees, notably the Economics and the Board of Censors, have been consulted recently by members on several offers of employment involving contracts. In other cases these committees have had brought to their attention existing contracts containing provisions which were potentially dangerous both to the patient and the practitioner. While the Academy, unlike some county medical societies, has no rule requiring its members to submit medical contracts before signing, consultations with the proper committee will many times save physicians embarrassment and more serious difficulties. In practically all cases examined to date, the intentions of both the physician and the other party to the contract were good, but the provisions were so worded as to make possible further difficulties.

"Young physicians having offers of employment are especially urged to consult Academy committees before assuming the obligations of contracts, either written or implied." — The Board of Directors.

Our by-laws require new contracts of certain kinds to be submitted to the Council. The purpose is precisely that set out by the Board of Directors of the Cleveland Academy. There is no desire to dictate to our members, but to help them.

Annual Meeting
For
ELECTION OF OFFICERS
Tuesday, December 20, 1938
YOUNGSTOWN CLUB
Social Hour to Follow

OUR MEDICAL CARE

Conditions sure are tough and getting tougher. In all lines of work, in a case of this kind, the first thought is strike. What would happen if the doctors would sit down and refuse to perform what appears to be their duty. Why, the tender-hearted doctors are not going to do anything like that. "They can't do that to us," so some people think—but wait and see what CAN happen if we let congressmen slip State Medicine over on us.

The doctors abroad are just as tender-hearted as ours but, sometime ago a bunch of them came to the end of their rope and did strike. They didn't refuse to see patients but did refuse to unwind the miles of red tape that politically-controlled medical service had imposed upon them. Every doctor in a certain district was ordered to keep records on every patient he treated. The time required for this was 14 minutes (4 hours and 40 minutes for 20 patients) and a string of patients waiting, most of them wanting to get their money's worth of this newly arranged for service, whether or not anything ailed them.

Is the present machinery connecting the patient with sources of medical care inadequate?

I don't think so.

—A PATIENT.

HOW MUCH SUN Does the Baby Really Get?

THIS BABY has been placed in the sunlight. (1) The mother discovers the baby is blinking, so she promptly shields its eyes and much of its face from the light. (2) Since the baby's body is covered, the child will then be getting only reflected light or "sky-shine" which is only 50% as effective as direct sunlight as an antiricketic agent (Tisdall). (3) Even if the baby were exposed nude, it has never been determined how much of the ergosterol of the skin is synthesized by the sun's rays (Hess). (4) Time of day also will affect the amount of sunshine or sky-shine reaching this baby's face. At 8:30 A. M., average loss of sunlight, regardless of season is over 31% and at 3:30 P. M. is over 21%. (5) Direct sunlight, moreover, is not always 100% efficient. U. S. Weather Bureau maps show that percentage of possible sunshine varies in different localities, due to differences in meteorological conditions. (6) In cities, smoke and dust, even in summer, are other factors reducing the amount of ultraviolet light.

While Oleum Percomorphum cannot replace the sun, it is a valuable supplement. Unlike the sun, it offers measurable potency in controlled dosage and does not vary from day to day or hour to hour. It is available at any hour, regardless of smoke, season, geography, or clothing. Having 100 times the vitamins A and D content of U. S. P. cod liver oil (U. S. P. minimum standard), Oleum Percomorphum can be administered in *drops*, which makes it an ideal year-round antiricketic. Use the sun, too.

For Greater Economy, the 50 cc. size of Oleum Percomorphum is now supplied with Mead's patented Vacap-Dropper. It keeps out dust and light, is spill-proof, unbreakable, and delivers a uniform drop. The 10 cc. size of Oleum Percomorphum is still offered with the regulation type dropper.

OLEUM PERCOMORPHUM

Ethically Marketed — Not Advertised to the Public

MEAD JOHNSON & COMPANY, EVANSVILLE, INDIANA, U. S. A.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons.

S.M.A. –FOR INFANTS DEPRIVED OF BREAST MILK

When diluted according to directions, S.M.A. closely resembles human milk, *NOT ONLY* in the percentages of protein, fat, carbohydrate and ash, *BUT ALSO* in the chemical constants and in physical properties.

When fed to infants as a supplement, complement or as a complete substitute for breast milk, S.M.A. consistently produces excellent nutritional results comparable to those obtained with normal breast-fed infants.

The quick, easy method of preparing S.M.A. feedings is unusually simple. A Minute Mix Method Set together with complete directions will be sent Free to physicians on request.

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 chlorides; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants and in physical properties.

S.M.A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

SMA