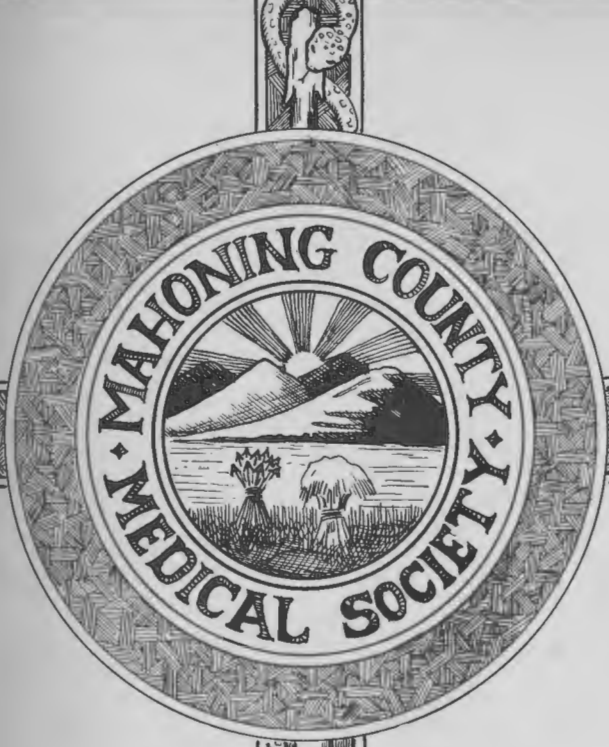

"Every man owes some of his time to the upbuilding of the profession to which he belongs."—Theodore Roosevelt.

BULLETIN

of the

Mahoning County Medical Society

ol. IX No. 8
ugust 1939

Suggestion FOR THE CONVENIENT PREPARATION OF BABY'S FEEDINGS *when traveling*

● We suggest the ease and simplicity with which Similac feedings can be prepared when traveling, anticipating that when you prescribe Similac for this special convenience during the vacation season, and observe the consistent results, Similac will be your choice throughout the year. While simplicity and convenience are definite advantages, the outstanding characteristic of Similac is its striking similarity to breast milk. Similac should be continued from birth until weaning, when breast milk is insufficient or entirely lacking.

●

The mother has only to measure out and place in dry, sterile feeding bottles, the prescribed number of measurefuls of Similac powder for each individual feeding. The bottles containing the measured Similac powder are then capped, and can be conveniently carried, along with a thermos bottle of boiled water cooled to about blood heat. At feeding time it is necessary only to pour into one of the bottles containing the measured Similac powder, the prescribed amount of water, then shake until the Similac is dissolved, place a nipple on the bottle, and feed.

Made from fresh skim milk, casein modified, with added lactose, milk fat and vegetable and cod-liver oils.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

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August, 1939

ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

BULLETIN *of the* . . . . . .
Mahoning County Medical Society

AUGUST 1939

Published monthly at
787 Wick Avenue, Youngstown, Ohio.

Annual Subscription, $2.00.

MEDICAL CALENDAR

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.

October 17—Youngstown Club, 6:30 P. M. Speaker.*

October 21—Second Annual Dinner Dance.

November 21—Youngstown Club, 6:30 P. M. Speaker.*

December 19—Annual Business Meeting, Youngstown Club.

*Speaker announced later.

MEDICAL TALKS OVER WKBN FOR AUGUST AND SEPTEMBER

Aug. 11—News from A. M. A. Annual Session - - - Dr. J. P. Harvey

Aug. 18—Relieving Hay Fever and Asthma - - Dr. A. R. Cukerbaum

Aug. 25—Your Doctor - - - - - - - - - - - - Dr. C. C. Wales

Sept. 1—Battle of the Children - - - - - - - Dr. R. H. Middleton

Sept. 8—Present Status of Health Examinations - - Dr. Guy Parillo

Sept. 15—Family Doctor - - - - - - - - - - - Dr. M. I. Berkson

Sept. 22—Overweight - - - - - - - - - - - - Dr. D. M. Rothrock

Sept. 29—Appendicitis Facts - - - - - - - Dr. D. E. Montgomery

A Modern Institution for the Care of Nervous and Mental Patients

Alcohol and Drug Addiction

A majority of the patients are referred to Fair Oaks Villa by members of the medical profession and it is only through the journals of the profession that any publicity is sought. The interests of FAIR OAKS VILLA, as an Institution, are completely dominated by those who have high regard and respect for the tenets of professional ethics.

The homelike atmosphere of Fair Oaks Villa is afforded by the pleasant rooms, by the eight and one-half acres of attractive lawns, picturesque landscaping and restful surroundings.

Since 1894

FAIR OAKS VILLA

Sanitarium

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Fair Oaks Sanitarium is a member of the American Hospital Association and the Central Neuropsychiatric Hospital Association.

PRESIDENT'S PAGE

At the Toledo meeting of the State organization, a Woman's Auxiliary was authorized by the House of Delegates.

Our State President, Dr. Park Smith, has appointed a committee of the State Council to gather facts pertaining to the organization of an Auxiliary. This should be given considerable thought by each member of our Society. It was brought up at a recent meeting of our Council and it was decided that ways and means be visualized.

The Woman's Auxiliary is sponsored by the County, State and National Medical Organizations. The County units work under the County Society with a Committee of the Society giving advise and supervising activities.

The purpose of this organization is to bring the members' wives in closer touch with each other, socially and medically. Naturally, doctors' wives are medically minded and if a member of an organization closely allied to the County Society, they will be of aid in furthering the activities of the Society.

The Auxiliary holds regular meetings, elects its officers and conducts its own business.

It may well be that the wife's interest in the auxiliary will improve the doctors' attendance at the County Society meetings. Many organizations have sponsored funds for libraries, doctors' retirement funds, care of indigent doctors, indigent families of doctors after the doctor is with us no longer, educational funds for sons and daughters of doctors unable to proceed with their education, such as medical training for sons and nurse training for daughters.

The Auxiliary will have a big job in bringing together loose ends of our organization which only a female hand can guide.

They will develop speakers for lay groups on medical subjects. They will become health minded, more so than at present, and will urge projects of community interest pertaining to the health of the community. The health of the school child will be of vital importance to them in seeing that health hazards are eliminated and that pre-school examinations, vaccinations and innoculations are performed before the child enters school.

Two such organizations are functioning in Ohio, one in Richland County, Mansfield, of recent origin, while the one in Stark County, Canton, is of eleven years' duration. The latter has done a wonderful work in bringing the wives together and in health matters in their community.

Let us all get behind this movement and see that it gets off to a good start. It is needed here. It will be a great benefit to the County Society members.

The Wagner Bill on health is dead at the present but not for long. It will be revived in the next session of Congress but we may not know it when it comes out of Committee. It is useless for us to think there will not be a Health Bill for there is going to be some form of aid to the medically needy, but we as medical men can and will direct this expenditure of tax money. Senator Taft said in Washington July 11, 1939, "Their (the Doctors') own interest and participation in the program will make it certain that it is not dominated by half-baked theorists or by those who believe in a totalitarian state, directing the lives and caring for the health of all its citizens through the mechanical and usually careless action of government bureaus." I believe a federal aid program can be worked out. I believe it can be much simpler and much more economical, and much more likely to preserve the essential independence of the doctors than the present Wagner bill. It should be worked out with the assistance and coöperation of the doctors.

WM. M. SKIPP, M. D.

1939

The seal of acceptance of the Committee on Foods of the American Medical Association appears on the cap of every bottle of Isaly's Vitamin D Milk.

ENCOURAGE THE BOY

To Drink Vitamin D Milk

Because Isaly's Vitamin D Milk contains not only all the body building qualities of standard milk but something more . . . something vitally important. This is an approved Vitamin D concentrate . . . the sunshine vitamin . . . which enables the body to utilize almost four times as much of the precious calcium and phosphorus in milk as is ordinarily the case. That's why parents should not only encourage children to drink Vitamin D Milk but should see that there is always plenty on hand to meet their requirements. Phone 65246 for Informative Booklet or the home delivery of this finer Isaly product.

ISALY'S

THE CHALLENGE

The problem of tuberculosis, its Roentgen diagnosis, its bone manifestations and the treatment of its pulmonary manifestations, was thought to be of sufficient importance by our program and public health committees, that a symposium was given at the February meeting of the Society by Drs. Baker, Morall and Keogh. However, nothing more seems to have come of the effort expended. While we are more informed on the pathology and treatment of bone and pulmonary tuberculosis, thanks to the splendid presentations of Drs. Morrall and Keogh, little consideration, seemingly, has been accorded the thought-provoking paper of Dr. Baker, relative to the public health problem that tuberculosis constantly presents in any and every community. It is for the purpose of belaboring this phase of the problem that this article is written.

A recent summary of the tuberculosis situation presents the following facts. Whereas in 1904, there was a death rate of 202 per every hundred thousand of the population, in 1937 only 55 persons and in some localities, but 30 persons per hundred thousand died from tuberculosis. This is a striking record of improvement but it is not enough. By applying the known methods of case finding and diagnosis, we can be as free of tuberculosis as we are of typhoid and diphtheria.

Another fact which emerges from the welter of studies on tuberculosis is that the primary invasion of the body by the tubercle bacillus does not produce the disease tuberculosis, as we know it clinically. Rather this primary invasion sensitizes the individual without producing any symptoms recognizable by clinical means. This invasion, under present conditions, is usually early in life, before the age of 15, although in localities free from open cases of tuberculosis, this sensitization may not occur until adult life. Furthermore, the delaying of sensitization into the adult years produces an effect in no way different from that in childhood. Infection by the tubercle bacillus, subsequent to the primary sensitization, results in clinical tuberculosis with attendant tissue destruction and in the lung, cavitation. The primary tissue sensitization does not cause tissue necrosis.

Chronic tuberculosis is a rare finding in children before adolescence; in the ages from 5 to 15. In 1936, there were in the United States, 24,403,489 children between 5 and 15 years of age. In that year, there were 1807 deaths among children of those ages from all forms of tuberculosis. This givens an infection rate of 0.074%. Consequently, in the hunt for infected individuals, less emphasis need be placed on this age group. Rather the search should be intensified upon the later 'teen ages and adults, not the least offenders among the latter being the aged adult. There is far more tuberculosis among the aged than we suspect.

In the light of the foregoing factual data, what are the procedures that an enlightened community, earnestly desirous of ridding itself of the scourge of tuberculosis should put into operation? First, of course, would be an institution properly equipped and staffed by a personnel trained in the modern methods of treatment. Tersely summarized, the treatment of tuberculosis is first, last and always, rest; rest of the individual and rest of the part affected. Rest of the part affected, in instances of pulmonary infection, has been greatly enhanced of late by the various procedures outlined in Dr. Keogh's paper.

Secondly, such a community must inaugurate a case finding campaign, that the open, infectious cases may be withdrawn from circulation and given the proper treatment to bring about an arrest and put an end to the men-

ace to the others. It must also institute a search for those individuals who have a minimal invasion, that they too may be brought to an arrested condition with a concomitant saving of time and expense.

Where then to begin? Logically it would seem advisable to begin with our school children in the Junior and Senior High Schools. Each year of the six-year period covered by these grades would afford an opportunity to follow this developing group, and no doubt would result in the early recognition of a few cases. The benefit to society of the recognition of early cases and their withdrawal from the intimate contacts of school life would be a salutary step in the control of the disease, apart from insuring to the individual affected the best opportunity of securing an arrest of the infection.

The summary earlier referred to advocates the tuberculin test as the first screen to be passed through, as it were, in the search for infected cases. Positive tuberculin tests are then to be followed by x-ray and clinical examinations of the individual to determine whether the disease is active and communicable. Later, the work of case finding would be extended to families through the follow-up of infections discovered in the schools, and by extending the scope of the test to include workers in the local industries.

The agencies that should coöperate in this work are the County Medical Society, the City and County Boards of Health, the County Tuberculosis Sanatorium, the school board, the local Red Cross Chapter and the Antituberculosis Society. All those agencies are present in our community. The question is, can they be made to function for the health and welfare of those future victims of tuberculosis? This is one of the tests of good citizenship and civic pride for Youngstown in the year 1939.

References: Bulletin, Mahoning County Medical Society for Mar. & Apr., 1939.
The Journal of the American Medical Association, Vol. 113, No. 3, July 15, 1939.

H. E. PATRICK, *Editor.*

GONORRHEA

By HENRI SCHMID, M.D.

The Medical Neisserian Society held its annual meeting in Milwaukee, June 20-22, 1939, in conjunction with the American Association for the Advancement of Science.

Thirty-three excellent papers were presented by research workers, clinicians and health officers. The following are a few practical points that may be of interest to the profession.

Chemotherapy by the sulfonamide compounds often renders gonorrhea, both acute and chronic, asymptomatic in a relatively short time. This early clinical response makes the determination of cure all the more difficult. The usual provocative tests and especially the popular alcohol-test are now no longer reliable in the asymptomatic gonorrhea produced by sulfanilamide.

The term "apparent cure" appears now very often in the literature. The frequent use of this term is an indication of the reluctance on the part of the physician to assume his proper share of responsibility in the determination of cure.

Articles which appear in the various Journals on the use of sulfanilamide in gonorrhea and which do not include the use of cultures as a test of cure, should be thrown into the waste-paper basket.

Cultures are superior to smears for the determination of the presence of gonococci especially in asymptomatic gonorrhea; in this condition the ratio is 4 to 1 in favor of cultures; the materials used are the prostatic secretion and the urine sediment obtained after stripping the urethra on a sound.

By cultural methods is meant the use of the newer culture media developed during the last two or three years such as the so-called "Chocolate Agar." The material for culture must be suspended in broth and then the suspension is inseminated.

The time has now come for the physicians to demand that the clinical laboratories and the various Boards of Health provide adequate and inexpensive cultural methods.

Smear methods should not be abandoned for cultural methods but supplemented by them. Material for smear is difficult to obtain in sulfanilamide treated gonorrhea. Prostatic secretion, semen, urine sediment (all washed in saline and re-centrifuged) are the substances used both for smears and cultures.

The discrepancy between the quick clinical response and the much slower bacteriological response in sulfanilamide treated gonorrhea has created a new social problem. The new drug readily produces a carrier state and since it is easily available for self-treatment it may eventually contribute to the spread of the disease. In the States where the state law does not prohibit the sale of the drug over the counter, the local Boards of Health should secure legislation to that effect.

The carrier state is common in women infected by sulfanilamide treated men; these women know nothing of their infection until accused of having transmitted it.

Since the recent introduction of hormone therapy for gonorrheal vaginitis in female children, no ill effects have been noted on the pubertal development of young girls treated by hormones. Nevertheless the smallest dose compatible with therapeutic efficiency should be used.

THE MEDICAL GOLF PICNIC

For once an outing of the Mahoning County Medical Society was not rained upon. Reference, of course, is to the Golf-Picnic-Dinner, held on Thursday afternoon, July 20th. Golf is a spirited exercise that starts the old pores oozing among softies whose game is distinctly more a matter of fatigue than finesse. That applied to most of the players on this occasion.

The Southern Hills course was beautiful. Up hill and down dale the light-hearted toilers strode, drinking in great gulps of air and scenery and such.

Then came a few minutes of pre-prandial quiet meditation, recommended for digestion. Then the dinner! You'd-a-thought everybody was simply starved. Everybody talking at once—such manners!

The golf results showed that Dr. Wm. Welsh won low gross; Dr. L. G. Coe, low net. Winners of blind bogeys were, Drs. J. C. Vance, John Welter, O. M. Lawton, Peter Boyle, Paul Mahar, Nathan Belinky, Dick Gross, Ralph Morrell, R. M. Morrison, E. J. Wenaas, C. M. Askue, John Rogers, Paul J. Harvey, Morris Deitchman, T. K. Golden, A. S. Parker, F. L. Tingwald, and N. R. Trimbur. The players were divided into reds and blues. The reds licked the blues for a ball each.

These experts received golf balls—as if such players ever needed them. The poor dubs, unwept, unhonored, and unsung—they of the cut and carved and bashed balls—they get no balls at all!

Pingpong was an exciting feature. Here Dr. Hodgen won, with Dr. Ray Hall runner-upper.

Door prizes, two electric clocks, which came from Mr. Earl Huffman, were awarded to Drs. John Noll and Woodrow S. Hazel.

After dinner came various activities, such as pinochle, African 7-up, pool, and so forth. One discovery

that is certain to be utilized some day —the world is waiting—is the tremendous vocal talent of several of our members. A little erring perhaps as to key, slightly dubious as to their ability to keep in tune—small things like that might be improved. But as to volume—sheer rafter-shaking—the boys are peerless. Once you have heard their rendition of "Ioway, Ioway, there's where the tall corn grows"—you'll appreciate what is meant.

Who did guide . . . who set the body and limbs of this great sport together? Dr. Dean Nesbit was general chairman, Drs. Welsh and Wenaas had charge of golf and Dr. Wenaas awarded the prizes. Dr. Rogers conducted the Pingpong contest; and Dr. Clarence Stefanski arranged the dinner.

It was universally agreed that these noble spirits did perform nobly. To them goes the Society's appreciation.

—Interested Spectator.

Accidents and Injuries

The month of August witnesses more outdoor accidents than any other single month of the year, which, of course, is easily explained by the fact that the summer is at its height then and vacations are in full swing. A physician's summer patients, therefore, are often very largely made up of those suffering from sprains, strains, cuts, puncture wounds, bruises, sunburn, plant-dermatitis, insect stings, and various other lesions resulting from falls, knocks, automobile accidents and sports of all kinds.

The choice of an all-round desirable surgical dressing for the treatment of accidents and injuries is sometimes a difficult one for the physician to decide. The majority of injuries require a dressing which, although antiseptic, is not also caustic; one which does not pain on application and is easily removed, and which is antiphlogistic, detergent, protective and repair-stimulating. A dressing embodying all these qualities is to be found in Antiphlogistine. The physician using it will find it to be practically the ideal application and surgical dressing for direct application to open wounds and raw surfaces, for dermatitis, sprains, strained ligaments and other injuries. He will find it one of the most generally useful surgical dressings to have always ready at hand during the hot weather months of the year.

SECRETARY'S REPORT

The next regular Council Meeting will be held Monday, September 11th, and the Scientific Meeting Tuesday, September 19th.

The summer activities have sure proven worth while and everyone is looking forward to the Picnic, scheduled for September 14th.

The regular routine business of the Society is being conducted as usual, with nothing of importance to be reported.

JOHN NOLL, M. D., Secretary.

St. Elizabeth's Hospital
Youngstown, Ohio

July 27, 1939.

Dr. William Skipp., President,
Mahoning County Medical Society,
Youngstown, Ohio.

Dear Dr. Skipp,

On behalf of the entire group, we would like to take this opportunity to express our appreciation for the enjoyable afternoon and evening given us last Thursday, July 20th, by the members of the Society. We remain,

Respectfully and professionally yours,

Internes and Residents
St. Elizabeth's Hospital.

Sixth Councilor District Meeting

ALLIANCE COUNTRY CLUB

ALLIANCE, OHIO

WEDNESDAY, AUGUST 30th, 1939

ELECTION OF OFFICERS

GOLF - - - DINNER

Annual Picnic

THURSDAY, SEPTEMBER 14th

MILLIKIN'S FARM

Same Place - Same Time - More Fun

Corn Roast and Clam Bake

ALL KINDS OF SPORTS

Scientific Meeting

TUESDAY, SEPTEMBER 19th

Guest Speaker

DR. WALTER M. SIMPSON

Subject

Artificial Fever Therapy

YOUNGSTOWN CLUB

8:30 P. M.

VOMITING IN INFANCY

By A. W. MIGLETS, M. D.

Vomiting, so frequent in infancy, must always be regarded as a symptom. It may indicate anything from slight overfilling of the stomach to the gravest conditions.

The four different varieties are: first, irritative; second, toxic; third, obstructive; and lastly central.

In the new born, *irritative* vomiting is a common event. 1) The irritation may be engendered by swallowing maternal discharges. Under these circumstances, the onset is within the first twelve hours and may be slight or severe. To meet this condition, no measure is more effective than stomach lavage.

2) Another source of irritative vomiting is the attempt to force too early feedings. This can be prevented if one gives a 5% Karo solution at 4 to 6 hour intervals during the first 48 hours.

3) Breast milk or artificial milk deficient in either quantity or quality, may be productive of vomiting. In such cases the rectification of the feeding will remedy the emesis. The accuracy of the diagnosis of insufficiency as indicated by loss of weight is sustained when the characteristic scanty, greenish-brown hunger stool is passed.

Emesis due to *toxemia* is a graver matter and frequently results in fatality. Among the least promising is the offspring of a toxemic mother. Fortunately not every such mother affects her baby in this way. These infants begin to vomit rather early, in the first 20 hours. Nursing at the breast merely aggravates the vomiting.

Stomach lavage alone will not effect a cure. Limited starvation together with intraperitoneal injection of normal saline solution, and in severer cases, injection into the longitudinal sinus of hypertonic glucose solution will be required.

Intractable vomiting may be one of the important symptoms indicating *sepsis of the new born.* The accompanying fever, or in the very weak infant, a subnormal temperature, together with the source of infection, will suggest a course of treatment aimed at eradicating the focus and sustaining the strength of the child. *Streptococcus infections* originating about the umbilicus running into peritonitis, infective cholangitis or general infection by way of the blood stream, are the most frequently encountered. The prognosis is of the gravest. The widespread infections of the skin are almost always accompanied by persistent vomiting.

Obstructions of any portion of the gastro-intestinal tract may result in vomiting. The higher up the inference, the more prompt and insistent will be the emesis. The most striking symptoms of this condition are visible peristalsis and distension of that portion of the tract lying above the obstruction.

The vomiting that indicates an intestinal obstruction is characteristic in that the rejection of the stomach contents passes through the stage of biliary emesis and if severe or neglected, eventuates in the vomiting of fecal matter. Pain, constipation and abdominal shock are symptoms of bowel obstruction. Other common obstructions are volvulus, intussusception and strangulated hernias.

The symptomatic vomiting of appendicitis and peritonitis are amenable only to surgical treatment directed toward removing the cause.

The most serious lesions which cause obstruction occur in the congenital atresias and stenoses. Such lesions in the esophagus are reported in medical literature and they are almost unfailingly fatal. However, a radiographic examination is always called for as it affords the only means

of determining the operability of the case. The cardiac end of the stomach may be involved in an obstructive malformation, and a similar defect is sometimes found in the duodenum of children who begin to vomit immediately after birth. Obstruction at the latter sight are cured through gastro-enterostomy.

Not always, however, can one expect a favorable outcome, because atresias and stenoses of the duodenum may be but part of a condition of multiple stenosis and atresias affecting all the anatomical divisions of the gut.

Microcolon and other inborn anatomical faults of the large intestine may be part of the clinical picture of multiple stenoses, or they may occur alone. Should the obstruction be single, or should it involve merely the rectum or anus, surgical procedures offer some hope that the child's life may be saved. But if, as so often happens, the intestine is obstructed at several points, surgery is powerless to aid the infant. With a simple obstruction of the anus, the sensation encountered is that of a flexible, thin and yielding membrane; while with an atresia, the palpitating finger meets with an unyielding and resistant mass.

Sometimes, in the presence of vigorous vomiting accompanied by a visible peristalsis, it is difficult to decide whether we are dealing with a *true developmental blocking of the gut, torsion of the mesentary, or with an intestinal obstruction due to an inspissated mass of meconium.* In either instance, stomach lavage is indicated; and this measure, together with large alkaline enemas, will relieve the obstruction, if the cause is accumulated intestinal contents. Use no purgatives.

Hernias, when obstructed, are an infrequent but possible source of vomiting in the infant. *Diaphragmatic hernias* may be responsible for the symptoms which will then be accompanied by much respiratory distress on account of the encroachment on the lungs of the gas containing abdominal viscera. Surgical intervention is the indicated treatment for such a case. It also must be resorted to in those cases of *internal hernia of the new born* in which a knuckle of intestine is strangulated by the adhesions which sometimes anchor a Meckel's diverticulum to some other part of the abdominal contents. Hernias strangulated through the usual openings, umbilical, inguinal, or femoral, seldom occur at an early age.

Vomiting may be a symptom of increased *intracranial pressure* in the new born. In such cases, it is explosive and refractory. In the earlier days of life, this type of vomiting is most often an indication of *intracranial hemorrhage.* Under these circumstances the vomiting will be accompanied by other and more striking signs of brain disturbance, such as changes in the reflexes, twitchings, respiratory and circulatory slowing and irregularities, as well as by alterations in consciousness. *Congenital hydrocephalus,* the *acute infective meningitides* and *encephalitedes* are sometimes causative of vomiting in the new born.

The endocrine system as well as the brain may be responsible for vomiting of the most violent and intractable type. The best example of this is afforded by the emesis which follows *hemorrhage into the adrenals.* Here the vomiting continues almost without cessation and is accompanied by all the evidences of abdominal shock—pallor, dilated pupils, irregular respiration and disturbed pulse rate. Almost inevitably, death supervenes with rapidity and treatment is impossible.

Vomiting as a symptom of disturbances of the *central nervous system* has certain specific qualities. It is infrequently preceded by nausea; as a rule it is not exhausting; and it is accompanied by other signs of intracranial disease such as eyegroud changes and headache. Uncomplicated by infection, the cause of such a state of affairs narrows down to

hydrocephalus and the *brain tumors,* of which the commonest in babyhood is glioma. The treatment of the symptom is that of the disease. The corpus callosum puncture of Anton is applicable and sometimes curative when the vomiting is due to hydrocephalus, of the variety as may happen in the course of a brain tumor, congenital defect or in the wake of a meningitis.

The vomiting that accompanies encephalitis, septic, specific or tuberculous meningitis is as much evidence of toxemia as it is of mechanical irritation of the central nervous system. There is no treatment for the emesis apart from the management of the underlying disease, although as a temporary expedient nothing is more palliative than an injection of a small dose of morphine sulphate. *Chloral* by rectum may sometimes bring temporary relief.

The syndrome known as *cyclical vomiting* may begin in late infancy; sometimes its onset is as early as the tenth month; but more often it comes on during the second year. The initial attack has all the characteristics of an acute duodenitis, and very often a carefully taken history will elicit that there has been a persistent overfeeding of fat. Frequently these children are emotionally unstable and are of families some of whose members show constitutional inferiority of the nervous system. Languor, fretfulness, irritability, headache, one or all, are apparent for some hours before the vomiting appears. Extreme constipation is almost always the rule, and the bowel movements are often characteristically foul-smelling and pale in color. The odor of the *acetone* on the breath is usually to be observed in these cases.

The frequent occurrence of prodomal infection in the upper respiratory tract led Eustace Smith and also Segewick, to the idea that herein lay the etiology. Comby believed that appendicitis was to blame. Undoubtedly an acute infection, be it in the respiratory, urinary, or digestive tracts, can precipitate the characteristic attacks of recurrent vomiting. The findings of Talbot and Shaw that blood sugar is uniformly lowered, supports the judgment of those who have contended that the complex is one of lowered oxidation caused by diminution of glycogen reserves, and explains the value of glucose in the treatment of the syndrome.

The symptom-complex is characterized by recurrent, intractable vomiting, a variable rise in temperature which may be excessive even to hyperpyrexia, extreme prostration, constipation and thirst. As the hours pass, the picture becomes one of shock; and the symptoms of a true acidosis intervene. Restlessness and irritability give way to apathy and drowsiness. The navicular abdomen, hollow eyes and sunken cheeks, thirst and progressive diminution of urine, all marks the loss of fluid, with the resulting concentration of the blood, which if unchecked may lead to fatal issue. The treatment will vary according to the stage at which the physician encounters the attack. If he is fortunate enough to be called during the stage of restlessness and irritability, and if he is warned by the palor about the mouth and nose and the highly flushed cheeks that toxemia is under way, the administration of a saline laxative together with a large saline enema may abort the disease. The same treatment may be effective if the vomiting has not persisted more than 24 hours.

Milk of magnesia is the most effective purgative. It should be given in teaspoon doses repeated every 20 minutes until from 10 to 15 teaspoons have been given. Between doses the child should be fed some small pieces of cracked ice. 6-8 oz. enemas should be given and allowed to syphon off, until 2 qts. are used. The last one to remain in the gut. After the last dose of the laxative is given, fluid by mouth should be started. Start with 5% sugar (either lactose, maltose or

glucose) with 1% or 2% iced sodium bicarbonate solution. In the second 12 hours of treatment high caloric orange juice is substituted for the simple sugar solution and 24 hours later solid food is allowed. *In mild cases seen early,* such a course of treatment will check vomiting and promptly restore the child to a normal condition.

It is essential that the fluid be put promptly into the tissues in the severer cases where the stage of dehydration has begun, the toxemia is profound, and the child is drowsy and lethargic. The most rapid and effective way of doing this is by the intraperitoneal route; 100 to 250 cc. of Ringer's solution containing 1 to 3 minims of a 1 to 1,000 adrenalin solution is injected. Fluid given in this manner may be excreted rapidly, and as we are dealing with a condition of concentration of blood proteins and lowered circulatory volume, it will be advantageous sometimes to use glucose solution intravenously. If the child's fontanel is still open, the longitudinal sinus route should be chosen and the injection given using the Goldbloom needle. If the fontanel is closed the largest available vein can be used and one of the simplest to use is the jugular. A hypertonic neutral solution of glucose 10% or 15% may be utilized as a fluid for injections. Gelston has emphasized the use of the injection of Insulin subcutaneously or intravenously, with the glucose solution. One unit of insulin should be employed for every 25 cc. of 10% glucose solution. In severe cases the same blood vessels should be utilized to transfuse the child with accurately grouped blood from a Wasserman-tested donor.

The only drug that can be recommended as of any value for the relief of the symptoms in cyclical vomiting is opium.

The prophylaxis of cyclical vomiting consists of searching out and remedying the infective process, if one can be found. Remembering the role played by duodenitis in the causation of the disorder, it is wise to limit the fat in the food.

Certain of the acute and subacute forms of *alimentary intoxication* that arise in infants, usually in the second half of the first year or the first half of the second year, are toxemias of graver import than those that lead to cyclical vomiting. Nevertheless, they are closely related in etiology, and for that reason the treatment detailed for the latter disease may be applied in exactly the same way for the relief in vomiting in these intoxications. Understanding of these cases rests upon an ultimate unknown etiology which Mellanby believes to be the absorption of protein split products; and that a fertile source of such split products lies in high protein low carbohydrate feeding, with the resultant establishment of a flora that elaborates toxic bodies related to the histamines and methylamines. The body, in attempting to eliminate these toxins, sets up a vomiting or diarrhea or both. Depletion and diminution of blood volume and concentration of blood protein follow, and the effective treatment must be directed toward the remedying this pathology as well as toward increasing the elimination of toxins and the prevention of their formation. These aims are well met in the treatment outlined above.

Other cases of acute alimentary intoxication and vomiting arise in the course of saccharolytic fermentation as well as in the infective diarrheas, and the same picture in its greatest development occurs in the major stage of the bacillary dysenteries in which death is definitely hastened by dehydration. The treatment of vomiting as it occurs in this group of cases must depend on the restoration of the fluid balance through the checking of the diarrhea and by measures enumerated in treating cyclical vomiting, especially the

use of glucose intravenously and insulin subcutaneously.

Vomiting and Anorexia subsequent to Weaning. This group of cases arises most often toward the end of the first year, in patients who have just been weaned. The cases of this group have been considered as of a nervous origin but some men consider these toxic in origin. The vomiting is always preceded by a period of anorexia, pallor and head sweating, and the clinical picture is generally one of subacute intoxication aggravated by self-enforced starvation. Stomach and colon lavage with alkaline solution, and gavage constitute a form of treatment that is usually a rapid amelioration of symptoms. In the less severe cases, spoon feeding with thick formulas will meet the necessities of the case.

In the various types of vomiting in all ages, the thick formula is a most valuable therapeutic defense. Attention was first called to its value by McClure who recommended it as a feeding for the habitually vomiting baby—the infant whose condition has been variously described as pyloric spasm, mucous gastritis or as a vomiting of nervous origin. The vomiting in such cases is persistent, not copious and without pain; the ejecta consists of unaltered food mixed with mucous. It is met most commonly during the second and third three-month periods of the infant's life. It has one curious characteristic—the more the food the more persistent and profuse the vomiting.

Certain *hypertonic infants* who are constipated, excitable, tender to touch, wakeful, and who cry easily, vomit habitually. Their symptoms become aggravated by the loss of fluid so that they are often diagnosed as victims of pyloric spasm. Fluid given freely, and 1/3000 or 1/4000 grain of atropine, will relieve such babies. Sodium phenobarbital is now being prescribed for this condition. The dose is one-quarter or one-eighth grain before feeding.

Pylorospasm, uncomplicated, is commonly seen, although it is not present as often as diagnosed. However, as a complication of hypertrophy of the muscles as the pylorus (congenital pyloric stenoses) it becomes important. Cumulative, propulsive vomiting is an essential part of the clinical picture of *obstruction at the pylorus in infants.* The time of the onset of the vomiting is also suggestive, as it is rare for such vomiting to be present before the second week of life, and usually it does not begin before the end of the third week. The possibility of this pathologic process evidenced by vomiting, makes it incumbent on the physician never to omit scrutiny of the abdomen of the child completely undressed. Such visual examination is best made while the child is taking food. If the presence of a visible peristaltic wave is revealed, the diagnosis of obstructive muscular hypertrophy at the pylorus is more than probable. Confirmatory signs are the diminution of urine, scant bowel evacuations, and persistent loss of weight. Of especial aid in arriving at a conclusion is the shield shape of the abdomen, wide and distended above and narrow and contracted below. One must not be misled by periods of amelioration with cessation of the vomiting, because spasm is a variable factor which at times may relax and allow some food to pass into the duodenum even when the hypertrophy of the circular pyloric muscle is extreme. The x-ray in the hands of competent observers is of utmost value in arriving at a diagnosis. Surgical intervention is radical, simple and effective.

Summary of the Treatment of Vomiting

1. Removal of the cause if possible.

2. But, apart from its cause, first we have means of palliation and relief through stomach lavage and the administration of certain drugs, some of which are used alkaline laxative, such as milk of magnesia; secondly, some as local anesthetics, examples,

½% solution of phenol or ½% solution of dilute hydrocyanic acid; third, opium and chloral in appropriate doses.

But the more effective than any other single measure is the reëstablishment of blood volume by the introduction of water into the circulation. The best and the simplest way to accomplish the state is to inject normal saline solution or Ringer's solution into the peritoneal cavity or under the skin.

THE MEDICAL CRIER

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

• The Continuation School of Medicine of Wayne County is in process of being organized in Detroit. It will combine the resources of the Wayne County Medical Society, the Detroit Department of Health, the Hospitals, the Department of Welfare and the College of Medicine of Wayne University. Through it is hoped that local physicians can spend an hour or more each week in bedside instruction without interrupting their regular work. Over one hundred fifty applications have been received. Courses will begin this fall.

• In Michigan it is now required by law that every physician attending a pregnant woman shall take at the first visit a sample of blood and submit it to an approved laboratory for a standard serological test for syphilis. The physician must state on the birth certificate whether or not such test was taken, and if not an explanation must be given why it was not made. The result of the test is not to be put on the certificate. Such reports are made available only to the local health officer and the physicians treating the patient.

• Medical Economics Magazine shows a disposition to criticise and deride the doctors who appeared before the Senate Committee conducting the Wagner Bill hearings. They reported that Dr. Arthur Booth showed ignorance of the bill and said that Dr. Leland was a weak witness. Probably true, but it must be remembered that those doctors were in a decidedly difficult situation, subjected to questioning by an antagonistic Senator who had written the bill and knew it forwards and backwards. On the whole, their testimony was very good and some of them could not be shaken. They could not be expected to give brilliant answers when asked how they would draft the bill. That is not their business. But when it came to medicine and its practice they were on firm ground. They were there to represent the membership of the A. M. A. and that is what they did.

The Editor of Medical Economics has been resentful of the lofty attitude of Dr. Fishbein, especially since he called that publication a "throw-away magazine." This is unfortunate, for Medical Economics is widely read and has a decided influence among the rank and file of practitioners. Their thrusts have a tendency to create a division of opinion among doctors and shake the confidence of some of them in their leaders, just at a time when unity is most essential. The A. M. A. belongs to us who practice medicine and if we are not satisfied with those who represent us, we can change them through our delegates. But it does no good to conduct propaganda against them in a semi-public magazine and thus wash our linen in public. There is enough criticism emanating from quacks and demagogues to keep us occupied without public dissention in our own ranks. Let's keep our differences to ourselves and maintain a united front against the forces that are trying to lower the standards of medical practice.

CASE REPORT

Mr. J. B., age 50, American Black —Admitted April 27, 1938.

Chief complaint: Pain in the abdomen.

Present illness: Patient states that he was in good health until 7:30 yesterday morning at which time the stomach began to hurt. At this time he vomited six or eight times and was unable to keep anything on his stomach. He had no bowel movements at the time and has had none since the onset. Repeated vomiting since the onset yielded only a few particles of food. He states that he eructated much gas and passed but little flatus. There is no history of any blood in the stools or any jaundice. He states that the pain has persisted since the onset and has been more or less continuous in nature.

Family history: Negative.

Marital history: Negative.

Past history: Essentially negative. Appendectomy 20 years ago.

Physical examination: Temperature 99.6; Respirations 22; Pulse 60; B.P. 140/80. Patient is a well developed, well nourished 50 year old negro lying on his back complaining of severe abdominal pain, very restless and acutely ill.

Skin—Negative.

Head—Negative.

EENT—Negative.

Mouth — Teeth carious. Breath foul. Tongue heavily coated. Pharynx somewhat injected

Neck—Negative.

Thorax—Symmetrical.

Lungs—Negative.

Heart—Negative.

Abdomen—There is an old right rectus scar present. There is rigidity over the entire abdomen but this is less marked in the right lower quadrant. There is severe pain on palpation over the entire abdomen, but this is more marked in the left upper and left lower quadrants. The abdomen is distended and tympanitic. No peristalsis can be heard. No fluid wave elicited. No hernia. Viscera not palpable.

Back—Negative.

Genitalia—Normal male.

Rectal examination—There is good sphincter tone. The prostate is very small, firm and smooth. About 7 cm. proximal to the anus a soft mass may be palpated which feels like a distended loop of bowel.

Extremities—Negative.

Sensation—Intact.

Reflexes—Physiological.

Impression:

1. Intestinal obstruction.
2. Possible Carcinoma of the Rectum.

Laboratory Findings & Progress Notes:

WBC on admission 8,000 — 88 Polys.—1 Monocytes—11 Lymphocytes.

4-28-38 — After admission patient vomited about 8 ounces of highly colored brown liquid with a fecal odor. The patient had fair results with an enema. Temperature 98.6—Respirations 12—Pulse 52. Urinalysis—Specific gravity 1.040; there is a faint trace of albumen. 7-8 WBC per HPF. ½ RBC per HPF.

4-29-38—X-ray shows gas throughout intestine with some dilated small intestine in left upper abdomen. RBC 4,300,000—Hgb. 85%—WBC 15,500—Polys 65—Eos. 3—Monocytes 1—Lymphocytes 31. Patient feels much better, taking a light diet. Has not vomited since immediately after admission. Has had good results with enemas. T.P.R. normal.

4-30-38 — X-ray shows apparent band in ascending colon near ileocecal junction with some dilatation of ileum.

5-2-38—Patient has continued to improve and operation was scheduled the following day. Blood Wassermann was negative.

5-3-38—Patient was operated and an Ilio-transverse-Colostomy was done, when an obstruction was found in the ascending colon. Enterostomy and Appendectomy were also done. Immediate postoperative condition satisfactory.

5-4-38—Condition fair. Temperature 100—Respiration 16—Pulse 50. Enterostomy tube draining. 2:30 P. M. patient had a temperature of 105 and began complaining of extreme pain in the abdomen.

5-5-38—Patient spent poor night and continued to run a high temperature. Temperature this A. M. 106.2—Respirations 30—Pulse 80. Patient somewhat comatose. Upon examination patient had signs of atelectasis, possibly pneumonia or embolism. X-ray showed massive atelectasis in left lung and a lobular atelectasis extending from the right hilus. Was taken to surgery for Bronchoscopy which revealed no evidence of any blocking of the bronchi. Patient was expectorating small amount of foamy, mucous-tinged blood. Patient's condition remained serious, kept comfortable with morphine and fluids were forced.

5-6-38—Patient very restless. Cheyne Stokes type of respirations. Temperature 104—Respirations 28—Pulse very weak, approximately 84. Oxygen administered. Stimulants given. Patient's condition grew weaker throughout the day. Patient expired at 4:30 P. M. Autopsy performed.

Conducted by Dr. J. Brown.

THANKS, BUT—

A recent survey of public opinion by the magazine *Fortune* suggests that the American people appreciate President Roosevelt's good intentions but mistrust their destination. While the President's enormous personal popularity remains unquestioned, his economic and political philosopsy does not appear to have won general acceptance.

This throws an interesting sidelight on recent medical events and confirms the profession's assertion that the Administration is creating a wholly artificial demand for compulsory sickness insurance. At the recent meeting of the American Public Health Association the Chairman of the Social Security Board referred repeatedly to a supposed popular desire for early governmental action. At the National Health Conference last summer Administration spokesmen painted a similar picture of public opinion.

Actually there has been very little spontaneous demand for governmental control of medical care. Such sentiment as exists for state medicine today is largely the product of continuous agitation by the Administration and interested groups of social workers. In fact, it is safe to say that most of the laymen who have succumbed to Federal propaganda and now favor compulsory sickness insurance have little or no idea of how it works, what they would receive under it or what it would cost.

The storm of protest aroused even in his own party by the Supreme Court packing plan, the primary "purge" and similar Presidential moves point to the fallacy of mistaking Mr. Roosevelt's personal popularity for a mandate to carry out his political and economic theories on which the public has had no opportunity to pass. Before the Administration undertakes to destroy private medical practice it should allow plenty of opportunity for the American people to study all sides of this complicated question and register its views, unbefogged by official propaganda.

NEWS ITEMS

St. Elizabeth's Hospital

By S. TAMARKIN, M.D.

Dr. S. R. Cafaro spent an enjoyable two weeks in Indiana.

Dr. Joseph Nagle is catching up with his fishing, spending two weeks in Canada.

Dr. M. M. Szucs has returned after an enjoyable two weeks spent in Michigan.

Dr. A. Marinelli had the misfortune to injure his back playing golf.

Drs. R. B. Poling and Morris Deitchman will leave shortly for Michael Reese Hospital, Chicago, to take a Postgraduate course on heart.

Dr. Howard Reese announces the opening of his new offices at 1705 Market Street.

Dr. Saul J. Tamarkin is vacationing at Madison-on-the-Lake.

Youngstown Hospital Association

By SAMUEL J. KLATMAN, M.D.

The annual reunion of former internes held July 27, 1939, at the Squaw Creek Country Club was well attended. As usual those present enjoyed the occasion, and the consensus of opinion was that it was a great party. Dr. W. K. Allsop was elected president of the group for the coming year and Dr. Simmerly was chosen as the new secretary. Spirited addresses were delivered by Drs. Patrick and Simmerly.

Many of our doctors are vacationing at present. Good luck and a good time.

Sometime ago we notified surrounding Counties of our willingness to print advance Program Schedules but are unable to do so as they fail to send them in.

Weather Report

A doctor delivered a first baby one night and upon visiting the patient the next morning inquired, "Well, how is the son and heir this morning?"

Whereupon the patient replied in a monotone, "I don't know—I ain't been outdoors yet this morning."

(Submitted by Catherine Dohr, R.N., Appleton, Wisc.)

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