Postgraduate Day
April 20th

BULLETIN

of the

Mahoning
County
Medical
Society

Vol. IX No. 4
April 1939

FEED THE BABY

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ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

BULLETIN of the . . . . . .
Mahoning County Medical Society
APRIL 1939

Published monthly at
787 Wick Avenue, Youngstown, Ohio.

Annual Subscription, $2.00.

MEDICAL CALENDAR

April 20—Postgraduate Day—U. of P. group, Drs. Wolferth, Pendegrast, Stokes, and Kern.
May 16—Intern Competition, Youngstown Club.
June 20—Speaker, Dr. August A. Werner, Endocrinology. Youngstown Club, 8:30 P. M.
July 20—Golf Party, So. Hills Country Club.
August 17—Golf Party, So. Hills Country Club.
September 14—Corn Roast and Clam Bake, Bert Millikin's Farm.
September 19—Speaker, Dr. Walter M. Simpson, Artificial Fever Therapy. Youngstown Club, 8:30 P. M.

FALL LECTURES

October 2, 3, and 4—By Dr. Bernard Fantus.

Monday—11:00 a. m. to 1:00 p. m.: Prescribing of Pleasant Medication.

Tuesday—11:00 a. m. to 1:00 p. m.: Therapeutic Use of Fluids.
8:30 to 9:30 p. m.: The Therapy of Insomnia.

Wednesday—11:00 a. m. to 1:00 p. m.: The Therapy of Colon Stasis.
8:30 to 9:30 p. m.: The Therapy of Cough.

RADIO TALKS

April 7—What's Behind a Prescription? - - - Dr. Samuel Schwebel
April 14—What Is Occupational Therapy? - - - - Dr. L. S. Shensa
April 21—Tired Legs from Altered Circulation - - Dr. M. H. Steinberg
April 28—Medical Ethics - - - - - - - - - - - Dr. Morris Belinky
May 5—Cosmetics and Common Sense - - - - Dr. Samuel Zoss
May 12—Invisible Handicap - - - - - - - - - Dr. Stanley Myers
May 19—Prevention of Blindness - - - - - Dr. William F. Hatcher

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April

PRESIDENT'S PAGE

Postgraduate Day

The biggest show of the year will be staged in Youngstown April 20, 1939. This will be the Twelfth Annual Postgraduate Assembly of the Mahoning County Society and from all indications it will be the greatest day the Society has ever sponsored.

May I extend to our guest speakers, Dr. Wolferth, Dr. Pendergrass, Dr. Kern, and Dr. Stokes, of the University of Pennsylvania, the Society's heartiest and sincere greetings. May they find us an attentive audience and appreciative of their efforts put forth for our benefit.

The Mahoning County Medical Society extends a cordial welcome to all members of the Profession near and far, and especially those of Ohio and Western Pennsylvania. We can without reservation promise a full day of valuable education and real enjoyment, meeting old and making new friends. The program is excellent, the food, none better, in fact the day's entertainment is complete in every detail. The Postgraduate Committee with the aid of the Program, Entertainment and Publicity Committees, will assure no hitch in the proceedings from beginning to end.

These Committees function so well there is no need for a directing head or a moment's worry, for the show is bound to be a success. They are all veterans, have been well trained, and no amount of effort on their part will be lacking so the show will go on full of vim and vigor, never a dull moment.

We solicit helpful criticism from our members and guests. Do not hesitate to call to the attention of any member of the committees or the officers of the Society any function that has not been to your liking.

It is our aim, as in the past, to have this the best meeting of its kind in this section of the country. We will have visiting doctors, new faces, whom we will not know. It is therefore the duty of each and everyone of us to extend a friendly hand of fellowship, help him to know our Society, its members, our city, and tell him of our aims and what our Society stands for in teaching scientific medicine and its ethical practice.

We must not forget our *Bulletin,* the mouthpiece of our Society, that through its ever-present reminding, our Postgraduate Day is made possible. Our Editor and co-workers never cease to be at work on the duties of our Society.

To our advertisers and exhibitors we extend a hearty welcome. Their displays are as good if not better than many State and National meetings. The business firms represented are honest, ethical and conscientious representatives of the trades that are essential to the practice of medicine.

The Mahoning County Medical Society sends greetings and a cordial invitation for all to attend this Twelfth Postgraduate Day Assembly, April 20, 1939, which will be held at the Ohio Hotel, Youngstown, Ohio.

May we see you there? To the members of our Society, this is your Postgraduate Day. It cannot be a success and function without your wholehearted support. The Committees can arrange the meeting but you must attend if victory would be ours.

— WM. M. SKIPP, M. D.

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ISALY'S

DAIRY SPECIALISTS

RECENT ADVANCES IN THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS

JOS. KEOGH, M. D.

The management of pulmonary tuberculosis is without question the most important problem with which thoracic surgery is confronted today. When one considers that there is an average of seventy deaths per hundred thousand inhabitants and seven tuberculosis patients for every death, we can readily see that this is true. While lung abscess, carcinoma of the lung, tumor of the lung and mediastium or bronchiectisis, all present more spectacular results, figures just quoted make these problems of secondary importance.

The treatment of pulmonary tuberculosis has undergone radical changes during the past few years. From being ultra-conservatively symptomatic, expectant, climatic and sanitorial, the pendulum has swung to the other extreme in many places and is entirely surgical. It is the purpose of this paper to present an attempt at a more rational balance between the two extremes and to empasize the indications for surgical intervention. It would be impossible in such a short paper to give any detailed technical description of each of the procedures used but there will be space I believe to indicate the method most suitable for use in the different types of cases.

As has been pointed out by the late Dr. Coryllos, three major morphological changes may occur in the parenchyma of the lung infected by the tubercle bacillus:

1. Infiltration and edema (allergic phase).

2. Caseous necrosis of the affected lung parenchyma (destructive phase).

3. Development of fibrous tissue in the involved areas (repairative stage).

Caseous necrosis of a portion of the parenchyma leads to the formation of tuberculous cavities following the elimination of the caseated material through the bronchi. These cavities, which are holes in the lung containing air, represent the most characteristic features of pulmonary tuberculosis and it is toward the closure of these cavities that surgical management is directed.

A study of the mechanism whereby closure of cavities is effected has resulted in many theories. Such answers as, "Nature has a tendency to produce closure of cavities," cannot be accepted. Some men have advocated the presence of a double system of concentric and radiating fibres, one of which tends to produce retraction and closure and the other, the opposite effect. Unfortunately, these fibres have never been visualized under the microscope. Others have based their theories on the changes in elasticity of the lung. For these, the elasticity is increased while for still others, it is decreased and even yet further, for Bendove, the elasticity of retraction is increased whereas, the elasticity of expansion is decreased. Since the elasticity of the lung is a function dependent upon the elastic fibres of the lung and since destruction of elastic tissue takes place in all diseases of the lung in general and in tuberculosis particularly, it would seem that the theory was defeated before it started. However, when one considers the physiology of the lung and compares it with the pathological physiology of the lung, the answer becomes obvious. The late Dr. Coryllos, in several recent papers, has advanced proof of the simplicity of this mechanism. A cavity appears spherical in the living subject by virtue of the atmosphere of pressure within, since the cavity is in direct communication with an open bronchus, being greater than that exerted by the surrounding lung. The pressure exerted by the surrounding lung is, of course, only equal to the negative intrapleural pressure. Closure of

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the communicating bronchus results in gradual absorption of air, collapse of the cavity and thus closure of the cavity. The changes in gaseous contents of the cavity before, during and after bronchial closure have been studied as well as measurements taken of the gaseous pressure within the cavity. All results obtained from this study indicate that closure of the cavity is effected by closure of the draining bronchus.

This discussion leads up to the consideration of the indications for collapse therapy in pulmonary tuberculosis because all collapse therapy is directed toward the closure of cavities. In the following discussion, the classifications presented by Ulmar, Ditter and Ornstein will be used. The acute exudative or allergic phase still belongs and should be managed along established conservative lines. Radical bed rest, good food, hygienic measures as well as general supportive measures remain the treatment of choice in this group. Many of these lesions, given time, will clear of themselves. Even aside from this, any collapse measures attempted on the acute exudative lesion may not only lead to the development of cavernous lesions but also may result in actual ulceration through and into the pleura or, finally, to a bronchogenic or hematogenous spread. It is our opinion that all such lesions should be carefully watched for at least a period of six months. During this length of time, the involved area will usually either show signs of regression or will go on to a definite caseous pneumonic type of disease.

Chronic productive pulmonary tuberculosis (Acinous Nodosa Form of Aschoff) presents a similar problem. Surgery on this type of lesion will produce spectacular results but actually most of these lesions will clear of themselves given adequate opportunity. Cases which have a caseous pneumonic lesion on one side often have productive changes on the contra-lateral or opposite side which automatically clear once the cavity has been closed.

Finally, we must consider the caseous pneumonic or chronic ulcerative form of pulmonary tuberculosis. By that we mean, those cases with open cavities and positive sputum. Even in this group, immediate surgical intervention is actually extremely radical but conversely as well such conservatism becomes even more radical when allowed to go on too long. About ten to twelve percent of caseous pneumonic lesions close spontaneously. In the face of no spread of disease, no progressive increase in the size of the cavity, they should be given a reasonable length of time to effect a closure. However, unnecessary delay is the most dangerous treatment one can offer a patient. The possibilities of such a thin walled cavity becoming a thick, giant or tension cavity (cavity over 8 cm. in diameter), source of bronchogenic spread to other lobes on the same side or contra-lateral side are far too great.

The indications for surgery narrow themselves for all intentions and purposes to the treatment of cavitation in the lung, hemorrhage and empyemata. The various surgical procedures utilized depend almost entirely upon the type and distribution of such lesions. This, of course, excludes from consideration that group having either a toxic tuberculous empyema, a mixed infection tuberculosis and pyogenic empyema with or without a broncho-pleural fistula. Briefly, all of this latter group requires immediate surgical intervention of a most radical nature.

As mentioned above, the choice of the procedure depends entirely upon the type and distribution of the lesion. Procedures now in vogue are:

1. Pneumothorax.

2. Closed pneumonolysis. Closed pneumonolysis, an operation to complete a pneumothorax by severing the adhesions suspending the lung to the

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chest wall. Actually, while the operation is apparently very simple, its performance requires more anatomical knowledge, keener judgment and better technique than do any of the apparently more radical procedures. Even the smallest error in judgment may result fatally through the development of a tension pneumothorax or a mixed infection empyema.

3. Phrenic nerve interruption, either temporary by crushing or permanent by section.

4. Apicolysis with packing or plombage.

5. Extra-pleural pneumothorax.

6. Thorocoplasty.

7. Thorocoplasty combined with Schedde for the obliteration of a chronic empyema space.

8. Lobectomy and pneumonectomy.

Rather than consider each of these procedures separately, it would seem better to consider the pathology requiring therapy and simply to name the procedure best suited for its control. Unilateral apical cavities are best controlled by apical thorocoplasty either in one or two stages. While this may seem extremely radical, actually, it is quite conservative. Pneumothorax therapy on such a lesion must be continued for the usual length of time. The most accepted time is three to five years. During this time, the patient is continually subject to the dangers of a spontaneous pneumothorax, which may be either traumatic or ulcerative. They are also subject to the development of a tuberculous empyema or even worse, a mixed infection empyema with bronch-pleural fistula. Thorocoplasty operations, at the present time, are not as deforming nor is the mortality rate as high as in previous years. When one considers that better than eighty percent of such unilateral lesions can be controlled by this procedure, meaning that within a period of six to eight weeks the cavity is usually closed and within a six-month period, the patient can be safely discharged. Then that which appears to be radical becomes conservative from the patient's standpoint, the public health standpoint and the cost of hospitalization for such an individual. Pneumothorax, on the other hand, should first be tried on cases demonstrating lesions disseminated throughout one lung. In the event that only a partial collapse can be obtained, this may be completed by means of a closed pneumolysis. It is often surprising how much can be done to complete what may appear to be a very inadequate pneumothorax by severing multiple adhesions in this manner. In all cases, where pneumothorax fails and cannot be completed by intra-pleural pneumolysis, thorocoplasty becomes the procedure of choice. This is usually a complete thorocoplasty requiring three stages.

Bilateral pulmonary tuberculosis, caseous pneumonic form, may be controlled in one of several ways. Bilateral apical lesions are best controlled by cilateral apical thorocoplasty.

In the presence of an apical lesion on one side and multiple cavities on the contra-lateral side, pneumothorax may be attempted on the side with the apical lesion and then, thorocoplasty done in the presence of the pneumothorax on the contra-lateral side. These cases must be handled with great care because of the possibility of a traumatic or actual spontaneous pneumothorax which may occur during the course of refills following operation. Bilateral, equally disseminated lesions may be controlled by bilateral pneumothorax which in many instances must be completed by unilateral or bilateral closed pneumonolysis. Another recent adjunct to bilateral collapse therapy has been the introduction of extrapleural pneumothorax. There are certain cases with bilateral lesions where pneumothorax is impossible on both sides and where bilateral thorocoplasty would be beyond the limit

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of that person's vital capacity. These cases were, therefore, outside the realm of thoracic surgery. With this new operation, following the resection of a short length of one rib, a pneumothorax space is operatively created by apicolysis in the extra-fascial plane. After an air-tight closure, this space is then filled with air and periodical refills given as in the management of an ordinary intra-pleural pneumothorax. Ordinarily, the first refills are quite difficult but once the space is established, the pneumothorax is easily maintained. Positive pressures are used.

The phrenic nerve operation has enjoyed a vogue over many years but in recent years is being abandoned by even those who formerly most strongly advocated its use. In our group of cases, we found one type of lesion most susceptible to control by this operation. These lesions are mid-field cavities on which a pneumothorax has had appreciably no effect. By combining the phrenic nerve operation with the pneumothorax, a closure has been effected. Elevation of the diaphragm is also of aid in many instances to help decrease the size of an empyema space.

Although, no details of technique can be gone into in a paper of this length, it seems only just that a few of the more recent changes in thorocoplasty technique should be mentioned. Instead of the old Sauerbrauch operation with the resection of short lengths of many ribs, we now do multiple stages with the resection of much greater lengths of rib. Complete thorocoplasty for a lung equally infected throughout, usually demands three stages. The first stage requires the sub-periosteal resection of total lengths of the first three ribs. During the second stage, three and sometimes, four ribs are removed while the third stage is limited to a maximum of three ribs because of the marked paradoxical respiration which follows removal of more than three. A new modification for the control of giant apical cavities has recently been introduced by Dr. Carl Semb. Briefly, the operation is done as follows: Following the resection of the first three ribs, the apex is decollated by blunt dissection to the level of the fourth rib posteriorly. A few of the surgeons using this procedure fill the dead space thus created with saline to insure maintainance of the drop. In our experience, this dead space fills completely within six hours post-operative with a sero-sanginous type of fluid. Up to the introduction of this modification, thoroco plasties on giant cavities had been almost a total failure and it is in this group, that most of the radical revisions had to be done. The Semb modification carries with it a slight increase in mortality but when one considers that formerly none of these cavities were closed without radical revisions, which in themselves carry a mortality of thirty-two percent, it seems the additional risk is well worth while. The most recent technical addition is one devised by the late Dr. Coryllos. Thorocoplasties on children under sixteen years of age had been more or less abandoned because of the marked scoliosis. The resulting deformity was often more severe than the disease. By combining spinal fusion and thorocoplasty done at the time of thorocoplasty, this complication has been overcome.

The other procedures such as apicolysis with plombage, oleothorax, etc., have all enjoyed a brief popular term but are not being generally used at the present time. Lobectomy and pneumonectomy have been unsuccessful up to very recently. Some few cases have been reported as successful but they are far too few to draw any conclusions as yet. Up to now, the complications following these procedures have been too serious to warrant their use.

There is no question that collapse therapy has markedly influenced the mortality rate in pulmonary tuberculosis. Spontaneous closure of ca-

vities takes place in about ten to twelve percent of all cases. About twenty percent of all cases receiving pneumo-thorax therapy becomes negative. Closed pneumonolysis completes about seventy percent of unilateral cases on which it is tried and approximately twenty-five percent of bilateral bases. Sixty-two percent of these people develop an effusion. Two and one-half percent develop a tuberculous empyema and about two percent a mixed infection empyema. In 529 cases or 1275 operations of thorocoplasty at Sea View Hospital, New York, the general mortality was 18.3% per patient mortality or 7.6% for operation. This, however, includes thirty-two deaths associated with operation for tuberculous empyema, mixed infection empyema and revision. The actual mortality for straight thorocoplasty is therefore, operatively 5.1%. This includes both unilateral and bilateral cases. The operative mortality for unilateral cases alone is 3.3%. Of this group, exclusive of the empyemas, 82% had conversion of sputum from positive to negative.

In conclusion, I should like to emphasize that of all those actively engaged in the control of pulmonary tuberculosis, the thoracic surgeon is the first to realize that surgery is not the final answer to the solution of the problem. Even further than that, it is not by any manner or means a direct attack upon the disease as a public health problem. The ultimate cure when it comes will be medical. However, collapse therapy in its various forms is, to date, the most effective means of controlling the individual case and in well regulated groups with close coöperation between the roentgenologist, the medical internist, the ear, nose and throat group and the surgeon, there has been and increasingly is found, a definite decrease in mortality. This is accompanied by a decrease in hospitalization and an even more definite and more important increase in the number of patients treated and in the number discharged under conditions suitable for their return to society with safety.

YOUNGSTOWN SYMPHONY ANNOUNCES 1939-1940 SOLOISTS

Soloists of unusual interest have been engaged to appear with the orchestra in addition to the local soloists Carmine Ficocelli, Jacob Huebert and Herman Gruss, who perform Beethoven's Triple Concerto on the February concert, five world famous solo attractions have been engaged. The list includes The Don Cossack Male Chorus, Serge Jaroff, conductor, who appear on the gala opening concert in an all-Russian program; Silvio and Isabel Scionti, brilliant duo-pianists who will play a two piano concerto with the orchestra; Moriz Rosenthal, greatest of Franz Liszt's pupils, who will be on his Golden Jubilee Tour with his famous gold piano; Helen Jepson, glamorous young American soprano of the Metropolitan Opera and native of Columbiana and Akron, Ohio. Albert Spalding, America's foremost violinist is the soloist on the closing concert in April.

Mr. Spalding appeared with the orchestra two years ago and many requests from patrons for a re-appearance prompted the engagement for next season.

The same low season prices will be in effect next year and subscriptions are now being received at the Symphony headquarters—307 Union National Bank Bldg., in Youngstown. The 1939-1940 series will again be sponsored by the Junior Chamber of Commerce.

POSTGRADUATE DAY FACULTY

Dr. Charles C. Wolferth

Professor of Clinical Medicine, School of Medicine, University of Pennsylvania.
Administrator, Robinette Foundation.
Member of Medical Staff, Hospital of the University of Pennsylvania.
Chief of Cardiac Section, Medical Division, University Hospital.
Consulting Physician, Fitzgerald Mercy Hospital
Consulting Physician, Underwood Hospital
Consulting Cardiologist, Jewish Hospital.
Consulting Cardiologist, St. Joseph's Hospital.

Dr. E. P. Pendergrass

Director of the Department of Radiology, University of Pennsylvania Hospital.

Professor of Radiology in the Graduate and Undergraduate Schools of the University of Pennsylvania.

Dr. Richard A. Kern

Graduate of the University of Pennsylvania—1914.

Professor of Clinical Medicine.

Head of the Allergy Clinic, University Hospital.

Dr. Joseph Stokes, Jr.

Haverford College, A. B., 1916.
School of Medicine, University of Pennsylvania —1920.
Pediatric Staff—Physician-in-Chief—Children's Hospital.
Society for Pediatric Research — One of the founders and former president American Pediatric Society.
American Academy of Pediatrics, Co-Chairman for Pennsylvania.

A Program You Cannot Afford to Miss!

By

GROUP FROM UNIVERSITY OF PENNSYLVANIA

Twelfth Annual

Postgraduate Assembly

APRIL 20, 1939

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MORNING SESSION

9 to 10 A. M. Cardinal Features of Coronary Disease - - - - - - - - Dr. C. C. Wolferth

10 to 11 A. M. Recent Advances in the Study and Treatment of Certain Virus Diseases - - Dr. Joseph Stokes

11 to 12 A. M. General Principles of Allergy and Clinical Manifestations of Allergy (Part 1) - - Dr. R. A. Kern

LUNCHEON

AFTERNOON SESSION

2 to 3 P. M. Silicosis and Silicosis with Infection - - - - - - Dr. E. P. Pendergrass

3 to 4 P. M. Clinical Manifestations of Allergy and Principles of Diagnosis and Treatment— (Part 2) - - - - - - - - - - Dr. R. A. Kern

4 to 5 P. M. Prophylaxis and Treatment in Certain Acute Infectious Diseases - - - Dr. Joseph Stokes

EVENING SESSION

6:30 P. M. Dinner

1. Roentgen Therapy of Infection - - - - - - Dr. E. P. Pendergrass
2. Physical Examination of the Heart with Special Reference to Heart Sounds - Dr. C. C. Wolferth

THE MEDICAL CRIER

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

• "One-third of the population is unable to obtain medical service." Where do they get that stuff? What factual study, what widespread survey has brought to light the existence of this deplorable state of affairs? Has this awful pronouncement so frequently used by proponents of Socialized Medicine any basis in fact? Certainly not around here. Every member of this Society is certain of that. But maybe we don't know about conditions in other parts of the country. Maybe the deep South or the far West are different.

Reports received on the American Medical Association Study of Need and Supply of Medical Care already cover a far larger sample of the population than has been covered by any previous survey. Questionnaires have been received from hospitals, nurses, health departments, schools, welfare and relief agencies, colleges and universities, fraternal organizations and pharmacists. Only one of the nine forms used in this survey has been directed to physicians and dentists. Not one significant source of first hand, reliable information as to medical conditions has been omitted, and so far there has been no sharp disagreement in the reports.

There is no locality in which any organization even suggests that one-third of the population is unable to obtain medical service.

The most general lack of medical care that is reported is with regard to insufficient appropriations for poor relief or governmental institutions. Isn't this significant?

• We saw with much pleasure the article on "Aesculapius" by Dr. Louis Deitchman reprinted with due credit to the M. C. M. S. Bulletin in the Westchester Medical Bulletin. It has been our privilege to print several of Dr. Deitchman's historical sketches, the most recent and instructive being the story of Washington's last illness presented in case history form. A collector of old books and first editions, his ventures into medical history have always been interesting and authentic. Not to mention the witty doggerel which formerly appeared under the pen name of Theophrastus Bombastus. If properly urged, no doubt this scholarly fellow would give us more in similar vein.

• There seems to be a premium placed nowadays on smartness. The bright fellow, the keen wit and the wisecracker get the headlines. Jimmie Cagney, movie star in the current picture "Oklahoma Kid" says, "Listen, the strong take it away from the weak, but the smart take it away from the strong." So it goes, but in the long run character is greater than smartness, especially in our profession. A great business leader once said, "My son is not smart, but he has character. I can hire a hundred men who are smart, but a man with character is mighty nice to live with." The prestige of the medical profession is enhanced by the few who are brilliant, but its reputation and confidence are built upon the solid foundation of its general good character.

J. L. F.

SECRETARY'S REPORT

March, 1939

At the regular March Council meeting held on the 13th of the month, the members surveyed the new bookkeeping system and membership files as recently set up by Mary Herald, the assistant secretary. This system has been approved by W. C. Fisher, auditor, and will make for more efficient bookkeeping records.

A special Council meeting was called by President Skipp following the regular meeting on March 21, to nominate three doctors for each of the following boards:

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(1) The Mahoning County Welfare Board;

(2) The Board of the Mahoning County Tuberculosis Sanitarium.

The following doctors were chosen: Dr. J. B. Birch, Dr. W. H. Evans, Dr. Barclay M. Brandmiller for the Welfare Board; Dr. C. R. Clark, Dr. L. S. Deitchman and Dr. E. J. Reilly for the Mahoning County Tuberculosis Sanitarium Board. These names were duly submitted to the Mahoning County Commissioners from which they will choose one for each board.

The regular monthly meeting for March was held on Tuesday evening, March 21, at the Youngstown Club.

The scientific program was presented by Dr. George M. Curtis, Chairman of the Department of Research Surgery at Ohio State University Medical College. He spoke on "The Iodine Metabolism in Thyroid Disease" and brought the work up to date citing interesting charts of Iodine Imbalance in Thyroid Disease. His work in this field is meticulous and shows very careful technique for accuracy. The presentation had many practical sides as well as of just scientific interest.

Following the scientific meeting a business meeting was held. The applications of the following doctors were read:

For Active Membership:
Dr. Wm. Peter Beckley
Dr. Milton Marvin Yarmy
For Associate, Class D:
Dr. John S. Goldcamp

Dr. Sedwitz moved that the Society approve the increase in State dues from $5.00 to $7.00, as explained in the January issue of the Ohio State Journal, and so instruct our State delegates to vote for the increase at the coming State meeting. Motion was duly seconded and passed.

Dr. Tims moved that the Society approve the redistricting of the State, adding one new district, the Eleventh, as described in the January issue of the Ohio State Journal; and so instruct our State delegates to vote for the amending of the State Constitution so that this can be possible. Motion was duly seconded and passed.

Dr. Skipp then announced that the County Commissioners have requested the names of three doctors of the Mahoning County Medical Society from which one will be chosen for each of two boards, namely, the Welfare Board and the Board of the Mahoning County Tuberculosis Sanitarium. Dr. Tims moved that Council be named a committee to choose the six nominees. Motion was duly seconded and passed. Dr. Skipp then called for a Council meeting immediately following this regular meeting, because the names must be submitted to the Commissioners by the following day.

Dr. Reilly then appealed for publicity on Postgraduate Day.

Dr. Skipp discussed the suggestion of changing of half holiday from Thursday to Wednesday afternoons. There was no discussion.

Meeting adjourned.

Council has approved the applications for membership in the Mahoning County Medical Society of the following:

For Active Membership:
Dr. M. M. Szucs
For Class D Membership:
Dr. John Smith, Sebring, O.

Unless objection in writing to any of these applicants is filed with the Secretary within 15 days, they will become members of the Society.

DR. JOHN NOLL, *Secretary.*

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THE MEDICAL MANAGEMENT OF PEPTIC ULCER*

L. S. SHENSA, M. D.

In this paper I shall attempt to review the various methods of treatment of peptic ulcer as practiced in several large clinics and also give an evaluation of their results.

The treatment of peptic ulcer requires a definite plan of education. Like the care of such diseases as diabetes, tuberculosis or chronic heart disease the full and intelligent cooperation of the patient must be gained if treatment is to be successful. The patient must not throw the whole burden of his disease on the physician's shoulders but he must cooperate intelligently with his doctor. We can never be sure that the peptic ulcer is permanently healed. Relaxation in therapy will result in an exacerbation of the disease in most instances. One of the most important points in the management of peptic ulcer is the modification of the patient's habits of living. We must secure tranquility of mind and body as far as his social and business conditions permit, nine hours of sleep at night, a mid-day rest of one-half hour and simple recreation during leisure hours are of vital and essential importance. A period of change away from the home environment is most valuable. Moderate work in the garden, music or some hobby will give a release from nervous tension. Frequently this treatment alone will produce relief from symptoms. Definite foci of infection should be eliminated at the proper time. Diseases of the pelvis or appendix may require surgical care.

Simple hypochromic anaemia will respond to adequate iron therapy, but it is best not to give iron by mouth until the painful stage of ulcer has passed.

The peptic ulcer patient should be sent to the hospital when he has suffered from one or more severe hemorrhages, when x-ray examination shows that a penetrating ulcer or pyloric obstruction is not improved with due trial with ambulatory care, and if the pain is so severe that there is some question as to the correct diagnosis.

The ambulatory method of treatment of peptic ulcer may be employed if the patient of limited financial resources desires to be kept on the job. This reduces his anxiety about the welfare of his family. His general strength will be preserved by keeping him on an adequate diet from the very beginning of his treatment, and he will be spared a difficult period of adjustment to normal living which often occurs if he has spent a few weeks in bed or in the hospital. Finally, the best reason is that in this type of treatment, if intelligently carried out, the results are very good.

The indications for surgical intervention in peptic ulcer are quite definite:

1. In cases of intractable ulcer.
2. In those cases of gastric ulcer in which bi-weekly follow-up x-ray studies fail to show regression of the condition. All gastric ulcers are under suspicion of cancer until they show definite evidence of healing.
3. Pyloric obstruction which resists medical therapy.
4. Persistent or recurrence of massive gastric hemorrhage.
5. Acute or chronic perforating ulcers.

Medicinal Therapy:

It is seldom that unusual or complicated medicinal therapy is required. Despite some opinions to the contrary belladonna or atropine are the most satisfactory anti-spasmodics. As a rule pyloric spasm and the gastro-intestinal hypermotility will be definitely abated by the use of belladonna. At

*Read to the Staff of St. Elizabeth's Hospital at its regular monthly meeting on March 14, 1939.

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times in highly nervous patients a bromide quiets the cerebral activity.

Dietetic Management:

The proper use of diet in the treatment of peptic ulcer has been the subject for controversy for many years. Many clinicians have continued to employ the Sippy diet. Such diets are rarely suitable to home treatment because hospital supervision of one trained in dietetics is usually required. Many clinicians use a soft, smooth diet. The patient can eat tender meat, puree of vegetables, soft-cooked eggs, cooked fruits, milk and cream, simple puddings and gelatine. With such food there is little danger of any disturbing effect on the ulcer and in addition the diet is well balanced. As a rule it is necessary to prohibit the use of tomatoes and fresh fruit until the acute symptoms of the ulcer subside. Several disadvantages of the Sippy and similar diets lie in the fact that there is usually a deficiency in iron.

Alkali Management: There are several combinations of various alkalis used in different clinics. On these I shall elaborate later.

Methods of medical treatment: While clinics and experienced physicians have fairly well established the mechanism by which ulcer is produced the specific cause of ulcer is still unknown. As a result treatment is in a sense symptomatic. Newer methods are constantly being advanced and there is no general agreement as to the best procedure. The doctor is therefore often at a loss as to what method of treatment to follow. Shall he continue along conventional lines or resort for example to parenteral administration of proprietory preparations now so much in vogue?

Various methods of medical treatment can be classified as follows:

1. Conventional diet—alkali—sedation (Modified Sippy regimen).
2. Administration of mucine, duodenal extracts, adsorbents (Kaolin and aluminum salts).
3. Duodenal or jejunal tube feedings.
4. Continuous alkalinized milk or aluminum hydroxide by slow drip.
5. Parenteral administration of proteins, pepsin, insulin, vaccines, synodal, histidine hydrochloride.
6. Combined methods.

The diet alkali method of treatment is the one employed by the large majority of members of the medical profession. There is ample clinical experience and surgical evidence that any procedure which adequately will control or neutralize excess gastric acidity and secretion and which in turn will correct any impairment of gastric motor function whenever present promises the greatest success. Modification of Sippy's original method was necessary in order to avoid alkalosis and other physiological or nutritional diseases. It is also recognized that complete neutralization was not necessary to promote healing. A recent report by Emery & Monroe based on experience in 1435 cases stated that their results were satisfactory with the complete Sippy regiment in 90% of the cases, with a partial Sippy in 87% of the cases. These observers drew the conclusion that none of the present methods of treatment do more than assist in the induction of remission no matter how strict the medical schedule or how radical the operation.

The mucine method of treatment: Mucine is a substance prepared from the mucosa of the stomach of hogs. It is useful in the treatment of peptic ulcer because it coats the ulcer and protects it against the proteolytic action of the gastric secretions and through its high combining power with free acid it unites with enough hydrochloric acid not only to neutralize the corrosive action of the gastric juices but also to prolong the rate of dialysis of pepsin through the protective layers of mucine. It is

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difficult, however, to insure the maintenance of adequate amounts of mucine in the gastric contents. Only 11% of physicians to whom questionnaires had been sent noted some improvement following its use. Duodenal extract has been tried by several clinics. Two capsules of 15 grs. each were given two hours after the principal meal of the day. The results were not remarkable.

Duodenal tube feedings: It has been suggested that the most satisfactory manner of treating peptic ulcers is to pass a small tube into the duodenum so that feedings can be accomplished beyond the area of ulceration. It is assumed the ulcer will heal more readily. It has been advised by some investigators in cases in which it is difficult to control night distress. Continuous drip feeding is suggested by some of the advocates of this method of therapy. Although this method of therapy may be advisable in certain instances it is obviously impractical and unnecessary in the average case of uncomplicated peptic ulcer. 50% of physicians to whom questionnaires had been sent said that they were of the opinion that this method had some usefulness in treatment.

The continuous alkalized milk or aluminum hydroxide method of treatment: A Rehfuss tube is passed into the stomach of the patient and a solution consisting of milk containing 5 gm. of soda bicarbonate to a quart is allowed to drip into the stomach at the rate of 30 drops a minute. Thus the patient receives three quarts of this mixture per day. Such a solution will theoretically neutralize nine quarts of 1/10 N. hydrochloric acid.

This treatment may be carried on uninterruptedly for a period of from 2-3 weeks.

The features of this type of treatment are:

1. Loss of all symptoms in from 4-6 hours after it is instituted.
2. Complete comfort of almost all patients while on the drip.
3. Eagerness to return to the drip on recurrence of even slight symptoms. In instances where no relief was obtained from the Sippy or mucine treatment immediate improvement followed the drip treatment.

The disadvantages are:

1. The method is inconvenient to the patient.
2. It is not ambulatory.
3. The tendency of the ulcer to recur after any form of therapy.
4. Probable intolerance in some patients to milk.

At the Mt. Sinai Hospital in New York 42 patients were treated by this method and they achieved results in about 70% of the cases.

Complete neutralization by the Sippy method may not always be accomplished for the following reasons:

1. Tendency of the stomach to respond to alkalosis by increased secretion of acid.
2. Secretion continues during the night in many instances and prevents healing.
3. The onset of alkalosis as a result of a large amount of alkali which may be required.

Crohn in 1929 found that colloidal aluminum hydroxide was an effective anti-acid and that it reduced total acidity to a point where complete cessation of subjective symptoms was almost an invariable rule and that it was nonabsorbable and nontoxic. Others have confirmed these statements. At Peter Bent Brigham Hospital 21 patients were treated by this method. All patients were relieved of their ulcer distress within 24 hours and had no recurrence of pain while remaining on the treatment. The only complaint of those who had followed the treatment was severe constipation in some instances. Nearly all of the patients had to take some mineral oil but clinicians believe that

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the colloidal aluminum hydroxide is a satisfactory anti-acid if given in large enough doses. At Tullane University 24 patients were treated by this method and 20 showed prompt relief of symptoms within three days.

Mutch at Royal Victoria Hospital at Montreal treated 36 patients with peptic ulcer with magnesium trisilicate and noted that following three months' observations 89% of the patients were completely free from symptoms. He stated that this alkali appears to be an efficient, non-toxic anti-acid causing rapid disappearance of symptoms, promotes healing, produces no general side effects and rarely disturbs the motility of the gastro-intestinal tract.

Kraemer of the Presbyterian Hospital in Newark treated 38 private patients with the above same anti-acid. He noted improvement in all of them and believes that magnesium trisilicate is a valuable anti-acid to be used in the treatment.

The parenteral treatment:

The use of vaccines, non-specific proteins and synodal (a foreign protein) are only mentioned here as having been tried by various clinics and discarded. Larostidine, a trade name for Histidine — mono-hydrochloride — is being used by quite a number of clinicians.

Rationale for the use of Histidine as stated by some workers is that the ulcer is produced by some deficiency and that Histidine (a derivative of protein metabolism) supplies this deficiency and produces a remission of symptoms and controls the hypersecretion of acid. Others believe that Histidine stimulates an outpouring of gastric mucine which exerts a protective effect on the ulcer. At the Harper Hospital in Detroit Sandweiss reported a series of 291 cases whom he treated with the dietetic alkali management and the Histidine methods. In the former, 90% became symptom free; in the latter, 60% became symptom free. Also 22 patients were injected with distilled water and comparable results were obtained. At the Metropolitan Hospital in New York a series of cases was treated with alkali diet management and compared with the Histidine form of therapy. The Sippy form of treatment gave the majority of patients definite relief. Sterile water was used as a control and in that group slightly more so-called cures than the Histidine form of treatment were obtained. In Kansas City hospital 42 cases were treated with Larostidine. 76% obtained relief. They were of the opinion that results obtained did not justify the routine use of this procedure. At Cornell University 41 patients were treated with Histidine and they found that clinical improvement appeared to be symptomatic and transient, that it had no constant effect on the hydrochloric acid secretion and that its indications are very limited.

At the Veteran's Hospital in New Mexico Benedict treated 132 cases of peptic ulcer with Larostidine. He noted prompt improvement with ambulatory treatment and soft diet. He believes that its daily parenteral administration is the therapy of choice of peptic ulcer.

At Mayo's the treatment of peptic ulcer by Larostidine has not been satisfactory.

The combined method of treatment:

Among the many forms of medical treatment, Sippy diet, alkali regimen together with the use of sedatives still ranks highest. It has been modified to avoid nutritional disturbances and unbalance of the acid base ratio. At Massachusetts General Hospital they alternate Sippy powders with aluminum hydroxide and use the Sippy diet with sedatives. To all practical purposes this seems to be the best regimen. It is convenient, practical and produces the least number of recurrences.

This treatment adequately controls

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symptoms of distress and complications in the acute stage of ulcers. It insures adequate healing by the application of physiological principles such as neutralization of acid and it decreases the peptic activity. Finally, together with sane living, adequate rest, supplementary feedings, avoidance of infection and non-stimulating diet, it prevents recurrences.

The treatment of peptic ulcer with hemorrhage:

At the Crile Clinic patients are put to bed at once, morphine and atrophine are given and the patient is starved for from 24-48 hours. If bleeding will not cease a careful gastric lavage with 4-6 ounces of ice cold water is tried. The wash fluid may consist of 1-1000 ferric chloride followed by the installation of 1 dram of 1-1000 of adrenalin. Blood transfusions are indicated if the hemoglobin falls to 40-50%.

Neulengrascht of Copenhagen treated 251 patients with bleeding duodenal ulcers by giving the patient a full puree diet with soda bicarbonate and magnesium subcarbonate and extract of hyoscyamine and ferric lactate. They were allowed to eat as much as they wanted. A few patients were given blood transfusions on admission. He had a mortality of 1%. Christianson of the same city treated 289 cases by the starvation method and had a mortality of 8%. Neulengrascht believes that many patients with bleeding ulcer die of exhaustion and not of hemorrhage. Patients past 50 years of age who have massive hemorrhages should be operated upon as soon as possible.

In the past five years 163 cases of peptic ulcer were treated at St. Elizabeth's Hospital. 55% of these were confirmed by x-ray. In this series of cases 79% were duodenal ulcer and 21% were gastric ulcer. There were 26 cases of peptic ulcer with hemorrhage with two deaths; a mortality of 7½%. In 80% of these cases the treatment was sedation, transfusions and Sippy diet. The rest of the cases were treated by transfusion, starvation and sedation. There were 35 perforations of peptic ulcer with ten deaths; a mortality of 29%.

Of the peptic ulcers treated medically 20% were treated with Creamalin and modified Sippy diet and antispasmodics, 60% with Sippy powders and Sippy diet, 17% with soft diet alone and 3% with Larostidine and soft diet. In all the cases the charts recorded improvement. We were unable to check the follow-up results. These are just to show the type of treatment that has been instituted in this hospital over the past five years.

In closing I would like to enumerate some of the measures which should govern and aid in the treatment of peptic ulcer, namely:

1. Individualize your case.
2. Treat the patient together with the ulcer.
3. Inasmuch as it is economically possible try to relieve the patient's mind from anxiety and worry.
4. Change the surroundings.
5. Demand the patient's coöperation, if not he will soon see another doctor.
6. Hospitalize acute cases.
7. Use alkalies, sedatives and antispasmodics to control symptoms. Be on guard for alkalosis.
8. A vacation may be your best alkali and antispasmodic available.
9. Use Sippy or a modified Sippy diet early and gradually work into a soft, bland diet.
10. Permit no smoking or alcohol.
11. Be on the look-out for complications such as hemorrhage and perforation and when found do not temporize but call in a surgical consultant.
12. Follow-up your patient as often as you think necessary for recurrences frequently occur. If possible check with x-rays. Finally:
13. Give your patient a certain amount of confidence in his own ability to get well.

NEWS

Dr. and Mrs. R. E. Odom are back from a vacation at Palm Beach, Florida.

Among those vacationing in Florida are Dr. and Mrs. J. B. Kupec.

Dr. E. C. Rinehart had the misfortune to fall and break his leg and is confined to the South Side Hospital.

Dr. J. P. Harvey is doing nicely after an appendectomy performed at the North Side a few days ago.

Dr. John Noll is attending a meeting of the American College of Physicians, New Orleans.

Dr. and Mrs. Colin R. Clark are home after spending a vacation at Atlantic City.

Dr. John M. McCann attended the American College of Physicians meeting at New Orleans.

Drs. Turner and McNamara spent a few days in Indianapolis attending a meeting of the American College of Surgeons.

Dr. Claude B. Norris addressed the Marion County Medical Society, April 4th, his subject being, "Fungus Infection of the Skin." Other addresses by Dr. Norris are:

April 6th, the Youngstown Technicians Society, subject: "Important Technical Procedure, Useful in Dermatology."

April 11th, the Salem and Sebring Rotary Clubs, subject: "Syphilis."

April 14th, Dr. Norris will address the Ashland County Medical Society, his subject being "The Management of Common Skin Disorders."

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