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Current Comment

The Month in Washington—
(Continued from page 4-A)

Prof. Wilbur Cohen, University of Michigan—The former Social Security official maintains that the system can stand the drain of hospitalization for the aged. It could be done for one half of 1% of taxable income, he argued, and he would raise the latter to the first $6,600 of income instead of the present $4,200.

W. Glenn Campbell, American Enterprise Association—Congress should give the medical profession and the insurance industry a chance to work out this problem through traditional methods rather than institute a costly compulsory system with all its attendant damage to the effective practice of medicine.

Two other panelists expressed parallel views on the broader and philosophical aspects of health and welfare:

Secretary Folsom of H.E.W.—The burdens of disease, disability, ignorance and insecurity cannot be escaped by under-investment in health, education and welfare. Such an under-investment would have a costly effect on private charities, budgets of governments, efficiency of industry and the purchasing power of consumers.

Prof. Clarence D. Long, Johns Hopkins University—An expansion of social welfare programs will have a very great stimulating effect on the economy, provided we play down those programs that involve mere charity and emphasize those that help people to help themselves.

On the day of the hearing on health, education and welfare, the panelists agreed that no crash programs in education were called for despite the scientific manpower shortages. Other comments on education:

Professor Paul J. Strayer, Princeton University—Either federal aid will be forthcoming on terms that can be acceptable to the states or we will suffer a general deterioration in the quality of education.

President Howard R. Bowen, Grinnell College—Federal aid should not be granted directly to colleges and universities but through intermediary non-profit corpora-

(Continued on page 22-A)

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**Current Comment**

The Month in Washington—
(Continued from page 15-A)

tions controlled by boards of trustees made up of distinguished citizens.

**NOTES:**

A possible indication of legislation in 1958 comes from a December tour of southern medical schools by members of the House Interstate and Foreign Commerce Committee’s health subcommittee. Among other things, they were concerned with the schools’ need for more laboratories and classrooms.

The Department of Health, Education, and Welfare has started a 12-year study on the activities of a group of 3,000 newly retired men and women.

Community-wide chest X-ray campaigns to detect tuberculosis, long a popular public service device, now are in disfavor with U.S. Public Health Service. P.H.S. recommends instead that tuberculin skin tests be used generally with chest X rays reserved for selective groups likely to have high incidence of the disease.

Between July 1 and mid-December, almost half the population of the country had been taken ill with an upper respiratory condition, including Asian influenza.

In its first year of operation, Medicare spent $43 million, with $22 million going to civilian physicians and $21 million to civilian hospitals; administrative costs ran about 3%. Some claims are still pending.

**Anti-vivisection Movement Alive—**

There is still a surprising amount of money and blind fanaticism behind the antivivisection movement according to an editorial in the Bulletin for Medical Research.

The National Antivivisection Society, one of the five national organizations working to prohibit or drastically limit animal experimentation last year had a total income of more than $138,000. Their largest source of income was from legacies and bequests. Some antivivisectionist societies are reported to have endowments that would be the envy of many small colleges. This particular organization had expenses exceeding $13,000 for legal fees during the same period.

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(Continued)

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EDITORIAL

THE NEBRASKA MEDICAL FOUNDATION

Yes, there is a Nebraska Medical Foundation. It seems too few people are aware that our Foundation exists — even some of our doctors do not know about it. It is not surprising that some of our own members are unaware of this opportunity to turn dollars into better medical practice. The tenth birthday of the Foundation comes in 1958, and during these ten years the Nebraska State Medical Association has added several hundred new doctors to its membership. If the Foundation is inarticulate and the physicians who know of its existence do not talk about it, how are the new members and the prospective donors to get the message?

The “Corner Stones” of “Better Health for Nebraska Citizens,” the announced objective of the Foundation, are Scholarships, Research, Postgraduate Medical Education, and Public Health. Obviously, funds must accumulate in substantial amounts before an institution with these aims can begin to function. During the five years beginning February 1, 1952, the growth in assets that accrued to the Foundation was approximately $10,000, and half of this was put in by the Nebraska State Medical Association as a Student Loan Fund.

The Student Loan Fund is the only portion of the Foundation’s total, now somewhat over $23,000, that is functioning except as interest-bearing investments. This fund is the only portion that can function until the total assets have grown quite considerably. What can be done, for example, with $400 for research in the field of cancer; $1,000 for research in the cardiovascular field; $65 for “arthritis” and a like amount for “leukemia?” For that matter, what could be accomplished with the income from all the present assets of the Foundation?

The answer to the problems of the Foundation, of course, is to induce people to give and to make clear to them exactly to which foundation they are giving. Even small gifts, if multiplied over and over, add up rapidly to usable amounts of money. A recent death netted near $1000 in lieu of flowers. Whenever a friend or a patient mentions a gift or a legacy we should put in a good word for our own Foundation. Remember that the expressed wishes of the donor will be honored; that memorials may be set up; that additions may be made in various ways, to an original gift; and that, finally, complete information may be obtained by addressing The Nebraska Medical Foundation, 1315 Sharp Building, Lincoln 8, Nebraska.

MEDICARE

(Guest Editorial)

Beginning in December, 1955, the American Medical Association and the Department of Defense collaborated in the development of Medicare. A “Task Force” of the A.M.A., developed the program to a point where legislation was enacted under Public Law 569. The A.M.A., and the state associations have indicated that they will continue this contact and co-operation and will keep the physicians informed about the program from time to time.

Medicare is operated in Nebraska by the Policy Committee of the Nebraska State Medical Association, under a resolution adopted by the House of Delegates. The Nebraska State Medical Association is the Contracting Agent and the Nebraska Blue Shield is the Fiscal Agent for the program. The Policy Committee has complete responsibility for the program’s operation in Nebraska and the Blue Shield Plan takes its part under the direction of the Policy Committee. The Policy Committee is to be commended for their efforts in making the program such a fine success in Nebraska.

In-as-much as we have not published or
generally distributed the Schedule of Allowances of the Medicare program, but have depended upon the request of the Policy Committee to the medical profession of the state, to cooperate in the matter of charges in the following manner:

The fees charged in Medicare should represent, generally, the average going fee for the same service in the community in which that service is rendered. Fees charged should not exceed the ordinary reasonable fee, charged by physicians and surgeons in their private practice for persons in the middle income group.

Of the 3277 claims, 99.5 per cent have been accepted as payment in full by the members of the medical profession in Nebraska i.e. service benefits. We think this is a very excellent demonstration of cooperation by the medical profession in the state. Only 15 claims have been sent in for special consideration. Average payment per claim was $64.78.

Medicare is a new and difficult program to administer. It is difficult for the state medical society and its Policy Committee to inform and keep the medical profession informed. Lack of information and misunderstanding have caused a moderate amount of difficulty in administering the program. Medicare has created many problems and difficulties for Blue Shield in its endeavor to administer the program according to the contract, and the pursuant directives they have received from the Department of Defense. We think the publication of a new procedure Manual containing the Schedule of Allowances and a compilation of the changes to date would help eliminate much of the criticism due to lack of detailed information as to what the Medicare-program provides and does not provide.

The Medicare-program represents a unique program of the first magnitude in the field of health care. Few can fully appreciate the vast amount of effort contributed to the development and the formulation of this program. But, this much can be said in all sincerity—local state medical societies, the profession, and the American Medical Association deserve commendation for the contributions they have made toward working out a program which will benefit millions of servicemen's dependents. By participating in the program, physicians will contribute much towards bolstering the morale of the men in the armed forces whose constant concern is the health and well-being of their loved ones at home. Organized medicine and physicians individually in all parts of the country have, by their efforts in supporting this program, demonstrated a capacity to render a public service of immense proportion and great value.

Although the selection of the local administrative machinery for this program was a choice left entirely to the state medical society, it has been gratifying that the Blue Shield Plan was chosen by the medical society to provide the administrative machinery for Medicare. This we think is as it should be, in as much as the Blue Shield Plan is so closely associated with and an integral part of the Nebraska State Medical Association. This bespeaks the confidence of the profession in this area in its Blue Shield Plan. It is a vote of confidence that Blue Shield values to the utmost.

Medicare is now Public Law 569. It is subject to revision of the contract from time to time. Its future operation will demand a great measure of medical statesmanship on the part of the profession, to prove whether the medical profession can cooperate with the Federal Government in this program and not be swallowed up by the Government in the process.

If we can make this program work successfully, and there are many indications that it can be made to work, then it will be unnecessary to build more government hospitals and draft more doctors to care for these dependents.

From now on, success or failure depends on the unselfish wholehearted participation of doctors of medicine everywhere. This is a responsibility that we physicians must assume with a high moral sense of obligation and dedicated duty. The entire future pattern of the practice of medicine could well depend on the success or failure of the Medicare program. Judging the future by the past, I think the medical profession has what it takes to make this program a success.

Arthur J. Offerman, M.D.
DEFINITIVE SURGERY for

Cancer of the Oral Cavity

This article was written in support of the application of "accepted surgical tenets to carcinoma of the tongue, oral cavity, and mandible." The authors relate the theory, describe its application, and support and illustrate their thesis by reports of cases.

—EDITOR

OUR interest in applying accepted surgical tenets to carcinoma of the tongue, oral cavity and mandible was stimulated by a publication of Slaughter and Southwick\(^1\) in 1952.

As they relate, the success of irradiation in intra-oral malignant disease has stabilized at a disease-free, five year survival rate ranging between 25 and 30 per cent. In the hopes of bettering this figure, they proposed an en bloc surgical procedure eradicating the primary lesion and including ablation of the area of lymphatic spread. This concept is as yet too young to permit of an appraisal of five year arrests, but it does have the appeal of being good cancer surgery comparable to that of other anatomical areas and holds the promise of superseding irradiation in both morbidity and cures.

Slaughter and Southwick's paper records the historical background of the procedure. They and others\(^2,3\) have modified its application somewhat. They presented fourteen cases.

In substance, the surgical approach is begun at the periphery of lymphatic spread at the base of the neck. This, of course, presupposes positive cytological diagnosis of the primary lesion. The neck dissection proceeds centripetally in the usual manner and the floor of the mouth is approached anteriorly. At this juncture, various modifications for exposure and those dictated by the primary lesion are continued.

A lesion of the floor of the mouth at least 1 cm. from the mandible may be mobilized by a widely positioned circumferential incision and a "pull-through" procedure instituted, withdrawing the lesion beneath the mandible in continuity with the neck dissection. Exposure may be augmented by extending the horizontal submandibular incision at right angles through the lower lip and then posteriorly along the mucous membrane lateral to the mandible. Mandibular excision, if required, can then be carried out easily along with the tumor. If only the inner periosteum of the mandible is involved, the "inner table" of bone alone may be included, leaving an osseous strut of mandible in continuity. It should be emphasized that involvement of the osseous mandible predicates that it be sacrificed at a distance from the tumor. Actual invasion of the mandible by tumor soon exposes the canal of the mental nerve and penetration by tumor through this channel of lessened resistance may occur an unsuspected distance from the actual site of invasion. Too, it is to be recalled that most of these patients are edentulous, with resultant thinning or narrowing of the mandible and relative elevation of the osseous canal of the mental nerve as the alveolus is absorbed. By division of the mandible at the mentum and lateral retraction of the rami, excellent exposure of the base of the tongue and tonsillar fossae is obtained. A portion of these structures can be easily included in the en bloc dissection as required.

In the event of mandibular resection, deformity is not marked if the mentum is not included. An "Andy Gump" deformity results if the chin must be sacrificed. Such deformity is to be regretted and is to be avoided insofar as possible, but since cancer is the problem its eradication must remain foremost.

Reconstitution of the surgical wound is surprisingly simple. The floor of the mouth is closed by approximating mucosa to mucosa, or buccal mucosa to the incised border of the tongue. Removal of portions of the lateral mandible offers no problem—stabilization is not required. A section of the midline of the mandible may be wired, fixed with small Steinman pins, or immobilized with an external fixation splint. The skin wound is approximated with silk, especially care be-
ing taken that the vermilion border of the lower lip is in exact approximation.

We have used catheter suction drainage of the neck wound and a complementary tracheostomy routinely. Gastric feedings via nasogastric tube are used until deglutition is accomplished easily.

Illustrative cases are as follows:

A. Carcinoma of the Tongue With Neck Dissection by “Pull-Through” Technique

Patient H.R., a 65-year-old female, was first seen August 27, 1956, complaining of “something on the tongue” for six weeks. She had worn dentures continually since 1933. Biopsy done elsewhere was reported as cornifying squamous cell carcinoma of the tongue, grade 3.

Examination disclosed a papillary tumor on the right border of the tongue extending minimally into the floor of the mouth, but toward the anterior tonsillar pillar where leukoplakia was present. The lesion was freely movable.

Surgery on August 28, conducted under intranasal-endotracheal anesthesia, was begun as a right radical neck dissection employing a horizontal submandibular incision with a vertical limb extending to the middle third of the clavicle. Anterior and posterior skin flaps were elevated and a neck dissection was completed except for separation of the submandibular tissues. The lower lip was bisected and the carcinoma of the tongue circumcised. This included the tonsillar pillar and involved area of the tongue. The lingual artery was ligated and the dissection mass removed through the floor of the mouth. Reconstruction was accomplished as previously described, with a complemental tracheostomy.

The final pathological diagnosis was epidermoid carcinoma of the tongue, grade 3, with hyperplasia of the cervical lymph nodes.

B. Carcinoma of Floor of Mouth With Radical Neck Dissection, Excision of Mandible and Floor of Mouth in Continuity

G.M., male, age 60, was first seen September 29, 1952 with the complaint of “soreness in throat and tenderness under jaw” of three months duration.

Examination disclosed a whitish serpiginous tumor in the left buccal gutter extending into the base of the tongue.

Surgery was performed on October 3, 1952. A preliminary biopsy with frozen section showed epidermoid carcinoma. A left radical neck dissection was done, the lower lip was divided, and the dissection was continued in the floor of the mouth. The lateral quarter of adjacent tongue and the adjacent mandible and floor of the mouth were then removed with the dissection mass. Closure was as usual without attempt at bridging the mandibular defect.

The final pathological diagnosis was epidermoid carcinoma, grade 3. Thirty-eight lymph nodes were negative for tumor. This patient has been followed and no evidence of recurrence has been found.

C. Post-Irradiation Carcinoma of the Lip With Submental Metastases Invading the Jaw

The patient, F.A., was treated by irradiation for cancer of the lower lip, in 1952. In December, 1953, the right submaxillary gland was removed for chronic infection and microscopic study; no neoplasm was found. In January, 1955, the patient was operated upon for obvious submental node metastases with fixation to the mandible and ulceration of the overlying skin. The cervical chain on the right was probably involved.

A right radical neck dissection with bilateral excision of the anterior extremity of the mandible and floor of the mouth was done on January 17, 1955. The pathological diagnosis was recurrent squamous cell carcinoma of the submental region with metastatic squamous cell carcinoma to the right cervical lymph nodes.

An intermandibular medullary bar was utilized in reconstruction and immobilization of the mandibles. This subsequently became exposed in the floor of the mouth and was removed on
March 30, 1955. Fibrous continuity then provided sufficient stabilization of the mandibles.

In September, 1955, a left radical neck dissection was done for possible involved nodes; however, pathological examination revealed no metastatic involvement, and to our knowledge the patient manifests no recurrent disease to date.

D. Recurrent Carcinoma of Tongue and Anterior Tonsillar Pillar; Excision With Neck Dissection and Bisection of Mandible

The patient, G.M., was treated in July, 1955, for an epidermoid carcinoma of the base of the tongue and right anterior tonsillar pillar, by intra-oral irradiation. His course was satisfactory until January, 1957, when a local recurrence in the tongue became manifest.

He was operated upon following a positive biopsy and a right radical neck dissection, hemiglossectomy, and removal of the anterior tonsillar pillar were done in continuity. A complementary tracheostomy was performed. Exposure of the pharynx was obtained by bisecting the mentum, subsequently stabilizing this with Steinmann pins. This patient showed no nodal involvement and is convalescing satisfactorily.

Some instability of the divided mandible persists. We now feel that division of the mandible at the midline for exposure purposes only is not completely satisfactory from a morbidity standpoint. In a recent conversation with Slaughter a similar dissatisfaction was stated and he has made the suggestion that the mandible be divided near its angle, stating that exposure is excellent, stability is satisfactory, and the morbidity much less. We have not as yet had an opportunity to utilize this suggestion.

As might be expected, hospital stay approximates two weeks. Discomfort from the intra-oral surgery is significant because of edema and salivation. We feel a tracheostomy is mandatory, particularly in procedures involving the tongue and because of considerable postoperative swelling most manifest on or about the fourth postoperative day. In the interval prior to this phenomenon, one is often inclined to wonder about the need of a tracheostomy, but never afterwards.

We have had no salivary fistulas through the floor of the mouth, and further emphasize the use of catheter suction in neck dissections in general.

Initially, when the lateral tongue border is sutured to the buccal mucosa, a thick, slurred speech is prominent but this improves as edema subsides.

A late problem is interesting our dental colleagues in the challenging problem of dental restorations of the lower jaw, particularly if portions of the mandibles are removed.

Finally, we feel that this surgical concept is to be encouraged and that it proposes an acceptable, definitive attack on intra-oral cancers commensurate with acceptable surgical disciplines utilized for cancers elsewhere.

REFERENCES


Current Comment

Heart Disease and Asian Flu—

Dr. Louis I. Dublin, Health and Welfare Consultant to the Institute of Life Insurance, has predicted that the effects of Asian flu while mild to the nation as a whole, may have an appreciable impact on the death rate from heart disease and related conditions. Dr. Dublin states that in the past, when influenza has struck on a nationwide scale, it has raised the death rate from cardiovascular disease.

The statistics of the insurance companies, covering many millions of life insurance policy holders, assembled by Dr. Dublin, indicate that for the first nine months of 1957 there are clear indications that the rising trend in mortality from heart disease will continue. This increase is probably independent of any future effects of Asiatic flu.
PREVENTIVE CARE of INFANTS and CHILDREN:

VI. Eating and Sleeping Problems of INFANCY and EARLY CHILDHOOD

This is the sixth in a series of articles by Doctor Tompkins and his co-authors dealing with sensible methods of "preventive care" of infants and young children. These papers seek to teach the proper methods of inducing normal habits of eating and sleeping, habits that keep the baby from developing colic, or malnutrition, or tension and discord with the rest of the family; habits which make the care and raising of the baby a pleasure to the whole household. In this, as in others, one is impressed with the "common sense" used as a backdrop.

—EDITOR

Eating and sleeping are like twins. They just naturally go together. It was so designed throughout nature. The relationship fits physiologically and psychologically. If one looks to the young in nature, there seems to be a universal pattern. The sequence seems to be to play (physiological wakeful period), to eat, and then to sleep. Every adult knows from experience that there are two simple factors that support sleep. One is to be awake for a time, which is the first part of the equation. During this time the second part of the equation is accruing, namely, the need to eat. To eat a big meal adds to the need for sleep. The associated appeasement of discomfort plus relative shift of blood to the splanchnic area, combines the psychological and physiological sleep mechanisms. It would appear to be in the nature of things, then, to find eating and sleeping equated with pleasure. If this equation of a wakeful period, eating, and then sleeping is maintained in an atmosphere of pleasure, we have the formula for avoiding eating and sleeping problems.

An important factor in prevention is inherent in the physiology and psychology of feeding as a technic. Again we can take a lesson from nature. In contrast to some human mothers, animals always permit the wakeful period. The young are never induced to eat before hunger activates them, and they in turn indicate the need. The physiological wakeful period thus is main-

tained. This illustrates an important psychological premise: To permit a child to active behavior as a result of internal motivation is conducive of creative activity and loving. To force behavior as a result of outside motivation is to thwart creative activity and mobilize anger; thus love is impaired. Likewise, in general, animal mothers in contrast to some human mothers, do not deny food after the young have indicated their need for it. In this relationship the infant’s need to play and eat is met as well as the mother’s need. Indeed in nature and with humans, ideally, both mother and child will simultaneously be meeting their own needs. The child will do so as he meets the need for calories which provides the energy for physical growth and through the associated good feelings, expresses his love of self and of his mother, which utilizes the energy for the emotional growth and satisfaction. The mother will be meeting her instinctive needs to give motherhood and mother-love expression. This pattern of not feeding the child until he cries but promptly when he does, helps to assure complete feedings. To feed upon awakening, rather than after hunger is indicated, results in a partial feeding, as does delaying the feeding after crying begins. This may predispose to three sleep-disturbing mechanisms:

1. The lack of the wakeful period before the feeding results in wakefulness afterward, or merely a "catnap," transiently induced by an inadequate shift of blood away from the brain.

2. Impartial fillings predispose some infants to colic because of undisplaced air passing into the intestine.

3. The incomplete feeding may allow hunger to manifest itself and awaken the baby before sleep is completed. Since
the need for sleep is almost as great as for food, the sleepy baby further reduces intake and a vicious cycle of frequent small feedings, colic, and short fitful sleep periods may continue around the clock. The pattern deprives the infant of the maximum pleasure naturally available in the three phases — wakefulness, eating, sleeping.

As discussed in foregoing papers, the prevention of eating and sleeping problems, to a great extent, may be assured through proper feeding technic, good family climate, and by harmonizing with certain physiological and psychological principles, as aided by interpretation of certain cues. The problem of colic as a factor in sleeping and feeding disturbances has also been discussed. Sometimes hospitalization may be necessary to discover and establish the normal sleeping patterns. This is done with the same technique as described in the paper on colic. The same faulty factors predisposing to colic will also predispose to sleep disturbances with or without colic.

If we are to prevent sleeping and eating problems, it is of course essential that the infant find the functions pleasurable. In the long view, these pleasures can only be sustained in settings that can maintain themselves indefinitely, and to the advantage of all concerned. To fall to sleep in a relaxed setting, free of anxiety, equated with the mother, may take place in a mother's lap or in bed. In the long view, it will be to the advantage of all if the baby equates these good feelings only with a bed. This equation should be with his and not the parents' bed. So in the interest of prevention, why not keep the rocking chair and all of its play equivalents for the play time, and only the bed, his bed, for sleep? If the playtime takes place during the physiological wakeful period, after the nap and before the feeding, the normal pattern is maintained in a setting acceptable to all at any age. However, many parents, for a time, will find it pleasurable to play with the baby after the feeding. This, as has been pointed out, disturbs nature's attempt to put the baby to sleep. These same parents may, at a later date, become hostile toward the baby who fights to maintain the unreasonable pattern they have caused him to set up. The problem they have created becomes evident when the infant's sleep requirements are less and his demands greater. If the normal wakeful time is exploited with play, companionship, or creative activity, until hunger is indicated and the feeding given, followed by sleep in his own bed, then each phase is equated with the parent in an atmosphere of good feelings. These three sequential phases are in harmony with basic reality or his own basic needs, that represent verities that stem from the heart of the universe and are built into the child. So the child experiences that harmonizing with reality (basic needs) feels good; moreover it feels good in relation to people (parents initially) or he may learn that to attempt to harmonize with reality, that is to play when rested, eat when hungry and sleep when sleepy, simply puts one out of harmony with the parents. Thus he learns early that to harmonize with what is naturally basic and right, feels good and is also acceptable to others (parents) or he learns early that to harmonize with the very laws of the universe is not acceptable. Too bad! Another psychological premise may be stated: Child rearing that permits and aids the child to fulfill natural needs, is conducive to love of self, fellowmen, and the universe, and so to mental health.

To block the child's attempt to harmonize to nature's verities and to insist on conformity to an unreasonable culture (originally parents') is to mobilize fear and anger and to decrease love. In short, to help the child harmonize with reality is in the direction of love and mental health but to teach and insist on conformity is in the direction of hate and emotional illness. In harmonizing we do what we do as a way of expressing love of self and of others, an emotionally healthy act. In conforming, we do what we do as a way of being loved, an emotionally unhealthy act, stemming from poor self-esteem and a feeling that love must be earned.

Another helpful preventive device is the use of a pull-over snuggle having a zipper on either side. Such a snuggle pulls over the mattress covered by contour sheets on either side. Thus both sides may be used. The infant is protected from smothering, strangling, falling out of bed and getting uncovered. He is less apt to develop patterns of thumb sucking, blanket fingering, rocking, or other conditioned reflexes that some parents find objectionable. When he gets older he doesn't become a night-prowl-
er. Yet he has complete freedom of movement. An additional advantage is that the mattress with the snuggle makes a portable bed easily taken about the house and away from the home. If it is to be used, it should be used from early infancy, because the infant will want to continue as he started. It may be used until the child elects to sleep without it. From the standpoint of establishing good sleep patterns, the baby is zipped in after feedings and taken out upon awakening. It is to be used only as a place to sleep. In hot weather the zipper is pulled down as soon as he falls to sleep. The snuggle is best made out of sheeting so that it is cool in the summer. Covers may be laid over the snuggle as indicated. It goes without saying that many children are overdressed, a factor conducive to sleep-disturbances.

Overstimulation and anxiety-tension-states are often associated with sleep-disturbances ranging from restlessness to panic states. The correction is to alter the daytime tensions and give night time reassurance as needed at the child's bedside but not in the parents' bed. An anxious child should never be left to cry it out whereas within the limits of becoming more hysterical, say up to 45 minutes, the cry-it-out technic may solve the problem in the child who is simply testing or coercing the parents. Many parents with the physician's support can use this “cry-it-out” technic in a kind but firm atmosphere. If the child is not afraid and is, in general, secure with his parents the technic is probably not harmful to the child. If the parents are overly anxious and find firmness too threatening, or if the neighbors in the adjoining apartment or father's pressure on the mother is too great to permit the “cry-it-out” technic, then one of the long acting sedatives may be helpful, such as “Eskabar” in one to two grain doses. If used over a period of a week or so, a new pattern may be established. Also, the packaging is changed so that the amount of sleeping done at night is more nearly completed, thereby reducing the daytime amount so that the child will then need to sleep through the next night.

In the overstimulated, anxious child, one of the tranquilizing drugs may be used. In addition, environmental changes may be indicated, such as less vigorous evening playing, less stimulating stories and radio or television programs. Sometimes it helps to shift from a nagging approach to a decisive, consistent, reasonable, to the point and brief but final disciplinary program in an overall background of good feelings.

During the latter part of the first year and for several years to come the child’s total caloric needs and the total hours of sleeping needs, diminish. It will take about three years for the child to gain as much as during the first year; so obviously, the food intake will diminish and sleep may cut down to as low as 8 to 10 hours per day. With supervision, the infant’s and child’s eating and sleeping needs and satisfaction can be synchronized with those of the rest of the family. He will furnish the cues. If given the opportunity, the child will often elect to eat two meals per day sometimes after the first year, a pattern which may persist until the second growth spurt. Children may awaken thirsty without being hungry. If water or fruit juice is given to quench the thirst, and the playtime is allowed until hungry, he will wait for a combined breakfast and lunch between 10:00 a.m. and noon. He therefore eats a big meal and takes an early but short afternoon nap which results in less daytime sleeping. If he is fed shortly after awakening and before he is hungry, he will not take a nap until nearly noon. This is a reversal of the aforementioned play-eat-sleep sequence. The two-meal technic, in the baby only needing two, assures the afternoon nap equated with pleasure, until it is no longer needed. If it is disturbed by too small feedings and reversal of the natural play-eat-sleep sequence, the nap may be resisted with the usual rebellion and the late afternoon may be hectic because of too great fatigue. This impairs the eating of a good evening meal, which would have been more conducive to a good night’s sleep free of demands for a night bottle. When the afternoon nap is no longer needed, the two-meal habit assures a large evening meal and drowsiness so the child is less apt to resist going down at night, right after the evening meal. If he doesn’t need to sleep 10-12 hours daily and awakens before the parents are ready to arise, the evening feeding may be split by giving an afternoon low caloric snack before he is asking for food. This delays the hunger for the big meal until a later evening hour so that he goes down simultaneously very sleepy and very full. An alternative is to let him eat his evening solid foods with the family and wait until he is
sleepy before giving his milk. Obviously the child allowed to harmonize to two meals, if that is all he needs, will not be the feeding problem that the child will be who is forced to conform to a three-meal pattern. The latter child will usually have related eating and sleeping problems.

SUMMARY

1. The functions of eating and sleeping are physiologically and psychologically intrinsically related. Understanding application maintains these relationships pleasurably in a complementary fashion. Mishandling of these factors results in displeasure at meal time and bedtime, one function disturbing the other.

2. The naturally pleasurable and supplementary eating and sleeping functions should be set up in equations geared to the long term mutual need of the parents and the child.

3. The use of a proper snuggle may prevent sleep-disturbances.

4. Proper control of the overstimulated child by environmental manipulation, sedation, or use of tranquilizers may resolve bedtime and night sleeping problems. In selected cases a firm, consistent disciplinary program in an overall background atmosphere of good feelings may be necessary.

5. When requirements for food and sleep diminish, the use of two meals and one nap may solve the problem resulting from the conventional three meals with two naps.

REFERENCES


Practical Aspects of NEWER AND OLDER Anesthetic Agents*

ANY anesthetic agents continue to be used safely without change through the years. Some require modification of use in light of newer laboratory and clinical findings. This outline is an expression of the views of the anesthesiologist in this respect with mention of newer drugs affecting anesthetized patients. These include cortisone and new aspects towards the armamentarium of pre- and postoperative medication by addition of tranquilizing drugs.

INTRAVENOUS BARBITURATES

Within the last few years new barbiturate anesthetic agents for intravenous administration have been placed on the market. We had the well established thiopental sodium (Pentothal Sodium). Next we had thiamylal sodium (Surital) and now the latest is Neraval Sodium.

Surital is a product resembling pentothal sodium. Its formula, dosage, and effects are for all clinical aspects very similar. When loaded in syringes without labels and tried by several members of a department of anesthesia the two drugs, in their induction, duration, and sedative effect, are indistinguishable.

The newest intravenous1 barbiturate is Neraval Sodium. It has in its chemical formula the methyl-thio-ethyl radical which is

*Read before the May 1957 Meeting of The Nebraska State Medical Society.
present in methionine, one of the essential amino acids which in itself plays a role in the detoxification processes of the body. It is considered that this radical has something to do with the rapid detoxification and elimination of Neraval. It seems to be the shortest-acting intravenous barbiturate available.

Pentothal Sodium and Surital have the same indications for use as have been set down for Pentothal during the last ten to twelve years. Neraval is recommended when a rapid recovery is desired after a short anesthetic. There is apparently a definite lack of cumulative effect in the shorter cases.

The short-duration cases in which Neraval excels are dilatation and curettage, cystoscopy, incision and drainage of abscesses, brief manipulations of fractures, and so forth.

It is the author’s opinion that Neraval has no advantage over Pentothal or Surital for the longer cases. Here one needs half again as much Neraval as of the Pentothal-Surital preparations.

Parasympathetic activity such as laryngospasm, bronchospasm, and cough is apt to occur with any of these barbiturates. For this reason they should not be administered without the use of atropine or scopolamine as premedication. A gas machine for assisting respiration should always be available.

**SPINAL ANESTHESIA**

Spinal anesthesia, per se, has changed little in the last ten to fifteen years. The same drugs are effective and popular. Procaine and Pontocaine continue to be the most widely used agents. New agents are frequently placed on the market but they are not widely accepted.

Perhaps the most marked change in administration of spinal drugs comes with the sterilization and care of ampules. A different method of sterilization is recommended. The old standard method of sterilization consisted of submerging the ampules in some solution of a strong bactericide and fungicide. This method has been safe for preparing ampules containing crystals. A broken or cracked ampule that leaked was readily detected. It has not been possible to note the leaky ampule among those containing solutions. Small cracks in these ampules have been unnoticed and have allowed a slow contamination of the contents with the sterilizing solution. These sterilizing solutions are known to be sclerosing agents when injected into tissue. This contamination has been considered the cause of some post-spinal complications. Adhesive arachnoiditis has been traced to this contamination. The medicolegal aspects alone make the change necessary.

Autoclaving of ampules is now the accepted safe technic for sterilization of spinal ampule. The ampules containing the drugs, either in solution or crystals, may be autoclaved with the spinal trays or separately in some safe durable container that will protect the exterior of the ampule from contamination.

We have found it convenient to autoclave the ampules in test tubes. Thus the labels can be easily read.

**RELAXANTS**

Everyone is familiar with curare as a relaxant for the surgical patient. It has been and remains a safe and reliable relaxant. Succinylcholine is a newer member of this group now being used in many cases for surgery requiring relaxation. The relaxing effect of this agent is of short duration. It acts on skelatal muscle as a depolarizing agent.

Succinylcholine is given as a single dose (20-50 mg.) for very brief periods of relaxation. Such uses include rapid endotracheal intubation, the manipulation of certain fractures or dislocations, and other short procedures. Unless given very slowly this dosage may cause total cessation of respiration. The period of apnea lasts 4 to 8 minutes. For this reason a gas machine or some other method of giving artificial respiration must be available.

For general surgery requiring prolonged relaxation the succinylcholine may be administered by the drip method. Here, proper titration of the drip will give adequate relaxation without apnea.

Occasionally apnea may occur during the use of succinylcholine and sometimes may be prolonged. There are several causes for apnea while using succinylcholine. Not always is it caused by the drug. Apnea may be due to:
(1) reflex breath-holding from too light a stage of anesthesia;
(2) hyperventilation;
(3) depression from opiates or anesthetic agents;
(4) overdosage with succinylcholine with abnormal response of the motor end-plate.

Treatment for each category consists of:
(1) deepening the anesthesia level;
(2) correcting the rate and tidal volume of respiration;
(3) lessening the depth of anesthesia; if due to large doses of narcotic analgesics give nalorphine 5-10 mg. or levallorphan 1-2 mg. The last category of treatment;
(4) that of overdosage or unusual sensitivity to succinylcholine may be considered to fall into the group with abnormal motor end-plate response. There is now some evidence that when used for long periods of time succinylcholine has a dual action of producing both the depolarizing action plus blocking action at myoneural junction or motor end-plate. Under these conditions prolonged apnea has sometimes responded to prostigmine or edrophonium (Tensilon) administration.

When judiciously used, succinylcholine is a very safe and efficient relaxant.

CORTISONE

Those of us who spend a good part of our time administering anesthetics wish to make a plea to the practitioners using cortisone and other adrenal hormones. Each patient being treated with one of the adrenocortical hormones should be informed of the identity of his medication and instructed to give this information to any other doctor he consults. We frequently see patients for either elective or emergency surgery who have been taking one of these steroids and are ignorant of this fact. We believe the patient who is being treated with one of the adrenocortical steroids should be as well informed as the diabetic when he comes for surgery.

Patients who have been on cortisone for any length of time must be considered to have some atrophy of the adrenal cortex. Under the stress of surgery, fever, and anesthesia, these patients may exhibit varying degrees of cortical insufficiency.

The usual signs of adrenal cortical insufficiency are persistent hypotension with failure to respond to blood replacement and vasoconstrictors, respiratory depression, and a prolonged recovery time after anesthesia and surgery. This insufficiency is not always exhibited while the patient is in the operating room or while still under anesthesia. The patient who has, up to time of operation, been on oral cortisone medication may respond normally in the immediate postoperative period. Several hours later the adrenal cortical insufficiency has been known to appear. Suddenly an apparently normal patient appears to pass into a critical condition.

Many authors have reported an elevated eosinophil count in the presence of operative or postoperative shock as a strong indication of an insufficient adrenal cortex.

To return to our plea for information concerning cortisone therapy, it is considered that anyone having been on effective cortisone therapy within three to six months prior to a surgical procedure but whose therapy has been discontinued should receive intensive intramuscular therapy preoperatively for three to four days. Therapy should be continued on day of operation and gradually tapered off in the postoperative week.

If a patient has been known to be on cortisone therapy up to preoperative time then the same regimen should be set up a few days preoperatively although doses of intramuscular cortisone need not be as large.

PHENERGAN (PROMETHAZINE)

Phenergan originally was placed upon the therapeutics list as an antihistaminic agent. It was soon discovered that its sedative effects was so great that, for ambulatory patients, its use was restricted. Early reports from France suggested its use also as a sedative. After various trials it was found to be useful in the sedation of patients preoperatively and postoperatively. It was also found useful as an antiemetic and in treatment of hiccups. For the average patient, 50 mg. is a sufficient sedative. For the hypertensive or excited patient the addition of
a 100 mg. dose of Seconal or Nembutal will produce excellent sedation.

Preoperatively, the use of 25-50 mg. of phenergan with one-half the dose of the usual narcotic analgesic parenterally plus the usual belladonna-like drugs renders a very well relaxed, sleepy patient without much respiratory depression. Anesthetic requirements seem also to be reduced.

Postoperatively, as an adjunct to narcotic analgesic, the combination of promethazine and narcotic analgesic reduces the opiate dosage without reduction in analgesic effect. It also extends the analgesic period between doses as compared to a narcotic analgesic alone. The incidence of postoperative nausea and emesis is thus also reduced. Promethazine, unlike chlorpromazine, has very rarely been responsible for hypotension and tachycardia.

There has been a great need for this combination in the obstetrical wards. Here the sedative and respiratory depressant effects of opiates alone to relieve labor pains has caused, in many cases, dangerous fetal depression. Whereas 100 mg. of Demerol with scopolamine was quite routine, the same analgesic effect is achieved by 50 mg. of Demerol and 25-50 mg. of promethazine, plus the usual dose of scopolamine. It may be divided, one-half intravenously and one-half intramuscularly. This combination may be repeated as needed depending upon the degree of maternal sedation desired. The patients observed in our hospital were well sedated and slept quietly through labor. At birth, a much more active newborn is delivered with a higher incidence of active spontaneous respiration.

SPARINE (PROMAZINE)

Another addition to these drugs is Sparine or promazine. Although it is very closely related to chlorpromazine it does not have the undesirable side effects that are, in some instances, seen with the latter drug.

Sparine is a "tranquillizer-type" drug. It should not be considered a tranquilizer in the same respects as are Equanil and Mil-town. Its use by the anesthetist and surgeon in the hospital is to quiet the wildly-agitated patient. We have found it excellent to quiet the agitated senile patient. It is the choice of medication postoperatively in our hospital for children in the immediate postoperative period following tonsillectomy and adenoidectomy. Given in small doses, parenterally, as the child returns from the operation, it changes the wild, crying emergence from anesthesia to a relatively quiet relaxed recovery. Much less use of opiates is needed postoperatively.

SUMMARY

Surital Sodium and Neraval Sodium have been added to the intravenous barbiturate family. Surital is much like Pentothal. Neraval is desirable in short duration cases. Spinal anesthetic drugs should be dry sterilized. Succinylcholine, a relaxant usually considered of extremely brief duration, has occasionally been known to produce prolonged apnea. Treatment here is with the usual curare antagonists including edrophonium and prostigmine. The hazard of surgical procedures upon patients only recently taken off cortisone is stressed. Suggested treatment includes increased dosages a few days preoperatively and through the surgical recovery period. Outlines of suggested dosages for Phenergan (promethazine) and Sparine (promazine) as sedative adjuncts to pre- and postoperative medication are given. The use of Phenergan-Demerol combinations for obstetrical analgesia is highly recommended.

REFERENCES


QUINIDINE INDUCED

Thrombocytopenia

The author presents two cases in each of which the patient had thrombocytopenia that resulted from the administration of quinidine. Accent is placed upon the availability of a simple test which proves that quinidine is the etiologic factor, leading, thus, to accurate diagnosis and to prompt and adequate treatment.

—EDITOR

ALTHOUGH hematological toxic reactions to quinidine are unusual, the frequent use of this drug for control of premature contractions and other cardiac irregularities makes the early recognition and diagnosis of such reactions important. These reactions are self-limited when the drug is discontinued; however, death may occur before the return of the platelets to normal levels in quinidine-induced thrombocytopenia, as occurred in our second patient.

The etiology of thrombocytopenic purpura in these patients was determined by a rather simple in vitro test as reported by Weisfuse, Spear and Sass. This syndrome was first recognized by Broch in 1941. Since then there have been several cases all of which have had thrombocytopenia. One of the cases due to quinine, reported by Creger and Houseworth, also had evidence of erythrophagocytosis, a finding associated with hemolytic anemia.

Both of our patients had some evidence of a hemolytic component and one had evidence of splenic neutropenia.

Case 1—Mrs. P.F.M., age 23:

Chief Complaint: The patient had bleeding from her mouth and blood spots on the skin during the past 24 hours.

Present Illness: This woman was admitted to the Immanuel Hospital on March 25, 1957, for the fourth time, with the following history: Five years ago she had an episode of fever, joint pains and "skipping" of her heart. She was hospitalized for one week, and rheumatic fever was considered as a possible diagnosis. Since that time she has had numerous episodes during which her heart "skips beats," particularly with fatigue. Approximately three years ago she was given quinidine, three grains every 4 hours, whenever her heart would skip beats, and this would relieve it. She has used quinidine approximately every three months since that time. One year ago she began having episodes of chills after taking the quinidine. At that time the quinidine was given in tablet-form instead of capsules. About March 15, 1957, she had palpitation, and took a quinidine tablet. This was followed by cramps in her abdomen.

On March 22, 1957, because her heart "skipped a beat" she took one quinidine tablet before going to bed. About midnight her husband, noticing blood running from her mouth, awakened her, and in the morning she noted small petechiae over her arms, legs and ankles.

Past History: This reveals two admissions for pregnancy and one for the possible rheumatic fever. The patient is allergic to penicillin and sulfa compounds. The sulfa compounds caused vomiting, and the penicillin caused dermatitis. There is no other significant past history.

Family History: This was non-contributory.

History by Systems: This was non-contributory except for epistaxis during pregnancy and hemoptysis three or four months ago. However, the patient states the blood she spat up was bright red and may have come from the back of the nose.

Physical Examination: Numerous petechial hemorrhages in the skin of her arms, legs and ankles, as well as the mucosa of her mouth and in the conjunc-

PEYTON T. PRATT, M.D.
Assistant Professor of Medicine, University of Nebraska College of Medicine; Director Hematology Laboratory, Immanuel Hospital Omaha, Nebraska

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tiva were seen. The spleen, liver and lymph nodes were not enlarged. There was a grade I systolic soft blowing murmur heard at the 4th interspace, to the left of the sternum. The rhythm was regular. There were no other significant findings.

Laboratory Data: On March 23, 1957, the erythrocyte count was 4,000,000 per cu. mm.; hemoglobin, 13 grams per 100 cc.; leukocyte count, 3,800 per cu. mm.; differential, 68% polymorphonuclear leukocytes, 20% lymphocytes, 8% monocytes, and 4% eosinophils. The platelet count was 12,000 per cu. mm., and the reticulocyte count was 2.8%. The bleeding time was over 20 minutes. Clot retraction was poor. A direct Coombs’ test was negative, and indirect Coombs’ was positive.

The bone marrow examination revealed the marrow to be moderately hypercellular; the megakaryocytes were present in slightly increased numbers and showed some immaturity. The red blood cell/white blood cell ratio was 2.5. Granulopoiesis was intact and slightly increased and the erythropoiesis was normoblastic and increased. No other abnormalities were noted. The impression was that this was an abnormal marrow compatible with the diagnosis of thrombocytopenic purpura and suggestive of pan-hypersplenism. The patient’s plasma with quinidine produced agglutination of normal platelets.

On March 24, 1957, the platelet count was 35,000 per cu. mm. On March 26, 1957, the platelet count was 135,000 per cu. mm. and the reticulocyte count was 2.3%. Upon repetition, the direct and indirect Coombs’ were negative. On March 27, 1957, the platelet count was 440,000.

Course: On the date of admission, in the afternoon after the initial blood studies were made, including a bone marrow aspiration, the patient was given prednisone 15 mg. every 6 hours. This was reduced to 10 mg. every 6 hours on the second day, to 5 mg. on the third day, and to 2.5 mg. every 6 hours on the fourth day. This drug was then gradually withdrawn. She was discharged on the 5th hospital day. After discharge, on April 3, 1957, the patient returned for re-evaluation. The platelet count was 437,000 per cu. mm.; hemoglobin 13 grams per 100 c.c.; red blood count, 4,420,000; white blood count, 7,050 per cu. mm. with a normal differential. Again on May 29, 1957, the platelet count was 341,250, per cu. mm.; the hemoglobin 14.1 grams per 100 c.c.; red blood count 4,450,000 per cu. mm.; white blood count, 8,000 per cu. mm. with a normal differential; reticulocyte count, 1.3%. The patient was well.

Case 2—Mrs. M.L.D., age 51:

Chief Complaint: The patient had anginal pain of two weeks duration and petechial hemorrhages over her entire body for the past three to four days.

Present Illness: She was admitted to the Immanuel Hospital on August 9, 1957, with a history of having been well and strong, except for rheumatic fever at the age of twelve, until two weeks ago. At that time she developed chest pain, thought to be anginal in type, and auricular fibrillation. She was treated with quinidine, three grains four times a day beginning one week ago. The last two days prior to admission she became increasingly weak and had marked shortness of breath.

The past history, family history, and history by systems were non-contributory, except for the history of rheumatic fever at the age of twelve. The history was obtained from the family.

Physical Examination: The patient had multiple petechial hemorrhages over her entire body. A systolic and a diastolic murmur were heard at the apex of the heart. The heart rate was rapid, 120, and revealed an irregular irregularity. The blood pressure was 116/76. Moist rales were heard throughout both lung fields. The spleen and lymph nodes were not enlarged; however, the liver was palpable two to three cm. below the costal margin and tender.

Laboratory: On August 9, 1957, the erythrocyte count was 3,320,000; hemoglobin, 9.8 grams per 100 cc.; leukocyte count, 13,200; reticulocyte count, 6%. A platelet count revealed no platelets on the preparation. The differential re-
revealed 74% polymorphonuclear leukocytes, 2% stabs, 1% eosinophils, 16% lymphocytes and 7% monocytes. Six nucleated red blood cells per 100 white blood cells were seen on the smears of peripheral blood. The prothrombin time was 16 seconds with a control of 12 seconds. The prothrombin consumption was 14 seconds with a control of 32 seconds. The bleeding time was longer than 30 minutes. Clot retraction was very poor. Direct and indirect Coombs' tests were negative. The serum bilirubin revealed a total bilirubin of 3.71 mg. with a prompt direct bilirubin of 1.62 mg. per 100 cc.

Bone marrow aspirated from the iliac crest revealed a slightly hypercellular marrow with normal numbers of megakaryocytes and decreased maturation. The red blood cell/white blood cell ratio was 1:2. Granulopoiesis was intact. Erythropoiesis was normoblastic and elevated; no other abnormality was noted. The impression was that this constituted an abnormal marrow compatible with thrombocytopenia with a slight hemolytic component.

An in vitro sensitivity test was done and was found to be positive.

Course: The patient showed increasingly severe signs of congestive failure. She was treated with oxygen, digitalis, and mercuhydrin. However, she expired approximately eighteen hours following admission, after a rapidly progressive down-hill course.

Post Mortem Examination: The gross findings included petechiae over the entire body. Other significant findings were primarily in the cardiovascular system which revealed an acute myocardial infarction in the left ventricle. This resulted from hemorrhage into the circumflex branch of the left coronary artery, causing an occlusion. Petechiae were present over the pericardial surface of the heart. There was also a rather marked rheumatic valvulitis involving the mitral valve and lesser involvement of the tricuspid and the aortic valves. The respiratory system revealed a hydrothorax of 700 c.c. on each side with a marked hemorrhagic congestion and edema of both lungs. There were no other significant findings excepting passive congestion and fibrosis of the liver and slight chronic passive congestion of the spleen.

The cause of death was felt to be an acute myocardial infarction resulting from hemorrhage. The hemorrhage was due to the quinidine induced thrombocytopenic purpura. There was associated rheumatic heart disease and acute congestive failure.

IN VITRO TEST FOR QUINIDINE SENSITIVITY

The materials needed are a 15 mg. per 100 c.c. solution of quinidine in normal saline, the patient's plasma, normal plasma and a platelet-rich normal plasma. The latter is obtained by carefully taking 10 c.c. of normal blood and decalcifying with 1 c.c. 0.1 N. disodium sequestrene. The blood is centrifuged at 1,000 rpm for 5 minutes. The plasma is removed and re-centrifuged at 3,000 rpm for 10 minutes. The top 80 to 90 per cent is removed and the remainder is examined for platelets, and if over 1,000,000 platelets are present and not agglutinated, this portion is used as the source of platelets.

Three tubes are set up to test the patient's sensitivity, as shown in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Tube I</th>
<th>Tube II</th>
<th>Tube III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet-rich plasma</td>
<td>0.1 c.c.</td>
<td>0.1 c.c.</td>
<td>0.1 c.c.</td>
</tr>
<tr>
<td>Quinidine solution</td>
<td></td>
<td>0.1 c.c.</td>
<td>0.1 c.c.</td>
</tr>
<tr>
<td>Isotonic saline</td>
<td>0.1 c.c.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal plasma</td>
<td>0.1 c.c.</td>
<td></td>
<td>0.1 c.c.</td>
</tr>
<tr>
<td>Patient's plasma</td>
<td>0.1 c.c.</td>
<td></td>
<td>0.1 c.c.</td>
</tr>
<tr>
<td>Agglutination</td>
<td>Negative</td>
<td>Negative</td>
<td>Positive</td>
</tr>
</tbody>
</table>

DISCUSSION

The in vitro test of sensitizing normal platelets with the patient's plasma plus quinidine produced definite agglutination in both patients, and the control tubes were negative. The diagnosis of thrombocytopenic purpura was made on the basis of a very low platelet count, poor clot retraction, prolonged bleeding time, abnormal prothrombin consumption, and presence of petechiae. The bone marrow aspirations both revealed an increased number of megakaryocytes but, in addition, showed moderate normocytic erythroid hyperplasia.

The presence of reticulocytosis in both patients with elevated indirect bilirubin in case 2 and a positive indirect Coombs' test.
in case 1 suggests a hemolytic component. In case one, the patient had a leukopenia and granulocytic hyperplasia in the marrow, suggesting splenic neutropenia. The direct Coombs' test was negative; however, the indirect Coombs' test can not be conclusively interpreted because of possible sub-group incompatibility.

In case one the patient was promptly started on steroid therapy because of fear of cerebral hemorrhage, therefore additional studies were not possible. The second patient was not given steroids because of severe congestive failure. The associated toxic reactions of quinidine may have been present in the first patient as manifested by headache, chills, fever, and abdominal pain which were present prior to the thrombocytopenia.

**Pulmonary Thromboembolism***

* A Study of Forty-Six Autopsied Cases†

The observations herein reported were based upon both clinical findings and the autopsy. They are significant in relation to frequency of pulmonary thromboembolism, its etiology, the resulting clinical and pathologic changes, and, finally, its treatment. An interesting section on experimental production of this condition in animals, has been omitted from the printed version in favor of greater brevity.

---EDITOR

EMBOLIC occlusion of pulmonary arteries long has been considered a major cause of death and has been extensively studied for many years. It is the purpose of this paper to discuss certain aspects of this disease and to present a series of cases of proven pulmonary embolism with reference to the characteristics of the illness and the factors which promote it.

**INCIDENCE**

The incidence of pulmonary embolism depends on the nature of the primary illness, age of the patient, and many other factors. These figures will vary a great deal in different surveys.

In a review of autopsies at Michael Reese and Chicago Memorial Hospitals† covering

*Submitted as the senior thesis at the University of Nebraska College of Medicine.
†From Nebraska Methodist Hospital, Omaha, Nebraska.

**SUMMARY**

Two cases of quinidine-induced thrombo-cytopenic purpura with possible pan-hypersplenism are presented. A prompt recovery occurred in the first woman whereas the second expired rapidly, probably due to hemorrhage into a coronary artery in a patient with rheumatic heart disease and congestive failure. A relatively simple agglutination test for determining quinidine sensitivity was discussed.

**REFERENCES**


GLEN C. ROSENQUIST, M.D.
Philadelphia, Pennsylvania

a period of 17 years, 56 cases of massive pulmonary embolism were found—an autopsy incidence of one per cent. In only three of these cases was a correct diagnosis made before death. In seven cases, there had been previously known thrombophlebitis.

At Charity Hospital, New Orleans, over a 13-year period, there were 32,254 deaths. During this period, a third of the deaths were submitted for postmortem examination. There was an incidence of .057 per cent fatal pulmonary embolism per hospital admission and an incidence of four per cent in autopsies performed. Thirty-seven children had developed pulmonary thromboembolism in this series — the majority following suppurrative phlebitis of cavernous or lateral sinuses.

An autopsy-series at Massachusetts General Hospital§ showed small incidental emboli present in approximately five per cent of autopsies, with massive emboli found in 1.86 to 3.5 per cent. This figure was dependent upon the period studied.

Among 567 autopsies conducted at Toronto

Nebraska S. M. J.
General Hospital, ten per cent were found to have some type of pulmonary embolism.

These statistics give a concept of the nature of this universal problem. For years, a pulmonary embolism often went unrecognized because the physician performing the autopsy was inexperienced or unaware of the possibility that an embolus was present. Thus it was not reported. In addition, pre-autopsy embalming sometimes obscures the diagnosis. Simple postmortem clots may not be easily distinguished grossly from emboli if there has been contact with embalming fluid. The true embolus may then be missed.

**DIAGNOSIS**

Pulmonary emboli are usually divided, as to size, into three types. The first is the massive pulmonary embolus, which usually lodges in the pulmonary artery and perhaps in the right heart as well, and may extend to the right and left main pulmonary vessels. This condition is characterized by sudden shock and by almost instantaneous death, unless the clot is quickly broken and distributed throughout the lung fields. Most of the acute and severe symptoms—such as chest pain, cyanosis, and severe dyspnea—can be attributed to this type of embolus.

The second type of embolus occludes the medium sized pulmonary arteries. Though it may be fatal, it does not often produce the picture of acute shock. However, chest pain (usually pleuritic or anginal in type), cyanosis, and dyspnea may be seen; and, with infarction, there may be localizing physical signs of consolidation or pleural effusion.

The third type of embolism—one which may be quite obscure clinically and may often go undiagnosed or misdiagnosed prior to autopsy—is that of multiple emboli scattered throughout the substance of the lung. Clinically, there may be chronic right heart failure with polycythemia, dyspnea, and cyanosis.

Thrombophlebitis or phlebothrombosis is often associated with emboli of this type. For example, swelling, cyanosis, pain or tenderness of the lower extremities often constitute the only warning that pulmonary embolism is imminent. But thrombophlebitis may not be clinically recognizable until after embolism has taken place. Pain in the chest is usually listed as the most common complaint if there has been embolism. Respiratory manifestations are listed as the second most common complaint. Of these, cyanosis, dyspnea, cough, tachypnea, hemoptysis, and pleural friction rub are the most common. There are usually signs of inflammation, such as moderate fever, fall in blood pressure, cold clammy skin, apprehension, arrhythmias, prominent pulsation in the second and third intercostal spaces to the left of the sternum, distended neck veins, rise in blood pressure, palpitation, systolic pulmonary murmur with sounds resembling a pericardial friction rub, accentuation of pulmonic sound, and pulmonic gallop rhythm.

There may be cerebral signs such as coma, sudden weakness, effort syncope, incontinence, dizziness, convulsions, and miscellaneous symptoms, such as nausea, vomiting, jaundice, epigastric distress, hiccups, muscular pains and aches, and abdominal pain.

The electrocardiogram may be an aid to diagnosis. However, most cases of massive pulmonary embolism succumb before electrocardiographic studies can be carried out. Nevertheless, when electrocardiograms can be taken, a characteristic pattern is often seen. One sometimes finds a right axis deviation and other signs of acute cor pulmonale. Differentiation from coronary thrombosis can usually be made. There may be a right bundle branch block. Though this picture is thought to be typical, only 11.1 per cent of a series of patients at Charity Hospital in New Orleans, with proved pulmonary embolism, showed these characteristic changes in the electrocardiogram. At Massachusetts General Hospital, 20 per cent of those who had electrocardiograms taken showed acute cor pulmonale.

Another aid to diagnosis, especially when there are infarcts present, is X ray. One may find prominent hilar areas and, with occlusion, avascular pulmonary fields. The heart shadow is sometimes considerably increased in size. The infarcts may have the appearance produced by pleural thickening rather than actual areas of consolidation. Infarcts are frequently fusiform in shape. At peripheries of the lobes, they are classically triangular or wedge-shaped. When there has been hemoptysis, one may find areas of homogeneous density attributed to intrapulmonary hemorrhage. The residual of an old pulmonary infarct shows on the X-ray film as a band-shaped or wedge-shaped shadow radiating from hilum to periphery.
MATERIAL AND METHODS

A 10-year study (1946-56) was made of 837 autopsies at Methodist Hospital, Omaha, Nebraska. Included in this series were all autopsies performed on persons 15 years of age and over, divided into groups according to age (Table I). There were 487 males and 350 females. If there was evidence of embolism, the pathologist performing the autopsy routinely examined inferior vena cavae, ili veins, and their tributaries, and "milking" the femoral veins. In no cases were the veins below the inguinal ligament actually opened and examined.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Cases</th>
<th>Cases With Pulmonary Embolism</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-28</td>
<td>43</td>
<td>Massive Embolism: 1, Other Embolism: 2, 4.7%</td>
</tr>
<tr>
<td>30-39</td>
<td>37</td>
<td>Massive Embolism: 0, Other Embolism: 0, 0%</td>
</tr>
<tr>
<td>40-49</td>
<td>104</td>
<td>Massive Embolism: 2, Other Embolism: 3, 2.9%</td>
</tr>
<tr>
<td>50-59</td>
<td>168</td>
<td>Massive Embolism: 3, Other Embolism: 7, 4.2%</td>
</tr>
<tr>
<td>60-69</td>
<td>228</td>
<td>Massive Embolism: 6, Other Embolism: 14, 6.1%</td>
</tr>
<tr>
<td>70-79</td>
<td>181</td>
<td>Massive Embolism: 9, Other Embolism: 15, 7.2%</td>
</tr>
<tr>
<td>80-89</td>
<td>76</td>
<td>Massive Embolism: 6, Other Embolism: 1, 7.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>837</td>
<td>Massive Embolism: 27, Other Embolism: 19, 46%</td>
</tr>
</tbody>
</table>

Table showing number of autopsies in each of seven age groups represented in this study, number of massive and other type pulmonary emboli occurring in each age group, and percentage of emboli in each age group.

No thrombus was considered embolic unless, in the opinion of the pathologist, it obviously was not conforming to the lumen of the pulmonary vessel, or loosely attached to the embolic site. In all cases the thrombus was examined microscopically and found to be of typical ante-mortem type, showing platelet layers, lines of Zahn or evidences of early organization. All other types of pulmonary embolism were excluded from this study, i.e., tumor embolism, fat embolism, etc. When an embolus was found to occlude the pulmonary trunk and its main branches or both, it was considered as massive pulmonary embolism and the cause of death. When embolus was discovered in the main branches of each pulmonary artery or in smaller ramifications, it was considered as an embolus of medium type and as a contributing factor to death or an incidental finding at autopsy.

RESULTS

A total of 46 patients were found to have had pulmonary thromboembolism. This represents an overall incidence of 5.5 per cent. Massive pulmonary embolism accounts for 3.2 per cent of the total and embolism of arteries of smaller caliber accounts for 2.3 per cent of the total.

Twenty-seven of the 46 patients, or 59 per cent, were found to have massive pulmonary embolism. Eighteen patients, or 39 per cent, had embolism of medium-sized arteries; and in one patient, the emboli were found limited to small-sized arteries. Four of those with emboli of medium-sized arteries also had emboli in smaller-sized vessels. Some of the cases dying of massive pulmonary embolism had emboli in medium-sized arteries as well as the pulmonary artery and its bifurcation.

It was found that 33 of the 46 patients, or 72 per cent, were listed as medical patients during their illness. The remaining 13 patients, or 28 per cent, had had recent surgery and thus were listed primarily as surgical patients. Of those 27 patients dying of massive pulmonary embolism, 11 had had previous surgery. Of those 19 patients showing embolism other than the massive type, three had had previous surgery.

Consideration of the 13 surgical patients, as a group, shows that 12 had the massive type of embolus. In contrast, only 2 of the 33 medical patients showing pulmonary thromboembolism at autopsy were of the massive type.

During the patients' illness, peripheral thrombophlebitis had been diagnosed in six of the 27 patients with massive pulmonary embolism, but in only two of the 19 patients with other types of embolism. The overall incidence of diagnosed thrombophlebitis prior to embolism was 17 per cent. In only three of the eight cases where thrombophlebitis had been diagnosed prior to death, could clot be demonstrated at autopsy in either the iliac or other pelvic veins, the inferior vena cava, or produced by "milking" the femoral veins.

Various degrees of infarction were noted in 24 of the 46 patients, or 52 per cent. Massive pulmonary embolism did not produce massive pulmonary infarction in any case. In one third of the cases having massive pulmonary infarction, small, usually wedge-shaped infarctions were noted, possibly from previous minor pulmonary embolism. However, pulmonary infarctions were found in 15 of the 19 patients with types of embolism other than massive.
TABLE II

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplastic Disease</td>
<td>16</td>
<td>34.8</td>
</tr>
<tr>
<td>Carcinoma, 12 cases; Brain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor, 3; Sarcoma, 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>11</td>
<td>24.0</td>
</tr>
<tr>
<td>Myocardial Infarction, 5 cases;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestive Heart Failure, 3;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertensive Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease, 1; Arteriosclerotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease, 1; Coronary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficiency, 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular Accident</td>
<td>5</td>
<td>10.9</td>
</tr>
<tr>
<td>Fracture</td>
<td>5</td>
<td>10.9</td>
</tr>
<tr>
<td>Femur, 3 cases; Ankle, 1; Thor-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>actic and Lumbar Vertebrae, 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>9</td>
<td>19.5</td>
</tr>
<tr>
<td>Ulcerative Colitis, 1; Cholecystitis, 1; Leiomyoma of Uterus, 1; Pneumonia, 1; Vesicular Calculi, 1; Strangulated Hernia, 1; Intestinal Obstruction, 1; Bronchial Asthma, 1; Diabetes, 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>46</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table giving the primary diagnosis and classification of 46 cases of pulmonary embolism and showing the number and percentage of cases in each classification.

The patients were all studied with reference to their primary illness, i.e., the illness for which they were hospitalized (Table II). It was found that 16 of the 46 patients, or 35 per cent, were suffering from neoplastic disease of some type. There were three cases of brain tumor, one sarcoma, three carcinomas of lung, two each of ovarian carcinoma and gastric carcinoma, and one each of carcinoma of the prostate, endometrium, cervix, and pancreas, and one was an undifferentiated carcinoma.

Eleven of the 16 patients with neoplastic disease in this series showed massive pulmonary embolism at autopsy; while the other five patients showed embolism of medium or small caliber vessels. Neoplastic disease as the major illness constituted 41 per cent of those dying of massive pulmonary embolism and 25 per cent of those showing less severe degrees of embolism.

Infarcts resulting from pulmonary embolism were found in eight of the 16 patients with neoplastic disease. A possible source of embolism was found at autopsy in seven of the 16 (Table III). The one patient in 46 who was demonstrated to have emboli limited to small-sized vessels was a patient whose primary diagnosis was carcinoma of the pancreas.

Eleven of the 46 cases (24 per cent) had some type of cardiac disease as a primary diagnosis. Of these, five were diagnosed as having myocardial infarction; three congestive heart failure of undetermined origin; one, hypertensive cardiovascular disease; one, coronary insufficiency; and one, arteriosclerotic heart disease.

TABLE III

<table>
<thead>
<tr>
<th>PATIENTS WITH NEOPLASTIC DISEASE</th>
<th>Overall Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massive Pulmonary Embolism</td>
<td>11</td>
<td>68.8</td>
</tr>
<tr>
<td>Embolism Other Than Massive</td>
<td>5</td>
<td>31.2</td>
</tr>
<tr>
<td>Producing Pulmonary Infarction</td>
<td>8</td>
<td>50.0</td>
</tr>
<tr>
<td>Appendicular or Mural Clot Found</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Other Possible Source for Emboli</td>
<td>5</td>
<td>31.2</td>
</tr>
<tr>
<td>Found</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Possible Source for Emboli</td>
<td>7</td>
<td>43.8</td>
</tr>
</tbody>
</table>

Table analyzing additional findings present in patients whose primary illness was some type of neoplastic disease, and comparison with entire series of 46 cases.

When considering the five cases of myocardial infarction as a separate group, none showed massive pulmonary embolism at autopsy. All had emboli of medium-sized vessels, or medium and small-sized vessels. Of the other six cardiac cases, three showed embolism of the massive type. Eight of the 11 had pulmonary infarction as a result of embolism.

Appendicular or mural clot was found in the heart in four of the eleven cases and peripheral clot in three of the 11 cases. Thus seven of the 11 cardiac cases were found to have a possible source of embolism (Table IV).

TABLE IV

<table>
<thead>
<tr>
<th>PATIENTS WITH CARDIAC DISEASE</th>
<th>Overall Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massive Pulmonary Infarction</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Embolism Other Than Massive</td>
<td>8</td>
<td>72.7</td>
</tr>
<tr>
<td>Producing Pulmonary Infarction</td>
<td>8</td>
<td>72.7</td>
</tr>
<tr>
<td>Appendicular or Mural Clot Found</td>
<td>4</td>
<td>36.3</td>
</tr>
<tr>
<td>Other Possible Source for Emboli Found</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Total Possible Source for Emboli</td>
<td></td>
<td>63.6</td>
</tr>
</tbody>
</table>

Table analyzing additional findings present in patients whose primary illness was some type of cardiac disease, and comparison with entire series of 46 cases.

In five cases of the 46, or 11 per cent, bone-fracture was the primary diagnosis. Three had fractured femurs, one had fractured ankle with cast, and one patient had compression fractures of thoracic and lumbar vertebrae. All five cases were found to have
massive pulmonary embolism, and three of the five had clinical evidence of thrombophlebitis of the legs prior to death. A possible source for embolism was found at autopsy in only one of the five cases (Table V).

**TABLE V**

<table>
<thead>
<tr>
<th>PATIENTS WITH FRACTURES</th>
<th>Overall %</th>
<th>Entire Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Findings</td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Massive Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embolism</td>
<td>5</td>
<td>100.0</td>
</tr>
<tr>
<td>Embolism Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Than Massive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Producing Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infarction</td>
<td>2</td>
<td>40.0</td>
</tr>
<tr>
<td>Total Possible Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for Embolism</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td>Diagnosed Before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>3</td>
<td>60.0</td>
</tr>
<tr>
<td>Thrombophlebitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed During Illness</td>
<td>3</td>
<td>60.0</td>
</tr>
</tbody>
</table>

Table analyzing additional findings present in patients whose primary illness was some type of fracture, and comparison with entire series of 46 cases.

Cerebrovascular accident was listed as the primary illness in five of the 46 cases (11 per cent). Precise information is available in only one case where autopsy permit included the cranium, and cerebral hemorrhage was found. In the other four (where examination of the head was not included post mortem), the patients were debilitated or bedfast for long periods of time prior to death. Two of the five had massive pulmonary embolism, and the other three showed embolism of lesser degree. Four of the five cases showed emboli-produced infarction at autopsy. None of the five had embolism or peripheral phlebitis diagnosed prior to death. A possible source of emboli was found in two patients at autopsy, however. One of these patients showed appendicular clot in the heart, possibly resulting from auricular fibrillation; the other had a clot in peripheral veins (Table VI).

**TABLE VI**

<table>
<thead>
<tr>
<th>PATIENTS WITH CEREBROVASCULAR ACCIDENT</th>
<th>Overall %</th>
<th>Entire Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Findings</td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Massive Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embolism</td>
<td>2</td>
<td>40.0</td>
</tr>
<tr>
<td>Embolism Other</td>
<td>3</td>
<td>60.0</td>
</tr>
<tr>
<td>Than Massive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Producing Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infarction</td>
<td>4</td>
<td>80.0</td>
</tr>
<tr>
<td>Total Possible Source</td>
<td>2</td>
<td>40.0</td>
</tr>
<tr>
<td>for Embolism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed Before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thrombophlebitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed During Illness</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table analyzing additional findings present in patients whose primary illness was some type of cerebrovascular accident, and comparison with entire series of 46 cases.

Of the 27 patients with massive pulmonary embolism, 15 succumbed within 25 minutes after acute symptoms developed; in 12, death was delayed. Of those dying suddenly, four had collapsed while straining at stool or getting out of bed for the first time after either surgery or debilitating illness.

Of the total group of 46 patients, a possible source of emboli was demonstrated at autopsy in 20 cases, or 44 per cent. Seven had ante-mortem thrombus in the heart (mural or appendicular) and 13 were found to have fragments of clot in inferior vena cava, pelvic and iliac veins, or were produced by “milking” the femoral veins.

The incidence of pulmonary thromboembolism increased with the age of the patient as shown in Table I. Thus, in the age-group 80 years and above, nine per cent of those autopsied were found to have embolism of some type. In this age-group, eight per cent died of massive pulmonary embolism.

**DISCUSSION**

It is interesting to compare this series of cases showing embolism with other similar series. This group of cases is, in general, comparable to the series at Charity Hospital, New Orleans, where fatal pulmonary embolism was found to occur in four per cent of autopsies performed (all age-groups included). At Michael Reese and Chicago Memorial Hospitals, there was an incidence of one per cent. At Massachusetts General Hospital, the incidence varied between 1.86 and 3.5 per cent massive pulmonary embolism.

Small incidental embolism with or without infarction was less common in this series than in that reported at the Massachusetts General Hospital — 0.6 per cent compared with 5.0 per cent.

In reviewing our cases, it is quite obvious that debilitating illnesses were a prominent factor in the development of thrombophlebitis and embolism or both. Including all cases of neoplastic disease in this series (15 cases) and adding the five cases of cerebrovascular accident, five cases of fracture, three cases of congestive heart failure, and those additional cases recuperating after either surgery or myocardial infarction (confined to bed), we have accounted for 42 of the 46 cases, or 91 per cent.
Small infarcts produced by possible previous small emboli were present in one third of the cases of massive pulmonary embolism. Patients with massive pulmonary embolism all succumbed before resultant infarction had time to develop. Therefore, the cause of death was massive embolism, not massive infarction. Perhaps the one third mentioned were the victims of previous small non-fatal embolic episodes.

If this was the case, then prophylactic treatment after the first episode might have aborted a tragic and sudden death. In those six cases of massive pulmonary embolism where thrombophlebitis of the legs had been diagnosed prior to embolism, some type of prophylaxis also might have been effective in avoiding death. However, in no case was venous ligation performed or anticoagulants administered.

Only six of the 27 cases of massive pulmonary embolism were correctly diagnosed as such before death or at time of death. Because massive pulmonary embolism is so often clinically indistinguishable from some other conditions (notably myocardial infarction), and because such a large percentage of the cases in this series actually died "slowly" (without acute onset or symptoms), it is understandable why so few of the patients had embolism diagnosed prior to death.

It is interesting to consider the role played by the fibrillating or otherwise damaged heart in the production of pulmonary emboli. When such clots form in the right heart and become detached, they pass to the pulmonary arteries. The size of the vessel occluded depends upon the size of the clot set free. This may or may not be followed by pulmonary infarction. In this series, this source for embolism was seen in seven of the 46 cases, of which three followed myocardial infarction.

As is usually the case in autopsy series presenting the problem of pulmonary embolism, a possible source for emboli was found in only a relatively small portion of patients. This may in part be attributed to limitations of autopsy, since leg-veins usually cannot be examined.

As is shown in Table I, there appears to be a rising incidence of pulmonary embolism with increasing age. However, with increasing age, there was also increasing tendency to confinement to bed and generalized debility. Of the 76 patients in the 80-and-over age-group, seven showed pulmonary embolism. Six of these seven were of the massive type, an incidence of eight per cent—more than twice the overall incidence.

**TREATMENT**

Treatment of pulmonary embolism now centers around its prevention. In massive embolism, the Trendelenberg operation, or embolectomy, has been occasionally performed, but strictly as a heroic measure. Its use has been disappointing, carrying with it 93.2 per cent mortality.

As soon as pulmonary embolism has been diagnosed, one should give supportive therapy designed to combat shock. There is no evidence that antibiotics are of value. Pleural effusions, as they develop, should be aspirated to allay dyspnea. Hemoptysis is rarely of sufficient magnitude to warrant treatment. Oxygen may be given. Papaverine and atropine were formerly administered routinely by many physicians because it was felt these drugs contributed to relaxation of the pulmonary bed.

In massive pulmonary embolism, any treatment designed to prevent further occurrence is usually of no avail. But with the appearance of smaller emboli in the pulmonary vessels, producing a less severe clinical picture, it is important that prophylaxis be attempted in order to prevent further embolism, which may be even more crippling, or fatal. At the present time, there are two major courses of treatment available to accomplish this purpose.

The first is venous ligation. Assuming that the thrombotic process is limited to the veins in the lower extremities, ligation of these veins will prevent further embolism. This is usually accomplished through an incision over the fossa ovalis with ligation of the superficial femoral vein just before it joins the deep femoral vein. If the latter is not also involved by an inflammatory process, it will carry collateral venous circulation following the ligation. The saphenous veins also contribute to collateral flow. When thrombophlebitis is found to involve the common femoral or iliac veins, ligation of the common iliac may be necessary. Even this procedure may fail to prevent embolization if there is unsuspected thrombosis in other pelvic plexuses. Occasionally the vena cava itself has been tied off.
A number of clinicians feel that ligation of the veins in the extremity where the patient has symptoms of inflammation is a futile procedure. They consider thrombophlebitis alone as never responsible for embolism but, instead, blame phlebothrombosis, where the clots are not attached to inflamed walls of the veins and thus more easily are set free in the venous circulation. They therefore advocate the ligation of the veins in the extremity not showing evidence of thrombophlebitis, despite the fact there may be no symptoms in that leg. Routine autopsy examination of calf-veins of patients confined to bed for varying periods of time showed thrombi somewhere in these vessels in 5 per cent of cases. Some groups have routinely ligated the veins of both extremities with the onset of the first symptom and as diagnosis could be made. They felt the patient was then free from the threat of subsequent embolism. It is believed that the great saphenous vein only rarely is implicated in thrombophlebitis or pulmonary embolism.

The other primary preventative measure is anticoagulant therapy. This is accomplished by the use of heparin or administration of dicumarol. The former drug, because of its rapid anticoagulant effect, is administered simultaneously with dicumarol until the latter, whose effect is delayed for several days, can be given alone and maintain anticoagulant effects. Anticoagulant therapy must be continued at effective levels for 14 to 28 days until all deep clots have organized and endothelialized. There is a certain amount of danger in the administration of these drugs. Bleeding and clotting times must be watched closely until the thrombotic process—which may be temporary—subsides.

Occasionally a patient receives anticoagulant drugs and in addition undergoes venous ligation. Many have found the use of sympathetic block, which reduces vasospasm and thus perhaps any thrombotic process, quite valuable usually as an additional procedure. The time-honored treatment of phlebitis in the legs was immobilization and elevation of the extremity involved. It was felt that leg-elevation promoted lymphatic drainage and thus prevented the formation of phlegmasia alba dolens. Immobilization of the limb was thought to be necessary if the inflammation were to subside. However, prior to signs of phlebitis, early ambulation fol-

lowing surgery, and exercises for all bedridden patients, have been advocated.

Various factors may predispose to venous thrombosis and thus to embolism. Among these are blood dyscrasia, muscle-injury, sprained ankles, fractures, vasospasm during cold weather, injections of hemorrhoids, anesthesia, toxins, use of tobacco, and application of excess cold or heat to extremities. In one study, it was found that the incidence of fatal pulmonary embolism was highest after certain operations, notably hernia repair, operations on the uterus, urinary bladder and gall bladder, splenectomy, resection of intestines and stomach, other intestinal operations, and prostatectomy. Heart disease may also predispose to development of this condition.

Precipitating factors of embolism may also include such mechanical influences as straining at the stool, active or passive physical exertion, a large enema, or getting out of bed for the first time after an operation. In addition, embolism may occur at the time of removal of a catheter from a femoral vein.

PROGNOSIS

Of those surviving an acute attack of pulmonary embolism, many will die later of other causes, with embolism as only a contributing factor. Many recover completely, having no recurrence of either venous thrombosis or embolism. Others may be subject to recurrent attacks of both and may later die of diseases which seem to predispose to thrombotic episodes, such as polycythemia, leukemia, and carcinoma — particularly of the visceral type.

Many patients survive, but are victims of chronic venous insufficiency of the legs. They may have ulcerations, induration, chronic cellulitis, and extensive pigmentation. Life may be maintained for years after recurrent embolization if adequate collateral circulation can be established, utilizing such channels as bronchial arteries. After some time, the emboli undergo organization, which may be complete, often with recanalization.

SUMMARY

In a series of 837 autopsies at Nebraska Methodist Hospital, Omaha, from 1946 to 1955, 46 cases of pulmonary thromboembolism were found. Of these, massive embolism
predominated. Although embolism-produced pulmonary infarction was more common in medical patients than in surgical patients, massive pulmonary embolism was more common if the patients had had recent surgery.

Though 5.5 per cent of the autopsies showed some type of pulmonary embolism, only a relatively small per cent of these had been diagnosed as such before death, had had antecedent diagnosed thrombophlebitis, or could be shown at autopsy to have a source for embolism.

Some of the deaths in this series might have been prevented by prophylaxis after an earlier, non-fatal embolus or with treatment of peripheral thrombophlebitis.

Among other factors, neoplastic disease, cardiac disease, fracture, or cerebrovascular accident, seemed to predispose to the development of pulmonary embolism.

I wish to express appreciation to Dr. Robert L. Grissom of the Department of Internal Medicine and Dr. John R. Schenkken, of the Department of Pathology, University of Nebraska College of Medicine, for their invaluable assistance and guidance.

REFERENCES

Current Comment

Obesity Is Not a Cosmetic Problem—

Many women put the cosmetic aspect of obesity ahead of its medical implications according to Dr. Hart Van Riper, formerly medical director of the National Foundation for Infantile Paralysis and now the medical director of a pharmaceutical company. Speaking to a predominantly female audi-

ence, he urged that women re-examine their attitudes, learn the facts and fallacies about overweight, and avoid the so-called "wonder diets" advocated by "fadists."

Popular diets lacking medical approval, may be divided into four categories: The type which exaggerates the value of one food; the type which completely cuts out certain foods because they are "fattening," even though they may be important; the type which emphasizes "natural" foods and is associated with "health fads;" and the combination diets consisting of two or three foods.

It was noted that the degree of weight reduction should depend upon the amount of overweight in relation to the person's age, height, frame and other factors. This requires the judgment of a physician. In this regard it was pointed out that without re-education of the faulty eating habits which lead to obesity, the individual had very little chance of remaining permanently reduced.

Doctor Van Riper said that studies have shown that only 10% of women who use "fadist" diets remain reduced for as long as two years. Commenting on prescription drugs available to help suppress the appetite, it was noted that no drug alone causes weight reduction. A drug can control the appetite while the eating habits are being changed.

The World Medical Association—

The United States Committee of the World Medical Association recently completed its second annual meeting.

The twelfth General Assembly of the World Medical Association will be held in Copenhagen, Denmark, August 15-20, 1958.

In the first six months of 1957, the U.S. Committee increased its membership by more than five hundred. The House of Delegates of the American Medical Association, on June 5, 1957, unanimously adopted a resolution urging all members of the A.M.A. to become members of the U.S. Committee of the World Medical Association. It is hoped that every state's society will take official action to implement this resolution. It is hoped that every doctor will realize that his basic membership and organized medicine is not complete until he belongs to the United States Committee of the World Medical Association.
It is now more than six months since the members of the Nebraska State Medical Association installed me as president. Fortunately, during my year as President-Elect I was able to attend practically every committee meeting of our Association, which gave me considerable experience in the problems that confront the various committees and further impressed upon me the seriousness with which most of our members assume their obligations when appointed to a committee. Some committees have only a minimal amount of work and few problems while others require frequent meetings and long hours. Of course from year to year the number of meetings of the different committees varies with the problems which come up.

After assuming the presidency, it was necessary to have very few meetings during the summer months, but, as usual about September 1 it was necessary to begin having meetings and these will continue up to the time of our annual meeting in the late spring. Unfortunately, I was not able to attend any committee meetings for a ten-week period this last fall because of being confined to the hospital, to my bed at home, and to restricted activities following an operation for a herniated disc. Nevertheless, the loyal members of our various committees have continued to function in high gear in a most admirable manner. There are many problems to face and there is much work to do by the American Medical Association, each State Medical Association, and each County or City Medical Society, to protect the American people from so-called "well doers." It is a nibble here and a nibble there that is trying to destroy the real American way of life. A nice apple with its protective skin under proper conditions will remain good for a long time, but one bite and it begins to soften, turn brown and shrink. The medical profession is a protective skin or cover for the American way of life and the American people in these United States. Let's keep working, and many thanks to all of you for your help and guidance. More later.

R. RUSSELL BEST, M.D.,
President, Nebraska State Medical Association.
Organization Section

Coming Meetings

AMERICAN ACADEMY OF GENERAL PRACTICE — Tenth Annual Scientific Assembly, March 24-27, 1958, Dallas, Texas.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS — 1958 Annual Convention, November 16-20, 1958, Statler Hilton Hotel, Dallas, Texas.

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE — Fifth International Congress, April 24-26, Sheraton Hotel, Philadelphia, Pennsylvania.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE—February 9-11, 1958, Palmer House, Chicago.

NEBRASKA STATE MEDICAL ASSOCIATION ANNUAL SESSION—April 28, 29, 30, and May 1, 1958.

“March of Medicine” TV Program
To Be Aired January 23—

The work of American physicians in remote regions of the world where native populations are largely dependent upon our doctors and medicine for their health and well-being is the television story to be aired coast-to-coast January 23. The title of the hour-long show will be “MD International,” and will be presented over NBC-TV. This is a part of a joint American Medical Association and Smith, Kline & French Laboratories project to inform the American public of people-to-people activities in the health profession for the promotion of better international understanding.

The telecast reports on doctors’ activities in thoracic and general surgery, orthopedics, ophthalmology and general medicine in such far-flung areas as Korea, Hong Kong, Burma, Sarawak, Nepal, India, Lebanon and Ethiopia. A special March of Medicine team traveled more than 34,000 miles to film these doctors in their official roles as America’s “medical diplomats.”

A.M.A.-A.H.A. Joint Committee Studies
Medicolegal Problems—

A concerted educational program on medical professional liability is being formulated by a joint committee of the American Medical Association and the American Hospital Association. Among other things, the liaison committee plans to study current medicolegal advisory set-ups in a number of states, the liability of charitable and governmental hospitals, and ways of promoting postgraduate education in the professional liability field. Progress reports will be submitted to the boards of trustees of the two associations, and physicians and hospital personnel will be kept informed on all action taken through the organizations’ official publications.

57-Year Doctor Keeps Door Open—

Genoa, Nebr. — A physician who at one time had what was believed to be the largest general practice in Nebraska is nearing the end of 57 years work here.

The day’s routine today is much lighter for Dr. Homer Davis, who at one time had nearly six hundred youngsters under his care “in one lump.”

He still maintains an office, however, and keeps abreast of medical developments. Farm property is his “outside” interest.

All of Dr. Davis’s career, except for a brief World War I Army Medical Corps service, has been spent in Genoa. He came here in 1900 after graduating from the old University of Omaha Medical School.

“For some reason, we caught on here at Genoa right away and soon I had all I could handle,” Dr. Davis said recently.

He was named physician to the Government Indian School here and held that position more than 30 years until its close in 1934. At its peak, the school enrolled nearly six hundred Indian boys and girls.

“They were fine people,” Dr. Davis said.

Meanwhile, his practice grew until he had to engage the services of younger doctors to help him from time to time.

Such was the achievement of a man who in 1877 at the age of 16 “struck out West” from Illinois to find his niche.

He got a country school teaching job near Huron, S.D., and had 16 pupils to watch over when the famous blizzard hit January 12, 1888.
"We had plenty of fuel and stuck it out overnight," he recalled.

That spring he enrolled at South Dakota State, Brookings, and was graduated in 1891.

Then he decided on a career in medicine and went to Iowa State, Ames, for his Master's Degree in science, working his way through school by teaching on the side.

He completed his training in Omaha.

He is a past president of the Nebraska State Medical Association, was Union Pacific surgeon more than 50 years and is now on the line's retired list.

A former member of the Genoa School Board, he was honored by local citizens a few years ago for his long service here. He is still in excellent health.

A son, Dr. Kenneth, is a roentgenologist in Beverly Hills, Calif. Another son, also a physician died during World War II.

Mrs. Davis died in 1954.

Illegal Diathermy Apparatus—

An editorial in a recent issue of the New England Medical Journal (Nov. 14, 1957) calls attention to disasters that may arise (and have on a few occasions) as a result of the use of illegal diathermy apparatus.

The F.C.C. has assigned two frequencies for use in diathermy machines and other similar equipment. An unauthorized frequency used in a diathermy machine may transmit several hundreds of miles, like a radio. Such illegal signals may interfere with radio communications. They could guide enemy planes to a friendly target; interrupt police, fire department, and civilian defense transmissions; plane, ship, and train control could become snarled.

Such illegal signals have been known to facilitate robberies and help the escape of the robber because the police signals were jammed. One doctor's ultra-short-wave set guided an army NIKE toward his residence. Catastrophy was narrowly avoided.

In 1954 there were about 20,000 such illegal machines in use. Now, this has been reduced to about half that number. The reduction is only half good enough, if we wish to avoid possible tragedy. The doctors should cooperate in abating this dangerous nuisance.

Gleaned From A.M.A. Washington Letters—

85-47.—In connection with Public Health Service's report on Asian influenza . . . the National Health Survey . . . notes a decline in upper respiratory diseases, but cautions that the drop may be a statistical one only, and not necessarily indicative of a firm trend.

85-47.—The Jenkins-Keogh plan for tax deferment on retirement funds paid by the self-employed may be made a part of an omnibus tax relief bill for small business . . . It is planned to have a committee bill reported out and ready for floor action by late January.

85-47. — Public Health Service, acting on advice of a committee of medical and public health leaders called in to re-evaluate recent changes in the nature of the tuberculosis problem, is recommending against community-wide chest X-ray examinations for detection of TB. At least one factor given consideration in this connection is "the problem of low-level radiation exposure from X rays."

85-47. — Announcing that it will "strongly oppose" the Forand bill for hospitalization and medical benefits under social security, the A.M.A. has explained its reasons. The Forand bill is H.R. 9467, introduced late last session. It offers 60 days of hospitalization, plus surgical benefits, and an additional 60 days of nursing home care, to all social security beneficiaries 65 years of age and older, and the same benefits to their survivors and dependents.

About this, President David B. Allman said:

"This proposal is clearly 'socialized medicine' for a segment of the American people. Enactment would permit the federal government to withdraw social security taxes on a compulsory basis from almost the entire working population and use those taxes to reimburse hospitals and physicians for services rendered to all persons eligible to receive old age and survivors benefits. The American Medical Association has repeatedly opposed compulsory health insurance and is unequivocally opposed to this new version."

Allied with the A.M.A. are many organizations and individuals such as American Farm Bureau Federation, the U.S. Chamber of Commerce, life and health insurance industries, and the National Association of Manufacturers.
News and Views

From the Lincoln Journal—

A former Nebraskan, now at the University of Kansas, has disclosed a recently discovered method for bone grafting.

Dr. Leonard F. Peltier, formerly of Lincoln, said plaster of Paris can be mixed with scarce bone grafts as an "extender," just as bread is used to extend hamburger.

The plaster eventually is absorbed as the body builds new bone to fill in the defect in about four months.

Dr. Peltier sees use for plaster in cases where a large segment of the bone is removed because of a tumor.

From the Omaha World-Herald—

Dr. Denham Harman of San Francisco, California, has been appointed to the newly-created chair of cardiovascular research at the University of Nebraska College of Medicine. Dr. Harman will join the faculty in July 1958.

The heart research professorship was established by the Nebraska Heart Association with a 20-thousand-dollar grant.

A similar professorship has been established at Creighton University, filled by Dr. Alfred W. Broady.

Dr. Harman has been a research assistant at the University of California the last four years. He has investigated the aging and thickening of the arteries.

The chairs at Nebraska and Creighton are two of seven in the nation, all established by the affiliates of the American Heart Association.

From the Franklin Sentinel—

An open house was held on October 27 for Dr. and Mrs. W. I. Devers of Pierce in honor of Dr. Devers' 45 years of medical practice.

Dr. Devers first began his medical practice in Upland, Nebraska, in 1915. During World War I he served with the medical corps. In 1934 he moved to Pierce where he has practiced ever since.

From the Omaha World-Herald—

The Nebraska Psychiatric Institute's outpatient service treated 1,145 patients during the past year according to Dr. Cecil L. Witterson.

Of this number, 905 were discharged from the institute's care. More than one-fourth of the total were children 17 and under.

They included 19 under 5 years of age, 115 between 5 and 9, 90 between 10-13, and 101 between 14 and 17. The youngest was 3 weeks old, the oldest 87.

From the Omaha World-Herald—

One of the 43 tuberculosis research projects in the nation financed by Christmas Seal funds is being carried out in Nebraska, officials of the Nebraska Tuberculosis Association have announced.

Dr. Warren E. Engelhard of the Department of Bacteriology at the University of Nebraska is studying the effect of enzymes on the tubercule bacillus through a research grant.

Dr. L. C. Albertson of Omaha, president of the Nebraska Trudeau Society, said Tuberculosis is one of the diseases against which notable progress has been made but that it isn't licked yet.

From the Omaha World-Herald—

The Omaha-Douglas County Medical Society announced recently that it will investigate recent outbreaks of food poisoning in Omaha.

One facet of the study, said Dr. Horace Giffen, chairman of the preventive medicine committee, will be to find out from Dr. Edwin Lyman, Omaha-Douglas County health director, "what is lacking in our city or our health department that permits these outbreaks."

Commented Dr. Paul Read, society president:

"In these days of modern refrigeration, our knowledge of the cause and spread of disease and our understanding of sanitation in handling food, it is hard to believe that such outbreaks are unavoidable."

From the Fullerton Journal—

A physician who at one time had what was believed to be the largest general practice in Nebraska is nearing the end of 57 years of practice.
He is Dr. Homer Davis of Genoa. The day's routine for the doctor is much lighter than at one time when he had nearly six hundred youngsters under his care "in one lump."

He still maintains an office, however, and keeps abreast of medical developments.

From the Omaha World-Herald—

Three retired doctors, who between them compiled a total of 104 years of practice at St. Catherine's Hospital were honored at a dinner recently.

They were Dr. Robert F. Farrell, 30 years on the hospital staff, and Drs. William H. Melcher and William L. Sucha, both with 37 years.

Each received a bronze plaque, presented by Dr. James F. Kelly, Sr., president of the hospital medical staff.

The three doctors were made honorary members of the medical staff.

From the Omaha World-Herald—

Omaha doctors are being asked to participate in the local and state program of physical fitness for youth.

Dr. Floyd O. Ring has been named to head a group to organize doctor participation.

He has sent questionnaires to all members of the Omaha-Douglas County Medical Society, asking them to suggest ideas on how the medical profession can take part.

J. Gordon Roberts heads the state's efforts. He is a member of the President's Council on the Fitness of Youth.

Doctors are being asked how a fitness program can be carried out and evaluated and how periodic dental, physical and mental examinations of youth can be handled.

Doctors Jailed and Murdered in Cuba?—

From Secretary's Letter No. 428:

"Dr. Louis H. Bauer, secretary-treasurer of the World Health Association, has requested permission of President Batista to send a small delegation to Cuba to investigate charges that members of the medical profession there have been murdered and jailed.

"In a letter to Batista, he cited allegations made during the last month that doctors had been 'persecuted, ill treated and tormented' for taking care of members of insurgent groups who were ill and wounded. Some physicians, Dr. Bauer said, have sought asylum in foreign embassies."

Citizen's Committee to Oppose I.L.O.—

A citizen's committee composed of leaders of industry and labor, education, information, and public affairs has been formed to promote public understanding of the purposes, objectives, and activities of the International Labor Organization.

The A.M.A. has long opposed the principles and philosophies of this League of Nations holdover that is now a part of the United Nations. The opposition is based upon the essentially socialistic policies and activities of I.L.O. The history of the nefarious activities of I.L.O. and the dangers to American Medicine and the American way inherent in those activities has been given, editorially, on a number of occasions, in your Journal.

American Cancer Society Disapproves United Fund Drives—

The American Cancer Society, Nebraska Division, Inc., meeting in executive session in Omaha, recently, approved the action taken by the Board of Directors of the American Cancer Society, Inc., at their recent Annual meeting in New York against participation in any United Fund drive.

The Nebraska Division has always felt that to participate in any United Fund drive would be to accept money from people who through local pressure were forced to give to United Fund drives but who might not wish to give any money to the Cancer drive. Since the Cancer Society's activities have always been considered as voluntary health agency work and since 95% of its workers are on a voluntary basis, it has always been thought that, to be truly voluntary, a separate drive for cancer funds should be made so that all money received would be voluntarily given.

The Cancer Society has an important program of cancer education for the layman to prevent cancer and assist in the early diagnosis of cancer as well as contributing to the medical research aspects of this program.
carried on by the Cancer Society for the layman and are anxious to contribute to the furtherance of this activity. It is to these people we appeal each year during the month of April, which is cancer month, and no authorization has been given to any United Fund organization to solicit funds for cancer. No such funds can be accepted by the Cancer Society.

United States Contributes $7 Million to W.H.O.—
As usual, we are “contributing” the major part of the dollars needed to carry out a project of the World Health Organization. On December 5, checks totaling seven million dollars were handed the World Health Organization (including the P.A.S.B.) to help carry out the eradication of malaria. This is a superbly admirable project having its maajr beneficial effects on the rest of the world. It seems, however, that we are the only ones with spare change threatening to wear holes in our pockets; therefore, why not have us pay the bill?

Anticoagulant Drugs to Prevent Strokes—
The National Institute of Neurological Diseases and Blindness has awarded $58,000 in grants to six medical research centers and medical schools to conduct the first cooperative study to evaluate the effectiveness of anticoagulant drugs to prevent strokes. The study will be conducted on approximately 1800 patients and will require about three years for completion.

Meningococcal Infections Reported
On Increase—
There is reported to have been about a 25 per cent rise in the number of meningococcal infections since September 1. Greatest increase is in New England, Middle Atlantic, East North Central, and Pacific Coast States.

Wife of Nebraska Doctor Dies—
Services for Mrs. Daniel T. Quigley, wife of a prominent Omaha physician, were held at North Platte on November 26th. Doctor Quigley was a member of the faculty of the Nebraska College of Medicine, and a son, Dr. Thomas B. Quigley, is Professor of Medicine at Harvard University.

A.M.E.F.-Dollars: Where Do They Come From?—
A recent “Progress Report” for 1956-1957 from the American Medical Education Foun-

dation lists the donors of $1,066,863.29 as the A.M.A.; Other Societies, Organizations and Clinics; Individual Physicians; and the Woman’s Auxiliary. Donations from “Laymen” only amounted to $183.50 and may be ignored. The report also says “Every cent raised has gone to medical schools because the American Medical Association has paid for all the administrative and promotional costs of the Foundation.” Can you think of any place any of these many dollars has come from excepting the pockets of the individual physician?”

Severe Penicillin Reactions More Frequent—
The F.D.A. says the number of serious reactions to penicillin increases from year to year. In a survey involving 3419 case histories of severe reactions to antibiotics ninetenths were due to penicillin, and one-third of them were life-threatening.

Approved Cancer Programs and Registries in Nebraska—
The American College of Surgeons recently published a list of approved cancer programs and cancer registries (Sept.-Oct., 1957). In Nebraska the following are approved as Cancer Consultation and Treatment Services:

Lincoln—
Lancaster County Medical Society
Tumor Clinic
Bryan Memorial Hospital
Lincoln General Hospital
St. Elizabeth Hospital

Omaha—
Creighton Memorial St. Joseph’s Hospital
Nebraska Methodist Hospital
St. Catherine’s Hospital
University of Nebraska Hospital

Medicine and Industry—
“Industrial medicine has assumed the proportions of an important and growing facet of the practice of medicine. It concerns every practicing physician—not just the general men nor limited fields . . . !

“This is the time to say ‘Doctor, take heed — stop, look and listen’ — If you don’t, as a profession, provide adequate care through an industrial medical program, the
unions will do it for you.” (From an editorial in The Bulletin, Omaha-Douglas County Medical Society, Oct. 1957).

Nebraskans Elected to Posts in M.V.M.S.—

At a recent meeting of the directors of the Mississippi Valley Medical Society, the following Nebraskans were elected to offices in the Society: Vice President, Earl F. Leining, McCook; Directors, Fay Smith, Imperial, and George Covey, Lincoln.

The “Forand Bill”—

A bill known as H.R. 9467 was introduced in the first session of the 85th Congress by Mr. Forand. This bill calls for expansion of the Social Security Act into medical and hospital care fields. It has been referred to the House Ways and Means Committee of which Mr. Forand is a member and has strong backing by A.F.L.-C.I.O.

H.R. 9467 proposes that the federal government, through the Social Security System, pay the cost of hospital, nursing home, and surgical service for persons eligible for old-age and survivors insurance benefits.

This proposal for socialized medicine for a large and growing segment of the American people is essentially the same as that of 1941-1951, when Wagner-Murray-Dingell bills called for “National Compulsory Health Insurance,” except that it applies to a smaller segment at this time. Enactment of this legislation will permit the federal government to withdraw Social Security taxes on a compulsory basis from almost the entire working population and to use those taxes to reimburse hospitals and physicians for services rendered to all persons eligible to receive old age and survivors benefits. (Twelve to thirteen million in this category at present).

Asian Influenza—

In four counties—Adams, Nance, Lancaster, and Douglas—in Nebraska, the presence of Asian Influenza has been confirmed by laboratory tests. The Department of Health of Nebraska has received reports of 1197 cases of influenza this year. Six hundred and sixty-nine were reported in October. The total number of cases reported in 1956 was 40 and, in 1955, 16. Nationally, a definite decline in incidence is indicated.

Nebraskans Elected to A.C.P.—

The following Nebraska physicians were elected as Associates in the American College of Physicians at the November 9-10 meeting of the Board of Regents:

Cletus Troy Frerichs, Beatrice
Jack Michael Stemper, Lincoln
Robert Harry Gregg, Omaha
Mary Josephine Henn, Omaha
Harold Allen Ladwig, Omaha

More Than One in Four Have Had Influenza—

The National Health Survey, basing its figures on a sampling of households, estimates that since mid-July approximately 50,700,000 persons, or more than one in four, have been confined to bed for a day or more because of acute upper respiratory diseases. For one of the weeks sampled, it was estimated that more than 6 million persons were confined to bed each day.

Medicare Claims Slow Coming In—

Between Dec. 7, 1956, the day Medicare became effective, and July 30, 1957 the Government reimbursed hospitals in the amount of over $21 million and physicians somewhat over $28 million. It is impossible to closely estimate the total because claims as old as those of December, 1956, are still coming in for payment. A report from the Office of Dependent Medical Care, rendered at the recent session of the A.M.A., indicate that the total for the period under discussion will prove to be about $76 million.

Hot Spots at the Philadelphia Meeting, A.M.A.—

President Allman, in his address, delivered at the opening session of the House of Delegates, dwelt strongly and at length on freedom. He said, “If I had one wish today, it would be that I could stimulate within every medical doctor in America the fire and devotion for personal and political freedom as expressed by our forefathers 181 years ago here in Philadelphia.” And again, “... freedom is a never-ending struggle, requiring the energy of each citizen no matter what his station in life.”

Doctor Allman’s remarks on freedom were the prelude to his warnings on the Forand bill. Of this proposed legislation he had this to say: “This is Socialized Medicine. This is Oscar Ewing’s National Compulsory Health Insurance all over again.

“It is the beginning of the end of the private practice of medicine.
"It is the death knell for the young, and growing health insurance industry.

"It is a serious threat to the well-being and local autonomy of the voluntary hospital at the community level.

"It is Socialism under the auspices of the federal government."

—Other items of more intense interest were the "Heller" report on reorganization of the A.M.A.; fluoridation of water supply; problems of aging; maternal and child care; medicare.

Watch for the report about this meeting by your delegates, for more details.

Accidents As a Cause of Death—

The annual number of the accidental deaths in this country has remained fairly constant at about 100,000 since 1932. Death rates per 100,000 population have gone down 40 per cent in the last half century. Medical advances have had much to do with this improvement.

Although the 1956 motor vehicle death toll, 40,000 was the largest in history, there are signs that automobile travel is becoming safer in terms of actual miles driven. The number of deaths per 100,000,000 miles of travel fell from 16.7 in 1934 to 6.4 in 1955 and 1956.

Little improvement has been shown in the American home, where about 30,000 accidental deaths occur each year. Most of them are caused by falls or fire, but old people and small children are the most frequent victims.

According to Health Information Foundation, safety against accidents has achieved the greatest success where society has been able to bring its organized influence to bear. Progress has been most slow where the individual himself must assume most of the responsibility for his own safety. It seems paradoxical that the individual with the greatest interest in safety, should evidence the least effective progress. A not insignificant factor in the reduction of accidental deaths has been the improvement of medical care, particularly with regard to deaths from industrial accidents. Medical care has reduced the possibility of dying as a result of an industrial accident. Strict enforcement of safety regulations and the growth of safety consciousness, as well as improved work conditions has reduced the severity and number of industrial accidents.

Chest X rays in Total Radiation Exposure—

The National Tuberculosis Association has publicized the work of several committees concerned with the amount of radiation received by the patient to produce a chest X ray. The report of these committees becomes of importance in view of the effect on the population of the testing of nuclear weapons and the possibility of future radiation likely to occur from the extension of peaceful uses of atomic energy. These sources of radiation are added to those about which nothing can be done, that is the radiation from radio active minerals, and cosmic rays from outer space.

Tenative conclusions include the observation that fluoroscopy should not be used for screening purposes. It is also suggested that any X-ray program yielding data of little or no significance should be discontinued. In this regard it has been noted that ordinarily the routine chest X rays of the general population under the age of 15 will not be often justified.

It is also noted that the standard 14x17 chest X-ray film gives a lower dosage of radiation to the patient than does the obtaining of smaller X-ray films of photofluorography methods.

Association of Military Surgeons—

The recent 64th annual convention of the Association of Military Surgeons of the United States indicate the place of medicine and allied fields in the effective maintenance of our armed forces.

This association was founded in 1891 by Nicholas Senn who at that time was Surgeon General of the Wisconsin National Guard. The objectives of the organization are to foster international exchange of ideas and uniformity of procedure in military medicine, to contribute to the improvement of all phases of these medical services and to promote among its members a constant readiness for duty in the armed forces.

The Need for Cadavers—

Anatomical science in the United States may be threatened by a substantial decrease in the supply of cadaver material at a time when the demand is increasing.
approximately 50% of the medical schools in this country are said to be plagued by the problem.

Of the 11.5 million people who die in this country each year, less than 5,000 bodies would meet the needs of all the anatomy teachers. The traditional source of cadavers has been the unclaimed bodies of the destitute. In 39 states there are various laws which provide that unclaimed bodies may be used in anatomical study. The first such law was enacted in Massachusetts in 1831. The effectiveness of these laws, from the standpoint of anatomical education, varies considerably from state to state.

A possible pattern for the future is presented by California where in 1944 a program for public solicitation for bequests of bodies was organized. Such a program must be preceded by legislation which recognizes the right of the individual to dispose of his own body after death.

There is some diversity of opinion regarding the suitability of publicity regarding anatomical material. It is held, however, that experience has proved that publicity is the force necessary to bring public attention to the value of the dead to the living.

The full text of a paper on this subject by Eugene Morris, 1957 graduate of Harvard School of Law, is available on loan from the National Society for Medical Research.

Animal Research for Animals—

A rapidly expanding field of research activity concerns the effects of chemicals which stimulate the growth of farm animals. Most drug companies are going into this field, according to the Bulletin of Medical Research, because of its rapidly expanding potential. For example, a steer can be given enough stilbestrol to put 60 extra pounds of weight on the animal at a cost of 18 to 27 cents. Experiments are concerned not only with the effectiveness of such chemicals which may be injected, mixed with the feed, or given in the drinking water, but also their safety as well as their method of action.

Antibiotics are commonly used as feed additives which shorten the feeding time required to reach a given weight. This effect was noted while investigating the effect of the antibiotics on animals, primarily in connection with their application to human disease.

Small Pox Epidemics—

A World Health organization committee reports that 18 countries were infected last year with small pox by international travelers. As a result, eight countries experienced epidemics of this disease, the committee on international quarantine announced. The committee advocates use of vaccines as well as proper vaccination procedures and it also has warned against any relaxation of vaccination measures. Small pox epidemics occurred in Ceylon, Ghana, Iran, Italy, Lebanon, Sierra Leone, Sudan, and the United Kingdom.

Tennessee State Medical Press Award—

The Tennessee State Medical Association has established a state medical press award program. It is in support of the thesis that an incentive might be needed to inspire interest in medical reporting among individual newsmen. Over a year ago 10 news editors were appointed to a committee to select the Tennessee reporter turning in the best job of medical news coverage during the then current year. The first award went to a reporter for her series of stories pointing out the need for improvement in nursing home conditions. The award consisted of a mounted plaque and a check for $300.00.

News from Our Medical Schools

Doctor Charles Richards, Associate Professor of Internal Medicine and Director of Dispensary Clinics at the University of Nebraska College of Medicine, will leave Omaha next month for far-away places.

His eventual destination will be Chiangmai, Thailand, where he will represent the United States government in helping the Thais set up a medical school. He will serve as Advisor on Medical Education—the Thai counterpart of an American college dean—for two years.

Doctor Richards will leave the College of Medicine the last week in December. He is to report to the nation’s Capitol for orientation the first week in January. From Washington, D.C., he will fly to Bangkok, the seat of the Thai government, to report
to officials there. And, finally, he will travel to Chiangmai in northwest Thailand where he is to do his work.

His duties will be primarily administrative. He expects his biggest job will be setting up an education program which will adequately train physicians to practice medicine in areas where there are no doctors or facilities. Because of its large population and relatively small number of physicians, doctors are needed badly in Thailand, he says. The average population-doctor ratio there is 10,000:1 as compared to 800:1 in the United States.

The Thai government has voted funds with which to set up another medical school. The new school in Chiangmai will be the third medical college in Thailand, the first one in the northern part of the country. The other two are in Bangkok.

Commenting on his future home, Doctor Richards says: “Chiangmai is a city of 44,000. It’s located in a semi-mountainous area . . . in the center of the teakwood country . . . Climate mild, tropical . . . Some friends of mine who spent some time there think Chiangmai is the loveliest city in Thailand.”

In preparation for his new position, he is currently studying books and journals so that he will be well-informed on the country when he arrives there. Upon his return to the United States in two years he hopes he may return to the University of Nebraska College of Medicine.

Doctor Richards is the son of the Reverend William Richards of Cambridge, Nebraska. He received his B.S. from Hastings College, his M.S. from Northwestern University, and his M.D. from the University of Nebraska College of Medicine, in 1940. He came to his medical alma mater as a staff member in the fall of 1955.

The Department of Internal Medicine at the University of Nebraska College of Medicine has just received a $5,000 unrestricted grant from Wyeth Laboratories, Inc.

Dr. Robert Grissom, Chairman of the Department, says tentative plans are to use the sum to equip a gastroenterology laboratory at the College. (Gastroenterology is the study of the stomach and intestines and their diseases). Such a laboratory would be used for the research and study of the functioning and the diseases of the stomach, intestines, and related internal organs.

The Wyeth grant to the University of Nebraska College of Medicine is one of several that the pharmaceutical company is presenting a few medical schools around the country. The company specifies that the sum is to be used as the grantee desires . . . The Internal Medicine Department at the University of Nebraska College of Medicine has long felt the need of a gastroenterology laboratory, so the grant will fill a real need.

News From Nebraska Heart Association

Membership Drive—

All Nebraska physicians are being asked to join the Nebraska Heart Association in the current annual membership drive. Dr. Stephen L. Magiera of Omaha, president, has sent special letters to all past members of recent years and a general invitation to all other physicians. Annual dues are $5. Each member receives the monthly summary, “Modern Concepts of Cardiovascular Diseases,” and bi-monthly “Heart Bulletin.” Members also receive specialized professional literature and can order public education materials for their patients and communities. Two free annual state scientific sessions are held to help physicians keep abreast of the latest developments. The Nebraska Heart Association’s physician-membership increased more than 50% this past year. There are now 343 members from more than 50 communities, making the Heart Association one of the largest medical specialty groups in the state.

New Executive Director—

The new Executive Director of the Nebraska Heart Association is Frank V. Whitley, who has been serving as the Information and Campaign Director since September 1954. He succeeded John B. Hermann, now the new Executive Director of the Iowa Heart Association. Mr. Whitley was in radio-TV news work and graduated with his Master’s Degree from State University of Iowa before joining the Heart Association. He led statewide Heart Fund campaigns which have almost quadrupled the Association’s income in the past three years and developed one of the most extensive Public Education Programs in the Heart field.
Grants for Study and Research—

Awarding of a major nursing scholarship and establishment of a heart research professorship have been announced by the Nebraska Heart Association.

Dr. Stephen L. Magiera, president, revealed that the second annual, $1100 Heart Fund scholarship in cardiac nursing has been awarded to Miss Mary Lou House of Omaha.

The University of Nebraska nursing instructor will begin a three-month course in nursing care of heart patients at the University of Minnesota next January. Only a dozen nurses are accepted for this course, co-sponsored by the National Heart Institute.

A $20,000 Heart Fund grant has been approved for establishment of a chair of cardiovascular research at the University of Nebraska College of Medicine.

Approved by the University to fill this professorship is Dr. Denham Harman, a 41-year-old physician and chemist from San Francisco, who will join the faculty next July.

Doctor Harman has been investigating the process of aging and atherosclerosis, which leads to heart attacks. His grant includes provisions for assistants and supplies.

Another chair had been created by the Nebraska Heart Association at Creighton University in Omaha. Dr. Alfred W. Brody was appointed to study the lungs and their blood vessels in relation to heart trouble.

Last year the Heart Association’s $1100 nursing scholarship went to Miss Rosemary Neville of Creighton University School of Nursing. She is now helping to plan Heart Association workshops to teach other Nebraska nurses.

Publication of Reports on Research—

Four Nebraska heart researchers have had reports on their projects published in the proceedings of the American Heart Association’s 30th Annual Scientific Sessions.

The reports covered two projects supported by Heart Fund grants from the Nebraska Heart Association and were among 250 outstanding studies chosen for inclusion in the publication:

—Drs. Charles A. Hamilton, Robert L. Grissom and Roderick R. Landers of University of Nebraska College of Medicine at Omaha reported on the effects of “deep freeze” techniques in heart surgery on blood circulation in arms and legs.

—Harry Lobel, Omaha electrical contractor, reported on his application of the principles of electrical impedance (overloading of the lines) to the blood vessels and hypertension.

Educational Conference—

Two physicians spoke at a Nebraska Heart Association nursing conference in Grand Island, Dec. 5, which was attended by nurses from a 29-county area. The speakers were Dr. Robert Munch, Medical Chief of Grand Island V.A. Hospital and Dr. Loren Imes of Grand Island. Cardiac nursing consultant was Miss Rosemary Neville, who attended a three-month national cardiac nursing course on an $1100 Nebraska Heart Fund scholarship. Arrangements Chairman was Mrs. Darlene Mattingly of St. Frances Hospital. Other cardiac nursing conferences will be held in Scottsbluff in January, in Lincoln in February, and in Omaha in March.

Announcements

New Orleans Graduate Medical Assembly—

The twenty-first annual meeting of the New Orleans Medical Assembly will be held March 3, 4, 5, and 6, 1958. Headquarters will be at the Roosevelt Hotel. The faculty contains many impressive names, and the subjects cover the field.

Nebraska Blue Cross Does Not Cover Any Medical Services—

Under an agreement formulated and adopted in 1955, medical services such as X rays, EKGs, BMRs, pathologic services, etc., written into a hospital contract issued by Health Service or any other national agency, are ceded to Nebraska Blue Shield. Premiums for such coverage are allocated to Blue Shield and claim payments are a charge against Blue Shield.

We, in Nebraska, do not have the problem of payment to hospitals for the practice of medicine.
Smallpox Must Not Be Ignored—

According to W.H.O., "no less than 18 countries were infected with smallpox by international travelers last year, and as a result eight of them suffered epidemics . . ." It is stated, also, that in the course of these epidemics some doctors treating tourists caught the infection and died. This suggests that medical personnel may be careless about revaccination to maintain a high level of immunity.

Resident Loan Funds Available for Study Of Chest Diseases—

We have been informed by the American College of Chest Diseases that loan-funds are available "To stimulate interest in postgraduate study of chest diseases, and to assist worthy students in continuation" of such studies. For full information address Dr. M. Jay Flipse, 550 Brickell Ave., Miami, Florida.

Board of Missions, Methodist Church, Wants Doctors—

The Board of Missions of the Methodist Church has announced a need for 20 doctors in its mission fields in 10 countries overseas, in 1958. The Board would like to obtain 10 men and 10 women. A variety of specialties is needed. The countries in which they are to work include areas in Asia, Africa, North and South America. The requirements, in addition to their Christian fundamentals, are essentially the same as in the United States.

If interested, write Office of Missionary Personnel, 150 Fifth Ave., New York 11, N.Y.

Medical Library Association to Meet—

The fifty-seventh annual meeting of the Medical Library Association will be held in Rochester, Minnesota from June 2 through June 6, 1958 with headquarters at the Hotel Kahler. The theme of the Rochester meeting will be "Advances in Medical Library Practice." Mr. Thomas E. Keys, Librarian of the Mayo Clinic, is Convention Chairman, and letters of inquiry should be addressed to him.

A pre-convention activity is being planned for Saturday, May 31. A series of refresher courses embracing many fields of medical library work will be given. Classes will be made up from the following subjects: Administration, Acquisitions, Classification, Cataloging, Non-book materials, Photoduplication, Public Relations, Reference Work, Rare Books, History of Medicine, Bibliographic Services, Periodicals, Binding, Library Architecture, Equipment, and Medical Terminology.

It will be possible for each participant to take four courses during the day, two in the morning and two in the afternoon. Each session will be 1 1/2 hours in length, the hour for a prepared lecture and a half hour for a discussion period.

Social Security Administration Wants Full- and Part-Time Doctors—

The Bureau of Old-Age and Survivors Insurance, Social Security Administration, has announced vacancies for full-time and part-time Medical Consultants in its Division of Disability Operations. The Division is responsible for making determinations of disability under the disability insurance provisions of the Social Security Act. These positions are available in the headquarters offices in Baltimore, Maryland.

The full-time positions are under Civil Service and incumbents will receive all Federal Civil Service benefits such as retirement, life insurance, and vacation and sick leave privileges. The salary range is $10,065 to $11,595 a year depending on the individual's qualifications. The salary in part-time positions is paid on a per diem basis.

The Medical Consultant position includes the following duties: Consultation with lay adjudicators in determining from evidence submitted the extent of medical disability and degree of loss of physical and mental capacity; determining the need for additional medical evidence; developing medical standards for evaluating disability; liaison with professional medical groups; assisting in staff training programs; and participating in studies and reports on medical aspects of the administration of the disability program. Incumbents may from time to time make visits to State agencies making disability determinations under agreements with the Federal Government, for consultation with physicians in these agencies. Medical Consultants do not perform examinations of disabled applicants. All necessary medical evidence of disability is secured from the appli-
cant's physician or through examinations performed by other physicians.

Physicians interested in either full-time or part-time positions may write to Dr. Arthur B. Price, Chief Medical Consultant, Division of Disability Operations, 200 West Baltimore Street, Baltimore 1, Maryland, for further information.

New Area Director, Veterans Administration—

Appointment of a new area medical director to succeed Dr. Einar C. Andreassen, who is retiring, has recently been announced. The new director is Dr. Oreon K. Timm. He will take charge of the area medical office at St. Paul and his district will be comprised of Illinois, Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wisconsin, Wyoming and the upper peninsula of Michigan.

A.C.R.P. to Hold Big Meeting in March—

The American Academy of General Practice Tenth Annual Scientific Assembly will be held March 24–27, in Dallas Memorial Auditorium, Dallas, Texas. More than 8,000 are expected to hear 35 medical experts, and view more than 90 scientific and 300 technical exhibits.

Informal Conference on Advances in Medicine—

On February 6, 7, and 8, 1958, the first Oklahoma Colloquy on Advances in Medicine will be held in Oklahoma City. It will be devoted to problems of Fluid, Electrolyte, and Nutritional Balance. Sponsored by Baxter Laboratories, the program will be developed by the Division of Postgraduate Medical Education of the University of Oklahoma. Registration will be open to all physicians and the fee will be $25. Write Division of Postgraduate Medical Education, University of Oklahoma School of Medicine, Oklahoma City for further details.

Postgraduate Course on Diseases of the Chest—

We are pleased to announce that the Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the 11th Annual Postgraduate Course on Diseases of the Chest at the Warwick Hotel, Philadelphia, March 3-7, 1958.

The most recent advances in the diagnosis and treatment of chest diseases — medical and surgical — will be presented. The tuition fee is $75 including round table lunches.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Postgraduate Courses in Obstetrics and Gynecology—

The Office of Postgraduate Affairs, University of Nebraska College of Medicine has announced a postgraduate course in obstetrics and gynecology to be given at Conkling Hall on the Omaha campus January 16 and 17, 1958. The following program will be presented:

POSTGRADUATE COURSE IN OBSTETRICS
AND GYNECOLOGY
Conkling Hall Postgraduate Room
THURSDAY, JANUARY 16, 1958
8:00 to
9:00 Registration, Conkling Hall Lobby.
9:00 Welcome, J. Perry Tollman, M.D., Dean of the University of Nebraska College of Medicine.
9:15 “Management of Incomplete Abortion,” Leon J. Olson, M.D.
9:45 “Changing Indication for Cesarean Section,” William C. Keettel, M.D.
10:00 Coffee.
10:50 “Post Operative Care,” Clyde E. Penner, M.D.
11:30 “Surgical Approach to Sterility,” Louis M. Hellman, M.D.
12:15 Lunch.
1:30 “Surgical Correction for Stress Incontinence,” John L. McKelvey, M.D.
2:15 “Cystometric Studies,” Roy G. Holly, M.D.
3:00 Coffee.
3:20 “Is the Manchester Operation of Value in the Treatment of Uterine Prolapse?” William C. Kettle, M.D.
4:00 Discussion: “Preservation of Ovarian Tissue at Surgery.”
Introductory Remarks: Hilton A. Salhanick, M.D.
Panel: John L. McKelvey, M.D.; Louis M. Hellman, M.D.; William C. Kettle, M.D.
FRIDAY, JANUARY 17, 1958
9:00 “The Incompetent Cervix,” William L. Rumbolz, M.D.
9:45 “Uterine Dysfunction,” Louis H. Hellman, M.D.
10:45 Coffee.
11:05 “Carcinoma of the Vulva,” John L. McKelvey, M.D.
12:15 Lunch.
1:30 “Management of Carcinoma of the Ovary,” William C. Keettel, M.D.
2:20 “Obstetric Anesthesia,” Louis M. Hellman, M.D.
3:15 Coffee.
3:30 “Local Anesthesia in Obstetrics and Gynecology,” John L. McKelvey, M.D.
4:30 Question and Answer Period.

GUEST FACULTY:

Louis M. Hellman, M.D., Professor Chairman Department of Obstetrics and Gynecology, State University of New York College of Medicine at New York.
William C. Keetel, M.D., Professor of Obstetrics and Gynecology, University of Iowa College of Medicine.
John L. McKelvey, M.D., Professor and Chairman of Obstetrics and Gynecology, University of Minnesota School of Medicine.

COLLEGE OF MEDICINE FACULTY:

Roy Holly, M.D., Professor and Chairman Department of Obstetrics and Gynecology.
Leland J. Olson, M.D., Associate in Obstetrics and Gynecology.
Clyde E. Penner, M.D., Resident in Obstetrics and Gynecology.
William L. Rumbolz, M.D., Assistant Professor in Obstetrics and Gynecology.
J. P. Tollman, Dean of the University of Nebraska College of Medicine.

Human Interest Tales

Dr. Avis Bray, formerly of Dorchester, has opened her practice in Beaver City.

Dr. and Mrs. J. M. Woodard, Aurora, took a week’s trip to Minnesota in November.

Dr. Edward J. Smith, Omaha, is the new president of the medical staff of Doctors Hospital.

Dr. Miles Foster, Omaha, was a guest speaker at a recent meeting of the Clarinda, Iowa, Lions Club.

Dr. and Mrs. G. E. Charlton, Norfolk, have gone to Hollywood, Florida, to spend the winter months.

Dr. Jack T. Harris, formerly of Cedar Falls, Iowa, has arrived in Stratton to begin his medical practice.

Dr. Charles Tompkins, Omaha, spoke at a Methodist Church Family Life Conference in Lincoln, in November.

The community of Axtell has recently organized to erect, own and maintain a community medical center.

Dr. Ralph Luikart, Omaha, has been elected president of the Nebraska State Obstetric and Gynecological Society.

Dr. S. E. Staley, Kearney, discussed a film on cancer at a recent meeting of the Town and Country Club of that city.

Dr. and Mrs. M. M. Sullivan, Spalding, were hosts to the Four County Medical Society for its November meeting.

Dr. and Mrs. John Gatewood, Omaha, spent several weeks in Virginia and Washington, D.C., during November.

Dr. H. E. Moore, Sutherland, gave a talk at a recent meeting of the Licensed Practical Nurses’ Association in Sutherland.

Dr. A. I. Webman, Superior, has been elected president of the Nuckolls County Medical Society for the coming year.

Dr. J. Dewey Bisgard, Omaha, attended the November meeting of the International Surgical Association in Mexico City.

Dr. John Aita, Omaha, has been given a key for his service as medical advisor to the Nebraska Multiple Sclerosis Society.

Dr. John L. Beattie and family of Omaha, have moved to Mitchell, South Dakota, where Dr. Beattie will resume his practice.

Dr. and Mrs. A. W. Anderson, West Point, took a trip in November to attend the Pan-Pacific Surgical Association in Hawaii.

Drs. Allen Trowbridge and C. G. McMahon, Superior, recently received plaques as 35-year members of the Kiwanis Club.

Dr. Paul Bancroft, Lincoln, was the guest speaker at a regular meeting of the Linden School PTA in Fremont in November.

Dr. Charles E. Richards, Omaha, will leave soon for Thailand as an advisor on medical education to the government of Thailand.

Dr. Jackson Smith, Omaha, presented a paper at the November meeting of the Southern Medical Association in Miami.

Dr. Abe Greenberg, Omaha, was a delegate to the 114th annual meeting of B’ani B’rith held in Washington, D.C., in November.

Dr. Carl Potthoff, Omaha, attended the annual meeting of the American Public Health Association in Cleveland in November.

Dr. and Mrs. Friedrich Niehaus, Omaha, recently returned from a meeting of the World Medical Association in Istanbul, Turkey.

Dr. and Mrs. Walter Harvey, Sr., Gering, traveled to Hawaii in November for the
meeting of the Pan Pacific Surgical Association.

Dr. Robert P. Heaney, Omaha, has been awarded a grant from the Atomic Energy Commission for research on diseases in bone metabolism.

The annual Christmas party for members of the Omaha-Douglas County Medical Society was held at the Sheraton-Fontenelle in December.

Drs. W. J. McMartin, M. E. Grier, Arnold Lempka, Omaha, attended the meeting of the Pan-Pacific Surgical Association in Hawaii in November.

Dr. James Dunlap, Norfolk, spoke on coronary heart disease at a regular meeting of the District 6 Nurses’ Association held in Norfolk in November.

Drs. Thaddeus Krush and Jerman W. Rose, Omaha, conducted a workshop on emotional problems in school-age children in Norfolk in November.

Drs. Herbert H. Davis and Charles McLaughlin, Jr., Omaha, attended the November meeting of the Western Surgical Association in Salt Lake City.

Dr. and Mrs. A. H. Holm, Wolbach, observed their 52nd wedding anniversary on October 27. More than 200 persons attended an open house for the couple.

Many friends of the late Dr. F. G. Kolouch of Schuyler are making memorial contributions to furnish a doctors' lounge at Memorial hospital in that city.

Dr. Walter C. MacKenzie, University of Alberta, Canada, was the principal speaker at the November meeting of the Omaha-Douglas County Medical Society.

Mrs. Charles Lucas, wife of the late Dr. Charles Lucas, who formerly practiced in Shelton, passed away at her home in Los Angeles, California, in November.

Dr. Harry H. McCarthy, Omaha, was a guest speaker at a November meeting of the Ak-Sar-Ben Chapter of the National Secretaries Association held in Omaha.

Dr. Gerald Kuehn, Hastings, gave a talk on immunization program for adults at the November meeting of the Business and Professional Women’s Club in Hastings.

Dr. John S. Hirschboeck, dean of the Marquette University School of Medicine, gave the Eben J. Carey Memorial Lecture at Creighton University in November.

Dr. H. F. Elias, Beatrice, presented a paper at the scientific meeting of the Nebraska Chapter of the American College of Surgeons held in Scottsbluff in November.

Book Review

"Clinical Toxicology of Commercial Products" by Pleason, Gosselin, and Hodge. Published by Williams and Wilkins, Baltimore, 1957.

This book (1160 pages) should be a part of the library of each hospital. The authors have compiled (a) a list of trade name products together with their ingredients when these have been available, (b) sample formulas of many types of products with an estimate of the toxicity of each formula, (c) toxicological information including an estimate of the toxicity of individual ingredients, (d) recommendations for treatment, (s) names and addresses of manufacturers.

The Woman’s Auxiliary

Report of the North Central Medical Conference—

On November 24, 1957, the legislative key men and women of the North Central States were invited to attend the annual meeting of the North Central Medical Conference in Minneapolis. This conference includes representatives of medical organizations from six states, Iowa, Minnesota, Nebraska, North Dakota, South Dakota and Wisconsin. Pertinent problems confronting medicine are presented and discussed.

As Nebraska's key legislative woman I was privileged to attend this meeting. Dr. Frank C. Coleman, Des Moines, Iowa, presided at the breakfast meeting of the group. A brief review of the legislative outlook for the second session of the 85th Congress which begins January 7, 1958 was given. The morning session of the Conference was devoted to the discussion of “Lay-Sponsored Medical Care Plans in the North Central Area,” “Medicare,” and “Hospitalization for Social Security Beneficiaries Over Age 65.” Dr. Gunnar Gundersen, president-elect of the American Medical Association, spoke at the noon meeting.

One of the most important and significant bills which demands our study and consideration is the Forand Bill—H.R. 9467. This bill was introduced in August, 1957, by Congressman A. J. Forand of Rhode Island. “Its
purpose is to amend the Social Security Act to increase benefits under the old-age, survivors, and disability insurance programs, and to provide insurance against hospital and surgical services for persons eligible for retirement benefits. This bill contains three major revisions of the present Social Security Act. It would: (1) initiate hospital, nursing care and surgical payments for persons eligible for retirement or survivorship benefits under O.A.E.I.; (2) increase the earnings formula under which persons would be taxed up to the first $6000 of earnings (present limit is $4200); and (3) increase dollar benefits payable to workers, their dependents, and survivors. Mr. Forand estimates that under this proposal 12 or 13 million persons could receive medical protection payments in the first year."

During the discussion of H.R. 9467, Mr. C. Joseph Stetler, American Medical Association, stated that this bill is really socialized medicine; that the sponsors of the bill have abandoned the subtle attack and now were direct for socialized medicine. Mr. Stetler emphasized that medicine must make every effort to defeat this bill. Allied with the American Medical Association in its opposition are the American Farm Bureau Federation, the National Retailers Federation, the United States Chamber of Commerce, the life insurance and health insurance industries, the National Association of Manufacturers and other organizations and individual citizens who are opposed to government intervention.

The A.M.A. has appointed a special committee to study the health needs of the population over the age of 65. The committee's first big job will be to define the relatively small group that needs the type of aid as proposed in the Forand Bill and offer solutions to the problem.

The delegates of the Conference were urged to inform the members of the local and state medical societies and the auxiliaries about the Forand Bill; to encourage Blue Cross and Blue Shield to expand coverage for the older age group; to contact the Congressmen before their return to the 85th Congress and enlist their support in defeating the bill; to contact all hospital chiefs-of-staff and administrators with the request that their boards of trustees be alerted to the dangers of H.R. 9467. (The American Hospital Association has not taken a stand on this bill).

For additional information please read the "President's Page" in the A.M.A. Journal, November 20, 1957—the A.M.A. Washington Letter and the Secretary's Letter, November 26, 1957.

Mrs. George E. Robertson.

Report on Conference of State Presidents—

The 14th Annual Conference of State Presidents, Presidents-elect and National Committee Chairmen was held at the Drake Hotel and A.M.A. headquarters in Chicago, October 20 to 23, 1957.

The program stressed the objectives of the Woman's Auxiliary and the relation of its activities to these objectives. Training periods were provided which afforded experience in group-discussion methods. The Conference was directed by Martin P. Shworerovsky, Ph.D., director, Albert M. Greenfield, Center for Human Relations, University of Pennsylvania.

The Conference was arranged in six small discussion groups to which conference members were assigned. There were two sessions of each group and the same topics were covered in all groups. There was ample opportunity to discuss activities with National Chairmen and A.M.A. staff members.

On Sunday evening, service teams were set up in order to expedite the discussion-basis phase of the program using the role-play technique. On Monday evening a program demonstration was conducted by Dr. Shworerovsky using these service teams.

A leader and recorder were appointed for each group. Complete summaries were made of each group's discussions. These were incorporated into a complete summary which was mimeographed and a copy sent to each participant.

The discussions covered a multitude of subjects and space will not permit a complete report. Since all phases seemed highly important, it is difficult to choose any as highlights, so I will report on a few chosen at random.

What makes a successful leader? A successful leader must know the particular problems of the group. She must make a sincere effort to translate the national program to fit the needs of her group. She must make every effort to have each member do her part. This can be done by stim-

January, 1958
ulating group discussions, thus tapping the wisdom of each member. It is important that the members of a group become well acquainted, using first names, thus creating a “warmer climate.” There should be a clear agenda. It is well to publicize this well in advance in order that members may be prepared. Last, but not least, it is important that the physical set-up is inviting. Have chairs arranged so that members can see each other and have an opportunity to become well acquainted.

Do Our Auxiliary Activities Mirror Our Objectives? We must plan our programs so that doctors’ wives learn about our activities and their importance. Auxiliaries must demonstrate to the public that our activities benefit the community.

It is highly important to strive for better member participation. Here again it is necessary to capture the interest of the member. The objectives should fit into the lives of your community and should have a purpose which will give the members pride in participation.

Our attention was called to medical legislation now in process in Washington which is of a very serious nature. It is the proposed amendment to the Social Security Act. It is sponsored by Labor and Socialists. This amendment provides a service benefit and is the first such proposal. It is imperative that this amendment be defeated. Therefore, every auxiliary member should acquaint herself with this amendment and its implications and fight it by explaining it to her friends and neighbors.

The National Priority Projects are as follows:

1. American Medical Education Foundation.
2. Today’s Health.
3. Legislation.
4. Safety.

You will note that National is not sending out the usual large quantities of material relating to auxiliary activities and projects. However, the material is available. When you have chosen your projects and find that you need help, you may ask the National to send you any amount of literature that you need. National will be very happy to help you in any way it can.

In conclusion, I will quote from “The President’s Message” as given by Mrs. Ma-

son G. Lawson. This, I believe, sums up very effectively the aims, purposes and responsibilities of an auxiliary member.

“Each organization is faced with the problem of competing with a variety of other activities for the attention of its membership. Every community has many outlets for the talents of an Auxiliary member. Our strength is measured by our unity of purpose and our effective partnership with the medical profession. Only as a doctor’s wife do you gain the privilege of membership in the Auxiliary. Understanding among ourselves and individual understanding of the aims of our program is the essential key to our success. Service is the fare we pay for the ride we take.

“As we think of our work together we should also think of how best we can stimulate communication with one another. Mass communication is not the answer. It must be augmented by personal contact.”

Elizabeth Covey,
President-elect.

Lancaster County Dolls—

Over sixty little girls were much happier as a result of the December meeting of the Woman’s Auxiliary to the Lancaster County Medical Society. This annual “Collection of Dolls” was held at the home of Mrs. J. Marshall Neely on Monday, December 2.

These attractively dressed dolls of every variety were given to the Family Welfare Service to be distributed for Christmas.

Entertainment was provided by the Lincoln General Nurses Triple Trio who presented holiday selections.

Assisting hostesses were Mrs. Harold Morgan and Mrs. N. Richard Miller.

Elizabeth Davies,
Publicity Chairman.

Mortality is not the real yardstick to measure the importance or judge the control of a disease. Even if there were drugs capable of preventing the sudden deaths resulting from hypertension and arteriosclerosis, these conditions would remain a tremendous medical and social problem. Similarly, adults do not commonly die of mental disorders, arthritis, or peptic ulcers. Yet, no one would claim that these afflictions have been conquered. Neither has tuberculosis been conquered. Instead, the forces which have been at work during the past century have slowly converted it from a killing to a chronic disease. (Rene J. Dubos, Ph.D., Nat. Tuberc. A. Tr., May, 1954).
Know Your 
Blue Shield Plan

Keeping in Step—

Keeping in step with the desires expressed by many Nebraska physicians and members, Nebraska Blue Shield is now offering a new series of coverages.

The Standard Blue Shield Agreement is now available with Medical Rider making in-hospital medical care effective the first day of hospitalization instead of the fourth day. Another feature of the Medical Rider is an allowance of up to $12 a day additional for any three days of intensive in-hospital medical care per admission. The number of days of in-hospital medical care has been extended from 90 days to 120 days under both the new Standard Agreement and Standard Agreement with Medical Rider.

The Preferred Blue Shield Agreement has been broadened to include hematologic and bacteriological examinations while member is bed patient in hospital. The number of days of in-hospital medical care has also been extended under the new Preferred Agreement from 120 days to 150 days.

Epilepsy has been eliminated as an exclusion in all Blue Shield Agreements.

The anesthesi-schedule has been changed from a time element basis to a procedure basis.

Two new riders will also be available for select Blue Shield groups: Ambulatory Diagnostic Benefits Rider — X ray and Pathology; and Ambulatory Diagnostic Benefits Rider — X ray, Pathology, and Home and Office visits.

A Comprehensive Major Medical Agreement has been developed by Nebraska Blue Cross-Blue Shield which is designed to give desired protection against long-term or catastrophic illness. This agreement will be offered to groups of ten or more employees. It incorporates, as the basic agreements, the Blue Cross Series 120 ($11 per day room allowance agreement) and the Standard Blue Shield with Medical Rider Agreement. It provides coverage for benefits either not covered by the basic agreements, or covered by the basic agreements but limited in amount.

The following are the types of benefits or services provided by this agreement in addition to the basic coverages:

1. *Hospital Services.* All regular charges of the hospital necessary for the treatment of an illness. Examples of these benefits are as follows:

   - Prescribed drugs and medicines.
   - Room allowances not to exceed $18 per day.
   - Blood and blood plasma.
   - Oxygen and other gas therapy including the administration thereof.
   - Central supplies, ambulatory and prosthetic appliances.
   - Anesthesia and supplies.

2. *Nursing Services.* The charges of registered and licensed practical nurses.

3. *Medical Services.* The charges of physicians for professional services and non-medical physiotherapists under the supervision of physicians.

4. *Miscellaneous Services.* Prescription drugs, artificial limbs or eyes, casts and splints, trusses or crutches, gas therapy, rental of wheelchairs or hospital type beds, rental of equipment for treatment of respiratory paralysis, and local ambulance service.

Each member covered under a Comprehensive Major Medical Agreement must incur out-of-pocket hospital and medical expenses each membership year equal to a deductible amount chosen by his group before the Major Medical portion applies. This deductible amount ($100—$150—$200), the percentage payment (75%—80%—85%) for benefits not provided by the basic agreements, as well as the maximum amount which may be payable ($500 - $10,000), will vary from group to group.

The physician should be sure to list all his charges when filing the Doctor’s Medical Report. Nebraska Blue Shield will pay on the basis of the basic agreement (Standard Blue Shield with Medical Rider) and compute and pay whatever amount is payable under the Major Medical portion of the agreement.
New "Participating Physicians Manuals" are now being printed. These new "Manuals" will be mailed to your office as soon as possible. Be sure to watch for them. Let us know if you need extra copies.

Doctor's Secretaries Meetings will be held throughout the state as soon as weather permits. Have your secretaries and assistants attend these meetings so that we may be better able to serve you.

TUBERCULOSIS ABSTRACTS

MINIMAL PULMONARY TUBERCULOSIS IN MILITARY PERSONNEL: WORLD WAR II

The mobilization and maintenance of the Army of the United States in World War II, with initial physical examination of all accepted military personnel and subsequent medical control and hospitalization as necessary, provided an exceptionally valuable opportunity for studying the fate of tuberculous lesions. The medical provisions of the mobilization regulations, permitting acceptance of men with small densely scarred lesions, and the occurrence of active tuberculosis in the military forces as a result of failure of detection on entry or new acquisition of the disease during service, made it possible to study in a known military environment, the progress of tuberculous lesions that became manifest under conditions ranging from sedentary occupations to the extreme physical strains of military combat.

The study here described was set up to take advantage of this unusual opportunity. Its findings are of interest and value at the present time for comparison with currently accumulating data on the course of pulmonary tuberculosis of similar character as affected by methods of treatment (specific chemotherapy) not available at the time of this study.

A research organization was established that would permit observation over a period of years of a group of a thousand men and women with pulmonary tuberculosis in the minimal stage at the time of its first detection, or with reliable records furnishing objective evidence of its presence in that stage at some previous period, e.g., in any induction station examination in which the lesion was overlooked. A group of approximately this size was selected and a system of follow-up was set up for a period of three years or more. Because of the nature of the material, the observations were oriented on a military basis. In essence, however, they apply equally well to tuberculosis in nonmilitary environment.

This study of minimal pulmonary tuberculosis as it occurred in the U.S. Army during World War II was begun in January, 1944; the last patient was included in the project in June, 1946, preceding the era of chemotherapy for tuberculosis. Observations were continued until September, 1949. The primary purpose of this study was to ascertain what happened under war conditions to military personnel developing minimal pulmonary tuberculosis while in service. It was also hoped to determine the reliability or unreliability of certain criteria for acceptance or rejection of recruits for military service, such as roentgenographic abnormalities and previous history of active tuberculosis.

After excluding the 35 persons who died during the study, the average follow-up period was 52 months for each person. Chest roentgenograms taken on entry into the army were reviewed for 918 of the 967 military personnel under observation. During the follow-up period, every person in the group was examined three to six times annually for three or more years, and more than 28 films per person were reviewed.

The method of selecting patients for study is believed to have yielded a valid random sample of minimal pulmonary tuberculosis in the army. For example, the median age of all patients included in this study was 28.2 years, compared with 28.8 years for the patients with minimal disease in the army as a whole during the same period.

Of 626 persons with active minimal tuberculosis at the time of the first clinical classification by the Army Research Section, the disease improved in one-third and was inactive during the period of observation. Of 342 persons with apparently inactive tuberculosis at first study, 78 per cent remained well, 9 per cent had relapses and later improved, while 13 per cent had relapses with subsequent worsening of their disease. The proportion of active cases in which improvement occurred was highest in the group 25 to 34 years of age.

Eighty-two persons developed active pulmonary tuberculosis within twelve months and 31 of them within six months after entry into military service. Despite "acceptable" roentgenograms, the majority of those with histories of active tuberculosis before admission to the army in World War II had relapses during military service. Of 94 persons with histories of pre-military active tuberculosis, 68 had relapses during service or after discharge. The probability of relapse was greatest in those with histories of pleural effusion, in those with previous extrathoracic tuberculosis, and those who had less than six months of rest treatment. On the other hand, 30 of the 112 persons with histories of active tuberculosis in the pre-military period remained well while in service and did not experience a relapse subsequently in the period of observation. Unless adequately treated before return to duty, the hazard of relapse during military service after apparent recovery from active tuberculosis is great. The figures involved are admittedly small. These observations were made before chemotherapy became available.

Persons with calcific elements in the parenchymal lesions shown on entry roentgenograms did better in every way than would be expected on the basis of chance alone. In the absence of pre-military skin tests, the implications of this observation are uncertain. In the estimation of activity and potential reactivation, the number, distribution, size, and character of intrathoracic lesions are not as helpful as roentgenographic evidences of stability or instability of the lesions. The value of a negative tuberculin test has been emphasized. Abnormal physical signs and symptoms were not very helpful in diagnosis. In 1939 (63 per cent) of the 625 persons with active tuberculosis at first examination.
tion, initial recognition of active pulmonary tuberculosis with no suspicious symptoms was due to routine roentgenograms of the chest.

Among the active cases the duration of overseas service bore little relation to "breakdown" with active disease or to the subsequent course of disease. Persons engaged in combat fared the worst, while those assigned to light or moderate work outside without combat duty fared the best.

Assignments of "poor risks" to limited duty within continental United States seemed to afford a measure of protection. Persons with active tuberculosis on limited duty did no better, however, than those on general duty. These findings substantiate the general medical opinion that heavier physical exertion increases the likelihood of "breakdown" with tuberculosis and also increases the likelihood of worsening in active disease.

The type of onset, with or without symptoms, did not bear a significant relationship to the course of disease; one-half of those presenting symptoms proved to have inactive tuberculosis. Persons with persistent rules were more apt to have recurrence of activity than those without rules. Single erythrocyte sedimentation rates did not prove helpful. "Active" cases with sputum persistently negative for tubercle bacilli did better than "active" cases with sputum positive for tubercle bacilli.

Patients with longer-periods of hospitalization did much better than those treated for less than six months. Approximately 96 per cent of all observed relapses occurred within the first three years after the end of treatment for the military episode of active disease. Relapses included practically all forms of intra- and extrathoracic tuberculosis.

At the end of the follow-up period in September, 1949, of 625 persons with active minimal tuberculosis at first observation, 370 were well, 228 had active disease, 16 were dead of tuberculosis, and 11 had died of other causes. Of 342 with inactive minimal tuberculosis, 262 were well, 72 had active disease, 4 were dead of tuberculosis and 4 had died of other causes. Of the 342 rated inactive at first observation, 75 had had relapses and had active disease.

In brief, of those diagnosed as having active tuberculosis at the time of the first clinical examination by the Army Research Section, 59 per cent were alive and well at the end of the period of observation, compared with 77 per cent of those diagnosed as having apparently inactive disease.

**A CHALLENGE**

In 1947, the use of streptomycin in the treatment of tuberculosis gave a sudden lift to hopes for the eventual conquest of the disease. Since that time combinations with PAS and isoniazid have provided added effectiveness. Other drugs are being intensively studied in hospitals and sanatoria. This avenue of approach seems certain to improve.

When the surgical removal of the cavitated discharging, and therefore infective, portion of the diseased lung become possible, a wave of optimism struck not only the public but the medical profession as well. A feeling arose that we would find an early solution to the problem of eliminating tuberculosis. Such optimism is not justified. The attack is still from the wrong angle.

True, the known case, if properly treated, is now restored to the community as a contributor to the economy and not a distributor of infection. However, the process is still slow and painstaking and full of pitfalls for the unwaried. Management if it is to be successful must be unwavering and uninterrupted and requires the utmost skill and training. The cooperation of the patient and the family is necessary. Treatment must be continued indefinitely after recovery or apparent arrest.

The family physician must be alert. He will be importuned to assume the care in the home of the active case. According to Dr. James E. Perkins, Managing Director of the National Tuberculosis Association, the cost of the average case of tuberculosis is about $15,000 including medical care, compensation, pensions, relief payments, and loss of salary. Few can bear such a burden without assistance. Nearly everyone wants to be cared for at home.

Few people are sufficiently informed to desire treatment in a sanatorium. Unless the physician is alert to the probable course of the disease and firm in his advocacy of sanatorium care, he may yield to entreaties and attempt home treatment with drugs. Soon the patient becomes aware of the expense involved. In time, he may assume that he has sufficiently recovered and abandon the treatment. This has occurred repeatedly. The physician is left helpless, and the patient is often hopeless. Many instances of the situation can be cited by anyone with experience in the field.

In the sanatorium, the entire cost of long-term care is supplied except for the very small percentage of patients who can well afford such expense. In fact, the patient who is charged a token per week pays less for sanatorium treatment than for home care. Infinitely more important are skill and specialized medical care by a staff alert by experience to the many pitfalls awaiting the unwary.

In the sanatorium, a rehabilitation program under skilled management is started immediately with education, occupational therapy, medical social service, and vocational guidance and placement, which is the sine qua non of a successful program of restoration. Such a program can be furnished only by an institution. Indefinite follow-up is needed to forestall the consequences of relapse.

However, the attack has just begun in spite of the mounting success in removing the patient with a known case of tuberculosis from his community as a source of infection and restoring him as a productive citizen to the community. While the death rate has already fallen, the incidence still remains little below that of ten years ago. Community-wide surveys, incomplete as they are, reveal shocking numbers of individuals in the infective stage who are unrestricted in the community and seeding the germs of the disease in ways which often we cannot as yet trace.

The 149 new active cases found in Minneapolis and Hennepin County in 1954 illustrate this point. Of these cases, 36 per cent, were reported from phy-
sicians’ offices and public clinics, and 22 per cent were hospital inpatients. Mobile-unit surveys and physical examinations with roentgenograms of apparently healthy people located 23 per cent. Follow-up of contacts of active cases accounted for 7 per cent; 2 per cent were found in death reports and were not previously reported. An additional 10 per cent of the cases had been diagnosed elsewhere.

The average attack rate in 1950 to 1954 by age and sex shows that men over 45 years of age comprise the group most likely to develop tuberculosis. Many of them are still supporting a family. The “dangerous age” for women is from 25 to 44, and for every woman who breaks down in this age period, there are almost twice as many men. In the occupational groups, new active case rates in 1954 were highest among the unemployed and next among food handlers and maids.

Routine roentgenographic surveys of all hospital admissions bring to light a significant number of cases. Sanatorium staffs also report a sequence that has not received sufficient attention from the general medical profession. Many cases appearing at first to be atypical, or so-called “virus” pneumonia, recover from the acute attack only to break down much later and prove the original infection to be of tuberculosis origin instead of “virus.” The development is usually so insidious and symptomless that only frequent and systematic follow-up can detect this sequence before it becomes a cavitated source of illness and infection.

Conditions in sanatoria throughout the nation quite generally follow a pattern illustrated in Minnesota. Disease on admission recorded in Minnesota’s Glen Lake Sanatorium. Approximately 10 per cent only are incipient and usually nonspreaders. Fifty per cent are moderately advanced, and 40 per cent are definitely far advanced. Thus, nearly 90 per cent of those admitted are spreaders of the disease. The local conditions cited illustrate the fact that innumerable sources of infection are present in a community which prides itself on accomplishment in this field.

Tuberculosis exists throughout the known world and has existed since disease in man became known. The causative organism has been known for only a moment in human history. Our success in its suppression has just begun. There is an enormous amount of tuberculosis in countries in which health measures are still retarded.

When we turn to our own country, we learn through the National Tuberculosis Association that “if by magic we could eliminate today all the known tuberculosis cases, we would still have about 50,000,000 people in this country harboring live, virulent tubercle bacilli in their bodies.” This seems incredible until we remember that, in the vast majority, the disorder is inactive. The impressive fact is the wide-spread silent character of the infection.

Here we rest our case. We conclude: 1. Efforts to find the active spreader of infection need to be intensified. While greater search must be made among the ethnic, occupational, and age groups most heavily infected, all possible sources must be explored.

2. All known cases must be removed from situations in which they can infect others. Isolation provided by the sanatorium is the only assurance against such infection.

3. Treatment now available must be applied under competent management without prospect of interruption and with complete rehabilitation as an added objective. Such treatment means sanatorium care.

4. Research must be intensified. There must be no letdown in the provisions for sanatorium care. Adequate facilities must be provided for communities not so equipped.


A Scientist Honored—

A scientist who has deliberately shunned the limelight during a 60-year career devoted to teaching and basic laboratory research was honored in New York, Dec. 10, 1957 by the nation’s manufacturers of medicines.

Dr. Torald Sollmann, 83, Dean Emeritus of Western Reserve University’s School of Medicine in Cleveland, Ohio, received the Annual Award of the American Pharmaceutical Manufacturers’ Association (A.P.M.A.) at a dinner in the Waldorf-Astoria.

Honored as the “Dean of American Pharmacology,” Dr. Sollmann came to national prominence in 1917 when he published the first textbook on pharmacology in the English language. The book in revised form is still a standard text for medical students.

Francis Brown, president of the organization, declared: “The Award Committee, in selecting Dr. Sollmann for this year’s award, is recognizing a man whose lifetime has been devoted to filling a very serious need of the nation: the training of an ever-growing number of men and women in the sciences.

“He has, through his writings, provided scientific groundwork from which an untold number of major discoveries have sprung. His students have become outstanding figures in industry and education.”

Mr. Brown cited Dr. Sollmann’s work on the Council on Pharmacy and Chemistry of the American Medical Association. He is a charter and still active member of the Council, and has served as chairman for more than 20 years.

Dr. Sollman has also contributed “unselfishly of his wisdom to the nation’s military services, the Department of Agriculture, and other federal, state and local government agencies,” said Mr. Brown, who is also president of the Schering Corporation.
a superior psychochemical
for the management of both
minor and major
emotional disturbances

Dartal is a unique development of Searle Research,
proved under everyday conditions of office practice

It is a single chemical substance, thoroughly tested and found particularly suited in the management of a wide range of conditions including psychotic, psycho-neurotic and psychosomatic disturbances.

Dartal is useful whenever the physician wants to ameliorate psychic agitation, whether it is basic or secondary to a systemic condition.

In extensive clinical trial Dartal caused no dangerous toxic reactions. Drowsiness and dizziness were the principal side effects reported by non-psychotic patients, but in almost all instances these were mild and caused no problem.

Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

**Usual Dosage**
- In psychoneuroses with anxiety and tension states one 5 mg. tablet t.i.d.
- In psychotic conditions one 10 mg. tablet t.i.d.
EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"

widely used
natural, oral
estrogen

Current Comment

Sterilization by Heat—

The destruction of all forms of microbial life is important to the practice of medicine. Mr. J. J. Perkins, Director of Research of American Sterilizer Co., in a series of lectures on the techniques of sterilizing medical and surgical equipment stated that "moist heat in the form of saturated steam under pressures the most dependable medium known in the destruction of all forms of microbial life." Boiling water is inadequate.

Bacterial spores are the most resistant of all living organisms to external destructive agents. Anthrax spores, dried on silk threads, have been found to be alive after sixty years. Spores have been known to survive for as long as 115 years in canned and hermetically sealed meat.

The minimum-time temperature ratio which is adequate or best for sterilizing non-porous materials, is 12 minutes at 250° F.

Some materials like greases, powders, and oils, cannot be sterilized with steam. For these materials dry heat of 320° F. is necessary and must be maintained for at least one hour.

Once sterilized, supplies wrapped in double muslin covers may be expected to remain sterile on supply shelves for at least four weeks. The best way to evaluate the effectiveness of a sterilizing process is by a culture test. By this method small strips of filter paper are inoculated with a heat resistant spore and after drying are placed in envelopes and included with the material to be sterilized. After completion of the sterilizing cycle, the envelopes are returned to the laboratory for sterility testing of the strips.

Supplies must be adequately cleaned prior to sterilization if the process is to be satisfactory.

New TB Film Ready—

A new film, "Are You Positive?" has been prepared by The National Tuberculosis Association to launch a nationwide campaign of public information and education through its 3,000 affiliates. The goal is to correct widely held public misconceptions about tuberculosis and its control. The film, produced in animation and color, deals with the most widespread misconceptions about TB.
Current Comment

Iowa Program for Farmers with Heart Disease—

Farmers with Heart Disease in Washington County, Iowa, are being helped to stay in farming through a project conducted by the American and Iowa Heart Associations according to a report sponsored by the Council on Medical Service of the American Medical Association.

The project, underway since September, 1955, is based on the principles of matching man and job that have been used in industry by many cardiac work classification clinics.

In Washington County, Iowa, patients are referred for evaluation by their family physician. Cardiologists from the State University evaluate the capacities of the patient as the farm operation is surveyed by the County Agricultural Extension Director.

The project team then evaluates these two sets of findings and attempts to develop a work prescription that will enable the patient to stay in agriculture. Greater mechanization, installation of work saving devices, redistributing of the work load over the year and more frequent “breaks” during the work day, are often recommended.

Of fifty patients that have been referred to this project since its inception, only four were advised to quit farming immediately.

Recruitment for Health Careers—

The National Health Council has announced the formation of a National Commission on Health Careers under the direction of Leonard H. Scheele, M.D., former Surgeon General of the United States Public Health Service. This Commission is being formed in answer to a growing shortage of personnel in many health areas, and is designed to assist the recruitment of the nations young people, and other potential health workers for career opportunities in the health field. The Commission will stimulate and provide guidance to all kinds of health career programs on local, regional, and national levels.

The availability of loan funds, aptitude testing, and studies of salary ranges in the health field will also be reviewed.

Commission membership will be drawn from leaders in the professions, government, labor, industry, and education.

when anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER

PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (400 mg.) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of duodenal ulcer — without fear of barbiturate loginess, hangover or habituation . . . with PATHILON (25 mg.) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. 
Supplied: Bottles of 100, 1,000.

*Trademark ® Registered Trademark for Tridihexyl Iodide Lederle
LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK
Current Comment

Welfare Costs Increasing at Same Rate As U.S. Production—

The Social Security Administration, completing a survey for the fiscal year ending June 30, 1956, reports that spending by public agencies — federal, state and local — for social activities is increasing at the same rate as the total national output of goods and services. That is the most recent year for which state and local figures are available. In fiscal year 1954-55 this type of welfare spending totaled $32.2 billion, and in fiscal 1955-56 it was $34.5 billion, $19.9 billion was state and local money, $14.6 billion U.S. money.

Activities covered include social insurance of all kinds, public assistance, public health and medical services, veterans' programs, education and public housing.

Health Insurance Outside the Hospital—

A broader type of voluntary health insurance which covers doctors' charges for services performed outside the hospital as well as inside, and as offered within the existing framework of fee-for-service medical practice, has been reported by the Health Information Foundation.

This report described the program offered by Windsor Medical Services, in Windsor, Ontario, Canada. This insurance plan serves an urban, industrial community with a population of about 160,000 and covers a broad range of doctors services, including care provided in hospital, office, and home. X ray and special services, maternity care, and preventive medical examinations are also covered. Payments are made to qualified physicians on a fee-for-service basis and the subscriber has free choice of physician. This last feature makes this program distinctive as compared to many types of comprehensive prepayment plan.

The review of the program suggests that subscribers to this insurance plan consulted physicians considerably more often than did the rest of the Windsor population and are also more likely to have a family physician than are their neighbors.

According to Health Information Foundation, there is no evidence of overuse of physicians' services or "doctor shopping," despite the broad coverage offered by the plan.
IN VITRO SENSITIVITY OF MIXED PATHOGENS TO CHLOROMYCETIN AND 4 OTHER WIDELY USED ANTIBIOTICS*

CHLOROMYCETIN 88%

ANTIBIOTIC A 76%

ANTIBIOTIC B 62%

ANTIBIOTIC C 56%

ANTIBIOTIC D 53%

*Adapted from Ditmore and Lind.* Organisms tested were isolated from stools of 48 patients.
Current Comment

The Month in Washington—

Russian advances in outer space have triggered a whole series of debates, not the least of which is the issue of the scope and extent of federal participation in higher education. From it may emerge at the very minimum a scholarship program benefitting pre-medical students and some medical students.

Here are some of the questions that Congress will have to answer before it writes a final bill on federal aid to higher education:

1. Should a program be limited to federal scholarships or should it include a grant money for improving and enlarging colleges and universities, or for loans to students?

2. If it is limited to scholarships, should they be non-categorical in nature rather than favoring specific disciplines?

3. If non-categorical and thus benefitting all phases of higher education, how best to justify this approach in the national interest and national security?

4. Finally, if aimed at specific disciplines, should not Congress require some obligation for service on the part of the recipient?

Some of the answers have been given in the administration’s plan now before Congress. As outlined by Secretary Folsom of the Department of Health, Education and Welfare, $1 billion would be authorized over a four-year period. The money would go for 10,000 scholarships a year to bright students unable to finance their schooling, for National Science Foundation grants and fellowships for post-doctoral training and up to $125,000 for any one school to improve facilities.

It has been explained that this program would benefit pre-medical students but that since scholarships would be limited to four years, students would have to find other ways to finance most of their years in medical school. After receiving their medical degrees, however, they would be eligible for the fellowships from the National Science Foundation.

(Continued on page 16-A)
THE FIRST TROCHE TO PROVIDE THREEFOLD BENEFITS

'PENTAZETS'

NON-NARCOTIC ANTITUSSIVE EFFICACY SHOWN TO APPROXIMATE THAT OF CODEINE

With the addition of a non-narcotic antitussive to troche medication, 'PENTAZETS' provides a new and extended therapeutic advantage in this convenient form of treatment.

Treatment of the cough too, so often a troublesome symptom of sore throat, combined with wide-range antibiotic activity and soothing analgesic benefit, now offers threefold relief in a variety of throat irritations.

And 'PENTAZETS' are pleasant-tasting, too, making them highly acceptable, especially to children.

'PENTAZETS' contains:

• Homarylamine—a new non-narcotic antitussive with cough control shown to approximate that of codeine. • Bacitracin-Tyrothricin-Neomycin—a combined antibiotic treatment against many pathogenic organisms with little danger of unfavorable side effects. • Benzocaine—a local anesthetic for soothing relief to inflamed tissues. Being slowly absorbed, it is especially beneficial for prolonged effect and benefit to surrounding areas.

Supplied: Vials of 12.

Each 'PENTAZETS' troche contains:

Homarylamine hydrochloride ................. 20 mg.
Zinc Bacitracin ................................ 50 units
Tyrorthoerin ...................................... 1 mg.
Neomycin sulfate ................................ 5 mg.
(equivalent to 3.5 mg. neomycin base)
Benzocaine ...................................... 5 mg.

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

PENTAZETS is a trademark of Merck & Co., Inc.
The administration program favors the non-categorical approach although preference would be given high school students with good preparation in math and the sciences. Students themselves would decide what college course to pursue.

This program has met mixed reaction. Educators say considerably more money should be authorized—some asking for as much as four times the proposed $1 billion.

The American Council on Education, which takes in nearly all accredited colleges, universities and junior colleges, told a House Education subcommittee that the 10,000 scholarships are "a minimum below which a program of effectiveness would be doubtful. . . ."

The council outlined for the subcommittee these guiding principles:

1. The student should have complete freedom to choose his own program of studies within the requirements set by the individual institution.

2. Stipends up to a maximum amount set generally for the program should be sufficient to enable the student to attend an eligible college.

3. The student should not be denied the opportunity to attend any recognized college or university properly accredited under a regional accrediting association.

4. There should be no discrimination because of race, creed, color or sex.

NOTES:

First legislative activity of interest to the medical profession this year was the House Ways and Means Committee's month-long hearing on tax revision; testimony in favor of the Jenkins-Keogh bill was presented late in January.

National Science Foundation is inviting colleges and universities to apply for financial help in conducting in-service courses and institutes for advanced study by high school mathematics and science teachers. Applications must be received by N.S.F. before March 15.

TAKE A LOOK AT NEW DIMETANE
THE UNEXCELLED ANTIHISTAMINE
Current Comment

The Month in Washington—

A new national organization has been established to help in finding a cure for ulcerative colitis. Encouraged by the National Institute of Arthritis and Metabolic Diseases, the new foundation will use its funds to supplement those awarded by the federal government.

After six months' operation of the disability payments program under social security, benefits were going to more than 131,000 and totaled $10 million a month. Within the next 12 months the rolls are expected to increase to about 200,000, at an annual cost of about $175 million.

Atomic Energy Commission has in effect reduced its permissible level of life-time radiation exposure by about two-thirds. The safety regulation applies to A.E.C. employees and those of A.E.C. contractors.

Influential Rep. John Fogarty (D., R.I.), wants the House to ask President Eisenhower to call a White House conference on aging, at which medical and all other problems of the older population would be taken up.

Mr. Fogarty also would attempt to interest states in similar conferences, to be conducted prior to the Washington meeting. (From A.M.A. Washington Office).

Medical Assistants Organize—

Over 400 of the girls who work in physicians offices turned out for the first national convention of the American Association of Medical Assistants in San Francisco, a three-day educational session.

Mr. Leo Brown, Director of Public Relations for the A.M.A. who attended the convention, reports that the organization, formed in Milwaukee last year, secured 4700 members in 1957 and expects its total membership to climb to 5000 in the near future. Nurses, secretaries, technicians, receptionists, and other types of medical office aids are members of this organization which seeks to "inspire members to render honest, loyal, and more efficient service" to the medical profession and the public.

The organization is based upon state groups which must have approval of the state medical society before they can gain a charter from the national organization.
The Future of "Social Security"—

O.A.S.I. is a system under which the active workers and their employers are contributing the taxes necessary to pay benefits to their fellow citizens on the benefit rolls. The active workers now covered under the system must look for their own old-age benefits, not in any large measure to the Trust Fund, which is only a moderate buffer fund to cover temporary excess of benefit payments over tax receipts, but mainly to the willingness of the next generation of active workers to pay the increased taxes out of which the retirement benefits will come.

Payments from "Social Security" include the following programs: First, Social Insurance which involves unemployment insurance and old age and survivors insurance; second, public assistance to the needy which includes old age assistance, aid to the needy blind, aid to dependent children, and aid to the permanently and totally disabled, and third, Children's services which takes care of maternal and child-health services, services for crippled children and child welfare services.

In other words: In spite of the fact that most of these represent federal grants to state aid, this Social Security program is being sold to you and me as "contributory social insurance."

Long-Term Danger from X Radiation Emphasized Too Much—

The Cancer Bulletin for Nov.-Dec., 1957 contains an article on "Control of Radiation Hazards." The final paragraph is quoted, as follows:

“More and more persons, frightened by headlines and dire genetic predictions, are refusing chest roentgenography, dental examinations, and urgently needed roentgen therapy. The physician must make them understand the value and importance of radiation as well as the possible disadvantages. The physician can point out that necessary examinations, performed by a properly trained physician who uses equipment designed to minimize exposure, are not perilous...”
EDITORIAL

HOW FAR HAVE WE COME?

Have you ever read the "Oath of Hippocrates" then the "New Principles of Medical Ethics" with the purpose of comparing and contrasting the two documents? In spite of the combined length of these documents it may interest some readers to have them together for comparative study. The editorial comment at the conclusion of this presentation is only "one man's opinion" of how far we have come.

The Oath of Hippocrates

I swear by Apollo, the Physician, and Aesculapius and Health, and All-heal and all the gods and goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

To reckon him who taught me the art equally dear to me as my parents, to share my substance with him and relieve his necessity if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by stipulation and oath, according to the law of medicine, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is detrimental and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With purity and with holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated may it be granted to me to enjoy life and practice the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

New Principles of Medical Ethics

PREAMBLE

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"Section 1—The principle objective of the medical profession is to render service to humanity with full respect for dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"Section 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"Section 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed
disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"Section 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient’s ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

"Section 8—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where the responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

There are many more words in our "Principles of Medical Ethics" than in "The Oath of Hippocrates," but there are no important additions to the thoughts presented in the older document. The increase in extent and complexity of our "Art," the vast increase in knowledge in the field of medicine, and the complexity of our civilization are not reflected in alterations in the principles that govern the profession; we have used more words to say it.

Both the "Oath" and the "Principles" ask doctors to be honorable gentlemen in their relations to each other, to their patients, and to the public at large. The Master boiled down both these documents to much fewer but equally meaningful words when he said—

Whatsoever ye would that men should do unto you, do ye even so to them;

WE SEE BY THE NEWSPAPERS

We see by the newspapers that vaccine for the prevention of Asiatic influenza was shipped from some manufacturers, directly to consumers, in Nebraska. Two companies who were said to have received direct shipments were named in the news. There may have been other recipients of direct shipments whose identity is not known to us. We heard, also, by the "grape-vine," that a few doctors received inordinately large quantities, considering the small amounts that were available to most of us.

One would naturally assume that regular channels—druggist, doctor, patient—would be the equitable method of distribution of a new product urgently needed. The Public Health Service, through agreements with the manufacturers, assumed control of distribution of vaccine for Asian influenza to the states but not within them. The P.H.S. and the American Medical Association recommended certain priorities in administration of the vaccine as it became available.

A.M.A. Washington Letter 85-42 told us that the Public Health Service called attention to disparities between amounts of vaccine shipped to states and state quotas agreed to under the voluntary allocation plan. P.H.S. also noted that 16 states had received over-shipments as of that date. Explanation seems to lie in "firm commitments made prior to . . . acceptance of the voluntary allocation program." One would like to know more.

On the other hand, a letter dated October 18, from Merck, Sharp & Dohme, states, (Continued on page 69)
Experience With TRANSURETHRAL 
Prostatic Resection and 
Perineal Prostatectomy
In One Clinic — A COMPARATIVE REVIEW OF 3400 PATIENTS*

These authors report, herein, on the use of the three methods of surgical treatment of prostatic obstruction of the vesical neck. They accent the wisdom of fitting the operation to the patient. A classification of pathologic conditions in relation to the choice of operation shows that they employ prostatic resection to relieve the obstructions caused by more minor lesions and perineal prostatectomy for those of more major kinds. An exception is carcinoma; the advanced lesion is treated by resection, while those confined within the capsule are treated by perineal prostatectomy. It appears that suprapubic prostatectomy is used only in instances where the other two operations are not possible, such as ankylosis of the hip joints. The regimen described, especially choosing the operation for the given patient, has resulted in excellent return to comfort and good function.

—EDITOR

THE literature contains many reports of experiences with perineal, suprapubic, and transurethral prostatectomy. However, the usual paper is limited to a single type of procedure performed as the operation of special interest by the author. As a means of choosing the proper procedure for any given patient, our urological group has followed the policy, since 1920, of “selection of cases.”** Thus, a consecutive series of 3400 prostatic surgical patients has been accumulated. Throughout this series, we endeavored to choose the proper operation for the individual’s prostatic disease, rather than to fit all patients to a single type of procedure.

PROSTATIC OPERATIONS—CLASSIFICATION AND INDICATIONS

It is generally recognized that indications for prostatic surgery vary among surgeons, so that the classification and indications used by one group will not be the same as by another. Henline2 expressed a sane and unprejudiced viewpoint in stating “surgical diseases of the prostate present so many variations that no one surgical procedure will obtain the best result in all cases.” Our classification and indications are as follows:

Transurethral Resection—For vesical neck obstruction caused by:
1. Small, benign hyperplasia of prostate.
2. Median Bar.
3. Hypertrophy of Mercier’s bar.
4. Advanced prostatic carcinoma.
5. Contracture of the vesical neck.

Perineal Prostatectomy—For vesical neck obstruction caused by:
1. Moderate to large grade benign hyperplasia. (Simple perineal enucleation).
2. Early intracapsular carcinoma of the prostate without demonstrable metastasis. (Total perineal prostatectomy).
3. Calculus disease of the prostate. (Total perineal prostatectomy).

Suprapubic Prostatectomy — For vesical neck obstruction caused by moderate to large grade benign prostatic hyperplasia in the following situations:
1. Ankylosis of hips.
3. Perineal scar.
4. Impassable urethral stricture.

PATIENTS OBSERVED

The total series is comprised of 3400 patients, of whom 1050 underwent transurethral resection and 2350, perineal prostatectomy. During the period of accumulation of this series of patients the need for performing a suprapubic prostatectomy occurred only 45 times. This small number was deemed too meager to be of statistical significance. Suffice it to say that among those patients subjected to suprapubic pros-
tatectomy the mortality and morbidity were relatively high as has been the experience of others reporting on suprapubic operations.

COMPARISON OF PREOPERATIVE PREPARATION

The preparation for either transurethral resection or perineal prostatectomy is the same. In addition to complete physical examination and routine laboratory studies, our usual preoperative preparation consists of blood nonprotein nitrogen determination, roentgenological study, vasectomy, and cystoscopic examination. The last, however, we occasionally omit if diagnosis of large benign hyperplasia is definitely established. Patients with residual urine in small amount, with normal temperature, and good appetite, with normal blood nonprotein nitrogen, and without cardiac or other medical contraindication may be operated upon without delay. Residual urine in large amount, however, and elevated blood nonprotein nitrogen, or both, call for caution. Preoperative treatment, when one or both these complications exist, must include forcing fluids and bladder drainage, either by retention catheter or suprapubic cystostomy. These procedures must be continued as long as may be necessary, regardless of urging to the contrary by the patient or relatives. Simply stated, and assuming no evidence of circulatory disorder, our “greenlight” criteria consist basically of blood nonprotein nitrogen below 40 mg. per 100 cc., normal temperature, and good appetite.

DESCRIPTION OF TECHNIQUES

For those patients undergoing transurethral resection, a low spinal, such as produced by “heavy” Cyclaine, 50 mg., is the anesthetic of choice. To perform the perineal prostatectomy, we prefer a continuous caudal anesthesia, using 0.5 per cent Cyclaine in the amount of 80 cc. as the initial dose. Spinal anesthesia also may be used for this procedure in certain instances.

For the transurethral resection, we use, routinely, a No. 24 Fr. Stern-McCarthy or Nesbit resectoscope. The smaller instrument is preferred because we feel the incidence of postoperative urethral stricture is thereby decreased. For the perineal prostatectomy, a modification of the classical Hugh H. Young technique is used. We conclude the procedure with an indwelling Foley urethral catheter and plastic closure of the capsule and perineum.

Details of the perineal operation may be seen in a series of photographs appearing in Archives of Surgery.

RESULTS

SUMMARY OF NUMBER OF PATIENTS AND IMMEDIATE HOSPITAL MORTALITY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total Number of Patients</th>
<th>Deaths*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transurethral Resection</td>
<td>1050</td>
<td>13</td>
</tr>
<tr>
<td>For Benign Hyperplasia</td>
<td>803</td>
<td>2</td>
</tr>
<tr>
<td>For Carcinoma</td>
<td>247</td>
<td>1</td>
</tr>
<tr>
<td>Total Deaths in Series</td>
<td>13</td>
<td>1.2</td>
</tr>
<tr>
<td>Mortality Percentage for Transurethral Resection</td>
<td>2.8*</td>
<td></td>
</tr>
<tr>
<td>Perineal Prostatectomy</td>
<td>2350</td>
<td>66*</td>
</tr>
<tr>
<td>For Benign Hyperplasia</td>
<td>2304</td>
<td></td>
</tr>
<tr>
<td>For Early Carcinoma</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Total Deaths in Series</td>
<td>66*</td>
<td></td>
</tr>
<tr>
<td>Mortality Percent for Perineal Prostatectomy</td>
<td>2.8*</td>
<td></td>
</tr>
<tr>
<td>Suprapubic Prostatectomy</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

*Most recent 1949 to 1956 series—625 patients had 12 deaths—a mortality rate for perineal prostatectomy of 1.9 per cent.

ANALYSIS OF DEATHS OCCURRING AFTER TRANSURETHRAL RESECTION

1050 Patients — 13 Deaths*  
Sepsis  2  
Uremia  1  
Coronary Thrombosis  6  
Pulmonary Embolus  4  
*Of the 13 deaths, 7 occurred in patients with advanced carcinoma.

ANALYSIS OF DEATHS OCCURRING AFTER PERINEAL PROSTATECTOMY

2350 Patients — 66 Deaths*  
Directly related to prostatic surgery  26  
Sepsis  17  
Hemorrhage  1  
Delayed Hemorrhage  5  
Uremia  3  
Possible relationship to prostatic surgery  40  
Cerebral Accident  8  
Coronary Thrombosis  8  
Pulmonary Embolus  16  
Bronchopneumonia  1  
Cerebrovascular disease  1  
Femoral Embolus  1  
Acute Gastroenteritis  1  
Perforation of Colon  1  
Parkinsonism  1  
Intestinal Obstruction  1  
Nasal Hemorrhage  1  

COMPARISON OF CONVALESCENCE AND COMPLICATIONS

Postoperative discomfort following either procedure was minimal in most instances. The administration of more than one or two hypodermics of narcotics* was rarely neces-

*Morphone sulfate gr. 1/6 - 1/4 or Demoral 50 to 100 mg. have usually been used. More recently Anileridine, 50 to 100 mg. has been used with satisfactory effect.
sary during the postoperative period. Bladder spasm, commonly associated with indwelling-catheter drainage, was usually controlled with Delkadon, 1 or 2 tablets q.i.d. The patients were allowed out of bed on the first or second postoperative day. In patients undergoing transurethral resection, the catheter was removed, as a rule, between the fourth and sixth postoperative days. In patients subjected to perineal prostatectomy, the catheter, sutures, and perineal Penrose drain were removed on the seventh postoperative day.

Prophylactic control of urinary infection was accomplished by the use of sulfadiazine, Thiosulfil, or other urinary antiseptic. Acute sepsis was a rare problem, and in those instances where simple urinary antiseptics did not control the infection, urinary antibiotic sensitivity tests were performed and the appropriate antibiotic administered.

The hazard of immediate and delayed postoperative hemorrhage forever faces those doing prostatic surgery, but it assumes major significance in only approximately one per cent of patients. The excellent coagulating current delivered by the newer electro-surgical units decreases the incidence of immediate hemorrhage with the transurethral resection. Nevertheless, with sloughing of the eschar some time between the seventh and twentieth postoperative days, there is a possibility of delayed hemorrhage. This is usually controllable by insertion of a urethral catheter; but sometimes evacuation of clot, followed by transurethral fulguration of the bleeding point, is necessary. The perineal procedure gives opportunity for sutureligature of the bleeders, thereby decreasing the occurrence of immediate postoperative bleeding; but, though rare, delayed hemorrhage as the urethra heals also may occur following this operation.

Postoperative urethral stricture is considerably more common following transurethral resection than after perineal prostatectomy. It is felt that overdistension of the urethra by the resectoscope, the heat generated by the current, and prolonged motion of the sheath during the operation are the main factors responsible for the development of this complication. Urethral stricture following perineal prostatectomy has been seen, but is, indeed, rare.

Although there is no external incision in patients undergoing transurethral resection, there is a rather extensive wound, comparable to a third degree burn, which must undergo healing. As a matter of fact, cystoscopic examination during the healing phase following transurethral resection will show that it takes many months for complete healing with epithelization of the prostatic urethra to take place. This slow healing accounts for the persistence of pyuria and microscopic hematuria following transurethral resection. On the other hand, the healing of a clean surgical incision incident to scalpel-dissection in perineal prostatectomy, takes place rapidly. The urine in such patients is usually clear of pyuria and microhematuria within six to eight weeks. Since the advent of plastic closure of the prostatic capsule and perineum by the members of our group, in 1946, we have seen no instance of persistent perineal fistula through the operative wound.

No discussion of prostatic surgery would be complete without mentioning postoperative urinary incontinence. With any type of prostatic surgery, some patients spend a period of time following the removal of the urethral catheter — a few days to a few weeks — before entirely satisfactory control develops. This is to be expected as part of the phase of wound healing during which new physiological adjustment must take place. Observations on our own patients, as well as those of others, convince us that "no one operation has a monopoly" on the postoperative urinary control problem. We have found the prescription given below to be helpful in certain patients in re-establishing urinary control. Bladder exercise treatments, in which the bladder is filled with water and the patient voids with "shutting off" on command, is also effective in many instances.

<table>
<thead>
<tr>
<th>Strychnine Sulf.</th>
<th>3 grains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fld. Ext. Ergot.</td>
<td>2 ounces</td>
</tr>
<tr>
<td>Ephedrine Sulf.</td>
<td>8 grains</td>
</tr>
<tr>
<td>Arom. Eliz. q.s.</td>
<td>ad. 8 ounces</td>
</tr>
<tr>
<td>Sig.—One teaspoonful four times daily.</td>
<td></td>
</tr>
</tbody>
</table>

For the treatment of the occasional patient having continued residual urine because of vesical detrusor-hypotonia after adequate transurethral resection or perineal enucleation, Urecholine, 5 to 25 mg. q.i.d. has proved helpful.

The complaint of impotence following perineal prostatectomy or transurethral resection has been reported to us rarely by our patients. As in the case of urinary incontinence no one prostatic operation has a
monopoly on blame for impotence. The inability to predict results in this regard is evidenced by the wife of a 65-year-old patient who had undergone prostatic seminal-vesiculectomy six months previously for early prostatic carcinoma. She complained that her husband's sexual prowess was vastly improved, so much, in fact, that she requested medication to "slow him down."

COMPARISON OF LATE FUNCTIONAL RESULTS

In the quest for unattainable perfection in any surgical field, the best to be hoped for is a near approach to the ultimate goal, that of removal of the pathological process and the achievement of symptomatic relief in a high percentage with minimum risk. Second in importance only to mortality rate is the recovery of comfort, including restoration of the involved organ to normal function.

It has come to be generally recognized, by the profession and the laity as well, that prostatic surgery not only may be performed with minimal risk (in this series a mortality rate less than 2 per cent) but offers a high percentage of good functional results. Because of improved diagnosis, technique, and antiseptics, together with the tendency toward earlier ambulation and shortened hospitalization, it is perhaps unfortunate that people have come to take too much for granted. They fail to realize that every surgical procedure has its serious aspects, and that a tragedy or an imperfect operative result might follow even relatively minor procedures, and, not infrequently, from some wholly unrelated cause.

The late functional results of prostatic surgery may be evaluated by follow-up inquiry. Those who have sought information by the analysis of questionnaire-responses from patients in this age group recognize this as a tedious and rather unsatisfactory process, beset with difficulties and inaccuracies at best. Some have died, some have disappeared, and others fail to reply. Many, rather than confining themselves to the specific questions, base their dissatisfaction upon wholly unrelated symptoms such as constipation or "rheumatism." Many are senile and mentally confused, therefore they tend to emphasize unrelated complaints. We attempt to follow our patients for a usual period of one to six months following dismissal from the hospital. During this healing phase, urinary infection, urethral narrowings, and problems of control and residual urine may be managed successfully in most instances.

Our observations would lead us to believe that, following either perineal enucleation or transurethral resection for benign prostatic hyperplasia in selected cases, the end results are encouragingly satisfactory. There is an occasional patient undergoing perineal prostatectomy who will require a transurethral resection for recurrent hyperplasia, and an occasional patient having transurethral resection who will require a second transurethral resection or even perineal prostatectomy as the future evolves. However, in either instance it is a rarity to need further prostatic surgery when the proper operation for the presenting pathologic condition is used initially.

CONCLUSION

1. Experience with transurethral resection and perineal prostatectomy in a series comprising 3400 patients is presented.

2. Preoperative management, mortality, morbidity, complications and results are discussed individually and comparatively as regards transurethral resection and perineal prostatectomy.

3. By reason of improved surgical technique, methods of anesthesia, and supportive treatment, prostatic surgery by either transurethral or perineal approach may now be undertaken with minimal risk. (Less than two per cent mortality).

BIBLIOGRAPHY


Is a "Simple" Mastectomy

The Total Removal of Breast Tissue?*

This author emphasizes the fact that "simple" surgery, so called, must be careful surgery. Removal of the breast that may be classified as simple may be so done as to leave bits of mammary tissue in the depth of the skin flaps, under the lateral margin of the pectoralis major muscle, or in the axillary space. Such bits of glandular tissue may constitute definite hazards for the future. The theme of his discussion is supported by both clinical and experimental data. Doctor Hoffman believes that proper operative technique carefully carried out can make the "simple" mastectomy, when indicated, a safe procedure.

—EDITOR

In reviewing the literature dealing with breast surgery, one is startled by the almost total lack of information regarding the recurrence of cystic disease following simple mastectomy. The title of this paper is intended to be entirely provocative. The major objection is the word simple and its implication. If we should substitute the phrase complete simple, or better yet, total mastectomy, it would more adequately describe what we try to accomplish and would indicate many of the inadequacies that seem frequently to occur in the procedure known as simple mastectomy. The end result in any surgical procedure can be no better than the degree of care and thoroughness with which the operation is carried out.

Breast surgery is, of necessity, a compromise. If the skin flaps are dissected to such a degree of thinness that there is no possibility of leaving bits of residual breast tissues, we are faced with the possibility of skin necrosis due to poor blood supply. Most surgeons feel that such a result may place them in an embarrassing position. However, if the surgeon points out to the patient, both preoperatively and postoperatively, the technical problems involved, he should have no cause for embarrassment. If skin flaps slough or show early necrosis, the time to debride and do skin grafting is in the first five to seven days.

Postoperative management following breast surgery has been improved markedly in the past couple of years by the use of continuous suction. This probably has done more to promote healing of skin flaps without necrosis than any other one procedure.

LLOYD O. HOFFMAN, M.D.
Omaha, Nebraska

Its success is dependent upon the use of rather large catheters, 22 to 24 F., and continuous suction for forty-eight to seventy-two hours.

It has been stated by Haagensen that skin flaps 1 cm. or more in thickness nearly always contain breast tissue. With this in mind and with the cooperation of Dr. John R. Schenken, several double dissections were carried out. First a simple mastectomy was performed leaving subcutaneous fat and breast tissue (?) for a distance of 1 to 1.5 cm. beneath the skin flaps. Then the flaps were redissected down to the skin itself and this shell of tissue utilized for microscopic examination. In each of the cases several areas were found to contain microscopic bits of breast tissue.

Nearly all surgeons see patients each year with recurrent cystic disease following simple mastectomy. In the larger percentage of cases these cysts occur beneath the median flap. Some show cystic disease in the axillary space and some develop cysts beneath the axillary border of the pectoralis major muscle. In our review of the anatomical variations of the breast it is interesting to note that in one to two per cent of cases, breast tissue is found beneath the fascia of the pectoralis major muscle, and breast tissue occurs rather commonly in the axilla and beneath the axillary border of the pectoralis major muscle.

We cannot hope to remove all breast tissue without removal of pectoralis major muscle. We can, however, by strict attention to detail, remove breast tissue from beneath skin flaps, the lateral margin of the pectoralis major muscle, and from the axillary space.

Many times we see recurrence of carcinoma following radical breast surgery. A question immediately arises in such instances: are we confronted with an actual recurrence of the original carcinoma, or is this a new carcinoma developing in residual breast tissue? It is my impression that the latter statement is much more often true than many of us have been led to believe.

*Read before Omaha Mid-West Clinical Society, October, 1956.

February, 1958
In dealing with cancer of the breast, surgical teams must include the pathologist. His functions are to confirm our gross pathological diagnosis and to guide us by his opinion regarding certain microscopical pathologic changes. While carcinoma of the breast can usually be confirmed by gross and frozen sections and radical surgery performed immediately, certain conditions require study of paraffin sections before the operation can proceed. This is true particularly in precancerous ductal changes and in possible ductal carcinoma in which "simple" (total) removal of the breast is adequate. Thus, a delay of forty-eight hours to permit study of permanent sections is necessary in a fair number of cases. This time interval does not increase the danger of metastases and, in some cases, forestalls the more radical operation.

We might mention the increasing popularity of McWhirter's procedure of simple mastectomy followed by intense radiation therapy. Although the author's published statistics are within a few percentage points of the reports on radical mastectomies, it would seem that any recommendations in the treatment of breast cancer should show better results rather than almost as good.

All of the published statistics show that if we subtract the essentially inoperable cases from a series that the five- and ten-year cure-rate is increased about thirty per cent. The surgeon's knife is a double edged sword that can do harm as well as good. Many lives of patients with breast cancers are shortened by ill-advised surgery. In the discussion of any type of breast surgery it is probably well to list the conditions in which Haagensen indicates breast carcinoma to be inoperable.

1. When extensive edema of the skin over the breast (more than one third of the skin area) is present.
2. When satellite nodules are present in the skin over the breast.
3. When the carcinoma is of inflammatory type.
4. When any two, or more, of the following signs of locally advanced carcinoma are present.
   (a) Ulceration of the skin.
   (b) Edema of the skin of limited extent (less than one third of the skin over the breast).
   (c) Solid fixation of the tumor to the chest wall.
   (d) Axillary lymph nodes measuring 2.5 cm. or more in transverse diameter.
   (e) Fixation of axillary lymph nodes to the skin or to the deep structures of the axilla.

5. When there is edema of the arm.
6. When, in patients with clinically involved axillary lymph nodes, biopsy of the apex of the axilla reveals metastases.
7. When biopsy of the internal mammary lymph nodes in the first interspace reveals metastases.
8. When roentgenographic study of the skeleton reveals metastases, or when trochar biopsy of a lumbar vertebra reveals metastases.
10. When palpation of the liver suggests that it contains metastases.

Lives of these inoperable cancer patients are prolonged and the morbidity and mortality is lessened when we rely upon adequate X-ray therapy alone. We can depend upon it to lock up the cancer cells with scar tissue and thus to prevent their spread along the pathway of lymph drainage for a considerable period of time. By following these suggestions it is apparent that breast surgery can point to a much better record of achievement.

In closing I would like to emphasize certain points. Because the breast is an external organ, unnecessary or ill-advised surgery can be easily carried out. The word simple is a dangerous word to employ. It can easily lull us into a false sense of security.

The use of the word total regarding mastectomy would be a constant reminder of the necessity of following a technique which actually removes all of the existing breast tissue.

BIBLIOGRAPHY
**Biopsy**

is immediate mastectomy necessary in carcinoma?

JOHN C. KENNEDY, M.D.
Omaha, Nebraska

**Biopsy** of the breast is a relatively simple minor operation, but when one considers that it is a diagnostic procedure upon which the patient's life may rest, it assumes all of the importance of a major operation. As one's experience increases, so does his ability to differentiate between benign and malignant tumors of the breast, but biopsy should be carried out in all cases in which there is the least doubt as to the correct diagnosis rather than risk a clinical error which might result in disaster to the patient. Undue delay in diagnosing a carcinoma may mean the difference between a curable tumor localized to the breast and an incurable tumor which has metastasized beyond the axilla. It is equally as distressing to see a patient who has been subjected to a radical mastectomy on the basis of a clinical diagnosis of carcinoma only to find that she was suffering from fat necrosis.

There was a time when many were opposed to the biopsy of any malignant lesion on the theory that tumor cells were freed into the wound, and lymphatic and blood vessels were opened to pick up these cells and carry them to more distant parts of the body. Although this possibility still is recognized, biopsy now is an accepted procedure, because it is felt that the importance of the information obtained far outweighs the danger of dissemination of the tumor.

Occasionally one encounters a patient who feels that carcinoma is a hopeless disease which is made worse by surgery and, although willing to undergo exploration for diagnosis, will not give permission for more extensive surgical treatment of a malignant tumor. For this reason, the various possibilities should be discussed with the patient in advance, and if he or she refuses to undergo further treatment if necessary, biopsy should not be performed because of the danger of hastening the spread of the disease.

While it is a minor surgical procedure, biopsy of the breast should be done under general anesthesia, whenever possible, with the intention of doing an immediate mastectomy if carcinoma is found. Although biopsy may be done under local anesthesia in some cases, many patients who already are under a severe mental strain become quite apprehensive while awaiting the report of the pathologist and, when informed of the presence of a malignancy and the need of further surgery, may undergo a serious emotional crisis. Another objection to the use of local anesthesia is that a small tumor may be lost in the infiltrated area and so cannot be found for removal; or, of even greater importance, a small lobule of normal breast tissue may be removed by mistake.

The usual procedure is to prepare the patient as for radical mastectomy. Although this is not necessary for the biopsy, it saves re-prepping and draping if further surgery is requisite. When dealing with a small tumor, it is helpful to mark the skin directly over the mass with an indelible marker after the patient has been positioned on the operating table but before the skin is prepped. This makes it possible to locate the tumor even though you cannot feel it with gloved hand. Additional drapes in the form of towels, or a small wound drape, should next be applied to prevent contamination of the mastectomy drapes with tumor cells.

Regardless of whether you are doing aspiration, or incisional or excisional biopsy, remember that you are freeing tumor cells that may be implanted in the normal tissue.

*Read before Omaha Mid-West Clinical Society, October, 1957.*

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Doctor Kennedy stresses the necessity for early and accurate diagnosis when a mass is found in the breast. Biopsy, in one form or another, is almost always a prudent procedure in arriving at an accurate diagnosis. The author discusses the technique of performing the biopsy recognizing the possibility of getting local implantation or distant spread of cancer cells. It is safest, he believes, to proceed with definitive treatment as soon following the biopsy as the diagnosis is established, but experience indicates that necessary delay such as sometimes required for study of permanent sections does not diminish the chance of cure.

—EDITOR
that must be traversed; the wound, therefore, should be planned in such a position that it can be excised in toto if mastectomy is carried out. Unusual approaches to avoid noticeable scars should not be employed in the biopsy of a possible carcinoma of the breast.

It must be remembered that instruments, sponges, sutures, and any other materials coming in contact with a biopsy wound may become contaminated with tumor cells. Such materials should be isolated so as not to touch the drapes or instruments to be used for mastectomy if it must be done. This isolation may be accomplished by using a special instrument tray to be removed on the completion of the biopsy or by placing these instruments on a towel draped across the patient's chest or abdomen. After the biopsy has been completed, all materials which have been in contact with the wound either directly or indirectly should be removed and all participants in the procedure should change gowns and gloves before proceeding with further surgery.

Aspiration or needle biopsy is the simplest but most unsatisfactory method of obtaining tissue for study. This type of biopsy sometimes is carried out in the office because of its simplicity, but also is done in the hospital under general anesthesia. An ordinary 18-gauge needle fitted to a syringe or a Vim-Silverman biopsy needle may be used. In using an ordinary needle, a small incision is made in the skin and the needle advanced to the tumor. Then while making strong suction with the syringe, the needle is forced into the tumor with a rotary motion and slowly withdrawn maintaining suction. The plug of tissue thus obtained is expressed on a slide and a smear made which is fixed, stained, and examined. When using the Vim-Silverman instrument, the needle is introduced to the tumor site, the stylet removed and the split-blade obturater is inserted through the cannula and into the tumor. The cannula is then advanced over the obturater with a rotary movement and then the entire instrument rotated through 180° and withdrawn. Needle biopsy does not always provide an adequate and representative specimen, therefore a negative result is meaningless. Biopsy is very difficult with small tumors, and cystic tumors might be aspirated without finding a small carcinoma. Another objection to needle biopsy is that it provides a cytologic rather than a histologic diagnosis, but this is of little importance in the case of breast tumors if they are to be treated surgically. The manipulation necessary to immobilize the tumor while the needle is being introduced and the possibility of entering large veins during the procedure might make dissemination of the tumor more of a hazard in needle biopsy than in excisional or incisional biopsy. If there is any question as to the diagnosis, more adequate tissue should be obtained by excisional or incisional biopsy.

Excisional and incisional biopsies are done under direct vision and vary only in the relative amount of tumor removed. In one the entire tumor is removed and in the other a small segment of the tumor is removed. Some feel that excision is the method of choice because the tumor is not incised and therefore there is less danger of hastening spread of the growth. Others point out that small projections from the tumor are cut across without being seen. Here the incision is made directly over the mass and carried down to the tumor by either cautery or knife. All bleeding vessels should be ligated with fine silk or catgut to provide as nearly a bloodless field as possible. Then, either the entire tumor is excised or a small wedge of tissue is removed for examination. The cautery should not be used in excising a segment of the tumor because of the possibility of “cooking” the tissue and rendering it unsuitable for diagnosis. While awaiting the pathologist's report, the incision should be closed; if the tumor is benign, the operation is complete; if further surgery is necessary, there is less danger of transplanting tumor cells. If there is any doubt as to the diagnosis made by means of frozen section, do not proceed with radical surgery, but wait for a report based on permanent sections.

“In case of doubt, wait for the permanent sections.” Here is a statement which is contrary to what many of us have been taught in the past, contrary to the old teaching that if carcinoma is present immediate mastectomy is necessary because once one cuts into the tumor it will spread rapidly. This teaching has created difficult problems for many physicians in smaller communities where no pathologist is available to make and examine frozen sections. The patient who consults her physician because of a lump in the breast may be perfectly willing to have him remove it in the local hospital, but
does not want to go to some more distant hospital for treatment unless absolutely necessary. Should she be kept under observation and possibly allow the tumor to metastasize before proper treatment is instituted? Should biopsy of the tumor be carried out and the tissue sent away for diagnosis causing the physician to risk the criticism of using poor surgical judgment and endangering the patient's chance of obtaining a cure? Or, should the physician depend on his own diagnosis based on gross examination of the tissue removed at biopsy and possibly submit the patient to the risk of a major and mutilating operation only to find later that it was not necessary? What is to be done by the family physician who does limited surgery but is not qualified to do a radical mastectomy, or whose local hospital facilities are not adequate for major surgery? Must he refer all of his patients with breast tumors to more qualified surgeons at home or in some other city, or can he remove the tumors with safety and refer only those patients in whom carcinoma is found?

Although many still feel that any delay between biopsy and mastectomy materially reduces the patient's chance for a permanent cure of carcinoma, most now feel that a delay of up to ten days has no appreciable effect on the eventual outcome of the disease. There has been little statistical evidence to support either side of the question, however, Haagensen and Stout in reviewing 640 mastectomies for carcinoma at New York Presbyterian Hospital have concluded that preliminary biopsy which was done in slightly more than one-third of the cases had no appreciable effect on the rate of cure even though it was done as much as ten days before mastectomy.

A few days delay, however, may make a big difference to the patient. The numerous articles on cancer which have appeared in the lay press in recent years have done much to educate the public and to aid in our fight against this disease, but, unfortunately, they have created a cancer phobia in some patients, and to them an immediate frozen-section report represents the proper test for cancer, and delay in making a correct diagnosis not only brings additional mental strain to these patients, but also creates doubt in their minds as to whether or not they are receiving the proper medical care.

**SUMMARY**

In summary it may be said that biopsy of the breast is a relatively simple and safe minor surgical procedure which should be carried out in all cases of tumor of the breast in which there is any doubt as to the correct diagnosis. Under ideal conditions it is carried out under general anesthesia in the hospital where frozen sections can be made and immediate mastectomy can be done if carcinoma is found. However, even though it is recognized that there is the possibility that biopsy will hasten the spread of a malignant tumor, when ideal facilities are lacking, a delay of up to a week or ten days will have no appreciable effect on the outcome of the disease, but such a delay should be avoided if possible because of the emotional upset which may occur in the patient.

**BIBLIOGRAPHY**


**Current Comment**

Prevalence of Osteoarthritis—

“It is estimated that one-quarter of the patients attended in general office and clinic practice have osteoarthritis. The practitioner sees this form of rheumatism nearly as often as all other types of the disease combined. The clinical importance of this disease stems chiefly from pain, not disabling deformity, as is so often the case with other kinds of rheumatic disease . . .” (Brown: GP, Dec. 1957, p. 99).
Use of **Glucagon** TO TERMINATE
**Insulin Reactions** IN **DIABETIC CHILDREN**

**Glucagon** is a hormone produced by the alpha cells of the pancreatic islets. It produces hyperglycemia by enhancing glycogenolysis in the liver. It has been used intravenously in one reported study to terminate therapeutic insulin shock on a psychiatric ward.

Epinephrine has long been used in therapy of insulin reactions. Glucagon would have the advantage of not possessing a hypertensive effect.

The present report concerns experience with glucagon used to treat mild insulin reactions on a pediatric ward. Glucagon was given subcutaneously in a dosage of 0.03 mg./kg. body weight. For purposes of the present observations, the attendants refrained from administering carbohydrate for one hour following the administration of the glucagon. Capillary blood was used for patient R.F. Venous blood was obtained before breakfast, and ranged from 10 to 30 units, adjusted by a plan of flexible insulin dosage. His diet contained approximately 1200 calories and included between-meal and bedtime snacks. On 5-21, his hypoglycemia was manifested by unconsciousness; on 5-28, he was merely drowsy and irritable. (See Table I).

**CASE II**

A.K. was a 10-year-old girl with diabetes complicated by hyperthyroidism. She was admitted to the University of Nebraska Hospital on 5-14-57. Her diabetes was of three years' duration. During these studies, she was receiving propylthiouracil in preparation for subtotal thyroidectomy. On the first four tests, hypoglycemia was suspected because of dizziness. The total daily insulin dosage of ordinary Lente was given before breakfast. Insulin dosage ranged from 24 to 44 units. Her diet contained approximately 2500 calories. The study on 8-3 was two days post-thyroidectomy. At that time, she was having some respiratory difficulty and complained of dizziness. This was interpreted clinically as hypoglycemia, but

<table>
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<th>Blood Sugar mg./100 ml.</th>
<th>Comment</th>
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<tr>
<td>R.F.</td>
<td>5/21</td>
<td>20 41</td>
<td>Responded clinically within 8 min.</td>
</tr>
<tr>
<td></td>
<td>5/28</td>
<td>32 127</td>
<td>Responded within 10 min.</td>
</tr>
<tr>
<td>A.K.</td>
<td>5/29</td>
<td>55 79</td>
<td>Responded within 10 min.</td>
</tr>
<tr>
<td></td>
<td>5/31</td>
<td>72 140</td>
<td>Felt better within 10 min.</td>
</tr>
<tr>
<td></td>
<td>7/24</td>
<td>41 111</td>
<td>Felt better within 10 min.</td>
</tr>
<tr>
<td></td>
<td>7/29</td>
<td>40 112</td>
<td>No improvement in symptoms</td>
</tr>
<tr>
<td></td>
<td>8/3</td>
<td>170 268</td>
<td></td>
</tr>
</tbody>
</table>

from patient A.K. Blood sugar was determined by the Benedict method after preparation of a tungstic acid filtrate.

**CASE I**

R.F. was a 25-month-old boy with diabetes of one week's known duration when admitted to the University of Nebraska Hospital on 4-27-57. He was receiving a mixture of Semi-Lente and Ultra-Lente insulins in a ratio of 3 to 1. His total daily insulin dosage was given

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*Article received for publication October 16, 1957.*

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Nebraska S. M. J.
the blood test later showed that her blood sugar was actually elevated. The glucagon, however, caused a further rise.

**SUMMARY**

Subcutaneous injection of glucagon provides a convenient means of treatment of insulin hypoglycemia in the diabetic child.

**REFERENCES**


2. Glucagon, Lilly, 1 mg. per ml., Batch C T 871.


**TUBERCULOSIS ABSTRACTS**

**ADVANTAGES OF HOSPITAL ADMISSION CHEST X-RAY EXAMINATIONS**

Routine hospital admission chest X-ray examinations are performed in only 21% of all hospitals in the United States according to the 1954 figures of the American Hospital Association. It is difficult to comprehend the reason for such a situation when the advantage of such examinations was demonstrated as long as 20 years ago. For many reasons chest X-ray examinations should be a necessary and integral part of a patient's studies in the hospital.

Communicable Diseases — Routine chest X-ray examination of the hospital population is important to all hospital personnel and to their families. The incidence of tuberculosis and other respiratory diseases is said to be greater among hospital personnel than among workers in any other industry. In any hospital chest X-ray program preemployment and at least annual chest X-ray examinations of employees are essential. The making of semi-annual chest X-ray films of those on the attending and house staffs is also inherent in such programs.

Errors in Diagnosis of Chest Diseases — The value and necessity of admission chest X-ray examination were demonstrated over 20 years ago when it was proved that, as a group, the physicians at the University of Michigan Hospitals committed one gross error a day without the benefit of such chest X-ray films. This demonstration in itself warrants the adoption of routine admission chest X-ray examination of all hospital patients.

Unsuspected Cases of Chest Disease — Many unsuspected cases of chest disease amenable to treatment are uncovered by admission chest X-ray examination. Prompt treatment of these patients decreases morbidity and mortality rates and the length of hospitalization. In this day of high hospital costs and shortages of hospital beds the latter consideration is not a minor one.

Preoperative Work-up — In the evaluation and preparation of the surgical patient, the routine admission chest radiograph furnishes information of value to surgeons and anesthesiologists. The correlation of the physical findings with the X-ray findings increases the accuracy of the appraisal of the patient's cardiopulmonary status and often influences the choice of the anesthetic agent and type of surgical procedure.

Record of Chest Condition — In everyday roentgenography of the chest, we are faced with the problems of ascertaining, if possible, the acuteness or chronicity of thoracic abnormalities. Many such questions can be resolved promptly and easily if previous chest films are available for comparison. Admission chest X-ray films provide such valuable records, particularly in patients with postoperative and other types of thoracic complications. X-ray diagnosis of chest disease is thus made more reliable and accurate.

Life History of Disease — Over 20 million patients are admitted to hospitals annually. Chest X-ray examination of all such patients would, not only provide information of immediate importance to the patient but also valuable data for the study of the natural history of many chest diseases. The potentialities of the use of such data in the study of primary cancer of the lung has been demonstrated.

Compensation and Accident Cases — In accident and compensation cases, as in other types of medical practice, negative and positive findings are of equal importance. The availability of a routine roentgenogram provides essential data for the treatment of the patient and in the consideration of compensation claims. Unsuspected traumatic lesions of the chest and adjoining tissues which may not produce immediate symptoms are not infrequently uncovered by admission chest X-ray films.

Trauma to other parts of the body may often be suspected or indicated on the basis of intrathoracic changes. For example, basilar atelectatic foci might reflect injury to intra-abdominal and/or diaphragmatic structures.

Teaching Program in General Hospitals — Survey chest X-ray films provide the members of the house staff with an opportunity to become acquainted with the appearance of the average or "normal" chest film, and provide a check on the physical findings. From such correlations the house staff members learn the limitations of the various forms of examination and the indications for further X-ray investigation. A chest X-ray admission program may help to make the hospital an educational center for detection, diagnosis, treatment and even follow-up of chest diseases.

Routine Hospital Examinations — Chest X-ray screening of hospital patients reveals significant positive abnormalities in 10 to 15% of patients. Granted that the presence of many of these abnormalities is suspected, but the severity or extent of disease and/or reactivation of previous disease is very often unsuspected. The percentage of significant positive findings disclosed by admission chest X-ray examination is greater than that revealed by any other routine hospital laboratory procedure.

Detection of Tuberculosis — The great strides made in the treatment of tuberculosis have given (Continued on page 61)
Gonorrhea in the Female

THE advent of penicillin a few years ago, plus the apparent response of gonorrhea to this drug suggested the possibility of an early end to the disease. Since the patient was quickly rendered non-infectious and the gonococcus subsequently eliminated from the host, time appeared to be the only limiting factor. This, however, has not come about, as evidenced by the current prevalence of gonorrhea in the state. (Figure 1). While many cases are being cured, the drop in total incidence in no way reflects the reduction to be expected in a disease so easily cured, at least in the male. Two possible reasons for this failure are now coming into focus:

FIGURE 1
GONORRHEA
(January thru June)

<table>
<thead>
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<th>Age</th>
<th>1956</th>
<th>1957</th>
</tr>
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<tbody>
<tr>
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<td>49</td>
<td>75</td>
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</tr>
<tr>
<td>Total</td>
<td>241</td>
<td>303</td>
</tr>
</tbody>
</table>

1. Although treatment and its effect was always recognized as one of several factors vital to the control of gonorrhea, treatment schedules were not suspected as being inadequate, especially since it had been proved that treatment with as little as 75,000 to 160,000 units of aqueous penicillin was sufficient to cure almost all cases of acute uncomplicated gonorrhea. Nevertheless, both clinicians and epidemiologists continued to observe many more (apparent) treatment failures among females than among males.

In January 1956, a study was conducted at the Memphis-Shelby County Health Department in which female patients with gonorrhea were treated with an injection of PAM (Penicillin G with 2 per cent aluminum monostearate), 600,000 units, plus an injection of benzathine penicillin G, 1,200,000 units. This schedule was based on the fact that a single injection of 1,200,000 units of benzathine penicillin G was reported to give blood concentrations of penicillin varying from 0.2 units per ml to 0.21 units per ml and no patient in that series failed to show a penicillin blood concentration up to 39 days. Blood levels of this duration were considered adequate to enable a female to overcome an infection, no matter how deeply seated in the paravaginal and cervical glands it might be. In the Memphis study the repeat rate for females reporting to the clinic was 1.7 per cent compared to 15 per cent when treatment schedule for females was 600,000 units of PAM. Other similar reports indicated a significant drop in treatment failures in gonorrhea in the female when this schedule was used.

As emphasized by Pelouze there is a vast difference between a gonorrheal anterior urethritis in the male, and complicated gonorrhea in the female. Dr. Garson relates some of the reasons why a disease caused by the same etiological agent responds so differently to penicillin therapy in the female as compared with the male:

(1) The female anatomical differences allow for much more invadable tissue in many more diverse locations than is to be found in the male.

(2) In practically every instance drainage is poorer from these locations in the female than in the male.

(3) Those regions are not bathed by an additional concentration of penicillin such as occurs in the male urethra.

(4) Cyclic physiological and biochemical changes in the adult female tend to confuse the issue diagnostically, if not actually aiding gonococcus in relation to the effectiveness of treatment.
In consideration of these findings and in accordance with the recommendations of the Venereal Disease Branch of the U.S. Public Health Service, the Nebraska State Health Department has amended its recommended schedules of treatment for gonorrhea as presented below (Figure 2) and penicillin in the amount indicated is replaced by the Health Department upon the submission of a morbidity report, in accordance with Paragraph 4 of the Venereal Disease Fee-for-Treatment Plan, Nebraska State Health Department.

**Figure 2**

**MANAGEMENT OF GONORRHEA**

Treatment, Males—
One intramuscular injection of procaine penicillin G in oil with 2 per cent aluminum monostearate (PAM), 600,000 units, OR benzathine penicillin G, 600,000 units.

Treatment, Females—
For diagnosed cases or sexual contacts to male cases: One intramuscular injection of 600,000 units procaine penicillin G in oil with 2 per cent aluminum monostearate (PAM) plus 1,200,000 units benzathine penicillin G; OR 1,800,000 units PAM as a single dosage of 600,000 units (3 cc) in each buttock.

Treatment, with Complications—
Complications as eye involvement, prostatitis, arthritis, etc. Aqueous penicillin G, 600,000 to 1,200,000 units per day at 2- to 4-hour intervals or equivalent amounts of repository penicillin until signs and symptoms have subsided.

Re-Treatment—
If discharge in uncomplicated gonorrhea persists for 3 days or more after initial treatment and smear or culture still is positive, re-treat with single injection of 1,200,000 units or two injections of 600,000 units on alternate days.

Serological Test for Syphilis (STS)—
Before treatment and monthly for 4 months following treatment.

2. A second reason for the high failure rate of cure of gonorrhea in women and therefore high prevalence rate of gonorrhea generally undoubtedly is the delay between time of infection and time of actual appearance of the patient in the doctor’s office for examination and treatment. This not only permits the disease to become more deeply entrenched, but facilitates her spreading it to others.

Most gonorrhea in women is in a latent or quiescent state at the time of study and even with slight clinical evidence it is frequently attended by a very low degree of suspicion by both patient and doctor. In addition to this, we have no simple or reliable means of obtaining bacteriological evidence of gonorrhea. It is reliably estimated that our best clinical and laboratory techniques fail to detect gonorrhea in women in at least half of the cases. Reference is again made to Pelouze concerning the obtaining of specimens for laboratory verification of gonorrhea in the female:

“Too much confidence in laboratory reports commonly based upon the decidedly poor material so frequently sent for study. (No laboratory report can be better than the material supplied).

Widespread lack of understanding among those obtaining material for spreads for cultures that quiescent gonorrhea is predominantly a disease of the smaller mucous glands whose secretions must be obtained, as a rule, if gonococci are to be found.

Overlooking the fact that in women there are TWO decidedly frequent areas of residual infection (Skene’s and the endocervical glands) and one less common but by no means less important site (Bartholin’s glands).

Slight changes in the far too common methods of obtaining material for study will result in the discovery of countless infections now escaping diagnosis and add immeasurably to the control of the disease.

Surface fluids from the vagina or vulva in the adult, except in the unusual fulminant case, are practically useless for study. Much laboratory time is wasted upon the study of material offering little chance for the detection of gonorrhea.”

In consideration of these factors it becomes clear that most treatment of females can result only from epidemiological investigation of contacts of male volunteer patients. To this can be added, of course, all prophylactic treatment of persons exposed. This involves the vital link which connects the volunteer cases of the private physician to the epidemiological facilities of the Health Department in order to establish a workable program. Misunderstandings have arisen in the past — the doctor feeling that the Health Department attached undue emphasis to epidemiology, and the Health Department feeling that the doctor threw an unreasonable cloak of protective confidence around the patient-doctor relationship. In the meantime, attention is focused on the fact that gonorrhea is increasing rather than decreas-
ing and its field of activity has moved from prostitutes and red-light districts into our public schools and other areas frequented by our own junior citizens.

SUMMARY

Past schedules of penicillin therapy for gonorrhea in the female are considered inadequate, both on basis of therapeutic value and period of time in which a female cannot be reinfected pending treatment of sexual partner.

Gonorrhea in Nebraska has increased in total number of cases with greatest percentage of increase in the teen-age group.

Because of several factors, gonorrhea in the female is a different disease from that observed in the male. Reasons for this difference are mentioned.

Observations by Pelouze concerning the techniques of taking specimens on females for laboratory examination for gonorrhea are quoted.

Epidemiology on volunteer (male) patients is the only means of bringing most infected females (source of infection as well as regular sex partners) to the doctor's office for treatment, either on basis of diagnosis or prophylactically.

The current recommended treatment schedule is presented.

REFERENCES


SCIENTIFIC PROGRAM and

Selected Abstracts*

OMAHA RESEARCH CLUB
Affiliated with the American Federation
for Clinical Research
Annual Fall Meeting
Thursday, November 21st, 1957 — 8:00 p.m.
Creighton Memorial St. Joseph Hospital


2. Left Heart Catheterization. J. Murphy, M.D., Department of Surgery, Creighton University School of Medicine.


INTERMISSION


5. Biossay of Follicle Stimulating Hormone. H. A. Salhanick, M.D., Ph.D., Department of Obstetrics and Gynecology, University of Nebraska, College of Medicine.


Previously, the determination of 5-hydroxyindole acetic acid (5-HIAA) was carried out by colorimetric analysis of the color reaction between 5-HIAA and either nitrosophthol or Ehrlich's reagent. We have recently developed a method of analysis based on the fluorescence emitted by solutions of 5-HIAA at 550 mu when activated by UV light of 300 mu wave length.

The quantity of 5-HIAA determined for a given urine specimen by our fluorometric method is approximately 3 times as great as the quantity determined by the nitrosophthol colorimetric method, and approximately equal to the quantity determined by use of Ehrlich's reagent. However, it has
been our experience to find the method using Ehrlich’s reagent to have a large experimental error.

The method we propose for urinary 5-HIAA utilizes N-butanol extraction while both the colorimetric methods use ether extracts. The use of different solvents may account for much of the difference in results obtained by our method and the nitroso-naphthol method. The procedure we use for fluorometric analysis is considered more specific for 5-HIAA than are the colorimetric methods. Furthermore the fluorometric analysis is less time-consuming and is 5 to 50 times as sensitive as the Ehrlich's and nitroso-naphthol reagent methods respectively.

Factors Influencing the Apparent Ceruloplasmin Activity of Blood. J. D. Stevens, M.D.; Fred L. Humoller, Ph.D.; J. M. Holthaus, M.D., and Frank J. Majka, M.D. (With the technical assistance of Yoshio Matsumoto). Veterans Administration Hospital, Omaha, Nebraska.

Recent reports by Leach and associates, and by Akerfeldt, have called attention to the possible qualitative or quantitative difference in ceruloplasmin in activity of blood obtained from normal individuals and from schizophrenic patients. A study of the factors involved in the Akerfeldt method revealed that the test-system is very sensitive to changes in pH. Optimum activity was obtained at pH 5.8-6.0. At this pH the test is routinely carried out using only 0.2 ml. of plasma. In agreement with Akerfeldt, it was found that —SH compounds, such as albumin and glutathione, inhibit the activity of the plasma amine oxidase system. However, in evaluating the inhibitory influence of any compound one must differentiate between the effect on the enzyme system itself, and the effect upon the detector system. Apparently failure to consider these two effects led Abood et al., to report that ascorbic acid is a strong inhibitor of the plasma oxidase system. In this laboratory no inhibitory effect of ascorbate could be detected.

The results obtained with E.D.T.A. in the present study strongly suggest either that two types of ceruloplasmins exist in the blood or that the copper atoms in this enzyme are held with unequal tenacity. The present study also produced some evidence suggesting the presence of a labile inhibitor to ceruloplasmin activity.

Although some of the findings of Akerfeldt could be substantiated in the present study it is tentatively concluded that a good deal more work will have to be done on the method before any diagnostic significance can be attached to it.

Tuberculosis Abstracts
(Continued from page 57)

us a false sense of security and have resulted in erroneous conclusions. Although the death rate from tuberculosis has fallen precipitously, the case rate in most areas has shown no corresponding or significant change. In the state of Wisconsin, for example, there has been only a slight decrease since the advent of therapy with streptomycin sulfate. Many studies have shown that the yield of tuberculosis among hospital patients is two to eight times greater than that found in mass surveys. Ill patients entering general hospitals are more likely to have more advanced forms of tuberculosis. Tuberculosis is overlooked more frequently in hospital patients over the age of 50 years than in those under the age of 40 years. One authority has emphasized the necessity of examining the aged — the neglected seedbed of the tubercle bacillus.

Diseases Other Than Tuberculosis — Diseases other than tuberculosis are found in 80 to 90% of the patients in whom there are significant positive findings in hospital admission surveys. Many great vessel and cardiac abnormalities are found in hospital chest X-ray surveys. The presence of some or most of these lesions is previously suspected, but in many patients the severity of the condition is underestimated. The number of patients in whom heart disease is detected is at least four times the number of those in whom tuberculosis is found.

Diaphragmatic abnormalities and changes in the lungs due to atelectasis as revealed on admission X-ray films often provide early clues to intraabdominal disease although primary intrathoracic disease may be responsible for the symptoms. When portions of the upper extremities and lower neck are included on admission chest minifilms, it is not unusual for unsuspected lesions in these areas to be detected.

The results of chest X-ray surveys for the detection of curable cancer of the lung have been disappointing. The poor results are not to be attributable to the X-ray method but more to lack of appreciation and delineation of the X-ray signs of early cancer of the lung. Unfortunately, when the X-ray evidence is characteristic, cure is almost impossible.

Attention must be focused on asymptomatic patients if we are to make any significant advance in the treatment of this disease. Surveys yield impressive dividends when abnormal shadows of any kind are suspected of indicating carcinoma in men over the age of 45. X-ray evidence of lung cancer is present in the average case for more than 24 months before the diagnosis is established. It is possible to detect the presence of cancer earlier if our suspicion is aroused by any unexplained pulmonary abnormality.

It is unfortunate that many people believe they can still retain all of their freedoms and have the government pay the way. If we look around the world, it is easy to see what has happened when a government takes over cradle-to-the-grave care and assumes control of industries. The result is bankruptcy and at the present time we are paying the bills of these other governments. If it happens to us, who is left to pay the way for us? Doctors as a group are the hard core of trying to keep the American way of life which is so attractive to other people of the world. Just stop and think how other people pray and try to get into our country, and how few, if any, try to become citizens of countries practicing facism, socialism, and communism. The inroads made along these lines in our country are much greater than many appreciate. Since this is on the march, our only hope is to stem the tide and try and mould the future pattern, but I doubt if we will ever regain what we have lost.

In the fall of 1956, the officers of the Nebraska State Medical Association went to Washington, D.C. for negotiations on Medicare. This is a socialistic program and some wonder why the State Medical Association signed up with the government. This is easily explained. Either we accepted and signed the agreement or the government would have gone ahead, increased hospital facilities and built new armed forces hospitals which would have amounted to millions and millions of dollars of the taxpayers' money. This would have necessitated calling more doctors into the armed services to take care of dependents and would have deprived the dependents of the free choice of physicians and hospitals. By signing a Medicare contract, the dependents could be taken care of in our present hospitals, thus avoiding the spending of untold amounts of money for constructing hospitals. The dependents could have free choice of a physician and avoid calling many additional doctors into the armed forces. However, the element of government control is in the picture and the doctor and hospital are paid directly or indirectly through an agent. Without doubt this latter program is the better one and we must make a success of it or the other plan will be put into operation. We must not fail by ignoring the plan and showing no spirit of cooperation as this will be the surest way to take this segment of our population away from private practice and the American way of medicine with free choice of hospitals and physicians. Of course there must be some restrictions on costs in any such venture, whether it be so-
cialistic or free enterprise. A few can always take advantage, making it embarrassing for many, and this is particularly true when dealing with a government.

The plan of contracts varied with the states and we were one of eight states who chose not to publish the maximum-fee allowance. We submitted what we felt was a good average fee schedule and felt that this would answer most bills submitted by members of our profession. The going fee of the community was urged and any unusual situations could be negotiated. Of course there would be some inadequacies and experience would bring out some weaknesses, but it was hoped these could be corrected at a later conference with the government.

There was some criticism by our profession in Nebraska on the policy of not publishing the schedule of maximum-fee allowances. The Office for Dependents Medical Care has informed members of the Nebraska State Medical Association that our plan resulted in the smoothest operating program and they wished all states had followed this pattern. Now at a recent meeting of the Policy Committee of the Nebraska State Medical Association, the decision was reached that, after a year of the Medicare Program, our members understood the general pattern and the schedule of maximum-fee allowances should be given to each member of our profession. We are negotiating to have this done at government expense rather than at the expense of the Nebraska State Medical Association. This timing pattern we believe will meet the approval of our members. The schedule for maximum-fee allowances will be sent to each member as soon as they are received. We know you will still follow the going fee of your community rather than to adhere to the maximum-fee schedule. If there should be an exception to the rule, great criticism would fall upon the medical profession locally, in the state, and nationally. A hundred right doings will not correct one unfair, unethical act.

It might be interesting for you to know that between December 6, 1956 and December, 1957, there were 321,116 claims paid to physicians, amounting to $23,089,310, and 198,235 claims paid to hospitals, amounting to $20,895,467. In these transactions the dependents had the free choice of their own doctors and hospitals.

Your suggestions, constructive criticism, and relating of adverse experiences are invited. Please address these to the Nebraska State Medical Association so that your committee will have material at hand when the time comes for the second negotiation in the fall of 1958.

R. RUSSELL BEST, M.D.,
President, Nebraska State Medical Association

Meet One of Our NEW MEMBERS

The Nebr. State Medical Assn.

John O. McCarthy, M.D., was born in Council Bluffs, Iowa, on March 27, 1919. His elementary education was obtained in Council Bluffs.

Doctor McCarthy received his degree, Doctor of Medicine, from the University of Nebraska College of Medicine in 1951, after obtaining his premedical education at Creighton University. He interned at Nebraska Methodist Hospital from 1951 to 1952.

After his military service, which consisted of 36 months in the United States Air Force, he served a 3-year residency in Obstetrics and Gynecology at the University of Nebraska Hospital, from 1954 to 1957.

Doctor McCarthy is now associated with John H. George, M.D., in the practice of Obstetrics and Gynecology. He is a part-time teacher at the University of Nebraska College of Medicine.

Doctor and Mrs. McCarthy (Helen Frances) and their son, Edward, reside at 1702 South 32nd Ave.

Doctor McCarthy is a member of the Omaha-Douglas County Medical Society, the American Medical Association, the Omaha-OB-Gyn Society and the Nebraska State OB-Gyn Society.

Address: 401 Center Bldg., 42nd and Center Sts., Omaha, Nebraska.

Current Comment

The Fourth Dose of Salk Vaccine—

Dr. Lewis L. Coriell, Associate Professor of Immunology in Pediatrics, University of Pennsylvania School of Medicine, says all persons who have had three "shots" of Salk vaccine would be provided with greater immunity if a fourth dose was given. He recommends this procedure.
Organization Section

Coming Meetings

CRIPPLED CHILDREN’S CLINICS—
February 15, Norfolk, Norfolk State Hospital
March 1, Scottsbluff, St. Mary Hospital
March 15, Broken Bow, Elks Club
March 29, Ainsworth, Elementary Grade School

MIDWINTER MEETING Board of Councillors of the Nebraska State Medical Association—February 9, 1958, 10:00 a.m., Hotel Cornhusker, Lincoln.

MIDWINTER MEETING House of Delegates of the Nebraska State Medical Association, February 16, 1958, 10:00 a.m., Hotel Cornhusker, Lincoln.

ANNUAL SESSION Nebraska State Medical Association, April 28-May 1, 1958, Hotel Cornhusker, Lincoln.

AMERICAN ACADEMY OF GENERAL PRACTICE—Tenth Annual Scientific Assembly, March 24-27, 1958, Dallas, Texas.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS — 1958 Annual Convention, November 16-20, 1958, Statler Hilton Hotel, Dallas, Texas.

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE — Fifth International Congress, April 24-26, Sheraton Hotel, Philadelphia, Pa.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE—February 9-11, 1958, Palmer House, Chicago.

American Hospital Association and the Forand Bill—

Mr. Elwood N. Thompson, president of the First Trust Company of Lincoln, Nebraska and a member of the Board of Trustees of the Bryan Memorial Hospital, was the author of a recent letter directed to the American Hospital Association and through them to the hospitals of the Nation.

This letter contains stern warning against the Forand Bill or any similar device that destroys the “traditional local autonomy of the hospital and the fee exercise of professional judgment by the physician. . .”

This letter should be read by every physician, but the following paragraphs summarize the most important facts:

“The American people have rejected decisively the concept of compulsory national health insurance and socialized medicine when the issue has been presented to them forthrightly. But, as a nation, we are in grave danger of having such a system fastened on us a bit at a time by such legislation as the Forand Bill. With the Federal restrictions, proper and necessary under a government plan, a comprehensive Federal medical care plan would become inevitable. This is the basic issue.

“The voluntary approach is working and is adequate to solve our health care problems. Why abandon it now?”

President Tol Terrell, American Hospital Association, addressed a letter to the members dated December 2, 1957. This letter states that the Association has been very active for the past three years “in the exploration of the problem of financing hospital care for the retired aged and for possible solutions.” The history of the activities in exploration of this problem is given in brief manner.

Appended to this letter is a “Statement on Financing of the Hospital Needs of the Retired Aged” as approved by the Board of Trustees November 27, 1957. The “summary” of the position taken by the Board is as follows:

1. The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored including methods by which the dangers inherent in the Social Security approach can be avoided.

4. It believes that the use of Social Security to provide the mechanism to assist in
the solution of the problem of financing the hospital needs of the retired aged may be necessary ultimately. However, it believes that every realistic effort should be made to meet these needs promptly through other mechanisms utilizing existing systems of voluntary prepayment.

From these statements it is obvious that the American Hospital Association is not, at the moment, favorable toward the Forand Bill or other legislation having the same philosophy. It is, however, equally obvious that the statements are made with tongue in cheek.

New A.M.A. General Manager—

A realignment of executive duties at the American Medical Association went into effect January 1. Dr. George F. Lull took over the position of assistant to the president. Dr. F. J. L. Blasingame of Wharton, Texas, assumed responsibility for over-all administration with the title of general manager.

Dr. Blasingame has been active in medical affairs, both at the state and national levels, for many years. Since 1949, he has been a member of the A.M.A. Board of Trustees, and in 1955 he served as president of the Texas State Medical Association.

In his new job, Dr. Lull will relieve the president of many of the burdens of that office in addition to serving as secretary of the Association. He will act as a special ambassador of the medical profession in cities and towns throughout the country. Dr. Lull joined the A.M.A. staff in 1946 after serving 34 years in the Army. His last position before Army retirement was as deputy surgeon general.

A.M.A. Prepares New TV Health Films—

The A.M.A. announces that two new 10-minute films will be available about February 1 for use on local television and for showings to school and church groups. “The Silent Killer” deals with the dangers of carbon monoxide poisonings from gasoline exhausts. “Out of Step” tells the dramatic story of an accident which occurs to a child whose father has always ridiculed safety measures, first aid and other so-called “boy scout” ideas. The Scouts, of course, come to the rescue in the end!

Both of these black-and-white sound films are available on loan to medical societies, local television stations (with medical society approval), health departments, voluntary health agencies and schools. Only charge is for return shipping. These films were developed by the Bureau of Health Education and produced by the Marshall Organization. W. W. Bauer, M.D., Bureau director, serves as narrator.

News and Views

From the Sioux City Journal—

Lincoln: The attorney general has held that it is unnecessary for state hospital authorities to secure permission of a patient’s family before treating the patient with insulin or electric shock therapy if he has been admitted on an involuntary basis.

The opinion also stated that a state hospital patient, admitted on his own written application, may be treated as is deemed for his best interests.

However, the opinion stated, this only holds true if the patient is not detained by the hospital superintendent for more than 10 days after he has indicated in writing his desire to leave the hospital, unless a county board of mental health or district court orders the patient to be further detained.

The opinion further said a patient, admitted on an involuntary basis, may not be turned out of a state hospital unless he has been cured.

The opinion was prepared by Clarence S. Beck, attorney general, and Richard H. Williams, assistant attorney general. It was requested by the state board of control on behalf of the Hastings hospital.

From the Seward Independent—

Fifty thousand copies of the December issue “Amerika Illustrated,” official U.S. government publication, are being distributed throughout Russia.

Among the articles is one on Dr. Will Kamprath and his wife, Dr. Coll Kamprath, of Utica—a reprint of a write-up that appeared originally in Redbook magazine.

The text of the story relates how the doctors met in medical school in Omaha, and after their graduation and marriage, estab-
lished a clinic at Utica. Six photographs illustrate the story.

"Amerika Illustrated" is printed in the Russian language and sold for $1.21 per copy and provide Russians with information about this country.

From the Grand Island Independent—

Thirty-one years ago a young doctor who had just finished his internship moved to Palmer and announced that he was starting a practice there. At that time three other doctors were practicing in Palmer.

Today this doctor is still living in Palmer and serving the town and surrounding community. He is Dr. J. Y. Racines.

Dr. Racines is a household name in almost every home in a radius of 30 miles. During his 31 years in Palmer he has been in almost every home in his territory from once to many times.

Since starting his practice Dr. Racines estimates he has brought between 1700 and 2000 babies into the world. He is now bringing in many second generation babies.

From the McCook Gazette—

The staff at St. Catherine's hospital in McCook has announced a forward step in its service to the community.

Dr. Paul E. Hamilton, Jr., Denver, will collaborate with hospital technologists in appraising present laboratory equipment and techniques. He will also act as supervisor and consultant to the laboratory staff. His first visit was in January.

From the Omaha World-Herald—

The first major addition to Omaha's private psychiatric facilities in nearly seven years was dedicated January 5th. On that day the new Richard H. Young Memorial Hospital was opened.

Formerly the Lutheran General Hospital, the structure has been remodeled with emphasis on the latest psychiatric care. It will concentrate on intensive treatment of the mentally ill.

The purpose is to treat psychiatric patients generally in the same manner as surgical and medical patients.

They are cared for at a private hospital by their private doctor, with the hospital stay being cut as short as possible. Between 80 and 85 per cent of the mental patients can be cured or definitely helped, according to Dr. John Aita of the Richard H. Young medical staff.

The new hospital will have no bars on the windows. The first floor will be an "open ward," with patients getting together for social activities as they will do when they are well.

There are small separate kitchens for parties and snacks. Colors are bright and furniture features the latest in design.

From the Gering Courier—

The West Nebraska General hospital has taken steps to provide for future expansion by purchasing a 25-foot lot immediately north of the hospital building.

The hospital board has no immediate plans for construction on the 25x140-foot property, but its long-range planning involves use of the area for an addition.

The proceeds of a $20,000 grant from the Ford Foundation will be applied on the purchase.

Preview of Regimented Medical Care Leaves Bitter Opposition—

It seems there has been sharp restriction in the number of hospitals and doctors that may be employed by mine workers. These restrictions were imposed by the United Mine Workers of America Welfare and Retirement Fund. The rank and file of the union are quite unhappy with these restrictions, and 9000 miners in four southeastern Ohio counties have written to John L. Lewis, national U.M.W. president, calling his attention to the dissatisfaction and asking for a solution to this problem. More such distasteful situations may get the word around that they are only minor examples of what state medicine might be.

Nebraska Society of Internal Medicine Organized—

On November 5, 1957, at the Omaha Club, the following officers were elected for the newly organized "Nebraska Society of Internal Medicine:
President, Henry J. Lehnhoff, Jr., M.D., 720 The Doctors Bldg., Omaha
Vice President, F. Lowell Dunn, M.D., 640 The Doctors Bldg., Omaha
President-Elect, Harold Neu, M.D., 324 City National Bank Bldg., Omaha

The Board of Directors, elected at the same meeting: Doctors Robert S. Long, Charles R. Hankins, Otto A. Wurl, all of Omaha; and Sanford Rathbun of Beatrice and Bowen E. Taylor of Lincoln.

Assistance Rolls Shorter, Price Higher—

From A.M.A. Washington Letter No. 85-45 we learn the following interesting data on assistance:

Fewer people are receiving old age assistance payments, but the total amount spent on O.A.A. continues to rise.

"O.A.A. payments—U.S.-state relief programs—go to men and women past 65 years of age who have not qualified for social security benefits, whose social security payments are inadequate, or who have little or no other income. The steady drop in individuals on O.A.A. is attributed largely to the expansion of social security coverage, which tends to keep more and more families off relief rolls.

"As of last August, Social Security Administration reports this situation: (1) For the first time since 1948 the total of persons on public assistance rolls had dropped below two and one half million . . . (2) During the seven years prior to last August, a total of 2,500,000 persons passed the 65-year mark, but the number receiving O.A.A. declined by 307,000. (3) At the same time, the total paid to O.A.A. recipients increased from $1,132,000,000 to $1,723,000,000. (4) In August assistance payments were made to 167 out of each 1,000 old people, compared with 226 per 1,000 in 1950. . ."

Substantial Addition to Research Grants by N.F.I.F.—

Basil O'Connor, president of the National Foundation for Infantile Paralysis, announced Nov. 8, that his organization has added $1 million to its research allocation for 1958, and that the larger part of this sum will be devoted to basic research.

Among the projects which will be continued and expanded under National Foundation grants are studies of how viruses affix themselves to and invade cells, studies on the composition and structure of viruses, studies of the structure and function of nucleic acid (a key chemical found in all living things), studies of viruses recently discovered whose relationship to disease is still not wholly understood, studies of reasons why certain drugs inhibit virus growth, and studies of the properties of cells which appear to have become malignant as they have been grown in laboratories.

The additional $1 million brings to $4,700,000 the National Foundation's research need for 1958, the largest in the organization's history.

Another National Society Withdraws From Joint Fund-Raising Activities—

Easter Seal societies may no longer participate in any form of joint or federated fund raising as a result of action of the full board of trustees and executive committee of the National Society for Crippled Children and Adults. The announcement was made by Paul Dietrich, Los Angeles, the organization's newly elected president.

The code revision adopted by the Society's governing body also makes mandatory that all Easter Seal groups now affiliated shall withdraw from such affiliation within a reasonable period of time and that in the future they shall participate actively in every Easter Seal campaign in all its phases.

In making the code revision, the board recognized that some of the organization's 1655 affiliates nationwide have derived support from Community Chests for many years and that difficult problems are inherent in bringing about the establishment of full independence in fund raising.

It nevertheless looked for accomplishment of independence at the earliest possible date without damage to the organization's direct care and treatment programs. Pending establishment of full independence, such units may continue to accept income from federated funds provided they conduct a full Easter Seal mail campaign each year and make continuous progress to independent fund raising.

February, 1958
Evaluation of Foreign Graduates and Their Credentials—

Secretary’s Letter No. 421 informs us that, after three years’ planning, the Educational Council for Foreign Medical Graduates has begun to function.

This Council has its offices in the Orrington Hotel in Evanston. It is headed by Dr. Dean F. Smiley and managed by a board of directors. While the Council is quite independent, it is sponsored by four organizations, namely, the A.M.A., the Association of American Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards of the United States.

The Council will undertake to determine:

1. Whether or not a student’s educational credentials meet the minimal standards;
2. The student’s knowledge of English; and
3. The student’s general knowledge of medicine.

Chemical vs. Physiologic Relationship of Drugs—

Because drugs may be related chemically does not warrant assumption that their action in the body will be similar. Carbromal and bromural, examples used by Feinblatt, et al., (J. Nerv. and and Ment. Dis., 125:335, 1957), are related to the barbiturates. While they are excellent sedatives and soporifics they lack, entirely, the habit-forming qualities of the barbiturates.

The Forand Bill—

Rep. John Fogarty, chairman of the House subcommittee that handles appropriations for nearly all U.S. health programs, recently spoke before the Washington chapter of the National Association of Social Workers. During this speech he cited several reasons for his belief that Congress will enact some legislation for the hospitalization of the aged. He gave, as his reasons, that we have growing unemployment which may put pressure on legislators, and that it will be an election year. If this legislation be not the Forand bill, it will be a modification of it. Fogarty also favors increasing monthly social security benefits, reducing the retirement age of both men and women to 60, and making social security payments available to the disabled regardless of age. This goes right down the line with A.F.L.-C.I.O.

Asian Flu Declining; Vaccination Neglected—

Surgeon General Burney said the nation is emerging from the most widespread influenza epidemic in 40 years. There was a steady decline in estimated number of cases to a low of 225,000 the last week in November. Other outbreaks are possible in January-March, and he renewed his appeal to the people to be vaccinated. Lack of demand for vaccine, the surgeon general admitted, has alarmed the manufacturers by the accumulation on the shelves of more than 20 out of the 50 million doses produced.

People, Including Doctors, Are Careless—

N.F.I.P. says: “Only three out of five Americans in the susceptible age group under 40 have had one or more injections of the Salk vaccine . . . This leaves two out of five who are just as vulnerable today to polio paralysis as if there had never been a Salk vaccine.”

Practitioners and Medical Research—

The cause of medical research would be greatly strengthened if more general practitioners conducted clinical investigations and reported their findings according to Dr. Hart Van Riper, Medical Director of a pharmaceutical company, who stated this at a meeting of the Michigan Academy of General Practice.

Dr. Van Riper stated that although there are many professional journals, each with a backlog of papers waiting for publication, too many published papers consist of reviews of previously published articles together with a summary by the author based on inadequate clinical experience.

The general practitioner is said to have the potential of an important role in this respect by studying, analyzing and reporting his clinical experience. These reports would serve a double purpose. First, they would improve the physicians own medical knowledge and thereby the quality of his practice. Second, they would provide clinical material which would contribute to our total fund of knowledge.

Dr. Van Riper cited as an example the opportunities afforded for clinical investigation by new drug developments. For the five-year period, 1952-57, the Food and Drug Administration made effective an average
of 372 new drug applications each year. Each of these applications required clinical trials to establish the utility of the new pharmaceutical agent. Physicians interested in trying new agents have available to them basic data sheets which provide them with all pertinent information concerning the new drug.

WE SEE BY THE NEWSPAPERS
(Continued from page 46)

"Please rest assured of our convictions that the ethical system of distribution (of the vaccine) involving physician, pharmacist and manufacturer is fundamental to the maintenance of public health."

It now appears that, because of the irregularities cited above, equable distribution of vaccine to physicians and thence to patients, with attention to the recommended priorities, became virtually impossible. Perhaps this was of little consequence, but it could be disastrous. One is tempted to believe that the Federal Government or the Public Health Service should have kept firm control of distribution, not only to the states, but within them. This statement sounds like heresy in the light of our indignation when we think the Government is interfering with our rights and privileges, but there are emergencies during which governmental control is necessary.

News From Nebraska Heart Association

Eighteen thousand volunteers will help the Nebraska Heart Association conduct its fight against cardiovascular diseases during the 1958 Heart Fund Drive, Feb. 1-28. Among the volunteers are a number of physicians. State Chairman, Stanley M. Huffman of Ewing, former State Commander of the American Legion, reports that every county and almost 500 communities will be solicited. Two new features of the campaign will be a Heart Business Campaign on Tuesday, Feb. 4 in about 12 major Nebraska cities, including Omaha and Lincoln, and Rural Heart Week personal solicitations Feb. 17-22. Again the major event will be the house-to-house canvass in urban areas on Heart Sunday, Feb. 23. A "kick-off" luncheon for the 1958 Campaign is scheduled for Friday, Jan. 31 at Omaha, with Governor Victor Anderson lighting the symbolic "Torch of Hope." State goal is $225,000, a 10 per cent increase over last year.

Eleven Project Research grants totaling almost $7,000 have been awarded by the Nebraska Heart Association. Dr. C. M. Wilhelmy, Chairman, reports the following awards: Drs. J. Raymond Johnson and Edward Grinnell, $1,000; Dr. Robert L. Grisom, $837; Dr. Gordon E. Gibbs, $900; Dr. William Reedy, $1,000; all new grants. Following were renewed at 50% of amount requested: Dr. Lawrence James, $500; Dr. Violet M. Wilder and Dr. Carol Angle, $400; Dr. C. A. Hamilton, $443; Dr. Léo P. Clements, $500, and Dr. William Angle, $500; Dr. Theodore Hubbard, $500; and Dr. Victor Levine, $375.

The Mid-Winter Scientific Sessions of the Nebraska Heart Association will be held in Lincoln, Saturday, March 15, at the Cornhusker Hotel. Two nationally known specialists will speak on endocarditis and participate in a panel discussion. Six Project Research investigators supported by the Nebraska Heart Fund will report on their studies. At 12 noon the semi-annual session of the Board of Trustees will be held to conduct Heart Association business, followed by a luncheon at 12:30. The newly formed Chapter of Internists are scheduling their organizational luncheon at 12:30 noon and the Scientific Program of the Nebraska College of Physicians begins at 2 p.m. There is no registration fee for the Heart Fund-supported Professional Education Program.

Appointments to four major Nebraska Heart Association Committees have been announced by Dr. Stephen L. Magiera, President.

Public Education—Dr. Richard L. Egan, chairman, Omaha; Dr. Raymond J. Wyrens, Dr. Robert H. Gregg, Dr. Charles M. Root, Dr. John R. Walsh, Miss Violet DuBois, all of Omaha, and Miss Helen Becker, Lincoln.

Professional Education—Dr. William D. Angle, Omaha, chairman; Dr. Otto A. Wurl, Dr. R. J. Fangman, both of Omaha, Dr. L. Smith of Lincoln, Dr. Dan A. Nye of Kearney, Dr. Douglas Campbell of Scottsbluff, Dr. Sanford M. Rathbun of Beatrice, Dr. Charles E. Hranac of Cozad, and Dr. Paul M. Scott of Auburn.

Assistance Requests Policy—Dr. Willis D. Wright, Omaha, chairman; Dr. William J.
Reedy, Dr. William J. Dickerson, and Dr. Robert E. Murphy, all of Omaha.

Medical School Research — Dr. George Loomis, Omaha, chairman; Dr. Jerome P. Murphy, Dr. Robert L. Grissom, Dr. Theodore F. Hubbard, and Dr. Richard L. Egan, all of Omaha.

Cardiac nursing conferences are scheduled in Lincoln on Febr. 6 and in Omaha on March 13, co-sponsored by the Nebraska Heart Association and the Nebraska State Nurses Association. The first regional conference was held at Grand Island on Dec. 5, when about 100 nurses from the Nursing District attended. A conference for Western Nebraska nurses was held at Scottsbluff, Jan. 9. Coronary artery disease is being stressed at all the conferences, which are supported by the Heart Fund.

In the first several weeks of the Nebraska Heart Association's annual membership campaign 250 physicians have already enrolled. Last year's membership of 343 physicians was a 50% increase and made the Heart Association one of the largest medical specialty groups in the state. Dr. Harold Neu, Omaha, Membership Chairman, hopes 500 doctors will join this year. For the first time, a concentrated drive is being made to enroll nurses. Dues are $5 for physicians and $2 for nurses including subscriptions to two publications.

Announcements

Postgraduate Conference at Creighton and St. Joseph's—

The Creighton University School of Medicine will present a Postgraduate Conference at the Creighton Memorial-St. Joseph's Hospital and the School of Medicine on April 8, 9 and 10, 1958. The first day will be devoted to Practical Clinical Hematology with Dr. William Harrington, Associate Professor of Medicine and Director of the Department of Hematology, Washington University School of Medicine, St. Louis, as guest speaker. The second day will be devoted to Rehabilitation Procedure with Dr. Frederick J. Kottke, Professor and Chairman of the Department of Physical Medicine and Rehabilitation, University of Minnesota School of Medicine as guest speaker. On the third day, some new practical office laboratory tests will be demonstrated at the School of Medicine. Emphasis will be placed on demonstrations and active participation of the registrants in procedures of interest to the general practitioner. The number of registrants will be limited to 50 in order to offer instruction to small groups. If interested, communicate with C. M. Wilhelmj, M.D., the Creighton University School of Medicine, Omaha 2, Nebraska.

Postgraduate Course on Fractures and Trauma—

The "Second Annual Postgraduate Course in Fractures and Other Trauma" will be given by the Chicago Committee on Trauma of the American College of Surgeons, Wednesday, April 16, through Saturday the 19th, at the John B. Murphy Memorial Auditorium, 40 East Erie Street, Chicago. The registration fee is $50.

All phases of trauma will be discussed by outstanding teachers from five medical schools, and chiefs of services of leading hospitals in the Chicago area as well as notable guest speakers from other parts of the country.

Clinical Reviews, Mayo Clinic and Foundation, April 14, 15, 16, 1958—

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery.

Up to twenty-one hours of Category I credit may be obtained by American Academy of General Practice members who attend.

There are no fees for this program.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

Postgraduate Conference on Edema—

A postgraduate conference on the subject of edema, its pathogenesis and management, will be held at the University of Colorado Medical Center, Denver, for three days—March 13 through the 15th, 1958. The conference will be devoted to the basic considerations and clinical applications of renal function, edema, and diuresis. It is designed to present in a comprehensive manner the prob-
lems of pathogenesis and management of edema as variously encountered in clinical medicine. Special emphasis will be placed on therapy. Five distinguished guest lecturers will participate in conducting the conference.

For further information and a detailed program, write: The Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

**Human Interest Tales**

Dr. H. D. Wesley, Howells, has been called to active duty with the army.

Dr. S. F. Blattspieler, formerly of Sutherland, has opened his offices in Mullen.

Dr. Donald E. Brewster, Holdrege, recently moved into his new medical offices.

Dr. and Mrs. Charles Brannen, Omaha, are the proud parents of a baby daughter.

Dr. Robert H. Westfall, native of Nebraska City, has joined Dr. R. J. Smith, of Albion.

Dr. John Hartigan, Omaha, has been named to the Omaha-Douglas County Health Board.

Dr. Richard Koefoot, Broken Bow, is the new president of the Custer County Medical Society.

Dr. Kenneth Treptow, formerly of Bassett, is now associated with Dr. A. D. Brown of Central City.

Dr. Frank McClanahan, Neligh, has purchased property which will be remodeled into a medical clinic.

Dr. Leslie Grace, Blair, has been elected president of the Memorial Community Hospital medical staff.

Dr. Robert Takenaga, North Platte, has been elected president of the medical staff of Memorial hospital.

Dr. N. P. McKee, Atkinson, has moved into his newly completed medical offices which were recently remodeled.

Dr. Charles Muffy, Pender, has been elected president of the Five-County Medical Society for the coming year.

Dr. E. J. Sanders, Omaha, has been added as one of the physicians for Creighton University athletic teams.

Dr. J. L. Dyer, North Bend, has been elected president of the Tri-County Medical Society for the coming year.

Dr. Leonard E. Alkire, a native of Lexington, has joined Drs. W. D. Lear and F. H. Shiffermiller of Ainsworth.

Dr. R. L. Cassell, Fairbury, was a guest speaker at a recent meeting of the Medical Careers club of Fairbury high school.

Dr. John R. Schenken, Omaha, was a guest speaker at a recent dinner given by the Lutheran Community Hospital in Norfolk.

Dr. Donald H. Sallenbach, recently released from the service, is making plans to return to his former practice in Gibbon.

Dr. S. M. Rathbun, Beatrice, has been named to the Professional Education Committee of the Nebraska Heart Association.

Dr. F. A. Bulawa, Norfolk, was a guest speaker at a recent meeting of the student body and faculty of Assumption Academy.

Dr. Walter Goehring, Blair, attended a refresher course at the University of Colorado Medical Center in Denver during January.

Dr. J. P. Hahn, Hartington, has left for Teheran, Iran, where he will be physician for the Morrison-Knutson Construction Company.

Dr. John A. Tamisiea, Omaha, attended the Executive Council Meeting of the Aeronautical Medical Association in Pensacola, Florida, in December.

Mrs. Catherine W. Moore, wife of a former Gothenburg physician, Dr. Milan S. Moore, passed away in December in Los Angeles, California.

Dr. G. A. Moorehouse, Benkelman, has received a citation for 10 years of active cooperation in the Dundy county March of Dimes campaign.

Dr. V. S. McDaniel, Sargent, was honored by more than 250 persons at a recent banquet celebrating his twenty years of practice in this community.

Dr. Harold Martin, Omaha, presented a paper at the December meeting of the American Academy for the Advancement of Science in Indianapolis, Indiana.

Dr. W. D. Ketter, Falls City, has announced his retirement from the practice of medicine. Dr. Ketter and his family plan to move to Boulder, Colorado.

New officers for the Lancaster County Medical Society are Drs. Fritz Teal, president; John T. McGreer, president-elect, and Forrest Rose, secretary-treasurer.
The members of the Box Butte County Medical Society were hosts to members of the Box Butte County Bar Association at an informal party in Alliance in December.

Dr. Robert McGowan, alumnus of the University of Nebraska, discussed his work and showed pictures of his work in a mission hospital in West Africa at a recent meeting of the Norfolk Kiwanis Club.

Dr. Michael F. Callaghan, Omaha, has been accepted for a residency in orthopedic surgery at the Mayo Foundation. Dr. Callaghan is a 1957-graduate of Creighton University School of Medicine.

The University of Nebraska College of Medicine has received a $5,000 grant from the Wyeth Laboratories, Inc. The money will be used to equip a laboratory to study diseases of the stomach and intestines.

Dr. Eran O. Burgert, of Omaha, has been appointed to the staff of the Mayo Clinic, in Rochester, Minnesota, as a consultant in pediatrics. From 1948 to 1950 and in 1952 and 1953 Dr. Burgert was a fellow in pediatrics in the Mayo Foundation at Rochester, which is a part of the Graduate School of the University of Minnesota.

BOOKS RECENTLY RECEIVED


Is medicine—by its sponsorship and control of Blue Shield—in the “insurance business?” Let us remember, first, that the medical profession organized these Plans at a time when the insurance industry said it couldn’t be done. And they were right. Adequate medical prepayment couldn’t be organized and offered by an insurance company. It had to be done by medicine, itself, to solve a pressing medical, social, economic problem.

Blue Shield succeeded because America’s doctors were behind it. They accepted less than normal schedules for their services; they agreed to accept pro-rated portions of those fees when the local Plan has been unable to pay the full schedule. Medicine’s leaders have accepted the responsibility for guiding and directing their local Blue Shield Plans—a job that accounts for an incalculable number of unremunerated hours on the part of hundreds of the country’s busiest physicians.

Have the members of our profession accepted these duties and responsibilities in order to put medicine “in the insurance business?” Certainly not! Medicine is in the business of providing medical care—nothing else. The profession has always been concerned with the ways and means by which patients pay for medical care and provide for future medical needs, and the profession quite naturally wants to control the basic economy of medical practice.

Medicine is not in the insurance business. But, through Blue Shield, the profession is in the business of helping patients pay for their doctors’ services. And in the final analysis, the patient, as well as the physician, profits through participation in Blue Shield.

Reminder ... Do You Know—

It is essential that physicians sign Blue Shield reports only for those services that they personally perform.

In those cases where one doctor is associated with another, only the doctor who performs the service should sign the Blue Shield report. Reporting of services not personally performed, or signing of reports for services not personally performed, results in subscriber-patient-Blue Shield confusion and payment may be made to the wrong physician.
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Increased nitrogen loss, with resulting negative nitrogen balance, occurs in infection, trauma, major surgery, extensive burns, certain endocrine disorders and starvation and emaciation syndromes. The intrinsic control of protein metabolism is lost and a protein “catabolic state” occurs. A patient requiring more than ten days of bedrest usually has had sufficient metabolic insult to precipitate such a “catabolic” phase.

Nilevar (brand of norethandrolone) has been used in patients with varied conditions including hyperthyroidism, poliomyelitis, aplastic anemia, glomerulonephritis, anorexia nervosa and postoperative protein depletion. The patients gained weight and felt better. It was concluded that “the drug certainly caused a reversal of rather recalcitrant or progressive catabolic patterns of disease.”

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent.

The suggested adult dosage is three to five tablets (30 to 50 mg.) daily. For children 1.5 mg. per kilogram of weight is recommended.


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Current Comment

Socialism and Medicine—
From the first issue of Challenge to Socialism we glean the following choice gems of political understanding:

While the Second session of the 85th Congress meets under the shadow of Red Sputniks and will be outwardly occupied with sputniks, defense, elections in the offing, and the battle of the budget, the same forces of Socialism will be at work... below these more spectacular manifestations of political activity in the Capitol, there is the same old propaganda for more Socialism here and abroad...” Our national apprehensions will be the present goad to Federal aid to education, Federal compulsory social security medicine, and the expansion of the Welfare programs.

We are reminded that Freedom’s fight is an individual job. Organizations do not vote but individuals do. We must let our Congressmen know by personal communication that we are opposed to further socialism in any form. In this connection the Challenge has the following to say:

“Federal officials, members of Congress, organized labor, and even a segment of the medical profession itself are currently determined to initiate a program of national compulsory health insurance and to force physicians into Social Security.”

It is pointed out that, contrary to the expectations of Congress, social security taxes have become insufficient to cover a pay-as-you-go operation. It is going to be necessary to dig into the non-existent “Trust” fund. The only way this can be remedied is to increase the tax. This can be accomplished in several ways. One way is to increase the rate, and another is to increase the tax-base. Under the Forand Bill the rate is fixed to rise to 7½ per cent by 1975 and the base to $6,000. In case these raises are made, the self-employed will pay a tax of $427.50 in 1975 as compared with $267.75 under the present law.

As this Session of the 85th Congress goes to work, it is more important than ever that freedom-loving doctors keep in close touch with all legislation which may endanger their freedom, study to understand it, and to communicate individual opinions to your Congressmen.
new for angina

CARTRAX

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In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inexorably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX “10” tablets (10 mg. PETN plus 10 mg. ATARAX) 5 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX “20” tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write “CARTRAX 10” or “CARTRAX 20.” In bottles of 100. CARTRAX should be taken 30 to 60 minutes before meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

“Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem.”


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Current Comment
And We Worry About Polypharmacy—

The following extracts from the record of a case reported before the Fifteenth Annual Session of the Nebraska State Medical Society, in May, 1883, contrasts vividly with the present practice of the art and science. We wonder how much different our procedures and medicaments may be in A.D. 2033.

"October 14, 1882, ......., aged 62, of temperate habits and by heredity of good constitution, requested me to examine his hand, and said that for two or three weeks he had suffered from bad blood as shown by numerous boils on various parts of his body for which he had taken molasses, sulphur and cream of tartar. He thought he had a chill on the previous day, and for several days had suffered from general malaise. Upon the back of the left hand were two or three hard, circumscribed swellings of unhealthy appearance and quite painful. I ordered Sul. of Cinchonidia every three hours, F. E. Sarsparilla Co., and Syr. of Iodide of Iron after each meal; also a bread and milk poultice saturated with equal parts of Tr. of Aconite Root and Tr. of Opium, constantly applied to the tender swellings. October 16, 8 a.m., I was sent for, and told by the patient that he was no better... the poultices were continued and to the internal remedies, an anodyne of Hyd. of Chloral, Brom. Potassium, Tr. of Aconite root and F. E. of Belladonna was directed every two hours... At 10 p.m., a messenger came for me hurriedly saying 'Mr. ......... is worse,' On arriving at the bedside of my patient, found him suffering severe pain in the region of the bladder, and making strenuous but unavailing efforts to pass water...

"Thinking my patient was suffering from retention caused by an enlarged prostate, I introduced the catheter, but only succeeded in getting a drachm or two of bloody fluid...

"The indications to relieve pain, secure action of the skin, kidneys and bowels were clear, and he took Res. of Phodophyllin and Fl. Ext. of Belladonna, drank freely of hot teas, and externally applied hot poultices. The pain increased in severity, small doses of Morphia were given, but seemed to afford no relief... (consultation was had and the

(Continued on page 47-A)
Why wine in Cardiology?

For generations without number wine has been extolled as an "effective stimulant" and, therefore, valuable aid to treatment in various types of cardiovascular disease. It was this peculiar property, no doubt, which prompted the poet, Salerno, some 800 years ago to write—"Sound wine revives in age the heart of youth."

Now, as a result of modern research, we are obtaining concrete evidence of the favorable physiologic action of wine to lend support to the empiricism of ancient usage.

Both brandy and wine in moderate quantities have been found to substantially increase the pulse rate and step up the stroke volume of the heart.

Wine has been found to aid drug therapy in relieving the pain of angina pectoris and obliterative vascular disease.

Moreover, aside from the purely hypotensive actions of wine, its unquestionable euphoric effects help counter the depression, apprehension and anxiety so frequently present in sufferers from heart and coronary disorders.

The beneficial actions of wine appear to transcend those of more concentrated alcoholic beverages—valuable cardiotonic properties having been attributed to the aliphatic aldehydes and other nonalcoholic compounds recently isolated from certain wines and grape varieties.

It goes without saying that the use of alcohol, even in the form of wine, is contraindicated in hypertension accompanied by certain types of renal disease.

For a discussion of the many modern Rx uses for wine, write for the brochure, "Uses of Wine in Medical Practice" to Wine Advisory Board, 717 Market Street, San Francisco 3, California.
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Current Comment

And We Worry About Polypharmacy!—
(Continued from page 40-A)

patient made his will). After examination, we were all of the opinion that our patient would recover, and gave in addition to the above treatment, Fl. Ext. of Buchu, Uva Ursae, Acetate of Potassium, and Spts. of Mindererus, every three hours..."

With ups and downs, the patient finally recovered but not before a further variety of medicaments were administered. As one contemplates the multiplicity of drugs used, usually a new one being given "in addition to the above treatment," he is awed by the resistance of the human constitution, yet the lists of medicines seen on some of our hospital charts differs not so much in number as in supposed proficiency and certainly, in cost.

More Women Than Men—

Each year over 200,000 more men than women die in this country. As a result there are 7,700,000 widows in our population and the number is expected to rise sharply in the years ahead. These figures according to Health Information Foundation suggest a challenge to medical science to find an answer to this question before American males, especially at age 45 and beyond, become in effect an underprivileged segment of the population.

Last year the death rate for males was 9.6 per thousand, a rate more than 50 per cent higher than that for females. This gap has been widening steadily since 1900, except the years following the influenza epidemic of 1918.

The imbalance between male and female deaths is itself partly the result of medical progress. In countries where standards of living and medical care are low, the Foundation noted, there has been an excess female mortality until recently, partly because of the hazards attending childbirth. In this country female mortality in childbirth has fallen from 20,000 lives in 1900 to just 1600 in 1956. In the past half century, the degenerating diseases have replaced communicable illnesses as the leading causes of death. The degenerating diseases are more of a
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a psychotropic agent with specific advantages
Current Comment

More Women Than Men—
(Continued from page 47-A)

threat to men than to women. Accidents are another major cause of excess male deaths despite a marked decline in their rate of frequency since 1900. At ages 20-24, for example, male mortality from accidents is 500 per cent higher than for female.

Paradoxically, although women live longer than men, they appear to have more illness. In any event, they see the doctor more frequently.

The result on the structure of our population is to cause among persons age 65 and over an excess of 1 million women in this country. If this trend continues, by 1975, the excess will have risen to 3 1/2 million. There is no simple explanation of why women live longer than men and that is the challenge to medical science.

Health Insurance Rates Increase—

The increase in health insurance premiums was recently noted by the Wall Street Journal. It appears that all insurance rates are climbing higher and higher. Various reasons are given, such as increasing hospital costs and increasing administrative costs of the insurance companies which provide insurance against the cost of illness. The Associated Hospital Service of New York has just recently presented its case for a 40 per cent increase in its rates.

A factor is that there are newer and costlier services being given now that were unknown some years ago, such as heart surgery. Abuses in the utilization of insurance benefits has also been mentioned as one of the reasons for the increasing cost of this type of insurance. Abuses mentioned were unnecessary hospitalization and lengthy stays for patients who for some reason or another did not want to be released.

Health insurance is becoming of increasing importance to our population because it is estimated that more than 70 million people at the end of 1957 were covered by hospital expense insurance underwritten by some 700 insurance companies. On the average someone becomes a hospital patient every 1.5 seconds or 57,000 persons each day.

(Continued on page 51-A)

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Current Comment

Health Insurance Rates Increase—
(Continued from page 49-A)

Of the 21 million persons annually admitted to hospitals, 8.6 million patients will have a substantial portion of their hospital bills financed by hospital insurance issued by insurance companies.

This pattern of increasing insurance coverage, is important in several respects. It represents an important source of hospital income and contributes to the stability of the hospital’s financial picture.

The Health Insurance Council, an organization representing the insurance companies of the United States which carries more than 90 per cent of the health insurance, plans to initiate a new series of information bulletins to hospital administrators in order that administrators may be apprised by the developments in Health Insurance coverage.

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<td>30-102</td>
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Current Comment

Ford Foundation Grants—

The Ford Foundation made new grants and appropriations totaling $83 million for education and other programs during its fiscal year, according to the 1957 annual report.

Actions during 1957 brought to more than $1 billion the Foundation’s grants and appropriations since it was established in 1936. The largest single grant was $24.5 million to expand nationally the Woodrow Wilson fellowship program to combat the shortage of college teachers.

Henry T. Heald, completing his first year as president of the Foundation, says in the report that “the cornerstone of the Foundation’s philosophy and program is the belief that through education society can realize its fullest potential for material abundance, intellectual enlightenment, and moral growth. Mr. Heald cited as pressures on higher education the larger number seeking education, the demand for more years of education, the expanding fund of knowledge, and the United States’ role as leader of the free world.

During the year the Foundation completed three programs by final payments from the special 1955 and 1956 appropriations, of $500 million. These were $260 million for college-faculty salaries, $200 million for extension of services in private, voluntary hospitals, and $90 million for improvement of instruction in forty-five privately controlled medical schools.

This report states that the purpose of the Ford Foundation is to serve society and, by extension, to advance human welfare, but concludes that no foundation or combination of foundations can solve the complex problems and plaguing needs of mankind. “The most a foundation can do is make a start, or indicate a route, or call attention to an idea. If the direction is right and the method sound, if a solution seems possible, then the people themselves — individually or collectively through their voluntary agencies or governments — will finish the job.”

(Continued on page 35-A)
Current Comment
Ford Foundation Grants—
(Continued from page 4-A)

The magnitude of this Foundation is indicated by its reported income in 1957 of $102,908,434 of which $86,717,324 was dividends from its Ford Motor Company stock. At the end of the fiscal year 1957, the net worth of the Foundation was reported at $549,397,635. This included $325,190,151 represented by 36,132,239 shares of Ford Motor Company Class A stock carried on the Foundation’s books of account at $9 a share. The net worth of the Foundation could be appraised at a higher figure if this stock, for which there is no quoted market, were assigned the market value of $50,375 a share at which Ford common stock closed on the New York Stock Exchange on September 30, 1957. The Foundation’s Class A stock would then have an assumed market valuation of $1,820,161,539. The balance of the Foundation’s investment portfolio consisted of United States Government securities and other bonds and notes.

Grants and appropriations totaling $32 million were directed primarily at the oncoming educational crisis in accommodating mounting school and college enrollments. The grant of $24.5 million to the Woodrow Wilson National Fellowship Foundation established on a nationwide basis its program for attracting able students into college teaching careers. The Fellowship Foundation, operating independently of the Ford Foundation, will award 1,000 graduate fellowships a year for the next five years. Colleges and universities where the fellows enroll will receive grants for graduate instruction. The program will also seek, through the direct participation of faculty members, to identify potential teachers on 1,000 or more college campuses.

Another independent organization, Educational Facilities Laboratories, was established, and will be supported for five years with an appropriation of $4.5 million. The Laboratories will support research and experimentation leading to improvements in the construction of school and college buildings. For completion of a program to improve secondary-school instruction in physics, the Massachusetts Institute of Technology was granted $500,000. Grants to assist educational television totaled $448,050.

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EDITORIAL

FORAND BILL* (Guest Editorial)

H.R. 9467 was introduced into the last session of Congress by Rep. Aime Forand (Dem., R.I.). It represents the second major extension of the compulsory Social Security, an act which forms the foundation of the Welfare State, U.S.A. The first extension was H.R. 7225 which makes disabled persons past 50 years of age eligible for Federal Social Security benefits.

The Forand bill provides for hospitalization and specified surgical benefits, if the surgical services are performed by a Board-certified surgeon or a member of the College of Surgeons. (A nice built-in method of creating a schism in the medical profession).

About 13,000,000 Americans will be eligible for its benefits and it will be financed by all persons who are now on the Social Security rolls, with the employees and the employer each paying an additional 2 to 3 per cent tax. Thus, the total social security contribution will be about 91½ per cent of the earned income subject to social security tax. It also provides an increase of this earned income subject to social security tax from $4,200 to $6,000 per year.

If this bill should become law, socialism in the United States will be assured because it is estimated that within 25 years, 30 to 40,000,000 Americans will be dependent upon the government for their health care and practically all persons will receive Social Security checks. The Marxian philosophy of individual dependence upon the central government will have been adopted through the democratic processes of a Republic. No wonder Khrushchev recently stated that war and revolution were no longer necessary to achieve the objective of Communism.

Organized medicine has much more at stake than the fear of professional regimentation under socialized medicine. Organized medicine must fear the ravages of all of the evils of socialism in a totalitarian state.

*Reprinted by permission from The Bulletin of the Omaha-Douglas County Medical Society.

The medical profession represents an informed group of professional persons who not only know that health care under a regimented system of government control soon deteriorates into an impersonal, unsympathetic trade-like service, but it also knows as a body of responsible citizens, that the passage of the Forand bill would mean the destruction of the last vestige of individual responsibility. By this I mean that our enormous inheritance tax places in the hands of the government the right to distribute a substantial part of our personal lifetime earnings to those in whom we have no personal interest or who do not deserve such a gratuity; our confiscatory income tax destroys any possibility of accumulating enough wealth which could be used as risk capital, the means by which this nation has developed the highest standard of living of any nation in the world; and now the proposed expanded social security act will soon make the government largely responsible for the health care of this nation, as well as the custodian of the “savings” program for all of its citizens, a program which, because of its compulsory nature, is based on the thesis that Americans are incapable of taking care of themselves.

What To Do? Organized medicine has done poorly in the national political ring. It has won only one major national political battle, the defeat of the Wagner-Murray-Dingell Bill in 1948. It immediately broke training after that victory and has not won a bout since. The worst defeat was the acceptance of the principle that Health, Education, and Welfare are close relatives and should be combined under one cabinet post. Oscar Ewing could not have done it better because all one needs to create a welfare state is control of education and health; Bismarck, Lloyd George, and Lenin all proved that.

We must revitalize the force which was mobilized to defeat the Wagner-Murray-Dingell Bill. We must join forces with enlightened groups such as the U.S. Chamber of Commerce and our numerous voluntary insurance carriers in the United States. We must tell the American people that they are
selling their birthright for a mess of pottage. And, finally and most important of all, we must make an all-out effort to analyze the health needs of the aging in order to provide on a voluntary but individual basis for the deficiencies which are present.

J. R. Schencken, M.D.,
Omaha, Nebraska.

MASS COMMUNICATION AND
THE DOCTOR

The practicing physician is often caught between the upper and nether milestones of “mass communications.” Newspapers, magazines, radio, and television, not to mention the various brochures from foundations for one or another disease, carry bits of medical information to the public daily and nightly. Some of this information is truth, some is untruth; some is premature, some passe; some stand the test of time, some is proved to have been wrong. Much of it falls on ears that hear without understanding.

In the February, 1958, issue of Reader’s Digest there is an article by Albert Q. Maisel entitled “What’s the Truth About Danger in X Rays.” Mr. Maisel seeks to quiet the jitters of those who have read or heard about the horrible things that may happen to the future offspring of people whose gonads receive more than a certain dosage of X radiation during the first thirty years of life. Last November the Public Health Service released information on this subject, and the newspapers made drama of this information. Between copy writers, headliners, and the readers there was abundant opportunity to draw wrong conclusions based upon scanty, inaccurate, or incomplete information, and that is what some readers did. Some went all the way and decided that all X ray is bad and that they would have none of it. Mr. Maisel’s article, published to pour oil on the troubled waters, is a good one. The author knows whereof he writes and expresses the present position of those who know most about this subject. This article is, however, a fine example of what should be unnecessary.

It is not only in this instance but in many fields that scraps of misinformation, bits of uncorrelated truths, and information not yet proved to be true, reach the public. Much of this is material for which the public is not fitted by nature or by training to translate into reasonable action, yet it flows freely by way of present-day rapid and abundant communication.

There are other features of mass communications that merit criticism. We have fostered the development of “well trained” science writers. If all science writers were well trained and conscientious we would have far less to criticize. All of them can not be so classified, and, to some of them a catchy new idea in medicine, especially one that may be given a glamorous or dramatic punch, probably means a “quick buck,” and a dollar is a dollar.

It has seemed a bit strange to the writer that so often the science writer knows and writes about a new product being developed in some laboratory or by one of the pharmaceutical companies long before the doctor has the information. We read in a newspaper or magazine about an item months before it appears in our literature, on our desks, or on the shelves of our pharmacy. We are compelled to answer questions propounded by our patients about products that have scarcely reached the stage of clinical trial. Could one suspect that such premature statements build up a prefabricated market for these items?

It has, also, seemed more than a coincidence, because it has happened so often, that a science writer bases an article for the public press on one that appears almost simultaneously in a leading medical journal. The short interval between the two raises a suspicion that the science writer had access to the material before it was published in the medical press. Perhaps there is justification for giving the science writer a preview of articles to be published, but such practice, if permitted, could become quite troublesome.

Many aspects of the subject of mass communications might be analyzed. This editorial does not concern the white-coated individual who pops up on the television screen to answer the question “but what do doctors do?” nor the misuse of medical and surgical trappings in general to dramatize or glamorize an otherwise dull television program. It is not to be presumed that mass communication relating to medical subjects is all bad. It is wished only to call attention to some of the bad features, those that could be controlled and corrected. Much good can and does result from proper use of these media in relation to medicine.

74 Nebraska S. M. J.
Management of the Burned Patient

II. TREATMENT OF THE BURN-WOUND

In this, the second of two papers on care of the burned patient by these authors, attention is focused upon the surgical management—the care of the wound. General care of the patient, so thoroughly discussed in the first article, is mentioned only as it applies particularly to healing, to control of infection, and to success of operative procedures such as skin-grafting and reconstructive surgery.

The major concern of the physician treating burns is the control of infection. Also of prime importance are early skin coverage, prevention or minimization of contractures, preservation of skeletal function, and maintenance of nutrition.

The attainment of rapid healing of a burn-wound, with or without grafting, is the ultimate aim of the physician. This necessarily implies the conversion of an open wound to a closed wound. In order to accomplish this, infection must be prevented or minimized.

As mentioned in "Initial Care of the Patient," (Nebraska M.J., 42:491, Oct., 1957), there are two methods of choice in treatment of the burn-wound: (1) the open or exposure technique, and (2) the closed or pressure dressing technique. Each of these methods has its advantages and disadvantages. They are closely related and even interchangeable, with a combination frequently being employed. The purpose of this paper is to review these techniques. Also to be discussed will be the basic principles in grafting of burn-wounds, and the management of the major problems (as related to the wounds) encountered in treating burns.

EXPOSURE METHOD

The quickest and most certain method of "closing" a burn-wound is to allow the surface plasma-exudate to clot. Once this occurs the wound becomes closed, irrespective of whether or not a dressing is applied. A dressing by itself never closes a wound completely. The plasma-crust (eschar) is a biological cover or dressing, second in value only to skin. It is, for practical purposes, an all-sufficient dressing until healing is completed. Organisms found on or in the crust do no harm. The absence of moisture, warmth, and darkness, discourages the growth of pathogenic bacteria. The early formation of an eschar is of paramount importance, because it protects the wound against the entrance of pathogenic organisms, provides a framework or scaffold for young epithelium, and, in deep burns, presents a barrier to the loss of protein, salts, and red blood cells. It is, therefore, important to do nothing either to delay the formation of the eschar or to disturb its integrity, unless infection or cracking develop.

It is unfortunate that the human body has had so little opportunity to demonstrate its own capabilities in the healing of burn-wounds. Local medicaments have been used varying from antiseptic solutions to tanning solutions, to all types of ointments. These have only contributed to raw surfaces further irritated, or kept moist and soggy, with a subsequent favorable medium for microorganisms.

If a burn-wound is properly exposed, positioned, and immobilized, eschar formation will proceed as nature intended. The exudate of a partial-thickness burn dries in 48 to 72 hours. Beneath this crust, epithelial regeneration proceeds and is usually complete in 14 to 21 days. Superficial second degree burns usually are healed by 14 days, whereas the deeper second degree burns often will take 21 days. In a third degree, or full-thickness burn, there is dehydration of the pearly white, or charred dead skin. This "skin" is converted to a protective eschar in the same period of time as in partial-thickness burns. Liquidation occurs in 14 to 21 days beneath this eschar. If there is doubt as to the depth of the burn, periodic observation of the eschar is often quite helpful. In superficial second degree burns the periphery of the eschar will begin to curl as re-epithelization takes place beneath. In deep second degree burns this curling or separation is seen somewhat later than in the more superficial burn, complete re-epithelization taking longer. In third degree burn-wounds

CARLYLE E. WILSON, M.D., and SAMUEL A. SWENSON, JR., M.D.
Omaha, Nebraska
the eschar never curls or loosens in this manner, but remains level with, or contract?
ed below the surrounding normal skin.

Minor burns of first degree character, or localized small second degree burns, may be
treated on an out-patient basis. Patients having burns of greater magnitude, possible
respiratory tract burns, and electrical burns, should be hospitalized.

Transportation of the burned patient to the hospital may be accomplished best by
covering the patient with a clean sheet, and administering a small dose (1/6 gr.) of mor-
phine intravenously. If more than a half-hour trip will be necessary, a larger dose of
morphine plus a plasma-volume expander, or lactated Ringer’s solution (Hartmann’s),
should be given. The United States Army and United States Air Force Medical Corps
have been very successful in transporting patients by air several hundred miles with-
out harmful effects, providing the above pre-
liminary treatment is carried out. It is re-
commended that after 24 hours patients not
be transported any great distance, because
they do not tolerate it nearly as well as dur-
ing the first day.

Upon admission to the hospital the pa-
tient is taken directly to surgery where all
personnel, including the patient, are capped
and masked. All of the patient’s remaining
clothing is removed and the burn-wound
thoroughly inspected under good light. Gen-
eral measures (as described in Part I) are
undertaken. All loose epithelium is sharply
derided. In the majority of instances,
cleansing with sterile cotton balls soaked in
warm Dial soap or Septisol solution usually
suffices. If there is very much grease or
oil, a detergent solution may be necessary.
Following completion of this phase, the
burn-wounds are thoroughly rinsed or irri-
gated with warm sterile saline. The burn-

wound is then softly dried with sterile ab-
sorbent gauze, and the patient transported
back to his room in a bed with clean sheets.
No anesthetic is necessary. If pain is pres-
ent, intravenous morphine will usually be
sufficient.

Most patients prefer to remain completely
exposed. Portions of clothing may be util-
ized, dependent upon the particular areas in-
volved. A clean sheet is draped over the
patient and supported by an overhead rod
running down the middle of the bed. It is
best to keep the patient in a private room
until the eschar has formed. He may then
be moved into a ward-type room. The tem-
perature should be normal hospital room
temperature, with care to avoid any drafts.

If the burn is of circumferential nature
involving the trunk, it is preferable to em-
ploy the closed method (this technique
will be described later). Some men, however, re-
port successful results in this type of burn
using a Stryker frame, turning the patient
every two or three hours, thus allowing a
slower eschar formation. If so desired, but
dependent on other areas involved, the pa-
tient can be placed either on his back or on
his abdomen, lying on vaseline gauze, with
heavy absorbent gauze between the latter
and the bed. The only other possible area
of burn that might best be dressed, is the
hand. It is here that a combination of
closed and open techniques may be employed.
One of the main problems in hand-burns is
edema. This phase lasts approximately 48
hours. It is a well established principle
that prolonged immobilization of hands and
fingers, particularly where edema is present,
will result in varying degrees of permanent-
ly impaired skeletal function. The chief fac-
tor seems to be the edema fluid itself, which,
if allowed to remain and be absorbed slow-
ly, contributes to the development of fibrotic
tissue. This is seen especially around the
joints and tendon sheaths. If carefully ap-
plied pressure dressings are used for a period
of 48 to 72 hours post-burn, the initial period
of edema is minimized considerably. Fol-
lowing removal of the pressure dressing an
eschar is allowed to develop. During this
time, and until complete healing is attained,
the hands and fingers may be exercised both
actively and passively, thus reducing any
residual edema and tendency towards stiff-
ness. Also of prime importance is the op-
portunity to observe frequently and carefully
the exact nature and depth of the burn-
wound. Burns of the dorsum of the hand
received first priority in skin grafting. The
advantage of exposure of hand burns is
therefore obvious. Circumferential burns of
the extremities, both upper and lower, may
be adequately and efficiently exposed by
means of various types of traction, depend-
ent upon the exact areas involved. Both
skeletal traction and extremity- traction
through supportive dressings or slings may
be employed. Again, this affords the patient
the opportunity to exercise important joints.
In the case of burns of hand or upper extremity, of circumferential nature, some men have reported the successful use of fingernail traction. In this technique, steel or heavy silk sutures are passed through the ends of the fingernails, centralized, and incorporated in a pulley-traction arrangement. This has been used effectively in small children. In lower extremity burns, both Kirschner and Steinman pins have been passed through various points, including the os calcis and anterior tibial plateau, for suspension in a skeletal traction arrangement. In small children, burns of the legs, thighs, and perineal areas may be effectively elevated and exposed by a traction device similar to that used in fractures of the femur.

Burns of the face, neck, buttocks, and perineal regions should rarely, if ever, be closed. The nursing of these areas when pressure dressings have been applied becomes quite difficult, and complications may develop before prophylactic measures can be instituted. Facial and neck burns should be treated with the bed elevated, to reduce edema. The eyelids, nose, lips, and external auditory canals are lightly smeared with sterile vaseline. Discharges are frequently and gently removed from eyes, nose, and ears. After a few hours the eyelids close due to edema, but will be open again in 72 hours to 96 hours. A burned neck should be hyperextended by placing supports under the shoulders. If there is evidence of tracheal edema, as the result of inhalation of hot fumes, tracheotomy may easily and quickly be carried out on the exposed neck.

The crust that forms during exposure may be heaped up here and there as a result of continually escaping serum. These areas should be removed daily in order to give free exit for any hidden pockets of serum. In addition, if the crusts become cracked, particularly over joints, a portion of the eschar should be sharply debrided to prevent constant irritation and infection. These open areas then may be dressed with a thin layer of fine mesh gauze, and sprayed frequently during the day with sterile saline solution. It is particularly important in circumferential burns of the fingers to observe frequently and carefully for any possibility of encircling bands that might result in ischemia. Release of the constricting band by incision of the eschar can be accomplished easily and quickly without anesthesia. If at any time areas of the crust or eschar become softened and appear to bulge, they should be suspected of hiding pus. When this occurs, the bulging eschar should be removed by sharp dissection, and the defect covered by fine mesh gauze. This should be sprayed, frequently, with sterile saline solution with or without an added antibiotic. Insofar as possible, the eschar should be allowed to remain intact and dry until natural separation occurs. This insures against early debridement of deep second degree burns and inadvertent removal of remaining islets of epithelium that would regenerate without the necessity of grafting. Occasionally three to four weeks of observation may be necessary before definitive debridement should be attempted.

Following natural or mechanical separation and removal of the eschar, if complete re-epithelialization has not taken place (except for very small isolated areas), skin grafting should be carried out.

On occasions, a patient will arrive at the hospital with burns already dressed in vaseline pressure bandages. The patient should be taken to surgery at the earliest practical time for removal of the dressings. Following complete inspection of the burn-wounds, decision may be made as to whether or not the entire burn should be exposed, the closed technique re instituted, a combined technique employed, or, if infection is present, the use of moist dressings or whirl-pool therapy. Old granulating burn-wounds should never be exposed.

**CLOSED METHOD**

The initial care of burn-wounds, where the closed or vaseline-pressure-dressing technique is to be employed, is exactly the same as described above in the exposure method. After the burn-wounds have been thoroughly dried, single layer strips of lightly impregnated vaseline fine-mesh gauze are laid over the wounds. These strips are never long enough to completely encircle an extremity, so as to produce later constriction. It is especially important to dress fingers separately and with the hand then immobilized by dressings in the position of function. The second layer is of bulky absorbent roller-gauze. It is this layer that will provide, besides its absorbent function, adequate even pressure. The third layer is the compressive dressing, usually stockinette cut on the bias, or an elastic-type bandage. The patient is
then returned to his room where he is properly positioned in bed. If extremities are involved they should be elevated and supported.

Needless to say, these dressings must be applied in the strictest sterile technique. Infection, as previously discussed, is more likely to develop in burn-wounds which are dressed as contrasted with those exposed. It is important, therefore, to keep this in mind during the dressing procedure. The dressings are usually removed at the end of one week. At this time, re-evaluation of the burn-wounds may be carried out, both as to depth and extent. If the burn-wounds are superficial second degree, they may often be exposed at this time. If they are deeper second degree, or possible third degree, they should be dressed in exactly the same manner as the first dressing. The second dressing-procedure usually takes place at the end of 14 days (post-burn) and again, in the operating room under sterile conditions. Usually, at this time, second degree burns will be healed if infection has not developed. Third degree burns, of course, will be open wounds and grafting will be necessary. Dressings, otherwise, should be changed whenever they become wet (wound drainage) and malodorous.

**COMPARISON OF THE OPEN AND CLOSED METHODS**

In comparing these methods it must be re-emphasized that either the open or closed method, if properly employed, will give satisfactory results in superficial burns. In deep burns the open method will usually give the better results. Frequently it is necessary to employ both techniques in deep burns in order to accomplish a satisfactory end result.

In attempting to compare the methods, Holman and his associates used the experimental laboratory for their studies. They found in controlled burns on animals, studied histologically, that the ratio of epithelialization in the open method compared to that in the closed method was 1.8 to 1.0. The average healing time was 21 days in the open method, as compared to 39 days in the closed method.

From the clinical standpoint, several large series of comparative studies have been carried out. Probably the most widely recognized are those of the U.S.S. Bennington disaster in 1954, studied by U.S. Naval Surgeons; the Cleveland Hill School fire victims of 1954, as reported by Schenk and associates; the Korean “Conflict” burn-casualties studied by United States Army Surgeons; and observations in burn-centers such as United States Army Hospital at Brooke Army Medical Center, San Antonio, Texas, and Blocker's burn-center at the University of Texas at Houston.

The most important advantage, found in these studies, of the exposure or open method over the closed or pressure dressing method, is that there is less infection. In superficial burns there should be no infection when either method is properly employed. In deeper burns, infection is more frequently seen in the wound that has been dressed than in the wound that has been exposed. One simple experiment illustrating this principle is the exposure of two nutrient agar plates in a hospital ward. One plate is then removed and placed in an incubator at the same temperature as is a dressed burn-wound. The other is left uncovered (exposed) in the room. After 48 hours considerable difference will be seen in comparing the two plates. No bacterial colonies will be visible in the exposed plate, compared to numerous colonies in incubated plates. Bacteriologic studies of these plates further substantiate this fact. Also illustrative of this problem, is that the exposure of infected burn-wounds to the air, along with periodic wet dressings using a single layer of fine mesh gauze, is the most effective means of controlling infection. The temperature of the exposed burn-wound is obviously going to be lower than in the burn-wound covered with vaseline impregnated gauze, absorbent gauze, and an elastic type bandage. The warm moist environment of the “closed” burn-wound is ideal for growth of pathogenic bacteria.

The chief reward in deeper burns that do not become infected, is the avoidance of destruction of remaining viable epithelial elements. These islets serve as the centers of re-epithelialization in deep second degree burn-wounds, that rarely will then need to be grafted. The recovery of the patient, as a result of less skin grafting, is thus shortened. Once infection develops beneath dressings, the necessity for frequent change of dressings is increased. This is an important advantage of the exposure method, namely,
the reduced need for frequent changes of dressings under anesthesia. The odor associated with the "closed" infected burn-wound can be quite offensive. The patient is affected by this odor in several ways, particularly in that the loss of appetite may be pronounced and result in nutritional problems. The dressing that is soaked and odorous is also a morale-factor as far as the patient is concerned. A bulky dressing that is infected, particularly in hot humid weather is extremely uncomfortable. If there is surface infection with systemic absorption, fever may become a problem. The exposure method reduces surface temperature by allowing more rapid dissipation of body heat.

Easier and earlier ambulation is possible, leading to less impairment of skeletal function, when the patient is not encumbered by heavy dressings. Of considerable importance in trunk-burns, is the possibility of pulmonary complications due to restricted breathing from encircling pressure dressings.

Various studies have borne out quite clearly the lowered blood, electrolyte, plasma, and fluid requirements in the burn-patient treated by the open method as compared to the closed method. Recent experimental studies have shown that an earlier theory in support of pressure dressings, namely, that "pressure prevents escape of plasma," is erroneous. The fluid is merely translocated rather than allowed to dry on the surface. This translocated fluid constitutes a functional loss in effective blood volume and is diuresed from the interstitial compartment after 72 hours. As previously mentioned, the opportunity of frequent accurate observation of the burn-wound is possible when it is exposed. One of the other chief advantages of the exposure method is that it can be more readily and easily applied in the case of mass casualties, either civilian or military.

A disadvantage claimed for the open method is that it cannot be utilized in children. This has been refuted by various observers, particularly a series reported by Wallace and Kyle in 1950. They treated 100 patients in Edinburgh Children's Hospital by pressure dressings and another 100 by the exposure method. They found that the children treated by the exposure method were more comfortable and content, they looked better, ate better, slept better, and readily became accustomed to the position in which they found themselves. There was less grafting required, less fever, less infection, and healing time averaged 21 days in the open or exposure group, as compared to 47 days in the pressure dressing group.

Recognized advantages of the closed method are: (1) applicable to practically all areas; (2) less nursing care required in extensive burns, initially; (3) aids in transportation over long distances; (5) minimizes the invitation to neglect that an open crusting burn-wound offers; and (6) better immobilization of certain areas may be obtained.

Disadvantages of the open method are:
(1) infection may develop under an eschar and, if not detected early, may convert a second degree burn into a third degree burn;
(2) patients may be more uncomfortable when they have to lie on a burn-wound; (3) usually more nursing care is required, initially; (4) circumferential eschars around fingers with edema may cause ischemia; (5) in removing the eschar, viable epithelial elements may be destroyed unless extreme care is taken; and (6) frequently it is psychologically difficult for a patient and his relatives to look at open burn-wounds.

**GRAFTING OF BURN WOUNDS**

In general, it may be stated that grafting should be carried out as early as possible. The prime advantage of early grafting in extensive burns is that the processes of wound healing are instituted prior to inevitable serious problems of nutrition and infection.

When the burn-areas are relatively small and definitely 3rd degree in depth, early "excisional" grafting may be easily carried out. Unfortunately, however, the depth of the burn-wound is not always clear-cut, nor is the burn-area small in size. As discussed previously, three weeks of observation may be necessary before definitive debridement of a burn-wound should be attempted, because it often takes this long before accurate differentiation can be made between deep 2nd degree burns (that will heal without grafting) and 3rd degree burns. When the open method is employed, skin grafting may be instituted following a natural or mechanical separation and removal of the eschar, if re-epithelialization has not taken place. A dressing should be applied immediately after
removal of the eschar and maintained until the wound is clean and granulating. Grafting should then be started. Sterile saline soaks may hasten the development of a clean wound. At no time should a granulating wound be completely exposed for more than a few minutes. When the closed method is used, grafting may be started when the wound is clean, and 3rd degree depth clearly apparent. Many men prefer to await the formation of a healthy granulation tissue bed, particularly if contracture in the involved area is not a factor.

The deep second degree burns which would ordinarily heal without grafting but with considerable formation of scar tissue, should also be excised and grafted when "cosmetic" areas, or areas of "skeletal function," are involved. The latter would include the anterior neck, the axilla, and the flexor surfaces of extremities. In these areas it is desired to keep contracture at a minimum, and, therefore, grafting should be carried out as early as practical.

The type of skin graft to be employed depends on the area to be grafted and the amount of available donor skin. It must be kept in mind that the thinner the graft the better will be the "take" and the poorer the functional coverage. Conversely, the thicker the graft the better the functional coverage, but the less will be the initial "take."

Whenever possible, donor skin should be removed by means of a dermatome. The dermatome may be either electric or manual in type. The skin removed should be approximately 1/1000 of an inch in thickness. This may be slightly varied according to the individual problem as discussed above. If donor skin is scanty and there is no threat of loss of life due to inadequate coverage, razor grafts may be employed. This allows donor skin in small and difficult areas to be more easily removed. When donor skin suitable for removal by dermatome is at a premium, the sheet removed may be divided into postage stamp-size areas and applied to the larger areas of burn-wound, in a manner similar to razor grafts. This technique should always be employed where there is a shortage of donor skin and the areas to be covered are not of vital cosmetic or functional classification, for it is obvious that the intervening space between the grafts will necessarily heal by formation of scar tissue.

Pedicle grafts necessarily must be employed when the burn-area involves complete-thickness destruction of skin overlying tendons of the hand and, often, areas overlying bone. The various types of pedicle grafts that may be used, and their particular technique, will not be discussed in this paper. The important principle to bear in mind is that exposed tendons must be covered early by a pedicle graft — full-thickness skin with a layer of subcutaneous fat — in order to preserve the gliding mechanism of the tendons. Free split-thickness skin grafts directly to bone will not take, due to insufficient blood supply. Usually it will be necessary to drill multiple holes in the cortex of bones in order to allow the formation of a granulation tissue bed for a graft.

When there is extensive skin destruction, for example a 50 per cent 3rd degree burn, and there is a serious threat to life, the use of homografts must be considered. This emergency closure of extensive open wounds is a temporary measure to save the patient for permanent healing. "Biological" closure of deep extensive burns may be accomplished by the use of homografts taken from either live or dead donors. The disadvantage of homografts from live donors is obviated by post-mortem homografts, according to James Barrett Brown. There is no disfigurement, time loss, anesthesia, or wound care of the donor-patient. Sufficient skin can be obtained without using groups of live donors, with the attendant personnel and operative time and expense for removal of skin from such a number of donors, or taking a large amount of skin from one live donor. Usually, when an extensively burned patient is ready for grafting, his general condition is so poor that removal of large amounts of available donor skin would be lethal. It is here that homografts may carry the patient through a critical period. When the patient's general condition has improved sufficiently, autografts can then be removed from the patient for permanent coverage. Brown is also of the opinion that improvement in general condition is definitely proportional to the amount of open area closed by grafting. If one-half of the open area is covered, the general condition will improve one-half or more. Homografts may be live for a period varying from two to six weeks, with an average of 4 weeks.

At the time of the first skin-grafting it is desirable to graft as large an area as prac-
tical. However, the creation of additional large or extensive open wounds in a patient in poor general condition with extensive open wounds may be disastrous. Besides the possibility of loss of the patient from shock or infection, or both, there is always the threat of conversion of the donor areas to “3rd degree” wounds of complete-thickness skin loss which will need to be grafted. If the “take” of the applied skin is poor, the loss of time may amount to weeks or even months. Careful judgment based on personal experience is the best precaution against such catastrophe. Occasionally it may be possible, and even feasible, to use as much autograft skin as deemed advisable, applying this skin to the more vital cosmetic and functional areas, and then to cover the remaining less important large areas with homograft skin. In this way all open wounds may be converted to closed wounds, with subsequent proportionate improvement in the patient’s general condition. At a later date homograft areas may be replaced with autograft donor skin as the need arises. Operating and anesthesia time must also be taken into account. It is unwise to subject the patients to a lengthy operation under general anesthesia, particularly when their general condition is not good. Shock and poor wound healing are the chief problems that may arise. A surgical team experienced in treatment of burns is invaluable in such instances, operating and anesthesia time being kept to a bare minimum.

The management of the grafted areas and the donor areas may be either by the open or the closed method. Considerable success has recently been obtained by the employment of exposure of both donor and grafted areas. Infection and healing time are considerably reduced. The technique essentially consists of application of hot moist packs to freshly created donor areas covered by a single layer of fine mesh gauze, until hemostasis is achieved. The area is then exposed to the air, and within 24 hours, a coagulum forms in the interstices of the fine mesh gauze. The eschar that subsequently forms serves as a “biologic” dressing for the wound, usually separating in 14 to 21 days, leaving a completely re-epithelialized surface. Skin grafts which have been tacked to the edges of defects with fine non-absorbable suture are covered with a dry dressing for the period of time necessary for the patient to completely awaken. These dressings are then removed and the grafts thus exposed to the air. In addition, grafts often will do better open than with a dressing, particularly if they are on the back where the frictional motion of the dressings tends to loosen them. Without dressings, the grafts will move with the undulation of the underlying muscles and hold their take more satisfactorily. Many skin grafts are undoubtedly lost or severely damaged by lysis of the tissue from bacterial enzymes present under bulky dressings after 3 or 4 days. Serum from the recipient surface tends to cement skin grafts in place within a few minutes after they are applied. Healing and a good “take” of the grafted skin will result if only gross sliding of the grafted skin is prevented. Judicious “pie-crusting” of dermatome sheets of skin (creating multiple minute holes) will allow any excess blood and serum to exude from beneath the graft. If the “closed” method is to be employed, experience has shown that Furacin-impregnated fine mesh gauze, and scarlet red gauze have been the dressings of choice. We have, however, recently been more satisfied with the use of a “dry” dressing to grafts. In this technique a single layer of dry fine mesh gauze is first applied, followed by multiple fluffs of wrung-out saline soaked gauze, in turn followed by a bulky compression dressing of a gauze roll and an outer bias stockinette covering. This initial dressing should be changed in about 7 days unless evidence of infection appears.

If infection is of any severity, skin grafting procedures may be temporarily delayed while the patient is treated by dressings moistened with saline, or periodic immersion in a Hubbard tank, wherein whirl-pool therapy is employed. If additional skin grafting procedures are to be carried out, these should be staged at intervals of approximately one week. This of course, depends on the patient’s general condition, particularly hemic and nutritional balance. Upon completion of skin coverage, a complete program of physiotherapy should be instituted if there has been any impairment of skeletal function as a result of areas involved in the burn wound, or areas necessarily immobilized for long periods of time.

OTHER MAJOR PROBLEMS IN SEVERE BURNS

Infection — The most feared complication in a severe burn is infection. The severe
burn that does not become at least slightly infected is a rarity. The type and severity of the infection that will develop is the important question. The best prophylaxis of infection in burns is early skin coverage of the open wound. The rapidity and efficiency of skin grafting therefore becomes of extreme importance. In extensive 3rd degree burns, as previously mentioned, early complete coverage may be obtained through the use of both autografts and homografts. This technique may carry the patient through the critical period where infection may markedly retard wound healing or may even be lethal. In the less extensive burn-wounds early complete coverage with autografts is the objective of all surgical procedures.

Septicemia and fluid imbalance are responsible for the majority of deaths seen in severe burns. In recent years the advances in fluid, electrolyte, and hemic therapy in severe burns has resulted in a lowering of the mortality rate due to this factor. It is rare that a patient will succumb under a properly administered program of blood, water, and electrolytes. Of the patients that are brought through the initial period of critical problems of fluid balance, many will survive only to expire as a result of an overwhelming infection.

Septicemia may begin gradually or suddenly with the appearance of a high fever, rapid respirations and pulse rate, and, frequently, a hypotension which is most difficult to manage by therapy directed towards increasing the blood volume. Disorientation is common at this stage. The urinary output becomes scanty or absent. Paralytic ileus is common, and jaundice and petechial hemorrhages may develop. Recognition of this syndrome is the most important step towards solution of the problem. Both blood culture and sensitivity studies must be carried out immediately, and under very careful technique. The appropriate antibiotics should be instituted as soon as possible. The treatment of burn-septicemia is not satisfactory at this time, therefore the best treatment is prevention.

All patients with extensive burns should be treated with antibiotics at the earliest opportunity. Penicillin and the tetracyclines appear to be the most effective agents initially. Perineal, gluteal, and thigh burns may be partially protected by the routine administration of sulfasuccidine or other intestinal antibiotics. If suppuration or septicemia develop, culture and sensitivity studies should direct further antibiotic therapy. Topical antibiotic therapy has not been satisfactory. The parenteral administration of antibiotics to patients with severe burns is mandatory. The latter may be carried out either by intravenous, intramuscular, or oral routes.

During the period of "preparation" of the burn-wound for grafting, daily careful observation for signs of infection beneath the eschar (open method) or beneath the dressings (closed method) must be made. As previously mentioned, this period averages three weeks, and may extend to four weeks. When the open method is employed, if the eschar at any time begins to separate, with fluctuation beneath, the presence of pus should be suspected. Excision of the overlying eschar is essential. The resultant open areas should then be covered with a single layer of fine mesh gauze and periodically, during the day, sprayed with sterile saline. If the entire eschar is undermined with infection, the patient should be completely debrided. This often may be accomplished in the patient's bed without anesthesia. Oral or intravenous demoral or morphine is often sufficient. Following removal of the eschar, moist dressings should be maintained daily. The type of solution to be used is dependent upon the organism involved. It is routine to obtain culture and sensitivity studies on any purulent exudate in a burn-wound, antibiotic therapy being directed accordingly. One-half per cent acetic acid solution is particularly effective where the greenish color of the exudate suggests the presence of pyocyanus or pseudomonas organisms. For routine use, a sterile isotonic saline solution is satisfactory. If Hubbard tanks are available, daily soaks in such tanks where the water has a whirl-pool action is most effective in cleansing the infected necrotic burn-wound. When the patient has returned to his room, the burn-wounds are covered with fine mesh gauze and a bulky coarse absorbent gauze, and then the appropriate solution periodically applied. Where the burn-wound involves the entire circumference of an extremity or the trunk, it may be necessary to completely enclose the burn-wound in circular dressings, incorporating multiple French catheters at strategic points. Additional holes are cut in the catheters ap-
proximately 1 inch apart to allow adequate diffusion of the solution in the dressings.

If, at any time during the course of skin grafting procedures, surface infection of any consequence develops, daily immersion in the Hubbard tank and continuous moist dressings, or both, should be instituted. Once the surface infection is brought under control grafting procedures may be started again.

It suffices to say that infection cannot be effectively treated in the presence of anemia or hypoproteinemia.

**Nutrition** — The problems of infection and malnutrition in severe burns are related. A vicious circle may be set up with the onset of these two complications. When infection develops the appetite leaves, and as the appetite diminishes, food intake is proportionately decreased, wound healing and resistance to infection being adversely affected. This stage in a severe burn is dreaded by everyone who has ever had the responsibility for such a patient. Strenuous efforts must be exerted constantly to avoid this catastrophic situation. The efforts to maintain good nutrition primarily consist of early institution of a diet high in calories, carbohydrates, and protein. Multiple vitamin therapy, particularly ascorbic acid, is essential. During the wound-healing phase, vitamin C should be administered in the amount of 1000 mg. daily. The caloric intake should be maintained at a minimum of 4000 calories in severely burned adults. When the patient’s appetite has diminished to the point that he can no longer eat these amounts, it will be necessary to supplement oral feeding with tube feedings. Many formulas have been proposed for tube feeding—the various protein hydrolysates. The natural foods have been and will be not only better tolerated by the patient but more effective. Attempt should be made to provide the necessary protein and carbohydrate intake with various forms of the natural foods. If such is not possible then one of the protein-amino acid hydrolysates may be employed. Various powdered protein supplements may be used. In the patient with a severe burn, where oral intake is essentially nil, the tube feeding formula may be administered by means of a pump which delivers about 2 cc. per minute into the nasogastric tube. A formula composed of milk, eggs, vegetables, and meat may be liquefied by means of a blending machine, and a protein hydrolysate added. Ravidin has described such a formula that provides 150 gm. of protein, 340 gm. of carbohydrate, and 60 gm. of fat per 1000 cc. Tube feeding should be continued until the burns are either healed or covered with skin grafts, and the patient is spontaneously eating well.

It is well to assign the responsibility of recording the dietary intake of the severely burned patient to a responsible individual from the dietary department, or, if none is available, to one of the nurses. Daily record may then be kept on the exact amount of intake of protein, carbohydrate, and fat. Total caloric intake as well as fluid intake and output may also be recorded. With such data as this, the physician may check the nutritional status of his burn-patients daily, and thus be forewarned of any impending deficiencies.

In children who have been severely burned, there will be a pronounced weight loss beginning a few days after the burn and proceeding rapidly to severe emaciation if the burn wounds are not closed. This marked weight loss is a cause for concern and should alert the physician in charge to the fact that the patient is headed for serious trouble. This bears out the importance of daily weighing of severely burned patients, if the proper apparatus is available.

A deficient nutritional status promotes the development of anemia, which may already be present as the result of skin grafting procedures. The judicious use of blood will obviate the latter cause, whereas nutritional anemia must be prevented by adequate food intake.

Trying to graft skin onto a burn-patient who is both anemic and hypoproteinemic is like "trying to grow hair on a billiard ball," or "grass on the Sahara Desert." The problem is just that difficult, and solution improbable.

**Reconstructive Surgery** — The prime concern in extensive burns is early complete skin coverage. The prevention or minimization of contracture, and preservation of skeletal function are aims to be constantly considered. Following completion of coverage of the average severe burn, the latter problems become foremost in the program of management.

The optimal time for initiation of reconstructive procedures on burn-scar deformities, is 6 months to a year after healing. At
this time the scar tissues are mature, and severe contractures have not yet developed. During the interval, special precautions should be taken with the involved legs, hands, and axillae, particularly as regards the flexor surfaces. Periodic splinting is of help. Massage of the scars or keloids with various ointments or creams is helpful. Active exercise of the joints, and protection from cold or trauma is important. The avoidance of edema of an extremity is particularly important. Elevation and elastic bandages may be of help.

During the period intervening between completion of skin coverage and institution of reconstructive surgery, physiotherapy is of extreme importance. Periodic visits by the patient to a qualified physiotherapist is essential in maintenance of muscular and skeletal function.

Reparative surgery in children should parallel the growth curve, giving first attention to parts where development may be retarded or deformed.

Scar tissue is best handled by complete excision if possible, and closure of the resultant defect with adjacent normal skin or with a skin graft. The most common deformity is that of the contracture-scar in a flexor surface. This usually can be handled, where tissue is adequate, by "Z"-plasty technique, wherein the scar lines may be improved by simple excision and revision of flaps. These contractures are almost inevitable in such areas in full thickness burns, and should be anticipated. They can be minimized if the wounds in these areas are closed early, and if the grafts are placed in such a way as to produce scars parallel to the crease. Early motion helps to keep joints mobile and prevent fixation of the contractures.

Split-thickness skin grafts of variable depths are the simplest kind for repairing large superficial defects. Neck deformities may usually be corrected by an intermediate-thickness graft. These grafts are also good for breast contractures in girls, or to replace contracted scar tissue in antecubital and popliteal spaces.

Full-thickness skin grafts are rarely used, and then only for small defects of the face and hands. Thick transplants have a better functional result but may not always take completely. They should be used on primary granulated wounds. Thinner grafts will have a tendency to contract and wrinkle, but will take better.

Pedicle flaps supply a solid mass of skin with attached subcutaneous fat and blood vessels. These are most commonly used in deep deformities and for contractures involving bony prominences or larger areas of motion. Many small facial deformities may be corrected by rotation of contiguous flaps.

Prevention of scarring after plastic repair generally depends on pressure dressings and lubrication of the scar. Radiation may be employed where there is an active hypertrophic scar or keloid.

**Duodenal Ulcer** — This complication is becoming more common as more extensively burned patients are carried through critical periods of fluid imbalance and infection. The commonly accepted theory as to the mechanism of "Curling's ulcer" is that of a severe stress reaction to extensive burns. This complication should be anticipated and, if suspected, an adequate ulcer regiment instituted promptly. Multiple gastrointestinal ulcerations with hemorrhage and death, as a result of the intense response of body to an overwhelming burn, are also seen in severe burns.

**Psyche** — Maintenance of morale in a seriously burned patient, whether child or adult, is a frequently neglected aspect in the overall program of managing the burned patient. The responsibility for this program lies with the physician in charge. He must adequately inform and instruct the nursing personnel, house staff, laboratory, surgery, and dietary departments in the more important forms of necessary psychotherapy. If at any time the patient's mental status becomes at all serious, a psychiatrist should be called in to help. Depression and defiance in a burn patient, particularly during the grafting and initial healing stages, may be the reason for ultimate clinical failure in the physical and mental rehabilitation of that patient.

**SUMMARY**

The basic principles of burn-management have been reviewed. These include the early general supportive therapy, initial care of the wound, grafting of areas having complete-thickness loss of skin, and the therapy of problems of infection and nutrition.
There has been considerable improvement in the general supportive program. The more recent advances in blood, fluid, and electrolyte therapy have contributed to the decreased mortality rate in severe burns since World War II. Advances in the knowledge of physiology and pathology in burns have also contributed towards an improved program of therapy. The two techniques of local care of burn-wounds, the open and the closed methods, complement each other in the management of the burn-wounds. The open method may also be applied to the donor sites of grafts. Post-mortem homografts are of definite value in the extensively burned patient. The complications most often seen in extensive deep burns are those of infection and nutritional imbalance.

The advances in coverage of burns by grafts have actually been relatively few. The electric dermatome, which is now fairly easily handled, has become a distinct hazard. Donor areas have been created so deep and so extensive that many become massive open wounds, thus adding injury to injury. The taking of skin grafts is still an art to be practiced by experienced hands.

The most practical method for coping with large numbers of burned patients, such as would be seen in an atomic disaster, is the exposure method. The open air method may not be the best treatment for all types of burns under all conditions, but, in combination with intensive supportive treatment and early skin grafting, it offers the best hope of preventing the sepsis which for so many years has complicated severe burns.

Emphasis is placed upon the “team” management of severe burns. The pediatrician, internist, pathologist, generalist, physiotherapist, and surgeon all play distinct roles in the successful management of the severely burned patient.

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**Current Comment**

A Strange Procedure—

It is common to see in print the terms catheter specimen or catheterized specimen in referring to urine. A moment’s consideration tells one that we never catheterize a specimen of urine—a strange procedure, indeed. Nor, do we examine a catheter as suggested by “catheter specimen.” What we do, of course, is to examine urine obtained by catheterizing the patient. This is a bit of “medicalese” we could well afford to omit in writing.
Management of

**Congestive Cardiac Failure**

The management of congestive cardiac failure has been altered so little over the years that a discussion of its details belongs, perchance, as much to medical history as to present-day clinical medicine. There are, as usual, a few controversial points, and there is the matter of differential diagnosis; both of these merit consideration in any exposition of treatment of heart failure. Furthermore, a review of an old regimen in the light of modern concepts is sufficiently instructive to justify the effort.

In managing congestive failure now, as always, it is most important to establish the diagnosis. The symptoms of the pathologic changes associated with congestive failure—the edema, the asthma, the hemoptysis, the hepatic enlargement, urinary suppression and dyspnea—are not necessarily associated with cardiac disability. They all may be symptoms of pathologic changes in other system-complexes.

Too often the patient who has lived a long time with a mildly incompetent heart develops symptoms associated with some other organ-system. In the minds of both patient and physician this new development becomes the focus of interest and sometimes leads to erroneous diagnosis and therapy. In 1946, I reviewed a small group of patients that had been seen in consultation. In a large measure these were patients who were being treated for gastrointestinal complaints and liver disease although the basic fault was cardiac failure.

In the succeeding ten years this type of patient has continued to be seen in consulting practice. Some of these patients even become candidates for surgical section of the abdomen although not as frequently as in the past.

Conversely, we must not be too quick to diagnose congestive failure on border-line evidence. The mistaken diagnosis of cardiac failure and institution of therapy recognized as such by the patient may, if the diagnosis be in error, produce a cardiac cripple of iatrogenic origin.

The sudden onset of acute failure with all its dramatic symptoms is easily recognized. In my practice and, I believe, in the practice of most of you it is becoming a rare phenomenon. It is seen mostly in the emergency rooms of hospitals and is a problem with which our house staff should be familiar. Occasionally this type of failure is seen in acute coronary occlusion and as a complication after surgical procedures.

It is the congestive failure of slow onset, usually following a typical pattern and with recognizable antecedents with which we are most concerned. Congestive failure means to me the inability of the cardiovascular system to support activity consistent with the general health and strength of the patient. This may follow any type of cardiac damage. It is seen in patients with arteriosclerosis, hypertension, coronary insufficiency and occlusion. It also occurs with acute infections, toxic myocarditis, rheumatic fever and rheumatic valvulitis. It, too, is associated with right ventricular failure in connection with pulmonary disease.

I will not attempt to expand on the diagnosis of congestive failure, but we find most frequently the complaints of fatigue, dyspnea, orthopnea, edema, non-productive cough, anorexia and abdominal distress. When we have the opportunity to follow patients over long periods of time these symptoms will be seen in their earliest stages. Our opportunity to prevent the discomfort of the grosser failure marked by cyanosis and extreme edema is gratifying.

Back in the nineteen thirties when I was in charge of the cardiac section of the Central Free Dispensary of Rush Medical College we saw from 30 to 50 cardiac patients daily and we saw them week in and week out, month in and month out. One reason for their regular visits was that they had no other place to go, and another, I believe, was that we gave them good care. During

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Earl Gray, M.D.
Chicago, Illinois

Nebraska S. M. J.
that time I saw, on occasions, detail men from the various drug houses and I was always asked why, in our dispensary, we used so little diuretic medication. My answer was that our objective was to prevent failure that made diuretics necessary. In our present dispensary service we use the diuretics with greater frequency because most of our patients now are referred from other agencies and we no longer have the stable group of patients that we knew then.

In 1928, Doctor Herrick gave a paper before the meeting of the Congress of Physicians and Surgeons, "Comments on the Treatment of Heart Disease." In the introduction he tells of talking with a surgeon-colleague about the paper. The surgeon said "That is easy, the treatment is rest and digitalis," At the completion of the paper Doctor Herrick commented: "You see he was right I have talked most of rest and digitalis." You may think that I, too, thirty years later have talked most of rest and digitalis.

Rest—The patient with congestive failure must have rest. His activity must be brought within his cardiovascular reserve. This need for rest may be relative. He may have to decrease his physical activity. He or she may need only periods of rest during the working day. As an example, the American Heart Association has planned kitchens for the use of the housewife with a low cardiac reserve.

In more severe cases the rest may need to be more complete, and absolute bed rest may be necessary for a period of time. Just at present, absolute bed rest has become unpopular. Part of this unpopularity we may lay at the door of our surgeon-friends who have stressed early ambulation. Absolute bed rest for the severely decompensated individual, however, has great value. It is frequently surprising to my resident staff the amazing results in treating cardiac failure that may be gained by rest in bed, even before supplementary medication has been started. The slowing of the pulse, the diuresis, and the control of cough and dyspnea may seem like magic.

For the accomplishment of adequate rest, sedation is helpful, and we have many medicines that help in securing rest. Of these I like best the derivatives of opium. Given cautiously, in small doses, codeine, morphia, or even tincture of opium relieve anxiety, slow the pulse, and control physical activity. The barbiturates are less satisfactory, especially for older patients and those in whom there is advanced arteriosclerosis.

The newer tranquilizing drugs I have found less effective as well as somewhat erratic in their action. For selected cases chloral hydrate or paraldehyde may be used. Patients under sedation of any sort should be watched carefully. The relief gained by a patient, long sleepless, may favor sleep so deep that it may and has caused asphyxiation.

Oxygen—Oxygen is very helpful in the treatment of moderate to severe congestive failure. I still prefer the tent type of administration despite its probable inefficiency. The use of masks and nasal catheters are sources of irritation that frequently cancel the beneficial action of oxygen.

Diuretics—Diuretics are valuable when needed. Many patients without readily demonstrable fluid retention will hold in their tissues considerable amounts of edema fluid. This fluid adds immeasurably to the work of the heart through the compression of smaller vessels. The elimination of this fluid will cause an immediate fall in venous pressure, and will ease respiratory difficulty.

Salt Restriction—Salt restriction is valuable in the immediate treatment of the patient in failure, yet at times we have gone a little too far in our enthusiasm for this measure. It has become so well ingrained in the younger graduates that I am having to go to the extreme of protecting my patients against too drastic a restriction. Many patients with heart disease need no restriction of salt and, in my experience, few need the sodium free diets attempted by so many. A low salt diet combined with oral diuretics can cause severe salt-depletion syndrome especially if the patient is permitted too free a scope in the use of his diuretic. During our Chicago summers, all too frequently, we see the uncomfortable salt-depleted cardiac.

Digitalis—Digitalis is still the sheet anchor on which most of our definitive medication depends. Each year sees modifications of digitalis preparations, some are of lasting influence, others are tried and discarded. One of my disappointments in my medical training was the realization that I had not been taught how to give digitalis. This was true even though I had attended the
lectures and clinics of Doctor Herrick and had worked in the clinic with Doctors Slaymaker and Irons. I had a clerkship with Doctors Joseph Capps and Joseph Miller and had been taught therapy by Doctor Fantus. These were all men active in teaching and in practice of internal medicine and cardiology. It is true I had been taught the dosage derived from the "Eggleston-Body Weight" method. It took a great deal of time and experience to learn that there is no magic formula that will apply to all patients.

Doctor Henry Christian of Harvard gave a paper in 1933, which helped me a great deal and which I still recommend to my students for outside reading. He also, about the same time, had published another paper on the use of digitalis. These two papers gave an organized picture of the place of digitalis in medicine up to that time. Later modifications have been largely supplementary measures in the treatment of congestive heart failure, but not in the basic uses of digitalis.

My answer remains, when asked how much digitalis to give: "Enough!" This sounds flippant but it is as true now as it was when Withering wrote his beautiful little book on "Foxglove." No two patients react in the same way to the measures we use to combat congestive failure. Very few need emergency therapy that does not permit the giving of digitalis slowly enough to let us evaluate the effect as we proceed. The measures of rest and oxygen in severe cases give immediate relief and the patient may have his digitalization over several days.

I have a few rough rules that have proven helpful. I think of digitalis in units. No matter what preparation is used I ask my resident to translate the dosage into units for his own thinking. Roughly, one unit is required for each ten pounds of normal body weight. The average patient on any but intravenous medication will excrete an estimated one unit daily.

On this basis we attempt to give one-half the estimated dosage in the first twenty-four hours and one-quarter in each succeeding twenty-four hours until the desired effect is obtained. This regimen usually has the patient completely digitalized within four days. The doses are divided in the third and fourth days so that over-digitalization is avoided. The pulse, blood pressure, and general well being of the patient are observed and anorexia and nausea avoided if possible. Once the patient has become nauseated on digitalis further medication with any form of the drug is frequently difficult.

I want to devote a few minutes to some of the advances in the pharmacological preparations we have seen in the recent past. Doctors Lowan and Levine, in 1954, reported that because of the variation in digitalis activity in patients the tolerance test was desirable. This would distinguish some tachycardias and other rhythmic aberrations caused by digitalis from those occurring in the course of the disease. By using a rapidly acting digitalis-like drug, quickly dissipated, they were able, by continuous electrocardiographic observation, to determine whether or not the basic cause was over- or under-digitalization.

We have used this in a few cases where we had been unfamiliar with the previous course of treatment of the patient's failure. It has been valuable. There are certain dangers inherent in the test, and we use it only when the patient's condition makes speed essential. Observation of the patient over a few days will give equally good information and is to be preferred.

In the recent past, strophanthin has been more widely used. It is a drug for serious arrhythmias rather than for congestive failure and will not be frequently indicated in ordinary management of failure. Doctors Shuman, Lerner and Doane, Jr. at Temple University, have used the ganglionic blocking agents tetraethylammonium bromide and hexamethonium iodide in treating congestive failure. These drugs lower the venous and arterial pressures. The relief of dyspnea was the most dramatic result. This lasted for twenty-four to forty-eight hours. The results in the few dramatic instances I have seen, all to patients in failure, with greatly elevated arterial tension have been much the same as I saw in patients treated by plebotomy in the past—marked improvement in respiration and lowering the arterial and venous pressures.

Glucoside-free digitalis (acetyl digitoxin) has been reported from Germany by Hausler and Hoertnagel and has been used experimentally here. I have had no experience with it in my practice.

The past ten years have seen the usual repeated experimentation with various frac-
tions of digitalis. Some of these have limited application. My advice is to become familiar with one or two preparations of digitalis and stick to the use of these. Knowing their general action and limitations will help both you and the patient. Reserve the unfamiliar preparations for the exceptional patient where they may be indicated.

Xanthines — I have always been interested in the action of the xanthine derivatives in the treatment of heart disease. I have felt that in many cases they were of distinct value especially in arteriosclerotic heart disease.

In 1955, Batterman, Grossman, Schwimmer and Blackman reported from New York Medical College their results in the use of choline theophyllinate in congestive failure and angina. There was relief in about 72 per cent of the patients they treated. This is about the result I have obtained by various preparations I have used, of which I try some form in all my congestive-failure patients. The disadvantages are of course symptoms of gastrointestinal irritation. Careful spacing of the doses and coincident use of alkalizing agents will prevent much of the gastritis.

The congestive failures of right ventricular origin remains one of our greatest problems. Digitalis is of far less value than in other types of failure. The frequent association of underlying chronic pulmonary disease produces an often unremediable burden on the heart. It also frequently interferes with the proper oxygenation of the blood with consequent anoxia of the heart muscle and other vital tissues. In no other type of failure is limitation of activity so necessary and so prolonged. The cardiac reserve is frequently almost non-existent. Oxygen is a must in these cases. Very few patients with severe right heart failure are able to adjust themselves to the strict regimen required.

In conclusion I would say that the problem of congestive heart failure is much the same as it always has been. I find myself talking, as ever, about "rest and digitalis." These measures are modified by our newer knowledge of supplementary aids. Successful treatment depends on:

1. A very careful evaluation of the patient, especially of his cardiac reserve.
2. Training the patient to live within this reserve.
3. Using our knowledge of familiar drugs to combat decompensation with sedation, oxygen, digitalis, diuretics, and vasodilators.
4. Supporting the patient's morale by permitting his return to all possible physical activity.

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Current Comment

Sensitivity Tests in Urinary Tract Infections —

New data demonstrating the value of sensitivity testing in the treatment of urinary tract infections has been provided by three Boston investigators. The effectiveness of seven different methods of sensitivity testing was studied by Drs. Ernest H. Beutner, Howard E. Lind and Howard M. Trafton. Results were then compared with the clinical responses to the drug.

Maximum correlation with clinical results was observed when a 4 mm. zone of inhibition was obtained with a disc. However, the authors point out that the "other testing procedures were equally accurate when proper criteria were selected for interpreting them." A disc test is reported to be as accurate as and less cumbersome than a tube dilution test.

Because of the well-known existence of predisposing factors to urinary tract infections, sensitivity tests should not be used exclusively as prognostic guides but merely to determine the response of existing infection to chemotherapeutic agents. Despite the frequency of complications, "treatment failure can be avoided in 1 out of every 4 or 5 cases by proper use of sensitivity tests," the authors conclude.

March 1958
Asthma in Infancy*

According to this author, a considerable percentage of asthmatics acquire their disease in infancy—approximately 20 per cent. Contrary to often expressed opinions, one can not assume that the infant will "outgrow" his asthma. It is necessary, therefore, to make a differential diagnosis, and, if the infant is found to suffer from asthma, the disease must be treated. One must not wait to see if he will "outgrow" it. The author discusses the pitfalls in differential diagnosis and the methods of treatment.

—EDITOR

BECAUSE there are nearly four million people in this country who suffer from asthma or hay fever, these conditions rank third in frequency among chronic diseases. More pertinent is the fact that ten thousand persons die from asthma every year, according to a statistical report from the National Institute of Health of the United States Public Health Service. Furthermore, it has been stated that over 60 per cent of allergies in adult life have their onset in childhood, and of these, 50 per cent began before the age of one year. These figures are inclusive of all allergic diseases and not limited to those of the respiratory passages. However, to use the figure of Bray and Buffum, we can demonstrate that in cases of asthma beginning in childhood 19 to 22 per cent will have had their inception before one year of age. In our own very short series of asthmatics this incidence was 18 per cent comparing with the broader experience of the aforementioned authors.

Therefore, the purposes of this paper are:
1. To call attention to the frequency of typical bronchial asthma in early life and the necessity for its specific treatment;
2. To emphasize the treacherous problems of its differential diagnosis; and
3. To review briefly the specific problem of infection as it is related to asthma of infancy.

However, we may add a fourth purpose though it may sound trite. It is to discourage the attitude that a small child will "outgrow" his asthma making specific treatment unnecessary. While children may and do apparently "outgrow" asthma in many cases, no one can predict which are the ones that will do so. While we wait for this phenomenal process to occur, the child suffers from chronic pulmonary insufficiency, secondary infection of sinuses and bronchi, and chest deformity, to say nothing of the psychic problems confronting any family when dealing with a chronic disease. We hasten to add, however, that it is not our belief that the psychic problems initiate the asthma but rather serve only to aggravate an allergic disease.

Definition—Before proceeding farther it would be wise to reiterate the time-worn phrase "all that wheezes is not asthma." In defining asthma we agree with Glaser who states that "asthma is a form of obstructive emphysema, involving both lung fields throughout, with wheezing heard on auscultation and relieved, at least early, by sympathetic-mimetic drugs." This emphasizes the fact that asthma is but one form of obstructive bronchial disease and serves to remind the physician of a grave responsibility to rule out all other diseases that may mimic asthma. This is particularly true in infancy. While it is true that the most common cause of wheezing is asthma, the list of nonallergic diseases producing this symptom is endless. The most important of these are:

1. Respiratory infections including croup, bronchitis, and pneumonia.
2. Congenital malformations of the respiratory passages including laryngeal stridor.
3. Foreign bodies in the respiratory passages.
4. Extrinsic masses impinging upon the respiratory passages such as lymph nodes, tumors, and aortic rings.
5. Fibrocystic disease with bronchiectasis.
6. Cardiac disease usually rheumatic or congenital.

At this point let us consider the diagnosis of infection in the bronchi producing capil-

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*Read before Omaha Mid-West Clinical Society, October, 1956.

DONALD C. NILSSON, M.D.
Omaha, Nebraska

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At this point let us consider the diagnosis of infection in the bronchi producing capil-
lary bronchitis, or asthmatic bronchitis, whichever we wish to call it. Whether this type of condition is entirely infectious, an allergic disease triggered by the lowering of resistance, or a pure allergic disease, per se, has been the subject of debate for decades. Boesen studied the outcome of this condition and found that only 10 per cent of the children under one year of age later developed asthma. Over the age of one year but without a family history of allergy, 30 per cent later developed asthma. However, in children over three years of age having an allergic family history 70 per cent developed asthma. This analysis suggests that the likelihood of asthmatic bronchitis developing into typical, allergic, bronchial asthma increases with age particularly when associated with a strong family history of allergy.

If of no other value, the term asthmatic bronchitis is useful to soften the blow when advising parents that their child may have a chronic pulmonary condition. Besides this usefulness, we certainly would delay skin testing and desensitization in any case of wheezing in infancy until there had been several attacks or an interval of six months had elapsed. During this period it is much more comforting to have the parent believe this to be an infectious condition until such time as a definite diagnosis of asthma can be made and definitive treatment started. About all we can say is that when a baby has a respiratory infection associated with wheezing, and when this pattern is persistent or recurrent, it is likely to be bronchial asthma.

**Diagnosis** — It would seem appropriate at this point to discuss the diagnosis of bronchial asthma in infancy in order to remind you of the pitfalls commonly attending this diagnostic procedure. The rapid respirations of the infant together with the lack of definitely prolonged expiration is, at times, most disconcerting. In fact, it is observed, occasionally, that the dyspnea is inspiratory. Fever may be present during an acute asthmatic attack and, in general, the younger the child the higher this may be. This does not amount to more than 1.5 degrees Fahrenheit and probably is the result of increased metabolism due to the muscular effort accompanying dyspnea. To assume that the attack is due to infection because of low grade fever is incorrect. Besides this, there may be a lack of eosinophilia in the blood, as well as in nasal, and pharyngeal secretions. Next, these young children may lie comfortably in bed and show no apparent improvement when in the upright position. Lastly, the results of skin tests may be indefinite under one year of age and certainly before the age of six months.

Specific causes of asthma in infancy may be but little different from those in the adult except for the fact that the diet and environment are much more limited in the infant. However, even during the first year of life, the causes of asthma usually are multiple. The cases in which asthma is cured by removal of a single offender such as milk or dog dander are the exceptions. In Hill's experience the most common causes are: pollen and molds; house dust; feathers; and cat dander.

Of these, the combination of infection with pollen sensitivity accounts for the majority. Of 218 positive skin tests to foods he could find but 44 which could be proved etiologic. Of these, 38 were due to: fish; egg white; walnut and peanut; and chocolate.

Milk and wheat frequently gave positive skin tests but, in his experience, rarely caused asthma. We disagree with this latter statement as do other authors, particularly when asthma begins before six months of age. It is wise to add that the only way to be certain that a food is causing symptoms is to delete the suspected offender and reproduce symptoms by trial feedings. Skin tests are uncertain, particularly when performed by the intradermal method.

**Treatment** — The treatment of asthma in infancy is not essentially different from that in the adult. Specific therapy requires the removal of known offenders, desensitization to those that cannot be removed, attention to foci of infection, and the treatment of the acute attack. Symptomatic treatment still requires bronchodilators, measures to liquefy secretions and mild sedation. On occasion in serious situations we may find it necessary to add adrenal steroids or ACTH. Hydration is the most important watchword in the treatment of the infant, and one must constantly be alerted to the possibility of dehydration. Lack of sufficient oral fluid intake and persistent vomiting require parenteral fluids. Failure to remember this frequently accounts for a moderately severe acute asthmatic attack becoming a desperately serious one.
Regarding the use of epinephrine in small children it is of the utmost importance to remember that very small doses of 1-3 minims of aqueous epinephrine given at intervals of 15 to 20 minutes is the treatment of choice. Larger doses must be discouraged and may do more harm than good. Following the relief of severe symptoms epinephrine in oil is sometimes helpful in doses of 0.3-0.5 cc. However, the parents must be warned that sporadic release of this drug from the intramuscular site may give symptoms of epinephrine intoxication for a variable length of time. Inhalations of epinephrine obviously have little place in the treatment of asthma in infancy.

Finally, steroid therapy is neither desirable for every case of asthma nor can it be a substitute for desensitization. Time does not permit a lengthy dissertation on the value and limitations of steroid therapy but it is necessary that several facts be emphasized. Firstly, they usually are not appropriate as the sole agents for the acute emergency treatment of status asthmaticus, because it requires 24 to 36 hours for full effect, the intravenous form being somewhat more rapid. Secondly, a maintenance dose of cortisone in excess of 35 mg. per square meter of body surface (average 30 kg. child) will produce growth retardation regularly. Lastly, it requires very small maintenance doses of all steroid drugs, even the newer derivatives, to prevent the undesirable side effects so well known to all of us. In summation, the steroid hormones are useful adjuvants in the management of acute or chronic asthma but certainly do not replace meticulous avoidance of known offending allergens or desensitization to substances which cannot be removed.

Finally, in our opinion, non-specific foreign protein therapy such as milk, Piroxen®, or histamine therapy is rarely helpful in management of allergic patients.

We have attempted to emphasize the frequency and severity of bronchial asthma in infancy and early childhood and to call attention to the need for specific treatment of this disease. The interested and enlightened family physician who takes care of 75 per cent of American children, and the pediatrician who cares for the remaining 25 per cent are forced to assume the responsibility for all but the most severe allergic diseases in childhood. This is as it should be, in our opinion, for it is our belief that these individuals are in a far better position to analyze the intricate reactions of the whole child. Briefly, they are:

1. The nutritional requirements for growth and development.
2. The peculiarities of the skin in infancy and childhood.
3. The psychologic aspects of the family pattern.
4. The relationship of the allergy to concomitant diseases which may be present at any time in the course of the allergic process.

However, when the problem is intricate, the aid of competent consultation in allergy; ear, nose and throat; dermatology; pediatrics, and other fields must be sought.

REFERENCES

Current Comment
A Scientist Honored, Dr. Sollman—

Dr. Sollmann was born in Coburg, Germany, in 1874. He became a naturalized U.S. citizen in 1896 and received his M.D. degree from Western Reserve University the same year. Other degrees include an L.L.D. from Western Reserve University, and an Hon. D.Sc. from Ohio State University.

He has also served as a consultant to the U.S. Public Health Service since 1935; a member of the Executive Revision Committee, U.S. Pharmacopoeia from 1910 to 1930; consultant, U.S. Army, U.S. Navy and U.S. Department of Agriculture, 1902, 1917. He is a Fellow, American Medical Association and member of many professional organizations.
Ovarian Tumor*
PRIMARY OR SECONDARY?

INTRODUCTION

Dr. Frank Tanner:

The case for discussion tonight is one of interest from the standpoint of relative rarity of the initial manifestations of the disease found in this patient and also from the standpoint of the additional information obtained later during life and at autopsy. The case does not lend itself to the so-called "Cabot" type of presentation, or guessing contest, but fits best into the category of a case report with discussion of the general problem it presents.

Dr. Palmer Johnson, resident in obstetrics and gynecology, will read the abstract of this case. We will then have general questions and comments from the audience. Finally, we will present the autopsy findings. Dr. Johnson will also give a brief statistical review of similar cases collected from the files of this hospital. Discussion by Dr. Harold Harvey and Dr. Robert Ehrlich will conclude the formal presentation.

CASE ABSTRACT

Dr. Palmer Johnson:

Mrs. A. R. (Case 64957), a white woman, was aged 44 when she entered the hospital for the third time on April 24, 1955.

Chief complaint on this admission was a sensation of pressure in the pelvis.

Present illness: The patient was not acutely ill, but stated that in the last month or six weeks she had been experiencing a sensation of pressure in the pelvis and that in the last two or three weeks this had been associated with some frequency of urination and some abdominal bloating. She felt that her general health had been good and she had no other specific complaints.

She had consulted her physician because of these findings and had been told that a pelvic mass was present.

Past History: No previous serious illness and no previous surgery. The patient's two previous admissions to hospital had been in 1945 and 1947 for spontaneous delivery of normal infants, with her pregnancy and post-partum course essentially normal on each occasion.

Menstrual History: Onset of menstruation at 14 years of age, regular, every 30 to 35 days, with duration of about 4 days.

Family History: Husband, age 48, living and well, and two children living and well. Father died at age 60 of heart disease. Mother and two sisters living and well.

Physical Examination: A white woman in no apparent distress. Her height was 65 inches (162.5 cm.) and weight, 134 lbs. (61 kg.). Body temperature was 99° F; pulse, 78; respiration, 20. Skin and mucosal surfaces were normal. No abnormalities were noted in her head and neck. Thorax: The bony thorax was symmetrical, diaphragmatic excursion was normal, the lung fields, normal, and the breasts, normal. Heart: Blood pressure, 130/78. Heart normal in every way. Abdomen: No masses palpable. Abdominal wall soft. No apparent enlargement of the kidneys, spleen, or liver. Spine and extremities: Normal in appearance. No abnormal reflexes demonstrated. Pelvic examination: uterus anterior in position and probably normal in size. Posterior to the uterus was a palpable mass about

*Presented November 11, 1957, by the Departments of Pathology, Obstetrics and Gynecology of Lincoln General Hospital and Bryan Memorial Hospital, Lincoln, Nebraska.
the size of an orange. It extended into the region of the adnexa. The mass seemed to be slightly fixed. Cervix, normal. Rectal examination, negative.

**Laboratory:** On admission; Hb, 13.6 grams (87%); RBC, 5,110,000; WBC, 4700. Differential: segmented neutrophils, 57%; staff neutrophils, 2%; eosinophiles, 3%; lymphocytes, 32%; monocytes, 6%. Wasserman negative. Blood group B, Rh negative. Urine analysis: color slightly cloudy, straw; reaction, 5.5, specific gravity, 1.020. Albumin, sugar, acetone and diacetic acid not found. Microscopic (catheterized), negative.

**Course in Hospital:** The day after admission, April 25, 1955, the patient had a surgical exploration of the pelvis. A large mass was found to the right of, and posterior to the uterus. It involved the right ovary. The right tube and ovary were removed and then the entire uterus and opposite tube and ovary were excised enmass. (Pathologic diagnosis: hypernephroma of the right ovary—primary?, secondary?; multiple small intramural fibromyomata of uterus; chronic cervicitis; squamous metaplasia of endocervix; benign endometrium in proliferative phase). Recovery from surgery was uneventful. An excretory urogram was made on May 2, 1955 and reported as negative. The patient made uneventful convalescence and was dismissed May 6, 1955, about 12 days after admission to the hospital.

**Re-admitted April 5, 1956.** Chief complaint at this time was pain in the back. In October and November 1955 the patient said she had had some pain in the back and that in November this pain seemed to be particularly severe over the left iliac crest with radiation down the anterior aspect of left thigh. She had lost some weight. She had had some bladder irritation recently, with urinary frequency. A cystoscopic examination performed prior to admission to the hospital had revealed a cystitis cystica which responded well to local treatment.

Roentgenographic studies at the time of first complaint and her physical examination in December 1955 were negative for abnormal changes in bone. A re-check X ray in March, 1956, revealed a definite lytic lesion in the region of the left ilium. The patient entered the hospital for biopsy of ilium.

**Laboratory:** Hb, 11.6 grams (75%); RBC, 4,680,000; differential, essentially normal. Urine analysis within normal limits. Chest X ray, negative. Skull X ray, negative.

**Course in Hospital:** Biopsy of ilium and excision of cyst of forehead were done on April 6, 1956. Pathologic diagnoses: metastatic hypernephroma of ilium; inflammatory sebaceous cyst of scalp. The patient was dismissed with note of contemplated roentgen therapy.

**Re-admitted July 25, 1956.** Admission note indicates that the patient had been receiving roentgen therapy. She had felt quite well until about July 4, when she had developed a severe left-sided headache. This had been constant. She had vomited on one occasion and nauseated most of the time. She had lost about 4 pounds and felt that she had been rather forgetful, and had compulsive speech but could not think of the proper words to say. She also complained of considerable pain in the left hip.

**Physical examination:** Not remarkable at this time. Clinical impression was probable cerebral metastasis.

**Laboratory:** Hb, 11 grams (70%); RBC, 4,270,000; WBC, 3900. Urine analysis essentially negative except for 1-6 pus cells per high power field in catheterized specimen. Sedimentation rate, 31 mm. in one hour. Roentgenograms of chest and skull were negative.

**Course in Hospital:** The patient received palliative radiation to head, completed August 7, 1956. Dismissed slightly improved.

**Re-admitted September 11, 1956.** The chief complaint was vomiting. The patient had been feeling fairly well at home until yesterday noon, when she became nauseated and began to vomit. She also complained of some pain in the right thigh. Physical examination was essentially negative except for weight loss and tenderness over right femur.
She was disoriented and appeared lethargic.

Laboratory: Hb., 9.5 grams (61%); RBC, 3,300,000; WBC, 2500; Differential: segmented neutrophils 83%; staff neutrophils, 7%; lymphocytes, 11%. Roentgenogram of right femur, negative. Urine analysis: straw colored and cloudy; reaction, 5.5; specific gravity, 1.022; albumin, none; sugar, 2 plus; acetone, one plus; diacetic acid, negative; leukocytes, 4-6 per high power field; erythrocytes, 1-2 per high power field (catheterized).

Administration of nitrogen mustard was begun and this was given daily between September 16, 1956, and September 20, 1956. She seemed to have a fairly good response and was dismissed on September 23, 1956.

Re-admitted October 30, 1956: Admitted because of recurrence of headache, and pain in left side of jaw. She had also had some temperature elevation in the last week. Antibiotics had been given without response.

Physical Examination: Temperature, 101.4° F.; pulse, 110; rhythm, regular. Moist rales were heard at left lung base. Abdomen, moderately distended and generally tender. No abdominal masses were palpated. A small mass was present over vertex of skull, and was said to have been present since previous admission but not enlarging.

Laboratory: Hb., 9.2 grams (59%); RBC, 3,310,000; WBC, 3900; differential count within normal limits. Blood culture, negative. Chest X ray shows an increase in heart-size since previous examination. Small amount of fluid present in left pleural sac.

Course in Hospital: The patient had pneumonitis and was semicomatose at times. On November 14, 1956, she showed slight improvement and was discharged. The patient expired at home two weeks after leaving the hospital.

RADIOPHGRAPHIC STUDIES

Dr. Orvis Neely:

(Shows roentgenograms). The first admission was in April, 1955. On April 5, 1956, this film of the pelvis was taken and shows a lytic lesion. You cannot follow the normal trabecular pattern through the area of destruction. No other areas of destruction were seen in the pelvic bones.

In May 1955, after the pelvic surgery, an intravenous pyelogram was reported as being negative. Under the “retrospectoscope,” I believe that a suggestive mass may be seen in this area. You notice that the upper pole of this kidney loses its definition at this point. There is, however, no distortion of internal renal structures. In July 1955, she was in the hospital for X-ray therapy. Roentgenograms of the skull made at that time were negative.

SURGICAL PATHOLOGY

Dr. Frank Tanner:

This colored slide shows the gross specimen removed surgically when this lady was first admitted to the hospital with the symptom, pressure in the pelvis and the physical findings of a mass in the pelvis. (Figure 1 and 2). This is an ovarian tumor. You can see its unusual appearance; a somewhat hemorrhagic cystic and solid tumor with a honey-comb appearance produced by little yellow streaks scattered between the areas of hemorrhage. This is a microscopic appearance of the surgical specimen. (Shows projected microscopic slides). Here
is compressed normal ovarian tissue and adjacent tumor; with higher magnification we can see that the tumor is made up of pale stained, clear cells, filled with lipoid which undoubtedly gave the yellow color to the gross specimen and which cells are intimately associated with the blood vascular system. This microscopic pattern is quite characteristic of a clear celled adenocarcinoma of the hypernephroma type, such as one would expect to see as a primary tumor in the kidney. In this case, since this specimen came from ovary and since it is possible for such tumors to be primary in the ovary, we made a diagnosis of hypernephroma of the ovary. We questioned whether the ovary contained the primary tumor or whether it was a metastatic lesion. At this time it may seem somewhat of an academic question, but at that time, or at any time, if there is a question of diagnosis as to a primary or secondary tumor of the ovary, it is important to make a correct evaluation. If one is dealing with a metastatic tumor in the ovary, so far as I know, the progress of the disease is always progressive and ultimately fatal; but, if it is a primary tumor of the ovary, even though malignant, surgical removal may result in a cure. From the standpoint of the patient's prognosis that decision obviously was not academic. We thought that if excretory urograms were found to be negative, the chances were that this was a primary ovarian tumor and that this patient's course might be quite satisfactory. As you have learned from the case abstract, her subsequent course was not satisfactory.

GENERAL DISCUSSION BY AUDIENCE

Are there any questions or comments from the audience before we present the autopsy findings? The only question before necropsy was whether this ovarian tumor was an unusual primary neoplasm or a secondary neoplasm?

Dr. Russell Gorthey:
Was the abdominal cavity explored at the time of oophorectomy?

Dr. Harold Harvey:
A general inspection within the limits of a pelvic laparotomy incision was carried out at surgery. Nothing diagnostic was found; however, we were thinking more in terms of a thecoma than of a secondary ovarian tumor. In 1952, this patient had a urinary tract infection. She did have microscopic blood in the urine at that time and she responded to urinary tract antibiotics. Did she have a renal tumor at that time?

Dr. Orvis Neely:
I think we can say that the internal structure of the kidneys was normal in May 1955. The only thing I pointed out was the questionable mass which, at the time of original interpretation, was thought to be a liver or gallbladder shadow superimposed on the upper pole of the kidney. I would like to hear Dr. McGreer's comments on that roentgenogram.

Dr. J. T. McGreer:
It would be unusual to have a mass that size primary in the kidney which would not produce a defect or distortion of the superior pole calyx.

Dr. Harold Harvey:
When we received the pathologist's report of hypernephroma of the ovary we decided to have pyelograms. After a number of in-
formal consultations we decided that if she had a metastatic lesion of long enough standing to produce an ovarian tumor of this size, she most certainly had other metastatic lesions. Finding no evidence of renal tumor, we decided that a direct exploration of the kidney areas was probably not justifiable.

**Dr. Howard Mitchell:**
I would like to ask the clinician a question. The notation here is that her response to radiation and nitrogen mustard was fairly good. What did you mean by that? Was it given for relief of pain, and did the patient have satisfactory relief of pain?

**Dr. Lee Stover:**
So far as cerebral symptoms were concerned, she was having severe one-sided headaches, speech difficulty, and considerable agitation. She obtained fairly good relief of these symptoms by her initial X-ray treatment. On her next admission we gave her nitrogen mustard and she had marked relief from these same symptoms for a period of three to four weeks.

**Dr. H. Mitchell:**
Did X-ray therapy to her ilium relieve the pain that she was having in her back?

**Dr. L. Stover:**
Not completely, but to a considerable degree.

**Dr. F. Tanner:**
In general, would you say, Dr. Neely, that pain in metastatic disease of bones can be alleviated by X-ray therapy?

**Dr. O. Neely:**
Yes, if you can get directly at the area that is causing the pain. Sometimes the area of pain production does not show any lesions on X-ray film and you may be treating the wrong area. Many times it is possible to get good temporary relief.

**PRESENTATION OF AUTOPSY FINDINGS**

**Dr. F. Tanner:**
The chief question remaining unanswered when this autopsy was begun was whether this malignant ovarian tumor was primary in the ovary, representing an unusual type of primary ovarian tumor known as hypernephroma of the ovary, or whether this malignant tumor of the ovary was actually a secondary process and had merely been the first evidence of a disseminated disease. The gross findings at autopsy were those of extensive metastatic disease which involved both adrenal glands, the lungs, pancreas, regional lymph nodes in pelvis and abdomen, various areas of the bony skeleton, and the dura mater. We felt from the gross autopsy findings that the primary tumor was definitely the right kidney, which at the time of the autopsy was replaced by massive neoplasm which seemed to be somewhat poly- and intimately associated with the right adrenal gland. Even at that late date, it produced very little distortion of the kidney pelvis or calyces. In addition to those findings she had a terminal congestive edema of the lungs and purulent bronchopneumonia. There was marked cerebral edema with evidence of increased intracranial pressure due to the involvement of the dura and petrous ridge by metastatic hypernephroma. Microscopic findings confirmed an adenocarcinoma of the clear celled, hypernephroma type involving the upper pole of the right kidney and extensive meta-
static hypernephroma in the areas previously mentioned, purulent bronchopneumonia, and a mild chronic cystitis. The left kidney was essentially normal, but the left adrenal did contain a small solitary metastatic lesion.

This color photograph shows the kidney tumor as it appeared at autopsy. (Figure 3). Here is the kidney tumor with contiguous involvement of the adrenal gland. One can easily see from this type of gross structure why these tumors were originally thought to be arising from the adrenals, hence the name “hypernephroma” or “on top of the kidney.”

Dr. O. Neely:
I think it should be pointed out that there is a 1 1/2 year interval between the time of the pyelograms previously shown and this specimen.

STATISTICAL REVIEW

Dr. P. Johnson:
The records of patients with ovarian tumors was obtained from the record room and covered the past 5 years. From those, the secondary tumors were selected. Only six metastatic ovarian tumors were found, that is, where such a discharge diagnosis had been made by the physician. (Brief reports on these six cases were given by Dr. Johnson). A recent report of metastatic tumors of the ovary was made in 91 cases in which oophorectomy was performed for treatment of carcinoma of the breast. These carcinomas had been treated by other means and therefore are assumed to be advanced. In these ovaries they found that one-fourth contained metastatic lesions. (Several additional examples of metastatic ovarian tumors were in pathology files but were not included in Dr. Johnson’s review of record room files).

Dr. F. Tanner:
Dr. Harvey, would you like to comment on this case and this general problem?

Dr. H. Harvey:
The early diagnosis and the treatment of ovarian malignancies leaves much to be desired. Most of the time these lesions are silent until they are far advanced. It is important, however, that we try to decide at the time of surgery whether or not a patient has a primary or a secondary lesion. Treatment of a primary lesion by total hysterectomy and bilateral salpingo-oophorectomy does hold a possibility of cure. In the case of a secondary lesion, probably a bilateral palliative oophorectomy is all that is needed.

Of the secondary malignant tumors, the majority come from the gastrointestinal tract and apparently most of them from the stomach or from the sigmoid colon. The next most common place seems to be from the genital areas, either the uterus itself or the breast. Quite a way down the list is the kidney as the primary site.

Dr. F. Tanner:
Approaching the problem from a different angle, and recognizing that quite a few women past the childbearing age have malignant tumors of the bowel and stomach, I wonder whether prophylactic removal of ovaries would be indicated as part of the treatment of the primary? Dr. Ehrlich, would you comment on that?

Dr. R. Ehrlich:
I was interested to hear the complete follow-up of this case because we presented this same case at the Lancaster County Medical Society Tumor Conference last year. At that time it was presented as possible primary ovarian hypernephroma.

We might say, first of all, that tumors which metastasize to the ovary have their origins in two common sites, either in the pelvis or the upper part of the abdominal cavity. When the primary site is in the pelvis (endometrium, uterus, fallopian tube or more frequently the recto-sigmoid region) we know that direct implantation is probably one mode of spread. The lymphatic vessels are another route of spread. So, if we are confronted by a tumor which arises primarily in the pelvis, and we fear metastatic involvement of the ovaries, then, I think, we have an indication for removing both the primary tumor (in the sigmoid for example), in continuity with the uterus, the tubes and the ovaries.

Unfortunately, a high percentage of the primary tumors arise in the upper part of the gastrointestinal tract. I was quite interested that, in Dr. Johnson's study, we did not have any arising in the stomach. In most series stomach accounts for about 75% of the primary lesions which metastasize to the ovary. When we are confronted with a
lesion which arises in the stomach or in the upper part of the gastrointestinal tract we are more or less defeated and a prophylactic oophorectomy or panhysterectomy usually would not be justified.

Dr. F. Tanner:

I think perhaps part of the difficulty in evaluating statistics concerning the usual primary sites of secondary ovarian neoplasms comes from the fact that until very recently it was thought one should include only the actual mucus-producing secondary tumors in the ovary under the name of Krukenberg tumors. The true Krukenberg tumor is one that contains signet-ring cells (mucus-producing). That type does arise in the gastrointestinal tract about 80% of the time. But, if we include all secondary ovarian tumors, such as the one presented here tonight, and several of those which Dr. Johnson selected, where the primary was in the ureter, breast, or some other organ, the ovarian metastasis would not present microscopic appearance of signet-ring cells and might not be called Krukenberg tumors by all observers. They are nevertheless, metastatic tumors. Part of the difference in the reported statistical data comes from that fact. As far as primary hypernephroma of the ovary is concerned, undoubtedly there have been some cases studied well enough to exclude the kidney as a primary source. In such instances it is thought that adrenal rests or one-sided development of teratomas or cell rests within the ovary are the point of origin, but actually there is very little written on that subject2.

SUMMARY

In summary we can say that an unusual tumor of the ovary was surgically removed; that the tumor was recognized as being malignant and of unusual character, but could not be classified with certainty as a primary hypernephroma or secondary tumor. Pyelographic studies of the kidneys were negative and the patient remained well for a year, then showed signs of bony and distant soft tissue metastasis. At autopsy a primary tumor of the right kidney was found which is considered to be the primary site.

REFERENCES


Current Comment

More on Radio-Activity—

Much comment continues in relation to the hazards of radiation, especially as regards its effect on human heredity. A more reasonable note becomes apparent in this controversy as a World Health Organization committee points out that while all ionizing radiation is harmful, and while diagnostic X ray is the most common source for most people of artificial radiation, the medical use of X ray is so important that reason must prevail.

This committee notes that natural sources of radiation are extremely variable. One living in a granite house receives more radiation than the individual living in a limestone building. This difference is greater than would be expected to result from atomic industrialization if this industrialization is accompanied by necessary precautions.

Another difference exists in the natural radiation received by the Swiss dwelling in the mountains as compared to those living at lower altitudes. The altitude at which some of the Swiss live, exposes them to greater amounts of natural radiation and yet they are not considered to have suffered any catastrophic results. The conclusion is that natural variations of radioactivity are always much greater than those expected from industrial causes.

Meals on Wheels—

Entitled “Meals on Wheels,” an article in What’s New for Christmas, 1957, begins with the following interesting paragraph:

“Over four million aged individuals in the United States live alone, and many of them are half-starved. But in Philadelphia, Pennsylvania, some of these lonely and infirm oldsters have literally taken a new lease on life. They are clients of “Meals on Wheels”—the first service in America to deliver well-balanced meals to aged and ailing people who can’t obtain or prepare them for themselves. Since deliveries began in January, 1954, every client has received his meals on schedule.”

Turkeys and Ornithosis—

“... From a public health viewpoint the domestic turkey is incriminated as the most serious reservoir of present ornithosis infection in the United States.” (What’s New, Christmas, 1957, p. 14).
The Voluntary
Health Insurance Partnership*

I. The Impact of Health Insurance

Within our own generation, we have been learning to use the stabilizing force of the insurance mechanism in a new field—health care. The revolution in medical science has brought health care and insurance together. Life insurance, which is owned by 86 per cent of all American families, has largely conquered dependency of widows and orphans. Casualty insurance has made it possible for small business and individuals to endure the normal hazards of our free enterprise system and still survive. But no use of the insurance mechanism has called for more ingenuity, flexibility and imagination than voluntary health insurance.

Today no family would willingly return to that era when a costly illness could plunge a family into poverty. No doctor really wants to go back to the days when his bills were paid in pigs and potatoes or other barter—or perhaps not paid at all. Health insurance is here to stay in spite of the problems inherent in adjusting the rigid insurance mechanism to the health field, where the only constant factor is change. It has demonstrated the contribution it can make to human welfare.

Health insurance is already big business. In 1956 it paid out through:

Life insurance companies......$1.7 billion
Casualty and other insurance companies .......... .4 billion
Independent programs ........... .1 billion
Blue Cross-Blue Shield .......... 1.4 billion

A Total of....................$3.6 billion

Compare this to life insurance payments of $2.4 billion in death benefits, and $3.5 billion in living benefits such as annuities, dividends, matured endowments, and dis-

*Presented before the Association of Life Insurance Medical Directors Meeting, Statler Hotel, New York, N.Y., October 28, 1957.

ability benefits, and you will see that health insurance handles a lot of money. These figures are growing, too, as broader benefits are brought to more people.

Health Insurance is big business socially. At the end of 1956, 116 million of our 170 million population had some form of health insurance protection. This is nearly 70 per cent of the population. Excluding unknown numbers not even eligible for health insurance, such as men in military hospitals, indigent veterans, inmates of homes for the aged, mental institutions, and many others, the proportion is even larger. Compare the 116 million with health insurance against the 70 million wage earners under social security, and the 118 million persons who own some form of life insurance and you see that the influence of health insurance upon our way of life is very great.

Health insurance is big business politically. It is almost inevitable that any social phenomenon that affects large numbers of people, sooner or later comes under political scrutiny—and government regulation. It is no news to anybody that health insurance is under political scrutiny here and abroad. It has become a government monopoly abroad; in this country voluntary health insurance has been the strongest single factor in holding off the government monopoly called socialized medicine.

Voluntary health insurance will continue to serve the American people just so long as the people are convinced that we serve them better than any other way. This is a real challenge to those of us who believe in our "voluntary—free enterprise" way of life.
II. The Partnership

The very name "Health Insurance" suggests that in its service to the American people, it is a partnership between two very old, and highly respected segments of our economy; the health care field—and the insurance business. As in any partnership, each partner depends upon the other for mutual cooperation.

With the voluntary health insurance mechanism, doctors might be working for a single, monopolistic employer, probably the federal government. They might even be discussing how to get a wage increase, as their British brethren recently did.

On the other hand, the insurance mechanism is quite literally at the mercy of its partner—the health care field, and particularly the medical profession. It is not unfair to say that health is the senior partner in health insurance—it is certainly the controlling partner.

The insurance company simply collects health care dollars into a common pool and pays it out according to very rigid rules. But who is the partner with his hand on the spigot? Who regulates the flow of health insurance dollars? The doctor. Every claim requires a certification of a doctor’s professional judgment.

The doctor’s professional judgment is often exercised under considerable pressure. At best, it involves subjective factors and influences.

In a fire insurance claim, the loss can be measured.

In a life insurance claim, a man is either dead or he’s not.

But in a health insurance claim, how sick is the patient?

Is an eloquent hypochondriac entitled to more benefits than a stoic?

For examples of the presures that doctors face in making these decisions, consider these:

The patient who wants to stay an extra day in the hospital “because I have insurance, doctor, and it won’t really cost any more.”

The patient who says, “Doctor, if you’ll put me in the hospital my insurance will pay your fee for that toenail operation.”

The patient who says, “Doctor, I have major medical insurance, and if you’ll make your bill 25 per cent higher, I’ll get enough to pay you in full and you won’t have to wait.”

The doctor who says to himself, “That patient has insurance so he’s well able to pay a little extra fee; and besides my services are worth it.”

The doctor who believes the insurance business has some sort of pipeline from Fort Knox; and that if he had all the money the insurance companies have, he wouldn’t be so petty about a minor increase in fees.

Or the doctor who has spent hours filling out 157 varieties of health insurance forms—all of them simple, but all of them different! What frame of mind is he in?

These are only a few of the pressures upon the practicing physician.

We need to know about them; we need to understand them. We need to support our partners—the doctors—in standing up under these pressures so they can make the sort of objective, professional judgments we must have, if health insurance is to remain voluntary.

The daily decisions of the practicing physician influence the total cost of health care. They also influence the attitude of the general public toward the present freedom and governmental regulation which medicine enjoys and which we want to preserve.

So now our problem is how to make the practicing physician aware of the cumulative consequences of his decisions as they influence the total cost of health care. He is entitled to know the financial, the sociological, the political influences of his decisions. He should know, for example, that:

Insurance is merely a stabilizer; it does not create more money. Insurance collects money and administers it, but the doctor’s professional judgment carries the responsibility for its expenditure. There is real danger of inflating the cost of voluntary health insurance beyond public tolerance.
III. The Health Insurance Council

More than ten years ago, insurance leaders recognized that the “partners in health insurance” must talk to each other and learn to work together in joint service to the public. They set up the Health Insurance Council for that purpose.

To avoid improper emphasis upon any single segment of the insurance business, the Council was made a federation of several existing associations. The insurance business is highly competitive, and because competition produces progress, we want to keep it that way. However, there should be no competition within the Council; our interests are identical and broad. We should speak with one voice for the insurance business as a whole on these vital issues. The federation concept should lift us above our competitive pressures as we try to tell the health insurance story to the producers of health services who are our partners in service to the public.

This is not the place to discuss the machinery of the Council, nor how it draws its committees from all segments of the industry.

It is proper to say, however, that the Council has become an effective voice for the industry as a whole, in communications with leaders of the hospital field and the medical profession.

The Board of Trustees of the American Hospital Association more than two years ago gave formal approval to our hospital admission forms. There have been many indications of improved understanding with hospital leaders, as they learn of our improved service to them.

Members of the Board of Trustees of the American Medical Association met this summer with Presidents and Medical Directors of several insurance companies to discuss how we could make voluntary health insurance serve the public better. It was agreed there that one of our principal problems is to bring a better understanding of health insurance principles to the medical profession at the practicing physician level. We promised we would do it. I am proud to say that our program has already been launched.

IV. The Communications Program

Our nation has nearly 200,000 doctors. We'll never reach them all if we depend entirely on staff of our member associations.

But doctors are in daily contact right now with insurance. For example, Workmen's Compensation, health insurance claim forms, life insurance examinations are only a few of the contacts.

Both the insurance business and the medical profession contribute their share of good citizens to civic and community life. These men meet each other in church work, community chest drives, hospital trusteeships, politics—even fishing and the golf course.

Practicing physicians as a class are well-educated, high earning, family men who believe in the ownership of life insurance to protect their families and to build their estates. Does it seem possible that our carefully selected, intelligently trained life insurance agents have not sought them out?

Last, but not least—every life insurance company requires administrative advice through full or part time medical directors. You gentlemen have a unique bond with your colleagues in practice. You belong to your local medical society, you maintain your interest in clinical medicine, you are interested in maintaining the free enterprise system in medicine and the insurance business. You can help.

In fact, it has been repeatedly brought home to me that the life insurance company medical director, is one of our best, most effective channels of communication between the insurance business and the medical profession. You must help. You are essential.

Now—our program has been launched. Here is what it is and how you can fit into it.

In each state we are designating a state chairman to organize Health Insurance Council activities. We have asked all the companies to suggest men of stature and competence to volunteer in helping us carry the health insurance story to doctors and hospitals. The reaction of companies has been splendid. Many have told us “We've been waiting for you to ask us to help.”

I suspect that many of you feel that way, too. The participation of your Association in the activities of the Health Insurance Council over the years has been one of our sources of strength. Here is a program where you can each participate—within the limits of your own busy lives—but with great personal satisfaction and effectiveness.

102 Nebraska S. M. J.
We ask that you seek out your state chairman and volunteer your help and support. If you don’t know who he is, ask us.

We are urging that state and county medical societies set up committees to meet with our local committees. We urge, too, that physicians be invited to address insurance gatherings and that insurance men appear on programs of state and county medical society meetings—and hospital staff meetings. We are offering articles by competent authorities in the insurance field for publication in both medical and insurance journals—and we invite short, simple articles on health insurance as it affects the doctor from any of you who would like to submit them.

Of course, we expect Health Insurance Council Staff to help the programs get organized and to assist and guide their development. We hope to provide helpful material—Speakers’ Kits and Aids. If you are a member of a state team, we’ll put you on our mailing list to receive this material. And we shall want reports from you of what you do.

We do not suggest any single, rigid pattern of state committee activity. Your state committee must meet the needs it finds. We do offer some examples and some precautions:

In Wisconsin, two years ago, a local company home office man made a tour of a dozen or more county societies. He got the support of the state society secretary, who made the tour with him. We have that man’s excellent notes of his experience.

In Pennsylvania, we are getting a Speaker’s Program under way, with several invitations already in from county societies.

In California, we’ve got a team in the field. It includes both lay people and doctors, and they have already made a fine beginning on an educational program, particularly with articles in county society bulletins.

In New Jersey, we have a committee of insurance people that has already developed a fine, friendly liaison with the medical society and the hospitals.

In Texas, the famous HIPJAC Committee was set up some years ago and still functions. We hope to enlist that Committee in our program.

In some states, we have negotiated service-type programs with state medical societies. Here’s my first caution: We earnestly urge that you avoid becoming involved in discussions of details and technicalities of specific programs. The negotiation of benefits, rates, interpretations of contracts, and so forth, require specially authorized committees for that purpose. But you can open doors. You can tell our story—be sure you know it first—and you can listen.

And here is my second caution: Don’t expect miracles to happen overnight. Insurance and medicine are going to live together a long time. Place the emphasis on making it a lasting friendship—an effective partnership that will serve the American public well.

THE STRENGTH OF VOLUNTARY HEALTH INSURANCE

In conclusion, one brief reference to a basic economic principle that is important to the insurance business, to the medical profession, to our free enterprise system: competition. The insurance business is highly competitive; a friend of mine has described the effort of the Health Insurance Council to develop a uniform program for the 800 companies writing health insurance as trying to put 800 cats in a bag.

Our 800 insurance companies compete vigorously for the right to serve the American people. Under our system, they do it by offering something better. We believe that if the American people are free to choose, and adequately informed, they will choose the best. When something better comes along they’ll choose that.

The practicing physician believes in freedom of choice, too. The sacred doctor-patient relationship includes the knowledge that if the doctor does not do his very best, the patient is free to choose another doctor.

It is this pressure for progress that makes our free enterprise system strong. It is our people who benefit from it. And it is we who must always remember that voluntary health insurance can only survive as long as it serves.

We in the insurance business, and our partners in the health care field, must work together to keep health care and health insurance voluntary so that these pressures for progress may continue.
THE PHENOMENAL GROWTH OF HEALTH INSURANCE PROTECTION

NUMBER OF PERSONS WITH VOLUNTARY HEALTH INSURANCE PROTECTION
(includes Insurance Companies, Blue Cross-Blue Shield, and Independent Plans)

116 MILLION

NUMBER OF PERSONS WITH LIFE INSURANCE PROTECTION

118 MILLION

NUMBER OF WAGE EARNERS FULLY INSURED UNDER OLD-AGE AND SURVIVORS' INSURANCE

71 MILLION

(As of December 31, 1956)


THE RISING FINANCIAL IMPACT OF HEALTH INSURANCE

Billions of Dollars

HEALTH INSURANCE BENEFIT PAYMENTS

3.6

LIFE INSURANCE BENEFIT PAYMENTS

5.9

(As of December 31, 1956)

Selected Abstracts:

The program of the Omaha Research Club and two abstracts of presentations listed therein were published in the February issue. The two abstracts which follow reached the editor too late for that issue and are, therefore, presented at this time.

Bioassay of Follicle Stimulating Hormone and Its Clinical Value. Hilton A. Salhanick, Ph.D., M.D., Department of Obstetrics and Gynecology, University of Nebraska College of Medicine, Omaha, Nebraska.

Bioassay methods in general use for measurement of urinary excretion of gonadotropins have measured “total gonadotropins.” The augmentation method utilizing human chorionic gonadotropin seems to be specific for FSH as well as extremely sensitive. The method has been applied to the study of the normal human menstrual cycle as well as various clinical gynecological endocrinologic problems such as anovulatory bleeding, primary and secondary amenorrhea, etc. Important prognostic conclusions can often be made on the basis of FSH excretion. Results of some of these studies are indicated.

Determination of Inulin in Blood and Urine by Means of Vanillin in Acid Medium. Victor E. Levine and William W. Becker, Department of Biological Chemistry and Nutrition, Creighton University School of Medicine, Omaha, Nebraska.

Vanillin reacts in acid medium with inulin to produce a characteristic red color yielding an absorption spectrum with a peak of 520 millimicra. For inulin in blood one volume of plasma is mixed with 5 volumes distilled water, 2 volumes 10 per cent zinc sulfate, and 2 volumes 0.5 N sodium hydroxide. 2 ml. of the protein-free filtrate are taken together with 0.8 ml. one per cent aqueous solution of vanillin and 2.2 ml. concentrated sulfuric acid. The mixture is heated in a boiling water bath for 2 minutes and cooled in ice water. The optical density is read within 10 to 20 minutes. For urine one volume is mixed with 5 volumes distilled water, 2 volumes 10 per cent zinc sulfate and 2 volumes 0.5 N sodium hydroxide. The Somogi reagent removes any protein present and serves to decolorize the urine. The filtrate is diluted so that the final dilution is 1:300. This dilution is necessary to lower the concentration of inuloid material. Two millimeters of the diluted filtrate is treated in the same manner as the plasma. In the determination of glomerular filtration, controls for both blood and urine samples prior to injection must be taken to measure inuloid material. The final calculation involves subtraction of the inuloid material.

(Supported by a United States Public Health Service grant.

Meet Our NEW MEMBERS
The Nebr. State Medical Assn.

William J. Russum, M.D., was born in Omaha, Nebraska, and is a graduate from Benson High School in Omaha. He completed his premedical education at Iowa State College and Northwestern University.

He attended the University of Nebraska College of Medicine from which he graduated with a degree Doctor of Medicine, in 1953.

Doctor Russum served in the United States Navy from 1943 to 1946.

He is a member of Alpha Omega Alpha from the University of Iowa. Doctor Russum is in general practice in Omaha, Nebraska. He is married and his hobbies are model railroading and “Hi Fi.”

Edward J. Sanders, M.D., was born March 2, 1925, in Omaha, Nebraska, and he graduated from Creighton Prep. He earned a Bachelor of Science degree at the University of Notre Dame. He graduated from the Creighton University School of Medicine in 1949.

Doctor Sanders interned at St. Catherine’s Hospital in Omaha.

Doctor Sanders was a Fellow in general surgery at the Mayo Clinic from 1952 to 1956. During that time he served as President of the Association of Fellows of the Mayo Foundation.

He is presently in private practice of surgery in Omaha, Nebraska, and is a member of the faculty of the Creighton University School of Medicine.

Doctor Sanders is single.
The rising cost of a medical education to produce a doctor is a most serious problem. The average young aspirant for an M.D. degree labors through eight to ten years—and quite a few others through ten to twelve years—worrying about how sufficient dollars will come up to complete his medical education, the parents usually making many sacrifices and wondering if the end will ever come in his educational program. The medical schools have the daily worry of meeting the high standards of accreditation of the modern medical school on too low a budget. As usual, some immediately advise turning to the paternalistic federal government for support. Those with foresight and wisdom do not want a federal entry into the field of medical education. To forestall any strong entering and controlling wedge, the American Medical Education Foundation and the National Fund for Medical Education were founded in 1951. The National Fund is industry’s effort, for which we must be most thankful and appreciative. The American Medical Education Foundation (AMEF) is the child of the medical profession—that is of us DOCTORS—spearheaded by an original grant of $500,000.00 from the A.M.A.

Now it is the medical profession’s responsibility to continue the success of AMEF. The profession’s concern for its medical schools is supported by the fact that in 1957 the AMEF gave $1,017,336.00 in grants to 83 medical schools and alumni associations of medical schools contributed $2,247,425.00. All contributions to AMEF go to the medical schools in full since the A.M.A. pays for all administrative and promotional costs of the Foundation.

On the surface there might appear to be a conflict between donations to the AMEF and to medical school alumni associations or drives by medical schools. Actually this conflict does not exist, as any money directed to the American Medical Education Foundation may be designated wholly or in part to any particular medical school. Simply earmark the check AMEF Medical College ________ or AMEF ________ Medical Alumni Association, or fill in the envelope provided by AMEF which asks for designation to the general fund or to a particular medical school and mail it to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10, Illinois.

Each state medical society has a responsibility and let’s have the record look good for Nebraska by directing donations through the American Medical Education Foundation. Please remember you can assign your money to any medical school in the country. Dr. Wilson B. Moody is Chairman of this project for Nebraska. He is donating much time and effort to getting this program organized. Please give him, your school and the Nebraska State Medical Association your support when you are contacted, and promote American Medicine the free way.
Organization Section

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
March 1, Scottsbluff, St. Mary Hospital
March 15, Broken Bow, Elks Club
March 29, Ainsworth, Elementary Grade School
April 12, McCook, St. Catherine Hospital
April 26, Ogallala, Elks Club

ANNUAL SESSION—Nebraska State Medical Association, April 28 - May 1, 1958, Hotel Cornhusker, Lincoln.


AMERICAN ACADEMY OF GENERAL PRACTICE—Tenth Annual Scientific Assembly, March 24-27, 1958, Dallas, Texas.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS — 1958 Annual Convention, Nov. 16-20, 1958, Statler Hilton Hotel, Dallas, Texas.

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE — Fifth International Congress, April 24-26, 1958, Sheraton Hotel, Philadelphia, Pa.

NOTICE TO ALL CONTRIBUTORS

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

DELEGATE'S REPORT

on the

PROCEEDINGS of the HOUSE of DELEGATES of the AMERICAN MEDICAL ASSOCIATION at the

CLINICAL MEETING

December 3 to 6, 1957

Philadelphia, Pennsylvania

THE ELEVENTH ANNUAL CLINICAL MEETING of the American Medical Association held in Philadelphia, December 3 to 6, 1957, taking into consideration all that enters into making a medical meeting ideal, such as scientific program, clinics, scientific and technical exhibits, televised and moving pictures, was most successful—weatherwise and attendance, not so good. Total registration was 6900, of which only 2637 were physicians. Physicians registering from Nebraska numbered eleven, which, percentage-wise, from the standpoint of total number of physicians practicing in our State was excellent, especially when compared to those registering from neighboring midwestern states.

It has been said that weather was the factor in reducing attendance. Admittedly, the weather included all the vagaries that Nature has to offer—torrential rains, sunshine, spring weather, and a snowstorm of near-to-real blizzard proportions—all within five days. However, with physician-population concentrated as it is on the Atlantic seashore, short distances to travel, superb highways well maintained, and rail, bus, and air transportation on near-to-commuter schedules—well, I am unable to accept “weather” in entirety as the cause for the comparatively small physician registration. In retrospect, a national organization cannot hold two meetings within a period of six months within a radius of 75 miles and hope to obtain a near-to-top mark in attendance. Physicians in the middle, far southern and western regions of our country, except for those obligated, such as officers, delegates, et cetera, cannot spare the time and the expense for such planning. In my experience this is the first time that two A.M.A. meetings have been held within six months in cities so close by. In the future, delegates should give more considered thought to the place for A.M.A. annual and clinical meetings, regardless of recommendations.

Incidentally, thought might well be given as to whether or not two meetings each year, comparable in all respects, should be continued by the A.M.A.; tremendous effort and expense ensue. In my opinion two sessions of the House of Delegates should be held each year—three or four if necessary—because after all, the decisions as to A.M.A. policy, and, to a considerable degree, that of the constituent associations, are made by the House of Delegates, a group of men chosen by the respective constituent societies, instructed or otherwise, to represent their membership in their desires. As I see it,
The House of Delegates, during the immediate past sessions, accomplished a tremendous amount of work in relatively short time. Approximately 30 resolutions and reports from the Officers, Board of Trustees, Councils, and Committees of the A.M.A. were introduced, necessitating lengthy consideration on the part of each reference committee and the House. Looking back, it is remarkable how efficiently the House of Delegates now accomplishes the work at hand as compared with only a few years ago. As of today ample time is provided for full discussion by opponents and proponents of all reports referred to reference committees for consideration. Each year sees more and more time given to this procedure, followed, of course, by lengthy executive sessions by the reference committees wherein decisions are made and encompassed in their reports to the House of Delegates. Evidently their accomplishments are of the first order, inasmuch as heated discussion on the floor of the House has been practically eliminated and thereby the work of the House expedited.

The President of the American Medical Association, Dr. David B. Allman, in his address to the House of Delegates, was superb and I am confident that those present will never forget his earnest and militant remarks relative to what has, is now, and may in the future affect the unfettered practice of medicine. He discussed the basic philosophies of American Government and then pointed out the many mutations encountered in the past twenty-five years. He then emphasized the effect of "Deal Philosophies" and their impact on all free enterprise, especially the practice of medicine. The already apparent trends of Government—and may I add Labor — are accumulating with only one inevitable end — communism, facism, socialism, totalitarianism. He urged active opposition to the "Forand Bill." The ideas contained in this bill will be engrafted on social security. This, in substance, means that all people reaching the age of 65 will be assured of totalitarian medicine — namely, "free" hospital service and all that that includes, "free" physician service and all that that includes, as well as "free" nursing service. Services such as these must be paid for, and inasmuch as our Government has no money except that which is collected through our tax system—another bite from us, the taxpayers. It is the fond hope of your delegates that all members of our State Association acquaint themselves with the particulars of the Forand Bill and use their influence not only with our representatives in Congress but all civic groups and individuals as well. I might add that the House of Delegates condemned the Forand Bill and endorsed with satisfaction the actions of the Board of Trustees, the Legislative Committee, and the special Task Force which was created for the purpose of defeating this particular legislation.

The most important item on the agenda for the consideration of the House was the Heller Report, in that it had to do with the entire reorganization of the A.M.A. This report had been studied at considerable length by the Hyland Committee, the members of which were Doctors William H. Hyland of Grand Rapids, Michigan, chairman; Lewis Alesen, Los Angeles, California; Harlan English, Danville, Illinois; Charles Stone, Galveston, Texas; and Norman Welch, Boston, Massachusetts. I received a most courteous hearing, as I had anticipated, because of the caliber of the personnel, when I appeared before this committee prior to the Clinical Meeting to present the objections of the Council on Medical Service to a number of items having to do with the reorganization of the Council and committees as contained in the Heller Report. Fortunately the Hyland Committee and the House of Delegates concurred in our objections, and all suggestions pertaining to the Council were negated.

Recommendations in the Heller Report relative to administration of the A.M.A., such as creating the post of Executive Vice President to replace that of Secretary and General Manager; combining the offices of Secretary and Treasurer, this office to be filled by a Trustee; appointing a joint House-Trustees committee to study and redefine "the central concept of A.M.A. objectives and basic programs;" creating a group to study the socio-economic problems and place more emphasis on scientific activities; the recommendation that the A.M.A. actively engage in "creating more cohesion among national medical societies"—all were approved by the House of Delegates and, in the opinion of your delegates, rightfully so. The House also decided that the Vice Presi-
dent, the Speaker and Vice Speaker of the House of Delegates would attend all Board meetings, this to include executive sessions, giving to these officers the right of discussion but not the right to vote.

Dr. F. J. L. Blasingame of Wharton, Texas, was appointed as the Executive Vice President succeeding Dr. George F. Lull.

Doctor Lull, it was announced, would succeed Dr. Louis H. Bauer as Secretary General of the American Medical Education Foundation.

In my opinion one of the most impressive ceremonies and one of the most popular recipients of the annual General Practitioner Award was Dr. Cecil W. Clark, age 33, who was practicing in Cameron, Louisiana, at the time of “Hurricane Audrey.” The exploits of Doctor Clark during this terrible blow by Nature, who during those days, not knowing the whereabouts of his wife and family nor that he had lost his home and three of his five children, have been publicized to the degree that I am sure all members of the Nebraska State Medical Association are well aware of what this true disciple of medicine accomplished. Doctor Clark surely knew the definition of “duty.”

Flouridation of water was a subject which, prior to and during the meeting of the House of Delegates, received due consideration. I am of the opinion that all physicians in the United States received the same stack of manuscripts, monographs and what-have-you as to the pros and cons on this subject prior to the Clinical Meeting. This, along with opinions of members of the House and members of the medical profession outside the House, consumed much time; the end result—concerned in by the reference committee and the House—was the adoption of a joint report of the Council on Drugs and the Council on Foods and Nutrition which “endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood.”

The House concurred in the idea that the Board of Trustees should confer with representatives of pharmaceutical organizations for the purpose of establishing a code of practices regulating the future distribution of important therapeutic products.

The “attitude and method of operation” of the United Mine Workers of America Welfare and Retirement Fund” was condemned, it being the belief of the House that it had much to do in lowering the quality and availability of medical and hospital care to its beneficiaries.

The House affirmed that “it is within the limits of ethical propriety for physicians to join together as partnerships, associations, or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians.”

The House reaffirmed a statement of the Judicial Council, which I think is of the utmost importance and should be given wide publicity so that all local medical societies understand their responsibilities. This endorsement reads as follows: “That if local societies fail to curtail unethical practices, ethics lose their effectiveness.” For all “local societies” — this pronouncement should be dogma.

Other matters receiving the endorsement of the House were the need for physicians to militantly support the enactment of the Jenkins-Keogh Bills having to do with retirement income for the self employed; a thorough investigation of the social security system by a qualified private agency; creation of a group to be known as the “American Medical Research Foundation,” the purposes of which would be to “initiate and encourage necessary medical research and correlate and disseminate the results of studies already under way.”

Among many other commitments, I attended two conferences, one on “Medicare” and the other on “Perinatal Mortality and Morbidity.” The Medicare conference was sponsored by the Medicare Task Force of the A.M.A., the research for which is accomplished by the Council staff. The other program was sponsored by the Committee on Maternal and Child Care, a committee of the Council on Medical Service. Both meetings had overflow audiences and it was the consensus that these two meetings had served their purposes to the Nth degree—that is, overall up-to-now information and full discussion on both subjects.

It is impossible to enumerate all of the Proceedings of the House of Delegates in this report and I would suggest that those interested read the transactions which will appear in one of the coming issues of the
of the American Medical Association.

I am of the opinion that too few know about the work of the Council on Medical Service, which covers problems incident to the actual Practice of Medicine. I would like to acquaint you with overall Council activities by naming the eight committees of the Council: Aging, Federal Medical Services, Indigent Care, Maternal and Child Care, Medical and Related Facilities, Medical Care for Industrial Workers, Prepayment Medical and Hospital Service, and Relations with Lay Sponsored Voluntary Health Plans, all of which have many interrelated problems which do not appear on the surface. Projects and progress reports of the work of the Council and its Committees appear in publications of the A.M.A. as well as in some state and county society journals. The Council courts opinions and suggestions from individual physicians.

I would like to express my appreciation to Dr. Earl F. Leininger, my associate Delegate; Dr. R. Russell Best, President of the Nebraska State Medical Association and Mr. M. C. Smith, our most efficient Executive Secretary, for their good counsel while in attendance at the meetings of the House of Delegates during the 1957 Clinical Meeting.

Respectfully submitted,

J. D. McCarthy, M.D.

The Month in Washington—

Those who are trying to follow the course of medical legislation, find an unusual situation developing in this session of Congress. All of Washington is being subjected to forces, some completely new, that often work at cross-purposes to each other. The result could be a moratorium on health legislation—or again it could be a flood of new laws.

At the start of the session, a new-born interest in science completely dominated the scene—by a frantic spending of billions of dollars we would overtake Russia. That was the theme in Washington, and it persisted despite a few quiet voices that asked whether Russia really had far outdistanced the U.S. or was merely exploiting a slight advantage.

Even before the American satellite started on its orbit, some of the panic had subsided, and most of the legislators had decided that advent of the space age had not removed all of the old problems and opportunities in legislation and politics. The familiar issues were still there, medical panaceas included.

The shock of Russian achievements will, at any rate, produce legislation designed to shore up our educational system. This seems to be generally accepted. For the medical profession, two provisions are of major interest. Scholarships would be either four years—possibly six—offering some assistance to premed students and in some cases to those in their first year of medical school. Also, fellowships would be available for medical and other graduates if they wanted to teach or go into research.

The administration’s idea was a program that would cost a billion dollars; several leading Democrats joined in a bill proposing three billion dollars as a stimulant to mathematics and science.

But there are other factors to be reckoned with. For the first time a President set down in black and white in his budget just how he proposed to withdraw the federal government from some activities, or limit its participation, and turn the programs back to the states. Mr. Eisenhower wants to slow down on the Hill-Burton hospital construction program and change its emphasis, he wants to mesh in some veterans’ benefits with social security payments, he would have the states do more and the U.S. less in public assistance (where medical payments are a growing factor), and he hopes to get Congress to drop the $50 million a year program of grants to help build water treatment plants.

Whether Congress will follow the President’s lead in the back-to-the-states movement is another question. At least he has said specifically what he thinks should be done, and when.

There was no expectation that the Russian scare would dilute politics this election year—and it hasn’t. If anything, the partisans are struggling harder than ever to make records that will reflect glory on them next November. Some of course, would be pressing for their projects regardless of the election.

So this is the prospect, in brief:

The Defense Department and science will get the major attention and the major
money, but some may spill over into medicine.

There is some interest in a tight domestic budget and returning certain activities to the states, but old fashioned politics combined with a fear of a continuing recession may again open up the federal purse.

Medical legislation, always a popular subject, may get more and more attention as the session rolls on. If so, the Forand bill among others would come immediately to the fore.

NOTES

Several developments in the legislative field on Jenkins-Keogh bills came early in the session. The American Thrift Assembly, representing some 10 million self-employed, urged favorable House Ways and Means action, and the American Medical Association pointed out that the proposal for tax deferment of money paid into retirement plans could help solve the problem of maldistribution of physicians.

In the Senate, a majority of the Small Business Committee introduced a tax relief bill with a J-K provision. The section would allow anyone not now benefiting from a qualified pension plan to set aside 10% of annual income ($1,000, maximum). The bill went to Senate Finance Committee.

A limited number of medical scientists from this country and Russia will give lectures in each other's countries this year in an exchange program worked out by the State Department and the Soviet government. Also planned are exchanges of medical journals between medical libraries and of medical films. All these are part of a broad scientific, cultural and education program between the two nations. Details haven't been worked out.

Six members of the Health Resources Advisory Committee have been named by Defense Mobilizer Gordon Gray. The committee, headed by Dr. Elmer Hess, advises government on health and medical problems in time of war or national emergency. Members are Dr. George C. Whitecotton, Oakland, Calif., Dr. Franklin Yoder, Cheyenne, Wyo., Dr. Mary Louise Gloechnor, Conshohocken, Pa., Harold Oppice, DDS, Chicago, Dr. William Walsh, Washington, D.C., and Frances Graff, RN, Grand Rapids, Mich. (From A.M.A. Washington Office).

Muscular Dystrophy Survey—

The following is published for your information at the request of Mrs. Marvin Traeger, President of the Muscular Dystrophy Foundation of Nebraska.

The Muscular Dystrophy Foundation of Nebraska has been asked by many interested persons to make a Muscular Dystrophy Survey to determine the number of such patients in the state. As far as is known, no state has undertaken such a survey. Therefore, we are calling on all the physicians of the state to help us make such a survey possible in Nebraska.

In the not too distant future, each physician will receive a patient-questionaire, and letter of explanation. We hope each one will provide us with the information he can, and return a reply to us. We feel that if each physician fills out a form, this will be the best method of conducting a successful survey.

The Foundation hopes to have a report completed by May 1, 1958. When all figures and information are secured and tabulated, a report will be sent to the Nebraska State Medical Association Executive Secretary and also to the Nebraska State Medical Journal.

Mrs. Marvin Traeger, President, Muscular Dystrophy Foundation of Nebraska.

A.M.A. Offers Aid in Battling the 1040 Form—

Don't let those income tax forms get you down!! Now's the time to write to the A.M.A. Law Department for its new booklet—"The Federal Income Tax Guide for Physicians"—for answers to some of your most perplexing tax problems. This timely new booklet has been compiled from court decisions as well as rulings, regulations and publications of the Internal Revenue Service. It has been designed to give physicians a better understanding of their rights and obligations under federal income tax laws. The Law Department staff has only one word of advice: Do not consider this booklet as a substitute for the services of a personal tax advisory.

March, 1958
Conference Scheduled on Perinatal Mortality—

The Committee on Maternal and Child Care of the A.M.A.'s Council on Medical Service will meet March 22-23 in Chicago. The second day of this meeting will be devoted to a joint conference with North Central area physicians interested in problems concerning perinatal mortality and morbidity. Topics to be discussed include terms and definitions used in perinatal mortality studies, organization and operation of such studies and classification of causes of perinatal deaths.

This will be the second regional meeting on this subject. Nebraska representatives from state and local medical society committees, state and local health departments, and individual hospitals have been invited.

Distinguished Service Award to
Dr. H. Winnett Orr—

From the January-February issue of Bulletin of the A.C.S. we take the following:

"The Distinguished Service Award of the American College of Surgeons has been given, posthumously, to Dr. H. Winnett Orr, Lincoln, Nebraska, who died October 11, 1956 . . .

"The citation reads: 'For his work as a surgical educator, for his contributions in clinical research, for his devotion to the American College of Surgeons for 42 years, and his many benefactions to its library, this Distinguished Service Award is bestowed on Dr. H. Winnett Orr, Lincoln, Nebraska, by the unanimous vote of the Board of Regents.'"

A.M.A. Drafts Model Law to Reduce Poison Deaths—

After a study requiring 15 months, the Committee on Toxicology of the A.M.A. has formulated and announced a broad and encompassing model law providing for the precautionary labeling of hazardous substances in commercial, household, and industrial chemical products. Such a law has been badly needed and should go far toward reducing the number of accidental poisonings.

Special Issue of A.M.A. Journal—

A special edition of the Journal of the A.M.A. under date of Febr. 15, will come to your desk. This 117-page issue is devoted to evaluation of permanent impairment of the extremities and back. It is the work of the committee on medical rating in physical impairment appointed by the Board of Trustees in September, 1956. This special edition is the first of a series of guides which the committee hopes to develop with the assistance of outstanding consultants.

Army Provides Earlier Release for Current Two-Year Medical, Dental Officers—

The Army has announced that due to the reduction in the Army's strength this fiscal year, a certain number of Army medical and dental officers scheduled to complete their two-year service agreements between February 1 and August 31, 1958, may be able to return to civilian status after 21 months of active duty.

Books—

Healthful School Living was prepared under the auspices of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. The contributors and the Joint Committee are representative of various fields of education, public health, and medicine.

This volume of 323 pages emphasizes solutions to health problems affecting pupils as they live and learn at school. Information on such items as school housekeeping, prevention of accidents, water supply and waste disposal, heating, ventilating and lighting, school building construction, and physical education is given. Suggestions are made on health problems involved in organization of the school day, on health implications of various classroom procedures, and about the special needs of rural schools.

This book was published during 1957, and is available from the American Medical Association at $5.00.


Doctor Danowski, Professor of Research Medicine at Pittsburgh School of Medicine, discusses diabetes showing the roles of doctor, patient, and family. The style is simple enough to permit understanding by the patient. All essential details are adequately covered.
Community leaders said the hospital can be purchased for 128 thousand dollars plus the cost of improvements now in progress estimated to be from five thousand to seven thousand dollars. Estimated cost of a new building with similar facilities is 300 thousand dollars.

A permanent hospital group has been appointed.

World Medical Association Grows in Number and Influence—

During 1957, the United States Committee of the W.M.A. added the greatest number of new members in any year since its organization—797. The growing interest of the U.S. Committee is illustrated by the increasing attendance at its “open meetings” held during the annual A.M.A. sessions. Dr. Louis H. Bauer, in commenting on the U.S. Committee says: “... The Committee has a right to be proud of the indispensable role it has played in helping to support the General Secretariat of the World Medical Association in New York, and in making possible the establishment and growth of the World Medical Journal. Here is another instance in which American leadership has been steady and strong; and our supporting committee has provided an example that has yet to be equalled by the profession in any other W.M.A. member country.”

Every American doctor should seriously consider membership on this committee. This is a way of serving the cause of freedom of practice of medicine on a worldwide basis.

What A.M.A. Meetings Mean to a City—

Under the above title, the Secretary’s Letter No. 428 gives the following information about the meeting in New York, last June:

- Total out-of-town attendance.............20,000
- Number of forms sent to
  - out-of-town physicians ................. 500
- Replies received ....161 covering 213 persons
- Average daily expenditure, per person ...........................................$35.27
- Average length of stay..................5 to 10 days
- Total expenditures for 20,000 visitors ..............................................$3,608,130
A.M.A. Offers Aid in Battling the 1040 Form—

Don't let those income tax forms get you down! Now's the time to write to the A.M.A. Law Department for its new booklet—"The Federal Income Tax Guide for Physicians"—for answers to some of your most perplexing tax problems. This timely new booklet has been compiled from court decisions as well as rulings, regulations and publications of the Internal Revenue Service. It has been designed to give physicians a better understanding of their rights and obligations under federal income tax laws. The Law Department staff has only one word of advice: Do not consider this booklet as a substitute for the services of a personal tax advisor! Incidentally, this material is also scheduled to appear in the Journal of the A.M.A.

Introducing the New Today's Health—

Today's Health—A.M.A.'s popular health magazine—is having its face lifted! In the coming months you'll see many changes in the magazine—a new logo (title line), new cover layout, tint block "news" page, broader editorial base, new editorial style and a completely new inside format. Since the A.M.A.'s Board of Trustees approved a reorganization plan for the magazine, the following changes in staff have been made: new editor James M. Liston, formerly special feature editor of Better Homes and Gardens; new associate editors—Dennis Orphan, previously associate editor of McGraw-Hill's Industrial Distribution, and William Vath, formerly managing editor of National Safety Council's Safety News; production coordinator Robert Hendrickson, previously with Popular Mechanics Magazine.

In addition, Today's Health now has its own advertising review committee—Leo E. Brown, A.M.A. public relations director, chairman; Dr. Austin Smith, editor of Journal of the A.M.A.; C. Joseph Stetler, director of the Law Department, and W. W. Hetherington, executive publisher, Today's Health.

On all counts, 1957 was a good year for Today's Health. . . advertising lineage increased more than 30 per cent over 1956 with dollar volume showing a 40 per cent gain; 1956 advertising was renewed at a rate exceeding 90 per cent; 51 new advertising accounts were established in 1957; circulation continued to grow, topping the 400,000 mark for 9 of the 12 issues.

Human Interest Tales

Dr. R. W. Roach, formerly of Omaha, has opened his medical office in Crete.

Dr. D. E. Wilkinson, Chicago, is a new associate of Dr. W. V. Glenn of Falls City.

Dr. F. G. Travnicke, Wilber, was recently appointed county physician for Saline County.

Dr. Donald Murray, Chicago, has moved to Hastings where he will set up his practice.

Dr. Bryce G. Shopp, Imperial, has become engaged to Miss Wanda Walbridge of Pawnee.

Dr. J. E. M. Thomson, Lincoln, has been re-elected as chairman of the state board of health.

The father of Dr. O. D. Prentice, Morrill, passed away in Cassville, Missouri, late in December.

Dr. John C. Finegan, Bertrand, has been elected chief of staff of Lexington Community Hospital.

Dr. L. V. Brennan, Falls City, has been appointed physician for the Missouri Pacific railroad.

Dr. W. J. Lear, Ainsworth, has moved to Norfolk to join the staff of the Norfolk Medical Group.

Dr. George Hoffmeister, Hastings, has been elected president of the Adams County Medical Society.

Dr. S. M. Weyer, Ogallala, spent several days in a Denver hospital for medical treatment in January.

Dr. Earl Leininger, McCook, has been elected vice president of the Mississippi Valley Medical Society.

Dr. Robert Heins, Alta, Iowa, has arrived in Falls City to open his offices for the practice of medicine.

Dr. William Boelte, Omaha, was a guest speaker at a recent meeting of the Phi Chi Wives' Club in Omaha.

Dr. S. T. Thierstein, Lincoln, is the new president of St. Elizabeth Hospital medical staff for the coming year.

Dr. F. G. Gillick, Omaha, attended the Congress on Medical Education and Licensure in Chicago in February.
Dr. Dwaine J. Peetz, Neligh, has been named chairman of the medical staff of the Antelope Memorial hospital.

Dr. A. J. Offerman, Omaha, has been named president-elect of the North Central Medical Conference for 1958.

Dr. Harold McConahay, Holdrege, was a guest speaker at the January meeting of the Holdrege Junior Woman's club.

Dr. C. T. Frerichs, Beatrice, has been notified of his election as an associate in the American College of Physicians.

Dr. Willard Hill, Fremont, is the newly elected president of the medical staff of Dodge County Community Hospital.

The Dawson County Medical Society Woman's Auxiliary has voted to increase its Nurse Scholarship Loan Fund to $300.

Dr. I. L. Thompson, West Point, gave a talk at the January meeting of the Cuming County Nurses Association, in Norfolk.

Dr. A. W. Anderson, West Point, was recently named president of the Farmers and Merchants National Bank of that city.

Dr. Gerald R. F. Landry, Council Bluffs, Iowa, has been named to the staff of the University of Nebraska College of Medicine.

Dr. John Yost, Hastings, was a guest speaker at the January meeting of the Junior Department of the Woman's Club in that city.

Dr. Henry Kammandel, Omaha, presented a paper at the January meeting of the Madison Six County Medical Society in Norfolk.

Dr. F. G. Gillick, Omaha, attended a recent meeting of the membership committee of the American Heart Association in Chicago.

Dr. O. A. Kostal, Hastings, has been re-elected chairman of the Mary Lanning Memorial Hospital School of Nursing advisory committee.

Dr. Earle G. Johnson, Grand Island, has announced his resignation from the Grand Island Board of Education after 22 years as a member.

The Omaha Chapter of Hadassah paid tribute to Dr. Abe Greenberg of Omaha, in January, for his forty years of service to the community.

Dr. Donald C. Nilsson, Omaha, presented a paper at the regular meeting of the Madison Six County Medical Society at Norfolk in January.

Dr. E. A. Steenburg, Aurora, is the new chairman of the Nebraska Joint Commission for Improvement of Patient Care, for the coming year.

Mrs. Helen M. Mongeau, mother of Dr. Donald C. Mongeau, Grand Island, passed away unexpectedly at her home in Grand Island in January.

Drs. Frank Kamm and Thomas Lucas, Blue Hill, presented a health program at a recent meeting of the Blue Hill Parent Teachers Association.

Open house was held in January for the new Pioneer Memorial Clinic in Mullen. Dr. S. F. Blattspeiler recently opened his practice in this community.

Dr. Charles Tompkins, Omaha, presented a talk on "Care of the Epileptic Child," at the January meeting of the Nebraska Epilepsy League in Omaha.

Mrs. Elizabeth Barrett passed away in Baltimore, Maryland, in January. She was the widow of the late Dr. J. E. Barrett, pioneer Lawrence physician.

The new officers for the Omaha-Douglas County Medical Society for the coming year are Drs. Maurice E. Grier, president; and E. K. Connors, secretary.

Dr. George O. Lewis, Broken Bow, has discontinued his practice in this city and has tentative plans to set up a residency in aviation medicine in the Air Force.

Dr. Robert Foreman, Beatrice, has left this city for Phoenix, Arizona, where he will be in private practice and also serve as company physician for an industrial firm.

Dr. Pauline Slaughter, Norfolk, discussed local and state health laws before a recent meeting of members of the citizenship department of the Norfolk Woman's Club.

Dr. C. J. Potthoff, Omaha, has received a certificate from the Douglas County Chapter of the Red Cross Safety Service Society for outstanding work in first-aid education.

The Nebraska Board of Control met with representatives of the medical and hospital professions in North Platte, in January, to
discuss establishment of a mental health clinic.

Dr. Jackson Smith, Omaha, discussed the topic "How to Live With Your Anxieties," at a series of lectures which was held at the Veterans Hospital in Grand Island, in January.

Drs. Ralph Moore, Omaha, and Charles Marsh, Valley, presented a discussion and showed slides on traffic safety, at the January meeting of the Tri-County Medical Society in Fremont.

**Announcements**

**Postgraduate Conference at Creighton And St. Joseph's—**

The Creighton University School of Medicine will present a Postgraduate Conference at the Creighton Memorial-St. Joseph's Hospital and the School of Medicine on April 8, 9 and 10, 1958. The first day will be devoted to Practical Clinical Hematology with Dr. William Harrington, Associate Professor of Medicine and Director of the Department of Hematology, Washington University School of Medicine, St. Louis, as guest speaker. The second day will be devoted to rehabilitation Procedures with Dr. Frederick J. Kottke, Professor and Chairman of the Department of Physical Medicine and Rehabilitation, University of Minnesota School of Medicine as guest speaker. On the third day, some new practical office laboratory tests will be demonstrated at the School of Medicine. Emphasis will be placed on demonstrations and active participation of the registrants in procedures of interest to the general practitioner. The number of registrants will be limited to 50 in order to offer instruction to small groups. If interested, communicate with C. M. Wilhelmj, M.D., The Creighton University School of Medicine, Omaha 2, Nebraska.

**Psychiatric Speakers Bureau—**

The General Practitioner Education Project, jointly sponsored by the American Psychiatric Association and the American Academy of General Practice, is interested in the development of postgraduate psychiatric education for the family physician. One of the services which is offered by the Project is a Speakers Bureau, which is prepared to offer names of psychiatrists who are willing to serve as guest lecturers while they are taking their vacation trips. Medical societies, hospitals, etc., which are interested in obtaining names of psychiatric speakers, please contact the G. P. Project, American Psychiatric Association, 1785 Massachusetts Avenue, N.W., Washington, D.C.

**Nebraska Society of Internal Medicine To Meet—**

The Nebraska Society of Internal Medicine, organized November 7, 1957, will hold its first Annual Meeting at the Hotel Cornhusker in Lincoln, March 15, 1958.

The officers of this new chapter were listed in the February issue of the Journal. Advisors to the Nebraska Society are Drs. J. D. McCarthy and Edmond M. Walsh of Omaha.

**National Foundation for Infantile Paralysis Offers Fellowships—**

The N.F.I.P. is offering fellowships to postdoctoral investigators, teachers, graduate students, and experienced laboratory personnel with the baccalaureate degree for participation in short courses in tissue culture. Financial assistance re: maintenance, tuition, fees, and transportation. For details write: Division of Professional Education, National Foundation for Infantile Paralysis, 301 E. 42nd St., New York 17, N.Y.

**National Postgraduate Conference on Venereal Disease—**

The 27th Annual National Venereal Disease Postgraduate Conference for physicians, sponsored by the Texas Postgraduate School of Medicine, Baylor University College of Medicine, Texas State Department of Health, will be held at the University of Texas, M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston, Texas, April 23-25, 1958.

Applications for admission are to be sent to: Dr. Grant Taylor, University of Texas Postgraduate School of Medicine, Houston, Texas.

**Aero Medical Association to Meet—**

The Annual Meeting of the Aero Medical Association will take place March 24-26, 1958, at the Statler Hotel in Washington,
D.C. The program will be put on by experts, but has been made sufficiently broad to serve all interests. It will be arranged in three simultaneous sessions so that each participant can select the material which suits his special interests. Many interesting activities will be provided for the wives of members.

A National Industrial Health Conference—

A National Industrial Health Conference devoted to the problems of keeping workers healthy and on the job through control of hazardous exposures and provision of preventive medical services in industry, will be held in Atlantic City, N. J., April 19-25, 1958.

Summer Camp for Diabetic Children—

The Summer Camp for Diabetic Children will be conducted for the tenth year under the auspices of the Chicago Diabetes Association from July 20th through August 10th, at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through fourteen years of age are eligible.

The camp will be staffed by resident physicians, a nurse, two dietitians, and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for Summer Camp are arranged in accordance with individual circumstances.

Applications may be obtained from, and inquiries should be addressed to: The Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3, Illinois. Phone ANdover 3-1861.

Deaths

Vernon M. Winkle, M.D., Norfolk—Doctor Winkle was fifty-six years old at the time of his death. Death occurred December 31, 1957 at a Topeka hospital. Dr. Winkle, who was formerly a physician and surgeon in Norfolk about 12 years, had been at Topeka 16 years as director of local health services for the Kansas State Board of Health. He suffered a cerebral hemorrhage at his home in Topeka the evening of December 30, 1957 and died the following noon. While in Norfolk Dr. Winkle was associated for several years with Dr. A. J. Schwedhelm. He was graduated from the University of Nebraska and its medical college and had a master's degree in public health from Vanderbilt University, Nashville.

Griffith A. DeMay, M.D., McCook—Doctor DeMay died January 6, 1958, at the age of sixty-seven, at St. Catherine's Hospital, Omaha, after being hospitalized about six months. Dr. DeMay began practicing medicine in Indianola when he was 25 and moved to McCook almost 40 years ago.

Orin C. Ehlers, M.D., Ravenna—Doctor Ehlers died in an aeroplane accident on January 30, 1958. He was fifty-two years old and had practiced in Ravenna for twenty-six years. He graduated from the University of Nebraska College of Medicine in 1930.

William James Douglas, M.D., Atkinson—After three years as a patient in St. Joseph's Hospital, Omaha, Doctor Douglas died on January 23, at the age of seventy-nine. The doctor graduated from the University of Nebraska College of Medicine in 1910. He practiced a year in Tilden, then moved to Atkinson. He practiced in this city until 1954.

William Edmonds, M.D., Nebraska City—Doctor Edmonds died January 24, 1958, at St. Mary's Hospital, Nebraska City, of pneumonia. Dr. Edmonds had been confined to a wheel chair for several years. The doctor was a graduate of Fredonia State College and the Jefferson Medical College of Philadelphia, Pa. He practiced medicine in Erie, Pa., before moving to Nebraska City in 1903. He served as a captain in the Army during World War I.

H. M. Harvey, M.D., Gothenburg—Doctor Harvey died at his home November 30, 1957, the victim of a gunshot wound. He died at the age of seventy-six years. He had been a Gothenburg physician for the past 31 years, moving there from Burchard, Nebr.

Elmer C. McAleer, M.D., Omaha—Doctor McAleer died at the age of fifty-eight in the Denver Veterans Administration Hospital. He was born in Monticello, Iowa. He graduated from Creighton University School of Medicine in Omaha. Doctor McAleer practiced medicine in Auburndale for several years, leaving there for the Omaha area.
W. C. Miller, M.D., Portland — Doctor Miller died November 29, 1957, of a heart attack at his office at the Rose Hill Clinic, Portland, Oregon. He had suffered from heart trouble the past several years and was carrying on only a limited practice. Doctor Miller was about sixty years of age when he died. He graduated from the University of Nebraska College of Medicine. The doctor was raised at Culbertson and moved to Arapahoe in 1921, shortly after graduation from University of Nebraska College of Medicine.

Rudolph E. Kriz, M.D., Lynch — Doctor Kriz died December 13, 1957 at the age of 65. Doctor Kriz, whose health had been failing for the past two years, died at the Clarkson-Memorial Hospital in Omaha. He received a Bachelor of Science degree from Fremont Normal College in 1913, attended Creighton University, and received his Doctor of Medicine from the University of Nebraska in 1917. He practiced medicine in Norfolk for a year and a half and moved to Lynch in June, 1921, where he had been practicing ever since.

Lester Shupe, M.D., Caldwell, Idaho — Doctor Shupe, who was formerly associated with the Lynch Clinic, died suddenly December 7, 1957, at Caldwell, Idaho, where he was chief surgeon of the Caldwell hospital. Doctor Shupe became associated with the Lynch Clinic in July, 1935, and left Lynch for service with the armed forces during World War II.

Nelson H. Rasmussen, M.D., Longmont, Colorado — Doctor Rasmussen, a former prominent Scottsbluff physician and surgeon, died November 27, 1957, in a Scottsbluff hospital at the age of 76. Doctor Rasmussen retired several years ago and moved to Longmont, Colorado. He received his medical degree from Creighton University in Omaha in 1915. He established a practice in Scottsbluff in 1917, and helped organize the Scottsbluff clinic in 1925.

G. E. Burman, M.D., De Smet — Doctor Burman whose death occurred November 26, 1957, died at the Huron, S.D. hospital following two months care there for a heart ailment. He was 67 years of age. He studied medicine at the University of Nebraska and graduated in 1918. He spent a year at the Mayo Clinic, Rochester, Minn., as first assistant in oral and plastic surgery. He has been practicing in De Smet since 1946.

Edwin B. Bradley, M.D., Spencer, Iowa — Doctor Bradley, seventy-eight, who practiced medicine in the Burke, S.D., and Spencer localities for more than a half-century, died November 27, 1957, in Sacred Heart hospital at Lynch. He graduated from Rush Medical College, Chicago, Illinois, in 1908. He practiced medicine in Chicago for one year. When the Rosebud territory in South Dakota was opened for settlement, the West beckoned and he established a general practice at Burke. In 1909, he moved to Spencer where he was a general practitioner 45 years, retiring in 1954. At the time of his retirement he was honored by the Nebraska State Medical Association and made a member of the 50 Year Club.

Frank Sisler, M.D., Bristow, Oklahoma — Doctor Sisler, forty-two, a former Kearney resident, died November 23, 1957, at Auburn, California. Doctor Sisler practiced medicine in Kearney from 1951 until 1954. He had been employed as a staff member of the state hospital at Auburn, California.

John F. Nilsson, M.D., Omaha — Doctor Nilsson died February 9, 1958, at age fifty-three. He had been ill for several months with a cardiac condition. The doctor, son of the late Dr. John R. Nilsson, long time chief surgeon of the Union Pacific Railroad, held several important positions in Omaha hospitals at the time of his death. He was also an instructor in surgery at the University of Nebraska College of Medicine.

George E. Lewis, M.D., Lincoln — Doctor Lewis died in an Omaha hospital February 7, 1958, at the age of sixty. A graduate of the University of Nebraska College of Medicine in 1925, he had practiced medicine, chiefly surgery, in Lincoln for more than thirty years. He served in the Army during WW I for thirty months. He was a Fellow of the International College of Surgery. He is survived by his wife and two sons, Doctor George E. Lewis, Jr., of Lincoln, and James L. of Saranac Lake, N.Y.
Is Blue Shield a “Third Party?”

“Blue Shield Plans exist only to help the medical profession facilitate the provision of its services to the people... Blue Shield is an organization of the profession itself, and not a third party between doctor and patient.”

So declared the Blue Shield Commission in a recent policy statement. The Commission is the elected board of directors of the national association, “Blue Shield Medical Care Plans,” whose members are the 70-odd medical society-sponsored, nonprofit Blue Shield Plans. A preponderant majority of the Commissioners are doctors of medicine.

The medical profession, through its own instrument, Blue Shield, pioneered the great uncharted realm of medical prepayment at a time when commercial insurance companies declared it was actuarially impossible, and when the bureaucrats in Washington asserted that only big government could do the job.

What is a “third party between doctor and patient?” In simplest terms, a “third party” must be some person or agency over whom neither the first party—the patient—nor the second party—the doctor—has any direct control; someone independent of both doctor and patient.

The first requirement of a medical prepayment plan that wants to call itself Blue Shield is that it be approved by the county or state society in the area that it serves. The second requirement is that all medical policies and operations be under medical control; and the third, that it earn the voluntary participation of at least a majority of the doctors in its territory.

Blue Shield is not a “third party.” In truth, Blue Shield has proved that doctors and patients, working together, can solve the problems of medical economics without needing any third party to come between them.

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**NOTICE TO ALL CONTRIBUTORS**

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

March, 1958

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**The Woman's Auxiliary**

Greetings from your State President:

I should like to talk with auxiliary members for a few paragraphs about the Forand Bill which is currently before Congress. It is as insidious as all the other proposed compulsory health insurance programs with which we have been plagued from one legislative session to another, except that this particular one is more dangerous. It is more dangerous because, in the first place, Mr. Forand, the father of the bill is a key man on the Ways and Means Committee to which this legislation will be referred for study and recommendation. In the second place, this bill, if enacted, would be socialized medicine. All the reasons that caused organized medicine to oppose the Truman socialized medicine bills (1948-1952) apply to the Forand bill.

Much unnecessary hospitalization would occur if the Forand bill were enacted because no outlay of money would be required of the patient to obtain hospitalization. This could crowd our medical facilities and in many cases make it difficult to get really sick persons under age sixty-five into our hospitals.

Please read Doctor Schenken's analysis of this bill to be found elsewhere in this issue of the Journal. Talk to your friends and neighbors about this bill and please write your Congressmen and urge laymen to do likewise. This is vital to the patient as well as the doctor.

Those of you who live in areas where there is no auxiliary to the Nebraska State Medical Association, when you receive your letter from Jean Waddell, our second vice president and members-at-large chairman, please put your three dollars in the envelope she sends to you and become a member-at-large. Remember: It is a privilege and an honor to be a doctor's wife. We are all proud to be. Evidence your pride in your husband's profession by affiliating with its auxiliary.

Our theme for this year is: Doctors' wives who are proud to be... all belong to Auxiliary.

To County Auxiliary Officers: Annual reports will be due next month. When the
reports come your way, please fill them out promptly and return them to your president.

Thank you all and love.

Helen Brady.

Lancaster County Auxiliary Meets—

Lancaster County’s Medical Auxiliary meeting on Monday, February third, was a pleasant and encouraging sight. A luncheon was held at the Lincoln General Nurses Home which was brimming full of attractive, alert-looking young girls—the senior nurses and their supervisors of all the Lincoln hospitals. They were our guests.

It was a special privilege to hear Mrs. R. R. Brady of Ainsworth, State President of the Auxiliary. She gave a challenging talk on the problems facing the Auxiliary which should change the least interested doctor’s wife into the most active auxiliary member.

An interesting interpretation of sidelong fashion as related to millinery was given by Mr. Julian Lyons, the “Hat Man.” This he completed with a showing of beautiful new spring hats.

The co-chairmen were Mrs. Kenneth T. McGinnis and Mrs. Kenneth J. Fijan.

Elizabeth Davis,
Publicity Chairman.

Woman’s Auxiliary to the Dawson County Medical Society—

The Dawson County Medical Auxiliary met in Gothenburg at the home of Mrs. B. W. Pyle, Monday, January 13, following their quarterly dinner meeting with the Dawson County Medical Society.

The Auxiliary voted to increase its Nurse Scholarship Loan Fund to $300. Any girl interested in nurses’ training who would like information about the fund should contact an auxiliary member in her town.

President Pat Perry, Gothenburg, asked for suggestions for the 1958 monthly programs. The programs were planned and Civil Defense home supplies were reviewed.

Mrs. Lynn Leibel was welcomed to her first auxiliary meeting.


Current Comment

Doctors Spending More on Aides’ Pay,
Study Shows—

“More doctors are paying more money to more office assistants than ever before,” according to an article in the January 6 issue of Medical Economics. This conclusion is based on a recent study of some 600 physicians’ personnel practices, with supporting evidence drawn from the magazine’s 8th Quadrennial Survey.

The typical physician in private practice spends almost $4,000 a year for full and/or part-time office help. This is about 50 per cent more than he spent in 1952, the article points out.

“Salary rises account for a portion of the hike,” it continues. “But it’s apparent that a good-sized chunk of the individual doctor’s growing payroll now goes for additional help. Some 40 per cent of all self-employed physicians had two or more non-M.D. assistants in 1956, as against about 25 per cent in 1952.”

How much does the typical doctor pay a full-time aide? Medical Economics’ newest study shows that the nation-wide median ranges from $60 to $65 a week, depending on the aide’s duties. In individual cases, salaries range as low as $25 a week and as high as $200 a week, depending on region of the country, community size, length of service, and the employer’s field of practice.

Laboratory Data in Medical Writing—

No section of an article which includes reports of cases is as badly written, as a rule, as the report of data obtained from the laboratory. Abbreviation of every possible term is employed. These abbreviations vary with the habits of the writer. If abbreviations are considered necessary they should be taken from a standard acceptable list.

The whole section on laboratory data is usually crowded together, more or less unclassified, and improperly punctuated. To read this and comprehend it, is virtually impossible. If data from the laboratory are needed, they should be written with the same care as the rest of the article.
Current Comment

How to Live Longer—

The ladies are now firmly established, statistically, as the stronger sex, according to Dr. Louis I. Dublin, health statistician.

If there were any doubts before, current health and longevity tabulations show that women have not only held their position of advantage of a generation ago, but have made still further gains, says the doctor, who is health and welfare consultant of the Institute of Life Insurance.

How long one lives is the ultimate measure of health he contends, and on this basis, the ladies are now several years healthier than men.

The average length of life of women in the United States is now 73 years. For men it is only 67 years. That is an advantage of 6 years for the women.

Both men and women have been adding years to their expectation of life. Since 1900, the gain for the nation as a whole has been 22 years. But the women's expectation of life has increased 25 years in this period, while that for men has risen only 20 years.

This improvement has not been at a constant rate over the half century. Certain periods have shown spurts in the gain. The period of greatest gain appears to have been the five-year period after World War I, which accounted for almost one-fourth of the total half-century improvement.

According to Dr. Dublin, the female health record is better than that for males at all age brackets. More boy babies are born than girl babies, but apparently that is nature's answer to the male's poorer life outlook. Almost immediately, the female infant records a better survival rate, and by teenage the girls are approaching the period when they have their best hold on life, and when they show the greatest advantage over the male group. For the 15 to 24 group, the male death rate is now three times that for females. This is a great gain over the record only 15 years ago, when the male death rate of this age group was less than one and one-half times that for females.

The greater relative gains shown by females at the younger ages have carried more women on to the older age groups—where

(Continued on page 44-A)
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while the drug works effectively... so does the patient

1. Comparative Effects of Various Rauwolfia Alkaloids in Hypertension. (Hypertension, in press.)
Current Comment

How to Live Longer—
(Continued from page 41-A)

women have an additional advantage over men. The woman of 65, for instance, has an expectation of 16 more years, while the man of that age can expect about 13 years.

This greater life expectancy of women is reflected through almost the entire range of diseases or disability, according to Dr. Dublin. Women show lower death rates than men from almost all of the major causes of death — all, in fact, with the single exception of diabetes. This has not always been true. Prior to 1945, women showed a higher cancer death rate than men. In the past 15 years, while the cancer death rate for women at most ages has declined 10 per cent, that for men has increased. In fact, the mortality rate among men for lung cancer has increased 180 per cent, in this period.

Women apparently don't gamble with their lives as much as men, the female death rate for accidents being less than half that for men. In heart and circulatory diseases, which accounts for half of all deaths, the female death rate is less than two-thirds that for males. Even in the infections, such as influenza and pneumonia, women show a death rate one-third less than men.

"Apparently women have a basic physiological advantage over men," Dr. Dublin said. "This is found pretty generally throughout the animal kingdom.

"Then, too, while there is not much statistical evidence other than absentee records in shops and offices, it seems quite evident that women show more inclination to take time out for sickness. That may be a long-term health factor. Perhaps this greater care, illness by illness, helps ward off the ultimate weakening of the system that brings on death. If so, this alone may be a contributing factor in making the ladies the stronger sex.''

Osteoarthritis of Thoracic Spine—

Speaking of the symptoms of osteoarthritis in the thoracic spine, Brown (GP, Dec. 1957, p. 114) says: "... The resulting root pain may simulate chest or abdominal disorders, depending upon which segments are involved."
The Achievement in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.6... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.7

The Achievement in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.8,9... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.10,11,12... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.13

Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

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Current Comment

Increasing Demands for Medical Services—

The demand for medical care is rising substantially in the United States and the country wide use of hospitals will very likely increase as much as fifty per cent in the next 20 years according to Mr. George Bugbee. These opinions by the President of Health Information Foundation were expressed in an address before the Ohio Society of Internal Medicine.

Mr. Bugbee, former director of the American Hospital Association, said that more people “are becoming expert in the utilization of medical care and expose themselves to the many types of health services now available, not only to extend life but to minimize pain and disability.”

“Moreover, with a population expected to grow to about 225 million by 1975, the demand created may be literally staggering,” he said.

He predicted also that the costs of medical care will continue to rise, but said that in an expanding economy there is reason to be optimistic, that “the public is able and willing to meet increased costs if they fully understand the circumstances.”

As evidence of public demand and acceptance, Mr. Bugbee cited the growth of voluntary health insurance from an enrollment of 66 million in 1950 to about 123 million today. He said that more than 70 per cent of the population now has some form of voluntary health insurance protection.

Foundation studies in recent years have shown that there is need for still greater enrollment, he said, and an extension of the benefits that voluntary health insurance offers. He described the role of Health Information Foundation, a research group sponsored by the drug, pharmaceutical, chemical and allied industries, as one of probing such problems in the health field and pointing toward practical solutions.

Progress such as the growth of health insurance and the wider use of health services creates many new problems, Mr. Bugbee pointed out. He said that the extension of insurance through enrollment and a wider range of benefits encourage a greater use of medical care.

(Continued on page 50-A)
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Current Comment

Increasing Demands for Medical Services—
(Continued from 48-A)

“The Foundation is concerned because there is much talk of overuse and abuse (of services) by the insured population,” he said. “But it seems equally possible and more likely that there is great under-use which may be concentrated in the uninsured group.”

He then quoted from several Foundation studies of American health habits, showing that in a survey of one poor, rural area where health services are available at no cost to patients there is nevertheless a tendency to call a physician only when someone is unable to go to work or do day-to-day household chores.

Mr. Bugbee also presented highlights from a current Foundation study of the health practices of people over 65. “Twenty per cent of those interviewed in this age group said that they had not had a physical examination in five or ten years or more.” This is the fastest-growing segment of the population, he pointed out, and is “a group regularly shown to have more need for medical care than the population generally.”

But he emphasized that times are changing and so are public attitudes. “Ninety-five per cent of the babies in this country arrive in hospitals. Only 20 years ago this figure was 37 per cent,” he said. “This is certainly indicative of the changing demand for hospital services and of changing attitudes toward consulting physicians.”

“The number of physician services per thousand people is likewise increasing,” he said, “and comprehensive insurance covering services in the home and in the doctor’s office (in addition to in-hospital physicians’ services) further increases the volume of care.” He then described a recent study by the Foundation of Windsor (Ontario) Medical Service, a medical society sponsored program offering comprehensive coverage for physicians’ services without changing the traditional fee-for-service method of payment for care.

Mr. Bugbee cautioned that with many problems arising from medical progress and increased demand for care there is danger in a wish for quick solutions and easy an-
He emphasized the need to preserve the professional freedoms of the American system of medical care and criticized government programs that would "control, through the device of financing, the quality and quantity of medical care available to each citizen."

"Ultimately the decision rests with the public," he said. "If the public is impressed that those who provide service are developing voluntary health insurance to meet the public need for financial protection — and that physicians and hospitals are using pre-payment funds economically in striving to improve the quality of care — then it is unlikely that control will be turned over to the government."

Non-clinical Health Research—

More than 600 current research projects in the health field are described in the sixth annual edition of An Inventory of Social and Economic Research in Health, published by Health Information Foundation.

The projects described in the new Inventory deal with such varied topics in the field as health facilities, the quantitative measurement of mental health, health personnel and economic and sociological factors relating to medical care. Information was gathered nationwide from independent research groups, universities and government agencies at all levels.

Sponsored by leading companies in the drug, pharmaceutical, chemical and allied industries, the Foundation itself is organized to conduct and finance research in the non-clinical aspects of health. It distributes the Inventory to a limited number of research groups as a catalogue and index of current research and as a means of stimulating new research as well.

The number of projects listed has more than doubled since the first Inventory was published in 1952.

As Dr. Odin W. Anderson, the Foundation's research director comments, "There is also evidence of growth in the quality of research; of more cooperative activity between research agencies; of diminishing duplication of research efforts and in the proper evaluation of what kind of research is needed to help define and resolve problems in the social and economic aspects of medical care."
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<td>Sumycin Suspension (per 5 cc.)</td>
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<td>2 oz. bottles</td>
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Current Comment

Time and Distance for House Calls—

Doctors in rural areas travel greater distances on the ordinary house call than do metropolitan physicians, but the time required for the complete trip is about the same according to a Medical Economics survey.

A study of the house calls of 1200 doctors indicated that the average house call takes about 45 minutes, including travel time both ways. The typical radius for calls was eight miles in urban and suburban areas, 10 miles in metropolitan areas and 15 miles in rural areas.

Why Patients Die of Hepatic Cirrhosis—

Chase et al (Am. J. Med. Soc., pp. 233-259, 1957) note that patients suffering from cirrhosis of the liver died mostly of pneumonia and other infections two decades ago, but now death is more often due to coma and hemorrhage. They anticipate further changes in mode of death as hemorrhage comes under better control.

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in functional uterine bleeding

Functional uterine-bleeding is usually due to failure of ovulation with sustained estrogenic stimulation of the endometrium in the absence of progesterone. The most effective type of hormone in arresting a bout of functional uterine bleeding is a progestational agent. Administered orally, NORLUTIN produces presecretory to secretory and marked progestational endometrium in 3 to 14 days. The return of normal menstruation frequently can be induced by continued cyclic therapy with NORLUTIN during successive months.

case summary

A 44-year-old woman had spotting and bleeding for 10 days. She was treated with NORLUTIN, 10 mg. twice daily for 4 days. Bleeding stopped during medication and 24 to 72 hours after cessation of therapy normal withdrawal bleeding occurred.


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INDICATIONS FOR NORLUTIN: conditions involving deficiency of progesterone such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

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Current Comment

The Month in Washington—

At least for this year, it appears the Congress will keep its hands off tranquilizer drug regulation. The issue was studied by a House Government Operations Subcommittee in three days of hearings, where experts on tranquillizers testified. With few exceptions, they told the subcommittee they thought the situation was well in hand now and that no new legislation was needed.

The investigation grew out of reports that (a) some tranquilizer manufacturers are misleading doctors in literature describing the drugs and in advertisements in medical journals, and (b) somehow the general public is reading these claims and prevailing on doctors to prescribe the drugs when they aren’t indicated medically.

A report, when issued by the full committee later in the year, is expected to point out some of the danger areas explored at the hearings, but not to make a strong demand for further federal regulation in this area.

Dr. Leo Bartemeier, chairman of the American Medical Association’s Council on Mental Health, told the subcommittee under Rep. John Blatnik (D., Minn.) that he knows of no “gross misrepresentation” of the drugs, and that it is his understanding that the producers subject the drugs to careful tests before releasing them to the medical profession. Dr. Bartemeier explained that the drugs are helpful in bringing mental patients in contact with reality, thus preparing them for treatment.

Dr. Robert H. Felix, head of the National Institute of Mental Health, agreed that the tranquilizers are “a new source of hope” for patients and psychiatrists alike, but he pointed out that their success actually highlighted the acute shortage of trained psychiatric personnel in public mental hospitals. He said that too many patients, after being made ready for treatment through use of the drugs, have to wait for long periods until overworked psychiatrists can start their treatments.

Two other government witnesses also said no new legislation is needed. They were Dr. Albert H. Holland, Jr., medical director of Food and Drug Administration, and Commissioner Sigurd Anderson of the Federal (Continued on page 19-A)

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Current Comment

The Month in Washington—
(Continued from page 4-A )

Trade Commission. They argued that even the most questionable wording does not mislead the wary physician, and that there is no record in 20 years of any drug advertisements sent exclusively to the profession that carried false or misleading claims.

Dr. Nathan Kline, research director for the New York State Department of Mental Hygiene, said there may be occasional abuses or “honest mistakes,” but that they are not frequent enough to justify new legislation.

Dr. Kline did suggest that it might be wise to give Food and Drug Administration full authority over policing of advertising. At present F.D.A. is responsible for checking on claims on labels or inclosed literature, and Federal Trade Commission for checking advertisements. The advantage would lie in F.D.A.’s authority to move faster against producers in case of abuse.

Among the few who called for new control legislation was Dr. J. Murray Steele, who headed a New York Academy of Medicine study of tranquilizer advertising.

In contrast to evidence from witnesses before the Blatnik subcommittee, Dr. Steele said a number of psychiatrists had told his panel that the ads often serve more to mislead than to guide physicians.

NOTES:

A four-day Washington conference of representatives of organizations concerned with nursing homes and homes for the aged agreed on the need for federal legislation to help renovate and build facilities. Left open was the question of whether aid should be through grants or mortgage guarantees. Surgeon General Burney told the group that lack of good nursing homes was keeping "tens of thousands of older patients in general hospitals for prolonged periods beyond the time when they need or even can benefit from ‘full-dress’ hospital services."

Dr. David B. Allman, A.M.A. president, has warned the country of food faddists and diet quacks. Speaking at the National Food Conference, he said too many people put off seeing a physician while accepting certain health foods, herb mixtures or "some other phony remedy." A.M.A. and Food and Drug

(Continued on page 28-A)
should a non-diabetic, transient glycosuria ever be considered unimportant?

Never. A patient showing even a mild transient glycosuria should be observed for years as a diabetic suspect.*

Ultimate diagnosis on 126 patients with a previous transient mild glycosuria. Twenty diabetics were discovered 5-10 years after a recorded glycosuria—10 diabetics after more than 10 years.*


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**TECHNICAL EXHIBITS**

**ABBOTT LABORATORIES,** North Chicago, Illinois—Booth No. 25. Members of the medical profession will be cordially welcomed at Abbott Laboratories' exhibit of leading specialties and new products. Our representatives will be available at the exhibit to give information on the products and to answer any questions you may have.

**AUDIO-DIGEST FOUNDATION,** 800 North Glendale Avenue, Glendale 6, California—Booth No. 29. Audio-Digest Foundation, a subsidiary of the California Medical Association, gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast," compiled and reviewed by a professional Board of Editors, may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

**BLUE CROSS - BLUE SHIELD,** 518 Kilpatrick Building, Omaha, Nebraska—Booth No. 19. Exhibit portraying Nebraska Prepayment Health team. Nebraska Physicians, Nebraska Hospitals, and Nebraska Blue Cross-Blue Shield.

**CIBA PHARMACEUTICAL PRODUCTS, INC.,** 556 Morris Avenue, Summit, New Jersey—Booth No. 9. “CIBA is featuring two prescription specialties. Doriden a nonbarbiturate hypnotic-sedative and Pyribenzamine Lontabs a totally new concept in long-acting antihistamines. Doriden is being widely used as a safe barbiturate replacement and is nonhabit forming. Pyribenzamine Lontabs provide speedy and sustained antiallergic action up to twelve hours. The tablet is not delayed action, not repeat action, but sustained antiallergic action.”

**THE COCA-COLA COMPANY, P.O. Drawer 1734,** Atlanta 3, Georgia—Booth No. 34. “Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Co. of Lincoln, Lincoln, Nebraska and The Coca-Cola Company.”

**COMPTOMETER DICTATION MACHINE COMPANY,** 239 North 11th Street, Lincoln, Nebraska—Booth No. 32. The feature of the annual Comptometer Dictation exhibit will be the recently introduced “Coronet” magnificent portable dictation machine. This revolutionary new dictation machine, weight less than four pounds, uses the identical magic Mylar belt that has so outstandingly received on the standard office models of the Comptometer Dictation Machines, making the Comptometer Coronet 100% compatible with all other Comptometer units. It is an electronic wonder that sets another new standard in the dictation-transcription field while eliminating all tubes and transformers yet retaining error-free, cost-free dictation.

**CROSBY SURGICAL COMPANY, INC.,** 111 North 18th Street, Omaha, Nebraska—Booth No. 10. It will be a pleasure to meet with you again this year. Your attendance at our booth is always appreciated. We will have a few of the very latest diagnostic and examination equipment pieces on display for your inspection.

**DAIRY COUNCIL OF LINCOLN,** 316 Sharp Building, Lincoln, Nebraska—Booth No. 33. The Lincoln Dairy Council will have samples of nutritional hand-out material. Materials will cover weight reduction, feeding of people over 40 and pre- and post-natal feeding. Order blanks will be available for doctors’ use in ordering supplies for office use. A trained dietitian will be at the exhibit. Free milk will be dispensed at the MILK BAR.

**DOHO CHEMICAL CORPORATION,** 100 Varick Street, New York 13, New York—Booth No. 28. Doho Chemical Corporation is pleased to exhibit: AURALGAN—Ear medication in Otitis Media and removal of Cerumen. OTOSMOSAN — Effective, non-toxic Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears. RHINALGAN—Nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged. NEW LARYLAN—Soothing throat spray and gargle for infectious and non-infectious sore throat involvements. Also featured is RECTALGAN—Liquid topical anesthesia, for relief of pain and discomfiture in hemorrhoids, pruritus and perianal suturing. DERMOPLAST—Aerosol freon propellant spray for fast relief of surface pain, itching, burns and abrasions. Also Obst. & Gyn. use.

**DONLEY MEDICAL SUPPLY COMPANY,** 2415 “O” Street, Lincoln, Nebraska—Booths No. 22, 23, 24. The Donley Medical Supply Company cordially invites you to visit booths 22, 23, 24, during the Annual Session. We will have on display the latest modern examining furniture, and diagnostic equipment. We are looking forward to again meeting all of our physician friends.

**J. J. EXON COMPANY,** 239 North 11th Street, Lincoln, Nebraska—Booth No. 31. The Thermo-Fax Copying Machine and the important Electric Billing is more fully described on another page of this month’s Journal. This 100% dry process, easily operated copying machine has been in-expensively employed by hundreds of physicians in Nebraska as the final and proven answer to the monthly statement problem, saving as much as 75% of the time formerly expended in this monthly endeavor while improving percentages of collections up to 20%. Take a few minutes to stop by the Thermo-Fax Copying Machine booth for a demonstratoin of Instant Electric Billing and the many other uses of this Dry process in your offices.

**GENERAL ELECTRIC COMPANY,** 2211 Grand Avenue, Des Moines, Iowa—Booth No. 8. You are invited to visit our booth where some interesting items will be on display.

**LEDNER LABORATORIES DIVISION,** American Cyanamid Company, Pearl River, New York—Booth No. 5. “You are cordially invited to visit the Lederle Booth where our Medical Representatives will be in attendance to provide the latest informa-

(Continued on page 48-A)
Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

**BENEFITS:**
- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
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**SUPPLIED:** 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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as simple as 1-2-3 in HYPERTENSION

1 INITIATE 'DIURIL' THERAPY
'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

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The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION
The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:
• improves and simplifies the management of hypertension
• markedly enhances the effects of antihypertensive agents
• reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
• smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'
Current Comment

The Month in Washington—
(Continued from page 19-A)

Administration are working on a program on the dangers of food quackery. This includes a television film.

Senator Lister Hill (D., Ala.), chairman of the Senate Appropriations subcommittee that handles the H.E.W. budget, is convinced work should be pushed on the new National Library of Medicine building. Only planning funds have been voted to date. Hill wants the administration to indorse $7 million for the library in the face of deterioration of the present structure. He cites an editorial in the Journal of the A.M.A. on the need for action.

Dr. F. J. L. Blasingame, A.M.A. general manager, has informed the House and Senate Armed Services committee of A.M.A. support for continuing the 1956 incentive pay act for medical officers. The House group is considering legislation to change the base pay of all military personnel; this would have the effect of cutting down the special pay for experienced medical officers.

Drug Addiction Among Physicians—

Drug addiction is 30 times more common among doctors than in the general population according to Dr. C. J. Glaspel of Grafton, N.D., President of the Federation of State Medical Boards who spoke on this subject at the A.M.A. Congress on Medical Education and Licensure.

The symposium on this subject indicated that physicians who become narcotic addicts often have psychological problems.

Dr. Louis C. Jones, of the California Board of Medical Examiners, reported that a policy exercised in California has shown that tempering justice with mercy can save many addicted doctors for productive lives in their
profession. In the California system a doctor found to be a drug addict is granted a hearing by the board and his license to practice is revoked. In the majority of cases, however, the revocation is stayed for a 3-5 year probation. Conditions of probation include abstention from narcotics and agreement to surrender the federal narcotic stamp. The probationers must make written and personal reports through the board.

According to Doctor Jones, the fact that more than 90 per cent did not return to the use of narcotics was believed to indicate the value of probationary system.

H.E.W. to Study Retirement Activities—

A 12-year study will be undertaken by the Department of Health, Education, and Welfare on the retirement activities of a group of 3,000 newly retired men and women.

This division of government wants to compile information that will throw light on the problems, interests, and capacities of older people. The individuals included in the study would be questioned at intervals of one or two years concerning their income and savings, employment, health expenditures, and varied activities. Initial interviews will be conducted by the census bureau and the social security administration will compile the data.

One Pay Medical Plan for Aged—

A new approach for hospital and medical insurance for retired employees utilizing a single premium, non-cancellable policy may hold the answer to the problem of providing necessary financial security for an increasing number of aged people.

This proposal is described in a recent issue of Insurance Economics Surveys. The plan is described as the type of policy that may still the demand for expansion of Federal Social Security coverage for those over 65 years of age.

Under this new type of insurance policy, the retired employee receives a non-cancellable individual policy in which the benefits are guaranteed for life. His dependent wife could also be given the same coverage. For a qualified group, issuance of the new policy would be guaranteed without medical examination and without regard to the employees health status at the date of issue.

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A NEW, CORTICOSTEROID MOLECULE WITH GREATER ANTIALLERGIC, ANTIRHEUMATIC AND ANTI-INFLAMMATORY ACTIVITY

for your patients with
- BRONCHIAL ASTHMA, ALLERGIC DISORDERS
- ARTHRITIC DISORDERS
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- far less gastrointestinal distress
- safe to use in asthma with associated cardiac disease; no sodium and water retention
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- often works when other glucocorticoids have failed
- and on a lower daily dosage range

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EDITORIAL

SCOTTS BLUFF®
(see cover)

“Scotts Bluff was a celebrated landmark on the Great North Platte Valley trunkline of ‘the Oregon Trail,’ the traditional route of overland migration to Oregon, California, and Utah. Today the massive castellated bluff looks down upon concrete highways, railways, airports, irrigated farms, and bustling communities of the mid-twentieth century; but it is the same awe-inspiring sentinel which 100 years ago watched the passage of countless trains of ox-drawn covered wagons, and the twinkling of many campfires. Scotts Bluff National Monument keeps alive the epic story of our ancestors who dared cross the wilderness of plains and mountains to plant the western stars in the American flag.” (Matthes)

Only the dim outlines of the prehistory of Scotts Bluff are emerging from archeological probing at the Bluff and in the immediate surrounding area. As this search continues it will be more and more intriguing. Already findings point to “unmistakable evidence of mysterious big game hunters who inhabited the plains 10,000 years ago.” They killed an extinct form of giant bison with stone projectile points of which “Scottsbluff points” are the classic type. Several separate “cultures” can be traced in near-by excavations to as remote a date as 5000 years ago.

“When White man first penetrated Nebraska, about 1700 A.D., the Central Plains were divided into hunting areas held by tribes living in large fortified villages, living partly on corn, beans and squash, partly on buffalo obtained by seasonal hunts. The Pawnee were the dominant Nebraska tribe at the dawn of history, but the region was soon invaded by Sioux, Cheyenne, Kiowa, and other tribes. With the advent of European horses and guns, the Plains Indian be-

1 I am deeply indebted to Mr. Merrill J. Matthes, of Omaha, Area Historian for Region Two, National Park Service, for the loan of his manuscript entitled “Scotts Bluff National Monument, Nebraska.” This is now in press at the U.S. Government Printing Office, Washington, D.C., as one of a series of Handbooks by the National Park Service.

came the bold, wide-ranging, buffalo hunters and fighters famous in annals of the white man’s ‘wild west.’” (Matthes)

The records seem to indicate that the first white men to behold Scotts Bluff were a group of seven returning from their trading post at the mouth of the Columbia River. The Bluffs were described in his journal by their leader—Robert Stuart—on Christmas day, 1812. Many white men are known to have passed Scotts Bluff between 1812 and 1832, but no one bothered to describe it in detail nor to name it. In June 1932, it came to light that a number of years since,” a member of a party coming down the river became too ill to proceed. The party was in such dire straights, due to inability to get food, that it was led to abandon the sick man, Hiram Scott. The next summer his bones were found near the Bluff and about 60 miles from the point where he had been abandoned. The Bluff was named, therefore, in his honor, and the name has persisted to the present.

Space forbids even the mention of momentous historical, archeological, and other connotations of the title, Scotts Bluff. The preservation of this landmark and some 2000 acres surrounding it as a national monument was fortunate and timely. It may signify the faith in American democracy so nurtured, tempered and vitalized, so significant of the freedom of thought, action, and equality of opportunity that led many thousands to cross the unfriendly plains and mountains in the face of great danger and privation. It is well that, in 1919, this area was set aside as the Scotts Bluff National Monument, administered by the National Park Service of the U.S. Department of the Interior. When we pass this historic landmark, let us think of what it signifies and thereby renew our faith in America.

MEDICAL EDUCATION WEEK

Medical-school business in America is big business—$200 million a year at present, and what it will be is anyone’s guess.

Those responsible for operating our Nebraska medical schools are faced with many
and varied problems not a few of which would be eliminated if adequate funds were always available. Progress must continue through the solution of problems each of which demands money. Progress has continued in spite of ever-present uncertainties as to how the bills will be met. Producing more, well-trained doctors without increasing the period of training, and fulfilling the duties of the medical school in relation to post-graduate education, perhaps embraces these problems although it sounds misleadingly simple. The problems are quite similar in our two Nebraska schools, though the solutions are necessarily tempered by the sources of their funds. Funds derived from taxes must be used within a certain framework.

Let us consider new admissions. To increase the number of students admitted to medical school from a diminishing list of applicants and still maintain quality by proper selections was becoming somewhat of an annual worry. Now, it seems, the number has suddenly increased, but selection remains difficult because other professions are skimming some of the cream. You see, the sudden increase in interest in various scientific pursuits incident to the age of the atom and the Sputnik gets the attention of a certain number of youth. In these fields the period of preparation is shorter and the income begins earlier than in medicine.

The material aspect of our schools—buildings and equipment—offers a constant challenge. Expanding curricula, increasing size of classes, the intrusion of increasing amounts of research, the struggle toward the "medical center" type of school, not to mention replacement of obsolete and deteriorating facilities, means a constantly increasing outlay of money.

As opposed to the material and visible, such as buildings and equipment, we have the operational and philosophic aspects. Obviously these different points of view can not be divorced from one another. The material changes and additions must follow the blue prints derived from careful operational planning. Where do we want to go in medical education; how far ahead can we get a clear view and plan with safety and precision; how near can we get to the ideal with the means at our disposal? The faculty, the curriculum, methods of teaching, the optimal amount of research, and finally, the question of postgraduate education must be under constant consideration.

The faculty must constantly be recruited. The trend is toward a greater proportion of full-time teachers. Judging from other schools, the proportion of full-time to part-time teachers will increase. The faculty must possess the flexibility demanded by constant review and revision of curricula.

Political and economic trends, changes in the makeup of our population such as the increased proportions in the early decades and in the old-age group, waxing and waning interests in various disciplines in medicine such as rehabilitation, the question as to how much research is optimal for the school and for the medical student, and many others must be examined and re-examined. The need must always be tempered with the question, "how much can we afford?"

Most of the questions mentioned above and many others could be discussed at great length but, for our purposes, need only to be brought to mind. They are called to your attention in connection with Medical Education Week, April 20-26. We have, in this special week, an opportunity to honor and aid our medical schools not only in Nebraska but throughout America. We, as the profession of this State, can join hands with the Auxiliary, the medical colleges, the A.M.E.F. and the National Fund for Medical Education to present the progress, problems, and challenges of American Medical Education to the American Public. We can contribute of our time and effort and of our dollars. Past efforts of these various agencies have been of tremendous help, and it is to be hoped the good results will increase this year and each year.

Remember, the overall cost is $200 million per year, and we can not afford to let the financial fingers of the Federal Government obtain a strangle hold on American Medicine.

RESOLUTIONS VS. PERSONAL COMMUNICATION

A resolution directed against the Forand bill, passed by our House of Delegates February 16, carried the provision that a copy be sent to each of our Senators and Representatives in Congress.

(Continued on page 145)
Splenectomy and Hypersplenism*

"The evidence now available fully justifies the belief that, if splenic pathology remains unrecognized in the human patient, chronic invalidism or acute hemolytic crises may result." This statement by Dr. Doan may encourage the medical profession to give further study to the type of blood picture involved in a patient’s illness. Hypersplenism may be a factor. In early reports, this factor was usually associated with splenomegaly. Today, it is recognized that splenic pathologic changes with hypersplenism are not necessarily accompanied by splenomegaly, although the two may be combined.

In the four case reports to follow, it is evident that non-palpable spleens may be serious offenders, and that hypersplenism does not depend on the size of the spleen. In these four case reports, hypersplenism was present without any enlargement of the spleen at the time these patients were first examined, yet splenectomy not only produced a clinical improvement in their general health, but it also eliminated the hypersplenism—the cause of the illness.

The spleen is an unique organ. It has a smooth, fibro-muscular capsule with trabeculae extending into its pulp. Such a structure permits the spleen to expand, and to serve as a reservoir, especially for the bone marrow cells. As certain demands of the body arise, the same structure contracts, emptying into the vascular system such cells as are needed. In the pulp of the spleen, we have a network of blood vessels, lymphoid tissue, and reticuloendothelial tissue. The spleen is one of the most vascular organs in the body. The splenic artery is the largest branch of the coeliac axis, and the splenic vein is equally as large. The lymphoid tissue is morphologically and functionally the same as that in other regions of the body.

The reticuloendothelial tissue is thought to be the same as that found outside of the spleen. However, some hematologists believe that the splenic reticuloendothelial tissue may develop an abnormal function, acquiring more phagocytic activity in relation to the cells arising in the normal bone marrow. As a result, there occur abnormal peripheral blood pictures, which we call splenic anemia, splenic neutropenia, splenic thrombocytopenia, or a combination of any three of this group. On the other hand, some hematologists state that the function of the spleen is inhibitory. It prevents normal cells from leaving the bone marrow. Clinically, both theories may be accepted. The removal of a malfunctioning spleen, with its consequent effect on the body and the peripheral blood cells, may become imperative, if it is a factor in the patient’s illness.

NOTE: In the 4 case reports to follow, abbreviations here listed are used to economize on space and avoid tiresome repetition of words: Hb for hemoglobin; RBC for erythrocytes; WBC for leukocytes; PMN for polymorphonuclear neutrophiles; L for lymphocytes; and He for hematocrit. The numbers of cells are per cubic millimeter of blood.

Case 1. This patient had aleukemic leukemia of myeloid type. Mr. E. F., age 63, was admitted to the hospital on July 22, 1954, for blood studies, because of fatigue, dyspnea, and loss of 55 pounds in weight. He dated his illness from March, 1954, when he had been vaccinated. This was followed by a severe reaction. General examination of the patient was negative, there being no generalized lymphadenopathy or splenic enlargement. A study of his blood revealed a Hb of 45%; RBC, 2.7 millions; WBC, 3100; PMN, 66%; L, 33%; platelets, 168,000; and hematocrit, 28%. Study of bone marrow showed the typical picture of myeloid leukemia. During the following eight months, outside the hospital, the patient received several transfusions and took cortisone as directed.

Readmission to the hospital was on November 24, 1954. At this time the Hb was 57%; RBC, 2.93 millions; WBC, 2250; PMN, 76%; and L, 22%. X-ray studies of the skeleton and the gastro-

*Read before Omaha Mid-West Clinical Society, October, 1956.
intestinal tract were negative, and his basal metabolic rate was plus 32%. During the next twenty-five days the patient received 3500 cc. of whole blood and continued to take cortisone. At the time of dismissal, December 19, 1954, his blood count was as follows: Hb, 77%; RBC, 3.96 millions; WBC, 3500; PMNs, 32%; and L, 61%.

For about eleven months he was treated at home by transfusions and cortisone. He was readmitted to hospital November 4, 1955. At the time of his admission, the spleen could be palpated for the first time. The blood picture was again one of anemia and leukopenia. The Hb was 40%; RBC, 1.83 millions; WBC, 2800; PMNs, 61; and L, 32%. After receiving 1500 cc. of blood by transfusion, his anemia had improved, but the leukopenia had increased, the total leucocyte count having dropped to 1450 of which 64% were PMNs and 34% lymphocytes. The platelet count was down to 63,000.

Because of increasing neutropenia, splenectomy was carried out. The spleen was about 100 grams heavier than normal, weighing 264 grams. Subsequent blood transfusions were given, and on December 17, when dismissed from hospital, the blood count was as follows: Hb, 62%; RBC, 3.43 millions; WBC, 3900; PMNs, 30%; L, 64%; and platelets, 102,000.

The course of this man, in relation to his blood picture from the time of splenectomy to his death is summarized in Table 1.

Comment: The question of surgery in myeloid leukemia has been a closed question over a period of years. However, in this patient with an aleukemic leukemia complicated by hypersplenism and an increasing neutropenia, splenectomy did improve his general condition and stopped the progress of the neutropenia. The blood picture in this patient is interesting in that the anemia was partially controlled by transfusions, while the leukopenia showed no response. After splenectomy, the leukopenia was temporarily corrected, but the anemia required transfusions during the remaining months of his life. Shortly before his death, his liver became greatly enlarged, and the leukocytic picture changed as is shown in the last blood count.

Case 2. The second patient, Mrs. E. K., aged 46, gave a history of having brucellosis followed, later, by rheumatoid spondylitis. When we first examined her June 5, 1946, she was found to have a mild, normochromic or slight-

<table>
<thead>
<tr>
<th>Date</th>
<th>Hb(%)</th>
<th>RBC</th>
<th>WBC</th>
<th>PMN(%)</th>
<th>L(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-5-46</td>
<td>78</td>
<td>3.96</td>
<td>7,350</td>
<td>59</td>
<td>38</td>
</tr>
<tr>
<td>5-21-52</td>
<td></td>
<td>not</td>
<td>2,100</td>
<td>18</td>
<td>79</td>
</tr>
<tr>
<td>4-16-54</td>
<td></td>
<td>essentially</td>
<td>3,800</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>3-12-56</td>
<td></td>
<td>different</td>
<td>3,400</td>
<td>24</td>
<td>65</td>
</tr>
<tr>
<td>5-14-56</td>
<td>79</td>
<td>3.93</td>
<td>2,800</td>
<td>20</td>
<td>65</td>
</tr>
<tr>
<td>5-24-56</td>
<td></td>
<td>Splenectomy</td>
<td>13,400</td>
<td>75</td>
<td>13</td>
</tr>
<tr>
<td>5-25-56</td>
<td>91</td>
<td>4.14</td>
<td>7,600</td>
<td>58</td>
<td>34</td>
</tr>
<tr>
<td>6-6-56</td>
<td>83</td>
<td>4.25</td>
<td>5,400</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>10-11-56</td>
<td>84</td>
<td>3.80</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ly hypochromic anemia, a normal total leukocyte count, and a slight reduction in granulocytes, percentage-wise. (All blood studies are recorded in Table 2).

Over a period of years, she was treated for both her spondylitis and the hypochromic anemia. On June 10, 1951, the patient was admitted to the hospital to receive X-ray therapy for the spinal arthritis. While in the hospital she received 1500 cc. of blood by transfusion, and the anemia improved somewhat.

When she was seen on May 21, 1952, the anemia was essentially unchanged, but the leukocyte count had dropped to 2100 (Table 2). As may be seen by the recorded data, the total leukocyte counts varied from 2100 to 3800 from this date to mid-May, 1956. In March, 1956, the symptom of fatigue became sufficient to prevent doing her work. Two thousand cubic centimeters of blood, given over a period of a few days, failed to alter the blood picture as recorded on May 14, 1956 (see Table 2). At this time the bone marrow showed a normoblastic hyperplasia.

In view of the persistent neutropenia, the findings in the bone marrow, and the increasing fatigue, splenectomy was performed on May 24, 1956. The spleen weighed 155 grams. Following operation, the patient was given 1,000 cc. of blood.

The postoperative course of the patient may be followed for the subsequent six months by the blood counts as shown in Table 2.

Comment: This patient had a definite neutropenia on May 21, 1952. Over a period of four years, the anemia responded fairly well to iron and transfusions. The neutropenia remained unchanged. Following splenectomy, both the neutropenia and the anemia lessened. The patient has shown general clinical improvement and does not complain of excessive fatigue at this time. The present therapy consists of iron for the anemia.

**Case 3.** Mrs. E. R. was seen and examined on October 18, 1943, because of rheumatoid arthritis affecting the joints of all extremities. This condition had been present for several years. Physical examination was negative excepting for the signs of arthritis. She gave a history of brucellosis in the past but at the time of our examination the agglutination titre for this infection was nil. The blood-picture was normal and the spleen not palpable.

The next observation was on March 6, 1946. At that time the spleen was palpably enlarged and she had a leukopenia; the percentages of granulocytes and lymphocytes was not remarkable. (See Table 3 for this and subsequent blood studies of this patient).

On May 7, 1947, along with more advanced arthritic changes she had increasing splenomegaly, moderate anemia, and a very low leukocyte count. In the hospital she received 1500 cc. of whole blood by transfusion with improvement in the blood picture but persistent leukopenia. (See Table 3 under dates May 7 and 17, 1947). Splenectomy was advised, but the patient refused the operation.

Nine years later, March 26, 1956, she was admitted with ascites and free fluid in the thoracic cavity, obviously the result of congestive heart failure. The spleen had increased in size, and she

### TABLE 3

<table>
<thead>
<tr>
<th>Date</th>
<th>Hb(%)</th>
<th>RBC</th>
<th>WBC</th>
<th>PMN(%)</th>
<th>L(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6-46</td>
<td>5.70</td>
<td>2,800</td>
<td>68</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>5-7-47</td>
<td>3.94</td>
<td>675</td>
<td>22</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>(Given 1500 cc. blood in ten days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-17-47</td>
<td>80</td>
<td>4.05</td>
<td>2,050</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>3-26-56</td>
<td>88</td>
<td>4.50</td>
<td>2,100</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td>(She was given 2500 cc. whole blood)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-6-56</td>
<td></td>
<td>1,650</td>
<td>37</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>7-25-56</td>
<td></td>
<td>2,150</td>
<td>4</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>(8-9-56 splenectomy. 4500 cc blood in 96 hours)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8-10-56</td>
<td>115</td>
<td>5.70</td>
<td>27,500</td>
<td>81</td>
<td>14</td>
</tr>
<tr>
<td>8-22-56</td>
<td>85</td>
<td>4.25</td>
<td>16,250</td>
<td>87</td>
<td>10</td>
</tr>
<tr>
<td>10-8-56</td>
<td>91</td>
<td>4.55</td>
<td>13,250</td>
<td>23</td>
<td>68</td>
</tr>
</tbody>
</table>
still had leukopenia with preponderance of lymphocytes. (Table 3). The cardiac failure was treated and 2500 cc. of blood given, but the blood picture was not bettered. (See counts of March 26 and April 6, in table). The patient again refused to have the spleen removed.

Three months later the blood picture was essentially unchanged; the bone marrow examination revealed mild normoblastic hypoplasia and a moderate increase in plasma cells. The spleen was removed on August 9, 1956. Four small accessory spleens were also taken out. Postoperatively, the patient received 4500 cc. of blood in 96 hours. Counts made during the following two months are shown in the table.

<table>
<thead>
<tr>
<th>Date</th>
<th>Hb(%)</th>
<th>RBC (million)</th>
<th>WBC</th>
<th>PMN(%)</th>
<th>L(%)</th>
<th>Platelets</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-2-53</td>
<td>29</td>
<td>1.41</td>
<td>5,000</td>
<td>69</td>
<td>27</td>
<td>122,000</td>
</tr>
<tr>
<td>(Received 5500 cc. blood in 20 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-22-53</td>
<td>53</td>
<td>2.88</td>
<td>4,250</td>
<td>52</td>
<td>39</td>
<td>190,000</td>
</tr>
<tr>
<td>4-25-55</td>
<td>49</td>
<td>2.63</td>
<td>7,450</td>
<td>86</td>
<td>14</td>
<td>46,000</td>
</tr>
<tr>
<td>5-27-56</td>
<td>36</td>
<td>2.58</td>
<td>7,450</td>
<td>86</td>
<td>14</td>
<td>46,000</td>
</tr>
<tr>
<td>(2000 cc. blood in four days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-27-56</td>
<td>67</td>
<td>3.63</td>
<td>4,700</td>
<td>56</td>
<td>39</td>
<td>64,000</td>
</tr>
<tr>
<td>(Splenectomy June 28)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1000 cc. blood after operation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-29-56</td>
<td>91</td>
<td>5.15</td>
<td>16,300</td>
<td>88</td>
<td>12</td>
<td>97,000</td>
</tr>
<tr>
<td>7-5-56</td>
<td>86</td>
<td>4.53</td>
<td>18,000</td>
<td>88</td>
<td>12</td>
<td>259,000</td>
</tr>
<tr>
<td>10-6-56</td>
<td>84</td>
<td>4.58</td>
<td>18,000</td>
<td>88</td>
<td>12</td>
<td>312,000</td>
</tr>
</tbody>
</table>

Comment: This patient had been seen over a period of thirteen years for a rheumatoid arthritis, and for the past ten years for an added complication, hypersplenism with neutropenia. Splenectomy removed this complication. Two months following surgery, the clinical result was excellent, and the blood picture improved.

Case 4. Mrs. T. V., aged 41, had a bleeding duodenal ulcer. It was resected on March 23, 1953. She was readmitted to the hospital because of melena, on December 2, 1953. Blood studies at the time of admission showed nothing remarkable excepting a marked normochromic anemia. (See Table 4 for this and subsequent blood counts in this case).

For twenty days this patient received the standard treatment for bleeding ulcer and during this time was given 5500 cc. of blood by transfusion. On dismissal, December 22, 1953, the blood picture still showed an anemia. (See Table 4).

Sixteen months later she was readmitted because of intractible gastric pain (April 25, 1955). An anastomotic ulcer was resected. At this time she again showed an anemia, platelet count of 195,000, and normal leukocytes.

About a year later, May 27, 1956, melena recurred over a period of several days accompanied by the usual symptoms of loss of blood. Again her anemia had increased, but now she had definite thrombocytopenia (46,000). Bleeding time and venous coagulation time were normal; Coombs’ test was negative; the bone marrow was not diagnostic.

During the first four days in the hospital the patient was given 2000 cc. of blood. For the period of hospitalization she was treated for bleeding duodenal ulcer. After the initial transfusions she was observed for twenty-seven days. A gradual deterioration of her blood picture was noted and melena persisted. (See Table 4, June 27).

Because of history of bruising easily, constant presence of blood in the gastrointestinal tract, and the low platelet count, splenectomy was performed on June 28, 1956. The spleen weighed 160 grams. Postoperatively, she received 1000 cc. of blood. The recorded blood counts (Table 4) depict the course of her recovery.

Comment: Since splenectomy this patient has not been given any specific treatment for anemia. Her blood findings would indicate that she not only had had a bleeding duodenal ulcer, but had also gradually

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developed a thrombocytopenic purpura. At the present time, not only her anemia and her thrombocytopenia, but also the melena have been relieved by the splenectomy. In cases of this type it is common experience that many patients with thrombocytopenic purpura, even the idiopathic type, may resume bleeding after splenectomy. In such instances, one may think of an accessory spleen. However, in the case being reported the abdomen was thoroughly explored for any accessory spleen. The patient has had an excellent result from her splenectomy.

CONCLUSIONS

1. These four cases present three different types of abnormal blood pictures, the result of hypersplenism.

2. In every instance, except the myeloid aleukemia, the bone marrow was normal, near normal, or hyperplastic. When such bone marrow findings are present, and all other specific causes for abnormal peripheral blood findings are eliminated, then one must consider hypersplenism as the cause, and splenectomy as the therapeutic procedure. At times, steroid therapy may be indicated. In the patient with aleukemic leukemia, and the two patients with rheumatoid arthritis, cortisone had been used without any effect on the neutropenia.

3. Following splenectomy in the cases reported, there was a clinical improvement in every instance, even in the aleukemic leukemia.

4. Never procrastinate in cases of anemia, neutropenia, or thrombocytopenia awaiting the time for the spleen to become palpable. Hypersplenism can be present with a non-palpable spleen.

REFERENCES


Acknowledgment is given to S. J. Carnazzo, M.D., for his aid in preparation of these patients. Splenectomies mentioned in case histories were performed at Creighton Memorial St. Joseph’s Hospital, Omaha, Nebraska, by Dr. Carnazzo.

Clinical Hemoglobinimetry

F EW would take exception to the statement that the results of estimation of the hemoglobin content of the blood is of importance to the physician in immediate attendance upon virtually any patient. Such opinion undoubtedly prompted a part of the current requirements of the Joint Commission on Accreditation of Hospitals. This part is to the effect that the blood must be tested either for hemoglobin content or red corpuscular volume in the case of every patient admitted to hospitals accredited by this organization. It seems, therefore, worthwhile to explore clinical hemoglobinimetry briefly to see if this procedure can give results sufficiently reliable to justify the confidence placed in it.

Certain well-known physical and chemical characteristics of hemoglobin may be utilized as a basis for quantitating this substance in a sample of blood. For instance, properly diluted blood exhibits optical density characteristics which are dependent largely upon the red color of hemoglobin and which can be translated into terms of hemoglobin content. Or, hemoglobin can be transformed into a number of pigments of variable stability which lend themselves to more or less satisfactory optical density measurements. All the iron in erythrocytes is bound in the hemoglobin molecule. Hence, the iron content of washed erythrocytes can provide a very accurate index of hemoglobin content of blood. The ability of hemoglobin to combine with certain gases can be employed for its quantitation. The characteristic absorption spectra of hemoglobin may be related to the quantity of this substance in given dilutions of blood and depths of solution employed. The refractive index of hemolyzed blood can be conveniently related

PIERCE T. SLOSS, M.D.
Grand Island, Nebraska
to hemoglobin content. Finally, the specific gravity of blood shows a rather uniform relationship to hemoglobin content. Application of any of these properties yields information as to the quantity of hemoglobin in blood only indirectly. The direct method, namely, extraction and gravimetric analysis of hemoglobin, may be accomplished but probably never can be applied to the rapid analysis of large numbers of blood samples.

In order to fulfill the needs of the busy clinical laboratory, any method of routine hemoglobinometry should be capable of the following: (1) rapidity of performance; (2) accuracy, meaning truthfulness, in its results and (3) precision, meaning reproducibility, in its results. The method which most closely meets these needs is one wherein the optical density or light transmittance of a derived pigment of hemoglobin is determined by use of a light-measuring instrument.

Of the several pigments into which hemoglobin can be converted for optical density measurements, cyanmethemoglobin provides an excellent choice. Carboxyhemoglobin also is excellent, but is somewhat tedious to prepare. Two other pigments, namely oxyhemoglobin and acid hematin are probably the most common ones employed the country over. Oxyhemoglobin, however, is not very satisfactory, principally because of its instability in high dilutions. Among several drawbacks of acid hematin is that of its being materially influenced by plasma. The prior washing of erythrocytes to remove all traces of plasma requires so much time as to be impractical for routine use.

Cyanmethemoglobin is formed when a sample of blood is added to 200 times its volume of a solution containing 0.03 per cent potassium ferricyanide, by weight, and 0.01 per cent sodium cyanide, by weight. Though solutions containing cyanide are rightly viewed with alarm, one would have to ingest a liter or more of this particular solution of cyanide to produce a fatal outcome. The possibility that this would be done accidently is remote. It is sometimes wise, however, that the solution be prepared by a chemist or purchased from a commercial supplier, inasmuch as the weighing of granular sodium cyanide can be very dangerous.

By use of the cyanide reagent described, hemoglobin and all of its closely related de-

rivatives, with the probable exception of sulfhemoglobin, are immediately converted into cyanmethemoglobin. The latter is stable to all usual conditions of light and temperature in the atmosphere of the clinical laboratory, for at least a day. It has a broad maximum absorption band which serves to minimize errors resulting from incorrect production of selected wave length in spectrophotometers. This pigment will obey the Bouguer-Beer law for hemoglobin concentrations within a wide range if the above dilution of blood with the cyanide reagent is followed. Efforts are being made on a national level to encourage the use of the cyanmethemoglobin method of hemoglobinometry in an effort to reduce discrepancies in hemoglobin measurements among different medical laboratories.

Since the end of World War II, photoelectric instruments have largely replaced visual colorimeters as measuring devices in colorimetric chemical procedures. The measuring ability of the many instruments commercially available varies considerably, though most can give good results when properly used. Two points concerning the operation of spectrophotometers and filter photometers should be stressed especially. Firstly, all of these devices should be individually and periodically calibrated in the particular laboratory in which they are used. Manufacturers' calibration tables supplied with some instruments may be correct under conditions of field operation, but they are not always so. As stated by Mann, "Anyone competent to use these instruments should be competent to calibrate them and should do so."

Secondly, it is necessary to have a constant invariable supply of electric current to instruments not equipped with internal standards. Since the line current of many communities is quite variable, either the use of storage batteries or a constant electronic voltage regulator is essential. This cannot be emphasized too strongly, even though instructions from the manufacturer may indicate the contrary.

Because of the broad maximum absorption band of cyanmethemoglobin, satisfactory readings of optical density may be taken between the wave lengths of 530 and 545 millimicrons.

For purposes of calibrating a photoelectric instrument, standards of known cyan-
methemoglobin concentration must be available. These can be conveniently prepared from blood in which the hemoglobin concentration is obtained by the oxygen capacity method or from iron content of the erythrocytes. Recently, standard solutions of cyanmethemoglobin have become commercially available. One of these has been used by the author and found entirely satisfactory.

There are two additional potential sources of error in hemoglobinometry worthy of note which are independent of the method employed. One of these may be classified as a personnel-source of error and includes such factors as improper collecting and improper procedure in the measurement of samples of blood for analysis, usually attributable to inexperience or to poor training. A more difficult personnel-problem is one of unconscious or conscious prepossession in reading of results. The former is unexplainable; the latter appears to be a nearly uncontrollable desire on the part of some technologists to make the results conform to those which are expected in certain patients.2

The other source of error to be mentioned is that of pipets, especially micropipets, used in measuring the sample of blood to be analyzed. Though the quality of micropipets has improved in the past few years, it is best that they be individually calibrated by the user. If this cannot be done, micropipets guaranteed by the manufacturer to be accurate within + or — 1% or provided with correction factors should be used.

The method of clinical hemoglobinometry, as given, embodies accepted principles of chemical analysis and contains no basic discrepancies. If properly followed, it will give results with practically negligible error. However, there is often little accomplished in having a good method for quantitating a particular constituent of the blood if no attention is paid to the circulating blood being in as basal a state as possible. It must be remembered that, as in the case of other blood constituents, the concentration of hemoglobin is subject to a number of physiologic influences. These include ingestion of food or drink, atmospheric temperature, muscular exercise and emotional excitement which may account, individually or collectively, for very appreciable changes in determined values for hemoglobin. If precision in results is desired, these influences should be kept at a minimum. This can best be done by obtaining the sample of blood for testing in the morning before breakfast, whenever possible.

SUMMARY

Clinical hemoglobinometry is briefly discussed with emphasis being given to common pitfalls encountered in its practice. The method of hemoglobinometry involving the photoelectric measurement of a derived pigment of hemoglobin, cyanmethemoglobin, is recommended.

REFERENCES


Current Comment

How Old “Medical Ethics”?—

The following, said to have been found in ancient Jewish writings, is quoted from Slaughter’s The Road to Bithynia:

PRAYER OF A PHYSICIAN

O stand by me, my God, in this truly important task;
Grant me success! For—
Without Thy loving counsel and support, Man can avail but naught.
Inspire me with true love for this my art and for Thy creatures,
O grant—
That neither greed nor gain, nor thirst for fame, nor vain ambition, May interfere with my activity.
For those I know are enemies of Truth and Love of men, And might beguile one in profession From furthering the welfare of Thy creatures.
O strengthen me.
Grant energy unto both body and soul That I might e’er unhindered ready be, To mitigate the woes, Sustain and help The rich and poor, the good and bad, enemy and friend. O let me e’er behold in the afflicted and suffering, Only the human being.
Ulcerative Colitis
A STAFF CONFERENCE—
CHILDREN'S MEMORIAL HOSPITAL

This clinical presentation and discussion of a four-year-old girl with a condition said to be ulcerative colitis brings out, with interesting emphasis, the place of psychiatric analysis and therapy in this syndrome. Furthermore, it presents the matter of family associations that may leave the psychosomatic imprint upon people so closely associated as mother and children. Hereditary acquisition of organs or systems especially vulnerable to pathologic reaction to tense situations is suggested.

—EDITOR

Dr. Sidney Rubin, Resident:

This 4-year-old girl was admitted to Children's Memorial Hospital for the second time on March 4, 1957, because of an increased number of stools for the last two months. Her previous admission, at 19 months, was for rather severe iron deficiency anemia. The father stated that the child had had watery stools approximately two months prior to admission and that they remained watery for about one month. The stools then became mushy and were well-formed for a few days about one week prior to admission. The child had been in another hospital for two weeks because of this condition and had been dismissed a week ago. An altered diet and vitamins were tried at that time. Six weeks prior to admission here the patient also had mumps but was not very ill at the time. The present illness preceded the onset of the mumps by two weeks. The father describes the stools as soft, bulky, brownish-gray, and frothy. They are also described as being extremely foul-smelling, the odor often permeating the entire house in the evening. There are, however, only three to five stools per day. There are no associated complaints except for some increased irritability. One year before admission she had a similar episode lasting two months. The mother has had ulcerative colitis, which is said to be quite severe, for about fifteen years.

The child is a well developed, well nourished white girl, slightly pale, quite cooperative, and in no apparent distress. The physical examination was completely within normal limits.

*From the Children's Memorial Hospital, Omaha, and the Departments of Pediatrics, Psychiatry and Radiology of the University of Nebraska, and the Department of Pediatrics of Creighton University.

The white cell count was 6950/mm³ with a normal differential. Hemoglobin was 12 gms. per 100 cc. and hematocrit 37%. The urinalysis was normal. Examination of the stool revealed it to be strongly positive for occult blood and to contain a small amount of neutral fat and a moderate amount of undigested starch. Two specimens were negative for ova, parasites, and cysts. The examination of stool for trypsin revealed it to be positive directly but negative in a 1:10 dilution. Two subsequent examinations were negative. The eosinophil count of the stool-mucus revealed 29% eosinophilia on one occasion and 35% two days later. Culture of the stools revealed an E. Coli and Proteus vulgaris which were sensitive to streptomycin, neomycin, chloramphenicol, and a penicillin-streptomycin combination. The stool specimen taken at the time of proctoscopy was also negative for ova and parasites. Scratch tests were done by Dr. Gibbs and the only significant reactions were to wheat and carrots. Proctoscopic examination was done by Dr. Stanley E. Potter and revealed a redundant mucosa but no ulcerations or polyps.

The patient was given a diet of soybean milk, whipped potatoes, cooked rice, applesauce, pears, beef, clear jello, squash, chicken, grape juice, and carbonated beverages. She was also allowed to have rye bread but no whole wheat bread. She was given Donnagel

Dr. Ralph C. Moore, X rays, (Figs. 1 and 2):

You can notice on the film that there are a number of rather classical changes due to ulcerative colitis: lack of haustration and a rather smooth granular appearance to the mucosa that appears almost polypoid in some areas. Of course there is a lot of dilute fecal material present which could simulate the appearance of polyps. The sec-
ond finding is the complete lack of any tone to the ileocecal valve. You see that there is free regurgitation into the ileum which is not too abnormal in an adult—it happens in about half the adults—but in a child it is very unusual to see free reflux of a barium enema into the ileum.

![Image](image.jpg)

**Fig. 1.** Bowel completely filled with barium showing smooth mucosal pattern and lack of tone and of haustrations. Free reflux into terminal ileum.

**Dr. Gilbert C. Schreiner:**

That point, Ralph, I would like to discuss. I thought about 25 per cent of normals will do that.

**Dr. Moore:**

Yes, I think you can get some reflux. If one starts manipulating during the barium enema he can get the barium to go through the ileocecal valve, but, ordinarily, just the pressure of the enema alone shouldn't cause a reflux. This ileocecal valve is wide open. This means there must be some change in the wall of the bowel which holds it rather widely patent at that level. The bowel is able to contract on evacuation so that it isn't a thick, scarred bowel which you might get in an adult. It is a rather thin bowel and the haustrations are completely gone which is definitely abnormal. The mucosa itself fails to show any definite ulceration. With typical ulcerative colitis you see little ulcerations tending to parallel the course of the bowel whereas in amebic colitis the little ulcers come out as short, stubby, little hair-like projections at right angles to the bowel. Furthermore, in amebic colitis, they tend to be patchy rather than diffuse until very, very late in the disease. The upper gastro-intestinal series showed no abnormality of the bowel pattern; in other words, there was no apparent nutritional deficiency sufficient to change the tone of the small bowel, and we saw no changes in the terminal ileum. This appears, then, to be just a generalized affliction of the colon with some thinning of the bowel walls, some polypoid changes in the mucosa, and a thickening or scarring around the ileocecal valve.

**Dr. Schreiner:**

Before you sit down, Ralph, I would like to ask a question. Do you think it is practical as a followup to evaluate treatment by barium studies?

**Dr. Moore:**

I wouldn't do them at all unless you had some indication such as excessive bleeding or something of that type in which you fear that carcinoma might be present or that polypoid changes might be becoming more prominent. Of course, the incidence of carcinoma is a good deal higher than it is statistically in normal children or adults. There are reported cases of carcinoma in children in the early teens who had ulcerative colitis,
but unless the child seems to be regressing or not getting along well, unless there is bleeding which hasn't been a prominent feature before, I think I would hold the X-ray down to a minimum. I don't feel that you need X-ray studies in order to make the diagnosis or to follow the changes. Proctoscopically, you can probably follow the changes in the mucosa better.

Dr. Schreiner:
But would proctoscopy show it? Here we have a reverse.

Dr. Moore:
That's right. This is the reverse of the usual situation. You usually make a diagnosis proctoscopically earlier than you do by X-ray. It is rather surprising that there weren't more changes.

Dr. Schreiner:
How long would you suppose it took to produce these changes?

Dr. Moore:
Without proctoscopic changes, I would think it might reverse the normal pattern in a year, maybe six months. But I think that the number of times you X-ray these people will depend entirely upon their progress. As long as they are getting along satisfactorily, especially children, it is a good idea not to X-ray them any more than you absolutely have to because you are X-raying the ovaries every time you do it.

Dr. Gordon E. Gibbs:
Dr. Starr, would you like to comment?

Dr. Phillip H. Starr:
The observations on this individual case may well be introduced by some remarks based upon the point of view of the psychiatrist and his approach to so-called psychosomatic disorders. To begin with, we feel strongly that this is a sort of borderland area. This particular area involves the need for a combined psychiatric and pediatric approach. The main consideration here is that diseases such as ulcerative colitis, or essential hypertension, or peptic ulcer, or neurodermatitis, the so-called psychosomatic disorders, are looked upon as having multiple etiologies — etiology that involves not only constitutional, physiological and biochemical factors, but also psychological factors. Such conditions not only involve the necessity for considering multiple etiologies but, also, multiple therapies. This particular case we have today requires, for example, an investigation of the mother's situation as well as that of the child. An important consideration is that when individuals are subjected to emotional distress and anxiety, there are certain particular parts of the body that represent loci minoris resistentiae. I think, in this particular family, it is of interest that the maternal grandfather had some colonic trouble that ultimately ended as cancer of the colon as I understand the history. Then, as you know, the mother also had a predisposition to ulcerative colitis, and now her child has it.

In the mother's history an interesting point was that her own mother apparently had very little to do with her upbringing. The mother went out into the fields and worked with her husband and left the raising of the children, of which this patient's mother was the third or fourth sibling, to the oldest sister. From what I can reconstruct, the oldest sister apparently felt very burdened by having to assume the home responsibilities for these children and apparently she went at it pretty spitefully. The mother describes repeated situations in which, if she left things around the house, the oldest sister would immediately destroy them, whether they were play-items or clothes-items. One gets the feeling that her relationship with the oldest sister was an extremely disordered one, an extremely conflicted one. The mother, as you interview her, impresses you as a highly overly-perfectionistic individual, a very over-regulated person who, in a sense, experiences this same type of relationship with her own daughter. Many of the features of this household reveal that she is extremely strict about how she takes care of this girl and the older boy. At one point in the interview she said, "Perhaps I have been too strict." I asked her why she feels this way. She went on to say that whenever she takes her kids out socially, whenever they are in the company of others, all the other parents have commended and complimented her on how nicely behaved her children are — how completely quiet they are. In a sense they are seen and not heard. The patient's mother went on to point out her tremendous sensitivity to noise and how she had disallowed much activity within the home for both of her children. She indicated further that her problem with her husband has become very much
exasperated. He has more or less disengaged himself from her during the last two years, largely because of the fact that she wants to run everything her way. She keeps an iron hand on the family, so to speak, having them do what she wants them to do and when she wants them to do it. Consequently, there appears to be a lot of rebellious feeling that is latent both within this girl and within the older boy. Incidentally, the boy has begun to stammer within the last year and a half.

During the interview with the child my attention was called to some very interesting observations made by some of the ward personnel. One of these was that after the little girl went to the toilet that she would wash her hands for as much as thirty minutes. What I am pointing to is the establishment of very severe compulsive features within her that have to do with her concern over cleanliness. This incidentally parallels a part of the mother's description in the home situation. The child follows the mother eternally throughout the rooms of the house with a dust rag. This goes on for hours every day. The mother's excessive concern about cleanliness and dirtiness have been, in a sense contagiously communicated to the child who has similar anxieties. In my interview with her she talked at some length about her concern about hurting animals or not liking to see animals hurt. There was a lot of emotion expressed, actually, in connection with her own regressive tendencies and her fears of her own anger. The patient herself actually is a very timid child. She is overly apprehensive and the impression I obtained of her is that she is excessively concerned about the expression of any antagonism or any type of open hostility towards the mother. Her only ways of expressing her antagonisms are indirect ways and I would like to speculate on these points.

From her earlier history we learn that the child wouldn't take solid foods for approximately 15 months. Finally, she was hospitalized here at the Childrens Hospital for transfusions. This was the time the milk anemia occurred, and the mother began to describe periods of struggles with her revolving around the problem of food intake. She would persistently refuse to take solid foods. Refusal to take certain foods only expressed her antagonisms to her mother—her differences with her mother. The mother also talked a little bit about the toilet-training-period. It is of very great interest that there was a period of approximately three to four months in which the child was soiling at the wrong place and at the wrong time so to speak. The mother became tremendously upset during this time. And the child was subjected to rather rigorous disciplinary acts on the part of the mother. One really gets the impression that the only way the child can react to her mother is not in words but in the form of food difficulties and the early elimination-problems we have mentioned. Incidentally, she has been enuretic for the last 12 months. This may also be closely connected with certain somatic ways of expressing herself and she may in a sense indicate her antagonism toward the mother in these indirect forms.

The question of psychotherapy and its value is a sharply contested area. There has been much work done psychiatrically with ulcerative colitis cases, and I can say to begin with that the results have been quite variable. There are many men who feel that psychotherapy has very limited possibilities. On the other hand, with the younger age-groups, before the personality has become fixed, so to speak, psychotherapeutic results have been a little more favorable. In this situation we have not only a child-problem but an overall family-problem—what I have already described to you as a conflict between the parents. The mother puts it in these words, "He won't have anything more to do with me, simply washed his hands of me." The mother has a guilty feeling that she has tried to impose her ideas on the whole household, and, incidentally, she has used her illness, her own ulcerative colitis, and her own "nervousness," as she puts it, to make others go along with her. When they don't cooperate with her she gets nervous and upset. In a sense she has used this as a club over the heads of the family. This has worried her and made her feel very guilty. Our psychotherapeutic approach would, therefore, really involve a clarification of the mother's problem in terms of both her own emotional difficulties and her own ulcerative colitis. As I already mentioned, the older sibling stammers and the patient we are discussing would seem to have an established emotional difficulty too.

What we shall try to do in psychotherapy is undo much of the mother's overly perfectionistic attitude in her relationship with her daughter. This girl, for example, becomes
excessively concerned when she misses going to Sunday School. The mother has brought out the fact that on a few occasions the child has attacks that resemble anxiety attacks when she can't go to Sunday School. There is an overly religious, an overly moralistic element within this household. This particular child has a conscience which would be more or less becoming to an adult but is out of keeping in a four-year-old. In our psychotherapeutic approach with the patient, we would teach her to express some of her hostilities in the form of her play activities. But, side by side with that, it is going to be imperative to help the mother so that she does not undo what we are trying to accomplish. We will meet the mother head-on because we are attempting to dilute some of this girl's perfectionistic attitudes. We shall try to water down her overly moralistic and overly critical self-attitudes. It will be extremely important to include the mother in the therapeutic effort, because her anxieties are going to be raised once the child begins to act differently as she responds to my psychotherapeutic interviews with her.

Dr. Gibbs:

Perhaps as part of the workup I should mention the allergy-possibilities here. It would be tragic to overlook an allergy in a situation like this. I don't know whether the X-ray picture could absolutely be incompatible with gastrointestinal allergy or not. That is up to Dr. Moore.

Dr. Moore:

In those allergic cases that we have seen, ordinarily the entire gastrointestinal tract is affected. It is not confined to the colon, and I have never seen a colon involved quite this far. Usually you will find variations in small-bowel-patterns predominant over variations in colonic patterns. The so-called "irritable colon syndrome" is practically normal because you see it occurring in all seasons of the year in many people and to establish an allergic pattern would require repeated studies over a long period of time in order to find out how much of it is seasonal variation, how much of it is emotional, and how much of it is allergic.

Dr. Gibbs:

As a first approach we did skin tests which everybody knows aren't worth much at this age with respect to foods, and the scratch tests showed absolutely nothing. So we went a step further. Intradermal tests, in the case of foods, are a little more reliable but I would say our results there were equivocal. We did not test with a very large number of foods. In food allergy, the real diagnostic approach is by elimination from or addition to the diet and that is a matter of a long period of time on an outpatient regimen, not in a hospital. In this patient, there was a 37 per cent eosinophilia in the colonic mucus. In my experience it has been very difficult to find any eosinophils even when were dealing with obvious allergy so that with this tremendous number of eosinophils we would like to make something of it. We know that in chronic illnesses of various sorts the psychology of the whole family gets in an uproar, and I think we have to be especially cautious in assuming it the main cause of all the trouble. Here it would seem to me that, as Dr. Starr presented it, the emotional side of the picture is predominant or an extremely important consideration. Any other comments or any questions for Dr. Starr?

Dr. E. Omer Burgert, Jr.:

Is the temperament of a child specific? I have often thought them highly intelligent and aware of parental tensions.

Dr. Starr:

The observation that you have made is particularly clear in ulcerative colitis in adults. I think the majority of patients that I have seen have been in the superior range in intelligence. There is a lot of conflict within psychiatry itself about this whole area as to whether one sees a certain pattern of personality in a specific psychosomatic disorder. For example the Chicago school of psychoanalysis feels that every patient with peptic ulcer has a certain type of personality-pattern, every type of mucous colitis problem has a certain pattern of personality and the same holds with essential hypertension or rheumatoid arthritis. I think that most of the investigations in the last few years have contradicted these views and our present view is somewhat as follows: we feel that an individual may have an Achilles heel, so to speak, within his body constitution, and that each one of us has vulnerability of a particular organ. It may be headache; it may be trouble with part of our gut; it may be the stomach; it may be hypertension, tachycardia, or some other symp-
tom. In other words, we look at it very non-
specifically. What we say is that, given a
certain amount of stress, an individual will
begin to show somatic symptoms in that part
of his body which one could refer to as a
locus minoris resistentiae. I think the idea of
having a specific personality constellation
is being by-passed now in terms of our
psychiatric investigation.

In the case under discussion, I would say
that the predominant personality features
are the compulsive features both in the moth-
er and, to a large degree, the child. This
makes treatment easy, because one can ac-
tually work in a parallel fashion with the
same problem in both mother and child. In
some ways you see in the child a carbon copy
of the mother’s difficulty. The origin of the
underlying psychologic quirk is the mother’s
personality, and the way she has raised the
child has paralleled the way in which she
was raised. Therefore, in working out the
problem one would have to go into the moth-
er’s relationship with her own older sister,
how she felt about this and what her antag-
onisms were. The basic conflict or the cen-
tral difficulty to work out in this situation is
the tremendous controlling attitudes on
the part of this mother toward her family.
I think we see problems in every inter-per-
sonal relationship; between the mother and
her husband, between the mother and this
boy who is now beginning to show the speech
disability, and particularly between the
mother and little girl who is beginning to
demonstrate ulcerative colitis. But, I would
be a strong proponent of the idea that there is
a constitutional predisposition to colitis
within this family, so that any stress factors
arising from any inner conflicts or from any
kind of situational problems might ultimate-
ly make themselves known by symptoms in
the colon. I think, if one approaches such
a problem with open mind, you have a much
better chance of getting at the conflict-areas
than if you develop in your own mind some
fixed ideas about problems that beset the pa-
tient who has ulcerative colitis or peptic ul-
cer patient. I think you are very often dis-
appointed when you do not encounter the
textbook picture in what you see.

Dr. Starr:

That is a very likely possibility. Like any
other therapy you are going to do more
harm than good unless you use carefully
calculated dosages. One avoids subjecting
the patient to too much anxiety or to over-
doses of anxiety in the course of uncovering
his problems. In other words there is an
optimum demand of anxiety that the patient
can experience, and he can use that amount
moving himself ahead in the therapy regi-
men. Now, greater amounts will do harm
rather than good. So we have to try to pace
ourselves and to get some concept of how
much an individual can tolerate. There are
some patients whose ego-strength, so to
speak, is so fragile that they can not delve
into their problems too intensively; to do so
will upset them more than help them. In
these patients we use a much more sup-
portive approach. We do not uncover too
many difficulties. On the other hand, if
one can calculate what the patient can stand
and how fast he or she can go, then one does
not run that risk. But, I agree with you
and I think this has happened. The im-
portant consideration is to treat the case in
an early stage. With children, my guess
would be that the prognosis is much better
than in adults, for two reasons: the dura-
tion of the actual physical disease is shorter,
and the personality-formation is not too
fixed—not too irreversible.

Question:

Do you think this is an advanced stage
of mucous colitis?

Dr. Starr:

That is an interesting speculation. I do
not know much about pathology. I do not
know what a pathologist might say about
that—whether or not the lesions or the up-
set physiology in the gut of the patient with
mucous colitis could be a precursor of the
lesions seen in the ulcerative colitis. I would
prefer not to comment on that point.

Dr. Gibbs:

Do you think that this is a sort of an ex-
aggeration of what we see around examina-
tion time?

Dr. Starr:

You know, it is interesting in this history
to go a little further back. Postnatally this
child had a diarrhea in relationship to some
food sensitivities. Dr. Schreiner, wasn’t that
reported in the history?
Dr. Schreiner:

The initial phase was interesting to me. The first time I saw the patient she was 18 months of age and she came to the office with only 3 gms. of hemoglobin, extremely pale, and short of breath. The father was studying, at that time, to be a laboratory technician which really astounded me although he was early in his studies. I had a problem right at that time convincing the family that she was really quite ill because of the severe anemia. Then I lost track of them until they re-appeared at this time. They are now living in Missouri, and the family physician down there called me stating that she had been in the hospital there for two weeks and had had difficulty with this diarrhea for two months. He had done a good workup, as much as we have done here, and felt lost as to the reason for the diarrhea.

Dr. Starr:

I think, in answer to Dr. Gibbs, we can reconstruct some of the history that I got from the mother about a week and a half ago. I’m almost certain the mother reported there was a period of about eight or nine days of diarrhea, postnatally, before the child came home from the hospital. Of course that puts it in the category of differential diagnosis. You can’t readily say whether that was infection, or food intolerance, or some type of nutritional upset. Although speculative, it seems to me this early episode of diarrhea again demonstrates the idea that there are certain vulnerable organs and that when an infant, for example, begins to show distress or anxiety, there is a certain predisposition for that anxiety to manifest itself in certain parts of its body. It may be more than coincidence that there was this pattern—early diarrhea and then constipation at about 12 months of age. Then came the “eliminating in the wrong place and at the wrong time” and then these diarrheal manifestations later on. I think this whole picture may be more than coincidence possibly contributed to by functional type of disorder.

Question:

How do you think this child would do if she were in a situation such as the children’s ward in the Nebraska Psychiatric Institute?

Dr. Starr:

At four years of age, my own impression is that it is better to avoid a hospital experience. I think it is probably a generally accepted pediatric practice to treat them in the home and avoid hospitalization if possible. My feeling here is that this child can respond to an outpatient type of program and that our biggest hurdle in this particular situation is the mother. I think if she can collaborate with me in terms of changing some of her rigid patterns and her basic convictions at this point, this girl, being young and malleable, will undergo changes in her thinking and in her attitudes about herself. Dr. Schreiner and I are planning to follow up on this and to see the mother and child every two weeks.

Question:

Do you expect to continue psychotherapy indefinitely?

Dr. Starr:

This is another misconception. I am glad these points are being brought up because I think there are many misconceptions. The two-or-three-year idea comes from the orthodox psychoanalytic approach in the treatment of adults in order to effect very basic and reconstructive personality changes. On the other hand, during the last ten years there has been an advent of short term therapy, and there are many situations that respond to a much shorter period of treatment. I think that in this particular situation it is hard to predict that this mother will continue on a once-every-two-week basis and bring the child in on a regular basis for approximately 12 months. If so, I would feel fairly optimistic in terms of the results to be obtained. I say that without any conclusiveness but base my prognostication on what I see about this problem, i.e. how extensive I feel it to be. There may be a good response in a shorter period of time particularly because this girl is only four years of age.

Dr. Schreiner:

I would like to make one more statement. We are dealing with a very serious entity and are faced with the major question, when do these patients deserve surgery? Dr. Orvar Swenson favors ileostomy or colostomy when the disease cannot be controlled medically and when it becomes chronic with permanent changes in the colon. Lyons says, “Wide differences of opinion exist on the frequency of the need for operation in adults with ulcerative colitis. The frequen-
cy varies from 30 to 10 per cent. Concerning children, there is almost universal reluctance to submit the patient to a definitive procedure which involves performing an ileostomy.

So there are two contrasting thoughts on whether or when these patients do deserve surgical treatment.

**Question:**
What is the prognosis for these children with ulcerative colitis?

**Dr. Schreiner:**
Lyons also quotes the series of 95 children followed by Jackman, Bargen and Helmholz, in 1940, of which over 50 per cent became worse or died, and also the observation by Kirsner, Raskin and Palmer of only 5 per cent mortality. Bargen and Kennedy reported on 139 children, ages 1-15 years. Twelve had rectal polyps; 2 had carcinoma at age 17; 18 had no evidence of the disease; and 10 were much improved. In general, the younger children have the better prognosis.

**Question:**
What kind of a medical program would you use in conjunction with psychotherapy?

**Dr. Schreiner:**
The diarrhea persists. Anywhere from two to six stools per day are passed here in the hospital, and they are green, some of them are mushy, none of them are normal stools. She has not had a normal stool in the two and a half weeks here. She is receiving neomycin, kaolin-pectin and Donnagle, and diet as noted in the protocol. From what I read, diet isn’t all-important. We thought it might be an allergic colitis because of the eosinophilia and eliminated milk, egg, wheat and other allergens and have substituted a moderately bland diet. No one seems to feel strongly that a strict diet makes much difference. Cheerfulness during the hospitalization is good thoughtful management. She has already been away from the home two weeks plus two and a half weeks here—that is over a month of being out of the home—and I don’t think her diarrhea is appreciably different. It must be better than it was early in the course. She must have had a pretty profound diarrhea at that time. Another thing that is hopeful in this case is that she has had a normal temperature curve. She has been afebrile. She does not have an elevated white cell count and does not have anemia.

Most authors say that salazopyrine is the most effective drug with antibiotics in acute exacerbations. Many report a good response to long term cortisol therapy.

**Dr. Starr:**
Now you are getting to the fact that most of the struggles in the home occur around the table. The mother is eternally after both of the kids to eat. She herself, incidentally, is very anorexic. I don’t know whether she has a lot of problems with this aspect.

**Dr. Schreiner:**
The mother is taking steroids and has been for over a year.

**Dr. Starr:**
I’m just bringing out this other dimension because I think there is a need for this kind of simultaneous approach while one thinks about diets. We must recognize some of the attitudes this child has towards food, attitudes which may have arisen, originally, in the way the mother handles her own food intake. You have to attend to that while you are developing an optimum dietary program.

**Dr. Charles A. Tompkins:**
Hasn’t this problem at the dinner table become almost universal?

**Dr. Starr:**
Yes, but it is a matter of degree. I think some of these things occur with all of us in all situations, but when it goes beyond a certain degree and becomes chronic and well established, then you are dealing with a problem of clinical significance.

**Dr. Tompkins:**
This must be an artifice in our culture. The culture must then be contradictory or how can there be conflict around everybody’s dinner table?

**Dr. Starr:**
Well, did you see the educational T-V program in which they discussed indigestion? And the little squirrel says, “That means they are civilized.”

**Dr. Tompkins:**
I was interested in some of the things Dr. Starr was saying as he presented the genesis of tension in this case. Here we start out with a conflict between the mother and child.
in several areas—the child really trying to make sense, trying to harmonize with reality almost compulsively you might say. It is a normal compulsion to eat when you are hungry and not eat when you are not hungry, and so on. Then the mother compulsively conforms to her own concepts and tries to get the child to conform to these rather than to harmonize with reality. If we put the emphasis on conformity rather than on harmony with basic needs, then we start creating tension. The mother feels most comfortable making nonsense, much more so than if she were making sense. So she feels herself a good mother when she is making her child conform. I can conceive, then, that when this child was going into the second year of life with increasing creativity, the mother channelized that and grouped it and actually discouraged creativeness in the guise of encouraging it. Then, later on, this was overcompensated by the competitive drive. Competition was probably completely unnecessary if she had not destroyed the natural creativeness. Then competition causes more tension, and the gimmick here is that it seems right, therefore the whole culture is uncomfortable when somebody tries to be normal.

Dr. Jeno Kramer:

Nobody has any doubt in mind that this is a psychosomatic condition, whether the psyche is the primary condition or is superimposed on some physical condition. In one respect I have some doubt that the diagnosis is ulcerative colitis. Two main points here do not agree with the diagnosis of ulcerative colitis, and one of these is the eosinophilia; the second is the unusual situation that you get a positive X-ray finding and negative proctoscopic findings. This is entirely unusual. A third point which I may add—this is a disease of two months duration. During the first month the child had loose, watery stools. I would like to ask Dr. Schreiner once more, how was the onset of the disease? Was it in sieges?

Dr. Schreiner:

Yes. Not an acute onset.

Dr. Kramer:

Not an acute, but certainly you can rule out that there might have been some infection at that time, let us say virus enteritis or something else out of which this condition developed.

Dr. Schreiner:

I would say it was pretty much an insidious onset. After it was going for about a month it seemed to be worse and then improved a little bit again.

Dr. Kramer:

And the child was perfectly normal prior to this onset?

Dr. Schreiner:

They tell me that. I don’t know whether it’s true or not.

Dr. Kramer:

Why I am debating this question of diagnosis of ulcerative colitis is this: When you speak of ulcerative colitis, then you speak of the possibility of operation. You are speaking in terms of duration, two years, three years, or many more. Can this not be a condition which is compatible with celiac syndrome? I have seen many cases of celiacs like this occurring after dysentery, and positive psychiatric therapy has been very good in controlling these stools...this we call a dysentery condition that lasts for months or one or two years and finally peters out completely.

Dr. Schreiner:

If you think it is primarily a bacterial thing.—

Dr. Kramer:

I don’t think it is bacterial. I am speaking of celiac syndrome which is not a bacterial concept. It is a concept of malabsorption...

Dr. Schreiner:

I’m a little reluctant to think of it although I haven’t done a glucose tolerance. The patient is very well nourished. She is extremely well developed. I find it hard to discount the X-ray findings, although, for example, they rarely may be found in other diseases such as fibrocystic disease in which ulcerative colitis is not the clinical diagnosis.

REFERENCES
Clinical and Laboratory Diagnosis

Doctor Kirk does not present "new" information in this article. This is an excellent illustration of the value of emphasizing the "old." The author brings the reader back to a "feet-on-the-ground" position in regard to the study of a patient. He does not decry the functions of the laboratory, but reminds us not to give those functions more than their relative values in arriving at a diagnosis.

—EDITOR

In a recent article a case of liver disorder was described in which a great variety of liver function tests were performed. It may be mentioned in passing that many of these tests are still poorly understood and their interpretations vary greatly. At last it was suggested that to find out what was really the matter with this patient the old-fashioned scheme of history taking should be tried, together with a thorough physical examination, and that these be supplemented with one or two carefully selected laboratory tests.

This instance was not selected with the intention of pointing out whether clinical or laboratory diagnosis is the more important, but to show that the two methods must be correlated in order to achieve a successful result, at any rate so far as the diagnosis and proper treatment of the patient is concerned.

I recall, vividly, a clinical clerk who was greatly upset because he was not allowed to see the electrocardiogram of his patient. This clerk was unable to discuss the history of the patient's illness nor such physical signs of the heart as the location of the point of maximum intensity of the apex beat, the relative size and configuration, the rhythm and character of the heart sounds, or the blood pressure. The reason he could not discuss this was simple. Actually, he had never examined the patient but assumed that he was dealing with a cardiac case be-

cause this was the diagnosis made on admission.

It may be of interest and of much value to all of us to review the fundamental and basic principles of physical diagnosis, not only because of its importance in teaching medical students but in everyday practice of medicine.

Let us begin with the definition of a medical history. In a broad sense the medical history purports to represent a chronological record of the development of a patient's symptoms and physical signs together with such laboratory findings as may be pertinent to the diagnosis and treatment of the disease. Let us state flatly that there is no other way to study a patient and that such a study of the symptoms constitutes the patient's "Present Illness." It is in this first approach to the patient that the fundamental and basic training as well as the doctor's experience is revealed. But to gather important information concerning the chronological and sequential development of a patient's symptoms is only one step; to classify and arrange these findings into a meaningful diagnosis is another. And this second step in which the symptoms are grouped and correlated into a diagnostic picture is a much more difficult accomplishment and the ability to do this requires long study and experience on the part of the physician. The symptoms and physical signs may bring the patient to the doctor, but to understand the symptoms one must understand the patient. A good medical history is the means by which this acquaintance with the patient is achieved. It has been often emphasized that the character of a medical school
can be gauged by the thoroughness with which its graduates write medical histories.

The recognition of the symptoms around which all the others revolve is probably the most important function of the "Present Illness." Many symptoms may not be recognized and, indeed, may not be known even to the patient but can be brought to light by a thorough investigation or interrogation in a "History by Systems." Such a history by systems can serve as an excellent check on the "Present Illness" and may reveal nonrelated disorders which the patient himself cannot differentiate. By proper questioning, the patient may even furnish information the meaning of which may be of significance to the physician alone. Thus, a patient may give a negative answer to a question referring to stomach trouble but answer in the affirmative when asked if he had ever had jaundice.

In searching for the causative factors of an illness, one must review carefully all portions of a medical history. This portion or section of the medical history is called the "Etiological Survey." It deals with such matters as family and marital history, previous illnesses and accidents, occupational history, as well as habits and personality traits. An experienced physician has acquired a method for analyzing systematically this "Etiological Survey."

While the study of "Present Illness," of a "History by Systems" and of the "Etiological Survey," are important because they reveal the patient's personality and his mental reactions, it is the physical examination that brings the physician and patient into actual contact. Since the days of Hippocrates physical examination has been the keystone of medical diagnosis. Of course, with a better understanding of physiological, biochemical, bacteriological, and pathological reactions and changes, our clinical understanding of symptoms is likewise improved and, perhaps, our data are also better interpreted.

The cardinal principles of physical examination must be mastered. Study and experience develop our keenness of inspection, palpation, percussion and auscultation. Inspection becomes more meaningful with a growing ability to observe and record. One learns not to underestimate a disturbed gait, to associate the pallor with the degree of shock resulting from a recent acute coronary occlusion, to note the bluish white sclera of a mild icterus, the spastic musculature of a cerebral disturbance (congenital or acquired), disabilities resulting from previous injuries and accidents, or the deadly pallor of arterial occlusion in a painful foot or lower extremity. One also learns to recognize the significance of odors as in renal failure, or in diabetic coma, or the lack of acetone odor as in hypoglycemic coma. Observation of any one sign may start a mental chain-reaction in the physician which may lead him to recognize conditions of which the patient is totally unaware.

I shall never forget the case of a 38-year-old woman who was admitted to the hospital in a state of coma. Her breath was free of acetone odor. She gave the appearance of a woman in her sixties; the scalp hair was very sparse; axillary and pubic hair was absent. An immediate blood sugar determination revealed a very low level of 33 mg. per 100 cc., and her condition was diagnosed as hyperinsulinism. After glucose intravenously consciousness was regained.

I recall another patient in coma. This was a severely hypertensive 40-year-old man whose symptoms were vomiting and diarrhea. There was no uremic odor to the breath. Before a blood chloride determination could be completed, intravenous chlorides were given in spite of sharp criticism against administering salt to a presumably uremic patient. The man regained consciousness, and, later, the analysis revealed that the blood chloride level was 220 mg. per 100 cc.; in other words the patient was actually in a state of hypochloremia.

In another instance a young man, a section hand, was brought into the hospital as an emergency. He had collapsed while working on a hot day in July. He was unable to stand and had excruciating severe cramps in his legs. From the patient's condition it was apparent that he suffered from an excessive loss of chlorides and upon administering salt solution intravenously he recovered immediately.

Another instance that comes to mind is that of a man who demanded compensation because of a base-ball deformity of the distal phalanx of a finger which he claimed was injured on the job. When his filed record was examined in his presence, it was discovered—to my delight and to his chagrin—
that this deformity had been fully described in his original pre-employment record.

A medical history or a laboratory study by itself cannot be substituted for a careful examination. The physical examination, or even repeated examinations, costs too little to excuse costly oversights due to careless examination or, still worse, to no examination at all. It seems to me that in every routine physical examination, examination of the area of the body suggested by the patient’s chief complaint should be done first. The reason for this is quite obvious.

The examination should always be oriented towards specific physical signs rather than towards any specific disease process. Then, at the conclusion, the patient will have been truly studied and analyzed. Then, and only then, will the patient be appraised as a living individual with definite symptoms, affected by many possible etiological factors, and associated with specific physical signs. The physician will thus get to know his patient as a human being afflicted with disease rather than a disease entity exemplified by a given patient. In the words of Osler—“it is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.”

The evaluation of the individual patient in his entirety will aid in unravelling the underlying disease process and clinical diagnosis. The procedures we have enumerated and the tentative diagnosis become the foundation for the judicious use of laboratory procedures. A wise and scientific selection of laboratory tests marks the physician as one who is imbued with knowledge of the pathological changes. The primary importance of laboratory findings is the light which these may shed on the clinical diagnosis. Laboratory findings without a thorough investigation of the patient do not make a diagnosis, but can aid the physician in four ways: first, they can confirm the clinical diagnosis; second, they can serve as a guide in therapeutics; third, they can contribute in the evaluation of prognosis; and lastly, they are invaluable in clinical research.

Ordinary laboratory tests (urinalysis, blood counts, and serological test) should be performed routinely and without regard to type of disease, but other tests should be ordered only if indicated by the clinical diagnosis. The selection of these tests should be based on full knowledge of their nature and appreciation of the special information to be derived from them. The ordinary hospital laboratory may not be set up to carry out certain tests, and a physician must be forbearing in his requests; above all else must have a clear understanding of the nature and scope of these tests. The laboratory should not be employed as a short-cut in arriving at a diagnosis and still less as a substitute for a thorough study of the patient. Certainly, an elevated white cell count and abdominal pain do not, in themselves, spell out the diagnosis of acute appendicitis with an appendectomy indicated. Neither do anemia and achlorhydria decide the requirement of liver, vitamin B₁₂, folic acid or iron medication, when gastric cancer may be the offending agent. Too easy a resort to laboratory testing, apart from being a drain on the economy of the patient, may actually indicate a mismanagement of the patient.

The physician should acquire the habit of consulting the hospital or clinical laboratory before ordering unusual tests or tests which are performed only rarely. Laboratory tests become more dependable the more frequently they are performed. For tests described in the current literature, laboratories need time to develop the special techniques. Physicians should be keenly aware of this before ordering such tests. Perhaps it would be a good idea if such special laboratory tests were discussed in a staff or county society meeting. In fact a reference list of tests for various disorders could be furnished to staff members and others, subject to revision. Such a list could serve as a useful guide for the physician.

Doctor — Does your wife like to read the Auxiliary news? Then be sure and take your copy home.

A salute to medical school progress

MEDICAL EDUCATION
WEEK — April 20-26

April 1958
The last days of this April will bring you the annual meeting of the Nebraska State Medical Association. The freedom of medical care and the stability of medical practice depend upon your county medical society, your state medical association and the American Medical Association. Just dissolve these organizations and imagine what would happen to the medical care of our people and to our profession. The inroads of quackery, deceitful and unfair practices by a small number of our own who seem to lack that something that makes a good doctor, and the impractical controls of government would make the situation intolerable. I am asking you to stop and think about this for just one moment. If you do, I am sure you will lend the necessary support to our annual meeting by your presence.

The members of your Scientific Assembly Committee (Program Committee) have many meetings and work many hours building up and arranging the program. They try to imagine what you want, what we all might need, and it is a terrific job—particularly for the Chairman of that committee.

Also it costs money to put on this annual meeting, and in our free way, exhibitors are permitted to display those products which are necessary in our practice. It is costly for these companies to get this information to us. It is this income which helps finance our state meeting and other meetings of the medical profession. It is our responsibility to express our appreciation for their assistance and to inform ourselves of their products and the advances made. During the last year, your association received several letters from previous exhibitors stating that they were withdrawing their support to our annual meeting because of the lack of interest by the doctors of our state. If this should become a trend, financing of our annual meeting could only be accomplished by marked increase in dues. The responsibility is yours.

Please plan on being with us, attend the meetings and visit the exhibits. This will show your courtesy and appreciation to those who are working with us.

R. RUSSELL BEST, M.D.,
President, Nebraska State Medical Association.
Organization Section

Coming Meetings

CRIPPLED CHILDREN’S CLINICS—
April 12, McCook, St. Catherine Hospital.
April 26, Ogallala, Elks Club.
May 10, Kearney, Good Samaritan Hospital.
May 24, Alliance, St. Joseph's Hospital.

ANNUAL SESSION NEBRASKA STATE MEDICAL ASSOCIATION — April 28-May 1, 1958, Hotel Cornhusker, Lincoln.

THIRD ANNUAL TRAUMA DAY — University of Nebraska College of Medicine, Omaha, May 7, 1958.


PEDIATRIC POSTGRADUATE COURSE —April 7-8, 1958, University of Nebraska College of Medicine, Conkling Hall.

DINNER MEETING NEBRASKA PEDIATRIC SOCIETY — Blackstone Hotel, Omaha, April 7 at 6:00 p.m.

SIXTH ANNUAL SPRING POSTGRADUATE ASSEMBLY—April 9-11, 1958, University of Nebraska College of Medicine.

THE ANNUAL C. W. M. POYNTER DINNER AND LECTURE — April 10, 1958, Town House Ballroom, Omaha. Dr. Walter C. Alvarez, speaker.

News and Views

From the Superior Express—
A Byron doctor was honored in January for long service to his community.

Dr. Rudolph Decker, the town’s only physician has been practicing in Byron for 50 years and was pleasantly surprised at the evening affair in his honor, when old friends gathered at Byron Memorial Hall to offer congratulations and wish him well. A pot luck dinner was served to about 200 persons.

Rev. Schiller of Byron was master of ceremonies and outlined the program that had as its theme, “This Is Your Life, Dr. Decker.” Many interesting incidents in the physician’s life were related by friends present, and flowers and letters from many other doctors and other friends who could not be there, were received.

Mrs. Ben Marquardt, mother of the first baby delivered by Dr. Decker, was present and spoke briefly, and many of the “babies” that he has brought into the world were present and acknowledged. Dr. Decker is a charter member of the Hebron American Legion post, and has served on the Byron town board for many years.

An interesting part of the evening’s program was the reading of items from an issue of the Byron Blade of 1908. The old newspaper has been carefully preserved by a Byron resident.

Dr. Becker was graduated from Jefferson Medical College at Philadelphia and interned in a Milwaukee hospital. He then located in Byron which has been his home ever since. His home town was Mendota, Illinois.

A bachelor for several years after starting in practice at Byron, Dr. Decker married Miss Theodora Proehl, also of Mendota, Illinois. They have three sons and one daughter.

Dr. and Mrs. Decker are both in good health, and while he has been trying to “ease up, a little” in recent years, he has no intentions of giving up his practice any time soon. His many friends are hoping that it will not be for a long time.

From the Broken Bow Chief—
For the first time in a long time, the community of Arnold is without a doctor.

Drs. Leslie Potts and A. F. Scheuneman have closed their office. The closing was an aftermath of a long, bitter controversy that saw Dr. E. H. Reeves leave the community.

Drs. Potts and Scheuneman plan to practice in Minnesota. Their departure presumably means the Arnold Hospital will close.

Dr. Reeves, now living in Grand Island, is reportedly considering setting up practice in Minatare or some other Nebraska town.

From the Lincoln Journal—
The State Board of Health has moved to discourage the practice of drug store patrons returning for refunds on unused portions of dispensed prescriptions.
The board approved a recommendation of the State Board of Pharmacists banning licensed pharmacists from accepting such materials for refunds. The ban also applies to certain surgical and sick room supplies except where the return is made under a warranty or guarantee.

Dr. E. A. Rogers, state health director, said the refund practice had become "rather a pernicious one."

From the Lincoln Star—

Nearly 200 doctors and lawyers met in Lincoln in February for a day-long meeting with a floor discussion of "Pathological Problems in Criminal Cases" led by Dr. John Schenken of Omaha.

Dr. Schenken and two other pathologists, Dr. Clarence McWhorter and Dr. Milton Simmons, drew on actual cases they have handled to develop the discussion at the annual meeting of the Lincoln Bar Association and the Lancaster County Medical Society.

In an afternoon session three doctors and three lawyers staged a mock court room scene to illustrate the technique of examinations of medical witnesses. The purpose of these activities, Dr. Schenken explained, is to develop better understanding of the problems involved in relationships of the two professions.

From the Gering Courier—

Dr. James E. Dusenberry, son of Mr. and Mrs. Ralph Dusenberry of Gering, has received a $2300 grant from the National Institute of Health for research into the alkaloidal content in the ergot fungus of some African grasses. Dr. Dusenberry is one of about 20 men throughout the nation who have obtained a Ph.D. in pharmacognosy which is the study of drugs and medicines produced by nature.

Dr. Dusenberry recently received two batches of ergots from Switzerland and Africa which he will study to determine what alkaloids the ergots contain and to isolate the ergots in pure cultures to see what alkaloids they will produce under these artificial conditions. He hopes to find new drugs and new sources of drugs and ways of producing them in larger quantities at cheaper prices.

Dr. Dusenberry is an assistant professor of pharmacognosy at the University of Arkansas school of pharmacy.

From the Grand Island Independent—

Lincoln: A four-member committee, appointed by the Lancaster County Association for Mental Health, will undertake a two-fold program toward formation of a Lincoln Mental Health Clinic.

The committee includes Mrs. Fern Hubbard Orme, the Rev. Thomas Johnson, Mrs. Henry Bader, and Dr. William Brill, professional advisor.

The committee will contact all other local agencies concerned with the formation of a mental health clinic, and work toward correlating these various groups into the plan.

It will also visit out-of-state cities of similar size having mental health clinics.

From the Omaha World-Herald—

Additional heart research grants totaling $2487 have been announced by the Nebraska Heart Association. They are:

Dr. John Ferguson, Creighton University, grant of 487 dollars to study the effect of drugs on artery muscles in high blood pressure.

Dr. Harle V. Barrett, Creighton University, one thousand dollars for the study of life factors—age, sex, occupation, diet and previous health—on heart diseases.

Dr. Herbert J. Jacobi, University of Nebraska, one thousand dollars to study heart blood vessels which have become clogged with fatty substances.

From the Grand Island Independent—

The resignation of Dr. Jack A. Wolford, superintendent of the Hastings State Hospital has been announced.

Dr. Wolford, who joined the Hastings staff in 1956, has accepted a position to teach in the Western Psychiatric Institute at the University of Pittsburgh and to act as liaison between the university and the state mental hospitals of that area.

From the Omaha World-Herald—

Dr. Ted Riddel who has practiced in Scottsbluff since 1925, was the first Univer-
sity of Nebraska athlete to earn letters in
four major sports. Dr. Riddell won letters in
football, basketball, track and baseball in
1915, 1916 and 1917.

Only one other Cornhusker athlete has
accomplished the feat, a check of the records
reveal. He is Elmer Dohrmann, who per-
formed some 20 years after Dr. Riddell.

The Scottsbluff physician played football
with Nebraska’s great Guy (The Champ)
Chamberlain. In basketball he was a mem-
er of the team that won the Missouri Valley
Conference championship in 1915. As a
member of the track team he threw the jav-
elin, put the shot, threw the discus. In base-
ball he was a catcher. He left the university
to serve in World War I before entering the
university’s College of Medicine in 1919. He
was graduated from the College of Medicine
in 1923.

A “First” for University of Nebraska
College of Medicine—

A long-needed innovation in the field of
postgraduate medicine was recently realized
—a short course for clergymen.

It was a one-day Institute dealing with the “Role of the Clergy in Effective General
Hospital Visitation.” The Institute was held
on Friday, February 28, in the Conkling
Hall Postgraduate Conference Room on the
College of Medicine campus. It was con-
ducted by the College, in cooperation with
the Omaha Council of Churches, the Arch-
diocese of Omaha, and the Omaha Syna-
gogue Council. Clergymen of all denomina-
tions from all over Nebraska were invited
to attend.

Keynote speaker for the course was the
Rev. Russell Striffler, Clinical Chaplain at
Iowa Methodist Hospital and Raymond
Blank Memorial Hospital for Children, Des
Moines, Iowa. Chaplain Striffler is also
Special Lecturer in Pastoral Psychology-
Clinical Pastoral Training at Drake Universi-
ty Divinity School.

In addition to the special guest speaker,
the program featured faculty members of
the University of Nebraska College of Medi-
cine, as well as local hospital chaplains.
Course coordinator was the Rev. Frank S.
Moyer, Protestant chaplain for University
Hospital.

Postgraduate Course in Obstetrics Held at
Lincoln General Hospital—

The sixth postgraduate program on the
University of Nebraska College of Medi-
cine’s refresher course schedule for 1957-
1958 was held at the Lincoln General Hos-
pital, Lincoln, Nebraska, on March 27. It
was a one-day course in “Obstetrics.”

Nebraska physicians taking the refresher
course heard lectures by two guest speakers
and by members of the College of Medicine
and University faculties.

Program moderator was Dr. Harold Mor-
gan, Lincoln. The two guest faculty mem-
bers for the course were: Dr. Isadore Dyer,
Professor of Obstetrics and Gynecology, Tu-
lane University School of Medicine, New Or-
leans, Louisiana; and Dr. John Foley, Senior
Assistant Surgeon, Epidemiologic Intelli-
gence Service, Communicable Disease Cen-
ter, U.S. Public Health Service, Kansas City,
Kansas.

Other faculty members for the program
included: Drs. J. William Ballew, Richard
E. Garlinghouse, Frank H. Tanner, and Dr.
Morgan, all of the College of Medicine’s Lin-
coln clinical faculty; Hilliard Pivnick, Ph.D.,
a member of the University of Nebraska fac-
culty, Lincoln; and Drs. Mary E. Soule, Roy
G. Holly, and Hilton A. Salhanick, all from
the College of Medicine’s Omaha campus.

RESOLUTIONS VS. PERSONAL
COMMUNICATION
(Continued from page 122)

This gesture is useful in trying to influ-
ence national legislation, but our members
should not feel that such a resolution ful-
fills, in any sense, the need for personal con-
tact with our law-makers. The personal
communication expressing your ideas in
your own way is many times more effective
than any group or organizational expression.
Our Association does not vote; its members
do.

April, 1958
PROGRAM and SPECIAL FEATURES of Ninetieth Annual Session Nebraska State Medical Association and Thirty-third Annual Meeting Woman's Auxiliary to the N.S.M.A.

R. RUSSELL BEST, M.D. President, 1957-1958

FAY SMITH, M.D. President, 1958-1959

Guest Speakers

Alexander Marble, M.D. Boston, Massachusetts

Graduate Harvard Medical School, 1927; Assistant Clinical Professor of Medicine, Harvard Medical School; Physician, Joslin Clinic and New England Deaconess Hospital, Boston; Consultant in Medicine, Veterans Administration. Member of Advisory Council to the Surgeon General, United States Army; Member of American Society for Clinic Investigation, Association of American Physicians, American College of Physicians, American Diabetes Association, Endocrine Society, Society for Experimental Biology and Medicine, Association of Military Surgeons.

"Present Status of the Oral Hypoglycemic Agents"

"Management of the Difficult Diabetic"

C. Joseph Stetler, LL. M. Chicago, Illinois

Director, L. w Department, American Medical Association; Graduate Catholic University, Washington, D.C., 1940; Admitted to the Bar of the District of Columbia and the State of Illinois. Member Chicago Bar Association, Illinois Bar Association, and American Bar Association. Has worked with the Civil Service Commission, Social Security Administration, Veterans Administration, and with the War Claims Commission as Director of Legislation and Opinions Service. Formerly Secretary to the Council on National Defense and Secretary to the Committee on Legislation, American Medical Association.

"Forand Bill" and "Present Status Keogh-Jenkins Bill"

"Malpractice"

Wm. J. Burns, LL. B. Lansing, Michigan

Executive Director of the Michigan State Medical Society; practiced law in Toledo, Ohio, before entering the medical association executive field; he was the first Executive Secretary of the Toledo Academy of Medicine; formerly Executive Secretary of the Wayne County Medical Society, Detroit; President of the Medical Society Executives Conference; in 1957 the Michigan State Medical Society elected him an honorary member, making him the seventh person so honored in the society's 92-year history; Honorary member Wayne State University Medical Alumni.

"Trial by Medical Jury or Problems of the Grievance Committee" (an audience participation skit)
Seymour J. Gray, M.D., Ph.D.
Boston, Massachusetts

M.D. University of Pennsylvania, 1938; Ph.D., University of Chicago, 1943; Assistant Professor of Medicine, Harvard; Physician, Peter Bent Brigham Hospital; Consultant in Medicine, U.S. Veterans Hospital, West Roxbury, Massachusetts; Consultant in Medicine, U.S. Naval Hospital, Chelsea, Massachusetts; Consultant, P.H.S., Gastrointestinal Cancer Committee, National Advisory Cancer Council; member of eleven American scientific societies; Honorary member of four foreign gastroenterology societies; Author and Co-Author of seventy-eight scientific articles and books.

"Diagnosis and Management of Upper Intestinal Hemorrhage"
"Stress, Hormones and Peptic Ulcer"

Michael L. Mason, M.D., Ph.D.
Chicago, Illinois

Professor of Surgery, Northwestern University Medical School; Attending Surgeon, Passavant Memorial Hospital, Chicago; Secretary of American College of Surgeons; Associate Editor, Surgery, Gynecology and Obstetrics; M.D., Northwestern University Medical School, 1924; Ph.D., Northwestern University Graduate School, 1931; began career as a Surgeon January 1, 1925; Associated with Dr. Allen B. Kanavel, 1926-1938, and Dr. Summer L. Koch since 1938. Has exhibited at many art galleries since 1938.

"Local Treatment of Small and Large Burns"
"Management of Tendon Injuries"

John R. Paine, M.D.
Buffalo, New York

Professor of Surgery, University of Buffalo School of Medicine, and Chief of Surgery, Buffalo General Hospital; formerly Professor of Surgery, University of Minnesota School of Medicine; Research interests largely concerned with (1) Intestinal Obstruction and Various Aspects of Bowel Physiology, (2) Elasticity of Lungs and Experimental Production of Emphysema, (3) Experimental Production of Thyroiditis.

"Pseudomembranous Colitis Due to Antibiotics"
"Evaluation of Surgical Deaths"

W. C. Keettel, M.D.
Iowa City, Iowa

Professor, Department of Obstetrics and Gynecology, State University of Iowa, College of Medicine, Iowa City, Iowa; Graduated University of Nebraska College of Medicine, 1936; formerly Obstetric Consultant, Wisconsin Medical School; formerly Chief of Obstetrics, Manhattan District Project, Oakridge, Tennessee. Special interest in Diabetes, Sterility and Endocrine Dysfunction.

"Induction of Labor"
"Functional Uterine Bleeding"

Major General
Paul I. Robinson, M.D.
Washington, D.C.

Executive Director of Medicare; Assigned to Army Surgeon General’s Office from Letterman Army Hospital, San Francisco, where he has been Commanding General since June 1955; the General has commanded three of the Army’s largest hospitals —Letterman; Madigan Army Hospital, Tacoma, Washington, and Fitzsimmons Army Hospital in Denver. Served as Eighth Army Surgeon in Korea, where he was awarded Korea’s Order of Military Merit, Tygur; in addition, the General holds the Legion of Merit with one Oak Leaf Cluster, the Philippine Military Medal of Merit, and several other ribbons.

Panel Member Thursday Luncheon on “MEDICARE"

April 1958
Guest Speakers

Kenneth McFarland, Ph.D.
Topeka, Kansas

Educational Consultant for General Motors; Master's Degree from Columbia University, New York City; Ph.D Stanford University, Palo Alto, California. He is a businessman, farmer, stock raiser, civic leader, church leader, personnel consultant, and public relations consultant. Named America's Outstanding Salesman for 1957 by National Sales Executive Clubs. In a survey by the United States Chamber of Commerce was named "America's Number One Speaker." He appears as a banquet speaker through the courtesy of General Motors.

"Selling America to Americans"

Things You Should Know

REGISTRATION — Mezzanine, Hotel Cornhusker, 3 p.m., Monday, April 28, 1958 and 8:30 a.m., each day thereafter.

GOLF TOURNAMENT — Hillcrest Country Club, 12:30 p.m., Monday, April 28, 1958.

Luncheon facilities are available at the Club.
Chairman: Jack G. Wiedman, M.D., Lincoln.

TRAP SHOOT—Lincoln Gun Club, 1:00 p.m., Monday, April 28, 1958.
Chairman: Harry E. Flansburg, M.D., Lincoln.

SPORTSMAN'S DINNER — Hillcrest Country Club, 7:00 p.m., Monday, April 28, 1958.
Chairman: Jack G. Wiedman, M.D., Lincoln.

GENERAL SESSIONS — Ballroom, Hotel Cornhusker.

FUN NIGHT — Officer's Club, Lincoln Air Force Base, 7:00 p.m., Tuesday, April 29, 1958.
Transportation will be furnished from Hotel Cornhusker.
Chairman: H. V. Munger, M.D., Lincoln.

PAST PRESIDENTS' BREAKFAST — Room 901, Hotel Cornhusker, 8:00 a.m., Wednesday, April 30, 1958.

SOCIAL HOUR — Honoring the President and the President of the Woman's Auxiliary. State Suite, Hotel Cornhusker, 6:00 p.m., Wednesday, April 30, 1958.

BANQUET—Ballroom, Hotel Cornhusker, 7:00 p.m., Wednesday, April 30, 1958.

Officers

President
Fay Smith, M.D. — Imperial

Vice President
George B. Salter, M.D. — Norfolk

Secretary-Treasurer
R. B. Adams, M.D. — Lincoln

Executive Secretary
Mr. M. C. Smith — Lincoln

Board of Councilors

District Term Expires
1. Harold Neu, M.D., Omaha 1960
2. R. E. Garlinninghouse, M.D., Lincoln 1960
3. Harvey Runty, M.D., DeWitt 1960
4. Walter Benthack, M.D., Wayne 1960
5. E. E. Koebbe, M.D., Columbus 1958
7. F. A. Mountford, M.D., Davenport 1958
8. Wilbur E. Johnson, M.D., Valentine 1958
9. B. R. Bancroft, M.D., Kearney 1959
10. F. M. Karrer, M.D., McCook 1959
11. H. L. Clarke, M.D., North Platte 1959
12. R. J. Morgan, M.D., Alliance 1959

Chairman of Board of Councilors
F. M. Karrer, M.D. — McCook

Speaker, House of Delegates
Fritz Teal, M.D., Lincoln — 1959

Vice Speaker, House of Delegates
J. B. Christensen, M.D., Omaha — 1959

Delegates to A.M.A.
J. D. McCarthy, M.D., Omaha — 1958
Earl F. Leininger, M.D., McCook — 1959

Alternates
Harold S. Morgan, M.D., Lincoln — 1958
W. C. Kenner, M.D., Nebraska City — 1959

Board of Trustees

A. A. Ashby, M.D., Chairman, Geneva — 1960
G. E. Peters, M.D., Randolph — 1958
C. N. Sorensen, M.D., Scottsbluff — 1959
M. E. Grier, M.D., Omaha — 1961
R. B. Adams, M.D., Lincoln — 1959

Nebraska S. M. J.
Program

TUESDAY MORNING, APRIL 29, 1958
8:30 Exhibits Open

GENERAL SESSION
J. M. Woodward, M.D., Lincoln, Presiding
10:00 Opening of Session, R. Russell Best, M.D., President
10:05 Invocation
—Reverend Frederick A. Roblee, D.D., Pastor, Westminster Presbyterian Church, Lincoln
10:10—Presidential Address
—R. Russell Best, M.D., Omaha
10:20 Installation of Incoming President
—Fay Smith, M.D., Imperial
10:30 Guest Introductions
—W. J. Brennan, D.D.S., President, Nebraska State Dental Association
—Mr. Paul Martin, President, Nebraska State Bar Association
10:40 Neurology
—George B. Salter, M.D., Norfolk
10:50 VIEW THE EXHIBITS

11:00 “Present Status of the Oral Hypoglycemic Agents”
—Alexander Marble, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School, Boston, Massachusetts

11:30 “Malpractice”
—Mr. C. Joseph Stetler, Director, Law Department, American Medical Association, Chicago, Illinois

TUESDAY AFTERNOON, APRIL 29, 1958
12:30 LUNCHEON
J. R. Schenken, M.D., Omaha, Presiding
“Forand Bill” and “Present Status of Keogh-Jenkins Bill”
—Mr. C. Joseph Stetler, Chicago, Illinois

GENERAL SESSION
Clarence Brott, M.D., Beatrice, Presiding
2:00 “Trial by Medical Jury or Problems of the Grievance Committee”
—Mr. William J. Burns, Executive Director, Michigan State Medical Society, Lansing, Michigan
3:30 VIEW THE EXHIBITS
3:40 “4-H Clubs and the Family Physician”
—Paul Bancroft, M.D., Lincoln
4:00 “Carcinoma of the Cervix Uteri, Invasive and In Situ”
—Howard Hunt, M.D., Omaha; Leon McGloon, M.D., Omaha, and Richard Bunting, M.D., Omaha
4:20 “Diagnosis and Management of Upper Intestinal Hemorrhage”
—Seymour J. Gray, M.D., Ph.D., Assistant Professor of Medicine, Harvard Medical School, Boston, Massachusetts
5:00 VIEW THE EXHIBITS

WEDNESDAY MORNING, APRIL 30, 1958
8:00 Past Presidents’ Breakfast, Room 901, Hotel Cornhusker
8:30 Exhibits Open

GENERAL SESSION
Orin R. Hayes, M.D., Kearney, Presiding
9:00 “Backache After Forty”
—C. F. Ferciot, M.D., and Paul Goetowski, M.D., Lincoln
9:20 “Management of the Difficult Diabetic”
—Alexander Marble, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School, Boston, Massachusetts
9:50 “Parenteral Iron Therapy”
—Roy G. Holly, M.D., Omaha
10:10 VIEW THE EXHIBITS

10:25 “Local Treatment of Small and Large Burns”
—Michael L. Mason, M.D., Professor of Surgery, Northwestern University Medical School, Chicago, Illinois
10:55 “Serological Survey for Q Fever in Packing House Workers”
—Matilda McIntire, M.D., Omaha
11:15 “Radio Isotopes”
—R. Ogborn, M.D., and L. R. James, M.D., Omaha
11:35 “Steroids, Present Status in Therapy”
—Richard Fangman, M.D., Omaha

WEDNESDAY AFTERNOON, APRIL 30, 1958
Frank H. Tanner, M.D., Lincoln, Moderator
12:30 LUNCHEON
“Clinical Pathological Conference”*
Panel of Experts
—Alexander Marble, M.D., Boston
—Seymour J. Gray, M.D., Boston
—Michael L. Mason, M.D., Chicago
—John R. Payne, M.D., Buffalo
—James F. Kelly, Sr., M.D., Omaha
—Horace K. Giffen, M.D., Omaha
*Case history is contained in your program.

GENERAL SESSION
Herbert D. Kuper, M.D., Columbus, Presiding
2:00 “Management of Tendon Injuries”
—Michael L. Mason, M.D., Chicago, Illinois
2:30 “X-ray Studies of Hip Fractures”
—C. N. Sorensen, M.D., Scottsbluff
2:50 “Treatment of Hip Fractures”
—F. M. Karrer, M.D., McCook
3:10 VIEW THE EXHIBITS

3:30 “Stress, Hormones and Peptic Ulcer”
—Seymour J. Gray, M.D., Boston, Massachusetts
4:00 “Facial Pain”
—Louis J. Gogela, M.D., Lincoln
4:20 “Palliative Treatment of Carcinoma of the Breast”
—John B. Davis, M.D., Omaha

5:00 VIEW THE EXHIBITS
6:00 Social Hour—Honoring the President and the President of the Woman’s Auxiliary—State Suite, Hotel Cornhusker

April 1958
Program

WEDNESDAY EVENING, APRIL 30, 1958
7:00 BANQUET
Fritz Teal, M.D., President, Lancaster County Medical Society, Presiding
Awarding of 50-Year Pins
"Selling America to Americans"
—Kenneth McFarland, Ph.D., Topeka, Kansas; Presented by General Motors

THURSDAY MORNING, MAY 1, 1958
8:30 Exhibits Open

GENERAL SESSION
R. W. Karrer, M.D., Scottsbluff, Presiding
9:00 "Induction of Labor"
—W. C. Keettel, M.D., Professor, Department of Obstetrics and Gynecology, State University of Iowa, College of Medicine, Iowa City, Iowa
9:30 "Resuscitation of the New-Born Infant and Possible Complications"
—Albert V. Stoesser, M.D., Clinical Professor of Pediatrics and Allergy, University of Minnesota, Minneapolis, Minnesota
10:00 "Five Year Report of the Cerebral Palsy Program at the Nebraska State Orthopedic Hospital"
—Howard E. Mitchell, M.D., Lincoln, and Benjamin W. Drompp, M.D., Lincoln
10:20 VIEW THE EXHIBITS
10:35 "Pseudomembranous Colitis Due to Antibiotics"
—John R. Paine, M.D., Professor of Surgery, University of Buffalo School of Medicine, and Chief of Surgery, Buffalo General Hospital, Buffalo, New York
11:05 "Television Advertising of Health Related Products"
—Carl J. Potthoff, M.D., Omaha
11:25 "Surgical Treatment of Gallbladder Disease"
—John H. Bogle, M.D., Loup City

THURSDAY AFTERNOON, MAY 1, 1958
R. Russell Best, M.D., Omaha, Presiding
12:15 LUNCHEON
"MEDI-CARE"
—Major General Paul I. Robinson, M.D., Medical Director, U.S. Army, Executive Director of MEDI-CARE, Washington, D.C.
—G. P. McArdle, M.D., Medical Director, Nebraska Medical Service, Omaha
—Mr. Dewey Bredemeyer, Nebraska Medical Service, Omaha

GENERAL SESSION
W. C. Kenner, M.D., Nebraska City, Presiding
2:00 "Proper Handling of the Allergic Child"
—Albert V. Stoesser, M.D., Minneapolis, Minnesota
2:30 "Food Sanitation in Nebraska"
—E. D. Lyman, M.D., Omaha
2:50 "The Interpretation of the Chest X-ray"
—J. Marshall Neely, M.D., Lincoln
3:10 VIEW THE EXHIBITS
3:25 "Evaluation of Surgical Deaths"
—John R. Paine, M.D., Buffalo, New York
3:55 "Functional Uterine Bleeding"
—W. C. Keettel, M.D., Iowa City, Iowa

Announcements

House of Delegates
1st Session: Tuesday, April 29, 1958, 8 a.m., Lancaster Room
2nd Session: Wednesday, April 30, 1958, 8 a.m., Lancaster Room
3rd Session: Thursday, May 1, 1958, 8 a.m., Lancaster Room

Board of Councilors
1st Session: Tuesday, April 29, 1958, 5 p.m., Lancaster Room
2nd Session: Wednesday, April 30, 1958, 9 a.m., Lancaster Room
3rd Session: Thursday, May 1, 1958, 9 a.m., Lancaster Room

Board of Trustees
Wednesday, April 30, 1958, 4 p.m., Lancaster Room

Woman's Auxiliary

CONVENTION COMMITTEES
General Chairman—Mrs. Donald F. Purvis
Social Chairmen and
Style Show—Mrs. Orvis A. Neely, Mrs. Jon T. Williams
Program Chairman and
Style Show—Mrs. E. S. Maness
Registration—Mrs. Paul Goetowski
Tickets and Finance—Mrs. John Brown III
Hospitality—Mrs. Paul Peterson
Flowers—Mrs. Robert Stein
Transportation—Mrs. Harold Harvey
Reservations—Mrs. W. W. Bartels
Publicity—Mrs. Horace Munger
Hostess Auxiliary—Lancaster County Medical Auxiliary

A cordial invitation is extended to all doctors' wives of Nebraska whether or not you are an Auxiliary member.

WHO MAY ATTEND
A cordial invitation is extended to ALL DOCTORS' WIVES, whether or not you are an auxiliary member. Frequently auxiliary interest and participation are sparked by attendance at Convention.

WHO IS EXPECTED TO ATTEND
Officers
Chairmen of Committees
Presidents of County Auxiliaries
District Councilors
New officers and chairmen, either on the state or local levels, will benefit from attending the sessions.

Nebraska S. M. J.
THIRTY-THIRD ANNUAL MEETING OF THE
WOMAN'S AUXILIARY TO THE
NEBRASKA STATE MEDICAL ASSOCIATION

A registration desk will be open at the Hotel Cornhusker all day Tuesday, April 29th and Wednesday, April 30th until 12:30 p.m. Registration will also be taken at the Lincoln Country Club preceding the Wednesday luncheon.

PROGRAM

Tuesday, April 29, 1958

8:45 a.m. Registration and coffee
9:00 a.m. Pre-convention Executive Board Meeting, State Suite 1 and 2, Hotel Cornhusker

Mrs. R. R. Brady, presiding
Reports of Officers and State Chairmen

12:00 Noon Brunch—Hotel Cornhusker, Rooms 901-921
Tickets available at Registration desk and Room 901—Price $2.00 incl. tip

1:00 p.m. Annual Business Meeting
Rooms 901-921, Hotel Cornhusker

Mrs. R. R. Brady, presiding
Mrs. Paul C. Craig, President of the Woman's Auxiliary to the American Medical Association, honored guest and speaker
Reports of County Presidents
Installation of New Officers

7:00 p.m. Fun Night

Wednesday, April 30, 1958

Free Morning
All those desiring transportation to the Country Club for the Wednesday luncheon, please register with the Transportation Chairman at the registration desk.

1:00 p.m. Luncheon — Ballroom of the Lincoln Country Club. Tickets available at the registration desk at the Hotel Cornhusker—Price $2.50.

Honored Guest and Speaker, Mr. E. J. Faulkner, President of Woodman Accident and Life Company of Lincoln, Nebraska, topic, “An American Philosophy of Health Care.”

Fashion Show—Models from the Lancaster County Medical Auxiliary. Clothes from Ben Simons.

7:00 p.m. Banquet—Hotel Cornhusker.

Thursday, May 1, 1958

9:00 a.m. Post Convention Executive Board Meeting, State Suite 1 and 2, Hotel Cornhusker

Mrs. George Covey, presiding
No host breakfast
The annual mid-winter meeting of the Board of Councilors was held at the Hotel Cornhusker, Lincoln, Nebraska, February 9, 1958. In the absence of a chairman, the meeting was called to order at 10 o’clock by Dr. F. M. Karrer, secretary.

Present were Drs. Harold Neu, R. E. Garlinghouse, Harvey Runty, Walter Benthack, E. E. Koebbe, B. N. Greenberg, F. A. Mountford, F. M. Karrer, R. J. Morgan; R. Russell Best, President; Fay Smith, President-elect; J. M. Woodward, Immediate Past President; Fritz Teal, Speaker, House of Delegates; J. B. Christensen, Vice Speaker, House of Delegates.

Others present were Drs. R. B. Adams, A. A. Ashby, G. E. Peters, C. N. Sorenson, M. E. Grier, Geo. N. Johnson, K. S. J. Hohlen, Geo. W. Covey, E. A. Rogers, Harold S. Morgan, Donald Bucholz, D. B. Steenburg, John W. Gatewood, A. J. Offerman, L. S. McNeill, James Kelly, Sr., W. Ray Hill, Earl F. Leininger, George Salter, W. B. Moody; Mr. M. C. Smith, Executive Secretary, and Mr. Dave Powell.

Nominations for chairman were called for and Dr. F. M. Karrer was nominated.

A motion was made that the nominations be closed and Dr. Karrer declared the unanimous choice of the Board of Councilors for chairman. The motion was seconded and carried.

Nominations for secretary were called for and Dr. Walter Benthack was nominated.

A motion was made that the nominations be closed and Dr. Benthack be declared the unanimous choice of the Board of Councilors for secretary. The motion was seconded and carried.

A motion was made that the minutes be adopted as published. The motion was seconded and carried.

Attention was called to the published report of the Nebraska chairman of the American Medical Education Foundation, and Dr. Benthack read the supplemental report which had been submitted by the chairman.

Dr. W. B. Moody was given permission of the floor and stated he had nothing to add to the report but that he would like very much to see the program carried on and developed for he felt there was a need for us to support the program for medical education in Nebraska. He further stated that he felt the Auxiliary were very interested and would make a capable ally in helping with the program.

A motion was made that the report be accepted and published. The motion was seconded and carried.

Attention was called to the report of the Secretary-Treasurer and the annual Audit.

A motion was made and seconded that the report of the Secretary-Treasurer and Audit be accepted and published. The motion carried.

A motion was made that the report of the Delegate to the A.M.A. be accepted and published. The motion was seconded and carried.

A motion was made and seconded that the report be accepted and published. The motion was seconded and carried.

A motion was made and seconded that the report of the Committee on Aging be accepted. The motion was seconded and carried.

The report of the Allied Professions Committee was read by Dr. Benthack.

A motion was made that the report be accepted and published. The motion was seconded and carried.

The report of the Civil Defense and Disaster Committee was called for and Dr. George Johnson, chairman, stated that in addition to the report printed in the brochure he would like to call the attention of the council to several maps which showed target cities and routes prepared by civil defense authorities. He further stated that they felt the secret in civil defense is communications which makes it mandatory that something be done about setting up an organization where the doctors throughout the State of Nebraska would know what is going on. At present there is no such organization but the committee is hopeful that a meeting will be set up soon through the councilors districts.

A motion was made that the report be accepted and published. The motion was seconded and carried.

Dr. K. S. J. Hohlen gave an oral report for the Council on Professional Ethics, and a motion was made, seconded and carried that the report be accepted.

A motion was made that the report of the Constitution and By-Laws Committee be accepted and published. The motion was seconded and carried.

Attention was called to the report of the Continuing Committee on Medical Practice. A motion was made and seconded that the report be accepted and published. The motion carried.

The report of the Editor was called for and Dr. George Covey stated he had nothing further to report than that in the printed brochure.

A motion was made that the report be accepted and published. The motion was seconded and carried.

A motion was made and seconded that the report of the Committee on Medical Education be accepted and published. The motion carried.

A motion was made and seconded that the report of the Planning Committee be accepted and published. The motion carried.

The report of the Prepayment Medical Care Committee was read by Dr. A. J. Offerman.

A motion was made that the report be accepted and published. The motion was seconded and carried.

The report of the Policy Committee was presented by Dr. R. Russell Best.

A motion was made that the report be accepted. The motion was seconded and carried.

A motion was made and seconded that the re-
The report of Executive Secretary M. C. Smith was accepted and published. The motion carried.

Dr. A. A. Ashby, chairman, read the report of the Board of Trustees.

A motion was made that the report be accepted and published, and that the budget for 1959 be recommended for approval by the House of Delegates. The motion was seconded and carried.

Mr. M. C. Smith reviewed the portion of the report of the Hospital and Professional Relations Committee which dealt with the Arnold Hospital situation and read a letter from Dr. E. A. Rogers, Director, State Department of Health, which complimented Dr. Schenken and his committee on the handling of this situation. He also read a supplementary report of other activities of the committee during the past year.

A motion was made that the report be accepted. The motion was seconded and carried.

The report of the Medicolegal Advice Committee was read by Mr. M. C. Smith.

A motion was made and seconded that the report be accepted. The motion carried.

The report of the Public Relations Committee was reviewed and a motion was made that the report be accepted and published. The motion was seconded and carried.

A motion was made that the report of the Rural Medical Service Committee be accepted and published. The motion was seconded and carried.

The following reports were accepted and ordered published:

- Speakers Bureau Committee
- Uniform Fee Schedule and Advisory to Governmental Agencies
- United Health Fund Committee
- Veterans Committee
- Cancer Committee
- Cardiovascular Committee
- Diabetes Committee
- Industrial Health Committee
- Joint Commission for Improvement of Care of the Patient

The report of the Maternal and Child Health Committee was reviewed and special attention was called to the recommendations in the last paragraph of the report. General discussion followed and clarification of the recommendations was given by Drs. Garlinghouse and Morgan.

A motion was made that the report be accepted and published. The motion was seconded and carried.

A recess was called by the chair, and refreshments and dinner were served in the Lancaster Room.

The meeting was again called to order by Dr. Karrer at 2 p.m.

The report of the Committee on Muscular Rehabilitation was reviewed and the recommendation that the committee be discontinued was discussed. It was thought the committee did have a useful function and that perhaps the word "muscular" could be dropped and thus make it wider in scope.

A motion was made that the report be accepted with the recommendation to the House of Delegates that the committee not be discontinued but that the word "muscular" be dropped from the title. The motion was seconded and carried.

The following reports were accepted and ordered published:

- Committee on Psychiatry
- Public Health Committee

The report of the Tuberculosis Committee was read by Dr. J. Harry Murphy.

A motion was made and seconded that the report be accepted and published. The motion carried.

The report of the Venereal Disease Committee was read by Dr. Donald Wilson.

A motion was made that the report be accepted and published. The motion was seconded and carried.

Dr. Fay Smith, President-elect, read his committee appointments for the year 1958-59.

A motion was made and seconded that the appointments made by Dr. Smith be confirmed. The motion carried.

Letters from Omaha-Douglas County Medical Society were read by Dr. Benthack requesting Life Memberships for the following physicians:

- Robert Farrell, M.D.
- Harry Jenkins, M.D.
- William Melcher, M.D.
- Eugene Simmons, M.D.

A motion was made and seconded that these doctors be recommended to the House of Delegates for Life Membership. The motion carried.

Mr. Smith asked for permission of the floor and stated that the Annual Meeting of the Nebraska Medical Foundation, Inc., would be held immediately upon adjournment of the Board of Councillors.

The suggestion of Dr. Best that consideration be given to encouraging more chairmen and committee members to attend meetings on the national level which concern activities of the various committees was again brought up for discussion.

A motion was made that it be recommended to the Board of Trustees to allow such funds that might be necessary to send appropriate delegates or members of the Association to such national meetings as would be in the interest of the Nebraska State Medical Association to have them attend. The motion was seconded and carried.

A motion was made and seconded to adjourn. The motion carried.

REPORT OF AMERICAN MEDICAL EDUCATION FOUNDATION (Nebraska)

The American Medical Education Foundation set up for support of teaching program of medical schools and subscriptions comes from the medical profession. A committee is to be appointed from each councilor district to aid in this work. Due to the illness of our President last fall, we were unable to get the groups nominated and brought together, so I went along with our appeal for money through the courteous and kind cooperation of Mr. Merrill Smith of Lincoln.

Naturally it is impossible to make a full report at this time as the year end figures are not available. Contributions through American Medical Education Foundation for Nebraska schools received from about one hundred physicians total $6,000; thirteen subscriptions for $800 for schools outside Ne-
braska, and eleven subscriptions for $300 were undesignated. Total received to date is $7,047.19.

Dr. Best and I will attend the meeting with all the members of the various states and the committee for A.M.A. on January 25th. I will be very pleased to make a full report at the meeting February 9th. And that time, Dr. Best and I will have completed our program for the coming year and will present it at that time.

Respectfully submitted,

WILLSON B. MOODY, M.D.,
Nebraska Chairman.

SUPPLEMENTAL REPORT OF AMERICAN MEDICAL EDUCATION FOUNDATION
( Nebraska)

Your present Chairman was appointed two years ago and since there was no program for the State of Nebraska at that time, studies were made with deans, the public relations men, and representatives for the alumni association of the two medical colleges in Nebraska—Creighton University School of Medicine and the University of Nebraska College of Medicine.

It was soon demonstrated that the deans felt it was a state organization and therefore they should not take too dominant an interest in it. The public relations men and the alumni representatives did not feel like throwing in their support and preferred to carry out their own programs. It was therefore decided to go ahead with a state organization of the A.M.E.F. There is probably a good deal to be said for both sides, as in this case it is generally very difficult to establish an overall group, and yet division weakens to some extent the general program.

The A.M.A sponsors a meeting of the A.M.E.F. in Chicago each January, and I am happy to report that representatives from all but three or four of the forty-eight states were present. The program consisted of the story of A.M.A.’s attempt at developing funds for various medical schools. Begun as an organization in conjunction with a National Medical Education Fund it soon ran into difficulty and separated, so now National’s funds are solicited from industry and A.M.E.F. from physicians.

Various representatives of A.M.A. spoke on medical organization, medical education and various problems of financing. There also was a report from the Women’s Auxiliary.

A panel discussion was held and various representatives of the states told their stories. Roundtable discussions were held with different subject matters as topics for discussion. The end result seemed to be that medical schools definitely are in need of funds for flexible support of education, and while private schools have different problems from state supported organizations, yet there is much in common. Most state funds are specifically set aside and there is very little opportunity for emergency operation. Thus medical education funds supply this flexibility and it is profoundly valuable in aiding the deans in their emergency finance problems.

A number of interesting sidelights from various states can be reported briefly. Summarizing this panel discussion, it may be said that in some states amounts of $10 to $25 were added to state dues.

In larger states this was quite valuable, but in the smaller states which were already highly charged many objected and a number of the programs were dropped.

Continuity of the various members of the soliciting group was urged, though replacements from time to time were considered essential to carrying on the best program.

As an average in the United States, from seven to ten per cent of the doctors contributed.

Some states reported a great deal of resentment from the out-state physicians toward contributing to a full time staff who act in competition to them.

Minneapolis developed an excellent program. They reported 3,200 members in 32 counties and $18 as the average contribution. They felt letters of solicitation were unsatisfactory, that a report made in the State Journal from time to time and also letters from the deans should be made to describe the use of the money. Emphasis was laid on organization and not on an individual. Voluntary contributions were considered preferable to assessments.

After studying all this and in consultation with Doctor Best, your President, I would like to make the following suggestions:

The program for Nebraska should have a state representative A.M.E.F. Chairman. Appointments for representatives from the various councilor districts should be made and a dinner meeting held for this organization. Invitations should be extended to the deans, the state officers, and the A.M.E.F. representative from Chicago.

Following this initial effort the story should then be told to the physicians in the state through editorials in state magazines, through representatives attending county society meetings, and efforts made to develop activity in the Women’s Auxiliary. Letters from time to time should be sent reporting progress and asking for further support followed by a personal appeal.

Results of the A.M.E.F. for the past two years are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Contributors</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>Creighton</td>
<td>$7,085.35</td>
</tr>
<tr>
<td></td>
<td>University of Nebr.</td>
<td>$3,929.35</td>
</tr>
<tr>
<td></td>
<td>Miscellaneous</td>
<td>$1,555.00</td>
</tr>
<tr>
<td></td>
<td>Undesignated</td>
<td>$182.00</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$12,151.70</strong></td>
</tr>
</tbody>
</table>

In summarizing, it is recommended that support of the state society be directed to A.M.E.F. with proper authority and organization, that the story of medical education be told to physicians of the state as clearly as possible and the need for funds of this type described, and at the same time permit the doctors in practice in the state to make constructive suggestions and criticisms which can be reported to the deans of the medical schools.

Respectfully submitted,

WILLSON B. MOODY, M.D.,
Nebraska Chairman.

Nebraska S. M. J.
REPORT OF SECRETARY-TREASURER

The year 1957 was another of our successful years. At its close we had 1291 members. We received 52 new members; 17 members died; and 27 members left the state.

The annual meeting, which is the high spot of the year, was a splendid meeting. The attendance was large with 490 physicians attending. This attendance ranks well with other states of a size similar in membership to Nebraska.

We had the usual large number of commercial exhibitors. Their exhibits were not attended as well as they should have been. It is their contribution to the Association that makes our good meetings possible. Also, the Scientific Sessions, while better attended than they were a few years ago, were not attended nearly as well as they should have been. If they were better attended, it would be easier to get high grade guest speakers.

The Committee on Scientific Sessions went back to our former custom of having a large part of the scientific program composed of our own members. These were well received by those in attendance.

In addition to these, there were nine guests from other states, namely, Dr. Dwight M. Murray from Napa, California, President of the American Medical Association; Mac F. Cahal, J.D., of Kansas City, Missouri, Executive Secretary and General Counsel of the American Academy of General Practice; Dr. Ernest B. Howard of Chicago, Illinois; Dr. John M. Sheldon of Ann Arbor, Michigan; Dr. Frederick J. Hofmeister of Milwaukee, Wisconsin; Dr. Earle Gray of Chicago, Illinois; Dr. Robert M. Hosler of Cleveland, Ohio; Dr. G. Obregon of Iowa City, Iowa; and Dr. William A. Silverman of New York City, New York. All of the guests gave excellent papers, which should have been heard by more of the members.

The House of Delegates held, as usual, three sessions and carried out a large amount of business. The meetings moved along fast under the direction of our able speaker. They have not been conflicting with the general sessions as they did in previous years.

The Board of Councilors and the Board of Trustees also held their regular meetings. The banquet with about 300 in attendance was definitely one of the popular events of the meeting.

Of our numerous committees, those that have been doing good work in previous years continued to do so. Those committees that have not worked, still do not work. The committees doing good work are the same committees that have been doing good work since their creation. Since they have been named in several Secretary-Treasurer's reports in the past years, I do not believe it is necessary to mention them again.

One committee which is a comparatively new committee should be desired. This is the Sub-committee to the Committee on Constitution and By-Laws. It is a large committee and has divided itself into a number of small sub-committees. Each of these has been assigned a certain part of the Constitution and By-Laws to study and make recommendations. There have been several meetings of the main committee, and a study of the whole Constitution and By-Laws is being made. This committee is working seriously and carefully. They expect to take enough time in this work to give the Association a good workable document without contradictions, repetitions, etc. cetera.

The mid-winter session of the Board of Councilors and House of Delegates was held in February 1957. The Board of Councilors considered the different committee reports which had been sent to them early enough so that they had time to study them. The Board of Councilors recommended several of these reports to the House of Delegates and rejected some. The House of Delegates later acted on the reports which had been referred to them.

The financial report, or audit, follows. I do not believe a discussion of it is necessary.

Respectfully submitted,
R. B. ADAMS, M.D.

AUDIT

January 15, 1958
Nebraska State Medical Association
Lincoln, Nebraska

We have examined the books and records of the Nebraska State Medical Association for the year 1957, and submit herewith our report. Included in the report are the following exhibits and schedules:

Exhibit A — Analysis of Fund Balances — Year 1957.
Exhibit B — Statement of Receipts and Disbursements — Year 1957.
Schedule B-1 — Statement of Receipts and Disbursements — Annual Session — Year 1957.
Schedule B-2 — Comparison of General Expense with Budget — Year 1957.
Schedule B-3 — Statement of Receipts and Disbursements — Hall of Health — Year 1957.
Exhibit C — Statement of Investments — Year 1957.
Schedule C-1 — Statement of Investment Balances.

EXHIBIT A

Exhibit A is the analysis of fund balances. During the year 1957 there was an increase in the balances of $6,832.43. The total balance on December 31, 1957 was $81,428.90, and was represented by cash in the regular account at the National Bank of Commerce, Lincoln, Nebraska, of $28,738.29, and investments of $52,690.61.

EXHIBIT B

The details of the changes in the operating fund cash balance are shown in Exhibit B. In this statement the incomes and expenses have been divided into three classifications. Under the heading of General Income, the principal items are membership dues of $41,790.00, interest collected of $470.30, Trust Account income of $1,226.74, and income from the Annual Session of $6,011.00. The chief items of income for the Journal during the year were advertising in the amount of $31,361.86 and subscriptions of $413.76.

Other receipts include cash received for the American Medical Association dues of $29,100.00 which was remitted to that Association as shown under Other Disbursements in this statement. United States Savings Bonds in the amount of $4,000.00 matured during the year and were cashed. Funds in the amount of $579.36 were received to rei-
burse the Association for expenses incurred in a prior year.

The disbursements of the Association are divided into the same classifications as the receipts. The total amount of general disbursements was $44,796.97. A comparison of these items with the budget items approved for 1957 is shown in Schedule B-2. The Journal expenses for the year totaled $31,279.96 and other disbursements were $33,456.40. This amount included American Medical Association dues of $29,100.00 and the purchase of United States Savings Bonds, Series J, at an issue price of $3,996.00. The total disbursements during the year were $109,583.39. The excess of receipts over disbursements for 1957 operations amounted to $5,982.31.

EXHIBIT C

The changes that occurred in the investment account during the year are shown in Exhibit C. The total amount of the investments at the beginning of the year was $51,840.49. Investments were increased in the amount of $629.45 in the Trust Account by the net gain of $590.29 on the sale of securities and by cash transferred from income to principal account of $39.16. The net increase in United States Government Bonds held by the Association was $21.17. Increases in the savings accounts consisting of 1957 income credited to principal amounted to $199.50. The total amount of the increases in investments was $850.12 and the total amount of the investments at December 31, 1957 was $52,690.61. A detailed list of the investments at the beginning and close of the year is shown in Schedule C-1.

EXHIBIT D

Exhibit D is a list of the Journal accounts receivable. Our examination of the accounts receivable record indicated that these accounts are amounts receivable for advertising during the months of November and December, 1957. This record also indicated that these accounts are being paid currently. As the Association operates on the cash basis, these items are not taken into income until cash is received.

SCOPE OF EXAMINATION AND GENERAL COMMENTS

Receipts for the year were traced through the books and into the bank account. In addition, tests were made of letters of transmittal tracing the items to the individual members' accounts. An inspection of the members' cards in connection with our examination of the receipts indicated that all cards issued to members during the year were accounted for on the books of the Association. It was also found that during the year 1957 cards were issued to five military members and 92 life members, for which no dues were collected.

Cancelled checks for the year were inspected and compared to the items in the check register. Invoices and creditors' statements were examined covering a selected portion of the disbursements. Minutes of the trustees' meetings during the year were examined in regard to authorization of salaries, budgets and other disbursements. The balances shown as cash in bank were confirmed by direct correspondence with the depository.

Our audit also included an inspection of securities owned by the Association at the close of the year.

Balances in savings and loan and investment accounts were confirmed by correspondence.

Subject to the foregoing comments, it is our opinion that the attached statements present fairly the financial position of the Association at December 31, 1957 and the operations for the year then ended. Should any additional information be desired concerning any matters falling within the scope of our examination, we shall be pleased to supply it upon request.

DANA F. COLE AND COMPANY

EXHIBIT A: NEBRASKA STATE MEDICAL ASSOCIATION ANALYSIS OF FUND BALANCES Year 1957

<table>
<thead>
<tr>
<th>Total Balance, January 1, 1957</th>
<th>$74,596.47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Represented by:</td>
<td></td>
</tr>
<tr>
<td>Cash—National Bank of Commerce, General Fund</td>
<td>$22,621.92</td>
</tr>
<tr>
<td>Cash on Hand—Deposited in</td>
<td></td>
</tr>
<tr>
<td>January, 1957</td>
<td>134.06</td>
</tr>
<tr>
<td>Investments—Exhibit C</td>
<td>$1,840.49</td>
</tr>
<tr>
<td></td>
<td>$74,596.47</td>
</tr>
<tr>
<td>Total Balance, December 31, 1957</td>
<td>$81,428.90</td>
</tr>
<tr>
<td>Represented by:</td>
<td></td>
</tr>
<tr>
<td>Cash—National Bank of Commerce, General Fund</td>
<td>$24,782.29</td>
</tr>
<tr>
<td>Investments—Exhibit C</td>
<td>$5,690.61</td>
</tr>
<tr>
<td></td>
<td>$81,428.90</td>
</tr>
</tbody>
</table>

EXHIBIT B: NEBRASKA STATE MEDICAL ASSOCIATION STATEMENT OF RECEIPTS AND DISBURSEMENTS Year 1957

<table>
<thead>
<tr>
<th>Cash Balances, January 1, 1957</th>
<th>32,621.92</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund—National Bank of Commerce</td>
<td>134.06</td>
</tr>
<tr>
<td>Cash on Hand—Deposited in</td>
<td>$22,755.98</td>
</tr>
<tr>
<td>January, 1957</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECEIPTS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General:</td>
<td></td>
</tr>
<tr>
<td>Membership Dues</td>
<td>$41,790.00</td>
</tr>
<tr>
<td>Interest Collected</td>
<td>470.30</td>
</tr>
<tr>
<td>Trust Account Income</td>
<td>1,226.74</td>
</tr>
<tr>
<td>Annual Session—Schedule B-1</td>
<td>6,011.00</td>
</tr>
<tr>
<td>A.M.A. Membership Expesne Rebate</td>
<td>209.75</td>
</tr>
<tr>
<td></td>
<td>49,788.79</td>
</tr>
<tr>
<td>Journal:</td>
<td></td>
</tr>
<tr>
<td>Advertising</td>
<td>31,361.85</td>
</tr>
<tr>
<td>Subscriptions</td>
<td>519.73</td>
</tr>
<tr>
<td>Copies Sold</td>
<td>10.85</td>
</tr>
<tr>
<td></td>
<td>31,792.45</td>
</tr>
<tr>
<td>Other Receipts:</td>
<td></td>
</tr>
<tr>
<td>A.M.A. Dues</td>
<td>29,100.00</td>
</tr>
<tr>
<td>Sale or Redemption of Securities</td>
<td>4,000.00</td>
</tr>
<tr>
<td>Formulary—Sale of Copies</td>
<td>12.00</td>
</tr>
<tr>
<td>Reimbursement for Prior Year's Committee Exsp...</td>
<td>579.36</td>
</tr>
<tr>
<td>Reimbursement for Cancer Detection Course Exp...</td>
<td>243.04</td>
</tr>
<tr>
<td></td>
<td>33,884.40</td>
</tr>
</tbody>
</table>

| TOTAL RECEIPTS:                            | $15,515.64  |

<table>
<thead>
<tr>
<th>DISBURSEMENTS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General:</td>
<td></td>
</tr>
<tr>
<td>Salaries and Social</td>
<td>23,404.58</td>
</tr>
<tr>
<td>Security Taxes</td>
<td>1,552.40</td>
</tr>
<tr>
<td>Travel</td>
<td>1,792.50</td>
</tr>
<tr>
<td>Office Expense</td>
<td>2,880.50</td>
</tr>
<tr>
<td>Rent</td>
<td>668.62</td>
</tr>
<tr>
<td>Mmograph</td>
<td>546.92</td>
</tr>
<tr>
<td>Printing</td>
<td>1,043.59</td>
</tr>
<tr>
<td>Postage</td>
<td>1,670.96</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>635.77</td>
</tr>
<tr>
<td>Councillor Expense</td>
<td>132.46</td>
</tr>
<tr>
<td>Annual Session (Schedule B-1)</td>
<td>5,045.14</td>
</tr>
<tr>
<td>Committee Expense</td>
<td>2,119.61</td>
</tr>
<tr>
<td>Regular</td>
<td>100.00</td>
</tr>
<tr>
<td>Committee Expense</td>
<td></td>
</tr>
<tr>
<td>Hall of Health</td>
<td></td>
</tr>
<tr>
<td>(Schedule B-2)</td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE B-3: NEBRASKA STATE MEDICAL ASSOCIATION

STATEMENT OF RECEIPTS AND DISBURSEMENTS
HALL OF HEALTH

Year 1957

UNEXPENDED BALANCE, Bank Balances:

UNEXPENDED BALANCE, Bank Balances:
National Bank of Commerce, December 31, 1957: $134.07

NOTE: The Hall of Health is jointly sponsored by the above organizations and the records are kept by the Nebraska State Medical Association. However, the funds for this project are not properly a part of the Association funds, and are kept in a separate bank account.

EXHIBIT C:
NEBRASKA STATE MEDICAL ASSOCIATION
STATEMENT OF INVESTMENTS
Year 1957

Total Investments, January 1, 1957 (Schedule C-1): $51,840.49

INCREASES IN TRUST ACCOUNT:
Trust Account Principal Transactions:
Sales Cost Gain or Loss
Standard Oil Co. (Indiana), 100 Shares $5,391.45 $5,814.25 $577.22
Standard Oil Co. (New Jersey), 100 Bts. 14.61 14.61
U.S. Treasury Notes, 7 3/4% $991.13 $992.67 1.54%
Income Cash Transferred to Principal, 39.16
Net Increase in Trust Account $629.45

INCREASES IN U.S. GOVERNMENT BONDS:
Increase in Value U.S. Savings Bonds, Series J—Less:
Cash Transferred to General Fund:
U.S. Savings Bonds, Series F, Matured and Cashed—4,000.00

MATURED VALUE OF U.S. GOVERNMENT BONDS:

Net Increase in Investments during 1957: $850.12

TOTAL INVESTMENTS, December 31, 1957 (Schedule C-1): $53,060.61

SCHEDULE B-2:
NEBRASKA STATE MEDICAL ASSOCIATION
COMPARISON OF GENERAL EXPENSE WITH BUDGET
Year 1957

<table>
<thead>
<tr>
<th>Item</th>
<th>Actual</th>
<th>Unexpended</th>
<th>Expense</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxes</td>
<td>$23,410.00</td>
<td>$23,404.68</td>
<td>$5.42</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>$1,550.00</td>
<td>$1,552.40</td>
<td>2.69</td>
<td></td>
</tr>
<tr>
<td>Office Expense</td>
<td>$2,880.00</td>
<td>$2,889.50</td>
<td>4.50</td>
<td></td>
</tr>
<tr>
<td>Microfilm</td>
<td>$668.62</td>
<td>$672.00</td>
<td>3.38</td>
<td></td>
</tr>
<tr>
<td>Printing</td>
<td>$750.00</td>
<td>$756.92</td>
<td>9.98</td>
<td></td>
</tr>
<tr>
<td>Postage</td>
<td>$1,928.00</td>
<td>$1,930.50</td>
<td>10.41</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>$1,675.00</td>
<td>$1,676.90</td>
<td>1.90</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>$600.00</td>
<td>$605.77</td>
<td>4.73</td>
<td></td>
</tr>
<tr>
<td>Council Expense</td>
<td>$100.00</td>
<td>$102.46</td>
<td>2.46</td>
<td></td>
</tr>
<tr>
<td>Annual Session</td>
<td>$5,415.00</td>
<td>$5,945.14</td>
<td>539.86</td>
<td></td>
</tr>
<tr>
<td>Audit Expense</td>
<td>$310.00</td>
<td>$310.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Attorneys’ Fees</td>
<td>$1,000.00</td>
<td>$662.00</td>
<td>338.00</td>
<td></td>
</tr>
<tr>
<td>Office Equipment</td>
<td>$325.00</td>
<td>$320.30</td>
<td>4.70</td>
<td></td>
</tr>
<tr>
<td>President’s Expense</td>
<td>$500.00</td>
<td>$500.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Committee Expense</td>
<td>$2,200.00</td>
<td>$2,216.61</td>
<td>9.61</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous, Due and Travel</td>
<td>$381.42</td>
<td>$381.42</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Delegate A.M.A.</td>
<td>$2,240.00</td>
<td>$2,238.25</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>Senior Medical Day</td>
<td>$510.00</td>
<td>$509.96</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Casualty and Disaster</td>
<td>$306.00</td>
<td>$295.50</td>
<td>10.50</td>
<td></td>
</tr>
<tr>
<td>Expansible Supplies</td>
<td>$10.00</td>
<td>$10.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Speaker’s Bureau</td>
<td>$300.00</td>
<td>$305.00</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$145.00</td>
<td>$145.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Total: $46,570.00 $44,796.97 $1,773.03

April 1958
<table>
<thead>
<tr>
<th>Hotel</th>
<th>News</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston Lighting &amp; Power Company</td>
<td>105 Shares Common (121 Shares)</td>
<td>3,425.08</td>
</tr>
<tr>
<td>Mission Corporation</td>
<td>100 Shares Common</td>
<td>2,710.04</td>
</tr>
<tr>
<td>Standard Oil Company (Indiana)</td>
<td>100 Shares Common</td>
<td>4,814.23</td>
</tr>
<tr>
<td>Standard Oil Company (New Jersey)</td>
<td>40 Shares Common</td>
<td>3,045.48</td>
</tr>
<tr>
<td>Union Carbide Corporation</td>
<td></td>
<td>5,045.48</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$23,806.62</strong></td>
</tr>
</tbody>
</table>

**U.S. GOVERNMENT BONDS:**
- U.S. Treasury Bonds, 2½% (Matures 6-15-63, Maturity Value $4,500)
- U.S. Savings Bonds, Series F (Issue price $2,960, Maturity Value $4,000)
- U.S. Savings Bonds, Series J (Issue Price $126.00, Maturity Value $175.00
- 12-31-56: Issue Price $4,122, Maturity Value $2,960
- 12-31-57: Issue Price $5,785.00 on 12-31-57

**Redemption Value**
- 4,000.00

**U.S. Savings Bonds, Series G**
- 120.85
- 1,451.02

**U.S. Savings Bonds, Series K**
- 11,000.00
- 13,000.00

- **Total U.S. Government Bonds**
  - $22,531.99
  - $22,553.16

**SAVINGS ACCOUNTS:**
- Omaha Loan & Trust Co., Association
- Conservative Savings & Loan Association
- Nebraska Central Bldg. & Loan Assn.
- Postal Savings Certificate

**Total Savings Accounts**
- 5,501.88
- 5,701.38

**TOTAL TRUST ACCOUNT**
- $23,806.62
- $24,456.07

**TOTAL U.S. GOVT. BONDS**
- 22,553.16

**TOTAL SAVINGS ACCOUNTS**
- 5,701.38

**GRAND TOTAL**
- $35,644.38
- $38,656.41

**EXHIBIT D:**
**NEBRASKA STATE MEDICAL ASSOCIATION JOURNAL ACCOUNTS RECEIVABLE**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 1957</td>
<td></td>
</tr>
<tr>
<td>Lincoln Splint and Brace Shop</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>News, Advertising Service</td>
<td>15.00</td>
</tr>
<tr>
<td>Hotel Paxton</td>
<td>24.00</td>
</tr>
<tr>
<td>Mr. H. J. Stoehr</td>
<td>20.00</td>
</tr>
<tr>
<td>State Medical Journal Advertising Bureau</td>
<td>3.30</td>
</tr>
<tr>
<td>W. E. Walsh, West Union, Iowa—Classified Ad</td>
<td>$4,027.38</td>
</tr>
</tbody>
</table>

**REPORT OF DELEGATE TO THE NORTH CENTRAL MEDICAL CONFERENCE**

Arthur J. Offerman, M.D.

This is a report of the Delegate to the North Central Medical Conference which was held November 24, 1957, at Minneapolis, Minnesota. As usual, it was an interesting meeting and many topics of great interest were on the program for discussion. Foremost among these was the Forand Bill. This bill would expand the benefits for social security recipients over age 65 to provide hospital and medical care. There was a great deal of discussion of this proposed legislation and particularly what constructive measures could be taken to make unnecessary this type of legislation. It was quite thoroughly agreed that the Voluntary Health Insurance seemed to be the most effective means at hand. Blue Cross and Blue Shield were urged to continue their very fine campaign to enroll and keep enrolled persons over 65 years of age.

MEDICARE came in for a good deal of discussion and the following editorial from the Nebraska State Medical Association Journal, January 1958, presents in concise form your delegate's comments on the current status of MEDICARE.

**MEDICARE**

Beginning in December 1955, the American Medical Association and the Department of Defense collaborated in the development of MEDICARE. A "Task Force" of the A.M.A., developed the program to a point where legislation was enacted under Public Law 569. The A.M.A. and the state associations have indicated that they will continue this contact and cooperation and will keep the physicians informed about the program from time to time.

MEDICARE is operated in Nebraska by the Policy Committee of the Nebraska State Medical Association, under a Resolution adopted by the House of Delegates. The Nebraska State Medical Association is the Contracting Agent and the Nebraska Blue Shield is the Fiscal Agent for the program. The Policy Committee has complete responsibility for the program's operation in Nebraska and the Blue Shield Plan takes its part in the administration of the plan, under the direction of the Policy Committee. The Policy Committee is to be commended for their efforts in making the program such a fine success in Nebraska.

Inasmuch as we have not published or generally distributed the Schedule of Allowances of the MEDICARE program, but have depended upon the request of the Policy Committee to the medical profession of the state in cooperation to have matters of charges in the following manner:

The fees charged in MEDICARE should represent generally the average going fee for the same service in the community in which that service is rendered. Fees charged should not exceed the ordinary reasonable fee charged by physicians and surgeons in their private practice for persons in the middle income group.

Of the 3,277 claims—99.5%—have been accepted as payment in full by the members of the medical profession in Nebraska; i.e., Service Benefits. We think this is a very excellent demonstration of cooperation by the medical profession in the state. Only 15 claims have been sent in for special consideration. Average payment per claim was $64.78.

It is a new and difficult program to administer. It is difficult for the state medical society and its Policy Committee to inform and keep the medical profession informed. Lack of information and misunderstanding has caused a moderate amount of difficulty in administering the program. MEDICARE has created many problems and difficulties for Blue Shield in its endeavor to administer the program according to the contract, and the pursuant directives they have received from the Department of Defense. We think the publication of a new manual containing the Schedule of Allowances and a compilation of the changes to date would help eliminate much of the criticism due to lack of detailed information, as to what the MEDICARE program provides and does not provide.

The MEDICARE program represents a unique program of the first magnitude in the field of health care. No one can fully appreciate the vast amount of effort contributed to the development and the formulation of this program; but this much can be said in all sincerity . . . local state medical societies, the profession, and the American Medical Association deserves commendation for the contribution they have made in working out a program which will benefit millions of servicemen's dependents. By participating in the program, physicians will contribute much towards bolstering the morale of the men in the armed forces whose constant
concern is the health and well being of their loved ones at home. Organized medicine and physicians individually in all parts of the country, have by their efforts in supporting this program, demonstrated a capacity to render a public service of immense value and proportion.

Although the selection of the local administrative machinery for this program was a choice left entirely to the state medical society, it has been gratifying that the Blue Shield Plan was chosen by the medical society to provide the administrative machinery for MEDICARE. This we think is as it should be, inasmuch as the Blue Shield Plan is so closely associated with and an integral part of the Nebraska State Medical Association. This bespeaks the confidence of the profession in this area in its Blue Shield Plan. It is a vote of confidence that Blue Shield values to the utmost.

MEDICARE is now Public Law 569. It is subject to revision of the contract from time to time. Its future operation will demand a great measure of medical statesmanship on the part of the profession, to prove whether the medical profession can cooperate with the Federal Government in this program and not be swallowed up by the Government in the process.

It we can make this program work successfully, and there are many indications that it can be made to work, then it will be unnecessary to build more government hospitals and draft more doctors to care for these dependents.

From now on success or failure depends on the unselfish wholehearted participation of doctors of medicine everywhere. This is a responsibility that we physicians must assume with a high moral sense of obligation and dedicated duty. The entire future pattern of the practice of medicine could well depend on the success or failure of the MEDICARE program. Judging the future by the past—I think the medical profession has what it takes to make this program a success.

Lay controlled plans were discussed as they exist, particularly in the State of Minnesota and several speakers urged that the medical society sponsored health care plans such as Blue Shield and the affiliated Blue Cross Plans expand their benefits to make unnecessary further expansion of lay sponsored health care plans.

Dr. John Gilligan of Nebraska City, Nebraska presented a very fine paper on the topic of "Malpractice Suits, How to Prevent Them." This paper was very interesting and reflected a great deal of thought and work on the part of the writer and his experience on the committee of the Nebraska State Medical Association handling the problems of the doctors in Nebraska. Dr. Gilligan had some very good advice for the medical profession in a terse comment "Don't talk too much."

Your delegate was named as President-Elect of the 1958 Conference.

Respectfully submitted,
ARTHUR J. OFFERMAN, M.D.

REPORT OF ALLIED PROFESSIONS COMMITTEE

W. J. McMARTIN, M.D., Chairman, Omaha; A. E. Freed, M.D., Omaha; Max Coe, M.D., Wakefield; N. Richard Miller, M.D., Lincoln; Otis Miller, M.D., Ord.

No meeting of the Allied Professions Committee was held as no business was referred to this committee during the past year.

The Chairman, Dr. W. Joseph McMartin, was invited to attend a dinner meeting of the Practical Nurse Association of Nebraska, Inc., at the Rome Hotel, but no new business came up before this group.

Through personal contact with some of the members of the Practical Nurse Association, I have been advised that the organization is now a united group which is working harmoniously, which was not the case prior to 1957. Some of the practical nurses in this organization withdrew from the Practical Nurse Association and some refused to pay dues.

I was asked by some of the members of the Practical Nurse Association to give them the names of some lawyers from which they could choose one to help them with their organization. From this group they chose Mr. William J. Hotz, Jr., of Omaha, who has been most helpful to this organization.

Other than this item, the Allied Professions Committee has nothing further to report.

Respectfully submitted,
W. J. McMARTIN, M.D., Chairman.

REPORT OF CIVIL DEFENSE AND DISASTER COMMITTEE

George N. Johnson, M.D., Chairman, Omaha; Arnold Lempka, M.D., Omaha; Isidah Lukens, M.D., Tekamah; John Wiedman, M.D., Lincoln; Joe Hasna, M.D., Scottsbluff; H. Dey Myers, M.D., Schuyler.

The Civil Defense and Disaster Committee for the Nebraska State Medical Association held its first official meeting June 19, 1957 at the Sheraton-Fontenelle Hotel in Omaha, Nebraska. At this meeting the over-all Civil Defense and Disaster plan from the medical standpoint was discussed. The routes of evacuation were discussed for the Lincoln and Omaha areas.

How best to set up the organization for the medical profession was discussed and it was agreed it could be organized along the following lines:

That each of the twelve Councilors in the Council Districts be assigned to serve as medical directors for his district and act as a coordinator for his area. Each Councilor would be furnished a set of plans covering disaster plans for the state, this information to be passed on to the physicians in his district so they would know their duties.

That the physician or physicians in each town decide where best to set up aid stations in their communities.

That all physicians should obtain Civil Defense identification cards which would be an official passport into disaster areas. These cards would be recognized by the National Guard and other law enforcement groups and allow the holder to enter the disaster area.

A billfold size card will be available to Omaha physicians in the near future which will list a number of towns to which the physician can go in case Omaha is evacuated. Upon his arrival in any one of these communities he will report to the communication center which will be set up, stating his name and type of practice. This center will inform the regional medical director that this doctor is available and ready for assignment to the area where he is most needed.

April 1958
Each committee member was asked to return to his community and urge other physicians and responsible officials to work out plans for their respective areas. Other meetings will be held to coordinate and consolidate plans which each area makes.

After discussing the best method of putting an organizational plan into action, Dr. Lukens moved that the Councilor in each district serve as medical director for the coordination of medical disaster planning for his district, and that Councilors serve as a member of a sub-committee to the Civil Defense and Disaster Committee of the Nebraska State Medical Association. The motion was seconded and carried.

Recommendations for future planning are as follows: There should be a top level meeting with all of the twelve Councilors from the Councilor Districts and the presidents of all of the local county medical societies in the very near future to coordinate a state-wide disaster plan. Many problems need to be ironed out and a formula for a definite plan of operation should be made as a standard operative procedure from a meeting of the above-mentioned members. It is very important that the entire medical profession be informed of the goings on in regard to disaster planning. This can be accomplished by a thorough understanding of the responsibilities that the medical profession will have to assume in times of disaster.

Respectfully submitted,
George N. Johnson, M.D.,
Chairman.

REPORT OF DIABETES COMMITTEE
Morris Margolin, M.D., Chairman, Omaha; Richard Fanger, M.D., Omaha; Dan Nye, M.D., Kearney.

1. PUBLICITY: As usual we had excellent coverage this year through newspapers, radio and television. In many cases these mediums were stimulated by contact made with them through local diabetes groups at the urging of your Diabetes Committee. Posters, furnished by the American Diabetes Association, were distributed to the drug stores throughout the state by courtesy of McKesson and Robbins, Inc., and to all hospitals by the Nebraska Hospital Association. In addition, a personal letter from the president to all members of the Nebraska State Medical Association urged participation in the detection drive. While there had been no special issue of the Nebraska State Medical Journal, a very fine editorial on Diabetes was published in the November issue.

2. RESULT OF DETECTION DRIVE: 142 responses to the questionnaires were received by our headquarters office, totaling 4806 tests as compared to the 3392 in 1955. Of the tests reported there were 157 positives, 22 of which were previously unknown.

3. PLANS FOR THE FUTURE:
(a) The committee is contemplating a blood sugar screening test project for the Nebraska State Fair of September 1958. Arrangements have already been made to obtain the equipment for running the tests from the U.S.P.H.S. The State Department of Public Health and the Nebraska Diabetes Association have offered cooperation for this project and steps are being taken to obtain the necessary technical and secretarial services at the least possible cost. We are in hopes of obtaining sufficient voluntary help to keep the expenses at a minimum.

(b) Your chairman was approached by representatives of the local AFL-CIO, pursuant to a policy adopted by the national organization in cooperation with the American Diabetes Association, relative to diabetes detection among union labor groups. Plans are now being considered for the inclusion of these groups in the detection drive in the coming year.

(c) Diabetes detection as a method of public education and promotion of good public relations has been proven to be of definite value. Since our regular program of diabetes detection rightly insists on maintenance of doctor-patient relationship in all aspects, these basic considerations shall be given in all projects for the coming year. We recommend the continuance of the free urine testing program for National Diabetes Week of 1958.

Our sincere gratitude to Messrs. M. C. Smith and K. Neff, as well as to the headquarters staff, for their invaluable help in planning and carrying through the many phases of our project.

Respectfully submitted,
Morris Margolin, M.D.,
Chairman.

REPORT OF CONSTITUTION AND BY-LAWS COMMITTEE
R. S. Wycoff, M.D., Chairman, Lexington; C. R. Brott, M.D., Beatrice; R. B. Adams, M.D., Lincoln.

The special committee on Constitution and By-Laws has met with the standing committee on three occasions since the last annual meeting. While never possible to have all members present at the same time, the attendance has been good and several members have been at all meetings. These meetings have been marked by frank discussion and numerous proposals for changes which will make our processes even more democratic, and will, we believe, speed up the orderly processes of legislation. Discussion has been vigorous but friendly throughout.

In order that the contemplated changes may be presented in order, I will begin with the first Article of the Constitution and go directly through the entire Constitution and By-Laws in order.

ARTICLE I. No proposal has been received for any change in the first Article of the Constitution.

ARTICLE II. It has been proposed to change this Article, and wording merely, but so as to somewhat clarify and make a little more specific the intent and purposes of the Constitution.

ARTICLE III. No change has been proposed. However, there has been some discussion of the idea of having medical societies larger than single counties, since many counties have very few physicians in them and, in this age of good roads and automobiles, distances are not so important as they were when county societies were first organized. This proposal, however, has not so far been worked out, and is being studied by another committee.

ARTICLE IV. It has been proposed to leave the statement as to the classes of membership where it is, but to move the description of these classes to the By-Laws.

ARTICLE V. No change has been proposed for this Article.
ARTICLE VI. There has been considerable discussion as to the advisability of changing the time at which the President-elect shall assume office as President. The main points that have been emphasized are that since the out-going president has guided the preparation for the Annual Session, he should be allowed to serve through all, or at least most, of the meeting which he has helped to arrange. With this thought in mind, any conclusion as to change in the actual time of induction of the President has not yet been decided on; however, there have been two principle ideas advanced. The first is that the President might well be installed at the beginning of the morning session on Thursday; the second is that the President be installed in a brief ceremony during the program of the annual banquet.

ARTICLE VI, Section 5 of the Constitution. It is proposed to delete the last sentence in this section, which provides that an active candidate for any State political office shall not be nominated for office in the Association. It is the feeling of the Committee that this might sometimes interfere with political activities of members of the Association who might be showing a healthy interest in our own state government.

ARTICLE XI. There are two changes proposed; first is that the ordering of a referendum shall require a vote of two-thirds of those present at the time of the vote. Then in the latter part of this Article there is already a proposition before the House to change the number of votes required to pass a referendum which will be included in the rewriting of this Article.

It should be noted at this point that throughout the entire Constitution and By-Laws there are numerous paragraphs that are repetitious and we hope to be able to combine these to avoid the repetition, and so eliminate some of the confusion that has resulted from this. This was particularly noted by one of the group committees as occurring in numerous parts of the By-Laws.

In Chapter II of the By-Laws, Section 2, and paragraph 3 of this Section, it is suggested that this duplicate in Chapter 15, Section 4; and the suggestion was also made that some considerable work for the secretary of the component society could be eliminated by asking him to report annually only removals, deaths, and new members, since the headquarters office already has a card file on the membership of each organization within its jurisdiction.

Also in Chapter II, Section 4 and paragraph 3, it is proposed to change somewhat the wording here, since the present By-Law states that delegates to the Association shall be paid an allowance and, since this does not intend to apply to delegates of the component societies to the Nebraska State Medical Association, it is felt that a clarification will be helpful.

Chapter IV, Section 7, this will need to be rewritten, since in another place it is planned to have the duties of the Committee on Journal and Publications assumed by the Board of Trustees. The suggestion has also been made that the order of the Sections in Chapter IV could be somewhat improved by rearranging, and this may be done at that time.

In Chapter V of the By-Laws, in the second paragraph, it is proposed to eliminate the second sentence, providing that a special session shall not be called within thirty days immediately preceding or following the annual session, mainly because it is conceivable that special conditions might arise at any time as an emergency.

In Section 2 it is proposed to provide that the President also may call a special session of the House of Delegates; and to delete the provision that each councilor district must be represented in calling a special session by the members of the House of Delegates.

In the second paragraph of Section 2, it is also proposed to change the required ten days notice of a special session of the House of Delegates, to fifteen days.

Under this Chapter V, in providing for special sessions, it is proposed to move Section 3 from Chapter X to this chapter, since this is a paragraph providing for a special meeting of the Board of Trustees, and it is felt that this should be included in the chapter providing for all special sessions.

Chapter VI, Section 4. It is planned to change the second paragraph to provide that either a delegate or his alternate may sit in the House of Delegates, and either alternately or consecutively as may be arranged between themselves. This was suggested because it was felt that many times component societies are denied the right of representation by the present ruling, which provides that no change or alternation may take place.

In Section 5 of the same chapter it is proposed to omit the last sentence which is merely a repetition.

In Chapter VII outlining the membership of the House of Delegates and its duties, it is proposed to list the duties somewhat as they are arranged under the Board of Trustees, first those duties which it "shall" perform; second, those duties which it "may" perform but which are not obligatory.

In Paragraph 10 of this same chapter it is proposed to eliminate the last half of the paragraph, since the Committee on Journal and Publications is to be done away with and these duties will be transferred to the Board of Trustees.

In Chapter VIII, in the second paragraph in which the duties of the nominating committee are outlined, it was proposed that we shall specify that each session of the nominating committee shall be for a period of not less than one hour.

In Section 2 of the chapter, it is proposed to change the wording to read "that the report of the nominating committee and the election of officers shall be at the final meeting of the House of Delegates on the last day of the annual session."

In Section 3 of Chapter VIII, it is proposed that the wording be slightly changed somewhat to provide that in the event of more than two nominations for any office, a majority of the delegates present shall elect; with the added provision that if there be more than two nominees and no majority declared the nominees and a runoff election be provided for between these two candidates.

In Chapter IX under the duties of the officers and the Executive Secretary, it is proposed to arrange these in the same manner under "shall" and "may" duties as was done in previous chapters.

In Section 6 of Chapter IX the duties of the Sec-
Secretary-Treasurer will be somewhat changed, since
the Committee on Journal and Publications is to
be done away with.
In the last paragraph of Section 7 of the same
chapter there appears to be a duplication of Chapter
IX, Section 6, paragraph 5 and this will be deleted.
In Section 9 there is a duplication somewhat
of Section 5, of Chapter X in Section 1, and this
will be smoothed out.
In Chapter X, Section 1 and Paragraph II, the
committee on Library, Necrology and Records is
to be eliminated as such, and the corresponding
change will be made in this item.
In Section 3 of this same Chapter, it is proposed
to add in the second sentence after the words
Secretary of the Board of Trustees the phrase “by
virtue of his office.” This is to clarify the state-
ment of membership, since the number of terms is
limited in the case of all other members of the
Board.
Chapter XI. It is proposed to list the duties of
the Board of Councilors in the same way as has
been proposed for the other groups under a “shall”
and “may” arrangement.
In the last paragraph of Section 4 of this same
chapter, it is proposed to change in the first line
the words recording to executive secretary and the
words Council to the State Association. Then at
the end of the sentence to add the words if so
requested, thus providing that the councilor may ap-
point honorary pallbearers to attend the funeral
of a member of his district.
Then in Chapter XII, in Section 1, it is proposed
to add at the end of the paragraph these words
members shall continue to serve until their suc-
cessors are appointed. Also in the second paragraph,
the committee feels that all committees of the As-
sociation should be six-men committees, two mem-
bers to be appointed each year for a three-year term.
Under Section 2 of the same chapter it is proposed
to do away with Committee G on Journal and Pub-
llication, Committee H on Library, Necrology and
Records, and Committee P, the Speakers Bureau.
These changes are simply following out recommen-
dations already made.
Further in Paragraph C of the same chapter it
has been suggested that the Committee on Creden-
tials might well be one of the reference commit-
tees, since many societies have no committee on
credentials as a standing committee.
Chapter IV, Section 4 outlines the duty of the
Committee on Journal and Publication and this is to
be rewritten into the duties of the Board of Trust-
ees. A definite question has been raised by the
committee whether or not this Board, because of
these added duties, might well be increased to
six or even seven members.
In Chapter XVII it is proposed to change the
words in the first line annual or interim to regular
and to add at the end of the paragraph the words
at which they are to be presented in order to some-
what clarify the intent of the paragraph.
The Committee on Aging, which was authorized
by order of the House of Delegates on May 16,
1957, has been appointed by Dr. Best; also the con-
stitutional change proposed at the 1957 interim ses-
sion of the House of Delegates remains to be read
for final passage. It is the plan of the committee
on Constitution and By-Laws, with the consent of
the Board of Councilors and the approval of the
House of Delegates, to suggest that these changes
be deferred for the present, and then incorporated
in the rewriting of the Constitution and By-Laws.
And finally, a note from Dr. W. R. Hansma, Chair-
man of the Committee on Muscular Rehabilitation,
addressed to Dr. R. B. Adams, recommends that
this committee be discontinued, since it has had no
meetings for the third year in succession, and also
since no problems have been presented to it.
This will be considered by the Committee at its
next meeting, which will be sometime after the
Interim Session of the House of Delegates.
Respectfully submitted,
RAY S. WCCOFF, M.D.,
Chairman.

REPORT OF CONTINUING COMMITTEE
ON MEDICAL PRACTICE
R. F. Sievers, M.D., Chairman; Blair; L. D. Cherry, M.D.,
Lincoln; Kenneth Rose, M.D., Lincoln; P. R. Olson, M.D.,
Lexington; J. J. Borchhoff, M.D., Omaha; Theo. A. Peterson,
M.D., Holdrege.
The Continuing Committee on Medical Practice has had no problems turned over to it for study
during the past year. No meeting has been held by this committee.
It was suggested that after this committee was estab-
lished a study be made as to the relative value of diagnostic, medical, and surgical services,
as rendered in the hospitals of this state, and to report its findings and recommendations to the
House of Delegates. This is a big order and no effort has been made so far to conduct this study.
This committee is supposed to stimulate interest in
the formation of a Department of General Prac-
tice in each medical school. Efforts have been
made to ascertain the amount of time that would
be given by general practitioners to support a De-
partment of General Practice. To date it is felt
that this support from general practitioners would
be completely inadequate to properly run such a
department. In this respect it should be pointed
out that the Preceptorship Program is functioning
well at the University of Nebraska College of Medi-
cine.
Several verbal complaints have been received
with regard to arbitrary restrictions by hospitals
against general practitioners as a group. Since
there were no written requests with respect to this
problem, no investigations were undertaken.
Respectfully submitted,
R. F. SIEVERS, M.D.,
Chairman.

REPORT OF THE EDITOR
Your Nebraska State Medical Journal comes to
you each month for your own inspection and evalua-
tion. It is possible that you, the readers, judge it
from a different point of view than we, the pro-
ducers. Furthermore, each of you, governed by in-
dividual tastes, likes, dislikes, and interests in
medicine, arrives at the results of your evaluation
by a different route.
Our recent survey by questionnaire, while initiated
by the State Medical Journal Advertising Bureau
primarily for the benefit of the advertisers, gave
the editorial staff much food for thought. We are making as much use of this information as we can.

The part we will heed most relates to what goes into the Journal. We have often remarked that "we can't print it if we don't get it." We must depend upon the good will of those who contribute to our organ; and this is a good place to say that the quantity and quality of articles offered for publication has steadily improved over the years. We take this opportunity to thank the profession of Nebraska for its loyal support.

On the other hand, it is possible to go out after certain types of articles rarely offered for publication—articles of kinds frequently mentioned in the survey. This we are doing, with some degree of success, and hope thereby to improve the Journal and its reader-interest.

What we print in the Journal can be strongly supported by how we print it. Your favorite food may be more enjoyable if tastily served and enhanced by the proverbial "sprig of parsley," so to speak. Just so, the composition, makeup, cover beauty, the type, the grade of paper, are the "sprig of parsley." Is it easy to find out what is contained in an article? Is it laid out so it is easy to read? Are the tables, charts, and illustrations well done, properly illustrative, and placed where they can easily be used while reading the article? All these items and more are the how of the production and must be given as much attention as the what.

Editors need to be a little bit engineers, artists, composers, and printers, and they just aren't born that way. In most cases, I suspect, they learn these things the hard way—experience. They are very fortunate, indeed, if like us, they have a happy liaison with those who print the magazine.

All-in-all, the Nebraska State Medical Journal has had a successful year, and, with the continued cooperation of our friends, in this endeavor, we expect the next volume to be better than the last.

Respectfully submitted,

GEORGE W. COVEY, M.D.,
Editor.

REPORT OF THE MEDICAL EDUCATION COMMITTEE

D. B. STEENBURG, M.D., Chairman, Aurora; Earle Johnson, M.D., Grand Island; H. S. Morgan, M.D., Lincoln; F. Lowell Dunn, M.D., Omaha; M. A. Johnson, M.D., Plaunaview; H. A. Jakeman, M.D., Fremont; Max Gentry, M.D., Gering.

There have been no meetings of the Committee as a whole. Your chairman has attended most of the meetings of the executive faculty of the University of Nebraska College of Medicine in Omaha and reports a steady growth and improvement of teaching and research facilities with an increasing number of individuals so engaged.

Unit 3 is awaiting the accumulation of tax money with which to build it. The allocation of the space is still being debated between the interested departments, but it is reasonable to assume that the requirements laid down by the American Association of Medical Schools and the American Medical Association will at least partially be met as to the number of beds per junior and senior students in the medical school.

As more tax money becomes available with which to enlarge the plant and personnel, more grants in aid will become available for research projects; one such is Dr. Holly's new laboratory presently being equipped in the basement of Conklin Hall with fine, ample equipment for research in the field of Hematology.

I am sure we are slowly but surely developing along the lines laid down for us by the American Association of Medical Schools and the American Medical Association in a manner satisfactory to the Nebraska State Medical Association and the people of the State of Nebraska.

In closing, may I again bespeak the continuing efforts of the whole body of the Nebraska State Medical Association in trying to enlist the support of all, and especially the elected representative to the State unicameral, in the College of Medicine, the University Hospital, their support, maintenance and growth.

Respectfully submitted,

D. B. STEENBURG, M.D.,
Chairman.

REPORT OF PLANNING COMMITTEE

Harold S. Morgan, M.D., Chairman, Lincoln; Harley Anderson, M.D., Omaha; H. D. Kuper, M.D., Columbus; W. W. Carveth, M.D., Lincoln; W. C. Kenner, M.D., Nebraska City.

The Planning Committee has met and studied two significant problems since our last report. One of these, the Indigent Medical Care Program is still under consideration. Your chairman attended a meeting of the Indigent Medical Care Committee of the A.M.A. and brought back with him information that will be of considerable help in the further study of this subject by the Planning Committee.

The committee has also met with representatives of the University of Nebraska College of Medicine and Creighton University School of Medicine to discuss matters pertaining to postgraduate medical education in Nebraska. It was the consensus of the group that a coordinated postgraduate medical program would be of distinct value to the medical profession of Nebraska and to that end it was agreed that it be recommended to the House of Delegates that the Nebraska State Medical Association co-sponsor any postgraduate course developed by Creighton University School of Medicine or the University of Nebraska College of Medicine, or any joint meeting organized by the two schools.

Respectfully submitted,

HAROLD S. MORGAN, M.D.,
Chairman.

REPORT OF PREPAYMENT MEDICAL CARE COMMITTEE

John H. Brush, M.D., Chairman, Omaha; B. R. Farmer, M.D., Norfolk; John T. McGregor, Jr., M.D., Lincoln.

This is a report on the accomplishments and activities of Nebraska Blue Shield for the year 1957 submitted by your Prepayment Medical Care Committee consisting of the above named members.

One or more members of your committee has attended all Nebraska Blue Shield Board Meetings during the year, and two of the members attended the National Conference of Blue Shield Plans. Every courtesy has been extended to this committee by Nebraska Blue Shield to better acquaint us with its operations. Although the operations of Nebraska Blue Shield have become much more complex and varied due to the addition of new contracts and
Medicare, the efficiency of the plan, and the morale of its employees continues to be excellent. Nebraska Blue Shield is also in excellent financial condition—one of the strongest in the nation.

Constantly keeping in mind the best interests of Nebraska subscribers and their physicians has resulted in a new high in Physician-Patient-Plan relationship.

Your committee should like to review a few of the more important phases of operations by Nebraska Blue Shield for the year 1957.

To help keep Nebraska physicians and their patients better informed on Blue Shield, the following are some of the more important services rendered by Physician Relations Department Personnel of Nebraska Blue Shield during 1957: 469 personal calls on 315 doctors of medicine; staffed exhibits at the Hall of Health, Nebraska Public Health Association, Nebraska State Nurses Association, Nebraska State Medical Association and Omaha Midwest Clinical Society; held several meetings with doctors and internes at hospitals. A new Participating Physicians Manual was compiled, and will be distributed to all Nebraska physicians.

Your Prepayment Medical Care Committee in conjunction with the Professional Service Committee of the Nebraska Blue Shield Board conducted an open meeting during the Annual Session of the Nebraska State Medical Association in May, 1957. This meeting was held to hear suggestions and recommendations from various specialty groups and doctors of medicine in Nebraska. Several good ideas were advanced, and resulted in Nebraska Blue Shield changing, broadening, and extending their coverages.

Nebraska Blue Shield coverages were improved and extended during 1957, and were offered to the public on January 1, 1958.

The Standard Blue Shield Agreement is now available with Medical Rider which makes in-hospital medical care effective the first day of hospitalization instead of the fourth day. We believe this Medical Rider will be of mutual benefit to both the physician and to his patient. The number of days of in-hospital medical care has been extended from 90 to 120 days under both the new Standard Agreement and Standard Agreement with Medical Rider.

The Preferred Blue Shield Agreement has been broadened to include hematologic and bacteriological examinations while member is bed patient in hospital. The number of days of in-hospital medical care has also been extended under the new Preferred Agreement from 120 to 150 days.

Epilepsy has been eliminated as an exclusion in all Blue Shield Agreements.

The anesthesia-schedule has been changed from a time element basis to a procedure basis.

Two new riders will also be available for select Blue Shield groups: Ambulatory Diagnostic Benefits Rider—X ray and Pathology; and Ambulatory Diagnostic Benefits Rider—X ray, Pathology, and Home or Office visits.

A Comprehensive Major Agreement has been developed by Nebraska Blue Cross-Blue Shield which is designed to give desired protection against long-term or catastrophic illness.

**RESOLUTION**

WHEREAS, the Board of Directors of Nebraska Blue Shield has adopted a resolution directing its Policy and Contract Committees to develop a new “BLUE SHIELD $7,500.00 SERVICE CONTRACT.”

WHEREAS, the needs and desires of many employees of nation-wide employers will be met by a Service contract, with a realistic income limit and adequate benefits which reflect current economic conditions.

WHEREAS, it is generally recognized by informed students of medical economics that Prepayment Medical Care Plans operating on a “Service Basis” are the best current answers to the needs of subscribers and the medical profession.

WHEREAS, the Nebraska Medical Service, “THE BLUE SHIELD PLAN,” is now preparing to issue a Service contract, with annual income limits of $6,000.00 for a single person and a total annual income of $7,500.00 for a family. This new contract will provide a schedule of benefits higher than the present Preferred contract and the dues will be appropriately higher than the present Preferred contract.

THEREFORE BE IT RESOLVED, that the Nebraska State Medical Association approves, endorses and sponsors this new “$7,500.00 Service contract” and recommends to members of the Association that they execute appropriate “Participating Physicians Agreements” with Nebraska Medical Service upon contractual terms and conditions similar to those upon which the two previous “Participating Physicians Agreements” were promised.

Operating under the direction of the Policy Committee of the Nebraska State Medical Association, Nebraska Blue Shield acts as Fiscal Agent for the Medicare program in this state. Medicare has created many problems and difficulties for Blue Shield in its endeavor to administer the program according to the contract, and the pursuant directives they have received from the Department of Defense. A new procedure Manual containing the “Schedule of Allowances” has been compiled and will be distributed to all Nebraska physicians during the ensuing year. We feel that this new Manual will help eliminate much of the confusion and criticism due to lack of detailed information as to what the Medicare program provides and does not provide.

Your committee is pleased to announce that Nebraska Blue Shield had a net gain of 7,311 new members in 1957. 209,401 Nebraskans are now covered by Blue Shield.

In view of knowledge gained, and observations made by your committee during 1957, the following recommendations are offered for your consideration:

1. If the American Medical Profession is to continue to have a say in “medical economic” matters in the practice of medicine,

2. If American Physicians desire a regulatory device as to rates charged, and monies paid, for medical services by certain Commercial Insurance Carriers,

3. If American Medicine does not care to be dictated to by government, in the practice of their profession,
4. If American Citizens want a sound, low over-head—high return means of prepaying for medical care, at a cost they can afford on a budget basis,

Then every American Doctor of Medicine should support, advise and develop Blue Shield in the in-
terests of his patients, himself, and his community.

Respectfully submitted,
JOHN H. BRUSH, M.D.,
Chairman.

REPORT OF EXECUTIVE SECRETARY

As in years past, this report of your Executive Secretary covers only the administrative activities of
the headquarters office in connection with the various committee functions and the over-all opera-
tion of your Nebraska State Medical Association.

Your Association is constantly expanding on all fronts and to get a clear picture of all activities, it is necessary for the interested member to read
the complete reports. We hope that our members take the time to do just this so that they may be
well informed as to the complete operation of an organization of such importance to the medical pro-

One of the interesting and significant items of interest in operation of your Association is the ratio of income from dues to the expenditures made
in benefits for the members. The audit sheet for 1957 shows that the total income from dues is
$41,790.00. The total expenditures is $109,533.33.

There is one item of expenditure of $29,100.00 which is A.M.A. dues and is merely a bookkeeping item. Deducting this from the total operation expense, we have an item of $80,433.33 which is expended for
membership benefits. The difference is made up in operation of the Journal, Annual Session, and other sources of income.

In other words, there is almost twice as much expended for membership benefits as is collected in
dues, giving membership benefits of almost 100%. Not many of us have such good investments.

The following headings give you some brief in-
formation about some of the outstanding activities:

MEDICARE

We have just completed approximately one year
of operation of this plan to provide medical care and hospitalization for dependents of those in the
uniformed services. Blue Shield, our fiscal agent,
has done an excellent job of administering the pro-
gram. It was known at the beginning that there would be some "bugs" in this program, but they have been held to a minimum through the fine cooperation of our members. We would dare to
predict and hope that the second year of operation will be smoother than the first. During the year there have been 4,787 cases handled in the state for which our members were paid $316,325.03,
or an average of $66.08 per case. At a recent meeting of the Policy Committee it was decided to
publish a fee schedule and distribute it to the mem-
ers. This is now in the process of being done and
should be completed shortly.

NEBRASKA STATE MEDICAL JOURNAL

The 1957 Nebraska State Medical Journal con-
tinued to grow both in size and income. The follow-
ing figures tend to show its growth over 1956:

<table>
<thead>
<tr>
<th>Year</th>
<th>Color</th>
<th>B&amp;W</th>
<th>Total</th>
<th>Gross</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>258</td>
<td>279</td>
<td>14 pgs</td>
<td>581/2</td>
</tr>
<tr>
<td>1957</td>
<td>725½</td>
<td>263½</td>
<td>74 pgs</td>
<td>585½</td>
</tr>
</tbody>
</table>

For the first time the total number of pages exceeded the total number of black and white pages. Inserts are becoming quite popular and are being used with
increased frequency as the table above denotes.

The first several issues of the 1958 Journal indi-
cates a continued growth. A new and heavier cover
is being considered for use in the near future which
will improve the appearance and durability of the

COMMITTEE ACTIVITY

Committee activity over the past year has main-
tained a busy pace. There were 35 meetings of var-
ious committees involving 145 physicians who con-
tributed approximately 580 hours of their valuable
time to association matters.

The following enumerated subjects will give you
an idea of the many matters which required action:
Legislation, Senior Medical Day, Hall of Health,
civil defense, diabetes detection week, polio im-
munization program, professional relations, Annual
Session, revision of the Constitution and By-Laws,
cancer detection program, and MEDICARE. The contributions of these committees have been a vital factor in the smooth functioning of this organiza-

HALL OF HEALTH

The Hall of Health continues to increase in popu-
ularity among the exhibitors and the public at the Nebraska State Fair. As evidence of its popularity, additional space is being acquired within the pres-
tent building which will make room for six more ex-
hibits.

Plans are already in process for the 1958 exhibit
which will provide space for 23 exhibits.

The many fields of medicine, together with the
fine cooperation and support of the participating health organizations, combine to assure the visiting public of many new and interesting phases of medici-

PLACEMENT SERVICE

The physicians placement service activities for
1957 can be summed up in a few words. The de-
mand is high but the supply is lower than we would
like to have.

During the year 14 physicians were placed through the placement service. More than half of these loca-
tions were in communities of less than 1,500 popu-
lation.

A total of 69 new physicians have moved into the state this year. Of this number 32 have located in
the larger cities, and 37 in the out-state areas. We have 57 communities looking for a physician; how-
ever, a large percentage of these could not support
a full-time physician. The end of the Doctor-Draft
Law does not seem to have affected the number of physicians looking for a location.

SENIOR MEDICAL DAY

This well established program is now entering its 7th year. The format has essentially remained unchanged since the first program was given, but its popularity has remained high with almost one hundred per cent attendance on the part of the stu-
dents at each program.
The credit for the success of the program must go to the members of the Rural Medical Service Committee and to the willing and able faculty which presents the program.

CANCER DETECTION PROGRAM

This course, which is sponsored by the Nebraska Division of the American Cancer Society in cooperation with the Cancer Committee of the Nebraska State Medical Association, will present its 4th annual program in April 1958. The principal aim of this course is to present the family physicians with up-to-date information on cancer detection methods and encourage every doctor to make his office a cancer detection center.

THE BULLETIN

The pink envelope and its contents brought many items of importance to the practicing physician during 1957. This quick and efficient method of communication with the membership is one of the ways in which the headquarters attempts to keep the physician informed.

When quick and concise information to the members is necessary, we use the pink sheet to thus inform you. The arrival of this material in your office is designed to inform you in a few minutes time of the issues at stake. We hope that it is prepared in a manner which fulfills its aim.

STATE OF MEMBERSHIP AS OF DECEMBER 31, 1957

The following are the usual tables indicating the state of membership for 1957:

| TABLE NO. 1 | Members deceased | 17 |
| Members deceased | 14 | 31 |
| Members moved out of state | 27 | 35 |
| Non members moved out of state | 8 | 66 |
| New physicians in state—members | 52 |
| Potential members | 20 | 72 |
| Net Gain | 6 |
| In active practice | 1,455 |
| Retired by eligible | 9 |
| Members—December 31, 1956 | 1,300 |
| Members—December 31, 1957 | 1,291 |
| Net Membership Loss | 9 |

| TABLE NO. 2 | Licensed physicians (last file count) | 2,668 |
| Residing out of state | 1,064 |
| Members | 1,274 |
| Associate members | 38 |
| Non eligible | 18 |
| Retired | 9 |
| Non members eligible | 143 |
| Unclassified | 122 | 2,668 |

(There are 12 members in the retired, Veterans Administration Service, professors; 5 inactive Service status).

| TABLE NO. 3 | Members | 1,291 |
| Active | 1,157 |
| Life (8 in deceased column) | 84 |
| Service (given Service Memberships in 1957) | 5 |
| Out of state | 28 |
| Deceased (8 Life Members) | 17 | 1,291 |

MAIL

During the past year your headquarters office has handled 48,900 pieces of mail; 8,039 pieces of mail were incoming, and the outgoing, first class mail amounted to 18,946 pieces. The balance consisted of bulletins to the members.

May I again close this annual report with a deepfelt expression of appreciation to the members for the fine cooperation which I have had during the year as in the many years past that I have been privileged to serve this Association. May I extend a warm wish for more of you to visit the headquarters at your convenience. We are always happy and honored to have you, and I am sure that the more you know about the detailed operation of your Association, the closer you will be to it. The closer cooperation we have, the better able we are to serve. The public looks to the medical professional for leadership in medical care. We want to give them the best of which we are capable.

Respectfully submitted,

M. C. SMITH,
Executive Secretary.

REPORT OF THE BOARD OF TRUSTEES

A. A. Ashby, M.D., Chairman, Geneva; G. E. Peters, M.D., Randolph; C. N. Sorensen, M.D., Scottsbluff; M. E. Grier, M.D., Omaha; R. B. Adams, M.D., Lincoln.

Four regular meetings were held during the past year. The Board appreciates the attendance at our meetings of both Dr. R. Russell Best, President, and Dr. Fay Smith, President-elect. The presence and suggestions of other officers and members of the Association have been of much assistance.

Our Hall of Health at the Nebraska State Fair is continuing in popularity. Interest is shown not only by attendance but also by favorable comment heard over the state.

The University of Nebraska reports that the safety film is being prepared for production.

The Board of Trustees is continuing the same investment policies that have been hitherto approved. The investment report made to the Trustees shows that the trust established on October 14, 1952 had an adjusted beginning balance of $22,770.00. At the December meeting the market value was $32,549.62, or a capital gain of $9,779.62. In addition to the capital gain we have collected interest each year.

There has been a gain in income for the Journal for the year of 1957. There has also been an increase in expense of publishing. A survey from the headquarters office shows definitely our members like our own Journal.

The Board of Trustees decided that since there was virtually no change in the ratio of income to expense that the same budget be approved for 1959 as was approved for 1958, and is as follows:

**BUDGET, 1959**

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The Board of Trustees asks the Board of Councilors to recommend to the House of Delegates the above budget for 1959.

Respectfully submitted,
A. A. ASHY, M.D.,
Chairman.

REPORT OF THE PUBLIC RELATIONS COMMITTEE

Houghton F. Elias, M.D., Chairman, Beatrice; J. P. Gilligan, M.D., Nebraska City; M. D. Feuer, M.D., Lincoln; George Hoffmeister, M.D., Hastings; Leroy Lee, M.D., Omaha; J. B. Christensen, M.D., Omaha; D. B. Wengert, M.D., Fremont; M. C. Smith, Secretary, Lincoln.

1. The Public Relations Committee met officially in February, and unofficially on several subsequent occasions, to arrange the polio vaccination program, and to further publicity of this program for the month of April. A remarkable response to the publicity was obtained, and a large per cent of people received shots. More could have been received had the local supplies of the vaccine been somewhat more adequate. However, in retrospect, this may be a reflection of credit upon the publicity given the vaccination program.

2. An enlarged Hall of Health program was developed through the year under the Public Relations Committee. The following organizations exhibited, with a most gratifying response as measured by the attendance:

- Nebraska State Department of Health
- Nebraska Pharmaceutical Association
- Nebraska Hospital Association
- Nebraska Blue Cross-Blue Shield
- Nebraska Psychiatric Institute
- Nebraska Tuberculosis Association
- Nebraska Society of X-Ray Technicians
- Nebraska Division, American Cancer Society
- Nebraska Society for Crippled Children
- Nebraska Heart Association
- Nebraska State Nurses Association
- National Foundation for Infantile Paralysis
- Lincoln Multiple Sclerosis Society

Over 50,000 people attended the exhibit with over 4,000 people being registered at the 203 showings of 45 of our health films.

To our knowledge, the Hall of Health is one of the few health exhibits, which is established on a permanent basis, under the auspices of a state medical association. The participation of the organizations mentioned above, not only adds to the educational value of the exhibit, but makes the quality of this exhibit available without tremendous expense to our medical society.

3. Meetings to evaluate the exhibits, to enlarge and improve the program for 1958, are underway.

4. Because of excellent publicity insofar as further polio immunization is concerned being made by other sources, it is felt that no duplication of that effort is warranted at this time.

5. No budgetary increase for the Public Relations Committee is anticipated.

Respectfully submitted,
HOUGHTON F. ELIAS, M.D.,
Chairman.

REPORT OF RURAL MEDICAL SERVICE COMMITTEE

C. F. Ashby, M.D., Chairman, Geneva; Clyde Kleager, M.D., Hastings; R. E. Kopp, M.D., Blair; Walter Reiner, M.D., Holdrege; Dan A. Nye, M.D., Kearney; Ralph Blair, M.D., Broken Bow.

The Rural Medical Service Committee sponsored the Sixth Annual Senior Medical Day, March 14, 1957 at the Hotel Paxton, Omaha, Nebraska. The following program was presented:

Presiding: J. M. Woodward, M.D., Lincoln, President, Nebraska State Medical Association

“You Will Soon Be a Doctor”
W. C. Kenner, M.D., Nebraska City
Chairman, Board of Councilors
Nebraska State Medical Association

“Why I Chose a Small Town to Practice Medicine”
Walter Reiner, M.D., Holdrege
Committee on Rural Medical Service

“The Mechanics of Establishing Your Office”
Mr. M. K. Mills, Waterloo, Iowa
General Manager, Professional Management

“The Role of the Physician in Blue Cross-Blue Shield”
Arthur J. Offerman, M.D., Omaha
President, Nebraska Medical Service (Blue Shield)

“The Role of the Professional Service Representative”
Mr. H. C. Hallum, Evansville, Indiana
Mead Johnson & Company

“The Art of the Practice of Medicine”
W. Max Gentry, M.D., Gering
Committee of Medical Education

“The Doctor’s Obligation to His Community”
Fay Smith, M.D., Imperial
Chairman, Board of Trustees
Nebraska State Medical Association

“Medical Ethics—The Doctor’s Golden Rule”
J. E. M. Thomson, M.D., Lincoln
Past President, Nebraska State Medical Association

Social Hour—Courtesy of Mead Johnson & Company

Following a six o’clock banquet, an informal discussion was held. The general practitioners present gave their ideas, advice, and experiences, with re-
sponsors by the class presidents of the University of Nebraska College of Medicine and Creighton University School of Medicine.

The program was modified this year in that two speakers from additional fields related to medicine replaced the usual movie. A representative from the insurance field and a professional service representative were included on the program. A short social hour was also included on the agenda and met with success.

The committee met with Mr. Aubrey Gates, Field Representative for the Rural Medical Service Committee of the American Medical Association, and Dr. Paul Bancroft. Dr. Bancroft presented a new plan to be used in connection with 4-H clubs health projects using growth charts. He is presenting his plan at the National Council of Rural Health in March and at the Nebraska State Medical Association meeting in May.

The committee met with Miss Helen Becker, Mrs. Dorothea Holstein, Miss Agnes Arthaud, Mr. E. W. Janke and Mr. Kenneth Schmidt, representative of the University of Nebraska Extension Service, and discussed our mutual problems. We plan to hold a similar meeting with the various farm organizations in the near future.

We plan to sponsor the Seventh Annual Senior Medical Day, March 18, 1958.

Respectfully submitted,
CHARLES F. ASHBY, M.D., Chairman.

REPORT OF SPEAKERS BUREAU COMMITTEE

C. F. Ferociot, M.D., Chairman, Lincoln; H. J. Lehnhoff, M.D., Omaha; J. J. O'Neill, M.D., Omaha; John Brown, M.D., Lincoln; J. E. Courtney, M.D., Omaha; R. O. Garlinghouse, M.D., Lincoln.

This Committee last met on December 7, 1956, at which time it was decided to discontinue the postgraduate training program but to continue a list of available speakers at the central office of the state medical society.

The Committee was continued on a tentative basis for an additional year. No problems have arisen during the past year that called for a meeting of this committee. There is no indication that the county medical societies are having any difficulty in arranging programs directly and I have noted with interest, the arrangement of refresher type courses by several of the local society groups.

At the present time, there appears to be little need for a Speakers Bureau and I would recommend that this committee be discontinued.

Respectfully submitted,
C. F. FERCIOT, M.D., Chairman.

REPORT OF COMMITTEE ON UNIFORM FEE SCHEDULE AND ADVISORY TO GOVERNMENTAL AGENCIES

Paul J. Maxwell, M.D., Chairman, Lincoln; A. J. Schwedhelm, M.D., Norfolk; B. R. Bancroft, M.D., Kearney; Ralph Moore, M.D., Omaha; L. S. Campbell, M.D., Omaha.

During the past year our committee has had one formal meeting which took place on December 12, 1957, in conjunction with a meeting of the Policy Committee. The meeting was called to discuss the forthcoming negotiation of the MEDICARE program. It is expected that such negotiation will take place in September, 1958. We have been advised that an entirely different approach in the designation of a MEDICARE fee schedule will be made; however, at the time of our meeting the Surgeon General's office had not forwarded to the Nebraska State Medical Association the material necessary for revising the schedule of fees. Your committee anticipates considerable work in the preparation of the new fee schedule and the subsequent negotiation of such fee schedule with the Surgeon General's office. It is our sincere hope that, after completing this program, we will be able to revise the fee schedule for governmental agencies in such a way as to utilize the relationship of one fee to another in the manner set forth in the MEDICARE schedule. It is further hoped that through cooperation of Blue Shield officials we will eventually be able to have a single schedule of relative values of fees for the Nebraska State Medical Association.

The above is offered primarily as a progress report.

Respectfully submitted,
PAUL J. MAXWELL, M.D., Chairman.

REPORT OF UNITED HEALTH FUND COMMITTEE

James F. Kelly, M.D., Chairman, Omaha; John Gatewood, M.D., Omaha; W. W. Carveth, M.D., Lincoln; Max Raines, M.D., North Platte; Eric G. DeFlon, M.D., Chadron.

This committee held one meeting this year and it was thought necessary to do so because of some misrepresentation which has arisen in connection with some drives and about which the medical association should be informed.

Recently some united fund drives in the state have given the public the impression that they are authorized to collect for heart, cancer, and polio. This is not so as all of these agencies at both the local and national level realize the essential difference in a Community Chest or United Fund Drive and a voluntary medical agency drive. In short, the Community Chest or United Fund Drive should be a "must give" drive conducted in a community to provide funds from "those who have" for use of that portion of the population requiring civic support on a charitable basis. The voluntary health agencies are not entitled to this superior consideration but they do have a worth-while message to objective and those who can afford to are urged to contribute. Their workers are voluntary and the money they get should come to them from those who wish to give voluntarily and not taken—so to speak—for support of those who are deserving of public support.

The voluntary health agencies are strictly free-enterprise activities and they should rise or fall, be given support or deprived of support, depending upon the good they do for the public at large. There should be no compulsion and the people of the state should be informed as to the essential differences in these two types of drives.

The other matter discussed was the grouping of all of the major voluntary health agencies into a single drive each year separate from the Community Chest or United Fund Drive so that there would be just two drives each year in a community—one for those deserving charitable consideration
and the other for the so-called voluntary health agencies. This committee feels that at the present time it would be impossible to unite the major voluntary health agencies as each feels that the importance of their educational and research programs is worthy of support and they are willing to continue to operate as individuals and will undoubtedly do so until the public feels that they are not deserving of support and they fail in their drive. Then it is conceivable that they would be willing to forego their individual drive and group with others in a common drive.

To join in a common drive would require permission to do so from the national headquarters of these various health agencies as at the present time any of the local branches of these health agencies would forfeit their charter in the state if they combined in a single fund raising campaign. The level of prosperity being what it has been during the past few years seems to have made it possible for all of these health agencies to secure adequate funds to carry on and it will take a national change in the economic picture to compel them to take part in one drive.

Another matter discussed was the annual occurrence of certain drives by organizations which have no representation in this state. These organizations collect considerable money and no accounting of these funds is ever made to the people of Nebraska. The people of Nebraska who contribute funds to these activities are entitled to know what is done with their money.

The committee thought that we should draw up a list of approved voluntary health agencies and all of those approved would have to meet certain criteria in order to qualify. Those failing to qualify would simply be omitted from the list. No attempt to question the right of anyone to take up a collection in Nebraska would be made but it could be known throughout the state that a list of drives approved by the Nebraska State Medical Association did or did not include certain organizations. To attempt to publicize the fact that the medical association condemned any particular organization would not be good, but to simply fail to include them in our list would be significant and that is all that we owe the public.

We should protect them from phony drives just as we protect them from phony drugs and other quack procedures.

Permission of the House of Delegates is requested to compile this approved list.

Respectfully submitted,
JAMES F. KELLY, M.D.,
Chairman.

REPORT OF VETERANS COMMITTEE

John W. Gatewood, M.D., Chairman, Omaha; Harry Jackson, M.D., Omaha; Dr. James S. Swenson, M.D., Omaha; Horace Munger, M.D., Lincoln; L. E. Sauer, M.D., Tekamah.

The Veterans Committee met in Omaha on January 6th, 1958.

At the opening of the meeting Dr. Best said that the meeting had been called to discuss veterans medical care legislation and the potential problems it presents. He felt that the committee should be informed on this legislation and know what is pending.

Dr. Gatewood discussed briefly the A.M.A. stand on non-service connected medical care of veterans and asked if there were any suggestions as to how Nebraska could support this stand. In the discussion that followed it was felt that a complete program of re-education of the public would need to be initiated to change the people’s minds about free medical care for non-service connected disabilities. Several instances of abuses of this free medical care by persons financially able to pay was cited by several members. It was generally agreed that more teeth should be put into the VA admission form 10-P-10, paragraphs 28 and 29, which asks the patient if he is able to pay for private care and if he can afford transportation to the hospital and his return home.

There was discussion regarding the preparation of a resolution for the House of Delegates urging enforcement of 10-P-10. However, it was thought at this time that further study should be made before a resolution should be adopted. Home town medical care of veterans was discussed by Dr. Best. It was noted that Nebraska does not have a contract or fee schedule to take care of veterans in their home towns. Present plans provide for the handling of these cases by the Veterans Administration on an individual basis. Mr. Smith said that it seemed to be working quite well here in the state. He said that he had received no complaints from physicians on this individual basis plan.

Dr. Sauer was asked to contact the VA and get information regarding the number of cases taken care of in Nebraska at the present time. If this was sufficient, further thought should be given to an intermediary contract. The committee feels that the veteran’s problem is one which warrants careful scrutiny since it affects not only medical care but medical education to such a degree that if not carefully controlled could lead to socialized medicine through the back door.

Respectfully submitted,
JOHN W. GATEWOOD, M.D.,
Chairman.

REPORT OF CANCER COMMITTEE

B. R. Bancroft, M.D., Chairman, Kearney; Howard B. Hunt, M.D., Omaha; J. Marshall Neely, M.D., Lincoln.

The 1957 program of your Cancer Committee was essentially unchanged. Most of its efforts have been expanded toward professional education. Cooperation with the volunteer workers of the American Cancer Society, Nebraska Division, in lay education is encouraged.

Nebraska Cancer Research and Educational Society, of which every member of the Nebraska State Medical Association is a member, will cease to exist upon the expenditure of such funds as are now in its possession. Your Cancer Committee recommends the formation of a cancer coordinating commission which will take over the duties of this society. Participation in this coordinating commission by the members of the Nebraska State Medical Association will be recommended to the House of Delegates by this committee.

The proposed cancer coordinating committee would consist of 4 members from the Nebraska State Medical Association, 4 volunteer lay members of the Nebraska Division of the American Cancer Society, 1 member from the Nebraska State Dental Association, and 1 member from the State Department of Health.

April, 1958
The function of this committee would be entirely a coordination of cancer control activities within the state. It would be financed by the American Cancer Society, Nebraska Division, which has already approved its participation in this committee.

PROFESSIONAL CANCER EDUCATION

1. Annual traveling cancer detection program developing the theme that every doctor's office should be a cancer detection center.

In 1957 these courses were given in Columbus, York, and Hastings on April 10, 11, and 12, by a guest faculty from the Cancer Detection Center of the University of Minnesota. Faculty consisted of:

W. Albert Sullivan, M.D.,
Assistant Professor of Surgery and Director of the Cancer Detection Center, University of Minnesota

Stewart Arhelger, M.D.,
Assistant Professor of Surgery and Head of the Tumor Service of the Surgical Division of the Cancer Detection Center, University of Minnesota

Alex R. Margulis, M.D.,
Assistant Professor of Radiology, University of Minnesota

In addition to the postgraduate cancer education program the public was invited to an evening meeting.

The 1958 program will be given in Omaha, Nebraska City, and Lincoln, on April 8, 9, 10, 1958.

2. Tumor Clinics—Local medical groups are encouraged to form their own tumor clinics. The Nebraska Cancer Research and Educational Society will assist in this as long as it exists.

3. Postgraduate cancer courses are encouraged at the University of Nebraska College of Medicine, and at Creighton University School of Medicine.

4. Adequate time has been devoted to cancer subjects at the Annual Session of the Nebraska State Medical Association.

5. Cancer speaker, Dr. M. E. Lichtenstein, Chicago, was sponsored by the American Cancer Society, Nebraska Division, through the Nebraska Cancer Research and Educational Society for the annual meeting of the Nebraska Chapter of the American Academy of General Practice held in September in Omaha.

LAY CANCER EDUCATION

1. This committee encourages cooperation with the Nebraska Division of the American Cancer Society with the formation of more local units. County medical societies should cooperate with the local units in furnishing advisors and cancer speakers whenever possible. Actual lay education will be left to the volunteer members of the American Cancer Society, Nebraska Division.

2. Subject to the approval of the House of Delegates, the National Cancer Institute and the National Office of Vital Statistics are prepared to conduct a survey of the possible relationships between cancer of the lung and smoking and cancer of the lung and occupational or environmental factors. They now propose to query ten per cent of the lung cancer deaths in all of the states, starting next March. Questionnaires would be directed first to the physicians named on the death certificates for the ten per cent sample, and then if the physician indicated that it was proper to do so, a questionnaire would be directed to the next of kin or the person supplying the non-medical information on the death certificate. Your Cancer Committee feels that this state should give its approval to this survey.

Suggestions which will improve this program are always welcome.

As usual, the chairman is indebted to the committee members for their help. The committee appreciates the cooperation of the executive offices of the Nebraska Division of the American Cancer Society and the generous assistance of the executive office of the Nebraska State Medical Association.

Respectfully submitted,
B. R. BANCROFT, M.D.,
Chairman.

REPORT OF CARDIOVASCULAR COMMITTEE

Friedrich W. Niehaus, M.D., Chairman, Omaha; W. M. McGrath, M.D., North Platte; Lee Stover, M.D., Lincoln.

Since the organization of the Nebraska Heart Association in 1950, the chief activity of the Cardiovascular Committee of the Nebraska State Medical Association has been to support the activities of this association. Members of our committee are active in the matter.

The field of professional and also lay education has been actively maintained. This committee feels that its chief function now is to sponsor and support the activities which are carried on by this organization.

It has always been the policy of the Journal of the Nebraska State Medical Association to make the February issue chiefly relating to heart diseases. I believe that this is maintained.

It might also be well at this date for the Nebraska State Medical Association to take cognizance of the fact that this committee was first appointed in 1954 by Dr. Homer Davis of Genoa, Nebraska, at the time he was president, and also that the present chairman of this committee also served as chairman of the committee at that time. In retrospect the Cardiovascular Committee of the Nebraska State Medical Association can look back with much pride that much ground work in the cardiovascular disease has been laid and much interest stimulated by this committee. When the Nebraska Heart Association was finally organized, it grew from a plant which had already well sprouted.

The founders of the Nebraska Heart Association were chiefly taken from the ranks of those who had served on this committee or given it much support.

Respectfully submitted,
FRIEDRICH W. NIEHAUS, M.D., Chairman.

REPORT OF INDUSTRIAL HEALTH COMMITTEE

G. P. McArdle, M.D.; Chairman, Omaha; Robert Hillyer, M.D., Lincoln; E. K. Connor, M.D., Omaha.

The Committee has not had any meetings to date in the year 1957-58 and, therefore, have no report to offer.

As a matter of recommendation, I have noted for some time, under the organizational setup of the
Nebraska State Medical Association, that the Committee on Industrial Health comes under Research. It would seem to me the status of Industrial Health should be raised, and of as much interest to the medical society as is that of our rural people. In this day and age, each and every state is fighting for more and more industry and if the society, as a whole, were to take more interest in Industrial Health, even to the point of recognizing it occasionally on the program of our state society, it would be an adjunct and an incentive for the Chambers of Commerce and other associations to point with pride to the Nebraska State Medical Association and their interest in the health of the industries which are being wooed to establish factories and plants within our state.

Respectfully submitted,
G. P. McArdle, M.D.,
Chairman.

REPORT OF JOINT COMMISSION FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

E. A. Steenburg, M.D., Chairman, Aurora; William Nutzman, M.D., Kearney; William E. Graham, M.D., Omaha.

The Joint Commission for the Improvement of Patient Care is comprised of representatives of the Nebraska Hospital Association, the State League for Nursing, the State Nurses Association and the Nebraska State Medical Association. The purpose of the Commission is to implement or sponsor activities or methods which will contribute to improved care of patients.

Four meetings are held yearly. Thus far this group has studied problems and programs of represented groups such as increasing efficiency of hospital in-patient care, and of standards and capabilities of nursing and rest homes. There has been implementation of the Practical Nursing Education Program. We have attempted to familiarize members of the medical association with the vocational rehabilitation facilities available in the state. The Commission is beginning sponsorship of a paramedical vocational recruitment program.

Respectfully submitted,
E. A. STEENBURG, M.D.,
Chairman.

REPORT OF MATERNAL AND CHILD HEALTH COMMITTEE

Donald C. Vroman, M.D., Chairman, Omaha; Harold Harvey, M.D., Lincoln; W. L. Rumbergs, M.D., Omaha

No new business has been officially brought before this committee during the current year. Several communications, principally regarding school health programs, were received by the Chairman of this committee. Since these matters were already under study by other committees of this Association, no action was taken by this committee.

The committee wishes to state that it deplores the action of the Reference Committee on the report of last year’s Maternal and Child Health Committee. The action taken by the Reference Committee shows an obvious lack of knowledge of maternal mortality studies, a lack of interest in maternal mortality studies, and a lack of responsibility regarding maternal mortality studies. It is a function of this committee to review reports of maternal mortality, to weigh all the information made available to us, and arrive at a decision as to whether the death was or was not preventable. We do so in the same manner that a jury weighs evidence presented to it. Obviously, since we are human, we can make errors but we still can arrive at a decision. It would seem that fear and ignorance are two of the greatest enemies of the progress of medicine. It is apparent that there is a fear of maternal mortality studies in this state. It is very obvious that there is complete ignorance of the manner in which maternal mortality studies are conducted. This committee has repeatedly recommended the establishment of a Maternal Mortality Committee under the Nebraska State Medical Association. These recommendations have never been accepted. The committee, therefore, wishes to make the following recommendations:

It is recommended that a special committee be established to study the feasibility of organizing and maintaining a maternal mortality study committee of the Nebraska State Medical Association. It is further recommended that this committee be composed of at least one councilor from each district of the state, by representatives of our two medical schools, and by representatives of the legal fraternity.

Respectfully submitted,
DONALD C. VROMAN, M.D.,
Chairman.

REPORT OF COMMITTEE ON PSYCHIATRY

Robert J. Stein, M.D., Chairman, Lincoln; Charles G. Ingram, M.D., Norfolk; J. Whitney Kelley, M.D., Omaha.

During the past year the Committee on Psychiatry has met on three different occasions following regular meetings of the Nebraska Society of Psychiatry and Neurology. There continues to be a close liaison between psychiatrists in private practice and those in the State Hospital system. This year we are endeavoring to improve the relationship between psychiatrists and other physicians, especially in regard to communication. Your Committee was asked to help in the preparation of the brochure entitled, “The Mental Health Problem in Nebraska,” which was published by the Nebraska Psychiatric Institute and Nebraska Department of Health and distributed to all of the doctors of Nebraska.

The Chairman of this Committee attended the Fourth Annual Conference of Mental Health Representatives of State Medical Associations, sponsored by the Council on Mental Health, American Medical Association, November 22-23, 1957 in Chicago, Illinois. The reports of four different discussion groups were obtained and sent to other members of our Committee, as well as the President and President-elect of the Nebraska State Medical Association. These reports were entitled as follows: “The Role of the General Practitioner in Relation to the Specific Psychiatric Case;” “Blue Cross-Blue Shield and Other Voluntary Health Insurance Plans for the Psychiatric Patient;” “Relationship of the Psychiatrist in Private Practice to the General Hospital in His Community;” “Psychiatric and Related Mental Health Problems in Industry.”

Your Committee requests permission for publication of these reports in the Nebraska State Medical Journal.

ROBERT J. STEIN, M.D.,
Chairman.
REPORT OF PUBLIC HEALTH COMMITTEE

H. C. Stewart, M.D., Chairman, Pawnee City; E. A. Rogers, M.D., Lincoln; O. R. Hayes, M.D., Kearney.

The Public Health Committee met August 31, 1957 to consider the question of a possible Asian flu epidemic. Dr. Rogers presented a great deal of material on vaccine, characteristics of the disease, and methods of diagnosis. It was decided to put out a “pink sheet” containing such information, suggested priorities, and the use of local civil defense organizations in each community should an epidemic of severe proportions arise. The actual work of writing the “pink sheet” and assembling the material was performed by Dr. E. A. Rogers and Mr. M. C. Smith.

The committee also discussed the Health Form for teachers certification purposes. It was found very inadequate and several changes were recommended. It was felt that the entire form should be revised in the future.

Respectfully submitted,

H. C. STEWART, M.D.,
Chairman.

REPORT OF TUBERCULOSIS COMMITTEE

J. Harry Murphy, M.D., Chairman, Omaha; Arthur Anderson, M.D., Lexington; Stanley Potter, M.D., Omaha.

The report of the Tuberculosis Committee of the Nebraska State Medical Association this year is one that will be directed toward the modernization, as it were, of our campaign in the control of tuberculosis.

In the past years there have been various topics concerning diagnosis, surgical approach, the management of particular classes of patients, rehabilitation of tuberculous patients discharged from our State Hospital and such subjects.

This year I think our attention should be directed toward the diagnosis of tuberculosis and this is one that is very closely allied with the matter of case finding by tuberculin testing and the case finding X-ray examination, and with the matter of X-ray used in films and fluoroscopy in the follow-up study of tuberculous patients.

The change in the realization of the risk of X-ray radiation that has been developing in very recent times directs itself naturally to our problem. We have been advocating case finding by tuberculin surveys, X-ray surveys, and hospital admission X-rays.

Therefore, we should examine our program in the light of the risk to our budget of safe dosage of X-ray radiation as it is recommended for the first 30 years of life.

In the first place, these case finding methods are valuable and they should be continued. Tuberculin testing and X-ray of positive reactors should be utilized at least through high school age, and probably in college age students.

In the second place, we recommend that necessary curbs and safeguards to patients and personnel should be insisted on. This should emanate from our own professional group. We should not wait until it comes from lay groups and legislation.

These safeguards are known to roentgenologists but they are not widely exercised.

Attention is directed:

1. To a record for the patient of X-ray exposures.
2. To reduction wherever possible of repetitious exposure on account of poor films.
3. Repetition of fluoroscopic examinations beyond those absolutely necessary.
4. Calibration of apparatus in order to provide maximum efficiency of X-ray machines.
5. Precaution against scatter-rays by necessary filters and tubes.

It is further recommended that the follow-up study of cases revealed by the positive tuberculin reaction and by the X-ray examination should be prosecuted more thoroughly and persistently in order to achieve the most efficient result of tests and the X-ray radiation used.

2. The importance of follow-up study suggests our next recommendation to the society, namely the increased number of public health or private nurses who will have been instructed in this phase of health work. There are only four counties with organized health departments, namely, Lancaster, Hall, Scottsbluff, and Douglas counties. In the remaining eighty-nine counties there are eight counties, namely Adams, Clay, Dawson, Gage, Hamilton, Lincoln, Sarpy, and Webster, in which there have been such operations. They have been largely conducted by the Nebraska Tuberculosis Association, whereby county and affiliated organizations have assisted. There have been nurses trained and paid for by seal sale funds to assist.

3. In support of the importance of detection of cases in the young child, we would like to report a survey which has been under the direction of the National Public Health Service wherein there were 1,394 cases of children who were showing primary type infection of tuberculosis, who were treated with Isoniazid and that they were also conducting at the same time controlled cases of 1,356 patients who were given Placebo. It is very remarkable to read from this and quote the risk of developing extra-pulmonary tuberculosis complications is related to both the age of the child and the extent of disease, as shown in Tuberculosis: Tuberculosis, the rates show a distinct pattern, increasing with the degree of roentgenographic involvement and decreasing with age, ranging from 182 per 1,000 among children less than one year of age with parenchymal involvement to zero among children more than three with negative films. The rates for children less than one year are markedly higher than for older children; the risk for these infants was not small even when the roentgenograms were negative for tuberculosis involvement. Among children between one and six years, the risk was substantiated only when there were positive roentgenographic findings. Among the children more than six the rate is 63 per 1,000 in those with parenchymal tuberculous involvement. It includes two adolescents who developed pleurisy with effusion. This is reported in detail to indicate the importance of close follow-up of our tuberculin survey cases and the benefits that may be derived by actively treating those primary type cases.

4. Further evidence of the results that have been accomplished by the improvement in the technique of treatment in the cases of tuberculosis, I think it would be well to note the results of treatment in cases of tuberculous meningitis which were as fol-
“54 patients with tuberculous meningitis have been treated with varying combinations of antituberculous drugs and FPD over a five-year period, with a survival rate of 81.5%, sequelae encountered have been deafness and loss of vestibular functions, orthopedic deformities, atrophy of the optic nerve and intellectual impairment, all of which may be minimized and perhaps eliminated by proper therapeutic measures.” This indicates the very remarkable improvement in the results of modern treatments.

Summary: Conclusion of these statements, then, appears to suggest to us that your committee recommend to the Nebraska State Medical Association

1. That the committee urges upon the Nebraska State Medical Association the importance of evaluating the risk of X-ray radiation and use every possible means to lessen this risk among our patients and our own personnel, professional and technological. X-ray examinations should not be reduced to a limit that may jeopardize our patients.

2. The importance of this is immediately seen in our tuberculosis campaign because of the methods that are necessarily used in diagnosis and follow-up of tuberculous cases and the necessity of X-ray films and fluoroscopic examinations. The reduction of the number of films and fluoroscopies that are used may very well begin in our tuberculosis campaign propaganda.

3. That we recommend strongly to our local committees and to the State Department of Health that there be adequate health nurse service that would permit adequate follow-up service in the case of tuberculosis case findings by tuberculin survey and by X-ray film survey.

4. The improvements that have been brought about through the modern use of earlier means of diagnosis, the antibiotics and antituberculous drugs that have become available impress upon us the importance of further urging the Nebraska State Medical Association to emphasize the importance of early diagnosis and close follow-up of all cases whether in private practice or survey. The importance of the availability of accurate treatment which must come to those patients who would need it, is paramount; and it can be instituted only if close follow-up of cases is prosecuted.

Respectfully submitted,

J. HARRY MURPHY, M.D.,
Chairman.

REPORT OF VENEREAL DISEASE COMMITTEE

Donald J. Wilson, M.D., Chairman, Omaha; William F. Novak, M.D., Omaha; J. H. Barthell, M.D., Lincoln.

Your committee has stood in readiness to be of any possible assistance to Doctor E. A. Rogers, Director, Department of Health for Nebraska, to the Board of Health, and to the Nebraska State Medical Association.

At the last annual meeting of the House of Delegates, action was taken by them approving changes in the accepted practices in venereal disease control as suggested by the Department of Health and approved by your committee. These changes are published in the bulletin entitled “VENEREAL DISEASE CONTROL,” State of Nebraska 1957.

That meeting also approved the extension of “fee for treatment” coverage to areas of the state with active health departments, namely, Lincoln and Omaha. The department reports that a few requests for fee-for-treatment have been received from Lincoln physicians although none have been received from Omaha.

The lone remaining clinic operated by the Omaha-Douglas County Health Department was closed in November 1957. The two medical school clinics, however, are caring for about 30 to 35 cases of gonorrhea per month.

Information from the Director of the State Department of Health indicates that in 1957 approximately 650 Nebraska physicians were personally visited by State V.D. personnel in familiarizing the doctor with reporting forms, procedures, and services provided by the Department.

Efforts by the Department are continuing to the end that contact interviewing as carried out in Lincoln can be carried out in other areas where V.D. clinics have been closed.

In keeping with the national trend, in November 1957 the penicillin dosage of treatment for gonorrhea in females, as recommended by the State Department of Health was raised from 600,000 units to 1,800,000 units. This is wholly within the recommendations of your committee.

During the year 917 cases of gonorrhea were reported as compared with 719 in 1956. Nationally gonorrhea seems again on the increase. In the country as a whole, 243,000 new cases of gonorrhea were reported in 1953.

Syphilis is not yet dead. Rosenthal and Vanderv in the report of venereal disease control in New York City, April 1956, reported in 1954 that although the new cases of syphilis were only about half as numerous as in 1938 (before the penicillin days), there were still 20,000 newly reported cases that year. In 1953 there were 156,000 new cases of syphilis reported in the United States.

Probably the most important change in the detection of syphilis in immediately recent years is the decreasing reliability of the serological tests. Some authorities now believe that approximately 50% of the positive tests are false positives. Accurate proof, of course, is not possible at present.

Because of the changing situation and the resurgence of the venereal disease, the following recommendations are made:

1. That the Venerel Disease Committee be retained as an active committee of the Nebraska State Medical Association;

2. That the Committee continue close liaison with the Nebraska State Board of Health;

3. That the Committee offer its assistance in any possible way to the Board of Health as far as advice and counsel are concerned; and

4. That the Committee assist in the education of lay groups and physicians regarding these diseases which are again on the ascendency.

I recommend the acceptance of this report.

Respectfully submitted,

DONALD J. WILSON, M.D.,
Chairman.

April, 1958

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The report of the Prepayment Medical Care Committee was read by Dr. Teal. Dr. A. J. Offerman was given permission of the floor and read a resolution which was supplemental to the report.

Dr. Teal referred both the committee report and the resolution to Reference Committee No. 4.

The report of the Committee on Allied Professions was read by Dr. Teal and referred to Reference Committee No. 5.

Dr. J. R. Schenken was given permission of the floor and summarized the Arnold Hospital situation, which comprised part of his committee report. Dr. Teal referred the report of the Hospital and Professional Relations Committee to Reference Committee No. 5.

Dr. R. Russell Best asked for permission of the floor and stated that the Policy Committee had reached the decision to send a copy of the MEDICARE fee schedule to the doctors in the state and thus we will be able to do a better job in handling the program and resolving the problems which arise.

Dr. Offerman discussed some of the problems that confronted Blue Shield in acting as fiscal agent for the MEDICARE program.

The report of the Medicolegal Advice Committee was read by Dr. Teal and then referred the report to Reference Committee No. 1.

The summary in the report of the Tuberculosis Committee was read by the chair and the committee report was referred to Reference Committee No. 6.

Dr. Teal read the report of the Joint Commission for Improvement of the Care of the Patient, and referred the report to Reference Committee No. 7.

Dr. James Kelly, Sr., asked for permission of the floor and read the following:

Resolution permitting the United Health Fund Committee to

1. Set up minimum essential criteria for approval of fund raising health agencies;
2. Report to the May meeting of the House of Delegates a list of agencies which meet these minimum requirements, and when the list is finally approved, that it be published.

The chair referred the resolution to Reference Committee No. 4.

Dr. J. R. Schenken read the following:

RESOLUTION

WHEREAS, Our American system of free competitive enterprise has produced the highest standards of health, high quality medical care and educational facilities, and

WHEREAS, National compulsory health insurance would constitute a distinct and radical departure from that system; therefore be it

RESOLVED, That the Nebraska State Medical Association does hereby go on record against any Forand type of legislation (H.R. 9467) that would amend Title II of the Social Security Act by introducing a hospital and medical benefit thereby establishing a national system of compulsory health insurance; and be in further

RESOLVED, That this resolution be pre-
resented to the House of Delegates of the American Medical Association; and be it further

RESOLVED, That a copy of this resolution be forwarded to our senators and congressmen in Washington.

This resolution was referred by the chair to Reference Committee No. 7.

Dr. Teal read the following resolution:

WHEREAS, The World Medical Association is the only international medical organization representing the practicing profession in the fields of medical economics and medical education and devoted to protection of the freedom of the practice of medicine, and

WHEREAS, the House of Delegates of the American Medical Association has reiterated its support of the World Medical Association and recommended that every member of the American Medical Association join the U.S. Committee of the World Medical Association,

BE IT RESOLVED, That the members of the Nebraska State Medical Association be urged to join and support the World Medical Association.

This resolution was referred by the chair to Reference Committee No. 7.

Dr. B. R. Bancroft asked for permission of the floor and read the following addition to paragraph 2 of the Report of the Cancer Committee:

The proposed Cancer Coordinating Committee would consist of 4 members from the Nebraska State Medical Association, 4 volunteer lay members of the Nebraska Division of the American Cancer Society, 1 member from the Nebraska State Dental Association, and 1 member from the State Department of Health. The function of this committee would be entirely a coordination of cancer control activities within the state. It would be financed by the American Cancer Society, Nebraska Division, which has already approved its participation in this committee.

This addition to the report of the Cancer Committee was referred by the chair to Reference Committee No. 7.

Dr. T. L. Weekes asked for permission of the floor and read the following:

RESOLUTION

WHEREAS, The Nebraska-Iowa Regional Blood Center in Omaha, sponsored by the American Red Cross, has performed meritorious service in furnishing a constant source of whole blood and its derivatives when needed by many physicians and hospitals in Nebraska in the treatment of the sick and injured, and

WHEREAS, Without the services provided by the Regional Blood Center, considerable difficulty would be encountered by physicians and hospitals in obtaining needed supplies of blood and blood derivatives, and

WHEREAS, The American Red Cross Blood Program is so organized and constituted to function for immediate action in blood procurement in the event of a national emergency,

NOW, THEREFORE, BE IT RESOLVED, That the House of Delegates of the Nebraska State Medical Association wholeheartedly endorse and commend the services provided by the Regional Blood Center; that the House of Delegates go on record expressing sincere thanks to the American Red Cross for providing such services.

BE IT FURTHER RESOLVED, That copies of this resolution be forwarded to regional and national officials of the American Red Cross.

This resolution was referred to Reference Committee No. 7 by the chair.

Mr. M. C. Smith was granted permission of the floor and read the following resolution which had been sent to the Nebraska State Medical Association by Dr. George F. Lull of the American Medical Association:

WHEREAS, The medical profession has and must continue to fulfill its pledged responsibility to maintain and improve the health of the general public; and

WHEREAS, The medical profession has made outstanding advances in the art and science of medicine to the extent that the public in these United States enjoys the highest standards of health ever attained; and

WHEREAS, There is yet a medical problem of major proportion facing the profession which has been neglected; and

WHEREAS, This medical problem, the killing and maiming of people on our highways, affects more persons than does all illness known today, therefore be it

RESOLVED, That the Traffic Safety Committee of the American Medical Association contact the various state societies suggesting the establishment of traffic safety committees on a state and local level and that it offer whatever help the various state and local societies need in establishment of these committees.

The above resolution was referred by the chair to Reference Committee No. 7.

Dr. Teal read the names of the men assigned to each reference committee again, and then read the following room assignments for the reference committees:

Reference Committee No. 1—Lincoln Room
Reference Committee No. 2—Lincoln Room
Reference Committee No. 3—no room necessary
Reference Committee No. 4—Room No. 600
Reference Committee No. 5—Room No. 800
Reference Committee No. 6—Lincoln Room
Reference Committee No. 7—Room No. 200

A motion was made and seconded that the Association pay for refreshments and meals for the group. The motion carried.

A recess was called by the chair in order that the reference committees could go over the material assigned them.

Dr. Teal stated the House would reconvene after dinner at approximately 1:30 p.m.

Dr. Teal called the House of Delegates to order at 1:45 p.m. and granted permission of the floor to Dr. Harold S. Morgan.

Dr. Morgan gave a short resume of the purposes and functions of the Nebraska Medical Foundation, Inc., calling particular attention to the need for funds to carry on the worth-while student loan program.

A motion was made that the executive secretary
suggest or write a letter to the Woman's Auxiliary that they make every effort they can to augment the fund in the Foundation by memorials given in lieu of flowers, etc. The motion was seconded and carried.

The chair called for the report of Reference Committee No. 6—Public Health, and Dr. W. E. Nutzman, chairman, presented the following report:

Reference Committee No. 6 recommends the acceptance of the report of the Tuberculosis Committee as read on the floor this morning. I so move.

The motion was seconded and carried.

We recommend the acceptance of the report of the Committee on Psychiatry as printed in the brochure. I so move.

The motion was seconded and carried.

We recommend the acceptance of the Report of the Committee on Diabetes as published in the brochure.

The motion was seconded and carried.

We recommend the acceptance of the Report of the Joint Commission for the Improvement of the Care of the Patient as read this morning. I so move.

The motion was seconded and carried.

We recommend the acceptance of the report of the Committee on Public Health, as published in the brochure. I so move.

The motion was seconded and carried.

We recommend the acceptance of the report of the Continuing Committee on Medical Practice as published in the brochure. I so move.

The motion was seconded and carried.

I move that the report of Reference Committee No. 6 be accepted.

The motion was seconded and carried.

The report for Reference Committee No. 1—Officers, was called for and Dr. O. A. Kostal, Chairman, gave the following report:

The report of the Secretary-Treasurer and the Audit was reviewed. I move the report be accepted and published.

The motion was seconded and carried.

The report of the Executive Secretary, Mr. M. C. Smith, was reviewed. It is an excellent, concise and comprehensive report and I move that it be accepted and published.

The motion was seconded and carried.

The report of the Delegate to the North Central Medical Conference was reviewed. It reflects the continued diligent efforts of Dr. A. J. Offerman. Dr. Offerman should be congratulated on his elevation to President-elect of the North Central Medical Conference. I move the report be accepted and published.

The motion was seconded and carried.

The report of the Editor was reviewed. This committee feels that Dr. Covey and his staff should be complimented on the high quality of the Journal—both as to contents and appearance. I move the report be accepted and published.

The motion was seconded and carried.

The report of the Medicolegal Advice Committee as read this morning was discussed. This committee requests that the executive office of the Nebraska State Medical Association investigate the coverage offered by the different carriers writing malpractice insurance in this state relative to the items referred to in point No. 2, item A and B, and a report of their findings be rendered to the membership of the N.S.M.A. through the medium of a news bulletin.

It was further suggested that the Insurance Committee of the N.S.M.A. continue its investigation of the feasibility of obtaining group malpractice insurance for members of the Nebraska State Medical Association.

I move that the report be accepted and published.

The motion was seconded and carried.

No report of the Council on Professional Ethics was available. The action of the Board of Councilors on Dr. K. S. J. Hohlen's oral report was noted.

A motion was made and seconded that the report as a whole of Reference Committee No. 1 be accepted. The motion carried.

The report of Reference Committee No. 2—Council, was given by Dr. L. S. McNeill, Chairman:

Annual Audit, pages 4-14 in brochure—Since this has been approved by the Board of Councilors and the audit was made by a reputable public accounting firm, we recommend the approval of the Annual Audit and so move.

The motion was seconded and carried.

Board of Trustees, pages 15 and 16—We recommend the approval of the report of the Board of Trustees together with their recommendation for the 1959 Budget, and so move.

The motion was seconded and carried.

Report of Delegate to A.M.A., pages 22-25—We recommend accepting this excellent report, and so move.

The motion was seconded and carried.

Life Memberships—Recommended for Life memberships by Omaha-Douglas County Medical Society were Drs. Robert Farrell, Harry Jenkins, Wm. Melcher, and Eugene Simmons. Letters have been read to the effect that all have retired due to ill health. They have been approved by the Board of Councilors. We recommend granting of Life memberships to the above men, and so move.

The motion was seconded and carried.

50-Year Pins—Letters recommending this award for three physicians were read from the following:

Madison Six County—C. J. Verges, M.D., Norfolk
Geo. E. Charlton, M.D., Norfolk
Omaha-Douglas County—Alfred E. Brown, M.D., Omaha

We recommend that these three men be awarded 50-Year Pins, and so move.

The motion was seconded and carried.

Your reference committee was asked to consider the minutes of the Board of Councilors
last week and we went over them rather carefully and there is one article which should be brought to the attention of the House. It is the following motion:

“A motion was made that it be recommended to the Board of Trustees to allow such funds that might be necessary to send appropriate delegates or members of the Association to such national meetings as would be in the interests of the Nebraska State Medical Association to have them attend. The motion was seconded and carried.”

This motion will be discussed by Reference Committee No. 4, so no action is needed at this time.

Your reference committee has read the minutes of the Interim Session of the Council, February 9, 1958. We find nothing objectionable in these minutes and recommend to the House of Delegates that these minutes be accepted as a whole at this time, and so move.

The motion was seconded and carried.

Mr. Speaker, I move that the report as a whole of Reference Committee No. 2 be accepted.

The motion was seconded and carried.

The chair stated that Reference Committee No. 3—Constitution and By-Laws, did not have a report to make at this time.

The report of Reference Committee No. 4—Voluntary Prepayment, was given by Dr. R. C. Reeder, Chairman:

Mr. Speaker, we recommend the acceptance of the report of the Committee on Uniform Fee Schedule and Advisory to Governmental Agencies as printed in the brochure, and I so move.

The motion was seconded and carried.

We move the acceptance of the report of the Prepayment Medical Care Committee as read this morning.

The motion was seconded and carried.

We move the acceptance of the resolution relative to Nebraska Blue Shield as read by Dr. A. J. Offerman this morning.

The motion was seconded and carried.

We move the acceptance of the report of the Committee on Rural Medical Service as published in the brochure.

The motion was seconded and carried.

We move the acceptance of the report of the Medical Education Committee as published in the brochure.

The motion was seconded and carried.

Your committee moves the acceptance of the report of the United Health Fund as published in the brochure.

The motion was seconded and carried.

We move the acceptance of the resolution which was read by Dr. Kelly this morning as a supplement to this report.

The motion was seconded and carried.

We have considered the report of the Policy Committee and the suggestions by Dr. Best which were a part of the report and wish to make the following recommendations:

Part I. We recommend that the transportation expenses of both alternate delegates be paid by the state medical society for the alternate to either the A.M.A. annual meeting or the interim meeting. It is further suggested by Reference Committee No. 4 that if possible one alternate attend the regular and the other the interim meeting, and I so move.

The motion was seconded and carried.

Part II. We recommend that the motion passed by the Board of Councilors re committee chairmen as published in their report be approved, except that these funds be limited to transportation, and I so move.

The motion was seconded and carried.

Mr. Speaker, I recommend the adoption of the report as a whole of Reference Committee No. 4, and I so move.

The motion was seconded and carried.

Dr. Richard Egan, Chairman, presented the following report for Reference Committee No. 5—Planning:

We recommend the adoption of the report of the Planning Committee and further recommend the intensive study by this committee of the problem of indigent medical care. I so move.

The motion was seconded and carried.

We recommend the adoption of the report of the Public Relations Committee as printed in the brochure. I so move.

The motion was seconded and carried.

With reference to the report of the Maternal and Child Health Committee, we recommend that a special committee of not more than 5 members be appointed, to include an obstetrician, a pathologist, and a general practitioner, to investigate and report to the House of Delegates at the May 1958 meeting of the House of Delegates regarding the feasibility of organizing and maintaining a maternal mortality study committee of the Nebraska State Medical Association.

In the second paragraph of this report we fail to see need for criticism of the report of the reference committee which considered this subject last year.

With these modifications, we recommend the adoption of this report. I so move.

The motion was seconded, and general discussion followed.

An amendment to the original motion was made that the special committee consist of 5 general practitioners only.

The motion was seconded, and after general discussion, the motion to amend the original motion carried.

A motion was made to further amend the original motion so that this committee would send to every member of the Association, at least a couple of weeks previous to the May meeting, their findings and recommendations so that we can all study it and have something definite to work on. The motion was seconded, but was lost.

A motion was made and seconded to table the original motion. The motion lost.

The question was called for and the original motion as first amended carried.
Dr. Teal appointed the following men as members of this special committee:

I. S. McNeill, M.D.
R. C. Reeder, M.D.
W. L. Hovell, M.D.
A. B. Anderson, M.D.
H. A. McComahay, M.D.

The report of Reference Committee No. 5 was continued by Dr. Egan.

We recommend the acceptance of the report of the Committee on Hospital and Professional Relations and commend the members of this committee for their good work. I so move.

The motion was seconded and carried.

With reference to the report of the Committee on Speakers Bureau, we recommend that this report be approved but also recommend that appropriate study be undertaken by the society in order to re-evaluate the functions and need for a Speakers Bureau. I so move.

The motion was seconded and carried.

We recommend the adoption of the report of the Committee on Aging. I so move.

The motion was seconded and carried.

We recommend the adoption of the report of the Committee on Allied Professions, and I so move.

The motion was seconded and carried.

I move the adoption of this report of Reference Committee No. 5 as respectfully submitted.

The motion was seconded and carried.

Dr. K. S. J. Hohlen, Chairman of the Council on Professional Ethics, was given permission of the floor and gave an oral report for this council.

A motion was made and seconded that the report of the Council on Professional Ethics be accepted. The motion carried.

Dr. John R. Thompson, Chairman, Reference Committee No. 7—Miscellaneous, presented the report for the committee:

Dr. B. R. Bancroft in his Cancer Committee report, through some misunderstanding on his part, forgot to include an addition to this report. This addition was read to the House in the morning session. We move that the recommendations of the Cancer Committee as printed on pages 30 and 31, and the addition as read, be accepted.

The motion was seconded and carried.

We recommend the adoption of the Cardiovascular Committee report as printed on page 32 of the brochure. I so move.

The motion was seconded and carried.

We recommend the adoption of the report of the Committee on Muscular Rehabilitation, and the committee discontinued. I so move.

The motion was seconded.

General discussion followed relative to the recommendation of the committee that it be discontinued.

A motion was made to amend the original motion recommending that the committee be continued but that the word “muscular” be dropped from the name of the committee. The amendment was seconded and carried.

The question was called for and the original motion as amended was passed.

We recommend that the Committee on Industrial Health be discontinued, and I so move.

The motion was seconded and carried.

We recommend acceptance of the printed American Medical Education Foundation report along with Dr. Moody's report that was read this morning. I so move.

The motion was seconded and carried.

We recommend the adoption of the report of the Veterans Committee as published in the brochure, and I so move.

The motion was seconded and carried.

We move the acceptance of the report of the Civil Defense and Disaster Committee.

The motion was seconded and carried.

We move the acceptance of the resolution regarding compulsory health insurance and Forand type of legislation.

The motion was seconded and carried.

We move the acceptance of the resolution which deals with the members of the N.S.M.A. being urged to join and support the World Medical Association.

The motion was seconded and carried.

We move the disapproval of the resolution relative to the Red Cross blood program.

The motion was seconded and discussion ensued.

A motion was made that the resolution be tabled.

The motion was seconded and carried.

We move the acceptance of the resolution read by Mr. R. M. C. Smith relative to the Traffic Safety Committee.

The motion was seconded and carried.

Reference Committee No. 7 recommends that the findings of this committee as a whole and as amended be approved. I so move.

The motion was seconded and carried.

Mr. R. M. C. Smith was given permission of the floor and read a letter from Mr. Glenn L. Anderson, Director, Retirement Systems of the State of Nebraska, in which he asked the councilors to recommend doctors for the Retirement Board to contact to give physical examinations.

A motion was made that this matter be referred to the Councilors for their disposal or appointment of doctors to serve in this capacity. The motion was seconded and carried.

Mr. Smith outlined a group insurance plan which had been presented to him by the John Hancock Mutual Life Insurance Company.

A motion was made that this be referred to the Insurance Committee. The motion was seconded and carried.

Mr. Smith, in the absence of Dr. E. B. Reed, gave a brief summary of legislative matters which have come to the attention of the Medical Service Committee.

Dr. R. Russell Best was given permission of the floor and stated he would like to make two recommendations.

1. That the chairmen or representatives of committees who go to the various meetings be requested to submit a written report.

2. That in the future the House of Delegates,
interim session, be provided with the noon meal by the Association.

A motion was made and seconded that the chairman or representatives who attend the various meetings with transportation expense paid by the Association should make a written report to the Board of Councilors. The motion was seconded and carried.

Dr. Adams stated that recommendation No. 2 would be carried out in the future.

Dr. John Schenken asked for permission of the floor and called attention to the Kintner report which contained material relative to a group of medical doctors who developed their own retirement program as medical associates rather than a corporation.

A motion was made that the chairman of the House of Delegates appoint someone or the proper committee to report the details of this Kintner report for our guidance. The motion was seconded and carried.

Dr. Teal stated this would be referred to the Medicolegial Advice Committee.

Dr. Wycoff was granted permission of the floor and stated that this committee would welcome suggestions that anyone had in mind that would simplify our Constitution; he further stated the revision was taking a lot of work and would take a lot more.

Dr. Teal stated the meeting would stand adjourned.

ROLL CALL OF THE HOUSE OF DELEGATES
February 16, 1958

ADAMS—
O. A. Kontal, Hastings (D) ........................................... P
G. P. Charlton, Hastings (A) ...........................................

BOONE—
Roy J. Smith, Albion (D) .............................................. P

BOX BUTTE—
Wm. L. Howell, Hyannis (D) ......................................... P
R. J. Morgan, Alliance (A) ............................................

BUFFALO—
W. E. Nutzman, Kearney (D) ......................................... P
H. V. Smith, Kearney (A) .............................................

BURT—
L. Morrow, Tekamah (D) .............................................. P
L. E. Sauer, Tekamah (A) ............................................

BUTLER—
C. A. Case—
R. R. Andersen, Nebawks (D) ......................................

FIVE COUNTY (CEDAR, DIXON, DAKOTA,
THURSTON, WAYNE)—
D. O. Craig, Winslow (D) ............................................. P
Chas. Muffly, Pender (A) .............................................
F. P. Dorsey, Hartington (D) ......................................... P
H. J. Billerbeck, Randolph (A) ......................................
L. T. Guthman, South Sioux City (D) ............................... P
R. E. Bray, Ponca (A) ................................................

CHEYENNE, KIMBELL AND DEUEL—
H. A. Cook, Sidney (D) ................................................

CLAY—
H. V. Nuss, Sutton (D) ................................................ P
R. G. Gelvick, Sutton (A) ............................................

COLFAX—
Clay—
Thos. Kofoot, Jr., Broken Bow (D) ................................ P

DAWSON—
Ray S. Wycoff, Lexington (D) ....................................... P
Arthur Anderson, Lexington (A) ....................................

DOUGLASS—
R. C. Reeder, Fremont (D) ...........................................
D. B. Wendt, Fremont (A) ...........................................

FILLMORE—
A. A. Ashby, Geneva (D) ............................................. P
C. F. Ashby, Geneva (A) .............................................

FRANKLIN—
L. S. McNell, Campbell (D) ......................................... P
W. A. Doering, Franklin (A) ........................................

FOUR COUNTRY—
Otis W. Miller, Ord (D) .............................................. P

GAGE—
C. T. Frerichs, Beatrice (D) ........................................ P
C. R. Brits, Beatrice (A) ............................................

GARDEN-KEITH-PERKINS—
E. B. Mullinhau, Big Springs (D) ................................ P

HALL—
Warren Bosley, Grand Island (D) ................................. P
Robert Munch, Grand Island (A) ...................................

HAMPTON—

HARLAN—
J. G. Minder, Alma (D) .............................................. P
W. R. Walker, Alma (A) .............................................

HOLT AND NORTHWEST—
James Ramsey, Atkinson (D) ...................................... P
N. P. McKeec, Atkinson (A) ........................................

HOWARD—
J. Y. Racine, Palmer (D) ............................................. P
R. W. Hanesch, St. Paul (A) ........................................

JEFFERSON—
R. J. Kenney, Fairbury (D) ......................................... P
W. F. Toodich, Fairbury (A) ........................................

JOHNSON—
J. C. Schota, Tecumseh (D) ........................................ P
L. J. Chadek, Tecumseh (A) ........................................

LANCASTER—
J. T. McGran, Lincoln (D) ......................................... P
K. T. McGinnis, Lincoln (D) ........................................ P
J. G. Wiseman, Lincoln (A) ......................................... P
H. V. Munger, Lincoln (D) ...........................................
S. T. Thirstein, Lincoln (A) ........................................ P
M. D. Frazer, Lincoln (D) ............................................. P
O. A. Neely, Lincoln (A) .............................................

LINCOLN—
Max M. Raine, North Platte (D) .................................. P
C. C. Pinkerton, North Platte (A) ................................

MADISON SIX—
W. D. Hansen, Wisner (D) ......................................... P
R. C. Kelley, Beatrice (A) .......................................... P
W. I. Devers, Pierce (D) ............................................. P
M. A. Johnson, Plattsmouth (A) ................................ P
G. B. Salter, Norfolk (D) ............................................ P
E. W. Carlson, Newman Grove (A) ............................... P
H. S. Tangent, Stanton (D) .......................................... P
W. E. Wright, Creighton (D) ....................................... P
R. L. Tolfson, Waunakee (A) ......................................
F. C. McLanehan, Neligh (D) ...................................... P
D. J. Peetz, Neligh (A) ............................................... P

MERRICK—
R. R. Douglas, Clarks (D) .......................................... P
E. T. Zikmund, Central City (A) ...................................

NANCE—
K. R. Dalton, Genoa (D) ............................................. P
J. C. Malo, Fullerton (A) ............................................

NEMaha—
John R. Thompson, Auburn (D) ................................... P
F. M. Tushia, Auburn (A) ...........................................

NORTHWEST NEBRASKA—
Frank Waesch, Gordon (D) ......................................... P
W. K. Wolf, Gordon (A) .............................................

NUCKOLLS—
Donald R. Marples, Nelson (D) .................................... P

OMAHA-DOUGLAS—
A. J. Offerman, Omaha (D) ......................................... P
Arnold Lempek, Omaha (A) ......................................... P
Richard Egan, Omaha (D) ...........................................
Wm. E. Kelley, Omaha (A) .......................................... P
John Bruch, Omaha (D) .............................................. P
C. A. McWhorter, Omaha (A) ...................................... P
J. R. Schenken, Omaha (D) ......................................... P
R. D. Smith, Omaha (A) ............................................. P
D. J. Buchanan, Omaha (D) ......................................... P
Arthur Abis, Omaha (A) ............................................. P
M. E. Stoner, Omaha (D) ............................................ P
Richard Crotty, Omaha (A) ......................................... P
Richard Fangman, Omaha (D) ....................................
Edward Connors, Omaha (A) ........................................
Harry McFadden, Omaha (D) ...................................... P
Lawrence James, Omaha (A) ......................................
Geo. McMurtry, Omaha (D) ........................................ P
John D. Coo, Omaha (A) ............................................

OTOE—
T. L. Weeks, Nebraska City (D) .................................
P. W. C. Kenner, Nebraska City (A) ............................

PAWNEE—
A. B. Anderson, Pawnee City (D) ..............................
H. C. Stewart, Pawnee City (A) ................................

PLEHPS—
H. A. Connaug, Holdroge (D) .................................... P

PLATTE—
E. E. Koehe, Columbus (D) ....................................... P
E. G. Brillhart, Columbus (A) ....................................

POLK—

RICHARDSON—
Wm. Shook, Shubert (D) ...........................................
Harian Heim, Humboldt (A) ......................................

April, 1958
News From Nebraska Heart Association

Dr. Robert W. Wilkins, President of the American Heart Association, has called on the medical profession to "help preserve its own freedom in the future" by insisting now that the "ethical voluntary health agencies" be freed of further pressures and coercion to join United Funds.

Dr. Wilkins emphasizes that the medical profession "owes a substantial debt" to the voluntary health agencies and should help maintain them as free institutions.

Dr. Wilkins warned that "if United Funds are permitted to continue to undermine the efforts of the voluntary health agencies, research will dwindle and the conquest of disease inevitably will be delayed." "The result," he added, "will be the needless loss of hundreds of thousands of lives."

Nebraska physicians attended the Nebraska Heart Association's Midwinter Scientific Conference on Saturday, March 15th in Lincoln.

Two nationally known experts spoke on endocarditis. They were: Ernest Jawetz, Ph.D., M.D., San Francisco, Professor of Microbiology, Lecturer in Medicine and in Pediatrics, University of California Medical Center; and, Norman J. Sweet, M.D., San Francisco, Associate Professor of Medicine, University of California School of Medicine. Dr. A. L. Smith, Jr., Lincoln, presided over this portion of the day's program.

With Dr. C. M. Wilhelmj, Omaha, presiding, reports from recipients of Nebraska Heart Association Project Research Grants were given by Harry Lobel, Harold G. Beenken, E.E., Charles Hamilton, M.D., Leo P. Clements, M.D., and Jerome P. Murphy, M.D., of Omaha.

Dr. Stephen L. Magiera, Omaha, President of the Nebraska Heart Association welcomed those in attendance. In charge of the Program was Dr. William Angle of Omaha, Professional Educational Committee Chairman.

The Nebraska Heart Association is now the third largest medical organization in the state with 350 physician-members representing 74 Nebraska communities.

Dr. Harold Neu of Omaha, Membership Chairman, announced that approximately 1 out of every 4 practicing physicians in the State are now members.

A campaign to enlist nursing-members was conducted for the first time this year resulting in over 75 members.

Dr. Neu pointed out that professional education programs are conducted throughout the year to help keep members and other interested physicians abreast of the latest developments in medical care of heart patients.

Additional project research grants totaling $2487 have been awarded by the Nebraska Heart Association.

Three Omaha physicians—one of whom is continuing research aided by a previous grant—are the recipients, according to Dr. C. M. Wilhelmj, Chairman of the Heart Association's Project Research Committee.

They are:

Dr. John Ferguson of Creighton University, renewal grant of $487 to continue his study of drugs which may affect artery muscles that control blood pressure.

Dr. Harle V. Barrett of Creighton U., one thousand dollar grant to aid his study of many life factors—age, sex, occupation, diet, previous illnesses—to find clues in prevention and control of heart disease. He plans to study records of University Clinic, which has 30,000 patients visit each year.

Dr. Herbert P. Jacobi of University of Nebraska College of Medicine, one thousand dollar grant to aid his study of aortas—main blood vessels from the heart — which have become clogged with fatty substances (lipoproteins).
Other researchers, their projects and the amount of their grants:

Dr. J. Raymond Johnson and Edward Grinnell, Creighton University School of Medicine, the effect of female hormones on heart muscle, $1000 (new).

Dr. Robert L. Grissom, University of Nebraska College of Medicine, the effect of age in high blood pressure patients, $837 (new).

Dr. Gordon E. Gibbs, Nebraska, evaluation of acute rheumatic fever, $900 (new).

Dr. William Reedy, Creighton, the effect of radio-opaque dyes used in heart examinations on stomach organs, $1000 (new).

Dr. Lawrence James, Immanuel Hospital, blood volume of aged cardiac patients, $500.

Dr. Violet M. Wilder, Nebraska, and Dr. Carol Angle, Children's Memorial Hospital, relation of body swelling to heart trouble, $400.

Dr. C. A. Hamilton, Nebraska, effect of lowering body temperature in heart surgery, $443.

Dr. Leo P. Clements, Creighton, relation of high blood pressure to small blood vessels, $500.

Drs. William Angle, Miles E. Foster and Earl G. Greene, Clarkson Hospital, interpretation of electrocardiography, $500.

Dr. Theodore Hubbard, Clarkson, evaluation of dye dilution curves in inborn heart disease, $500.

Dr. Victor Levine, Creighton, determination of normal amount of cholesterol in blood, $375.

The Research, Education and Community Service Programs of the Heart Association are supported by the annual February Heart Fund Drive.

Nurses from a seven-county area attended a Cardiac Nursing Conference sponsored by the Nebraska Heart Association Thursday at Duchesne College, on March 13, 1958.

The conference featured a simulated staff conference on heart patient treatment with two of the conference's major speakers—Drs. John R. Walsh and Jerome Murphy of the Creighton University School of Medicine—participating.

Other participants were Mrs. Josephine John, St. Joseph's Hospital nursing staff; Miss Joan Sheehan, St. Joseph's Hospital dietitian; Miss Evelyn Schellak, Director of Social Service at University Hospital, and Miss Darlene Levin, Educational Supervisor of the Omaha Visiting Nurses' Association.

Miss Ida Smith, Medical Supervisor at Veterans Hospital, Omaha, was Conference Program Chairman.

The Conference was one of four sponsored by the Nebraska Heart Association in cooperation with the Nurses' Association in the past four months. It is part of the Heart Association's Professional Education Program, supported by the annual February Heart Fund Drive.

Three new booklets developed by the American Heart Association to assist in prescribing sodium-restricted diets for therapeutic reasons have been distributed to physician-members of the Nebraska Heart Association.

This service is part of the Public Education Program of the Nebraska Heart Association. Dr. Richard L. Egan of Omaha, Chairman of the Public Education Committee calls attention to other free booklets on such subjects as varicose veins, heart attacks, strokes, high blood pressure, rheumatic fever, and living with heart trouble.

Heart Association President Asks Physicians to Help Free Voluntary Health Agencies From United Fund Attacks on Independent Campaigns—

Dr. Robert W. Wilkins, President of the American Heart Association, has called on the medical profession to "help preserve its own freedom in the future" by insisting now that the "ethical voluntary health agencies" be freed of further pressures and coercion to join United Funds.

In a special message to physicians published in (the February issue of) "Modern Concepts of Cardiovascular Disease," a monthly professional bulletin issued by the Heart Association, Dr. Wilkins asserted, "Medicine cannot continue to ignore or condone the threats to itself through the increasing attacks by United Funds on the voluntary health agencies" to force them into giving up their independent campaigns. Dr. Wilkins warned that "if United Funds are permitted to continue to undermine the efforts of the voluntary health agencies,"

April, 1958
research will dwindle and the conquest of disease inevitably will be delayed. "The result," he added, "will be the needless loss of hundreds of thousands of lives."

Dr. Wilkins, who is Professor of Medicine at Boston University School of Medicine and one of the nation's leading research scientists, also emphasized the following points:

1. Heart Associations are not opposed to United Funds, but "regard federated plans of fund raising, especially for local charity causes, as fully worthy of support, provided they are truly voluntary and not forced on either the people or the participating agencies."

2. The "rough pressure methods" brought to bear by United Funds upon the voluntary health agencies in an "organized effort" to "regiment" them into a single plan of fund raising "have been almost incredible." These methods have included the solicitation of funds for "health causes" such as heart disease, cancer, and polio, leading the public to believe that the respective voluntary health agencies which already exist to combat these diseases will actually receive the funds, "despite advance public declaration by the voluntary agencies that they must decline such funds and will continue to conduct their independent campaigns." Referring to the establishment of "health foundations" to expend funds declined for policy reasons by the voluntary health agencies, Dr. Wilkins said, "Ironically, United Fund promoters do what they profess to abhor: they establish yet another agency!"

3. The medical profession "owes a substantial debt" to the voluntary health agencies and should help to maintain them as free institutions. These agencies are leading the way toward the control of the major Chronic diseases and have made impressive contributions to medicine in the past decade; they have made known to the public the work and achievements of private medicine; and they have acted as buffers to protect it from "governmental domination on one side and from local dictatorship on the other."

4. Competition is the American way, and health needs, like other needs must compete for public support. "Fund raising, except by taxation, is not easy. Indeed," Dr. Wilkins stated, "it should not be easy . . . The law of supply and demand cannot be repealed, and the Heart Association is willing to accept this fact. We believe that the people will continue to supply the funds, as long, but only as long, as a major health need exists. When the cardiovascular diseases are conquered, the Heart Association's work will be done."

Noting that the American Heart Association is entering its second decade as a voluntary health agency, Dr. Wilkins said, "Just as we begin to glimpse where and how the answers to strokes, coronary disease and hypertension may be found, we are turned aside from our main task by the necessity of defending ourselves against an organized effort designed to regiment us into a single plan of fund raising."

It has been "openly proclaimed that rough pressure methods 'with teeth in them' will be used against the agencies that do not participate in United Funds," Dr. Wilkins said. "Their tactics have included economic threats against, and boycotts of, many private individuals, as well as business organizations. Thus they tell the public not only how to give, but where to give, when to give, and often how much to give."

"In the face of such tactics, the national voluntary health agencies have been hard pressed to protect themselves," Dr. Wilkins said. "They have not wished to launch a counterattack, believing that two wrongs do not make a right, and beside they do not wish to fight United Funds. They have resorted heretofore merely to passive resistance, relying on the American people to recognize in time the value of the independent way and to find a solution other than regimentation."

The medical profession is directly involved in this controversy, Dr. Wilkins declared, "for United Funds are promoting a movement under which uninformed, though conceivably well intentioned, local laymen are entering directly into national medical fields of health and disease and deciding where and when funds should be spent for each purpose and how much. United Fund people may understand local charity needs," he added, "but they know nothing about the requirements of the nationally coordinated programs of medical research being conducted by the voluntary health agencies."

During its early years, he recalled, "the Heart Association participated in over 450 United Funds, and sadly learned not only that the amounts collected were inadequate,
but also that devotion and zeal were lost even among dedicated Heart Volunteers when they succumbed to the siren song of "once for all." Heart Associations have now withdrawn from all but 270 of these Funds.

"Based on their per capita giving in the remaining funds," Dr. Wilkins added, "the Heart Association in 1957 would have raised less than half the amount it did raise had it participated in a United Fund everywhere. It therefore becomes forcefully apparent that the Heart program would have suffered a serious setback in research, not to mention all other phases of its work, had the Heart Association been forced to abandon its independence under coercion by the United Funds.

"Every physician should give most thoughtful consideration to the problems created by the United Fund philosophy and tactics," Dr. Wilkins stated. "Freedom is indivisible. It is for all, or for none. The medical profession will help to preserve its freedom in the future if it insists now, through its county, state, and national organizations, that the ethical voluntary health agencies be freed of further coercion by United Funds."

Announcements

Two Forthcoming Postgraduate Courses—

Special attention is directed to two postgraduate courses to be given by the University of Nebraska College of Medicine during the week April 7 through the 11th:

1. Pediatric—April 7 and 8. Course Fee, $20. A.A.G.P. credit, Category 1, 12 hours.

2. Recent Advances in Clinical Medicine—April 9, 10, and 11. Course Fee, $30. A.A.G.P. credit, Category 1, 18 hours.

Both programs reveal faculties composed not only of the University's own teachers but a liberal sprinkling of well-known guest teachers.

Contact Lawrence A. Cappiello, H.S.D., Supervisor of Medical Extension, University of Nebraska College of Medicine, 42nd and Dewey Avenue, Omaha 5, Nebraska.

American Goitre Association to Meet—

The 1958 meeting of the American Goitre Association will be held at the St. Francis Hotel, San Francisco, Calif., June 17, 18, and 19. If you expect to attend, write the "Goitre Housing Bureau," Room 300, 61 Grove Street, San Francisco and get hotel reservations. Your request should be accompanied by $10.00 per room.

American College of Obstetricians and Gynecologists to Meet—

Sixth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Hotel Statler, Los Angeles, Calif., April 21-23, 1958. This meeting will offer the usual round of Breakfast Conferences, Round Table Discussions, Technical and Scientific Exhibits, banquets, and specially arranged entertainment for the ladies.

Gerontological Society to Meet—

The eleventh annual scientific meeting of the Gerontological Society, Inc., will be held at the Bellevue Stratford Hotel, Philadelphia, Nov. 6, 7, and 8, 1958.

Abstracts of papers for the program should be submitted to the Program Committee for consideration by July 1, 1958.

For further details write Dr. Joseph T. Freeman, 1530 Locust Street, Philadelphia 2, Pa.

Institute on Law-Medicine To Be Held—

Western Reserve University's Law-Medicine Center has scheduled the fourth in a series of institutes for April 25-26, 1958.

Under the title of "The Mind: A Law-Medicine Problem" the institute will be held in the court-room of the University's School of Law. The primary purpose is to indicate the effects of trauma to the human body.

Sessions will begin at 9:00 a.m. and end at 4:30 p.m., on Friday and 3:30 p.m. on Saturday. Tuition, $25.00.

For details, write Oliver C. Schroeder, Jr., director, Law-Medicine Center, Western Reserve University, Cleveland 6, Ohio.

A New Reward for Medical Writing—

The Editors of Modern Medical Monographs, a quarterly publication, announce an award for the best unpublished manuscript for a short book on a clinical subject in the field of internal medicine. The purpose of this award, which will be known as the Modern Medical Monograph Award, is to
stimulate young physicians to communicate their work in the classical form of the monograph and to achieve high standards of medical writing. The winner of this competition will receive five hundred dollars. In addition, the winning monograph, if found suitable, will be published as a book in the series Modern Medical Monographs. The generosity and cooperation of Dr. Henry M. Stratton, President of Grune and Stratton, Inc., publishers of the series, have made this award possible.

The entries will be judged for style and clarity of expression by a committee of the American Medical Writers' Association and for clinical interest and scientific value by the Editors and Advisory Board of Modern Medical Monographs.

RULES:
1. The author, or authors, must be a graduate physician, less than 40 years of age. Single authorship is preferred, but two co-authors will be acceptable. The name of the medical school from which the author graduated and his date of graduation should be stated.
2. Manuscripts should be submitted in duplicate (original and one copy) by registered mail postmarked no later than October 1, 1958, to Richard H. Orr, M.D., 37 East 67th St., New York 21, New York.
3. The manuscript, including the bibliography, must consist of between 115 and 200 double-spaced typewritten pages with ample margins and not more than 40 illustrations (figures or photographs). For each illustration used, the allowable upper limit of typewritten manuscript pages should be reduced by one.
4. Fishbein's book, "Medical Writing" (third addition), should be followed in preparation of the manuscript, use of abbreviations, and bibliographic form.

Exclusive Translation Rights to 20 Russian Scientific Journals—

The Consultants Bureau, Inc., has obtained the exclusive world-wide right to translate and publish complete English language editions of twenty Soviet scientific and technical journals. These journals are in the fields of physics, chemistry, electronics, metallurgy, biology, and medicine.

Anyone desiring further information about this translation program, write Consultants Bureau, 227 West 17th Street, New York 11, N.Y.

Human Interest Tales

Dr. J. G. Minder, Alma, has moved to Mound, Minnesota, where he will resume his practice.

Dr. E. T. Zikmund, Central City, is the new president of the Merrick County Medical Society.

Dr. N. P. McKee, Atkinson, has resigned from the Atkinson school board after 24 years of service.

Dr. V. Robert Watson, Seward, is the newly elected president of the Seward County Medical Society.

Dr. Stanley E. Potter, Omaha, has been re-elected president of the medical staff of Clarkson Hospital.

Dr. John Finkner, Minden, was a guest speaker at the February meeting of the Axtell Woman's Club.

Dr. and Mrs. E. H. Reeves, Grand Island, visited Minatare with the thought of opening a practice in that city.

Dr. Hugh Hussey, Washington, D.C., was a guest speaker at the Creighton University Student Center in March.

Dr. and Mrs. K. C. McGrew, Orleans, journeyed to California in February to visit their daughter who was ill.

Dr. Howard Morrison, Omaha, presented a paper on glaucoma at the Florida Mid-Year Seminar in February.

Dr. Robert C. Rosenlof who was recently released from the Air Force is now associated with Dr. Dan Nye of Kearney.

Dr. R. D. Miller of the Mayo Clinic spoke at a meeting of the Omaha St. Catherine's Hospital staff doctors in February.

Dr. and Mrs. N. H. Moss, Arcadia, were hosts to the February meeting of the Four County Medical Society at their home.

Dr. Harlan Heim, Humboldt, attended a refresher course at the University of Iowa Medical School at Iowa City in February.

Dr. Pierce T. Sloss, Grand Island, gave a talk on antibiotics at a regular meeting of the Grand Island Rotary Club in February.
Dr. A. I. Finlayson, Omaha, attended a meeting of the Neuro-Surgical Society of America in Key Biscayne, Florida, in February.

Dr. S. A. Kerkhoff, North Platte, was a guest speaker at a recent meeting of the Memorial Hospital Guild in that city in February.

Dr. L. S. Kau, Grand Island, has resigned his position at the Veterans Hospital and will take a new position in Ashland, Pennsylvania.

Dr. John Batty, McCook, was a guest speaker at a regular meeting of the McCook Business and Professional Women’s club in February.

Dr. W. P. Jensen, Omaha, traveled to New York City in February to attend the meeting of the American Academy of Orthopedic Surgeons.

Dr. James J. O’Neil, Omaha, presented a paper on “Tracheotomy” at a February meeting of the Shelby Medical Society of Harlan, Iowa.

Dr. E. H. Grinnel, Omaha, has been given a Lederle award carrying a value of $7620. He is in the second year of a three-year Lederle award.

Drs. M. M. Musselman and Robert Grissom, Omaha, were guest speakers at the February meeting of the Sixth Councilor Medical Society in York.

Dr. Donald Sallenbach, Gibbon, suffered an estimated $10,000 damage to his office and equipment which was caused by a recent explosion and fire.

Dr. Maurice Frazer, Lincoln, has been named as Chairman of the Commission on Legislation and Public Policy for the American College of Radiology.

Dr. and Mrs. Howard Hunt, Omaha, journeyed to Arizona in February where Dr. Hunt attended the meeting of the American Cancer Society at Tucson.

Dr. A. J. Merrick, Fremont, presented a discussion on the heart at a regular meeting of the Fremont Business and Professional Women’s club in February.

Dr. O. C. Kreyemborg, North Platte, was one of the guest speakers at the 30th Annual Fire Department Instructors’ Conference in Memphis, Tennessee in February.

Dr. Manuel A. Torres of San Juan, Puerto Rico, was a house guest in February of Dr. and Mrs. B. P. Carey of Omaha. Dr. Torres is sub-secretary of health in Puerto Rico.

Dr. and Mrs. J. E. M. Thomson, Lincoln, journeyed to New York City for the meeting of the American Academy of Orthopedic Surgery in February. Following the meeting they took a trip through the Caribbean.

Dr. Wayne Southwick, a graduate of the University of Nebraska College of Medicine, has been named an associate professor and director of the section of orthopedic surgery at the Yale University School of Medicine.

Dr. Harry H. McCarthy, Professor of Surgery, Creighton University School of Medicine, presented a paper and movie on “Chylo-peritoneum” at the Central Surgical Society Meeting held in Columbus, Ohio, February 20th, 21st, and 22nd, 1958.

Dr. Donald J. Wilson, Omaha dermatologist, visited the Grand Island and Cheyenne Veterans Hospitals on Feb. 26 and 27 where he saw cases with dermatologic problems and gave illustrated lectures on “Dermatitis of External Origin.” Doctor Wilson had visited these same hospitals and lectured two years ago.

The Woman’s Auxiliary

The big auxiliary news this month is the organization of the Auxiliary to the Richardson County Medical Society. Mrs. Farrell, first vice president and organization chairman and I met with nine ladies from Falls City and two from Humboldt, on Monday noon, March 10, to acquaint them with auxiliary procedure. With permission from the president of their county medical society, they signed the resolution to organize and formulated their constitution and by-laws. It was a distinct honor for Mrs. Farrell and me to be able to assist these fine ladies in setting up their organization, and I’m sure that the auxiliary members throughout the State of Nebraska join with us in wishing them every success in auxiliary activity through the years to come.

Monday evening, March 10th, it was my pleasure to visit the joint meeting of the Tri-County Medical Society and its Auxiliary, in Fremont. I might add that this visit was made possible through the cooperation of Doctor Chester Farrell and his two small sons of Omaha and Doctor and Mrs.
Wengert of Fremont. These two gracious gentlemen met at Valley and like a relay operation, passed the president from one car to another and we were on our way. My most sincere thanks to both good doctors.

The program of the Auxiliary meeting in Lincoln is complete and I should like at this time to make an especial plea to the auxiliary members of the State of Nebraska to attend your state meeting April 28, 29, 30, and the 1st of May. It has been a disturbing observation of mine in years past that the attendance at the annual business meeting of the auxiliary held on Tuesday afternoon is, with a few exceptions, made up of the executive board; that the members of the auxiliary and members-at-large are not present.

Our national President, Mrs. Paul Craig, will be our honored guest at this Tuesday afternoon meeting. Let us all show to her our appreciation of her visit by coming out for this Tuesday afternoon general session. Please!

Mrs. Craig will be unable to meet with us Wednesday afternoon because she will be on route to the Arizona State meeting. Besides the showing of fashions from Ben Simons, modelled by the members of the Lancaster Auxiliary; Mr. Eddie Faulkner, President of the Woodman Accident and Life Company of Lincoln, will speak to us on the topic, “An American Philosophy of Health Care.” Please come to state meeting this year and help make our thirty-third annual session the best ever.

In this, my last official letter to the Journal, I should like to say a more than perfunctory thank you to each of you. Serving as auxiliary president this year has given to me the wonderful sense of still belonging, which is difficult to discard after twenty-two years. There has been a very tangible feeling of cooperation and love not only from the Auxiliary members but their husbands as well. Because of your abiding steadfastness, this year, which could have been such a desolate one, has been a rich and rewarding experience. I love you all.

Helen Brady.

FALL EXECUTIVE BOARD MEETING
September 18, 1957

The executive board of the Woman’s Auxiliary to the Nebraska State Medical Asso-

ication convened at 9:30 a.m. at the Cornhusker Hotel, Lincoln, Nebraska, on September 18, 1957. The meeting was called to order by the president, Mrs. R. R. Brady.

Following the invocation, the roll call was answered by eight officers, three directors, fourteen committee chairmen, four councilors and two county presidents.

The Auxiliary Pledge was repeated by the members.

The minutes of the post-convention board meeting of May 16, 1957 were read and approved.

The treasurer’s report was read and placed on file.

Mrs. A. J. Offerman read the budget. It was moved, seconded and carried that the treasurer’s report and the finance report be accepted.

Mrs. Woodward made the motion that the bills for the directories and stationery be allowed. The motion was seconded and carried.

Mrs. A. J. Offerman moved that the treasurer, at her discretion, be instructed to buy what bonds are available with $200. The motion was seconded and passed.

The following correspondence was read by Mrs. John Christlieb:

A letter from Dr. Mal Rumph concerning the physicians and surgeons essay contest.

A letter from Mrs. George Garrison urging us to accept sponsorship of medical students in our own communities.

A letter from Dr. James Kelly in support of the essay contest.

Mrs. B. R. Bancroft spoke to the board members on increasing the dues for the Bulletin and urging everyone to keep well informed by reading the Bulletin.

Mrs. Brady led a discussion concerning the essay contest.

Mrs. John Christlieb made a motion that we recommend to the Auxiliary that $50 be taken out of project money for prizes for essay contest winners. The motion was seconded and carried.

An envelope was passed for Bulletin subscriptions.
Mrs. George Covey talked briefly about the advantages of incorporating and of bonding the treasurer.

Mrs. Covey moved that we recommend to the state auxiliary that the treasurer be bonded. The motion was seconded and carried.

The president, Mrs. Brady, appointed Mrs. George Covey to find out what is involved in becoming incorporated.

Mrs. A. J. Offerman made the motion that the money necessary for bonding the treasurer be taken from the treasurer’s funds. The motion was seconded and carried.

Mrs. James Donelan reported on A.M.E.F. Mrs. George Robertson is the new regional chairman for A.M.E.F.

Mrs. Hiram Hilton reported on Bulletin.

Mrs. Warren Bosley reported on Legislation and asked for a list of those wanting subscriptions to the Washington News Letter.

The Mental Health report was given by Mrs. Kenneth Muehlig. Mrs. Muehlig made the motion that we recommend to the state auxiliary that we consider the purchase of the film “Angry Boy.” The motion was seconded and passed.

The meeting recessed for luncheon and reconvened at 2:00 p.m.

Mrs. R. R. Brady expressed the appreciation of the board to Mrs. George Covey for the luncheon arrangements.

The News Letter report was given by Mrs. R. E. Garlinghouse.

Mrs. Victor Norall, Program Chairman, urged the county auxiliaries to continue their pet projects and referred the county presidents to the suggested program outline from National.

Mrs. D. B. Wengert, Safety chairman, reported that safety is a priority project and urged the county auxiliaries to have a safety program.

Today’s Health chairman, Mrs. James Ramsay, urged the county auxiliaries to try to do even better than last year in their sale of subscriptions.

Mrs. George Robertson was introduced and reported that the Nebraska Auxiliary received national recognition for their work on A.M.E.F. and Today’s Health. She stressed the importance of the priority projects and programs and talked about civil defense.

The following were accepted as members of the nominating committee:

Mrs. George Robertson, chairman
Mrs. R. E. Garlinghouse
Mrs. H. D. Runty
Mrs. Edwin Lyman
Mrs. R. E. Harry

The president, Mrs. R. R. Brady, thanked the board for their attendance and support and expressed her willingness to visit county auxiliaries.

The meeting was adjourned.

Respectfully submitted,
Mrs. F. H. Shiffermiller,
Recording Secretary.

POST-CONVENTION EXECUTIVE BOARD MEETING
May 16, 1957

The Executive Board of the Woman’s Auxiliary to the Nebraska State Medical Association met in its post-convention meeting on Thursday, May 16, 1957, at the Paxton Hotel, Omaha.

Following the breakfast, the president, Mrs. R. R. Brady, Ainsworth, opened the meeting and thanked the board for their welcome to her.

The Auxiliary Pledge was repeated.

The following past presidents were then presented: Mrs. George Robertson, Mrs. J. M. Woodward, Mrs. James Donelan, Mrs. Lukens, Mrs. P.O. Marvel.

Following the invocation, roll call was answered by seven officers, one director, nine committee chairmen, and three counselors.

Business of the day was as follows:

It was decided to take up important problems in the board meeting and bring recommendations to the main meeting.

County auxiliaries were urged to write to the president concerning any problems that come up so that she is aware of what to put on her agenda.
All county presidents were asked to be sure to make reports.

Mrs. George Robertson was appointed chairman of the delegates to the National Convention of the Woman's Auxiliary to the American Medical Association. Mrs. Arthur Offerman was appointed delegate.

The president, Mrs. R. R. Brady, recommended a letter be sent to all members-at-large telling them of the auxiliary's activities and what they may do to take part.

Mrs. James Donelan reported that A.M.E.F. donations totaled $2,093.19.

An envelope was circulated for subscriptions to the Bulletin.

The proposed budget for 1957-58 was discussed.

Mrs. Warren Bosley discussed the Jenkins-Keogh Bill.

A motion was made, seconded and passed that we rent a film on mental health, with purchase in mind, to be shown at board meetings.

The name of the Nurse Recruitment committee has been changed to just Recruitment.

County auxiliaries were urged to include a safety program during the coming year.

Thanks were voted to the Douglas County Auxiliary for a fine convention.

Mrs. Rodney Stoltz, National Today's Health Chairman and guest speaker at the convention was presented and talked briefly about how national committee chairmen are selected. Her state must recommend a candidate for chairmanship to the national nominating committee. She is always a past state president.

Dr. Russell Best, president of the Nebraska State Medical Association, greeted the members of the Executive Board, suggested ways in which the Auxiliary could be helpful to the State Medical Association, discussed the problem of training practical nurses, and talked briefly about the Jenkins-Keogh Bill.

There being no further business, the meeting was adjourned.

Respectfully submitted,

Mrs. F. H. Shiffermiller,
Recording Secretary.

Woman's Auxiliary to the Lancaster County Medical Society—

The Lincoln Country Club was the setting of a lovely dinner-dance on Saturday night, March first, for the Lancaster County doctors and their wives. Special guests were the residents and their wives of the Bryan Memorial, Lincoln General, and St. Elizabeth Hospitals. Dr. and Mrs. Orvis Neely, Dr. and Mrs. Jon Williams and Dr. and Mrs. E. S. Maness were in charge of arrangements.

Lancaster County's Medical Auxiliary meeting was held as a coffee-sandwich luncheon at the home of Mrs. M. P. Brosim on March third. Mrs. Harry Hathaway of Holdrege gave a clever and entertaining review of a new Broadway comedy, Aunt Mame. The co-chairmen were Mrs. LaVerne Pfeifer and Mrs. Dwight Cherry.

Mrs. Elizabeth Davies,
Publicity Chairman.

Woman's Auxiliary to the Dawson County Medical Society—

Mrs. A. W. Anderson presented the program "Mental Health" at the February meeting of Woman's Auxiliary to the Dawson County Medical Society, in Lexington, Friday.

Meeting at Mrs. Ray Wycoff's home, the twelve members agreed to increase their $300 Scholarship Loan Fund to include applicants not only for training in the nursing profession but in allied fields as well—such as X-ray or laboratory technology or medical social work.

Memorial Chairman Mrs. Charles Hranac, announced that anyone in Dawson County wanting to donate a gift in memory of a friend may contribute to the American Medical Education Foundation Auxiliary Fund by sending the donation to Mrs. Charles Hranac, Cozad, Nebraska. All gifts will be acknowledged.

Vaginal discharge is one of the most common and most troublesome complaints met in practice. Trichomoniasis and monilial vaginitis, by far the most common causes of leukorrhea, are often the most difficult to control. Unless the normal acid secretions are restored and the protective Döderlein bacilli return, the infection usually persists.

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The following therapeutic procedure is suggested: One or two tablets are inserted by the patient each night and each morning; treatment is continued for four to eight weeks.

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Current Comment

Annual A.M.A. Meeting in San Francisco—

Between 12,000 and 15,000 physicians are expected to go West in June to attend the 107th annual meeting of the American Medical Association in San Francisco. The five days of June 22-27 will include scientific lectures, special panel discussions and demonstrations, the always popular scientific exhibits, motion pictures, televised surgical procedures, and commercial exhibits. The House of Delegates will also meet.

The scientific exhibit section will include exhibits by two high school winners of A.M.A. Scientific Awards at the National Science Fair. Also, the top winners of the intern-resident and medical student exhibits at the student A.M.A. convention will be invited for the first time to exhibit an A.M.A. meeting.

Death Rate Up in 1957—

For the first time in several years the death rate among life insurance policy holders will show a slight increase in 1957, according to the Institute of Life Insurance.

The cardiovascular-renal diseases continue to play the major role and are largely responsible for the higher death rate.

The epidemic of Asiatic influenza has also been a contributing factor in the higher mortality. This epidemic was widely spread and responsible for more deaths from respiratory diseases than in a number of years. It is also alleged that a significant number of deaths from heart conditions, especially among older persons can be attributed to the effect of the influenza virus.

The number of cancer deaths will show a rise when the final figures are compiled.

Stop Worrying—
(Keys to Happiness: A. J. Cronin)

"An estimate of what most people worry about runs as follows: Things that never happen: 40 per cent. Things over and past that can't be changed by all the worry in the world: 30 per cent. Needless health worries: 12 per cent. Real legitimate worries: eight per cent."

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Current Comment
Physicians Compensation Under Socialized Medicine—

The Westchester Medical Bulletin points out that in England under the National Health Act physicians have had to threaten mass resignation in order to secure an upward adjustment of the changes.

Even more impressive is a quote from William J. Jordon of the New York Times who interviewed eleven Russian citizens selected from various occupations. The physician's base pay was the lowest of all those interviewed, including a bus driver, farmer, and steel worker.

Questions and Answers in the J.A.M.A.—

With the first issue for 1958 the Journal of the A.M.A. changed the heading of the "Queries and Minor Notes" section to the title of "Questions and Answers." A check into the history of this service indicates that the first question from a physician was answered in an 1899 issue under the heading "Questions and Answers."

Each year approximately 2400 questions relating to practical medical problems arrive in the editorial offices of the J.A.M.A. Each question receives a personal reply. The answers are prepared by consultants recognized as competent authorities in their respective medical fields. About 900 authorities in all parts of the United States and Canada cooperate as consultants to give this service. About 900 of these questions and answers are published each year. For many years the majority of questions were on dermatological problems but during 1957 there was a definite shift to questions on diet and nutrition.

National Library of Medicine: Money for Planning But None for Building—

A couple of years ago Congress changed the name of the Armed Forces Medical Library to National Library of Medicine and authorized construction of a building to house it. So far, only the money for planning it has been appropriated. In the meantime, destruction and loss of valuable books goes on and the $2 billion of postoffice reconstruction and renovation goes forward but the $7 millions for the library are not to be had.

42-A You can enhance the value of your own Journal by patronizing its advertisers

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Current Comment

Antivivisectionists Remain a Problem—

In spite of much progress, legal obstacles make difficult the use of animals for medical research.

A progress report from the National Society for Medical Research indicates that approximately four out of five research and teaching institutions in the United States now can obtain dogs and cats from public pounds. In the face of this progress, problems still exist. Associated with this problem is the problem of supplying sufficient cadavers for the teaching of anatomy. In New York state the University of Buffalo has encountered a problem by provisions of the state welfare laws which take away a source of cadavers for this medical school.

Antivivisection organizations are still active in their program to prevent the use of animals for research. In Phoenix, Arizona, the city council dismissed an antivivisection proposal to prohibit all experiments on animals.

The National Society for Medical Research is an organization founded in 1946 by the Association of Medical Colleges to improve public understanding of the methods and needs of the biological medical sciences. In the opinion of this organization, public understanding is necessary if legislative efforts are to be favorable to the continued expansion of medical knowledge. It is pointed out that legislations and court discussions represent the ultimate crystallization of public understanding and prejudices. The law, it is said, marks the score for most public educational endeavors.

The Bulletin from Medical Research, a periodical published by this organization, takes note of an article in Coronet magazine for November, 1957, which is said to indicate a new slant to this whole problem. The article, unlike the writings of the "old time" antivivisectionists does not oppose all animal experimentation but rather seeks to regulate and limit the use of animals on the grounds that research and teaching institutions can not be relied upon to give proper and humane treatment to animals. On this basis they advocate laws to restrict the use of animals in biology and medicine.

It is stated that the article in Coronet fails
to mention the widespread efforts of those who have worked with animals to devise and improve the code of animal care that is now official in most of the laboratories in the United States.

It is to be concluded that this is one more area which requires continuing vigilance on the part of the medical profession.

Our Pets and Human Disease—

More than eighty animal diseases can be passed to humans and a few like rabies, ornithosis brucellosis, and Rocky Mountain spotted fever must at least be considered by most practicing physicians.

According to a recent article, these animal diseases have three characteristics in common. They seldom are passed from man to man; they are similar in both man and animals if the infections enter the body in the same way; and their incidence is highest among persons in close contact with animals and animal products. The most serious of these diseases is rabies, the virus of which is present in the saliva of the rabid animal, and enters man’s body through bites or when the saliva contacts an open wound. A new potential source of infection has been found in the bat. Anyone bitten by a bat should consider himself exposed to rabies. Ornithosis, or “parrot fever” was becoming less frequently encountered until parakeets, together with love birds, pigeons, and ducks became reservoirs for the virus of this disease. In this area, brucellosis is a common disease in this group.

A Message on United Fund Drives—

President Robert W. Wilkins of the American Heart Association, in a message to physicians about “Doctors, Heart Associations, and United Funds,” tells many of the reasons we must resist the “One-gift-for-all—one-campaign-for-all” idea. Among other reasons, the results are inadequate and lay people enter into the direction of medical research. In this regard Doctor Wilkins states “... United Fund people may understand local charity needs, but they know nothing about the requirements of the nationally coordinated programs of medical research being conducted by the voluntary health agencies.”

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TECHNICAL EXHIBITS
(Continued from page 25-A)

ELI LILLY & COMPANY, Indianapolis, Indiana—Booth No. 3. You are cordially invited to visit the Lilly exhibit located in space number 3. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

LINCOLN OFFICE EQUIPMENT COMPANY, 1217 P Street, Lincoln, Nebraska—Booth No. 4. Gray Audograph run the gamut of dictation service in offering full compatible, portable (Gray Key-Note), on the desk, heavy-duty (Gray Model 5A), and remote, i.e., telephone dictation (Gray Phon-Audograph). This equipment is patterned to your exact needs at a minimum initial cost of operation and a minimum of cost of service. May we suggest you stop for a demonstration of this outstanding equipment.

MEAD JOHNSON & COMPANY, Evansville, Indiana—Booth No. 6. The Mead Johnson exhibit (Booth No. 6) has been arranged to give you the optimum in quick service and product information. To make your visit productive, especially trained representatives will be on duty to tell you about their Formula Products Family: the Colese Products Family. Tempra, the first physician-controlled antipyretic analgesic in two liquid dosage forms, and Sustagen, the only single food complete in all essential nutrients.

MEDICAL PROTECTIVE COMPANY, 5814 Reed Road, Fort Wayne, Indiana—Booth No. 14. "More doctors insured than ever before, fewer claims and suits filed in 1957"—that's the unique accomplishment in the professional liability insurance field of The Medical Protective Company from a half century of effective prophylactic procedures. Skilled defense, unhandicapped by excessive insurance, likewise reduced losses. Specialized Service makes our doctor safer.

MILEX PRODUCTS, 2517 No. Prospect Road, Peoria, Illinois—Booth No. 26. Milex Products will display a full line of GYNESIC specialties, including the MILEX FOLDING PESSARIES, CRESTCENT, TRICHO-SAN, and LESTENS. In addition we will show a new instrument for cold coning of the cervix—with a combination attachment for coagulation combined with suction.

PHYSICIANS & HOSPITAL SUPPLY COMPANY, 1400 Harmon Place, Minneapolis, Minnesota—Booth No. 12. Our representatives will be on duty during the Annual Session at booth 12. They will be very happy to demonstrate our latest equipment which will be on display. Please stop by and see us.

PICKER X-RAY CORPORATION OF NEBRASKA, 3810 Farnam, Omaha, Nebraska—Booth No. 20. "Now that practically all modern x-ray equipment is shockproof, operators and patients are practically free from electrical dangers. There are, however, two other problems confronting radiologists, surgeons and general practitioners. The first is the use of portable x-ray equipment in the operating room. Several years ago Picker brought out a 15MA Mobile unit which was safe to use in operating rooms or other places where heavy gases were being used. There has been a constant demand for a higher powered OR unit and Picker X-Ray now are proud to announce that they will demonstrate a 500 MA 125KV Mobile unit that is safe to use in the OR room.

PROFESSIONAL MANAGEMENT, 404 Insurance Building, Waterloo, Iowa—Booth No. 15. "Professional Management offers you assistance in all business matters including office records and routines, personnel training, credit and collections, fees, office layouts, public relations, insurance, investments and taxes. Thirteen years of experience with hundreds of doctors in solo and group practice have given us the "know how" we'd like to share with you. Whatever your problems, we invite you to discuss them with us."

A. H. ROBINS COMPANY, INC., 1407 Cummings Drive, Richmond, Virginia—Booth No. 16. The A. H. Robins exhibit spotlights DIMETANE, the new and unexcelled antihistamine (available in Tablets, Elixir and long-acting Extempants), and ROBAXIN, the important new skeletal muscle relaxant, Synthesized in Robins Research Laboratories. Representatives in attendance at the booth will also be happy to discuss the therapeutic advantages of ALLBEE with C, AMBAR and DONTAL PLUS or other Robins prescription items.


JULIUS SCHMID, INC., 423-439 W. 55th Street, New York, New York—Booth No. 2. An interesting and informative exhibit featuring the RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal re-infection.

G. D. SEARLE & COMPANY, P.O. Box 5110, Chicago, Illinois—Booth No. 21. You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Emovid, the new synthetic steroid for treatment of various menstrual disorders; Zan chol, a new biliary absetgent; Nilevar, the new anabolic agent, and Rolloton, a new safe, non-mercurial oral diuretic.

SEILER SURGICAL COMPANY, INC., 111 So. 17th Street, Omaha, Nebraska—Booth No. 17. We (Continued on page 54-A)
Current Comment

Physicians From Behind Iron Curtain to Participate in International Congress On Internal Medicine—

A news release about the coming meeting (April 24-25) of the “Fifth International Congress of Internal Medicine,” in Philadelphia, reveals that among the 81 foreign speakers will be “leading physicians from the Soviet Union, Czechoslovakia, Hungary, Rumania, and Poland.” It is said that “Their participation emphasizes that medical science knows no geographical or political barriers.” Whether the corollary of this is true is not stated.

“Characters” and the Welfare State—

“Something in our modern society operates against the production of ‘characters.’ The welfare state, for one thing, is by its very nature bound to set a premium on conventionality: social security is its watchword. Whenever a government becomes certain that it knows what is best for its citizens, these become more and more like citizens and less and less like characters . . .” (Fadiman: Do Not Destroy Those Originals. Reader’s Digest, Jan., 1958, p. 160).

“A Free Ride vs. a Free Nation”—

Under the above title, the author says: “. . . Inevitably a choice must be made between the promised bounty of more paternalism on the part of the government and the preservation of individual initiative and self-reliance which are the cornerstones of freedom. No nation can have both, for as people become more reliant on government for personal security they necessarily cede some measure of their personal freedom . . .” (Blue Shield Medical Care Plans Newsletter for February, 1958).

TUBERCULOSIS ABSTRACTS

TUBERCULOSIS—IN AND OUT OF INDUSTRY

These are changing times in tuberculosis. Death rates have fallen sharply and there has been a small but steady decline in incidence rates. New drugs and resection surgery have had so profound an effect that there is danger of over-optimism. Tuberculosis is far from eradicated.

THE PROBLEM

This year, approximately 50 persons in every 100,000 in the U.S. will develop tuberculosis. In 1955 of 100,000 new patients 75,000 had active disease.
clinical evidence* indicates BUFFERED "Predni-steroids" for rheumatoid arthritis..............
Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem—well documented in a growing body of literature.

"In view of the beneficial responses observed when antacids and bland diets were used concomitantly with prednisone and prednisolone, we feel that these measures should be employed prophylactically to offset any gastrointestinal side effects."—Dordick, J. R. et al.: N. Y. State J. Med. 57:2049 (June 15) 1957.

"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.


One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing Co-Deltra or Co-Hydeltra.

Co-Deltra®

Provide all the benefits of "Predni-steroid" therapy—plus positive antacid protection against gastric distress

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TUBERCULOSIS ABSTRACTS

(Continued from page 49-A)

ease. There were 15,000 people who died with tuberculosis. During this same year an increase in the number of new cases was reported by 15 states and the District of Columbia—and the District of Columbia and 6 states reported an increase in the number of deaths.

In the New England States in 1955 of 4,000 newly reported cases, 3,500 had active disease. There were 800 people who died with tuberculosis.

MANAGEMENT

How about the old familiar landmarks in the management of tuberculosis—hospitalization, absolute bed rest, collapse therapy, sputum studies, X rays, symptoms, exercise, work tolerance, rehabilitation and follow-up?

Active tuberculosis is best managed in the hospital. Absolute bed rest has been modified and is being evaluated under the protective umbrella of drug therapy. We are learning to use the new methods and evaluate the old, retaining whatever of the old that is good and replacing only when we have something better. Drug therapy, blood banks and advances in anesthesiology have contributed to the development of resection surgery. Wedge and segmental resections, lobectomy and pneumonectomy offer the advantage of removal of tuberculous tissue and have largely replaced collapse therapy measures, although pneumothorax and pneumoperitoneum are occasionally used, and plombage and thoracoplasty have a limited place in today's surgical procedures.

Drug therapy has cut down on the amount of sputum. In most patients conversion from positive to negative sputum occurs in three or four months. Sputum usually remains negative while the patients are on drugs but may revert to positive when drugs are discontinued. A series of negative sputum examinations on smear, culture and animal inoculations is of less prognostic significance if the patient is on drug therapy than it is after the drugs have been discontinued for three or more months.

Sensitivity studies on positive cultures guide changes in chemotherapy. Proper significance must be placed on "nonvirulent" and "nonpathogenic" acid fast organisms. Sputum examinations and the significance of sputum findings have indeed become complex.

Conventional X-ray examination, aided by body section laminography, helps to determine stability. We still find bacteriological relapse with an unchanged X-ray picture, but today there is also the question of the "sterile cavity." Suffice it to say, cavity or bleb, sterile or non-sterile cavity—we prefer surgical removal when possible.

A feeling of well-being early in the course of recovery is the rule more so today than in the past. Graduated exercise, work tolerance and rehabilitation, like bed rest, are being modified and evaluated. Follow-up after discharge is important for the protection of the patient and for the proper evaluation of today's changing picture of treatment and management.

As for chemotherapy, the search is still on for the nontoxic, inexpensive bactericidal oral drug.
TECHNICAL EXHIBITS
(Continued from page 48-A)

will have on exhibit the latest in Heart Monitors by
Durdick also the new Barco Jackets for office use.
It is our pleasure to welcome the members to view
our exhibit in Booth 17.

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No. 14th Street, Lincoln, Nebraska—Booth No. 18.
At booth 18 we will have a complete display of our
office equipment for your inspection. Our staff will
be happy to answer any questions you may have
and will also be glad to demonstrate the equipment
which will be on display. You are cordially invited
to stop by and visit our booth.

THE SMITH-DORSEY COMPANY, 233 So. 10th
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respiratory disorders. Let us give you a rubber nose
to remind you of the Triaminic family.

E. R. SQUIBB & SONS, 745 Fifth Avenue, New
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tic agents for prevention and treatment of dis-
cases. The results of our diligent research are
available to the Medical Profession in new products
or developments in products already marketed. At
Booth 7, we are pleased to present up-to-date infor-
mation on these advances for your consideration."

THE STUART COMPANY, 35 East Wacker
Drive, Chicago, Illinois—Booth No. 30. "The Stu-
art representatives in charge of our exhibit extend
a cordial invitation to the doctors to stop at our
booth and discuss the new products we are cur-
rently detailing to the Medical profession."

ULMER PHARMACAL COMPANY, 1400 Har-
mon Place, Minneapolis, Minnesota—Booth No. 11.
Trained staff members will be on hand at the An-
nual Session to discuss with you the products which
will be on display at our booth. We welcome your
questions and will be happy to have you visit our
booth.

WINTHROP LABORATORIES, 1450 Broadway,
New York, New York—Booth No. 13. Dilcoron, a
new flavor-timed, dual action, coronary vasodila-
tor for angina pectoris; orally for dependable pro-
phylaxis and sublingually for immediate relief. The
sublingual—oral tablet has a quick acting layer of
nitroglycerin 0.4 mg. over a central core of pro-
longed acting pentaerythritol tetranitrate 15 mg.

DOCTOR — Please take each copy of
your Journal home. The wives complain
that they never get to read the Aux-
iliary column.

Know Your
Blue Shield Plan

One Step Ahead of Blue Shield?

Someone has said that the medical profes-
sion should always be one step ahead of
Blue Shield. This is roughly equivalent to
saying that the horse should be in front of
the cart. The main point is that medical
doctors—for their own sake as well as for
the good of their patients—should always
lead and guide this prodigious child of theirs,
Blue Shield—not vice versa.

Fifteen years is not a long period in the
brief span of the average man's adult life. Yet,
15 years ago Blue Shield was little more than
a gleam in the eyes of a few groups of
doctors in various parts of the U.S.A.
Today, Blue Shield is a nationwide associa-
tion of medically-approved non-profit prepay-
ment plans that are now paying aggregate
benefits at a rate of more than half a bil-
lion dollars per year for covered services
rendered by physicians.

These 70-odd locally-sponsored and locally
controlled plans are engaged in an endless
effort to help the medical profession provide
an even greater degree of medical-care se-
curity to more than 40 million Blue Shield
subscriber-members.

If Blue Shield has a big job to do, medical
doctors have a bigger one, for Blue Shield is
"their baby"—to nurture and direct. They
cannot escape the ultimate responsibility for
what Blue Shield is, and for what it shall
become. Nor would any of them want to
deny their profession the credit for having
built this mechanism that serves as a bridge
of mutual benefit between doctors and pa-
tients.

Medical doctors need Blue Shield — and
Blue Shield needs the guidance that only
their profession can give it, if Blue Shield
is to do the job for which they created it.

a salute to
medical school progress

MEDICAL EDUCATION
WEEK .... April 20-26
respiratory infections
gastrointestinal infections
genitourinary infections
miscellaneous infections

immediate therapeutic response

use Sumycin intramuscular

250 mg. per 1 dose vial
100 mg. per 1 dose vial

- when oral therapy is contraindicated (vomiting, dysphagia, intestinal obstruction, gastrointestinal disorders)
- when the patient is comatose or in shock
- postoperatively
1. fast peak blood and tissue concentrations
2. high cerebrospinal levels
3. for practical purposes, Sumycin is sodium-free

Each vial contains tetracycline phosphate complex equivalent to 250 mg., or 100 mg., of tetracycline HCl. (Note: 250 mg. dose may produce more local discomfort than the 100 mg. dose.)

FLEXIBLE DOSAGE FORMS FOR CONTINUING ORAL THERAPY

<table>
<thead>
<tr>
<th>Tetracycline phosphate complex equiv. tetracycline HCl (mg.)</th>
<th>Packaging</th>
</tr>
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<tbody>
<tr>
<td>Capsules (per capsule)</td>
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<tr>
<td>Bottles of 16 and 100</td>
<td></td>
</tr>
<tr>
<td>Half Strength Capsules (per capsule)</td>
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<tr>
<td>Bottles of 16 and 100</td>
<td></td>
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<tr>
<td>Suspension (per 5 cc. teaspoonful)</td>
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<td>60 cc. bottles</td>
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<tr>
<td>Pediatric Drops (per cc.—20 drops)</td>
<td>100</td>
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<tr>
<td>10 cc. bottles with dropper</td>
<td></td>
</tr>
</tbody>
</table>

Squibb Quality—the Priceless Ingredient

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PHYSICIANS’ EXCHANGE

FOR SALE — Westinghouse Simplex Diagnostic X-ray unit with essential accessories; Jone metabolism unit, good condition; office furniture, ten pieces, including medicine cabinet, examining table, waste container, stool, desk, chairs, all in excellent condition. Write Box 2, 1315 Sharp Building, Nebraska State Medical Journal, Lincoln 8, Nebraska.

OPPORTUNITY — Office equipment for sale in town of 6000 in southeastern Nebraska, very active practice. Will introduce for several months if desired. Good opportunity to establish practice with modest investment. Good hospital facilities available. Write Box 3, Nebraska State Medical Journal, 1315 Sharp Bldg., Lincoln, Nebraska.

FOR RENT: Residential office suite with 2 examining rooms, laboratory, reception room and private office. New building, ground floor, office parking area. Contact Drs. Seberg & Seberg, 515 West 9th Street, Hastings, Nebraska.

WANTED — A recent medical graduate having completed one year’s internship. For experience and training in internal medicine in office and hospital work. This would serve as graduate preceptorship. Good remuneration is offered. Tenure three months to one year. Write Drs. Niehaus & Wright, 1622 Medical Arts Bldg., Omaha 2, Nebraska.

FOR SALE — One Jones Metabolic Machine with extra oxygen tank in excellent condition. Price to suit person interested. Contact I. W. Irvin, M.D., Auburn, Nebraska.

FOR SALE — Equipment and office lease of late G. A. DeMay, M.D. This new, modern, air conditioned office has a five year lease available. The office consists of six fully equipped examining and treatment rooms, waiting room, business office area, and private lavatory. All equipment in excellent condition. For further information regarding this excellent location in southwest Nebraska, contact George H. DeMay, M.D., 721 West 7th St., Grand Island, Nebraska.


LOCUM TENENS AVAILABLE — Physician, married, wishes a locum tenens opening for the months of April, May, and the first-half of June, 1958. Qualified to take over complete practice. Contact John Quin, M.D., St. Elizabeth Hospital, Lincoln, Nebraska.
TUBERCULOSIS ABSTRACTS
(Continued from page 53-A)

while today's drugs are used in conjunction with modified rest, supplemented by surgery when indicated. Drug therapy is usually used for all active disease. Streptomycin and isoniazid are major drugs. Para-aminosalicylic acid is the most commonly used minor drug. Pyrinesalicylate and cycloserine are minor drugs that are more recently available. Because tubercle bacilli, resistant to available drugs have grown out when drugs are used singly—they are used in combination, preferably a major and a minor, keeping one of the majors in reserve. Isonicotinic acid hydrazide and para-aminosalicylic acid or streptomycin and para-aminosalicylic acid are two such combinations.

Exudative and pneumatic disease tends to resolve more rapidly than fibroid or cavitary disease. Definitive resection surgery properly timed during the course of drug therapy is used for selected cases.

How long the patient should be kept on drug therapy is not known, but it has been found necessary to increase the average time repeatedly. At present, in a general way, one might suggest as a minimum period of time on drug therapy: (a) for minimal pulmonary tuberculosis, a minimum of one year; (b) for advanced pulmonary tuberculosis, a minimum of 18 months; (c) for genitourinary, military, and meningal tuberculosis, a minimum of two years. These are minimum periods; drug therapy may be continued indefinitely beyond these minimum periods in the presence of continuing active disease.

THE FUTURE

Since the mean hospital stay is decreasing and the duration of drug therapy is increasing, a higher proportion of patients will be returning to work while still on drug therapy. Negative sputum needs to be confirmed when the drugs have been discontinued. Relapse rates under modern treatment are not available for a long enough period of time. However, preliminary trends suggest 8% to 10%, with over half of the relapse occurring within the first year after hospital discharge. Sputum examinations and X-ray comparisons continue to be the bulwark of follow-up.

INDUSTRY AND TUBERCULOSIS

How does this affect industry? The chest X-ray as part of a pre-employment examination gives the physician in industry a permanent and valuable record of the employee and indicates the need for medical investigation with a high degree of accuracy in chest disease. Mass chest X-ray examinations of all employees at stated intervals rounds out the advantages gained by pre-employment examination.

Differential diagnosis and the determination of activity in tuberculosis may be quite simple or extremely complex, and may be most easily carried out in the hospital. The employee who is known to have had active tuberculosis should be under adequate supervision. The patient who is on chemotherapy should have X-ray and sputum studies once a month. Follow-up may be provided by the family physician, by the hospital outpatient department, (Continued on page 61-A)
Patient J. I.
Duodenal Ulcer
before PATHIBAMATE

PATHIB

Lederle LABORATORIES DIVISION, AMERICAN

*Trademark
®Registered Trademark for Tridihexyl Iodide Lederle
TUBERCULOSIS ABSTRACTS
(Continued from 57-A)
by the local health department, or by the Medical Department of the industry. The patient should be taught the value of a free exchange of information between these medical teams.

The patient who has had tuberculosis has always been a valuable asset to industry. He has learned to live moderately. He is usually on time, does his work well, and loses below average time for sick leave. The patient who is diagnosed early, treated by today's standards and adequately followed, will have less of a physical handicap than the patient who had tuberculosis 10 or more years ago; and he will, therefore, be an even greater asset to industry.

SUMMARY
Tuberculosis is still with us; the death rate has fallen remarkably; the incidence is slowly decreasing; treatment is a rapidly changing picture; adequate follow-up protects the patient and industry; and the patient who has had tuberculosis is a valuable asset to industry.

The death rate from cardiovascular disease, which now claims one out of every two American lives, varies from state to state, according to a new publication, "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. The New England states rank first in heart disease death rates and the southwestern states are at the bottom of the list, according to the publication.

Must all cardiac patients cut down drastically on exercise? Studies show that over 80 per cent of them require no restriction of activity whatever, according to a new publication Patterns of Disease, prepared by Parke, Davis & Company for the medical profession. Approximately another 40 per cent must avoid only severe exertion, "Patterns" says. In fact, less than one per cent require "complete rest."

Heart disease, now one of our greatest health problems, costs the U.S. government over $700 million annually, according to a new publication, Patterns of Disease, prepared by Parke, Davis & Company for the medical profession.

Loss in working time caused by the disease amounts to approximately $3 billion per year, "Patterns" says. It further points out that the total annual outlay of the major sources of research support is currently estimated at $33,672,725.
Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

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SURGEONS DENTISTS

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Since 1902

Malpractice Prophylaxis
IT'S NOT AN ACCIDENT
our claims and suits
 go down while else-
where they go up

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Fort Wayne, Indiana
Professional Protection Exclusively
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IN VITRO SENSITIVITY OF FOUR COMMON PATHOGENS TO CHLOROMYCETIN FROM 1952 TO 1956*

**STAPHYLOCOCCUS PYOGENES**

<table>
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<td>1954</td>
<td>749</td>
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<td>1953</td>
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**ESCHERICHIA COLI**

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**PROTEUS MIRABILIS**

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<td>1953</td>
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<td>1952</td>
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<td>64%</td>
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**PSEUDOMONAS AERUGINOSA**

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<tr>
<td>1952</td>
<td>51</td>
<td>29%</td>
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</tbody>
</table>

*Adapted from Roy and others.*

*From 1952 to 1956, the in vitro sensitivity of four common pathogens to chloromycetin was studied. The table above shows the percentage of strains sensitive to chloromycetin for each year and pathogen.*
Current Comment

The Month in Washington—

The recession continues to influence the course of much legislation, as Congress points toward the windup of its session. Even in the health fields, bills that promise in one way or another to alleviate unemployment appear to have priority. At the same time, federal departments are favoring construction grants to projects that can be started without much delay.

In legislation, here are some of the developments:

1. Liberalization in unemployment compensation and in social security are receiving constant attention on Capitol Hill. At this writing, the bill to extend the period for unemployment compensation payments is making progress. There is the possibility also that it will make participation mandatory for all employers.

Prominent among proposed changes in the social security program itself is the Forand bill for free hospitalization and in-hospital medical care and surgery for persons entitled to social security benefits. It is being pushed by the A.F.L.-C.I.O. and by some liberal Democrats, and opposed by the American Medical Association and a growing group of other organizations. The opposition is convinced that the Forand bill is unnecessary, that it would be far more costly than anticipated, and that it would point the way to a broad national medical care plan for all persons covered by social security.

2. A controversial bill to vastly increase money available for grants for community facilities—waste plants, hospitals, state medical schools included—is active in Congress. One proposal is to vote a billion dollars, to be lent out (at about 3½% interest for 50 years) to communities. The objective here, as in many other measures, is to put people to work on construction projects.

Federal agencies have evolved a number of schemes to get U.S. dollars into circulation faster, and are attempting to work out others. In each case described below, no additional appropriation is involved; money is

(Continued on page 20-A)
"Most likely candidate for ORINASE"

now more than
250,000 diabetics enjoy
oral therapy
Current Comment
The Month in Washington—
(Continued from page 4-A)

shifted from a project that is getting a slow start to one that is about ready to begin construction. Also, all totals given represent amounts to be spent by the sponsors as well as the federal government. Here are arrangements already made:

1. In January, the Hill-Burton hospital construction program called for U.S. grants to start buildings valued at $381 million; this figure has been stepped up to $405 million by July 1.

2. Between January and July 1, the original plan was to allocate enough money to start $120 million in construction for health research plants. This has been increased to $182 million.

3. Before the recession became so prominent an issue, the plan was to grant enough U.S. money to start construction of $170 million in sewage plants. Under pressure, the total has been increased to $215 million.

In most cases, when a project is delayed and thus loses its allocation, the grant is rescheduled for next fiscal year.

American Medical Association is one of the four sponsors of a new Joint Council to Improve the Health Care of the Aged. The others are American Dental Association, American Hospital Association and American Nursing Homes Association.

The council already has authorized research in a number of directions to (a) analyze the health needs of the aged, (b) appraise health resources for them, and (c) develop the best possible health care for them, regardless of their economic status.

Effects of the united front action should be felt when Congress takes up the Forand bill and other legislation pointed toward relief for the aged.

NOTES:

American Medical Association is asking Congress to strengthen the Civil Aeronautics Administration's medical department so it can properly supervise fliers' physical examinations and advise on other aviation medi-

Doctors, too, like “Premarin”

The reasons are fairly simple. Doctors like “Premarin,” in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen.

Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms before the menopause and even after, “Premarin” takes care of that, too.

Women, of course, like “Premarin,” too, because it quickly relieves their symptoms and gives them a “sense of well-being.”

“PREMARIN®
conjugated estrogens (equine)

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cal matters. A.M.A. also is recommending that an office of civil air surgeon and a medical research laboratory be established within C.A.A.

Congress has under consideration several plans for reorganizing the Defense Department, two of which would result in elimination of the office of Assistant Secretary for Health and Medical matters.

Progress on appropriation bills indicates more money for research at the Institutes of Health, and at least $121.2 million (the same as this year) for Hill-Burton hospital construction.

Andrew Biemiller, top legislative man for the A.F.L.-C.I.O., told a recent delegation just returned from visiting Capitol Hill: “Congressmen are falling all over themselves in wanting to do something in the recession. I think we can cash in on this.”

Testifying before a House appropriations subcommittee, Secretary Folsom said coverage under major medical insurance has gone up almost 20-fold in the last five years.

Medicare is working up a new claim form that will have a check-list of common errors on the back; this is intended to eliminate much correspondence now necessary when the physician makes an error on the form.

Reported Cases of Syphilis Increase—

The total number of reported cases of syphilis in all stages has risen in the United States for the second consecutive year. The increase is evidenced in the total number of reported cases from the individual health departments of all the states and territories. Although cases of primary and secondary syphilis reported show a slight decline, there was an increase in the number of early latent syphilis cases to produce an over-all increase.

Health officials are said to believe that some of the increase in total cases represents better case finding and better employment by state and local governments of the tools of control.

A number of cases of gonorrhea reported continues its downward trend but it is believed that the reporting of this disease is especially spotty and that the incidents may be considerably greater than the number of cases actually reported.

---

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Hospital practice

of infant feeding

Standard formulas for WELL INFANTS

Since age, appetite and digestive capacity vary, hospital practice favors an individualized formula for each infant.

The total daily feeding usually amounts to 2 ounces of milk per pound of body weight, plus 1 ounce of Karo Syrup with enough water to satisfy fluid requirements.

The newborn usually takes from 2 to 3 ounces of formula per feeding; the very young infant, 4 to 5 ounces—the daily quota yielding over 50 calories for each pound the infant weighs. The quantity per feeding should not exceed 8 ounces.

Newborns are fed at 3 to 4 hour intervals throughout the 24-hour period—the 2 or 3 A.M. feeding is discontinued after the neonatal period. In the third or fourth month the 10 or 12 P.M. feeding is discontinued, once the infant fails to awaken for the bottle.

Standard but individualized formulas which constitute the hospital infant feeding regimen are shown here.

WHOLE MILK FORMULAS

<table>
<thead>
<tr>
<th>Age Months</th>
<th>Cow's Milk Fluid Oz.</th>
<th>Water Oz.</th>
<th>KARO Tbsp.</th>
<th>Each Feeding Oz.</th>
<th>Feedings in 24 Hrs</th>
<th>Calories</th>
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</thead>
<tbody>
<tr>
<td>Birth</td>
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<td>13</td>
<td>3</td>
<td>4 1/2</td>
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<td>7</td>
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EVAPORATED MILK FORMULAS

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<td>22</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>768</td>
</tr>
</tbody>
</table>

ADVANTAGES OF KARO®IN INFANT FEEDING

Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

Free to Physicians—Book of Infant Feeding Formulas with convenient schedule pads. Write: Medical Division C</ref>
EDITORIAL

"SEX" IN POPULAR PERIODICALS

A cursory survey of a few popular magazines reveals many articles dealing with quasimedical subjects. Recently, many of these articles concern the area of the human body bounded above by the iliac crests and below by a line drawn through a point just below the great trochanters of the femurs. Their titles may be somewhat deceptive. The real objective may have a wordy approach somewhat like telling the girl how pretty she is and how soft her skin feels, or the writer may be abrupt and get right down to the sex-angle.

Ten issues of five household magazines published in and since November 1957, were found to contain eight such articles. Another magazine contains such an article almost every month. Titles such as "The American Wife," "The New Kinsey Report," "What Sex Manuals Do Not Tell You," "I Saw My Sorn Born," and "Love By the Book" are not very revealing, as titles, but undoubtedly serve to attract many readers.

Finally, "The Frank Facts About Sex and Your Heart" by George Riemer in Pageant for March 1958, gets right at the hard core of the matter. The foundation-information in this article was gleaned from data assembled by physicians and scientists and reported to medical audiences—information of importance to the public by way of their physicians, not via the interpretations placed upon it by the lay writer. The opening paragraph sets the stage as follows:

"In Milwaukee this past May, thousands of troubled men read newspaper excerpts of Dr. William Dock's report to a Wisconsin Heart Association conference on physical exertion. That night, a good number of them avoided their wives."

Besides describing the methods used by Doctors E. P. Boas and Roscoe Bartlett in collecting what appear to be facts about the effects of coitus, conclusions are drawn or implied that may not be justifiable. These conclusions could have deleterious effects upon medically ignorant readers, not the least of which might be fear. The ramifications of fear as related to sexual things is obvious. For example, the following passage is a scare-message:

"Normal, healthy men and women past the age of 37 shouldn't take chances at overloading their hearts either. Ardent love-making after arduous exercise isn't smart. Neither is love after an eight-course dinner..."

As a scientific study in medicine, reported to doctors, the information discussed in this article is quite justifiable. As an article in a popular magazine it needs only a few appropriate illustrations to make it eligible for the label pornography. For instance, the following passage would lend itself to such illustration:

"...There was usually a steep increase in heart rate at the moment of intromission and then a steep descent at withdrawal."

No doubt certain segments of the reading public are attracted by these articles, thus increasing the magazine's circulation; the writer profits by the demand for his semi-pornographic creations; but it can not be said that they furnish necessary or even helpful information and interpretation to those readers who have not the background to draw justifiable and useful conclusions.

This exemplifies another twig on the great tree of the knowledge of good and evil that we call "mass communication," as it applies to the field of medicine.

A TALE OF TWO DOCTORS

(A Guest Editorial)

Doctor Horace E. Campbell, Denver, Colorado, spends much time and energy promoting motor-car safety. It will be recalled that he presented two papers on this subject at the annual session of the Nebraska State Medical Association two years ago. One was published in our Journal. See Nebraska M.J., 41:307, August, 1956.

These two crash incidents are typical urban intersection episodes and the
speeds involved are very moderate, well within the urban speed limits. These were not high-speed highway accidents, against which most people would admit that special crash protection might be necessary. These were the kinds of accidents that occur to those who say, "I never drive fast; I never go out of the city."

On June 19, 1957, in Salt Lake City, Dr. Robert Snow was driving eastward during the morning rush hour and had just entered an intersection when a south-bound car, which had stopped at the intersection, found a break in the dense west-bound traffic, and dashed through the intersection, accelerating as he came. The doctor writes, "He crossed the intersection and hit my car at the left rear, throwing it to the right so forcibly that its right rear struck an automobile standing at the stop sign in the line of traffic waiting to go north at the same intersection.

"Despite the fact that the initial impact of the striking automobile forced the doors on the left to fly open, followed immediately by a secondary impact on the right side forcing the door on the right hand to fly open, I was held in my seat by a seat belt and felt myself jostled so strongly that I had a lame set of muscles about my pelvis for two or three days. In addition, my neck was somewhat lame for a week, but aside from that I had no injuries.

"I stayed with the automobile, which proceeded down the street some eighty feet before it came to a stop, inasmuch as my brakes had been destroyed by the initial blow.

"Inspection of my automobile revealed that the car had been compressed from side to side in the rear so badly that it was deemed best by both the insurance company and me to scrap the automobile and start over with a new one. Because I felt a deep gratitude for the seat belts, I arranged for them to be removed, and when they were taken out I discovered that the one that had been around me had some tears in the fabric, indicating the forces I had withstood. However, the seat belts were not torn in two. But for safety's sake they were discarded and replaced with a new set in my present automobile."

Just a month later to the day, on July 19, 1957, Dr. John Reinhold was driving west at 5th and Steele Streets in Denver. He had the right-of-way over the car which approached him from the left and which struck his car on the left rear fender. The driver of this car states that he was traveling no faster than 10 miles per hour and this was sustained by the investigation. He says he did not see the doctor's car, which witnesses state was going not faster than twenty-five miles per hour. Some say that it made two complete spins, others that it made three complete spins. The left door flew open, and because the car was a two-door model and the door therefore a very wide door, it was the bracing of this door against the ground that kept the car from turning over. Near the end of this first spin or revolution, the doctor was thrown out the door and slid down the pavement to a point 53 feet from the point of impact. The gyrating car overtook him, and he was fatally injured by the front wheel of his own car.

Dr. Snow writes further, "Subsequently, in Salt Lake City, a woman driving an automobile through an intersection in which she was going uphill, had exactly the same accident happen to her as happened to me, but with the car striking her travelling at a much slower rate of speed. Her car was thrown to the right, striking a curb at which moment her right hand door flew open and she fell partially out of the automobile, and the car then rolled back down the hill over her, killing her."

The present writer personally knows of two Denver young ladies, patients of his, whose convertible, equipped with belts just that morning, was struck on the right rear fender by a delivery truck which did not stop for a stop sign. The car made two and a half revolutions, both doors flew open, and both ladies sustained bruises to the shins as their extremities flailed about in the car. The driver claims she was able to miss two cars in their mad spin, by vigorous manipulations of the steering wheel.

A physicist has informed us that when the forward energy of an automobile travelling only thirty miles an hour is transformed into a spinning motion, the centrifugal forces, while diminishing rapidly, are at the outset almost astronomical. This explains, perhaps, the often tragic sequels of what would seem to be rather minor collisions.

Horace E. Campbell, M.D.

Nebraska S. M. J.
VARIATION OF SYMPTOMS with Herniation of Intervertebral Discs

EVERYONE should be familiar with the typical symptoms of herniation or rupture of a lumbar intervertebral disc. (Fig. 1). Characteristically, this occurs in a large muscular man who has had preceding episodes of postural low back trouble or "catch in the back" and who feels something "give away" in his back when he is lifting in a stooped position. Following this episode he develops pain which lateralizes in one "hip" or superior gluteal region and later radiates down this leg in "sciatic" distribution. With this lateralization the midline back-pain improves but the hip- and leg-pain persists, with protective list and limp and often with numb sensation and motor weakness in the foot. This man, in all probability, has some extruded disc tissue packed beneath a nerve root within the lower lumbar spinal canal and usually is not relieved satisfactorily by conservative treatment. Traction or a brace does not help or may make him worse, for this only tightens the nerve over the disc herniation and is likely to cause paralysis of that nerve. If conservative treatment is to be followed, it is better to permit this man to assume a semiflexed position which gives him some relief of pain. If lateralized nerve-root compression-pain persists longer than one or two weeks it is an economy of time and disability to have the extruded disc tissue removed surgically. The operation requires about one week in the hospital, with immediate relief of the intoler-

J. JAY KEEGAN, M.D.
Omaha, Nebraska

In this article Doctor Keegan sets forth, clearly and concisely, the fundamental information about herniation of intervertebral discs with which "everyone should be familiar." The illustrations supplement the text in a highly effective manner.

—EDITOR
able hip- and leg-pain, and two or three weeks for gradual resumption of normal activity.

Herniation of cervical intervertebral discs is less common but quite characteristic in the majority of cases. The patient, with previous episodes of “stiff” neck, wakes up with a very painful neck. He blames the draft from an open window, but the pain really is due to sleeping with his neck twisted. The pain soon extends into one upper medial scapular region and later radiates down the arm, often with numb sensation in one or more fingers or thumb and motor weakness in the arm. These lateralized symptoms are increased by turning the head and neck to that side and, if not relieved within one or two weeks time by protective posturing and rest, can be relieved quite satisfactorily by surgical removal of the extruded disc tissue from beneath the involved nerve root.

The typical discrete posterolateral extrusion of tissue from an intervertebral disc compresses only one nerve root within the spinal canal, and the lateralized symptoms and signs of that patient represent the distribution of that nerve. Accurate diagnosis of the nerve and disc involved usually can be made from the sensory, motor and tendon-reflex findings without the necessity of a myelogram. A useful chart of these single nerve root syndromes is presented in the accompanying illustration. (Fig. 2).

The occasional difficulty in diagnosis of herniation of intervertebral disc is due to variation in the character, size and location of the extruded tissue. In the early stage of central degeneration of a disc this loose tissue simply pushes or is displaced posterolaterally within the disc to cause bulging or protrusion without rupture of the disc or pressure on a nerve root. This stretches the very sensitive posterior longitudinal ligament over the disc and causes only midline back pain, noted particularly when seated. If this shifting of loose tissue within the disc develops suddenly as a “catch in the back” it usually returns to its normal central position within a few days, with relief of symptoms but tendency to recurrence. Occasionally, an early manipulation of various types will restore this displaced tissue to its normal central position with immediate symptomatic relief.

The next stage or type of disc herniation is the partial extrusion of loose tissue through the annulus of the disc where it variably compresses a nerve root and gives rise to lateralized radiating nerve root pain, chiefly in the superior gluteal or hip region. If the posterior longitudinal ligament is not ruptured over this small extrusion, there will be considerable midline back pain, differing from the patient with ruptured ligament who commonly states that his “back doesn’t hurt anymore.” This somewhat hour-glass shaped partly extruded tissue remains quite troublesome and disabling to the patient, as the remaining central piece tends to squeeze out with work-activity and intermittently compresses the overlying nerve root. The repeated trauma develops a very sensitive traumatic neuritis. This patient can do very little work, and his symptoms continue indefinitely. He is satisfactorily relieved by operation if all of the loose tissue within the disc is removed. If any of this remains it is likely to be squeezed out shortly after the operation and reoperation then is necessary.

The larger more complete extrusion of tissue from an intervertebral disc has a more favorable outlook, depending on its size. If it is not too large, it may flatten down and heal as a firm disc-elevation, with satisfactory and permanent relief of symptoms in two or three weeks. However, if the extrusion is large enough to continuously compress the overlying nerve foot, (Fig. 1) there will be evidence of sensory and motor paralysis of that nerve, developing within a few hours, and it is questionable whether waiting for very uncertain recovery without surgery is warranted. Pain may be relieved when the nerve becomes dead, and this gives a false impression of recovery. It will require a year or more to learn if motor recovery will occur after the nerve root has become functionless, even with surgical decompression, because axone regeneration develops at a rate of less than an inch a month. If pressure on the dead nerve continues and fibrosis develops there can be no nerve regeneration or recovery of motor loss, hence it seems better policy to remove the disc extrusion promptly by surgery when motor loss is evident.

Discrete posterolateral extrusion of tissue from a lumbar intervertebral disc does not always occur at the usual site beneath a single nerve root, but may be located more laterally or medially over the disc, or may dissect upward or downward over the body of a vertebra. (Fig. 3, A-H). The usual site of

Nebraska S. M. J.
COMMON SINGLE NERVE ROOT SYNDROMES

LOWER CERVICAL

FIFTH CERVICAL
PAIN UPPER BORDER SCAPULA.
TENDERNESS OVER TRANSVERSE PROCESS C4 - 5 VERTEBRAE.
RADIATION OF PAIN TO ANTEROLATERAL ARM.
NUMB SENSATION ANTEROLATERAL FOREARM.
HYPOALGESIA AS OUTLINED.
REFLEX OF BICEPS TENDON REDUCED.
MOTOR WEAKNESS & ATROPHY OF SERRATUS MAGNUS (WINGED SCAPULA) AND ANTERIOR DELTOID MUSCLES.

SIXTH CERVICAL
PAIN UPPER MEDIAL SCAPULA.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO POSTEROMEDIAL ARM.
NUMB SENSATION 4TH & 5TH DIGITS.
HYPOALGESIA AS OUTLINED.
REFLEX NO CHANGES RECOGNIZED.
MOTOR WEAKNESS & ATROPHY OF INTRINSIC MUSCLES OF HAND.

SEVENTH CERVICAL
PAIN UPPER MEDIAL SCAPULA.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO POSTEROMEDIAL ARM.
NUMB SENSATION 2ND & 3RD DIGITS.
HYPOALGESIA AS OUTLINED.
REFLEX OF TRICEPS TENDON REDUCED OR ABSENT.
MOTOR WEAKNESS & ATROPHY OF TRICEPS MUSCLE.

EIGHTH CERVICAL
PAIN OVER MEDIAL SCAPULAR SPINE.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO POSTEROMEDIAL ARM.
NUMB SENSATION 4TH & 5TH DIGITS.
HYPOALGESIA AS OUTLINED.
REFLEX NO CHANGES RECOGNIZED.
MOTOR WEAKNESS & ATROPHY OF ANTERIOR MUSCLES OF ARM.

LUMBAR SACRAL

FOURTH LUMBAR
PAIN IN GLUTEAL (HIP) REGION OVER TROCHANTER.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO ANTERIOR THIGH & LEG.
NUMB SENSATION ANTERIOR LEG, GREAT TOE.
HYPOALGESIA AS OUTLINED.
REFLEX OF PATELLAR TENDON REDUCED OR ABSENT.
MOTOR WEAKNESS & ATROPHY OF QUADRICEPS MUSCLE.

FIFTH LUMBAR
PAIN IN GLUTEAL (HIP) REGION BETWEEN ISCHIAL TUBerosITY & GREATER TROCHANTER.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO LATERAL THIGH AND LEG.
NUMB SENSATION LATERAL LEG, THREE MIDDLE (OR GREAT) TOES.
HYPOALGESIA AS OUTLINED.
REFLEX USUALLY NO ALTERATION.
MOTOR WEAKNESS & ATROPHY OF DORSAL FLEXORS OF ANKLE AND TOES.

FIRST SACRAL
PAIN IN MEDIAL GLUTEAL (HIP) REGION OVER ISCHIAL TUBERCITY.
TENDERNESS OVER TRANSVERSE PROCESS OF VERTEBRA.
RADIATION OF PAIN TO POSTERIOR THIGH & LEG.
NUMB SENSATION POSTERIOR LEG, LITTLE TOE.
HYPOALGESIA AS OUTLINED.
REFLEX OF ACHILLES TENDON REDUCED OR ABSENT.
MOTOR WEAKNESS & ATROPHY OF PLANTAR FLEXORS.

SECOND SACRAL
PAIN IN MEDIAL GLUTEAL FOLD.
TENDERNESS OVER UPPER LATERAL SACRUM.
RADIATION OF PAIN TO POSTERO-MEDIAL THIGH, LEG AND REEL.
NUMB SENSATION MEDIAL GLUTEAL FOLD, LABIUM MAJUS OR SCROTUM.
HYPOALGESIA AS OUTLINED.
REFLEX PLANTAR FLEXION RESPONSE REDUCED.
MOTOR WEAKNESS NONE RECOGNIZED.

Figure 2. Common nerve-root compression-syndromes in the lower lumbar region, caused by herniation of inter-vertebral discs.

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a lumbar disc herniation is directly beneath the next nerve root below that numbered disc because of the oblique course of the nerves. Thus the first sacral nerve root is compressed by herniation of the fifth lumbar disc and others correspondingly. A more medial herniation may compress the adjoining nerve root in addition to the usual one. A far lateral disc herniation, in the intervertebral canal, will compress the corresponding nerve root and will not be visible in a myelogram. Diagnosis then must be made from the history and neurological signs, uncovering the known involved nerve root through its intervertebral canal until the extruded tissue is found. Likewise, descent of extruded disc tissue downward over the body of the lumbar vertebra necessitates removal of that lamina to find it. Upward and lateral extension of the extruded tissue may compress chiefly the nerve root above and easily be missed in surgical exploration. It is important to recognize these variations in the site of disc herniation and to depend, in a major degree, on accurate neurological diagnosis.

There is an age-factor in the type or location of disc herniation. Young persons in their twenties rarely develop rupture of a disc because of the elasticity of their tissues, but may develop a localized protrusion which compresses a single nerve root. The common age for disc rupture is between thirty-five and forty in a large man who continues to place excessive strain on his back as he did safely in his twenties. As age advances, disc herniation tends to occur at a higher lumbar level, the less common third or second lumbar disc herniation usually occurring beyond fifty years of age and being more laterally located over the disc.

Diffuse degeneration of discs commonly occurs in older persons without posterior herniation but with prominent anterior and lateral protrusion. This gives rise to the hypertrophic spurs so commonly seen in X rays in both the lumbar and cervical regions. This leads to moderate spine-pain and limitation of motion as age and sclerosis advance. Occasionally such a diffusely degenerated disc in a younger person extrudes posteriorly. If a large midline extrusion occurs suddenly from violent flexion-strain on the neck or lumbar region, the extruded tissue may seriously compress the spinal cord or cauda equina and cause serious paraplegia. (Fig. 3-1, H). Prompt diagnosis and surgical relief then is indicated to prevent permanent paraplegia. Occasionally, an isolated diffusely degenerated lumbar disc with persisting midline back pain requires spinal fusion for relief, although it may become stable after considerable time as a result of sclerosis. Fusion is not indicated when the pain has become lateralized to one hip and leg because this represents nerve root involvement. Likewise the recurring midline back pain associated with “catch in the back,” which disappears when disc rupture has occurred, is not an indication for spinal fusion. Posterior ridging of diffusely degenerated discs sometimes gives rise to slowly progressive compression of the spinal cord or cauda equina. This is very difficult to differentiate from degenerative diseases of the spinal cord or cauda equina.
SOME ANATOMICAL CONSIDERATIONS OF

Pelvic Injuries and Their Complications

THE increasing frequency of pelvic injuries is accompanied by an increasing need for accurate knowledge of some of the anatomical features of the pelvis and pelvic viscera, which may aid in understanding these injuries, their complications and their treatment.

In a limited review such as this it is only possible to call attention to a few points which seem to be the most important and of most general application. Among these might be included, the structure of the bony pelvis as a weight bearing system, the peritoneal and fascial relations of the pelvic viscera, the nature of urogenital diaphragm, some of the relations of the urethra, particularly in the male, and the position of vessels most likely to be involved in hemorrhage.

The bony pelvis transmits weight through a system of two primary arches both of which have the sacrum as an apex or key-stone and both of which include the sacroiliac joints and ilia (Fig. 1). One of these, employed in standing, throws the weight to the acetabula and thence to the femoral heads. The other, involved in sitting transmits the weight to the ischial tuberosities. Both of these primary arches are reinforced by a third arch consisting of the horizontal and ascending rami of the pubes which join at the symphysis pubis and convert the pelvis into a ring.

An injury to the pelvis which does not actually break up this ring will not disrupt the weight bearing system and can usually be handled without prolonged hospitalization. In order to break continuity of the pelvic ring, it must be fractured in at least two places, or there must be extensive injury to the sacroiliac joint and one fracture. Thus, many of the cases of pelvic fractures need not involve the disadvantage of long continued confinement to bed.

Injuries to the urethra and bladder are common both as complications to pelvic fractures and independently. In penetrating and gunshot wounds the rectum is also involved rather frequently. In such cases it is important to know where the contents of ruptured or perforated viscera is likely to spread. This is determined to a considerable degree by the fascial and peritoneal relations.

The bladder, rectum, uterus and vagina are all invested by fascia which is reflected onto them at the points where they pass through the levator ani muscle (Figs. 2 and 3). These fascial investments are mostly thin except near the pelvic floor. The prostate is surrounded by a heavy layer which thins out over the bladder and the fascia surrounding the vagina is heavy, but thins out before it covers the uterus. The fascia covering the superior or pelvic surface of the levator ani muscle is, in turn, derived from the obturator fascia along the course of the white line or arcus tendineus, from which the muscle takes origin (Fig. 4). It has been known under various names such as parietal pelvic fascia, levator ani fascia, and superior anal fascia.

The fascia covering the bladder is joined at the fundus by another layer coming down the ventral abdominal wall which is deep to and distinct from the transversalis fascia.
in the lower part of the abdomen (Figs. 2 and 3). This layer may be known as the preperitoneal fascia. The retropubic space or space of Retzius (A Figs. 2 and 3) lies between the preperitoneal fascia and the transversalis fascia as far inferiorly as the sym-physis pubis. Below that level it lies between the pubis and bladder and is continued inferiorly to the pelvic floor.

The peritoneum investing the pelvic structure does not reach the pelvic floor at any point. In the female it extends only far enough inferiorly to cover the posterior fornix of the vagina, (Fig. 3) and in the male, to invest the tips of the seminal vesicles (Fig. 2). Between the peritoneum and the pelvic floor is a rather extensive space occupied only by loose areolar tissue and traversed by the ureters and the vessels and nerves to the lower pelvic viscera (B, Figs. 2, 3 and 4). This space can permit large accumulations of extravasated urine, fecal material, pus, or blood. Material accumulating here can spread anteriorly between the bladder and pubis and up the ventral abdominal wall in the space of Retzius, between the transversalis and preperitoneal fasciae deep to the abdominal musculature (Fig. 2). It
can spread laterally and posteriorly and so reach the gluteal region through the sciatic foramen either above or below the pyriformis muscle. It can spread posteriorly and up along the sacrum, past the sacroiliac joints into the lumbar region behind the prevertebral fascia.

Penetrating wounds and ruptures of the pelvic viscera can, of course, break the peritoneum and thus involve the peritoneal cavity directly.

In the male, where rupture of the urethra may complicate pelvic injuries, the relations of this structure are particularly important.

The male urethra begins as the prostatic urethra and having traversed the prostate gland it perforates the superior layer of the urogenital diaphragm and is continued between its two layers as the membranous urethra. It reaches the perineum by passing through the inferior layer of the urogenital diaphragm and becomes the cavernous urethra which is surrounded by the bulb, the corpus cavernosum urethrae and the bulbocavernosus muscle (Figs. 2 and 4).

The prostatic urethra is well protected by the prostate gland and is not readily ruptured. The vulnerable points are just above the urogenital diaphragm, where the wall thins out, the membranous urethra, and just below the urogenital diaphragm at the origin of the cavernous urethra. The entire cavernous urethra is, however, relatively exposed and may be subject to injury.

The course of escaping urine depends upon the position of rupture. Above the urogenital diaphragm rupture will be into the pelvis and the course of escaping urine will be determined by the relationships previously discussed. Spread will be into the loose tissue of the pelvis and into the retropubic space with extension up the deep surface of the ventral abdominal wall.

The membranous urethra will rupture into a closed space (C Figs. 2 and 4) and the urine will be confined until one or the other of the walls breaks down. If rupture occurs below the inferior layer of the urogenital diaphragm urine can escape into the perineum and will not reach the pelvis. The urine may be confined for a time by the fascia investing the bulbocavernous muscle (Buck's fascia). On rupture of this layer it is free to spread over the perineum, but its further extension will be limited by the attachments of the deep membranous layer of the superficial fascia (Figs. 2 and 4). This layer over the perineum is widely known under the name of Colles' fascia. Lateral to the scrotum on either side it is continued up the lower part of the ventral abdominal wall under the name of Scarpa's fascia. Colles' fascia is distinct from the overlying fatty superficial fascia over the perineum. In the scrotum, however, two layers cannot be distinguished, the subcutaneous tissue forming the dartos tunic. As Scarpa's fascia it again becomes distinct over the lower portion of the ventral ab-

Figure 4. Frontal section male pelvis: diagramatic.
dominal wall and is gradually lost if followed superiorly above the umbilicus (Fig. 2). The space deep to it, however, remains unobstructed and leads up into the pectoral region.

On the perineum, Colles' fascia is adherent to the posterior free margin of the urogenital diaphragm (Figs. 2 and 3) and to the fascia lata along the pubic arch (Fig. 4). Thus urine escaping deep to it (into space D, Figs. 2 and 4) is prevented from extending, either into the medial thigh or posteriorly into the ischiorectal fossa. Instead it is directed forward through and around the scrotum to the ventral abdominal wall deep to Scarpa's fascia. Scarpa's fascia in turn is adherent to the fascia lata along the course of the inguinal ligaments preventing extension into the anterior thigh. Thus the urine is directed up to the ventral abdominal wall where it may continue into the pectoral region.

The nature of the inferior layer of the urogenital diaphragm is important in determining the frequency of perineal injuries, especially in the male. This diaphragm is a two layered structure stretching across the pubic arch with a free posterior border between the ischial tuberosities (Fig. 2). Under the symphysis pubis it is incomplete where the deep dorsal vein of the penis passes through it.

The superior layer is thin and is derived from the pelvic fascia (Fig. 4). The inferior layer, however, is not composed of fascia. It is an independent structure consisting of dense white fibrous connective tissue and can more properly be considered as a ligament. As such it is rigid and unyielding. Hence, contusions to the perineum are likely to result in injury to the corpora cavernosa, and to the cavernous urethra.

Finally, hemorrhage can be a serious complication to soft tissue injury in the pelvis. When it occurs it can be difficult to control because the vessels involved are usually deeply placed and difficult to reach. The loose tissue in the pelvis permits extensive hematomas to form without giving much external evidence.

Arterial bleeding is usually from one of the branches of the hypogastric artery. In the gluteal region the superior or inferior gluteal arteries are likely to be involved. Both leave the pelvis through the great sciatic foramen, the former above and the latter below the pyriformis muscle. The internal pudendal artery is sometimes injured. It reaches the perineum by passing around the ischial spine first through the greater then the lesser sciatic foramina. Within the pelvis, bleeding may come from the superior, middle, or inferior vesicle arteries, the middle hemorrhoidal (which is often rather small) or, in the female, the uterine artery.

It is well to remember that venous hemorrhage into the pelvis is common and may be extensive. There are richplexuses of veins deep in the pelvis. In the male these are related to the prostate and inferior aspect of the bladder, and, in the female, to the vagina.

All of these vessels are rather inaccessible and adequate exposure is necessary in order to reach and control them.

In summary it has been pointed out that pelvic fractures may not require prolonged hospitalization unless the pelvic ring is disrupted. This requires fracture in at least two places or fracture and damage to the sacroiliac joint. The relationship of the adjacent fascia and peritoneum to the pelvic viscera has been described and their effects on the accumulation and spread of escaping material indicated.

The more frequent points of injury to the urethra have been explained and course of extravasated urine in each case followed. It has been emphasized that the unyielding nature of the inferior layer of the urogenital diaphragm is responsible for rupture of the urethra in many of the injuries occurring in the male perineum.

The most likely sources of severe hemorrhage in pelvic injuries have been indicated. It is emphasized that extensive venous bleeding may occur and that wide exposure is necessary to reach and control the vessels usually involved.

Three-fourths of all hospital assets—nearly $10 billion—are invested in institutions providing general care or specialized services other than psychiatric or tuberculosis. Psychiatric hospitals, which provide nearly half of all the beds in this country, own only about 20 per cent of the total hospital assets according to Health Information Foundation.
PRESENT DAY CONCEPT of

Atherogenesis*

This talk is based on the 36th Mellon Lecture delivered November 5, 1952, before the Society for Biological Research, Pittsburgh, Pennsylvania. It has been brought up to date for the current presentation.

ALTHOUGH there have been many theories advanced as to the cause and progression of atherosclerotic plaque, there are two that hold the limelight at the present time. One advanced by Duguid1,2 postulates that, under certain conditions, thrombi form on the intima of arteries, become attached and a layer of endothelium extends over the thrombus so that the lumen of the artery is once again intact, so far as the endothelium is concerned. An exaggeration of this process would be the complete occlusion of an artery with subsequent recanalization taking place and the integrity of the endothelium again being restored by its extending through the new channel. The thrombus may now be organized and converted to fibrous tissue or, "more often, before the process (organization) has reached the center, fatty degeneration and sometimes softening take place, and thus the picture of atherosclerosis is produced."

It is undoubtedly true that a process similar to the above takes place in the peripheral arteries and sometimes in the pulmonary arteries. Most authorities on the North American continent, however, feel that it does not explain the formation of atheroma in the coronary arteries and probably not all of the atheroma in the sites mentioned.

A more generally accepted theory is one that, while not new, has found its most recent and forceful advocate in Holman3. This concept postulates:

1. A focal lipid infiltration at the junction of the intima and media.
2. Progression of this lipid infiltration to an atheroma (yellow or lipid plaque).

3. Progression from the lipid plaque through fibrosis, vascularization and calcification to the pearly (fibrous) plaque.
4. In the experimental animal the lipid plaque is reversible while the pearly plaque is not. We must assume that this is also true in the human.

All of the above can take place without any clinical evidence that atherosclerosis is present. The state that we term disease is the result of some complication affecting

CHARLES F. WILKINSON, JR., M.D.
From the Department of Medicine, New York University Post-Graduate Medical School, and the Fourth Medical (N.Y.U.) Division, Bellevue Hospital New York, New York

Figure 1. This illustration shows the schematic progression from atheroma to pearly plaque. Under complications are shown some of the ways in which the plaque may cause the blood supply to be decreased distal to the lesion. Under disease are listed some of the ways in which these complications manifest themselves clinically.

*Given at the Conference on Coronary Heart Disease, Eighth Annual Scientific Session of the Nebraska Heart Association, October 3, 1957, Omaha, Nebraska.

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either the lipid or pearly plaque, usually the pearly plaque (Figure 1).

It is important to stress that one or more complications must occur before we have clinical evidence of atherosclerosis.

Holman has also demonstrated that the beginning of this process can occur in infancy. The progress of atherogenesis is continuous, though episodic: slow at first with a rather pronounced increase in rate in the middle 20's. About the age of 45 there is another sharp increase in rate until the middle 50's, then a decline until 65, then another sharp increase in rate (Figure 2).

![Figure 2](image.png)

Figure 2. Bottom line shows the incidence of 4+ atherosclerosis when plotted against age in years.

At this point we may well ask several questions. Why is this lesion focal? Why is the progress episodic? What determines the rate of development?

Many feel that the focal nature of the lesion can be explained by inherent trauma. This concept has been well presented by Dock and experimentally confirmed by Taylor to name one who has published extensively on the subject. Others, including myself, feel that a strong case can be made for a genetic factor, an inherited diathesis.

The primary factor, or factors, neither explain different rates of atherogenesis nor its episodic nature. For this reason we postulate secondary factors that speed up the rate of development and/or give it its episodic character. Atherosclerosis is, as Page has pointed out, a "multifaceted disease."

Since it is unlikely that we can control the primary factors, we are forced to concentrate on the known or suspected secondary factors. Among these are: arterial blood pressure, diet, body weight, chemical composition of the blood, metabolic disease (i.e., diabetes, familial hyperlipemia, myxedema, nephrosis, etc.) and, of course, sex.

Many efforts have been made to control one or all of the above, even sex. You would not forgive me if I attempted to present all of the data available. The rest of this conference would hardly supply enough time. Because of this I make no apologies for selecting the authorities I quote, fully realizing that I shall arbitrarily have to disagree with some and, what is worse, ignore others.

To me the most important of these secondary factors is hypertension. It is my opinion that Dr. Irvin Page spoke for the vast majority in this field when he said, "if we could cure hypertension we would have the problem more than half licked." I completely agree with him and, since I can't cure hypertension, I will leave this larger part of the problem to those who are in this field of investigation. Progress is being made by these investigators and I would only emphasize again its importance to the problem.

A somewhat humorous piece appeared in "The Lancet" which, in spite of its humor, contains a real lesson. It refers to a country where the life expectancy was so low that milk, butter, cream and eggs had to be furnished to the people so that they could increase their life expectancy to the point
at which they would have the dubious pleasure of either dying of a coronary occlusion or else stop eating milk, butter, cream and eggs.

In many cultures, dietary habits have become established which, to the outsider, seem absurd or disgusting. As one inquires more deeply into these eating habits, however, one finds that there is usually a sound metabolic purpose served by these apparently outlandish foods. The kimchi of the Koreans does not usually seem appetizing to the Western palate, but it contains many of their essential vitamins and is, in fact, one of the richest sources of Vitamin C yet recorded. The same can be said for the addition of ground limestone to the rice flour of the Formosans. It would appear that it is added to make the flour more attractive and white, but it furnishes the bulk of calcium in their diet.

Far too little is known about the role of unsaturated (essential) fatty acids to deny future generations their fat, particularly all types of fat, without regard to type or fatty acid content, just because correlation is present to a greater or lesser degree between the incidence of coronary occlusion (as reflected by vital statistics) and the fat content of the diet (as determined by interview or Government data on the sale of foodstuffs). There are so many variables that are known, and presumably more still unknown, that even if correlation is high such a hypothesis must be tested before a cause-and-effect relationship can be established.

There are several things that the diet must do. First it must supply adequate calories, proteins, vitamins and minerals and the proteins must contain all of the essential amino acids. The diet should probably contain unsaturated fatty acids, at least during the period of growth. Finally, if the above components are to be made available, the diet must be palatable. A diet extremely low in fat, rightly or wrongly is not palatable to most of us. One wonders if, after reducing the fat to the point where the diet becomes unpalatable, a person will eat enough of it to obtain the nutrient materials required.

If the concept of the early reversibility of the atheromatous plaque is accepted, then the ideal treatment of atherosclerosis is prevention. An extremely low fat diet inaugurated in the late teens or early twenties could conceivably cause conditions that are equally as lethal as atherosclerosis. Most physicians have seen cirrhosis of the liver develop as a result of diet fads where, for one reason or another, essential food elements were lacking. If we are to prescribe a change in diet for a growing generation, we must be sure that we are not depriving them of these essential elements while we are trying to prevent a condition, the causes of which are multiple.

Cow’s milk and human milk contain approximately the same amount of fat, while the human milk contains less than half the amount of protein present in cow’s milk and more carbohydrate. Certainly the carbohydrate and fat have a protein-sparing action that enables the growing child to utilize the protein in either for anabolic purposes. When fat-free or low fat formulae are used, they are difficult to prepare and, in the long run, may be upsetting to the child and even interfere with its normal development. Certainly no pediatrician would recommend this as an ideal way to nourish a normal baby.

Granted that some people are not able to handle fat as well as other people, this still does not mean that a ubiquitous reduction in the fat content of our diets is necessarily desirable. For instance, it appears that individuals with familial hyperlipemia can handle fat in large amounts, provided it is properly spaced in time. We must not confuse a working hypothesis with an established fact.

Another point that should be emphasized is that many dietary surveys are based on the food that is purchased, rather than the food that is consumed. For instance, if one is to take the Department of Agriculture’s figures on the amount of fat bought by the average American family and use it as the amount, or approximate amount, of fat consumed by the average American family, he would discount entirely the fact that much of this fat is not eaten, but is thrown away. In some households, for instance, it might be said that people throw away more fat than they drink coffee, because there are never enough coffee cans present to contain the fat that is discarded.

It is essential then, that we not be stampeded into changing the way of life, or rather trying to change the way of life, of our population. Metabolically, fat is a good food. It spares protein for anabolic pur-
poses, makes our diet more palatable and, because of its high energy value per weight, reduces the cost of transportation of food.

It has been shown by Hatch and co-workers that with patients on a rice diet (low fat), the triglycerides increased in the blood. Ahrens and his colleagues added cogent support to this observation by demonstrating that the triglyceride blood level responded in a reciprocal fashion to the amount of fat in the diet. The highest levels of triglycerides were on a diet where corn oil made up 10% of the calories, lower when it supplied 40% and lowest of all at the 70% level. Protein was kept constant. Whether this is the result of high unsaturated fat or low carbohydrate is still unknown.

Several years ago Kinsell demonstrated that the blood cholesterol could be lowered by the ingestion of a diet where the fat content of the diet was made up of unsaturated fatty acids. These findings have been confirmed by Ahreng and his colleagues who also demonstrated that above the iodine number of 90 there is very little difference in the action of fats, no matter how unsaturated they may be (Figure 3).

These strong differences of opinion may be differences in degree, but they are widely divergent. All will agree that there are certain conditions where diets should be prescribed by the patient’s physician. Many of us feel, however, that to recommend a drastic nation-wide change in diet at this time would be wrong.

Probably no one would try to make a case for obesity as an etiological factor in any type of heart disease with the possible exception of hypertensive and atherosclerotic. Essential hypertension and hypertension secondary to chronic renal disease are undoubtedly complicated by obesity, as is any heart disease. It can hardly be said, however, that obesity is a true etiological factor. Simple hypertension, which is often nonsymptomatic, does seem to be etiologically related to obesity. The obese person with mild hypertension usually has a reduction in blood pressure when his weight is reduced to ideal. If, however, he again becomes obese we can expect to find his blood pressure elevated.

This mechanism is not clear. The increased capillary bed of the adipose tissue has been implicated, as has the extra effort required to transport the excessive poundage. Certainly the metabolic processes of the fat person are increased. All in all, whatever the mechanics, we can state with assurance that many cases of simple hypertension can be correlated with obesity.

Does obesity predispose to a great incidence of atherosclerosis? Here there is an honest difference of opinion. Wilens has pointed out that, in autopsy cases studied by him at Bellevue Hospital, the degree of atherosclerosis found in those that were obese at death was significantly greater than those not obese at death. He has also shown that individuals who had been obese but, for one reason or another, died not obese had less atherosclerosis than would have been predicted had they continued to be obese. This is disputed by some authorities and confirmed by others.

Most of us, while not entirely satisfied that obesity is, per se, a simple, direct, secondary factor, have misgivings about the fat man or woman and would, I am sure, feel better if they were to reduce, and I believe we should make every effort to reduce them.

At this point, I would like to state that I
do not subscribe to the proposition that too much fat in the diet equals too much fat in the blood equals too much fat in the artery.

The composition of the blood lipids has come in for considerable study. Cholesterol, because of the development of the Liebermann-Burchard reaction, has been the easiest fat to determine, and has received the most attention. In fact, it has been said that "this reaction may have been a blue-green herring across the trail of investigation."12 If, for instance, triglycerides had been easy to determine, the early emphasis might have been quite different. It is my opinion that hyperlipemia (elevation of triglycerides) with or without hypercholesterolemia is of more importance than primary hypercholesterolemia. This opinion is based, in part, on the study a group of us conducted on a large family several years ago23, 24. We were unable to demonstrate any difference in frequency of heart disease in the normcholesterolemic and the heterozygous hypercholesterolemic (Figures 4 and 5).

\[
\begin{align*}
C &= \text{HYPERCHOLESTEROLEMIA} \\
C &= \text{NORMOCHESTEROLEMIA} \\
CC &= \text{HOMOZYGOUS ABNORMAL} \\
Cc &= \text{HETEROZYGOUS ABNORMAL} \\
cc &= \text{HOMOZYGOUS NORMAL}
\end{align*}
\]

Figure 4. This illustration shows the genetic mode of transmission in essential familial hypercholesterolemia.

This is not true of the homozygous abnormal. Xanthomatosis and coronary heart disease are common when two genes for hypercholesterolemia are present in the same person.

On the other hand, those metabolic diseases designated above have hyperlipemia, either primary in the case of familial hyperlipemia, or secondary in the others. The cholesterol is usually elevated in all of them but we feel that this is a secondary elevation. These are all conditions which predispose to increased atherogenesis; the management of hyperlipemia is the management of the disease and the spacing of ingested fat where indicated, but this will be taken up later in the week25.

Another indictment of the hyperlipemic state is the observation of several observers that lipemia may affect the clotting mechanism so that various parts of it are speeded up. This is, of course, in vitro clotting and neither the part of the mechanism affected nor the admission that it is affected is agreed upon by all authors26-30.

For years the student of atherosclerosis has been fascinated by sex, but for two reasons. The second one being that the female, other things being equal, is protected from the coronary complications of this disease when compared to the male. This protection lasts from puberty until the menopause. It has been shown by Horlick and Katz31 that experimentally, this can be demonstrated and the difference wiped out if the male is gelded with large doses of estrogens. Barr32, among others, has shown that the typical female alpha-beta-lipoprotein pattern of the premenopausal female is changed in the direction of the male pattern when she is afflicted with those metabolic conditions that obliterate her natural immunity to coronary atherosclerosis. He has also shown that the male pattern can be changed toward the female, if large doses of estrogens are given33.

It follows, of course, that a combination of two or more secondary factors would further speed up the process of atherogenesis.

Let us return to Figure 2 and speculate. Is the break in the curve of 4+ lesions at 45 due to one or more of these secondary factors? Does the decrease from 55 to 65 rep-
resent those who have died too young because these secondary factors have not been controlled? Is the natural progress of atherosclerosis a smoother curve as represented in Figure 6? Does the cross-hatched triangular area represent the people we might save if we were diligent in our search for these secondary factors?

Should we go back even farther and imagine a more gentle slope from the age of 35 (Figure 7) if all the secondary factors both known and unknown could be corrected?

I do not know the answer and I doubt if anyone does. It is my opinion, however, that when we can identify and correct, insofar as is possible, all these secondary factors we will achieve the slope for increase in advanced lesions as shown in Figure 7. This may not be tomorrow, but it is the goal we strive for.

The author is indebted to Dr. R. L. Holman and to the Association of Life Insurance Medical Directors of America for permission to reproduce Figures 1 and 2. The author is also indebted to Dr. Edward H. Ahrens, Jr., and the editors of The Lancet for permission to use Figure 3.

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Current Comment

Heart Attacks Occur at Rest—

Heart attacks strike far more often when a person is resting than when he is working, according to the current issue of the new monthly publication Patterns of Disease.

Approximately 30 per cent of all coronary heart attacks occur when people are resting; a mere two per cent when they are engaged in "sports, running, lifting or moving a load," and studies are cited to indicate that the highest death rate in males occurs among those employed at sedentary jobs.

It is noted that deaths from heart disease tend to rise during the winter months and to decline during the summer. Death rates for heart disease vary, too, from state to state, with the New England states heading the list and southwestern states such as Arizona and New Mexico ranking last.

As far as classification is concerned, Patterns cites hypertension and arteriosclerosis as accounting for over 90 per cent of deaths from cardiovascular disease, including vascular lesions affecting the central nervous system and myocardium. Coronary heart disease remains the leading heart problem.

Almost 8 per cent of all visits to practicing physicians are for cardiovascular disease, and 60 per cent of these patients consult general practitioners, 36 per cent consult specialists, and 4 per cent consult other types of physicians.
SEROLOGICAL SURVEY OF
PACKING HOUSE WORKERS
In Omaha for
Q Fever

In the more than twenty years since Q fever was identified and described, this disease has been rarely recognized and reported excepting in epidemics. This rickettsial disease was known to infect a number of ticks, but domestic animals have been thought to be the more common source of infection in man. The investigation herein reported supports the thesis of animal source, proves that Q fever is present in this area, and that it is not diagnosed as a rule.

—EDITOR

IN 1937, Derrick¹ of Australia published his classic description of a previously unrecognized disease entity to which he gave the tentative name of "Q" fever (for Query or Questionable). The disease since has been reported throughout the world. In the United States, outbreaks have occurred in many of the major slaughter houses and serological surveys have indicated a widespread geographic distribution of Q fever in this country. Although Omaha is recognized as one of the largest livestock centers in the world, not a single case of Q fever has been reported among employees of the Omaha packing plants.

In view of these facts, it appeared desirable to undertake a serological survey to determine the frequency with which antibodies against Coxiella burnetii antigen occurred among the Omaha packing-house workers. Two hundred and thirty-five blood samples were obtained from employees of eight Omaha packing houses and complement fixation studies employed for detection of the Q fever agent. The results of the studies have been analyzed and presented in this report.

Q fever is an acute infectious disease caused by C. burnetii and characterized by sudden onset of fever, frontal headache, weakness, malaise, severe sweating, and roentgenologic evidence of pulmonary infiltration with minimal symptoms referable to the respiratory tract. It differs from other rickettsial diseases in that cutaneous exanthema is not a feature of the disease.

C. burnetii is an obligate intracellular parasite. It is a minute, pleomorphic organism resembling the rickettsia morphologically and in its staining characteristics. On the other hand, it differs from the other rickettsiae in that it does not develop agglutinins for any known strain of Proteus and is readily filtrable through both Berkefeld N and W filters. These variations coupled with the fact that the organism shows greater resistance to physical and chemical agents than other rickettsiae lead to the new generic term, Coxiella.

Epidemiological studies² indicate that an important source of infection is through the mediums of contaminated air, insects, dung of infected animals, or handling of infected raw meat. It is clear that association with livestock, especially cattle as in abattoirs or in stockyards and dairies, constitutes a distinct hazard with respect to Q fever. Laboratory workers and persons drinking raw milk are especially susceptible to infection. It is of interest that C. burnetii can survive the recommended pasteurization temperatures of 145° F. for thirty minutes. In the United States a number of ticks are naturally infected, especially Dermacentor andersoni and Amblyomma americanum. Ticks, however, have very little relation to human infection for not one patient in a hundred suffering from Q fever gives a history of contact with ticks. Person to person contact infection is on record, but rare.

Clinically, the disease resembles the atypical- or virus-pneumonia group. After a latent period of about nineteen days, severe persistent headache develops accompanied by chills, fever, sweating, generalized malaise, nausea and vomiting, and rarely, a hacking cough. The fever is marked by wide fluctuations and remains for three to fourteen days. The chest X ray reveals soft, infiltrative lesions which are present by the third to fourth day of the disease. The le-

*Director of the Division of Preventable Disease Control, Omaha-Douglas County Health Department.

**Medical Student, the Creighton University School of Medicine; Fellow of National Foundation for Infantile Paralysis, whose funds made this study possible.

***Director, Division of Laboratories, Omaha-Douglas County Health Department.
sions are indistinguishable from those of primary atypical pneumonia. Complications are rare but convalescence progresses slowly for several weeks and it is not uncommon for patients to lose fifteen to twenty pounds during the active stages of the disease. The course of the disease is generally benign, except in the protracted form which may show hepatic involvement with clinically detectable icterus.

The laboratory confirmation of the diagnosis may be by: (1) complement fixation reaction through demonstration of rise in antibody titer between acute and convalescent specimens; (2) agglutination; or (3) recovery of the causative organism from blood of the patient. Recovery of the organism from the diseased person is readily accomplished, but it is hazardous to laboratory workers.

Cox, Bengtson and Smadel have done work in the preparation of Q fever vaccines, but as to date, sufficient field data is lacking to indicate their protective value. It should be noted that no laboratory workers who have been vaccinated have contracted the disease.

An accurate morbidity report of Q fever in the United States is not available for two reasons: first, Q fever is not ordinarily differentiated from other respiratory diseases; and second, the disease is reportable in only a few states.

The National Office of Vital Statistics reports the following incidence of the disease covering the period between 1947 and 1955:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>63</td>
</tr>
<tr>
<td>1954</td>
<td>8</td>
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<tr>
<td>1953</td>
<td>4</td>
</tr>
<tr>
<td>1952</td>
<td>8</td>
</tr>
<tr>
<td>1951</td>
<td>0</td>
</tr>
<tr>
<td>1950</td>
<td>0</td>
</tr>
<tr>
<td>1949</td>
<td>2</td>
</tr>
<tr>
<td>1948</td>
<td>1</td>
</tr>
<tr>
<td>1947</td>
<td>0</td>
</tr>
</tbody>
</table>

Of the sixty-three cases reported in 1955, fifty-nine were reported in California, three in Idaho and one in Iowa. The disease has been shown to be endemic in both northern and southern California, and the great amount of research done in that state has brought about increased case recognition as can be attested by the foregoing figures.

The monthly morbidity as reported by the National Office of Vital Statistics, for 1955, is:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1</td>
</tr>
<tr>
<td>February</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>3</td>
</tr>
<tr>
<td>April</td>
<td>9</td>
</tr>
<tr>
<td>May</td>
<td>15</td>
</tr>
<tr>
<td>June</td>
<td>11</td>
</tr>
<tr>
<td>July</td>
<td>8</td>
</tr>
<tr>
<td>August</td>
<td>3</td>
</tr>
<tr>
<td>September</td>
<td>3</td>
</tr>
<tr>
<td>October</td>
<td>5</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
</tr>
<tr>
<td>December</td>
<td>4</td>
</tr>
</tbody>
</table>

It appears from this limited data that the disease has its highest morbidity rate during the spring and early summer months with 63.2 per cent occurring during April, May, June, and July. This seasonal incidence may be partially explained in that lambing occurs at this season and contamination of the environment is likely to occur from infected placentae and milk. Those associated with the sheep show the greatest rate of infection at this time.

Strauss and Sulkin in April 1949, reported on serological surveys to determine the frequency with which antibodies against C. burnetti occurred in different geographic areas and among different occupational groups. Tests were performed on 5470 sera obtained from persons residing in Massachusetts, Minnesota, Oregon and Texas. Only those titers above 1:8 were considered positive.

The results of complement fixation test against C. burnetti were as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Number Tested</th>
<th>Positive</th>
<th>Per Cent Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Worth Meat Packers</td>
<td>May-June, 1947</td>
<td>1463</td>
<td>114</td>
<td>8.0</td>
</tr>
<tr>
<td>Minnesota Meat Packers</td>
<td>Nov. 1947</td>
<td>150</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Amarillo Serology Lab</td>
<td>Aug. 1947</td>
<td>175</td>
<td>14</td>
<td>7.9</td>
</tr>
<tr>
<td>Dallas Serology Lab</td>
<td>July 1947</td>
<td>1033</td>
<td>105</td>
<td>10.2</td>
</tr>
<tr>
<td>Boston Serology Lab</td>
<td>Oct.-Nov.</td>
<td>965</td>
<td>11</td>
<td>1.1</td>
</tr>
<tr>
<td>Dallas Blood Donors</td>
<td>Dec. 1947-Mar. 1948</td>
<td>798</td>
<td>17</td>
<td>2.1</td>
</tr>
<tr>
<td>Dallas Dairy Workers</td>
<td>Mar.-April</td>
<td>350</td>
<td>7</td>
<td>2.0</td>
</tr>
<tr>
<td>Portland, Ore. Serology Lab</td>
<td>1948</td>
<td>566</td>
<td>10</td>
<td>1.8</td>
</tr>
</tbody>
</table>
This serological survey indicates that Q fever may occur in low incidence throughout the country and that the residents of the southwestern part of the United States show a higher incidence than other areas tested. The over-all incidence of the 5470 sera was 3.2 per cent with an incidence of only 0.4 per cent in areas other than the southwestern part of the United States.

PROCEDURE

Blood samples were obtained from 235 employees of eight Omaha packing plants. The serum was stored by freezing until serological tests were made.

The complement fixation test used was a modification of the Kolmer-Boerner technique which uses the over night icebox incubation period for fixation of complement. The antigen used was the American Strain, also known as the Nine Mile Strain. Titration of serum was done in the following manner: 0.25 ml. amounts of serial two-fold dilutions of inactivated serum were placed in each tube. To each tube was added 0.25 ml. of diluted rickettsial suspension which contained two units of antigen per ml. and 0.50 ml. of guinea pig serum containing two units of complement as determined by titration in the presence of antigen and with preliminary incubation at 37° C, for one hour before addition of sensitized sheep cells. The mixture of serum, antigen, and complement was then placed in the icebox over night. The following morning 0.25 ml. of hemolysin containing two units per ml. and 0.25 ml. of 2 per cent suspension of sheep cells were added. After an additional fifteen minutes incubation at 37° C, the test was read in the usual manner. The end point was selected as that dilution of serum which gave at least three plus fixation. Suitable controls were included in each protocol. Only specimens with a titer of 1:8 or higher were considered positive.

Specimens were collected from any employee who wished to volunteer, so that office help, government inspectors, yardmen, clean up personnel, and buyers were all included. The largest group, however, consisted of packing house workers who actually handled meat and meat products in the plants.

RESULTS

Of 235 sera tested, eleven, or 4.7 per cent, were positive. Seven of the eleven sera, or 63.7 per cent, had titers of sixteen or over. Among these, four had a titer of sixteen, two a titer of thirty-two, and one a titer of 128. The titers are recorded in Table 1.

Of the eight packing houses in which tests were made, five were represented among the final 4.7 per cent showing titers of 1:8 or higher. Of the five represented, packing house A had six individuals showing a positive titer; packing house B, two; D and E, one each. The number of specimens and the number positive, as well as the per cent positive per packing house are shown in Table 1.

The six in group I constitutes a miscellaneous group of milk handlers and laboratory persons handling milk samples.

A summary of the positive specimens is recorded in table 2:

Ten of the eleven positives were white males; the other a Negro. Their ages ranged from twenty-one to forty-three with an av-

---

**TABLE 1**

<table>
<thead>
<tr>
<th>Packing House</th>
<th>Number of Specimens</th>
<th>Number Positive</th>
<th>Per Cent Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>85</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>B</td>
<td>26</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>C</td>
<td>32</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>D</td>
<td>10</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>E</td>
<td>8</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>F</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I (Mis. Group)</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**TABLE 2**

<table>
<thead>
<tr>
<th>Specimen Number</th>
<th>Packing House</th>
<th>Titer</th>
<th>Sex</th>
<th>Race</th>
<th>Age</th>
<th>Yrs. Around</th>
<th>Animals in Contact With</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>1:128</td>
<td>M</td>
<td>W</td>
<td>31</td>
<td>8</td>
<td>Cattle</td>
</tr>
<tr>
<td>2</td>
<td>A</td>
<td>1:32</td>
<td>M</td>
<td>W</td>
<td>35</td>
<td>11</td>
<td>Cattle</td>
</tr>
<tr>
<td>3</td>
<td>A</td>
<td>1:32</td>
<td>M</td>
<td>W</td>
<td>54</td>
<td>10</td>
<td>Cattle, Sheep</td>
</tr>
<tr>
<td>4</td>
<td>A</td>
<td>1:16</td>
<td>M</td>
<td>W</td>
<td>21</td>
<td>1</td>
<td>Cattle</td>
</tr>
<tr>
<td>5</td>
<td>A</td>
<td>1:16</td>
<td>M</td>
<td>W</td>
<td>51</td>
<td>30</td>
<td>Cattle, Sheep</td>
</tr>
<tr>
<td>6</td>
<td>B</td>
<td>1:8</td>
<td>M</td>
<td>N</td>
<td>41</td>
<td>5</td>
<td>Cattle</td>
</tr>
<tr>
<td>7</td>
<td>C</td>
<td>1:16</td>
<td>M</td>
<td>W</td>
<td>35</td>
<td>11</td>
<td>Cattle, Sheep</td>
</tr>
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<td>8</td>
<td>A</td>
<td>1:8</td>
<td>M</td>
<td>W</td>
<td>30</td>
<td>3</td>
<td>Cattle, Sheep</td>
</tr>
<tr>
<td>9</td>
<td>B</td>
<td>1:8</td>
<td>M</td>
<td>W</td>
<td>41</td>
<td>15</td>
<td>Cattle</td>
</tr>
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average of 37.5. The duration of time which
the group had worked with livestock ranged
from one to thirty years with an average of
11.7 years.

The positive specimens ranged in titer
from 1:8 to 1:128. Packing house A was
represented by six positive specimens, or
54.5 per cent of the reactor group, yet the
specimens of this packing house represented
only 31.9 per cent of the total tested. It
also will be noted that the titers of packing
house A ranged higher than those of the
other reactors. The median titer for speci-
mens from plant A is 1:24 with a range
from 1:8 to 1:128. The median for speci-
mens from other plants combined is 1:8 with
a range of 1:8 to 1:16. It is interesting to
note that no positives were found in 8 of the
8 packing houses.

CONCLUSIONS

The total incidence of positive serological
reaction is high, as disclosed by this sur-
vey. The incidence of higher titers and large
numbers of positive reactors in packing
house A points strongly to the assumption
that prior to this survey a small, unrecog-
nized outbreak might have occurred among
the employees of this plant. At this time it
was not feasible to interview the individuals
with high titers regarding past illness.

SUMMARY

1. Two hundred and thirty-five blood
specimens obtained from packing house
workers, a limited number of milk han-
dlers, and laboratory workers were ex-
amined by complement fixation for Q
fever.

2. Of the 235 blood specimens tested, elev-
en or 4.7 per cent, showed antibodies
for the Q fever agent, C. burnetii.

3. The positive group consisted of packing
house workers. No reactors were
found among the small group of milk
handlers and laboratory workers.

4. No correlation could be shown between
the elevation of the titer, the type of
cattle handled, or duration of time asso-
ciated with livestock.

5. The survey reveals 54.5 per cent of
positive titers were obtained in em-
ployees of a single packing house. This
cannot be explained satisfactorily, but
may point to a recent unrecognized out-
break in the one packing plant.

6. Further serological studies should be
done on both cattle and human beings
in Nebraska to determine whether or
not Q fever is endemic to this area.

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Current Comment

Home Nursing Plan May Cut Medical Cost—

Hope for shortening hospital stays by add-
ing a period of home nursing care for pa-
tients whose earlier discharge is thereby
made possible is indicated by a five-year
study conducted by Associated Hospital Ser-
vice of New York (Blue Cross) in cooperation
with local hospitals and visiting nurse agen-
cies.

Results of the study, published in a 67-
page report, shows that the combination of
hospital and home nursing services as part
of the Blue Cross program could reduce the
costs of illness and produce other benefits
for patients and the community.

The study was based on the experience of
500 hospitalized Blue Cross subscribers
who were selected by attending physicians
and accepted as eligible by A.H.S. Early dis-
charge from the hospital and subsequent
home nursing care for these subscribers re-
sulted in the saving of 7,948 days of hos-
pital care, the report states. At the same
time, the hospital beds so freed could have
been used by more than 700 other patients
for an average hospital stay of 11 days.

Although hospitals belonging to nonprofit
organizations have only one-fourth of the na-
tion’s hospital beds, they own almost half
the total hospital assets in this country, ac-
cording to Health Information Foundation.
Such hospitals rank high in provision of spe-
cial facilities and services.
Epidural Hematoma

A Staff Conference
Childrens Memorial Hospital

Richert Taylor, Creighton Senior:

Chief Complaint: Head injury three days before admission.

Present Illness: This three-year-old white boy received a seemingly minor bump on the head when he fell from his father's tractor about 4:30 p.m. three days ago, but about 9:00 p.m. that evening he vomited and lost consciousness for a few minutes. He improved throughout the night but the next day he vomited intermittently so was hospitalized. By the next day he was very irritable and irrational and at 6:30 a.m. on the third day had a generalized convolution lasting 30 minutes. At 7:30 a.m., one half hour later, another convolution of shorter duration occurred. At 9:00 a.m. he has given sodium luminal, 100 mg., and had no more convulsions. He arrived here at 12:00 noon on the third day of his illness, sixty-eight hours after the accident. Past history was essentially non-contributory.

Physical Examination: He was a well nourished, well developed three-year-old white boy who was semicomatose and cried occasionally. Temperature was 100.4 degrees F. Blood pressure was 100/62. When aroused, the child's speech was incoherent. All extremities moved in response to painful stimuli. The right pupil was slightly larger than the left. The eyes were divergent. Retinal veins were distended. The reflexes were hyperactive; bilateral plantar extensor response was present.

Laboratory Reports: On admission, the urinalysis was essentially negative except for positive acetone. The white cell count was 19,500 with 81 segmented neutrophiles; 5 staff forms; 14 lymphocytes. Hemoglobin, 11.5 gm. per 100 cc., and hematocrit, 37%.

Clinical Course: Five hours after admission the patient was taken to surgery and, under general anesthesia, multiple exploratory burr-holes were made. In the left temporal region an extradural hematoma was found. A craniectomy was done with removal of the hematoma. The branch of the middle meningeal artery which had been severed was ligated. Postoperatively the patient did very well and was discharged six days after admission, improved.

Kenneth M. Browne:

Dr. Kenneth M. Browne:

There are several things here that are of interest and a little bit unusual. First of all, the injury as noted was a minor injury. The boy was riding on the tractor with his father when he slipped. His father grabbed him by the arm but he fell and bumped the left side of his head against the axle of the tractor. He was not unconscious and didn't seem to be injured. He did the chores with his mother that evening. Then, at about nine o'clock that night, he had some sort of a spell which the mother described as a "stiffening out." There were no clonic movements. Following that episode which, in retrospect, I think was a decerebrate attack, he was taken to the hospital. During the night he was quite ill, but gradually improved and by the morning he was up and running around in his crib. He vomited all that day but he was awake and alert.

The second day following the injury, while he was still in the hospital, he became a little less responsive, and early in the morning of the third day he had another seizure which was described as an arching of the back and throwing back of the head. He was given a sedative, and a lumbar puncture was done with normal findings.

When he came in here he certainly presented a difficult diagnostic problem. The X rays that were sent in with him showed...
no fracture. He did have a little bit of swelling over his left temporal area but it did not appear significant. He would respond only to painful stimuli and, as far as I could tell, had no focal signs. His eyes tended to diverge during sleep. He was quite dehydrated so we did a cutdown and gave him fluid for about four to six hours, between 12:00 noon and 5:00 p.m., then we operated upon him. We made multiple burr holes and didn’t find anything abnormal. We were just about to reposition him for exploration of the posterior fossa but we thought we might put in just one more hole low down in the left temporal region and there we found the extradural hematoma. When the temporalis muscle was separated from the bone, a fracture of the temporal bone was found that we could not see on the X ray. In fact, the only reason we saw it, I think, was because a piece of the pericranium was pinched in that fracture line and tore as it was elevated causing a little bleeding on that site. It certainly was an extremely minor fracture.

The reason this child lived as long as he did with an extradural hematoma was that the fracture was quite far posterior and a small branch of the middle meningeal artery was torn. The bleeding was not as vigorous as if he had torn a branch near the main trunk. Going back over the history it seems to me that he did get the fracture and tear of the artery at the time he struck the axle and he did bleed extradurally at that time. He had the characteristic lucid period so often associated with extradural bleeding from the middle meningeal artery, lasting about five hours, at which time he had a decerebrate attack from the compression of the brain stem. At about that stage, the bleeding must have stopped. Possibly it stopped because the dura would no longer strip readily and the clot acted as a sort of tamponade to the bleeding artery. Usually by the time a patient with an extradural hematoma has had a decerebrate attack it is a question of a few hours at best before death ensues secondary to brain stem compression. As the posterior cerebral artery is compressed at the tentorial notch, brain-stem hemorrhages occur in the pons and the midbrain. These hemorrhages are the cause of death. These patients characteristically do have decerebrate attacks terminally such as this boy did. The unusual fact in this case is that he was alive three days after having had a decerebrate attack.

One of the things that threw us off regarding a possible extradural hematoma was the apparent absence of a fracture. Extradural hemorrhage from a tear of the middle meningeal artery rarely occurs without a demonstrable skull fracture in the vicinity of the artery.

A normal lumbar puncture does not rule out the presence of an intracranial mass lesion as is illustrated in this case. Here was a little boy who could well have been brought into the accident room perfectly conscious and quite asymptomatic. They could have even taken an X ray of the boy’s head without noting the fracture and let him go home. He might very well have died that night in his sleep, and it is a wonder he didn’t because he had gone to bed and was asleep at the time he had this first decerebrate seizure. This certainly illustrates the fact that when you see a head injury, even though it appears to be minor, and you don’t want to keep the patient in the hospital you should make it clear that you are concerned about the welfare of this child for the first 24 to 48 hours. Tell them that you are letting the child go home with them only on the condition that they must watch the child just as you would have observed it in the hospital. They should arrange shifts and stay awake with the child or at least waken the child every hour or two throughout the night and be certain that the child can be aroused. The most important single thing to order in the hospital on head-injury patients is not the blood pressure or the pulse but the state of consciousness. Be sure that the nurses go in and awaken the child and be certain that he can be aroused. As long as the patient will wake up and talk to you relevantly he probably is not getting any worse. His blood pressure may go up or down, his pulse may be slow or fast, his temperature may be elevated but as long as he is awake and talking and seemingly quite lucid he certainly is not likely to be in any immediate danger of dying. It is easy for the nurse to check the state of consciousness and look at the pupils to check their equality and reaction to light. When a patient is developing compression of the brain stem as in the case of extradural hematomas there soon will be deterioration in his state of consciousness and some degree of paralysis of the third nerve with dilatation of the pupil. It need not be on the side of the hemorrhage but it usually is. A de-
crease in the ipsilateral corneal reflex and a contralateral hemiparesis may develop. Most of the patients with extradural hematomas who are operated before they are in extremis recover.

Dr. Herman M. Jahr:

Thank you, Dr. Browne. Are there any questions or remarks about this case? There is one item here, Dr. Browne. This boy had a leucocyte count of 19,000 with 81 per cent segmented neutrophiles. He had a convulsion. The high white count was accompanied by a normal spinal fluid. One can be easily misled into thinking of no more than a febrile convulsion.

Dr. Charles A. Tompkins:

What would you do about this problem if you were far removed from a hospital and a neurosurgeon?

Dr. Browne:

If you see a patient with a head injury who has swelling in the temporal region and X-ray evidence of a fracture line across that area you should be alert to the possibility of a developing extradural clot. You would have strong presumptive evidence in favor of the diagnosis if, in addition, pupillary inequality and decerebrate seizures ensue. There are several things that you can do. Ligation of the ipsilateral external carotid artery may slow the bleeding. The most important immediate action should be directed toward decompression of the brain stem as rapidly as possible. Occasionally this may mean an emergency, makeshift burr opening with carpenter’s tools as frequently advised in textbooks. I think this action alone is seldom justified for the following reasons: An extradural hematoma is not a liquid hematoma but a solid clot. There usually is active bleeding underneath the clot. If you simply expose the clot with a burr hole a little bit of the clot will be forced out under pressure but the main mass of the clot will not extrude and the brain stem will not be decompressed. A rather wide removal of temporal bone must be done to extract the clot and to identify the bleeding vessel. In my experience, if the arterial bleeding is not stopped, the clot rapidly reforms. Without adequate light and instruments the bleeding will seldom be effectively controlled. I am extremely dubious that a patient would often be saved by a simple burr hole. With the present-day modes of travel such a patient usually can reach the operating room of a trained neurosurgeon within a few hours at the most following an alerting telephone call. The operating room is ready, proper instruments, light, and assistance are available, and definitive care can be given. I have recently had the experience of operating on a child for an extradural hematoma who had been having decerebrate seizures for five hours and who made a good recovery. Large-ly because of experiences during surgery with patients who have extradural hematomas, I have come to the conclusion that an emergency burr hole alone would seldom save a patient. If emergency surgery were performed, enough bone should be removed to allow evacuation of the clot. Perhaps ligation of the external carotid artery should be done also if the site of the bleeding was not seen and could not be controlled.

SECOND CASE

Edwin E. Westura, Creighton Senior:

Chief Complaint: This 11½-year-old white boy arrived at Children’s Memori-al Hospital in the Rescue Squad’s ambulance. An informant stated that the child had been struck by a truck while riding his bicycle about 4:10 p.m. and had been unconscious since the time of the accident.

Physical Examination: Vital signs on admission were: blood pressure of 110/60; respirations of 16/minute; pulse 120; and temperature of 99 degrees F. A subgaleal hematoma was noted over the left parietal region. There was a stellate laceration of the right forehead and evidence of bleeding from the nose. The pupils were 2-3 mm., reacted to light, and were equal. Both eyes deviated to the left. There were no retinal hemorrhages. Examination of the extremities revealed extensive abrasions of the left leg with bluish discoloration and swelling above the knee. The patient reacted to painful stimuli. Deep tendon reflexes were hyperactive but equal bilaterally, and no pathological reflexes were present. There were no other significant positive findings.

Laboratory Reports: The leucocyte count was 11,400 with a normal differential; red cells, 4,387,000; hemoglobin, 12 gm. per 100 cc.; and hematocrit, 41
per cent. Urine obtained by catheter had a pH of 5.0, 2 plus albumin, and 0-2 erythrocytes per high powered field. Two days later, hemoglobin was 10 gm. and red cell count 3,710,000.

**X-ray Report:** Examination of the skull on admission revealed a long linear fracture extending superiorly from the posterior aspect of the left temporal bone to the midpoint of the left parietal bone. (Fig. 1). Films of the left femur, thorax, and abdomen were negative.

![Fig. 1. Lateral view of skull in the second case showing long linear fracture extending from posterior aspect of left temporal bone to midpoint of left parietal bone.](image)

**Clinical Course:** Because of the X-ray and other clinical findings, a left temporal craniectomy was performed. During the operation 2.5 liters of blood were given. On the day following the operation, slight improvement was noted. There seemed to be a third nerve palsy on the left. On the fourth postoperative day the patient was responding much better and still showed a residual partial left third nerve palsy with ptosis of the left eyelid. On the fourth to the twentieth postoperative days the patient continued to improve except for a phlebitis which responded well to local therapy. His entire recovery had been uneventful except for the phlebitis on the fourth postoperative day and a transient episode of clonic seizures on the eighth postoperative day.

**Dr. Jahr:**

**Dr. Browne?**

**Dr. Browne:**

This is a good illustration of a problem that is seen almost daily at this hospital: A child is admitted in an unconscious state after a head injury but shows nothing else unusual on neurological examination. What should be done at this stage? A general examination should, of course, be completed rapidly with special regard to the nature of the airway and the normalcy of the thoracic cage and its contents. After the immediate shock-state is under control, roentgenologic studies are desirable before restlessness ensues, unless contraindications exist such as multiple injuries to the extremities and spine. **Careful notation of the state of consciousness should be instituted as early as possible and be repeated at frequent intervals.** It is important to make accurate, objective observations. Notations such as "responds only to painful stimuli, answers relevantly with coherent sentences, and so forth" are much more helpful to the person trying to determine subsequently whether or not the patient's state of consciousness is improving than are statements such as "lethargic," "semicomaatose", and so forth, which mean different things to different examiners. Initially, the pulse, blood pressure, and respirations should be checked every 30 minutes. After a few hours, if progress is good, this interval may be increased to once an hour. Temperature should be recorded every two hours and orders should be left for exposure of the patient if rectal temperature exceeds 103 degrees F., fanning if over 104 degrees F., and sponging if over 105 degrees F. Aspirin given rectally helps to control pain and fever. Sedation is rarely necessary and should be avoided if the patient is still in need of careful observation regarding the state of consciousness. This is usually the case for at least 12 or 24 hours after consciousness is regained. Occasionally a distended bladder is the source of restlessness. If signs of a surgical complication appear, the above program will ordinarily make that fact obvious.

The course of this patient in the hospital was as follows: His initial state of unconsciousness and minimal response to painful stimuli persisted for several hours. He then began to show an elevation in his blood pressure and dilatation of the left pupil. Within about thirty minutes his respirations were labored and irregular. As preparation of the head for surgery was completed his respirations ceased. At this time the left pupil was fully dilated and unresponsive to light. An endotracheal tube was inserted and artificial
respirations were begun. The left temporal area was wiped with merthiolate and the skin was incised without anesthesia. A burr hole disclosed the extradural clot which was rapidly evacuated by finger-dissection after a craniectomy was performed. Spontaneous respirations immediately ensued. The site of the hemorrhage was not immediately apparent. The wound was loosely sutured closed while instruments were sorted, blood was obtained for transfusion, and order was established in the operating room. During this interval of perhaps 30 to 45 minutes the patient again showed signs of brain stem compression and re-opening of the wound revealed reaccumulation of a large extradural clot. The incision was extended and the bleeding arterial branch was found far posteriorly.

The patient has made a complete recovery from the head injury except for minimal residual of a left third nerve palsy. A secondary cranioplasty will be advised because of the extensive craniectomy necessitated by search for the site of bleeding.

Question: What is the eventual outlook for these patients?

Dr. Browne:

The outlook for the two patients discussed today is excellent. Both have made good immediate responses to evacuation of the extradural hematoma. The residual third nerve palsy will probably improve considerably and, not uncommonly, essentially complete recovery of the nerve is seen.

Generally speaking, the recovery of children from head injuries is remarkable. They tolerate head injury much better than adults, possibly because of their more efficient cerebral circulation for one thing. In my experience, the most common complication of head injuries in children is a persistence of neurologic deficits incurred at the time of the injury. A severe cerebral contusion with a resultant hemiparesis is one such example. Aphasia will not develop subsequent to a unilateral lesion in an infant regardless of the hemisphere involved since speech engrams have not as yet been laid down. Older children seem to recover from aphasias more completely and more rapidly than adults. Children frequently survive extremely severe head injuries which result in prolonged decerebrate rigidity. Recovery is slow and attended with residual severe rigidity or even involuntary choreoathetoid movements but the mental status may be sufficient for near average intellectual development.

The next most common type of neurologic complication of a head injury is a deficit resulting from an immediate complication of the injury. The third nerve palsy produced by an extradural hematoma is an example of this type. Meningitis following a compound fracture or penetrating injury is not uncommon but rarely follows the frequent basilar fracture associated with bleeding and leak of cerebrospinal fluid from the ear. Rhinorrhea is a more serious complication than otorrhea. A delayed peripheral type of facial palsy may complicate fractures associated with bleeding from the ear and usually recovers completely. Convulsive seizures are seen following closed head injuries in 3-5 per cent of cases whereas their incidence after penetrating injuries is 30-50 per cent. Most post-traumatic seizures occur within the first year after the injury. The so-called post-traumatic syndrome of headache, dizziness, and a variety of mental symptoms such as easy fatigability and inability to concentrate, is seldom seen in children.

Dr. Jahr:

Any discussion? Any question?

Dr. Gilbert Schreiner:

About the lumbar puncture—when do you and do you not use this, from the newborn period on up? Do you think that the lumbar spinal puncture contributes very much in acute head injuries and in newborn injuries?

Dr. Browne:

In my opinion lumbar punctures are of limited value in the treatment of acute head injuries as well as in head injuries of the newborn. A lumbar puncture is an unreliable indicator of the intracranial pressure. Normal lumbar punctures have been reported in brain tumors, subdural hematomas, epidural hematomas and brain abscesses. If you remember that a normal lumbar puncture does not rule out the possibility of a surgical lesion you are much less likely to get into difficulty than by making the patient worse simply as a result of doing the procedure. The presence of blood in the cerebrospinal fluid of a head injury patient is not uncommon and, in itself, does not indicate
the existence of a surgical complication. Lumbar punctures performed after one or more days may be helpful in establishing the diagnosis of a complicating meningitis.

Lumbar punctures are sometimes indicated in children suspected of having brain tumor but should not be done in the presence of signs and symptoms of increased intracranial pressure. This is particularly true when the neurologic examination and history strongly suggest a posterior fossa tumor. Other examinations such as roentgenograms of the skull showing separated suture lines or a funduscopic examination revealing papilledema give the information which is being sought without risk to the patient.

Lumbar punctures find their greatest usefulness in pediatrics in the case of infectious diseases and, with the exception of a brain abscess, can be done with negligible risk in such patients.

**Current Comment**

**How Much Professional Courtesy—**

The typical doctor treats about 2 per cent of his patients on a "professional courtesy" basis, according to Medical Economics, and if he's a specialist, this figure rises to about 5 per cent.

The magazine recently asked more than 1000 doctors about their habits in granting professional courtesy to non-M.D.S. The above findings appear in the first of several articles based on this survey.

Such courtesy care is usually limited to persons in professions allied to medicine, to close friends and relatives, and to clergymen. The article contains eight tables showing the percentages of respondents who make no charge, give discounts, or charge full fees for 36 specific kinds of non-M.D. patients.

Highest on the no-charge list are doctors' own office workers (95 per cent of the respondents said they give their employees free care). Medical students get full professional courtesy from 87 per cent of respondents; clergymen of their own faith, from 78 per cent of the respondents; nurses they've worked with, from 66 per cent; and the family dentist, from 62 per cent.

Nearly all the surveyed doctors said the kind of services rendered—whether a routine office visit or major surgery—has no bearing on whether professional courtesy is granted. "Once the typical doctor decides to extend professional courtesy to an individual, he extends it all the way," according to the survey. "If he doesn't charge his dentist's wife, say, for treating her cold, he won't charge her for even the most time- and energy-consuming operation."

**Hospital Assets Reach $13 Billion—**

The nation's investment in hospital resources is at an all-time high, Health Information Foundation reported recently. In its monthly statistical bulletin, *Progress in Health Services*, the Foundation stated that the total value of hospital buildings, equipment, and other assets today stands at about $13 billion—or three and two-thirds times the investment 30 years ago.

The current figure breaks down to $8100 per hospital bed, $590 per patient admitted to a hospital during the year, or $78 per person in the United States.

The value of hospital assets has risen rapidly in recent years, especially since the end of World War II. The increase in assets per bed has been especially rapid, largely because of more adequate provision of modern, highly specialized equipment and the replacement of outmoded facilities. Hospital construction has also increased sharply since the war.

But the mere size of the country's investment in hospitals "is no guarantee that it is enough for present and future needs," said George Bugbee, Foundation president. "Most recognized sources indicate that there is a large deficit of beds for the care of patients with mental illness and chronic illness. Furthermore, a recent survey by the American Hospital Association reports a need for an additional $1 billion to rehabilitate existing hospital buildings."

Private philanthropy, Mr. Bugbee continued, must remain an important source of hospital funds. Last year, of an estimated $505 million spent on private hospital construction, three-fifths came in the form of voluntary contributions.

**DOCTOR** — Does your wife like to read the Auxiliary news? Then be sure and take your copy home.
"To Be or Not to Be. That is the question."

Today's physician finds himself musing over a problem that would also have caused Shakespeare's Hamlet some confusion. The doctor finds himself confronted with an issue that has many implications.

This state of confusion stems from a cloud of conflicting statements that have been raised by those forces favoring compulsory Social Security and those violently opposing it.

The opposition is led by the American Medical Association and its legal and economic advisors. Their advice and feeling is also echoed by most of the state and local medical groups. The organization pounding the drum for the inclusion in Social Security is the Physicians Forum and its Committee on Social Security for Physicians. Both sides have convincing arguments, but issues are clouded by conflicting claims.

It is the purpose of this article to clear the air and show what the basic issues involve and why a conflict exists. In effect there are moral-philosophical issues, political aspects and economic issues. Each will be presented as briefly as possible.

A. Moral-Philosophical Issues

1. The A.M.A. is violently opposed to Social Security because they believe it is a forerunner to socialized medicine. They point to history to show that ever since Bismarck introduced "socialized insurance" in Germany seventy-five years ago and followed with socialized medicine, other countries with social security schemes have followed the same course. They give examples in England, Denmark, and France. Our own American historical path suggests a similar course as shown by the sequence of: (a) retirement benefits, (b) survivorship payments, (c) permanent and total disability payments and (d) present proposed legislation for temporary sickness cash benefits and federal hospital care for groups now receiving Social Security payments. The A.M.A. seems to have a justifiable worry that Social Insurance taxation leads to state controlled medical and hospital care.

2. The Physicians Forum claims that socialization is already part of our economic life and that we as doctors can do nothing to stop it. They say...
that if Social Security is good enough for bankers, lawyers, farmers and business men, it is good enough for physicians. They further claim, and with a certain amount of political reality, that it will come eventually, why not now? They say it is ridiculous for 200,000 physicians to try and hold out against 170,000,000 citizens already under Social Security coverage. Their main argument seems to be simply stated: "Join the crowd!"

3. The A.M.A. counters with hot suspicion because of the "shady" reputation of the Physicians Forum. They point out that the Physicians Forum was the main leader in those groups favoring socialized medicine in the great fight that was waged in 1949-52, against Oscar Ewing and his gang. The A.M.A. also shows the Physicians Forum was formed by the late Dr. Ernst P. Boas, an active communist-front sponsor.

4. The Physicians Forum claims that the A.M.A.'s position is antagonizing Congress and the public, and that the physician could have a better chance of warding off socialized medicine by integrating his profession with the American people rather than standing aloof from them.

5. The A.M.A. believes that there is a major moral, democratic issue besides that of mere Social Security coverage. It is also taking its stand of opposition because of the trend toward more and more federal government control over all phases of American life. The A.M.A. points to the general laxness, on the part of the public, that exists today and is hoping that this campaign will stimulate interest in the innumerable other "welfare projects" by which taxes of one group are siphoned into the pockets of another group for political or expedient reasons. These unsound financial schemes, they believe, may soon destroy individual initiative and eventually American freedom.

B. Political Aspects

1. Certain politicians have found a "golden egg" in health and Social Security legislation. They find here a method to further their own careers and have found the going easy, except for the opposition of the A.M.A. With the general slogan of "Getting Something for Nothing," they have enticed nearly every occupation or profession into the folds of Social Security.

2. Labor leaders also active in political circles have seen a chance for more "fringe" benefits for their members and are beating the drums for Social Security for physicians. They see in this move a step nearer their goal of socialized medicine. Many of our national labor leaders were cohorts and supporters of Oscar Ewing and his Wagner-Murray-Dingell bills for government medicine. By getting physicians enrolled in Social Security they might quiet their opposition to socialized medicine.

C. Economic Issues

1. The A.M.A. contends, and has information to prove it, that despite the label "Old Age Survivors Insurance," it is not an insurance program. Recent studies show that the program will soon have a level of expenditures in excess of income. The present rate of 2½ per cent for Social Security taxes is going to increase to 6½ per cent by 1975 but even that will not be enough. To merit the label of "insurance," income and outgo should be fairly well matched, yet during an investigation of Social Security by the House Ways and Means Committee in 1954, it was found that as of December, 1952, retired eligible beneficiaries were receiving, on the average, benefits equal to $24.00 for each 50c paid in taxes by them! With new legislation and greater benefits passed in 1954 and 1956, the figure is now well over $30.00 for each 50c paid in. Thus, the A.M.A. contends that the whole system is actuarially unsound when the government provides something to a group for less than it costs. The deficit must be made up by someone else paying more taxes.

2. The Physicians Forum says that it may be true that the Social Security
structure may be unstable, but taxes
to this represent only a small frac-
tion of the total taxes paid by indi-
viduals; and it is hardly objective to
single out Social Security for a spe-
cial attack, particularly since this tax
yields substantial benefits.

3. The A.M.A. labels the Social Security
setup as not "security" but just an-
other tax because the money goes in-
to the general treasury as does any
other tax. Proponents say there is a
twenty-three billion dollar surplus in
the O.A.S.I. Trust Fund, but the
A.M.A. contends it is merely an arti-
ficial system of I.O.U.s and that only
seven per cent of the estimated lia-
bilities are backed by cash funds.
The rest of the money exists as
I.O.U.s, and much of the money col-
clected has been used to pay other
governmental expenses over the past
twenty years like any other tax.
Thus, with a deficit financing pro-
gram that would cause federal au-
thorities to close a private insurance
company, the Social Security pro-
gram needs, in the future, higher
and higher taxes, great reductions in
benefits—or the alternative of a col-
lapse of the whole system.

4. Another criticism of the system, by
those opposed to Social Security for
physicians, is that the working and
income habits of doctors do not lend
themselves to the present social in-
surance laws. Doctors work until
they are about 74, and thus would
have to pay in benefits for seven or
eight years longer than the average
citizen before getting any benefits.
The opposition also claims that many
of the rigid provisions of the system
make it unsatisfactory for a doctor
to use as a retirement plan.

5. The final hard financial fact, though,
is that a dollar spent today in Social
Security is a good investment. To-
morrow's possible tax laws may not
make it such a good buy, but today it
is a bargain. In the February 3,
1958 issue of Medical Economics, a
thorough study reveals that Social
Security gives you a program at fifty
per cent of the cost of private insur-
ance. This is, of course, because of
the before mentioned financial struc-
ture of Social Security and may well
change with future legislation so
that the "bargain price" features of
government insurance will then dis-
appear. It provides a real oppor-
tunity for doctors soon to retire, but a
large question mark for the younger
physician!

In summary then, what are the issues
which today's doctor must evaluate to decide
on compulsory coverage in Social Security?

1. The moral issues involve the possibil-
ity of socialized medicine following
close on the heels of full social se-
curity and the fight against more and
more federal controls on American
life. They are countered by the
statement that we are nearly all so-
cialized now anyway so why not get
on the band wagon.

2. The political issues involve the fight
of organized medicine through the
voice of the American Medical Asso-
ciation against labor and political
leaders who would help pave the way
to socialized medicine by including
doctors in Social Security.

3. The economic issues show that pres-
ent day Social Security is definitely
unsound, but represents a good buy
for some physicians nearing retire-
ment. Perhaps with better future
legislation improvements could be
made to stabilize the program and
make it worth considering for to-
morrow's doctor.

Meanwhile, today's doctor may well have
to follow the leadership of the A.M.A. and
might profit by listening to Hamlet again
as he asks: "Whether 'tis nobler in the mind
to suffer the slings and arrows of outrageous
fortune, or take arms against a sea of trou-
bles, and by opposing end them."

Women are far more prone to rheumatic
disease than men, according to the publica-
tion "Patterns of Disease," prepared by
Parke, Davis & Company for the medical
profession. It reveals that two out of every
three persons affected by the disease are
women. Moreover, the incidence among
women is higher in all forms of rheumatic
disease "except rheumatic heart disease and
rheumatic fever with heart involvement."
Organization Section

Coming Meetings

CRIPPLED CHILDREN’S CLINICS—
May 10, Kearney, Good Samaritan Hospital
May 24, Alliance, St. Joseph’s Hospital
June 14, Wayne, Student Union Building
June 28, Hastings, Mary Lanning Hospital

THIRD ANNUAL TRAUMA DAY—University of Nebraska College of Medicine, Omaha, May 7, 1958.


Corrections—

In the article by Albert V. Whitehall, Nebraska M.J., 43:100 (March) 1958, second paragraph, page 101, the word with should be without. The paragraph would then read:

"Without the voluntary health insurance mechanism, doctors might be working for a single, monopolistic employer, probably the federal government . . .”

In the editorial entitled "Scotts Bluff," Nebraska M.J., 43:121 (March) 1958, fourth paragraph, tenth line, the date, 1932, should read 1832.

Medicine’s Fourth Estate (World Medical Association)—

Every active physician recognizes the constantly growing importance of his county, state and national medical societies — the three great “estates” of organized medicine in America.

In the past few decades, medical practice has become ever more complex. Doctors today must deal not only with more than a score of fellow medical specialists, but with several score of “paramedical” technicians, many of whom are finding it difficult to adjust themselves to a “table of organization” in which the Doctor of Medicine must, by training and responsibility, be the captain of the team.

Then, too, in the areas of hospital-physician relations, of public health, of medical care prepayment, and of social security, organized medicine is required to think in new terms and to act with decision, if it is to retain the leadership which the people expect of their physicians. The demands of our time call for medical statesmanship of the highest order.

And now, medicine has added a “fourth estate,” The World Medical Association, which, though it was founded only a little more than ten years ago, has already earned for itself world-wide recognition as “the international voice of organized medicine.”

Our American Medical Association is one of the 53 national medical associations which comprise the membership of The World Medical Association. Within the United States, some 5500 leading American physicians have formed a supporting committee, known as the United States Committee of The World Medical Association. President of the U.S. Committee is Dr. Austin Smith, Editor of the Journal A.M.A., and its Secretary-Treasurer is Dr. Louis H. Bauer, who has also served as Secretary General of The World Medical Association since its founding in 1947.

The purpose of the U.S. Committee are those of W.M.A. itself: to work for the highest standards of medical care in all parts of the world, to defend and preserve the freedoms that are essential to good medical practice; to provide a forum for the solution of problems common to physicians the world over; and to promote world peace.

You have an opportunity to play your part in this vital cause by becoming a member of the U.S. Committee of W.M.A. The A.M.A. House of Delegates has urged that every member of A.M.A. join the U.S. Committee. Annual dues are $10.00, and the Committee's headquarters are at 10 Columbus Circle, New York 19, New York. The W.M.A. State Chairman is Harry W. McFadden, Jr., M.D., Omaha. (See page 28-A).

Safeguards Against Malpractice Claims—

Colonel Raymond Coward summarizes his views about avoidance of malpractice suits (U.S. Armed Forces M.J., 9:224, Febr., 1958) as follows:

"1. Avoid careless remarks about the medical treatment the patient may have received previously from another doctor.

"2. Keep thorough, accurate, and com-
plete medical records. These should include case history as well as clinical records.

3. Make thorough examinations of the patient, including all necessary laboratory tests, roentgenograms, et cetera, and record the results in the patient's medical record.

4. Obtain the confidence of the patient, establish rapport with him, and in general, improve the doctor-patient relationship as well as the relationship with the patient's family.

5. Do not experiment with unproven medicines, procedures, or technics, but adhere to proven and accepted medical principles and practices.

6. Do not guarantee cures or fixed degrees of improvement as a result of following certain prescribed medical treatments.

7. Explain the risks in surgical or medical procedures proposed, so the patient understands the situation.

8. Obtain the written consent of the patient and the next of kin, in appropriate cases, keeping in mind that for the consent to be valid there must be full safeguards against malpractice explanation of the procedures and the risks involved.

9. In dealing with a patient with a mental illness, obtain the written consent of the next of kin if at all practicable, even though written consent of the patient is granted, as the patient's mental capacity to give valid consent may be put in issue at a later date. The advisability of having such a patient examined by more than one doctor also should be considered. This will afford the doctor better protection, particularly in a case where restraint is used, as he may later be charged with false imprisonment.

10. Beware of the dangers involved in diagnosis and prescription by telephone, without seeing or examining the patient.

YOUR PATIENT AND SOCIAL SECURITY

Many physicians have heard from patients recently about the disability provisions in the social security law.

One provision, effective with the month of July 1957, provides for payment of cash benefits to totally disabled persons 50 years of age and older. Another provision, added to the old-age and survivors insurance program in 1954, permits people under 50 years of age and who have prolonged total disability, to apply to have their social security records frozen for the period of their disability. Thus, the time when they could not work and so had no earnings credited to their accounts does not count against them in determining their rights to benefits, nor the amount of benefits which will be payable to them later, or to their families in case they die.

Work Requirements

Certain work requirements must be met before a disabled salaried or self-employed person can become entitled to cash benefits or to have his record frozen. His social security record up to the time of his disability must show that he was in fact a worker, with a fairly regular and recent work history.

Medical Requirements

In addition, he must be shown to have a medically determinable physical or mental impairment severe enough to keep him from engaging in any substantial gainful activity—one which has existed for more than six months and is expected to last indefinitely or to end in death.

The requirements to establish disability under the social security law are strict and take into consideration the applicant's possible residual capacity to engage in gainful employment. Some people with severe impairments nevertheless are able to work because of special knowledge or skills. If a severely disabled person is working in spite of his handicap, all of the facts about his work are examined to see whether it amounts to substantial gainful activity. This includes consideration of the duties of his job, the amount of time he works, and the physical and mental effort and degree of skill required. Attention is given to any special circumstances of his employment—whether it is temporary or on a trial basis, full time or less than full time. If these facts show that the handicapped person is engaged in substantial gainful activity, he cannot qualify as "disabled" under the social security law.

Securing the Medical Evidence Of Disability

The medical evidence needed to establish the nature and severity of the applicant's
disability, the date it began, and its prognosis comes from the doctor who has treated the individual and knows his case, or from the hospital or institution in which he has been confined.

A Medical Report form was designed to assist the physician in furnishing the needed medical evidence and to indicate the nature and extent of clinical detail which would be necessary. It is given to the applicant and he is asked to have it filled out by the physician most familiar with his impairment. The form itself is modeled after the medical report used by major life insurance companies in their disability claims work. In adapting it for use in the disability program, the recommendations of a Medical Advisory Committee were closely followed. This Committee, composed of well qualified representatives of the medical and related non-medical professions, gives advice and guidance to the Social Security Administration on the medical aspects of the program.

If you have received this medical form to fill out for any of your patients, you are probably aware that the law makes the disabled worker responsible for seeing that medical evidence is submitted and for paying any costs involved. The law does not permit the government to pay any costs in connection with securing the medical evidence needed for a determination of disability. You may also know that to insure the confidentiality of the medical evidence, the medical report form is not to be returned to the patient but is to be mailed by the physician direct to the local social security office. This office is ready to furnish additional information to the physician and he should feel free to call on it.

Determining Disability

Determinations as to disability based on the evidence submitted are made under an agreement with the Federal Government, by professional members of an agency of the state in which the applicant resides. In most states, as in Nebraska, this is the vocational rehabilitation agency. Since referral of disabled individuals for any rehabilitative services which might return them to gainful work is an important aspect of the program, each applicant is told about the availability of vocational rehabilitation services.

On the professional team in the state agency at least one member is a doctor of medicine. The team reviews and evaluates all medical evidence assembled in the applicant's file, as well as such non-medical factors as age, education and occupational experience. Certain medical guides and standards, worked out with the advice of the Medical Advisory Committee are used in the consideration of the medical evidence. Although these guides and standards can be applied in most cases, they are not rigid and arbitrary. The final determination in each case is based on all the available facts on the individual's impairment and vocational history, and there is consultation among physicians in any borderline situation.

Guides to Filling Out the Medical Report Form

No matter how good the standards, nor how considered the judgment of the reviewing team, the determination reached can be no sounder than the evidence upon which it is based. To make sure that he is providing sufficient medical evidence for a prompt and fair determination, the doctor will want to consider the following guides in filling out medical report forms for those of his patients who have applied for the social security disability freeze or for cash disability benefits:

First, include sufficient clinical detail to enable the reviewing team to make a sound determination as to the severity and extent of the patient's current condition;

Second, give enough of the clinical history to provide information as to when the disability began and when it became so severe as to keep the patient from working;

Third, describe the probable course of the condition from now on, so that a decision can be reached as to whether the impairment is likely to continue indefinitely or end in death, or whether it is self-limiting or removable in the foreseeable future.

A. F. SILBER,
District Manager,
Social Security Administration,
402 Veterans Building,
Lincoln, Nebraska.
Phone 5-3273; Ext. 467.

Of more than $500 million spent on private hospital construction in the U.S. last year, an estimated three-fifths came in the form of voluntary contributions, Health Information Foundation reports.
News and Views

From the Lincoln Star—

The Lincoln Surgical Society, a non-profit group of Lincoln surgical specialists, formed to advance the science and practice of surgery within the city, has filed articles of incorporation with the secretary of state.

According to Dr. H. D. Hilton, president, about 17 Lincoln surgeons have joined the society. Monthly meetings are planned with scientific presentations, Dr. Hilton said. "One of our jobs," he said, "will be the maintaining and upgrading of surgery, and to encourage scientific investigation."

Dr. Hilton said there "is a probability" that the society will finance study groups and scientific investigations.

From the Omaha World-Herald—

The Creighton University School of Medicine has received $50,151.69 in separate contributions from the National Fund for Medical Education and the American Medical Education Foundation.

Of this figure, $33,655 was given by N.P.M.E. and $16,496.69 by the A.M.E.F. according to Dr. F. G. Gillick, dean.

From the Omaha World-Herald—

The Nebraska Heart Association is now the third largest medical group in the state, Dr. Harold Neu of Omaha, membership chairman, said recently. Medical membership is 350 representing 74 counties.

From the O'Neil Independent—

Members of the Commercial club at Page honored the late Dr. E. J. Bild at a memorial program in March. (It would not have been possible during his lifetime as Dr. Bild would not allow it).

Short talks were made in his honor which gave recognition to his civic interests and to the fact that it was largely due to his interest that the town had a show and a commercial club through the years.

From the Lincoln Star—

Dr. Wiktor Dage, noted Polish orthopedic surgeon and leader in rehabilitation research, visited in Lincoln in March as part of a nation-wide tour of orthopedic and rehabilitation centers.

He was invited to the United States to lecture at the American Academy of Orthopedic Surgeons in New York in February. In Lincoln he was the guest of Dr. J. E. M. Thomson.

Dr. Dage, who is a professor at the Medical Academy of Poznan, spoke highly of American teaching and training in orthopedic surgery. He was especially impressed, he said, by the number of research centers, even in small hospitals.

University of Nebraska College of Medicine—

Ten new appointments to the faculty at the University of Nebraska College of Medicine were made by the state Board of Regents at their April 1 meeting.

The appointments include: John D. Egan, M.D., James L. Knott, M.D., and Orest J. Parrillo, M.D., instructors in internal medicine; Catherine O. Salhanick, M.D., and Thomas E. Zion, M.D., instructors in pediatrics; and John O. McCarthy, M.D., assistant instructor in obstetrics and gynecology.

Others are Drs. Thomas W. Deakin, Valentine, Louis J. Ekeler, William C. Niehaus, both of David City; H. C. Stewart, Pawnee City. These four physicians have been named clinical associates in general practice.

From the Lincoln Star—

A Nebraska couple and their children will soon be living in Sierra Leone, West Africa.

Dr. and Mrs. George L. Harris are now taking special training in London before going to Africa as medical missionaries for the Evangelical United Brethren Church.

Dr. Harris, a native of Nelson, is a graduate of the University of Nebraska College of Medicine.

From the Omaha World-Herald—

Papers by members of the Creighton University School of Medicine faculty were presented at the meeting of the American Association of Anatomists in Buffalo, New York, in April.

Those who wrote papers were Drs. L. P. Clements, William T. Niemer, Ervin W. Powell, Julian J. Bamuel, and R. Dale Smith.
Dr. From the Grand Island Independent—

Nebraska led the nation in reducing new admissions to mental hospitals during 1957, the American Psychiatric Association and the National Association for Mental Health report.

The state had a reduction of 23.5 per cent during the year, the associations said. Dr. Cecil L. Wittson, director of the Nebraska Psychiatric Institute, said the reduction could be credited in part to the establishment of out-patient clinics.

Nebraska had an average reduction for 1957 of 5.2 per cent in the number of patients per 100,000 population in mental hospitals, compared to a national average reduction of 2.3.

From the Hastings Tribune—

Miss Shari Erikson, is the winner of the annual essay contest sponsored by the Adams County Medical Auxiliary.

Miss Erikson, a senior in high school, will be awarded a cash prize of $25 for her winning essay, entitled, "The Advantages of Private Medical Care."

Her essay will be entered in the state contest sponsored by the Nebraska State Medical Auxiliary.

From the Benkelman Post—

A plan became a reality recently when the Lions Club of Perkins County, Grant, Madison and Venango, received their Eye Bank Kit from the State Eye Bank Committee. Such action was made possible by the donation of $2 per member of every club in the 38th District of Lionism.

From the Omaha World-Herald—

Dr. Robert S. Long has been named chairman of the executive committee of the Nebraska chapter of the Arthritis and Rheumatism Foundation.

Other officers: Howard LeClair, president; Dr. Mary Jo Henn, Dr. Fred Fricke and Henry Lee, vice presidents; Dr. W. E. Graham, secretary, and Mrs. Lane A. Vogel, treasurer.

More than six hundred arthritis victims in Western Iowa and Eastern Nebraska were treated last year at clinics at the University of Nebraska College of Medicine and Creighton University School of Medicine, Dr. Long reported.

Whitley Resigns—

Frank V. Whitley, Executive Director of the Nebraska Heart Association, resigned as of March 31, to become State Public Relations Director of New Jersey Mental Health Association. Before Mr. Whitley's appointment as Executive Director of Nebraska Heart, he served as Information-Campaign Director for three years. Under his guidance the income of the Association quadrupled and membership more than tripled. Under his direction several important new activities were introduced including the Business-Industrial Program, Booklet-of-the-Month Promotion, and year 'round use of radio, TV, and newspapers in the publicity and educational programs of the association.

Civic Pride in "Young Men in Medicine"
From a Community—

Doctor Charles G. McMahon of Superior, Nebraska, has taken a certain pride in following young men of his community who have embarked on a career in medicine. In March the Journal received a letter from Doctor McMahon containing the following interesting information: "For many years none of the young men of Nuckolls County studied medicine. Of late, several have and a check on them shows the following accomplishments:"

1. Dr. William Niehouse is a busy and highly successful practitioner in David City, Nebraska.

2. Dr. Richard J. Meyers received a M.Sc. in Pediatrics from the Mayo Clinic. He now has a flourishing pediatric practice in Green Bay, Wis.

3. Dr. Don Crilly is in his third year of a surgical 4-year fellowship at Mayo Clinic.

4. Dr. Clifton Baker begins a Fellowship in Orthopedic Surgery at Mayo Clinic on April 1st, next.

5. Dr. John Gaskill is completing his internship in a Kansas City hospital and then has a four-year residency in surgery awaiting him in the same hospital."

Doctor McMahon concludes with this remark:
"Other Nebraska counties may have more in quantity. None can top our record in quality."

How interesting it would be if various communities would record in this Journal data about their medical graduates, either as communities or as families!

Accelerate Polio Vaccination or Suffer An Epidemic—

The Public Health Service announced that as of March 1, there were 48.5 million people under the age of 40 years who had not had any polio vaccine. This compares poorly with a total of 42.5 million who have had the three innoculations. The Surgeon General estimates that, if we have a bad year like 1952, as many as 300,000 cases could occur among the unprotected.

Inferiority Complex, the G.P.'s?—

We see in The Cornhusker G.P. for March that some doctor thinks the general practitioners have inferiority complexes. We suspect that this condition is no more prevalent among G.P.'s than any other group of doctors. There is no reason for this affliction to be more prevalent among G.P.'s; they are doing a bang-up job, all in all, taking good care of sick people.

From Washington Letter 85-66 We Learn—

Senator Morse (D., Ore.), would like to name the social security act. For this purpose he introduced S. 3508. This bill would:

(a) Provide hospital nursing-home care and surgical benefits identical with those in the Forand bill;

(b) Increase the wage-base and rate for social security payroll taxes; and

(c) Increase social security benefits.

This bill would increase the minimum to $40 per month, the maximum family benefit from $200 to $346.40, and the maximum individual primary benefit from the present $108.50 to $173.20. A more liberal "drop-out period" would be provided. The wage-base on which tax is levied would be increased from the present $4200 to $6000, and the rate increased adequately to cover the obvious deficit. This bill would also increase public assistance payments by 25%.

While it does not seem possible that astute Congressmen will pass such a bill, it shows us the way the "wind blows" — more and more paternalism by the government and less and less left in the hands of the individual.

Two Civil Defense Programs Scheduled In San Francisco—

Two medical civil defense meetings will be held in San Francisco immediately preceding the American Medical Association's 107th Annual Meeting. On June 19-20, the 12th Naval District will sponsor a symposium on "Medical Problems of Modern Warfare and Civil Defense" at the U.S. Naval Radiological Defense Laboratory, and on June 21 the A.M.A.'s Council on National Defense will sponsor its 6th Annual National Medical Civil Defense Conference in the Sheraton-Palace Hotel. Dr. David B. Allman, A.M.A. president, and Frank W. Barton, secretary, A.M.A. Council on National Defense, will speak at the naval symposium on the plan and activities of organized medicine for medical preparedness in disasters or in the event of all-out war.

Dr. Gunnar Gundersen, A.M.A. president-elect, will welcome participants to the A.M.A.'s civil defense meeting on June 21. The current federal civil defense program including the national plan for mobilization of resources (personnel, facilities, supplies) will be outlined during the morning session by officials of federal governmental agencies involved. Also scheduled for the morning session will be a discussion of the threat and impact of newer weapons and delivery systems by an outstanding military planner, and a report on the legislative program now pending before congress for a national survival plan by the Hon. Chet Holifield, U.S. congressman, 19th district of California.

During the afternoon, the Surgeons-General of the Army, Navy, Air Force and Public Health Service will discuss the civil defense role and responsibilities of civilian physicians. Two other subjects to be covered include the radioactive fall-out problem and the feasibility of a national shelter program.

All physicians interested in civil defense planning are urged to attend these two worthwhile meetings.
Indictment or Praise—

"...Pride in profession — independence of government..."

A tough and unyielding barrier has been the pride in profession of a limited group who have made independence of government in their economic activities a political religion reminiscent of that of our Victorian grandfathers.

This is an intended indictment of our profession expressed in an article by Professor J. Douglas Brown on "The American Philosophy of Social Insurance" and published in a recent issue of the "Bulletin of the International Social Security Association."

We think this is one of the most eloquent compliments ever tendered our profession. How rare today is such a thing as "pride in profession!" And how rare, too, is "independence of government!" That our pride in our profession and our determination to be independent of government should be a fault in anyone's view is a sad commentary on the degree to which the world wide drive to socialism has corrupted our sense of values.

Let us keep up this "tough and unyielding barrier" — by strengthening our county, state and national medical societies — and The World Medical Association — which are tough and unyielding defenders of our pride in profession and our independence of government in medicine! (From World Medical Association Newsletter No. 11).

Current Comment

Mental Health Aspect of Atomic Energy
(News Release from P.A.S.B.)—

Geneva, November 25—Atomic power is news today in all parts of the world and everything concerned with this subject provokes an emotional reaction on the part of the public. Often perfectly healthy and reasonable, this reaction may also take the form of irrational fears and irrational hopes. Thus with the advent of the atomic age humanity seems to be faced with certain mental health problems, and these have been reviewed by a Study Group of the World Health Organization (W.H.O.) at a meeting held in Geneva under the chairmanship of Professor Hans Hoff, of Vienna. Particip-

News From Nebraska Heart Association

Good News about congenital heart disease... Less than 1% of children are born with defective hearts. Except for a small percentage of cases which are apparently due to the fact that the mother had German measles in the first third of her pregnancy, we do not know the cause of these abnormalities. It is unusual for more than one child in a family to have this type of heart condition. Sometimes the new-born's heart is so defective that he can live for only a few months or a few minutes. Sometimes the defect is so mild that it is not recognized during a long lifetime.

The more common congenital heart abnormalities which can often be corrected by surgery include patent ductus arteriosus, tetralogy of Fallot ("blue Baby"), coartation of the aorta, valvular pulmonary stenosis, and septal defects.

Considerable advances have been made in developing new surgical techniques for correcting other types of congenital heart defects. They offer promise, but, as with all new surgical techniques, further study is required to judge their usefulness. Without question, many conditions which are now hopeless will be corrected in the future.

Three co-sponsors have been announced for the Nebraska Heart Association's Fall Scientific Conference October 2-4 in Omaha.

The University of Nebraska and Creighton medical schools and the Iowa Heart Association will join Nebraska Heart in presenting this special program on "Rheumatic Fever and Rheumatic Heart Disease."

The Iowa Association is giving its support as a special service to physicians in Western Iowa.

Six nationally-known experts in treatment, diagnosis and prevention of rheumatic heart disease will speak at the 21/2-day conference.

The Session, which will be held at the Town House, will also include the Annual Meeting of the Nebraska Heart Association with election of officers and awards.

The Nebraska Heart Association has launched a program of Research Recruit-
ment to stimulate interest in heart research careers among high school and college students.

The Association is currently studying activities of other Heart Associations with respect to such a program. Under consideration are fellowships, tours of research centers, summer research clinics and cash awards for biological science displays.

Special attention is being given to the problem of stimulating the teachers of science subjects by supplying counselling materials as well as materials for teacher-student projects.

Announcements

Advance Tables of Contents—In English—of the Soviet Journals Being Published for Translation

A monthly guide to current Soviet research, each issue of which will contain English titles of all papers appearing in the most recent issues of the 59 Soviet journals currently being translated into English, is to be published by Consultants Bureau, Inc., beginning in May of this year. This guide, entitled “Express Contents of Soviet Journals,” will make it possible for Western researchers to know the contents of Soviet periodicals published as recently as two months previously, and from two to six months before the complete translations are published.

Express Contents will include the Tables of Contents of Soviet scientific and technical journals (in all fields) which are being published in English translation by Consultants Bureau, by other private agencies, or by scientific societies. Anticipation of translation needs will be made possible by a feature of Express Contents: Each Table of Contents included will cite the estimated date of publication of the specific issue in translation, as well as pertinent information as to publisher, subscription price and individual issue/article price. This unique service, which begins with a May 1958 issue, will be available on an annual subscription basis at $25.00, from Consultants Bureau, Inc., 227 West 17th Street, New York 11, N.Y. As cover-to-cover translations of other journals are undertaken, their Tables of Contents will be included.

World Conference on Welfare of Cripples—

The Eighth World Congress of the International Society for the Welfare of Cripples will convene in New York at the Waldorf-Astoria Hotel, August 29, 1960, with Dr. Howard Rusk, internationally known American Specialist in physical medicine and rehabilitation, as president, and with the National Society for Crippled Children and Adults as the host-organization.

Further information about the 1960 World Congress may be obtained from Donald V. Wilson, Secretary General, International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y., or from Dean W. Roberts, M.D., Executive Director, National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.

Postgraduate Refresher Course on Shipboard And in Honolulu—

From Aug. 5 to Aug. 21, the University of Southern California School of Medicine will hold a postgraduate course in Honolulu and on board the S. S. Matsonia. The course will be centered around actual case histories, which will be used to emphasize diagnostic and therapeutic features.

Price range from $382.15 to $657.25, plus tuition $125. For information address Director, Postgraduate Division, U.S.C. School of Medicine, 2025 Zonal Ave., Los Angeles 33, Calif.

Annual Meeting National Tuberculosis Association—

The annual meeting of the National Tuberculosis Association and of its medical section, the American Trudeau Society, will be held at the Convention Hall and the Bellevue-Stratford in Philadelphia, May 19-22, 1958. For further information contact Agnes Fahy, 1790 Broadway, New York 19, N.Y.

Medical Lecture Tour to Asia—

The Asia-Pacific Academy of Ophthalmology (Hawaii) is sponsoring a good-will tour to countries of the Orient following the International Congress of Ophthalmology in Brussels in September 1958. The purpose of this tour, which is to last approximately one month, is to hold joint meetings with

Nebraska S. M. J.
ophthalmologists in Pakistan, India, Thailand, the Phillipines, and Hong Kong.

The purpose of this trip, besides that of creating good will between the East and West, is to exchange information and techniques, treatments and devices for the care of the ill and blind.

Physicians and their families other than ophthalmologists are welcome to join the tour. If you wish to participate in post-graduate lectures and seminars, contact William John Holmes, M.D., Laiason Secretary, Suite 280, Alexander Young Building, Honolulu 13, Hawaii. Inquiries about travel should be addressed to Compass Travel Bureau, 55 W. 42nd St., New York 36, N.Y.

Three Weeks School of Tuberculosis and Other Pulmonary Diseases—

The Trudeau School of Tuberculosis and Other Pulmonary Diseases will conduct its 43rd session in Saranac Lake, N.Y., from June 2nd to 20th, 1958. Outstanding instruction will be provided by a faculty of experts at a tuition of $100. Enrollment is limited, therefore application should be made early. Write Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N.Y.

Hawaii Summer Medical Conference to Follow A.M.A. Meeting—

The Hawaii Medical Association, constituent society of the A.M.A., invites mainland doctors to attend the Hawaii Summer Medical Conference in Honolulu following the annual sessions of the A.M.A. in San Francisco. The dates of the Conference are July 1-3, 1958. Contact Lee Kirkland Travel, c/o Medical Tours, P.O. Box 3433, Chicago 54, Ill., for information, reservations, or Conference Registration Forms.

Golf Tournament at San Francisco During A.M.A. Meeting—

The American Medical Golfing Association is holding its annual golf tournament in conjunction with the A.M.A. Convention, June 23, 1958 at the beautiful Olympic Lakeside Golf and Country Club, San Francisco, California. This will be a whole day of rest and relaxation with golf, luncheon, banquet, and a prize for everyone. We have left no stone unturned to assure you the very best. Tee off time 8 a.m. and 2 p.m. We cordially invite all golfing doctors to attend. Handicaps scratch to 30 in flights.

For information, contact James J. Leary, M.D., Secretary, 450 Sutter Street, San Francisco, California.

Public Health Association 86th Annual Meeting—

In a continuing effort to help health services on national, state and local levels to keep pace with changing human needs and technological advances, the American Public Health Association is scheduling research reports and discussions on a wide variety of topics for its 36th annual meeting in St. Louis, October 27-31.

Rocky Mountain Cancer Conference—

The 12th Annual Rocky Mountain Cancer Conference will be held in Denver, Colorado, July 9 and 10, 1958. Those interested in attending may address Alexis E. Lubchenco, M.D., Chairman of the Conference, at 835 Republic Building, Denver 2, for further information.

Human Interest Tales

Dr. and Mrs. C. A. McWhorter, Omaha, spent a week at Sun Valley, in March.

Dr. H. V. Nuss, Sutton, has been appointed county physician for Clay County.

Dr. Paul Bancroft, Lincoln, spoke at a recent meeting of the Child and Youth Department of the York Woman’s Club.

Dr. F. W. Niehaus, Omaha, recently returned home from the International Conference of the Chicago Heart Association.

Dr. Herman Jahr, Omaha, was a guest speaker at the meeting of the Omaha Elementary School Principals Club, in March.

Dr. Ralph Paul, Lincoln, now interning at a Lincoln hospital, has announced plans to set up his practice in Sterling, in July.

Dr. H. C. Anderson, Grand Island, has again been elected president of the medical staff of the Lutheran Hospital in that city.

Dr. W. V. Glenn, Falls City, attended a sectional meeting of the American College of Surgeons in Des Moines, in March.
Dr. and Mrs. J. P. Gilligan, Nebraska City, spent three weeks vacationing in Florida and along the Gulf, in March.

Dr. J. P. Murphy, Omaha, has had an article published in “Circulation,” official journal of the American Heart Association.

Drs. H. S. Heim and A. P. Stappenbeck, Humboldt, recently installed a new X-ray and fluoroscopic machine in their office.

Dr. J. S. Bell, York, has been re-elected president of the York General Hospital Medical Staff.

Dr. Samuel Swenson, Omaha, was the guest speaker at the March meeting of the Tri-County Medical Society held in Fremont.

Dr. H. A. Blackstone, Bridgeport, in March, visited his grandchildren in Seattle, Washington.

Dr. E. R. Core, Kimball, attended the March meeting of the International College of Surgeons at Los Angeles, California.

Dr. George Hoffmeister, Imperial, has been nominated for a district director of the University of Nebraska Alumni Association.

Dr. Kenneth Browne, Omaha, attended the March meeting of the Houston, Texas, Urological Society.

Captain David C. Meek, (MC), has been assigned to the Sioux Ordnance Depot in Sidney and will serve as Depot Surgeon.

Dr. E. G. Ewing, native of Madison, has announced plans to open his medical office in that city.

Dr. and Mrs. Frank Kamm, Blue Hill, attended the annual meeting of the American Academy of General Practice in Dallas, Texas, in March.

Dr. William Nutzman, Kearney, was the principal speaker at the March meeting of the Adams County Tuberculosis Association, in Hastings.

Mr. Herbert A. Anderson, Lincoln, administrator of Lincoln General Hospital, has been named president-elect of the Midwest Hospital Association.

Dr. J. A. Tamisiea, of Omaha, is a member of the Committee on Resolutions of the Aero Medical Association. This Association held its 29th Annual Meeting on March 24-26 at the Statler Hotel, Washington, D.C.

Dr. W. Max Gentry, Gering, participated in a panel discussion on “Alcoholism” at a meeting of the North Platte Valley Ministerial Association in Gering, in March.

Dr. and Mrs. James D. Flood, West Point, have left for Terre Haute, Indiana, where Dr. Flood will enter the Public Health Service.

Dr. and Mrs. Lloyd O'Holleran, Sidney, were hosts to the regular meeting of the Cheyenne-Kimball-Deuel County Medical Society in March.

Dr. W. P. Jensen, Omaha, journeyed to Little Rock, Arkansas, in March, where he was installed as president of the Mid-Central States Orthopedic Society.

Dr. R. P. Carroll, Laurel, was elected president of the Sioux Valley Medical Society at their annual meeting in Sioux Falls, South Dakota, in February.

Drs. F. G. Gillick, Harold Neu, Robert H. Gregg, and R. Dale Smith, all of Omaha, attended a polio rehabilitation meeting in Tulsa, Oklahoma, in March.

Dr. H. V. Munger, Lincoln, will present a paper on Hematuria at the May meeting of the Arkansas Medical Association held in Hot Springs, Arkansas.

Dr. Juul C. Nielsen, Petersburg, Virginia, former superintendent of the Hastings State Hospital, has been reappointed to the post, effective July 1, 1958.

Drs. Ralph Moore and Charles Marsh, Omaha and Valley respectively, presented a program on safety at the March luncheon of the Women's Auxiliary of the Omaha-Douglas County Medical Society.

Drs. E. S. Wagner, Kenneth Fijan, and Herbert Ahrens, Lincoln, were panelists at a poison control clinic conducted by the Lincoln-Lancaster County Safety Council in March.

Dr. Richard Ford, Professor of Medicine at Harvard University, was the principal speaker at the fifth annual joint session of the Omaha Bar Association and the Omaha-Douglas County Medical Society in March.

Dr. J. William Ballew of Lincoln spoke on the subject of ovarian hormones at a recent meeting of the Sixth Counselor District Medical Society at York. Dr. B. N. Greenberg was re-elected Counselor from this district.
The Woman's Auxiliary

The thirty-fifth annual convention of the Woman's Auxiliary to the American Medical Association will meet in San Francisco, California, June 23-27, 1958 at the Fairmont Hotel. Mrs. Matthew N. Hosmer and Mrs. Samuel R. Sherman are the convention chairmen.

A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests and the guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general meetings of the Auxiliary.

Tickets for the various functions will be available at the registration desk. The Hospitality Room will be in the Green and Empire Rooms on the first floor.

Doctors' Wives Plan June Convention—

The call of the west will be heeded by physicians' wives as they travel to San Francisco in June for the 35th annual convention of the Woman's Auxiliary to the American Medical Association at the Fairmont Hotel. National committee meetings and round table discussions will be held June 21-23 with formal opening of the convention slated for Tuesday morning, June 24. An interesting and varied program is being arranged by co-chairmen Mrs. Matthew N. Hosmer, San Rafael, Calif., and Mrs. Samuel R. Sherman, San Francisco, Calif.

Business sessions on Tuesday and Wednesday will be devoted to state and national committee reports and discussions on current projects. Tuesday's luncheon in honor of past presidents will feature guest speaker Mr. Richard H. McFeeley, principal of George School, Bucks County, Penn. Speaker at Wednesday's luncheon in honor of the president (Mrs. Paul C. Craig of Pennsylvania) and the president-elect (Mrs. E. Arthur Underwood of Washington) will be Dr. David B. Allman, immediate past president of the A.M.A. At this session Mrs. Craig will present the Woman's Auxiliary contribution to the American Medical Education Foundation, and Dr. George F. Lull, A.M.E.F. president, will present A.M.E.F. awards to the auxiliaries.

Election and installation of national officers will be held Thursday morning with adjournment scheduled for noon.

One of the highlights of the convention will be the premiere showing of the new recruitment film, "Helping Hands for Julie," at 3 p.m. Wednesday. Produced by the A.M.A., the American Hospital Association and E. R. Squibb and Company, the film is designed to encourage young people on medical health careers. All Auxiliary members, their husbands and friends, career guidance counselors and members of allied medical groups are invited to attend this showing.

Omaha-Douglas County—

The Woman's Auxiliary to the Omaha-Douglas County Medical Society held a benefit luncheon for the American Medical Education Foundation. Mrs. Ralph Luikart was the hostess.

Drs. Ralph Moore and Charles L. Marsh presented a program on safety.

Mrs. William Otis of the United Community Services and the Junior League spoke on the need for volunteer workers.

Adams County—

New officers of the Adams County Medical Auxiliary are Mrs. Warren Richard, president; Mrs. Robert C. Smith, vice president, and Mrs. Fred Rutt, Jr., secretary and treasurer.

The women met for dinner with the Medical Society members and held a separate meeting during the evening.

Mrs. Tom Creigh presented a program, "Hastings College Through the Years," using as basis for her discussion the book written by her father, Dean F. E. Weyer, which she helped to compile and edit.

Richardson County—

Mrs. R. R. Brady, Ainsworth, president of the Auxiliary to the Nebraska State Medical Association, and Mrs. C. H. Farrell, Omaha, first vice president of the organization, met in Falls City with the wives and doctors of Richardson county to take steps in organizing an Auxiliary to the Richardson County Medical Society.

Mrs. William V. Glenn was named temporary chairman.
The group met for a 1 o'clock luncheon at the Hotel Stephenson. Present besides the out-of-county officers were: Mrs. L. V. Brennan, Mrs. S. D. Cowan, Sr., Mrs. D. E. Wilkinson, Mrs. C. L. Hustead, Mrs. Robert L. Heins, Mrs. J. C. Gillespie and Mrs. Glenn, all of Falls City; Mrs. Harlan S. Heim and Mrs. A. P. Stappenbeck, both of Humboldt.

The next meeting will be held in conjunction with the Richardson County Medical Society.

Dawson County Medical Auxiliary—

New officers were chosen at the March 21st meeting of the Dawson County Medical Auxiliary, in Cozad. Meeting at the home of Mrs. Charles Sheets, auxiliary members selected the following: President, Mrs. Rodney Sittorious, Cozad; vice president, Mrs. Ray Wycoff, Lexington; secretary-treasurer, Mrs. Dean McGee, Lexington; Scholarship Loan chairman, Mrs. P. B. Olsson, Lexington; Public Relations chairman, Mrs. Wm. B. Long, Lexington.

Sgt. J. W. Carter and Sgt. S. W. Bullock, of the North Platte Filter Center, presented a film depicting the workings of United States Civil Defense organizations. They then explained the operations of the Ground Observer Corps and the necessity for local volunteers for maintaining it.

The April meeting will be a joint one with the doctors of the Dawson County Medical Society, at which time Dr. Charles Marsh, Valley, Nebraska, will present his slides on “Safety.”


Private nonprofit hospitals in this county have an average of more than $14,000 in assets per bed, according to Health Information Foundation. Comparable figures are $10,000 for federal hospitals; $5,000 for non-federal government hospitals; and $4,300 for proprietary hospitals.
Dr. McKeown said that these Plans had given "... to American Medicine freedom from socialization. To the people of America they have given the best medical care provided free men in the world."

Dr. McKeown cited three problems which he described as major issues confronting Blue Shield and other medical care programs. He said that Plans must find a satisfactory solution to the "ever increasing demands of patients and some physicians for more complete and comprehensive medical and surgical coverage"; that Plans "must develop acceptable means and methods to provide adequate coverage for those not presently covered"; and that "open panel plans must meet and solve the challenge of the so-called closed panel type of prepaid medical care."

"Our failure or inability to solve these three challenges," Dr. McKeown said, "will but lead others to enter the arena and provide the answer. The solutions these outsiders provide might materially change the practice of medicine as we have known it these many years. It could even spell the end of freedom for the medical profession."

TUBERCULOSIS ABSTRACTS

BASIC PROBLEMS IN THE DIAGNOSIS AND MANAGEMENT OF TUBERCULOSIS

Early Diagnosis. The photofluorographic process and the wider use of X rays disclose many thoracic lesions which when not frankly tuberculous, require careful clinical study and observation. On general hospital care this may be an expensive procedure. The concept of an asymptomatic illness which has not caused a loss or impairment of physical power is rarely familiar to the patient and he is apt to regard the physician who insists on clinical studies with faint ridicule. Here obviously we need a program of extended education which will teach the public and many general practitioners the need for early studies of chest X-ray findings in the absence of symptoms.

The influence of general factors. It is well known that economic and vocational status influence the potential severity of a tuberculous lesion. Among young women the probability of an apical lesion becoming active increases with pregnancy, particularly if the standard of living is low. Tuberculous lesions are potentially active among the aging, particularly among pensioners who have lowered their standard of living, or have substituted alcohol for more nutritious elements of diet. Among those under 5 years of age, a tuberculous infection is generally to be regarded as carrying a grave prognosis.

Intercurrent disease. Patients with diabetes in any age group are prone to develop progressive tuberculous. The combination of an X-ray lesion and diabetes is a signal for vigorous study and early treatment.

Malnutrition. Malnutrition may be a serious contributing factor to tuberculous activity and progression.

Industrial dust exposure. The combination of exposure to silica dust and tuberculous infection precedes the development of massive progressive disease in the lung. Similarly the combination of tuberculosis and pneumoconiosis of coal workers apparently leads to a massive progressive fibrosis which can be recognized from characteristic X-ray findings and the history of dust exposure. The patient’s general background should be considered, once an abnormal chest X ray is found.

Factors in Differential Diagnosis. Aside from the background of the patient differential diagnostic studies are needed. These vary according to the type of lesion. A high index of suspicion is a paramount need in the recognition of bronchial and other forms of thoracic carcinoma. One must be prompt to use surgical consultation and bronchoscopy. It may be well to remember that recurrent episodes of pneumonia or shortness of breath, of nonproductive persistent cough, of chest pain or hemoptysis, may be more significant than the X-ray findings. Inexplicable thoracic symptoms always require careful study to rule out carcinoma.

Other Chronic Pulmonary Diseases. Many of the other chronic pulmonary diseases such as bronchiectasis, supplicative pneumonitis and chronic emphysema can be recognized from a careful radiologic study and a clinical and laboratory evaluation. Testing of sputum for tubercle bacilli is always a wise precaution.

Tuberculin Testing. The intradermal tuberculin test is a basic diagnostic weapon. At the present time there is considerable disagreement concerning the meaning of positive reactions obtained with strong dilutions of tuberculin. There is a possibility that positive reactions to strong dilutions are due to some cross sensitivity rather than to tuberculous allergy. Many clinicians regard induration in excess of 5 mm. largest diameter as positive only when the maximal doses employed are 0.0002 mg. of PPD or 0.1 mg. of OT. Completely negative reactions to the intermediate dosage, or larger, rules out the presence of tuberculosis in the absence of a premorbid state, cortisone or ACTH medication or extremely high fever. Many adults in middle-age have negative reactions and our diagnostic problem is thereby simplified.

Sputum Testing. Three successive morning specimens of the sputum when pooled and examined by smear and culture give evidence of the presence of tubercle bacilli in the majority of new cavitary cases. This method is as reliable as the patient who collects the specimen according to instructions.

In too many cases expectoration is absent. Gas- tric lavage is satisfactory on patients under study in the hospital but it is not practical as an office or clinical procedure. On our service we have studied the inhalation of nebulized water as a means of provoking cough and expectoration. By
Adequate Physical, Removal" Nebraska it hospitalization. The basic treatment of tuberculosis is dependent upon the following factors:

1. Adequate bacteriostasis through drugs.
2. Healing of the damaged lung through rest, nutritional management and graded exercise.
3. Removal of diseased lung which remains potentially active in the face of bacteriostasis and the normal healing process.
4. Physical, occupational and emotional therapy which will restore patients to independence.

Adequate bacteriostasis requires the early and vigorous use of drugs. On our services we use Isoniazid, 5 mg. per kilo, and Streptomycin, 1 gm. daily for 42 to 90 days. With this regimen we have not found significant toxicity from either drug nor significant development of resistance. Following the period of intensive drug therapy the combination of Isoniazid and PAS daily now seems the most generally used routine for the maintenance of bacteriostasis. This is continued for two years for most patients but for those cavitary patients who cannot take surgical therapy, drugs probably must be continued for life.

The antituberculous drugs diminish the inflammatory changes in the lung by suppressing bacterial growth. Healing of tuberculosis depends upon rest, adequate dietary management and treatment of other illnesses. The medical management of the damaged lung is hardly possible without hospitalization.

The aging patient, the alcoholic, the diabetic, manage the healing of tuberculosis poorly and remain disabled for longer periods than younger patients who heal more rapidly once the suppression of bacterial growth is accomplished.

For all patients whose inflammatory residues remain after 4 to 6 months of drug therapy, surgical excision or, more rarely, surgical collapse is necessary. This is best done after adequate drug therapy and a study of the patient's breathing capacity, both being hospital procedures.

There are many patients with a history of lung exposure to coal dust who exhibit extensive disease on the X-ray, a positive sputum, and some degree of respiratory disability. These men have pneumoconiosis of soft coal workers, with tuberculosis and progressive massive pulmonary fibrosis. Drug therapy may control the growth of bacilli, fever and malaise disappear, and there is an increased sense of well-being. However, dyspnea does not improve nor is there appreciable X-ray clearing. In our opinion these men can be discharged only to the most vigilant medical supervision and even then remain potential spreaders of tubercle bacilli. The early and vigorous treatment of all lung infection of soft coal workers seems indicated.

These patients and the aging are those most difficult to treat. Younger patients with no dust exposure recover and are discharged. Many others remain capable of spreading infection despite apparent recovery. For these we need hospital care and isolation, lacking clinical and home care facilities at their homes.


Government for the People—

During the Second Session of the 85th Congress, the Hon. Ralph W. Gwinn, New York, recorded an "Extension of Remarks" in the House. The following excerpt deserves considerable thought by doctors:

"A good many years ago I heard the late President Lowell of Harvard say that a civilization is seldom murdered; it commits suicide. And I wish that he had added that it commits suicide unwittingly. The road downhill is extremely easy. It is marked by little indulgencies—by minor compromises with principle to escape temporary discomfort or hardship. Each step downward makes the next one seem a little more logical and a little harder to resist. That has been the recent history of our own country . . ."

Rheumatic disease, which afflicts an estimated one out of every 16 Americans, causes more disability than all accidents combined, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. Close to three million persons have been forced to change their occupation or give up normal activity; 1,500,000 are partially disabled; 218,000 are completely disabled, and 320,000 are unemployed. Persons with rheumatic disease lose an average of 15 working days each year, "Patterns" reports.

Though heart attacks are often associated by laymen with over-exertion, they are far more likely to occur during periods of rest. Over half of the victims of coronary heart attacks are stricken while resting or sleeping, according to a new publication Patterns of Disease, prepared by Parke, Davis & Company for the medical profession. Less than two per cent are afflicted when engaging in "sports, running, lifting or moving a load."
Pro-Banthine® "proved almost invariably effective in the relief of ulcer pain,

*in depressing gastric secretory volume and in inhibiting gastrointestinal motility."

Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies."

Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is primary. During treatment, Pro-Banthine has been shown repeatedly to be a most valuable agent when used in conjunction with diet, antacids and essential psychotherapy.

Therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly referred to in the recent medical literature.

**Pro-Banthine Dosage**

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No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases. Each sodium-free BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.


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Current Comment

Aspirin Treatment of Diabetes!—

Ignored medical reports of the early 20th century concerning the effectiveness of aspirin in treating diabetes mellitus may have been accurate, in the opinion of a British medical team. (British Medical Journal: Nov. 9, 1957).

Seven diabetic patients given an intensive two-weeks course of therapy with pure aspirin alone had their blood sugar and urine sugar levels restored to normal, according to Drs. James Reid and A. I. MacDougall. All clinical symptoms of the disease, such as thirst, excessive secretion and discharge of urine, and intense itching, were “completely relieved.”

All patients had been victims of diabetes for periods ranging from one month to five years. Their age-range was from 15 to 65. To investigate the effect of maximum tolerated doses, the investigators note, each patient received between 3 and 5 five-grain tablets of aspirin every four hours except in the middle of the night.

The course of treatment was deliberately brief (10 to 14 days) and intensive in order to attain rapid build-up of blood salicylate levels. Despite the relatively high aspirin doses, side effects such as nausea and vomiting, classed as serious by the authors, were uncommon and easily controlled.

Drs. Reid and MacDougall made the study following the accidental discovery that aspirin was “strikingly” effective in relieving diabetes in a young patient who was actually being treated for rheumatic fever. Checking back in medical literature revealed that aspirin “was in fact used in the treatment of diabetes and that it prevented glycosuria (sugar in the urine).” More recent results of experiments with rats confirmed their interest in doing further clinical tests.

Without exception, in the seven diabetics subsequently studied, aspirin reduced blood sugar levels “to normal or near normal by the end of the course of treatment, and after it was discontinued the sugar concentrations started to rise again.” Aspirin had the “same striking effect” in lowering sugar in the urine, it is noted.

Recommending further study of aspirin, they say:

(Continued on page 42-A)

36-A You can enhance the value of your own Journal by patronising its advertisers
Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem—well documented in a growing body of literature.

*"In view of the beneficial responses observed when antacids and bland diets were used concomitantly with prednisone and prednisolone, we feel that these measures should be employed prophylactically to offset any gastrointestinal side effects."—Dordick, J. R. et al.: N. Y. State J. Med. 57:2049 (June 15) 1957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.


One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

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PREDNISONE BUFFERED
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Current Comment
Aspirin Treatment of Diabetes!—
(Continued from page 36-A)

“If there is a genuine need for an oral compound to control diabetes mellitus, aspirin has an obvious advantage over the sulphonylureas in that it may be given for prolonged periods without risk of agranulocytosis.

“Another point in its favor is that maximal tolerated doses such as were given to our patient lower the fasting blood sugar to normal without inducing hypoglycemia.”

Aspirin’s action, the researchers report, is located in the tissues and is of interest because the drug has been found to be “a peripheral-acting metabolic stimulant.”

NOTICE TO ALL CONTRIBUTORS
The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.
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LINCOLN, NEBRASKA
Current Comment

San Francisco Program for Young Physicians—

Helping young physicians bridge the gap between medical training and medical practice is the goal of an unusual and still expanding program inaugurated seven years ago by the San Francisco Medical Society and described in Scope Weekly.

The program offers a wide range of practical assistance to students at the city's two schools of medicine—the University of California and Stanford University—as well as to interns and residents at all San Francisco hospitals.

Services sponsored by the Society's Young Physicians Committee include a loan fund, social get-togethers, student affiliation with the Society, a preceptorship system, evening discussion groups, and an all- or half-day seminar put on in cooperation with the California Medical Association. Currently, a central clearing-house of information useful to the student or physician in training is being developed.

The program began in 1951 with the establishment of an emergency loan fund open to interns and residents. That year the Society also sponsored the first of what have become traditional receptions each fall for medical students, interns, residents, and their wives.

BULLETIN SPURRED INTEREST

Ideas for expansion came when senior students were invited to present their viewpoints in the Bulletin of the San Francisco Medical Society. One author discussed the ignorance of practical matters often shown by new doctors just starting practice and suggested that they needed to know more about medical economics, medicolegal problems, insurance, and similar nonscholastic topics.

This article stimulated several projects. As a member of the Young Physicians Committee recently commented, "There's a big hiatus between postgraduate work and the corollary aspects of medicine. The young physician may be highly skilled medically and still be at a complete loss on how to conduct a practice."

As an initial step, the Society offered student affiliation to senior students of both
medical schools and encouraged them to attend scientific and business meetings. Ex-officio membership on the Young Physicians Committee has since been extended to junior- and senior-class presidents of both schools and to representatives from the house staffs of larger hospitals.

Preceptorships in some of the major specialties augment the preceptorship program successfully launched by the California Academy of General Practice several years ago, and the two sponsoring groups work in close cooperation. Students are eligible in the summer months after their junior year.

Preceptors do not attempt to show a student how to do a physical examination or perform an appendectomy. The student has a chance to observe how fees are discussed or how the necessity for a pelvic exam is explained and sees something of the physician-patient relationship.

They can study office space arrangements and equipment, learn about the roles of medical assistants and nurses, examine methods of bookkeeping, and find out about such business necessities as insurance forms, employee bonding, and professional liability protection.

Evening discussion meetings planned by the Committee are held three or four times during the school year. All students, interns, and residents are invited, along with their wives.

Doctors and Donations—

Along with the usual wet feet, academy awards, and robins typical of this time of year comes another sure sign of spring — fund raising drives. And as civic-minded citizens, doctors have an obligation to support worthwhile projects, especially in the health field, according to an Erie County (Pa.) Stethoscope editorial. It states, “Before each physician moans about giving ... or tries to avoid the issue in one way or another, please consider the burden he would have to shoulder if these agencies were not functioning.” Many of the health agencies supported by fund drives, the editorial says, give much needed help to the doctor in his practice. “The communities look to the physicians to show interest and support in the voluntary health agencies,” the editorial says.

"No patient failed to improve."

phISOHex washing added to standard treatment in acne produced results that "...far excelled... results with the many measures usually advocated."

phISOHex maintains normal skin pH, cleans and degerms better than soap. In acne, it removes oil and virtually all skin bacteria without scrubbing.

For best results — four to six washings a day with phISOHex will keep the acne area "surgically" clean.

Current Comment

Conferees Discuss Rural Health Problems—

Many changes in rural health during recent years have resulted from the philosophy that if you have a problem, you should sit down and talk it over with the people involved, according to an American Medical Association trustee.

This philosophy is illustrated by the annual Conference on Rural Health, sponsored by the A.M.A. Council on Rural Health, Dr. George M. Fister, Ogden, Utah, said at the opening session of the 13th annual conference.

For three days (March 6-8) 400 representatives of medicine, farm groups, governmental agencies, and other groups discussed such rural problems as nutrition, dentistry, safety, doctor-patient relationships, physician distribution, health service costs and the changing patterns of rural society.

At the banquet session, Dr. F. J. L. Blasingame, Chicago, general manager of the A.M.A., called for cooperation between medical and rural people in constructing area hospitals, based on accessibility to a scattered population. These would help give rural people medical care of a quality equal to that of city people.

"The word accessible is the key to the success of area hospitals," he said. "Most rural people have cars and do not mind driving 30 to 40 miles for medical services."

He recommended that the hospitals be located on the basis of needs and anticipated growth, perhaps using the "medical trading areas" mapped out several years ago by the A.M.A. Bureau of Medical Economic Research.

Four areas of change in rural society outlined by A. F. Wileen, Ph.D., professor of rural sociology at the University of Wisconsin, Madison, are:

- Only about 40 per cent of the total American population lived in rural areas in 1950, as compared with 60 per cent in 1900. Only 38 per cent of these rural people in 1950 resided on farms. By 1957 the "farm" population had dropped to about 13 per cent of the total population and was still steadily decreasing.

(Continued on page 48-A)

NEBRASKA STATE MEDICAL ASSOCIATION
Councilor Districts and Component County Medical Societies

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COUNCILORS DISTRICTS AND COUNTIES

| First District: | Councilor: Harold New, Omaha. Counties: Douglas, Sarpy |
| Third District: | Councilor: Harvey Runy, DeWitt Counties: Gage, Johnson, Nemaha, Pawnee, Richardson |
| Fourth District: | Councilor: W. R. Benth, Verdigre Counties: Cedar, Dixon, Dakota, Antelope, Pierce, Thurston, Madison, Stanton |
| Seventh District: | Councilor: F. A. Mountford, Davenport Counties: saline, Clay, Fillmore, Nuckolls, Meade |
| Eighth District: | Councilor: W. E. Johnson, Valentine Counties: Cherry, Kearney, Brown, Rock, Holt, Sherman, Boyd |
| Ninth District: | Councilor: B. W. Bancroft, Kearney Counties: Hall, Carter, Valley, Greetey, Gage, Filmore, Grant, Hooker, Thomas, Grant, Chase, Frontier, Dundy, Hitchcock |
| Tenth District: | Councilor: F. M. Karr, McCook Counties: Gosper, Pierce, Garfield, Harlan, Franklin, Webster, Kearney, Redick, Willow, Chase, Frontier, Dundy, Hitchcock |
| Twelfth District: | Councilor: R. J. Morgan, Alliance Counties: Scotts Bluff, Banner, Box Butte, Merritt, Kimball, Cheyenne, Dawes |
**CYTELLIN** REDUCES HYPERCHOLESTEREMIA

<table>
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<th>Percentage reduction of excess serum cholesterol (over 150 mg. percent)</th>
<th>Percentage of patients experiencing various degrees of decline in excess serum cholesterol</th>
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<tr>
<td>Less than 20%</td>
<td>12.5%</td>
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<tr>
<td>20-40%</td>
<td>55%</td>
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<tr>
<td>More than 40%</td>
<td>32.5%</td>
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...without the necessity of dietary restrictions

'CYTELLIN' provides the most rational and practical therapy available. Without any dietary adjustments, it lowers elevated serum cholesterol concentrations in most patients.

In a number of studies, every patient who co-operated obtained good results from 'CYTELLIN' therapy. On the average, a 34 percent reduction of excess serum cholesterol (over 150 mg. percent) has been experienced.

In addition to lowering hypercholesteremia, 'CYTELLIN' has been reported to effect reductions in C/P ratio, S<sub>10</sub>-100 and S<sub>2</sub>100 lipoproteins, "atherogenic index," beta lipoproteins, and total lipids.

May we send more complete information and bibliography?

---

*CYTELLIN* (Sitosterols, Lilly)
Current Comment
Conferees Discuss Rural Health Problems—
(Continued from page 46-A)

—This drop in farm population is partly
the result of increasing technology on the
farm. Fifty years ago it took about one
person on the farm to supply one additional
nonfarm person. Today it takes only one
person on the farm to supply about six addi-
tional nonfarm people.

—The old isolation of the farm, which
was a matter of much concern 50 years ago,
is pretty much a thing of the past. Farming
is no longer viewed as a way of life as it
once was. It has become more of a busi-
ness.

—The neighborhood, once the strongest
unit of social organization in rural America,
is dying out. A new type of community,
called the “town-country” community, is de-
veloping as former farmers move to towns to
be nearer their jobs and city people move to
the smaller towns.

U. S. Program Aids Medical Schools—
Half of the Federal Government’s three-
year program of enlarging and modernizing
medical laboratories will be under construc-
tion this year, according to a report in Insur-
ce Economics Surveys.

The program got under way in 1956 and
the last date for acceptance of applications
is June 30, 1958. In the three fiscal years
ending at that time, the Federal Government
will have given $90,000,000 to public and
private institutions for laboratories. Funds
provided by the institutions aided will bring
the total outlay up to $120,000,000.

“As much as $90,000,000 worth of labora-
tories will be under construction during
1958,” Frank Schmehl, spokesman for the
National Advisory Committee on Health Re-
search Facilities at the National Institutes
of Health, said. This twelve-member com-
mittee recommends how the Federal money
should be allocated.

Bradshaw Mintener, former Assistant Sec-
retary of Health, Education and Welfare and
one of two non-medical members of the ad-
visory committee, today predicted in a New
York Times statement this modernization
would increase the nation’s health resources
by perhaps as much as 50 per cent.
If
Monilial overgrowth
is a factor

Achrostatin V
TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

Combines ACHROMYCIN V with NYSTATIN

SUPPLIED:
CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of Achrostatin V per day, equivalent to 1 Gm. of Achromycin V.

ACHROSTATIN V combines ACHROMYCIN V
...the new rapid-acting oral form of ACHROMYCIN V
Tetracycline...noted for its outstanding effectiveness against more than 50 different infections
...and NYSTATIN...the antifungal specific.
ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N.Y. *

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59-A
LABORATORY REAGENTS and stains

New CATALOG

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It is our objective to produce the finest reagents obtainable for clinical laboratory use. Their consistent accuracy saves hours of the technician’s time.

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Current Comment

Mental Health Aspect of Atomic Energy
(News Release from P.A.S.B.)—
(Continued from page 225)

parting in this group were representatives of disciplines as different as psychiatry, atomic and radiation medicine, public health, social anthropology and journalism.

The Study Group examined reports from many countries concerning the emotional impact of atomic energy developments as reflected in everyday life, public statements, the press, letters to leaders in the atomic, health and political fields . . . They found that in general, irrational fears were expressed far more often than irrational hopes. A reason for this might be found in the fact that people were first made aware of radiation as a means for diagnosing or treating two awe-inspiring diseases, tuberculosis and cancer. Then atomic energy was used as a weapon, and this had aroused a deep sense of fear, and in some people also of moral involvement and guilt, the Group said.

But there were also other factors influencing public attitudes to atomic energy. One of them was the mysterious, almost magical aura of atomic power. Atomic radiation was invisible, unheard, unfelt, apparently infinitely powerful yet springing from an almost infinitely small source and, as far as ordinary people were concerned, it was uncontrollable. It was credited with almost infinite potentialities for both good and evil, and represented man’s most amazing success in his search for power. Now, the oldest myths and legends shared by mankind since the dawn of history showed that man’s quest for power often resulted in terrible divine punishment: Prometheus stealing fire from the gods, Pandora unleashing forces she could not control, Faust evoking the Devil, the alchemists of the Middle Ages, all paid a heavy penalty for their daring. These tales were found in one form or another in nearly all cultures, as witness an ancient Egyptian saying: “When man learns what moves the stars, the Sphinx will laugh and life will be destroyed.”

Perhaps the most terrifying and characteristic aspect of atomic energy for the popular imagination was that its tremendous power might get out of control. People were also beginning to fear a biological chain re-

(Continued on page 56-A)
there is one tranquilizer clearly indicated in peptic ulcer...

*Tests in a series of 25 patients show that there is “a definite and distinct lowering [of both volume of secretions and of free hydrochloric acid] in the majority of patients. . . . No patients had shown any increase in gastric secretions following administration of the drug.”

Now you have 4 advantages when you calm ulcer patients with ATARAX:

1. ATARAX suppresses gastric secretions; others commonly increase acidity.
2. ATARAX is “the safest of the mild tranquilizers.” (No parkinsonian effect or blood dyscrasias ever reported.)
3. It is effective in 9 of every 10 tense and anxious patients.
4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.


New York 17, New York
Division, Chas. Pfizer & Co., Inc.
Mental Health Aspect of Atomic Energy
(News Release from P.A.S.B.)—
(Continued from page 54-A)

action: fall-out and atomic wastes would poison air, water and soil, then plants and cattle, then the men who ate them, and above all their children and their descendants. This, the W.H.O. Study Group found, was a deeper and more subtle fear than that of the unleashing of energy that might destroy the universe.

MISTRUST IS SPREADING

The W.H.O. Study Group further found that there was a widespread sense of disorientation in regard to atomic energy matters, and a mistrust of most information sources. For this state of affairs, they said, there were many past and present reasons: wars, psychological warfare, political propaganda, etc. Even competitive commercial advertising contributed its share. Furthermore, science today had lost the infallibility with which it was credited in the nineteenth century and the publicizing of disagreements and contradictions among scientists, for ex-

ample, about polio vaccine, or the cancer-producing effects of tobacco, had also contributed to this mistrust. Although a section of public opinion would always continue to place confidence in authoritative declarations, one could note in many countries a general distrust of scientific pronouncements. This mistrust was often reflected in deliberately anti-scientific attitudes.

Other factors which had contributed a disturbing background to the emergence of atomic energy included science fiction — a literature which had steadily stressed the horror of scientific power, the “death ray,” the “mad scientist.”

In conclusion, the Group stated that its findings were in no way alarming. It was however convinced that they were concrete enough to warrant the attention of those in authority. The Group hoped that persons in authority would be prepared to accept its conclusion that the behavioural sciences could make a valuable and concrete contribution to the adaptation of mankind to the advent of atomic power, making it indeed as painless and harmless as possible and allowing man to reap a rich harvest from the seed his inventive genius had sown.
IN VITRO SENSITIVITY OF THREE COMMON PATHOGENS TO CHLOROMYCETIN AND TO A WIDELY USED ANTIBIOTIC GROUP*

**STAPHYLOCOCCUS PYOGENES**
- 518 strains
- Chloromycin 96%

**PROTEUS MIRABILIS**
- 46 strains
- Chloromycin 89%
- Antibiotic Group 3%

**PSEUDOMONAS AERUGINOSA**
- 55 strains
- Chloromycin 38%
- Antibiotic Group 14%

Current Comment

Victory Over Sleeping Sickness in Africa—

In four decades, incidence of the dread sleeping sickness disease in French Tropical Africa has been reduced to 0.79 per cent, from former local rates of 80 to 97 per cent. The previous mortality rate was 22 per cent; today it is just about zero. This fine record is largely due to the perseverance of Dr. Eugene Jamot (1879-1937), who died twenty years ago after two decades of exhausting work in French Africa.

After graduation from the Marseilles School of Colonial Health in 1910, Dr. Jamot decided to dedicate his life to the needs of natives in French Tropical Africa, and went off at once to take up a series of posts in the Tchad, Congo, Cameroons, and Niger River region.

It was when he moved to Yaonde in the Cameroons during World War I, that he first became interested in endemic and epidemic sleeping sickness. He went back to Paris for a term of study at the Pasteur Institute located in Brazzaville to launch the campaign he had laid out against the illness. With a tiny staff and little equipment, he quickly reduced mortality at Ubangi-Shari by 65 per cent.

In 1922, in the Cameroons, Dr. Jamot organized the first prophylactic center in the Haut-Nyong, created a specialized clinic at Ayos, and set up native auxiliary units. The League of Nations Mandate Commission in Geneva commended this Frenchman’s crusade against the parasite-caused, fever-dazing and mad-making paralysis. In 1925, the French Government organized the Permanent Mission for the Fight Against Sleeping Sickness, and appointed Dr. Jamot its head.

Jamot developed mobile health units and used the latest drugs available—Atroxyl, discovered in 1866 by Bechamp, a Frenchman, and Tryparsamide. (Today Lomidine and Arsobal are considered most effective). His medical work in the villages all over French Tropical Africa and the inspiration he left to his scientific and medical successors, have written another great page in France’s record of contributions to the better life in hottest Africa.
Current Comment

One New Product Each Day—

The stepped-up tempo of the war on disease has reached a point where new pharmaceuticals and changes in the medical profession are considered commonplace rather than “miracles,” Dr. F. J. L. Blasingame, general manager of the American Medical Association told the 51st annual meeting of the American Pharmaceutical Manufacturers’ Association.

Dr. Blasingame noted that in the past decade the pharmaceutical industry has introduced 3,600 products, or one new pharmaceutical per day for 10 years.

As a result of this and other “fortuitous circumstances” Dr. Blasingame said that “the center of medical culture the world around is now the United States of America. In this leadership your industry and my profession can take pride.

“Perhaps the most important factor that has brought about such spectacular developments is the economic climate of freedom and competition,” Dr. Blasingame said.

Dr. Blasingame called for closer liaison between the medical and the pharmaceutical industry “to work intelligently for solutions of problems and to promote active recognition of mutual interests.” In this connection he said that the A.M.A. will examine every means of making its publications a useful, efficient and economical channel of communication between you (A.P.M.A.) and the medical profession.

One of these means of communication, Dr. Blasingame revealed, will be a bi-weekly publication soon to be inaugurated. Called the A.M.A. News, its purpose will be to present “timely organizational news and social-economic legislative developments.” With a view to stimulating greater alertness among physicians and other allied groups to the political trends of the times.

“We are members of a medical team — along with nurses, hospitals, pharmacists, technicians, researchers and many others—which has brought this country dramatic medical progress under the private enterprise system. This system has in recent years been threatened by the spreading philosophy of government control. The major

(Continued on page 42-A)
clinical evidence indicates BUFFERED "Predni-steroids" for rheumatoid arthritis
EDITORIAL

FEAR GAS

Recently, items have appeared in the news which state, categorically, that radioactive fallout is producing a marked increase in bone sarcomas ("bone cancer") and in congenital defects in the newborn; in some instances the statements are less bold but can be interpreted by the lay reader in no other way. Some of these items are attributed to doctors of medicine and they are named.

Our public is beset by predictions of fearful things to come or that could happen because of this or that or the other circumstance. News dispensing media hammer at them day and night along these lines. Of course, such constant exposure to predictions of awful things to come arouses fear. Fear, one of our strongest emotions, is a "must" for survival of the human being, but fear over and beyond that which is useful to man is productive of evil in relation to the health and activities of our people. The only time when doctors should publish to the lay public, by way of any of our means of communication, any further items that arouse fear should be when a definite, helpful or necessary end is sought. At such times the truth of our information should be beyond any reasonable doubt, or, if it be conjectural, this fact should be made crystal clear.

We are passing through a period of public hysteria regarding X rays. This was brought about by the unwise publication to the public of data about possible harm that might arise from too generous use of the X ray in diagnostic studies. The most effective and least frightening way to correct any existing over-use or careless use of X ray would have been through the medical profession and the manufacturers of equipment. How much better it would have been if doctors had told patients why a limited number of X-ray examinations should be carried out than to have the patients object to, or refuse any X-ray studies because of unreasonable fear.

To return to bone sarcoma and congenital defects due to radioactive fallout, one must deny that any definitive scientifically substantiated conclusions are available at this time. Certain assumptions may be justifiable in this matter, assumptions which may prove to be correct, but which can only arouse undue fear in those who do not know and understand the scientific background of the subject.

It has been accurately determined that radioactive strontium, for example, is deposited in the bones. This deposition is greatest during the first decade of life. In fact, it may occur only during that period and may tend to decline after puberty. It is measurable in millioths of a Curie, a mighty small amount, to be sure, and this deposit occurs almost entirely in inhabitants of the north Temperate Zone. The possible effects of this radioactive material as related to malignancy (including leukemia) and congenital defects can be only conjectured as regards man. Curves have been plotted suggesting what the effects may be providing several factors remain constant.

It is difficult to see what good end can be accomplished by publicizing such inconclusive material. It seems unscientific if not untruthful to say that certain things are happening now when all we have is a suspicion that they may happen in the future providing this and that remain constant. One is reminded of the Civil Defense tests carried out in Lincoln the past two days. If the bomb had fallen at the point designated, and if C.D. had carried out all its plans, so-and-so many thousand would be dead, and so-and-so many thousand seriously injured, and the heart of the city would be in ruins; we are thus informed as to the results of C.D.'s tests by radio, TV, and the newspapers.

We, as physicians, can not keep our brothers from seeking publicity, we can't restrain science writers and news gatherers from writing frightening stuff, we can't keep newspapers, radio and TV from disseminating such material, but we can refrain from taking any part in making misleading and
unnecessarily frightening statements about medical items. All people seem to place (and misplace) wholehearted faith and belief in the printed word, right or wrong.

OLD NOTES ON PR

In sorting old notes to throw away the useless or outdated to make room for some new ones which will soon be useless and outdated, the following came to light. Apparently an editorial on public relations never got beyond the stage of note making. Perhaps such an editorial would have been better than anticipated when the project was dropped. You be the judge; here are the notes:

“1. ‘Stunts’ that have been used to improve PR—
   a. Sending a letter with statement.
   b. Various ‘plaques’ on the reception room walls.
   c. ‘Sweet girl’ help, especially the receptionist.
   d. Itemizing all bills.
   e. Forgiving debts at Christmas time.
   f. Prompt processing of insurance blanks.

“2. Recommended methods—
   a. Be friendly.
   b. Do not act like either a prince or a jackass. Just be human. Do not be a “milk toast” or a “high and mighty.” Keep in mind that you are just another human being subject to the same weaknesses, strengths and foibles as your patient.
   c. Remember that “nuts” are sick. They can feel just as badly as if they had some dire physical disease. Do you remember that when you first studied meningitis, polio, tuberculosis and a host of other diseases you promptly developed an attack yourself?
   d. Try to avoid the ‘everybody is a little queer but thee and me’ attitude.
   d. The workman is worthy of his hire. Do the best job you can; be sure you have ‘delivered the goods,’ then charge for it. Do not charge more than it is worth. Do not load your charge because the patient happens to be richer than the average.

   e. Do the highest quality work you can on every case. Some patients may be seen briefly because of an ‘insignificant’ symptom, but be sure it is insignificant.

   d. You may be able to do better than your doctor-neighbor—your competitor—or not as well. No matter! Do it the best you can.

“A friendly doctor who always does the best work he can and charges a legitimate fee for it will not need ‘gimmicks’ to promote good public relations. Certainly, if he wants to write a newsletter to send with his statements; if he wishes to furnish his community with a monthly resume of new drugs, instruments and procedures; if he wants to do work in his church, if he likes his lodge, civic services, boy scout work, etc., etc., fine! Just carry these things to the point of good citizenship and community interest, not to the point of drawing unusual attention.

“Finally, do not step on your competitor’s toes; remain well within the code of ethics.”

Maybe these old notes would not have been any better had they been written today.

Current Comment

Committee Studies A.M.A.’s Basic Programs—

One of the first projects of the Committee to study A.M.A. Objectives and Basic Programs will be to send out a questionnaire inviting suggestions and criticisms of the Association. This questionnaire will be based on the following four points which were listed by the House of Delegates when the committee was organized last December: (1) re-defining the central concept of A.M.A. objectives and basic programs; (2) placing more emphasis on scientific activities; (3) taking the lead in creating more cohesion among national medical societies, and (4) studying socioeconomic problems.

The questionnaires will be sent to not only state and county medical societies, specialty groups and other national medical organizations but also to a probability sample of more than 3,000 physicians chosen systematically from the new A.M.A. Directory. The latter sample will include both A.M.A. members and non-members.
Psychotherapy

IN VARIOUS PSYCHIATRIC CONDITIONS*
(A Comparative Evaluation)

Doctor Ring defines the place of psychotherapy in the treatment of various psychiatric conditions. He evaluates this method of treatment on the basis of what it will or will not accomplish as related to the type and duration of the mental aberration. He stresses the point that a good prognostic evaluation based upon individual factors is more important than the diagnostic niche filled by the patient's illness.

—EDITOR

BEFORE we get into any comparisons of psychiatric conditions and results of psychotherapy, let us establish a basis upon which we can work. Following is a short case study which illustrates the more important factors involved in the application and potential efficacy of psychotherapy in any psychiatric condition.

Case History:

This patient was born thirty-three years ago on a farm in northern Kansas. When he was four years old his father was taken to a tuberculosis sanitarium, never to return. His mother went to work one hundred miles away and he saw relatively little of her. He stayed on the farm with his elderly grandmother and when he was five years old she bundled him off to school. "I thought my little heart would break" he related later, "I think I must have been the most lonesome little bastard in the world."

He never enjoyed school and was always clinging to an older brother who resented this and employed many tricks to get rid of him. At age ten the patient was admitted to the tuberculosis sanitarium where his father had died. He resented lying in bed and undergoing periodical medical procedures because he did not feel sick. He was a patient there for two years.

Back to school, he was a sidelinier in activities and when they cheered the athletic teams he preferred to be off to himself yelling "rah, rah for me." He quit school in the eleventh grade, passed service examinations and joined the marines. His attitude toward other people was so hostile and negative that after two years' service he was discharged as incompatible. After his discharge he related that the nearest he came to finding the glamour he sought was picking up cigarette butts in the company area. The mountains and oceans he thought might bolster his enthusiasm for living turned out to be "nothing but piles of dirt and a bunch of water."

One of the best examples of his relations with people was seen in his purchase of a pair of socks. He gave the clerk a dollar bill, took a 35c pair of socks and hurriedly left the store, only to be angry at the clerk that he did not get his change nor a pair of socks that fit.

He seldom dated or engaged in social affairs but would sometimes bolster himself with alcohol and try. As he said, "someone could dance with me — so what — a lot of fun they would have with a clod like me. Someone could beat me up — so I get beat up, that's all. Stick me with a pin — I wouldn't even feel it."

One night, eight years ago, he looked at his grandmother sitting across the living room and heard a voice within him saying "kill her." He jumped out the window and lay prone on the ground, trying to prevent himself from doing anything wrong. The next day he went to a psychiatric hospital and requested that he be locked up because he was sure he was crazy.

This was a case of schizophrenia, undifferentiated type. To most psychiatrists he would be considered an early psychotic.
What chance had this patient to return to mental health by means of psychotherapy? Having made a sketch of an illness we are going to treat, we must now establish what we mean by psychotherapy — the means with which we intend to treat this illness.

First, let us mention some of the things which psychotherapy is not. Psychotherapy is not a process in which a patient just “ventilates” or gets things “off his chest.” Likewise, it is not a process in which the psychiatrist talks to the patient in order to give him reassurance, advice, recommendations, a prescription for a way of living, or points out to him how he functions, his psychodynamics, what is wrong with him, or what he must do. It is not a giving of “insight,” since insight by itself in no way implies change. It is not a series of fact-gathering or history-taking or question-and-answer sessions. It is not an attempt to do a patient’s thinking for him. It is not, per se, an occasion for the patient to get mad, sound off, or “act out.”

Now let us define what psychotherapy is. Since this patient was treated with psychotherapy, a sketch of his treatment will illustrate what psychotherapy is.

A definite and exacting schedule of one-hour interviews twice a week was established. The duration of these was to be indefinite, and turned out to be eleven months. If the patient was late or absent, he was asked the reason, with emphasis on the possibility that the reason may have been concerned with negative feelings toward treatment. If the psychiatrist was late or absent the patient was encouraged to clarify the issue in the same way. In actual practice, the patient put this to various tests — such as by coming late, missing appointments, name-calling, dozing off during interviews, criticism of the therapist, his office and the like — in order to see if in some way or for any reason he might find himself rejected. He was not permitted to feel rejected but he was confronted with what he was doing and was asked why he did so. Soon he began to note irrationalities in these acts, to understand why they occurred, and how they affected his adjustment to life.

The psychiatrist maintained a relatively impersonal, non-directive and non-judgmental role. He served mainly to reflect upon and aid in the understanding of current feelings and behavior. Because of the nature of the psychiatrist’s role, many of the patient’s feelings toward him were determined more by preconceived ideas than by reality. A thorough understanding of his attitudes toward the psychiatrist helped him toward a thorough understanding of the fundamental nature of his attitudes toward all people.

It was seen how the patient looked upon all people as he had his father who left him and didn’t come back, his mother who also deserted him to a certain extent, the people in the tuberculosis sanitarium who treated him mechanically, and his grandmother who was never interested in his affairs.

Sometimes the patient thought of the psychiatrist as his grandmother. He sometimes thought of him as a sort of policeman, judge, or army officer. If there was an occasion for the psychiatrist to show him unusual interest or kindness, the patient sometimes thought of him as a homosexual trying to seduce him.

By bringing his thoughts, feelings, and fears into the open through the interactions of the interpersonal relationship he gained considerable factual information and lost much of his fear of the unknown. He developed a sense of values of his own and no longer felt so much of the uncertainty and fear of how he should behave or of what other people might think of him. He did not just “ventilate” his feelings but, since they were usually in the context of the current relationship, he could investigate their origins, meanings, and rationality. He could substitute appropriate feelings and actions for some of his inappropriate ones once he could see the present situation objectively. Once during treatment he observed and stated, “I don’t hurt people’s feelings unless I like them.” This meant that he would test people he liked to see how much they would tolerate from him. In the past he had usually driven them away. If he didn’t like them he wouldn’t bother.

After four months of treatment he felt safe to go back to the farm, but continued treatment twice weekly for a few more months, then once weekly. During treatment it had become his great ambition to get away from the farm and get a selling job with a certain well-known manufacturer of tractors and farm implements. However, he was never able to apply because of fear of being turned down, even laughed at for applying. Shortly after treatment was
terminated he did apply and was accepted. Two years later he was in charge of a sales division, with several salesmen under him. He still holds that position. During treatment he began dating girls for the first time in his life and six months after treatment he was married. Follow-up reports indicate he is probably living a more successful and contented life than the average person.

Obviously, this case was picked as an example of a most successfully treated patient. Recovery seems complete, lasting, and was accomplished in the minimum of time. Do persons with this kind of psychiatric condition usually achieve this kind of result with psychotherapy? How do persons with other kinds of psychiatric conditions respond to psychotherapy? How do they differ from this case? Why?

Before answering these questions we should establish more foundation by illuminating the pertinent factors in this patient’s favorable response to psychotherapy:

1. He wanted psychiatric treatment and wanted to recover. No factor in the patient is more important to successful treatment. He did not gain much satisfaction from his illness. There was no extreme nor gratifying “acting out” behavior.

2. He was not so psychotic as to be unable to recognize existing relationships between events when confronted with them. Real delusions and hallucinations were not evident once treatment began. He was not retarded by obsessiveness or compulsiveness.

3. He was active, vigorous, and energetic.

4. He was not too burdened with financial, physical, and other side-issues to prohibit concentration on his mental adjustment.

5. In the course of his illness and its many discomforts he had not established a substitute or compensative neurosis such as habitual use of alcohol, drugs, tranquilizers, or intellectual defenses. Had tranquilizers been in use at that time as they are today, he might somehow have temporarily limited his treatment to the use of these and delayed definitive treatment until his real recovery was more difficult or even impossible.

6. He had accomplished a certain, if small, measure of success in his early-life adjustment. His severe illness had been of relatively short duration.

7. His illness was sufficiently severe that he was uncomfortable. The success of psychotherapy is often very much related to the degree of discomfort. Before the acute disturbance, this patient may not have been willing to work toward the eradication of his maladjustment.

8. He was old enough to enter into an adult person-to-person relationship, and not so old as to be impaired. Anyone between the extremes of childhood and senility is a good candidate for psychotherapy from the standpoint of age.

9. He was able to recognize that there were relationships between his thoughts, attitudes, feelings, behavior, and interpersonal relationships.

Now we can take a look at other psychiatric conditions and see how the average patient with any one of them might compare with this patient. Certain psychiatric conditions as a whole have their own characteristic groupings or balances of the factors just listed. These have always made them more or less consistent in their response to psychotherapy. Patients in some categories—that is, those having certain psychiatric conditions—generally have the sort of make-up which facilitates rather uniformly successful treatment. In some psychiatric illnesses the balance of factors is in the opposite direction so as to reduce the effectiveness of psychotherapy.

There follows a fairly complete list of psychiatric conditions, starting with those generally most responsive and ending with those least responsive to psychotherapy. Having considered what psychotherapy is and some of the factors favoring success or failure with patients, it will require only a little knowledge of the psychological characteristics of these to see why they usually respond as they do.

1. Psychosomatic conditions in which the patient can see the relationship between emotions and physical reactions.

a. Those with reversible organic changes. (Both mental and physical conditions may benefit.)

Migraine
Dermatitis and pruritis
Hyperventilation syndrome
(some)
Menstrual irregularities
Asthmatics (some)
b. Those with irreversibly organic changes. (Personality and emotional factors which predispose to the organic illness may change but residual organic impairment may remain.)
Peptic ulcer (some)
Ulcerative Colitis (some)
Coronary Sclerosis and Thrombosis
2. Non-psychotic schizophrenic disorders. (This is a frequently occurring entity in the terminologies of those who do not wait for the onset of psychosis before considering an illness to be of a schizophrenic nature.)
3. Neurotic disorders.
Phobic reactions
Chronic anxieties without pathological use of alcohol, drugs or other substitutive neurosis.
4. Obsessive-compulsive neurosis.
These are listed separately from other neurotic disorders because they can be more difficult therapy-cases.
5. Psychosomatic conditions wherein the patient does not readily recognize a relationship between his thoughts, emotions, and physical reactions.
Many asthmatics
Some ulcer and pylorospasm cases
Some colitis and irritable colon cases
Hyperthyroids
Diabetics
Certain types of muscle cramps
Some menstrual irregularities
Rheumatoid arthritis (these patients are especially prone to suppress their emotional feelings).
This group of patients see their trouble entirely physical, though often emotions play a large role in etiology and/or exacerbations. Onset of personality problems is early, and problems are so deeply engrained as to be more difficult to evaluate objectively. Often they have fixated their attention on only the physical aspect of their illness.
6. Psychoses.
Manic-depressive
Schizophrenia. There is great difference in the treatability of the pre-psychotic and the psychotic individual. The patient who says, “This idea (false idea) keeps occurring to me though I know it’s not true” is much more readily treatable than the one who says, “This idea (false idea) is true!” (delusional)
Paranoid schizophrenia. This is listed separately from other schizophrenias because psychotherapy is especially difficult due to the mechanism of projection. They believe another person is responsible for their trouble and refuse to examine themselves.
They won’t work on their problem as this patient did.
8. Inadequate and immature personalities.
They cannot work effectively.
9. Hypochondriacs (certain ones of long duration who are “addicted” to medical examinations and treatment procedures).
Those who (so long as they do not run into excessive conflict with their environment) find certain subjective enjoyments from their abnormality and do not desire to change.
Psychopaths
Addicts
Sex deviates
It is seen that there are two ways of considering various psychiatric conditions: One is from the individual patient’s standpoint with a consideration of the various “therapeutic” factors in that patient; the other is from the standpoint of diagnostic category. Each has its merits though the consideration of any patient on individual factors is the more satisfactory.
It would be correct to conclude that patients who respond best to psychotherapy are usually those who are not too severely
nor too chronically ill. These and the individual factors listed in this paper are more important than is the diagnostic category. A far greater service can be done for psychiatric patients when there is wider recognition of which ones might or might not benefit by psychotherapy and when there is wider appreciation for the dangers and the vicissitudes of many forms of psychopathology when left without adequate psychotherapy.

Though certain psychiatric diagnoses may suggest certain psychotherapeutic potentials, a good prognostic evaluation places more emphasis on the individual patient qualities than on the diagnostic grouping. The key words to success in psychotherapy are early and thorough, plus the individual patient qualities listed. In other words, the individual patient and when, where, and how psychotherapy is applied is a more important prognostic consideration than whether the patient has "schizophrenia" or "claustrophobia."

Conduction Deafness
An Evaluation of Our Results With
MOBILIZATION OF THE STAPES*

The author reviews, briefly, the history of the development of the operative procedure he has used in mobilization of the stapes. He describes the operative procedure and indicates its usefulness in certain conditions other than otosclerosis that may produce deafness. Doctor Carp analyzes his results and reports one case in each category — otosclerosis, chronic adhesive otitis, and prolonged serous otitis media.

—EDITOR

INTRODUCTION AND HISTORY

TWO years ago, I reported before this society my early results with a transtympanic ear operation for the improvement of hearing in conduction deafness. This procedure had then been in use since late in 1952 when Dr. Samuel Rosen of Mount Sinai Hospital, New York City, began his work on the Stapes Mobilization Operation.

The modern era in transtympanic surgery seems to date from the report by Dr. Julius Lemper, in 1946, on his transtympanic approach to the tympanic plexus for a surgical tympano-sympathectomy in the treatment of tinnitus. This operation was not productive in the treatment of tinnitus, but it did open the way for Dr. Samuel Rosen to experiment with palpation of the stapes in cases of otosclerosis. It was during one of his experiments through this approach that he accidentally loosened an ankylosed stapes and was startled by the amazing restoration of hearing in a case of otosclerotic deafness.

*Presented before the Omaha Mid-West Clinical Society, November, 1957.

OSCAR CARP, M.D.
Department of Otolaryngology,
University of Nebraska College of Medicine
Omaha, Nebraska

Since my last report to this society, the otologic literature has been filled to overflowing with reports of success in the surgical therapy for correction of stapes fixation secondary to otosclerosis. In most papers, a successful restoration of functional hearing is said to occur in about 30 to 40 per cent of selected cases. This improvement in hearing seems to be retained for long periods.

For the most part, all reports on transtympanic surgery emphasize its use in cases of stapes fixation in otosclerosis. While most of my cases are examples of otosclerosis, I have also used this procedure with good results in cases of chronic adhesive otitis, and in cases of prolonged serous otitis media. I will therefore divide my case reports into three parts, otosclerosis, chronic adhesive otitis, and prolonged serous otitis media.

THE OPERATION

In almost every case, the technique is the same. The operation is conducted under local anesthesia for the most part, because it causes very little discomfort for the patient, and because the operator is better able to judge his success in restoring hearing when
the patient can respond to auditory stimuli during the operation. In very apprehensive patients, general anesthesia was used.

The operation has been carried out with the use of the Cameron Lempert headlight, and the Lempert Storz magnifying glasses. The skin of the external canal is infiltrated with Xylocaine down to the tympanic membrane. The skin is incised a few millimeters from the tympanic membrane in an arc which runs from about the angle of the short process of the hammer handle down to about 5:00 or 7:00 o'clock in the left and right ears respectively. The skin and tympanic membranes are elevated to expose the posterior and lower three-fourths of the tympanic cavity.

In cases of serous otitis, the cavity is then very easily suctioned dry of secretion. In cases of adhesive otitis, the adhesions are broken up under direct observation. In cases of fixation of the stapes due to otosclerosis, the stapes is rocked fore and aft in the classical Rosen maneuver. An attempt is sometimes made to loosen the foot-plate of the stapes or to make a window through the footplate of the stapes directly to the membrane of the oval window.

In any case, after the indicated procedure has been carried out, the tympanic membrane and its attached skin flap are unfolded back into the sulcus tympanius and the skin incision respectively. No packing is placed in the ear. The incision heals very rapidly. Any antibiotic of choice can be given during this healing period.

MATERIAL

This report will cover 58 patients on whom this procedure was carried out in the two years since our last report. Some patients have had the procedure performed on both ears. Some patients have had to have the operation repeated because the results were not satisfactory after the first procedure. A total of 71 operations was performed during this interval.

Our patients were both male and female, white and colored, and ranged in age from 16 years to 81 years. There were 37 females and 21 males in our series. The youngest patient was a girl of sixteen. There was only one other patient in the teen-age group, a boy of seventeen. Nine patients were in their twenties. Twelve patients were in their thirties. The largest group of patients, twenty-four, were in the age-group between 40 and 50. Seven patients were in their fifties. Three patients were in their sixties and one patient was 81 years old. Three of our patients were of the colored race; the rest were white. The left ear was involved in 33 patients and the right ear, in 25 patients.

Fifty of our cases could be classified as otosclerosis.

Five cases involved hearing loss secondary to chronic serous otitis media of long duration.

Three cases of chronic adhesive otitis of long standing are included in our series.

INDICATIONS FOR TRANSTYMOPANIC SURGERY

The ideal cases were those in whom bone conduction was well above the thirty decibel level and in which comparative readings showed air conduction to be at least 30 decibels lower than the bone conduction at all frequency levels. Many of our patients who did not show this ideal loss-record were operated with good results.

Otosclerosis

Thirty-six cases of otosclerosis in this series could be classified as ideal for either mobilization of the stapes or fenestration of the oval window. In those cases bone conduction in the common frequencies (256, 512, 1024, 2048) measured less than 30 decibels of loss, and air conduction readings showed at least 30 decibels greater loss than that of bone conduction. In other words there was at least 30 decibels more loss measured in the air conduction than was noted in the bone conduction in these ideal cases.

A good operative result then was one which brought air conduction loss up to at least the 30 decibel level and optimally to the level of the bone conduction reading in the deafened ear. Only air conduction readings for the four frequencies (256, 512, 1024 and 2048) could be regarded as serviceable. Twelve of our cases in this group showed a gain in hearing to this level. A good surgical result was therefore obtained in one of every three patients in this group.

Case No. 1. Mr. R.P., age 32, had a bilateral hearing defect which had been
noticeable for 20 years. The left ear seemed to the patient to be his worse ear. There was no history of infection in either ear. The patient was in the service for three years as a radio operator. The patient's sister was deafened at age two from scarlet fever. There was no other history of deafness in his family.

In the thirteen cases of otosclerosis in which nerve degeneration was very apparent, the increase in hearing acuity in several cases showed improvement above the preoperative level, but in none of these pa-

The physical examination showed normal tympanic membranes and a clean nose and throat. The initial audiogram taken on May 1st, 1956, showed a classical instance of conduction deafness due to otosclerosis of the stapes in the oval window. The left stapes was mobilized under local anesthesia on June 8th, 1956. The patient has maintained his hearing gain to date.

Of the group of twelve who had excellent results, seven were women and five were men. One girl of 16 had an excellent result. Two men and two of the women were in their
Chronic Serous Otitis Media

In each patient, at operation, considerable thick serous secretion was found in the middle ear. In two cases the secretion pulsated for several minutes when the tympanic membrane was elevated. Hearing seemed to return at the table.

Postoperatively, this group was a problem. In some the tympanic membrane closed too
early and before the underlying process was reversed. In the first early case, the tympanic membrane was re-elevated and a small portion of tympanic membrane was removed. By the time it had healed again the underlying process had resolved and the patient maintained his hearing gain. Later, it became routine to leave a small gap in the tympanic membrane when it was replaced so that the serous drainage could be completed. All the tympanic membranes healed and no postoperative perforations were sustained.

Only one patient in this series failed to maintain his good result. This case was that of an 81-year-old woman whose ear blocked up again one week after operation. Her internist advised against re-operation.

Case No. 2. Mr. E.P.A., was a 50-year-old white male. This patient began to have attacks of serous otitis media in 1947. He seemed to respond well to simple myringotomies at that time. He had a recurrence of this difficulty with blocking ears in 1953, 1954, 1955, and 1956. Until 1956, he seemed to respond well to repeated myringotomies in either ear. Late in 1956, he began to complain of a constant blockage of the right ear which could not be relieved by repeated myringotomies and eustachian catheterization. A transtympanic operation on the right ear was performed on January 11th, 1957. Considerable mucouserous fluid was removed from the right middle ear. The patient’s hearing immediately improved. The improvement in hearing has been maintained to date. There is no recurrence of fluid in the middle ear.

Chronic Adhesive Otitis

Our series of three cases of chronic adhesive otitis showed wide variations in their preoperative audiograms. They ranged from good bone conduction to marked losses in the frequency levels of 2048 and 4096. In two patients the 256, 512 and 1024 levels were above 30 decibels. The first of these cases was so successful after operation on one ear that the patient had the second ear operated. He has since stopped wearing his hearing aid.

The last case showed marked variations in bone conduction acuity at 4096, and, although not suitable by most standards for this operation, was operated on to satisfy the patient’s desire to try most anything to restore some of her hearing. This case was not successful, but the patient was convinced that trying had helped her.

Case No. 3. Mr. F.G. was a 38-year-old white man who had had a bilateral hearing defect for 20 years. He felt that his hearing loss followed injuries to both ears suffered during high school football games. He seemed to hear better in noisy places such as bowling alleys. He had worn a hearing aid for 13 years.

Examination of the ears revealed markedly scarred, retracted, but healed tympanic membranes in both ears.

Since the patient wore his hearing aid in his left ear it was decided that he could best have the operation performed on the right ear.

At operation, on July 19th, 1956, the adhesions were noticed to have bound the incus and stapes very rigidly to the middle ear cavity and the tympanic membranes. When these were broken up the stapes seemed to move easily in the oval window.

The patient’s recovery of hearing was so remarkable, he ceased wearing his hearing aid in the left ear. The left ear was operated upon March 29th, 1957, with similarly good improvement of hearing.

SUMMARY

1. Fifty-eight patients had seventy-one transtympanic procedures for the correction of conduction deafness.

2. Twelve of the thirty-six patients who had otosclerosis and fixation of the stapes from this disease recovered serviceable hearing following mobilization of the stapes, through the trans tympanic approach. The first such successful case has been followed since November, 1954, and has been maintained to date.

3. All patients who had a successful operation with hearing improved to serviceable level, have maintained such improvement for one, two and even three years, to date.
4. In four out of five efforts to relieve a chronic serous otitis media we met with success in maintaining a clear middle ear and the subsequent return of normal hearing.

5. One case out of the three cases of chronic adhesive otitis operated had a good recovery in both ears when the middle ear was cleaned and the ossicles remobilized. One patient had only a mediocre return of hearing, and one case was a complete failure.

6. The transtympanic approach to the middle ear has opened a new avenue for the correction of conduction deafness. Perhaps new steps now under consideration can be devised to help the group of patients who did not respond to this operation. They constitute a large group, and they have high hopes that soon something more can be done to restore their hearing to normal.

REFERENCES
Aspiration of Foreign Body
A Staff Conference
Childrens Memorial Hospital

Dr. John Galloway, intern:

This 21-month-old boy entered the hospital with the chief complaint of choking and difficulty in breathing following probable ingestion of a nut, four days before admission. He was taken to a local hospital and diagnosed as having a peanut in the left lung. Since then he has been lethargic and had an elevation of temperature. He has eaten very little since the incident, taking mainly liquids. The day before admission he coughed up some bloody mucus.

Physical Examination: The child was a well developed, well nourished, white boy who was slightly lethargic. The nose showed some evidence of recent epistaxis and its mucosa was slightly hyperemic. The throat was slightly inflamed. The neck revealed no masses or tenderness. The thorax showed no deformity, but there was decreased expansion on the left and definite dullness over the left lung field. Breath sounds were decreased to absent over the left lung and there were no rales. Respiratory rate, 48. Pulse, 136. Temperature, 102.6° F.

Laboratory Reports: Urinalysis was normal. Leucocytes, 18,300 per cu. mm. with a shift to the left. The bacteriological studies of secretions taken at bronchoscopy showed alpha and beta Streptococcus hemolyticus and coagulase-negative Staphylococcus aureus.

Clinical Course: The boy was admitted with the diagnosis of foreign body in the left lung. Bronchoscopy was carried out on the day of admission, December 25. The bronchoscopist noted excessive secretions in the trachea. At the orifice of the left main bronchus the foreign body was visualized, with no apparent airway around it, and was removed. Some laryngeal spasm followed withdrawal of the scope, but this was only transient. Postoperatively the child was placed in a croupette with oxygen and received penicillin and streptomycin. On the day after admission, the breath sounds on the left were still diminished and a few wheezes and rhonchi were heard anteriorly.

JOHN L. GEDGOUD, M.D.,
ROBERT E. LOVGREN, M.D., and
CAROL R. ANGLE, M.D.*
Omaha, Nebraska

The child’s fever had subsided, but he was still coughing. Two days after admission no essential change was noted in chest X rays, and the diagnosis of a remaining nut fragment was entertained. The temperature was above normal on the fourth, fifth, and sixth days. Bronchoscopy was repeated and demonstrated a moderate amount of mucopurulent exudate in the trachea and in the left main bronchus with some redness and edema of the mucosa. No foreign body was found. The left lung cleared slowly over the next nine days.

Dr. Ralph C. Moore, X rays:

The chief finding here as compared with other types of foreign body reaction in the lung is a definite increase in X-ray density of the lung. I am not going into a general discussion of foreign bodies except to state that, with the exception of peanuts, the immediate reaction is one of emphysema and a later reaction is one of increased density due to obstruction of the airway followed by absorption of air from the obstructed lung resulting in atelectasis. Emphysema, with a mediastinal shift to the unaffected side seen on the expiratory film, is usually the only early finding. If a patient comes into the hospital within the first 12 to 24 hours after possible aspiration of a foreign body, and the X ray shows a marked increase in density of the lung, then you suspect a peanut because of the intense reaction that occurs almost immediately. In the first film (Fig. 1) there is a marked increase in density obscuring the diaphragm and the heart. The heart is shifted a little bit to the left. The trachea can barely be seen here. The right lung appears clear. There is over-expansion of the left upper lobe probably due to collapse of the lower lobe. Ten

*From Childrens Memorial Hospital, Omaha, the Departments of Pediatrics and Otolaryngology, University of Nebraska and the Department of Pediatrics, Creighton University.
days later (Fig. 2), the area of density is less marked. The trachea now is shifted back to its normal position with the left border of the trachea in the midline. If the center of the trachea is in the midline then that is an appreciable shift. In the final film taken two weeks after admission, there is still a little reaction along the heart border but, because of the intensity of original response, one would expect some residue.

The main thing to remember is that if there is an intense reaction in the lung almost immediately after aspiration of a foreign body, a most likely agent is a peanut. This is about the only solid foreign body that I know of that will set up such a reaction. Of course, if a foreign body has been in for a long time, expect consolidation, atelectasis, and even abscess formation. However, that comes on after several days or a week rather than immediately.

**Dr. Gordon E. Gibbs:**

Dr. Gedgoud?

**Dr. John L. Gedgoud:**

The local physician waited four days because he wasn’t sure that the child had aspirated a foreign body until very definite fever and a little cough occurred. The mother was not present when this child aspirated this foreign body, and when she was quizzed about what kind of material it might have been, she was quite vague. All she knew was that it might have been a nut, and I thought it might be a peanut.

Bronchoscopy was done on Christmas day and the material which the operator recovered was not, I believe, a peanut, because it had the configuration of a piece of hazel nut or filbert. There was a definite skin on it.

**Dr. Gibbs:**

Dr. Lovgren?

**Dr. Robert E. Lovgren:**

The bronchoscopy was done under general anesthesia. If this child had had any res-
piratory distress at that time we would undoubtedly have done it without any anesthesia or with just a little barbiturate per rectum. The foreign body, a nut of some type, was found to be completely occluding the orifice of the left main bronchus just lateral to the main division between the right and left main bronchi. In removing a foreign body that is larger than the lumen of the scope which has been inserted, one must remove it with what we call trailing. In other words, you remove the foreign body and the scope at the same time through the larynx. Following this there was some laryngeal spasm from which he rather quickly recovered.

Since his progress seemed rather slow it was deemed advisable to see if there could be a second foreign body. Now, the reason we didn't re-insert the scope the first time was the fact that if you traumatize the larynx in the removal of a foreign body there will be some edema present, and to obviate the necessity of a tracheotomy I think it is often wise to send the child back to the ward and then, if necessary, repeat the procedure at a later date. When the scope was reinserted we could see the segmental divisions of the lower lobe orifices and there was no evidence of any foreign body. I still think that there is a possibility that there might be a fragment of the foreign body there and Dr. Gedgoud has told the doctor that if there is any recurrence of any pneumonic process on either side, because these foreign bodies sometimes move, the child should again be subject to bronchoscopy.

Dr. Gibbs:
Dr. Rubin?

Dr. Sidney Rubin, pediatric resident:

I reviewed all the cases of aspiration of foreign body that we have had here. I found 69 cases in which the foreign body was recovered at the time of bronchoscopy, was coughed up, or was found on the tip of the suction apparatus when the bronchoscope was removed. It was not seen in all cases. By nature, the foreign bodies could be divided into three groups. Most of them were foods, and peanuts headed the list.

As to the procedures that were performed on these children: 54 had single bronchoscopies; bronchoscopy was done on two occasions either for something like the case under discussion, or because of secretion, in ten cases; one case had three bronchoscopies; one had only a laryngoscopy; seven of these cases eventually had to have tracheotomy performed.

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<thead>
<tr>
<th>Nature of Foreign Body</th>
<th>No. of Cases</th>
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<tbody>
<tr>
<td>FOOD—58 Cases</td>
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<tr>
<td>Peanuts</td>
<td>25</td>
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<tr>
<td>Carrot</td>
<td>6</td>
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<td>Corn Kernel</td>
<td>6</td>
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<td>Popcorn</td>
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<td>Sunflower Seed</td>
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<td>Bean</td>
<td>3</td>
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<td>Pea</td>
<td>2</td>
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<td>Meat</td>
<td>2</td>
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<tr>
<td>Chicken Bone</td>
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<td>Candy</td>
<td>1</td>
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<td>Apple</td>
<td>1</td>
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<tr>
<td>Egg Shell</td>
<td>1</td>
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<td>METALLIC OBJECT—4</td>
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<tr>
<td>3/4-in. Screw</td>
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<tr>
<td>Straight Pin</td>
<td>1</td>
</tr>
<tr>
<td>Safety Pin (Open)</td>
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</tr>
<tr>
<td>Nail</td>
<td>1</td>
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<tr>
<td>MISCELLANEOUS—7</td>
<td></td>
</tr>
<tr>
<td>Plastic Fragment from Chair Cover</td>
<td>1</td>
</tr>
<tr>
<td>Tooth, during T&amp;A</td>
<td>1</td>
</tr>
<tr>
<td>Tile</td>
<td>1</td>
</tr>
<tr>
<td>Tinkertoy</td>
<td>1</td>
</tr>
<tr>
<td>Stone</td>
<td>1</td>
</tr>
<tr>
<td>Eraser</td>
<td>1</td>
</tr>
<tr>
<td>Aspirin Tablet</td>
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</tr>
<tr>
<td>Total</td>
<td>69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Bronchoscopies</td>
<td>54</td>
</tr>
<tr>
<td>Bronchoscopy on 2 occasions</td>
<td>10</td>
</tr>
<tr>
<td>Bronchoscopy on 3 occasions</td>
<td>1</td>
</tr>
<tr>
<td>Tracheotomy</td>
<td>7</td>
</tr>
<tr>
<td>Laryngoscopy on 2 occasions</td>
<td>1</td>
</tr>
</tbody>
</table>

As to the location of the foreign body: 25 were found in the right main stem bronchus; 15, in the left main stem bronchus; 6 were lodged in various areas of the trachea; 5 were in the left lower lobe bronchial orifice; 4 were in the larynx; 2 were in the right lower lobe bronchus; and 5 were things that disseminated throughout the tracheobronchial tree.

<table>
<thead>
<tr>
<th>Location of Foreign Body</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rt. Main Stem Bronchus</td>
<td>25</td>
</tr>
<tr>
<td>Lt. Main Stem Bronchus</td>
<td>15</td>
</tr>
<tr>
<td>Trachea</td>
<td>6</td>
</tr>
<tr>
<td>Lt. Lower Lobe Bronchus</td>
<td>5</td>
</tr>
<tr>
<td>Larynx</td>
<td>4</td>
</tr>
<tr>
<td>Trachea and Both Main Stem Bronchi</td>
<td>4</td>
</tr>
<tr>
<td>Rt. Lower Lobe Bronchus</td>
<td>2</td>
</tr>
<tr>
<td>Trachea &amp; Rt. Main Stem Bronchus</td>
<td>1</td>
</tr>
<tr>
<td>Esophagus</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
</tr>
</tbody>
</table>

The average stay in the hospital for these patients was 5.2 days with a range from
one to 26 days. There was one death in the group. This particular child was in the hospital only one day and had a chicken bone lodged in the trachea. Although this patient was bronchoscoped completely there was still another chicken bone that could not be visualized. It was in the right main stem bronchus. The child died because of inflammatory secretions. The age-range of all these patients was three months to 15 years, but 81 per cent were between eight and thirty months. In this group of 69 patients there were only three that did not have an acute history. One patient had aspirated five days before and two had had the foreign body in for two weeks. All the others were acute.

Dr. Gedgoud:

Prevention of foreign body aspirations is a matter of education, and this is something we try to incorporate into our regular visits. If you lecture a parent on a given subject for ten or fifteen minutes, they may remember very little of it, but if they ask you a question which gives you a lead into the subject, then they will remember it. Therefore, I usually incorporate my talk into the answer to the question, “What else can my child eat?” That is usually somewhere between ten months and a year of age, because parents are always interested in what more the child can eat. At that time, when the children are on a rather general diet and are eating from the table, it is important to make the point that we do not want them to have nuts in any form. As far as further measures are concerned, perhaps Dr. McIntire has some information on what our County Health Department is doing. Are you doing anything in an educational way?

Dr. Matilda S. McIntire:

Our educational program is being carried out in the Child Health Stations and indirectly through poisonings seen at the hospital’s Poison Control Center. Poisonings, of course, are strictly home accidents, but that is just one segment of the entire picture. Poisonings rank about fifth among accidents in children, the more frequent being motor vehicles, falls, burns, suffocations, and drownings. We are now in the process of trying to compile a check list to give to every parent of children from eight to ten months on up through the toddler period. In this, not only will they be cautioned on keeping nuts, beans, and things like that away from the child, but also to check through the usual hazards that are in the kitchen—the pots and pans and the knives—in the bathroom, and so forth.

Dr. Lovgren:

There is a booklet of that sort published by one of the insurance companies.

Dr. McIntire:

In the Health Stations we have been using “Formula for Child Safety” published by the Metropolitan Life Insurance Company, New York City. This lists the hazards at various ages. In other words, when the baby is only eight to ten months old, the mother is not so worried about the hazards of the bathroom, but at eight to ten months we do worry about the child reaching up to the table and grabbing peanuts or hot coffee. In that respect it is a very good booklet, and if anybody is interested in it in any numbers, write to the company and they will send you, upon your request, enough for your office, classes, or clinics.

Dr. Gibbs:

In regard to poisoning, I have always wondered why more homes didn’t have locks on their medicine cabinets. From my experience that seems to be very uncommon, and I think it ought to be encouraged somewhat.

Dr. McIntire:

I think it has been uncommon here to have our medicines locked up because I don’t think we realized until rather recently how many youngsters were coming in for stomach washings. I think when it is brought to people’s attention they will certainly try to lock up all family medicines.

Dr. Gibbs:

And simply having them up high is no protection because children are great climbers. They are just like monkeys and can get into almost any closet.

Dr. E. Omer Burgert, Jr.:

I do not think I have ever seen a commercially manufactured medicine cabinet, such as used in homes, that had a lock on it.
Dr. Gibbs:

I would like to ask Dr. McIntire one other thing. What about the education of the child? You can protect an individual up to a certain point, but he has to learn to protect himself, too. At what age do you start teaching children that it is "hands off" certain things?

Dr. McIntire:

That is one thing we have been concerned about in our experience in working on this literature. One insurance company also puts out a booklet that stresses the very fact you mention. They stress that up to the first eight months to one year, the responsibility of protecting that child is the parents'. From the ages of one to five the educational process rapidly progresses and when a youngster is five or six and goes off to school, he is essentially on his own for a great number of hours during the day. We are working on that now so that we can incorporate the best ideas we can find on how to educate your youngster, not only in health habits such as brushing teeth and washing hands, but also in habits of safety.

Dr. Burgert:

As far as safety is concerned, I have found that the little Golden books and Wonder books that describe safety are read and enjoyed, and the child, at least in our family, accepts the idea of recognizing and avoiding certain dangers. Safety is impressed on them more by seeing Smokey The Bear, or Donald Duck and his three cohorts. They accept it much better than if you specifically say, "Now you are not supposed to do so and so."

Dr. Carol R. Angle:

I wonder if, in telling parents to educate the children, we give them the false idea that they should give the child a lecture. That seems the wrong way to educate anybody about safety. The constant example of the parents' own attention to safety seems more valuable.

Dr. Moore:

What is the opinion on lavaging these children that are brought in having ingested only a questionable amount of aspirin? Will this dramatic experience teach the child not to fool with the medicine cabinet?

Dr. McIntire:

I do think that any child who swallows anything of a potentially toxic nature should be completely washed out because you can't be sure—there is no way you can be sure. Sometimes I think that in older children, as I think Dr. Moore agrees, the experience of having their stomachs washed might even be helpful too.

Dr. Moore:

Yes, we struggled with one of mine.

Dr. McIntire:

Has she ever done it again?

Dr. Moore:

No. She said, "I'll never take that again." And that was candy aspirin which brings up another point. This product may not be so safe to keep around the house.

Dr. McIntire:

No. As a matter of fact, the candy aspirin is not allowed to be sold now in Connecticut. Some of the newer ones are in bottles with special tops that are difficult to open.

Current Comment

A.M.A. Health Shows on Radio—

A.M.A.'s health messages are reaching the American people via radio. A glance at the latest Bureau of Health Education report shows that 574 sets of A.M.A. transcriptions were in the hands of local broadcasters throughout the country on April 28, 1958. Since there are 13 programs in each set, this represents approximately 7,500 local broadcasts which have been, are being, or will be made from these transcriptions. Some of the most popular series include "Menu for Health" (45 sets), "Harmony and Health" (46 sets), and "Interlude" (28 sets). Not included in these figures are the monthly platters entitled, "Health Magazine of the Air."

DOCTOR — Please take each copy of your Journal home. The wives complain that they never get to read the Auxiliary column.
The physician must ever be alert to the possibility of the existence of malignancy in the ear, nose, and throat. His problem is made difficult by the fact that the patient with such disease quite often presents complaints identical with those of nervous exhaustion. Moreover, the physical findings frequently resemble those of the more common inflammatory diseases.

Malignancy of the auricle is ordinarily detected with ease, because it is visible and looks like the usual squamous or basal cell carcinoma. On the other hand, cancer of the external auditory canal may stealthily resemble otitis externa for a long time before its identity is discovered. Itching, serious discharge, bleeding and hearing-loss are suspicious signs in this area.

When carcinoma invades the middle ear it may pose as chronic otitis media; granulation tissue, polyps, and pus may appear as hearing-loss progresses. Middle-ear granulations deserve biopsy in every case if unilateral. The patient who complains of loco-motive tinnitus may be a victim of tumor of the glomus jugulare. In the presence of this tumor, a red appearance in the posterior or inferior quadrant of the tympanic membrane is the first physical sign.

A mucoid nasal discharge may sound a warning note indicating malignancy of the nose or nasopharynx, and one should be wary of the sudden appearance of unilateral nasal polyps, particularly in an elderly person who previously has been free of nasal difficulty. Airway obstruction, bleeding, and external deformity are also conditions worthy of suspicion. Unfortunately, a diagnosis of neoplasm of the paranasal sinuses is ordinarily made quite late, and an x-ray revealing erosion of bone and soft tissue invasion is taken too late for patient-salvage. The best insurance is early radiographic study whenever sinusitis is apparent.

Malignant disease of the nasopharynx is the most deceptive of all, because it remains asymptomatic for some time and resides in a region which is difficult to inspect. Effusion in the middle ear is commonly the sentinel, and every patient suffering from it deserves a nasopharyngeal examination even if a general anesthetic is necessary. Hearing-loss, aural discharge, nasal hemorrhage or discharge, polyps, nasal obstruction, posterior neck-pain, postnasal discharge, and exophthalmos are also danger signals. Cervical lymphadenopathy may appear early or late and may be on the side opposite the primary lesion. Tumors of the postnasal space may remain asymptomatic for such a period that vertebral involvement occurs before the patient seeks care with the complaint that he is unable to hold his head erect.

Malignant disease of the tonsil is usually first noted by the patient himself while brushing his teeth, but the appearance of a peritonsillar abscess in an elderly adult should arouse suspicion. Cervical metastasis and pain, however, are usually late manifestations. The complaint of "lump in the throat" calls for a careful pharyngeal and hypopharyngeal inspection, because dysphagia is a hopelessly late symptom of cancer of the pharynx. The same may be said for carcinoma of the tongue where pain comes late and indicates involvement of the base rather than the tip.

An ill-fitting denture should not always bring criticism of the dentist; but it should always stimulate palpation and observation of the palate, the dorsal as well as the ventral surface.

*Presented before the Omaha Mid-West Clinical Society, November, 1957.
**From the Department of Otorhinolaryngology, the University of Kansas School of Medicine, Kansas City, Kansas.
Intermittent dysphonia may suggest hysteria, but persistent hoarseness is always suggestive of laryngeal cancer. If the larynx of the hoarse patient cannot be seen with a mirror a period of two weeks of voice-rest is granted. If the dysphonia has not then vanished, laryngoscopy must be done since nearly every attack of laryngitis will resolve in two weeks. Only carcinoma of the true vocal cords produces early hoarseness. In other parts of the voice box malignancy may become quite extensive before hoarseness appears.

In summary it may be said that the common complaints of “drawing leaders” in the back of the neck, postnasal drip, a lump in the throat, and nasal obstruction do not always spell psychoneurosis but may, on occasions, point to serious malignant disease.

Cataracts
The 1957 Treatment and Management*

A brief historical account forms the background for each of the author's pronouncements concerning the treatment and management of cataracts as seen from the 1957 point of view.

—EDITOR

KNOWLEDGE of the crystalline lens, its physiology and chemistry has progressed considerably. Nutrition and other factors which favor health, and thereby maintain transparency and function are known only partially. Despite our efforts to prevent the formation of cataracts (opacities of the crystalline lens) or to retard and stop their progress, the result is too frequently failure. Loosely speaking, any opacification of the crystalline lense can be termed a cataract. We shall reserve the term, in this communication, for those cases with sufficient opacification to justify surgical removal.

Our knowledge of the crystalline lens, its physiology, chemistry, and other factors, has progressed considerably since the first known treatise on surgery of the cataract as practiced by Susruta and recorded in the Hindu manuscripts. This method consisted of couching (displacing the cataractous lens into the vitreous body posteriorly). This resulted in temporary improvement of vision, but led to later complications of secondary glaucoma (increased intraocular pressure) and retinal separation, with eventual loss of sight.

Herophilus was the first to remove the cataractous lens, but his method was not followed by others and was lost for centuries until the Kepler Maitre-Hean and Brisseau demonstration that “Cataract was an opacity of the crystalline lens.” In 1708, the French Academy of Science established this as fact thus paving the way for extraction of the cataractous lens rather than couching as the accepted surgical procedure. In spite of this, when Daviel, in 1748, published the first account of extraction, it created a great controversy and was not generally accepted. During this period all cataract surgery was done with the patient sitting facing the surgeon, but Pamrad, in 1758, added the refinement of having the patient recline during the surgery. Cataract surgery gained its next great advancement with the development and use of cocaine by Carl Koller, in 1884. Although Novocaine was discovered by Einhorn in 1904, its first use for lid injection to control action of the eyelids during surgery, by Van Lint, appeared in 1912. In the last 15 to 20 years have appeared the facial block, retrobulbar anesthesia, corneoscleral sutures, hyaluronidase, and cortisone, each of which has added its own influence so that the present day surgical approach and postoperative care in the intracapsular cataract extraction of the opaque crystalline lens have evolved.

When Daviel first published his account of extraction of the lens, it produced the usual furor, but gradually, as it became understood and tried, this was found to be the superior procedure. The surgery was done without the benefit of local anesthesia, per se, and required the cooperation of the patient plus great dexterity on the part of the surgeon. With the advent of cocaine and

MAYNARD M. GREENBERG, M.D.
Omaha, Nebraska

*Presented before the Omaha Mid-West Clinical Society, November, 1957.
Novocaine came the greater control of the patient and less requirement for surgical speed, this permitting greater exactness and refinement of the surgical technique. The ability of the surgeon to control eye movements and action of the eyelids during surgery has reduced the necessity of depending on the patient's cooperation. Thus became possible the development of the first extracapsular extraction which was found to result in the secondary cataract produced by the remaining lens capsule and the lens fibers not completely extracted at the time of surgery. The secondary cataract necessitated a second surgical procedure to procure an opening through which the eye could see. Also, the extracapsular method was the reason for waiting until the cataract was "ripe" (all fibers had become opaque) since otherwise the incidence of secondary cataract was much higher. With the use of local anesthetics and their refinements, came the ophthalmic sutures. This permitted the surgeon greater latitude and precision during the procedure. This greater precision during surgery shortened the convalescent period. Great improvement in sharpness and the inverted cutting edge of corneal needles has been a distinct contribution to the precision of the surgery. Cataract patients in former years spent the first 8 to 10 days following their surgery lying rigidly still. They often developed complications of a pulmonary nature or the males developed urinary retention. Today, hospitalization is from 5 to 7 days with the patient being relatively quiet the day of surgery, at the most. Some surgeons permit the patient to be up and about after 6 hours.

The procedure of choice today is removal of the cataractous lens in its capsule making use of corneal scleral sutures to shorten the convalescent period and produce better postoperative results. Most ophthalmic surgeons attempt to remove the cataract through a round pupil; this preserves the physiology of the light-protection mechanism of the active pupil. The intracapsular procedure permits extraction as soon as the vision is sufficiently reduced to interfere with the demands of the individual's visual needs. It is no longer necessary to wait for a mature, "ripened" cataract with complete blindness before surgery can be performed. The nuclear cataract with the sclerosed center and greatly reduced vision can be removed today. It never has opaque peripheral (cortical) fibers, so could not be operated by the extracapsular method.

The corneal scleral sutures have refined the surgical technique and shortened the hospital stay. They are usually placed in a preplaced partial incision insuring better apposition of the corneal incision for better healing. A groove is prepared where the incision is to be made, and the sutures inserted. The incision is then made in the groove without cutting these sutures, thus insuring a return of the incised cornea to its original position. The sutures add strength to the wound during the healing period thus permitting the patient earlier freedom. Some men permit the patient to be up within six hours after surgery because of the safety of these sutures.

Marked improvement in surgical techniques has resulted, also, in marked improvement of visual results following healing. The optical methods to permit the eye to see following such surgery have not progressed as rapidly as have the visual results of operation, thus producing a new problem for the ophthalmic surgeon. Twenty years ago the cataract patient was usually the elderly individual with ripened cataracts, practically blind, and retired from active business or professional life. His sight had to be almost gone before surgery was considered and by that time he was also retired from his job. He was resigned to an inactive, if not useless existence. The cataract glass with its great magnifying and distortional effect was by far the best and only corrective measure at hand to replace the function of the normal crystalline lens. This lens was a magnifier enlarging the retinal image and making orientation difficult for the individual. It was also a heavy pair of glasses. The individual resigned to retirement was satisfied after complete blindness to mull along with such inconveniences and difficulties. But the cataract patient of today is younger in spirit and wants to drive a car as well as continue in his business. He wishes to remain active as long as his physical and mental condition permit. The improvement in visual results which improved techniques permit must be matched by the optical devices to produce comfortably improved vision.

First attempts were directed toward lightening the weight of the lens. This was a step only in removing the weight and did
very little to reduce the size of the retinal image or enlarge the visual field so that the patient would be normally oriented in space. Vision through the optical center of the glass was good to excellent, often better than 20/20, but, slightly removed from the center, distorted and reduced the vision. The active cataract patient was handicapped, and the intelligent patient was fearful of operating a motor vehicle because of the resultant "gun barrel" vision. Some of the more adaptable overlooked this handicap and eventually managed well enough, but the majority did not feel sufficiently secure to venture down town without assistance.

Fredrick Ridley of London attempted a very bold and ingenious method of restoring vision to the aphakic eye following cataract extraction. His contribution was the implantation of a plastic disc inside the eye at the time of the extraction to take the place of, and optically replace, the extracted cataractous lens. Optically, the idea was perfection, to make it possible for the patient to see without the heavy aphakic lens. Unfortunately, although plastic is comparatively inert in tissue, it was sufficiently irritating when placed inside the eye to produce undesired results. Most men, including Ridley, have given up the procedure.

In the last year or two the corneal contact lenses have become sufficiently perfected to warrant their use. The contact lens enlarges the visual field, removes distortion, and eliminates the weight-handicap. It is true that contact lenses of other types were available prior to the perfection of the corneal contact plastic lens. However, these had disadvantages that almost completely excluded their usefulness. The plastic contact lens has also made a change in the handling of the cataract patient. Previously it had always been to the advantage of the patient to delay cataract extraction on the eye with the greatest visual reduction until the fellow eye had sufficiently reduced vision to justify the inconveniences and the difficulties produced by the wearing of the thick, heavy corrective lens. This lens could not be used with the fellow eye with reduced vision to even 20/50, because of the differences of the size of the retinal images in the two eyes. These patients would not wear the aphakic correction because of the stated inconveniences, even if the aphakic correction gave better than 20/20 vision while the fellow eye had vision reduced to 20/100 or even worse. Thus, many patients with reduced vision either from choice or on advice of the ophthalmologist, did their best to carry on their daily visual tasks with the visual handicap.

The active cataract patient with good mental and physical status can have the more advanced cataractous eye operated at an earlier date, and wear a corneal contact lens which produces normal vision, and without interference by the poor vision of the unoperated eye. He may even obtain binocular vision. This enables the individual to carry on his daily activities without interruption while awaiting the optimum time to operate on the second eye. This mental relief obtained by the cataractous patient with the knowledge of his ability to continue his daily activities without waiting for blindness is truly important and constitutes a great step forward in the care and management of these people. Of course, the cataract patient with reduced mental facilities is not a fit subject for the contact lens. The heavy aphakic correction is still the method of choice for visual improvement in such patients.

**BIBLIOGRAPHY**

The Future of Blue Shield

(The following article is reprinted with permission of the author and the New York State Journal of Medicine. Dr. Bauer is chairman of the board of United Medical Service, The Blue Shield Plan of New York).

A lot of doctors believe we ought to get rid of Blue Shield. These doctors say that socialized medicine is a dead issue in America, so why do we need Blue Shield? For years doctors have been voicing their opinion that socialized medicine is a dead issue in America. During the depression doctors used to orate that the government might socialize everything else, but it wouldn't have a chance with medicine. A look of astonishment appeared on their faces when in 1939 Senator Wagner began to push through a bill for country-wide, tax-supported health care on a compulsory basis. Luckily a sizable enough force was organized to see that this measure met its deserved doom. At the same time, as bulwark to further attacks by socialism, physicians created Blue Shield. They did this after appealing to private insurance companies to do it and being told it was an impossible task. Although the voluntary way had a rather feeble beginning, it did grow in strength. The advocates of socialized medicine didn't like that.

In 1943 the Senate marshalled supporters behind most vigorous attempts to defeat the private practice of medicine. An intricate system for the government administration of medicine was evolved that would subjugate the private practitioner to the political bigwig. Spearheaded by the A.M.A., physicians thwarted that bill's adoption too. Many more doctors jumped on the Blue Shield bandwagon, and the plans really grew. But some of the socialism's flavor lingered in the Washington air, as will be shown presently.

When The World Medical Association was organized in 1947, socialized medicine, according to many far-sighted physicians, was definitely dead in the United States. Socialized medicine might creep into foreign countries, they thought, but never at home. A year later, 1949, saw the introduction of the Murray-Wagner-Dingell Bill into our Congress and I am sure that there are many physicians who recall the strenuous opposition the profession, again led by the A.M.A., made against that bill, although some doctors might have taken a back seat in the fighting. But how many doctors realize that today all but one of that bill's socialistic provisions have been enacted into law, and that a good start has been made toward enacting the remaining provision?

There are other examples of our country's peculiar form of socialized medicine. One might mention, for example, our Government's fantastically over-powering role in the medical care of our 20 million war veterans (many of them with nonservice-connected disabilities), our present and future inductees, and all their dependents.

Those of us closely connected with The World Medical Association have an opportunity to see firsthand how medicine is progressing in other countries, and we have come to the conclusion that in foreign countries, wherever doctors could not agree among themselves that socialized medicine was a living threat to private practice, socialized medicine was swept in. If you have any idea that government is not a threat to the private practice of medicine, note what has been going on in England, Sweden, Austria, and Japan, as well as what is now going on in Belgium, France, India, and Thailand.

Wherever any successful stand has been made against government control of medicine, the entire medical profession of the country has stood together as a unit. Whenever they have quarreled among themselves or started negotiating in separate groups, they have been completely taken over.

This is brought to your attention because in the United States there are countless doc-
tors who refuse to profit by the experience of doctors elsewhere in the world. Our physicians, like the physicians in some other countries, refuse to admit that a threat of socialized medicine exists. Literally thousands of doctors in the United States have their heads in the sand and do not see that they form a large and powerful group that is unwittingly permitting the insidious form of socialism to flatten out our traditional form of medical practice. Politicians will wait only for the opportune moment, and the opportune moment grows closer as more and more physicians disregard the social changes that are taking place in our country.

Now there are certain facts that must be accepted about these changes. In the past doctors have ignored the changes or have refused to face up to them, either because the physician is traditionally naive politically or because he is simply disinterested. But no longer can those facts be passed over! First, the cost of medical care has so increased that too many people are no longer able to pay their bills without some sort of help, and they will take out insurance to provide that help. Second, the prepayment of medical care is here to stay. Whether we like it or not makes no difference. We have it, and we are going to have it indefinitely. The question to be decided is whether we want the prepayment on a voluntary or a government-run, compulsory basis. I believe the majority of the profession prefers the voluntary method.

If that be the case, the next question is: Do we want the plan to be one in which we have a voice or one in which we have no say whatsoever? Again, I am certain that a majority will reply that they wish to maintain control of the health plans. If this be true—and this point must be stressed—the profession had better wake up and do something about it. A great number of individual doctors are knowingly or unknowingly doing their best to turn the whole business of voluntary health care over to nonmedical bodies. Also bear this in mind: So urgent is the desire of the public to have prepayment medical protection that they will take this protection from whichever plan seems most opportune. At present there are unions who have talked their members into buying union-run pre-payment care in preference to doctor-sponsored care. What the unions can do, the Government can do. All they have to do is convince the taxpayer that the voluntary system is not the best system, and the government can do it. They can do it because many doctors no longer respect the provision of Blue Shield. Because some doctors do not live up to the philosophy of voluntary health movement, the public is growing dissatisfied. They are not getting the care they expect.

For many years the medical profession was able to show that the best form of prepayment was Blue Shield with its Service Benefits. The country-wide success of Blue Shield was proof of this. The key to success was the Blue Shield benefits in the form of doctor's services: Service Benefits. It was and is the only real benefit the majority of consumers want. One need only listen to the spokesmen for the various organized subscribers to realize this. They want prepayment in full, that is, Blue Shield service benefits, and they will exert whatever pressure is necessary to get it. As long as doctors participated in Blue Shield, kept control of it, and continued to give benefits in the form of service, there was no threat to voluntary, doctor-run health insurance.

However, it has been reported that some physicians are playing havoc with Blue Shield by raising their fees as soon as they discover their patients have coverage with the local Blue Shield Plan. For example, the doctor's usual charge for a particular operation may be $100. Blue Shield may pay $100 for that procedure. But suddenly the fee becomes inadequate in the doctor's eye. He informs the patient that the fee is $200! Thus, the patient has to pay $100 out of his pocket. The doctor, in other words, has changed Blue Shield into an indemnity plan! The doctor argues that the patient has insurance and is therefore better able to pay his bill. This is a sad commentary on his intelligence, not to say his ethics. He apparently has not considered that the reason behind the patient's having insurance in the first place is his inability to afford large, unexpected cash outlays. The patient in the case cited above would be better off with no insurance at all. Not only did it fail to serve him, but he paid a premium on which he received no real return. Such a doctor is not only a disgrace to the profession but he is defeating the very purpose of voluntary health insurance, and is playing into the hands of the socializers.

How long will the consumer stand for such treatment? The politicians watch con-
sumers' attitudes quite closely, and we may be assured that if voluntary prepayment continues along questionable lines, we will soon have it replaced by compulsory insurance.

The Blue Shield philosophy is this: No doctor is compelled to belong to Blue Shield as a Participating Physician. But if he does, he has to accept the schedule of allowances (which he has approved and which provides service benefits only for those members within certain income ceilings, again decided on by the doctor).

Service benefits distinguish Blue Shield from other plans. But some doctors and medical societies have denounced service benefits. They call it “socialization,” and (they add haughtily) no one can tell them what to charge. As to the first criticism, socialization cannot exist without government intervention nor, usually, without taxation. Far from being “socialistic,” Blue Shield and its service benefits feature is the best and in fact the only real defense against socialization of medicine. As to the second objection, certainly no outside agency should tell doctors what to charge. The profession is best qualified to decide on fees, and that is what physicians do through Blue Shield. Blue Shield is not an outside agency nor a third party. Blue Shield is the doctor's own organization. Or it should be. If it is not, then it is the doctors' own fault for letting the control slip out of their hands.

There is another physician practice that may also lead us to socialized medicine. It is a more wide-spread habit, seemingly more harmless, but one that under examination proves to be the more pernicious. This concerns Blue Shield Participating Physicians who “double in brass,” who participate in plans of other companies (plans not always approved by their medical societies), medical panels, group medical centers, and competing plans generally, in addition to their own Blue Shield Plan. They even accept schedules which they will not approve for U.M.S. on the grounds that they are too low. Some of these plans accumulate their reserves by directing patients into wards and therefore do not pay the doctors.

Let it be clear that we are talking about individual doctors. We know that the medical profession as an organized group, as component medical societies, took clear-cut, effective action in resolving our medical eco-

nomic problems of the 30’s and 40’s by originally forming and continuing to back Blue Shield.

When an individual doctor supports a competing plan, he also endorses the philosophy of that plan, which more often than not is at complete variance with Blue Shield and medical society philosophy. Few other plans offer free choice of physician. They have standards for procedures and for fees that are not arrived at by physicians. They offer service benefits without any regard for the patient's income. These are all conditions contrary to Blue Shield’s views, yet Blue Shield is supposedly the profession’s ideal plan. In other words, such a doctor has very carefully organized definite and utilitarian conditions for his own plan, declaring it best, and then he does an immediate about-face by merrily supporting other plans over which he has no control and which he does not force to live up to any of the profession’s valuable Blue Shield standards. Not only is the participation in unapproved plans bad in theory, but in practice it may well prove to be the ruination of voluntary health insurance.

Consider the structure of Blue Shield: It was devised primarily to take care of the low-income groups. It did this by combining the higher risk of illness of low-income groups with medium-income groups having a lower illness rate. An average or community illness rate was the result, and both income groups were charged an identical premium, a premium both could easily afford. To keep this rate from rising now, Blue Shield must maintain an average enrollment of healthy and unhealthy persons. It must continue to attract persons from all walks of life and with average and above-average health as well as persons who are poor health risks. This is the philosophy that participating physicians in Blue Shield originated and continue to support. But what happens when Blue Shield allegiance is shared with a private insurance company or a closed panel? Remember that private insurers do not try to insure the unhealthy. They are interested primarily in large groups with excellent health experiences. Therefore, they can offer insurance at a lower premium. As a result they attract from Blue Shield the very good health population Blue Shield needs in order to survive. The above explains why the problem cannot be turned over to the private insurance com-
panies as some doctors advise. To meet the needs of the public, one must provide a community plan. Many private companies also cancel policies for age or frequent utilization, which Blue Shield does not.

Another suggestion is co-insurance, the patient paying the first few dollars and the insurance company the rest. At first glance this sounds attractive, but it fails to take into consideration two factors. First, such a plan does not cover the needs of the low-income group, for they have to pay not only the premium but also those first 10, 15, 25, or more dollars which they cannot afford. Second, there being no service benefit with an income ceiling, the plan tends to encourage gradual increase in medical fees.

Next, consider a union’s clinic or a medical panel. A union will of necessity devote its money toward protecting its active members. This leaves the retired, the aged, the unemployed, and many dependents out of union plans. These people are also the poor health risks. They are thrown into the community to seek care wherever they can. The only place they find prepayment protection is in Blue Shield. If, however, Blue Shield is put in a position where it must continually take in poor risks without at the same time balancing that intake with healthier persons, then Blue Shield rates must soar, and eventually they will rise so high that the persons who need protection most will not be able to pay for it. They will look elsewhere for care, and they will get that care from charity, the doctors, or the government. The opportune moment for which the politicians are always looking will have arrived.

If, in other words, this double-sided game is continued to be played by means of supporting one plan on Monday and a second on Tuesday, the doctor’s own plan, Blue Shield, will disappear from the scene and the doctor will find himself under the complete control of agencies over which he has no influence. It requires little imagination to see that if Blue Shield fails, compulsory health insurance will follow swiftly.

This foolish competition in which doctors are now engaged is a clear indication of the disunity that is the present sad characteristic of the American medical profession. It is a disunity that bears a frightening resemblance to the lack of harmony that prevailed in foreign countries that saw government medicine swept in. Only in countries where the physicians have remained united have voluntary methods and traditional practices been retained.

Blue Shield could insure against all kinds of medical expense, but doctors must be realistic enough to know that the premium may be so high as to price it out of the market. To obtain what is desired may require some sacrifice on the doctor’s part. The alternative to sacrifice now may be a system in the future that will resemble England’s, with its doctor income governed by politicians.

If the doctors desire a fee-for-service, free choice of doctor plan and want it to compete successfully with other plans, then they had better stand directly behind their own plan, control it, and see that it meets the needs of the community and not just a favored few. Competition usually affords stimulation, often progress, but one does not compete against oneself. In the last analysis, we are all competing against government-run medicine, and we need united strength because the enemy is formidable.

We cannot win the battle by fighting each other or by frittering away our strength in independent groups working at cross purposes.

You’re a more likely candidate for rheumatoid arthritis if one of your relatives is afflicted with some form of rheumatic disease, according to the current issue of the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. “Patterns” reports on a study of over 5000 persons, comprising patients with rheumatoid arthritis, control subjects and relatives of both. Results showed that the incidence of rheumatic disease among relatives of rheumatoid arthritis patients was five times as high as that among controls.

The total value of the buildings, equipment, and other assets of hospitals in this country is now $13 billion, Health Information Foundation reports. This is the equivalent of $8,100 per hospital bed, $590 per hospital admission, or $78 per person in the United States.
Allen J. Alderman, M.D., was born in Chadron, Nebraska, on November 17, 1928. After graduation from Chadron High School he completed his pre-medical education at Chadron State Teachers College. He took his medical education at the University of Nebraska College of Medicine from which he received the degree Doctor of Medicine in 1954.

Following his internship at the Fitzsimmons Army Hospital in Denver, Colorado, he served in the United States Air Force for two years. Doctor Alderman served one and one-half years in the Army prior to his medical education.

He and his wife, Shirley, are the parents of two children, Greg 6, and Karen 4.

For recreation Doctor Alderman enjoys hunting and fishing.

Doctor Alderman is associated with the Chadron Medical Association.

Raymond Henry Olson, M.D., was born in Omaha, Nebraska, on June 29, 1926. After graduation from Benson High School in Omaha he attended the University of Nebraska and the Iowa State College receiving his Master of Science degree in Biochemistry in 1952. He received his medical education at the University of Nebraska College of Medicine from which he received his degree, Doctor of Medicine, in 1956.

Following his internship at the Deaconess Hospital in Spokane, Washington, from 1956 to 1957, he served in the United States Navy. He has been in practice at Sidney, Nebraska, since 1957.

Doctor Olson is a member of the American Academy of General Practice (Associate).

Doctor Olson, his wife, Alberta, and their two children, Deborah Rose 3½ and Daniel Raymond 1, reside at 1332 23rd Avenue, Sidney, Nebraska.

For recreation Doctor Olson enjoys golf and bridge.

Donald E. Wilkinson, M.D., was born in Valentine, Nebraska, on August 24, 1929. His elementary education was received in the Valentine schools and his pre-medical education at Chadron State Teachers College. He matriculated at the University of Nebraska College of Medicine from which he graduated, with the degree Doctor of Medicine, in 1956. He interned at the Deaconess Hospital in Spokane, Washington, from 1956 to 1957.

Doctor Wilkinson is an associate member of the American Academy of General Practice.

Doctor and Mrs. Wilkinson (Natha) reside at 1640 Dodge Street, Sidney, Nebraska, with their three children, Chris 4, Steven 3, and Kevin 1.

Hunting and fishing are favorite forms of recreation. Since September 1957, Doctor Wilkinson has practiced in Sidney, Nebraska.
Harle V. Barrett, M.D., was born in Shawnee, Oklahoma, on November 5, 1917, where he received his elementary education. He attended the Oklahoma Baptist University and the Oklahoma A & M College and, in 1942, received a Master of Science degree in Bacteriology from the Kansas State College.

Doctor Barrett received the degree of Doctor of Medicine from the University of Kansas School of Medicine in 1946, after which he interned at St. Margaret’s Hospital in Kansas City. A Master of Public Health degree was received from the Harvard University School of Public Health in 1950.

Doctor Barrett’s tour with the Medical Service of the United States Army was completed in 1954.

Doctor Barrett is a diplomate of the American Board of Preventive Medicine.

Before assuming his present duties as Assistant Professor of Public Health and Preventive Medicine and acting director of the department as well as Executive Director of the Dispensary of the Creighton University School of Medicine, Doctor Barrett had served as Director of the Kay County Health Department, Ponca City, Oklahoma.

Doctor Barrett and his wife, Lucille, have four children, Barbara 12, Philip 9, Jane 5, and Richard 3.

He enjoys reading and is a collector of stamps.

Howard L. Fencl, M.D., was born in Abie, Nebraska, on August 29, 1928. After elementary education in David City, Nebraska, he attended Luther College and the University of Nebraska for his pre-medical education.

After graduating from the University of Nebraska College of Medicine in 1954, he interned at the Bishop Clarkson Memorial Hospital in Omaha.

He served for two years in the United States Air Force as Division Surgeon.

Doctor Fencl and his wife, Martha, reside in Schuyler, Nebraska, where Doctor Fencl has been in practice since August 12, 1957.

Donald Eugene Parkinson, M.D., was born in Ansley, Nebraska, on September 3, 1929. He received his early education at Sargent, Nebraska. For his pre-medical studies he attended the Nebraska Wesleyan University. His medical education was received from the University of Nebraska College of Medicine, from which he graduated in 1956. His internship was served at the Nebraska Methodist Hospital in Omaha.

He is an Associate member of the American Academy of General Practice, and a member of the Nebraska Heart Association.

He and his wife, Margaret, are the parents of two children, Janet Louise 5 and Susan Jane 3.

For recreation Doctor Parkinson enjoys golf, archery, and photography.

Doctor Parkinson has been in practice at 627 Doctors Bldg., Omaha, Nebraska, since July 1, 1957.
Comments From Your President

FAY SMITH, M.D.
President, N.S.M.A.

With this issue of the Journal come my first "Comments from the President." My appreciation goes to all the doctors of Nebraska for their confidence in me. I assure you that I will do everything I can to make this a good year for Medicine in Nebraska. My thanks also to the doctors of the State for their fine attendance at our Annual Meeting just passed. It was a fine meeting, well repaying those in attendance with an excellent program.

We have had complaints in the past from Exhibitors because we did not visit them sufficiently to make their booths worthwhile. This year I talked to a number of Exhibitors and they were happy with the response from the doctors. I appreciate the fact that you did make an effort to attend the exhibits this year. Not only did they finance our state meeting, but you gained in medical knowledge also.

Your President and President-elect met with the Woman's Auxiliary to the Nebraska State Medical Association. Under the guidance of their President, Mrs. George Covey, they will have a very active year. They are so valuable to our Association that I urge you to give them all your support in their various activities over the State.

Public thanks goes to our state newspapers. We had excellent coverage on our Annual Meeting. Twice each day all three papers had their reporters call for any news reports of the convention. We also had good TV coverage throughout the meeting. Doctors should always work for good public relations and I feel we had them this year.

One of the first problems to be faced this year will be the negotiation of a new contract for Medicare. This will be done in Washington in September of this year. I assure you that every effort will be made to get a good contract for the doctors of Nebraska. My definition of a good contract is one which is fair to both the doctors and the Federal Government. Our Association contracts with the Government to render this care to the dependents of our service men. Blue Shield acts only as our agent in this service. As soon as the contracts have been signed we plan to place a manual in the hands of every doctor in our Association which will list every procedure covered by Medicare.

I hope to see many of you at the A.M.A. Meeting in San Francisco next month.

FAY SMITH, President.
The old law of supply and demand has not freely operated in America for about a quarter of a century. During the 1930's the rule book did not work. Nothing worked. Nobody worked. Then in the 1940's the situation turned around completely and everything worked. You could win with one hand tied behind you. This condition prevailed in most lines of endeavor right on up to 1954 and 1955.

Now we must play by the rules. But we must face up to the fact that nearly forty million people in America earned their first money since 1929. This means that nearly two-thirds of our adults never before worked under the rule book! Why should we be so surprised that they do not know how to meet the problems of "normalcy"?

We must quit assuming that people know things they never heard. We must teach such fundamental facts as this:

1. When the rule book is working all the people on one pay roll are for all practical purposes on one boat. You can't sink half a ship. You can't sink just the officers quarters and let the crew sail on. You can't sink just the crew and let the officers continue the cruise. They all go down together or they all stay up together.

2. When the law of supply and demand is working it is not the "boss" who decides whether a person can have a pay raise or increased "benefits," but it is the customer who decides those things. The "boss" can sign a contract to raise an employee's wages but the customer is not bound by the contract. He can cut the wages, or stop them completely.

3. We must teach people that the success of everybody in an organization again depends upon how well that organization serves the public. If it serves better than the competition, it grows and prospers. Growth, then is the inevitable result of better service.

4. The only way the "masses" can have things is for mass production to get the prices down within the range of all. This means bigness is essential to the American way of life. "Big business" is not the enemy of the little man or of little business. They are all inextricably intermeshed and are completely interdependent. This is big America! Big labor, big government, big education, big debts! Why pick out one
thing that must largely support the rest and say, "That is bad because it is big?"

The great progress made in the Russian school system has been accomplished by adopting the American free enterprise philosophy of competition, incentives, and rewards — for both students and teachers. At the same time Progressive Educationists in America were adopting the communist philosophy of no competition, abolishing grades, and not admitting that anyone could achieve more than anyone else. Now we have a lot of folks who think the American schools should adopt the Russian plan. What we really need to do is to re-adopt the American plan.

Yes, let's quit assuming that the American people inherit in their blood streams a working knowledge of the American system. They don't. It must be taught constantly and effectively. The big job of leadership in 1958 is to substitute confidence for panic by selling America to the American people.

Voluntary Health Insurance for the Aged—

An article in the April, 1958, issue of the *Chronic Illness Newsletter*, published bi-monthly by the A.M.A. Council on Medical Service, describes some of the methods by which persons over 65 are being increasingly included in voluntary health insurance coverage. The article breaks down various groups within this over-65 population by type of protection or lack of it, describes a number of the programs currently underway by the Blue Shield-Blue Cross plans, private insurance companies, industry and others in extending voluntary health protection for these groups, and analyzes the socioeconomic forces behind a rising trend in coverage of this section of the population. Additional copies of this issue of the *Newsletter* are available on request from the Council.

Professional Relations Conference of Blue Shield Plans; A Report to the Profession Of Nebraska—

The Professional Relations Conference of Blue Shield Medical Care Plans was held in Chicago on March 3, 4, and 5 of this year. Approximately 300 delegates attended. They came from all segments of the profession—board members, public and professional relations personnel, executive secretaries of state medical societies, executive directors of plans, and just plain interested doctors.

Doctor Arthur J. Offerman, president of Blue Shield Medical Care Plans, welcomed the delegates with an inspirational talk calling for greater cooperation and unity between the profession and the Blue Shield Plans. In his address of welcome Doctor Offerman stated that future freedom in the practice of medicine depends upon how well we succeed in selling the Blue Shield idea of community service to the profession.

The program consisted of formal presentation of papers during the forenoon sessions. Afternoon sessions were allocated to discussion groups. These groups were small, consisting of approximately 18 to 20 delegates. Board members, executive directors of plans, executive directors of medical societies, and administrative personnel of Blue Shield Plans were all present. Problems common to all groups were discussed. These were extremely valuable sessions.

At the end of three days a summary of recommendations of Physician Relation Discussion Groups was compiled and is as follows:

1. Blue Shield must be truly sponsored by the medical profession and be actually the agent of the medical societies. Whenever the Blue Shield organization is not in such a relationship, the medical profession should take immediate action to bring the Blue Shield Plan into the correct relationship. Sponsorship by a medical society is a requirement of a member plan using the name and symbol Blue Shield.

2. Strenuous efforts must be made continually to keep physicians informed of the distinctive nature of Blue Shield, its policies and problems, and the promise it holds for averting government medicine. The threat of government medicine is now more imminent than at any time in the last decade, and Blue Shield represents the best and perhaps the only hope of averting it. This is fundamentally a job for organized medicine in its county societies.

3. The physician can be a most effective instrument in selling Blue Shield and free medical practice to the public, and means should be provided for using him in this role. Bureaus of speakers to appear before service clubs, church meetings, and other groups have been developed in a few places and merit much greater use. A committee of the medical society to consult with labor and
management can be very useful when committee members are expert enough to act as consultants. The doctors’ plan must be intelligently presented to the public by doctors themselves.

4. Extension of prepayment to the retired is a problem which must be solved. This is the business of the medical profession and its agent, Blue Shield. A positive program must be developed unless we wish to abdicate our responsibility—and with it our freedom—in favor of government. Each Blue Shield Plan, each medical society, should study this problem now, at once, and report its recommendations through appropriate channels to the A.M.A. trustees and the Fister Committee, to the A.M.A. House of Delegates, or to the Blue Shield Conference of Plans and the Commission.

Lewis G. Hersey, Executive Director of Utah’s Blue Shield Plan, presented one of the outstanding papers of the Conference. Amongst other very pertinent comments Mr. Hersey said, “We must find ways and means of convincing a small segment of the medical profession that even though the Blue Shield was organized by physicians, it is not operated solely for the benefit of one specialty group, let alone one doctor. We must educate those who so believe that Blue Shield was developed in the public interest.”

These, I think, are the highlights of the meeting in Chicago.

Harry A. Jakeman, M.D.,
Fremont, Nebraska.

The Medicare Program in Operation—

The Medicare program has been in effect in Nebraska with the Nebraska Medical Service (Blue Shield) acting as fiscal agent for over one year. During the past year, as in any new program of its kind, many new developments and changes have been made to supplement the original directives. These changes were necessary to smooth the operation and to give better interpretations of the existing directives.

It has been the objective of Blue Shield and the Nebraska State Medical Association to keep Nebraska Physicians informed of these new developments and to help them to understand the existing regulations.

In order to do a better job of keeping physicians informed, a series of articles are planned which will deal with the aspects of the program which, from experience, have been found are most generally misunderstood and about which most inquiries have been received.

The purpose of the Medicare program is to make available to the servicemens’ dependents a free choice of physicians and hospitals. Since this is intended to relieve the service member of fear concerning the quality and cost of the care provided his dependents, it is intended that, except for certain specified items to be paid for by the patient, the services which are provided by the physicians will be furnished without cost to the dependent. The private physician will receive an amount established in the local schedule of maximum allowances or his usual charge whichever is less. If the physician feels that the unusual nature of the specific case he is treating would justify a fee greater than that in the schedule of maximum allowances, it is his privilege to submit a letter with his statement stating the reasons for his fee. Blue Shield, the fiscal agent, will submit this to the Policy Committee of the Nebraska State Medical Association, the contractor agent; or he may appear in person to present his views as to why his fee rather than the scheduled fee should be paid. The final approval must be made by the government.

For the past few months the fiscal agent, Blue Shield, has been notified of the importance of the proper identification of dependents eligible for services under the Medicare program. This identification is a requirement which has not been thoroughly clarified in the past. The DA Form 1863 has a space provided for the dependents medical authorization card number. However, until recently these cards had not been issued to all dependents, so the government required only that the physician be satisfied of the dependent’s eligibility. However, they now require either that the authorization card number be given or that if for some reason this is not available one of the following forms of identification be given: (a) statement of a local commander having knowledge of the sponsor’s status that the patient is a bona fide dependent; (b) other official uniformed services documents or identification cards signed by an official reflecting the patient as being a dependent
eligible for civilian medical care; or (c) statement of the physician that he has personal knowledge of the identification of the patient, of her dependency status and eligibility under Medicare.

The next article will review the latest information in regard to maternity care under the Medicare program.

Government Health Insurance in Europe:
Latest Report—

The following is reprinted from Blue Shield Medical Care Plans Newsletter for April, 1958:

Government health insurance programs in Europe are costing the taxpayer more and more and the service provided continues to deteriorate. This is the gist of a recent report on socialized health systems that have been adopted in every European country except Switzerland, where the government's involvement in health care programs is confined to subsidization of medical cooperatives.

The report on European governmental health insurance systems was prepared by Professor Melchior Palyi, who has written extensively on government health insurance programs and their development in Europe.

In a recent article, Professor Palyi reported that in every country where government health insurance is in effect, the profession has grown increasingly restive and that in Austria, Germany, France and Britain, the doctors have threatened to go on strike because of their dissatisfaction. In Italy, according to Professor Palyi, the doctors actually did strike in protest against the government health program in that country.

Professor Palyi pointed out that the costs of every European program "are rising relentlessly, but nowhere as fast as in Britain." He also pointed out that in Britain more than in any other country the insurance principle has been almost completely "perverted into a communistic practice . . ." 

Indicative of the fantastic cost of the British program, Professor Palyi reported in his article that in a nine year period while retail prices increased in the neighborhood of 40 per cent, the cost of the government's health insurance program increased by more than three times. Presently, Professor Palyi pointed out, the cost of the scheme "amounts to more than 10 per cent" of the national budget. Professor Palyi also wrote that the people in Britain are gradually becoming aware of the fact that under their health insurance scheme "they have caught the proverbial bear by the tail." In the first three years he indicated that for the "40 million people in England and Wales alone, 609 million prescriptions, 19½ million pairs of glasses, 7 million dentures, 700,000 appliances of 'main types' and 130,000 hearing aids were dispensed.

And, according to Professor Palyi, "the only check on the demand was the fact that the supplies ran out." Shortly thereafter, deductibles were instituted whereby by 1952 patients were charged with half the price of dentures and appliances and about 14 cents for each prescription. In spite of these "deductibles" Professor Palyi pointed out that the costs of the program continue to climb at an astonishing rate.

What effect has been noted in the quality of care being received by patients? Professor Palyi offered the observation that patients are "shunted back and forth between overworked and (due to lack of sufficient income) poorly equipped general practitioners and overcrowded and undermanned institutions." Under these conditions Professor Palyi pointed out that, "if the quality of service has not greatly deteriorated as yet, it is because nine years of strain and stress could not change the standards of the profession. But young doctors pour into the career in large numbers—thanks to the policy of the British welfare state to . . . provide free education from the kindergarten to the doctoral examination. Thus, "wrote Professor Palyi, "the ethical standards and medical techniques of this new generation of doctors remain to be seen."

The Month in Washington—

The Hill-Burton program for U.S. grants to states to help build hospitals and other health facilities has run a successful course for almost 12 years. It has never been cut back in scope, and once (in 1954) it was expanded to take in diagnostic-treatment centers, nursing homes, chronic disease hospitals and rehabilitation centers.

On the overall, the U.S. puts up one-third of the money for a state's projects, but the state may give individual projects as much as two-thirds of their costs.
In the 12 years, 3,725 projects have been completed, are under construction or have been approved. They represent a total investment of about $3 billion, just under one-third of it federal money. Included are 156,658 hospital beds, 4,542 nursing beds, and almost 1,000 other facilities, such as rehabilitation centers.

Congress, as it has several times in the past, now is being asked to renew the program, which no doubt it will do. Also, the Department of Health, Education, and Welfare and several organizations in the health fields have looked over the 12 years' experience, and want some changes made in the way the program is handled. None of them, however, wants to end it.

The American Medical Association, for example, is suggesting that diagnostic-treatment and public health centers be dropped from the program, and that the mandatory emphasis on rural communities also be eliminated. These and other A.M.A. recommendations are the result of a 14-state survey by the association.

Also, the A.M.A. joins with the Department of Health, Education, and Welfare in proposing that emphasis be placed on facilities for the chronically ill and nursing homes, and that states be given more freedom in shifting money among the various categories.

Both the A.M.A. and the A.H.A. want Congress to authorize loans for hospitals and nursing homes, with the A.M.A. recommending that loan guarantees be offered to proprietary as well as nonprofit institutions.

Before Congress are a dozen or more other suggested changes. Several groups want the research fund raised from the present $1.5 million a year to $4 or $5 million, and H.E.W. would like to be able to advance money for planning when this action would hurry construction. H.E.W. also, along with several Congressmen and state medical societies, would like to see the eligibility requirements eased so more nonprofit groups can build diagnostic-treatment centers. Another H.E.W. proposal would recognize a rehabilitation center even if it did not furnish psychological, social and vocational evaluation services, as well as medical; now the center has to furnish all four services.

At this writing, indications are Congress will not allow a slip-up in extending the program, which is scheduled to expire June 30, 1959, even if it has to move along a simple extension bill, then try to work out agreement on all the suggested changes.

Regardless what happens, Hill-Burton is undergoing more friendly—but critical—examination than it has experienced since its birth in 1946.

NOTES:

American Association of Medical Colleges estimates that the country's 85 medical schools will require $275 million for rehabilitation and new construction in the next few years, not including money for research and hospital construction.

To learn how far our supplies could be stretched in event of nuclear attack, the Office of Defense Mobilization has asked Public Health Service to survey 700 wholesale drug houses, surgical supply firms and chain drug store warehouses for an inventory of their stocks.

American Medical Association, among other groups, is supporting legislation that would request President Eisenhower to call a 1960 White House Conference on the problems of the aged. However, H.E.W. sees no need for the conference, nor does it favor suggestions that a new bureau be set up to handle the problem, nor a commission created. (From Washington Office, A.M.A.)

After conclusion of hearings, a House subcommittee has under consideration legislation for "bricks-and-mortar" U.S. grants to help medical and dental schools finance buildings and purchase of equipment; money could not be used for general operating expenses.

Dr. Thomas H. Alphin has resigned as director of A.M.A.'s Washington Office to become associate medical director of the Equitable Life Assurance Society at the group's main office in New York. Dr. William J. Kennard, deputy director, has been named acting director of the Washington Office.

V.A. is calling for bids on 12 construction projects estimated to cost a total of at least $4.2 million. Locations include Murfreesboro, Tenn.; Tomah, Wis.; Columbia, S.C.; Bay Pines, Fla.; Newington, Conn.; Iowa City, Iowa; West Roxbury, Mass.; Rutland Heights, Mass.; Walla Walla, Wash.; Wood, Wis.; Wadsworth, Kan.
News and Views

From the Alliance Times-Herald—

A new eye machine purchased by the Chadron Lions Club is being made available to all schools in Dawes County for determining deficiencies in students' vision.

The Keystone Tele-Binocular is used as a checking method and not a final determining factor in the fitting of glasses. With this machine students who show defects in eye sight will be told through a letter to the parents, that they should visit their family eye doctor.

Sight conservation and the eye bank are major programs of the club.

From the Broken Bow Chief—

Wayne, Nebraska citizens have approved the purchase of the Benthack hospital by a 7 to 1 margin. In approving the purchase, citizens authorized the city council to issue $150,000 in bonds to buy the facilities.

From the York Times—

Speakers for the April meeting of the Sixth Councilor District Medical Society were Dr. Paul Goetowski, team physician for the University of Nebraska; Paul Schneider, head trainer for the University, and his assistant, Bob Knaub. They gave a talk on “Athletic Injuries — Their Treatment and Prevention.” The meeting was held at the York Country Club.

From the Friend Sentinel—

Dr. Frank T. Hamilton of Friend was one of three persons honored at a recognition dinner by the citizens of Friend for their long years of service to the community.

Dr. Charles Arnold of Lincoln, guest speaker, paid tribute to Dr. Hamilton, a long-time friend, because he upheld the highest demands of the ethics of medicine. Dr. Hamilton observed 50 years of practice in Friend, on May 12th.

In a brief response Dr. Hamilton expressed deep appreciation to the honors accorded him. He said that his most valued treasures are the friendships he has enjoyed through the years.

From the Aurora News-Register—

A new drug that can often pull people out of the fatal coma of liver failure has been made in quantity for the first time by General Mills. The drug is a chemical called “arginine” never before available except in small quantities.

The new drug is sometimes life-saving according to Dr. Leslie Zieve of Minneapolis, Minnesota Veteran's Hospital, though it does not cure the basic trouble in most of the patients. “It is certainly dramatic though to see some of these men sit up, in cases where they had been in deep coma with death expected.”

Dr. Norval Barker and his associates have labored four years to perfect these processes. Through their efforts commercial quantities of both L-arginine of 99 per cent purity and L-lusine of 98 per cent purity can be turned out.

Technical names of the new arginine products are L-arginine, L-arginine monohydrochloride and L-argininium-glutamate.

Health Insurance Council Elects
Mr. E. J. Faulkner—

Mr. E. J. Faulkner, President of Woodmen Accident and Life Company of Lincoln was elected Chairman-Elect of Health Insurance Council on April 18. Mr. Faulkner had served as Chairman of the Council’s Medical Relations Committee.

The new Chairmen-Elect served as first President of the Health Insurance Association of America (1956) and is a member of the American Medical Association Commission on Health Care. He has served the cause of medical freedom well.

List of Officers, American Academy of General Practice—

For those of our readers who may wish to communicate with officers of the American Academy of General Practice we publish the following list of its officers:

OFFICERS
President—Holland T. Jackson, M.D., Medical Arts Building, Fort Worth, Texas
Vice President—Charles C. Cooper, M.D., 332 Hamm Building, St. Paul, Minnesota
President-elect—Fount Richardson, M.D., 316 West Dickson, Fayetteville, Arkansas
Chairman of the Board—John G. Walsh, M.D., 2901 Capitol Avenue, Sacramento, California
Treasurer—Albert E. Ritt, M.D., 490 North Snelling Avenue, St. Paul, Minnesota
Executive Director and General Counsel—Mac F. Cahal, J.D., Volker Boulevard at Brookside, Kansas City, Missouri
Ten Fellowships by Smith Kline & French Foundation—

The American Psychiatric Association recently announced the award of 10 Smith Kline & French Foundation Fellowships in Psychiatry.

The S.K.F. Fellowships, totaling $13,150, are the final awards of the three-year, $90,000 grant established in 1955 to provide a broad range of training opportunities in psychiatry.

The Smith Kline & French Foundation, supported principally by contributions from Smith Kline & French Laboratories, Philadelphia pharmaceutical firm, recently awarded a $100,000 grant to the American Psychiatric Association to continue the S.K.F. Fellowships through 1960.

A total of 14 recipients, including 10 medical students, will benefit in the latest group of grants. Their projects vary from a study of the treatment results in schizophrenia to experiments with mescaline, a hallucinating agent.

The S.K.F. Fellowships are administered by a committee named by the American Psychiatric Association consisting of Drs. Kenneth E. Appel, Philadelphia, Chairman; Daniel Blain, Washington, D.C.; Henry Brill, Albany, N.Y.; Jacob E. Finesinger, Baltimore; Francis J. Gerty, Chicago; Robert G. Heath, New Orleans; David A. Young, Raleigh, N.C., and Seymour Vestermark, Bethesda, Md.

The Road Toll for 1957—

Traffic accidents for 1957, as awful as usual, were as follows:

Deaths, 38,700
Injuries, 2,525,000
Casualties from speeding, 850,800
Pedestrian casualties, 229,700
Deaths on weekends, 15,670
Drivers involved, under 25 years of age, 26.9%.

Total deaths from traffic accidents highest in history.

Hometown V.A. Medical Care on Informal Agreements—

Veterans Administration proposes to replace formal contracts with state medical associations for its hometown medical program by informally negotiated agreements with the associations, beginning July 1, 1958. Nebraska is one of 15 states that has no VA contract with the state association. These states will be offered opportunity to negotiate fee schedules.

Health Insurance Benefit Payments High—

Benefit payments by insurance companies to people in Nebraska who are covered by health insurance policies reached a new high in 1957, as reported by the Health Insurance Institute.

In the period from January 1 through December 31, 1957, over $18.2 million was paid out to help cover the cost of hospital and doctor bills, and to replace income lost through sickness or disability. This rise in Nebraska reflects that of the nation as a whole.

New Drugs and Legal Liability—

Implied warranties, as illustrated by the California case in which a pharmaceutical manufacturing company was successfully sued for damages because live vaccine was included in a shipment of its polio "shots," today received the worried attention of top industry leaders gathered for the 51st annual meeting of the American Pharmaceutical Manufacturers' Association.

Wallace E. Sedgwick, partner in a San Francisco law firm, cited the Cutter Laboratories case as an example of a special and unique set of rules applicable only to the drug and food industry, but not to manufacturers of other products.

"It seems essentially unfair to single out your industry (and food processors) for special treatment," he said.

In the California case, the jury found that the laboratory was not guilty of any negligence and had complied to the fullest extent with the regulations and tests governing the production of the Salk vaccine. At the same time the jury awarded heavy damages to the plaintiff.

Mr. Sedgwick quoted the U.S. Public Health Service itself as recognizing the risk
involved in the introduction of new treatment and pharmaceuticals. He quoted the Health Service as saying: "Throughout the history of medicine and public health most advances have been made step by step, with each new and unforeseen obstacle overcome as it is encountered. This has always involved a certain amount of risk, trial and error, discovery of new knowledge in production and clinical use, and resumption of forward movement. As in all scientific and medical endeavor we must weight potential benefits against possible hazards."

Industry leaders attending the meeting here view the matter this way: If the California verdict awarding damages is upheld by the higher court to which it has been appealed progress in pharmaceutical and medical research will be slowed to a walk.

"Who will dare to introduce new products with the threat of implied warranties—and damage suits—constantly a jeopardy to such advances?" one industry leader asked.

A side effect of the California case, Mr. Sedgwick said, is that pharmaceutical manufacturers are being viewed as askance by insurance companies.

"Top insurance executives are already concerned about this type of risk and one has expressed doubt to me personally that his company can continue to insure pharmaceutical manufacturers if a threat toward absolute warranty liability develops, thus making the extent of the risk unpredictable. Many substantial underwriters have placed serious restrictions upon the writing of certain classes of product liability insurances," he said.

Mr. Sedgwick said that from his knowledge of the pharmaceutical industry he felt that its attitude in the matter is this. "It (the industry) wants the law to be interpreted fairly for both consumer and manufacturer. If the manufacturer is careless in manufacturing a product (the court found the California company was not) the industry agrees there should be a liability. If for any reason a product is not properly manufactured or tested there should be a liability for any harm that results.

"But where a product is manufactured without negligence and is properly developed and tested in accordance with the best scientific knowledge then available and all applicable government regulations are fulfilled, the manufacturer should not be held to blame solely by the application of implied warranties."

Form Council for Health Care of the Aged—

The foundation has been laid by some of the important organizations in the health field to solve the problem of the health care of the aged.

For this purpose the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association announced the establishment of the Joint Council to Improve the Health Care of the Aged.

Objectives of the council, the formation of which has been under consideration for some time by the sponsoring groups, were announced as:

"To identify and analyze the health needs of the aged; to appraise available health resources for the aged; and to develop programs to foster the best possible health care for the aged regardless of their economic status."

The Joint Council to Improve the Health Care of the Aged is made up of three representatives of each sponsoring organization.

One of the first jobs of the council will be to determine exactly what are the health problems of the aged. Studies have been underway for the past several years by the organizations making up the council, but now, through joint efforts, research will be intensified and projects for meeting the problem will be activated as rapidly as possible. The council will be the agency through which the efforts of the sponsoring member organizations will be coordinated to solve the health problems of the aged.

The sponsoring organizations pointed out that the need for new programs in this field is accented by the fact that the life expectancy of individuals has been constantly increasing in recent years. In 1935 life expectancy in the United States was an average 60.2 years. The most recent figure indicates the average life expectancy now to be 70.0 years.

The council will have as one of its principal immediate projects the development of programs and facilities to be tailored to the health needs and finances of the aged.
Another facet of the council’s broad-range program will be to work closely with health insurance groups in an effort to improve the coverage of the aged and to see that their insurance dollars go further.

It is the belief of the Joint Council to Improve the Health Care of the Aged that much can be done for older people by the states and communities, and the council will endeavor to stimulate the activities at these levels of government.

Special research projects are contemplated by each of the organizations supporting the council. This research will then be pooled and programs developed to meet the health needs of the aged. The ultimate goal is to provide adequate health care at reasonable costs.

**Announcements**

THE FLOYD ROGERS CAMP FOR DIABETIC CHILDREN will be held at Camp Catron at Nebraska City, June 8-21. For details contact Miss Hannah Smrha at the Department of Health, State Capitol Bldg., Lincoln, Nebraska.

Fall Scientific Sessions on Heart—

Rheumatic fever and rheumatic heart disease will be the subjects of a two and one-half day conference on October 2, 3, and 4. This will be held at Town House, Dodge and 70th, Omaha. It will be sponsored by the Nebraska and Iowa Heart Associations and co-sponsored by Creighton University School of Medicine and the University of Nebraska College of Medicine. There will be seven outstanding speakers.

Fellowships Offered in Study of Arthritis and Rheumatism—

The Arthritis and Rheumatism Foundation offers predoctoral, post-doctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1959. Deadline for applications is October 31, 1958.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for three awards:

1. **Predoctoral Fellowships** are limited to students who hold a bachelor’s degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $1500 to $3000 per year, depending upon the family responsibilities of the Fellow.

2. **Postdoctoral Fellowships** are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy — or their equivalent. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $4000 to $6000 per year, depending upon the family responsibilities of the Fellow.

3. **Senior Investigator Awards** are made to candidates holding or eligible for a “faculty rank” such as Instructor or Assistant Professor (or equivalent) and who are sponsored by their institution. Stipends are from $6000 to $7500 per year and are tenable for five years.

A sum of $500 will be paid to cover the laboratory expenses of each postdoctoral fellow and senior investigator. An equal sum will be paid to cover the tuition expenses of each predoctoral fellow.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N.Y.

**Fifth Annual St. Joseph's Clinic**

To Be in Denver—

The Fifth Annual St. Joseph’s Clinics are to be held in Denver, Colorado, July 31 and August 1 and 2. Guest speakers from the Institute of Metabolic Research of Oakland, Calif., and from the Department of Surgery, University of Texas will take part in the program along with members of the St. Joseph’s Hospital staff. This will be an invitation affair, but doctors who do not receive an invitation may obtain one by writing to Mrs. Eugene Hogue, St. Joseph’s Hospital, 18th and Humboldt, Denver 18, Colorado.

**International Congress on Occupational Health—**

The 13th International Congress on Occupational Health will take place in New York City in July, 1960. It is to highlight preven-
tion, rather than cure, of occupational injury and disease. Experts from all over the world will discuss the problems.

Fourth World Assembly Israel Medical Association—
The Fourth World Assembly of the Israel Medical Association will be held in Tel Aviv, Jerusalem and Haifa from August 12th to 24th, 1958. These dates correspond to the Israel's tenth anniversary celebration and may be of special interest to many Americans. There will be a special, all-inclusive tour to Israel. For further information, write American Physician's Fellowship, Inc., 130 Beacon Street, Brookline, Mass.

American Nurses' Association to Hold Annual Convention—
The 1958 convention of A.N.A. will be held in Atlantic City, N.J., June 9 through 13th. Headquarters, Room 8, second floor, Convention Hall.

National Society for Crippled Children—
The 1958 convention of the National Society for Crippled Children and Adults will be held at the Statler Hotel, Dallas, Texas, Nov. 16-20, 1958.

Second Oklahoma Colloquy To Be Held—
The Second Oklahoma Colloquy on Advances in Medicine will be held Nov. 12, 13, 14, and 15. For further information write to The Division of Postgraduate Education, University of Oklahoma School of Medicine, Oklahoma City, Oklahoma.

Assembly in Otolaryngology—
The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 29 through October 5, 1958. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat. Interested physicians should write to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Human Interest Tales

Dr. Dale Marcotte, Lincoln, has announced plans to set up his practice in Ceresco.

Dr. and Mrs. H. F. Friesen, Henderson, are the parents of a daughter born in April.

Dr. S. P. Brown, Lincoln, has been appointed chief of surgical service at the Lincoln V.A. Hospital.

The office of Dr. A. R. Pantano, Omaha, was looted in April. The thief made off with about 85 dollars.

Dr. E. W. Walsh, Omaha, has been elected to the Board of Governors of the American College of Physicians.

Dr. Charles Landgraf, Hastings, addressed the public affairs dinner at the Hastings Y.W.C.A. in April.

Dr. John H. Calvert, Pierce, received the honorary degree, Doctor of Science, in April from Wesleyan University.

Drs. H. J. Phillips and J. L. Kramar, Omaha, have been elected to membership in the American Physiology Society.

Dr. Robert F. Moore, a native of Greenfield, Massachusetts, is a new staff member at the Lincoln V.A. Hospital.

Dr. N. H. Moss, Arcadia, began a three-month course in anesthesiology at the University of Minnesota in April.

Dr. H. D. Myers, Schuyler, attended the Trauma meeting of the American College of Surgeons in Chicago in April.

Dr. E. H. Reeves, Grand Island, has leased the medical clinic building in Scotia where he plans to resume his practice.

Dr. Jack Bankead, Alliance, has left this city and has moved to St. Louis, Missouri for specialty training in anesthesiology.

Dr. Henry Kammandel, Omaha, was the guest speaker at the April meeting of the Tri-County Medical Society in Fremont.

Dr. and Mrs. Dean Bloch, Omaha, have made plans to move to Arlington where Dr. Bloch will join his father in the practice of medicine.

Dr. James M. Woodward, Lincoln, was elected president elect of the American Association of Railway Surgeons at the annual meeting in Chicago in April.
The April meeting of the Tri-County Medical Society was a combined event with the Women's Auxiliary meeting with their husbands at the Fremont Golf Club.

Miss Neannene C. Kenney of Omaha, educational director of St. Catherine's Hospital School of Nursing, is the new president of the Nebraska State League for Nursing.

Dr. Betty Clements, a native of Elmwood, has returned from England and will move to Phoenix, Arizona, to set up her practice. Dr. Clements studied neurology for three months in England.

Drs. John Hartigan, Omaha; John Brazer, Omaha; and B. E. Taylor, Lincoln, were elected to fellowship in the American College of Physicians at the annual meeting in April in Atlantic City, New Jersey.

Dr. D. Richard Jones has been appointed a fellow in pathology in the Mayo Foundation at Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota. Dr. Jones is a 1954 graduate of the Creighton University School of Medicine.

Dr. Clifton E. Baker has been appointed a fellow in orthopedic surgery in the Mayo Foundation at Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota. Dr. Baker is a 1951 graduate of the University of Nebraska College of Medicine.

Deaths

William S. Ramacciotti, M.D., Nebraska City—Doctor Ramacciotti died suddenly of a heart attack at his home at 7 p.m., March 3. He had not been ill. He was fifty-six years old. Doctor Ramacciotti belonged to the American Association of Railroad Surgeons, Industrial Medical Association, American Academy of General Practice, and others. He taught for a time in Creighton Medical School. He was appointed the medical member of the Otoe County Board of Mental Health in June of 1949, and had served ever since.

Benjamin A. Root, M.D., York — Doctor Root died at the age of eighty-three at York General Hospital, April 4. He had been in failing health the past two years but became critically ill at his home April 2. Doctor Root retired from active practice in February, 1953, after nearly a half century of practice in York. He graduated from the Lincoln Medical College in 1905, and began the practice of medicine at Phillips in Hamilton County. He came to York, in 1908, to establish a practice and spent the remainder of his active years there. He was an honorary member of the American, Nebraska, and York County Medical Societies and received his 50-year-pin from the N.S.M.A. in 1955.

William James Douglas, M.D., Atkinson—Doctor Douglas who practiced medicine in Atkinson for more than a half century, died January 23, 1958, at St. Joseph's Hospital in Omaha, where he had been a patient for two or three years. He was eighty-one years of age. Doctor Douglas was mayor of Atkinson for twenty-six years and was also prominently identified with all manner of community betterment projects. He served as a captain in the medical corps during World War I and for many years was a leader in American Legion activities.

J. Richard Paul, M.D., Hollywood, California—Doctor Paul suffered a severe heart attack which claimed his life at the age of forty-three, March 28. Doctor Paul was born in St. Paul, Nebraska and was a graduate of the University of Nebraska College of Medicine. He was a member of Beta Theta Pi, Theta Nu Epsilon, and Phi Rho Sigma. He was a member of the Episcopal Church, the Nebraska State Medical Association, American Medical Association, a Pastoral Psychology Club, the Aero Medical Association, and a Fellow of the American Psychiatric Association.

Joseph J. Warta, M.D., Omaha — Doctor Warta, a teacher and oculist-aurist in Omaha for 45 years, died April 14, 1958, at the age of eighty-one. He was a graduate of Creighton University in 1902, and he practiced in Sargent for eleven years. After coming to Omaha he taught for thirty-three years at the Creighton University School of Medicine and lectured eight years to nursing students at St. Joseph's Hospital.

Esther I. McEachen, M.D., San Francisco, California — Doctor McEachen suffered a heart attack in a San Francisco hospital and died March 8, 1958. She was to have under-
gone surgery. Doctor McEachen received her degree Doctor of Medicine from the Nebraska University College of Medicine. She practiced in Omaha before going to California several years ago.

Ellsworth F. Malloy, M.D., Fremont—Doctor Malloy died at a Fremont Hospital after a brief illness, April 15, 1958. He was fifty-nine years old. He began his practice in Fremont in 1945. Previously he had practiced medicine at Rochester, N.Y., Greeley, and Bellwood and was resident doctor at Douglas County Hospital in Omaha. He graduated from the Creighton University School of Medicine. Doctor Malloy was a member of the American Medical Association.

The Woman's Auxiliary

PRESIDENTIAL GREETINGS
to the Woman's Auxiliary to the Nebraska State Medical Association
April 29, 1958

It is with mixed feelings of pride and apprehension that I assume the office of president of this organization. I appreciate the honor you have given me, and I will do my best to fulfill the duties of this office.

During my childhood my contact with medicine was limited to that of emergency and critical illnesses of the family. As a young woman I chose a career in Medical Technology. This was extremely challenging. The results of this work carried much responsibility as an aid in the physician's diagnosis, differential diagnosis, course of treatment, and progress-determination.

Being a doctor's wife and auxiliary member is no less challenging. Our husbands' profession is unique. The fringe benefits are in direct proportion to the service given and are not to be received as a matter of course.

We do not wish to fall into the confusion of those who do not understand or are untroubled because of their lack of understanding. So, it is well, periodically, to stop and consider who we are and why we exist as an auxiliary.

The answers to both of these questions are given in our constitution, which states that active membership is limited to the wives of doctors who are members of the American Medical Association.

Why we exist is also stated in our constitution as follows:

1. To assist the A.M.A. in its program for the advancement of medicine and public health.
2. To coordinate and advise concerning the activities of constituent auxiliaries.
3. To cultivate friendly relations and promote mutual understanding among physicians' families.

At first glance, these sound like very simple rules and responsibilities. However, on closer analysis we find a good deal of responsibility involved.

Our membership is our good fortune. We happened to fall in love with and marry a doctor of medicine. By virtue of this good fortune we have fallen heir to these very definite responsibilities as cited in our constitution. In general, these responsibilities can be placed under the heading of "Public Relations."

What is "Public Relations?" A very brief definition is the art of displaying sincere interest in others. How do we display this sincere interest in others?

First, let me say, that "others" begin with our family, then come our neighbors, then on to an ever widening circle—our community, our nation, and other nations.

We can do this by having enough love in our hearts to want to help others, by merely being friendly, exchanging ideas, and inspiring others to do likewise.

In this way, we can help develop a thinking nation—by keeping the individual strong. We must understand our purpose and feel an urgency in the need of that purpose. We must believe in it. We must believe passionately and ruthlessly. This is a simple thing, but a strength that can not be resisted. It is the belief that makes the difference. Strength is born of the stupidity, ignorance and hypocray of others. Believing gives direction to that strength. Only in this way can we keep our nation from over-conforming and thus retain our personal freedom.

We are slowly being robbed of this free-
dom. We are being degraded both in mind and in spirit. Each day we are being more and more denied the dignity which belongs even to animals, that of being responsible for our own lives, food, shelter, and provision of security for our future.

The government is making decisions for us, giving us pensions and providing the security which we should provide for ourselves with dignity and satisfaction; a privilege that is our blessing from God.

Our middle class complacency can bring us only more regimentation. It will reduce our lives to a monotonous level of uninspired work.

If this situation sounds foreign to you, you have been living with your heads above the clouds.

The problem, of which I have merely scratched the surface, is our responsibility as wives, mothers, and citizens. It is not right to pray for good crops unless we are willing to till the soil. Daniel Webster explained the constitution in this way, "The national government possesses those powers which it can be shown the people have conferred on it and no more." Our special interest is in legislative matters pertaining to the practice of medicine. It is our business to see that proper legislation is enacted. In order to do this effectively there are a number of things we must do. First, we must acquaint ourselves with all pending medical legislation and evaluate its merits. We must learn all about the people we send to represent us in our law-making bodies both in local and national capacity. We must inform our husbands; confer with our friends and neighbors and tell them what we know; help them to understand what is being done, and why. Practice principle, not prejudice!

This will mean work. It will mean practicing public relations of the highest order. It will mean active participation of each one of you. No one else can do your part. It is a job which we can do with pride. The women of this country have never failed in any job they have sincerely undertaken. I am sure we will not change this pattern.

Mrs. George Covey.

Mrs. Paul C. Craig of Wyomissing, Pa., president of the Woman's Auxiliary to the A.M.A., was guest speaker at the annual business meeting of the Nebraska State Medical Association Auxiliary. Mrs. George Covey, Lincoln, was elected president; Mrs. C. H. Farrell, Omaha, president-elect; Mrs. Frank Tanner, Lincoln, second vice president; Mrs. W. W. Waddell, Beatrice, first vice president; and Mrs. Robert Hillyer, Lincoln, treasurer; Mrs. R. E. Garlinghouse, Lincoln, recording secretary; Mrs. O. A. Neely, Lincoln, corresponding secretary; Mrs. W. E. Johnson, Valentine, and Mrs. Sam Perry, Gothenburg, directors.

Dawson County—

The Dawson County Medical Auxiliary met for dinner with the men of the medical society at the Parkway Cafe, Lexington, April 14. Dr. Ralph Moore, Omaha, presented a lecture, illustrated by slides, on "Medical Aspects of Automotive Safety."

Auxiliary members then held their separate business meeting at the home of Dr. and Mrs. D. A. McGee, after which the men joined them for a coffee hour.

Douglas County—

The Woman's Auxiliary to the Douglas County Medical Society held a program-tea at Conklin Hall on the University of Nebraska Medical School campus. Dr. Charles M. Wilhelmj, professor of physiology and director of research at Creighton University, spoke on the topic "Research in Medicine." Some 75 women's organizations interested in educational and philanthropic projects were guests.

Mrs. James Donelan was chairman for the arrangements.

Adams County—

New officers of the Adams County Medical Auxiliary were present for the annual coffee sponsored by the group during Medical Education Week. Mrs. Warren Richard, auxiliary president, was coffee hostess. Mrs. Robert C. Smith is vice president; Mrs. Fred Rutt, Jr., secretary-treasurer; Mrs. Russell McIntire, chairman of Education Week, and Mrs. O. A. Kostal, co-chairman.

Lancaster County

A lovely annual spring luncheon of the Woman's Auxiliary to the Lancaster County Medical Society was held April 14th at the
University Club. Committee chairman presented their reports and the new officers were elected:

President—Mrs. W. W. Bartels
President-elect—Mrs. LaVerne F. Pfeifer
Treasurer—Mrs. Orvis A. Neely
Mrs. E. S. Maness was appointed to serve as secretary.

Mrs. H. V. Munger, Publicity Chairman.

Know Your Blue Shield Plan

The Western Conference of Prepaid Medical Care Plans has a reputation for programming annual meetings that attract nationwide attention. Its 1957 annual conference held in Portland, Oregon, was no exception.

Speakers at the Conference included Dr. Raymond M. McKeown, trustee of the American Medical Association; and Dr. Ira C. Layton, trustee of Kansas City Blue Shield.

Dr. Raymond M. McKeown, in addressing the Western Conference delegates, indicated that organized groups and the general public are becoming increasingly inclined toward complete coverage for medical costs. "The full extent of this demand," Dr. McKeown said, "remains to be determined. That it exists and is becoming very vocal is unquestioned." Because of this, he suggested that the profession must "anticipate medical economic trends" and be prepared "to determine the medical needs of the general public and meet them by the most acceptable means available."

He warned that extensions of Federal paternalism through social security and political pressures favoring more extensive public health and welfare programs make it imperative that the people be alerted to the inevitable price of such programs. "Whether the public has developed simultaneously a proper evaluation and awareness of the consequences of many of these projects is of critical importance," Dr. McKeown emphasized. "Students of medical economics are agreed that a fundamental demand exists for a factual educational program directed at our people, and even some physicians, to enable them to more realistically evaluate these proposals for more and more medical coverage. If existing prepaid medical plans of our nation, regardless of origin or administration, did nothing in 1958 but disseminate widely, through all available means of communication, factual information on these subjects great good would result."

Urging support of voluntary, medically sponsored prepayment plans, Dr. Ira C. Layton indicated that the expansion of such plans was essential to the future welfare of the medical profession. He went on to indicate that more participation in the affairs of Blue Shield would help secure the interests of both the profession and the public.

To demonstrate the desirability of this, Dr. Layton asked, "How does the doctor's attitude toward Blue Shield compare with that he holds toward the commercial insurance companies?" The answer he suggested was this: "Unfortunately, through lack of proper information, too many of the profession are not aware that a difference between the two does exist. Too often, the physician sees only a high-grade commercial contract carrying a generous fee schedule and is unaware that such a contract is not available to the general public. He wonders why Blue Shield cannot equal these offerings. He hears complaints from patients when additional charges above the Blue Shield allowance are made. Seldom is a complaint registered from a patient who carries a commercial contract for in this instance the patient does not anticipate that his bill will be paid in full. Through lack of knowledge and a narrow exposure, the doctor's feelings toward Blue Shield are often warped and in the wrong direction. Selection of risks, limitations of fee schedules and many other . . . practices are not known to him. It is imperative that as many members of the profession as possible be drawn into the operations of Blue Shield Plans, for in this way, better understanding of insurance principles, basic aims and other problems may be gained."

NOTICE TO ALL CONTRIBUTORS
The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.
TUBERCULOSIS ABSTRACTS

TREATMENT OF TUBERCULOSIS IN THE ELDERLY INDIVIDUAL

Many changes have occurred in the clinical and epidemiologic picture of tuberculosis in the past twenty-five years, one of which has been a change in age distribution. A quarter of a century ago, tuberculosis was considered to be a disease of young people, with the older age groups relatively immune or having it in a rather benign chronic form. They were the true consumptives who never died of their disease and never recovered from it. Frequently not much attention was paid to the elderly individual, even though he had some trouble with a chronic cough until a grandchild or great-grandchild died of tuberculosis meningitis, thus establishing the diagnosis.

The Shift in Age Group — At Glen Lake Sanatorium (Minn.) in 1925 the typical patient admitted was a young woman in her late teens or 20’s. The situation today is totally different. The typical admission patient is a man, 50 or above, who may be a drifter or an alcoholic. Likewise, in 1925 at Glen Lake only nine per cent were the age of 50; in 1955, over 40 per cent were in this age group. Somewhat comparable figures come from nearby sanatoriums.

We must realize, of course, that many of the individuals who are now being admitted to the tuberculosis sanatoria with active tuberculosis belong to the same generation as the patients who were being admitted to the institutions some twenty-five to thirty years ago. Did they receive their contamination long ago and only now develop their active disease, or did they escape at that time to be contaminated at a subsequent date? The clinical picture, in some at least, would seem to suggest a more recent exposure, for there is frequently little to show for any old disease. In 1925, there was much discussion of preventoria and institutions for the treatment of younger individuals. The emphasis now is on institutions for elderly individuals. The numbers of older individuals in our population have increased and we should expect more of them in public institutions.

Where Is Tuberculosis Found? — The first and most important thing that the average physician must realize is that pulmonary tuberculosis is a disease of the human race and is present among all ages, races, and in all strata of society. A generation ago, when the disease was more prevalent, all physicians were constantly confronted with it. Nowadays, with its low incidence and its low mortality, it is frequently overlooked in a differential diagnosis. The younger generation of physicians has been taught to fear the condition and has been shielded from any first-hand knowledge of it. Is it any wonder, then, that the condition is frequently overlooked?

Tuberculosis in the aged may present itself in a typical and easily recognized fashion. It is perhaps a little more likely to be masked by or confused with chronic bronchitis, bronchiectasis, pulmonary abscess, pulmonary infaracts, bronchogenic carcinoma, atypical pneumonia, virus pneumonia, or various other conditions. Tuberculosis is where you find it, and it may only be discovered by intensive search. Even when the physician is suspicious and submits a sputum specimen to the average laboratory, the specimen is frequently sent on to the State Board of Health for culture, thus delaying the diagnosis for an extra six to eight weeks.

Diagnosis — A high index of suspicion of tuberculosis is of great value to the physician when he confronts a patient with chest complaints and particularly when the patient is an elderly individual who may present a ready-made diagnosis. The diagnosis of asthma, bronchitis, bronchiectasis, pneumonia, virus pneumonia and unresolved pneumonia, hay fever, allergy, emphysema, smoker’s cough, or cigarette cough may not only hide a multitude of sins but millions of tubercle bacilli. The problem is the more difficult when the patient actually has two or three conditions at one time, such as carcinoma of the lung, tuberculosis, asthma and tuberculosis, and so on. It may be that the presence of tuberculosis can be ruled out or confirmed only by a careful history, physical examination, X-ray studies, and repeated laboratory studies.

The prevalence of tuberculosis among patients with diabetes, gastric resections, chronic alcoholism, insanity, and other debilitating conditions is sometimes not properly appreciated by physicians. When there is a known history of exposure to the disease it is a mistake to check the individual once or perhaps twice over a period of a few months and overlook the fact that clinical disease may be slow to develop or may not become evident until some debilitating process lowers the resistance.

Another common mistake lies in assuming that a few fibroid or calcified deposits in one apex have no clinical significance. This is especially true when such findings are recorded on routine survey films, since the patient is entirely asymptomatic. Even more pernicious is the categorical statement by a roentgenologist that a certain lesion is of no clinical significance. Activity or communicability of tuberculosis cannot be accurately determined from X-ray studies alone. This requires careful clinical and laboratory study, often over long periods.

The course of pulmonary tuberculosis in the elderly individual varies widely. There are some who present acute exudative disease which progresses rapidly and apparently is of very recent development. Many others have chronic disease which smolders at a very slow rate with only intermittent spells of activity and liberation of tubercle bacilli. The same manifestations may be observed when the patient is under treatment.

Treatment — Fundamentally the treatment of pulmonary tuberculosis in the aged is much the same as in other age groups, but with certain exceptions. Isolation and treatment in a sanatorium are best for all concerned. Before the advent of chemotherapy, much reliance was placed on bed rest, but it was found that prolonged intensive bed-rest treatment was not well tolerated, either mentally or physically. Complications in the form of decubitus ulcers, nutritional disturbances, contractures, hypostasis, and thrombotic phenomena occurred too commonly. A more modern approach, is a program of intensive therapy with two of the drugs, streptomycin, isonicotinic acid hydrazide (INH), and para-

June, 1958 275
aminosalicylic acid (PAS), using only a moderate restriction of physical activities. Under such a program, many individuals who are advanced in years can be treated, handle their tuberculosis very well. In this category, we find that individuals who have been exposed to tuberculosis in older adults, children, and the elderly can be effectively treated with PAS. This type of treatment is often more suitable for individuals with advanced age or physical disabilities.

**Collapse Therapy** — Collapse therapy of various types, as artificial pneumothorax, extrapleural pneumothorax, plombage, or limited thoracoplasty, which have been largely abandoned in the treatment of tuberculosis in younger individuals, could be revisited. For example, in young individuals who cannot undergo chemotherapy, pneumothorax treatment may be a viable option. It can help in the regression of disease and prevent relapse without drug therapy very real.

**Resection and Other Thoracic Surgery** — Modern chemotherapy, blood transfusions, and modern anesthesia have made it possible to carry out many major surgical procedures on patients of advanced years. It is definitely physiologic age and associated conditions, rather than attained age, which is important.

There are many factors that affect the surgical risk in older patients and each factor must be carefully studied in each individual before surgical treatment can be undertaken. From the standpoint of the respiratory system alone, the extent of the patient’s disease, the amount of lung or breathing space that must be sacrificed, the vital capacity, the amount of limitation of chest wall and diaphragmatic motion, and the amount of emphysema present must be carefully evaluated. There is little virtue in curing a patient of his tuberculosis if in the process he becomes a respiratory cripple.

We cannot rehabilitate many of these patients, but if we can return them to their families without risk of contamination, it is worth the effort.

—By Thomas J. Kinsella, M.D., Geriatrics, June, 1957.

**PROTECTIVE ISOLATION OF THE TUBERCULOUS**

Compulsory isolation of the tuberculous patient was considered at a Conference on Protective Isolation of the Tuberculous, held at Denver, Colo., January 22-23, 1967. The recalcitrant tuberculous patient and methods of dealing with him have been subjects of increasing concern recently. Attending the meeting were interested persons from many fields including officials from state and national agencies, tuberculosis control officers, tuberculosis hospital directors, private practitioners, psychiatrists, sociologists, social workers, lawyers, nurses, and health educators.

**ARGUMENTS PRO**

The case for compulsory hospitalization was led by Dr. Edward Kupka, Chief, Tuberculosis Control, California State Department of Public Health. These arguments were offered:

1. Tuberculosis is a communicable disease spread from person to person. Its spread can be prevented by the identification and isolation of all grossly infectious persons.

2. The civil liberties of a citizen do not include the right to endanger the health and welfare of other citizens. It is difficult to prove that a person is recalcitrant.

3. Compulsory isolation serves as a deterrent to other individuals with tuberculosis who might otherwise fail to cooperate.

4. The truly recalcitrant patient is probably more dangerous to the public health than is the non-recalcitrant known case. As the number of infectious tuberculous patients decreases, each recalcitrant becomes relatively more important.

5. There is a small hard core of socially irresponsible persons who, in spite of a concerted psycho-social attack, will expose their fellow men to infection unless restrained.

6. Basically democratic administration of isolation laws, like all laws, is a fair general assumption in the United States today.

7. Alternatives consist mainly in preventive measures which are too costly to be practical.

8. The program has worked well in those States with both a good overall tuberculosis control program and good facilities for compulsory isolation.

**ARGUMENTS CON**

Dr. Sidney Dresser, medical director, National Jewish Hospital, Denver, led the case against compulsory hospitalization. His team set forth the following arguments:

1. Recalcitrance is not a crime and may reflect psychosocial disease in the patient or the failure of the professional staff to deal with this disorder, or both. Some of these problems result from improper handling by health officials.

2. Recalcitrance is usually preventable by proper medical, social, and psychiatric care.

3. Recalcitrants represent such a small fraction of the potential source of infection that the expenditure of time, effort, and money necessary for isolating them is not justified.

4. Enforced isolation as a rule does not make recalcitrant patients cooperative and, in fact, may drive tuberculosis underground and tend to create more recalcitrants.

5. There are adequate alternatives to enforced isolation.

6. Tuberculosis is only mildly contagious.

7. There is no evidence to show that compulsory isolation has succeeded in preventing additional cases or that incarceration has favorably influenced the infection rates in a community.

8. Since many of the patients who would be prosecuted are unable to defend themselves, such laws could easily lead to abuse by authorities. Civil liberties may be unnecessarily lost or curtailed.

9. Tuberculosis control officials have ample tools for protecting the environment from the recalcitrant. The unknown tuberculosis cases are the main hazard. The institution of forcible hospitalization would add no more to tuberculosis control than would more vigorous application of those methods now in use.

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Current Comment

One New Product Each Day—
(Continued from page 21-A)
dramatic issue of our time is whether we
want more government or more freedom,
more federal handouts and more individual
responsibility.”

Dr. Blasingame warned that medical care
has been the favorite target of those who
would like to socialize our entire economy.

“But,” he said, “if physicians and hos-
pitals are brought under government con-
tral, the drug industry soon will follow. If
the bell tolls for any one of us it will inevi-
tably toll for all.

“Physicians appreciate the support which
your industry has given us and we hope and
believe that it will continue. By the same
token, we should oppose unnecessary govern-
ment regulation of the drug industry when
it goes beyond the need of public safety.”

Mental Hospital Population Decreases—
The mental hospital population in the
U.S. has declined for the second successive
year but admissions continue to climb. New
forms of treatment for the mentally ill are shrinking the length of hospitalization.

The downward trend began in 1956 with about 8000 fewer persons in the public mental hospital population than in 1955. However, there were about 3000 more first admissions in 1956 than in 1955. It is not clear whether this is due to an increase in mental illness itself or “merely an increased use of expanding facilities.”

The new tranquilizing agents developed over the past few years have played a role in shortening hospitalization. One Veterans Administration report shows that about half of its patients under psychiatric care are receiving tranquilizing drugs “with a remarkable shortening of acute phases of illness” in many of them.

However, despite new chemical agents and improved treatment programs, mental illness still looms as one of our greatest U.S. health problems. About one out of every 10 Americans have some form of mental or emotional disorder requiring treatment. Emotional complications are an important factor in about 50 per cent of complaints voiced to the general practitioner and 30 per cent of physical ailments treated in general hospitals.

Schizophrenia ranks as the leading cause of hospitalization for mental illness, accounting for 22.6 per cent of all first admissions. Next are senile psychoses, which total 20.8 per cent. Severe alcoholism is the third leading single cause, with 13.7 per cent.

SOCIAL AND ECONOMIC FACTORS

People in the upper social and economic bracket have the lowest rate of psychoses and the highest rate for neuroses, with men outnumbering women in that bracket in both types of mental illness.

The type of mental illness varies, too, in different age groups and according to sex. For instance, few persons develop schizophrenia after 50. More women are hospitalized for schizophrenia and psychoneurotic reactions than men, it discloses. On the other hand, approximately four times as many men as women are admitted to hospitals with severe alcoholism.

The annual cost of mental illness totals approximately $2,400,000,000, “Patterns of Disease” reports, “plus the incalculable (Continued on page 47-A)
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fair or moderate ................ 8.6%
poor or none ...................... 3.6%

*Summary of published clinical studies.
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- combining musculotropic and neurotropic action
  with mild central nervous system sedation.

**dosage:** one tablet before each meal and at bedtime.

**Current Comment**

Mental Hospital Population Decreases—
(Continued from page 43-A)
losses to industry for illnesses with a psychologic component.” The care and treatment cost for each patient in a public mental hospital per year is estimated at $1,327.51 or $3.64 per patient day. This cost has increased about 11 per cent since 1956.

Despite the enormity of the problem, however, “Patterns” discloses, only about $29,484,863 is being spent annually for research—“the smallest amount for research in any medical specialty.”

A.M.A. Issues Two New Leaflets—

The personal, human qualities of medical practice are emphasized in two new American Medical Association leaflets designed for the general public. The first — “Do You Like to Make Decisions?” — states that the physician applies the “skill of his profession with the art of his understanding” in prescribing a specific treatment suited to the patient’s individual needs. In selecting a particular treatment, the doctor is guided by his knowledge of the patient and his faith in his own judgment. The second leaflet—“The Fifth Freedom” points out every American’s basic right to choose not only where he will live or the church he will attend but also the physician in whom he has greatest confidence. Free choice and mutual understanding are essential to the formation of a good doctor-patient relationship.

Both pamphlets are being distributed this month (May) to state and county medical societies for distribution at local fairs and similar public gatherings.

Guide for Committees on Aging—

“Suggested Guides for Medical Society Committees on Aging” is the title of a new booklet being prepared by the A.M.A.’s Committee on Aging for use by state and county medical societies. The booklet contains suggestions as to (1) purposes of a medical society committee on aging; (2) membership and format; (3) tenure of members; (4) meetings, and (5) activities. Copies of the pamphlet will be available from the Council on Medical Service.
Current Comment

Noise and Hearing Loss—

One of the most comprehensive studies on industrial hearing loss undertaken in this country points to the possibility of hearing damage under certain noise conditions within a few months of exposure rather than after many years, as has been commonly thought, according to a U.S. Public Health Service official. Further observation will be required to determine how much of this hearing loss is permanent and how much is temporary.

Mr. C. D. Yaffe, who is in charge of a Public Health Service study now in its sixth year, stated that industry has been aware of the noise problem for some time and has been taking steps to control it. With the increasing background of noise to which all Americans are subjected through the wider use of automobiles, trains, planes, buses, and subways, power mowers, electric shavers, vacuum cleaners, outboard motors, radio and television sets, and other sound and noise producing devices, we may be approaching the point where the hearing of a significant portion of the population is being affected. This ever-increasing exposure, he said, makes it all the more important to reduce noise in industry.

In many work situations noise exposures can produce significant hearing loss regardless of whether the individual is exposed to any noise of consequence off the job. The number of workers exposed to hazardous noise levels probably exceeds the number exposed to any other occupational hazard, he said. It may run over one million, he indicated.

Mr. Yaffe explained that adequate information is lacking on which to base standards to control noise. Such standards cannot be based solely on the amount of noise, expressed in decibel units, he said. Several factors, in addition to the decibel level, determine whether the noise is injurious. One of these, he indicated, is the character of the noise: whether it is high-pitched or low-pitched; whether it is of a continuous or an intermittent nature; and whether it has sharp energy peaks, as produced by the impact of a hammer striking metal.
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17-A
Current Comment

How Much Is Health Insurance Used?—

Two out of every five American families who are protected against the cost of illness or accident have used their health insurance in the past year to defray medical expenses, the Health Insurance Institute reports. A nation-wide consumer survey of health insurance just completed, the Institute said, shows that seven out of ten families who have such insurance have used it at some time during the period their policies were in force.

The study, conducted by an independent research organization, was undertaken to obtain information on what people know and think about health insurance, how they use it, and also how such factors as age, income, education, and place of residence are related to health insurance coverage. The survey is the first of its kind to be undertaken on a nation-wide scale for insurance companies and involved interviews with 2,000 families across the country, yielding information on more than 6,600 individuals.

On 53% of all claims, the survey reveals, families received payment on all or most of the medical bill, while in 20% of the cases payment was received for about three-quarters of the bill, and in 15% of the claims, one-half of the total expenses were paid.

Some 78% of the families using their health insurance expressed satisfaction with the service of the insuring organizations in paying benefits, while 4% were dissatisfied and 18% had no definite opinion.

These figures are said to be consistent with the generally favorable attitude of the population toward health insurance which is revealed by the survey. Some 81% of the people interviewed expressed a favorable attitude toward the idea of having health insurance for themselves, while 9% were neutral in their comments and 8% were unfavorable. Of the insured families, 90% were favorable, and 55% of the families without coverage expressed a favorable attitude.

The pattern of attitudes on this question is almost identical for those covered by Blue Cross-Blue Shield organizations and families protected through insurance companies. Nor is there significant variation in this attitude among different income groups, or among families covered through group insur-

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*See food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.
ance plans and those with individual insurance policies.

Some 25% of the families had suggestions to make for improving health insurance plans or services. Of the families with suggestions, 25% desired more information on health insurance, while 20% wanted more benefits in terms of dollars or number of days, and 14% suggested lower premium costs. The responses were found to vary little by type of insuring organization.

The survey figures are consistent with previously published data showing that nearly three out of four American families have some form of health insurance. In 73% of all families, there is some health insurance coverage and in 60% of all families every family member is protected. In 27% of families, no one is insured, the survey points out. It further reveals that men, women and children are covered with virtually the same frequency, with 69% of the men insured, 67% of the women and 66% of children under eighteen so protected.

In the selection of families to be interviewed, the survey, conducted for the Health Insurance Institute by National Analysts Inc. of Philadelphia, followed a method similar to that used by the U.S. Bureau of the Census in its sample interview surveys. The Institute study required approximately eight months to complete, with each interview lasting about one and one-quarter hours. The Health Insurance Institute is the central source of information for the nation's insurance companies serving the public through voluntary health insurance.

Hospitals and "Staph" Infections—

Measures to aid in reducing the current worldwide problem of infections in hospitals caused by antibiotic-resistant staphylococci have been recommended by the American Hospital Association.

The recommendations were included in a bulletin on "Prevention and Control of Staphylococcus Infections in Hospitals" mailed by the Association to the more than 7,000 hospitals in the United States and Canada. The bulletin was adopted by the Association's Board of Trustees at a May 13 meeting in Chicago.

"Information is inadequate as to the incidence of staphylococcus infections which are

(Continued on page 28-A)

In a recent 140-patient study¹ DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.


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"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."

MERCk SHARp & DOHME Division of MERCk & CO., Inc., Philadelphia 1, Pa.
EDITORIAL

CERTIFICATION FOR GP'S

The assumed value of "certification" by a "board" can be an illusion. Certification does have an over-all value to the profession at large; a value to the quality of specialization; a stimulus to the individual in preparation for practice and, to some extent, in postgraduate efforts to keep abreast of medical advances. "Boards" seem to have a tendency to an accretion of power and authority that sometimes threatens to defeat the purposes for which they were created. Some of them could be likened to Courts whose rules of law are self-made, exercised without restraint and from which there is no appeal.

There are many doctors practicing internal medicine, for example, who spent the required time and effort in preparation for the examinations but failed, again and again, to pass. Many of these "failures" are far from stupid. What are they doing? They are practicing internal medicine alongside of those who are certified; they are just as highly respected as their comrades; and what is more, most of them are just as good internists. They might be prevented, at some time or another, from getting appointments where certified internists are required, but, in general, they enjoy all the privileges and emoluments of the "diplomate."

Now, judging from the writings of the general practitioners, many of this great group are seriously disturbed about the possibility or the advisability of developing a board of certification. They wonder whether they should promote or resist it; they fear that if the American Medical Association is permitted too great a hand in forming such a board it may favor the internists because some have predicted that future general practitioners may all be internists. The arguments, pro and con, present all sorts of views; they remind one of the man who dashed out the door, leaped on his horse and rode away in all directions.

It is not to dampen the ardor expressed in arguments that we presume to write about this subject but to promote argument based upon deep consideration of all sides of the question. All the possible benefits should be contrasted, critically and honestly, with all the elements that may be harmful—harmful to the general practice of medicine, to the generalist himself, and to those good people he must serve to the best of his ability. The generalist need not worry about other specialists encroaching upon his field. Any internist or other specialist who turns to general practice will probably be a good generalist but a proportionately poor specialist.

It has been said that the surgeon is a general practitioner who operates, and an internist is a general practitioner who does not have the advantage of surgical fees. In all probability the generalist will remain as safe from poachers in his field as he has been in the past. Therefore, he should make his decision about a board on other, more fundamental grounds. If possible, such a board of certification should be kept more responsive to the will of those it serves and somewhat less autocratic than those we have as examples.

BLUE SHIELD—AMERICA'S UNIQUE CONTRIBUTION

(A Guest Editorial)

In these days of instantaneous communication and over-night travel to the most remote places in the world, few nations can claim any social ideas or innovations as exclusively their own.

But the fact is that in the field of medical economics American medicine has produced a program that is uniquely American. There is nothing comparable to Blue Shield in any other nation today.

Specifically, in no other country has the medical profession been able to develop a non-profit plan for medical care prepayment in which the participation of both patient and doctor is voluntary, there is complete freedom of choice for doctor and pa-
tient, services are paid for on a fee-for-service basis with the payments subject to medical control, in which there is no third party to regulate the doctor's practice, and no governmental agency has contributed one cent of direct subsidy to the program.

As a spokesman for the World Medical Association the "international voice of organized medicine" representing 750,000 physicians in 53 nations of the "free world," said recently: "American physicians are singularly fortunate in having met their social and economic problems by voluntary action, turning back the threat of political domination."

Of course the plain fact is that although physicians have met their social and economic problems, they are still a long way from solving them. Through their own Blue Shield program, and with the help of the many commercial companies that have followed the trails blazed by Blue Shield, physicians have made a strong and substantial beginning toward providing basic medical care security for all of their patients.

But there are big and difficult problems yet to be solved — in the care of long term and chronic illness, the aged, the rural populations, the indigent, etc.

Blue Shield offers us a unique instrument with which to tackle these problems. Whether or not it will yet suffice to save America from resorting to the state Socialism and the compulsory solutions that most other countries have adopted will probably depend on the vision and the energy and the public spirit which every doctor brings to the support and guidance of his own Blue Shield Plan. (Blue Shield Commission).

HALF A CENTURY OF SERVICE

We know there are always among us doctors who have practiced medicine half a century. What we may not realize is the meaning of each of these half centuries to the doctor, to his family, to his community, or to the human race. Only experience can impress these things upon us. It is difficult to visualize the work and worry; the effort to keep abreast of the march of medicine; the changes in manner of thinking and action that must be made again and again to mold these fifty years into a life of good service to humanity; the personal trauma that comes with failures; the sense of triumph with success and the final recognition of approaching obscurity long before all the plans have been fulfilled.

It is even unlikely that the doctor who approaches the Fifty-Year-Pin ceremony ever sat down in solitude and added up the accounts of his years in terms of pleasure and pain; of good and less than good; of what he might have done in contrast with what he did; of the deep values of his personal service to himself, his family, his friends, his people.

Some such thoughts as these undoubtedly stirred the hearts when the Fifty-Year-Pin ceremony was performed again at the Annual Banquet of the Ninetieth Annual Session of the Nebraska State Medical Association, April 30, 1958. The following named doctors of our State participated in the ceremony and received their pins:

Alfred E. Brown, M.D., Omaha
George E. Charlton, M.D., Norfolk
O. G. Longacre, M.D., Rising City
Charles J. Nemec, M.D., Omaha
John E. Simpson, M.D., Omaha
William L. Sucha, M.D., Omaha
I. L. Thompson, M.D., West Point
C. J. Verges, M.D., Norfolk
George H. Walker, M.D., Lincoln
E. A. Watson, M.D., Grand Island
C. D. Williams, M.D., Genoa

Let us hope that these fine old doctors will now take the time to cast up their accounts; that they will discount or blot out of memory all the unpleasant in favor of enjoying to the utmost every good and soul-satisfying feature of the past half century. Let that half-century mark not be a graduation but a commencement in their experience; let them look forward to the next half century and enjoy to its fullest every day of it that is granted to them.

Women, traditionally the weaker sex, are rapidly becoming much harder than men in one major health area, according to a new publication, Patterns of Disease, prepared by Parke, Davis & Company for the medical profession.

It shows that while in 1915 the two sexes faced the same death risk from heart disease, the death risk for women is now one-half of that for men.
Recent Important Developments in Dermatology*

Doctor Woodburne calls attention, in this article, to the increased number of skin reactions to drugs coincident with the great increase in number and change in character of drugs and chemicals being used as medicines. Furthermore, the character of the lesions of the skin differs from those previously seen to result from a more limited group of drugs. The author points out that the therapy of the newer types of lesions differs, also, from that formerly in vogue.

—EDITOR

Most of our new developments that would interest this group I am sure are in the field of treatment and we will spend some time on this. There are, however, a few new things in the way of skin reactions to some of the newer drugs that should be of interest.

Until a relatively short time ago only a few drugs were even considered as causes of eruptions. In Kaposis' text on dermatology, published in 1898, only thirteen drugs are mentioned as causes of rashes; these were quinine, opium, morphia, chloral, chloroform, turpentine, digitalis, antipyrin, phenacitin, rhubarb, mercury, iodine and bromine. In the texts on dermatology thirty-five years later, Kaposis' list was not greatly increased. Arsenic, phenolphthalein, barbiturates, and salicylates were the chief additions. Clinically, drug eruptions were, and still are, classified into several types: maculo-papular or morbilliform; erythematous or scarlatiniform; urticarial; purpuric; vesicular or vesiculo-bullous; erythema multiforme-like; nodose; or fixed drug eruption. They generally occur with sudden onset, are widespread in distribution, inflammatory in appearance, and pruritic. The recognition of these eruptions is relatively simple since they followed a definite morphological clinical pattern. In many instances, where the clinical features are atypical, the diagnosis of drug eruptions can be made on the basis of exclusion of disease-causing exanthemata.

In 1937, Newman and Sharlitz¹ described a new type of drug reaction, "a sulfanilamide photosensitizing eruption." Because of its resemblance to the photosensitive porphyrias, the only previously known photosensitive eruption, they postulated that the mechanism of the sulfanilamide photosensitivity was caused by abnormal formation of porphyrins. Many weeks were spent looking for porphyrins in their patients, chemically and spectroscopically, without results. This was the first recognized instance in which a drug produced a reaction simulating a known disease. Since then, of course, other drugs have been recognized as capable of producing eruptions due to photosensitization (e.g., penicillin, quinidine, chlorpromazine) as well as simulating other known diseases. Actually, most of the untoward reactions to drugs occur as skin eruptions. Systemic reactions are in the minority and appear principally as blood dyscrasias, serum sickness-like reactions, bronchial asthmatic attacks, periarteritis nodosa, conjunctivo-retinitis, and anaphylactic shock.

We must now recognize that cutaneous reactions to drugs are becoming more complex and more imitative of known disease, particularly in the face of the volley of new drugs being hurled at both physician and patient. In addition to the foregoing examples of altering forms of reactions from the classical types (maculo-papular, erythematous, urticarial, vesiculo-bullous types, etc.), dermatologists have been aware of other such imitative cutaneous reactions in recent years. The lichen planus-like reaction to atabrine seen during World War II gave rise to considerable consternation even though lichen planus-like reactions to gold and arsenic had been noted previously. Seborrheic dermatitis-like eruptions from gold, pemphigus vulgaris-like eruptions from sulfonamides, and disseminated lupus erythematosus-like eruptions from Apresoline are further examples of the mimicry of drug eruptions. My associate, Dr. O. S. Philpott² reported in 1947, in the Archives of Dermatology, on
“Sulfonamide Psoriasiform Dermatitis.” Here, both the clinical and histologic pictures were typical. The grouping of these disease-simulating reactions to drugs should help to focus our attention on their increasing frequency and to promote their early recognition.

Although much has been written about so-called “drug allergy” no progress has been made in determining the mechanism of drug allergy or hypersusceptibility reactions, until very recently. During the past five years several basic investigations have demonstrated that certain drug reactions may be caused by hereditary deficiencies in cellular enzymes. A group of individuals with deficient sulfhydryl groups in their red blood cells have been known to develop hemolytic anemia from an average dose of certain antimalarial drugs. A similar enzymatic deficiency in the liver has been postulated for the mechanism of intermittent prophylaxis precipitated by barbiturates or alcohol. Hence, it is possible that in the near future, with increased knowledge of the metabolic fate of various drugs and with the development of methods of studying the enzyme reactions, we may be able to elicit the pathogenesis of drug eruptions; and this in turn may well uncover the pathogenesis for many of our troublesome cutaneous diseases.

Kynex\(^{R}\), a new sulfonamide claimed to be much less toxic, has proved to be not entirely innocuous. We have seen three patients in the past six months with vesicular erythema multiforme-type eruptions as a dermatitis medicamentosa from its use. One was very sick with temperature up to 105° F. Kynex\(^{R}\) is a less toxic sulfonamide but not without some of the dangers of previous drugs in this group.

The Rauwolfia compounds have been used very extensively, and in recent months we are beginning to recognize a specific dermatitis medicamentosa from this group.

The eruption here begins as asymptomatic tiny purpuric macules and papules about the ankles. These fade, leaving small hemosiderin freckles. As the eruption progresses, new lesions develop further up the leg, thigh and lower trunk, the individual lesions get larger and after a few months may form palm sized plaques. The eruption fades in a few weeks after the drug is discontinued and recurs in five to seven days after the drug is again taken. This eruption strongly suggests a purpura simplex, however, capillary fragility studies, and hematologic work-up are entirely negative.

Meprobamate (Miltown) has proven to be the cause of nummular eczema in certain cases. We have seen, for years, coin-like, round eczematous patches developing on the arms, legs and trunk, particularly in cold weather, which would ordinarily respond to colloid or oil baths, stimulation with ichthyol or tar ointments, the use of topical neosporin or hydrocortisone, alone or in combination, X-ray therapy and staphylococcus toxoid injections. Several patients with this type eruption were seen who failed to respond to any of the above methods of treatment. They cleared immediately when Miltown was discontinued and flared promptly when the use of this drug was resumed. It is, therefore, important for us all to inquire into the history of the use of drugs of this type when investigating a case of nummular eczema.

Amphetamine compounds are used more and more extensively in the program of weight reduction; despite this, untoward reactions to their use have been rare. We have seen a few cases of dermatitis medicamentosa produced by these drugs which have been characterized by the features of a photosensitive eruption. The patient developed bright red edematous papules on exposed surfaces, largely the lateral surface of the arms, the V of the neck, and the malar areas of the face. These papules enlarge, sometimes become confluent to form large patches, and may fuse to form a diffuse erythematous dermatitis of all exposed areas. The eruption has cleared under therapy after discontinuing the drug only to recur within several hours after taking a single dextroamphetamine tablet.

The newer antitubercular drugs have been prone to produce various untoward skin reactions. Streptomycin and dihydro-streptomycin are strong epidermal sensitizers and have proved to sensitize many of the nurses giving this medicine producing, often, a violent contact dermatitis of the hands and face. When given parenterally these drugs have produced patchy eczematous dermatitis which has gone on to generalized exfoliative dermatitis in the more acute reactions and have produced localized patches of simple lichenification resembling entirely the patches of localized neurodermatitis in more
chronic forms. INH (Isoniazid, Lilly) has produced vague scaly, patchy dermatitis, particularly of the trunk. The differential diagnosis between this and pityriasis rosae is often difficult. Paraminosalicylic acid also produces usually macular, sometimes morbilliform and sometimes scaly eruption of the trunk and extremities.

Chlorpromazine, a commonly used tranquilizer, has been incriminated in the production of an obstructive type jaundice due to damage to liver sinuses. It is also a violent epidermal sensitizer and we have had several nurses and physicians who had to give up entirely handling the drug. The dermatitis venenata which chlorpromazine produces is often aggravated by light, and other chemicals more easily irritate after Thorazine sensitization.

So much for untoward reactions to newer drugs. We will now discuss the use and abuses of some new products.

When the antihistaminic drugs first came out they were used for everything and without any reason. By this time their usefulness is fairly generally understood, and, in most instances, they are used with discretion. They are still employed extensively in the handling of contact dermatitis. Since this is an epidermal sensitization and not a histamine vascular reaction, there seems to be no logical use for these drugs in this situation. To excuse their use here, most of them have some antipruritic effect. We have had for clinical trial Temaril, one of the antihistamine group, which is being evaluated by the University of Pennsylvania as an internally administered antipruritic pure and simple. In some cases it has proved excellent but in many, I am sorry to say, it is not particularly valuable. It comes in 2.5 and 5 mg. tablets and may be taken as much as 8-12 a day without untoward effects.

Ten or fifteen years ago Urbach suggested that the skin in certain diseases became overloaded with sugar. He termed this cutaneous diabetes and showed that this condition was often the predisposing cause of chronic and recurrent pyodermia, abscesses, boils et cetera. Orinase, the new oral antidiabetic drug, has been used with marked success in handling these conditions. Orinase gm. 0.5, one tablet twice a day, produces very nice results and is helpful in deep infected acne as well.

The large group of ataractic drugs now available have been helpful in disseminate neurodermatitis but have given us no dramatic results.

The corticosteroids have been of tremendous help but at present are in the phase of being used for most everything. We rarely see a patient now who has not taken steroids internally or by topical application. Topical steroids are helpful in small areas of localized neurodermatitis such as anal and vulvar pruritis but are dangerous and too expensive to use on large areas.

There are two groups of dermatoses in which systemic use of the steroids is best. The first group consists of acute self-limited dermatoses such as poison ivy dermatitis and other acute contact dermatitides, dermatitis medicamentosa et cetera. Here we know the steroid will be required for only a week or ten days and will give immediate relief.

The other group of dermatoses are those fatal or extremely serious in which we plan on steroids indefinitely and in which they are necessary for preservation of life or comfort for the patient. In this group are pemphigus, disseminate lupus erythematosus, exfoliative dermatitis and, in some cases, severe generalized atopic dermatitis. Here the drug is pushed until symptoms and signs are controlled, then tapered off to a maintenance level. In pemphigus and disseminate lupus erythematosus the dose sometimes is pushed very high to control at first, and we at times combine ACTH with one of the oral steroids to get best results. Most of these cases can be brought under control with (ACTH), corticotropin 80 U. in saline intravenously and 60-80 mg. of Meticorten orally, daily. However, some very acute fulminating cases of both diseases frequently require tremendous doses. We had one patient with pemphigus, who died despite 3000 mg. of cortisone and 100 U. ACTH daily. The one thing that the steroids did accomplish was to make her sufficiently euphoric that the disease and death was of no consequence to her. Maintenance doses in the atopic group usually can be as low as 5-10 mg. Meticorten a day. In the others 10-30 mg. is required.

The new oral steroids Medrol, Aristocort, and Kenicort have been used for too short a time to know whether they will be as effective as the older drugs. It is the feeling of those at the University of Colorado who
have used them more than we have that their anti-inflammatory action is less marked than that of prednisone and hydrocortisone. Water retention is often as marked as with the earlier steroids. They also have added some new complications such as severe muscle cramps and wasting which continues after they are stopped. Oral reports indicate also that all the previous complications are seen.

Amphotericin B, a new antibiotic, has shown very great promise in several systemic fungus infections. I have recently seen unpublished reports of eight cases of disseminated coccidiomycosis all showing marked benefit. Twenty-four cases of cryptococcosis were apparently all cured despite the almost universal mortality previous to the use of this antibiotic. One case of cryptococcosis meningitis which we followed personally was almost moribund when treatment was started. She was clinically well in four weeks, and seven months after therapy her spinal fluid is still free of organisms.

Histoplasmosis responds almost as dramatically as cryptococcosis and marked improvement was reported in four cases of systemic moniliasis. Blastomycosis, six cases, were reported with excellent results. We can add one of our own who had forty-two days of treatment with complete clinical cure of epididymitis, skin ulcers, osteomyelitis and pulmonary infiltration.

Amphotericin B at first could not be dissolved and severe reactions were encountered from its use; however, it is now combined with sodium desoxycholate. Each ampule contains 50 mg. of the antibiotic and 43 mg. of the desoxycholate. When the content of this ampule is added to 5 per cent dextrose a clear solution is produced. Ten cc. of 5 per cent dextrose should be injected into the ampule and agitated thoroughly until a clear solution is obtained. Each cc. of solution then contains 5 mg. of Amphotericin B activity. Calculated amounts may then be withdrawn from the vial. The amount to be injected should be diluted in 5 per cent dextrose to an optimum concentration of 1 mg. per 10 cc. of solution. Saline must not be used to dissolve this antibiotic since it precipitates it from solution. In the refrigerator the solution is stable for twenty-four hours and the powder for six months. Only clear solutions should be injected and very slowly over approximately six hours. Our routine at present is to give 0.10 mg./Kg. the first day; 0.25 mg./Kg. the second day; 0.50 mg./Kg. the third day; 0.75 mg./Kg. the fourth day and 1.0 mg./Kg. the fifth day. Thereafter 1.0 mg./Kg. daily. Reactions of malaise, fever, nausea et cetera may be prevented frequently by premedication of aspirin or antihistaminics. It is wise to stop the flow of the infusion and watch the patient if he has a reaction. Spasm and thrombosis of veins used for injection is one of the annoying complications of this therapy.

Periodic check of the blood, urea-nitrogen, non-protein nitrogen, liver and kidney function and bone marrow should be done. Reactions causing much distress may be decreased by giving injections only every other day. Intrathecal and intramuscular use of the drug have been employed with success; however, the intramuscular use is less effective than the intravenous.

One recent development in dermatologic therapy has received much lay publicity; that is, dermabrasion or skin planing. We have followed a large series at Fitzsimmons Army Hospital, the University of Colorado, and in our own office. We are now much more conservative in promising results. We have had excellent results in fairly flat acne scars. We have had some good results in ichthyosis hystrix and some other benign nevoid conditions and especially gratifying results in deep scarred cystic acne as often seen on the back of the neck. A new development in the treatment of keloids consists of planing them to the surface and following this with X-ray therapy to prevent overgrowth of scar. The characteristic grooves and ridges of the tips of the fingers may be obliterated by this modality without leaving residual scarring.

REFERENCES

DOCTOR — Does your wife like to read the Auxiliary news? Then be sure and take your copy home.
The
Nervous System in the TREATMENT
of
Acute Chemical Poisoning

Doctor Aita emphasizes, in this article, the difficulties of diagnosis and treatment, the need to identify the poison concerned, the necessity of teamwork, the necessary finesse of judgment, and the promptness with which one should anticipate and meet the emergencies when dealing with poisoning by one of the many commercial poisons now used on farm and in the home. While he deals primarily with the effects on the central nervous system, other serious effects are indicated and their concomitant treatment suggested.

—EDITOR

EVERY day in this country, eight people die of accidental or intentional poisoning1. Many more survive through vigorous therapeutic effort. Children are frequent victims.

Approximately 40 classes of chemicals found today in commercial products for home and farm use2,3, and approximately 30 classes of medication4,5 used at present have considerable potential for toxic involvement of the nervous system. (Table 1).

| TABLE 1 |
| SOURCES OF EXOGENOUS POISONING |
| 1) Commercial and chemical products used in the home or on the farm. |
| 2) Medications, commercial and prescribed. |
| 3) Industrial materials (including air pollution). |
| 4) Laboratory and research materials. |
| 5) Biological toxins. |
| a. Food poisoning, including mushrooms and botulism. |
| b. Insect, spider, scorpion bites. |
| c. Snake bites. |

Competent treatment requires more consideration than gastric lavage, instillation of antidotes and symptomatic grapping.

TREATMENT IN GENERAL

It is not within the scope of this paper to discuss in detail all of the dimensions of treatment of acute poisoning. We have limited ourselves to one aspect, the neurologic, and the reader is urged to consult other texts6 for details of the total problem and its many facets. Though the magnifying glass is turned on one aspect, that must be understood in its proper perspective and place, actually, the whole organism, struggling to regain homeostasis, is under treatment. Therapy of acute poisoning is multidimensional and the therapist must be recognizing and treating several physiologic disturbances simultaneously. (Table 2).

| TABLE 2 |
| TREATMENT OF ACUTE POISONING |
| Stage One |
| 1) Detoxifying; universal antidotes. Hemodialysis in some cases. Exchange transfusions? |
| 2) Preventing aspiration into bronchial tree. |
| 3) Identifying the poison (or poisons) and recalling that the vehicle may be, at least in part, culpable. |
| 4) After some definitive knowledge of the poison, or its type, knowing then: |
| a. The more or less specific antidotes. |
| b. Specific contraindications advisable with certain poisons. |
| c. What to expect from this particular poison; its characteristic, acute effects (for instance, pulmonary edema, hemolysis). |
| 5) Urgent supportive treatment in one or more of the following disturbed, critical areas: |
| a. Respiratory system. |
| b. Circulatory system. |
| c. Nervous system. (Table 3). |
| d. Blood constituents, including hemoglobin, glucose, electrolytes, pH, and fluid balance. |
| e. Occasionally gastrointestinal system (with markedly irritating or corrosive poisons). |

| Stage Two |
| 1) Gastrointestinal system (if this were not a primary problem during Stage One). |
| 2) Hyper- or hypothermia. |
| 3) Kidney (and bladder). |
| 4) Liver. |
| 5) Prevention of infection (for instance, pneumonia). |

| Stage Three |
| 1) Lingering, subacute problems from the above stages (for instance, respirator). |
| 2) Stasis and prolonged coma. |
| 3) Nutrition. |
| 4) Suicidal precautions (poisoning may have been due to suicidal attempt). |
| 5) Residuals. |
| 6) Convalescence and rehabilitation. |

JOHN A. AITA, M.D.
Associate Professor of Neurology and Psychiatry.
University of Nebraska College of Medicine
Omaha, Nebraska

July, 1958
The type of poison and its vehicle must be identified if at all possible. Consequently, with the physician busy in therapy, his detectives may have to search texts of toxicology or call, long-distance, to the manufacturer, a department of pharmacology, or the United States Public Health Service for up-to-date information (especially regarding "specific" antidotes, therapeutic measures, and particularly touchy contraindications in treatment) on less well-known poisons.

The first stage of therapy calls for a quick assessment of what is taking place, what is probably taking place, and what is going to take place. The talents of several specialties are often required — definitive, sensitive knowledge concerning function of the lungs, heart, blood vessels, nervous system, fluids, pH, and electrolytes. The services of an anesthesiologist may be invaluable for his abilities with respiratory problems, endoscopy, therapy of shock, narcosis, anoxia, and depressed medullary function. Children and the elderly may require the knowledge and finesse of someone acquainted with the physiologic peculiarities of those age-groups.

The value of supportive treatment cannot be over-emphasized. To expect detoxification, antidotes, and symptomatic management to accomplish most of the responsibility is erroneous. The respiratory system will be closely attended to maintain a clean respiratory tract and unobstructed, effective oxygenation. Pulmonary edema may require preventive or active management. The vascular system may present problems of angitis; damage to capillaries, arterioles and venules; spasm or dilatation; congestion, sludging, and thrombosis; marked transudation and loss of fluid; hemolysis; hemorrhage. Vasomotor function may be altered by direct or medullary effects, transudation and oligemia, physical shock and hemorrhage to effect dangerous degrees of hypotension. The heart may be affected by disturbances of pacemakers or the conduction system, reduced effectiveness due to excessive tachycardia, and occasionally, ventricular fibrillation and arrest. Toxie "myocarditis," myocardial failure, acute left ventricular failure (with acute pulmonary edema), and myocardial infarction are all common possibilities.

Table 3 outlines the principal neurologic problems confronting the therapist.

### TABLE 3

THE NEUROLOGIC CONSIDERATIONS

1) Pain, distress.
2) Toxic stimulation of nervous system (excitement, delirium).
3) Convulsions; decerebrate rigidity.
4) Toxic depression (narcosis) of nervous system.
5) Striated muscle paralysis.
6) Tetany.
7) Other acute neurologic concomitants.

### PAIN, DISTRESS

Pain, subjective distress, and fear are often prominent features of acute poisoning. There is a high priority on these considerations in treatment, not only from a humanitarian standpoint, but also in that they may contribute to a vicious cycle of inability to cooperate, “fighting” therapy, loss of desire to survive, exhaustion, untoward reflex and hormonal changes, and excessive use of functions (pulmonary, heart) already strained. Physical discomfort has some diagnostic value and also helps to suggest the trend of events. (Table 4).

Table 5 outlines the therapeutic problem.

### TABLE 4

CAUSES OF PAIN AND DISTRESS IN ACUTE POISONING

1) Local, external irritative and corrosive effects. Eyes, mouth, nasopharynx, skin.
2) Gastrointestinal irritative or corrosive effects and smooth muscle spasm.
3) Respiratory impairment and hypoxia.
4) Circulatory failure.
5) Stimulation (toxic) of central nervous system.
6) Emotional excitement; occasionally an underlying psychiatric condition.
7) Skeletal muscle pain and spasm.
8) Therapeutic measures such as intubation, venepuncture, tracheotomy.
9) Concomitant physical injury (e.g., fractured rib, peripheral nerve contusion).
10) Distended viscus: bladder, stomach.

### TABLE 5

TREATMENT OF PAIN AND DISTRESS IN ACUTE POISONING

1) Seek definitive causes.
2) Attend to hypoxia and circulatory failure.
3) Chemotherapy.
4) Physical measures.
5) This problem may overlap much with the next: toxic stimulation of the nervous system.

Analgics drugs may not always be required. At times the antispasmodic drugs, such as atropine or methadone bromide (Banthine), occasionally even nitrates, topical or local anesthetics, hot or cold applications, sedatives or tranquilizers are useful.
What one hesitates to use, of course, are narcotics, because there is risk of contributing now or later to dangerous depression of vital medullary centers. Simple aspirin or aspirin-phenacetin-caffeine compound, when practical, must not be overlooked in quest for analgesia. A new, non-narcotic analgesic, dextropropoxyphene (Darvon), appears to be useful, in 64 mg. doses.

However, knowing the poison and its usual features (particularly that it is not a potent depressant whose full-blown effects are not yet felt), anticipating no later great need for anticonvulsants or tranquilizers which may be additive, having the “feel” of some trend in the case at hand and appraising the indications as important, the physician will use narcotics for relief of physical pain. Codeine or meperidine hydrochloride (Demerol) are preferable, having less depressing medullary effects or likelihood of causing or aggravating acute brain-syndrome (toxic delirium).

TOXIC STIMULATION OF THE CENTRAL NERVOUS SYSTEM

The clinical picture of acute chemical stimulation of the nervous system is comparable to that seen in progressive dosage with amphetamines, strychnine, or picrotoxin (although these each act primarily at different levels of the nervous system). The onset is often quite similar to that seen in acute alcoholic intoxication with excitement, increased psychomotor activity, grandiosity, and uninhibited activity. The mood often becomes quite labile — facetious, euphoric, whimsical, quickly irritable, or tearful. The individual is said to be “high” or “hyper;” he is restless, agitated.

With progression, emotional distress grows and lingers—marked anxiety, tension, panic, and dread. Though sensorium is clear, thoughts rush continually and under pressure. Gradually confusion sets in with a picture of excited delirium (acute brain-syndrome) or hallucinosis. Motor spasms, tremors, and twitches may build up to near convulsive levels. Behavior may become increasingly frenzied, manic, psychotic. Grand mal convulsions are common with this syndrome. (Tables 6 and 7).

1) It may cause direct and critical exhaustion of vital medullary centers.
2) Already limited cardiac and respiratory functions are strained further. Rest and basal conditions may be vital for recovery, for instance, with pulmonary edema, myocardial failure. Hypoxia aggravated by activity may further depress (narcotize) medullary centers.
3) It causes great anguish to the patient.
4) It is a problem of physical management. Cooperation is difficult to obtain. The patient is at least restless and distracted, at times frenzied or combative.
5) The patient may injure himself or others (falling, running, striking, in desperation).

**TABLE 7**

CAUSES OF STIMULATION OF NERVOUS SYSTEM IN ACUTE POISONING
1) Basic, direct effect of the poison on the nervous system.
2) Transient pseudostimulation due primarily to depression of inhibitory or controlling functions.
3) Pain and distress problems (see Table 5).
4) Early loss of critical cerebral support due to respiratory or circulatory failure.
5) Excessive analeptic (stimulant) chemotherapy.

To know the poison is to know what to anticipate. In some cases stimulation may be transient and “benign” and require no therapy. In other cases, it may herald the onset of considerable depression of the central nervous system. In some cases, prolonged or severe stimulation itself leads to medullary depression if it is not effectively curbed. Management must be guarded or vigorous accordingly. (Table 8).

**TABLE 8**

TREATMENT OF STIMULATION OF NERVOUS SYSTEM IN ACUTE POISONING
1) Seek definitive, treatable causes besides the direct effect of poisons on nervous system.
2) Reduce sensory stimuli, environmental excitement, provocative medical procedures.
3) Treat hypoxia and circulatory failure.
4) Physical restraint.
5) Physical sedative measures: packs, tubs.
6) Chemotherapy.

The progression of hypotension, myocardial failure, hypoxia, or the continued direct effects of the poison may becalm many cases of psychomotor excitement. Excitement often leads to exhaustion and thus may be self-limiting, even dangerously so. (Tables 9 and 10).

**TABLE 9**

PSYCHOMOTOR EXCITEMENT requires direct, aggressive treatment when:
1) There is risk of physical strain and exhaustion of vital functions: medullary, heart, respiratory.
There is need for restraint for medical or surgical treatment.

3) This causes great emotional distress to the patient.

TABLE 10

PSYCHOMOTOR EXCITEMENT may require judicious “neglect” when:

1) There is minimal, if any, risk of exhaustion of vital functions.

2) Restraint is not needed for medical or surgical reasons.

3) Anguish to the patient is not great. (One does not risk chemotherapy for the “looks of the thing,” for the tranquility of hospital personnel nor for the hospital “routine.”)

4) The basic or subsequent, rapid and direct effects of the specific poison are anticipated to be depressing (narcotizing) on medullary centers.

5) It is likely caused or aggravated by early loss of cerebral support (anoxia, acidosis, hypotension, etc.) which should be sought and treated.

It is inadvisable to try to abolish completely the clinical manifestations of excitement. Under-treatment is less dangerous than overtreatment in most cases.

TABLE 11

CHEMOTHERAPY OF TOXIC EXCITEMENT

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Adult Dose</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promethazine</td>
<td>I.M.</td>
<td>25-50 mg.</td>
<td>Repeat if necessary</td>
</tr>
<tr>
<td>(Phenergan)</td>
<td>I.V.</td>
<td>25-200 mg.</td>
<td>after 15-30 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>very slowly to</td>
<td>desired end-point</td>
</tr>
<tr>
<td>Promazine</td>
<td>I.M.</td>
<td>25-50 mg.</td>
<td>Repeat if necessary</td>
</tr>
<tr>
<td>(Sparine)</td>
<td>I.V.</td>
<td>25-200 mg.</td>
<td>after 15-30 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>very slowly to</td>
<td>desired end-point</td>
</tr>
<tr>
<td>Mepazine</td>
<td>I.M.</td>
<td>25-50 mg.</td>
<td>Repeat if necessary</td>
</tr>
<tr>
<td>(Pacatal)</td>
<td>I.V.</td>
<td>25-200 mg.</td>
<td>after 15-30 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>very slowly to</td>
<td>desired end-point</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>I.M.</td>
<td>25 mg.</td>
<td>repeat if necessary</td>
</tr>
<tr>
<td>(Thorazine)</td>
<td>I.V.</td>
<td>25-200 mg.</td>
<td>after 15-30 minutes</td>
</tr>
<tr>
<td>Reserpine</td>
<td>I.M.</td>
<td>1-5 mg.</td>
<td>repeat 2 mg. after</td>
</tr>
<tr>
<td>(Serpasil)</td>
<td></td>
<td>30 minutes</td>
<td>if necessary.</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>Oral.</td>
<td>400-800 mg.</td>
<td></td>
</tr>
</tbody>
</table>

With prior narcotics, sedation, or acute alcoholic intoxications, a cautious approach with one-third or one-half above doses is indicated.

If the patient’s physical condition permits, he may do best by being “turned loose” in a quiet, well-lit “disturbed room.” Physical restraints may be indicated for urgent medical purposes and at least briefly in some instances; leather cuffs and belt, sheets or a net over the bed. Such restraints are useful as emergency measures only and are fraught with risks of the patient “fighting them” thus increasing his terror and exhaustion.

Cold or warm wet-sheet packs, long useful in psychiatric treatment, have valuable sedative effects if personnel know how to use them. Psychiatric texts describing nursing procedures will detail their correct application. In this day of chemotherapy, these older, useful modes of treatment are no longer stressed, and it is the rare nurse or doctor who can skillfully apply sedative packs today. Warm tub hydrotherapy (“continuous warm tub”) may also prove useful, if available. These physical sedative measures are especially valuable where potent chemotherapy (sedatives, tranquilizers) is contra-indicated.

Of chemotherapies, there are two main groups: The time-honored sedatives (paraldehyde, chloral hydrate, barbiturates) and the newer tranquilizers. Narcotics are contraindicated for the primary treatment of toxic excitement.

The tranquilizers have the advantage of less depressive effect, quieting psychomotor activity more specifically with less effect on consciousness and medullary centers. However, they may (some in particular such as chlorpromazine and reserpine) have important hypotensive effects at a time when this is particularly undesirable.

The tranquilizers have greatly simplified the treatment of acutely disturbed patients. Sedatives are more likely to depress the total nervous system, including medullary centers, and to cause stupor. The present trend, therefore, is away from the use of traditional sedative medicines, though they may still be valuable if:
1. In a given patient, tranquilizers have no effect or untoward effects. Remember, however, that sedatives plus tranquilizers are additive.

2. Convulsions are present or are anticipated as a problem (tranquilizers are ineffective with acute toxic convulsions).

CHEMOTHERAPY: TRANQUILIZERS

Recalling (1) that the excitement stage may bring about or be followed by central depression with a number of absorbed poisons, and (2) that it is not necessary to "anesthetize" the patient, the physician has chemotherapy for consideration as outlined in Table 11.

CONVULSIONS

Principal considerations are outlined in Tables 12 through 16.

Cautions are cited in Table 14 to provoke thinking before using depressive, sedative medicines which may only add to the physiologic confusion and toxicity. It may be best to tolerate an occasional seizure than to struggle with an over-narcotized, non-breathing patient.

Note again and again that neurologic chemotherapies require skill, aggressiveness, and experience to steer in what may be a narrow margin between:

1. Using enough chemotherapy to attain therapeutic effectiveness.
2. Stopping short of adding to critical depression of vital medullary centers.

**TABLE 12**

**CAUSES OF CONVULSIONS IN ACUTE POISONING**

1) Direct chemical stimulation of the central nervous system.
2) Rapid or abrupt loss of critical cerebral support due to failure in ventilation, blood constituents, vascular channels. Convulsions appear as these vital needs fall quickly, as anoxia, exhaustion and circulatory failure rapidly appear. Other rapidly appearing physiologic alterations may affect cerebral neurons, such as acidosis, cerebral edema, hypoglycemia, hyperthermia and electrolyte changes.
3) Late grave, cumulative and near-terminal loss of cerebral support.
4) Patient has a low convulsive threshold. This may be "constitutional" or due to drug addiction, alcoholism, etc.
5) Chemotherapy: Excessive analeptics (stimulating drugs).
6) Concomitant structural cerebral pathology: Cerebral thrombosis, embolism, hemorrhage, edema; injury from a fall or prior convulsion.

**TABLE 13**

**CONVULSIONS**

present the following concerns:

1) Each seizure means that medullary vital centers are directly and violently stimulated, then exhausted.
2) Each seizure is accompanied by anoxia (especially critical since anoxia may further narcotize medullary centers).
3) Each seizure requires considerable physical exertion, exhausting peripheral musculature, straining respiratory and heart function.
4) Each seizure may indicate rapid or continued rapid deterioration of critical cerebral support (respiratory, blood borne, vascular, cardiac, etc.)
5) Each seizure presents mechanical problems of managing someone in convulsions. Risks of injury; post-seizure confusion.

**TABLE 14**

**CHEMOTHERAPY FOR CONVULSIONS**

inadvisable if there is:

1) An isolated seizure and no definite reason to expect more.
2) An occasional seizure, every half hour, especially if mild and brief, with good restitution and no ill effects.
3) No trend appearing to indicate frequent or increasing seizure activity.
4) Important cause for convulsions from other supportive functions, tangible and amenable to therapy (for instance, rapidly developing anoxia, acidosis, etc.)

**TABLE 15**

**TREATMENT OF CONVULSIONS IN ACUTE POISONING**

1) Airway and oxygen during and following each seizure.
2) Artificial respiration or positive pressure oxygen at once if patient does not start breathing quickly after a seizure.
3) Treatment of underlying disturbances of cerebral support (pulmonary edema, heart failure, acidosis, loss of blood, etc.)
4) Chemotherapy of convulsions.
5) Prevent aspiration!
6) If medical procedures appear provocative (as in strychnine poisoning), reduce stimuli until control is maintained.
7) Be ready to administer prolonged artificial respiration (mechanical respirator).
8) Reduce increased intracranial pressure if this is present.
9) Differentiate convulsive state, decerebrate state and tetany.
10) Prevent injury during convulsion.

Increased intracranial pressure when present is due to cerebral edema, vascular congestion, and occasionally hemorrhage. If other measures of seizure-control are of no avail, increased intracranial pressure may be an important factor for therapeutic concern. Its reduction is not a simple matter but can be tried in two ways: (1) Hypertonic solutions; (2) spinal fluid drainage.
Of the two, spinal fluid drainage is far more satisfactory and definite, but fraught with risk of compressing medullary structures into the foramen magnum. This method is less dangerous if:

1. It is used in the cases with relatively less elevated spinal fluid pressure (around 250 mm. of water).

2. It is accomplished slowly, removing no more than 15 drops a minute, until the pressure is reduced to either half the original reading or into a normal range (130 mm.), whichever is attained first. If the pressure continues elevated, and there is indication to do so, further spinal drainage may be done after waiting 20 to 30 minutes.

In cases with more critically elevated spinal fluid pressure, particularly 300 mm. of water or more, the use of intravenous hypertonic solutions may be advisable. For this purpose, 50 per cent glucose or sucrose is given intravenously in quantities from 50 to 300 cc. If available, concentrates of serum albumin are similarly useful.

Table 16 outlines most useful emergency chemotherapy of convulsions.

Narcotics are never advised as chemotherapy for convulsions. "Tranquilizers" are of no value for convulsions. Intravenous barbiturates may cause a rapid, though transitory, drop in the blood pressure.

With prior narcotics or tranquilizers, caution and small (one-third or one-half of that recommended) doses of anticonvulsants are indicated.

Electroencephalographic control of sedation may be of value in skilled hands.

Ether by inhalation may occasionally provide the treatment of choice. This has the advantage of fairly rapid effect, following which the depth of sedation can be quickly manipulated. It may be useful thus to ward off threatening seizures, or to briefly augment barbiturates already given. It is especially useful in those cases where one dares use only light and transient sedation or where the injected sedative drugs are not controlling the seizures and to press them further is risky. The open drop method is used to the induction of light surgical anesthesia and maintained there until the seizure or imminent seizure passes. Ether should not be used if there is likelihood of respiratory irritation, pulmonary edema, acidosis, or increasing intracranial pressure. Of course, if seizure control must be maintained for a longer period than ether-administration permits, other drugs must be used.

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**TABLE 16**

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Route</th>
<th>Adult Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbiturates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenobarbital sodium</td>
<td>I.M.</td>
<td>0.2 gm. Repeat 0.1-0.2 gm. if necessary in 15 minutes. Cautious repetitions every ½ hour if necessary but don't exceed 1 gm. dose.</td>
</tr>
<tr>
<td>Pentabarbital sodium (Nembutal)</td>
<td>I.M.</td>
<td>0.2-0.4 gm. May repeat after ten minutes if necessary.</td>
</tr>
<tr>
<td>Secobarbital sodium (Seconal)</td>
<td>I.V.</td>
<td>0.1-0.2 gm. May repeat after one minute if necessary.</td>
</tr>
<tr>
<td>Amobarbital sodium (Sodium amytal)</td>
<td>I.V.</td>
<td>0.2-0.4 gm. May repeat after ten minutes if necessary.</td>
</tr>
<tr>
<td>Thiopental (Pentothal)</td>
<td>I.V.</td>
<td>0.05-0.1 gm. Repeat in one minute if necessary. Care with laryngospasm.</td>
</tr>
<tr>
<td>Diphenylhydantoin (Dilantin)</td>
<td>I.M.</td>
<td>150-200 mg. Repeat in ½ hour if necessary.</td>
</tr>
<tr>
<td>Paraldehyde</td>
<td>I.M.</td>
<td>2-4 c.c. Repeat in 15 minutes if necessary. Contraindicated with likelihood of pulmonary edema, gastric irritation, liver damage.</td>
</tr>
</tbody>
</table>

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Skeletal muscle paralyzers such as D-Tubocurarine (curare) and succinylcholine (Anectine) may be considered in cases where:

1. Sedative medication does not control convulsions.
2. Sedative medication or dosages required will depress medullary centers dangerously.

These drugs require a physician experienced in their use, usually an anesthesiologist, as well as equipment for respiration, intubation, oxygenation, and suction. It is often difficult to maintain a desired end point between too much muscular paralysis and too little. At times, the best compromise must allow some mild convulsive phenomena (clonic jerks, for instance) or considerable muscular paralysis. In the latter case, this problem is easier to manage (in a respirator) during the acute poisoning than frequent, severe or prolonged convulsions.

**DECREASEBRATE STATES**

While the subject of decerebrate states belongs more properly under the next heading of toxic depression of the central nervous system, it will be discussed here because it may be confused with the convulsive state. (Table 17).

In acute toxicity the decerebrate state usually represents a stage in progressive narcosis. There appears a temporary halt with depression of cortical and midbrain function, but as yet minimal depression of brainstem function. If the tide of narcosis advances beyond this point, medullary function also may be swept out.

In treatment of decerebrate state due to acute poisoning, the temptation is to treat as for convulsive state. However, to rush to add further narcosis to a condition already produced by rather serious narcosis is not logical. Decerebrate state may be made to disappear by (1) **reviving** the higher (cerebral, midbrain) centers or by (2) cautiously **depressing** the nervous system further to narcotize higher brainstem centers without involving lower, vital medullary centers (which are the last to be affected by the process of narcosis).

Cerebral and midbrain centers may be revived by vigorous supportive (circulatory and respiratory) management, detoxifying,

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**TABLE 17**

<table>
<thead>
<tr>
<th>DIFFERENTIAL</th>
<th>CONVULSION, DECEREBRATION, TETANY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsion</td>
<td>Decerebrate State</td>
</tr>
<tr>
<td>Alteration of areas of neuronal activity in cortex and midbrain.</td>
<td>Considerable narcosis or paralysis of neuronal activity throughout cortex and midbrain.</td>
</tr>
<tr>
<td>Disruption by stimulation, partial narcosis, or loss of critical physiologic support.</td>
<td>Brainstem largely spared.</td>
</tr>
<tr>
<td>Grand mal features</td>
<td>More or less continuous rigidity (tonus) in extension, including opisthotonus.</td>
</tr>
<tr>
<td>Outcry</td>
<td>Hands, feet, digits flexed.</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>Arms, legs adducted.</td>
</tr>
<tr>
<td>Tonus followed by clonus</td>
<td>Breathing may be labored but continues.</td>
</tr>
<tr>
<td>Cyanosis; breathing stops</td>
<td>Temperature control may be lost.</td>
</tr>
<tr>
<td>Frothing</td>
<td>Tonic neck reflexes (rotate head to right, right limbs extend in hypertonus, left limbs flex and lose tonus).</td>
</tr>
<tr>
<td>Loss of sphincter control</td>
<td>Clasp-knife test (on flexing limb forcibly, rigidity remains to certain point, then suddenly gives way).</td>
</tr>
<tr>
<td>Post-convulsive stupor</td>
<td></td>
</tr>
<tr>
<td>Pupils large, immobile</td>
<td></td>
</tr>
<tr>
<td>Tetany</td>
<td>Irritability, restlessness, muscular pains, muscular tremors, twitches.</td>
</tr>
<tr>
<td></td>
<td>Carpal spasm begins in small muscles of hand, contracting interossei, flexing basal phalanges, extending distal phalanges, thumb opposed and adducted with flexion at wrist.</td>
</tr>
<tr>
<td></td>
<td>Pedal spasm with feet and toes flexed.</td>
</tr>
<tr>
<td></td>
<td>Laryngospasm. Signs of Chvostek and Trouseau</td>
</tr>
<tr>
<td></td>
<td>Consciousness not lost</td>
</tr>
</tbody>
</table>
and antidotes. Uninhibited (released) brainstem antics may be depressed by cautious use of tranquilizers.

One is left with the same problems posed in treatment of acute toxic stimulation and convulsive states: to treat or not to treat; if treated, how much and how vigorously. One must consider (1) the mechanical stress posed by the decerebrate state and (2) whether the poisonous agent is sufficiently a depressant, a narcotizer. If mechanical stress is minimal and the poison a sufficiently potent depressant whose full scale effects are not yet felt, it is advisable to withhold tranquilizing drugs. At the other end of the spectrum are those cases where decerebrate state causes critical mechanical stress, the poison is not basically a serious depressant, and the peak of its direct activity is over; in these cases, tranquilizing chemotherapy appears advisable. (Table 18).

TABLE 18
TREATMENT OF DECEREBRATE STATE IN ACUTE POISONING
1) Respiratory and circulatory support.
2) Reduce increased intracranial pressure if present.
3) Exercise great caution in adding further depressants if the poison is basically a potent depressant (narcotizer).
4) Tranquilizing chemotherapy preferable to sedatives (see Table 11).

TOXIC DEPRESSION OF THE CENTRAL NERVOUS SYSTEM

The clinical picture of acute chemical depression (narcosis) of the nervous system is comparable to that seen in progressive dosage with ether, alcohol, or barbiturates, progressive anoxia, or hypoglycemia. Narcosis proceeds through the various stages as outlined in pharmacologic texts describing anesthesia, or as outlined in psychiatric texts detailing treatment by insulin coma. After a brief initial stage of exhilaration or excitement, then drowsiness, ataxia and weakness ensue. Consciousness dwindles into dazed, trance-like or drunken lethargy. Hallucinations, delirium (acute brain syndrome), blind rage, primitive acts and movements, tonic spasms, torsion and decerebrate rigidity (described above) may follow. Progressively deep stupor over-whelms all, finally, and may proceed to severe medullary depression, asphyxial or terminal convulsions, and death. (Table 19).

TABLE 19
CAUSES OF TOXIC DEPRESSION OF NERVOUS SYSTEM IN ACUTE POISONING
1) Direct chemical depression (narcosis) of nervous system.
2) Indirect depression through loss or alteration of critical cerebral supports (e.g., oxygen, circulatory, pH, etc.)
3) Excessive chemotherapy (tranquillizers, sedatives).

Great or progressive depression of the central nervous system is a critical development because eventually vital medullary centers are paralyzed (vagal, vasopressor, respiratory).

Again, management will depend on knowing the poison and its unique "mischief" — what to anticipate directly on the nervous system and indirectly through other critical supports. Anoxia, circulatory failure, fluid loss, ketosis and acidosis, hemoglobin loss, and cerebral edema must be treated vigorously. Skillful, multidimensional, supportive care is often more important than antidepressive chemotherapies since we have no satisfactory, definitive drugs of this much-needed type as yet. Our presently available, stimulating or analeptic drugs provide only one part, and often a minor part, in therapy. Reduction of increased intracranial pressure (as described under "Convulsions") may be beneficial. Skillful and early use of the respirator and of tracheotomy may be most valuable therapeutic tools in treating medullary depression.

To press the use of drugs to precipitate convulsions is to invite serious complications of further medullary depression. Improvement in vital signs and return of corneal and other reflexes are sought, basically. Some return of sensation, muscle activity, and awareness is heartening but it is not necessary to restore consciousness since this invites over-treatment. (Tables 20 and 21).

TABLE 20
TREATMENT OF DEPRESSION OF NERVOUS SYSTEM IN ACUTE POISONING
1. Respiratory support
   1) Respirator
   2) Scrupulously clean airway
      Nasopharyngeal suction
      Avoid aspiration
      Endoscopic suction
      Postural drainage
      Intubation
      Tracheotomy
   3) Oxygen
   4) Monitor alveolar CO2

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5) Prevent or treat Pulmonary edema
Atelectasis
6) Prevent or decompress Gastric or intestinal distention
7) Prevent infection (antibiotics)

II. Circulatory support
1) Hypotension; vasopressor drugs
2) Myocardium; digitalis, Ca and K ions
3) Pacemakers, arrhythmias, cardiac arrest. Quinidine, Pronestyl, Ephedrine, etc.
4) Circulating blood volume Including functioning hemoglobin
Hydration
5) Control Metabolic demands Hyperthermia; activity
6) Acidosis

III. Medullary support
1) Stimulant (analectic) drugs
2) Prevent and control convulsions
3) Reduce increased intracranial pressure

STRIATED MUSCLE PARALYSIS

A toxic cholinergic or curare effect occurs in some cases of acute poisoning to produce marked striated muscle paralysis, serious when it affects efficiency of respiratory muscles, swallowing, cough reflex, and vocal cords. (Table 22).

Treatment of skeletal muscle paralysis is outlined in Table 23.

Chemotherapy will depend on the nature of the poison and will require cholinergic drugs such as neostigmine or edrophonium (Tensilon) if the poison is of the curare group. If the poison is a cholinergic type, then atropine will be used in generous amounts. Several of the poisonous products found in homes and on the farm have a

<table>
<thead>
<tr>
<th>Drug</th>
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</tr>
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<tbody>
<tr>
<td>Caffeine sodiobenzoate</td>
<td>I.M.</td>
<td>0.5 gm. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Dextro-amphetamine</td>
<td>I.M.</td>
<td>20 mg. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>I.V.</td>
<td>20-50 mg. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Ephedrine sulphate</td>
<td>I.M.</td>
<td>50 mg. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Mepheneteramine (Wyamine)</td>
<td>I.M.</td>
<td>5 mg. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Pipradal (Meratran)</td>
<td>I.M.</td>
<td>20 mg. and repeat in 15 minutes if necessary.</td>
</tr>
<tr>
<td>Methylphenidyl acetate (Ritalin)</td>
<td>I.M.</td>
<td>1-5 cc. of 25% solution and repeat as needed.</td>
</tr>
<tr>
<td>Nikethamide (Coramine)</td>
<td>I.V.</td>
<td>Try 5 cc. of 10% solution slowly I.V. If this lessens depressed state in any manner, its further use is likely unnecessary. 10 cc. doses thereafter.</td>
</tr>
<tr>
<td>Pentoxylenetrazol (Megamid)</td>
<td>I.M.</td>
<td>3-12 mg. I.V. slowly and repeat every 15 minutes. Alternative: 1 mg, per minute until corneal reflexes appear.</td>
</tr>
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It has been noted that use of drugs in rotation or in combination may have advantages:

1. This reduces cumulative toxicity.
2. Each drug may cover a facet of the therapeutic problem, untouched by another. This is theoretical, of course, but a possibility since the action of these drugs is not well understood.

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TABLE 22
EARLY SIGNS OF STRIATED MUSCLE PARALYSIS
1) Weakness of limb musculature. At first, this may appear crudely like a loss of muscle coordination because some muscles weaken more rapidly than others. Jerking, weak, flail-like and drunken features may appear before more obvious paralysis. Fasciculations and small twitchings may also be noted in the muscles.
2) Cranial nerves; general.
   a. Weakness of head and neck striated muscles. Extracranial muscles, eyelids, masticators, facial, throat, neck and tongue muscles become weak, poorly coordinated and may reveal small twitchings before finally becoming paralyzed. Facial expressiveness disappears and assumes a mask-like or “deadpan” appearance.
3) Cranial nerves; speech, swallowing and respiration.
   a. The patient speaks less and in short, hasty reports; the voice becomes weak, nasal, husky. Slurring (from weak tongue and lips) or dysarthria (weak palate and larynx) appears.
   b. Excessive secretions collect in the throat; oronasal froth or bubbling appears; he clears his throat or coughs weakly and hardly effectively. Nasal regurgitation is noted on swallowing. Choking, stridor; futile, explosive, single coughs or grunts occur.
4) General respiratory.
   a. Rate, rhythm, depth of breathing deteriorates.
   b. Accessory muscles are being used.
   c. Breathlessness
   d. Disphragmatic, thoracic or asymmetrical breathing appear.
5) Mental status changes. Mental confusion, anxiety; random, purposeless, weak, jerky movements are characteristic features. Illusions and hallucinations appear. At first the patient may appear “stimulated” but rapidly passes into lethargy. This comprises the acute brain syndrome (delirium) from hypoxia.
6) Appearance of hypertension, tachycardia.
7) Cyanosis; oximeter readings; alveolar CO2.

TABLE 23
TREATMENT OF SKELETAL MUSCLE PARALYSIS IN ACUTE POISONING
1) Respiratory support.
2) Treat hypoxia and circulatory failure.
3) Chemotherapy.
4) Attention to potassium ion balance.

diagnostic on electrocardiographic tracing). Low blood plasma levels (occurring with severe vomiting or diarrhea, hemorrhage, shock, dehydration, acidosis and some types of alkalosis) may result in marked skeletal muscle weakness (as well as cardiac disturbance). Treatment of hyperkalemia will require treatment of the underlying cause. Hyperkalemia requires similar concern, but also cautious replacement (in the adult, subcutaneously, in Ringer’s or Darrow’s solution, potassium chloride not to exceed one gram per hour). Careful attention must be paid to its effect on the heart. Renal function must be adequate lest dangerous hyperkalemia develop during therapy.

TETANY
This problem (Table 24) occurs occasionally (with fluoride or oxalate toxicity or with hyperventilation).

Chemotherapy of tetany consists of intravenous injection of 10 per cent solution of calcium gluconate (or 5 per cent calcium chloride), 10 to 20 cc. slowly and repeated as needed. Hypercalcemia may disturb cardiac rhythm seriously.

TABLE 24
TETANY IN ACUTE POISONING
1) May hinder efficient respiration and throw additional strain on functions already needing rest.
2) May be mistaken for decerebrate rigidity or grand mal convulsions, hence be improperly treated. (See Table 17.)
3) Poses mechanical problems, problems of patient cooperating and distress.
4) Is a condition which responds to fairly definitive treatment.

OTHER NEUROLOGIC AND PSYCHIATRIC CONCOMITANTS
Occasionally, other neurologic and psychiatric complications are present or develop with acute poisoning and must be anticipated or recognized during acute treatment. (Table 25.)

TABLE 25
DO NOT OVERLOOK:
1) Cerebral infarction (especially in older patients)
   a. Thrombosis due to hypotension.
   b. Hemorrhage from toxic “arteritis”
   c. Embolism from cardiac or pulmonary sources; air or fat embolism.
2) Psychiatric condition which preceded and resulted in acute poisoning. Suicide risk may continue great through therapy and the unguarded, therapeutically responding patient may quickly seek to complete his demise in the hospital. The patient may present a full-blown psychosis. Chronic alcoholism and its complications may be present.
3) Secondary neurologic injury. This is usually a result of falling and collapse, convulsions, excitement, parenteral injections or rough handling of a disturbed or comatose patient. Included here are basal skull fracture, intracranial hematoma; injury to carotid or vertebral arteries in neck; injury to cervical spinal cord, a plexus or peripheral nerve.

SUMMARY
The clinical features of acute poisoning may be kaleidoscopic, rapidly changing. The physician and his team must monitor many
physiologic parameters simultaneously, sensitively, definitively. At first, there may be local irritation and pain, then vomiting and aspiration. Pulmonary edema, shock, and hypotension may appear just before a grand mal convulsion with prolonged apnea and anoxia, then exhaustion and a drowsy delirium. This may all go slowly — in orderly phases, waxing and waning. This may go with pell mell rapidity, changes or crises occurring quickly, tumbled one atop the other.

Therapy is directed toward preserving and restoring the chemical and physical homeostasis of the organism. The unique, multipotential mischief of each poison must be reasonably anticipated. It is well to know, for instance, if pulmonary edema, medullary depression, ventricular fibrillation, or convulsions are common features with this poison.

Unfortunately, treatment will not always be methodical, orderly, “by the numbers,” nor always according to the usual expectations of this poison. The ability of the physician and his team to “free wheel,” “catch-as-catch-can” and “play it by ear” with good judgment is also an important talent in therapy.

Chemotherapy requires skill with several classes of potent drugs which usually must be injected. They all have the potential to further complicate and befoul many conditions already disturbed. Several of these drugs may be additive in their effects.

Therapy of acute poisoning may call for many decisions to act or to wait; the physician must take a stand early and not late, as each phase erupts or unfolds. “Judicious neglect” and observation of trends may be wise — or may result in serious consequences. Tracheotomy, cardiac massage, respirator; digitalis, pressor drugs, narcotics, tranquillizers, anti-convulsants, and stimulants may require quick thought, knowledge of indications, value, and contraindications. Chemotherapy may best be withheld; or given cautiously, in repeated small doses; or given aggressively in full measure. Modification must be known for children, the aged, and patients with other, incidental, conditions.

Acute poisoning points up the very important integration and interdependence of medullary, respiratory, and circulatory functions. Impairment of one may quickly affect the others. Vicious cycle aggravations are evident. Therapy directed to one function must require therapy of the other two.

The treatment of the neurologic aspects of acute toxic syndrome is described in detail. Treatment of acute poisoning is multidimensional and requires careful attention to a number of disturbed functions simultaneously. Antidotes and symptomatic control of neurologic developments alone are insufficient. Alert, sensitive, definitive, and effective supportive care of the nervous system as well as other systems is mandatory.

The neurologic problems are:
1. Pain and distress.
2. Toxic stimulation of the nervous system (excitation, delirium).
3. Convulsions; decerebrate states.
4. Toxic depression of the nervous system (narcosis).
5. Striated muscle paralysis.
6. Tetany.
7. Other neurological and psychiatric concomitants such as cerebral infarction, primary psychiatric conditions, and secondary neurologic injury.

Treatment will require special attention to the respiratory system, cardiovascular system, electrolytes, blood pH, and fluid balances.

Skill and experience will steer the physician with valuable chemotherapies through a narrow margin between aggressively attaining therapeutic effectiveness and stopping short of adding to confusion or ultimate depression of vital medullary centers.

REFERENCES
Differential Diagnosis of Miliary Disease of the Lungs

In many respects it was easier to practice medicine a generation ago. A patient with miliary disease of the lungs was called tuberculous, thereby settling all diagnostic problems in the case.

As time went on more information was obtained about other pulmonary infections, due to bacteria, fungi, and viruses. In certain areas knowledge of industrial diseases came into prominence. Metabolic diseases, allergy, blood diseases, and tumors have been found to show pulmonary manifestations.

There is not time to describe here all the types of lesions produced by diseases in these various categories of disease-processes when they attack the lungs. The point to be made now is that some diseases falling in these various classes, whether because of hematogenous dissemination or because of massive inhalation, may produce miliary disease in the lungs resembling what was formerly called "typical miliary tuberculosis."

Banyai and Peabody\(^1\) list thirty-seven types of disease-processes which produce miliary shadows in the chest roentgenogram. In the time allotted to this paper, several of the more common ones will be discussed.

In our differential study let us first review the symptoms and signs in miliary tuberculosis of the lungs. Even before the tubercles are large enough to show up on the X-ray film, the patient will complain of weakness, malaise, loss of appetite, loss of weight, subfebrile temperature, dyspnea, chest-pain, and dry cough. Physical examination of the chest may be entirely negative. These symptoms will increase in severity quite rapidly, weakness and weight-loss being especially prominent. Within a few weeks the patient will become bed-ridden and the tubercles may show faintly on the X-ray film. There will be little or no expectoration, and sputum and gastric cultures will be negative for acid-fast bacilli. The tuberculin test will usually be positive, but in a small percentage of cases may be negative because of lack of antibodies due to poor resistance on the part of the patient. When the tubercles increase in number and in size to the extent that they become conglomerate, then, because of insufficient blood supply, necrosis will set in, producing sputum containing tubercle bacilli, which can be readily identified. Blood-spitting may be present now. At this stage physical examination will show impairment of resonance, changes in breath-sounds, and moist rales.

Prior to 1944, most of these patients died in a few months. Now, many are saved if the diagnosis is made early and specific drug therapy is started.

Craddock and Meredith\(^2\) reported a case in which two diagnostic methods yielded an early diagnosis. The patient had been well five weeks before admission to the hospital. Sputum, gastric washings, and bone marrow smears were negative for acid-fast organisms. Four days after admission to the hospital a punch biopsy of the liver was done. The specimen thus obtained showed typical small tubercles which contained acid-fast bacilli. Culture of the bone marrow was positive for acid-fast bacilli at the end of the fourth hospital week. Drug therapy was started as soon as the report of the liver-biopsy was obtained, resulting in early improvement in the patient's condition.

Shefts, Terrill, and Swindell\(^3\) reported a series of 187 patients with pulmonary disease in 67 of which scalene-node-biopsy helped make the differential diagnosis. Through a 3 cm. incision above the clavicle, under local anesthesia, one or more lymph nodes are located in the fat pad lying on the anterior scalenus muscle, and are dissected out for study.

\(^*\)Presented before Mississippi Valley Trudeau Society in Omaha, Nebraska, on October 11, 1957.

MAX FLEISHMAN, M.D.
Omaha, Nebraska

Nebraska S. M. J.
For those cases in which lymph-node-biopsy, liver-biopsy, and bone-marrow-culture are negative, Andrews and Klassen have reported on eight years' experience with pulmonary biopsy in 118 patients with bilateral diffuse respiratory disease. Under general anesthesia an 8 to 10 cm. submammary incision is made anteriorly in the 3rd or 4th intercostal space. The anesthetist applies positive pressure to inflate the lung, which is pulled into the thoracotomy incision by a non-crushing clamp. Two forceps are applied and a 3x3 cm. wedge is resected. Several of the patients left the hospital 48 hours later, the average, 4 days after operation. In this series of 118 cases there were 4 deaths, in patients with malignancy, and 14 cases who developed complications. The biopsy furnished findings that were of great help in differential diagnosis and in deciding what treatment should be carried out.

Now let us consider an acute infectious pulmonary disease, quite severe. It may occur in patients at any age, produce marked malaise, fever of 103 or 104 degrees F., considerable cough, substernal pain or pain elsewhere in the chest, dyspnea, and cyanosis. The X-ray film of the chest may show miliary lesions in the lungs, produced in this instance by a severe type of broncho-pneumonia, a bronchiolitis. The pathologic process is chiefly in the bronchi and extends to the alveoli, where there is proliferation and desquamation of the epithelial cells lining the alveolar wall. In the early stage there is no visible consolidation. Later, on cross-section, the lung has a mottled appearance, due to minute areas of atelectasis, consolidation, emphysema, and normal lung.

At the onset the physical signs are those of capillary bronchitis and congestion, normal resonance, fine rales, and feeble breath-sounds. Later, resonance may become impaired, breath-sounds harsher, vocal resonance louder, and the rales louder. The disease may be primary, especially in young children. It may be secondary, after contagious diseases in children, or after various infectious conditions in adults. No specific bacteria are involved. The pneumococcus, streptococcus, staphylococcus, influenza bacillus, or other organisms may be involved. The leucocyte count reaches 20,000 to 25,000 per cu. mm. Prior to the days of the antibiotics and chemotherapeutic agents, most of these patients died in two or three days. This diagnosis is made by inference if the patient recovers with the use of antibiotics.

Another type of acute pulmonary infection, much milder in degree of severity, may be atypical pneumonia, caused by virus infection, which produces an acute bronchitis and interstitial pneumonitis. Some cases show a miliary type of lesions on the chest X-ray. There may be either a normal leucocyte count or a leucopenia. The disease runs a benign course ending by lysis. Death rarely occurs.

Finding cold agglutinins in the blood serum will give the clue to diagnosis. They begin to appear seven to fourteen days after the onset, reach a peak in twenty-one days, then start to fall. In 50 to 60 per cent of cases the titre will be 40 or more. Streptococcus MG agglutination, in a titre of 20 or more, appears in 50 per cent of cases.

A chronic type of infectious disease which may cause miliary lesions in the lungs is syphilis. Serological studies will suggest the diagnosis, and it will be confirmed by response to specific antiluetic therapy. The presence of luetic lesions elsewhere in the body aids in making the diagnosis.

Various types of mycoses, or fungus infections, may produce miliary lesions in the lungs. These include actinomycosis, aspirgillosis, blastomycosis, coccidioidomycosis, histoplasmosis, moniliasis, and torulosis. Fungus infections occur commonly in farmers, grain-handlers, and hair and fur handlers. Residence in desert areas suggests the possibility of coccidioidomycosis; in the Midwest it suggests histoplasmosis; and in the tropics and subtropics, moniliasis.

The symptomatology may range from none at all to mild, moderate, or extremely severe symptoms, likewise the physical findings may vary greatly. Specific skin tests, when positive, may indicate past or present disease, but may be negative during active disease. Complement fixation and precipitin tests may be negative or positive during active disease. Both skin and serologic tests may show a cross reaction with certain other fungi. Anaerobic cultures, sometimes aerobic cultures, of the fungus from sputum, from pus from abscesses, or from biopsy material from diseased organs may provide the diagnosis. Bone-marrow-culture, scalene-node-biopsy, liver-biopsy, or lung-biopsy may give valuable information. Animal culture, using mice, rats, or guinea pigs, may iden-
tify the fungus. Eosinophilia may be present. The hilar lymph nodes are usually involved in pulmonary mycoses, and certain fungi commonly attack other organs, too.

Hunter, Willcox and Woolf⁵ reported the case of a woman with exfoliative dermatitis for almost a year whose chest X-ray film showed diffuse, micronodular, soft mottling throughout both lung fields. Histologic study showed miliary abscesses of the lung containing numerous branching mycelia.

Actinomycosis bovis is anaerobic. Actinomyces astroides is aerobic. Sulphur colored granules are found in this disease in pus from draining thoracic sinuses or bone-lesions.

World War II training of U.S. troops for desert warfare increased the incidence of coccidioidomycosis as well as our knowledge of the disease. Margolis⁸ reported the case of a 32-year-old male who had weight-loss of 30 pounds in 6 weeks, pain in the back and in the neck for 3 weeks, stiffness in the neck and fever of 101 degrees F. Chest X-ray showed a fine miliary infiltration throughout both lungs and no calcification in either hilum. Sputum and blood cultures were negative. The patient ran a septic course, developing an abscess in one of his ribs. The abscess was drained, but the patient went into coma the next day and died on the second day. The lungs and spleen were granular and shot-like on cut-section. Cultures of pus from the rib grew Coccidioides immitis.

In numerous articles in recent years Furbelow¹⁹ has pointed out the great prevalence of histoplasmosis in certain Mississippi Valley states.

Sarcoidosis¹¹ is sometimes present in miliary form in the lungs. The symptoms are often mild, but may be severe. The lymphatic nodes are usually involved, and massive involvement of the hilar nodes is common. Other areas of the body commonly involved are the skin, the uvea of the eye, the salivary glands, and bones of the extremities. There may be leucopenia, cosinophilia, anemia, and acceleration of the erythrocyte sedimentation rate. The Kveim skin test may develop a papule one to several weeks after injection. Biopsy of lymph nodes, tonsils, liver, or lung may give the diagnosis, showing hard or non-caseating tubercles. Langhan's type of giant cells are present. The lesions are not exudative, but productive or fibrotic.

Pneumoconioses¹² from inhalation of mineral dust in industry may produce pulmonary lesions resembling miliary tuberculosis. One type is reticulation with beading or pseudonodulation, which is found in anthracosis and in siderosis of soft-coal workers and welders, and also in silicatoses due to inhalation of talcum and mica. A second type is granularity or fine miliary stippling due to chronic berylliosis. A third type is discrete nodulation (whorled nodular fibrosis) due to simple silicosis of rock drillers and stone cutters.

The occupational history is of extreme importance in diagnosing pneumoconiosis. Hardy¹³ points out that there may be an interval as long as ten years between exposure to toxic beryllium compounds and any sign of disease. Aids in diagnosis are the detection of beryllium by spectrographic analysis of urine or in biopsied or autopsied material of lung, liver, spleen, lymph nodes, myocardium, and kidneys.

Dusts of irritant gases can cause chemical inflammation in the lungs. Victims of the Cocoaanut Grove Fire¹⁴ in Boston showed a miliary type of atelectasis in the lungs. Grayson¹⁵ has reported on nitrogen dioxide pneumonia from silage-gas poisoning with exposure of only five to eight minutes, and death in 29 hours with consolidation in all lobes.

Lupus Erythematosus¹⁶ is a collagen disease with pleuropulmonary manifestations and may occur in miliary form. The disease is characterized by a toxic state with prolonged fever and with a remittent cachectic course. The skin manifestations may aid the diagnosis. In one type there is the butterfly eruption over the bridge of the nose and malar prominences. In the second type there is an acute disseminating form which tends to spread all over the face, ears, arms, chest, and all over the body. Visceral lesions include polyarthritis, polyserositis, endocarditis, nephritis, lymphadenopathy, retinitis, cerebral involvement, and pulmonary involvement. Finding L.E. cells in the bone marrow or in the blood supports the diagnosis.

Periarteritis nodosa¹⁷ is a disease of vascular origin with hypersensitivity as a causative factor. This may involve the lungs in
miliary form. The pulmonary artery is involved in 25 per cent of necropsied cases. There are 4 to 5 mm. nodules in the lungs. Twenty per cent of cases of periarteritis nodosa have asthma and over 50 per cent have dyspnea on exertion. Eosinophilia is present in 36 per cent of patients with periarteritis nodosa and in over 90 per cent of such patients with asthma. The eosinophilia may comprise 84 per cent of the white cells. Biopsy of the deltoid or gastrocnemius muscle, or biopsy of subcutaneous nodules may give the diagnosis.

Hodgkins disease, a malignant tumor of the reticulo-endothelial system, may present a miliary form in the lungs. The superficial lymph nodes and the mediastinal nodes are frequently involved. Splenomegaly is present in two-thirds of the advanced cases. Bone lesions are present in 15 per cent of cases, pulmonary lesions in 40 to 60 per cent, and thoracic lesions in 50 to 95 per cent. Material obtained by biopsy will show the Sternberg or Dorothy Reed cells— multinuclear giant cells.

Rubin describes metabolic and inflammatory diseases of the reticuloendothelial system or histiocytosis, which may be present in miliary form in the lungs. In the metabolic type, specific lipids are deposited in the cells; cerebroside in Gaucher's disease and phosphatid in Niemann-Pick's disease. These two are hereditary diseases found almost exclusively in the young. The lipids are present in the cells, but not in the blood.

The inflammatory type occurs chiefly in the young, but may be seen in older persons. In Hand-Schuller-Christian's disease, there is an increase in cholesterol esters in the blood as well as in the tissues. Letterer-Siwe's disease is a nonlipid histiocytosis, but an increase in lipid content may be present. The mildest form of inflammatory histiocytosis is eosinophilic granuloma of one or several bones.

Finding histiocytes or large "foam" cells in the sputum helps pin-point the diagnosis. Lung-biopsy may be necessary, or bone-biopsy when bone lesions are also present. Chemical study discloses the specific lipid present.

Carcinoma of the lung, both primary and metastatic, may appear as miliary nodules. Locating the primary tumor elsewhere in the body will give a clue in the metastatic type. Lymph-node-biopsy or lung-biopsy may be necessary.

I have been able to cover only a few of the different types of disease-processes that may produce miliary lesions in the lungs. The purpose of this paper is to acquaint you with the great diversity of etiologic agents which might cause this type of lesion, formerly called "typical miliary tuberculosis."

REFERENCES

7. Ref. 1, p. 178.
12. Ref. 1, p. 716.
17. Ref. 1, p. 565.
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July, 1958
Blue Shield

VIEWPOINT of a MEDICAL

I have been requested to present a personal evaluation of Blue Shield which would encompass the viewpoint of a medical executive secretary. It is the intention that this thesis should cover the position of Blue Shield in the field of medical care with an inclusion of the relationship desired and attained between the operators of these plans and the medical profession as a whole. A further request has been to cover something of the future potential of Blue Shield in this medical care field and the capacity for service to the public in the interests of good medical care and service to the medical profession.

As we survey this situation, there is one basic premise that presents itself again and again until it assumes such importance that it must be an integral part of any discussion of this kind.

"Blue Shield is the doctor's answer to socialized medicine."

Before I address myself to my principle theme, I should like to comment to those engaged in this field that here is one of the most important endeavors of today. You are engaged in an effort which makes it possible for the people to receive good medical care on a prepaid basis. The need for governmental interference is thus eliminated. No doubt the picture would be different today were it not for the job you are doing. Not another nation in the world has any comparable semblance of freedom in the medical care field that we have right here in America. It is the history of nations that when the freedoms of medical care disappear and the medical profession is shackled, it is not long until the people have lost most or all of their important freedoms. Here then is one of the important facets of the operational benefits of Blue Shield. Perhaps this might be the most important one.

About fifteen years ago an important meeting was held in Saint Paul, Minnesota, which marked an outstanding chapter in the development of prepayment medical care, at least for the middle West. This was a meeting of the old Northwest Conference, a regional meeting of the six states—North Dakota, South Dakota, Wisconsin, Minnesota, Iowa, and Nebraska. At this meeting a full day was spent in discussing the possibilities of prepaid medical care. Some top insurance underwriter executives were present and carried an important part of the discussion. At that particular time the Roosevelt Administration seemed determined to start some kind of governmental medical care program. Messrs. Wagner-Murray-and Dingell were threatening the medical scene and were attempting to pass national legislation providing for compulsory health insurance. Something needed to be done and it needed to be done in a hurry. The medical horizon was certainly threatened seriously.

Late in the afternoon of that fateful day the insurance men present stated in no uncertain terms that prepaid medical care on a service basis was impossible. There were too many unknowns. There was no actuarial background. There were too many possibilities and lack of controls. They felt that no insurance company would or could make any attempt to operate a plan of this type. The medical profession was on its own to defend the free practice of medicine.

About that time the movement to establish such plans was just starting with varied degrees of operational success. Most of them were having financial difficulties and had had them since organization. These plans, without exception, had been organized or promoted by the medical profession. The organization pattern was universally the same. A few public spirited doctors would get together and, realizing that they had

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*Presented before the Professional Relations Conference of Blue Shield Medical Care Plans, Chicago, Ill., March, 1948.
very little of a foundation to start with, nevertheless they did make a start. They decided to create their own actuarial background by the trial and error method. They were sailing an uncharted sea. Colleagues helped in the financing and contributed time, effort and counsel. Lay individuals with varying types of background were sought out and brought into the administrative picture.

Thus Blue Shield was born, and thus it continues to operate. Most of the plans lost money in those early days. Everybody was learning by doing and it was the only way to learn. In almost every instance the doctors accepted low fees or none at all to keep the plans solvent. The job was accomplished by cooperation — by working together — and it is only natural to assume that future success must be based on the same method.

Quite recently I was a member of the Public Relations Advisory Committee of the American Medical Association. One of our meetings was attended, at their request, by a group of officers of the Blue Shield Commission. They presented a problem to us that was unthinkable in its portent. It was a physician-relations problem. We learned that only about fifty per cent of the plans in the country had any physician-relations at all. Not only was there a lack of cooperation between the plan and the physician, in many instances there was definite antagonism. The plans, of course, were having trouble. The commercial companies, with generations of operation know-how behind them, presented problems that the plans could scarcely hope to surmount without help. Certainly, if nothing more, it was a demonstration of the need for cooperation and the need of physician-relations for successful operation. Without close cooperation with the physicians, a Blue Shield plan becomes just another insurance company and must operate on that basis in a highly competitive field. Fortunately, the picture has changed materially. I am sure that the statement can be made without fear of contradiction that the success of each Blue Shield plan is in almost direct proportion to the efficiency of its physician relationship. Surely someone has learned a lesson, and we may hope that such a lack of relationship will never enter into this picture again. It is an expensive luxury that we can ill afford.

There are many of our members who feel that doctors should not be engaged in the insurance business, nor have any close connection with it. The insurance business should be left to insurance people. With that point of view, there is a more or less general agreement. During that early period of organization of the plans, there was the feeling to the effect that as soon as the danger period was over we should get out of the insurance business and turn it all over to the commercials. Much water has gone over the dam. How, and when, and who shall decide when that date has arrived? Certainly the threat of socialization of medicine is not over. The Socializers are probably more determined than ever. We should never permit ourselves to ever again get into that situation of extreme danger and with no help in sight. We are more or less obligated to maintain Blue Shield to better serve the people. Our members should be conversant with these facts to attract their closer cooperation. This is a must in the physicians-relation field and the obligation of every plan.

Another area of important relationships for the plans is with the commercial insurance companies. I am sure that most of us have had the feeling in the past that the commercial companies are archenemies of the prepayment medical care plans on a service basis, and as such, have been ruthless competition. This is not the time nor place to discuss this question excepting to say that, true or not, the only hope for both is a peaceful coexistence. Only recently I discussed this matter with one of the recognized outstanding leaders in the insurance industry. I was surprised at his statement that the commercial companies would go out of their way to an extended degree to keep the plans operating in the field. His explanation of his statement was little short of amazing to me, perhaps because of my lack of knowledge in this field. At least it was revealing although it may contain nothing new to those of you engaged in this field. According to his statement, the Blue Shield plan, because of its type of organization, can and does assume risks which are truly in the non-profit field, and, as such, undesirable to the commercial company. Thus, a segment of our population is served that would not otherwise receive the benefits of the prepayment method. This we desire.
Perhaps it should be pointed out that herein lies the great difference between the commercials and our own Blue Shield. The commercials are organized for profit and operated for that purpose. The sole purpose of Blue Shield is to solve a social problem by providing a means whereby an improvident population may anticipate or pay in advance for medical care, in the same manner in which they provide themselves with other necessities and many of the luxuries.

The purpose for which Blue Shield was organized still exists, and I am sure it will be with us for some time to come.

If any of us there are who have a feeling that the threat of governmental interference into the practice of medicine has been eliminated, or that socializers have or will discontinue their efforts to add their paternal touch to the practice of medicine, we have only to look at the passing scene on the governmental front to remind us that the dangers are not past. Only the methods are different. Here is our field of operation.

We may survey Medicare, which came into being on December 7, 1956. While this is a continuation of a plan of many years standing to provide medical service for dependents of the uniformed services, it is an entirely new approach. Certainly it is establishing a pattern for future governmental programs. Let us not be misled. Already a secondary program in the old age assistance group has been put into operation. The Forand Bill, presently before Congress, is a long step toward further socialization. What is to prevent the establishment of programs covering federal employees, social security recipients, and finally dependents of veterans? All of these are but single steps toward socialization of the medical profession. What we were able to defeat in the Wagner-Murray-Dingell era, we are losing now in small segments.

What is the answer? There can be only one answer. Medicine and Blue Shield, with the able help of the commercials, must work closely together. Through Blue Shield we must provide a plan of service to the people that will win their approval. We must sell our own prepayment plan. To do this job we must have the finest physician-relationships between Blue Shield and our doctors. We must provide leadership which will win the approval of the commercials, and warrant their supreme effort in accomplishing our purpose.

There are those astute economists who now tell us that this era of socialization is on the wane. Some will even go so far as to set dates, when the people — yes, the world, will return to the sanity of the rights of the individual.

Until that time, we must be vigilant. We must hold the front. Upon us may depend the future freedoms of the world, not only the freedom of the practice of medicine, but all of those freedoms which we hold must dear.

Current Comment

Illinois Plans Continuing Glaucoma Program—

The Illinois Society for Prevention of Blindness according to an A.M.A. publication has drafted a five-point educational and casefinding program for glaucoma. It has been estimated that some 40,000 adults in Illinois state unknowingly have this disease, characterized by an unexplained increase of pressure within the eyeball, and which can lead to irreversible blindness if not corrected, and it is toward this group that educational and casefinding efforts will be primarily directed.

Since pain is an early symptom of glaucoma in only one out of every ten cases, permanent damage is often done before the victim seeks treatment. The Illinois program will therefore emphasize early detection and treatment, carrying this theme out on five fronts.

First, selected private physicians throughout the state will be asked to maintain low-cost, reliable vision screening equipment in their offices, including tonometers for measuring pressure in the eyeball, and to routinely use this equipment in their physical examinations. Second, industrial and business management will be encouraged to make general use of eye checks in routine employee physical examinations, and third, bulletin board and other educational material urging employees to take the tests will be supplied to industrial plants. Fourth, the Society will work with insurance companies to include glaucoma testing in physicals for policies, and fifth, it will conduct a statewide public information campaign on glaucoma, its dangers, and its early symptoms.
Ceremonies
Attendant Upon Opening of
NINetieth ANNUAL SESSION
Nebraska State Medical Association

Presidential Address
R. Russell Best, M.D.
Omaha, Nebraska

Members of The Nebraska State Medical Association, Guests, Ladies and Gentlemen:

One of the duties of the president before transferring some problems to his successor is to relate in as few words as possible the state of the association—that is, your own Nebraska State Medical Association. The president should be forever thankful for having had the opportunity to serve you. He must express his appreciation to all other officers, the Board of Councilors, the House of Delegates, the Board of Trustees, the staff in the state office, and not least or last, those faithful committee members, for without them your organization would be dormant. These committees tackle the details of the many problems which confront our organization. Your Policy Committee, consisting of the three immediate past presidents, the president and the president-elect, is a splendid plan as it offers continuity in thinking and planning and lends security to the president, as each term of office has had some particular hurdle. These past presidents also have the feeling of a strong attachment to the Board of Councilors and House of Delegates, many of whom served with these past presidents.

During this year the committees have been brought into action in the usual manner. Two new standing committees have been appointed, namely the Civil Defense and Disaster Committee and the Committee on Aging. The former has the responsibility of coordinating state activities so as to be prepared in the event of any major disaster. Although a national plan is most necessary, actual control and operation are better, safer, and more efficient at the state and community levels. There still is considerable work to be done in this area, the public is depending on us, and we must not fail them. The Committee on Aging is just going into action and has had one meeting. Here is a field that is open for the well-doers who look for large central government patterns that will give them jobs or positions and opportunity for excessive, inefficient expenditures of money and paternalistic control over people. These Committees on Aging are being developed in each state and they have a great responsibility to our people. Their contributions could be unlimited in setting up a pattern for the care of the aged which would prevent another segment of the health-life from being brought into socialization. Possibly something better than the Medicare program may be developed and I say this knowing that Medicare is a form of socialized medicine. In this matter we had no alternative, a subject which I discussed in our Journal. Nevertheless, under this program the patient does have free choice of physician and hospital, there are fees for services and there is no complete fee fixing at a national level.

As for the Medicare program, we must make it work. Inconsistencies and weaknesses can be corrected with time and experience. The doctors of our association have given wonderful cooperation and most of the problems have been settled either by your president who serves as chairman of the Policy Committee or by some other member of the Policy Committee. It was necessary to have three meetings of this committee during the year. It might be interesting for you to know that there were really only two cases where the fee was entirely out of line, based on what would be the going charge to an individual of that community, which is the philosophy and practice of the Medicare program in our state.

Your state organization, in order to better combat undesirable legislation involving the health-life of our people, now has a state legislative contact individual who is kept informed by the A.M.A. of all proposed legisla-
tion. Each Councilor District is organized so that members of each political party are appointed as a committee by constituent medical societies and it is their duty to make the desirable moves.

Since doctors of medicine have always been interested in promoting medical education and stimulating dependable young men to enter the profession, even to the degree of extending financial assistance, the American Medical Education Foundation has been re-activated in our state.

Last year, Dr. Woodward, in his Presidential Address, stated that the state association had some committees which now had no purpose and should be deleted. Several committees have been dropped and others are being considered for deletion. This whole subject is now being reviewed by your Committee on Constitution and By-Laws. In fact, this committee was augmented this last year to help review and rewrite our by-laws, not only as regards committees but to streamline them and have them answer some questions which are not clear at present. Under the able chairmanship of Dr. Raymond Wykoff, there has been a great deal of study and work done and these members will have made a real contribution to our association.

It has been my duty to attend many meetings of the committees of our state organization, meetings called by the A.M.A., the annual meetings of the A.M.A. in Chicago and New York, and the interim meeting in Philadelphia. From these experiences as well as some previous experiences with our state and national organizations, it seemed that here in Nebraska we should make some changes and improvements if we are going to hold up our part of organized medicine. At present we have been paying the expenses of our A.M.A. delegates to the annual and interim meetings of the A.M.A. Meetings of the House of Delegates of the A.M.A. require time and experience of its members. A new delegate is lost, and each state should be developing strong reserve representation. Many other states have had a proportionately greater unofficial representation preparing, training and acquainting their members in our national organization. It seemed to me that something should be done to encourage our alternate delegates to attend these meetings, as this would result in wider dissemination of national-meeting activities to our state membership and help to train members for any future responsibilities. Therefore, the House of Delegates of your Nebraska State Medical Association, at the interim meeting in February, passed a resolution to permit payment of transportation expenses of the alternate delegates to either the annual or interim meeting. This is a step forward.

During the year, the A.M.A. sponsors various meetings which pertain to the activities in the fields which our various state committees represent. It is important that our state association take part in these meetings, get the thinking in the various sections of our country, and help make some contributions. In the past, only on very rare occasions has the state paid the expenses of a chairman, some member of a committee, or some officer of the association to such a meeting. However, some of us have also attended as chairman of a committee, a member of a committee or just as an individual interested in a certain field and in our state association, without any assistance from our state organization. This matter was discussed with the House of Delegates at the interim meeting in February and a resolution was passed permitting the state association to pay transportation expenses of a chairman or his representative to these meetings where our state association felt we should be represented. Again we will be making a contribution to better acquaint our members in the fields involved as well as to promote attention to meetings and action and interest in our state association. We owe a vote of thanks to our Board of Councilors and House of Delegates for these important decisions.

These previous remarks have been words of intended commendation for all concerned. However, we must never fail in our individual lives, professional lives, and community lives to look in the mirror and observe those things for which we might be criticized. During the last two years I have become very sensitive—in fact, allergic—to an “agin it” attitude of our profession and being “agin it,” having failed to substitute a plan to meet the issue. This has concerned me greatly and I am sure each one of you would have had the same reaction if you had been so favored as to have had my position for observation these last two years as president-elect and president of
your state association. Surely we should always concern ourselves enough to criticize, but, as doctors of medicine, we should also offer a panacea or at least constructive criticism. As an example, our people are demanding more security for their later years and we are responsible for the great advance in longevity. This thinking is not wrong but the manner in which it will be accomplished is where the evil lies. The Forand manner is wrong, but we must start thinking, along with the business world, and particularly those in the insurance field, as to just how we can care for the aging in the American way or the Forand type of legislation will be adopted. If each of us will take a more active leadership in our civic and community life, offer leadership, assume responsibilities, and make it a point to commend people and organizations who take an interest in fields kindred to medicine, we can help direct the future pattern of the American way of life rather than to be led and pushed into the ravines of socialism.

In a matter of minutes I will be your retired president, and my final statement is that a better acquaintance with the members of the Nebraska State Medical Association and some interesting experiences further impress me that most of the members have a sincere interest in assuming responsibilities and cooperating in working out the problems for the best medical care of our patients and in accord with good sound medical practice. Again my thanks to all of you.

Remarks of Incoming President

FAY SMITH, M.D.
Imperial, Nebraska

Thank you, Dr. Best.

Dr. Woodward, Members of the Association: I certainly do want to thank you most sincerely for the honor that you have bestowed upon me, but almost at the same time I must say that through the past year, as your president-elect, I have found that there is considerably more than honor that you have bestowed upon me, because I have tried to keep up with Dr. Best; and that is a job. Dr. Best has set a pattern and a pace that is hard to follow. He lives 60 miles from Lincoln and I live 300 miles from Lincoln so that a trip for me does mean 600 miles and I may find it a bit more difficult to attend all the meetings, or at least as many as Dr. Best has attended.

I can assure you that Dr. Best has given of himself, his time, and his substance in great measure and all of you should be very appreciative of him.

I want to say that I could not perform this duty in any manner if it were not for my two partners at home, Doctor Yaw and Doctor Shopp, who are so gracious and so willing to stay at home and keep the doors swinging while I am chasing around the state as your president.

I want to pledge to you that I will do my best. I hope that we will have a good year. I hope that we can handle the things that are thrown at us that are so many and that have attached to them so much taint of government medicine and socialized medicine. Many of them we have to handle whether we like it or not, and it is probably better that we do keep it within our own association, but please don’t think that Dr. Best or I or those who follow me are social-minded when we do try to carry out these programs that the Government forces upon us.

I have two very pleasant duties to perform. One is to pin a Past President’s badge upon Dr. Best, and the other is to present to him the Distinguished Service Award in recognition of distinguished service rendered as President during the year of 1957-58.

Now, Dr. Best, if you will please come forward I will trade a white badge for a green one. I don’t believe it means you have run up a white flag or anything of that sort, but it does mean that you have become a past president. Someone has said that there is nothing quite so past as a past president, but on behalf of all of these men here and on behalf of 1300 doctors throughout Nebraska I want to thank you for what you have done this past year and tell you that we all do truly appreciate it.

CHAIRMAN WOODWARD: It has become almost traditional in the state organization to have representation from certain allied professions as our guests and to have
Greetings from Nebraska State Dental Association

W. J. BRENNAN, D.D.S.
Omaha, Nebraska

Thank you, Dr. Woodward. As a representative of the Nebraska State Dental Association I am both pleased and proud to bring greetings and to wish you Godspeed in launching the 90th annual session of the Nebraska State Medical Association.

May I say that this year’s greeting bearer is cast in the same mold as your last year’s greeter only because our election is still twenty-four hours away.

Since our aims and purposes are identical, this traditional exchange of greetings should continue on down through the years between members of the healing arts. Our problems also are identical in the changing pattern of professional practice wherein the ancient, honorable, direct relationship of patient to health-servant is being replaced by the entrance of the third party: labor unions, governmental agencies, or insurance companies. We, too, are studying the situation but offer no solution. Soon some fifty per cent of our people will be receiving treatment in this manner.

We in dentistry have become a separate, natural, autonomous profession. Our roots are deep in medicine and all of our services must be primarily health-services aside from the mechanical. Consequently, we observe closely and benefit greatly from your research and clinical practice, much of which is first publicized at meetings such as this. Therefore, we pray God will be with you in your deliberations these days in wisdom and that the meeting will be highly successful.

Thank you very much. It is nice to again have the privilege of extending greetings from the Nebraska State Dental Association.

CHAIRMAN WOODWARD: The next item on our program will be a word of greeting from Mr. Paul Martin, president of the Nebraska State Bar Association.

Greetings from Nebraska State Bar Association

MR. PAUL MARTIN
Omaha, Nebraska

Dr. Woodward, and Members of the Nebraska State Medical Association: I am very happy to bring you greetings and best wishes from the Nebraska State Bar Association on this 90th Annual Session of the Nebraska State Medical Association.

When I came to Lincoln I considered what I should say to you in response to my introduction. I thought that this would be a marvelous opportunity to spend at least an hour on the discussion of Law Day, U.S.A., on May 1st, but when I obtained a copy of your printed program I completely changed my mind as to any message to you. I do admire the neatness and dispatch with which you have planned this session. No wonder you can accomplish what you do each day: five minutes to open the meeting; five minutes for the invocation; ten minutes for the presidential address; ten minutes for installation of incoming president; and five minutes each for guest introductions. So I will restrict myself to the allotted time and merely thank you for letting me be with you.

Our purposes are very much the same. We want to raise the standards of the members of our profession. We want to make this a better country in which to live. And, incidentally, we want to be successful enough in the practice of our profession to raise our standard of living, to support our families, and educate our children, and at the same time enable us to save enough money so as to live in comfort in our declining years.

Your Association is doing an excellent job of selling the medical profession to the public-at-large. We envy you your success and hope to benefit by our mutual cooperation. Whenever we can help you in your program, call on us.

Thanks again for the privilege of being with you.

The report of the Necrology Committee was read by Donald J. Wilson, M.D., Omaha, for George B. Salter, M.D., Norfolk, chairman, who has contracted laryngitis. At the conclusion of the reading of the Necrology List the members stood for thirty seconds in silent tribute to, and in memory of the deceased members.
Organization Section

Coming Meetings

Crippled Children's Clinics—
July 12, Chadron, Elks Club
July 26, North Platte, Lutheran Ed. Bldg.
August 9, Broken Bow, Elks Club
August 23, O'Neill, High School

The Month in Washington—

After five months of almost no action whatever on health-medical bills, Congress turned toward them late in the session, with the result that quite a number may be passed before the expected mid-August adjournment.

Most important, the House Ways and Means Committee held two weeks of hearings on the Forand bill and other social security issues. The Forand bill is a highly controversial piece of legislation that first came before Congress in another form six years ago but on which no action has been taken. The bill, strongly opposed by the American Medical Association and most other professional groups, would offer up to 120 days a year of hospital-nursing home care plus surgical services to social security beneficiaries.

Critics of the Forand bill list among their principal objections that the age line couldn't be held once the program were set up, and that the result evenually would be total national compulsory health insurance.

There was no indication from the committee whether it really was serious about the Forand bill or was admitting testimony on it merely because there was no easy way to stop such testimony once it was decided to open up the social security program. There was evidence that the committee probably would give priority to increases in public assistance payments, in view of the unusually large numbers of unemployed.

There was also an unexpected flare-up over Medicare, the military dependent medical care program that has been in effect for 18 months. Here the House Appropriations Committee, acting on mis-information, decided it would save tax money by cutting down on funds for the civilian phase of Medicare, thereby forcing more dependents to use military hospitals, which already care for about 60% of them.

However, before the money bill passed the House, proponents of the cut were convinced that they might have gone too far. They agreed to adopt in conference any reasonable amendments that might be worked out with the Senate.

American Medical Association, American Hospital Association and other professional groups carried on the fight to save Medicare.

Late in the session, Senate committee decided to approve FHA-type mortgage insurance for proprietary nursing homes. This proposal had been supported by the American Medical Association. Speaking for the Association, Dr. R. B. Robins told the Senators that most of the aged population needs a certain amount of skilled nursing and medical care, but not necessarily expensive hospital care. He said that if more and better nursing homes were built, one of the major problems of the aged population would be solved.

Congress also indicated it would enact a number of other health bills, including the following:

A three-year extension of the Hill-Burton hospital construction program, with an amendment to allow loans in place of grants to institutions that objected to direct government aid for religious reasons.

Salary increases for medical personnel in Veterans Administration and general pay raises for the military, which would benefit doctors in uniform.

Authorization for grants totaling $1 million a year to the nation's schools of public health; this was amended to rule out use of the money for ordinary operating expenses.

A public works program, under which communities would be eligible for grants to build schools, hospitals, nursing homes and other facilities.

NOTES

Congressmen frequently sound out voter sentiment through the well-used poll method. A recent one by Rep. Harold Collier (R., Ill.), who comes from Chicago, turned up some interesting views on the question of whether the social security system should be used to finance medical care to all those under the program. Opposed were 73%.

(Continued on page 310)
Lee D. Gartner, M.D., was born in Lincoln, Nebraska, on August 31, 1927. His pre-medical education was completed at the University of Nebraska. He graduated from the University of Nebraska College of Medicine in 1949.

Following his internship at the Alameda County Hospital, Oakland, California, from 1949 to 1950, he completed a three-year residency in Urology at the Duke University Hospital in Durham, North Carolina from 1952 to 1955.

Doctor Gartner served from 1949 to 1952 as a Medical Officer with the United States Navy.

He practiced Urology at Olympia, Washington, from 1955 to 1956. In 1957 he entered practice in association with Dr. Louis W. Gilbert at Lincoln, Nebraska.

Doctor Gartner is a member of the Northwest Urologic Society. He is a diplomate of the American Board of Urology.

He and his wife, Lois, are the parents of Deborah Jean, 3 and Joe Alvin, 2. They reside at 898 Moraine Drive, Lincoln, Nebraska.

Hunting and fishing are Doctor Gartner's favorite pastimes.

Randal N. Ochs, M.D., was born in Idaho, on October 4, 1917. He received his elementary education in Oregon and his pre-medical education at Walla Walla College in Walla Walla, Washington.

He received his Doctor of Medicine degree from the College of Medical Evangelists in Los Angeles, California, in 1953, after which he interned at the Deaconess Hospital.

Doctor Ochs is a member of the American Academy of General Practice.

He was in general practice in Wheaton, Missouri, from 1955 to 1957. He has been in practice in Omaha since August, 1957. He, his wife, Ellen, and their three children, Daryl 17, Sharlene 14, and Randy 4 reside at 3560 South 48th Street, Omaha, Nebraska.

Carl Peter Tranisi, M.D., was born in Omaha, Nebraska, on October 27, 1922. He received his elementary education in Omaha, Nebraska. After completing his pre-medical education at the Creighton University, he attended the Creighton University School of Medicine from which he graduated in 1950.

Following his internship at St. Joseph's Hospital in Omaha, from 1950 to 1951, he completed a residency in General Surgery at the Creighton group of hospitals and at the Omaha Veterans Hospital.

Doctor Tranisi served as Chief of Surgery in an Air Force hospital for two years. After returning to Omaha, in 1957, Doctor Tranisi was Assistant Chief of Surgery from 1957 to 1958 at the Omaha Veterans Hospital.

Doctor Tranisi, his wife, Marie, and their four children, Carla 6, Christy 5, Paul 2½, and Frank 8 months, reside at 3123 South 72nd Avenue in Omaha.

His favorite pastime is photography.

Since January, 1958, Dr. Tranisi has been in private practice at 1515 Medical Arts, Omaha, Nebraska.
MEMBERS

Patrick C. Gillespie, M.D., was born in Omaha, Nebraska, on February 9, 1922. His early education was received at St. John's Grade School and Central High School in Omaha. His pre-medical education was taken at Creighton University. After receiving his degree, Doctor of Medicine, from the Creighton University in 1952, he interned from July, 1952 to July, 1953 at St. Joseph's Hospital in Omaha, Nebraska.

After a one year residency in Internal Medicine and a two-year residency in Diagnostic Radiology at the Omaha Veterans Hospital, Dr. Gillespie completed a one year residency in Therapeutic Radiology at the Methodist and University of Nebraska Hospitals.

Doctor Gillespie served with the United States Army from 1943-1946.

Doctor Gillespie is a member of the Phi Beta Pi, medical fraternity and the Nebraska State Radiological Society, and is an associate member of the American College of Radiology.

He began practice July 1, 1957, in Beatrice, Nebraska, doing the radiology for the Mennonite and Lutheran Hospitals and the Beatrice State Home. He, his wife, Donna, and their three children, Stephen 3, Mary 2, and Sean 1 reside at 1708 North 15th Street in Beatrice, Nebraska.

Doctor Gillespie enjoys golf, gardening, and reading.

Ronald E. Waggener, M.D., was born in Green River, Wyoming, on October 6, 1926. He received his elementary education in Cheyenne, Wyoming, and his pre-medical education at Colorado A & M, Oregon State College, and the University of Nebraska where he received his Bachelor of Science Degree.

Doctor Waggener graduated in Medicine from the University of Nebraska in 1954, and interned at the University of Nebraska Hospital. He completed a residency in radiology at the University of Nebraska Hospital and the Nebraska Methodist Hospital in Omaha, and St. Bartholomew's Hospital in London. He also received a Master of Science degree in Anatomy and a Ph.D. in Medical Science (Radiology) from the University of Nebraska.

At the present time Doctor Waggener is on a tour of British and Continental Medical Centers as a Fellow in Radiotherapy of the American Cancer Society. His wife, Ann, and four children, Marta 8, Nancy 5, Paul 3, and Daphne 1½ are touring Europe with him.

Doctor Waggener's tour with the United States Army was completed in 1946. He is a member of the Sigma Xi, Alpha Omega Alpha, British Institute of Radiology, American Association for Cancer Research, Associate in Nebraska State Radiological Society, and is an Associate in the Royal Society of Medicine.

Doctor Waggener's hobbies other than his four children, which take up most of his time, are photography and radiobiology.
In Memory of Our Deceased

NECROLOGY LIST
90th Annual Session
Nebraska State Medical Association
(1957-1958)

BABCOCK, J. BLAINE.............................................. Los Angeles, Calif..............................May 25, 1957
(Ingleside)

BRADLEY, EDWIN B.................................................. Spencer..............................November 27, 1957

BRADY, R. R.......................................................... Ainsworth.........................June 28, 1957

BRYSON, R. D.......................................................... Callaway.................................July 19, 1957

BYERS, JOY CLAYTON................................................ Phoenix, Ariz.................................May 25, 1957
(Friend)

CHURCHILL, I. W.................................................. Lincoln.................................October 4, 1957

CLARKE, F. S.......................................................... Omaha.................................October 21, 1957

DE MAY, G. A.......................................................... McCook.................................January 6, 1958

DOUGLAS, W. J.......................................................... Atkinson.........................January 23, 1958

DRUMMOND, C. C.................................................. Medford, Ore..........................September 25, 1957
(Norfolk)

DUNCAN, CARY G.................................................. Lincoln.................................January 25, 1957

ECKLES, DORA B.................................................. York.................................August 28, 1956

EDMONDS, WILLIAM.............................................. Nebraska City.........................January 24, 1958

EHLERS, O. C.......................................................... Ravenna.................................January 30, 1958

GARNER, F. L.......................................................... Madison.................................October 14, 1957

GASS, CHARLES C.................................................. Omaha.................................May 31, 1957

GERALD, HERBERT F............................................... Lake Zurich, Ill.........................October 18, 1957
( Omaha)

GERISH, NETTIE L.................................................. Omaha.................................October 16, 1957

GILLISPIE, EDWARD.............................................. Los Angeles, Calif...................March 21, 1957
(Fullerton)

GLATFELTER, HARVEY E.......................................... Central City............................August 26, 1957

HANSEN, N. P....................................................... Omaha.................................November 2, 1957

HART, R. L............................................................ Kearney...............................July 31, 1957

HARVEY, HENRY M................................................. Gothenburg..............................November 30, 1957

HENSEK, J. A.......................................................... Omaha.................................June 23, 1956

HUBER, PAUL.......................................................... Crete.................................October 31, 1957

INGRAM, J. E.......................................................... Nelson.................................September 18, 1957

JUDKINS-DAVIES, D. M............................................. Silver Springs, Md.......................October 9, 1957
(Ingleside)

KENNEDY, H. B....................................................... Omaha.................................August 22, 1957

KOLOUCH, F. G...................................................... Schuyler.................................October 10, 1957

KORTH, Z. N.......................................................... Omaha.................................January 30, 1958
In Memory of Our Deceased

NECROLOGY LIST
90th Annual Session
Nebraska State Medical Association
(1957-1958)

KRIZ, R. E..............................Lynch..........................December 15, 1957
LEAR, WILLIAM D......................Ainsworth.........................February 10, 1958
LEWIS, GEORGE ......................Lincoln..........................February 7, 1958
LYMAN, R. A..........................Lincoln..........................October 12, 1957
MALLOY, E. F........................Fremont..........................April 15, 1958
MARTIN, R. D........................Grand Island.........................July 1, 1957
McEACHEN, ESTHER I..............Eldridge, Calif..........................**

MEISENBACK, GEO. W..................Plymouth..........................October 2, 1957
MILLER, W. C..........................Portland, Ore......................November 29, 1957

NILSSON, JOHN FREDERICK...........Omaha..........................February 9, 1958
NOYES, W. W..........................Ceresco..........................August 4, 1957
PANTER, S. G., JR......................Hebron..........................July 25, 1957
PAUL, JAMES R......................North Hollywood, Calif.............March 30, 1958

PETERSON, JOHN......................Lincoln..........................February 13, 1958
RAMACIOTTI, W. S....................Nebraska City........................March 3, 1958
RASMUSSEN, N. H.....................Longmont, Colo.....................November 27, 1957

RAYNOLDS, ELMER L...................Mankato, Kansas....................July 29, 1957

RICH, R. G..........................David City........................February 13, 1958
ROOT, B. A............................York............................April 4, 1958
SHUPE, Lester........................Caldwell, Idaho..................December 7, 1957

SISLER, FRANK H......................Bristow, Oklahoma..............November 23, 1957

SWANSON, L. A.......................Camarillo, Calif..................October 21, 1957

VAN METRE, R. T.....................Bradenton, Florida..............June 14, 1957
WALLINGFORD, CHARLES C............Los Angeles, Calif................August 16, 1957

WARTA, J. J..........................Omaha..........................April 14, 1958
WINKLE, V. M........................Topeka, Kansas..................December 31, 1957

YOUNG, G. ALEXANDER.............Omaha....................................November 3, 1957
The Month in Washington—
(Continued from page 305)
favoring were 26%, and only 1% had no opinion. On the question of expanding mandatory social security, the response was 47% yes, 48% no and 5% no opinion.

The National Health Survey has found in a preliminary study that 25 million persons in the country were injured badly enough in the second half of 1957 to require medical attention or to limit their activities for at least a day. Home accidents led the cause of injuries, 40.3%; work accidents, 16.7%; motor accidents, 9.8%, and others (including violence), 33.1%.

The A.M.A. has gone to bat for the post of Assistant Secretary of Defense for health and medical affairs. Under proposals of the administration and Congress, the job would be downgraded to that of special assistant. Dr. F. J. L. Blasingame, A.M.A. general manager, told Congress the best interests of the military, the medical services and the country would be served by continuing the post.

Dr. James V. Lowry has been named chief of the Bureau of Medical Services. He has served as deputy chief under the late Dr. John Cronin. Dr. Lowry is a graduate of the University of Wisconsin Medical School.

Rep. Thomas Jenkins (R., Ohio), who is planning to retire from Congress, has been praised by Senator Bricker for his important contribution in the field of legislation for the self-employed. He is the author of a bill to permit physicians and others to defer income tax payments on funds paid into annuity plans.

MEDICARE IN OPERATION

(In the Journal for June, p. 263, appeared the first in a series of articles under this title. Editor).

This is the second in a series of articles designed to give more information regarding the Dependents' Medical Care Act. This article will deal with Obstetrical and Maternity services.

A scale by which ante-partum fees are calculated is as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. First 6 weeks of pregnancy</td>
<td>$6.25</td>
</tr>
<tr>
<td>b. Next 4 weeks of pregnancy</td>
<td>3.00</td>
</tr>
<tr>
<td>c. Next 4 weeks of pregnancy</td>
<td>3.00</td>
</tr>
<tr>
<td>d. Next 5 weeks of pregnancy</td>
<td>4.00</td>
</tr>
<tr>
<td>e. Next 4 weeks of pregnancy</td>
<td>4.00</td>
</tr>
<tr>
<td>f. Next 4 weeks of pregnancy</td>
<td>4.00</td>
</tr>
<tr>
<td>g. Next 3 weeks of pregnancy</td>
<td>8.50</td>
</tr>
<tr>
<td>h. Next 3 weeks of pregnancy</td>
<td>8.50</td>
</tr>
<tr>
<td>i. Next 3 weeks of pregnancy</td>
<td>8.50</td>
</tr>
</tbody>
</table>

A physician rendering normal ante-partum care may be considered to have rendered full care for the fractional period of a trimester if he sees the patient but one time in this period.

A physician rendering ante-partum care beginning anytime within the first eight weeks of pregnancy, continuing with the patient through delivery and post partum care is entitled to full maternity care, if he does not submit his statement until post-partum care is completed. In order to cut down on the time consumed in completing the statement, it is permissible to list the inclusive dates of prenatal care rather than list each visit separately with the charge calculated according to the chart.

A physician may also add to his statement the cost of laboratory work performed for maternity patients in his office or for work performed in a laboratory for which the physician has paid. If the laboratory is operated by a physician, the laboratory physician may submit a statement for service rendered indicating that he has performed the service at the request of the attending physician. This refers to all necessary laboratory services, with the exception of routine urinalysis, for which there is no allowance.

A physician, if he feels that remuneration above that is called for in the schedule of allowances is justified by multiple births or other complications of pregnancy, may submit a special report justifying his additional charge. This report will be submitted to the Policy Committee of the Nebraska State Medical Association, the contracting agent, for their recommendation, who will forward it to the Office for Dependents' Medical Care for adjudication.

If pregnancy terminates in any type of caesarean section and the patient is referred to another physician for the operation, the referring physician is entitled to fee for any ante-partum care he may have rendered and to the fee for post-partum care if he renders this service. However, if the same physician that provides the ante-partum and
post-partum care does, the surgery, the change for these services are included in the payment for the surgery.

In accordance with O.D.M.C. Letter No. 13-58 dated May 29, 1958, oral drugs will no longer be furnished to maternity patients at government expense through Medicare after July 1, 1958. After this date, payment for oral medication dispensed or prescribed by physicians providing care authorized under the Medicare Program to eligible dependents will be the responsibility of the patient or sponsor.

Physicians furnishing authorized care to eligible dependents under Medicare may include the cost of them, of those drugs which they administer parenterally, provided such drugs are necessary and directly related to the condition for which authorized care and treatment are being furnished.

In order for a physician to obtain reimbursement for any drug administered parenterally, he must identify the nomenclature and quantity of the drug and set forth the cost to him on the claim form or attached thereto. No service or breakage charge is payable.

Claims received on or after July 1, 1958, for drug items furnished prior thereto may be paid in accordance with the policy in effect on that date.

Medicare patients may continue to obtain medication from pharmacies of uniformed services medical facilities upon prescription of a civilian physician if the items prescribed are available there; or, they may obtain such medication from civilian pharmacies at their own expense.

MEDICINE IN THE NEWS
From the Osceola Record—

Dr. Charles W. Jeffrey of Rawlins, Wyoming, made a recent visit to Osceola and at that time completed all the necessary arrangements for the financing and construction of a hospital addition. This addition will be attached to the present hospital building and will provide additional patient rooms, sun porch, formula room and nurses' station.

The estimated cost of this addition is from $120,000 to $150,000. In order to make it possible to construct this addition at this time, rather than wait until sufficient funds have accumulated, Dr. Jeffrey approved plans for immediate construction and advanced the hospital trust fund a sum of $100,000 to be used with present funds to pay for the building of the addition.

From the West Point Republican—

The Medical Staff of Memorial hospital at West Point and their wives were honored at an informal banquet by the Sisters of the hospital early in May.

Senator John E. Beaver of Beemer presented an informative talk explaining the legislation concerning the “For and Bill” and its possible consequences.

Dr. I. L. Thompson was given special honor for his 50 years of medical service rendered to this community and surrounding area. He was presented with a set of gold embossed book ends, in behalf of the Sisters, in lieu of his golden anniversary.

From the Lincoln State Journal—

Lincoln may have its first community-wide mental health clinic by early 1959. Father Tom Johnson made this report to the Lancaster County Association for Mental Health at their first annual meeting, in May.

He said plans of the special mental health committee recently set up by the Community Council "give me every reason to believe a clinic will be operating by or about January of next year."

Roger Dickeson, association president, said the organization will work primarily for mental health education in the community. This function, he said, can perform a vital service to the proposed Community Council's mental health clinic by funneling persons to the clinic, education to the public on the clinic facilities and by volunteers' service to the clinic.

From the Columbus Telegram—

Creighton University has received a $1000 grant from the Columbus United Fund for use in heart research. The formal presentation of the check was made by Dr. E. E. Koebbe of Columbus who is a member of the Creighton Faculty.

A similar grant of $1000 for heart research will also be made to the University of Nebraska.
The United Fund board has also announced a grant for infantile paralysis research and plans to make a grant for cancer research.

From the Columbus Telegram—

The State of Nebraska will buy $12,000 worth of Salk polio vaccine during the current and coming fiscal years, State Director of Health Dr. E. A. Rogers has announced.

The vaccine will be kept at the statehouse and shipped to physicians upon request, he said.

The House of Delegates of the Nebraska State Medical Association approved such purchases at the annual session in April so that the state could provide it to doctors for the needy and indigents.

From the Cozad Local—

Because Dr. T. D. Fitzgerald loves to teach, he doesn't mind a 900-mile commuting trip.

Once every two weeks, Dr. Fitzgerald travels from Alliance to Omaha to spend a day teaching in the Creighton University department of preventive medicine and public health which he formerly headed. He returns to Alliance that night.

"I've been doing this since 1953, Dr. Fitzgerald says. "It's a voluntary arrangement."

From the Hastings Tribune—

Five additional psychiatrists, trained at the Nebraska Psychiatric Institute in Omaha, will be placed in Nebraska’s State Mental Hospitals at Norfolk, Hastings, and Lincoln sometime in July, according to Board of Control Member Charles Leeman.

Mr. Leeman said they are the first to be trained under a program at the institute which carries the stipulation that psychiatrists will serve the state in a mental hospital for two years.

The availability of five psychiatrists every year for the hospitals will relieve the physician shortage, he said.

From the Lincoln Journal—

A 3-man research team at Creighton University School of Medicine has received a $12,748 extension grant for cancer research from the National Cancer Institute.

Team members are Dr. L. T. Heywood, associate professor of obstetrics and gynecology; Dr. Vincent Moragues, professor of pathology; and Dr. John F. Sheehan, research associate professor of cytology.

From the Hastings Tribune—

The Board of Directors of the Oxford Hospital have approved a construction program for a $25,000 addition to the hospital in Oxford.

The new wing will provide the hospital with a complete maternity ward on the second floor. The first will provide an apartment for the director of the nursing staff.

From the Omaha World-Herald—

Plans for an "intensive care unit" in Immanuel Hospital's soon-to-be-built surgical suite were announced recently.

The unit plan has been adopted by the hospital to keep costs at a minimum for patients who do not require constant attention.

The intensive care unit will be for critically-ill patients. Already in use are units for recovery after surgery, standard floor care and minimal care.

The latter is for patients in for diagnosis, laboratory tests and X rays. Costs in this unit are reduced 40 to 50 per cent because the patients need little nursing care.

From the Omaha World-Herald—

Some 60 children between the ages of eight and 15 enjoyed a two-week camping session at Camp Floyd Rogers near Nebraska City during the first two weeks in June.

They enjoyed all the games and activities of summer camp. But in one respect these children were different. They were diabetics and in addition to normal activities they learned how to care for themselves and why care is necessary.

The camp is co-sponsored by the Nebraska Diabetic Society, Nebraska State Medical Association and Creighton University and University of Nebraska Medical Schools.

Miss Anna Smrha of the State Health Department in Lincoln was in charge. Miss Smrha said the camping session gives the
children independence from their parents and give the parents a welcome relief.

From the Omaha World-Herald—

Dr. Earle G. Johnson, Grand Island, was one of three University of Nebraska alumni to receive Distinguished Service Awards at the annual commencement exercises in June.

Presentation of the awards, conferred jointly by the university’s Alumni Association and Board of Regents, were made at the annual alumni Roundup luncheon. The recipients were also honored at the morning commencement program and were presented medallions from the university.

Dr. Johnson served on the Board of Regents from 1951 to 1958 when he resigned.

DOCTOR GUNNAR GUNDERSEN

In taking the oath of office as 112th president of the American Medical Association June 24 in San Francisco, Dr. Gunnar Gundersen called attention to the physician’s obligations on the international scene. The 61-year-old LaCrosse, Wis., surgeon said: “As both physicians and citizens, we must see that medicine plays its full role, not only in promoting better world health, but also in helping the search for brotherhood and peace.”

As American citizens, Dr. Gundersen said, “our first duty is to this country. But as members of the brotherhood of man, we also have a duty toward all men who yearn for freedom, dignity and peace.” He further pointed out that “medicine can play a vitally effective part in bringing reality to the dream of world peace. For medicine, despite the designs of politicians or dictators, is above the harsh conflicts of ideologies and power policies. Medicine, like religion, speaks a universal language which passes all barriers of race, creed, color and nationality.”

Dr. Gundersen has been active in state and national medical affairs throughout his practice. He was president of the State Medical Society of Wisconsin in 1941-42, served on a number of the society’s committees, and was speaker of its House of Delegates for about five years. He was a member of the A.M.A.’s House of Delegates in 1937-38 and was elected to the A.M.A. Board of Trustees in 1948. He became chairman of the Board in June, 1955. His keen interest in hospital affairs and the quality of hospital service led to his election as the first chairman of the Joint Commission on Accreditation of Hospitals when it was formed in 1951. He served in that capacity until 1953.

He now operates the Gundersen Clinic in LaCrosse, along with three of his physician brothers, Sigurd B., Alf H., and Thorolf E. Two other physician brothers, Drs. Trygve and Sven M. Gundersen, are practicing in Boston and Hanover, N.H., respectively.

Dr. Gundersen did his prep school work in Oslo, Norway, and returned to the U.S. to obtain his B.S. degree from the University of Wisconsin in 1917, and his M.D. from Columbia University in 1920. He served his internship and residency at LaCrosse Lutheran Hospital from 1920 to 1922. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons and the International College of Surgeons, a member of the Council of the World Medical Association, and a member of the American Public Health Association.

NEBRASKA DOCTORS RECEIVE PUBLIC ACCLAIM

Public expressions of respect, gratitude, friendship, and love warm the hearts of many of our doctors from time to time. Such public acclaim usually, and rightfully, falls to the lot of the family doctor. During the past month the newspapers have carried stories of a number of such heart-warming experiences. Those we have come upon are as follows:

Doctor John Woodin of Grand Island was honored at a special service and reception at the First Baptist Church of Grand Island on June first. A special program entitled “This Is Your Life” was narrated by Merton Bilsland. The doctor’s fifty years of service to humanity and his community formed the background of this special acclaim. (From Grand Island Independent).

Doctor C. D. Williams of Genoa was the subject of resume of his long service in that community, published in the Leader-Times of Genoa, May 29th, under the heading “Dr. Williams Honored for Half Century of Practice.”
Doctor Homer Davis, also of Genoa, received acclaim in the Independent, Grand Island, under the title “Genoa Doctor Practiced for 57 Years.” In this, Jack Bailey has touched all the important highlights of a great professional life.

Doctor I. L. Thompson of West Point, we see by the West Point Democrat, was honored by his hometown through the Chamber of Commerce, for his fifty years of service to the community by the practice of medicine and civic activities. The celebration took place on June 9th.

PROTECT YOUR MEDICAL CREDENTIALS

Today, hundreds of doctors who left their homelands during World War II and the Hungarian uprising are working as laborers, research assistants, or hospital service personnel because they have no means of proving they are medically trained and fully accredited medical practitioners. This could happen to American doctors.

The World Medical Association has provided insurance against such loss by providing a central repository at which all judicious precautions will be exercised to protect the depositor’s records. To utilize this service the doctor completes application and identification forms which he transmits with microfilm or photostatic copies of his credentials to the Secretariat. When he needs his credentials they are returned to him or to his duly authorized representative upon submitting suitable acceptable identification proving the credentials to be his property.

The rates for this service are reasonable and based upon the cost. Write The Secretariat, The World Medical Association, 10 Columbus Circle, New York, N.Y., for information and application blanks.

FLUORIDATION OF WATER
FOR PUBLIC CONSUMPTION

In sharp and direct contrast with the action of the House of Delegates of the American Medical Association is that of the Association of American Physicians and Surgeons, Inc. It is somewhat difficult to understand how, upon similar information, these two bodies were diametrically opposite in their conclusions. The principle enunciated in the first “WHEREAS” in the following resolution seems so clearcut that one is inclined to favor the action of the Association of American Physicians and Surgeons in passing this resolution:

RESOLUTION ON USE OF WATER SUPPLY AS VEHICLE FOR DRUGS

WHEREAS, the right to determine what shall be done to one’s own body is fundamental, and

WHEREAS, water is necessary for life, and

WHEREAS, many people are dependent on public supplies for water,

THEREFORE, BE IT RESOLVED that the Assembly and House of Delegates of the Association of American Physicians and Surgeons, Inc., in regular session assembled in San Francisco, California this 12th day of April, 1958, condemns the addition of any substance to public water supplies for the purpose of affecting the bodies or the bodily or mental functions of the consumers,

AND BE IT FURTHER RESOLVED that copies of this resolution be transmitted to the President of the United States, the members of Congress, the Governors of the several states, and the mayors of our principal cities, and released to the media of public information.

News and Views

Texas Medical Association Withdraws
From Medicare—

Under the above headline the Texas State Journal of Medicine announces the withdrawal of the Texas Medical Association from the Medicare program. The Texas House of Delegates “... reiterated its disapproval of federal control of medical service to civilians and stated that Medicare is a potent opening wedge for the complete nationalization of the American system of medical practice which would lower the present high quality of medical care. . . .”

“Stormy as debate on the Medicare proposal has been in each session of the Texas House of Delegates . . ., there seemed to be unanimity in the 1958 House (1) that adequate medical care should be available to families of servicemen with free choice of physician, (2) that the principle of government interference is to be censured, and (3) that the Board of Trustees, the Committee
on Medicare, and Blue Shield of Texas deserve commendation for their service on behalf of the Association."

It is pointed out the families of servicemen can still get the same care from civilian sources, but that the individual private doctor who wishes to continue service will deal directly with the patient and the government.

Donations to Heart Fund Highly Satisfactory—

While complete campaign returns were still not in, it appeared that the total donations would approach the "national probability" of $22 million. The more interested the average layman in a given organ and its diseases, the heart, for example, the more freely he donates when there comes an appeal for funds to study and perhaps relieve the ills of that organ.

Why Do Doctors Support Blue Shield?—

An instance of mistaking Blue Shield for just plain health insurance rather than as a means of supplying people in lesser income brackets with good medical care is described in Secretary's Letter No. 437, as follows:

"Profound changes took place recently within the Connecticut State Medical Society as a result of the still unresolved controversy between a large number of physicians of Connecticut and the Connecticut Medical Services, Inc. (Blue Shield). Continued negotiations to end the controversy are earnestly desired by both parties.

"In 1949, Connecticut Medical Service was sponsored by the Connecticut State Medical Society as its agency to sell and administer a low cost contract for prepayment of physicians' services. The original intent of the society was to provide service benefits for subscribers in the lowest one-third income group only, but coverage was gradually extended until 52 per cent of Connecticut wage earners and their families (up to $5,000 family income) were eligible. Over 90 per cent of the doctors of the state participated in this program.

"The present controversy developed rather abruptly on Feb. 5, 1958, when Connecticut Medical Service announced in its bulletin to participating physicians that the state insurance commissioner had just approved a new CMS contract which (1) raised service bene-

fit levels to $7,500 family income, (2) integrated CMS with a private insurance carrier to provide medical catastrophe expense benefits, and (3) included a number of stipulations and restrictions not in prior contracts.

"Several questions were raised:

"(1) Why had no detailed information concerning this contract been distributed to physicians of the state in general and to CMS participating physicians in particular? "(2) Why had the new contract not been submitted to the House of Delegates of the Connecticut State Medical Society for approval before its presentation to the insurance commissioner?

"Protests by small groups of physicians proved ineffectual in alerting the situation and opposition snowballed to such size as to elect practically a complete new slate of officers in three of the largest county associations, defeating incumbent slates. Similar action was achieved in the state society April 29, 1958, and the House of Delegates, by an appreciable majority, voted to disapprove the new CMS (integrated) contract and requested CMS to withdraw it immediately and permanently.

"The Council's public statement on May 6, 1958, outlined the official position of the Connecticut State Medical Society as made clear at the House of Delegates meeting on April 29, 1958, and indicated its desire to continue negotiations with the board of directors of Connecticut Medical Service, Inc."

"New Captain of the Men of Death"—

Under the above title appeared a short editorial in a recent issue of the New York State J. Med. This is to the point in discussion of the "New Captain"—the hemolytic staphylococcus aureus—especially in recent respiratory infections. Distinct, pointed, concrete suggestions are made about the methods of treatment as well as means of protecting other patients from the infection.

Financing Health-Care for the Senior Citizens—

At the annual meeting of the Health Insurance Association of America, in May, Dr. F. J. L. Blasingame, General Manager of the A.M.A., posed the financing of health-care of the senior citizen as one of the major problems needing immediate solution by health insurance and medicine. He cited as
objectives of a newly formed Council to Improve the Health Care of the Aged, the development of a program to foster better health care for older people regardless of economic status, and to increase their health insurance coverage. This new council is jointly sponsored by the A.M.A., American Hospital Association, American Dental Association, and American Nursing Home Association. This council will "explore economic mechanisms for meeting the problem without federal intervention."

Doctor Blasingame said "In one area, however, the promotion of better facilities designed especially for the aged, the Joint Council will press for federal assistance. We need special facilities tailored to meet the problems of the aged patient, where the health care provided is adequate and the cost is low."

Army Medical Interns Announced for 1958-59—

The Surgeon General of the Army has announced that during the fiscal year 1959, which begins July 1, 1958, a total of 178 Army interns, representing 67 medical schools throughout the United States, will begin a 1-year rotating type internship at 10 Army Hospitals. These interns will receive essential experience in surgery, including urology and orthopedics; medicine including contagious diseases; pediatrics, gynecology, and obstetrics.

The Hebrew Medical Journal—

We are in receipt of the two volumes of The Hebrew Medical Journal published in 1957. This journal has been in continuous publication for 30 years; it is written in Hebrew with summaries in English. The chief aim of this publication has been to help create a medical terminology and literature in the language of the Bible. It has presented many important original medical studies on the medicine of the Bible, Mishnah, and Talmud, as well as the role played by Jewish physicians in the history of medicine throughout the ages.

Volume 2, 1957, is especially interesting because it presents the health conditions in Israel. It reveals the remarkable advances made along many lines during the short space of time, 1949-1957.

More Social(?) Security(?)—

We see by the A.M.A. Washington Letter 85-74 that: A bill that may eventually be considered by the House Ways and Means Committee is Rep. Hale Boggs' H.R. 12493. It increases existing social security benefits by 10% or $5, whichever is larger, and provides for an increase of the existing schedule of taxes by approximately 1/2%. Another bill by Rep. Anfuso, H.R. 12568, provides for a 40% increase in benefits and more than doubles the tax rates to meet the higher costs. The bill also lowers retirement age for men and women to 62 with no diminution of benefits."

To Limit Freedom of Choice in Medicine—

The effort to limit freedom of choice in Defense Department's Medicare program has begun. It has been predicted that, although the Medicare program is a form of state medicine, it would not be pleasing to the socialists. It permits too much freedom to doctors and patients. The present effort at limitation has begun as a limitation of funds; to stay within the budget of lowered funds, it will be necessary to limit free choice of physician and hospital and direct more of the sick dependents to utilize hospitals and medical facilities of the services. This move is said to be due to a misinterpretation of information furnished the House Appropriation Committee. It will be interesting to watch and try to determine how much misinterpretation has been wilful and how much accidental.

Four Countries Have Contributed to "Special Malaria Fund"—

Since the organization of the special fund for eradication of malaria, in 1957, four countries of the many under the P.A.S.B., Regional Office of the World Health Organization, have contributed to this fund, as follows:

The Dominican Republic, $100,000; the United States, $3,500,000 (over and above the payment of one-third of the more than $13 million annual budget of W.H.O.); Venezuela, $300,000; and Haiti, $5,000.

A.A.G.P. and A.M.A.: A Disturbing Comparison—

The Annual Clinical Meeting of the A.M.A. held in Philadelphia last December, a meeting designed particularly for the generalists, had a registration of 2637 physicians. Eleven registrants were from Nebraska. The Dallas meeting of the A.A.G.P. in March had more than 3500 registrants.
and 49 of them were from Nebraska. Perhaps it is high time to delete the midwinter clinical meeting of the A.M.A.

How the A.M.A. Spends Its Dollar—

According to the Illinois Medical Journal the A.M.A.-dollar is spent as follows:

Public Relations Department.$400,000  
Council on Medical Education and Hospitals 376,000  
Bureau of Health Education 296,000  
Washington Office 227,000  
Council on Medical Service 206,000  
Membership Records 202,000  
Bureau of Medical Economic Research 173,000  
Biographical Records 155,000  
A.M.E.F. Overhead 119,000  
Law Department 111,000  
Bureau of Exhibits 109,000  
Council on Drugs 99,000  
Council on Industrial Health 76,000  
Council on Rural Health 68,000  
Council on Medical Physics 61,000  
Council on Foods and Nutrition 56,000  

Annual receipts amount to about $10 million of which about one-half is derived from dues and subscriptions and the remainder from advertising and “other sources.”

Hospital Construction in Nebraska—

A note from the Washington Office, American Medical Association dated April 30, advises that the status of hospital construction in Nebraska may be summed up as follows:

Approved, but not yet under construction: 48 projects at a total cost of $25,296,715, including $7,046,508 federal contribution and designed to supply 1,141 additional beds.

Under construction: 10 projects at a total cost of $6,309,421, including $2,230,650 federal contribution and designed to supply 105 beds.

Completed and in operation: one project at a total cost of $340,280, including federal contribution of $136,112 and supplying 12 additional beds.

This signifies that the average cost per bed in the completed project is more than $28,000 and for the total approved construction, more than $22,000.

Foreign Graduates in the United States—

The foreign graduate in medicine who comes to the United States either on an exchange educational basis or immigration basis has many serious problems to meet. The corollary of this is that they bring many problems to hospitals, teaching facilities, and state boards for licensure. Doctor S. D. Ezell, Secretary of the State Board of Medical Examiners for New York has discussed this problem and thoroughly analyzed it in World Medical Journal for May, 1958.

Doctor Ezell points to three outstanding handicaps — language, citizenship-requirement, and lack of good evidence of adequate medical education in their homelands. Evidence of the size of the problem and its lack of solution can be seen by reference to the following statement: “Since 1935, there have been more than 25,000 foreign trained physicians admitted to the licensing examinations. Since 1946, a total of 7,225 of these have passed the licensing examinations in one of the state boards, and are licensed to practice.”

Believing the language-problem to be paramount, Doctor Ezell suggests: “Prospective Exchange Visitors should have intensive English language practice for at least six months before arrival.” Having this experience with our language, the visitor should be introduced to American methods in teaching and practice by way of an internship for the first year. This will allow proper orientation for more specialized training.

Attendance at House of Delegates—

It is encouraging as well as interesting to note that more of our constituent societies were represented during the annual session than has been the case in some of our meetings of the House of Delegates of the Nebraska State Medical Association in the last few years. Even so, eighteen of our counties or areas were not represented. The delegates who were here to represent their societies did so with much greater regularity. Most of them attended all three sessions of the House.

Sprue and Military Research—

Sprue and gastro-intestinal wounds are uncommon among peacetime U.S. Army personnel. Army scientists seeking more effective means of treating extensive gastro-in-

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intestinal wounds which may occur in any future war have found that patients suffering from sprue provide them with their best opportunity in peacetime for the study of metabolic abnormalities which resemble those found in patients with extensive gastro-intestinal wounds.

Puerto Rican civilians suffering from the malnutrition deficiency disease known as sprue may volunteer for hospitalization and treatment by Army Medical Service researchers investigating the disease, the Army Surgeon General's Office has announced.

Officials at the University of Puerto Rico are enthusiastic in their support of the project, as the civilian population of that country will benefit from the studies.

Cooperating with the Army investigators will be Dr. Harold K. Hinman, Dean of the Medical School, and Dr. E. Diaz-Rivera, Professor of Medicine at the University of Puerto Rico, who will select suitable Puerto Rican civilians with sprue for hospitalization for research purposes.

Those patients who volunteer for hospitalization will be treated in a new research ward at Rodriguez U.S. Army Hospital, San Juan, to be established as a part of the U.S. Army Tropical Research Medical Laboratory.

Doctors and Drug Samples—

As a service to the pharmaceutical industry, the American Medical Association's advertising department is sponsoring a study of the part that drug samples play in medical practice.

The program is being conducted by Taylor, Hawkins and Lea, Inc., a medical marketing research firm with offices in Philadelphia.

The program is designed to provide basic facts on the uses to which drug samples are being put by practicing physicians. Information on what actually is done with samples reaching a physician will be studied in relation to the kinds of patients he sees and the conditions he treats, the types of drugs which he uses and other aspects of his practice.

Results of the study being conducted on a nationwide basis during the spring and summer will be made available to the industry by the A.M.A. in a series of detailed reports. A.M.A. Advertising Manager, Robert J. Lyon, says these reports will be designed to provide practical guidance in the use of samples as a marketing technique.

Health Information Foundation Elects New Chairman—

New Chairman of the Board of Directors of Health Information Foundation has been named as Eugene N. Beesley, president of Eli Lilly and Company.

Mr. Beesley succeeds George F. Smith, president of Johnson and Johnson, who was elected a Vice President of the Foundation. The election took place at the ninth annual meeting of the Foundation at the Waldorf-Astoria.

Sponsored by firms in the drug, pharmaceutical, chemical and allied industries, the Foundation conducts research in the social and economic aspects of medical care in the United States. Since 1950 it has made 25 grants to 17 universities and research centers and has itself conducted 11 projects to “search for answers to some of the obstacles standing in the way of greater progress in health.”

George Bugbee was re-elected President of the Foundation. Re-elected as Vice Presidents are: J. Mark Hiebert, M.D., president of Sterling Drug, Inc.; John G. Searle, president of G. D. Searle and Co.; George Van Gorder, chairman of the board, McKesson and Robbins, Inc.; and Ernest H. Volwiler, president and general manager, Abbott Laboratories.

Fellowships Awarded in Rehabilitation—

Fellowship and scholarship awards for the specialized training of 34 professional workers who are giving rehabilitation services to the crippled were announced jointly by the National Society for Crippled Children and Adults and two national women's organizations.

The announcement came from the Easter Seal Society following a meeting of the Society's scholarship committee and representatives of Alpha Gamma Delta, and of Alpha Chi Omega.

Alpha Chi Omega financed 14 scholarship awards to doctors, therapists, teachers,
administrators and other specialists who treat and train crippled children and adults having cerebral palsy and other severe handicaps.

Alpha Gamma Delta provided funds for 20 fellowships to counselors, guidance teachers, employment interviewers, placement personnel and other professional workers who will receive specialized training in counseling and placement of severely handicapped persons including those with cerebral palsy in a special four-week training course at the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center.

Kenneth R. Bzoch, Ph.D., administrator, Cleft Palate Institute, Northwestern University, Chicago; Mrs. Anne T. Dally, instructor in occupational therapy and therapist in Center for Handicapped Children, University of Illinois, Chicago; Anne V. Fayan, supervisor, physical therapy, Hartford Rehabilitation Center, Hartford, Conn.; Howard A. Grey, graduate student and graduate assistant, Speech Division, University of California at Los Angeles; Elizabeth R. Phillips, Pine Bank, Pa., assistant professor in speech, West Virginia University, Morgantown.

Changing Pattern of Hospitalization—

The average American is more likely to use hospital services nowadays than ever before—but he probably won’t stay so long once he’s hospitalized.

Within the last two decades the admission rate to general hospitals in this country more than doubled—from 59 per 1,000 population in 1935 to 129 per 1,000 in 1956. During the same period, however, the average length of stay per patient declined from 15.0 days per admission to 9.7 days.

These figures, from Health Information Foundation, also note an increase in the average annual number of patient-days per person. In 1935, this average was 2.5 days and now is 3.0 days per person. At any given moment about 1 out of 125 Americans is a hospital patient.

Two main reasons cited for the rise in hospital utilization are that ever-larger proportions of the seriously ill are receiving treatment in hospitals, and Doctors are relying more and more on highly specialized hospital facilities for diagnostic purposes and health maintenance.

Most of the increase in hospital use since 1935 can be traced to general hospitals. Utilization of mental hospitals has also increased since the mid-thirties, but less sharply. In the last few years, because of new drugs and other therapeutic advances, utilization has actually dropped in both mental and tuberculosis hospitals.

But mental illness is still the major cause of hospitalization in this country. Not only do psychiatric hospitals account for more than half of all patient-days, but many beds in other types of hospitals are reserved for psychiatric patients.

According to an American Medical Association study, about 1 million patients a year are hospitalized for cardiac disease, 720,000 for fractures, and 550,000 for cancer. About 8 million admissions a year—two-fifths of the total—are for surgery.

Annual admissions to hospitals for maternity care increased by almost five times from 1935 to 1955—from 800,000 live births in hospitals to over 3.8 million. But since the average length of stay per confinement has declined (from 10.8 days in 1946 to 5.2 days in 1956) the impact of obstetrical changes on the total rise in hospital use has been relatively small.

Art, History, and Medicine—

Hippocrates, the “Father of Medicine,” probably did not write the famed Hippocratic Oath, according to research editor George A. Bender of Parke, Davis & Company.

“Hippocrates: Medicine Becomes a Science,” is one of 12 History of Medicine in Paintings to be shown at the American Medical Association’s 1958 annual convention in San Francisco.

“So far as I have been able to determine,” Bender said, “no one feels Hippocrates wrote the oath attributed to him. But, rather it was drafted by one of his disciples, based on Hippocrates’ beliefs.”

Bender, who conceived the idea for the History of Medicine, and artist Robert Thorne pored over countless reference books, artifacts and paintings to “get the feel” of Hippocrates. They then conferred at great length with various persons in the Greek
Archdiocese of North and South America in New York.

The painting shows Hippocrates palpating a young patient, while the boy's Mother looks on. The kindliness and concern, embodied in his aphorism "Where there is love for mankind, there is the love for the art of healing," are reflected in Hippocrates' face.

Research shows, Bender said, that Hippocrates was the first to free medicine from "trammels of superstition and delusions of philosophy."

Hippocrates was the outstanding representative of the Greek school of thought which concerned itself with prognosis and with treatment of the patient as a whole. He disapproved of the medical school of thought which emphasized diagnosis, localist explanation of disease, and active treatment of individual organs.

"Thus," Bender pointed out, "the same question we have today of general practitioner versus the specialist was prominent in Greece in the fifth century B.C."

While Bender handles the research for all the caption material accompanying the paintings, Thom searches out for correct clothing, faces, hair styles and the like, because as the editor-artist says:

"These are not mere artistic conceptions of the periods of medical history, but are paintings as authentic as we can possibly make them, down to the smallest detail."

For example, it was thought the Mother in the Hippocrates painting had cheekbones which were too high. However, after checking with various sources, it was decided that her facial features were those of a 5th century B.C. Grecian lady.

The first 12 paintings to be displayed at San Francisco represent the period from 1500 B.C. to 1500 A.D. and comprise about one-third to one-quarter of the complete History of Medicine series.

Lower Death Rate Among Infants—

Well over 70,000 more of this year's crop of babies will be knocking at the doors of the nation's high schools than would be doing so under the health conditions of only ten years ago.

Some 700,000 more will reach the high schools than would under the conditions prevailing in 1900.

These estimates are given by Dr. Louis I. Dublin, health statistician and consultant on health and welfare for the Institute of Life Insurance, in analyzing the long-sustained progress in child health.

"Few realize how great the advances have been in recent years in safeguarding the lives of our children," Dr. Dublin said. "Today about 97% of the more than 4,000,000 children born annually will be alive to celebrate their 15th birthday. In 1900 only 79% would have survived 15 years. And the gains continue to be made, demonstrated by the one-third drop in child death rates in the last ten years for which figures are available."

At the same time that this illustrates the advances in medicine and public health, it points up the problems of educators who must make provision for this increasing school population, the impact of the future increase in new family formation on our people, and on our economy, according to the Institute consultant.

The largest single factor in the child-health gains has been the saving of infant lives in the first year. First-year deaths have always accounted for the greater part of the total deaths under age 15. In the early years of this century, half of all child deaths were in the first year; today nearly three-fourths are in the first year. The difference is that in 1900, every sixth infant died in the first year of life and today one in 33 will die in the first year. Even ten years ago, the first-year death rate was half again as large as today. Significant gains have been made in all the years of childhood up to the 15th year. First-year death rates have dropped over 80% since 1900 — 36% in the past ten years. Death rates among the 1-4 year-olds have dropped 94% since 1900 — 39% in the past ten years. Among 5-14 year-olds, the decline has been 87% since 1900 — 38% in ten years.

Explaining how this has been accomplished, Dr. Dublin cited the control of the specific disease of childhood.

Diarrhea and enteritis, once the scourge of infancy have been sharply curtailed as a cause of infant deaths and all but eliminated at certain ages—about 0.3 per 100,000 today at ages 5-14. Whooping cough, measles, scarlet fever and diphtheria, combined, were dreaded by all parents in 1900, while today relatively few children succumb to these dis-
eases and nowhere do we have recurring out-
breaks such as perennially mowed down these
youngsters. The Salk vaccine promises a
similar victory over the once dread polio.
Tuberculosis is today almost a rarity among
children, the toll having been cut 90% in
just the past decade.

Even the accident rate has been sharply
reduced — down one-fourth in the past de-
cade alone. Accidents, however, stand as one
of the major problems remaining in the area
of child health, because today, improved as
conditions may be, it is the leading cause of
death among children 1 to 14 and an im-
portant cause in the first year. Inasmuch as
practically all accidents are preventable, this
is a challenge to parents throughout the
country. The accident picture is even worse
than the fatality figures show, for there are
many accidents which do not kill, but maim
for life. Certainly, parents can do much to
surround their children with greater safe-
guards against the many accidents in home
and public places.

Another serious problem still facing child
health is in the realm of cancers. Contrary
to practically all other causes of death, can-
cer has shown a rising trend of death rates
among children. In the past decade alone,
the cancer death rate among those under
age 15 has doubled. Leukemias, Hodgkins
disease, and the cancers of the brain and
nervous system are the chief types involved
with children and together, they account for
almost 10% of all deaths of children 1 to 14.
It is largely through these gains that the aver-
age length of life at birth has increased
by more than 20 years in the last half cen-
tury. That is why the expectation of life
today has reached the unprecedented figure
of 70 years."

Human Interest Tales

Dr. E. H. Reeves, Grand Island, has opened
his office in Scotia.

The Holdrege Lions Club has furnished
this city with an eye bank kit.

Dr. Frank McClanahan, Neligh, has moved
into his newly completed office in that city.

Dr. and Mr. W. H. Heine, Fremont, cele-
brated their 50th wedding anniversary, in
May.

Dr. and Mrs. A. I. Webman, Superior,
spent the month of June touring the east
coast.

Dr. E. B. Mullinaux, Big Springs, has
closed his office in this city and moved to
Derby, Colorado.

Dr. Bowen E. Taylor, Lincoln, has been
elected to fellowship in the American Col-
lege of Physicians.

Dr. and Mrs. R. W. Tyson, Murray, spent
a two-week vacation in the south during the
early part of May.

Dr. W. W. Arrasmith, Alliance, has been
appointed a senior staff member at the V.A.
Hospital in Lincoln.

Dr. N. H. Moss, Arcadia, has terminated
his practice in this city. He has not an-
nounced his future plans.

Dr. Marshall Neeley, Lincoln, spoke before
the May meeting of the Beatrice Rotary Club
on the subject of cancer.

Drs. Walter and Robert Benthack, Wayne,
have purchased ground for the construction
of a new office building.

Dr. Vincent Moragues, Omaha, has been
elected to the American Association of Path-
ologists and Bacteriologists.

Dr. James F. Kelly, Omaha, was a guest
speaker at May meeting of the Four County
Medical Society in Spalding.

Dr. Alan Gilloon, Grand Island, presented
a talk on obstetrics before a meeting of the
St. Francis Nurses Alumni, in May.

Dr. Alphonsus McCarthy, a former native
of Greeley, was recently elected president of
the California State Medical Association.

Dr. John Gilligan, Nebraska City, was a
guest speaker at the May meeting of the
Buffalo County Medical Society in Kearney.

Dr. Blanton E. Russell, Cincinnati, Ohio,
has begun his duties as fourth manager of
the Omaha Veterans Administration Hos-
pital.

Dr. J. H. Barthell, Lincoln, was the guest
speaker for the May meeting of the Sixth
Councilor District Medical Society held in
York.

Dr. C. M. Pierce, Chadron, attended the
50th anniversary reunion of his class at the
Northwestern University School of Medicine,
in May.

Dr. H. J. Billerbeck, Randolph, is erecting
a new office building. It is expected to be
ready for occupancy by the middle of the summer.

Dr. Earl J. Dean, Oxford, has finished his active duty with the Army and has opened an office in Arapahoe. He will reside in Oxford.

Dr. Edward F. Fleming, Rockwell, Iowa, has been appointed director of the department of anesthesia at St. Catherine's Hospital in Omaha.

Dr. C. M. Bonniwell, Omaha, recently sold 23 head of cattle at the Omaha stockyards which brought a five-year record price of $30 per hundred.

Dr. Herman F. Johnson, Omaha, attended the meeting of the Orthopedic Associations of the English Speaking World in Washington, D.C., in May.

Dr. B. L. Miller, Loup City, was injured in a one car accident near that city, in May. Dr. Miller attempted to miss a calf which walked on to the road.

Dr. Donald C. Nilsson, Omaha, is spending four months at Ann Arbor, Michigan, taking a post-graduate course at the University of Michigan Medical School.

Dr. Jesse Federle, who formerly practiced in Sidney will open his practice in Bayard. Dr. Federle recently completed two years' active duty with the Navy.

Dr. James J. O'Neil, Omaha, was elected to membership in the American Laryngological, Rhinological, and Otological Society at their annual meeting in San Francisco, in May.

Dr. and Mrs. H. D. Runty, Dewitt, entertained the officers and committee chairman of the Nebraska Chapter of the American Academy of General Practice at a dinner at the Paddock Hotel in Beatrice, in May.

Dr. Harold S. Morgan, Lincoln, was recently presented with a portrait of himself to be hung in the Lincoln General Hospital amphitheatre. Similar portraits have been given other physicians who have served as chief of staff of the hospital.

The University of Nebraska College of Medicine will operate a clinical training center this summer for pastors of all denominations and physicians to discuss inter-professional problems and solutions. The program begins June 23 and ends August 1.

Dr. Gordon E. Gibbs, Professor and Chairman, Department of Pediatrics, University of Nebraska College of Medicine, was a member of the panel for discussion of "Physiologic Treatment of Pulmonary Disease in Children," at the 24th Annual Meeting of the American College of Chest Physicians held at San Francisco, in June.

At least three Nebraska Doctors will be trying for election to public offices, come next election. They are:

Doctor Fay Smith, Imperial — for the Legislature;
Doctor Ben Greenberg, York—for Board of Regents, University;
Doctor Gregory L. Enders, Omaha—for Director, Omaha Public Power District, Omaha Subdivision.

Dr. Russell Best, Omaha, retiring president of the Nebraska State Medical Association, spoke to the Nebraska State Association of Chiropodists, in Columbus, Nebraska, on Thursday evening, May 8th. His topic was, The Care of the Aged, and he also spoke on national legislation concerning the medical profession and the chiropody profession. Dr. E. E. Koebbe, Columbus, Nebraska, the president-elect of the Nebraska State Medical Association, was a special guest.

**Announcements**

The Omaha Mid-West Clinical Society, Assembly in November—

The Omaha Mid-West Clinical Society will hold its twenty-sixth Annual Assembly, Nov. 3-6, inclusive, 1958.

The completed program is not available at this time, but an impressive panel of guest speakers has been obtained. Such names are noted as Victor Goodhill, Los Angeles; Louis Byars, St. Louis; W. Edward Chamberlain, Washington, D.C.; S. Leon Israel, Philadelphia; Julian Jacobs, Charlotte, North Carolina; E. M. Litin, Rochester, Minn.; Earl D. Osborne, Buffalo, N.Y.; Myron Prinzmetal, Los Angeles; Thomas H. McGavack, George Washington University, and Benjamin Gasul of Chicago.

A complete program will be published at a later date.

**Urology Award**—

The American Urological Association offers an annual award of $1000 (first prize of
$500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, April 20-23, 1959.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1958.

PROCEEDINGS

Board of Councillors

Nebraska State Medical Association

April 29, 1958

The Board of Councillors held their first meeting in the Lancaster Room, Hotel Cornhusker, and it was called to order at 5 o'clock by Dr. F. M. Karrer, Chairman.

The following members were present: Drs. Harold N. Neu, R. E. Garlinghouse, Walter Benthack, E. E. Koebbe, B. N. Greenberg, F. A. Mountford, Wilbur E. Johnson, B. R. Bancroft, F. M. Karrer, H. L. Clarke, R. J. Morgan, R. Russell Best, Immediate Past President, and Fay Smith, President.

Also present were Drs. R. B. Adams, Theo. Peterson, C. N. Sorensen, and Mr. M. C. Smith.

A motion was made and seconded that the minutes of the February 9, 1958 meeting be adopted as published in the April 1958 issue of The Nebraska State Medical Journal. The motion carried.

Nominations were called for one member of the Board of Trustees, the term of Dr. G. E. Peters expiring in 1958.

The names of Dr. J. M. Woodward, Lincoln, and Dr. George Salter, Norfolk, were placed in nomination.

A motion was made that the nominations be closed. The motion was seconded and carried.

Ballots were prepared and counted, and Dr. J. M. Woodward, Lincoln, was declared elected as a member of the Board of Trustees.

The chair stated that the term of Dr. John R. Schenken as a member of the Medicolegal Advice Committee expires in 1958 and nominations were in order for this office.

A motion was made and seconded that Dr. Schenken be unanimously reelected as a member of the Medicolegal Advice Committee. The motion carried.

Nominations were called for one member of the Council on Professional Ethics, the term of Dr. J. R. Kleyla expiring in 1958. Dr. Kleyla was nominated to succeed himself.

A motion was made that the nominations be closed and that the unanimous ballot be cast for Dr. Kleyla as a member of the Council on Professional Ethics. The motion was seconded and carried.

The following requests for Life Memberships were presented:

Gage County—H. G. Penner, M.D., Beatrice
Lancaster County—Frank T. Wright, M.D., Lincoln (Denver, Colorado)
Nuckolls County—H. S. Reed, M.D., Guide Rock
Omaha-Douglas County—Sven Isacsen, M.D., Omaha
Saline County—Frank Hamilton, M.D., Friend

A motion was made that approval be given for these Life Memberships and that they be so recommended to the House of Delegates. The motion was seconded and carried.

Dr. Benthack read the report submitted by Dr. Harold E. Harvey on the Second Regional Conference on Perinatal Mortality and Morbidity Problems in the United States.

A motion was made and seconded that the report be adopted and published, and that it be referred to the House of Delegates. The motion carried.

Dr. Theo. Peterson read his report relative to the White House Conference on Traffic Safety.

A motion was made that the report be accepted and referred to the House of Delegates. The motion was seconded and carried.

A motion was made and seconded to adjourn. The motion carried.

April 30, 1958

The second session of the Board of Councillors was called to order by Chairman F. M. Karrer in the Lancaster Room, Hotel Cornhusker, Lincoln, immediately after adjournment of the House of Delegates.

The following members were present: Drs. Harold N. Neu, R. E. Garlinghouse, Harvey Runty, Walter Benthack, E. E. Koebbe, F. A. Mountford, Wilbur E. Johnson, B. R. Bancroft, F. M. Karrer, H. L. Clarke, R. J. Morgan, R. Russell Best, and Fay Smith.

Also present were Dr. R. B. Adams and Mr. M. C. Smith.

The minutes of the first session were read by Dr. Benthack and approved with one deletion.

New business was called for and Dr. R. J. Morgan asked for permission of the floor to discuss the feasibility of some method of inspecting the small hospitals on a professional level. He pointed out that actually the conduct of professional affairs in such hospitals was not under supervision and he felt that such inspection would be for the protection of the doctor himself; it would help in the doctor's education; and it would raise the standards in such hospitals. He proposed that consideration be given to inspection of small hospitals on a professional level so that they would have professional supervision the same as the larger hospitals.
Lengthy discussion ensued relative to the problems which would be encountered, the enabling legislation that might be necessary, and the funds that it would take to administer such inspection. It was the consensus of the group that a study of this problem was a step in the right direction and that it should be referred to some group or committee to see what action could be taken.

A motion was made by Dr. B. R. Bancroft that this problem of inspection of hospitals which are not inspected by the joint accreditation committee be referred to the Planning Committee for study. The motion was seconded and carried.

A motion was made to adjourn. The motion was seconded and carried.

May 1, 1958

The third session of the Board of Councilors was called to order immediately upon adjournment of the House of Delegates by Dr. F. M. Karrer, Chairman, in the Lancaster Room, Hotel Cornhusker, Lincoln.

The following members were present: Drs. R. E. Garlinghouse, Walter Benthack, E. E. Koebebe, F. A. Mountford, Wilbur E. Johnson, B. R. Bancroft, F. M. Karrer, J. R. Morgan, R. Russell Best, and Fay Smith.

Also present were Drs. R. B. Adams, Earl Leininger, R. C. Reeder, and Mr. M. C. Smith.

The minutes of the second session were read by Dr. Benthack and approved as read.

General discussion followed relative to the worthwhileness of the itemized expense sheet and annual report which each councilor was required to make up for the year.

A motion was made by Dr. Morgan that these two reports be called to the attention of the Constitution and By-Laws Committee with the recommendation that they be discontinued. The motion was seconded and carried.

Dr. R. C. Reeder, newly elected councilor for the 5th District, was welcomed as a new member of the Board of Councilors.

A motion was made and seconded to adjourn. The motion carried.

**ROSTER OF HOUSE OF DELEGATES**

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Nebraska S. M. J.
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John Brush, Omaha (D) ........................................... P P P
C. A. McWhorter, Omaha (A) ..................................... P P P
J. R. Schenken, Omaha (D) ....................................... P P P
R. D. Smith, Omaha (A) ........................................... P
D. J. Bucholz, Omaha (D) .......................................... P
Richard Crotty, Omaha (A). ........................................ P
M. E. Stoner, Omaha (D) ........................................... P
A. W. Abts, Omaha (A) ........................................... P
Richard Fangman, Omaha (D) ...................................... P
Edward Connors, Omaha (A) ....................................... P
Harry McFadden, Omaha (D) ....................................... P
John D. Coe, Omaha (A) ........................................... P
Geo. McMurry, Omaha (D) ......................................... P
Lawrence James, Omaha (A) ...................................... P

OGDEN—
T. L. Weeke, Nebraska City (D) .................................. P
W. C. Kenner, Nebraska City (A) ................................. P

PANAMA—
A. B. Anderson, Pawnee City (D) ................................. P
H. C. Stewart, Pawnee City (A) ................................ P

PHelps—
H. A. McConahay, Holdrege (D) ................................. P
Walter Reiner, Holdrege (A) .................................... P

PLATTE—
E. F. Koehne, Columbus (D) ..................................... P
E. G. Brillhart, Columbus (A) ..................................... P

POlK—
C. L. Anderson, Stromsburg (D) ................................. P
H. S. Ecklund, Osceola (A) ....................................... P

RICHARDSooN—
Wm. Shock, Shubert (D) .......................................... P
Harlan Heim, Humboldt (A) ...................................... P

SALINE—
W. F. Forney, Crete (D) .......................................... P
R. W. Homan, Crete (A) .......................................... P

SauNDers—
J. M. French, Wahoo (D) ......................................... P
E. J. Hiarchis, Wahoo (A) ........................................ P

SCottS BLUFF—
Ed. J. Loeffel, Mitchell (D) ..................................... P
Carl Frank, Scottsbluff (A) ....................................... P

SEwARd—
W. Ray Hill, Seward (D) ......................................... P
R. W. Herpolshiemer, Staplehurst (A) ......................... P

SOUTHWEST NEBRASKA—
Van H. Magill, Curtis (D) ....................................... P
Bryce Shoppe, Imperial (A) ...................................... P

ThAYER—
L. G. Bunting, Hebron (D) ...................................... P
R. E. Perry, Hebron (A) .......................................... P

WASHINGTON—
E. F. Sievers, Blair (D) .......................................... P
W. E. Goehring, Blair (A) ........................................ P

YORK—
E. E. Harry, York (D) ........................................... P
H. Friesen, Henderson (A) ........................................ P
Fritz Teal, M.D., Lincoln ......................................... P
Speaker, House of Delegates .................................... P
J. B. Christensen, M.D., Omaha ................................. P
Vice Speaker, House of Delegates ............................... P

PROCEEDINGS
House of Delegates
Nebraska State Medical Association

April 29, 1958

The first session of the House of Delegates was held in the Lancaster Room, Hotel Cornhusker, Lincoln, and roll call showed 38 members present.

The meeting was called to order by Dr. Fritz Teal, Speaker.

The report of the Credentials Committee was read by Dr. R. B. Adams.

To: The House of Delegates
Nebraska State Medical Association

The Credentials Committee met and examined the credentials as sent in by the county medical societies and recommends to the House of Delegates that the list made from the credentials be accepted as the official roll call of the House of Delegates for the 1958 Annual Session.

Signed:
R. B. ADAMS,
R. S. WYCOFF,
E. E. KOEBBE.

A motion was made that the report of the Credentials Committee be accepted. The motion was seconded and carried.

A motion was made and seconded that the minutes of the Interim Session, February 16, 1958, be accepted as published in the April 1958 issue of The Nebraska State Medical Journal. The motion carried.

Dr. Teal stated there would be a short recess for the purpose of selecting a Nominating Committee.

The House was again called to order and the nominees presented were as follows:

1st District—John R. Schenken, M.D., Omaha
2nd District—John T. McGreer, Jr., M.D., Lincoln
3rd District—H. C. Stewart, M.D., Pawnee City
4th District—Wm. E. Wright, M.D., Croxton
5th District—R. C. Reeder, M.D., Fremont
6th District—C. L. Anderson, M.D., Stromsburg
7th District—H. V. Nuss, M.D., Sutton
8th District—
9th District—Wm. Nutzman, M.D., Kearney
10th District—H. A. McConahay, M.D., Holdrege
11th District—C. C. Pinkerton, M.D., North Platte
12th District—H. A. Cook, M.D., Sidney

A motion was made and seconded that the gentlemen named would become the Nominating Committee. The motion carried.

Dr. Teal stated he would appoint Dr. R. C. Reeder Chairman pro tem.

The chair stated the following reference committees to serve during the Annual Session:

Reference Committee No. 1—Officers:
O. A. Kostal, M.D., Hastings, Chairman
C. A. McWhorter, M.D., Omaha
H. A. McConahay, M.D., Holdrege

Reference Committee No. 2—Council:
L. S. McNeill, M.D., Campbell, Chairman
W. C. Kenner, M.D., Nebraska City
Van H. Magill, M.D., Curtis

Reference Committee No. 3—Constitution and By-Laws:
Ray S. Wycoff, M.D., Lexington, Chairman
D. J. Bucholz, M.D., Omaha
H. V. Nuss, M.D., Sutton

Reference Committee No. 4—Voluntary Prepayment:
R. C. Reeder, M.D., Chairman, Fremont
C. C. Pinkerton, M.D., North Platte
S. T. Thierstein, M.D., Lincoln

Reference Committee No. 5—Planning:
Richard Egan, M.D., Omaha, Chairman
R. E. Harry, M.D., York
Ed. J. Loeffel, M.D., Mitchell

July, 1958
Reference Committee No. 6—Public Health:
W. E. Nutzman, M.D., Kearney, Chairman
W. Ray Hill, M.D., Seward
Frank Wanek, M.D., Gordon

Reference Committee No. 7—Miscellaneous:
John R. Thompson, M.D., Auburn, Chairman
H. A. Cook, M.D., Sidney
C. L. Anderson, M.D., Stromsburg

The chair called for committee reports and Dr. L. S. McNeill, Chairman of the Special Committee appointed by the House of Delegates to Study Maternal Deaths, read this committee’s report.

Dr. Teal stated that he felt the report was of sufficient interest to all the members of the House that he would hold it open for discussion at this time.

Dr. Harold Morgan discussed the Minnesota law and stated that there are 7 states that are working under similar laws and many other states considering such legislation.

Dr. Teal again read the six suggestions and recommendations submitted by the committee and discussion followed relative to the perinatal studies.

A motion was made that the report be accepted. The motion was seconded and further discussion ensued.

Discussion developed the thought that acceptance of the report would not mean final approval but that it would give the green light to proceed to formulate plans to bring back to the next session of the House; that proper legislation could be studied through the Medical Service Committee; and that the proper committee could be constitutionally appointed to act as the advisory committee to the Maternal and Child Health Committee.

The question was called for and the motion carried.

Dr. James Kelly, Chairman of the United Health Fund Committee, read the following resolution:

Since there has been considerable confusion regarding the relative status of the United Health Fund Committee of the Nebraska State Medical Association and the United Fund organization which is a fund-raising organization organized on a national scale to control the operation of all organizations soliciting funds from the general public for various social, charitable, and health agencies; and

Since this confusion has resulted in some doctors supporting the United Fund activities when they thought they were supporting the United Health Fund Committee of the Nebraska State Medical Association,

Therefore, be it resolved that the name of the United Health Fund Committee be changed to

THE VOLUNTARY HEALTH AGENCY COMMITTEE.

He also presented a sample questionnaire which had been sent to the national organizations, and then read the following:

RESOLUTION
In order to clarify the status of the voluntary health agencies which put on drives in Nebraska for funds to carry on their work, we feel that it is the duty of the Nebraska State Medical Association to set some type of a standard for these agencies to meet so that agencies with proper objectives can be so identified by the people of this state.

This would call for listing agencies which have an independent fund-raising drive and meet the other established criteria for voluntary health agencies approved by the Nebraska State Medical Association.

Therefore, be it resolved that the United Health Fund Committee be allowed to examine the activities and objectives of these agencies and form such an official list.

The final approval of all agencies included in this list shall be subject to review by the House of Delegates.

The chair ruled this material and the resolutions would be referred to Reference Committee No. 4—Voluntary Prepayment.

Dr. Teal announced that the Nominating Committee would meet in the Lancaster Room today between the hours of 4 and 5 p.m., and that the two meetings for tomorrow would be announced later.

The report of the Public Health Committee was read by Dr. H. C. Stewart, Chairman.

The chair ruled this would be referred to Reference Committee No. 6—Public Health.

Unfinished business was called for but none was presented.

New business was next on the agenda and Dr. R. Russell Best asked permission of the floor to read the report of the Policy Committee pertaining to the Medicare program.

Dr. Teal referred the report to Reference Committee No. 4—Voluntary Prepayment.

Mr. M. C. Smith presented Mrs. Paul Craig, President of the Woman’s Auxiliary of the American Medical Association to the House and Mrs. Craig talked briefly on the program which the Auxiliary is carrying on at the present time.

Mr. Smith was again given permission of the floor and presented the matter of a group life insurance plan for the members of the state medical association which he felt might be sent to a reference committee for study.

Dr. Teal referred the matter to Reference Committee No. 5—Planning.

Mr. Smith further stated that he had been instructed to write Mrs. R. R. Brady, President of the Woman’s Auxiliary, relative to the Nebraska Medical Foundation, and that he would read the reply received. In this reply Mrs. Brady stated that Mr. Smith’s letter would be presented to the executive board on Tuesday, April 29, at 9:30 a.m.

Dr. R. Russell Best stated he had been asked to appear before the group relative to the American Medical Education Foundation and he would appreciate an expression from the House which would give him some help in discussing both the A.M.E.F. and Nebraska Medical Foundation with the Auxiliary.
General discussion followed, and it seemed to be the consensus of the House that it was a matter of education in pointing out that the A.M.E.F. was for the support of the medical schools while the Nebraska Medical Foundation had for its main purpose student loans and research. It was thought that both should be supported.

Mr. Smith further stated that the resolution passed by the House at the Interim Session relative to Forand-type legislation had been sent to the designated parties and then read letters from Representative Phil Weaver, Senator Carl T. Curtis, and Senator Roman L. Hruska.

Mr. Smith next read a letter he had received pertaining to fees collected from an out-patient for laboratory work done in a hospital. Dr. Teal stated he felt this matter should be referred to the Council on Professional Ethics, and he would so rule.

Dr. Richard Egan asked permission of the floor and stated that he would like to make the motion to suspend the rules in order to adopt the following resolution:

WHEREAS, The following members of the Omaha-Douglas County Medical Society are certified by the president of the Omaha-Douglas County Medical Society as eligible to receive 50-year pins from the Nebraska State Medical Association:

Charles J. Nemec, M.D., age 74 years
John Emerson Simpson, M.D., age 87 years
William Louis Sucha, M.D., age 74 years

and,

WHEREAS, Copies of the certification of their eligibility are attached herewith showing they have served many long years in the medical field, and

WHEREAS, It has been the custom of the Nebraska State Medical Association to award these pins in the 50th year of practice,

BE IT THEREFORE RESOLVED, That Charles J. Nemec, M.D., John Emerson Simpson, M.D., and William Louis Sucha, M.D., be awarded 50-year pins at the 1958 Annual Banquet of the Nebraska State Medical Association, April 30, 1958, and

BE IT FURTHER RESOLVED, That these members be notified immediately of their awards so that they can receive them at the banquet.

The motion was seconded, and discussion followed.

It was brought to the attention of the House that there had been four other inquiries sent to the headquarters office relative to physicians eligible for this honor which had been turned down due to the fact they could not be processed according to the existing By-Law, and also that pins would not be available for presentation the night of the banquet.

After further discussion relative to establishing eligibility for recipients of this honor, it was decided that these physicians could be checked through records at the headquarters office and telephone calls made to each to see whether or not they could be present at the banquet Wednesday, April 30, and that it would be explained that pins would be sent to them at a later date.

The original question was called for and the motion passed.

Dr. Egan then presented the following resolution:

WHEREAS, It has been brought to the attention of the executive board of Omaha-Douglas County Medical Society that solicitations for the listings and cards of specialists are made by publishers of various medical bulletins and journals for printing in their publications, and

WHEREAS, The Code of Ethics of the American Medical Association specifically states:

"Sec. 4—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical . . . The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical," and

WHEREAS, the Nebraska State Medical Association has no established policy that governs such publications that would serve as a guide to physicians in this locality,

BE IT THEREFORE RESOLVED, That the House of Delegates of the Nebraska State Medical Association review this problem thoroughly and establish a policy for the medical profession in this state, and

BE IT FURTHER RESOLVED, That it is the opinion of the executive board of the Omaha-Douglas County Medical Society that such a practice should not be recommended and that the House of Delegates consider this opinion in their deliberations.

Dr. Teal ruled this resolution would be referred to Reference Committee No. 1—Officers.

Dr. Egan next introduced the following resolution:

WHEREAS, The delegates from the Omaha-Douglas County Medical Society believe that individual members of the Nebraska State Medical Association do not avail themselves of information in published reports, and

WHEREAS, It is believed to be in the best interests of the Nebraska State Medical Association that its House of Delegates be informed regarding the deliberations of the House of Delegates of the American Medical Association and particularly the vote cast and other stands taken on important issues by our delegates, and

WHEREAS, It is believed to be in the best interests of the Nebraska State Medical Association that our delegates to the House of Delegates of the American Medical Association be sensitive to the desires and needs of the individual members of the Nebraska State Medical Association,

BE IT THEREFORE RESOLVED, That the Board of Councilors of the Nebraska State Medi-
Dr. Teal stated this resolution would also be referred to Reference Committee No. 1—Officers.

Dr. Teal asked that reference committee chairmen come to the table and pick up the material assigned to them immediately upon adjournment. He further stated that the Lancaster Room and State Suites 1, 2, and 3 were available for reference committee meetings, and that each chairman should select a time and place for his meeting in order that it might be posted on the bulletin board.

There being no further business, the meeting adjourned.

April 30, 1958

The second session of the House of Delegates was held in the Lancaster Room, Hotel Cornhusker, Lincoln, and was called to order by Dr. Fritz Teal, Speaker. Roll call showed 39 members present.

The minutes of the first session were scanned by Dr. Teal.

A motion was made and seconded that the minutes be accepted as outlined. The motion carried.

Dr. Teal read the report from the Council on Professional Ethics relative to the communication referred to them by the House in regard to fees collected for laboratory work done in a hospital.

A motion was made that Dr. Andrews be informed of the action of the Council on Professional Ethics. The motion was seconded and carried.

Dr. Teal stated he would leave it to Mr. Smith to see that this was done.

Dr. Teal read the following list of Life Memberships which had been recommended by the Board of Councilors:

- H. G. Penner, M.D., Beatrice, Gage County
- Frank T. Wright, M.D., Lincoln, Lancaster County (Denver, Colorado)
- H. S. Reed, M.D., Guide Rock, Nuckolls County
- Sven Isachsen, M.D., Omaha, Omaha - Douglas County
- Frank Hamilton, M.D., Friend, Saline County

The chair stated these would be referred to Reference Committee No. 2—Council.

Dr. Teal read the report, referred to the House by the Board of Councilors, by Dr. Theo. Peterson relative to the White House Conference on Traffic Safety.

This report was referred to Reference Committee No. 6—Public Health.

A report made by Dr. Harold Harvey on the Second Regional Conference on Perinatal Mortality and Morbidity Problems in the United States was read by Dr. Teal.

This report was referred to Reference Committee No. 2—Council.

Unfinished business was called for.

Dr. John McGee asked permission of the floor and made the motion that the rules again be suspended and that Dr. George Walker, Lincoln, be added to the list of names to receive the 50-year pin at the annual banquet. The motion was seconded and carried.

Reference committee reports were called for and Dr. O. A. Kostal, Chairman, Reference Committee No. 1, gave the following report:

Our first consideration was the request from the Omaha-Douglas County Medical Society in the form of a resolution relative to the Delegates to the American Medical Association.

The delegates to the annual, interim, or special sessions of the American Medical Association make an annual report of their activities to the Board of Councillors of the Nebraska State Medical Association and such reports may be published in the Journal on order of the Board.

This committee recommends that in addition to the above report, these delegates shall appear before the House of Delegates of the Nebraska State Medical Association each year and discuss the significant deliberations of and the action taken by the House of Delegates of the American Medical Association.

It is further recommended that Chapter 9, Section 10, of the Constitution and By-Laws be amended to include this action.

I move the adoption of this recommendation. The motion was seconded and carried.

The second matter considered again came from the Omaha-Douglas County Medical Society. It had to do with the publication of lists of names in medical publications.

It is the opinion of this committee that the House of Delegates of the Nebraska State Medical Association consider unethical the paid listings of physicians, cards or announcements in medical publications.

I move the adoption of this recommendation. The motion was seconded and general discussion followed.

The question was called for and the motion carried.

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1.

The motion was seconded and carried.

The chair called for the report of Reference Committee No. 2—Council, and the Chairman, Dr. L. S. McNell, stated there had been no material referred to them for study until they were given the matter of Life Memberships in today's session.

Dr. R. S. Wycoff, Chairman, Reference Committee No. 3, stated that no matters had been referred to this committee, but that the larger committee working on the revision of the Constitution and By-Laws was of the opinion that all proposed changes should be held for the final revision which they hoped to be able to present a year from now. He
stated that any suggestions or corrections that would help to clarify and make the Constitution more easily workable were welcome at any time.

Dr. Teal stated Dr. Wycoff's report was accepted.

Dr. R. C. Reeder, Chairman, Reference Committee No. 4—Voluntary Prepayment, gave the following report:

Mr. Speaker,

Reference Committee No. 4 recommends that the report of the Policy Committee be accepted as read, and I so move.

The motion was seconded and carried.

Mr. Speaker,

Reference Committee No. 4 recommends that the resolution pertaining to the change of name of the United Health Fund Committee to The Voluntary Health Agency Committee be adopted, and I so move.

The motion was seconded and carried.

Mr. Speaker,

Reference Committee No. 4 recommends that the resolution pertaining to the standards of voluntary health agencies be adopted, and that the questionnaire pertaining to these standards be adopted. I so move.

The motion was seconded and carried.

Mr. Speaker,

I move that the report of Reference Committee No. 4 as a whole be accepted.

The motion was seconded and carried.

Dr. Richard Egan, Chairman, Reference Committee No. 5, stated that no one had appeared before the committee relative to the group insurance plan which had been referred to the committee for study and, therefore, the committee was not ready to report.

Dr. Teal suggested that perhaps another attempt should be made to get interested individuals to meet with the committee, and Dr. Egan asked that the committee be assigned a room for such a meeting.

Dr. Teal stated that State Suite 1 would be open and that Dr. Egan should decide upon a time and post it on the bulletin board.

The report of Reference Committee No. 6—Public Health, was called for and Dr. Wm. Nutzman, Chairman, gave the following report:

Reference Committee No. 6 was given the report of Dr. Theo. Peterson relative to the White House Conference on Traffic Safety, and we move the acceptance of this report.

The motion was seconded and carried.

Item number two which we were asked to consider was the Public Health Committee report relative to polio vaccine.

The Public Health Committee held a meeting April 22, at which time Dr. J. E. M. Thomson, Chairman of the State Board of Health, submitted the problem of demand for polio vaccine for the medically indigent. According to Dr. Rogers, he has been receiving requests for vaccine from out-state physicians at a rate of more than one per week. Consequently, they asked that the Public Health Committee of the Association come up with some answers. The Public Health Committee decided the problem should be submitted to us for consideration and submitted the following for consideration:

1. That the present policy should be continued even though it fails to face the fact that a proven preventive such as polio vaccine should be available on the same basis as other preventives such as D.P., D.P.T., Smallpox vaccine, etc.

2. Or should it agree that the State Department of Health should distribute polio vaccine on the same basis as other vaccines. This is, of course, limited to medical indigents and could be decided on a local basis as to eligibility.

After due deliberation and visiting with several members and the adjoining reference committee, Reference Committee No. 6 presents the following resolution:

WHEREAS, It has been a long established medical concept that it is necessary to immunize as many humans as possible against diptheria, pertussis, tetanus, and smallpox; and

WHEREAS, The Nebraska State Medical Association has for many years sanctioned the Nebraska State Department of Health policy of furnishing D.P., D.P.T., and Smallpox vaccine to certain segments of the population of Nebraska to prevent serious morbidity of the above-mentioned diseases; and

WHEREAS, Poliomyelitis is a serious disease whose incidence can be significantly reduced by proper use of vaccine; and

WHEREAS, Within a few months polio vaccine will probably be incorporated by the manufacturers of vaccine into either or both D.P. and D.P.T. vaccines,

THEREFORE BE IT RESOLVED, That the Nebraska State Medical Association reaffirm the stand, which has been its policy for many years, that the Nebraska State Department of Health furnish D.P., D.P.T., and Smallpox vaccines for the indigent population of Nebraska and that the policies for the administration of these vaccines shall be established by the individual county medical societies.

BE IT FURTHER RESOLVED, That polio vaccine be added to previously approved vaccines D.P., D.P.T., and Smallpox under the same established procedures aforementioned.

A motion was made that the resolution be accepted. The motion was seconded and carried.

Mr. Speaker, I move the report as a whole of Reference Committee No. 6 be accepted.

The motion was seconded and carried.

Reference Committee No. 7 stated they had no report to make.

New business was called for by the chair, but none was presented.

Dr. Teal stated the Nominating Committee would meet today in the Lancaster Room at 10:30 a.m. and 4 p.m.
A motion was made to adjourn which was seconded and carried.

May 1, 1958

The third session of the House of Delegates was called to order by Dr. Fritz Teal, Speaker, in the Lancaster Room, Hotel Cornhusker, at 8 a.m. Roll call showed 33 members present.

The minutes of the second session were scanned by Dr. Teal, and a motion was made that the minutes as scanned be accepted. The motion was seconded and carried.

The report of the Nominating Committee was called for and Dr. R. C. Reeder, Chairman, presented the following slate:

For President-elect—E. E. Koebbe, M.D., Columbus
Vice President—Marvin A. Johnson, M.D., Plainview
Counselors—
5th District—R. C. Reeder, M.D., Fremont
6th District—B. N. Greenberg, M.D., York
7th District—H. V. Nuss, M.D., Sutton
8th District—Wilbur Johnson, M.D., Valentine
Delegate to A.M.A.—J. D. McCarthy, M.D., Omaha
Alternate Delegate to A.M.A.—Harold Morgan, M.D., Lincoln
Delegate, North Central Medical Conference—A. J. Offerman, M.D., Omaha
Board of Directors, Nebraska Medical Service—
1. George Covey, M.D., Lincoln
2. J. J. Keegan, M.D., Omaha
3. A. J. Offerman, M.D., Omaha
4. Donald Steenburg, M.D., Aurora

Nominations from the floor were called for but none was presented.

A motion was made that the nominations be closed and that the secretary be instructed to cast the unanimous ballot of the House of Delegates for the nominees presented. The motion was seconded and carried.

Dr. Teal asked Drs. Warren Bosley and John Thompson to get the President-elect and Vice President and present them to the House.

Report of Reference Committee No. 1 was called for but the chairman stated there was no further report.

Dr. L. S. McNeill, Chairman, Reference Committee No. 2, stated they had been referred the following Life Memberships applications:

Gage County—H. G. Penner, M.D., Beatrice
Lancaster County—Frank T. Wright, M.D., Lincoln (Denver, Colorado)
Nuckolls County—H. S. Reed, M.D., Guide Rock
Omaha-Douglas County—Sven Isachsen, M.D., Omaha
Saline County—Frank Hamilton, M.D., Friend

A motion was made and seconded that the list as read be accepted for Life Memberships. The motion carried.

Dr. McNeill further stated that his committee had been given the report made by Dr. Harold E. Harvey on the Second Regional Conference on Perinatal Mortality and Morbidity Problems in the United States, and while they felt the report should be accepted, they also felt that since it reported on matters which fitted into the problems studied by the special committee of the House of Delegates relative to maternal deaths, they recommended the report be tabled and referred to the Maternal and Child Health Committee and the advisory committee that has been set up, and they would so move. The motion was seconded and carried.

Dr. Teal stated that the report would be referred to the Maternal and Child Health Committee.

Dr. E. E. Koebbe, President-elect, and Dr. Marvin Johnson, Vice President, were presented to the House and each expressed his appreciation of the honor bestowed upon him.

The chairmen for both Reference Committee No. 3 and Reference Committee No. 4 stated they had nothing further to report.

Dr. Richard Egan gave the following report for Reference Committee No. 5:

The House of Delegates has referred to our committee the question of the desirability of this organization seeking information regarding group life insurance.

Reference Committee No. 5 recommends that the House of Delegates instruct the Insurance Committee of the Nebraska State Medical Association to investigate plans and rates of group life insurance and to report recommendations to this House.

It also is recommended that the Insurance Committee be instructed to seek proposals from insurance companies, agencies, and agents in Nebraska, as well as from other companies elsewhere, and that the Insurance Committee seek appropriate advice of legal and insurance experts. I so move.

The motion was seconded and carried.

Reference Committee No. 6 and Reference Committee No. 7 stated there was no further report from their committees.

Dr. E. J. Loeffel asked for permission of the floor to discuss the problem of some type of professional supervision in the small hospitals where in many cases elective surgery was done without professional assistance; where sometimes major surgery was done without professional assistance; and where surgery was done without tissue reports. He felt that consideration should be given to the inspection of these small hospitals so that they would have professional supervision the same as the larger hospitals. He stated he would like to move that the House of Delegates take under consideration the referring to the Planning Committee the study of ways and means of establishing a permanent committee of this Association whose duty is to provide all the hospital staffs of this state with the similar high standards of professional staff management as required by the joint commission on accreditation.

The motion was seconded and carried.
Dr. Teal stated this would be referred to the Planning Committee with the notation that they try to come up with some workable ideas by the mid-winter meeting of the House of Delegates.

Dr. Fay Smith asked for permission of the floor and called attention to the confusion relative to the presentation of the 50-year pins. He thought we should direct the executive secretary, M. C. Smith, to go through the records each year and pick up all of the names of physicians who graduated 50 years ago. Mr. Smith, then would present the list to the mid-winter session of the House of Delegates for their approval, and if there was anyone on the list not entitled to the honor it would be discussed at the interim session.

A motion was made that Mr. Smith check the records of the Association and present to the interim session of the House of Delegates a list of all physicians who were eligible to receive the 50-year recognition. The motion was seconded.

Discussion followed, and a motion was made to amend the motion to state that the list prepared by Mr. Smith would be sent to each county secretary previous to the interim session, and unless a reply was received to the contrary, the name would be presented to the House of Delegates at the mid-winter meeting for approval. The motion was seconded and carried.

The question was called for and the original motion, as amended, carried.

Dr. G. P. McArdle was given permission of the floor and discussed the action of the House relative to abolishing the Industrial Health Committee. He stated it was true the committee—at least on paper—had been rather inactive, but that he had had and was still receiving calls from industry relative to industrial health problems. He felt that industrial medicine was here to stay and did not think we should in any way, shape or form antagonize industry at this time. He asked that the decision be reconsidered and that perhaps even on the state program we could give occupational medicine some recognition. He felt that we were fast becoming an industrial as well as an agricultural state.

A suggestion was made that the Constitution and By-Laws Committee take the matter under consideration in their revision and that perhaps the two terms of industrial and occupational health should be incorporated in the name of the committee.

A motion was made that we instruct the Committee on Constitution and By-Laws to reconsider this matter and to reestablish a committee on occupational and industrial health. The motion was seconded, and general discussion followed.

Discussion brought out that points to be considered in establishing such a committee were job hazards and the educational program which would reduce occupational hazards; accident injury treatment and prevention; the hazard of panel medicine; and the hazard of industry enlisting private capital to erect a building and hire doctors.

The question was called for and the motion carried.

Dr. Teal stated the next order of business was the selection of a place for the 1959 Annual Session, and Dr. John R. Schunken issued an invitation for the Nebraska State Medical Association to meet in Omaha next year.

A motion was made and seconded to accept the invitation. The motion carried.

A motion was made to send the usual letters of appreciation to the Chamber of Commerce, the Hotel Cornhusker, and the Lancaster County Medical Society. The motion was seconded and carried.

Dr. Teal stated there being no further business the meeting would stand adjourned until the mid-winter session.

The Woman's Auxiliary

Dawson County—

The Dawson County Medical Auxiliary met Friday, May 23, at the home of Mrs. Sam Perry, Gothenburg.

Members were proud to learn of the appointment of Mrs. Perry as one of the directors of the Nebraska auxiliary. She read her president's report of last year's Dawson County activities which she had presented at the state convention.

Sgt. Lee Oberg, Nebraska Safety Patrol, presented a program on Highway Safety, which he illustrated with slides. An interesting highlight of his talk was his demonstration of proper parallel parking.

President Virginia Sittorious announced the following committee appointments: Today's Health, Mrs. B. W. Pyle; Legislation, Mrs. V. D. Norall; Program, Mrs. C. H. Sheets, Mrs. P. B. Olsson, and Mrs. H. M. Harvey; A.M.E.F., Mrs. Charles Hranac; Nurse Loan Fund, Mrs. Sam Perry, Mrs. A. W. Anderson, and Mrs. J. V. Scholz; Nurse Fund Treasurer, Mrs. P. B. Olsson.


Mrs. Wm. B. Long.

RESOLUTIONS AND REVISIONS

WHEREAS, We consider it fitting and proper to express our thanks to all those who have contributed to the success of this convention and to the accomplishments of our past year's work; Therefore be it

RESOLVED, That we, the members of the Woman's Auxiliary to the Nebraska State
Medical Association, extend our grateful thanks to the officers and other members of the Executive Board of our organization who have so ably carried on the business necessary for the proper functioning of the Auxiliary; and be it

RESOLVED Further, That we express our thanks and appreciation to the Lancaster County Auxiliary, hostess to this Thirty-Third Annual Meeting, for its welcome hospitality to all of us; and be it

Further RESOLVED, That we express particular gratitude to Mrs. Donald Purvis, General Chairman, and to all of her committee chairman for their work and thoughtfulness in planning for our convenience and entertainment; and be it

RESOLVED Further, That the Nebraska State Medical Association be advised that we appreciate their leadership and assistance, and that in particular, the Advisory Council, namely, Dr. R. Russell Best, President of the Nebraska Medical Association, Dr. Raymond Lewis, Dr. Robert Morgan and Dr. L. E. Sharrar be informed of our gratefulness for their guidance throughout the year; and be it

RESOLVED Further, That the Blue Cross-Blue Shield organization know that we are grateful for their generosity in providing notebooks, pencils and other materials which have facilitated the transaction of our business during the convention meetings; and be it

RESOLVED Further, That Dr. George Covey, Editor of the Nebraska State Medical Journal; Mr. M. C. Smith, Executive Secretary of the Nebraska Medical Association; Mrs. Ruth Murphy be advised of our sincere thanks for the efficient way they have handled our Auxiliary news, and for their ever ready assistance whenever we have asked for it; and be it

RESOLVED Further, That our special thanks go to the following drug houses for their contributions of Door Prizes for our Wednesday Luncheon and Style Show: Wagey, Wrights, Gilmore-Danielson, Stoner, Rupperts, Van Dorn, Donley-Stahl, Bradley, Allen, Dennison, State Pharmacy and the Pharmacy Department of Gold and Co.; and be it

RESOLVED Further, That we express our thanks to Ben Simon's; their fashion coor-
side, we contemplate the ugly possibility of domination by pressure groups such as labor unions or dictation from commercial interests...to mention only two out of many contemporaries. In front of us we face the inescapable and insurmountable wall of rising costs, in which doctors' fees play only an insignificant part as compared to the staggering costs of hospitalization. Behind us we hear the hue and cry of an increasingly hostile public opinion, unleashed and led on by demagogues who clamor for the priceless gifts of life and health at bargain rates and at the taxpayers' expense. As we fare forth into this dark and uncertain forest of 'social progress,' we can expect about as much security as Little Red Riding Hood enjoyed when she went to visit Grandma!"

Dr. Bradford points out that in the face of these conditions, Blue Shield may well "represent one of medicine's few hopes for survival as a self-determining profession." In support of this view, he emphasizes that Blue Shield has provided the profession with "an intelligently coordinated and professionally controlled corporate body" through which the profession and public may deal effectively in their common interest and to their mutual benefit. Dr. Bradford continues by suggesting that if the profession continues "to administer Blue Shield wisely" it may be all that doctors need to maintain their "professional independence."

What does Dr. Bradford conceive as the elements of a wise administration of its own Blue Shield Plans? "To administer it wisely," Dr. Bradford writes, "we must be willing to give as well as to receive—to regulate our practice and our fees so as to preserve our freedom from being regulated and to grant the public as many benefits as we hope to assure for ourselves."

Dr. Bradford expresses the view that the future effectiveness of Blue Shield will depend to a considerable extent on proper and effective management. "A capable management," he writes, "will continue to increase the service of Blue Shield..." And in Dr. Bradford's view, the source of management strength in Blue Shield necessarily is derived from the profession itself, for, as he sees it, "We, as doctors and as members of the Medical Society, are the managers of Blue Shield. Its success depends on us. Its failures remain our responsibility."

Dr. Bradford concludes by urging doctors to put aside arguments over fee schedules and income levels so that they may "grasp the larger significance" of Blue Shield. "We must," Dr. Bradford concludes, "stand behind it in its major decisions—not for selfish gain, but to share with the public a mutual service and benefit. In this way, and in no other, can the medical profession preserve its time-honored status as an altruistic body of men, free from the sordid controls of politics or commerce, devoting itself wholeheartedly to scientific and humanitarian tasks."

**TUBERCULOSIS ABSTRACTS**

**REPORT OF THE ADVISORY COMMITTEE ON BCG TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE**

A committee invited by Surgeon General Leroy E. Burney, to examine the Public Health Service policy and program in the field of BCG vaccination, met in Washington, June 14, 1957. The committee was asked to formulate a new statement and make new recommendations, if it seemed appropriate, on the use of BCG vaccination as a public health procedure, and on further research as to its value.

A previous advisory committee had considered the question of BCG vaccination, and a statement on the use of BCG, consistent with its recommendations was issued by the Public Health Service in August, 1950. The Public Health Service then stated that mass BCG vaccination programs were not indicated in this country, and that vaccination should be limited to persons with unusually great exposure to tuberculous infection.

It appeared to the present committee that a logical evaluation of BCG vaccination and the formulation of recommendations on the policy of the U.S. Public Health Service, could be made only after broad consideration of the present status of the tuberculosis problem; facts on BCG vaccination that have become available since the last statement; the contribution to be expected from BCG in diminishing the problem; and the advantages and disadvantages of various public health applications of BCG.

**Present Status of Tuberculosis Problem**—Nearly all aspects of the tuberculosis problem have undergone great changes during the past decade. The mortality rate has decreased from about 30 per 100,000 in 1946, to less than 10 in 1956. The morbidity rate and the risk of infection have also declined, but not so rapidly. The consequences of tuberculosis morbidity have been lessened by antimicrobial agents, particularly isoniazid. Further research on the effectiveness of antimicrobial drugs in first infection is desirable.

**BCG Vaccination**—The basic premise for use of BCG is that the changes produced in the host by vaccination will protect in some measure against the hazards resulting from tuberculous infection. It is generally accepted that vaccination be restricted to noninfected persons, i.e., nonreactors to tuberculin. In general population groups, it has been usual to
limit vaccination to the younger segments, in which there has been little opportunity for infection.

Recent well-controlled studies have shown that tuberculous disease is more likely to develop among those found positive to tuberculin than among those not reacting. Accordingly, chief attention from the point of view of tuberculosis control should be devoted to those found to react to tuberculin. It is obvious, however, that every tuberculosis program should include measures to prevent infection.

The value of BCG vaccination in controlling tuberculosis in the U.S. has been a matter of controversy in recent years. There is convincing evidence that vaccination in man with a strain of BCG known to be of high potency leads to some degree of increased resistance against tuberculosis disease. How long this increased resistance persists is not known. BCG appears to be as safe as other vaccines in common use, but cases of progressive disease and death attributable to BCG have been reported.

In considering disadvantages attendant upon use of BCG vaccination, the tuberculin reaction was stressed. Since BCG vaccination converts nonreactors into reactors to tuberculin, the procedure makes it impossible to use the tuberculin test: (1) as evidence of recent infection in the individual; (2) as an index of infection in population groups; (3) for the location of sources of contagion; (4) as a preliminary screening device or, (5) for differential diagnosis. This is of increasing importance in the light of the current continuing decline in the prevalence of infection and manifest increasing concern over the hazards of excessive radiation by X-rays.

Wide use of BCG vaccination may lead to a false sense of security, which could result in failure to observe precautions that otherwise might be taken.

Since 1946 numerous investigations have shown a wide range of variation from 0 to 80 per cent in the reported efficacy of BCG. The degree of protection afforded by the vaccine appears to be far from absolute. In a British Medical Research Council study, the morbidity rate among the vaccinated was only one-fifth of that reported for a nonvaccinated group of 13,200 studied concurrently; in a Public Health Service study in Puerto Rico, the rate was two-thirds of that recorded for some 27,000 controls concurrently studied.

In a Public Health Service trial of BCG vaccination in Georgia and Alabama there was no statistically significant difference in the tuberculosis developing among vaccinated and nonvaccinated persons after six years of observation. A striking finding in both the British and PHS studies was a high subsequent incidence of tuberculosis morbidity in persons strongly sensitive to tuberculin at the time of surveys.

The members of the committee were particularly impressed by the apparent variability in vaccinating potency of different BCG strains, as shown by laboratory studies and by the diversity of results in field trials. The significance of apparent variations in potency of strains is not yet understood.

Reductions in tuberculosis mortality have been as great in certain European countries that do not practice BCG vaccination as in those of comparable size and economic state in which BCG is widely used.

With all of these considerations in mind the committee did not believe that a categorical statement on the degree of protection afforded by BCG vaccination could be made.

The committee expressed the opinion that the use of BCG should be determined by local circumstances such as the strength of the tuberculosis program, the prevalence of tuberculosis in the community at the time, and the probable risk of infection in the future. The question will arise chiefly where exposure is high and weakness in other means of control is recognized.

The committee is convinced that large-scale BCG vaccination programs, including routine vaccination of the newborn, are not indicated in this country. However, advantages of vaccination outweigh the disadvantages for tuberculin-negative persons who are exposed to a definite risk of infection. Under certain circumstances, the following individuals and groups are examples of suitable subjects for BCG vaccination:

1. Physicians, nurses, medical and nursing students, laboratory workers, and hospital employees. (If a hospital has established an adequate tuberculosis control program very little exposure to tuberculosis will occur in that institution). 2. Persons unavoidably exposed to continued contact with infectious cases of tuberculosis in the home. 3. Patients, inmates, and employees of institutions such as mental hospitals and prisons, in which case-finding programs indicate that exposure to tuberculosis is likely to be high.

It is the consensus of the committee that, in view of the apparent low risk of tuberculosis among present nonreactors in the United States, new investigations on the value of BCG cannot be made without excessively large study populations. For this reason, it did not recommend that the Public Health Service initiate new vaccination trials. However, it recommends strongly that the controlled studies on population groups already started be carried on as long as they furnish significant information on the rates of development of tuberculosis in the vaccinated and control groups now under observation.

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Emotional or physical strain may play an important role in triggering an attack of rheumatoid arthritis, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. The publication reports on a study in which 144 patients with rheumatoid arthritis described factors precipitating their disease. Emotional or physical strain, or both, amounted to a high of 42 per cent of the incidence of all factors reported, and infections to 26 per cent. Exposure to dampness or cold accounted for only 16 per cent.

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**NOTICE TO ALL CONTRIBUTORS**

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

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Hospitals and “Staph” Infections—
(Continued from page 19-A)

acquired in hospitals, but there is evidence that the number of such infections is increasing,” the bulletin said.

“Infections with antibiotic-resistant staphylococci constitute the main difficulty. Hospitals are clearly the reservoir of most antibiotic-resistant strains,” according to the bulletin. “One of the major factors in the current situation is the widespread use of antibiotics which eliminates susceptible strains of staphylococcus and leaves uncontrolled the resistant strains.”

Examples of staphylococcus infections given in the bulletin included skin infections in newborn infants and children, in newly-delivered mothers, in burns, in incisions made during surgery and in pneumonia in debilitated patients.

The bulletin recommended that “all hospitals should establish committees on infections to devote particular attention to infections which are acquired in hospitals so they may be reduced to the lowest possible minimum,” and suggested that “the local health officer should be urged to serve as a consultant to the committee.”

Recommended functions of the committee on infections should include:

1. Establishment of a system of reporting infections among patients and personnel.
2. Keeping of records of infections.
3. Distinguishing as far as possible between infections acquired in the hospital and infections acquired elsewhere.
4. Reviewing the hospital’s bacteriological service to insure its quality and accessibility.
5. Reviewing aseptic techniques used in operating rooms, delivery rooms and nurseries, and if necessary, recommending methods of improving these techniques.
6. Reducing “to the minimum consistent with adequate patient care” the “use of antibiotics, especially as ‘prophylaxis’ in clean elective surgery,” and treatment with adrenocortical steroids.
7. Undertaking an educational program to convince medical staff and hospital employees of the importance of report-

(Continued on page 41-A)
Hospitals and "Staph" Infections—
(Continued from page 28-A)

...ing skin infections, boils and upper respiratory infections.

8. Establishing follow-up techniques to find sources of infections and to locate infections acquired in the hospital which do not appear until after discharge.

The bulletin was prepared by the Association’s Committee on Infections Within Hospitals. Members of the Committee are Dr. Dean A. Clark, chairman, general director, Massachusetts General Hospital, Boston; Dr. William A. Altemeier, professor of surgery, University of Cincinnati, Cincinnati General Hospital, Cincinnati; C. P. Cardwell, Jr., director, Medical College of Virginia, Richmond; Dr. James P. Dixon, Commissioner, Department of Public Health, City of Philadelphia; Dr. Maxwell Finland, Physician-in-Charge, Boston City Hospital, Boston; Dr. Horace L. Hodes, director, department of pediatrics, Mount Sinai Hospital, New York City; Dr. Alexander P. Langmuir, Chief, Epidemiology Branch, Communicable Disease Center, Atlanta; and Miss Martha Johnson, R.N., Assistant to the Director Joint Commission on Accreditation of Hospitals, Chicago. Consultants to the Committee on the preparation of the bulletin were Dr. Kenneth B. Babcock, director, Joint Commission on Accreditation of Hospitals, Chicago; and Dr. William H. Stewart, Office of the Surgeon General, Public Health Service, Washington, D.C.

Easter Seal Research Grants—

Factors influencing bone formation and malformation will be studied under five research grants announced by the Easter Seal Research Foundation. A sixth award will make possible a study of the educational needs of cerebral palsied children in the South.

The Foundation’s newest awards, totalling $86,390 and including renewed support also to five continuing projects, are announced by Dr. William T. Sanger, chancellor of the Medical College of Virginia and chairman of the Foundation’s board of trustees.

The awards are from funds raised during the annual Easter Seal campaign. The Foundation, established by the National Society for Crippled Children and Adults, supports research dealing with causes and prevention of crippling conditions and improved rehabilitation techniques.
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Current Comment

The Month in Washington—

For the first time since the idea was proposed more than seven years ago by President Truman and Oscar Ewing, legislation to tack a hospital and medical service program onto social security has received a thorough airing before a Congressional committee.

For 11 days the House Ways and Means Committee listened to testimony on this and other suggested changes in the law. The hospitalization plan—now identified as the Forand bill, for its sponsor, Rep. Aime J. Forand (D., R.I.)—was by far the most controversial issue. It came up repeatedly and each time was the signal for either sharp questions or praise from Mr. Forand, depending on what the particular witness thought about the bill.

At the end of the hearings, it appeared that a majority of the committee was not inclined to press for enactment of the Forand bill, although there remained the possibility sentiment change. At this writing, the prospect is that a bill may be enacted to raise both social security and old-age assistance payments, with a $600 increase in the amount of taxable salary or self-employment income to meet the extra O.A.S.I. cost; public assistance payments came out of general revenue.

What did the Forand hearings produce? For one thing, the proponents and opponents lined up in columns to be identified. The one important exception was the American Hospital Association. The A.H.A. specifically opposed the Forand bill “at this time,” but left itself room for maneuvering.

The hospital witnesses, Ray Amberg, president-elect of the A.H.A., and Dr. James P. Dixon, chairman of its committee to study health needs of the aged, said their conclusion was that federal help of some sort was needed to finance the health care of the aged, and that the social security approach might be the ultimate decision.

However, for the present the hospital spokesmen proposed that the Ways and Means Committee set up a special advisory

(Continued on page 15-A)
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The Month in Washington—
(Continued from page 4-A)
committee—health personnel and others—to bring together all information on the health problems of the aged, study the data and make recommendations to the committee before January 1, 1960.

American Medical Association led the parade of opponents of the Forand bill, and its witnesses, Drs. Leonard Larson, a trustee, and Frank Krusen of the Mayo clinic, were subjected to close but not unfriendly questioning by Mr. Forand.

At one point Dr. Larson, the new chairman of the A.M.A. Board of Trustees, told Mr. Forand: "As chairman, I shall devote all my energies to solving this problem and other problems of medical care plans in general. This is my primary interest. I rise or fall on what happens in this field."

Lined up with the A.M.A. in opposing the Forand plan (in addition to the A.H.A.) are the American Dental Association, Blue Shield, the insurance industry in general, the U.S. Chamber of Commerce and a number of other business and professional groups.

The A.F.L.-C.I.O. appears to be the backbone of forces working for the Forand bill. Labor's spokesmen, however, have the backing of several welfare organizations (plus the Illinois and Massachusetts welfare directors), the American Nurses Association and the Physicians Forum, among others. The latter group also informed the committee that it favors a compulsory social security coverage for physicians. (From Washington Office, A.M.A.).

Photometers and Laboratory Results—

Physicians who must supervise clinical laboratories as well as those who in their daily work must rely upon laboratory results may be interested in an opinion from the Council on Clinical Chemistry of the American Society of Clinical Pathologists.

Discussing the current use of precalibrated photo-electric photometers, it is noted that using such an instrument requires several unjustified assumptions. It must be assumed that there will be no change from day to day in the reagents, in the technical handling, in the conditions of the procedure or in the instrument itself, from the date of fact-
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine plus decongestant action — systemically — with TRIAMINIC.

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Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:
Phenylpropanolamine HCl .......... 50 mg.
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low half-dosages for the 6- to 12-year-old child, with the timed-release construction for pro-
longed relief.

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IN ARTHRITIS

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No sodium accumulation. Because BUFFERIN is sodium-free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases. Each sodium-free BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.


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Photometers and Laboratory Results—
(Continued from page 15-A)

tory calibration to the date of use. In practice it is possible to control these variables only by the routine use of standards. These standards must be used frequently to verify or when necessary change the calibration of the instrument.

The Council on Clinical Chemistry strongly urged that manufacturers of instruments supply in their procedure-manuals the specific directions for the preparation and use of daily standards.

End of Penalty Mail for Reporting Communicable Disease—

Effective on July 1, 1958, the penalty mail privilege which provided postage free cards and envelopes for reporting communicable diseases became illegal. According to the State Health Department, case report cards and envelopes addressed to the Collaborating Epidemiologist and bearing the federal franking notation should be destroyed or returned to the State Health Department. Their use at the present time is a federal offense under postal laws. According to plan, the State Health Department has mailed a new form “Disease Case Report” to all physicians. This form permits the easy reporting of communicable disease and postage will be paid by the addressee, The Nebraska State Department of Health.

In Omaha, reports may be telephoned or mailed to the Omaha-Douglas County Health Departments.

This unexplained change in procedure by the Federal Government serves as an occasion to note the plea from the State Health Department, attached to the May, 1958, Nebraska Morbidity report, for continuing reporting of communicable diseases. It is stated that while modern methods of treatment have limited periods of communicability the increased speed and frequency of global travel as well as the movement of migratory labor has complicated the problem of communicable disease control. It is also noted that the control of disease such as smallpox, typhoid and malaria has resulted in a population which no longer has naturally developed immunity. The reporting of these diseases also provides the basic raw material for research and advancement in this field.
besides diabetes, what diseases may cause symptoms of polyuria, polydipsia, increased fatigability and loss of weight?

Various renal diseases with isosthenuria, portal obstruction, functional dipsomania, hyperparathyroidism, acromegaly, primary aldosteronism, chronic mercury poisoning, hypervitaminoses A or D, Hand-Schüller-Christian lipoidosis, fructosuria, pentosuria and sucrosuria.*

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Miltown (meprobamate, Wallace) ... 400 mg.
2-methyl-2-n-propyl-1,3-propanediol dicarbamate
Conjugated Estrogens (equine) ... ... .4 mg.

Supplied: Bottles of 60 tablets.
Dosage: 1 tablet t.i.d. in 21-day courses with one week rest periods; should be adjusted to individual requirements.

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Current Comment

Financial Aid for Nursing Education—

A broad program of aid to the fields of education for nursing and utilization of nursing services involving grants totaling $1,473,800 has been announced by the Sealantic Fund, a philanthropic corporation established by John D. Rockefeller, Jr. These grants, made possible by a special gift to the Fund from Mr. Rockefeller, are directed toward helping to reduce the acute shortage of trained nurses in this country.

The grants cover five general areas: an intensified program to encourage recruits into the nursing field; development of two-year courses in basic nurse education in junior and community colleges throughout the country; pilot programs in collegiate schools of nursing to prepare more nurses as teachers; grants for baccalaureate nursing scholarships to thirty-two colleges and universities; and research into the economic utilization of nursing and related personnel in the operation of hospitals.

A total of $411,000 has been given to the National League for Nursing to carry out an expanded four-year program to encour-

age more young people to enter the nursing profession. The League has conducted work in this area for many years and particularly since 1948, when its Committee on Careers was formed. But there is an immediate need for intensifying the recruitment program, in view of the fact that if admissions of students to nursing schools remain at the present level, the ratio of professional nurses per 100,000 population will drop, instead of increase, from the present 259 to 246 by 1970.

The Sealantic grant will enable the League to double its vocational information program and will assist schools and individuals within the states and localities to strengthen their own nursing career efforts. The national program includes an active publication program of posters, pamphlets, and visual aids as well as work with vocational counselors and libraries. The approximately 2,300 Future Nurses Clubs which have been organized in secondary schools throughout the country is one of the aspects of this program which has been particularly effective. These Clubs, through classroom instruction and service in hospitals, give young people a basic understanding of nurs-

(Continued on page 28-A)
EDITORIAL

WHAT OTHERS HAVE SAID


“Many drugs prescribed today are likely to produce effects dulling mental, sensory, and physical reactions. Since so many people propel themselves about in machines of great power which require split-second judgments and timing to operate safely, the doctor has a clear and presently grave responsibility. He must know thoroughly both the drug and the patient.”

The writer believes we should:
—broaden our testing for allergic and idiosyncratic reactions;
—watch for side effects of serious import as we push up the dosage for full physiological effects. Tranquilizers in full dosage may produce transient episodes of faintness or giddiness (while driving 70 m.p.h.);
—check each individual regarding amount of drowsiness produced by antihistamines and motion sickness drugs;
He points out that:
—chlorpromazine may bring out latent convulsive disorders;
—the amphetamine group, while at first stimulating, have a reactive period of fatigue and depression; and
—the amount of hypnotics sold indicates wide usage.

He concludes as follows:
“Our profession is working valiantly to promote safety features in automobiles. While we have been pointing out the mote in the manufacturer’s eyes, have we failed to see the beam in our own — potent drugs prodigally prescribed?”


Antimicrobial drugs are being given in great quantities as may be guessed from a single fact—“in 1956, production of penicillin reached 597,589 pounds” (almost 300 tons).

These drugs are not only given to cure specifically known infections, for prevention of extension of present bacterial infections, as prophylaxis against possible bacterial infections, but “not infrequently they are given for viral or non-infectious diseases without proper bacterial study. For these they are administered by virtually every conceivable route.”

After brief consideration of some of the ill-effects, some of which “have been more serious than the original illness . . . “and have ended fatally, the author has the following to say:

“. . . It does not appear to be wise to use antibacterial substances without a clear-cut indication and without a proper pretreatment bacteriologic study. It should be remembered that the use of any therapeutic substances is accompanied by a calculated risk,” and, further: “Once again it must be emphasized that the physician should exercise superlative discretion and discrimination when he prescribes any chemotherapeutic material.”

“The Surface Area of the Body.”

In the Journal of the American Medical Association for July 5, 1958, p. 1248, the editor discusses this subject in a very spicy and readable fashion. One should read the editorial to appreciate fully the sharpness of the writer’s points. We will quote only two sentences because of their general application to many situations in practice as well as in medical literature. They are as follows: “There is a danger in repeated allusions to something that is never seen, handled, or measured; one may come to believe it important when it does not even exist. There is danger in using mathematics and statistics to embroider a medical contribution; such embellishment does not make a paper scientific, and it may do the reverse; it may take a sharp-eyed scholar indeed to see through the camouflage of cosines and logarithms behind which some fallacies are entrenched.”
WHAT ABOUT AMERICAN MEN?

More and more evidence appears in newspapers and magazines indicating that thinking people are becoming worried and articulate about the future status of men in relation to family, state, nation, and the human race in general. One finds this evidence in all sorts of literature, in religious as well as secular.

In a recent issue of a church magazine an article is to be found entitled "Automation Is Increasing Our Leisure Time — for What?" The Lincoln Sunday Journal and Star for June 18, 1958, p. 4-B, discussing Father's Day in the column entitled "More or Less Personal," indicates that Father has lost his position as "Head of the House," and the writer of the column has a difficult time proving to himself or to the reader that Father has gained any quality or advantage to replace what he admittedly has lost. Coronet magazine for July, 1958, contains two articles applicable to this line of thought, "Wives and the 'Middle-Age Crush'" and "For Husbands: 31 Household Hints." The foreword of this article has the following to say: "For scientific studies prove that males are doing more housework these days than ever before in history. Their chores include such diversified activities as baby care, kitchen work (including cooking), house cleaning and various types of do-it-yourself." This is, certainly, only a fraction of what could be found if one carried out a careful research of current literature.

At this point let us call attention of the reader to the Special Article, "Strategy Is Everybody's Business," by Frank Rockwell Barnett, in this issue of your Journal, page 358. It tells us many things we do not like to hear but points the way for all, men and women alike, who enjoy life as we have it, a way of life never before seen in this world, and who do not want that "American Way of Life" to be taken from them.

It is not possible, in this editorial, to offer an analysis of our socio-economic status, even if the writer felt qualified, nor to present any formula for correction of the underlying faults of our economy. It may be said, however, without fear of contradiction, that all influences in our lives that separate families, day after day and year after year, reducing the home to a house to which we resort chiefly to grab a bite to eat, change our clothes, and get a few winks of sleep, should be altered. Money and soft-living must not lead us to give up our influence in home and family primarily, but, after that, in the community, state, and nation.

A.M.A. HOUSE OF DELEGATES:
SAN FRANCISCO, 1958

You will receive a report from your delegates, in a future issue of the Journal, concerning the actions of the House, as it met in San Francisco. There will be a report in the Journal of the American Medical Association at an early date giving you the result of actions of the House of Delegates. In neither of these will you get the "feeling" of what transpired. To be present at the sessions of the House and to follow some of the more controversial items through the Reference Committees, and finally, to listen to the reports of these committees, helps one to understand the general trends of opinion. An item may be reported as passed by the House whereas it actually met much adverse opinion and the vote may have been very close.

This year your editor was unable to attend but, fortunately, was ably represented by Assistant Editor Frank P. Stone of Lincoln. In a communication from Doctor Stone we find that involuntary coverage of all doctors by Social Security was a subject that elicited heated argument. So far as is now evident, the kettle is kept boiling by a certain relatively small group of doctors in a couple of eastern states. They may be identified by their former favorable and articulate attitude toward the Wagner-Murray-Dingle type of bills in Congress and any other influences favoring universal compulsory health insurance. Their effort now is to get the medical profession harnessed with Social Security. The present point of attack is to break down the unfavorable position taken by the A.M.A. by forcing a man-to-man survey of members in the hope that the number of leftist leanings, with indifferent attitudes, or with lack of understanding may be great enough to strengthen the position taken by the original group.

At the opposite extreme was the unanimous "roar" of disapproval when the subject of the Forand bill came before the House. Is it little hard to understand how we can so thoroughly hate an out-and-out (Continued on page 372)
Pre-Term Delivery of the Erythroblastic Infant*  

LEON S. MC GOOGAN, M.D.  
Omaha, Nebraska  

Doctor McGoogan reports, in this article, the results obtained in increasing fetal salvage in erythroblastic infants. Following the lead of a few other obstetricians, he induces labor at about 37 weeks gestation. This is late enough to avoid ill effects of immaturity and saves the fetus from a more “prolonged exposure to the erythroblastic environment.” In twenty-seven instances in which this procedure was carried out he reports a survival rate of 62.9 per cent. This compares very favorably with 36.7 per cent survival using the usual procedures.

—EDITOR

PRE-TERM delivery of the erythroblastic infant has been recommended by various medical authorities. Arguments for and against the procedure have occurred rather frequently in the recent literature. There have been, in the past year, four excellent articles dealing with this particular phase of the problem1-4. Evans5, in 1956, presented a series of 26 cases of erythroblastosis fetalis in which part of the treatment was pre-term delivery. When the history of amenorrhea, and the clinical and X-ray findings indicated that the pregnancy was of at least eight months duration, and that prematurity would no longer play a major role in fetal survival, the pregnancies were terminated by medical or surgical induction of labor or both. Pre-term delivery coupled with prompt exchange transfusions resulted in a fetal survival rate of 91 per cent contrasted with a 36.7 per cent survival rate in the previous erythroblastic infants. Allen4 also advises the induction of labor at 37 weeks, and uses approximately the same indications as those of Evans. Walker, Murray and Russell6 concluded that if there had been a previous stillbirth due to hemolytic disease and a subsequent positive fetus reaches 35 weeks gestation, alive and not hydropic on X-ray examination, premature induction at this stage gives a better chance of live birth than does spontaneous labor. Fisher3 reports a survival rate of 84 per cent in his induced series and a lower survival rate of 71 per cent in the spontaneous series. Careful reading of these four articles, particularly that of Evans, tends to make the reader enthusi-

*Read before Omaha Mid-West Clinical Society, November, 1957.

astic about the procedure of pre-term delivery and encouraged to put it into practice.

The author has long felt that it was unwise to subject the fetus to the original erythroblastic environment any longer than necessary, and that there might be a time in the last month of pregnancy when delivery followed by prompt transfusion would salvage many infants who, if left in utero until delivery at full term, would be so severely affected that they would succumb in utero and not respond to extraterine therapy. Is there a point of no return in the intrauterine life of an infant subjected to the erythroblastic environment? Is there a point of time prior to which salvage would be increased and after which neonatal and perinatal death rate increased? In 1947 the author began to attempt to deliver, whenever possible, the suspected erythroblastic infant at or about the thirty-eighth week. With the appearance of Evan’s report the evaluation of the author’s own cases seemed desirable.

From January 1, 1947, through July 31, 1957, a period of ten and one-half years, a series of 37 pregnancies were observed. These pregnancies occurred in 32 women. In every instance the fetus was a potential or actual erythroblastic infant, and pre-term delivery was planned with the ultimate aim of increasing fetal salvage.

Every Rh negative, pregnant female who had been previously pregnant and possibly sensitized, or who gave a history of possible Rh sensitization by blood transfusion or by the intramuscular injection of whole blood, was considered a candidate for pre-term delivery. The presence of Rh antibodies in the maternal blood proves the presence of previous sensitization. Accordingly, Rh antibody titers were recorded on the first visit during each pregnancy and again during the seventh and eighth months of pregnancy. The presence of the positive titer seemed to be more important than the numerical dilu-
tion at which it is no longer present. On the other hand, a number of reporters have used the titer of 1:64 as being the level at which more or less severe erythroblastosis should be expected, and at which survival would be greatly lessened. The author has, however, observed a rather severe erythroblastosis in an infant with the maternal antibody titer of only 1:2. He has also observed no evidence of disease in an infant who was Rh negative with a maternal antibody titer that was 1:1024; the latter, of course, being an example of the amnestic reaction.

If the patient had been previously sensitized, and if the titer was positive, pre-term delivery at approximately the thirty-seventh week was planned, although a few were done later due to the fact that some of the consultation-cases were not seen until the thirty-eighth or thirty-ninth week of pregnancy. A few cases delivered early because of the spontaneous onset of labor. If, at the thirty-seventh week, or if the patient was first seen at a later time, the cervix was soft and dilated to admit an examining finger, and if the presenting part was entering the pelvis, medical induction done with intravenous pitocin drip (5 units of pitocin to 500 cc. of 5% glucose and water) accompanied by the artificial rupture of the membranes. If the findings were not favorable or if there were other obstetrical indications, the pregnancy was terminated by cesarean section.

At the time of delivery a specimen of cord blood was obtained for Coombs’ test, Rh factor, hemoglobin, red blood cell count, white blood cell count, and the number of nucleated reds per 100 white blood cells. In the early part of the series cephalin flocculation tests were also done, but more recently these have been replaced with bilirubin tests.

Since the patients were all private patients it was impossible, for obvious reasons, to utilize the same pediatrician for all babies. There resulted, therefore, some variations in indications for transfusions, and the type of transfusions employed, that is, frequent small transfusions vs. exchange transfusions, as well as the time interval between delivery and the transfusions. As noted in Table No. 1 there were 36 multipara and 1 primigravida. This latter patient had been sensitized as a child by the intramuscular injection of whole blood. The blood had been obtained from her father and was given as a prophylactic protective measure after her exposure to poliomyelitis. Sensitization to the Rh factor became apparent during the last trimester of pregnancy with the appearance of a positive titer. One additional patient had also received whole blood intramuscularly, as a child. Four patients were apparently sensitized as a result of blood transfusions following a delivery or an operative procedure, and were presumed to have been sensitized as a result of the transfusion of improperly matched blood. The remaining patients are presumed to have become sensitized as a result of a previous pregnancy. In 6 of the 37 pregnancies the fetus died intrauterio prior to the thirty-sixth week of gestation, and, hence, were no longer candidates for pre-term delivery. In 4 other cases the baby, although delivered early, was Rh negative. There are, therefore, 27 pregnancies in which pre-term delivery was employed in an effort to salvage a baby affected by erythroblastosis. These 27 cases have been placed in 4 separate groups.

**Group 1: Pre-term delivery without previous erythroblastosis** — There were 7 patients in whom an Rh positive antibody sensitization was discovered although there was no history of a previous erythroblastotic infant. All husbands were presumably homozygous except one. One patient was a primipara; the remaining 6 were multipara, as shown in Table No. 2. Induction of labor with artificial rupture of the membranes was done in 6 and one patient fell into labor spontaneously. Exchange transfusions were employed 5 times, 2 of the infants dying of acute cardiac arrest during the transfusion procedure. Two infants received only small repeated transfusions and one of these died of kernicterus. There were 3 fetal deaths and 4 surviving infants, a salvage rate of 57.14 per cent.

**Group 2: Pre-term delivery after erythroblastotic infant, but without previous**

<table>
<thead>
<tr>
<th>Total Number of Patients</th>
<th>37</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primigravida</td>
<td>1</td>
</tr>
<tr>
<td>Multigravida</td>
<td>36</td>
</tr>
<tr>
<td>Macerated Fetuses prior to 36 weeks</td>
<td>6</td>
</tr>
<tr>
<td>Rh negative</td>
<td>4</td>
</tr>
<tr>
<td>Potential Erythroblastotic Infants</td>
<td></td>
</tr>
<tr>
<td>past 36 weeks gestation</td>
<td>27</td>
</tr>
<tr>
<td>Medication Induction</td>
<td>15</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>10</td>
</tr>
<tr>
<td>Spontaneous Labor</td>
<td>2</td>
</tr>
</tbody>
</table>

Nebraska S. M. J.
TABLE II
NO PREVIOUS ERYTHROBLASTOSIS

<table>
<thead>
<tr>
<th>Case</th>
<th>Parity</th>
<th>Previous Erythroblastosis</th>
<th>Previous Stillbirths</th>
<th>Previous Miscarriages</th>
<th>Husband's Zygosity</th>
<th>Weeks Pregnant</th>
<th>Artificial Indication of Labor</th>
<th>Cesarean Section</th>
<th>Infant's Weight</th>
<th>Coombs' Test</th>
<th>Hgb. (g%)</th>
<th>RBC (Million/cc)</th>
<th>Transfusion</th>
<th>End Result</th>
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<tbody>
<tr>
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<td>0</td>
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<td>Homo</td>
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<td>3045</td>
<td>x</td>
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<td></td>
<td>3408</td>
<td>x</td>
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<td>Homo</td>
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<td>x</td>
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<td></td>
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<td></td>
<td>3004</td>
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<td>4.9</td>
<td>Ex.</td>
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<td>0</td>
<td>0</td>
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<td>2500</td>
<td>x</td>
<td>17</td>
<td>4.8</td>
<td>Sm.</td>
<td></td>
</tr>
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</table>

x—means present or positive or performed.

perinatal or neonatal deaths.—There were 6 patients who had had previous erythroblastotic infants, without a previous neonatal or perinatal death, as shown in Table No. 3. The husband was homozygous in every instance. Four patients had their pregnancies terminated by medical induction and two by cesarean section. Three of the babies were given exchange transfusions and three, although having positive Coombs' tests, did not receive any blood at all. Two babies died, both having been previously transfused. One infant was markedly hydropic and died two and one-half hours after transfusion. The second infant succumbed to pneumonia on the fourth day after delivery. Four babies survived for a fetal salvage of 66.66 per cent.

Group No. 3: Pre-term delivery of women after previous neonatal deaths from erythroblastosis.—There were 10 patients with a history of previous neonatal deaths from erythroblastosis as shown in Table No. 4. In 8 instances the husband was presumed to be homozygous and in 2 instances presumed to be heterozygous. Six patients had their pregnancies terminated by medical induction and 3 by cesarean section. One fell into labor spontaneously at 37 weeks. Six of the infants received exchange transfusions, and 1 developed acute cardiac arrest during the transfusion and succumbed. One infant received multiple small transfusions and survived. Three infants were so severely affected by the erythroblastotic process that they died before transfusions could be employed. There were 6 survivors or 60 per cent survival rate.

Group No. 4: Pre-term delivery of women after previous stillbirths of erythroblas-
TABLE IV
PRE-TERM DELIVERY AFTER PREVIOUS NEONATAL DEATHS FROM ERYTHROBLASTOSIS

| Case | Parity | Previous Stillbirths | Previous Neonatal Deaths | Hemoglobin's Rearing | Weeks Pregnant | Indication | Cesarean | Infant's Weight | Coombs Test | Hgb. | RBC | Jaundice | Transfusion | End Result |
|------|--------|----------------------|--------------------------|----------------------|---------------|------------|----------|----------------|-------------|------|-----|---------|-------------|------------|-----------|
| 1    | 3      | 2                    | 0                        | x                    | Homo         | 37         |         | 2837           | x           | 8.6 | 2.2 | 0       | 0           | Survived   |
| 2    | 3      | 2                    | 0                        | x                    | Homo         | 37         |         | 2696           | x           | 4    | 0.6 | -       | 0           | Deceased   |
| 3    | 5      | 3                    | 3                        | Homo                 | 36           | x          | -        | 2837           | x           | 10   | 2.1 | 0       | x           | Deceased   |
| 4    | 2      | 1                    | 0                        | 1                    | Homo         | 36         | 0        | 2696           | x           | 12   | 4    | 0       | MS          | Survived   |
| 5(4) | 3      | 2                    | 0                        | 1                    | Homo         | 36         | 0        | 2637           | x           | 14   | 3.7 | 0       | x           | Survived   |
| 6    | 2      | 1                    | 0                        | 1                    | Homo         | 37         | 0        | 2159           | x           | 8.8  | 1.7 | 0       | x           | Survived   |
| 7    | 2      | 1                    | 0                        | 1                    | Homo         | 37         | x        | 3272           | x           | 15   | 5    | x       | x           | Survived   |
| 8    | 4      | 3                    | 0                        | 1                    | Homo         | 37         | x        | 3270           | x           | 11   | 2.8 | 0       | x           | Survived   |
| 9    | 3      | 2                    | 0                        | 1                    | Hetero       | 37         | 0        | 2470           | x           | 5    | 1.9 | 0       | 0           | Deceased   |
| 10   | 3      | 1                    | 0                        | 1                    | Hetero       | 38         | x        | 3636           | x           | 4    | 1.7 | 0       | Deceased    |            |

x—means present or positive or performed.

totic infants.—There were 4 women who had had previous stillbirths due to erythroblastosis, as shown in Table No. 5. All husbands were presumably homozygous. All four of the pregnancies were terminated by cesarean section. Three of the babies were given immediate exchange transfusions and all survived. The fourth baby was deemed by

SUMMARY

There were, therefore, 10 neonatal deaths and 17 surviving babies, for a survival rate of 62.9 per cent. Twenty of the pregnancies had been preceded by previous erythroblastotic infants; only 6 of these infants survived for a survival rate of 30 per cent. The survival rate, with the subsequent pre-term delivery, was, in these 20 patients, 65 per cent, a little more than double that of the previous rate without pre-term delivery. Although the rate is not as high as that reported by Evans, it demonstrates a trend and therefore reinforces the opinion that pre-term delivery does play a definite role in the survival rate of the suspected erythroblastotic infant.

TABLE V
PRE-TERM DELIVERY AFTER PREVIOUS STILLBIRTHS OF ERYTHROBLASTOTIC INFANTS

| Case | Parity | Previous Stillbirths | Previous Neonatal Deaths | Hemoglobin's Rearing | Weeks Pregnant | Indication | Cesarean | Infant's Weight | Coombs Test | Hgb. | RBC | Jaundice | Transfusion | End Result |
|------|--------|----------------------|--------------------------|----------------------|---------------|------------|----------|----------------|-------------|------|-----|---------|-------------|------------|-----------|
| 1    | 3      | 2                    | 2                        | 0                    | Homo         | 37         | 0        | 2450           | 14.1        | 3.6  | x   | x       | x           | Survived   |
| 2    | 3      | 1                    | 1                        | 0                    | Homo         | 38         | 0        | 2630           | 11.2        | 2.9  | 0   | x       | 0           | Survived   |
| 3(2) | 4      | 2                    | 1                        | 0                    | Homo         | 37         | 0        | 2725           | 6.9         | 1.5  | 0   | x       | 0           | Survived   |
| 4    | 3      | 1                    | 1                        | 0                    | Homo         | 37         | 0        | 2820           | 7           | 3.5  | x   | x       | -           | Deceased-Atelectasis Erythroblastosis |

x—means present or positive or performed.

the attending physician to be in good condition at the time of birth although there was a moderate anemia. Jaundice became clinically apparent eight hours after delivery and progressed very rapidly. The baby succumbed fifteen hours after delivery, without treatment. Three infants survived in this group for a survival rate of 75 per cent.
Teamwork with the pediatrician who has an interest in the problem of erythroblastosis and who is disciplined in the technique of exchange transfusions is most important. Three infants developed acute cardiac arrest during the transfusion procedure. Although acute cardiac arrest is a well known risk and complication in exchange transfusion, three deaths in 17 procedures is 17.64 per cent and entirely too high and calls to attention the need of experience by the man administering the transfusion.

THE

4-H Clubs and the Doctors of NEBRASKA*

Doctor Bancroft presents, herein, an important problem in public relations. A solution to this problem, adopted in Nebraska, bids fair to become nationwide in its application. Success in this important project, like most efforts at good PR, requires cooperation from all our doctors.

—EDITOR

A PROBLEM IN MEDICAL PUBLIC RELATIONS

In a recent encounter with an intelligent English layman, he said of English doctors, “We have got the arrogant doctors where we jolly well want them and we are going to keep them there.” This statement is very revealing. It has been repeatedly pointed out that the technique of the English Socialist was to teach the English voters to hate their doctors. When the majority of Englishmen came to resent their physicians they made them servants of the State.

The same technique is being exploited by Socialists and Communists as they attempt to undermine private enterprise here. If they can teach the majority of our voters to resent us, then we, too, will become servants of the State.

Our problem is apparent. Our need is obvious. The course of action is evident. If all that we are—our private lives, our professional behavior, indeed, all of our relationships to the community—are such as to inspire warmth of friendships and confi-

*Read before Annual Convention Nebraska State Medical Association, April 29, 1958.

BIBLIOGRAPHY


PAUL M. BANCROFT, M.D.
Lincoln, Nebraska

dence, then indeed, the march of Socialism and Communism will be slow. Any action which makes us appear arrogant or which destroys confidence facilitates the progress of our opponents. There is a responsibility for each one of us. This is not an assignment for some other doctor. This is not a matter for officers of medical organizations. This is the direct concern of each doctor in his own office, on his every house call and in all of his community assignments.

THE HEALTH INTERESTS OF LAY GROUPS

There are many lay groups who have a legal or proper community interest in health. These groups are often sponsored by politically conservative leadership who come to the medical profession seeking our counsel and cooperation. We, understandably, are hypersensitive about invasions of our field. We often act hastily with resentment, and refuse to participate in such projects. In so doing we make ourselves appear selfish, un-cooperative and arrogant.

THE 4-H CLUBS OF AMERICA

The 4-H Clubs of America probably represents the largest and the most powerful youth-organization in the United States. It derives some of its strength from the fact that it is in part supported by federal and state funds and is actively promoted by the extension services of the various agricultural colleges. The membership is composed of young people from ten to twenty-one years of age. There is a total membership of 2,200,000 and there are 275,000 adult and
95,000 assistant leaders in addition to the personnel of the various extension services. In the State of Nebraska there are, this year, approximately 30,000 members. The relationship which the doctors of Nebraska maintain with this large group of our finest rural and suburban young people will have a direct bearing upon the attitudes of the citizens of this State toward the medical profession throughout many years to come.

The symbol of the 4-H Clubs is the four leaf clover. On each leaf is imprinted the letter H, one stands for the Head, one for the Hand, one for the Heart and the last, for Health. This represents a well rounded program, directly concerned with the integrity of the home and the community and attempting to meet in part the needs of young people in the intellectual, spiritual, vocational, and health fields. The achievements in the first three areas have been noteworthy. Our concern is with the fourth leaf which bears the H for Health.

The health objectives of the 4-H Clubs have been described in their literature in these words: “. . . to develop in rural boys and girls habits of healthful living . . . that they may live fuller and richer lives.” Their creed states, “I believe in the training of my health for the strength it will give me to enjoy life, to resist disease and to work more efficiently.” In their pledge they state, “I pledge my health to better living.” All of these objectives are modest, involve no invasion of the medical field and are worthy of our endorsement.

The founders of the 4-H Clubs wished to arouse and maintain interest in personal, family, and community health. Being leaders in agriculture it was natural that they would adopt the techniques with which they were familiar. Since competitive livestock shows have been useful in promoting interest in the quality and health of livestock, this method was adopted. Boys and girls were brought to the county fairs where a team of doctors, like livestock judges, examined and helped to select a champion boy and girl. The winners were sent to the Nebraska State Fair where they competed with the winners of other counties and a state champion boy and girl were sent to the national contest.

In establishing the state contest, in 1923, in connection with the State Fair in Lincoln, the leaders of the 4-H Clubs very properly approached the Nebraska State Medical Association seeking its help in securing a panel of doctors to examine the participants. The officers of the State Association, being conscious of professional problems that might arise, determined that, since the contest was to be held in Lincoln, Lincoln doctors should not be employed. A panel of Omaha doctors, members of the staff of the College of Medicine, and under the leadership of Dr. E. L. McQuiddy, were brought to Lincoln for this purpose. The examinations were conducted on the State Fair grounds. This arrangement worked for a number of years. It was very successful. Through it the Nebraska State Medical Association, that is, the doctors of the State, appeared in the eyes of the public as cooperative, public spirited, and generous.

Subsequently, and for reasons I have been unable to learn, the examinations were removed from the State Fair grounds and the panel of doctors from the Medical College was no longer used. The State Medical Association lost control. Instead, the offices, facilities and staff of a private medical group were employed for a number of years. In their naivety the leaders of the 4-H Club entered into a relationship which now made it appear to the other doctors of Lincoln that the physical examination of this fine, select group of young people from all parts of Nebraska, was being exploited to the advantage of one particular group. To the dismay of the lay leaders of the 4-H Clubs, there was loud and violent reaction on the part of many doctors. One prominent Lincoln doctor told the head of the extension service that the 4-H Clubs could take their health contests and “go to H.......,” that he would have nothing to do with a project that promoted and advertised a competitor's office throughout the State. He had a right to complain, but how much better it would have been if he had taken his complaint to the Nebraska State Medical Association instead of storming at laymen.

The effect of these violent reactions upon the intelligent laymen who represented the Clubs was most unfortunate. One of the staff of the University came to me and complained bitterly of the doctors of the State as self-seeking, avaricious, un-cooperative, and arrogant. Subsequently the contest was removed to the University campus where a group of Lincoln doctors, meeting on neutral territory, conducted the examinations without intraprofessional strife. This was
an improvement and displayed the profession to the public as cooperative, public spirited, and generous.

Although the arrangement on the University campus was an improvement there was still an outcry from doctors over the State. When the 4-H Clubs took young people to be examined in the metropolitan center by doctors represented as prominent specialists, it is obvious that these same young people would find it easier to seek medical counsel in the metropolitan center subsequently, to the disadvantage to the local physician. In recent years agricultural leaders have become very conscious of the fact that there has developed a great dearth of physicians in the smaller communities. If this is to be corrected the rural communities, in order to secure a physician and to keep him, must lend him loyal support. In harmony with this attitude the 4-H Clubs in Nebraska have abandoned the examination in Lincoln in favor of having these young people examined by the local physician in his own office. This represents a radical departure from the original program. Nebraska is the first State in the Union to adopt this change. Here is an opportunity. Here is a very large organization of young people who are to be taught to go to the office of their local physician. They are going to be taught to respect his judgment relative to their physical fitness. They are to be taught to respect him as an important member of the local community. How will we use this opportunity? I could easily believe that some of us will be too busy to take the time for the examination of these well children. I could believe that some of us will be too preoccupied with other things and, as a consequence, display irritation and annoyance with inquiries relative to physical fitness. I am concerned lest the doctors of the State will fail to see in this opportunity one of the finest occasions to promote the best of good public relations with those who will be some of the most powerful leaders of Nebraska in the next generation.

The concern of the Clubs is that these young people receive the benefit of an adequate health examination and interview. As a part of this experience the author knows of no objection to a standard fee. It is good service, not free service that has been asked of us.

The subject matter of this paper was presented to the committee on Rural Health of the Nebraska State Association and to the American Medical Association. It was very well received. As a consequence your speaker presented a similar paper to the A.M.A. sponsored National Meeting on Rural Health in Jackson, Mississippi. The presentation will be made next year in Kansas City before a similar group. It is the hope of the American Medical Association that this movement to put the examination of 4-H Club members in the office of the local physician, which has been pioneered in Nebraska, will be adopted throughout the forty-eight states.

TUBERCULOSIS ABSTRACTS

BRONCHIECTASIS AND ACUTE PNEUMONIA

Bronchiectasis should be suspected when the roentgenogram of a patient with recent acute pneumonia shows very slow resolution of the pneumonic process and persistence of parenchymal rules and productive cough are noted.

Introduction — Bronchiectasis has been considered a disease that originates in childhood after a severe respiratory infection. During the past ten years, however, studies on young adults who recently had bouts of acute pneumonia suggested that adult infections might also be a cause of bronchiectasis. Studies of such "postpneumonic bronchiectasis" have indicated that in some instances the bronchogram naturally reverts to normal. The present study is concerned with the incidence, diagnostic features, and stability of bronchiectasis first discovered after recent pneumonic infections.

Methods — The clinical records and roentgenograms of 94 patients on whom bronchograms were performed over a 28 month period at the U.S. Army Hospital, Fort Dix, New Jersey, were reviewed. The first group consisted of 69 patients selected for bronchography from a total of 1,711 patients seen with acute pneumonia. The second group consisted of 25 patients whose history or chest roentgenograms suggested chronic bronchiectasis. Patient selection of bronchography was done on the basis of uniform criteria.

Bronchography was performed on the patients with pneumonia not less than one month after all clinical evidence of activity had subsided, and only after any residual roentgenographic abnormality was shown to be stable for at least three weeks. Repeat studies were made in 24 instances and each was performed at least eight weeks after the preceding one. All of the patients were bronchosced immediately prior to the first bronchogram.

Bronchiectasis was diagnosed only by the presence of obvious cylindrical or saccular dilatation of the bronchial lumen. No untoward reaction to the procedure was encountered except in patients with bronchial asthma. The latter all developed moderately severe wheezing that responded satisfactorily to standard therapy.

(Continued on page 349)
Wound Closure
BY USE OF A Plastic Substance

Doctor Elias gives us a brief, concise, and well illustrated paper of practical import. This is a "how-to-do-it" discussion of a method of closing certain wounds, especially in children, that seems to have more advantages than disadvantages.

—EDITOR

RECENTLY a plastic material has been developed which is non-toxic, non-sensitizing and non-allergenic. This vinyl resin base is apparently inert; the film which it forms is insoluble in body fluids; and the ethyl acetate-acetone solvent evaporates in seconds following its application. It has been used as a protective covering for burns and wounds.

This transparent dressing was developed to allow critical evaluation of the progress of healing as well as to judge indications for removal and redressing. It is an ethyl acetate-acetone solution of co-polymers of hydroxyvinyl chloride-acetate and sebacic acid, 9.3 per cent by weight, and modified maleic acid rosen ester, 31 per cent by weight, with flurochloro hydrocarbon gas as a propellant. An aerosol-type applicator can be used to apply this material. The material, itself, has been found to be sterile.

An additional advantage of this material is its elastic nature. It will withstand washing, and despite friction or the stress of motion it will remain in place. The film can be removed rather simply by the process of peeling.

Such a film can be applied to the skin surface in less than 30 seconds. This film, which is tough and yet flexible, need be no thicker than .002 to .003 inch, for considerable strength.

As the use of this substance became more widespread and its characteristics became familiar to me, it seemed that it might well serve as an ideal dressing for pediatric surgery, because:

1. It is waterproof.
2. It will stand the stress of repeated flexing.
3. It is easy to apply.
4. It is simple to remove.

Furthermore, it occurred to us that modification of this film to attain added strength, might be accomplished by incorporating gauze mesh, much as wire mesh reinforcement is used in construction with concrete. This, it was felt, would give sufficient strength to maintain wound edges which had been approximated by a subcuticular stitch, and diminish undue elasticity in this particular area. With this in mind, a subcutaneous "basting stitch" was used on several wounds. It was soon found that the "basting stitch" could be removed after a few moments, and that adequate wound approximation was maintained by the plastic-with-gauze combination.

The figures, Nos. 1 to 6, serve to illustrate the various steps in closing a wound in the manner described. These illustrated steps are as follows:

Fig. 1. This shows wound closure accomplished by a subcuticular silk suture. (Cotton does not work well; it is too difficult to withdraw).

Fig. 2. Plastic has been applied to the closed wound.

Fig. 3. This shows the site of the wound after 1" or 2" gauze mesh has been applied.

Fig. 4. Shows reapplication of plastic material over the gauze to incorporate it into the plastic film.

Fig. 5. This figure shows the subcuticular suture cut and withdrawn. This leaves the wound held together by plastic and gauze only.

Fig. 6. This shows such a wound one year after closure by this method. (Only a
portion of the wound is visible below the dressing).

RESULTS

One hundred consecutive wound closures of this type were observed closely. One of the advantages, of course, is quite apparent to anyone who has attempted to remove sutures from a youngster in the office.

A disadvantage of this method is that there is occasional bleeding beneath the plastic film. This, at first, was somewhat disconcerting, and several of the film type dressings were removed for examination. Wound approximation was found to be excellent, and the dressing was simply reapplied. There have been no hematomas which required evacuation. Bleeding can be minimized if the spray is held a greater distance from the skin, so that more of the solvent, which causes the bleeding, can evaporate.

At present, this complication of bleeding is simply controlled by a pressure dressing which can be held in place by adhesive tape. The entire dressing can then be removed one week following the operation. This latter method, of course, has the inherent disadvantages which accompany the use of adhesive tape on children.

In addition to children, this is an excellent
means of securing any relatively short, straight, incision, where skin cleavage lines are followed, as the dressing is convenient, and gives accurate approximation.

SUMMARY

This vinyl resin base apparently forms an inert film which, when combined with fine mesh gauze, has sufficient strength to maintain wound approximation without skin sutures. When properly applied to an aseptic wound, sterility is maintained.

This wound closure, besides having the advantages of no skin sutures, is flexible, waterproof, adheres well, and yet is conveniently removed.

REFERENCES


SURGICAL MANAGEMENT of

**Thyroiditis**

Because of the advent of antithyroid drugs, the successful prevention of much of the endemic colloid goiter, and the apparent or real increase of thyroiditis, much of the surgical treatment of the diseases of the thyroid gland has to do with the latter — thyroiditis; so says the author. Doctor Coe enters at some length into descriptions of the various types of thyroiditis and their differential diagnosis. He indicates the function of surgical treatment in these entities.

—EDITOR

THE surgical management of thyroiditis has become increasingly important and interesting the past few years because of several factors. First, with the advent of the antithyroid drugs and radioactive iodine the urgency and importance of surgery in the treatment of primary hyperthyroidism has somewhat lessened. Second, the increased educational efforts over the past thirty years in the prevention of endemic colloid goiter through the dietary use of iodine has borne fruit. Third, although it may be more apparent than real, there seems to be an increasing incidence of thyroiditis.

The widespread use of antibiotics has almost relegated acute and subacute infectious thyroiditis to that large category of infrequent diseases. With the decrease in frequency of surgically treated hyperthyroidism most of the surgeon’s attention is directed to the single adenomas, multiple nodular goiters, and thyroiditis. I have been impressed during the past few years with the increasing frequency of thyroiditis which has not been suspected preoperatively. This attains even greater significance since the gross differentiation between thyroiditis and carcinoma is sometimes difficult. At this point the surgeon is placed in the dilemma, not knowing whether or not a thyroidectomy is indicated.

A brief review of the classification of thyroid disease follows.

*Primary hyperthyroidism* or Graves disease which produces increased pulse rate, increased pulse pressure, sweating, tremor, weight loss, and exophthalmos.

*Nodular goiter with hyperthyroidism* is also seen but usually occurs somewhat later in life and does not produce exophthalmos.

*Nodular goiter without hyperthyroidism* produces an enlargement of the thyroid gland and the symptoms are the result of this mechanical enlargement, such as a mass in the neck, dysphagia, dyspnea and, in some instances, hoarseness.

*Carcinoma of the thyroid* is the most serious of the diseases of this organ, and its symptoms resemble those of the nodular goiter, in the early phases — mechanical problems in the neck.

The remaining group of thyroid diseases that must be considered contains the vari-

*Read before the Omaha Mid-West Clinical Society, November, 1957.*
ous types of thyroiditis and this can be further classified in more detail, as follows:

Acute thyroiditis is an acute infectious process usually following an upper respiratory infection and is manifest by pain and swelling of the thyroid gland. There is usually considerable pain and in addition to pain in the gland itself, there may be radiation of the pain up under and behind the ears. These cases are infrequent and respond readily to antibiotic therapy. The only surgical treatment indicated is surgical drainage of an abscess if one should occur.

Subacute thyroiditis is somewhat similar but of a lesser degree of severity and has a more prolonged course. It may be due to a virus infection which destroys part of the thyroid epithelium and may allow the colloid to extravasate into the thyroid tissue setting up considerable fibrosis and foreign body reaction. The disease is self-limiting and may be treated symptomatically. X-ray therapy in doses of about 800 r is of value. In recent years cortisone has been used in doses of 25 mg. four times a day, with some degree of success. There may be a relapse following the cortisone therapy in which case X-ray treatment is used.

Chronic non-specific thyroiditis is the group which most often demands the attention of the surgeon, and there are three general types of these.

The first and most common is struma lymphomatosa or Hashimoto's disease. This has a close similarity with carcinoma which makes it difficult to recognize. It is characterized by epithelial degeneration, lymphoid infiltration, and fibrosis. Because of the tissue destruction there is a compensatory enlargement of the thyroid gland which produces the clinical symptoms. These all develop in women in the child-bearing period, and usually come to treatment at about the time of the menopause. They produce enlargement, dyspnea, dysphagia, pressure, nervousness, fatigue, coughing, hoarseness, pain, and tenderness in some instances.

The second and much less common is granulomatous or giant cell type of thyroiditis, sometimes known as DeQuervain's disease. This produces enlargement of the thyroid gland. The disease usually is of long standing and results in permanent damage to the gland. Because of the giant cell pattern seen microscopically this is also called pseudo-tuberculous goiter and actually resembles the picture seen in subacute thyroiditis. This type of disease responds well to X-ray therapy.

The third type is Riedel's struma and this is relatively uncommon. The gland in this instance is grossly fibrous and woody and extends into the surrounding structures of the neck. If one adheres to this designation he finds Riedel's struma is quite a rare entity. It was seen in only 0.05 per cent in 42,000 thyroidectomies at the Mayo Clinic. This disease may be either unilateral or bilateral.

The etiology of chronic non-specific thyroiditis is somewhat obscure although there have been several different causes suggested.

For many years infection has been suggested as a possible cause of this disease. However, repeated attempts to culture an infectious agent such as bacteria or virus have proved unsuccessful. Infection certainly seems possible, in theory, when we consider the frequency of throat infections and the closely associated abundant lymphatic supply in the throat and neck.

Degeneration has been the most widely accepted theory as to etiology and certainly there is considerable microscopic evidence to substantiate degeneration of the thyroid cell, from whatever cause, and its replacement by lymphoid and fibrous tissue. It was thought for a considerable period of time that all chronic non-specific thyroiditis represented one disease in various stages of its development. This was rather conclusively discredited by Graham in 1931, when he proved that Riedel's is not a progression from Hashimoto's disease. This he substantiated by serial-biopsy sections over several years which showed no evidence of progression.

It has been suggested for years that there was a progression from primary hyperthyroidism to struma lymphomatosa and, in some instances, to Riedel's struma. This theory gained popular appeal in that certainly long standing hyperthyroidism presents adequate cause for exhaustion of the thyroid cell and eventual degeneration. However, most often an adequate history of hyperthyroidism cannot be obtained, and the study of multiple serial specimens obtained by biopsy in a series of 76 patients showed that it was impossible to demonstrate pro-
gression from thyroid hyperplasia to struma lymphomatosa. There was some evidence, in seven cases, of exhausting atrophy which somewhat resembled struma lymphomatosa, but all the diagnostic criteria could not be satisfied.

It has also been suggested by Crile that struma lymphomatosa is not a true thyroiditis, but rather a primary thyroid-cell failure from an unknown cause with subsequent thyroid enlargement. This thyroid-cell failure produces a deficiency of circulating thyroxin which influences the pituitary and produces an increase in thyrotropin. This, in turn, produces the compensatory thyroid enlargement.

Recently it has been suggested that the thyroid gland can become antigenic within the same species or within the same individual. It has been assumed that in chronic human thyroiditis there is a slow but continuous release of thyroglobulin into the circulation and that this acts as a constant antigenic stimulus. It is not understood how the intact thyroglobulin would be circulating in the blood because normally it is subject to a breakdown by enzymes. However, antigenic substances have been isolated from the serum of patients having chronic thyroiditis.

The diagnosis of thyroiditis, although frequently not made until the gland is exposed during surgery, may be suspected by the symptoms present. There is always some degree of thyroid enlargement, and the gland is most often very firm, suggesting carcinoma. Some degree of dyspnea and dysphagia may be present if the gland is of sufficient size to exert pressure on the trachea and esophagus. Most often the patient complains of a sensation of pressure. Fatigue may be in evidence although it is not on the same basis of exhaustion as seen in hyperthyroidism. Hoarseness may be an accompaniment if there is sufficient pressure on the recurrent laryngeal nerve to disturb its function. Pain and tenderness may accompany the swelling, although these are certainly not constant symptoms.

The diagnosis may also be aided by Silverman needle biopsy. The fear always haunts one, however, with such a small biopsy specimen that a carcinoma may be overlooked.

Crile has suggested the TSH or thyroid stimulating hormone test. The patient is given a tracer dose of radioactive iodine and following this 4 units of TSH. The following day another tracer test dose of radioactive iodine is given. In struma lymphomatosa there is no significant change in the radioactive iodine uptake whereas in non-toxic adenoma and carcinoma of the thyroid there is a marked uptake.

In our own experience the pathological reports on the glands obtained have been interesting. In a total of 18 cases 6 were reported as simple Hashimoto’s disease, and 2 were reported as Riedel’s struma. However, in many instances in our experience, the thyroiditis is found in association with other changes in the thyroid, particularly adenomas. Most often the thyroid was exposed for removal of the adenoma and the unsuspected thyroiditis was discovered. In contradistinction to considerable investigative work, one of our sections showed what the pathologist thought represented a transition from Hashimoto’s disease to a Riedel’s struma. To further substantiate the impression that this is becoming a more common disease it is interesting to note that of the 18 cases represented, thirteen have been seen during the last four years, in contradistinction to 5 cases seen over the period of the preceding 9 years.

The ages of these patients varied from 25 to 83 years with an average age of 43 years. All were female as is the experience in all series reviewed.

Treatment of this disease involves X-ray therapy, desiccated thyroid, and surgery. X ray has proved quite effective in the granulomatous giant cell type of thyroiditis and also in the subacute type of thyroiditis. A dose of 800r is given and in most instances considerable benefit is obtained. It has not proved particularly effective in either Hashimoto’s disease or Riedel’s struma and may well have a deleterious effect in that additional thyroid tissue may be destroyed in a gland that already has considerable destruction due to the progression of the disease process.

Dessicated thyroid has been used most enthusiastically by Crile and his group. This is on the basis that there is a primary failure of the thyroid cell which decreased the amount of circulating thyroxin. This re-acts on the pituitary, stimulating that gland to liberate more thyrotrophic hormone. This, in turn, produces a compensatory enlargement of the thyroid. If dessicated thyroid is given this cycle is broken and the gland
reverts to a normal size. They use 3 grains of thyroid extract daily, and generally the patient must continue this medication for the rest of his life.

Surgery actually plays a minor but important role in thyroiditis. Its specific indications are in those cases wherein there is sufficient progress of the disease to produce a constriction of the trachea. In these instances, the isthmus of the thyroid is resected and the cut edges of each lateral lobe are carefully sutured to prevent further scarring over the trachea. It is important to the surgeon to recognize thyroiditis at the time of operation and in such circumstances not to remove any more of the gland than is necessary. This caution must be taken because the disease is progressive, destructive, and self-limited, and hence unnecessary removal of gland should not be done.

If the possibility of thyroiditis is kept in mind most often it can be recognized grossly. The gland is much firmer than usual and retains instruments in a manner not common to normal thyroid tissue. Much has been said of the brownish color of the gland, but, in our experience, that has not been a constant finding. The tissue most often is grayish pink in color. The common struma lymphomatosa is usually diffusely nodular in contradistinction to carcinoma in which the nodules are larger and more discrete. Struma lymphomatosa does not invade adjacent structures as does carcinoma, although Riedel’s struma may produce this feature.

In summary, chronic thyroiditis has assumed a new role of importance in recent years and merits greater attention. The disease process is frequently not recognized until the time of operation and occasionally not until the microscopic study is made. It is important that we have some concept of the nature of this disease and understand the part surgery plays in its treatment.

BIBLIOGRAPHY

TUBERCULOSIS ABSTRACTS
(Continued from page 348)

Results — Of the 69 patients who recently had acute pneumonia, 29 were found to have bronchiectasis. One patient had an abnormal bronchogram that reverted to normal on the repeat study. Of the 18 patients who had not had an immediately preceding pneumonia, 5 had bronchiectasis and 13 were normal. Seven patients with asthma and chronic cough were studied. Six were found normal and one patient had an abnormal bronchogram.

The 29 patients with recent acute pneumonia who had bronchiectasis represent 1.7 per cent of the total number of patients with pneumonia seen during the same period. There was no significant difference in the past respiratory history of the bronchiectatic subjects compared with the group found to have normal bronchograms. There were significant differences, however, in the nature of the immediately preceding pneumonia in the two groups. In the bronchiectatic group the mean duration of roentgenographic evidence of pneumonia was two months, while it was one month in the normal group.

There was no significant difference between the two groups with respect to the extent of the pneumonic process as seen on the roentgenogram. A significantly greater proportion of patients in the group with bronchiectasis had prolonged fever and leukocytosis than of those in the nonbronchiectatic group, while there was no difference in the frequency of elevated cold and influenza hemagglutinin titers.

There was a significant difference between the two groups in the physical findings of the chest. While persistent parenchymal rales for one or more weeks following the subsidence of all acute manifestations of the pneumonia were noted in 75 per cent of the patients with bronchiectasis, this was true in only 11 per cent of the patients in the nonbronchiectatic group. There appeared to be a similar increase in the frequency with which productive cough was present in the bronchiectatic group.

In 20 patients, of the 29 studied, there was a direct correlation between the site of the bronchiectasis and the location of the preceding pneumonia.

Eighteen patients had bronchograms performed for indications other than those arising during the course of an acute pneumonia. All but three of this group were seen initially because of acute nonpneumonic respiratory infections (pharyngitis, bronchitis), and a suggestive respiratory history or abnormal chest roentgenogram. Five patients in this group were found to have bronchiectasis and 13 had normal bronchograms.

(Continued on page 357)
PERICARDITIS may be caused by or associated with a variety of infections or disease states. If the more specific causes—acute bacterial infections, tuberculosis, uremia, neoplasms, rheumatic fever, myocardial infarcts, etc.—are excluded, there remains a group of cases with the typical findings of pericarditis which are without apparent etiology. Those cases have been variously termed idiopathic pericarditis, acute recurrent pericarditis, acute benign pericarditis, and acute non-specific pericarditis.¹

Although the majority of the reported cases have been preceded by upper respiratory infections, it is probable that more than one agent is responsible for this illness.² The popular theories include (1) viral infection, (2) pericardial reaction to unknown toxins, and (3) a response to hypersensitivity.

Cases of nonspecific pericarditis have been recorded in all decades of life. The greatest incidence, however, occurs in the third, fourth, and fifth decades. In all the reported cases, males have had a significant predominance over the number of females.

The onset of the pericarditis is usually abrupt and associated with chest pain. The pain in many respects resembles that associated with myocardial infarction. It is substernal or precordial and frequently radiates to the left shoulder and arm, to the neck, and also the back. Only rarely does the pain extend to the right arm or to the jaw. Of differential value is the fact that the intensity of the chest pain of nonspecific pericarditis increases with changes in position, swallowing, cough, and deep inspiration. In the majority of the cases, the pain and aching, or sense of constriction, is not as severe as that of a myocardial infarct. However, pain severe enough to cause circulatory collapse has been described. Abdominal pain has preceded and later has been replaced by chest pain in a small percentage of cases.³

The other more common symptoms of acute nonspecific pericarditis are fever, malaise, cough, dyspnea, and nausea. With the onset of symptoms the temperature usually rises to 100 degrees or above and may go as high as 105 degrees, Fahrenheit. Such a marked and sudden elevation of temperature is uncommon in occlusive coronary arterial disease. Dyspnea has been attributed to the rapid, shallow breathing associated with chest pain, and also a tendency to “split” the chest. Complications such as pneumonitis, pulmonary congestion, and pleural effusion may also cause dyspnea during the course of the disease. Dyspnea has in some cases been due to mechanical compression of the lungs and bronchi by the dilating heart or pericardial effusion.⁴ Cough is most prominent when there is an associated respiratory infection or pneumonitis. Malaise is a rather nonspecific symptom noted in most of these patients. Nausea is noted less commonly and usually is not a difficult symptom to control.

The early onset of a pericardial friction rub is the significant clinical sign of nonspecific pericarditis. Its incidence has been reported in 70 per cent to as high as 95 per cent of the cases. The friction rub is usually audible over a period of one to four weeks and may be audible before electrocardiographic changes become apparent. The friction rub is usually heard over a larger area than that heard with myocardial infarcts and its intensity may be greater. An increased area of cardiac dullness is expected to be found in about one-half of the patients with this illness. This finding may be present early in the illness or develop during the course of the illness. Some authors believe that this enlargement is due primarily to cardiac dilatation. However, pericardial effusion probably is the more common cause of the increased area of cardiac dullness.⁵ In those instances when effusion has been tapped, the fluid most often is sanguineous in nature. Cardiac tamponade has been reported but is rare. In one such reported case of death associated with pericarditis, tamponade was attributed to the use of anti-
coagulants administered when the patient was considered to have a myocardial infarct. 6

A basilar type of pneumonitis occurs and is more often demonstrable when there is evidence of pericardial effusion. In approximately 25 per cent of the cases pleural effusion occurs, being either left-sided or bilateral.

Laboratory aids in the diagnosis include the sedimentation rate which is rather consistently elevated in association with acute nonspecific pericarditis. In general, the sedimentation rate varies with the clinical course of the illness. There is also a polymorphonuclear leukocytosis in the majority of cases. The white count usually exceeds 10,000 per cubic mm.

Characteristic electrocardiographic changes are present in almost every case of acute nonspecific pericarditis. The initial changes in the electrocardiogram consist of an elevation of the S-T segments which are present ordinarily in all three standard leads and in most of the precordial leads. Lead AVR may have a depression of the S-T segment. This segment, in pericarditis, is more apt to have a curvature which is concave upward and may be used as an aid in distinguishing it from the convexity of the S-T segment associated with myocardial infarction. However, this latter point is not completely reliable. The T-waves at first remain upright and may seem to be rounded or increased in amplitude. Later, as the disease progresses, the T-waves become flat, the S-T segments return to the base line, and typically the T-waves later become inverted. 7 This inversion may persist for weeks or months. The QRS complex is not diagnostic. A decrease in amplitude of the QRS has been attributed to pericardial effusion.

The S-T segment displacement demonstrated in pericarditis has two possible explanations: (1) That the S-T segment is actually isoelectric but the TP segment which is used as the base line has shifted as a result of the difference in potential developed in the inflamed epicardium, thus causing a displacement of the TP segment during the diastolic phase of the cardiac cycle. (2) That the ST segment fails to return to the isoelectric level because the injured area of the epicardium is not depolarized during systole, with a result that there is a potential difference between the depolarized myocardium and epicardium. 8

DIFFERENTIAL DIAGNOSIS

Occurring as it frequently does in the middle decades, acute nonspecific pericarditis is likely to be confused with acute myocardial infarction. Because of the effect on the patient’s mental attitude and also for the sake of the patient’s future insurability, it is well to postpone the making of a definite diagnosis for a few days. Briefly, acute pericarditis is apt to have the chest pain altered or its intensity increased by changes in position, by turning, by coughing, and by inspiration. The pain rarely extends into the jaw or the right arm and it is unusual for the onset to be associated with shock. The early onset of a pericardial friction rub associated with rather marked elevation of temperature favors the diagnosis of pericarditis. The presence of a localized pulmonary infiltration or pneumonitis and the absence of distortion of the QRS complex on the electrocardiographic tracing also supports the diagnosis of nonspecific pericarditis.

COURSE OF THE DISEASE

There is considerable variation in the clinical course of nonspecific pericarditis. Because of the tendency for recurrences of the pathologic process, it has been termed “recurrent pericarditis” by some authors. In some instances the disease follows a rather mild course, but it is not uncommon for the patient to be free of symptoms for a few days or months and then develop an acute exacerbation or relapse. The duration of the acute illness has varied from ten days to as long as ninety days. Although at times these patients are seriously ill, the overall prognosis seems to be uniformly good. In contrast to a tuberculous pericarditis, these patients probably never develop constrictive pericarditis.

CASE REPORTS

Case 1:

The first case to be presented is that of a 47-year-old white businessman who developed a tight or squeezing sensation in his chest while at work. This was associated with a sensation of dyspnea. Lying down aggravated the pain and dyspnea, and because of the persistence of the pain he returned home. His wife immediately took him to the hospital and his pain was relieved by administration of a narcotic. There was no radiation of the pain, no tendency to
perspire, and no history of recent upper respiratory infection. (Fig. 1).

The initial examination was not remarkable. The white blood count was 12,500 and the sedimentation rate was 17 mm. in one hour. The X ray of the chest (Fig. 2) and electrocardiogram were within normal limits. The following day the patient was found to have a friction rub over the entire pre-
cordium. He had no further pain, and on June 3, although the friction rub persisted, he was allowed to return home on oral medications, at his request.

This man returned to the hospital on June 7, because of elevation of temperature to 102° F. associated with a recurrence of his chest pain. At this time the pain was aggravated by deep breathing and by the supine position. The
friction rub continued to be audible over the precordium and it was apparent that there was an increase in the size of the area of the cardiac dullness as determined by percussion. On June 12, the patient had developed a non-productive cough and there were crepitant rales audible at the base of the left lung, posteriorly. At this time the patient complained of pain primarily in the left shoulder, posteriorly, and the base of the neck. It was considered that this might be a diaphragmatic type of referred pain. Tuberculin skin tests were negative. Blood cultures were negative as was the C reactive protein. The white count varied from 10,200 to 13,420. On the 20th of June, tetracycline was discontinued and the patient had a recurrence of low chest pain associated with aching along the base of the neck, radiating into the left shoulder. The friction rub disappeared at this time. On the 4th of July the patient complained of weakness, had a chill and elevation of temperature. There were no new findings except for the presence of moist rales at the left lung-base. On the 5th of July, the patient had a nonproductive cough and continued elevation of temperature. (Fig. 1). He gradually became asymptomatic and returned home on the 27th of July, without further recurrence of symptoms.

The sedimentation rate on the 12th of June and the 5th of July was 25 mm. in one hour. An electrocardiogram recorded on the 13th of September had returned to the same contours as demonstrated on an electrocardiogram taken in 1952. (Fig. 3).

Case 2:

The second case, a 39-year-old white man, an accountant, was first aware of a gradual onset of pain in the left lower chest in the apical cardiac area. This tended to radiate laterally in the chest wall. The patient was seen initially in the morning and the electrocardiogram was normal. Later in the afternoon, because the pain had increased in severity, did radiate into the left arm, and was associated with apprehension, the patient was hospitalized. (Fig. 4 and Fig. 5).

On examination the patient was a
well developed and slightly obese individual. The general physical examination was essentially normal. The blood pressure was 130, systolic and 80, diastolic. The pain was relieved by administration of a narcotic. The next day a friction rub was heard over most of the precordium to the left of the sternum. At this time the pain radiated from the left lower chest to the left side of the neck. The initial white count was 9,350. First strength tuber-

![Figure 4](image-url)

**Figure 4.** Graphic representation of hospital stay of C. M., patient No. 2. It shows: (1) the temperature curve; (2) rub—paroxysm of audible friction rub; (3) narcotic (hypodermic) required for relief of pain; (4) mycin—tetracycline therapy; (5) penstrep—penicillin and streptomycin combined, intramuscular; (6) salicylate therapy—aspirin 10-15 gr., q.i.d.; (7) digitoxin; (8) steroid therapy; (9) 0₂—use of oxygen per nasal catheter for relief of dyspnea.

![Figure 5](image-url)

**Figure 5.** Electrocardiogram of C. M., patient No. 2, taken on day of onset and showing changes in the S-T segments.
culin was negative. Second strength of tuberculin was positive. The patient was asymptomatic after 72 hours and was anxious to return home. A recurrence of pain then occurred along the sternum, radiated to the base of the neck, was aggravated by taking a deep breath, and was partially relieved by breathing. There were fine moist rales at both lung bases with some question of fluid in the left pleural cavity. By the 23rd of May the friction rub had disappeared, but the patient was having considerable parasternal pain associated with a sense of dyspnea. He was given oxygen for relief of the dyspnea. There was definite evidence of fluid in the left lower thoracic cavity. Following this episode the patient had a period of seven or eight good days and the temperature

Figure 6. X rays taken 5-19-56 (left) and 6-20-56 (right). The first shows evidence of pericardial effusion and pulmonary congestion; the second shows clearing of the pulmonary fields and essentially normal cardiac contours.

Figure 7. Electrocardiogram taken on C. M. on 5-26-56, thirty-one days after onset. It shows inverted T-waves in nearly all leads.

the sitting position. The friction rub had disappeared at this time. On May 11, the friction rub was again audible. Four days later, on the 15th of May, there was evidence of increase in the area of cardiac dullness, and the friction rub persisted. On the 18th of May,
was normal. He then had a recurrence of low thoracic and sternal pain on the 11th of June with fluid again in both lung bases and the heart sounds were distant. At no time was there evidence of venous congestion.

The sedimentation rate on the 10th of May, was 26 mm. in one hour. The blood culture was negative. Blood counts varied from 7,000 to 9,000 except on the 5th of June, when the white count was 15,600. The patient was completely asymptomatic on the 14th of June and was dismissed from the hospital June 22. He has had no recurrences of his chest pain during the past year. The electrocardiogram which had shown persistent flat and inverted T-waves did not return to its previous contour until January of 1957, a period of more than eight months.

Case 3:

The third case is that of a 19-year-old white man, and is included because of the contrast with the more severe cases presented above. This young man had recently returned from a naval summer cruise and had no history of recent upper respiratory infection. He was awakened on the morning of the admission to the hospital, about 6 a.m., because of pain in the precordial and substernal areas. The pain radiated to the left shoulder and down the medial aspect of the left arm. It was aggravated by breathing. The patient described the pain as if it were "intensified by each heart beat." The pain was also aggravated by change of position, coughing, and swallowing. Lying on either side intensified the pain, as did leaning forward. However, he did relieve the pain by a position of extension or "tripod" position. This pain increased in severity quite rapidly.

On admission to the hospital the findings on general physical examination were normal except for the presence of a coarse friction rub heard best in the 3rd and 4th interspaces to the left of the sternum.

X-ray of the chest was normal. The electrocardiogram was considered to be within normal limits. The white count and sedimentation rate were also normal.

The patient's pain was relieved initially by narcotics, and later by salicylates; and after three days he was essentially asymptomatic except when leaning forward. He was dismissed from the hospital in one week and allowed to return to his college studies in ten days. He was seen ten days later and there was still a to-and-fro friction sound audible in the third interspace to the left of the sternum.

The patient was observed again on the 24th of September at which time he had some sternal pain radiating to the left pectoral area. At that time the friction rub was not audible and his symptoms were controlled by aspirin compound with codeine. The patient has had no further difficulties after this recurrence, and the condition of the heart seems normal.

These cases demonstrate the typical characteristics of acute nonspecific pericarditis, whether the disease is of short or prolonged duration.

TREATMENT

The treatment, like the etiology, is also nonspecific. Good results with the use of Aureomycin were reported by Tobenhaus and Brams, but others have not been able to obtain consistently good results. All of the antibiotics and various steroids have been tried. In the first case described, the patient felt certain that the tetracycline drug which he had been taking was of value because several days after it had been discontinued he had a recurrence of the symptoms of the pericarditis. Steroid therapy seemed to add to the patient's symptomatic relief and sense of well-being. However, it did not prevent recurrences in either of the two more severe cases reported. A frank discussion with the patient advising him of the natural history of the disease and the possibility of relapses helps to prevent him from becoming depressed and losing confidence. When these patients have been told that they have a more benign disease than myocardial infarction, and yet in the more severe cases they find that their hospitalization is being extended beyond the commonly recognized period of hospitalization associated with a myocardial episode, they quite naturally are concerned whether or not they do have the less serious of the two diseases. In these instances, reassurance is essential not only for the patient, but also for the relatives. As
yet, the treatment is primarily symptomatic. Large and frequent doses of psychotherapy must be administered.

As mentioned previously, the overall prognosis of this disease is good. Only two fatal cases have been reported. Cases of chronic constrictive pericarditis developing after episodes of acute pericarditis have been reported. However, this seems to be rather uncommon and is much more likely to be associated with tuberculous pericarditis.

In the light of recent enthusiasm for the use of pericardial poudrage to establish a chemical pericarditis to increase the blood supply to the myocardium, it would be of interest to speculate whether these individuals, by reason of their pathologic process, have possibly accomplished a secondary beneficial effect and thereby decreased the risk of a later myocardial infarct.

When these patients have recovered from their acute disease they can return to their usual occupations without restrictions of their physical activities.

REFERENCES


TUBERCULOSIS ABSTRACTS

(Continued from page 349)

No differences were found in the two groups with regard to past history of pulmonary disease.

Seven patients with bronchial asthma were bronchographed because of the presence of bothersome, chronic productive coughs. Six of these had normal bronchograms. The seventh had an irregular dilatation of an intermediate bronchus.

Discussion — The results of this study indicate that bronchiectasis is a common pulmonary lesion and that its presence should be considered during the course of an acute pneumonia when certain clinical features are manifest. The most important of these features is a persistently abnormal chest roentgenogram, indicating incomplete resolution of the pneumonic process.

Parenchymal rules that persist longer than clinical signs of activity are of considerable importance. If, in addition to the above findings, the patient's pneumonia is characterized by prolonged fever, continued productive cough, and leukocytosis, the diagnosis of bronchiectasis is rendered more likely.

A bronchogram is warranted in every case. The procedure is easy to perform, carries no significant danger, and is the only objective method of demonstrating the presence and extent of the abnormality.

In the present series only one of 14 patients with bronchiectasis, in whom the examination was repeated, showed reversion of the process to a normal state.

Undoubtedly, persistent but reversible bronchial dilatation does occur after a pneumonia although the occurrence is not common. Furthermore, the presence of artefacts and the difficulties inherent in borderline diagnosis should caution against overstating the problem.

In the group of 18 patients bronchographed because of an abnormal respiratory history, 5 patients were found to have bronchiectasis. Specific history of rapidly repeated bouts of pneumonia, all of which cleared rapidly, was not found to be indicative of bronchiectasis. The roentgenographic finding of localized emphysema, segmental atelectasis, or honeycombing was confined to the bronchiectatic group. A plain film of the chest, if it shows the positive findings noted above, is therefore of some value in the pre-bronchographic diagnosis of bronchiectasis.

A normal chest roentgenogram in no way excludes the possibility of the presence of bronchiectasis.

The relationship of a preceding pneumonia to the bronchiectasis is uncertain. An underlying bronchiectasis could predispose to a more protracted course of pneumonia or, alternatively, a more severe pneumonic infection could so damage normal lung as to leave some permanent damage in the form of bronchiectasis.

It is believed that the available evidence does not warrant a definite conclusion on the subject. The mere association of two events does not denote a cause and effect relationship. The most that one can say is that the bronchiectasis first noted after a recent pneumonia may possibly, but not definitely, have been caused by the acute infection. Further proof will be necessary to establish this as a certainty.

SPECIAL ARTICLE

STRATEGY IS Everybody's Business*

IT is always a genuine pleasure for a research professor to be unchained — temporarily — from his shelf in the ivory tower and afforded the chance to inflict his theories on a whole roomful of practical-minded men of affairs. I hope to prove, however, that one of the most practical, down-to-earth assignments for the American doctor today is to become a serious student of Public Affairs — including politics, economic philosophy, foreign policy, national defense strategy and the educational theory that molds your children — and through them — the will and character of this nation in the time of trouble that lies before us. For the next two decades may decide the fate of man for the next 500 years, or forever.

Doctors are often very stern when they prescribe for patients who refuse to take warning signs seriously. May I, as a layman, turn the tables and be somewhat stern with this distinguished body? The "patient" in this case is the body politic: a free society which encourages individual initiative in business, law, medicine and engineering. The diagnosis for that civilization is cancer in the intestines and paralysis of the will. The prognosis is an untimely and for a patient too soft to endure surgery, too undisciplined to take medicine, too purposeless to survive. It will involve intellectual therapy and moral hygiene; or, in old-fashioned terms, homework and willpower.

I hope to demonstrate that it is important for doctors to think about political muscle tone, ideological X rays, and preventive education. I hope also to indicate that — unless at least one man out of every three in this room commits himself to an active role in Public Affairs — then it is unlikely that your profession will survive its competition. By "competition," I do not mean the friendly race between Blue Cross and other insurance programs. There is a new kind of "competition" abroad in the world today. This form of COMPETITION, spelled in "all-caps," is designed to destroy — utterly and for all time — the moral, legal and political framework of the civilization which undergirds our voluntary society. If Genghis Khan & Co. win this competitive struggle, there will be no second chance for freedom.

The American Voluntary Society faces two mighty competitors — World Communism and International Socialism. Some students would argue that Communism and Socialism are twin engines in the same juggernaut. But perhaps there are useful distinctions. The threat of Communism is largely external, military, scientific, political, and economic. It is an immediate threat. Its weapons are violence, subversion, propaganda and blackmail. The danger of Socialism is largely internal and long-range. Its weapons are education, persuasion and the ballot-box.

Many Socialists are firmly opposed to the force and terror of Communism. Socialists — unlike hard core, fanatical Communists — are sometimes open to counter persuasion from men sufficiently articulate to debate issues with them. Socialists have been voted out of power in England and Australia — but when Communists have been threatened by the will of the people, they have, as in Hungary, sent in armored divisions to crush the opposition to lifeless pulp.

Although I do not in any way agree with Socialist economic theory, it is only fair to admit that many Socialists — as human beings — are honorable, decent and even idealistic people who want to achieve good things for humanity. They are not professional revolutionaries or conspirators like the Communists. Indeed, some Socialists are so idealistic they cannot comprehend how ruthless and cynical Communists can be. When Communists come to power, Socialist intel-

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FRANK ROCKWELL BARNETT
Director of Research, The Richardson Foundation, Inc.
New York, N.Y.

†The opinions herein expressed do not necessarily represent those of the Richardson Foundation, Inc.

Nebraska S. M. J.
llectuals are often the first to be purged. In Czechoslovakia, for example, a Socialist leader named Masaryk tried to walk a “middle course” between Communism and Western Democracy. He ended up, still in the middle-of-the-road all right—but from nine stories up where someone had pushed him out of the window.

Although they use different means, both Communism and Socialism confront America with a mortal challenge—and we are in danger of being caught between hammer and anvil. The external threat is ubiquitous and terribly real; yet free men hesitate to oppose the Communist enemy on all fronts for fear we may gradually surrender our own civil liberties, economic freedoms and political liberties to Big Government here at home.

Is there any way out of the dilemma? One remedy is to apply the American genius for voluntary action to the realm of public affairs. But this requires that the managers and professional leaders of our society must make Public Affairs their avocation—their full-time hobby. They dare not hold aloof from political life and from hard intellectual effort. They will have to do their “homework” in philosophy and history. And they must not wait for another Pearl Harbor or giant depression to move them to prudent action.

Pearl Harbor proves a point—because Pearl Harbor was an event that permanently changed the lives, fortunes and future of every man in this room. Beyond that, Pearl Harbor radically revised American axioms about world geography and power politics. In a handful of minutes, Japanese dive-bombers not only sank our Pacific Fleet; they also torpedoed unreal assumptions about the technical capacity of “foreigners” and the use of trade or good will as effective means of deterring aggression.

We had thought that East was East and West was West. We learned the hard way that 20th Century America is cheek by jowl with the Orient, that the Burma Road intersects with Main Street, that Tokyo and Berlin—and now Moscow and Peiping—are closer to Chicago than Philadelphia was to Boston at the time of the American revolution.

These lessons were derived from the bombing of December 7th, 1941. But on December 6th, 1941, America was already at war, even though we didn’t know it; for while it takes two to keep peace, it takes only one to make a war. So, as America slept, the carriers of Imperial Japan were converging on Hawaii. The bombs had been loaded, the pilots briefed, the mission assigned, the die cast for our people by war lords on the far side of the earth. We learned that war starts—not at the moment of the surprise attack—but when the enemy completes his final plans and commits his resources to conflict.

Again we are at war—a new kind of war with unorthodox rules and camouflaged weapons. Our failure to recognize that fact does not affect the designs of the Kremlin. Again, it is an enemy—not ourselves—who has decided to involve the United States in conflict. Again, our own good intentions are beside the point. And, again, there is danger our country may drowse through the afternoon of its December 6th, through a night of no return, into another kind of Pearl Harbor—where the hour and the place, and the cost and the sacrifice are all determined by factors outside our control.

Only this time, the odds are much heavier against America than on that other December 6th, sixteen years ago. What if, in 1941, the power of Japan had already swallowed two-fifths of the earth? What if Japanese science had in some respects surpassed our own? What if Tokyo had dominated a billion people whose labor could be coerced to the cause of conquest? What if her fifth columns had penetrated every country in the world, including the United States? What if Japan had had vast natural resources, abundant water power, access to oil, no need to import steel or coal? And what if Japanese submarines and bombers, armed with atomic weapons, had been based as close as Alaska, Mexico, Canada, Catalina, Nantucket, Key West and Bermuda? The equivalent of this nightmare supposition has come to pass since 1945, with the Soviet Conquest of space and the invention of guided missiles—with the manpower of China and the resources of Eastern Europe feeding the Communist war machine—and with India, the wealth of Indonesia and the oil-rich Middle East only three assassinations and a few street fights removed from the grasp of the Kremlin.

In short, an Asiatic conqueror stands on our frontier. Owing to science, the Atlantic Ocean is no wider than the Rio Grande. Owing to technology, the Pacific is no
broader than Lake Michigan; and the wastelands of the North can be bridged in a few hours' flight. We Americans are face to face with the descendants of Genghis Khan.

Indeed, television brings Mr. Khrushchev into millions of American living rooms to lecture on the glories and inevitable triumphs of World Socialism. When a Soviet leader denounces Wall Street monopolies, his message is transmitted free of charge on the front pages of American newspapers and contributes to the general climate of opinion in this country.

HIS ARMIES PRACTICE “CONQUEST BY COMMUNICATION”

Khrushchev & Co. are no longer a rude barbarian horde. They are disciplined in science and well-armed with engineering. They are schooled in economics and political theory. They speak many languages. They have learned to use education, literature, art, trade and even religion as weapons of subversion. Above all, they are superbly trained in the conduct of symbol-warfare—in conquest by communication and warfare by words.

THE MILITARY CANNOT DEFEND AMERICA AGAINST SYMBOL-WARFARE

That is why we must talk about management's responsibility for Public Affairs and National Security. In the past, wars were chiefly shooting matches, and businessmen naturally left Defense problems in the hands of America's soldiers. Today, the front is everywhere. Certain intangibles can literally “wash out” the material foundations of defense. If the world climate of opinion is mobilized against us by propaganda, we will lose markets, air bases and access to strategic raw materials. If, here at home, we lose the will to sacrifice or cynically disregard our spiritual traditions, our physical wealth will not safeguard American Civilization. Today, National Defense begins at the level of domestic political morality, the quality of citizenship training for our youth, and the reputation of American business growth both here and abroad. These “intangibles” are the clear responsibility of private citizens.

WE ARE FACED WITH THE PROBLEM OF NATIONAL SURVIVAL

Ancient Carthage, with its luxury standard of living, refused to make minimum sacrifices to support Hannibal and did not survive. Cato's relentless chant — “Carthage must be destroyed” — did not awaken the indolent Africans from their preoccupation with business-as-usual. They couldn't believe that Cato, like Khrushchev, meant what he threatened. Similarly, Rome itself, entranced with bread-and-circuses and arrogant in its splendor, did not survive the onslaught of the Vandals and Visigoths. The technical skill that built her roads and aqueducts, the “know-how” of her administrators, the glory of her law — none of these assets saved an effete and over-civilized Rome.

Nor did Rome's Gross National Product protect her. The Visigoths had no GNP whatsoever — only weapons and will power. These dismal comments on Carthage and Rome could be repeated for other proud civilizations. Many times in the past, nations with high standards of living have been pushed to the grave by nations with low standards of dying.

History teaches us that when a people put indulgence before discipline, worship welfare and discourage risk-taking, they are likely soon to be forced into bankruptcy by a more vital Competition. Especially if they no longer believe in themselves. For nearly twenty-five years this country has been confused by a Cult of Doubt. Too many Americans suffer an odd guilt complex about their own way of life. Meanwhile the missionaries and conquistadors of the Communist Church Militant advance Marxism as the one true faith — and they are willing to die for their belief. That is why the battles of the Cold War are fought on our side of the Iron Curtain and at the Kremlin's initiative. That is why trying to contain Communism with a Maginot line of dollars and diplomacy is bound to fail. We forget that no status quo power has ever checked the thrust of a dynamic barbarian — for even if the “Defense” is ninety per cent successful on every occasion, a civilization can be driven to its doom ten yards at a time.

THE SOVIETS HAVE MADE STARTLING TECHNICAL GAINS

In 1945, America enjoyed absolute atomic supremacy. In less than a decade, Russia has broken our monopoly in nuclear weapons, beaten us into space, produced jet
aircraft and tested guided missiles. A system once contemptuously called the “ox-cart economy” has built the world’s second largest navy, graduates more than twice as many engineers as America, and, by ruthlessly disregarding the claims of its consumers, is out-producing us in heavy machine tools, the basic equipment of war.

THE REAL THREAT: SOVIET FOURTH DIMENSIONAL WARFARE

But the greatest threat to our civilization may not stem from Soviet guided missiles or engineering of atomic weapons. We have brilliant scientists, able generals and inventive industrialists who doubtless can safeguard National Security on the technological front. It is in the realm of “Fourth Dimensional Warfare” — or psycho-social combat — that we are hopelessly outclassed. We know a lot about the tricks and techniques of mass persuasion — but we have not yet applied that knowledge to the main challenge of our time — how to beat Communism without fighting a hot war.

We use advertising skills and the “hidden persuaders” to change consumer taste in salad dressing. We use high-powered public relations to boost the boxoffice appeal of a rock-and-roll cowboy. The Soviets exploit Pavlov, propaganda and group dynamics to overthrow empires and condition the masses to become addicts of Socialism. They use psychology to win the world.

Propaganda has always been a tool of the Conqueror. In the age of radio, television and mass literacy, however, political warfare has become a primary weapon. The Communists, like the Nazis before them, use the strategy of terror to frighten the West into inaction, to promote class warfare and thus divide and conquer, to encourage neutrals to ride the Soviet wave of the future. The danger of the Russian sputnik is not just that it means Moscow can probably put a missile on New York or, in the near future, aim atomic guns at Pittsburgh and Detroit from a platform in outer space. Sputnik is a symbol of Successful Socialism. All over the world, intellectuals and politicians — already half in love with Marx — are saying: “If Socialism can do such wonderful things in science, why not give it another chance with business? If Communism is efficient in the laboratory, let’s try it in our factories. If Marxism can plan a sputnik and build so many splendid schools of engineering, we must have Social planning and Social engineering for every part of our society. Capitalism is obsolete.”

Despite the record of American enterprise, millions of people — including some in this country — will believe that propaganda. Why? Because very few Americans can articulate what it is we really stand for. We perform, but performance is not enough in an age of mass media. The Communists capture the slogans, manipulate the symbols, pervert the communications. The facts are on our side; but the facts don’t necessarily move men to action. More often, men are motivated by theories, by hopes and hatreds, by envy, fear or inspiration. The Communists have done their homework in the human subconscious. From superstitions and buried emotions and bedrock beliefs, they have mixed the weapons of fourth dimensional warfare.

They have put this knowledge to practical use. With backmail and infiltration, they captured Czechoslovakia without firing a shot. That meant they got the Skoda Works intact. For thirty years Moscow trained many oriental Communists in its academies of political warfare. The alumni are today the rulers of Red China, the overlords of North Korea, the leaders of the Communist thrust into Southeast Asia. No Russian soldiers died to score these victories. In recent months, Communism has won elections in India, Indonesia and South America. It has penetrated Syria and Egypt. It is growing like a weed in the fertile fields of Africa. It controls powerful party machines in France and Italy. Communist political strategy, in short, is not an ivory tower experiment. It pays Moscow huge dividends in real estate, military bases, raw materials, manpower — and continuous trouble for the United States.

These things don’t happen by accident. Communism is not just an idea; it is a power-technique. Behind the Iron Curtain, there are more than 100 schools and colleges of propaganda and subversion. Many Russians get a first-class education in math, physics, and foreign languages. But other Russians — and selected recruits from Asia, Africa and Latin America — receive professional training in Conflict Management and psychological tactics. We have the Har-
ward School of Business; they have the Lenin Institute of Political Warfare — for politics is the chief business of Communism.

It is imperative, of course, for this nation to win the contest of science, electronics and military hardware. Otherwise, the Soviets will blackmail us into surrender. But we cannot guarantee our security by simply catching up or staying ahead in science. After all, we were ahead of them for thirty-five years when, in spite of our technological superiority, they scored victories by irregular methods. We must create a shield of science to ward off a hot war; but we must also learn to make stronger moves on the ideological, political and economic squares of the Cold War Chessboard.

To do that, we must raise the standards and improve the quality of education in economics and philosophy, American History, political science and foreign languages—as well as in science and engineering. And we must not be afraid of competition in the classroom, for young America in the next two decades is going to face the most ruthless competition the world has ever known.

American Business cannot afford to be a mere spectator at this match for the future of mankind. The “managers” of Soviet Society are all committed to agitation and politics. They are conflict minded. You can’t do business with Moscow, because Communists are not businessmen or statesmen. They are professional revolutionaries. Their foreign aid personnel are commandos; their artists are propagandists; their diplomats are spies; their economy is based on the cost accounting of the battle field, where every resource is squandered in order to defeat the enemy. Since Communists have a combat mentality, you can’t reason with them. If we don’t want to fight them—or surrender — we must learn to beat them in the precincts of the Middle East, in the lobbies of the United Nations, in our own classrooms and pulpits, and before the court of world opinion. Our own managers dare not be aloof to this challenge.

The Communist Party, through the apparatus of total government, can mobilize the total resources of the Sino-Soviet Empire. Our limited government, by definition, cannot and should not compete with Moscow across the board. If it did, Washington would have to regulate business, control the press, police our schools and regiment our voluntary agencies. This means that, unless private institutions take over many areas of non-military defense, the ubiquitous thrust of Communist Conflict Management will be unchecked at crucial points.

Why should business be asked to serve? Primarily, because our economic system is the crux of the whole struggle — and because, in a sense, this is the Business Society. Each year, a very high percentage of our college graduates are recruited by Business. Although there are extremely able men in other walks of life, our greatest reservoirs of inventive talent, drive, organizational vitality and brainpower lie in the world of industry, commerce and finance. Yet with certain notable exceptions, Business Leadership has not taken full responsibility for safeguarding the moral, intellectual and political framework which ensures its opportunities to make the economic system “pay off” for all America.

BUSINESSMEN CANNOT STAND ALOOF FROM POLITICS

This Republic was founded, of course, by bankers and lawyers, businessmen and a general. The frontier was “civilized” by business leaders who took an active part in the citizenship function. Today, however, many business leaders regard “politics” as beneath their dignity. Unfortunately, American civilization can be crippled — and even destroyed — by concepts which lead first to changes in the “climate of opinion” and, ultimately, to the hard facts of power politics.

If the “Business Society” is destroyed outright — or simply “withered” by politics and propaganda — business leadership has only itself to blame. After all, every great corporation has more than enough “surplus” to allow some of its best brains to stop thinking about production and sales and start thinking about National Defense, Citizenship Education, Foreign Policy and Economic Philosophy. One way for business to attack these complex problems systematically — and with sophistication — would be to build an Academy of Industrial Statesmanship. This would be, in effect, the equivalent of the Harvard School of Advanced Management in the area of Public Affairs, National Defense, Citizenship Training, and the “theology” of American-style capitalism. Its purpose would be to produce articulate champions of freedom who could compete with
the lobbyists for Marx in the never-ending battle to condition the climate of opinion.

Another place to improve the machinery of Ideological Defense might be with the lever of Corporate Philanthropy. American Business now gives to good causes more than $500 million a year. Perhaps 5% of that total should be used to pay a cultural life insurance premium on America, in the light of Krushchev's boast that our grandchildren will live in a Soviet Socialist America. Recent events suggest at least three more questions about private philanthropy:

1. If the Soviet challenge is not to result in eventual Federal control of our schools, must not business give even more generously to improve the quality of American education?

2. Cannot business get much more for its charitable dollar by applying the same professional standards to giving away money that it does to making it in the first place?

3. Should not industry begin to reappraise its pattern of giving — shifting some investments from the portfolio of community welfare to the portfolio of National Survival, allocating priorities, evaluating results and, in general, managing corporate largesse with the same discrimination and purpose that mark other phases of business operations?

GOALS FOR THE FUTURE: VICE-PRESIDENTS OF PUBLIC AFFAIRS

Ultimately, it may be desirable — even necessary — for great corporations to appoint Vice Presidents of Public Affairs to spend full time on these matters. A waste of talent? At the beginning of the century, certain firms refused to adopt advertising. They perished. Now, most firms are hospitable to the subtler meanings of Public Relations. But beyond orthodox "public relations" lies the arena of Public Affairs in which the fate of American Civilization may well be decided in the next decade.

THE ULTIMATE WEAPON

One word more. The ultimate weapon is neither science nor politics nor psychological warfare. The ultimate weapon is human courage — and faith in certain unalterable moral laws. Unfortunately, some people have forgotten the true meaning of America. We are already half afraid of the honorable word "revolution," although we are the true revolutionaries. It was an American Revolution that gave the world its finest revolutionary idea — the notion that government is the servant, not the master, of the people. The Communists — who call us "reactionary" — have turned society back to the days of the Pharaohs. The monuments to "Socialist Progress" erected in the USSR — like the pyramids of ancient Egypt — have been built with slave labor.

WE MUST NOT PERISH THROUGH FAILURE TO RECRUIT OUR ELITE

On the other hand, we Americans have developed the most flexible, continually progressing society known to man. Our so-called "masses" already enjoy luxuries undreamed of in other parts of the world. Our unique type of capitalism — almost as different from European cartel-capitalism as it is from Socialism — produces more welfare and more social justice than Communist Functionaries would even dare to imagine. But beyond that is the fact that we are truly free men. We have plenty AND freedom, together. We must not let this remarkable experiment in human liberty and opportunity perish from want of courage, or lack of sophistication, or failure to meet the problem with the ablest human resources at our disposal. That is why these questions of National Strategy and Public Affairs urgently require the attention of this audience.

It may be argued, of course, that the profession of medicine is a thing unto itself, that doctors have no business to "intervene" in the great affairs of state. The health of a democracy depends, however, to a large degree on the quality of its participating units. If doctors are to abdicate their responsibilities as citizens, why should not engineers and scientists, college professors and bankers take a similar view? In a sense, we are all professionals; and we are all responsible for preserving our freedoms. If we are to safeguard a society in which political ethics make possible professionalism, we dare not leave the formation of public opinion to demagogues. American doctors who are "too busy" to engage in public affairs — or do their homework —
may find, in the years to come, that they may have to spend full time in some dismal underground, as did their colleagues in Nazi Germany or as men do today in Poland, Hungary and Czechoslovakia. Never before in history have the moral implications of the Hippocratic Oath been more urgently required, not alone for medicine, but for the whole free society.

The task may seem enormous; but the stakes are even higher. And let us remember that great events are always determined by minorities. Forty years ago Communism was confined to a rented room in Zurich, the brains of Lenin and the ambition of a few other outcasts. Less than 100 men made the American Revolution. For a time the whole future of this nation was carried in the will and heart of a lonely man who walked the winter lines at Valley Forge persuading his ragged countrymen not to quit and go home. There is more than enough talent in this one room to change the course of history. But time is impartial. In politics and war, as in business, time is only on that side which knows how to use it.

**TUBERCULOSIS ABSTRACTS**

**THE SURGICAL TREATMENT OF PULMONARY COCCIDIOIDOMYCOSIS WITH A COMPREHENSIVE SUMMARY OF THE COMPLICATIONS FOLLOWING THIS TYPE OF SURGERY**

- Surgery has a definite place in the treatment of pulmonary coccidioidomycosis despite a complication rate of 13 per cent in the 400 cases studied. There is no good antifungal agent now available to assist in protecting the patient when surgery is performed.

**Introduction.** This is a report on 400 cases of coccidioidomycosis treated by surgery. Sixty-six different surgeons participated, including the writer.

The data for the most part were gathered by the questionnaire method. One such questionnaire was sent out in 1950 and a second in 1953. A questionnaire for 1957 is incomplete. Some of the 1957 data are, nevertheless, used in order to bring the report up to date.

**Indications for Surgical Therapy.** The indications for surgical therapy are presented in a somewhat arbitrary grouping, but it is hoped this will aid in clarification.

**Absolute Indications—Group I**

- a. Giant Cavity (more than 5 cm.);
- b. Infected cavity;
- c. Ruptured cavity—giving rise to Bronchopleural fistula, Empyema, Nonexpansile lung, or Persistent pneumothorax.

**Probable Indications—Group II**


**Possible Indications—Group III**


The absolute indications under Group I will cause very little comment, as the necessity for surgery is obvious.

The probable indications under Group II are those cases with definite warning signs of impending complications. Definitive surgical therapy is considered to be indicated. An enlarging cavity, particularly if it is near the visceral surface of the lung, may rupture. This not infrequently results in a pneumothorax. The more disturbing sequelae of rupture are bronchopleural fistula, empyema, and nonexpansile lung. Rarely a patient may be fortunate enough to have only a minimal pleural effusion following rupture. Intraoperative hemorrhage may be severe. Recurrent hemorrhage in a cavity usually demands surgical extirpation.

The possible indications (Group III) will not be universally accepted among thoracic surgeons. Most thoracic surgeons are inclined to the well-founded belief that all "coin lesions" demand early thoracotomy in order to establish the diagnosis with accuracy. Emphasis has been placed on the high percentage of malignancy (15 to 35 per cent) in the coin lesion.

The "coin lesion" due to coccidioidomycosis is a frequent finding in the endemic area. It is estimated that the "coin lesion" in the endemic area will be found to be malignant in less than 5 per cent of cases. The decision to be made by the individual surgeon in such an area is whether this reduction in percentage justifies conservatism.

It would appear, therefore, that the "coin lesion" in the endemic area should be given more scrutiny than the "coin lesion" in other geographic areas. This would imply a careful history of past febrile episodes, adequate skin testing (with particular attention to the 1:100 to 1:10 coccidiodin), plus blood-agglutination and complement-fixation tests. It is believed by some that the roentgenographic appearance exhibits characteristic highly suggestive of coccidioidomycosis. The disease is not infrequently located near one of the pulmonary fissures and it has a propensity for burrowing across the fissure from one lobe to another. This "crossing the fissure" sign lends weight to a presumptive diagnosis of coccidioidomycosis. If, after careful search, the diagnosis of the "coin lesion" remains indeterminate, the decision for exploratory thoracotomy will not be questioned. Caution, however, should be exercised by the surgeon. In one report of resections for "coin lesions," the surgeon performed lobectomy in three of four cases. In order to prevent undue loss of lung tissue, a more localized excision may be advisable to establish the diagnosis.

The second possible indication is persistent cavi- tation. Depending on the size of the cavity, most physicians (and even some surgeons) would prefer to treat such a case conservatively. The cavity may

(Continued on page 39-A)
Comments From Your President

Many Nebraska Doctors were in attendance at the A.M.A. meeting in San Francisco this past month. I enjoyed the sessions and feel that all could profit from such a meeting.

The House of Delegates met at the Sheraton-Palace Hotel and the Technical and Scientific Exhibits were at the Civic Auditorium. Either could take one's entire time. I tried to cover both! The House of Delegates, which speaks for all American Medicine is a fascinating sight in action. The Delegates work hard and long hours. Nebraska Medicine is well represented by our two Delegates, Dr. Joseph McCarthy and Dr. E. F. Leininger. They have both served enough years that they are well known and respected by the other members of that body. I can vouch for their faithful attendance at all sessions.

Dr. Frank Stone, representing our Editor, Dr. George Covey, who unfortunately could not attend, covered all activities connected with the meeting very well. Our Journal will reflect his diligence. It is impossible to list all subjects which were discussed. Some were more outstanding than others. The Forand Bill was condemned by resolutions from many states. Social Security for physicians was an important topic. A number of Eastern States asked that a referendum on this question be held by the A.M.A.

Committee recommendations were for continuing the Hill-Burton hospital-construction program. They asked for elimination of all categories and for the elimination of the Treatment and Diagnostic Centers from the program.

One entire day was spent on Civil Defense. Top governmental representatives from Washington spoke. The meeting was led by Dr. Harold Lueth, former Dean of the University of Nebraska College of Medicine. One was impressed with the difficulty in creating sufficient interest in the general public to get a proper functioning program. It was stressed that in the event of an atomic bombing survival would be a personal individual effort and not one of some branch of Government. Much remains to be done in Nebraska along this line. We have a committee working on the problem. Dr. R. Russell Best and his group in Douglas County are to be complimented on their far-sighted planning.

There is another subject that I would like to stress. That is the excessive use or abuse of our Blue Cross and Blue Shield Plans. These plans are run strictly by the Doctors of Nebraska. It is our answer to Socialized Medicine. We must make them work. Since the first of the year the premiums have not covered the use. Each of the 1,300 physicians of Nebraska should make himself a watchman of this program. He must attempt to make each hospital stay equal only the number of days necessary for the patient. He must make his charges fair and not attempt to "load" his bill. If these two things are done I am sure that it will strengthen our Blue Cross and Shield Plans immeasurably.

Medicare is another responsibility of our State Medical Association. A new contract will be negotiated by your representatives when they go to Washington this September. Dr. Paul Maxwell and his Committee on Uniform Fee Schedule and Advisory to Government Agencies are spending this spring and summer hearing all segments of medicine so that everyone can express his ideas and desires. I would like to stress that anyone who feels that he has not had a chance to express himself on this program is urged to put his thoughts in writing and send them to either Dr. Maxwell or your President. They will be carried to Washington and you will be represented there as faithfully as we know how.

FAY SMITH, President.
Organization Section
Coming Meetings

Crippled Childrens' Clinics—
August 9, Broken Bow, Elks Club.
August 23, O'Neill, High School.
September 13, McCook, St. Catherine Hospital.
September 27, Scottsbluff, St. Mary Hospital.

International College of Surgeons—
2. Tennessee Surgical Section, Chattanooga, September 29th. William G. Stephenson, M.D., 612 Medical Arts Building, Chattanooga 3.
3. (A correction). Alabama Surgical Section, Admiral Semmes Hotel, Mobile, October 3-4. Edwin V. Caldwell, M.D., 2215 Memorial Parkway, Huntsville, Ala.
4. Western regional meeting, Reno, Nev., August 21-23. For information, write to Frederick M. Anderson, M.D., 6 South State Street, Reno, regent of Nevada.
5. Southeastern regional meeting, Miami, January 4-7, 1959. For information, write to Harold O. Hallstrand, M.D., 7210 Red Road, South Miami, Fla., chairman.
6. International College of Surgeons—Third around-the-world postgraduate refresher clinic tour, October 10 to December 3. For information, write to Arnold S. Jackson, M.D., 16 South Henry Street, Madison 3, Wis.

MEDICINE IN THE NEWS

From the Geneva Signal—
At a recent meeting of the Fillmore county board of supervisors, the Fillmore county hospital committee appeared to present a deed to the land in Geneva where the old hospital is located. The ground was presented as a gift to the county. The county board designated the land as the site of the new hospital which is to be built.

From the Lincoln Star—
The State Health Department has received its first shipment of Salk vaccine purchased with federal funds.

The vaccine, purchased with federally appropriated maternal and child health funds, must be used according to certain prescribed methods.

Physicians must request the vaccine from the Health Department; they may not charge for the vaccine itself, only for their professional services; they must report the number of persons using the vaccine, and those receiving the vaccine, and those receiving the vaccine must either be under 21 or expectant mothers. The vaccine will be added to the list of vaccine which indigent patients may receive.

Dr. E. A. Rogers said the Salk vaccine program would be a continuous one.

From the Omaha World-Herald—
Two weeks of fun and relaxation without thoughts of crutches and wheelchairs was provided for 30 youngsters attending the annual Cerebral Palsy Day Camp in Omaha in June.

Games and handicrafts were directed by volunteers and therapists from the Dr. Lord School, which the children attend. The camp is financed by the United Cerebral Palsy Association of Omaha.

NEBRASKA DOCTORS IN THE NEWS

We see by the newspapers . . .

—That Doctor C. M. Pierce, physician practicing in Chadron for thirty-seven years of the fifty since his graduation, was honored by a "City-Wide Dinner" on June 18, 1958.

—That Doctor James L. Burford and his wife, Winifred, celebrated their 60th wedding anniversary. The "occasion" took place at the home of their son, John Hayden, in Omaha.

—That Doctor Juul Nielsen, formerly superintendent of the State Hospital at Hastings, returned, after a seven-year absence, to resume his former position on June 1, 1958.

—Doctor Harley S. Eklund, of Osceola, was honored by the medical staff, nursing staff, and members of all other hospital departments, at a surprise coffee party at the Annie Jeffrey Memorial County Hospital, June 10. This was the occasion of completion of 25 years of practice in the community. (Record, Osceola; Progress, Polk; and Telegram, Columbus).
MEDICARE IN OPERATION

The June and July issues of this Journal carried the first two items under the above title. These are published with the aim of furnishing helpful information in taking care of patients under Medicare. Editor.)

This article is a digest of Office for Dependents' Medical Care Letter No. 12-58 which deals with the responsibility of the government for the payment of claims covering care of controversial conditions and procedures which may or may not be considered as belonging in the general classification of elective medical and surgical treatment.

The following specific conditions and procedures are examples which are not all inclusive; however, they are representative of the vast majority of claims and inquiries concerning questionably authorized care referred to the Office for Dependents' Medical Care.

Treatment of chronic conditions is authorized only if acute exacerbations or acute complications exist, or if surgical or other treatment procedures are expected to result in functional improvement.

a. Ears: Large, flapping, elephant-like or otherwise deformed or absent. Reconstruction and/or revisions of external ear only are elective and not payable under Medicare. Surgery performed for, and based solely on, psychological reason is not allowable. Necessary procedures for the restoration of hearing, to include reconstruction of the middle and/or inner ear and/or such part of the external ear as may be required for restoration of hearing, is allowable under the program.

b. Eyes: Surgery for glaucoma, cataracts, strabismus (squint) or other conditions to aid or improve the vision of the affected eyes is allowable. The cost of prosthetic devices or orthoptic exercises is not allowable; neither is surgery performed solely for improvement of appearance.

c. Harelip and/or Cleft Palate: Surgery for the initial repair, including surgery considered an integral continuing part of the initial repair, is allowable. Subsequent procedures, employed for the improvement of appearance only, are not allowable.

d. Rhinoplasties: When performed solely for improvement of appearance, Rhinoplasties are not allowable.

e. Congenital Defects — Skeletal: Allowable when prescribed treatment is required to be performed in the hospital on an "in-patient" basis. Where it is customary for plaster casts to be applied on an outpatient basis and hospitalization is not required for proper treatment, such procedures are not allowable. Examples:

1. Clubfoot—uni- or bi-lateral.
2. Congenital dislocation of hips—uni- or bi-lateral.
3. Other types of congenital skeletal defects requiring casts or other treatments.

f. Cerebral Palsy or Poliomyelitis (residuals): Surgical procedures such as arthrodesis, osteotomies, or tendon transplants required for the improvement or restoration of function are allowable only for the pertinent period of hospitalization specifically related to the surgical procedure but not for medical care related to the basic condition. Consequently, follow-up treatments for rehabilitation of the basic condition are not authorized; neither are payments for wheel chairs, crutches, braces, and prosthetic devices, or other adjunctive surgical support items authorized.

g. Central Nervous System—Congenital Defects: Surgical correction of evaginations of the contents of the vertebral column, as well as hydrocephalus and other congenital abnormalities, is allowable.

h. Supernumerary Digits and Syndactylism: Surgery required to improve function of the involved extremity(ies) is allowable. When performed solely at the request of the patient and/or sponsor in the absence of functional impairment, payment is not authorized.

i. Scars: Except as provided herein, surgery or other medical treatment on well-healed scars is not authorized. Treatment of scars that are ulcerated, or show clinical evidence of malignancy, or cause contractures which impair anatomical function is allowable. Reconstructive surgery incident to an injury is allowable as a part of the continuing total treatment of that injury and may be performed on an outpatient basis, if appropriate.
j. Removal of Plantar Warts, Other Warts (Verrucae, Sebaceous Cysts, Condylomata, Moles, Pigmented Nevi, Hemangiomata and/or Telangiectatic Lesions: Authorized only if they are bleeding, ulcerated, painful, or show clinical evidence of malignancy, or if the size and location produces functional impairment.

k. Removal of Tattoos: Not allowable.

l. Tubal Ligation or Other Sterilization Procedures: Authorized for payment only when, in the opinion of the charge physician and consulting physician (s), the procedure is a necessary requirement in the proper medical management of an otherwise unrelated medical or surgical condition for which treatment is authorized under the program. Multiparity and/or the social-economic status of the patient are not bona fide reasons for payment of sterilization procedures under the Dependents’ Medical Care Program.

m. Mammoplasty: Surgical procedures on the breast (s) for the purpose of effecting symmetry or alteration of size are not authorized except when severe pain and/or marked disability is present.

n. Tests and Procedures for Sterility or Fertility Influences: Are allowable only when clinical indication of associated pathological condition causing impairment is present. Tests are not allowable when performed solely at the request or desire of the patient (sponsor).

o. Tests for Pregnancy: Allowable only if the patient is, in fact pregnant; or when considered necessary for the proper conduct of maternity or postpartum care, regardless of the test results (i.e. hydatidiform mole). These tests are not allowable when requested by the patient and are found to be negative. When authorized, these tests may be performed on an outpatient basis as other antepartum or postpartum care.

p. Services for “Exceptional” Children: Not authorized. Examples include:

1. Cerebral palsy treatment including surgical procedures unless they qualify under paragraph 2f above.
2. Speech and/or hearing therapy, or remedial reading.
3. Psychological testing.

For all conditions outlined above and other similar or questionable cases, physicians are urged to attach a statement to the Medicare Claim at the time it is submitted to the Fiscal Agent.

For these conditions or similar conditions, physicians are urged to pre-determine its eligibility for payment under the Program. Prior to acceptance of the patient for treatment, any questionable case should be referred to the fiscal administrator for assistance in determining eligibility. The government is not liable for payment of unauthor-ized care.

THE “PHOSPHENATOR” DEVICE FOR TESTING FOR GLAUCOMA

The Department of Health, Education and Welfare, through the Department of Health of the State of Nebraska, seeks to warn physicians about the “Phosphenator” device. The warning originated with the Glaucoma Consultant Committee of the Chronic Disease Service of the Public Health Service.

The “Phosphenator Test” was first announced in a paper by C. E. Humphrey and V. J. Murgolo that appeared in the February issue of Eye, Ear, Nose and Throat Monthly, Volume 36, pages 106 and 107. A pulsating electric current passed between electrodes so applied to the head that the current traversed the eyes caused the sensation of light (electric phosphene), which flickered at the rate of the pulsations. The color of this electric phosphene was supposed to indicate the condition of the eye.

At least two papers have appeared since the above date denying that the test is reliable in any way and asserting that the color of the electric phosphene is no indication of the presence or absence of glaucoma and no indication of the amount of intraocular pressure. These papers are as follows:


STATEMENT BY AMERICAN COLLEGE OF CHEST PHYSICIANS RE: BCG

The American College of Chest Physicians, an organization comprised of 6403 physicians in 89 countries and territories throughout the world, met in annual session in San Francisco. Their Executive Council passed the following resolution:

"In view of the vital interest in improving public health and welfare, and in the eradication of diseases of the chest in particular, our position regarding the use of BCG (bacillus Calmette-Guerin) against tuberculosis in the United States should be made known. At the present time, there is insufficient evidence that significant protection is afforded by its use. The Council fully endorses the antituberculosis control program of the U.S. Public Health Service which includes research in BCG, and urges the continued support of their program."

A Good Book—

A small, highly useful, easily readable, well written new book of compendium style has recently appeared. It is "new" only in the sense of being a recent, thoroughly revised eighth edition, the first having appeared in 1906. Written by an Englishman, Dr. E. F. Sutton, it is clear and easily readable. Printed by Balliere, Tindall and Cox, London; The Williams & Wilkins Co., Baltimore, exclusive U.S. agents. Title, Aids to Medical Diagnosis; Price, $3.50.

Intrusion of Federal Government Into Lives of Citizens Centers on Medical and Social Security Fields—

As usual, paternalism of our Federal Government is to be expanded. The fields that seem most feasible and come readymade, are those of medicine and social security. We hear from the Washington Office that "scores of liberalizations in social security program" have been suggested and considered. It is believed unlikely that many of them will be incorporated into law, but equally likely that some of them will. Apparently no influential Congressman has taken serious note of the sensible and businesslike suggestion often made—to investigate the whole field of social security to find out how far we can go with it without bankruptcy, and having determined this, abide by it.

The Forand bill, an additional way of increasing taxation with a plausible sop at the end—more help for our pitiable elder folk—is receiving heavy support from unions, Americans for Democratic Action and one of the Roosevelts.

Medicare is too liberal for the socialistic element and is in the process of being trimmed of "free choice" and money.

News and Views

National Foundation for Infantile Paralysis Offers Postgraduate Education—

September 1 and December 1 are the deadlines for applications to the National Foundation for postdoctoral fellowships in research and academic medicine or in clinical fields of rehabilitation, orthopaedics, and preventive medicine. For complete information address Division of Professional Education, National Foundation for Infantile Paralysis, 301 East 42nd Street, New York 17, N.Y.

Reprints Received—


W.H.O. 1959 Budget Approved in Minneapolis—

A budget of $14,287,600 proposed for 1959 by Dr. M. G. Candau, Director-General of the World Health Organization, was approved unanimously and by acclamation by the two main committees of the Eleventh World Health Assembly in a joint session held at Minneapolis, June 4, under the chairmanship of Prof. N. N. Pesonen (Finland).

The approval came after a brief statement by Dr. Candau, and a more detailed explanation given by Sir John Charles (United Kingdom), Chairman of the Executive Board. This is the first time in W.H.O.'s 10 years of history that the budget proposed by the Director-General was approved without a dissenting voice, a W.H.O. spokesman stated.

In the discussion which preceded the adoption of the budget, several delegates said that although they were very happy at the unanimous approval given to the Direc-
Postgraduate Programs, 1958-59, University of Nebraska College of Medicine—

The following are the dates and the departments involved in a series of postgraduate programs planned for the practicing physicians of Nebraska:

Sept. 29, 30, and Oct. 1—Electrocardiography.

October 15-16—Hematology.

December 4—Neurology and Psychiatry.

January 15-16—Obstetrics and Gynecology.

February 26—Physical Medicine.

March 26—Obstetrics (Lincoln).

April 13-14—Pediatrics.

April 15, 16 and 17—Seventh Annual Spring Postgraduate Assembly.

May 5—Anesthesiology.

May 6—Fourth Annual Trauma Day.

In addition to these short courses there will be offered three Postgraduate Traineeships of one week each. These will be in the departments of Surgery, Pediatrics, and Obstetrics & Gynecology.

Lack of Accommodations Again Brands San Francisco As Unsuitable for A.M.A. Conventions—

We see by the San Francisco newspapers that what we already feared and suspected because of previous experience has happened again. In fact the following statement from the newspaper summarizes the whole story:

"Partly as a result of the lack of hotel rooms, and the asserted unwillingness of some hotels to 'co-operate' with the A.M.A., there is already talk that 'this is the last year the A.M.A. will meet in San Francisco.'"

An Oversight—

In the May issue of the Journal we published an editorial by Dr. Horace E. Campbell entitled "A Tale of Two Doctors." We mentioned having published a paper read by Doctor Campbell at our Annual Sessions of 1956 but neglected to mention a second paper by the same author on the subject of built-in safety in automobiles. This appeared in the April, 1957, issue. It is to our advantage to be familiar with Doctor Campbell's profound knowledge of this subject.

We Are in No Danger of Having "State Medicine"?—

From A.M.A. Washington Letter 85-77 we see how easy it is to be influenced by the side that butters our bread. We must, also, assume that nearly all doctors and hospitals not under government or union control are basically dishonest, overchargers, cheaters, and furnish a poor grade of care for our patients. The note from which this inference is drawn is as follows:

"The United Mine Workers Welfare and Retirement Fund has announced that it is closing the door of free choice of physicians in its big hospital and medical care program. Dr. Warren F. Draper, fund medical director, told the National Conference on Labor Health Services that the fund "... will never return to free choice of physicians. In order to continue to provide its present liberal medical and hospital benefits, the trust fund will deal only with those physicians and hospitals which it considers necessary and essential ... It is the right of all labor health services to control its own medical care programs and they must insist on this right if the cost of medical care for their people is to be kept within reasonable bounds."
A.M.A. Conducts Nursing Home Study—

A field survey of approximately 25 skilled nursing homes in various sections of the country is being conducted this summer by the A.M.A.'s Council on Medical Service. Primary purpose of visits to these public, proprietary and non-profit facilities will be to obtain data that will aid in developing recommended guides and standards governing medical care in nursing homes. It is expected that much valuable information will be gathered on other important phases of nursing home operation—including nursing care, social service, food service, staffing and personnel policies, and costs. Tentative plans call for publishing the results of the survey, along with suggested standards for medical care and supervision, this fall.

This field study is one of the activities which has grown out of meetings of the liaison committee of the American Medical Association and the American Nursing Home Association. Other problems currently under the committee's consideration are the adequacy of welfare payments for nursing home care, ways of financing new and improved nursing home facilities, and stimulation of a better working relationship between nursing homes and physicians at both the state and local levels.

A.M.A. Adopts New Code for Doctors and Lawyers

A new “National Interprofessional Code for Physicians and Attorneys” was approved by the A.M.A.'s House of Delegates at its Annual Meeting in San Francisco. The Code will serve as a suggested guide for physicians and attorneys in their inter-related practice in the areas covered by its provisions—subject to the principles of medical and legal ethics and the rules of law prescribed for their individual conduct.

The Code was formulated by a joint national medicolegal liaison committee made up of representatives appointed by the American Bar Association and the American Medical Association. The three medical representatives include Doctors David B. Allman, Hugh Hussey and George Fister. Besides drawing up this new Code, the joint committee has considered such things as the encouragement of state and local medicolegal meetings, medical professional liability problems, medicolegal forms and the possibility of establishing medicolegal courses in law schools and medical schools.

The Code has been prepared in general terms to permit its adaptation in light of local conditions. The same Code will be presented for approval to the Board of Governors and the House of Delegates of the American Bar Association at its meeting in August.

In the preamble the Code states that it “will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.” Various sections cover such topics as medical reports; conferences between the physician and the attorney; subpoena for medical witness; arrangements for court appearances; physician called as witness; fees for services of physician relative to litigation; payment of medical fees; implementation of the Code at state and local levels; consideration and disposition of complaints.

Federal Government Puts on Another Muzzle—

(From Secretary's Letter No. 439): “The federal government recently applied another muzzle, this time to utilities which have been fighting public power propagandists.

"The Internal Revenue Service announced rulings disallowing anti-public power advertising as a deductible business expense.

"Who will be next?"

“One utility official, commenting on the rulings, said tax-paying, investor-owned utilities should be allowed to use advertising to meet any competitor, even when that competitor is the federal government. Moreover, he said, the cost of such advertising should be deductible as an ordinary business expense.”

A Physician-Guest From South Africa—

Lincoln had as its guest, on June 5-9, Dr. George Dommissi, an eminent orthopaedic surgeon from Pretoria, South Africa. Doctor Dommissi is Secretary of the South African Orthopaedic Association, and came to this Country to attend the joint orthopaedic meeting in Washington in May. He is making a tour of the orthopaedic clinics in the United States before returning to his native land.
Doctor Dommissi wished to come to Lincoln particularly, because of the fact that Pretoria, Capital of the Union of South Africa, and Lincoln are of similar size, are cultural and educational centers, and have about the same industrial and agricultural atmosphere. He wished to compare the orthopaedic problems and facilities. While here he spoke on a new approach to management of fractures of the pelvis.

A.M.A. HOUSE OF DELEGATES:
SAN FRANCISCO, 1958
(Continued from page 336)

state medicine bill and, at the same time, hold out our hands for some of the fruits of a socialistic experiment?

The straightforward attitude of the profession of Texas regarding Medicare, which they have refused to re-negotiate, is to be complimented. They do not believe the highest quality of medical care can be given under this setup, they abhor anything that smacks of government-controlled medicine, and they foresee the gradual alteration of this program to give the government greater control and to minimize the vaunted “freedom of choice” on which we hang so much faith. Texas may be setting a good example. The more we dabble with Socialism the more easily we will be “sucked in,” eventually.

The V.A. medical program came in for its usual tongue-lashing. If all the words spoken on this subject in our House could be laid end to end they would probably reach the moon. The results of all this vituperation are barely visible. We need a political Einstein to give us the right formula.

These are only sidelights so visible to an old hand at listenin’. You will get all the meat from those delegated to represent you.

Human Interest Tales

Dr. Dale Ebers, Omaha, is now associated with Dr. George Stafford of Lincoln.

Dr. D. B. Mullikin, Chester, celebrated 50 years of medical practice on May 21st.

Dr. and Mrs. Lloyd O’Holleran, Sidney, are the parents of a baby born in June.

Dr. and Mrs. A. E. Mailliard, Osmond, spent several weeks visiting in California in June.

Dr. M. L. Sucha, O’Neill, has moved to Schuyler where he is associated with Dr. Howard Fencel.

Dr. F. J. Murray, Omaha, recently presented the University of Omaha with an electrocardiograph machine.

Dr. N. H. Moss, formerly of Arcadia, has become associated with Drs. H. E. Moore and J. C. Baker of Sutherland.

Dr. Richard N. Todd has recently become associated with Dr. Maurice Frazer in the practice of radiology, in Lincoln.

Dr. L. H. Cowan, Scottsbluff, has assumed the duties of administrator of the Community Hospital in Lewellen.

Dr. Donald F. Prince has recently moved to Minden where he has opened his office. Dr. Prince is a native of Bayard.

Dr. George John, Schuyler, has closed his office in this city and has moved to Wayne where he will resume his medical practice.

Mrs. Charles J. Warner, Waverly, has been appointed to the advisory board for the Lincoln State Hospital by Governor Anderson.

Dr. C. N. Sorensen, Scottsbluff, has been reelected to his third term as president of the West Nebraska General Hospital Medical Staff.

Dr. W. D. Ketter, formerly of Falls City, has been appointed medical director of the Boulder County General Hospital in Boulder, Colorado.

Dr. and Mrs. R. S. Kelley and family of Beemer, have moved to Lead, South Dakota, where Dr. Kelley has accepted a position with a clinic.

Dr. O. C. Kreymborg, North Platte, was a guest speaker at the 34th University of Illinois Fire College meeting held at Urbana, Illinois, in June.

Dr. K. J. Kenney, Fairbury, has been appointed a clinical associate in general practice on the staff of the University of Nebraska College of Medicine.

Dr. Juul Nielsen, former superintendent of the Hastings State Hospital has again taken over active direction of the hospital after an absence of 7 years.

Dr. I. L. Thompson, West Point, was honored by the Chamber of Commerce of that
city in June in recognition of his 50 years of medical practice to the community.

Dr. Max Fleishman of Omaha was re-elected to the Board of Governors of the American College of Chest Physicians at its recent annual session held in San Francisco.

Dr. Alan R. Moritz, former graduate of the University of Nebraska College of Medicine, has been elected president of the American Association of Pathologists and Bacteriologists.

Dr. D. B. Mullikin, Chester, was presented a past master's apron by members of Chester Lodge No. 298, A.F.&A.M., in June in recognition of his many years of service to the lodge.

Dr. H. S. Eklund, Osceola, was honored by the medical staff and nursing staff of the Annie Jeffrey County Hospital, in June, in recognition of his 25 years of service in Polk county.

Dr. W. C. Kenner, Nebraska City, attended the meeting of the American Medical Association in San Francisco in June. He is an alternate delegate of the Nebraska State Medical Association.

Dr. Richard Steenburg of Boston, son of Dr. and Mrs. E. K. Steenburg, Aurora, has accepted an appointment as associate professor in surgery and research at Johns Hopkins School of Medicine.

Dr. Ernest Lennemann, Falls City, has announced that he will close his office on August 1. Dr. Lennemann has accepted a position with the Eastern State Hospital near Spokane, Washington.

Dr. Russell M. Brauer, Lincoln, has been elected president of the Nebraska Society of Anesthesiologists. Other officers elected were vice president, Keay Hachiya, Lincoln, and secretary-treasurer, Dean C. Watland, Omaha.

Drs. F. D. Coleman, E. S. Wegner, George Misko and Earl V. Wiedman, all of Lincoln, held their first reunion at the Lincoln Country Club in June. All four doctors are 1919 graduates of the University of Nebraska College of Medicine.

Drs. Robert Therien and Leroy Lee, Omaha, presented a report describing the results of their research program on new analgesic and sedative drugs at the annual meeting of the American Medical Association in San Francisco. Drs. Neal Davis and Edward Malashock also worked in the investigative program.


Announcements
A Suggestion to Contributors to This Department—

A large number of organizations, medical and paramedical, furnish editors of state medical journals with copy with the hope it may be printed. This offers information thought to be of interest to the readers. For this very reason and for no other the editor selects some and rejects the remainder. The editor is often confronted by what amounts to a short essay on the subject. From this he must choose what to print, must boil the matter down to reasonable length, and must compose the copy for final use. This is time-consuming and editors are busy men.

Some copy comes in such form and length that it could be utilized without change, but nine times out of ten, it is single spaced. Anyone connected with the production of journals or books knows that copy must be double spaced if the good will of the printer is to be kept.

If these two items could be impressed upon those who prepare the material much more of it would be printed.

Nation's Oldest Essay Contest—

The Trustees of American's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Bronchogenic Carcinoma — Predisposing Causes." The dissertation must be type-written, double spaced, and should not exceed 10,000 words. A cash prize of $300 is offered. Essays must be submitted by December 31, 1958.

For complete information regarding regulations, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, Rhode Island.
Applications for Certification, American Board of Obstetrics and Gynecology—

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II, are now being accepted. Deadline date for receipt of all such applications is September 1, 1958. No applications can be accepted after that time.

Apply to Office of the Secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

Postgraduate Courses in Obstetrics Are Offered the Generalist—

The Woman’s Hospital in New York City is offering two courses in Obstetrics, to general practitioners only. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled “Ante-partum Care” and “The Conduct of Labor and Delivery.” They will be given from October 16-31, 1958.

These are full time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this postgraduate instruction will please address Mr. Carl P. Wright, Jr., Woman’s Hospital, 141 West 109th Street, New York 25, N.Y., and an application blank and prospectus will be forwarded.

Scientific Program on Clinical Use of Hypnosis—

The Society for Clinical and Experimental Hypnosis, an International Scientific Society, comprised of physicians, dentists and psychologists engaged in the clinical use of hypnosis, will present an outstanding scientific program in Chicago at the Morrison Hotel, October 29-31, 1958.

The Program will include Breakfast Seminars, Round-table Luncheons, Panel Discussions and Formal Presentations.

The Medical Program will include topics dealing with the value of hypnosis in many branches of medicine and surgery.

For a copy of the program and more detailed information, write to the Administrative Secretary, Society for Clinical and Experimental Hypnosis, 750 N. Michigan Avenue, Chicago 11, Illinois.

Interim Meeting of the American Institute of Ultrasonics in Medicine—


Second Conference on Uniform Labeling Law—

The second in a series of conferences to discuss model legislation for labeling hazardous substances will be held Friday, July 25, at the American Medical Association’s Chicago headquarters.

Sponsored by A.M.A.’s Committee on Toxicology, invitations have been sent to more than 60 organizations representing trade associations, toxicity-testing laboratories, chemical trade unions, and other interested groups.

Under discussion will be the “Uniform Hazardous Substances Act” which has been drafted by the committee and is intended to close the gap in label legislation.

Bernard E. Conley, Ph.D., committee secretary said, “Existing legislation shows a sketchy, non-uniform, and generally inadequate pattern of labeling regulations at state and national levels.”

“Ninety per cent of the states lack requirements for the precautionary labeling of commercial as well as household chemical products,” he added.

More than 40 organizations, including representatives of government, agriculture, and medicine attended the first in this series of conferences in Chicago on May 9.

American Association of Medical Assistants—

Plans have been made for the Second Annual Convention of the American Association of Medical Assistants to be held at the Palmer House, Chicago, Illinois, on October 31, November 1 and 2, 1958.

The American Association of Medical Assistants is made up of men and women employed as assistants in the offices of Doc—
tors of Medicine. The Association was conceived in Kansas City, Kansas, during the fall of 1955 when interested persons from fifteen states met to make plans for a formal organization. The second meeting was held the following year in Milwaukee, Wisconsin at which time a Constitution and By-Laws were adopted and the Association formally set up. During this first official year, a great deal of work was done and the First Annual Convention was held in San Francisco, California, in October, 1957. Now, with a membership of nearly 6000 representing seventeen states, and with the approval of state medical societies and the American Medical Association, this Association is well under way.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve. To strive at all times to cooperate with the medical profession in improving public relations. To render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation among the societies. To encourage and assist all unorganized medical assistants in forming local and state societies. This Association is declared to be non-profit. It is not nor shall it ever become a trade union or collective bargaining agency.

Several states now offer fine educational courses with the cooperation of their colleges and universities which will help the assistant to become more valuable in the doctor’s office. Physicians realize that the well-trained assistant is an asset to their profession and that these courses will relieve them of much of the time-consuming work of on-the-job training. The American Association plans to offer courses on a national level as soon as a suitable curriculum has been set up.

Membership in medical assistants societies throughout the country has provided an opportunity for the assistant to benefit from the many fine lectures, workshops and seminars as a part of regular programs.

The American Association of Medical Assistants is now offering its members a comprehensive insurance program. This is a salary replacement (sickness and accident) plan with option major hospital, nurse expense and surgical benefits.

It is to the advantage of the medical profession to have their medical assistants affiliated with this organization.

The American Association of Medical Assistants would welcome the opportunity to give information concerning the organization and to assist with the formation of county and state societies. Inquiries may be addressed to Miss Hallie Cummins, R.R.L., Chairman of the Public Relations Committee, Medical Record Library, Caro State Hospital for Epileptics, Caro, Michigan.

Deaths

John C. Peterson, M.D., Lincoln—Doctor Peterson, a Lincoln eye specialist for 25 years, died February 13, 1958, of a heart attack at his home in Lincoln. He was 55 years old at the time of his death. Dr. Peterson was born at Geneva. He graduated in 1928 from the University of Nebraska College of Medicine. After taking his internship at Clarkson Memorial Hospital in Omaha, he did graduate work in eye, ear, nose and throat at the New York Post-Graduate School. He served as medical consultant for the Nebraska State Services for the Blind for many years. He began his practice in Lincoln in 1930 and practiced there since that time, except from 1942 to 1954, when he served as a Commander in the U.S. Navy.

R. G. Rich, M. D., David City—Doctor Rich died at his home February 13, 1958 at the age of 93 years. Dr. Rich attended the medical school of the University of Illinois, receiving his M.D. degree in 1899. He practiced medicine in Hampton, Iowa, for two years. In 1901 he moved to David City, and his practice of medicine in that community continued for more than 50 years. He served David City as Health Officer for a number of years.

William D. Lear, M.D., Ainsworth—Doctor Lear passed away suddenly at his home February 10, 1958, as a result of a heart attack. Dr. Lear graduated from the University of Nebraska College of Medicine in 1924. He came to Springview in 1926 to begin the practice of medicine. Remaining there until September 1936, he then entered a partnership with Dr. R. R. Brady, Wood Lake, in
the purchase of the Ainsworth hospital. He continued as physician and surgeon at the clinic-hospital in Ainsworth, serving countless patients from a wide territory, until the time of his death. Dr. Lear was a commissioned officer in the Army during World War I. He was a member of the American Medical Association, Nebraska State Medical Association; past president of the North Nebraska Medical Society and at the time of his passing, a member of the faculty of University of Nebraska College of Medicine.

William H. Gray, M.D., Broadwater—Doctor Gray died at the age of 82 at his home in Broadwater where he has been a resident since 1918 and a practicing physician for more than 50 years. He graduated from the University of Nebraska College of Medicine and began his practice at Osceola in 1903. He also practiced at Minot, North Dakota, before coming to Western Nebraska in 1917.

John A. Tamisiea, M.D., Omaha—Doctor Tamisiea, a specialist in aviation medicine and a veteran of three wars, died in an Omaha hospital June 5th at the age of 65. He graduated from the Creighton University School of Medicine in 1916. His interest in aviation medicine began in World War I while he was a surgeon with a British flying unit. He later was wounded and gassed in France. He also saw service in World War II and the Korean War. He retired as an Air Force colonel. For many years he was a flight surgeon and medical examiner for the United States Department of Commerce and the United Air Lines. Doctor Tamisiea was a past-president of the Aero-Medical Association International, past-president and a charter member of the Civil Aeronautical Medical Association, a fellow of the American College of Preventive Medicine and first vice president of the Air Line Medical Examiners Association. He also was a member of the Douglas County Medical Society, the American Medical Association, the Doctors Hospital board of directors and the staffs of St. Catherine’s and St. Joseph’s Hospitals in Omaha.

Percy C. Mockett, M.D., Kimball—Doctor Mockett, 83, a pioneer physician of Kimball, died May 26, 1958, at the Emory John Brady hospital in Colorado Springs, where he had been a patient for several months.

Dr. Mockett was born in London, England, September 26, 1874, and moved to Philadelphia with his parents when a small child. He obtained his medical degree at the University of Denver, and in 1902 came to Kimball where he spent many years in the practice of medicine. Doctor Mockett’s hobby was travel and he had visited nearly every country in the world.

Delia A. Lynch, M.D., Omaha — Doctor Lynch died in a hospital after a week’s illness at the age of 83. She had practiced medicine in Omaha for nearly 50 years. In 1954, Doctor Lynch was named “Nebraska Medical Woman of the Year,” by the American Medical Women’s Association. She was a leader, in 1947, of a crusade to eliminate rats. Doctor Lynch was a graduate of Creighton University School of Medicine in 1909.

Know Your Blue Shield Plan

The Other Side of the Blue Shield Coin—

Scandals, murders, and robberies nearly always get bolder headlines than marriages, births, or philanthropic donations — or the professional achievements of modern medicine. By the same rule of human perversity, doctors often take articulate notice of Blue Shield only when they have some fault to find with it.

Whenever four or five colleagues are gathered together—at a medical meeting, on the golf course, or in the hospital staff room—someone is bound to take out after the Blue Shield Plan. Very often the complaint has something to do with the Plan’s payments. Perhaps the allowance for a certain procedure seemed quite inadequate for the particular case treated last month; or the Plan didn’t cover any of the diagnostic work that was done for Mrs. Smith; or the Plan has been persistently requesting a detailed operative report to explain a pending surgical claim.

What’s good about Blue Shield, anyway?

Well, first of all, haven’t you found that— for every single case where the Plan’s payment has been inadequate for the service re-
acquired, or delayed for further information, or refused as ineligible — there have been scores of other cases for which reasonable payment has been promptly received? After all, when you come to think of it, isn’t Blue Shield’s payment for an eligible claim, properly presented, about as fast and dependable as any source of income you’ve ever had on your books?

As for the Blue Shield payment in any given case, doctors have a unique recourse here, too. For the Blue Shield schedule of payments is arrived at — and continually adjusted — with the advice or at the request of the local profession. And if the scheduled payment is out of line with the service required in a particular case, you can ask for a review by a committee of qualified physicians. Blue Shield is the only prepayment program whose medical policies are subject to our guidance and control.

Another unique virtue of Blue Shield has to do with the economic segments of the patients whom it covers. Because of its community approach and its unmatched economy of operation, Blue Shield is the one medical prepayment plan that covers — or even tries to cover — the lower income groups who most need protection.

So it is that through Blue Shield, doctors are now being compensated for servicesrendered to a considerable number of people who, were it not for Blue Shield, would still qualify for our free services in hospital wards and clinics.

Most important of all good things about Blue Shield is that it is the Profession’s Plan, and a successful plan, too. Nearly 43 million patients are now buying Blue Shield every month, and thousands more are joining them every day. In so doing, these friends and neighbors are expressing their confidence in medicine and in our American system of independent private practice.

If they think well of Blue Shield, maybe it merits a pat on the back from doctors too.

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NOTICE TO ALL CONTRIBUTORS

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

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TUBERCULOSIS ABSTRACTS

THE PRACTICAL VALUE OF THE TUBERCULIN TEST

The tuberculin test has long been accepted as a simple and highly specific test for the presence of tuberculous infection, but its possibilities and its limitations tend to be overlooked. Studies done in recent years by the World Health Organization in connection with BCG vaccination programs, and observations made by the U.S. Public Health Service and others have provided valuable information, but there is still much to be learned.

Significance of Dose of Tuberculin. There is a tendency to think of the tuberculin reaction as an "all or none" phenomenon, although every pediatrician has learned that there is a wide range of tuberculin sensitivity in any group tested. Usually a tuberculin test is called positive or negative on the basis of size of reaction. If a Mantoux test is done, the indurations larger than five or six millimeters in diameter are arbitrarily called positive, but their are many smaller than this which represent some degree of sensitivity. Are these people with just a little sensitivity infected with tubercle bacilli? Undoubtedly some are but there is now good evidence that many represent a cross sensitization with other antigens. Studies now in progress may reveal the nature of the antigen or antigens able to produce some tuberculin sensitivity.

These findings give additional emphasis to an earlier study with graduated dosage of PPD which showed that in tuberculous patients extremely small doses produce no reactors but with a gradual stepping up of the PPD strength an increasing percentage was positive until the dose of 0.0001 mg. was reached. At this point practically all persons with tuberculosis had a reaction of five millimeters or more. If the dose was further increased reactions were obtained in large numbers of children who were probably not infected. This with other studies indicate that a standard dose of 0.0001 mg. of PPD is satisfactory for most purposes.

The size of the tuberculin reaction may also be of diagnostic and prognostic significance. Recent preliminary studies (unpublished) at the Phipps Institute in Philadelphia indicate that the size of the tuberculin reaction is correlated with the probability of active tuberculosis; the bigger the reaction, the more likely it is that active disease is present.

Many observations point up the increasing usefulness of the tuberculin test to the pediatrician. The interpretations of various degrees of tuberculin sensitivity may be summarized as follows:

1. If a child has no reaction to 0.0001 mg. of PPD there is little possibility that he has a tuberculous infection. Periodic testing, at least annually would establish the approximate time of a tuberculous infection.

2. A low degree of sensitivity with induration under five millimeters (5 mm.) in diameter could be the result of some other infection, or an insignificant tuberculous infection. The chance of active disease being present is extremely small.

3. With a reaction over five millimeters in size, the chances increase that active tuberculosis is now
present, or will develop. Each child with such a reaction should have a thorough examination to confirm or exclude the presence of an active lesion. Most of such children will not have active lesions but will have an increased risk as they go through the ages 15 to 30, so long-term followups and periodic examinations are important.

Effect of BCG on Tuberculin Test. If a child has a positive test when first seen by the pediatrician, it will be important to know whether BCG has been given or not. The reaction may be a result of the BCG inoculation. A positive test should lead up to a search for tubercle bacilli if there is reason to suspect a virulent infection. Some children do acquire serious tuberculosis disease in spite of a BCG vaccination.

Chemoprophylaxis in Tuberculin Positive Children. Isoniazid prophylactic treatment of tuberculin reactors to prevent the subsequent development of active disease has been advocated frequently in recent years. Perhaps studies now in progress will provide more precise indications for chemoprophylaxis. At this time, however, opinion is divided and the physician will have to use his best judgment based on such things as recency of infection, the age of the child, the size of the tuberculin reaction, the presence of any lesions on X ray, the presence of predisposing conditions such as diabetes, and the future exposure to infection. Current investigations have confirmed the considerable risk of future disease in tuberculin reactors.

Tuberculin Testing in Community Case Finding. Tuberculin testing in private practice will pay an extra dividend in community tuberculosis control by providing leads to active cases which might escape detection otherwise. If the test is positive in a young child, the infection must be recent and its source is likely to be an active case among his close associates. In older children the source of infection may be more remote. The size of the reaction is important here too. Not only are those with larger reactions much more likely to have active tuberculosis, but higher rates of tuberculosis are found among their contacts. The physician can be of help to public health authorities by insisting that all associates of tuberculin reactors receive adequate examination.

Tuberculin Testing as an Index to Tuberculosis Prevalence. The tuberculin test is a relatively simple and inexpensive procedure for determining infection rates in groups of children and adults. If these groups are retested at intervals, trends in the rates of new infection can be detected. It is quite clear from the evidence now available that infection rates have dropped markedly in the last few years in the United States. The need for more accurate measurement of tuberculin sensitivity is increasingly apparent. The only quantitative procedure now available is the Mantoux or intradermal test. The method and material used in the test has been described often and need not be repeated.

The patch test has been used extensively because of its convenience and the fact that no needle is necessary. However, it does have serious basic limitations and is not recommended. Many attempts have been made to improve patch test results but the dose of tuberculin cannot be controlled, because of the many factors which affect absorption of tuberculin through the skin.

Tuberculin Testing Schedule. A practical age schedule for tuberculin testing must always be a compromise. It seems to be common practice to test at least once each year as long as there is no reaction, substituting annual X-ray examination if the test becomes positive. Finding even an occasional new infection should be worth the little effort it takes in view of the risk to the child of future serious complication and the effectiveness of therapy.

If school children are being tested, the grades tested will depend somewhat on the number of new infections expected per year. In a low rate area it may be sufficient to test beginning students in kindergarten or the first grade, children about to leave elementary school and the last year in high school. In a high rate area it may be worthwhile to test all grades every year. Such group tuberculin testing programs must be carefully planned so the essential followup of contacts will not be neglected and to provide for a critical evaluation at the end.

Tuberculin testing of children cannot take the place of the established public health program for tuberculosis control. Isolation and treatment of infectious patients, supervision of inactive cases, examination of contact of active cases, X-ray screening of high rate groups, and programs to improve general public health are basic to any organized attack on the disease. However, routine tuberculin testing by all physicians coupled with well planned group testing of school children and others in a community can provide additional information useful for a more direct attack on the disease with the present effective therapeutic tools.


• • •

Passenger cars are involved in more accidents than other types of motor vehicles, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. It cites motor vehicles as the leading cause of accidental death, which claims 93,000 American lives annually. Last year, according to “Patterns,” passenger cars were involved in 78 per cent of fatal and 86 per cent of non-fatal motor vehicle accidents.

A word of warning to jaywalkers is sounded in the current issue of “Patterns of Disease” prepared by Parke, Davis & Company for the medical profession. Jaywalking is responsible for most pedestrian injuries in motor vehicle accidents, “Patterns” says. Approximately 48 per cent of fatal and nonfatal pedestrian injuries occurred because persons crossed between intersections and came from behind parked cars.
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Financial Aid in Nursing Education—

(Continued from page 20-A)

ing and its opportunities as a career. It is hoped that the Clubs' program will expand to include many more of the nation's total of 24,000 secondary schools.

A grant of $165,000 also to the National League for Nursing will enable it to carry forward over the next four years a Consultant Service in Junior College Education in Nursing. In 1952 Teachers College, Columbia University, as a demonstration initiated associate degree programs in basic nurse training in six junior and community colleges. The number of institutions cooperating in this demonstration has since quadrupled and at least fifty additional institutions are giving consideration to adopting the program.

On a longer-range basis, a grant of $215,-000 has been made to the National League for Nursing for distribution to selected universities undertaking pilot demonstrations to increase the number of their graduates qualified as nurse teachers. In view of the fact that student admissions, both to two-year and three-year basic nurse training programs, are expected to increase from the present level of 46,000 to about 70,000 by 1970, it is imperative that there be an immediate increase of postgraduate nurses qualified to enter the teaching profession.

Grants for scholarship assistance to candidates for baccalaureate degrees in nursing, ranging from $4,000 to $24,000 and totaling $322,800, have been distributed among thirty-two colleges and universities. At the baccalaureate degree level, previously available scholarship funds have not been as generous as those for study on the master's or doctoral degree level.

Dissolving Blood Clots . . . A Trial—

A new blood-clot dissolving enzyme promising effective control in thromboembolic diseases was described by three investigators at the annual meeting of the American Medical Association.

The report on the enzyme fibrinolysin was given by Dr. H. O. Singher, D. S. Pattison and R. V. Chapple, of the Ortho Research Foundation.

They described its intravenous use in

(Continued on page 32-A)
DIURIL caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria...."
Dissolving Blood Clots . . . A Trial—
(Continued from page 28-A)

phlebothrombosis, vascular surgery, pulmonary embolism, cerebral thrombosis, and mesenteric thrombosis.

The new agent is currently under clinical trial. Preliminary studies indicate that its main advantages are: "the capability to induce and maintain a fibrinolytic level, the lack of hemorrhage in the face of this level, and the fact that it can be employed in the presence of anticoagulants," according to the investigators. They stress that "its mechanism is dissolution, not prevention of clot formation."

Major problems in treating clots are prevention of further extension of a clot and the dissolving of an existing clot or embolus, the investigators said. None of the anticoagulants are capable of dissolving a clot once it has been formed, although in many instances of minor clots, dissolution will be made by the body's own clot dissolving mechanism. "However, in most major thrombotic episodes, the fibrinolytic mechanisms are inadequate."

"The supplementation of these mecha-

nisms has been the object of many years of research," according to the investigators.

The agent is prepared by activating plasminogen with streptokinase to form fibrinolyisin or plasmin, the clot-dissolving substance.

The investigators described a study on 122 unselected cases with various conditions. They emphasized that no attempt was made to classify the patients treated on the basis of the duration of the clot before therapy was begun. "Early treatment is of paramount importance," they added. Results were classified as "excellent" in 78 cases, "fair" in 21, and "poor" in 23.

The investigators also described the enzyme's topical use in chronic poor healing wounds. In a wide range of wounds, including varicose ulcers and acute and chronic abscesses, this enzyme has proved effective in removing necrotic tissue, therefore promoting more rapid healing, they stated. Moreover, used topically, it has "not produced any side effects, allergic or pyrogenic reactions," they said. "Its simplicity of use and effectivity indicate a new vista of therapeu
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32-A You can enhance the value of your own Journal by patronizing its advertisers
Current Comment

Racial Gap in Mortality Narrowing—

Within the last half-century the life expectancy of the typical nonwhite infant in this country has almost doubled. In its monthly statistical bulletin, Health Information Foundation states that the nonwhite infant born in 1900 could expect an average lifetime of only 33.0 years. By 1955 the figure had risen to 63.2 years.

This was still seven years less than the comparable average for whites. Nevertheless, since 1900 “the decline in nonwhite mortality has been even more striking than the decline for whites.” By 1955 nonwhite mortality was down to 10.8 per 1,000 population, only 3.4 above the figure for whites.

According to the U.S. Census Bureau, nonwhites today constitute 11 per cent of the nation’s population—18.8 million persons in mid-1957. The vast majority of persons classified as nonwhite are Negroes, and two-thirds of the nonwhite population lives in the South.

Nonwhites have long had higher-than-average death rates from such contagious diseases as pneumonia-influenza and tuberculosis. As medical science and the development of new drugs have brought these diseases more and more under control, the mortality differential between the races has declined.

Nevertheless nonwhites still have a higher-than-average mortality from most causes of death, notably heart and kidney diseases, cancer, and risks incidental to childbirth.

What is the most frequent childhood accident? Falls rank first, accounting for 39 per cent of these accidents, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. The report is based on a large-scale study of fatal and nonfatal accidents among children aged 16 and under. Blows and collisions are second, and cutting and piercing third. Although burns only account for three per cent of such injuries, they are often extensive and deep when they do occur. As a result, they are the second leading cause of accidental death among children, following motor vehicles.
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SIGN OF GOOD TASTE

Current Comment

Allergy Increases in Importance—

More and more Americans are wheezing, coughing, sneezing, or itching due to some allergy, according to "Patterns of Disease."

About one out of every 10 Americans is said to be afflicted with some form of allergy, and the number of allergic patients seems to be multiplying. There are a number of possible reasons for the increase.

One is the greater likelihood of acquiring pollen asthma due to the wider distribution of the ragweed plant and more long distance driving by the populations.

Another is the extensive substitution of cow's milk for breast milk in infants' diets. Seven times more infants develop allergic eczema from cow's milk than from breast milk, "Patterns" reveals, and eighty per cent of these infants later develop respiratory allergies.

"Smog" irritants in industrial areas may be implicated too, and the high incidence of asthma in U.S. Army personnel stationed in Japan appears to be related to "smog" since patients are greatly relieved within a few hours of leaving industrial areas.

Other reasons include increasing hypersensitivity to new synthetic products and drugs, and greater diversity of foods in the average diet.

What factors trigger an allergic attack? Food ranks as the greatest offender, according to the publication, accounting for the onset of an attack in more than 60 per cent of allergic patients. Inhalant sensitizers such as strong odors, irritating fumes and house dust rank second, accounting 23 per cent. Contact allergens are responsible for about 15 per cent.

Emotional stress, too, can play a role. "An emotional situation may precipitate asthma in a potentially allergic child or it may aggravate an asthmatic attack in others," "Patterns" states.

HEREDITARY ROLE

The hereditary factor is important and it is stated that, over 50 per cent of allergic

(Continued on page 39-A)
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patients give a history of allergic diseases in other members of the family. An allergic tendency seems to be transmitted twice as frequently through women as through men.

Allergy may develop at any age and middle-aged persons may experience their first attacks after living allergy-free for many years. However, the initial symptoms occur more often in the first two decades than in later life. The over-all incidence of allergies in children is about 14 per cent.

"The majority of cases of asthma begin in childhood and, if neglected, they may lead to serious, disabling pulmonary disease in adult life," "Patterns" states.

Allergic diseases are seldom fatal, but they rank third in prevalence among chronic diseases and are calculated to account for over 100 million days of disability each year. In the working population alone, the estimated days of disability for allergic diseases each year are 42 million—at a staggering cost to industry.

disappear and surgery be unnecessary. Some California surgeons believe disappearance of a cavity is wishful thinking and that "recavitation" in the same area will occur sooner or later. One surgeon, however, found cavity closure to occur in 25 per cent of his first ninety-two patients. Cavitary lesions have been observed to remain the same size for months and even years. The present writer has observed one case of bilateral cavitation with gradual decrease in size of both cavities and eventual disappearance during a period of two and one-half years. If a cavity persists for twelve to eighteen months without closure and specifically if it is not definitely decreasing in size, the chances of its closing spontaneously are remote indeed. One should bear in mind that the complications reported in the latter part of this paper have been found to follow cavitary lesions much more frequently than to follow surgery on solid lesions. This may be explained by the fact that the mycelial form of Coccidioides immittis is present in 50 per cent of cavitary cases and in only 10 per cent of solid lesions.

Comprehensive Summary of the Complications Following Surgical Therapy. The complications following surgery for coccidioidomycosis are probably higher than might be surmised from reading the reports in the literature. A recent article states that complications were experienced in three of seven patients operated upon.

(Continued on page 45-A)
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TUBERCULOSIS ABSTRACTS

(Continued from page 39-A)

The 400 cases herein reported have had a complication rate of 13 per cent (seven deaths occurred in this group). One group of surgeons reported only five complications in 110 cases, while another in their 55 cases, reported five complications.

The complications range from persistent postoperative pneumothorax through empyema and nonexpansile lung to bronchopulmonary cutaneous fistula and multiple chest wall sinuses. In the 54 cases reported by the present writer, the ten complications can be divided into five major and five minor complications. The major complications were:

1. Bronchopulmonary cutaneous fistula with multiple chest wall sinuses.
2. Bronchopulmonary cutaneous fistula with empyema characterized by debilitation and invalidism of the patient.
3. Recurrence of cavity resulting in bronchopulmonary cutaneous fistula following secondary operation.
4. Bronchopulmonary fistula with empyema requiring open drainage and followed by a prolonged period of healing.
5. Persistent cavitation at the same site of removal of the original cavity.

The five minor complications included two cases of empyema treated successfully by repeated thoracostatis; one case of persistent minimal hemoptysis (present over a period of fifteen months) thought to be due to a small cavity in the same area at the original resection with eventual spontaneous closure of cavity and cessation of hemoptysis; progressive pneumonitis in the same area as the resection with evidence of a small cavity with eventual spontaneous resolution and cavity closure; and one case of persistent pneumothorax followed resection.

The over-all complication rate of 13 per cent may be expected to continue as long as the etiologic agent is not controlled by any of the known antimicrobial drugs. Despite the complications, there is no doubt that surgery has a definite place in the treatment of pulmonary coccidiodiomycosis.


It was late in the session before Congress indicated it would continue the Hill-Burton program; legislation virtually certain of enactment would extend the operation for three years, and authorize long-term loans to non-profit sponsors who for religious or other reasons do not want federal grants.
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IN VITRO SENSITIVITY OF SEVEN GRAM-NEGATIVE PATHOGENS TO CHLOROMYCETIN AND TO ANOTHER WIDELY USED ANTIBIOTIC*

ESCHERICHIA COLI

395 STRAINS

1

CHLOROMYCETIN 82.8%

151 STRAINS

ANTIBIOTIC A 58.9%

AEROBACTER AEROGENES

391 STRAINS

2

CHLOROMYCETIN 66.5%

148 STRAINS

ANTIBIOTIC A 32.4%

BACILLUS PROTEUS

314 STRAINS

3

CHLOROMYCETIN 72.6%

101 STRAINS

ANTIBIOTIC A 5.0%

B. PYOCYANEUS

269 STRAINS

4

CHLOROMYCETIN 16.0%

103 STRAINS

ANTIBIOTIC A 24.3%

SALMONELLA

13 STRAINS

5

CHLOROMYCETIN 92.3%

12 STRAINS

ANTIBIOTIC A 91.7%

B. ALKALIGENES FECALIS

7 STRAINS

6

CHLOROMYCETIN 57.1%

4 STRAINS

ANTIBIOTIC A 75.0%

B. FRIEDLANDER

6 STRAINS

7

CHLOROMYCETIN 66.7%

5 STRAINS

ANTIBIOTIC A 40.0%

*Adapted from Schneierson.
Current Comment

The Month in Washington—

The civilian Medicare program is struggling through an uncomfortable period of readjustment while attempting to cut its costs by about 30%.

Had the program continued the way it was operating last year, the cost this year would be an estimated $100 million. Instead, the Defense Department, on the urging of Congress, is attempting to keep the costs within the appropriated $70.2 million.

No one can estimate as yet actually what is being saved. Some services that previously were authorized in civilian hospitals and from civilian doctors have been eliminated, thus shifting these costs from the government to the service families. At the same time many dependents who had been cared for outside the military now are required to go to the service hospitals.

If they don't like what is happening, there is not much the Medicare administrators, the doctors and the hospitals can do about it, at least not until the new Congress meets next January. Then, if situation is out of hand and there is widespread discontent among the service families, the problem could be returned to the lap of Congress.

Awkward as are the restrictions in some areas, the situation could have been much worse. The House originally proposed only $60 million for the civilian program, and ordered the Defense Department not to exceed that figure. In the Senate, Senator Knowland (R., Calif.) sponsored an amendment increasing the total to $70.2 million, and lifting the ceiling on spending. The Knowland proposal was approved.

The conference committee accepted the Senate changes, but in its report on the bill instructed the department to stay within the $70.2 million. This the department is attempting to do, but if the figure has to be exceeded for good reasons, the department would have to shift funds or ask for a supplemental appropriation and explain the need.

If the ceiling had been kept in the bill it—

(Continued on page 14-A)
...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.\(^6\) ...Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.\(^7\)

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of aristocort as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.\(^6,9\) ...Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.\(^10,11,12\) ...Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.\(^13\)

Depending on the acuteness and severity of the disease under therapy, the initial dosage of aristocort is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to aristocort from prednisone indicate a dosage of aristocort lower by about \(\frac{3}{8}\) in rheumatoid arthritis, by \(\frac{3}{8}\) in allergic rhinitis and bronchial asthma, and by \(\frac{1}{2}\) to \(\frac{1}{4}\) in inflammatory and allergic skin diseases. With aristocort, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

aristocort is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.
TAKE A NEW LOOK AT FOOD ALLERGENS
TAKE A LOOK AT NEW DIMETANE

DIMETANE Extentabs (12 mg. each, coated) provide antihista-
mine effects daylong or nightlong for 10-12 hours. Tablets (4 mg.
each, scored) or pleasant-tasting Elixir (2 mg./5 cc.) may be
prescribed t.i.d. or q.i.d., or as supplementary dosage to Ex-
tentabs in acute allergic situations. A. H. ROBINS CO., INC., Rich-
mond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878.

*See food—source of highly potent allergens. Typical arc: lobster, tuna, sturgeon roe; fish oil used to prepare
leather, chamois, soaps, cattlefish bone for polishing material and tooth powder; glues made from fish products.
of state and local governments, if the veteran is unable to pay for his care.

Before adjourning, the House Committee introduced a bill that did little to clear up the issue of non-service-connected care. It was aimed rather at the Budget Bureau in an effort to assure that some 5,000 beds now closed because of “administrative decisions” would be placed in use—presumably for non-service-connected cases.

NOTES

A group of physicians, research executives and a former director of the Budget Bureau has concluded that the nation should treble its expenditures for medical research and double its annual output of physicians, all in the next 12 years. The consultants’ group to the Secretary of Health, Education, and Welfare proposes that the federal government supply about half a billion dollars by 1970, with an equal amount to come from industry and philanthropy. Head of the study group was Dr. Stanhope Bayne-Jones, former dean of the Yale medical school.

Under a Senate resolution, a statue of the late Dr. Florence Rena Sabin, who was noted for her research in the lymphatic system and tuberculosis would be placed in the Capitol’s Statuary Hall, as one of Colorado’s distinguished citizens. Each state is allowed two such statues. (From Washington Office, A.M.A.).

Physicians in Congress—

Although no physician is known to have been a member of the first Continental Congress in 1774, four were members in 1775 of the second Continental Congress according to a supplement made available by the A.M.A. Washington Letter.

Between 1774 and 1956, 359 members of Congress are known to have been physicians, a peak having been reached in the 24th Congress (1835-37) when 18 physicians were elected. Six physicians are members of the 85th or present Congress.

Political party affiliation of the physician members of Congress has been varied but Democrats have outnumbered Republicans 165 to 68 and one, Doctor George Washington Kittredge of New Hampshire, a Member of the House in 1853-55, is listed as an Anti-Nebraska Democrat.

In a recent 140-patient study¹ DIMETANE gave “more relief or was superior to other antihistamines,” in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

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"On chlorothiazide the response was striking with . . . improvement in cardiac status and loss of toxic symptomatology. . . . One of the most important effects of the potent oral diuretic was the smooth continuous diuresis. There was less fluctuation in the weight . . . marked diminution in the number of acute episodes of congestive heart failure such as paroxysmal dyspnea and pulmonary edema. . . . [DIURIL] appeared as potent a diuretic as parenteral mercurials and indeed in some patients it was effective when parenteral mercurials failed. . . . We have encountered no patient who once responsive to chlorothiazide later developed resistance to it."

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markedly relieves pulmonary edema

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL
Current Comment

Is the Diagnosis Related to Insurance Benefits?—

This question, with particular reference to psychiatric diagnoses is discussed in a recent editorial in The Pennsylvania Medical Journal. It is stated that a large percentage of the patients admitted to a general hospital are there for psychiatric reasons and if accurately diagnosed would be so classified. A review of admitting diagnoses in general hospitals only rarely reveals a psychiatric diagnosis.

It is suggested that one important factor that determines the absence of psychiatric diagnoses is the insurance benefit to be derived by the patient. As an example, the patient with paroxysmal tachycardia is cited. Such a superficial descriptive diagnosis would result in complete medical insurance coverage. If the tachycardia is due to anxiety and a more complete and scientific diagnosis is established, i.e., psychoneurosis-anxiety reaction with tachycardia, the insurance benefits would vary with the provisions of the policy. These provisions vary from no coverage to coverage approximating medical and surgical coverage, but in no instance as complete.

The establishment of a complete, descriptive, etiologic diagnosis is the goal of every physician. With his psychiatric patients he must struggle with the problem of making a complete diagnosis, as a result of which his patient will suffer financially, or making an incomplete, not necessarily incorrect diagnosis so that his patient may derive greater financial benefits.

The writer of the editorial suggests that the search, sometimes unreasonable, for an organic diagnosis, results in repeated laboratory procedures and consultations which result in greater expense to the patient, and to the insurance plans, and further traumatizes the patient. If present, the establishment of a psychiatric diagnosis is believed essential if the patient is to understand the nature of his illness and to be spared repeated hospital admissions in a search of organic disease. More freedom in this important diagnostic area would make hospital diagnostic statistics more accurate and prevent insurance influences from placing an additional stigma on psychiatric diagnosis.

Doctors, too, like "Premarin"

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them - it replaces what the patient lacks - natural estrogen.

Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms before the menopause and even after, "Premarin" takes care of that, too.

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EDITORIAL

BAIT

In times past, doctors attended local medical society meetings to learn something from their colleagues and, perchance, to pass on something from their own experiences. Incidentally they enjoyed the congenial atmosphere attendant upon association with others in the profession.

As time has passed, various influences have detracted from the popularity of meetings of the local societies. The greatest influence seems to have been the great increase in number of meetings, some of which demanded attendance. There are staff meetings, regional and sectional meetings of “Colleges,” “congresses” of various kinds, refresher courses, world postgraduate tours, and now the “colloquy” among many others not mentioned. Doctors could be baited only by widely known speakers from afar. Even our annual sessions of the State Medical Association had to be bolstered by a long list of Big-Name speakers, thus depriving members of the privilege of participating actively in the sessions.

Rules and tradition demanded that constituent societies meet regularly to transact business and give the appearance of active, aggressive medical societies. Being financially unable to use nationally known speakers as bait, even if they were available, some have fallen back upon the appetite to bolster attendance records. The bait now is, in this order, alcohol, food, speaker. After an hour or more over the cups, a heavy meal is eaten. During the postprandial period of tranquility and drowsiness produced by alcohol and a full stomach, the speaker is introduced. He must be unusually dynamic to break through the mental fog of his audience and leave a lasting impression.

An editorial in the Illinois Medical Journal for April, 1958, is, in itself, evidence that the bait of alcohol and food is used rather widely. The writer of that editorial has the following to say:

“For the time the speaker is introduced, his first chill reaction sets in. The sensible, thought-provoking study he has prepared is not suitable at this time. His colleagues would prefer gay, light-hearted entertainment.”

If doctors do not wish to abandon the tranquilizing somnificents, food and alcohol, and get down to the business of having county society meetings with a real educational kick to them, why not meet only to transact business, and stop pretending.

ASSEMBLY LINE RESEARCH

Research is not an impersonal, assembly line project comparable to making a machine. While lack of funds is sometimes a deterrent to privately conducted research, more than money is required to initiate, pursue, and successfully conclude study of a problem that is born of man’s intelligence and imagination—a project that seeks undiscovered truths. Such a piece of work is as truly a journey into the unknown as a trip into outer space would be.

The health-field in general seems to have triggered something akin to mild insanity among Congressmen. Knowing little or nothing about medicine and related sciences, Congress appropriates more and more of the Nation’s money for “health” purposes; and not a little of this appropriation is earmarked for use in the field of “research.”

For a long time it has been an accepted principle that what the Government subsidizes it controls. Justice Robert H. Jackson expressed this principle in 1942, when he said: “It is hardly lack of due process for the Government to regulate that which it subsidizes.” For the sake of emphasis let us picture in our minds’ eye a Congressional committee sending out a set of directives to its research workers to find the cause and cure of this or that disease. They might go so far as to set a deadline-date for reports satisfying the terms of the directives and penalizing failure by veiled threats of loss of status or job.
Such considerations as these, expressed in less ludicrous, more gentle, and somewhat indirect language may have motivated the National Foundation for Infantile Paralysis to say: "There is a growing concern over the tendency of government to pre-empt medical research in this country." And again, "One way to make democracy work is to create voluntary groups that give the individual a chance once again to take back some of the control of his own life that has seemed to slip away—to give him a chance to participate productively in the affairs of his community."

DESTINY OF THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

When it became obvious, in 1952, that paralytic poliomyelitis could be and would be abolished, the National Foundation was confronted with many weighty decisions the first of which was "Should it complete its work in poliomyelitis and then terminate its activities? Or should it turn to newer and greater challenges?"

A great number of truths about the Foundation had to be considered. One of the most significant items is the fundamental character of the institution and the values derived from this character. The N.F.I.P. has always been supported by individual donations by a great many of our citizens without being subsidized or suffering interference by the Government. Any accomplishments such as eradication of paralytic polio rightfully make the individual citizens proud that they have had a direct part in saving lives and reducing morbidity in their fellowmen.

Another important character-item is that this Foundation was able to raise hundreds of millions of dollars and could, therefore, do things the "small-budget" organizations could not undertake. Because no strings were attached beyond the moral responsibility to account to the citizens who gave the funds, much greater risks could be assumed whenever it seemed there was a fair chance of success. An example of the advantage of having ample funds was the ability of the Foundation to set aside $19 million for one item—gamma globulin—when the occasion demanded. Another example is that it could and did underwrite the cost of extensive preliminary clinical trials of Salk vaccine. The "calculated risk" is exemplified by the expenditure of $9 million for the purchase of Salk vaccine before the true value of this agent had been proved. Taking this risk permitted earlier, more rapid vaccination of more susceptible people than could possibly have been accomplished had this risk not been assumed.

To be considered, also, were accomplishments of the Foundation other than in polio. In the course of research on polio, many other fields had been probed, such as other viruses and the diseases they cause, notably the encephalitides; tissue culture and the characteristics of the cells thus grown; the hospital care of polio patients and, indirectly, that of other patients; rehabilitation; professional education related directly or indirectly to the care of polio paralysis; and others. It is believed that truths turned up in the study of polio will be of definite value in the fight against cancer, heart disease, mumps, and others.

Consideration of the items we have mentioned and of many others, aided by extensive, multiple surveys of public opinion led to the firm belief that the Foundation should continue to exist in its original role as an institution supported by private donations from many people. Furthermore, a careful consideration of a large number of diseases and conditions, and the present status of knowledge concerning them led to the conclusion that the chosen field or fields should be "area(s) of major, unmet needs."

The following quotation reveals the position finally adopted as to the future of the National Foundation:

"It is proposed that the National Foundation for Infantile Paralysis expand its objectives to become an organized force for medical research, patient care, and professional education . . . flexible enough to meet new health problems as they arise. Initially, it would continue to work in poliomyelitis and the virus field, adding to it work in arthritis and birth defects. But it would not stop there. It would follow leads as they develop and accept challenges as they occur, not confining its support to any particular disease or group of diseases."

(Facts and quotations were taken from a booklet by the Foundation, No. 5, July, 1958, entitled "Information for Physicians.")
Food Sanitation in Nebraska

Doctor Lyman gives the reader a vivid description of the status of food-sanitation in Nebraska. He includes restaurants, food stores, the killing and handling of animals for food, and the milksheds. His analysis of our laws and our methods of inspection and licensure leaves little doubt that a revision and modernization are needed and that little improvement can be expected until these basic requirements are met.

INCIDENCE OF FOOD-BORNE DISEASE

No reliable figures exist to indicate the true incidence of food poisoning and of food-borne disease in this country. Only occasionally is attention focused on this problem and then usually through the occurrence of a major outbreak of food poisoning.

Recently, an outbreak of salmonellosis among parishioners of an Omaha church involved approximately 1000 of 1500 persons. During 1957, five major outbreaks with an estimated number of 1500 stricken individuals were reported to the Omaha-Douglas County Health department. Groups involved included a boys' camp, a village centennial, a church, and two banquets, one at a steak house and one at a large hotel.

The report of one outbreak often leads to the disclosure of one or more others. Thus an apparent epidemic of outbreaks may ensue depending upon how much interest has been aroused.

It is estimated that one-half of the American public eats in public eating establishments at least one meal every day. One could logically assume, then, that from the 80,000,000 meals served each day hundreds of cases of food-borne diseases result. Of these, only a fraction are recognized or reported as stemming from food sources.

Failure to recognize food poisoning or food-borne disease by either the patient or the physician is perhaps the chief reason for incomplete reporting. Ordinarily it is difficult and of questionable value to attempt to establish a diagnosis of food poisoning in an isolated case exhibiting symptoms of vomiting, diarrhea, fever, and prostration. If the physician, however, learns that his patient has been a member of a group with a definite exposure to a common meal and that others likewise became ill with similar symptoms, establishment of a diagnosis becomes simplified. Most meals are consumed by individuals singly or in very small groups so that the physician loses the advantages to be gained through comparison.

Fear of becoming involved, a misdirected desire to protect a restaurant or hotel, and the absence of a suitable office to which a report can be directed, also serve to deter one from reporting. An incomplete picture of the nature and extent of the problem accordingly results.

The incidence of food poisoning and food-borne disease remains high and should cause us in the medical profession to ask how this can be. Today, we have considerable knowledge of the cause and spread of these diseases, and their prevention depends upon putting into effect elementary practices of good food sanitation. Means of prevention are so well understood that an outbreak of food poisoning is truly inexcusable.

PHYSICIANS AND FOOD SANITATION

The medical profession long has been concerned in the sanitary control of foods and food products destined for human consumption. In their efforts to prevent disease, physicians have taken leadership in promoting food sanitation. Physicians have occupied positions of prominence in battles waged to secure safe water supplies, Grade A milk, and sanitary practices in public eating establishments.

The struggle to attain and maintain high standards of sanitation throughout the food industry has not been won. The very nature of the problem is such as to be never ending.

*Read before Annual Convention Nebraska State Medical Association, May 1, 1958.
GOVERNMENTAL REGULATION
OF FOOD SANITATION

Laws have been passed on all levels of government to protect the consumer. Federal, State, and local agencies are charged with their enforcement.

In the Federal Government the three agencies primarily concerned are the United States Department of Agriculture, the Pure Food and Drug Administration, and the United States Public Health Service. Each Department is concerned with definite areas of responsibility and possesses various means of performing its duties. The Federal agencies regulate only those industries whose products enter interstate commerce. The approach of each agency differs by law.

The United States Department of Agriculture, in regulation of the meat packing industry and now, more recently, the poultry processing industry, has established strict standards governing both the ante- and post-mortem inspection of livestock and also the sanitary operation of plants. Published standards exist and are enforced by a full inspection corps present at all times during the whole of the slaughtering operation. Inspection is carried out for the most part by lay inspectors under the direction of veterinarians. The United States Department of Agriculture recognizes no other inspection than its own, and what little dependence it now places on local and state inspection services is being withdrawn. In Nebraska, a total of 25 meat packing plants, of which 18, or 72 per cent, are situated in Omaha, are under Federal inspection.

The Pure Food and Drug Administration has published standards of sanitation and quality governing food and drug products entering interstate commerce without being covered by the United States Department of Agriculture or the United States Public Health Service. These standards serve as guides by which manufacturers must abide. The Administration does not provide plant inspection at all times during operation. Thus, the emphasis is upon corrective or curative measures rather than preventive measures in enforcement of the law. Such an approach has certain inherent disadvantages inasmuch as the Department must proceed largely upon a complaint-basis and not upon a program-basis. Under such circumstances the relationship between the regulator is certain to be somewhat strained.

The United States Public Health Service, so far as interstate commerce is concerned, is concerned chiefly with the interstate shipment of milk. To expedite the flow of milk from one state to another, the United States Public Health Service encourages states, through the state's local health departments, to provide their own inspection and control. The Service, with cooperation of industry and state and local departments, has drafted a model milk code which communities or states may adopt for their own use after such modification as is necessary. This code or its equivalent has been adopted by hundreds of communities throughout the country.

Semiannually, the Service publishes an honor roll of cities and towns throughout the country whose milksheds rate 90 per cent or more. These ratings are carried out by state Grade-A-milk raters trained and standardized by the Public Health Service. This philosophy of encouraging states and local communities to cope with their local problems locally is one which we can all heartily support. Of course it goes without saying that this procedure cannot be employed throughout the food industry.

The Public Health Service has developed other model ordinances governing sanitary handling of food that does not enter into interstate commerce. An example is the model ordinance regulating sanitation in eating and drinking establishments. The Service has gone so far as to prepare two ordinances. One provides for grading of eating establishments; the other does not. This permits communities to select what seems best to meet their particular needs.

The State Government of Nebraska vests the enforcement of sanitary regulations of the food industry in the State Department of Agriculture. The State Department of Health is not responsible for enforcement of any laws governing food sanitation in spite of the fact that such regulations are designed for the prevention of disease. The question arises as to why this happened. The forty-eight states follow three basic patterns in the enforcement of regulations. In some, all inspections are carried out by the agricultural department; in others, by the health department; and in many the responsibility is shared.

Nebraska S. M. J.
In agricultural states, the first pattern is generally followed. In Nebraska, the agricultural department is designated as the inspection agency of the state government and therefore must carry out all inspection work required. This practice of having but one inspection service, although adopted by economy-minded legislatures to avoid duplications, is in itself a wasteful and costly procedure.

In local government the community turns to the local health department for enforcement of sanitary regulations relating to food and milk. In the mind of the public this is a matter involving health rather than agriculture. In Nebraska, unfortunately, there are not more than four full-time local health departments and in only two of these is there a full-time physician to give direction.

STATUS OF FOOD SANITATION IN NEBRASKA

Of all segments of the food industry in Nebraska, perhaps none has operated under sanitary regulations for as long a period as the meat packing industry. Exposures of flagrant insanitary conditions existing in slaughter houses and abattoirs in the early 1900's led an aroused public to take action. This came in the form of Federal legislation governing plants engaged in interstate commerce. Today, Federally inspected packing houses assure the customer of adequate protection. Many packing houses throughout the State do not have Federal inspection. Although licensed by the State Department of Agriculture, the inspection is made by local veterinarians paid directly by the plant under licensure. An elementary principle, basic to good inspection service, is that the inspector be paid by the inspecting agency and by no one else. No money should ever pass between the inspector and the inspected.

In 1954, the City of Omaha modified the meat packing ordinance in such a manner as to prohibit the sale of meat within the city limits unless from a plant under Federal inspection. All meat sold in Omaha after July, 1958, will be from Federally inspected houses. State inspection is not recognized.

Great gains have been made in the sanitary quality of milk. Until 1953, however, the only control of milk supplies in Nebraska was exerted through local municipal ordinances. In that year the State Legislature passed the State Grade A Milk law.

Under this law milk could only be labeled Grade A if produced and processed under Grade-A standards. Other grades could still be sold but could not bear the Grade-A label. The 1957-legislature modified this law so that, in 1959, only Grade A milk can be sold for human consumption in fluid form. At present, Grade A pasteurized milk is available in every city, village, and hamlet throughout the State. The milk law is enforced by the State Department of Agriculture, but the Department recognizes inspections and licensure by local health departments where this is done. In this manner local regulation is encouraged and duplication of inspection and licensure avoided.

The gains made in milk sanitation, particularly in the past ten years, have been made possible only through cooperation of producers, haulers, processors, and sanitarians of the health departments. Sanitation has been good business for the milk industry.

At the present time only one milkshed in Nebraska rates over 90 per cent. This is the Omaha shed from Atlantic, Iowa, on the east to near Grand Island on the west. The 950 producers in this area shipping milk into Omaha, rate 92 per cent. Recent conversion to bulk milk production at an estimated cost of $5,000,000 to farmers on the Omaha and Lincoln sheds has aided materially in improving milk sanitation. This conversion was made by action of the Milk Producers Association itself and was not a governmental requirement.

Much remains to be done in the improvement of sanitation of public eating establishments such as restaurants, cafes, taverns, fountains, schools, and hospitals. Anyone traveling in the State of Nebraska is well acquainted with the scarcity of good sanitary places at which to eat. Just five cities have adopted the United States Public Health Service model ordinance governing sanitation in such establishments. These are Grand Island, Hastings, Lincoln, Omaha, and Scottsbluff. Only in these communities, through their local health departments, is any effort made to improve conditions.

All eating establishments are under the inspection and licensure of the State Department of Agriculture. In the above-named communities it has been recognized that inspection by the State agency is inadequate and ineffective, and thus additional inspec-
tion by local government has been provided to meet the problem.

With half of our population eating out at least one meal every day, either through choice or more often through necessity, it is incumbent upon us to see that safe sanitary establishments are provided.

There are two aspects to a program of sanitation aimed at upgrading public eating establishments. First, proper facilities and equipment are a prerequisite to a satisfactory sanitary operation. The acquisition of facilities and equipment is comparatively simple. Much is known about design of efficient, economic layouts for food service. Likewise equipment tested and approved by the competent non-profit organization known as the National Sanitation Foundation is available. Second, there is need for understanding on the part of management and food handlers as to what constitutes good food-handling practices. Facilities and equipment are of little value if the food handler ignores sanitation. Such equipment is designed to assist the operator to effect a sanitary operation and cannot be considered license to violate good practices. Education is the basis for all sanitation programs, and in no area is education more needed or more productive than in that of food service.

Food sanitation programs should not be built up around the highly questionable practice of physical examinations of food handlers. Every food handler must be considered to be, at all times, a potential danger to the public. The public finds greater protection in a food handler who follows sanitary practices than in one who has passed an annual physical examination probably consisting of an X ray for tuberculosis and a Wasserman for syphilis. On brief reflection it is obvious that neither disease is likely to be spread through consumption of food in an eating establishment.

Sanitary practices in grocery stores, meat markets, and food processing establishments not engaged in interstate commerce are, as a rule, deplorable. Although such establishments are inspected by the State Department of Agriculture, the department is seriously handicapped by the inadequacy of applicable laws.

Omaha first became concerned with sanitation in grocery stores as a result of an outbreak of food poisoning due to nicotinic acid in meat. This was reported in the May, 1957 issue of *The Nebraska State Medical Journal* and is the first report of such an occurrence. A subsequent survey of 354 grocery stores and meat markets in Omaha revealed that 69 per cent failed to meet minimum sanitation standards. Six stores had no running water; 80 had no hot water or facilities to heat water; 27 took the equipment home to be washed; and 3 washed equipment in discarded bath tubs. This one item is indicative of the general sanitary practices and facilities in grocery stores and meat markets.

State law is so inadequate as not to require warm or hot water or even running water. The law merely states that the water must be clean. There are, moreover, no provisions demanding refrigeration. This is understandable, for effective mechanical refrigeration has developed largely since passage of the last relevant state food-sanitation law in 1929.

The Omaha-Douglas County Medical Society has become alarmed at the findings contained in this survey and has appointed a committee consisting of Doctors Read, Giffen, and Potthoff to study ways and means of effecting improvement. It is obvious to those of us engaged in sanitary regulation that, eventually, a code or ordinance providing local inspection and enforcement must be adopted. A survey of the fifty largest cities of this country revealed all but six, Omaha included, had local ordinance enforced by the local department of health.

**RELATIONSHIP OF ENFORCING AGENCIES**

It has been shown that within the State of Nebraska sanitation inspection of food is provided by Federal, State, and local governments. There is evidence in many instances of close cooperation among inspection agencies, and, likewise, there is evidence of duplication in inspection and licensure. Much can be done to avoid such duplication and to gain even more harmonious working relations between inspecting agencies. Encouragement and recognition by state agencies of local control, wherever possible, might be considered a first step to this end. The best example of recognition of local inspection can be found in the field of milk sanitation. Here, as stated previously, the United States Public Health Service depends upon the
State for inspection service and in turn the State recognizes local inspection work where it is competently performed.

RECOMMENDATIONS TO FURTHER FOOD SANITATION IN THE STATE OF NEBRASKA

The following are recommendations to further food sanitation in the State of Nebraska:

1. The medical profession could do much to upgrade sanitation in the food industry by encouraging a greater interest among its members in food poisoning and food-borne disease. Reports of possible cases of food-borne disease by physicians make possible initiation of epidemiological studies which work wonders in effecting sanitary improvement, not only in individual stores but also in the industry as a whole. Had not a physician reported two families showing symptoms of nicotinic acid poisoning, the Nebraska State Medical Journal would not have registered a first in an original paper nor would the whole problem of sanitation in grocery stores and meat markets been brought under scrutiny so soon.

2. Transfer of responsibility for sanitary inspection of food industry from the State Department of Agriculture to the State Department of Health should be made at an early date. The basic reason for such inspection is for the purpose of health protection and therefore should be under direction of personnel trained in the field of health. State laws should be so written as to encourage local control of local problems. Local inspection should be recognized so that duplication of inspection and licensure may be avoided.

3. Modernization of State and local laws as to items of sanitation should be undertaken. Such laws should cover all segments of the food industry and should be enforceable.

4. Every effort should be made to secure adequate and qualified sanitation staff both in the food industry and in government inspection agencies. Inasmuch as the program must be based on education and leadership, it is advisable that sanitarians be college graduates with training in the physical and biological sciences. Second-rate sanitation personnel cannot be tolerated by the food industry, the public, or the medical profession. Qualified staff can be justified from an economic viewpoint alone if for no other consideration. Qualified personnel in both industry and government make it possible for harmonious relationships between both groups. Where dissension occurs, it is usually due to lack of such staff on one or both sides. Sanitation programs can be built only on mutual confidence, trust, and faith, and never upon fear.

Early diagnosis and treatment of an allergy can play an important role both in providing greater relief and forestalling complications, according to the publication "Patterns of Disease" prepared by Parke, Davis & Company for the medical profession. In a study of 972 allergy sufferers, patients under 20 were found to have much better prospects of obtaining "marked relief" from various types of allergy, except hay fever, than did older people. However, adults suffering from hay fever have far better prospects of obtaining relief than people with other allergic complaints.

Although, according to "Patterns," it has been stated that the odds are 8 or 9 to 1 that a child with asthma will 'grow out of it'," many asthmatic children develop severe complications difficult to treat.

Treatment of major allergies in early childhood, including hypersensitization against pollen and other inhalant allergens, may prevent not only asthma and hay fever but also reduce the frequency of recurring upper respiratory infections.

Safety campaigns against industrial accidents have paid valuable dividends, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. It reports that over a 10-year period ending in 1956 injuries per million man-hours dropped more than half.

For the time being, neither doctors nor hospitals will have the exclusive radio frequencies they are attempting to obtain. They were temporarily turned down by the Federal Communications Commission in one category, but will continue their efforts to obtain the frequencies for emergency as well as day-to-day communications.
Mitral Stenosis
University of Nebraska Hospital
A Medical-Surgical Conference

Dr. R. L. Grissom:

Almost 10 years ago, on June 24, 1948, the first commissurotomy on a patient with mitral stenosis was done by Dr. Charles Bailey of Philadelphia. That patient is still living and well. Since then mitral commissurotomies have been done all over the world. There has been a lot of discussion as to whether this operation should be called "mitral valvotomy" or "mitral valvuloplasty," but the term "mitral commissurotomy" is the one that seems to be most used. Today, we have 4 patients, all with mitral stenosis, but each with other problems as well. The question is whether they are suitable for mitral commissurotomy; all have been recommended for this procedure by at least one individual. The patients will be presented in the order listed in the chart. Because we have four patients and must finish on time, we will present them briefly. The first patient will be presented by Dr. Blackard.

Dr. Clyde Blackard, Intern:

Our first patient, now 34 years old, had rheumatic fever at the age of seven. Following this, he says, he had an enlarged heart with a leaking valve. However, he was in no real trouble until November 28, 1957, at which time he suddenly lost his speech and some of his memory. He recovered from this after two days and was well until December 7, 1957, when he suffered a right hemiparesis and further loss of memory and speech. This lasted four days. Though his recovery was nearly complete, he still has very slight residual hemiparesis on the right side. He is normally left-handed. The cardiac examination shows: apical impulse in the 6th intercostal space at the anterior axillary line; irregular rhythm with an apical rate of 70; the BJ 128/86. At the apex there is a loud diastolic rumble, a soft blowing systolic murmur, an accentuated first mitral sound and an opening snap. An ejection type murmur has been heard faintly at the aortic area by one or two observers. Some of us thought he had basal rales at the time of admission and others did not.

He has had no dependent edema. His C-reactive protein is negative, his sedimentation rate is 2, and the anti-streptolysin titre is 100, all normal findings. The electrocardiogram shows evidence of left ventricular hypertrophy perhaps combined with right, and he has had a gallop rhythm. The patient's only medication is dicumarol. (The patient is brought in on a cart, but is in no obvious distress).

Dr. Grissom:

Thank you, Dr. Blackard. You observe that he is not orthopneic. Could you tell the people here about your stroke?

1st Patient: Well, I guess it came on awful quick. I was working there at home. All at once I couldn't move either my arm or my leg on the right side. Everything just went numb. I even sat on my leg and arm getting into bed, and I didn't realize I was twisted.

Dr. Grissom:

I have asked him to describe his stroke so that you will appreciate the degree of his recovery. His speech is normal; on casual observation an observer might not notice any weakness or disability. (The patient leaves).

Dr. Fred Ware, Resident in Internal Medicine:

Until he became ill with his stroke he was able to work fifteen hours a day at his job. This shows that physical incapacitation from his mitral stenosis had not been a problem. If surgery is advised it should be on the basis of reducing the likelihood of subsequent emboli.

Dr. Shaun Gunderson, Radiologist:

Radiographs consisting of a PA, left lateral and both oblique views were taken at
the time of fluoroscopy. I will summarize
the radiographic features. (See Fig. 1).
There is cardiomegaly, measuring approxi-
mately 15 per cent above expected limits for
his height and weight. The lateral view
shows some esophageal displacement con-
sistent with left atrial enlargement, and
there is minimal encroachment on the infra-
bronchial angle. In the left anterior oblique
view there is suggestive left ventricular en-
largement. Beyond that there is no cham-
ber enlargement. The aorta is relatively
small. I think there is minimal increase in
the pulmonary vascularity especially in the
primary branches. There is no evidence of
parenchymal fibrosis that would suggest pul-
monary infarction, and no evidence of septal
lines.

Figure 1. See text: Left atrial and suggestive evidence for left ventricular enlargement; slightly in-
creased pulmonary vascularity.

Dr. Clem Hagedorn, Intern:

Our 2nd patient is a 48-year-old gravel-
worker. He had rheumatic fever at age 17.
It was manifested by joint pain and fever.
He remained in bed for seven days at that
time. About ten days later he had a tonsil-
lectomy. Thereafter he was asymptomatic
until 1953, when he had pneumonia. Since
that time he has had dyspnea with exertion,
mainly on going up hill when he worked in
a gravel pit. As long as he walked slowly
on the level, he had no dyspnea. In Septem-
ber of 1957, a mobile chest X-ray report
stated that he had an enlarged heart. He
was first seen in our Internal Medicine Clin-
ic on the 19th of December at which time
he was digitalized for the first time. When
he returned to the Clinic, two days later, he
had a cerebral vascular lesion with a right-
sided hemiplegia. He recovered from the
stroke completely in two or three days. He
was thought to be in mild failure, but with
appropriate diuretics he improved rapidly.
The important cardiac findings are summa-
rized in the chart. We believe that the sounds
are typical for mitral stenosis, with pulmon-
ary hypertension and a Graham Steell mur-
mur of pulmonary insufficiency. The lack
of an opening snap sound made us wonder
if the mitral valve was so damaged that it
could not be mobilized surgically to become
an effective valve.

Dr. Grissom:

Thank you, Dr. Hagedorn. (To the pa-
tient). How are you feeling now as com-
pared to the way you felt when you came to the hospital?

2nd Patient: Better. I'm not as short of breath.

Dr. Grissom:
Are you looking forward to an operation on your heart?
2nd Patient: I'm ready and waiting.

Dr. Ware:
His murmurs, particularly the systolic ones are much less prominent now than they were when he entered the hospital. There was congestive failure with hepatomegaly then.

Dr. Gunderson:
The chest films exhibit cardiomegaly with a transcardiac diameter of 162 mm. (See Fig. 2). He has left auricular enlargement and also right ventricular enlargement as manifested by obliteration of the retrosternal space seen in the lateral view. His X ray shows more pulmonary vascular engorge- ment than did our first case; it also demonstrates, beautifully, the septal lines that are described with long standing mitral stenosis. At fluoroscopy, a calcified mitral valve was seen.

Mr. Gordon Johnson, 4th Year Medical Student:
Our 3rd patient is a 40-year-old white woman. She entered the University of Nebraska Hospital for the first time on January 24, 1958, with the chief complaint of inability to do her housework since February, 1957, because of dyspnea, weakness, and tiredness. As a child she had frequent bouts of tonsillitis, sore throats, and ear infections until she had a tonsillectomy at the age of 17. At the age of 15 an enlargement of the thyroid was discovered for which she took Lugol's solution for five years. Rheumatic fever was diagnosed at age 20, in 1938, because of migratory polyarthritis, edema of the feet, and a heart murmur. She has had no recurrences of rheumatic fever. In 1940, she had an uncomplicated pregnancy and delivery. In 1944, she had an appendectomy without difficulty. In 1946, while pregnant the second time, at five months gestation, she had an episode of congestion

Figure 2. See text: Left atrial and right ventricular enlargement; pulmonary vascular engorgement; "septal" lobular lines in periphery of lungs laterally.

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of the lungs with dyspnea, cough, and hemoptysis. Delivery, however, was without complication. Two days after the delivery she developed a blood clot in the left eye which has left a residual scotoma. In 1948, she had a cholecystectomy without complications. In 1950, she again became pregnant, but at two months a therapeutic abortion was performed because it was thought her cardiac status made pregnancy hazardous. After the abortion she had a severe hemorrhage, requiring transfusions. In 1954, following a panhysterectomy, she developed a pulmonary embolism. This cleared up within ten days, but she has had “three-pillow” orthopnea since. In April, 1957, she says her heart began to fibrillate and she developed dyspnea, tiredness, and edema for which she was placed on digitalis and a low salt diet. She now has dyspnea after walking one-half block or when climbing stairs at an ordinary rate. The C reactive protein was elevated to 4+ on one occasion, but the second time it was negative.

Dr. Grissom:
Thank you, Mr. Johnson. (To the patient): Would you tell the doctors here whether it is excessive tiredness, or is it shortness of breath which gives you the most trouble?

3rd Patient: It is as much one as it is the other.

Doctor:
Have you been frightened at any time by this blood you spat up?

Patient: Yes, I was very much.

Doctor:
How do you feel about having an operation?

Patient: Scared to death.
from her height and weight. (See Fig. 3). There is left auricular enlargement; and there is suggestive evidence of right ventricular enlargement in addition. The primary pulmonary vascular pattern is a little accentuated. There is some fibrosis in the right upper lobe which may be residual from her previous infarction.

Dr. Ware:

She is a nervous individual and becomes frightened very easily. When she first came into the hospital she was upset because she stated we had been telling her things here that contradicted what her home physician had told her about possibilities of surgery. She has been depressed fearing that she is becoming bedridden. I think all of us who have seen her feel that some neurotic complaints contribute to her disability. We try to encourage her to be up and around as much as possible. It is possible that part of her fatigue is due to functional disorders rather than heart failure.

Mr. Richard Hill, 4th Year Medical Student:

Our 4th patient, a 39-year-old white woman, entered the University Hospital for the fifth time on January 27, 1958, for evaluation of mitral stenosis. She had scarlet fever at age eight and rheumatic fever was diagnosed following that. She states she had uncontrollable shaking of her hands from her ninth to twenty-third year, and was told by her physician that it was St. Vitus's dance. During her second pregnancy she was told she had an enlarged and leaking heart. She had slight exertional dyspnea through the 1940's, and, in 1950, she had an episode of unexplained chills and fever followed by a worsening of the exertional dyspnea. She now has dyspnea upon walking rapidly 20 to 30 yards, and cannot climb a flight of stairs without resting. She claims "two-pillow" orthopnea, and a cough which is rarely productive, never blood-stained. She denies ever having had edema. She has had an undiagnosed illness since 1942 with the primary features of splenomegaly, leukopenia, and an elevated total serum protein with the globulin fraction varying from 3.6 to 5.2 Gms. The bone marrow examinations have been inconclusive. Splenic biopsy, in 1952, showed no hematopoietic activity. The sedimentation rate has been consistently elevated, ranging from 14 to 55 since 1951. Thymol turbidity (now 17.3 units) and cephalin flocculation (now 4+) have been consistently elevated, while the bromsulphalein and alkaline phosphatase show no elevation. LE preparations have been negative. In addition to the physical findings listed on the chart, she has a few small punctate scars on her forearms and on the upper back between the shoulders; the liver and spleen are still palpable.

Dr. Grissom:

Thank you, Mr. Hill. (To the patient) Are you having any difficulty today with shortness of breath?

4th Patient: Well, I do when I get out of my bed and when I get from the chair to my bed.

Doctor:

Do you ever wake up during the night short of wind?

Patient: No.

Dr. Gunderson:

Our fourth patient exhibited moderate cardiomegaly with a transcardiac diameter of 160 mm. (See Fig. 4). She has left auricular enlargement and minimal right ventricular enlargement as well as left ventricular enlargement. There is accentuation of the pulmonary vascular pattern. She does have fine septal lines in the peripheral lung fields, evident in the PA view particularly. In 1951 her PA chest film showed quite a similar situation with the exception of some increase in heart size since then. In 1951 it measured 140 mm, now 162 mm.

Dr. Grissom:

I would like to open the discussion now for consideration of the four patients and for the general subject of mitral-valve surgery. Dr. Hubbard, do you wish at this time to commit yourself about these patients, or to make any comments about choosing patients for mitral-valve surgery?

Dr. Hubbard:

It is very difficult to comment on these patients specifically in the time allotted. In general, the ideal indications for mitral commissurotomy are "pure" mitral stenosis and Class 2 symptoms provided there are no contraindications. The diagnosis of "pure" mitral stenosis is made with the greatest facil-
ity—and there is no substitute for this, nor any test which parallels it in importance—by careful auscultation of the heart. There are two main points to be established, both requiring skillful physical examination. The first, to establish that the heart lesion is just mitral stenosis, without other complicating valvular lesions; and second, that it is the kind of valve which will yield to surgical opening, and still leave a valve which opens freely in diastole and doesn’t leak.

flexible valve, the essential auscultatory phenomena are the low pitched diastolic apical murmur, the opening-snap-sound, the accentuated, crisp, high-pitched first mitral sound. The second heart sounds result from closure of the semilunar valves. A short period after this (from 0.05 to 0.12 second) we hear a sharp snap which results from ballooning down of the flexible, though stenotic, mitral valve into the ventricle. When the valvular disease has resulted in a rigid

We’re finding now that patients with rigid, inflexible valves do poorly after surgery. Such a patient will get in trouble within a year or so after surgery with restenosis or insufficiency.

In mitral stenosis the major dynamic abnormality is the obstruction to the diastolic filling of the left ventricle, and the essential hemodynamic feature is a significant pressure gradient between left atrial pressure and left ventricular pressure in diastole. Normally, ventricular filling takes place with so little resistance that there is no significant gradient in diastole between left atrium and left ventricle.

In the presence of mitral stenosis with diaphragm no opening snap sound will occur or, if it occurs, it will have a dull, muffled tone. The diastolic rumble which starts with the opening snap is indicative of turbulent flow during diastole from left atrium to left ventricle. A good snapping, high-pitched mitral first sound, the closing snap, occurs during isometric ventricular contraction when the pressure in the left ventricle exceeds that in the left atrium. At this instant the valve leaflets are snapped into a reversed position ballooning into the atrium. Again, when the valve is too rigid, very little leaflet motion occurs and the sound will be a low-pitched and muffled one.

At about the time of auricular contraction,
the A-V flow may increase a little and with the movement of the valves a crescendo high-pitched sound is produced. This sound occurs in presystole and in early isometric ventricular contraction, but we call it presystolic because it occurs before the phenomena which cause the first heart sound.

Dr. Grissom:

You wouldn’t say this presystolic accentuation necessarily depends on the presence of atrial contraction and sinus rhythm then?

Dr. Hubbard:

It is a function of both these phenomena. Now, in young individuals we often hear a third heart sound. This is the sound that occurs during the peak of rapid filling of the ventricle. When the A-V valves first open in the normal individual there is a rapid flow of blood from atrium to ventricle. The peak of this rapid flood produces a little positive wave in the left ventricular pressure trace and causes a small sound. In pure mitral stenosis this sound is never present. This little wave doesn’t occur in mitral stenosis because there is a slow filling of the ventricles throughout diastole with almost constant steady flow, not a rapid phase followed by a slower phase. If we do hear a third heart sound, it is an indication that the patient does not have pure mitral stenosis but more likely a widely open valve, quite often with ventricular dilatation and predominately mitral insufficiency. This third heart sound of mitral insufficiency and the opening snap sound are easily confused, but there are ways in which you can differentiate them. The principal clue in examination of the heart is by palpation of a small positive impulse at the apex. This will not occur with pure mitral stenosis. The third sound usually occurs somewhat later than an opening snap sound.

| TABLE 1 |

<table>
<thead>
<tr>
<th></th>
<th>1st Patient</th>
<th>2nd Patient</th>
<th>3rd Patient</th>
<th>4th Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Male</td>
<td>Male</td>
<td>Female</td>
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</tr>
<tr>
<td><strong>Age</strong></td>
<td>34</td>
<td>48</td>
<td>40</td>
<td>39</td>
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<tr>
<td>Previous peripheral failure</td>
<td>0</td>
<td>+++</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Peripheral embolism</strong></td>
<td>twice</td>
<td>twice</td>
<td>once</td>
<td></td>
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<tr>
<td>Previous pulmonary symptoms</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Hemoptysis</td>
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<tr>
<td>Paroxysmal nocturnal dyspnea</td>
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<td>+</td>
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<tr>
<td><strong>Apical diastolic rumble and thrill</strong></td>
<td>+++</td>
<td>+++</td>
<td>++++</td>
<td>+++</td>
</tr>
<tr>
<td><strong>Apical systolic murmur</strong></td>
<td>++</td>
<td>+</td>
<td>0</td>
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<tr>
<td>Opening snap</td>
<td>Sharp</td>
<td>Absent</td>
<td>Slight</td>
<td>Sharp</td>
</tr>
<tr>
<td>1st mitral sound</td>
<td>Sharp</td>
<td>Dull</td>
<td>Sharp</td>
<td>Sharp</td>
</tr>
<tr>
<td>Parasternal lift</td>
<td>0</td>
<td>+</td>
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<tr>
<td>Complicating valvular disease</td>
<td>0</td>
<td>Graham Steell murmur of pul. insufficiency</td>
<td>Soft aortic syst. &amp; diast. murmurs</td>
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<tr>
<td><strong>Accentuated P2</strong></td>
<td>P2= A2</td>
<td>P2= A2</td>
<td>P2= A2</td>
<td>P2= A2</td>
</tr>
<tr>
<td><strong>Apical Impulse</strong></td>
<td>6th intersp. ant. ax. line</td>
<td>5th intersp. mid clav. line</td>
<td>Diffuse 5th intersp. outside mid clav. line</td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>128/86</td>
<td>104/70</td>
<td>110/70</td>
<td>120/70</td>
</tr>
<tr>
<td>Rhythm</td>
<td>Atrial fibrillation</td>
<td>Sinus</td>
<td>Atrial fibrillation</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>ECG</td>
<td>Combined left &amp; right hypertrophy</td>
<td>Right vent. &amp; left atrial hypertrophy</td>
<td>Probable right ventricular hypertrophy</td>
<td>No ventricular dominance</td>
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</tbody>
</table>

It is also possible to estimate the degree of mitral stenosis by these acoustic phenomena. The shorter the interval from the aortic second sound to opening snap, the greater the degree of mitral stenosis. Likewise, with phonocardiography the time from the q of the EKG to the first vibrations of the first heart sound is inversely proportional to the A-V pressure gradient. Thus, by auscultation, one can estimate the degree of
elevation of left atrial pressure and pulmonary venous pressure. From the left parasternal impulse and intensity of $P_2$, one can estimate the degree of pulmonary hypertension. From the pulse volume at the wrist one can estimate the degree of impairment of cardiac output. Once it is decided that there is pure mitral stenosis one can intelligently guess the kind of valve the surgeon will have to work with. If all these things are right the patient is a good candidate and the risk is small; if there is an immobile valve the results are usually poor, the risk is high, and the patient is back within 2 or 3 years in worse condition. We are starting now to see more and more of these patients who, although they had adequate opening of the valve, had inflexible valves and results were poor.

Dr. Grissom:

If I had realized you didn't have these four patients straight, Ted, I wouldn't have called on you. I'd like to point out that the $M_1$ which Dr. Hubbard has discussed, as a closing sound of similar importance to the opening snap — the increased $M_1$, and the opening snap are present in patients one, three and four. Patient two had neither a very good $M_1$ or a good opening snap, and his is the only valve with calcification visible at fluoroscopy. I would like to ask someone who has remembered these individual patients—Dr. Angle, do you want to make some specific comments about these patients? Anything that is on your heart and soul that you wish to say?

Dr. William Angle:

I don't have anything on my conscience, particularly. I favor surgery for all of them. The contraindications are about the only things we haven't covered. One of the contraindications we have the greatest trouble evaluating is the presence of rheumatic fever. This is a contraindication in two senses: One, that it adds potential myocardial failure to the mechanical valve problem; the other, that these people will do much better by treating their rheumatic fever than by operation. In the fourth patient the elevated sedimentation rate is probably due to the complicating undiagnosed illness causing abnormal globulins rather than to rheumatic fever. Other errors in diagnosis come to mind also. One is the presence of some other lesion that mimics mitral stenosis, such as atrial septal defect. Another problem in evaluation is identification of the Graham Steell murmur as differentiated from aortic insufficiency. This is sometimes a problem, although it is difficult only when the aortic insufficiency is of mild degree and consequently not of great importance. Incidentally, Graham Steell is one fellow. He described this murmur about eighty years ago and understood it pretty well. He said that whenever there is excessive pressure in the pulmonary arterial circuit over a long period of time this diastolic murmur occurs in the pulmonary valve area, and the pulmonary second sound usually produces a palpable thud. Another relative contraindication is marked pulmonary arteriolar constriction which is of uncertain genesis and uncertain prognosis after surgery. It's presence does not necessarily mean that pulmonary hypertension is irreversible, assuming a successful operative procedure. We'll learn a little bit more about this as time goes on, but in some cases we know now that it will decrease.

Dr. Grissom:

As you observe on the chart there are three of the patients who are suspected of having aortic valvular disease. It is well known that, with mitral stenosis restricting the forward flow of the blood, the aortic valve murmurs are consequently much less prominent. I'd like to ask Dr. Bisgard about his experience in doing direct left ventricular pressure tracings to demonstrate a pressure gradient across the aortic valve as a help in the diagnosis of aortic stenosis.

Dr. James Bisgard:

We have done a few readings — perhaps half a dozen — direct percutaneous needle puncture into the ventricular apex and a small number into the left atrium posteriorly. We get more definite information with simultaneous left ventricular and peripheral arterial tracings. It is not without hazard, but when there is a question it is very useful. Unfortunately it tells us almost nothing about aortic insufficiency until the degree of insufficiency becomes very gross.

Dr. Grissom:

May I now go to one more question. Dr. Bailey, whom we mentioned earlier, now favors a right anterior lateral approach.
Most people, I think, make the approach on the left, is that not correct, Dr. Bisgard?

Dr. Bisgard:

I think he rather frequently explores the atrial septum also. By making the right lateral approach he does not go through the left atrial appendage but through the left atrial wall itself. He feels he can operate on the mitral valve better, and that he is in a better position to do something about the aortic valve if necessary.

Dr. Grissom:

You do not do the right sided approach yourself?

Dr. Bisgard:

No, we have not done that approach. Most surgeons still do the left sided approach.

Dr. Grissom:

Do you take any precautions at the time of surgery to prevent embolization?

Dr. Bisgard:

Well, we used to run tape loops around the carotid arteries with the idea of this reducing emboli to the brain. I think everyone has discontinued that practice; it didn’t reduce the cerebral embolization significantly, and there was the additional hazard of interrupting the circulation to the brain. The other thing to do is to go through the auricular appendage, let it bleed freely to wash out clots before beginning manipulation, and to take special precautions within the heart itself.

Dr. Grissom:

I’d like to quote some figures I looked up last evening. Of the first 800 cases that were operated on by Dr. Harken, 139 (17%) had had preoperative embolization in one or more attacks. At the time of the operation both the history of previous embolization and the presence of atrial fibrillation increased the likelihood of embolization during the operation. However, postoperatively the incidence of embolization was very low. Out of the 800 patients followed for almost two years only 7 had emboli. Glover, in a series of 500 patients, had only one patient who threw off any clinically evident emboli postoperatively. Our series, locally, though smaller reflects a similar reduction of emboli after operation. These results indicate that the presence of embolization preoperatively becomes an indication for surgery rather than a contraindication.

Dr. Hubbard:

With the proviso, of course, the patient does not get it during surgery.

Dr. Grissom:

I would like to ask Dr. Bisgard, since you have seen all four of these patients, are you willing to operate on all of them?

Dr. Bisgard:

I think so, yes, especially the first two patients. The last patient I am not at all clear about the liver status, and how you explain her splenomegaly and poor liver function.

Dr. Grissom:

Neither are we. I think we can summarize by noting that this ideal patient Dr. Hubbard spoke about is not seen too often. I have big circles on my chart around all the relative contraindications on each of these patients; I find one or more relative contraindications in each of the four. Each case must be judged individually. Then one balances all the factors as best he can, seeks consultation to help decide which one is suitable and which one is not, and hopes he is right. Many patients who will benefit from the operation, will not be ideal; unfortunately too many patients are being operated upon who are made worse, not better.

ADDENDUM

The first patient was subsequently discharged without operation. It is anticipated that he will continue anticoagulant therapy (Warfarin®) for some time in the hope of avoiding further embolization.

The other three patients were operated upon. The second and third patients both had prolonged convalescence with “post-comissurotomy syndrome” complicating their course. The fourth patient had the most flexible valve and the most easily repaired valve at surgery and should have the best result. The associated hepatic and splenic disease did not seem to influence her recovery.

It is too early to assess improvement at this time.

Nebraska S. M. J.
What Makes My Child Allergic?*

Doctor Stafford's exposition of the causes of allergic sensitization of infants and young children places emphasis upon the frequency of this condition at these ages, the difficulties in making the diagnosis, the advantages of early recognition of allergy, and upon the various probable causes. The author believes the early feeding of various solid foods may be a large factor in sensitization of infants. In his opinion there is nothing to be gained by this early feeding of solids and the practice should be discontinued.

—EDITOR

A

N answer to the question "What makes my child allergic?" will have to be given several times each day by every physician who accepts the responsibility of caring for infants and children. Rowe1 has stated, "Allergy, next to infection, is probably the most important single etiologic agent in human symptomatology." Although it is generally accepted that about ten per cent of the adult population suffers from some major allergy2, it would seem to be a problem which occurs more frequently in pediatrics. This is evidenced by much literature on the subject and the frequency of allergic problems in pediatric practice. The frequency with which allergic diagnoses are made will vary in the individual practice depending upon the interest of the individual physician in allergic problems and upon his training and experience.

Interest and knowledge in any phase of medicine is necessary before a correct diagnosis can be made, but the problems of allergy are sometimes so indefinite that there is real danger that allergic problems be considered as infectious and occasionally non-allergic problems, as allergy. In either instance proper treatment will be neglected. The investigation necessary to solve individual allergic problems is so time consuming and tedious that the physician who shows willingness to assume the problem finds that the percentage of allergic patients in his practice increases. The true picture of the incidence of allergic disease in pediatric patients is difficult to obtain, because differences between infection and allergy are less distinct than in patients in older age groups.

A paper was recently published concerning the percentage of allergic patients seen

G. E. STAFFORD, M.D.
Associate Professor of Clinical Pediatrics.
University of Nebraska College of Medicine
Lincoln, Nebraska

in a general pediatric practice. Crook, Harrison and Crawford3 reviewed the histories of 1225 children. They found that 14 per cent of their patients were allergic and 45 per cent were not allergic. Of the remaining 41 per cent, twenty-three per cent were unknown so far as their allergic state was concerned. They classified the remaining 18 per cent as probably allergic. These figures again point up the fact that problems of allergy in children are not always black and white, but that there is a considerable number of patients who may or may not be allergic so far as we are able to tell at the present time. It is clear, however, that these authors considered one-third of their patients to be at least probably suffering from allergic disease.

Pediatric allergy is a problem of much current interest. Its incidence is likely to increase as the allergens to which we are all continually exposed increase in number and complexity. Only through consideration of the known and suspected facts about allergy will we be able to lessen its incidence. Those physicians who care for infants and children are in a position of vantage in that proper and intelligent management of the feeding and environment at the earliest possible age can delay and sometimes prevent the establishment of active allergy so that the question "What makes my child allergic?" will not have to be answered so often.

Allergy represents a protective mechanism of the human body in which normal physiology has been disturbed and it is closely related to the immunological processes. The late Bret Ratner4 has said, "Much as we would desire it, I cannot conceive of a universal cure-all for allergy. Its very nature, and its underlying antigen-antibody mechanism preclude it. Were we to discover how to prevent the development of allergic antibodies, the problem would be settled. But the essence of allergic antibodies is the very essence of all antibodies. A substance that would destroy all antibodies would obviously lead to a state incompatible with survival.

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against noxious substances. The body must continually manufacture immunizing agents. Allergy is an ever present battle against all types of foreign substances, inhaled, ingested, or injected."

Allergy, then, is a physiological disturbance which results from an excess of some allergenic agent and the effort of the body to protect against the excess. The introduction of the allergen into a susceptible individual results in sensitized cells in one or more organs of the body through reaction with the tissue cells. These organs then become the shock organs, and reintroduction of the specific allergen results in imbalance of the sympathetic-parasympathetic system. Activation of the cholinergic system results in the allergic reaction which has as its basis increased capillary permeability, edema, increased production of mucus, and smooth muscle spasm.

Many factors must be considered in the production of the allergic state. It depends not only on inheritance, but on the nature of the allergen, the degree and duration of exposure, and on the time that the exposure takes place. In order for the allergen to cause sensitization it must enter the blood. Our skin and mucous membranes act as protection against allergens, and the permeability of the intestinal mucosa must be a factor in initiation of allergy in the very young infant. Further differences must exist in the young infant in that the immunological processes are not fully developed.

Much of the information that appears in the literature about allergy must be accepted on faith, realizing that there is much controversy on most of the basic points. No fundamental difference has been proved between the so-called non-allergic and the allergic individual. Acceptance of the statement that all individuals are potentially allergic, the difference being only one of degree, would seem necessary in order to fit the facts known about the problem. The discovery of epinephrin and the recent development of ACTH (corticotrophin) and cortison have done much to show that the adrenergic system is most important in the allergic mechanism. These developments help to show more clearly why such factors as trauma, psychosomatic factors, intercurrent infection, and others, influence the allergic state by disturbance of the adrenergic system.

We, as physicians, are confronted with the difficult problem of deciding at which stage of his progress the infant can be classified as an allergic individual. For instance, colic is not always allergic in nature, but sometimes it is, and must arouse the possibility in the mind of the alert physician. New allergic syndromes are being described and no doubt conditions which, at this time, are not considered allergic may later be proven as such. The recognition of the first allergic symptom as it occurs in the patient is important so that treatment can be initiated and prophylaxis against further sensitization can be established through proper feeding and environmental control.

Once a definite allergic syndrome has made its appearance in a child, he is classified as an allergic individual and our course is more clearly defined. However, there are many children who, because of a positive history of allergy in the immediate family, are better classified as pre-allergic individuals. Because of the frequency with which they develop allergy, these patients are deserving of special consideration to prevent the first allergic syndrome. The same consideration should be given the child who, because of indefinite symptoms, has to be called a probably allergic individual.

The author has made a study of the number of eosinophiles found in the blood of allergic and non-allergic children. This investigation showed the well known fact that eosinophiles are in greater concentration in the blood of actively allergic children. However, there were many children who were not known to be allergic but who had a higher percentage of eosinophiles in their blood than was considered normal. This could not be explained on any basis. Whether these children represented cases of subclinical allergy or some as yet unknown allergic syndrome is not known. At any rate, more of these children subsequently developed clinical allergy than one would expect. This happened often enough to make it appear children showing unexplained eosinophilia should be considered allergic so far as management is concerned.

Rather showed years ago that the human fetus could be sensitized during pregnancy to protein-containing foods consumed by the mother, and, further, that the infant could be passively sensitized through antibodies present in the blood of the mother. These
facts would indicate that the diet of the pregnant woman should be closely supervised and indulgence in "cravings" for highly allergenic foods be curtailed. Intrauterine sensitization, either passive or active, could account for allergic reactions seen in the infant the first time it is fed new foods.

In practice, most allergic patients seem to have an inherited background for their abnormality. The tendency to become sensitized easily seems to be inherited, rather than the specific sensitization itself. Todd states that the infant whose parents are both allergic has a seventy-five per cent chance of becoming allergic. Clein, reporting on 100 allergic and 100 non-allergic children, from birth to five years, found that seventy-one per cent of the allergic group had parents with allergic disease. In only twelve per cent of the non-allergic group were the parents allergic.

The results of studies by other investigators, however, would seem to discount the importance of heredity in allergy. Ratner and Silberman found, in a group of 250 allergic children, that only 11.8 per cent of the parents were allergic. This would mean that the incidence of allergy in the parents of this group was not significantly greater than in the general population. Bowen described fifty-nine sets of identical twins. In 52 of these sets only one twin was clinically allergic. Despite this evidence to the contrary it is the experience of most workers in the field of allergy that the ease with which the individual is sensitized follows the characteristics of a dominant inherited trait.

A positive family history of allergy should arouse our suspicion that we are dealing with a child who is very likely to become allergic unless a definite prophylactic program is used in his feeding and environmental management.

Allergic histories are frequently misleading. Either allergic symptoms have been so mild as to have been forgotten, or are not recognized as such, or the parents of the allergic child are too young to have developed allergic symptoms. Positive histories of allergy in the immediate family are not necessary for the diagnosis of allergy but it is almost the only way in which we can select the pre-allergic child who deserves special consideration as regards prophylaxis of sensitization. Since we are not always able to select these individuals, all infants should be managed having in mind prophylaxis of sensitization.

Grulke and Sanford have shown that eczema is seven times less frequent in the breast fed infant. There is little doubt that the apparent and actual increase in allergic diseases in infants and children at the present time is due, at least in part, to the unpopularity of breast feeding. Breast feeding should be encouraged in all infants and particularly in infants who are considered pre-allergic.

The infant who has siblings or parents with allergy and who is deprived of breast milk needs careful attention as regards his diet. Glaser has been able to prevent allergy in this type of patient in a significant number. His method of feeding these infants utilizes soybean or meat-base milks along with careful supervision of the infant's additional diet for the first year. In his series only 15 per cent of the infants fed in this way developed major allergy before the age of six years. In contrast, 60 per cent of these infants fed on cow's milk and the usual allergenic foods developed severe disease during the same period.

Glaser's method of feeding pre-allergic infants has proved practical in the author's experience and is used routinely when pre-allergic infants are deprived of breast milk.

The very early introduction of solid foods, many of which are highly allergenic, has become very popular during the past decade. The Committee on Nutrition of the American Academy of Pediatrics does not feel that the early introduction of solids into the diet of the very young infant contributes to an increase in allergy. It has been the experience of the author that this practice has been the cause of the early initiation of allergy in numerous instances. If solids are introduced at a very early age the physician should realize that these foods can cause the first sensitization followed by the well known progression of allergic syndromes. Gyorgy makes strong points against the early introduction of solid foods into any infant's diet during the first few weeks. He says, "There is no reasonable scientific medical support for early mixed feeding of infants," and further states, "Even without any conclusive evidence in support of the following statement, it may be assumed that a widely varied menu consisting of a large

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number of potential allergens may promote the development of allergy in infants, especially in early age with physiological high permeability of the intestinal mucosa for incompletely digested proteins.” Since there have never been any reasonable data presented to show that early feeding of solids was in any way helpful to the infant and sometimes causes definite harm, a retreat to the later introduction of solids is indicated in all infants. The important contributing factor in early feeding of solids has always been the mother’s insistance and she can be easily convinced that such a program can be harmful to her baby.

Infants and children suffering from gastrointestinal diseases are more likely to become sensitized if fed highly allergenic foods and the diet offered in such patients should consist of non-allergenic foods because of the increased permeability of the unhealthy mucous membranes.

It is the experience of all physicians that asthma in children sometimes makes its first appearance after the acute contagious diseases or pneumonia. Prevention, modification, and early treatment of these diseases should be a factor in decreasing the incidence of allergy in susceptible individuals.

SUMMARY

An answer to the question “What makes my child allergic?” has to be given often in pediatric practice. It cannot always be answered to our complete satisfaction. However, certain facts are known about the initiation of allergy in children. Proper attention to the diet of infants and children recovering from acute gastrointestinal diseases and prompt treatment and modification of the acute contagious diseases can prevent or at least delay allergy in a certain percentage of cases.

REFERENCES


Many patients with cancer could be “alive five years after diagnosis” if the disease were detected and treated earlier.

Striking evidence pointing to this conclusion is presented in the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession.

Uterine cancer which kills 16,000 women annually is almost 100 per cent curable if detected early enough, says “Patterns.” The survival rate for cancer of the breast, one of the commonest forms of cancer in women, could be raised from its present 46 per cent to 81 per cent, and of cancer of the lung, from 4 per cent to 34 per cent.

New Mexico, Utah, and North and South Carolina have the lowest death rate from cancer in the country, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. The northeastern states rank highest in the national pattern of cancer deaths, with Massachusetts heading the list.
Love, Affection and Human Relatedness

The authors present love, stripped of its sensual wrappings, as a powerful, beneficial human emotion; the mainspring of health and happiness, when properly interpreted. On the other hand, misunderstanding and wrong interpretation may become the cause of misery and sickness in many who travel the road of life. One is reminded of St. Paul’s definition of love and especially of the following sentence: "So faith, hope, love abide, these three; but the greatest of these is love."

—EDITOR

THE frontiers and new vistas urgently awaiting attention are not in physical and chemical research and engineering but in man himself; not in technologies but in the wisdoms that give meaning and direction to them. Science has released to us tremendous energies and opportunities, but we must turn inward for understanding and direction of these things. As scientists our opportunity is to see the interdependence of our individual specialties and the order of the Universe, of our individual selves and all mankind. We must understand more about healthy self-interest and our interdependence for we have neglected their importance to the lopsided cultivation of profits, power, prestige and "success," pseudovalues, mirages and means rather than ends. We are part of humanity, units of living and loving and reasoning that are genuine communities, whose members are part of each other not in standardized parts but in common eagerness for the same values.

The psychiatrist sees considerable human suffering, much close at hand in individuals, much afar in society and its problems. Asking why, he knows it isn’t all simply and primarily due to biochemical aberrations. Man is complex and much depends on how he uses (or fails to use) his brain, for there are many, obvious ways in which man sells himself short, is his own worst enemy, and makes his own unhappiness. Most of the great problems of humanity today are those made by man.

Psychiatrists are among the few scientists who use the word love without apology or embarrassment. To them love appears important in human living and health. It appears to be something that can be fostered and extended, used to replace anger and fear, to build, reconstruct, soothe and heal.

Many attainments such as power, money, success, and prestige are rated by our present civilization as more important than love. We devote much thinking and tremendous energies to developing these as goals in themselves. Does love “profit only the soul?” Is it only for dreamers and sentimentals? Is it only an extra-curricular activity or a feminine luxury? Or does it supply the secrets of something man has long sought in the understanding of himself, his illnesses, and the many forms of unhappiness which only human beings can devise.

The physician or scientist who attempts to speak on the human phenomenon of love finds himself treading a no-man’s land. Here is a term which still defies concise definition and he who would define it finds himself sorting concepts of sentiment, Pollyanna, humor, cynicism, poetry, religion, philosophy, and semantics. In our present culture, the term has been so taken over by the popular media of cinema, television, popular music, and story-writers that its frivolous, glamorous or sensuous wrappings are often mistaken for the whole package.

Love has been called an “euphemism,” a wishful symbol with meanings too subjective. Warnings have been posted that, “The poet has sung his best about love, the cynic has said his worst, but the scientist has said very little that is worth remembering.” He who tries to define love may reveal more
about himself than he does about the subject. One may readily find himself engulfed in a "profusion of concepts and feelings surrounded by a wall of words." We truly may know more about automobiles, atomic energy and possibly even space travel than we do about love.

In 1958, we may be somewhat like the scientists of a hundred years ago as they pondered on electricity. We are confronted with vaguely delineated phenomena and we know somewhat more about its manifestations than we do about it, specifically.

Despite limitations of knowledge in 1958, and recalling that science may be defined as "an orderly arrangement of what at the moment appear to be the facts," nevertheless we may seek basic laws of human phenomena. Although what we say today may remain only as a stepping stone or a distraction, it may at least serve as a provocation.

Love has many interpretations, manifestations, and dimensions. It merges imperceptibly with other experiences and expressions of human relatedness. The glamorous outer wrappings of "romance" are known. Feelings of sympathy, pity, anger, and fear as well as desires to depend on or control are often present at least as human "contaminants." The experience of love is often accompanied by an euphoria, "do good" feelings, benevolence, and magnanimity.

It may come as a surprise to some that one who is rich in all of the qualities of love is not "weak" or given to sentimentality. One who is truly loving is orderly, assertive, and aggressive, possessed of "backbone" and good judgment, formulates solid ideals and values, and lives well within the wisdom of the Ten Commandments.

In our present state of knowledge, we see a definition of love utilizing the following nine significant, though overlapping, words:

- Self-love  
- Action  
- Relatedness  
- Warmth  
- Understanding

**SELF-LOVE**

Love is a phenomenon of life and particularly of human life. Self-love represents man's deeply felt appreciation and joyous use of the wondrous quality of this gift, his life.

**Self-preservation.** Every living species has a built-in means of survival and growth. This is automatic, involuntary, *instinctive*. While man has an instinct of self-preservation, he may misdirect it greatly. Given life, an instinct of self-preservation, and a very good brain, man has all of the tools needed for survival and happiness. But he must work out his own clear reasoning, develop his own knowledge, maintain his own realistic awareness, and arrange his own strategy for living happily. Survival, fulfillment and happiness are not given to man—only the opportunities for them are provided.

**Self-knowledge, self-interest, self-esteem and self-reliance** are instinctive in man. They are natural capacities, present for his survival and happiness. As instincts, in their natural state, they operate without awareness or concern. They function well, smoothly, automatically; and, they function best when man does not misdirect them, try to deny them or apologize for them.

**Self-knowledge.** Awareness of self may be in the form of troubled preoccupation, bewildered self-concern or in clear automatic self-understanding. Here develops the knowledge of the full spectrum of one's assets, strengths, and potentials. Here is where the individual maintains straight forward "tab" on himself and is aware of how he functions in diverse situations rather than developing great skill in evasion, blaming others, and rationalizing.

**Self-interest.** Knowledge without interest is frail, stagnant. Knowledge requires vigor and direction. The individual who reasons clearly and knows himself with considerable reality cannot help but operate with self-interest.

Self-interest is a means of automatic operation which stems from the realization of one's own goodness, preciousness, God-given qualities, and quest for order. As human beings, we have tremendous, as yet un plumbed potentials for discovery, invention, and creativity. There is every evidence of this in us. We must know and be interested in our own capacities for producing a rich and meaningful life.

**Self-esteem.** The desire for self-preservation is strong. It is our individual opportunity to attend to our own needs for survival, health, growth, and happiness. Requisite to
this, then, is a healthy respect and esteem for ourselves. As we know our own preciousness and value, we shall do better for ourselves. Basically our self-fulfillment is our own individual opportunity and responsibility. We have to live with ourselves. This could lead to self-condemnation, hopelessness, despair or carelessness about self, unless it is offset by the knowledge and application of the great amount of the “best” in ourselves.

New Testament wisdom advised, “Love thy neighbor as thyself,” to respect the preciousness of one’s life, integrity, and uniqueness. Loving one’s self cannot be separated from loving others. In being loving, we cannot exclude ourselves from others. To be anything less than loving of one’s self is to be at least unconcerned, neglectful, or indifferent.

There is no contradiction between love of self and loving others. Self-love is not selfishness; self-esteem is not arrogance. Greed and conceit may, in fact, appear because of a lack of self-love. A selfish or conceited person is usually not a loving person. Energy committed to hate and againstness is lost to love. Energies lost to love go into armor ing and defense.

The capacity to love is rooted in the affirmation of the individual’s own gift of life, his happiness, growth, and freedom. Someone else’s love and esteem do not truly give you your own basic, personal value. One may lose faith in himself by investing faith in others. This is seen when we concern ourselves so with “They say” rather than “I know.” As we make others more than they are, we make ourselves less. Security, confidence, belief and trust in self are fundamental requisites to healthy effective living.

Self-esteem is born of self-interest and knowledge that I am competent to regulate my life, that I’m “fit” to exist, and that I’m worthy of it. Self-interest and self-esteem give me direction and purpose. I can soon learn of my abilities, goals, and virtues and there need be no apologies nor guilt for my attributes. Faith and belief in self are born of self-esteem.

Straits-jacketed by a need to conform and to seek approval outside himself, the human being may lose much of himself—his self-knowledge, freedom, identity, and uniqueness—in the mass. Thus the quest for iden-

Self-reliance. In the wisdom of our own strength, goodness, capabilities, and clear reasoning we need not clutch and cling to others for security, assurance, approval, or favors. We are not helpless victims of circumstances, sociologic tides and countless other things we blame readily. Knowing our own richness, integrity, freedom, and individuality, we are unh hampered to develop our talents and eagerness and to recognize and solve our own “problems.” We wish to live in full measure, we know how, and we find it a challenge — interesting, meaningful and enjoyable. Steering one’s own self is more efficient than getting lost in the confusion of being steered by others. Since each individual can only know himself best, only know his own reasoning and only feel his own emotions, he does best with the joyful opportunity to govern himself. Self-fulfillment is our own primary business, as individuals. Tending to our own business, we may do a better job with ourselves; and doing so individually, we may improve collectively. We can become too lost in one another, so concerned with other people’s “problems” that we neglect the heart of the opportunity and responsibility within ourselves. Self-reliance is knowledge of and using what has been given us and not bemoaning what seemingly has not been given us.

The preservation of life, the knowledge, interest, esteem, and reliance of the human being must begin in self.

The neuro-physiologic apparatus for loving lies within each of us individually. We can love only and be loving within ourselves. We can love only with ourselves. Love starts within us and begins with self-love. If we do not love ourselves, we cannot be loving.

To the degree one loves himself, he is loving of others. Love is not exclusive. Love cannot be miserly, apportioned, budgeted. The capacity to love, like breathing, is limitless, un tiring. When one loves, he loves all persons, the world, the gift of his life; he does not exclude himself. One loves when he loves himself and, through himself, others. In love there is the basic experience of wholeness, union and integration within one’s self, of interest and esteem in one’s self.
If you do not love yourself, you likely cannot be loving at all. If you cannot make yourself happy, you cannot make others happy. Any message we may try to bring to others is effective only if it is in accord with what we are to ourselves. Truly, “Charity begins at home.”

Action for self is not action against others. Action against others is energy lost to self-interest.

Self-interest is the natural eagerness for survival, growth, health, and happiness.

The blending of primary biologic energies, reasoning, and interest in self characterizes man. Self-esteem and self-love represent the powerful and efficient internal sources, within each human, of his ability to love.

Love is a force in the organism working to effect survival, orderliness and a pleasurable, satisfying state of affairs within the individual, and, subsequently, to those about him.

Love is a code word for a feeling-tone experienced by man when he is actively using what God gave him.

**ACTION**

Love without action is only a potential, a state of paralysis. Love is living, doing, loving. Love is the active experience of one’s own life and the active expression of one’s own life. Love is action for, beginning with action for self. Love attends to its own needs and fulfillment; it sustains itself. The unhappy person can hardly be loving. Love starts from within and sees to its own happiness first. It is self-interest in action for self-fulfillment and enjoyment of one’s gifts and opportunities.

Love is not transient, nor intermittent but steady and constant utilization. One does not precipitously fall in love. Rather one is loving—a state of being which ideally is eager, ever present, free flowing and enduring.

In love one expresses and experiences his strength, agility, wealth, and joy. Love begins with an active interest in our own lives and talents. Love is the active utilization of all our assets.

Love is manifest in progress, growth, effectiveness, and fulfillment. Work is love made visible.

It is inevitable that we love. We are helplessly loving. Even when we’re most unfriendly, we are still loving.

**RELATEDNESS**

Love is an abiding desire on the part of two or more people to create together conditions under which each can be his real self and spontaneously express and fulfill his real self; to create together an intellectual enlightenment and an emotional warmth in which each can flourish, far superior to what one would achieve alone. Provided here is the positive, enjoyable opportunity of togetherness. Since the dawn of mankind it has been known that two can have more fun than one. Simultaneously experienced pleasures mean enjoying multiple satisfactions.

Love is an experience in human relatedness. It is a contrast to the experience of mere business relationships, “tolerance” or “cooperation.”

Humanity is a part of an ever-widening, ever-extending self. Humanity is our greatest resource.

Relatedness knows a sense of belonging, of feeling that you are part of humanity. Paraphrased, the classic lines of John Donne remind us that no man is an island entirely of himself. Every man is a piece of the continent, a part of the main. If a cloud is washed into the sea, the continent is less as though an entire promontory were washed in for it affects all. Any man’s death diminishes us personally because we are involved in mankind. When someone is hurt or perishes, a little part of all of us is affected.

As a man develops schizophrenia, goes to war, or becomes a criminal, society is the less. Here is talent and energy that could have contributed knowledge, order, and solution; qualities that may have extended man’s achievements beyond the stars.

Relatedness recognizes that many conveniences and opportunities about us are provided by our fellow men, the gifts of combined efforts, the bonus of all the brains of humanity, the achievement of many projects which one alone cannot do.

Love determines the relatedness of a person to living and to the whole world, not toward one or several individuals. If one loves
only a limited few special persons and no one else, he is not truly loving. This is a rationed, concentrated, often frightened attempt to love; an inability to love with all one's love thus missing the broad fulfillment to love with all one's capacity. In loving, we love ourselves, we love life, we love the world, and we find opportunity and convenience in all of humanity. We appreciate the wondrousness of God's gift, our being.

In relatedness lies an eagerness for constructive action, for living satisfactions which respond to cries for help without question. It contains an earnestness which is unable to ponder on evil and hate and which gives others the benefit of the doubt. It does not judge nor condemn. Relatedness bears a fervid love of life that makes one believe that all others must love it greatly too.

Love unites man with others, helps to overcome his loneliness or isolation, though he retains his own integrity and individuality. Man does not live alone nor does he want to do so. Loneliness is one of our self-made perversities and hence one of our greatest fears. Since nature meant man to be loving and together, then friendliness and companionship are great, natural opportunities and pleasures. A mutual interdependence of all mankind is recognized and stems from man's self-interest. Opportunity and convenience are ever roundabout us if we will but avail ourselves. Relatedness knows that the world is not run by others, but by us; the "powers-that-be" are not somehow they, but we.

WARMTH

Warmth is an expression and sensation of loving. It means welcomed closeness, gentleness, and tenderness. It knows no fears of loving, is not abashed by it. Arms ever open, we are not afraid of people nor their closeness. We are free in expression. As humans, we have hearty, cuddly feelings, intense and intimate feelings which bear expression. They present to us another opportunity for fulfillment and enjoyment and are not indications of dangerous submissiveness, weakness, and so on. Part of the meaningfulness of good human relations is experienced in "good, warm feelings," a glow, animation, unvarnished cordiality.

Vigor, spirit, and zest, depth and eagerness characterize the full sentiment of human affection.

UNDERSTANDING

Understanding starts with the ancient wisdom to "Know thyself." Understanding is rooted in self-esteem and self-acceptance. It is more concerned with opportunities to love than with finding fault or passing judgment on others. Understanding expresses live-and-let-live attitudes. It emphasizes and stresses the good in ourselves and in others and recalls that God is not malicious. It reminds us, too, that the problems we so keenly see in others we have in ourselves, else we wouldn't be so attuned to these concerns. The wisdom of understanding realizes that every mistake and all ignorance are, in a sense, the product of all preceding mistakes and ignorance. For this reason they may be considered the collective problems of all mankind.

The untutored American Indian knew of understanding when he declared, "Do not judge another man until you have walked in his moccasins ten days." This may have been his recall of New Testament wisdom to "Judge not" and "Cast ye the first stone."

Understanding is human insight applied kindly and wisely. It is not energy wasted on angry projects, vengeance, righteous indignation, and collecting injustices.

In understanding, we do not "throw out the baby with the bath water." While we may not agree with certain opinions or acts of our fellowmen, this does not mean we cannot accept, understand, or love them. We may still accept and enjoy the wonderful goodness and potential which each individual possesses. ("The sinner may be much less evil than his sin.")

Understanding combines reality and objectivity with wisdom and affection. It knows there are equalities and inequalities among all men, that we each bear our unique human powers and limitations. Understanding ponders not on what is "right" or "good" but on what is true and orderly and meaningful.

TRUST

Trust starts with self. Trust is the belief in one's own goodness. The suspicions we have of others arise in the knowledge we have of ourselves. When we suspect badness in others we have already thought of it in ourselves.

Much of the concept of trust hinges on
whether we trust and esteem ourselves and on what we are seeking. We judge others by ourselves. (“It takes one to know one.”) When we are feeling angry, the world about us may appear unfriendly and threatening. To be loving means to be trusting. To be mistrusting is to emphasize “againstness,” to be unsure, to search for injustices and indignation, and to spend less time and energy on what we are for. We usually find what we seek. When we are mistrusting, we are certainly looking for the worst in others and not emphasizing the best; likely we are not minding our own business.

Love is free and in abundance. It need not be hoarded, rationed nor used exploitively. It is not a sacrifice but a fulfillment in itself. For in loving, one is never left with less nor deprived. Love is not doing someone else a favor. It is not an object of barter or investment.

The hoarder who worries so about losing what he has in abundance is an impoverished man for he neither uses nor enjoys his wealth.

Deserved or earned “love” is not love. This is a relationship of barter and exchange; to love because, leaves doubt and un- sureness, compulsion to please, the knowledge that one is being used. Love is misnamed if it is used to teach people lessons, to manipulate, or to punish them. To trust is to believe in, to feel secure with, first ourselves, then through ourselves, others.

FREEDOM

Freedom begins with the experience of our own freedom. It is the reminder to “Be thyself.”

Frequently love is thought of as bondage with shackles, or as a burden, however “sweet.” Our culture has emphasized excessively the aspect of service, duty, and obligation in our relationship to others. We may try hard then to always put others first, ourselves last, and then we may become confused, angry, rebellious and pouting. Love is a natural state of being, an eagerness within us. In real love, we do not possess nor are we possessed, we do not submit others or ourselves, we do not control nor be controlled. Freedom is part of love—our own individuality, talents, goodness and dignity are still ours to use for our own survival, health, and happiness. It is to our own interest to use this freedom.

We do not truly love if we are “purchased” or forced, nor because someone does for us or gives to us. One really loves neither out of a sense of duty nor in order to be loved or favored in return. We love only because we are loving (“Love seeks naught but its own fulfillment.”) It is difficult not to be loving; we need very much to love. However, it becomes confused when we make it a must rather than its own natural eagerness.

Really loving people have a great sense of personal freedom. They do not feel demanded upon, shackled, restricted, or burdened. They know the full extent of their capabilities and talents and enjoy bringing these into action.

Love exists only in freedom, not in compulsion. The very nature of freedom is such that it is not granted. Real freedom is always an opportunity to be taken, to be utilized as spontaneous choice of action.

COMMUNICATION

The medium through which social interaction occurs is called communication—the interchange of meanings through the use of symbols, language, vocalization, and movement. Communication is the portrayal of our knowledge and eagerness at that instant.

Communication, like all things human, begins with self, with clear, interested thinking, frankness, and definition of issues. Communication is a basis of understanding—to understand one’s self, and through one’s self, others. We are our own best listeners.

It is important that we “reach each other.” Communication, highly developed in the human being, is the means for mutuality and interchange of action, for enlightenment, enjoyment, and relating. Ideally, communication is straightforward and clear. One does not use “codes” whereby the other is left to wonder what was really meant or to “read between the lines.” Communication transports the other features of love such as self-interest, relatedness, warmth, and so on.

Through efficient communication, we may constantly inform others of these ready qualities within ourselves.

The importance of a good “gab fest” in human relatedness is well-known. Our ability to communicate is part of our own indi-
vidual creativeness and goodness in action. Communication provides information, acquaintance, and allows us to "let our hair down," say what we mean and mean what we say and not have to hide behind defenses and false fronts. Used tangentially or disguised with "tact," "diplomacy" and "gush," communication becomes useless and confusing or an angry fencing foil.

Communication is necessary for striving to define and attain opportunities of life. Without communication, we would expect others to be mind readers and we could hardly delineate the opportunities to our own happiness.

The old democratic principle of "I may not agree with what you have to say, but I will fight for your right to say it" applies here. We must be able to "talk up" to one another, to be very much to the point. Clarity and realism must not be beclouded by the guise of tact or politeness. This does not mean that we have to take advantage of this privilege to hurt one another. However, it also means that we not be so easily "hurt" ourselves that we can't "take it." We enjoy "sparring partners." We give one another the privilege and the dignity to "sound off," to speak straight from the shoulder and, knowing that we have the same privilege, not be hurt by it. The qualities of love will enable us to do this. Conflict may exist without anger; it may occur among those who are loving. Disagreement, "problems," differences of opinions, and misunderstanding, comprising part of the interesting challenges and opportunities of life, do not require anger for solution.

ENJOYMENT

Enjoyment can occur only within self. A loving person is interested in himself, in life. Through his self-interest he develops enthusiasm for the world, the people about him. Love is joyous naturalness. Love is life worth living. It differentiates man from robot. The greatest pleasure man can ever achieve exists in his own lovingness.

When we are loving, we are healthy, effective, happy, and creative. When we are unloving, we run risks of being just the opposite. It is love that carries us beyond the suspended animation of mere comfort, monotonous well-being, and banal existence.

Human beings have the opportunity to enjoy themselves with one another. This is not luxury, whimsy or superficial gaiety, but appears to be a basic need of each individual; a need which has deep sense and meaning and which "pays off" in human relatedness. It appears to be part of the old teaching "that ye love one another" which was probably presented not as a duty or admonition but as a reminder of our own natural eagerness. Considerable of health and happiness depend on enjoying ourselves with others just because they are just wonderful, meaningful fellow human beings.

In the natural orderliness of things, we seek joy and happiness. Happiness springs from the matrix of health and the order of the Universe. Life is meant to be interesting, challenging and adventurous.

Happiness is not somehow wrong. Neither is it "everything" in life. A happy life is not a life without some challenges and problems. Happiness and health go together. Clinical experience sees happiness, friendliness, and health as directly related. The ability to find joy and pleasure within one's self, in one's life, is neither mindless self-indulgence, whimsical hedonism, nor irresponsible frivolity. Your measure of happiness is the purpose of your life. It is not a responsibility to be dreaded, evaded, or put on others. Your health and happiness appear in the appreciation of the gift of your life, in the loyalty to the achievement of your values, in magnificent devotion to self, in recognition of the hero in your own soul, and the productive efforts of your own mind.

The pursuit of one's desire to live and to live happily is healthy.

There are those who spend a lifetime in adjusting rather than in living. There are many who devote much time to avoiding what they fear or dislike rather than seeking what they wish and enjoy. Considerable time may be spent in operation against rather than in operation for. Some only put up with living, tolerate it. To many the primary concern is not a life they wish to live but a death they are trying to avoid.

We humans take the enjoyment out of love in many ways. Inadvertently, at least, we are educated to distort its natural eagerness. Love is basically an opportunity for loving although we often see it the other way around and are far more concerned about
being loved and lovable. Unhappily we see ourselves more as love-demanding and love-expecting than as just loving. From here we readily get lost in other people's business, because we feel it is somehow our duty to get them to notice us. We will strive to be successful, powerful, rich, sexy, or attractive. We will knock ourselves out to please, or we will even become unassertive "yes men" — all of this that we may be esteemed, approved of, loved. Much energy is thus misdirected, many disillusionments and deep "hurts" occur because we try to activate others to love rather than just being enjoyably loving ourselves. One can always find things or people to love. It is far more natural and enjoyable to just be loving.

Our civilization has stressed the need for favorable exchange and bargain. Love is included, unfortunately. In loving we may seek the opportunity and convenience of our fellow men. We may miss the point by becoming bargain-hunters concerned (at least wistfully) by "What's in it for me?" If we expect anything more than the assured joy of relatedness and companionship with fellow men we are apt to be "disappointed in love." We have so stressed a marketing orientation and material successes, it is not surprising that human love relationships follow the patterns of exchange which regulate the labor and commodity market. The misconception is that in loving, you are doing some one else a favor. Then love becomes a gift proffered, a legal tender, an investment. Something is expected in return from the other person (at least, "appreciation"), and if it appears not forthcoming, anger (in one of its many forms) ensues. The unhappy consequences of so-called love, the disappointments, the angry "hurts" are well-known then.

CONCERNING ALTRUISM

Altruism, a recognition of our interdependence, is a common accompaniment of love. Yet, one may "do for others" and be anything but loving. This may be the case when we "do for others" with undiscovered motives to "run others" (to even dominate them through our selflessness), or compulsion to duty rather than eagerness, creativeness, lovingness. "Doing for others" per se is not love; it does not make love nor does it equal love. It may indeed be "undoing" in the anger and unhappiness it attempts to conceal or which it may generate. There is always risk in making others happy in your terms (of what you believe is best for them).

Altruism ideally is a product of man's self-interest, the application of his own friendliness, creativeness, lovingness. It is inspired by man's longing to use his goodness, talents, and strength.

"Doing for others" may occur without love. Altruism and love expect no returns, no appreciation, no acclaim and are not compulsion. They sense neither burden, sacrifice, nor duty for they are sufficient unto themselves; they constitute their own gratification.

Altruism and unselfishness have many definitions and may provide masks for greedy concern, possessiveness, angry righteousness, minding other people's business, control and manipulation. Dislike of life and self can be taught under the guise of altruism and virtue.

Altruism is often unknowingly a matter of self-interest. Altruism and self-interest occur simultaneously and overlap. We may "kill two birds with one stone." Thus, we may bring food to a friend because we enjoy ourselves much (self-interest) with him. Self-interest is a natural, healthy motive in altruism. Recognized, it may be beneficially used to the full extent and happy opportunity of all concerned. Unrecognized or denied, it becomes a confused game where the tail tries to wag the dog.

Self-interest is often mistaken for selfishness, conceit, and "feeling sorry for yourself" from which it may be sharply distinguished. It exists naturally in all men, however much it is stifled, hidden or disguised. Born with a natural, built in, automatic self-interest, we often distort it, work too hard on it, deny it, evade it, betray it, denounce it, pretend it does not exist. Man is often caught in his confusion of selfishness half-conceded, half-avoided and sacrifice half-obeyed, half-pretended. He fails thereby to be directed by his healthy self-interest. Rather he struggles to maintain this direction by many neurotic symptoms and syndromes of fear and anger. Many inadvertently "take good care of themselves" in unclear ways unrecognized by themselves.

Among other things in life, what is more enjoyable than using one's talents and capabilities to help a fellow man as our own self-
interest remains intact? One may knowingly and planfully, adequately, and satisfyingly take care of his own realistic interests, basic needs and values. Thus, operating in full awareness and efficiently, we may usually find there is "more than enough to go around," the altruistic accompaniments or byproducts are many, the cup runs over. It is enjoyable to experience one's talents in action for us and, coincidentally then, for others. We may enjoy ourselves much with others, finding warmth, closeness and value in them. As I find you my convenient opportunity so you find me yours.

SEX

On discussing love, one may be asked also about sex. Like altruism, it begins attention too, as it has been often considered somehow synonymous with or part of love. Sex may exist without love; and love may exist without sex. (Whether the Freudian belief is a fact, that all means of human relating have some sexual connotation or substrate, we shall not discuss here).

Sex is an interesting extension of interdependence. It is a means of enjoying self, relating, and creating. It may be expressed in many ways and mean many things. Combined with love, it provides a powerful and significant means of self-fulfillment and happiness.

Sexual desire may often be aroused by any strong emotion or need and may blend imperceptibly and deceptively with these. Love may inspire a wish for sexual union. Sex may be used in anger and violence, in sport, in conquest, in submission, and in the need to "produce" or prove self, for favors. Sex may be used in healthy self-interest and with all of the other qualities of love.

TUBERCULOSIS ABSTRACTS

THE CHEST ROENTGENOGRAM AND CHEST ROENTGENOGRAPHIC SURVEYS RELATED TO X-RAY RADIATION EFFECTS AND PROTECTION FROM RADIATION EXPOSURE

The chest X-ray continues to be an important part of all tuberculosis case-finding programs and an important and depending tool in early diagnosis of unsuspected chest disease.

In June of 1956 the National Academy of Sciences, National Research Council, called attention to the "Biological Effects of Atomic Radiation," especially as it affects the human body and its reproductive organs. Later reports discussed the possibilities of effects of body radiation upon the blood system, with leukemia as a delayed effect.

This discussion on radiation effects has led everyone — scientists, physicians, and laymen — to think deeply concerning them and to weigh the benefits from X-ray diagnostic procedures against the liability of harmful effects of radiation. Most of the factual information on this aspect of low doses of ionizing radiation has come from animal experimentation.

In people who are ill, the needs for radiological studies are great and the diagnostic benefits outweigh the possible hazardous effects of radiation. All radiation exposure that serves no useful purpose should be scrupulously avoided.

It is well recognized that no standard pattern of radiation exposure is delivered by any standard type of X-ray machine. Each X-ray unit must be provided with all necessary safety devices for minimizing gonadal and general body radiation. This must be done by persons trained in radiological protection.

WHO SHOULD GET X RAYS?

The American Trudeau Society has emphasized that chest roentgenograms are only justified if they lead to the detection of previously unsuspected or clinically significant, curable lung disease, followed with appropriate therapy. If abnormal chests are not followed up, radiation has been wasted.

Therefore, it is essential for those engaged in the detection of pulmonary disease to evaluate their yields. Among certain population segments in which there are high yields, periodic chest X rays are the most practical approach. Among infants, children, young adults, prenatal patients, and especially young diabetics, the tuberculin test should be used as the preliminary screening technique whenever possible, and the tuberculin reactors should have X-ray examinations of the lungs. However, aside from screening, every child should have a single X-ray film for the identification of congenital or developmental defects and nontuberculous disease, and for comparison with any films taken later in life. Only those X-ray units that meet modern requirements for radiation protection should be used.

WHAT TYPE OF APPARATUS SHOULD BE USED?

Other factors being equal, the amount of radiation necessary for satisfactory chest film is least with a standard 14x17 film in a cassette with intensifying screens. In comparison, there is approximately 3 to 5 times more radiation using the mirror optics photofluoroscopic unit and about 10 to 20 times the radiation exposure when using the standard lens camera photofluorographic machine. This is still a very small amount of radiation, but these figures may be multiplied by 100 if the apparatus is not properly equipped with protective devices.

(Continued on page 414)
Aging

A SOCIOLOGICAL PROBLEM*

Why a Sociological Problem?

During the past twenty years in which my work has been concerned with the aged, the basic question has been: How are we to provide value and dignity to the lives of an ever-increasing number of aged persons in a social culture that accentuates youth? The aged have been affected more directly and dramatically than any other group in the population by the triple impact of the industrial, social, and medical revolutions of the past century.

First, the industrial revolution forced the aged worker to lose his job and with it his status in the economy.

Second, the social revolution resulted in the aged losing significance and security in the family.

Third, advancements in medical science made the aged live longer when there was less justification for their doing so.

Aging, therefore, is a problem basically because of the great economic, social and medical changes which have taken place in the United States since 1890.

In American society, the role of the aged is quite different from their role in primitive communities, as well as earlier periods of our history. American culture is now highly oriented toward the young. Speed and efficiency are highly valued. We idolize the young, the strong, and the beautiful. Moreover, the rapidity with which our culture changes, quickly outdates past methods of dealing with our social problems. Many of the difficult situations with which the aged are faced are the result of misunderstanding of the role they are expected to play in our society. Since prestige is given to the skill, speed, and efficiency characteristic of youth, the elderly persons find their qualities of experience, wisdom, and maturity devaluated.

The sociologist understands that the major problems of aging today are the result of the cultural lag; "the delay between material inventions and physical discoveries and the required adjustments in our social institutions and systems of belief." In the case of the aged, this cultural lag is particularly great. We Americans are quick to accept and apply new inventions and discoveries but many times very slow to understand and accept the necessity of finding ways and means for controlling their effects. The same forces of industrialization and urbanization which have made this country rich, make it difficult, if not impossible, to assure old folks the prestige and sense of belonging they once enjoyed. Modern civilization has created more problems for the aged than it has solved, because now we are insuring more and more of life with less and less in it.

It is quite common to find three times the rate of aged in our mental hospitals (as compared to the total population); the younger generation moving to roomy, one-floor, suburban ranch homes, leaving the old three-story, crowded, urban firetrap-residences to be used as nursing homes for the aged; the number of aged population increasing, and the retirement age being reduced; the older population requiring more medical and hospital care, finding their medical insurance canceled at the time their needs are greatest; the relatively stable, simple, self-protective, self-supporting rural family life supplanted by the highly mobile, complex living arrangement of high-tempo urban life. In many ways, the cultural lag has become an unbridgeable gulf of misunderstanding, apathy, and dishonor.

Nature of the Problem

1. Increased Number of Aged. — During the glory of the Roman Empire, with its
large aqueducts, good roads and the longest period of peace recorded in imperial history, the population had an average life expectancy of only 22 years. With a life expectancy of almost 70 years, people born today in the United States can look forward to lives three times as long as could the Roman. Gains in life expectancy have been coming at an accelerating rate. In the first 1700 years of the Christian era, life expectancy gained only 10 years; in the 200 years that followed, medical progress increased somewhat and life expectancy advanced by 16 years; and with the rapid development of modern medicine and the discovery of sulpha drugs and antibiotics, life expectancy has increased by 20 years in a little more than half a century. (Health Information Foundation, May, 1956).

Since 1900, the per cent of the population over 65 has increased in the country from 4 to 9, resulting in a total increase in population over that age of 11 million persons. The rate of increase of older persons has been twice that of the total population. Now 800,000 persons reach the age of 65 each year and can expect another 12 years of life. In Nebraska, more than 10 per cent of the population is now 65 years and over. In this community, the aged population has doubled in the past 25 years; five times the rate of the general population.

2. Socioeconomic Deprivations of Aged.—Perhaps the most serious problem facing the aged is loss of employment and with it dependency and substandard living. The proportion of men 65 years and over who are gainfully employed decreased from 68 per cent in 1890, to 42 per cent in 1950, and if the present trend continues, by 1975 only 35 per cent of older men will be employed. Today, only 25 per cent of both sexes over 65 are gainfully employed. Scarcely 5 per cent of those over 65 have saved enough to be self-supporting. This means that 70 per cent are dependent on other less acceptable means of support.

A nationwide study based on a sample of persons 65 and over showed that 36 per cent had incomes less than the amount needed to meet a minimum budget, and that 53 per cent received incomes less than required for a self-respecting standard of living. Another survey has determined that approximately half the recipients of Old Age and Survivors Insurance (6 million) have little or no income other than their O.A.S.I. payments which approximate $64 monthly. Since the turn of the century, there has been a widening of the gap between the life span and the working span. In 1900, it was approximately 3 years; now an aged person can expect 6 years of retirement, and by 1975, approximately 9½ years (males).

In general, it can be stated that the savings of the aged are disproportionately small; on the relief rolls they number six times their proportion of the population; their income, on the average, is one-half of the nation's average; their state of health is suggested by the fact that two-thirds of the aged beneficiaries under Old Age and Survivors Insurance suffer from chronic diseases; their days in the hospital total about three times those of the whole population, and yet only 15 per cent are covered by hospital insurance; their housing and institutional facilities are far below minimum requirements; their access to jobs is blocked by ignorance and lack of flexibility of management; and their pension and Old Age and Survivors Insurance payments are woefully inadequate.

3. Urbanization. — Consider also what the continued trend to urbanization has meant to the economic-social life of older persons. Seventy-five years ago, well over 60 per cent of the aged population lived in rural areas and almost 40 per cent lived on farms. The older farmer led a satisfying life. He was usually self-employed and owner of his own land. He retired gradually, if at all. His larger family was an insurance for his own future because his married children tended to remain in the same rural neighborhood. He was a participant in outdoor life — fishing, hunting, and other recreational activities — with his children and grandchildren. He had a recognized status in the community.

Today the population shift is just reversed, with 65 per cent of the aged living in cities and only one-third the number still living on the farms. The older worker may likely be employed in a factory, working under a foreman. He is forced to retire at the will of his employer. Any economic security is dependent upon the union, the employer, or the government. His children probably have moved away. He is more likely to be a spectator than a participant in the recreational and social life of the urban commun-
ity. He has an uncertain and undefined role and lowered social status.

Old people are now a problem because we are living in an urban, industrial society which has shown little concern with aging as an accompanying factor. The aging individual and his family have lost the security and self-sufficiency of rural life. The older person can no longer rely on his savings, family and friends to take care of his needs. Retirement, a relatively new phenomenon in American life, means to many older persons an abrupt transition from independence to dependence; from a recognized role to lack of recognition. The social culture has failed completely to provide a satisfactory status for our elder citizens.

4. Loss of Status. — It is difficult to over emphasize the sociologic significance of loss of status of any age group in society. A social culture which ignores and neglects the aged contributes directly to feelings of loneliness, uselessness and isolation. Furthermore, a substantial proportion of older persons are deprived of any family-living. Approximately 30 per cent of women and 19 per cent of men over 65 live alone. Nearly 22 per cent of aged men and 55 per cent of women have lost their spouse, adding to the bereavement and loneliness. It is fair to observe that thousands of our aged population have lost any meaningful association with any group — a pathetic isolation has engulfed them. Is it any wonder that scores of these aged persons show up every year in our county institutions, mentally ill and physically malnourished?

Dr. Leo Simmons, Department of Sociology, Yale University, makes what I consider an excellent analysis of the basic sociological needs and interests of the aged:

"1. To live as long as possible; or at least until life's satisfactions no longer compensate for its privations, or until the advantages of death seem to outweigh the burdens of life. Life is, indeed, precious to the old.

"2. To safeguard or even strengthen any prerogatives acquired, i.e., skills, possessions, rights, authority, prestige, etc. The aged want to hold on to whatever they have. Seniority rights are zealously guarded.

"3. To remain active participants in group affairs in either operational or supervisory roles; any participation being preferable to idleness and indifference. 'Something to do, and nothing to be done,' is perhaps the main idea.

"4. To get more rest; or release from the necessity of wearisome exertion at humdrum tasks and to get protection from too great exposure to physical hazards. Opportunities, in other words, to safeguard and preserve waning physical energies. Old people have to learn to hoard their energies.

"5. Finally, to withdraw from life, when necessity requires it, as honorably and comfortably as possible and with maximal prospects for an attractive hereafter."

Dealing With the Problem

The sociological problem of aging requires a multi-attack based on the varied and basic needs of our elder citizens.

First, priority should be given to making possible employment for every aged person who is able and willing to work. Opportunity to continue production regardless of age protects the status of the individual, continues his usefulness and value to society. It retains the independence and economic self-sufficiency of the aged. It reduces the burden of support on the younger population and the drain on old age pension and insurance funds.

It is obvious that the age-of-65 working limit was pulled out of a hat. For example, in this community during the first eighteen months of World War II, over 900 aged persons left the assistance rolls voluntarily to take jobs. This reduced taxes approximately one-half million dollars annually and contributed directly to the war effort. In 1950, the Census Bureau found 27 per cent of the aged employed, producing goods and services annually estimated at more than $10 billion. It has been determined that at least half the aged have been prematurely retired. If we believe that wages for work is the first line of defense against sociological problems of the aged, we will junk arbitrary retirement policies, find ways of adjusting work conditions by means of shifts.
to jobs characteristic of older workers, create part-time jobs and, most important, make some basic changes in attitude and philosophy with respect to the worthwhileness of the later years of life. In other words, instead of mere existence on an inadequate pension, isolated in a lonely city, the older person should be kept working, kept self-supporting and then, like everyone else, he is kept happy by being useful. There are deep emotional reasons why workers want to continue to work. Work is status, prestige, success; it stimulates inter-human relations; it is more than a means of making a living—it is a way of life itself.

Second, for the aged who can't or don't want regular employment, we should provide the next best thing—creative activity. It is essential to the physical, mental and social well-being of any person to keep himself active. Literally thousands of our elder citizens are vegetating mentally and physically in a half-human existence of apathy and inactivity.

We now know that occupational therapy, sheltered workshops, organized recreational activities, and avocational pursuits are essential to the aged and pay sizeable dividends to society.

Finally, every community should have a public service Committee on Aging concerning itself regularly and zealously with the problems and needs of older citizens. Such a Committee would be responsible for:

1. Maintaining current data on the aged population in the community and educate the public as to the facts.
2. Promote maximum utilization of the skills and productive capacity of the aged.
3. Support welfare services in the fields of recreation, housing, vocational counseling and rehabilitation, safety, etc.
4. Assist in coordination and integration of all available resources and facilities in the community for all citizens rather than separating the old from the remainder of the population.

Abstracts:

The following abstracts are of papers read at the Winter and Spring Meetings of the Omaha Research Club. This club is an affiliate of the American Federation for Clinical Research.

A Bioautographic Technique for Assay of Folic and Folinic Acids. O'Brien, John S., M.S., and Terry D. W., M.D., Department of Internal Medicine, Creighton University School of Medicine, Omaha, Nebraska.

A bioautographic technique has been perfected for the assay of folic and folic acid in biological materials. The assay organisms used are *Streptococcus fecalis* for folic acid and *Leuconostoc citrovorum* for folic acid. The measurement of growth response to these vitamins is seen by a zone of growth around a paper pad containing the vitamin, which is placed on a vitamin-free agar media. The size of the growth zone is directly proportional to the amount of the vitamin present on the paper pad. The zones are measured and a standard curve constructed. Unknowns are run off this curve. The urinary excretion of folic acid in 27 normal adults on unrestricted diets was 0.97 micrograms per 24 hours with a Standard Deviation of 0.46. These values are expressed in relation to a synthetic standard of folinic acid (Leucovorin-Lederle). The average error of these 70 determinations was 10.2%. The advantages of this technique are: (1) Simplicity and ease of use; (2) ability to detect inhibitory compounds; (3) lack of interference with high salt concentrations; (4) applicability to chromatography; and (5) ability to run many simultaneous determinations. We feel that the bioautographic technique is a very useful one and is the method of choice in investigating those patients with suspected folic and folic acid deficiencies.

Nyolidrin Hydrochloride* Effects on Cold Vasospasm. Hamilton, Charles A., M.D., Department of Internal Medicine, University of Nebraska College of Medicine.

The arterial pressure, heart rate, femoral artery flow, and femoral resistance responses were tested in seven dog experiments during hypothermia or after rapid rewarming. Drug test doses ranged from 1 to 5 mg given intravenously or intra-arterially by rapid injection or slow infusion. The responses were elicited after induction of regional hypothermia of the hind limb by
blood stream cooling or general hypothermia by immersion.

In intravenous injection at a variety of doses and rates the anticipated rise of femoral artery flow, or fall of resistance, were not observed. Instead, was observed, usually, decrease of systemic arterial pressure with decreased peripheral blood flow. Heart rate increased.

On intra-arterial injection of nylidrin at a variety of doses and rates the femoral artery flow rose immediately and increased flow with decreased resistance were sustained for 15 to 30 minutes. The increases of femoral artery flow ranged from 200 to 1,180% of the pre-injection control level.

Nylidrin hydrochloride has thus been shown to be a potent extremity vasodilator agent when given intra-arterially. Theoretical applications for improving peripheral circulation during certain circumstances of clinical hypothermia should not be tried until further animal investigation shows safety from hypotension and ventricular arrhythmias.

*Arlésin, Arlington-Frank Laboratories, U.S. Vitamin Corporation, New York, N.Y.*


About two years ago a Scandinavian biochemist, Akerfeldt, announced that he's work with the plasma amine oxidase (PAO) system suggested that a simple test might be devised which could be used to differentiate schizophrenia from other mental disease. This hypothesis was based on the observations that (1) the PAO activity of schizophrenics is higher than that of normals, and (2) that apparently there is an abnormal relationship between the PAO and the ascorbic acid (AA) content in the plasma of schizophrenics. This latter concept has created a good deal of confusion and misconception among other investigators who have tried to repeat or extend Akerfeldt's findings. Thus, it has been reported by one group of investigators that AA is one of the most potent inhibitors of the PAO system, while another group found that orally administered AA greatly inhibited the PAO. The work of the present investigators is based on more than 100 determinations. It showed that in every case the only effect of AA added to the test system was a prolongation of the "lag period" proportional to the amount of AA added. In no case would a significant inhibition of the reaction rate (oxidation of substrate per minute) be detected.

The PAO activity of carcinoma of the prostate patients studied is extremely high, but it was demonstrated that this increase was not due to the malignancy, but due to the treatment (orchietomy and/or estrogen therapy). Administration of diethyl stilbesteral to volunteers increased the PAO level to three times the normal. In pregnancy, the PAO level stayed essentially normal for the first two trimesters but increased to several fold its basal level in the third trimester. After parturition it returned to normal level.


Recently three different authors have published some very favorable findings with respect to blood glutathione (GSH) levels in schizophrenic patients. They state that the glutathione levels in the schizophrenics are significantly lower than those in normal individuals.

Martens at Tulane reported an average GSH index (mg. glutathione per 100 ml of red blood cells) of 65 for chronic schizophrenics and an average index of 78 for his control group. Angel, also of the Tulane group, has reported an average value of 71 for his control group, an average of 69 for acute schizophrenics and 65 for chronic schizophrenics.

Altschule, working in Boston, has reported that his controls showed an over-all range of from 34 - 75 index units and the schizophrenics studied ranged from 10 - 50. Since Altschule, et al, reported so much lower GSH values in schizophrenia our present work was initiated to test the possible merit of GSH index as an aid in the diagnosis of schizophrenia.

During a period of 6 weeks several GSH indexes were determined on each of 15 male, active schizophrenics and on 36 normal male subjects. Repeated determinations were carried out in order to determine the random fluctuations in the GSH index.
In our normal series of 36 individuals, 70 determinations were carried out. With these determinations we obtained an average of 62 ± 10 and the values ranged from 40 - 85. In the schizophrenic group of 15 patients, 36 determinations were carried out giving an average of 63 ± 8. These values varied over a range of from 47 to 79. We found that the difference between the control and schizophrenic group is not statistically significant at the 5% level. In our study only two indexes below 50 were obtained in our schizophrenic group. We also found that the glutathione level in a given individual may fluctuate over a considerable range. We found that the indexes may fluctuate as much as 25 units during a 6-week period.

Based on these findings it is difficult to see that the GSH determination would be of any assistance in diagnosing schizophrenia.

Development of the Diaphragm. Kleitsch, Wm. P., M.D. From the Surgical Service of Creighton University School of Medicine, the University of Nebraska College of Medicine, and the U.S. Veterans Hospital, Omaha, Nebraska.

The usual diagrams found in current text books of embryology representing the “descent of the diaphragm” give an erroneous impression. These diagrams show the diaphragm descending in fetal life in relation to fixed vertebral bodies. The true development revolves about the septum transversum and this structure is indeed a fixed point about which the embryo develops. The pericardium, septum transversum and umbilicus have a fixed relationship which does not vary. The vertebral bodies grow away from this fixed area and the correct interpretation of the positional changes of vertebral bodies to septum transversum must show the septum transversum as a fixed point.

The adult diaphragm consists of a central tendon surrounded by a halo of muscle. The halo of muscle can be divided into three main segments. A dorsal and ventral longitudinal segment and a lateral transverse muscle on each side. These three muscle groups can be regarded as the diaphragmatic homologues of cervical and abdominal muscle masses. This point of view is supported by the fact that these muscle masses are indeed absent in the thorax. Moreover, the diaphragmatic muscle masses are continuous with their abdominal homologues. How these muscle masses enter into the diaphragm is an intriguing developmental story.

A seldom emphasized fact is that as the pharyngeal pouches develop they seem to stimulate the development of adjacent niches in the subjacent pericardial and peritoneal coeloms. Such niches can be identified in relation to the second, third and fourth pharyngeal pouches. Number five is absent but the sixth, seventh and eight can also be demonstrated. As the trachea and lung buds may be considered to be modified pharyngeal pouches, niche number eight develops in relation to them.

At this point in development the embryo is approximately 4 mm. in length and the septum transversum reaches from one lateral body wall to the other but does not reach the dorsal body wall. The open space thus formed permits the peritoneal and pericardial coeloms to communicate with each other. At that point where the most dorsal portion of the septum transversum meets the lateral body wall, niche number seven is located. It has two folds, one of which extends ventrally to the dorsal surface of the septum transversum and the other dorsally over the mesonephros. The niche communicates caudally with the peritoneal cavity. These folds were first described by Uskow and are known as the dorsal and ventral pillars of the pleuroperitoneal membrane. This latter membrane is formed by the fusion of these pillars.

With this arrangement in mind, one must recall the fact that with the abandonment of the vitelline vascular system and the development of the umbilical blood supply there is an immensely accelerated growth of the upper part of the embryo. This results in the growth of the forward portion of the body away from the septum transversum in all directions. The septum which is firmly attached to the lateral body wall will dissect the innermost muscle masses away from the body wall by virtue of its attachment to them and its inelasticity. As this occurs a split forms immediately cranial to the pleuroperitoneal membrane dissecting away the musculature of the dorsal body wall to form the muscle mass of the dorsal part of the diaphragmatic musculature.

In considering the types of transdiaphragmatic hernias one discovers that there are three types of embryologic defects which are responsible for these hernias. They may vary considerably in size but they can only occur in three locations: anteriorly, through
the triangular defect where the transverse muscle joins the ventral muscle through the spaces of Larrey. This type of hernia is known as the Foramen of Morgagni hernia. Dorsally, where the lateral muscle joins the dorsal muscle mass there is a triangular space known as the lumbocostal trigone. Hernias in this area are referred to as the Foramen of Bochdalek hernia. These two types of hernias are simply explained as failures of fusion of the dorsal and ventral muscle mass with the lateral muscle mass.

The third type of congenital diaphragmatic hernia is the result of the failure of the muscle dissection to extend dorsally behind the pleuroperitoneal membrane, and subsequent failure of the dorsal muscle mass to be incorporated in the diaphragm. This type of hernia usually occurs on the left side and is called by the French “Hernie en croissant.” This may also be regarded as being a persistent coelomic tract or pleuroperitoneal canal.

### TUBERCULOSIS ABSTRACTS
(Continued from page 407)

Where the number of survey films taken is small or when modern protective devices have not been installed, it is better to use standard 14x17 films, even at a higher cost. Where the number of films taken per day is large, or the machine must be moved frequently, a properly equipped photofluorographic unit is the most practical apparatus. The increased amount of radiation involved is small and is warranted where the yield of new cases is significant.

Whenever a new photofluorographic unit is purchased the newer mirror optical system camera is to be preferred over the ordinary lens system even at greater cost. Screening of groups by fluoroscopy should be discouraged because the results are not accurate enough for diagnostic purposes; there is no permanent film record of the examination; and the radiation exposure involved is excessive.

### THE NATURE OF RADIATION EFFECTS

Populations are being exposed to a variety of radiations from natural and artificial backgrounds as well as from medical examinations. Exposure received by the population today from all sources appears to be at a lower level than that which has produced harmful effects in humans and experimental animals.

Those responsible for screening programs should ensure that the radiation dose is maintained at the lowest practicable level both to those being examined and to equipment operators.

Conclusions: The kernel of the problem of radiation effects is the awareness by the public, physicians, and tuberculosis workers that the whole subject is one of weighing the benefits of radiography against the known and the unknown effects of radiation exposure. It should remain clear that radiation that serves a useful and necessary purpose is warranted, but it should be used with the best protective devices. Putting the chest X-ray examination in its proper perspective, the radiation exposure to the gonads or body from a single chest film, using a well monitored machine, is infinitesimal when compared to the commonly used X-ray diagnostic procedures directly involving the gonadal areas.

Recommendations: Several specific recommendations from this report can be made to the constituent associations of the National Tuberculosis Association and American and State Trudeau Societies.

1. Chest X-ray surveys must be continued in the field of tuberculosis, in the detection of cancer, industrial thoracic disease, acute and chronic non-tuberculosis infections, chest tumors, and cardiovascular abnormalities.

2. Conventional and photofluorographic X-ray units with adequate protective devices may be used to survey segments of the population which are expected to show a high yield of thoracic disease.

   a. The installment of certain protective devices should be made now. These include proper cones, proper filtering, shielding devices for subject and operator, and exposure controls of an automatic nature.

3. Tuberculin testing in infants, children, young adults, prenatales and young diabetics should be developed as a primary guide to tuberculosis contacts and as one case-finding method, limiting X ray of the chest to those with a positive tuberculin test.

4. Case-finding programs should be reassessed to determine those segments of the population most deserving of chest X-ray surveys or tuberculin testing.

5. The instruction and training of personnel should include information concerning the protective devices for all types of X-ray units.

6. It should be made known to health workers and the public that effective steps have been taken to minimize radiation exposure involved in taking chest X rays. The need for early diagnosis and treatment of all forms of pulmonary disease should be emphasized.

7. Members of the American Trudeau Society and constituent associations of the National Tuberculosis Association might well promote the training of personnel skilled in radiation protection. The leadership of these organizations in the field of thoracic disease would help to assure the public that radiation exposure was at a minimum and that protection was maximum wherever chest X-ray examinations are conducted under their sponsorship.

Organization Section

Coming Meetings

Crippled Children’s Clinics—
September 13, McCall, St. Catherine Hospital
September 27, Scottsbluff, St. Mary Hospital
October 11, Ogallala, Elks Club
October 25, Lexington, High School

MID-STATE CLINIC ON DIABETES MELLITUS—Fort Kearney Hotel, Kearney, November 25, 1958. Contact Dr. O. R. Hayes, Kearney.

AMERICAN COLLEGE OF SURGEONS—The 44th Annual Clinical Congress; October 6-10, 1958, Chicago, Conrad Hilton Hotel.

AMERICAN CANCER SOCIETY—Symposium on Carcinoma of the Colon and Rectum, to be presented at the Annual Scientific Session, October 20-21, 1958, New York City, Biltmore Hotel.

MISSISSIPPI VALLEY MEDICAL SOCIETY—23rd Annual Meeting, Chicago, Sept. 24-26, Hotel Morrison.


OMAHA MID-WEST CLINICAL SOCIETY—26th Annual Assembly, November 3, 4, 5, and 6, Omaha, at Hotel Sheraton Fontenelle. (Approved for Category 1 credits to members of American Academy of General Practice).

Members Are Invited to Present Papers
At Next Annual Meeting—

The Scientific Assembly Committee of the Nebraska State Medical Association again invites members to present papers at the Annual Session in 1959.

Any member who plans to present a paper at this meeting must forward its title to E. L. MacQuiddy, Jr., M.D., at 1315 Sharp Building, Lincoln 8, in care of Mr. M. C. Smith. The deadline for offering titles will be September 21, 1958.

MEDICARE IN OPERATION

(This is the fourth in a series of short articles published in the Journal, monthly, designed to acquaint the practitioners with details of regulations governing the care of military dependents.

—Editor).

The Medicare Plan

Philosophy—Local Customary Practices.

—The basic philosophy of the civilian portion of the Dependents’ Medical Care Program, while fundamentally concerned with the eligible dependents, has carefully focused on the individual physician, his relationship to the dependent, to his community, to his local county and state medical society. The personnel of the Office for Dependents’ Medical Care have, from the very inception of the program, recognized that basic to its success was the necessity to preserve and maintain the normal customary and established practice of medicine throughout the United States and its Territories.

Principles of the Plan.—Several important aspects of the guiding principles are worthy of special attention as follows:

(1) The philosophy of free choice is reciprocal between patient and physician.

(2) Standards of physician services for eligible dependents are the same as standards established for other civilians and, in most instances, are closely monitored by state or territorial medical regulating bodies.

(3) Only duly licensed physicians are eligible to participate.

(4) Hospitalization for eligible dependents is provided under two circumstances: (a) Emergency care wherein any hospital or clinic may provide care and be paid for its services; (b) routine care can be provided only by hospitals that qualify under standards detailed in the Joint Directive.

“Free Choice.”—The principle of “free choice” has often been discussed in medical circles since the advent of health care plans. Since its inception, Medicare has adhered to three free choice principles, namely: (1) The right of the patient to choose between medical care in uniformed services or civilian facilities, (2) the right of hospitals and physicians to choose not to accept patients under the Plan, and (3) the right of the patient to choose the civilian physician de-
sired. The Appropriations Committee of the House of Representatives, in its report in 1957, recommended that consideration be given to requiring dependents, residing within reasonable distances of uniformed services medical facilities, to use these service facilities for reasons of economy. There is no known comparison of costs, between uniformed service and civilian facilities, for medical care of young women and children. In fact, overall comparison is most difficult because of the differences in organization and mission. The loss of dependent patients in uniformed service facilities is largely accounted for by maternity cases and it is in this area that service facilities were overcrowded prior to Medicare. Hospital stay of young mothers was too short in many places. Frequent moves of patients to other sections of the hospital were often necessary to make beds available to expectant mothers. Now, those cared for in uniformed services facilities may be allowed to remain an acceptable five to seven days. Consideration must also be given to the following important factors:

(1) Morale. A restriction of “free choice” would require dependents in restricted areas to apply for and receive special authority for civilian care and if not administered most wisely, could conceivably result in an extremely adverse morale-reaction among troops.

Acute Emotional Disorders.—Emergency care to dependents suffering from acute emotional disorders is available, when the attending physician certifies that an acute emergency exists and requires treatment in a hospital for the life, health, and well-being of the patient. Authority to treat these patients arises from Public Law 569, since the condition is, broadly speaking, an acute medical condition. The emergency care provided has been administratively limited to 21 days with extension of the treatment time granted only by the Office for Dependents’ Medical Care, and for only the following reasons:

(a) Allow sponsor to return home (from overseas, sea duty, etc.), or to assume responsibility for care at other Government expense.

(b) Allow patient to return home as “cured” or in a remission.

(c) Allow more time for the physician to make a diagnosis. The entire subject of providing even limited psychiatric coverage has been fraught with confusion, colored by emotions, surrounded with administrative complexities, and jeopardized by differences in semantics. Despite these obstacles, considerable care of this nature has been provided dependents amounting to 1,271 claims from 7 December 1956 to 1 June 1958. Physicians and hospitals throughout the nation are gradually becoming aware of the requirements which must be met in order for dependents to qualify for care. This part of the program is operating more smoothly except that dependents are still frequently the recipients of large bills resulting from unauthorized care, which the dependent, physician and hospital presumably believed to be payable by the Government.

The most significant advancement in the administration of this complexity has been the inclusion of a section on acute emotional disorders in the new Schedule of Maximum Allowances to be negotiated. This section includes values of treatments of these conditions hitherto not included in the schedule. When negotiations with the various states are completed in November 1958, fiscal administrators will be able to pay claims in this category, for care that does not exceed 21 days, without referral to the Office for Dependents’ Medical Care. Each such case must be certified as having been an acute emergency, meeting the requirement mentioned above.

Outpatient Care.—No provision exists in Title II, Public Law 569, for paying civilian physicians for medical care rendered dependents who are not admitted to a hospital on an “inpatient” basis except for care of maternity cases and bodily injury. The sponsor is responsible for outpatient charges of this type. Due to the lack of complete understanding of the provisions of Title II, Public Law 569, and the Joint Directive, these legal limitations have not been clearly understood by civilian physicians, dependents, sponsors, and, all too frequently, our military physicians. The situation is becoming less acute than formerly through information-releases and correspondence with physicians and contractors. A 25-minute training film has been prepared for showing to all military personnel to help explain the type of care which is authorized and that not authorized from civilian sources; it also has great potential for showing to dependents as well. Provisions in the
new schedule of allowances, presently under negotiation with the states, will enable the local fiscal administrators to pay claims for authorized outpatient care according to the negotiated amounts. This provision will reduce the volume of correspondence and special reports, as well as speed up payments to physicians. As pointed out previously, for authorized outpatient care, the patient is normally responsible for the first $15.00 of the physician’s fee.

INFECTIONS IN HOSPITALS

(“Bulletin of the Joint Commission on Accreditation of Hospitals,” No. 18, August, 1958, is presented below, because it deals with a challenging problem of the moment and gives suggestions that may be helpful.—Editor).

The presence of infections of various kinds will always be with us and we must accept it. To keep these infections to an absolute minimum is of paramount concern to all. This can be done only through continuous education and re-education of all hospital personnel, to carry out known control methods with strict discipline at all times.

The Commissioners of the Joint Commission on Accreditations of Hospitals think that the matter is of such grave importance that they urge hospitals to study their own problem and set up systematic controls. The Commission cannot dictate what these controls should be. However, this Bulletin suggests an approach which might be used as a pattern. Each hospital should develop its own methods of study and control to meet its specific needs.

I. Committee on Infections

The Commissioners recommend that every hospital have an “Infection Committee” charged with the responsibility of investigation, control and prevention of infections within hospitals. Membership on this committee should include the medical staff, administration and nursing service personnel. Where possible, participation with community health organizations such as health departments, medical societies and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself. The responsibility of the committee can appropriately include the following:

A. Establishment of definite controls. Control measures must have validity.

B. Establishment of techniques for discovering infections on patients who have left the hospital:
   1. Trace source of infection for which a patient may be admitted.
   2. Periodic sampling by letter, card, call or visit of discharged patients.

C. Make certain that bacteriologic services in or out of the hospital are available.

D. Establish a system of reporting all infections among patients and personnel and keep records as a basis for studying the source of infections.

II. Review Existing Practices

A. Clean and aseptic techniques should be practiced on all services of every hospital at all times. This includes the following procedures involved in patient care:

   1. Re-check all dietary and food handling procedures, such as proper dishwashing techniques, preparation and disposal of food, refrigeration, sanitation of ice bins, and the disinfection of contaminated utensils and equipment. There should be a special technique for infected or “isolation” patients.

   2. Review laundry practices. This involves linen control, blanket control, special technique in handling and disposal of contaminated laundry in patients’ rooms, nursery, operating room and the laundry itself.

   3. Study carefully methods of handling and disposing wastes and excreta of sputum, feces and urine, and the environmental wastes of dressings, floor sweepings and food.

   4. Re-study traffic controls and visiting rules in all areas, especially in operating rooms, nurseries and on obstetrical floors. They must be kept at an absolute minimum. Diligent maintenance of general cleanliness in all areas of the hospital, especially in service areas like util-

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ity rooms, janitors' closets, trash closets, etc.

5. Check source of air pollution. Air conditioning and ventilating units should be inspected regularly for contamination through intake sources, screens and filters (wet or dry). Hospital floors and corridors must be considered as potential spreaders of infection. Wet mopping is far preferable to dry sweeping. There should be a definite practice established for the care and cleanliness of the mop after each usage; a dirty mop spreads infection.

6. Routine, periodic culturing of autoclaves and water sterilizers, which is a must for all hospitals.

B. Educate and orient all personnel in the practice of aseptic techniques. An informed worker is a better and a safer worker. It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice. The following practices are some which should be studied:

1. Hand washing and scrubbing practices with review of proper soaps and detergents. Sinks with foot or knee controls in operating rooms, nurseries and isolation rooms are especially vital.

2. Proper gown techniques.

3. Proper mask techniques.

4. Proper dressing cart techniques and procedures.

5. Proper packaging of all goods, materials and instruments for steam sterilization.

6. Proper packaging of autoclaves. No autoclave should be so tightly packed that the packages are either tight together or tightly pressed against the walls. It is especially important that all impervious containers such as cans, jars, test tubes and deep trays be so placed in the autoclave that they lie on their sides, or with the opening downward, which prevents the trapping of air and failure of sterilization at the bottom of the container. Improper packaging and improper packing by unskilled people can undo the finest autoclaving precautions.

III. Control Use of Antibiotics

The medical profession has become increasingly aware of the problems created by the routine and indiscriminate use of antibiotics. Hospital surveys by the Commission reveal that the infection rate in most hospitals using antibiotics routinely is higher than in those not doing so. The common denominator in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusions drawn are that this increase in infections is due to the routine, indiscriminate use of preventive antibiotics in the absence of infection, and the indiscriminate use of antibiotics in the presence of infection without preceding cultures and sensitivity tests. In this latter type of case it is more than useless since without an adequate antibiotic, one may only inhibit the infectious agent and also at the same time stimulate the growth of other organisms which then become pathogenic.

IV. Recognizing the Human Factor

Any machine or equipment is only as good as the individual using it. All the rules, regulations and controls mean nothing if hospital personnel do not constantly check themselves for human errors. Continuing education and eternal vigilance in the cause, effect, and elimination of infections, in addition to instituting proper control methods, are important.

The recognition and elimination of infections in patients and personnel are thought by many to be the most important single facet in the control of infections. No hospital employee with a carbuncle, boil, acne, paronychia, fungus infection, upper respiratory infection, diarrhea, common cold, or in fact any infection, should be allowed in contact with patients. The reverse is true of infected patients. They must be isolated. One of the commonest avenues overlooked is by the physician not notifying the admitting office of the presence of infection already in the patient, or the admitting office or
floor nurse not recognizing its very obvious presence on admittance.

There is no single factor responsible for so-called hospital infections. There are many factors and causes and each should be investigated. The Joint Commission cannot supply and does not have literature on special techniques and treatments. For specific articles refer to medical and hospital library indices on the subject.

A Message From the Horse's Mouth on England's Socialized Medicine—

We all know about socialized medicine and more particularly about the British system. Too many of us are complacent about the possibility of having such a system forced upon us. Our complacency may be because we cling to that old, good feeling that it can't happen to us; it may be we have faith that others will fight our battle for us; perhaps some of us are ignorant that state medicine is being set up in the United States little by little, and some fine morning we will find ourselves in the shoes of the English doctor. The Oscar Ewing guild is not unaware of what is happening and are always on hand to give Socialism a boost.

It is for these and other reasons that we quote an editorial from the Sunday World-Herald for July 13, 1958, as follows:

THE UNSUGARED PILL

Ten years ago this month every man, woman and child in Britain became eligible for free medical and dental service. Everything from hospital care to wigs was included in this boon from the creators of the welfare state.

Socialized medicine came to Britain, as the London Economist reminds its readers, on the promise that publicly provided medicine would be no more of a burden on the economy than private medicine, and that the benefits would be so great "we cannot afford not to have it."

The Economist reports that today little is heard of these promises. The British have learned that Government cannot reduce sickness simply by providing free treatment. And the people have found that as taxpayers they are spending a lot more for medical treatment than they did as paying patients.

There weren't enough medical resources in Britain in pre-Socialist days to provide for all who wanted service, and there aren't enough facilities today, says the Economist. In fact, in the past 10 years only one small new hospital has been built in all the British Isles. And the rush of people for treatment has handicapped many who need it most—and who were provided with excellent free treatment before socialized medicine came along. These are the aged, the chronic sick who have been crowded out of the hospitals, and school children who need dental care.

Before 1948 there would have been a national rumpus if an old man or woman had died in poverty or loneliness because no hospital would take him in. Today this happens, says the Economist. The overriding obligation of the poor law has been abolished, and nobody is legally to blame if old people die of neglect.

The problems of rising costs, the need to squeeze budgets, says the Economist, were left to the politicians. "No one seems to have been concerned with insuring that the best value has been obtained for the money allocated."

To keep the total bill down, the Government has been driven from expedient to expedient. It raised the health service "contribution," or tax. It vetoed pay increases for certain health service workers—and finally it started charging patients small fees. Nevertheless, the health service has to have more money and soon.

The Economist says the solutions are obvious but are being avoided by the politicians. These solutions include more and larger fees for the services rendered, if the individual can pay. The health tax will have to be re-jiggered and scaled so that people with higher incomes pay more.

In other words, according to this authoritative view, strict socialism isn't working in Britain's socialized medicine, and the system will have to be patched up by resorting to more private payment plus higher taxes. The Economist's report is particularly enlightening because there has been so much propaganda in America recently about the magnificent, overwhelming success of Britain's "free" medicine. The facts indicate that it's not very good and that its problems are growing.
The British experience is a pretty good argument for keeping the private medical system which we Americans now have.

Important Jobs Still To Be Done by
Blue Shield—
(The following two items are from Blue Shield Newsletter, July).

Dr. Aims C. McGuinness, special assistant to H.E.W. Secretary Folsom, told delegates at a recent meeting of the Middle Atlantic Hospital Assembly that, "The present administration earnestly believes that voluntary health insurance offers the best means of helping most people meet the costs of health care and at the same time of maintaining a free enterprise system among those who provide the care."

Dr. McGuinness warned, however, that if costs of care continue to increase at the present pace, health plans might conceivably be priced out of the reach of the average citizen. To prevent this, he said that it will be essential to "... explore every possibility for arresting the upward trend in the costs of health care" to assure that insurance carriers and prepayment plans may continue to develop broader coverage at rates people can afford. And he concluded, "It is the job of everyone—the medical profession, the insurance business, the government and the people who use health services—to join together in an effort to extend voluntary prepaid health insurance to those who are not now protected. And every effort must be exerted to broaden the type of coverage available."

Dr. Donald Stubbs, Chairman of the Board of Blue Shield Medical Care Plans, addressed the graduating class of the University of Arkansas Medical School recently and told the graduates that, "Doctors, starting Blue Shield, were fighting a threat of socialism which they feared. Some," he continued, "mistakenly think the fight was won, but we know that there is no permanent victory, but only enough to encourage us to go on. We cannot turn back now for the inexorable force of economic pressure and the accelerating growth of our credit economy leave no choice except the voluntary system we support."

W.M.A. Provides Central Repository for Medical Credentials—

On page 814 of the July issue of your Journal, under the heading "Protect Your Medical Credentials," attention is directed to a central repository for medical credentials of doctors. The World Medical Association has dealt with many instances where doctors have irretrievably lost their credentials and are forever unable to establish their identity as M.D.'s. Realizing how catastrophic this may be to an individual as well as the increasing possibility of such a catastrophe, W.M.A. has established a central repository where all possible precautions are provided to protect these important documents against loss or damage.

Any Nebraska doctor who is interested in using the repository may communicate with Dr. H. W. McFadden, Jr., at the University of Nebraska College of Medicine, Omaha, or with your editor, and a packet of application forms and instructions will be sent to you.

Muscular Dystrophy Survey of Nebraska—

The following information was furnished by Mrs. Marvin Traeger of Fairbury, Nebraska. Mrs. Traeger is president of the Muscular Dystrophy Foundation of Nebraska. The survey was conducted by means of questionnaires sent to the doctors.

The total number of cases now known to the Muscular Dystrophy Foundation of Nebraska is 79. The age and sex distribution of these cases is as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-10 years</td>
<td>14 cases</td>
</tr>
<tr>
<td>11-21 years</td>
<td>14 cases</td>
</tr>
<tr>
<td>22-33 years</td>
<td>9 cases</td>
</tr>
<tr>
<td>34-85 years</td>
<td>42 cases</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
</tr>
</tbody>
</table>

Males—70% ; Females—30%

MEDICINE IN THE NEWS
From the Omaha World-Herald—

A 25-hundred-dollar grant for experimental studies of eye changes caused by diabetes has been made to the University of Nebraska College of Medicine by the National Society for the Prevention of Blindness.

Drs. Gordon E. Gibbs, Harold Gifford and Richard Wilson will supervise the study. The grant is one of 13 totaling 30 thousand dollars made by the society to colleges and hospitals.
From the Scottsbluff Star-Herald—

Nebraska will get almost two million dollars in Hill-Burton funds for the 1958-59 fiscal year. State Director of Health Dr. E. A. Rogers said Nebraska’s estimated amount will total $1,874,384.

Of this amount, Dr. Rogers said, $1,481,770 will go for general hospital construction. The remaining funds will be used for rehabilitation units, medical centers, and nursing homes.

From the Albion News—

For “unprofessional conduct,” Dr. Robert McShane has lost his license to practice medicine and surgery in Nebraska, State Health Director E. A. Rogers told the Albion News. Dr. Rogers said a notice was mailed to Dr. McShane telling him of the action.

A former doctor in Albion, Dr. McShane had been asked to appear at a hearing called by the Attorney General. Dr. McShane was asked to reply to charges of being “addicted to habitual intoxication which conduct constitutes grounds for revocation of his license for the practice of medicine and surgery.”

Dr. Rogers said his information was that Dr. McShane recently was transferred from an Omaha hospital to Norfolk State Hospital, where he is undergoing treatment.

From the Omaha World-Herald—

Dr. Kenneth A. Blinn, an Omaha native and graduate of the University of Nebraska College of Medicine, has designed electronic equipment which checks reactions of psychoanalysts and their patients during conferences. Dr. Blinn is a clinical neurophysiologist at Mount Sinai Hospital in Los Angeles.

The equipment he developed is considered valuable in psychotherapy. It helps the analyst check his own reactions in dealing with patients.

The equipment not only tape records conversations but registers changes of skin temperature at the fingertips and changes in the electrical conductivity of the skin. It also records heartbeat and body motion of patient, doctor and observers.

From the Hebron Register—

Superintendent Robert Hill of Thayer County Memorial Hospital has been given a special Distinguished Achievement Award by the National Society of Medical Technicians, in recognition of his work in setting up the Nebraska Branch of the organization.

The award was made at the National Convention in Philadelphia in June. The Nebraska group was organized about one year ago.

From the Bellevue Press—

Mr. Albert Hansen who passed away on July 1, is the first person in Nebraska Lions Eye Bank program to have donated his eyes to the Eye Bank.

Mr. Hansen’s eyes were removed shortly after his death and have been sent to the Iowa Lions’ Eye Bank at the University of Iowa where, it is hoped they will be used to restore the sight of a blind person.

Mr. Hansen was one of about a thousand Nebraskans who signed pledges during the last year to donate their eyes.

From the Omaha World-Herald—

The co-operation of the Creighton University School of Medicine has drawn high praise from a visiting group from Washington.

Representative Fred Marshall from Minnesota and several others ended a tour of reservations in North and South Dakota and Nebraska with a meeting of Dr. F. G. Gillick, dean of the school.

Mr. Marshall is a member of the subcommittee which recommends appropriations for the Indian health program.

Dean Gillick said the medical school is the only one in the country which is directly tied to the Government in the treating of Indians. He said a busload of Indians is brought into Omaha three or four times a week for treatment in the Creighton clinic.

“The Indian treatment setup in Omaha seems to be an ideal one both from the standpoint of Creighton University and the Government,” Mr. Marshall said, “with the Indians benefiting most of all.”

Dean Gillick said it is a dream of his to create a medical ward for Indians in an Omaha hospital.

“We could give the Indians who need it sustained treatment and then bill the Gov-
government on a cost basis,” Dr. Gillick said. “We have had good success in our medical relations with the Indians we have treated and would like to show constant improvement.”

From the Omaha World-Herald—

Methodist Hospital of Omaha has announced plans for a 800-thousand-dollar expansion program for its School of Nursing and interns’ living quarters. The hospital hopes to start work in the fall according to Mr. James B. Low, board president.

A 625-thousand-dollar addition will be made to the present School of Nursing dormitory and a 175-thousand-dollar apartment building for married interns and their families will be constructed.

The 20-unit apartment building will be the first such living quarters in the city for young doctors, said Mr. Low.

The dormitory for male student nurses takes cognizance of the fact that more men are going into the nursing profession.

The School of Nursing addition will allow enrollment to be increased from 130, to about two hundred. It will have living quarters, a library, conference rooms and an auditorium.

From the Lincoln Journal—

Omaha: Dr. J. P. Tollman, dean of the University of Nebraska College of Medicine, and Dr. F. Lowell Dunn, building committee chairman, have estimated that increased cost will cut off about 30% of the expansion planned for the college.

Work on a $1,800,000 addition to University Hospital is to start next fall.

Dr. Dunn said “costs have risen about 30% since 1953 and may be up 50% before $6 million dollars approved by the Legislature, is collected in its entirety in 1961 or 1962.”

Some medical departments will be short of office and research space and there also will be fewer rooms for examining patients.

Dr. Tollman said the new unit will emphasize out-patient care.

**NOTICE TO ALL CONTRIBUTORS**

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

**News and Views**

Arthritis and Rheumatism Foundation Will Not Merge With N.F.I.P.—

The Arthritis and Rheumatism Foundation has recently announced that it is unable to accept a proposal to merge with the National Foundation for Infantile Paralysis. According to the announcement it had been proposed “that the Arthritis and Rheumatism Foundation and most if not all its more than 50 local chapters disband, turn over these functions to the National Foundation for Infantile Paralysis and thereafter work as an absorbed part of that organization.”

Differences in organization and methods can not be reconciled; local chapters of A. and R.F. are practically autonomous in contrast to those of N.F.I.P.; and methods of fund-raising are different.

In view of the irreconcilable differences and the accomplishments of the Arthritis and Rheumatism Foundation to date, it proposes to continue as an independent organization.

The Life Insurance Medical Research Fund—

The Life Insurance Medical Research Fund, organized in 1946 by a group of life insurance companies, has devoted its entire resources to fighting the nation’s No. 1 cause of death—heart disease. Each year the fund allocates more than one million dollars for heart research. The fund receives its support from about 150 life insurance companies in the United States and Canada.

The Life Insurance Medical Research Fund has given 81 awards totalling $1,098,680 in support of heart research during the coming year. Fifty-seven of the awards are in the form of grants to research institutions—medical schools, universities and hospitals—for specified projects in basic heart research. These institutions are located in 18 states, the District of Columbia, Puerto Rico, four Canadian provinces and The Netherlands.

The individual grants range from $1,760 to $29,700, with the average standing at $17,123.

A Good Book for Parents and Teachers—

The Association of American Physicians and Surgeons, Inc., calls attention of the profession to a book entitled "Bending the
Twig," a bird's eye view of the evil effects of Progressive-New Education on the youth of our country presented by Colonel Augustin G. Rudd in an attempt to "return common sense to the public education of our children." Colonel Rudd has assigned all royalties to the Sons of the American Revolution. The book may be purchased from the New York Chapter, S.A.R., 15 Pine St., New York 5, N.Y. ($3.95 per copy).

Standards for Blood Transfusion Services Approved—

A recent release by the Joint Blood Council informs us that standards for evaluating and comparing policies and technical procedures of blood transfusion services throughout the country have been established by the Joint Blood Council, Inc. These standards may be used by blood banks as a yardstick for voluntarily evaluating themselves. Methods are described for collection, storage, laboratory processing, and preparation of certain blood derivatives, as well as testing procedures to insure compatibility with patients' blood.

It is hoped use of these standards will improve technical qualifications of blood technologists and encourage continuing research in the field.

Announcements

Postgraduate Courses in Obstetrics Are Offered the Generalist—

The Woman's Hospital in New York City is offering two courses in Obstetrics, to general practitioners only. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled "Ante-partum Care" and "The Conduct of Labor and Delivery." They will be given from October 16-31, 1958.

These are full time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this postgraduate instruction will please address Mr. Carl P. Wright, Jr., Woman's Hospital, 141 West 109th Street, New York 25, N.Y., and an application blank and prospectus will be forwarded.

General Practice Residencies Available—

The Air Force still needs general practitioners. Approved residencies in General Practice are available at the U.S.A.F. Hospital, Maxwell Air Force Base, Alabama, and certain civilian hospitals. Others will soon be approved in other Air Force Hospitals.

After completing residency training in General Practice, medical officers may attend Primary Course in Aviation Medicine, if they desire and are physically qualified. If interested, write The Surgeon General, Headquarters, U.S.A.F., Washington 25, D.C.

Second Oklahoma Colloquy on Advances In Medicine—

On November 12, 13, 14, and 15, 1958, the Second Oklahoma Colloquy on Advances in Medicine, devoted to arthritis and related disorders. This will be held in the Auditorium, University of Oklahoma School of Medicine, Oklahoma City. This is being developed by the Department of Medicine and Division of Postgraduate Education of the School of Medicine, and sponsored by several pharmaceutical firms and the Oklahoma Chapter, Arthritis and Rheumatism Foundation.

Eleven nationally prominent investigators will participate and present the results of original work and clinical experience.

Registration fee, $25. Missouri-Oklahoma football nearby on the last day of meeting.

Postgraduate Course, International College of Surgeons—

A postgraduate course in surgery will be presented by the United States Section of the International College of Surgeons in conjunction with the Cook County Graduate School of Medicine, Chicago, October 13-17, 1958. For full information, write International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, or Cook County Graduate School of Medicine, 707 South Wood St., Chicago 12.

Mary Putnam Jacobi Fellowship—

The Women's Medical Association of the City of New York offers the Mary Putnam...
Jacobi Fellowship to a graduate woman physician, either American or Foreign. This Fellowship will start Oct. 1, 1959, and will amount to $2000, one-half being available Oct. 1, 1959. Full details may be had by writing Ada Chree Reid, M.D., Secretary, 118 Riverside Drive, New York 24, N.Y.

Symposium on Infectious Diseases—
A one-day symposium on infectious diseases, jointly sponsored by the American Academy of General Practice, Kansas University Medical Center, and Lederle Laboratories will be held Friday, Sept. 19, at Battenfeld Auditorium on the Medical Center campus, Kansas City, Kan. Address the A.A.G.P. in Kansas City, Mo., for details.

Human Interest Tales
Dr. J. E. Ramsay, Atkinson, underwent surgery at an Omaha hospital in July.

Dr. M. A. Quaife, Omaha, is the new associate of Dr. S. O. Staley of Kearney.

The Kearney Clinic, Kearney, has announced a new associate—Dr. Lawrence W. Bauer.

Dr. Stuart McWhorter, Osawatomie, Kansas, has joined the staff of the Lincoln State Hospital.

Dr. T. L. Weekes, Nebraska City, has been named Medical Chairman of the Otoe County Cancer Society.

Dr. H. V. Nuss, Sutton, left in July for a month’s tour of Europe. He was accompanied by his daughter.

Dr. and Mrs. Charles McLaughlin, Omaha, recently returned home from a six week trip to Northern Europe.

Dr. Robert L. Heins, Falls City, is the newly appointed local chairman of the Nebraska Heart Association.

Dr. Houtz Steenburg, Sayre, Pennsylvania, has returned to Aurora where he will join his father Dr. Don Steenburg.

Dr. Robert L. Bass and family have made their new home in Genoa where Dr. Bass is associated with Dr. Kenneth Dalton.

Dr. H. S. Heim and family of Humboldt, spent their summer vacation in Beverly, Kentucky, where Dr. Heim formerly lived.

Dr. Gordon Francis, who recently completed his military service, is now associated with his father Dr. M. B. Francis of Bellevue.

Dr. John H. Story, Crawford, has left this community and has moved to Lovell, Wyoming, where Dr. Story will open a new office.

Two new doctors have located in O’Neill. Dr. Robert Waters, a native of Scotia, and Dr. George Carstens of Mitchell, South Dakota.

Dr. and Mrs. Charles Tompkins and family of Omaha have moved to Tucson, Arizona, where Dr. Tompkins will resume his practice.

Dr. Robert C. Anderson, Omaha, has moved to Ainsworth where he will be a member of the staff of the Ainsworth Clinic-Hospital.

Dr. and Mrs. R. P. Lichtenberg and family of Grand Island have moved to Keokuk, Iowa, where Dr. Lichtenberg will practice medicine.

Dr. S. R. Rathbun, a 1957-graduate of the University of Nebraska College of Medicine, is the new associate of Dr. Ben Bishop in Crawford.

Dr. T. K. Lin, Kansas City, Kansas, has been appointed assistant professor of medicine at the University of Creighton School of Medicine.

Dr. John D. Ewing, Omaha, recently completed a mass casualty medical management course at Brooke Army Medical Center, Fort Sam Houston, Texas.

Drs. J. R. Finkner and R. C. Butler, Minden, will move into a new $25,000 medical clinic in October. The facilities will provide room for three doctors.

Dr. Henry Caes, Hastings, is leaving this city and will move to Sioux City, Iowa, where he has accepted a position with the St. Joseph’s Mercy Hospital.

Dr. Gerald R. Holcomb is the new associate of Dr. George Hoffmeister of Hastings. Dr. Holcomb completed his internship at an Omaha hospital in July.

Drs. Roland Morgan and Gene Gross, formerly of Omaha, are now associated with Dr. C. E. Minnick of Cambridge. Both doctors recently completed their internships.
Dr. J. Ralston Wells, Grand Island, has announced his retirement as manager of the Grand Island Veterans Hospital. Dr. Wells plans to move to St. John's River, Florida.

Dr. C. A. Rydberg, Litchfield, has returned home after an extensive trip to the west coast and Hawaii. The trip also included attendance at the annual meeting of the American Medical Association.

Dr. Glen E. Burbridge, Nebraska City, has received a certificate of appreciation by President Eisenhower in recognition of five years of service as a medical advisor of the selective service board of Otoe county.

Dr. Payson Adams, Omaha, has returned from a round-the-world trip en route to Stockholm, Sweden, where he attended the joint meeting of the American College of Surgeons and the Swedish Surgical Society.

Dr. J. D. McCarthy, Omaha, visited his son and daughter and their families while attending the annual meeting of the American Medical Association in San Francisco, California. The family reunion was held in Van Nuys, California.

Dr. John M. McKain has been named to the newly created position of assistant professor of surgery at the Creighton University School of Medicine. Dr. McKain was formerly associated with the Indiana University Medical Center.

Dr. Robert Koefoot, Grand Island, has been appointed chairman of the medical division of the disaster program of the Hall County Red Cross. Dr. Donald Watson has been appointed deputy chairman and Dr. G. W. Graupner as alternate chairman.

What role does heredity play in allergy? Over half of all allergy sufferers give a history of allergic diseases in other members of the family, according to the publication "Patterns of Disease" prepared by Parke, Davis & Company for the medical profession. Transmission of the allergic tendency seems to occur twice as frequently through the woman as through the man. When both parents are allergic there is a 75 per cent chance that the offspring will be too. With one allergic parent, there is a 25 to 50 per cent chance, but with neither parent allergic the possibility declines sharply.

Know Your Blue Shield Plan

The "Blue Shield Idea"—

(Quoted from "The Milwaukee Medical Society Times")

"I believe that the whole structure of voluntary health insurance is dependent upon Blue Shield. By that I mean that Blue Cross will not survive without Blue Shield, nor will the commercial insurance industry, especially the major medical part of it. Only a compulsory, regimented system can supplant this whole voluntary system, and the keynote to its survival is the Blue Shield idea. . ."

These words are quoted from a recent address by Dr. Donald Stubbs of Washington, who currently serves as President of the District of Columbia's Blue Shield Plan and as Chairman of the Board of the national association of Blue Shield Medical Care Plans.

What is the "Blue Shield idea"? And why is this idea the keynote to the survival of our voluntary health insurance program in America?

First of all, the Blue Shield idea exemplifies medicine's responsible service to the community. It represents our profession's greatest and most successful effort to break the money barrier between patients of limited income and the professional services—of unpredictable amounts and incalculable costs—that we stand ready to provide them. It represents the one prepayment plan that seeks to protect, first of all, the least profitable "risks" — those people who can least afford our services and who, generally, most frequently need them.

Second, the Blue Shield idea is the idea of providing dependable benefit to the patient. Blue Shield Plans pay their "participating physicians" directly for services rendered Blue Shield member-patients. In most areas, these "participating physicians," through their agreements with their local Plans, have given assurance to their patients in the lower and moderate income groups that their Blue Shield membership will meet the full cost of services covered by their contracts. Even where Blue Shield payments are accepted by doctors on an "in-
demnity” basis, the Plans are constantly seeking to equate their payments to the normal fees of the local physicians — so that Blue Shield may offer the patient of limited means a reliable assurance that the Plan’s payments will meet the actual costs of covered services.

Third, the Blue Shield idea is the idea of preserving the private, confidential relationship between doctor and patient. No “third party” enters into the Blue Shield transaction between doctor and patient. The Blue Shield is the doctor’s own mechanism, created in his own image, and dedicated to the sole purpose of helping the doctor the better to serve his patients. Blue Shield pays no tribute in the form of profits to third party owners; nor is Blue Shield subservient to the whims of social theorists who want to reshape medical practice to suit their own ideologies, or to the vote-catching designs of politicians.

Service to the community . . . dependable benefit to the patient . . . the private, confidential relationship of doctor and patient — these are the exclusive hallmarks of Blue Shield, and the bulwark of our voluntary plan of medical care prepayment in America.

The Blue Shield idea is rooted in the vital needs of the human being and in the best aspirations and traditions of the physician.

The Woman's Auxiliary

Pre-Convention Executive Board Meeting, April 29, 1958—

The preconvention executive board meeting of the Woman’s Auxiliary to the Nebraska State Medical Association convened at nine o’clock, Tuesday, April 29, 1958, at the Cornhusker Hotel, Lincoln.

The meeting was called to order by Mrs. R. R. Brady, president. Mrs. P. O. Marvel gave the invocation and the Auxiliary Pledge was repeated.

Roll call was answered by eight officers, one director, ten committee chairmen, four councilors and three county presidents.

Mrs. Brady announced that the minutes of the postconvention and fall board meetings had been published in the Nebraska State Medical Journal and would not be read. They were approved as published.

Mrs. Brady presented Mrs. Paul Craig, National Auxiliary president, who offered her help and friendship.

Mrs. Donald Purvis, Lancaster County Auxiliary president, was presented.

Correspondence was read as follows:

a. Concerning the Forand bill.

b. From Creighton University thanking the Auxiliary for their A.M.E.F. contribution.

c. From Mr. Merrill Smith asking help for the Nebraska Medical Foundation.

d. From Dr. Mal Rumph reporting on the essay contest.

Mrs. Robert Hillyer gave the treasurer’s report which was placed on file. The auditing committee reported the treasurer’s books to be in order. Mrs. O. A. Kostal made a motion that the auditor’s report be accepted. The motion was seconded and carried.

Mrs. Donald Purvis moved that the convention bills be allowed. The motion was seconded and carried.

Mrs. James Donelan read the proposed budget for 1958-59, in the absence of Mrs. Offerman. A motion was made by Mrs. Donelan that the proposed budget be accepted. The motion was seconded and passed.

Mrs. James Donelan made a motion recommending that the Nebraska State Medical Auxiliary make a contribution of $1200.00 to A.M.E.F. in memory of Dr. R. R. Brady. The motion was seconded and carried.

Mrs. C. H. Farrell took the chair while Mrs. Brady gave her annual report.

The following reports were given by committee chairmen:

Mrs. C. H. Farrell—Organization

Mrs. Wayne Waddell — Members at large

Mrs. James Donelan—A.M.E.F.

Mrs. Hiram Hilton—Bulletin

Mrs. George Robertson (in absence of Mrs. Bosley)—Legislation

Mrs. George Robertson (in absence of Mrs. Muehlig)—Mental Health

Mrs. R. E. Garlinghouse—Newsletter

Mrs. F. G. Travniecek—Public Relations

Mrs. F. H. Tanner—Essay Contest

Mrs. W. C. Kenner—Recruitment
Mrs. Lloyd McNeill — Resolutions and Revisions
Mrs. D. B. Wengert—Safety
Mrs. J. M. Christlieb (in absence of Mrs. James Ramsay) — Today’s Health

A motion was made by Mrs. George Covey that reports of officers and state chairmen be accepted. The motion was seconded and carried.

Mrs. Paul Craig talked on the Forand bill urging us to help open people’s eyes as to how this could mean socialized medicine. She suggested we work with our doctors, talk to friends and acquaintances, and find ways to take care of our own aged.

A motion was made, seconded and carried that we accept the printed program as the official convention program.

Mrs. George Covey reported that the State Medical Association advised against bonding our treasurer.

Mrs. George Robertson made a motion that the motion of the fall board meeting to purchase the film “Angry Boy” be rescinded. The motion was seconded and carried.

A motion was made by Mrs. George Robertson that Mrs. George Covey be chairman of delegates to the National Convention. The motion was seconded and carried.

Mrs. Brady reported that the Nebraska Medical Foundation funds are used as loan funds for students of Nebraska schools only, and that they are in need of funds. Anyone making contributions should differentiate between A.M.E.F. and the Nebraska Medical Foundation.

A motion was made by Mrs. R. E. Garlinghouse that we recommend at the annual business meeting that we renew our support of the Nebraska Medical Foundation without detracting from A.M.E.F. The motion was seconded and carried.

The report of the nominating committee was made and filed. The nominees are as follows:

President—Mrs. George Covey
President-Elect—Mrs. C. H. Farrell
First Vice Pres.—Mrs. Wayne Waddell
Second Vice Pres.—Mrs. Frank T. Tanner
Treasurer—Mrs. Robert Hillyer
Recording Secy.—Mrs. R. E. Garlinghouse
Corresponding Secy.—Mrs. O. A. Neely

DIRECTORS:
One Year—
Mrs. Everett Brillhart
Mrs. Dan Nye

Two Years—
Mrs. W. E. Johnson
Mrs. Sam Perry

Mrs. George Robertson moved that the report of the nominating committee be accepted. The motion was seconded and carried.

The meeting was adjourned.

Respectfully submitted,

Mrs. F. H. Shiffermiller,
Recording Secretary.

Thirty-Third Annual Business Meeting,
April 29, 1958—

The Thirty-third Annual Meeting of the Woman’s Auxiliary to the Nebraska State Medical Association was called to order by the president, Mrs. R. R. Brady, on April 29, 1958, at one-thirty o’clock at the Cornhusker Hotel, Lincoln.

The invocation was given by Mrs. P. O. Marvel and the Auxiliary Pledge was repeated.

Dr. Russell Best talked on A.M.E.F. and the Nebraska Medical Foundation. The A.M.E.F. donations are used for teachers’ salaries, equipment, etc. Donations to the Nebraska Medical Foundation are used for scholarships, nursing education and some research.

Mrs. Paul Craig, our National Auxiliary President and guest speaker was introduced. She talked on:

a. Cooperation between County, State and National auxiliaries.

b. How our projects need to fit the times and situations.

c. Promotion of the art and science of medicine and improvement of public relations.

d. Recruitment — a new film is available after July.

September, 1958
e. Outline of program at National Convention—
   1. By-law revision.
   2. Qualifications for officers.
f. Ways of promoting interest in auxiliary—
   1. Create a sense of belonging, accomplishment and recognition.
   2. Look for talents and interests of members and use and recognize them.

Mrs. Brady introduced Mrs. Donald Purvis, general chairman of the convention, and thanked her and the Lancaster County Auxiliary for a fine convention.

The following past presidents were recognized:
Mrs. James M. Woodward
Mrs. George Robertson
Mrs. L. E. Sharrar
Mrs. Wm. Carveth
Mrs. R. E. Garlinghouse
Mrs. James Donelan
Mrs. P. O. Marvel

The following recommendations from the fall board meeting and the pre-convention board meeting were read:

1. That we add a Nebraska Medical Foundation chairman and that we renew our support of the Foundation.
2. That the treasurer, at her discretion, be instructed to buy what bonds are available with $200.00.
3. That $50.00 be taken out of project money for prizes for essay contest winners.
4. That $1200.00 be donated to A.M.E.F. in memory of Dr. R. R. Brady.

Mrs. Robert Hillyer gave the treasurer's report. The auditor's report was read. Mrs. Kostal moved that the report of the auditing committee be accepted. The motion was seconded and carried.

A motion was made by Mrs. Carveth that convention expenses be allowed as they come in. The motion was seconded and carried.

Mrs. James Donelan read the proposed budget for 1958-59.

Mrs. C. H. Farrell took the chair while Mrs. Brady gave her annual report.

Mrs. Donald Purvis made a motion that the treasurer's report be accepted. The motion was seconded and carried.

Mrs. P. O. Marvel made a motion that the proposed budget be accepted. The motion was seconded and passed.

Mrs. R. R. Brady made a motion that the president's report be accepted. The motion was seconded and carried.

Mrs. P. O. Marvel conducted a memorial ceremony for Mrs. Floyd Clark, Mrs. J. A. Henskif and Mrs. Neumarker.

Mrs. Carveth made a motion that the recommendations of the fall board meeting and the pre-convention board meeting be accepted as read. The motion was seconded and carried.

Mrs. Lloyd McNeill read the resolutions and revisions and made a motion that they be accepted as read. The motion was seconded and passed.

Mrs. Frank Tanner reported on the essay contest. Mrs. Sharrar made a motion that, with letters of congratulations, the prize money be sent to the three winners of the essay contest. The motion was seconded and carried.

Mrs. George Covey asked that anyone planning to attend the National Convention please get in touch with her. Seven delegates are allowed.

The following county reports were given:
Mrs. O. A. Kostal—Adams
Mrs. C. J. Miller—Four County
Mrs. Harry M. Hepperlen—Gage
Mrs. W. E. Johnson—Holt Northwest
Mrs. Donald Purvis—Lancaster
Mrs. R. W. Karrer—Scottsbluff
Mrs. P. O. Marvel—Sixth Councilor District
Mrs. D. B. Wengert—Tri County II
Mrs. C. H. Farrell—Richardson
Mrs. J. M. Christlieb—Douglas
Mrs. J. M. Christlieb (in absence of a member of the auxiliary)—Dawson, Buffalo, Kimball - Cheyenne - Deuel, Lincoln, Northwest

Mrs. George Robertson made a motion that we accept the recommendation to add a
Nebraska Medical Foundation chairman and renew our support of the Foundation. The motion was seconded and carried.

The recommendations of the nominating committee were read. Mrs. Christlieb moved that we accept the recommendations made by the nominating committee. The motion was seconded and carried.

Mrs. P. O. Marvel conducted the installation of the new officers.

Mrs. George Covey gave her pledge of service to the Auxiliary.

The meeting was adjourned.

Respectfully submitted,

Mrs. F. H. Shiffermiller,
Recording Secretary.

TUBERCULOSIS ABSTRACTS

SOME NEW FRONTIERS IN ADULT HEALTH—1956

- New knowledge of respiratory infections has made the goal of controlling them a possibility. Community understanding and effort are needed if the prevention of both infectious and non-infectious illnesses is to be effected.

A frontier may be defined as a border between opposites—between the known and the unknown. As the unknown becomes known, new frontiers become apparent. Progress in social and biologic sciences has made it possible for public health to identify some new frontiers.

The fundamental knowledge which made a vaccine against paralytic poliomyelitis possible also makes possible the identification of viruses which play a part in causing acute respiratory infections. This group of infections, usually lumped together under the title of "a cold," is not often considered as a public health problem. But the common respiratory infections are the leading causes of job and school absenteeism, responsible for tremendous losses in productivity; are in each age group the most frequent cause of illness, and are serious obstacles to personal and community well-being.

Not only is the community as a whole directly affected by "colds" but it is clear that achievement of control requires organized community effort. Community support will be required to continue the search for new knowledge and to apply knowledge now available. For example, experimental vaccines against viruses of the respiratory group are being developed and tested with indications of future success. Our understanding and ability to control the serious effects of the many diseases caused by the viruses—measles, mumps, chicken pox, and, more recently, infectious hepatitis—is being advanced likewise.

Our successes in the control of many acute communicable diseases and our increasing concern with noninfectious disease have tended to divert both public and professional attention from other persistent problems of infectious disease. Yet some new frontiers in relation to such old problems might be indicated. There is the need for a new emphasis on common infectious diseases especially in the light of a well-justified concern over long-term illness. Current thinking about the causes of chronic disease and disability, and ultimately of death, has begun to theorize about a casual relationship between the so-called minor illnesses, most of them infectious, and the occurrence of long-term illness and final fatal illness. New clues to the control of disease and disability undoubtedly will be found in studies of man's susceptibility to disease.

This chain of thought leads away from infectious disease, but let us return for a moment to one in particular. New knowledge of this disease has brought the realization that the goal of eradication has been accepted as valid by many in the past. Many well have been illusory; that a goal of control is still to be achieved. However, control seems more possible for the future than hind-sight tells us it might have been in the past—if we can apply the knowledge we already have.

In 1955 this disease killed 15,000 men and women in the United States and an estimated 250,000 were ill with it. In New York City alone there were 1,000 deaths, a total of over 12,000 known cases and an estimated 10,000 persons who did not, and probably do not, know they have this disease. I am speaking of tuberculosis. The dramatic fall in mortality from tuberculosis, beginning in 1947 and greatly accelerating the downward trend already evident, created a false sense of security. The number of newly reported cases has not fallen at the same rate. Adults are still evidencing their infection by the presence of active tuberculosis with tubercle bacilli in their sputum, or by the presence of tuberculosis in their children. Eighteen of every 1,000 youngsters in a group of pre-school children seen in New York City Child Health Stations in 1955 showed positive skin tests for tuberculosis—evidence, in children, usually not only of recent infection but of an open, active case of tuberculosis in some adult in the child's immediate environment.

This is despite the fact that most patients with tuberculosis can now be rendered noninfectious and that the disease in the patient can be brought under control more readily, since the advent of the antimicrobial drugs. Recent evidence from animal and human experiments suggests that the disease can even be prevented in individuals exposed to a high risk of infection through the prophylactic use of one of these drugs. But the application of these measures of individual treatment and control requires that the presence of the disease be known and that the patient be willing to accept treatment.

We must intensify our efforts to find cases by concentrating on the population groups most likely to harbor tuberculosis. We still have to learn how to reach these groups successfully so that they will make use of the available case-finding services. We
also have to learn how to help people accept treatment. Social scientists are working together with other public health people to achieve these ends. Ways are being found to inform and move to action the varied ethnic and cultural groups which make up city populations.

The most difficult group to move to action—at least in terms of one’s reasonable expectations—may come as a surprise. Tuberculosis may be found many times more often among people who are entering general hospitals than in the population at large. Therefore, a simple, effective, and economic case-finding device is a routine chest X-ray for all general hospital admissions. As of the beginning of 1956, less than one half of the general hospitals in New York City had instituted such a procedure.

Nevertheless, it is estimated that about one million New Yorkers have their chests X-rayed each year by their own physicians, by union or employer health programs, by health department clinics, by hospitals, and by the mass X-ray survey teams.

The frontier is the effective control of tuberculosis. To reach it, all the knowledge of the past, concerning the relationship between poor housing and overcrowding, malnutrition, and oppressive conditions of work, all concomitants of a low standard of living, and the incidence of tuberculosis, must continue to be applied, together with our newer knowledge concerning the biologic aspects of tuberculosis control.

It is of special interest in talking of the new frontiers of public health as they affect our adult population to recall that tuberculosis was displaced as the leading cause of death in the United States less than fifty years ago, in 1910, when coronary heart disease as we know it today, rose to occupy this position. It has continued to occupy this post of dubious distinction ever since and will probably occupy it for some years to come.

There are many other areas along the frontiers of public health—the prevention of coronary heart disease, the indications for the use of the drugs known as tranquilizers in mental disease, the public health significance of our aging population, may be mentioned as examples. They suggest some of the important adult health responsibilities in our communities. We have helped some people to live longer—we must strive to make that life healthful and satisfying.

—Jonas N. Muller, M.D., New York State Journal of Medicine, February 15, 1958.

“Longevity is not just a statistic. We can increase it only by saving the lives of many of the 112,000 infants who died last year before they had a chance, of the 75,000 men and women who were struck down by cancer in their thirties, forties and fifties, of the 158,000 whose heart or blood vessels failed them before they had even tasted the first year of retirement . . .” (Connor, A Global War Against Disease).

How common are allergies among U.S. children? An estimated 10,000,000 children under 16 have some form of allergy and 2,500,000 have "major respiratory allergies requiring treatment," according to the publication "Patterns of Disease" prepared by Parke, Davis & Company for the medical profession. Asthma is one of the more frequent causes of referral to pediatric outpatient clinics and children's hospital wards each year, "Patterns" states.

About 17 million Americans are or can expect in their lifetime to be wheezing, coughing, sneezing or itching due to allergy, according to the publication "Patterns of Disease" prepared by Parke, Davis & Company for the medical profession. Hay fever is the commonest single allergic complaint, accounting for between seven and eight million people. Asthma afflicts approximately three million. Short-term allergic reactions occur at one time or another in about 60 per cent of the population, "Patterns" states.

One out of every four patients visiting a pediatrician does so because of an allergy, according to the publication "Patterns of Disease" prepared by Parke, Davis & Company for the medical profession. Allergies also account for ten per cent of patients seeing a dermatologist, and three per cent of visits of the general practitioner. There are only 1,500 physicians in the country specializing in allergy, which means an impossible load of 10,000 allergic patients for each specialist, "Patterns" states.

Smoking may be a pleasurable habit for many people but it can also be a major health hazard.

If you smoke two packs of cigarettes or more daily, your chances of developing cancer of the lung are one in 10, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. These chances decline to one in 36 if you’re a moderate “less than a pack a day” smoker, and drop sharply to one in 270 if you don’t smoke at all.

However, the proof that smoking is a cause of cancer in man must be documented by further intensive research, “Patterns” stresses.
Nebraska State Medical Association Officers and Committees

OFFICERS

President A. A. Ashby, Chm.
President-Elect M. E. Grier
Executive Secretary R. B. Adams
Secretary-Treasurer J. M. Woodward

Delegates—J. D. McCarthy, Omaha; Earl Leininger, McCook
Alternates—H. S. Morgan, Lincoln; W. C. Kenner, Nebraska City

COUNCIL ON
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37-A
Current Comment

Current Status of Therapy in Anemias—


"Anemia is not a disease but a designation given to a laboratory finding present in all chronically ill patients and in many whose illness is of short duration. When possible, therapy is directed at the underlying disease. This implies the necessity for a precise diagnosis. Often, careful analysis of the blood by the judicious use of clinical laboratory methods is of great assistance in arriving at a diagnosis and thereby the selection of effective therapeutic agents."

Gelatin Capsules Developed 125 Years Ago—

Capsules were first developed in France, by Monsieur A. De Mothe in 1833, over a century ago, according to pharmaceutical history.

De Mothe, perfected a soft, elastic, one-piece capsule from a mixture of gelatin, glycerin, sugar, and water.

Many of the first capsules were made by filling oiled chamois-skin bags with mercury, which were dipped into gelatin solution. When the solution congealed around the bag, the mercury was removed, allowing the bag to collapse, and the empty capsule was removed.

Capsules, slowly made by hand in that manner, were spheroid in shape, with elongated lips. The lips were removed, and after medicinal ingredients were placed into them, the openings were sealed by applying a drop of gelatin solution.

Gelatin, glycerine, sugar, and water still form the basic recipe for soft-elastic capsules, however the manufacturing process has changed greatly during their 125-year history. Today, an increasing proportion of capsules are the hard, two-piece telescoping type, as the item of choice for refined pharmaceutical powdered products.

"Gelatin—the old reliable—is an amazing material, according to S. L. Shenefield, superintendent of Parke, Davis & Company"
“Unsaturated Fats and Serum Cholesterol”

...a review of the latest Concepts and Results of Current Research

Now ready for distribution to physicians as a special service by Corn Products Refining Company, this book supplements and supersedes the 1957 monograph "Vegetable Oils in Nutrition" and provides a broader coverage of this important subject.

This new book is the most up-to-date annotated bibliography on current research pertaining to:

1. The origin and behavior of cholesterol in the human body;
2. The effect of different dietary fats on serum cholesterol levels;
3. The nature of the active components in vegetable oils;
4. Suggestions for practical diets.

As a regular part of daily meals Mazola® Corn Oil can be used for control of serum cholesterol levels

MAZOLA CORN OIL, a natural food and a superior salad and cooking oil, used as part of the daily diet, can be helpful in the control of serum cholesterol levels.

Extensive clinical findings now show that serum cholesterol levels tend to be lower when an adequate amount of MAZOLA CORN OIL is part of the daily meals... high levels are lowered, normal levels remain normal.

MAZOLA... the only readily available vegetable oil made from golden corn oil... is rich in the important unsaturated fatty acids. 85% of all the fatty acids in MAZOLA are unsaturated and 56% of the fatty acid content is linoleic.

As a result, MAZOLA CORN OIL is unusually well suited for helping achieve dietary adjustments commonly recommended by authorities on nutrition—that from one-third to one-half of the total fat in-take should be of the unsaturated type when serum cholesterol control is a problem.

Being a natural food, MAZOLA CORN OIL can be included as part of the every day meals—simply and without disturbing the patient's usual eating habits.

Each Tablespoonful of Mazola® Corn Oil Provides Approximately 126 Calories— and:

Linoleic Acid ........ 7.4 Gm.
Sitosterol ............. 130 mg.
Natural Tocopherol .... 15 mg.

Typical Amounts Per Diet
For a 3600 calorie diet 3 tablespoonsful
For a 3000 calorie diet 2.5 tablespoonsful
For a 2000 calorie diet 1.5 tablespoonsful

Current Comment
(Continued from page 38-A)
capsule division, which for over 60 years has been one of the world's largest producers of gelatin capsules.

"Gelatin capsules, although extremely inert, dissolve rapidly, the expert continues, "only 30 seconds after swallowing, the capsule releases its content in the stomach.

"Capsules are free from sensitization reactions, and irrespective of whether they are to be used in very dry or very humid countries, retain their maximum functional qualities." To produce a single capsule by modern methods, the huge machinery at Parke-Davis sets in motion 40,000 accurate, precision-made casting molds, which resemble short, jewel-bright "fingers." When the capsules have congealed and are assembled automatically, each one is passed over an illuminated surface where trained personnel eliminate defective capsules. A final inspection is then made, before the capsules are ready for use.

Humidity and temperature are important in the exacting conditions necessary for modern capsule manufacturing procedures. "75 F., with thoroughly adjusted relative humidity, is considered ideal for production rooms," Shenefield states.

One Material for Multiple Immunizations—
A two-year search by a pharmaceutical company may make available a product to immunize children against poliomyelitis, whooping cough, diphtheria and tetanus. Three injections, each a month apart, were given to 300 children in a trial of the product. The purpose of the research program was to develop a vaccine which would protect children against polio, as well as the other three diseases, without increasing the volume of vaccine or the number of injections.

The clinical trial evaluated the development of immunity in response to the injections. A good antibody response was noted in children from 2½ months to five years of age. A fourth dose was found desirable for children younger than four months. A "booster" dose is planned for 15 to 16 months after the primary series of inoculations.
Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine... higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.¹

Unprecedented Low Dosage—Less sulfa for the kidney to cope with... yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.²

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7 ½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.


References:

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

DOCTOR . . . Would you like to prescribe a remedy for your office girl to use on those past due accounts?

You can you know, by using the services of

The Professional Credit Protective Bureau

Office management authorities say it costs $2.00 per letter for your office to contact those old accounts. Why not let the PROFESSIONAL CREDIT PROTECTIVE BUREAU handle these costly accounts — our fees are only $1.00 per account and 20% of the amount actually collected. All money is paid directly to your office, you retain control of the account at all times.

NOW is the time to apply persistent and persuasive action on those delinquent accounts.

Let us show you what we are doing for the Medical people of Nebraska. For our representative to call, without any obligation, drop a card to

PROFESSIONAL CREDIT PROTECTIVE BUREAU
1026 Trust Bldg.
LINCOLN, NEBRASKA

Current Comment

Foreign Physicians Secure Training in U.S. Hospitals—

A total of 7,622 foreign physicians, or 13 per cent more than the previous year, were in residency or internship in this country in 1957-58. The area sending the largest number was the Far East. The Philippines leads all countries in training medical personnel in the United States.

These figures, from the Institutes of International Education also indicate that 22 per cent of the foreign physicians in training were women.

General surgery was the most popular field of specialization among these physicians, followed by general medicine, obstetrics, gynecology, pathology, psychiatry, pediatrics, anesthesiology and internal medicine.

Twenty-five per cent of the foreign doctors were found in New York, with the remainder distributed throughout 44 other states. Eight hospitals, led by Bellevue Hospital Center reported more than 50 foreign physicians on their staffs.

More of Cigarettes—

The continuing controversy regarding the possible relation between cigarette smoking and pulmonary neoplasms reaches even to the floor of the United States Senate and the Congressional Record. At the instigation of a member of the Senate from Kentucky, a number of opinions are cited. Each of them questions the validity of the statistics commonly cited to indicate a relation between cancer of the lungs and smoking.

Many of the "doubting" opinions are distributed by The Tobacco Institute, and include one by Dr. Joseph Berkson, head, Section of Biometry and Medical Statistics, Mayo Clinic. It is explained by Dr. Berkson that the statistical approach has inherent limitations as an investigative tool. As a result of surveys it appears that there is a correlation between smoking and not only lung cancer but a number of other diseases which lead to a death rate higher among smokers than among non-smokers. To be statistically valid, a common link between smoking and a variety of human disease would be necessary and such a link is not now known.
Panalba* effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:
1. Panalba Capsules, packets of 16 and 100 capsules. Each capsule contains:
   - Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride 250 mg.
   - Albamycin (as neomycin sodium) 125 mg.

2. Panalba KM,® Flavored Granules, 60 cc. size bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:
   - Panmycin (tetracycline) equivalent to tetracycline hydrochloride 125 mg.
   - Albamycin (as neomycin calcium) 60.5 mg.
   - Potassium metaphosphate 100 mg.

Dosage:
Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses.
Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.
Current Comment
Some Drug Products Do Not Return a Profit—

The pharmaceutical industry, while currently under some fire for its prices and profits, may overlook profit potential in answer to a public need.

One such new product is estimated to be of value in the treatment of only 420 new patients each year. After two years of research, a limited market and high production costs, the product will be sold at cost.

The preparation will have a potential value in the treatment of phenylketonuria, an uncommon congenital metabolic disorder which if not successfully managed may result in mental impairment. Phenylalanine, an essential amino acid present in all protein foods, cannot be metabolized by patients with this disease and the suggested treatment is to provide a diet so low in this amino acid that an abnormal blood level will not develop. A minimum amount must be retained in the diet as an essential for normal growth.

The product is an infant formula which has had all but a necessary minimum of phenylalanine removed. It is available from Mead Johnson.

New Jersey, Rhode Island, New York, and Connecticut can boast the best safety records in the country, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. It reports on a recent study which revealed that the accidental death rates in those states was under 50 per 100,000 population. The geographic pattern of accidental death rates is largely determined by the death rate from motor vehicle accidents, leading cause of accidental deaths in this country, “Patterns” points out.

While avoiding “campaigning against smoking,” the U.S. Public Health Service is going to pass on to the public all the information it has on the subject. Its most recent effort in this direction was release of a report, based on studies of 200,000 veterans, that showed a much higher death rate for “cigarette only” smokers.
Current Comment

Leprosy in the Americas—

Although leprosy is not a clinical problem in Nebraska, it is estimated that between 3 and 10 million cases exist in the Americas, and one-third of the victims are moderately or severely disabled. Leprosy occurs in four of the United States and necessitates the leprosarium in Carville, Louisiana. This disease is more of a problem for other countries in the Americas and particularly in South America.

Development of the sulfone drugs, which can arrest or retard the disease in the individual, often removes the symptoms and prevents its transmission to others, has revolutionized the approach, as well as the public attitude toward leprosy. Lifetime isolation is no longer necessary, and victims of what is also known as Hansen's disease need no longer be considered outcasts. As a result many hidden cases are coming to light and the scope of the problem has become much broader than was known a few years ago.

The Pan American Sanitary Bureau was scheduled to participate in a Seminar on Leprosy Control to be held in Brazil. The purpose of the meeting was announced as the study of the use of newer drug and treatment techniques for a concerted attack on leprosy in the Americas.

Accidents, which have claimed an average of 93,000 lives annually over the past 10 years, are responsible for six per cent of all deaths in the United States, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. Among persons one to 36 years of age they are a leading cause of death.

The publication further points out that accidents play an important role in the mortality of the aged, a fact that may be overlooked because of the high incidence of chronic diseases in that group.

"Among persons past age 64, accidents cause between 25,000 and 26,000 deaths annually," "Patterns" states. "Aging persons account for one out of every four accidental deaths."
in spasticity of the GI tract

Pavatrine®
125 mg.
with Phenobarbital
15 mg.

- is an effective dual antispasmodic
- combining musculotropic and neurotropic action plus mild central nervous system sedation for "the butterfly stomach."

dosage: one tablet before each meal and at bedtime.

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CAR-PARK
For the convenience of physicians, dentists and their patients.

Free wheel chair service from Car-Park to physicians’ offices.

Close to Lincoln’s department stores, theatres and leading hotel.

More than half of the Sharp Building is designed for and occupied by leading physicians and dentists serving families throughout Nebraska and the Missouri Valley.

We invite your inquiries for medical space.

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Lincoln, Nebraska
new 3-way build-up for the under par child...

Improve appetite and energy
with ample amounts of vitamins — B₁, B₆, B₁₂.

strengthen bodies with needed protein
Through the action of L-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate... plus sorbitol for enhanced absorption of both iron and B₁₂.

new INCREASE WITH IRON SYRUP

delicious cherry flavor — no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.
Each teaspoonful (5 cc.) contains:
- L-Lysine HCl .......................... 300 mg.
- Thiamine HCl (B₁) ..................... 25 mcgm.
- Pyridoxine HCl (B₆) .................. 10 mg.
- Ferric Pyrophosphate (Soluble) .... 550 mg.
- Iron (as Ferric Pyrophosphate) ...... 30 mg.
- Sorbitol .................................. 3.5 Gm.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York


You can enhance the value of your own Journal by patronizing its advertisers.
"No patient failed to improve."

pHisoHex washing added to standard treatment in acne produced results that "...far excelled... results with the many measures usually advocated."

pHisoHex maintains normal skin pH, cleans and degemrs better than soap. In acne, it removes oil and virtually all skin bacteria without scrubbing.

For best results—four to six washings a day with pHisoHex will keep the acne area "surgically" clean.


Cancer accounts for one out of every six deaths in this country annually, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. The disease has jumped from seventh place to second in U.S. mortality tables in the last fifty years, says "Patterns." If the present rates continue, the annual death toll from cancer will double within the next 50 years, "in part due to an increase in the population."
BY MOUTH

progestational agent

with unexcelled potency

d unsurpassed efficacy
Current Comment

BOOKS RECEIVED


Wikler, Abraham, M.D.: The Relation of Psychiatry to Pharmacology: Published for the American Society for Pharmacology and Experimental Therapeutics, by The Williams and Wilkins Company, Baltimore. Price $4.00.

Booklet on Strokes—

A new booklet, entitled "Strokes, a Guide for the Family," has been published by the American Heart Association. As the title indicates, it was prepared primarily for those who live with or care for the stroke-patient. Copies of this booklet are available from the Nebraska Heart Association and may be requested by physicians to give to the families of such patients.

The booklet emphasizes the importance of early rehabilitation and of close cooperation between the physician and members of the family in helping stroke-patients regain many of their abilities. It gives specific suggestions for self-help devices that can be used at home and also lists a number of sources through which additional help may be sought during the rehabilitation process. Also included are recommendations for the families of patients requiring treatment over a long period of time and a discussion of special problems of the patient with aphasia. It may be obtained by writing "Heart," Omaha 1, Nebraska.
thank you, doctor

Proven in research
1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice
4. More rapid clinical response
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Current Comment

Colorado Tick Fever—

Colorado tick fever is the only known tick-transmitted virus disease of humans found in the United States according to our State Department of Health. It is characterized by sudden onset of headache, chilly sensations, moderate to severe low back pain, and fever 4 to 5 days after exposure to ticks. In exceptional circumstances onset may be delayed for as long as two weeks. Temperature ranges from 102° F. to 106° F. and is usually sustained for 36 to 48 hours. A remission of 1 to 2 days follows and then another febrile period of similar duration usually occurs. There are no significant physical findings and there is no characteristic rash, although cases have been reported in which one was present. Leucopenia with white blood cell counts of 1300 to 4500 is characteristic. A bleeding tendency has been noted in some cases. The disease may not always be as mild as originally described. Virus has been isolated from the blood of cases with evidence of central nervous system involvement, and one fatal case has been encountered.

Treatment of Colorado tick fever thus far has been purely symptomatic. Because of the sharp drop in temperature following febrile episodes, results obtained with antibiotics should be interpreted with caution. Care should be exercised not to confuse the early, pre-rash stage of Rocky Mountain spotted fever with Colorado tick fever because prompt antibiotic treatment is very efficacious in the former. In the Rocky Mountain area, both diseases are transmitted to man by the wood tick, Dermacentor andersoni.

During the 1957 tick season 119 isolations of Colorado tick fever virus were made from blood samples forwarded to the Rocky Mountain Laboratory (located in Hamilton, Montana). The virus is resistant and can be recovered from blood samples collected within the first 6 to 8 days after onset, by injecting suckling mice. Neutralizing antibodies appear in the serum about 12 days after onset and persist for several years. These can be detected by tests performed in mice and in tissue culture. Complement-fixing antibodies appear 18 or more days after onset.

The Rocky Mountain Laboratory is engaged in a study of ecology, epidemiology, (Continued on page 26-A)
Comments by investigators on Robaxin

(Methocarbamol Robins, U.S. Pat. No. 3770440)

the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

Published References:

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

A. H. ROBINS CO., INC., Richmond 20, Va.
Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:
Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm

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<td>Contusions, fractures, and muscle soreness due to accidents</td>
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<tr>
<td>TOTALS</td>
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<td>104</td>
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</table>

(75.3%) (20.3%)

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants..." 1/2

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm." 5

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes." 6

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions." 11
Colorado Tick Fever—
(Continued from page 12-A)
and clinical course of Colorado tick fever. Evaluation of laboratory procedures for aid in diagnosis is also being carried out. The Nebraska State Health Department Laboratory is interested in receiving specimens from suspected Colorado tick fever cases. A blood sample should be taken as soon as this disease is suspected and again about one month later. The second specimen is for the purpose of demonstrating a rise in titer of antibodies. Paired specimens are essential in determining whether antibodies found are the result of the current illness.

About 6 to 8 cc. of whole blood should be taken with a sterile, dry syringe and placed in a sterile, tightly-stoppered vial. No anticoagulant or preservative is necessary. Date of onset of illness, date specimen was collected, clinical and laboratory findings, and brief epidemiological history should accompany the specimen. Specimens should be mailed to:

State Department of Health
Division of Laboratories
1019 State Capitol Building
Lincoln 9, Nebraska.

Quinidine and Anticoagulant Therapy—
Many patients under anticoagulant therapy are simultaneously being treated with quinidine for auricular fibrillation. Effective as it is in decreasing cardiac arrhythmia, quinidine can also depress thromboplastin or platelet formation.

Patients so treated are exposed to the danger of hemorrhage because the prothrombin time can be in the “therapeutic range,” while the added effect of platelet destruction is not being measured.

Individually, the prothrombin time and platelet count may not be within the “danger area”: The combination of prothrombin and platelet (thromboplastin) reduction can cause hemorrhage—which when judged by either prothrombin time or platelet count alone, should not occur.

Whenever a patient on anticoagulant therapy is being treated with quinidine, it is advisable to run, along with the routine prothrombin time, the prothrombin consumption test as well. This will indicate whether simultaneous thromboplastic reduction is producing hidden threats to the patient’s safety.
THE COMING NATIONAL ELECTION

Doctors are citizens first and physicians afterwards. We like to pursue our professional work uninterrupted and untroubled by the duties of citizenship as we were wont to do in the era before socialization began in the United States. Full realization began to dawn upon us when we were confronted by bills in Congress which would have created state medicine overnight; before the International Labor Organization fed treaty after treaty into our President’s hands, any one of which, had it been acted upon favorably by two-thirds of those present and voting in our Senate on any day it was in session, could have had the same result; before the proponents of socialization adopted the piecemeal method now in operation to accomplish the same end. As things stand today, we must work at politics, or we shall become employees of our Government, always shadowed by “third parties” and unable to pursue our professional lives without interference.

In his message to the profession in “The President’s Page” of the Journal of the American Medical Association of August 30th, President Gunderson urges every doctor to acquaint himself with the candidates for Congress and their position in these important matters. He says:

“Doctors, you have only two months to carry out one of the most important political tasks you have faced in the last decade.

“I appeal to you to help elect United States Senators and Representatives who are dedicated to the promotion and strengthening of freedom and self-government and who support medicine’s position against proposed legislation calling for hospitalization and medical care benefits for Social Security beneficiaries.”

In this connection it must be reiterated that collective recommendations to Congressmen, such as resolutions passed by various societies are of scant value. Personal approach by voters to each candidate is of infinitely more value than an approach through your organization. You have every right as well as duty to interrogate the candidate, in person or by letter, and to get answers that do not have a double or an indefinite meaning — answers about his position on legislation that is of such importance to you. It is urged that doctors take time and create opportunities to find out how each candidate stands on these important matters. We can vote, then, with much more intelligence and confidence.

PHYSICIANS IN GOVERNMENT

It is good to have physicians in government—good for the governed and good for our profession. As a rule, too few men and women who have a background of culture, education, and wisdom are willing to make the sacrifice that is inherent in service to the people by way of government. The majority of doctors of medicine have the desirable attributes that are needed to make good public servants, be it as members of small bodies such as school boards or city councils, or of great bodies such as Congress.

Since the founding of our Nation, about 360 physicians have been members of Congress, and an unknown but undoubtedly impressive number have taken their parts in smaller, less spectacular areas of government. If it were possible to study the records of each, doctors in government service would, without doubt, be found, on the average, to have been on the side of wise, equitable, conservative, constitutional government. The mistakes attributable to human frailty probably would be found well below the average.

This year the medical profession of Nebraska has three of its members running for election or reelection to government offices, as follows: Doctor A. L. Miller is up for reelection to the House of Representatives; Doctor B. N. Greenberg, reelection as a Regent of the University of Nebraska; and
President Fay Smith for election to the Nebraska Unicameral Legislature. Doctors Greenberg and Miller have given excellent service, and Doctor Fay Smith can be expected to live up to his sterling reputation, if elected. As voters, we can do our part for medicine and for society by helping to elect men who understand our problems.

VACCINATION AGAINST POLIO

What can doctors do to promote greater utilization of Salk vaccine? This is a question that merits examination and answer. One could wish that Reader's Digest, Red Book Magazine, and other popular guides-to-health would replace some of their more intriguing but less useful articles by others stressing the necessity of vaccination if we hope to conquer paralytic poliomyelitis.

The latest report from the National Foundation contains quite discouraging data. It is true, the Foundation points out, that there has been a steady decline in incidence of paralytic polio over the last three years, from an average of 38,727 per year in the five years preceding the Salk vaccine, to 5894 in 1957. During the three years, 1955 to 1957, 62,500,000 Americans were inoculated with one or more doses of Salk vaccine, leaving 48,500,000 persons under 40 years of age who had received no vaccine. These figures have become slightly more favorable in the past eight months. The Foundation would like to believe this decline in incidence can be attributed to the fractional vaccination attained, but epidemiologists think not. They give vaccination credit for a definite part in this falling-off, but believe other factors are of substantial importance.

The medical profession and the American public should accept the latter point of view and spare no effort to get the 40 per cent of unvaccinated susceptible persons vaccinated. Doctors can not force people to be vaccinated, but they can keep in mind to “talk it up” at every opportunity. We can't keep people awake but we can arouse them.

“SHOTS”

Should one be elated by degradation of our language because we are intrigued by its increasing facility of expressing our ideas? If so, where should we put the “floor” as accepted expressions slip downward?

Doctors began to call the giving of hypodermic medication “shots.” After an unexpected length of time, the newspapers and popular magazines adopted the word shots. It seemed likely to stop at this point, but, amazingly, this misnomer crept into releases from the A.M.A. This is “topped” by a recent release from the dignified Department of the Army in which “shot” is used to mean inoculation by hypodermic route. So far as we know this degraded English has not been seen in British literature.

Current Comment

Medical Problems on the Far Side of One World—

The cholera situation in Asia is the most serious in years. Cases and deaths are twice as numerous as last year in India and East Pakistan, and an epidemic has struck Thailand for the first time in many years. Cholera has also been recorded in Cambodia and Burma.

Cumulative totals in Asia for the first seven months of 1958, include 48,729 cases with 20,687 deaths.

Strict observance of the International Sanitary Regulations is important to prevent the spread of quarantinable diseases. In the case of cholera, which may have an incubation period up to five days, any person coming from an infected area, even if he is in possession of a vaccination certificate against cholera, may be placed under surveillance for a maximum of five days. If the traveller is not in possession of such a certificate, he may be placed in isolation for the five-day period.

With the development of modern means of transportation, and the great increase in travel throughout the world, outbreaks of cholera, typhus, plague, smallpox and other pestilential diseases are a threat anywhere in the world so long as they are allowed to remain in their endemic seedbeds.

Don’t throw out the dirty water until you have some clean.
Staphylococcus Enterocolitis*

Doctor Paine bases the following timely paper upon a rather wide experience with fulminating cases of staphylococcus enterocolitis. Many of these followed therapy with antibiotic drugs. His discussion treats the subject from many points of view including the historical, the etiologic, the clinical, the pathologic, and the therapeutic. He leaves the subject of pathogenesis as an unanswered question being content to state known facts and to point out some important unknowns.

—EDITOR

INTRODUCTION

THE ever wider and continued use of the antibiotic drugs during the past ten years has been associated with the appearance of a clinical syndrome characterized by an acute inflammation of the gastrointestinal tract. The predominant symptoms of this disease are a copious watery diarrhea, fever, nausea, and abdominal distention. In many instances circulatory collapse followed by death occurs after a few hours or days of illness. In most cases these symptoms have occurred in patients receiving any of a variety of drugs and from the feces of whom a pathogenic Staphylococcus aureus can be cultured. A great deal of evidence has accumulated to indicate that this syndrome is caused by a change in the bacterial flora of the intestinal tract incident to the administration of an antibiotic drug and this in turn followed by the proliferation of a drug-resistant strain of staphylococcus. However, much remains to be explained before this condition is fully understood.

Great interest is attached to the question of whether or not there is any relationship between this staphylococcal enterocolitis and pseudomembranous enterocolitis first described in 1893, some fifty years prior to the antibiotic era. Finney of the Johns Hopkins Hospital, in 1893, described the case of a 22-year-old colored female who died fifteen days following the performance of a gastroenterostomy for a stenosing gastric ulcer of the pylorus. On the tenth postoperative day, a severe and persisting diarrhea began which continued for five days until death occurred with the patient in circulatory collapse. Post-mortem examination revealed severe inflammation of the intestinal tract beginning about 30 centimeters proximal to the ileocecal valve. During the succeeding years similar cases were observed and reported from time to time, but the etiology remained a mystery. Prior to the use of the sulfa drugs the largest series of patients with this condition was reported from the Mayo Clinic—15 cases observed between 1925 and 193811,6. Characteristically the symptoms were abdominal distention, nausea, vomiting, and persistent watery diarrhea. The mortality was extremely high with death following circulatory collapse usually within twenty-four hours. Pathological studies of the involved bowel revealed a pseudomembranous type of enterocolitis, varying in extent and severity. In certain areas the mucous membrane was found to be completely necrotic. Peritonitis of some degree was an occasional associated finding. Most cases appeared to follow some surgical procedure performed upon the gastrointestinal tract. Similar pathological changes in the bowel have been recognized for a long time as occurring not infrequently during the course of the specific dysenteries, in heavy metal poisoning, and in uremia. The etiology of the condition in this latter group is much easier to understand.

Such bacteriological studies as were done in these early cases of unknown etiology are of little significance for the present problem, since the technics for the successful culture of the staphylococcus from fecal material were not developed until the 1940's and not widely employed in bacteriological laboratories until about 1950. Prior to 1940, it was thought that pathogenic staphylococci were rarely present in human feces—perhaps in less than 5 per cent of patients. In 1945, however, Chapman4, with improved culture media, was able to demonstrate this type of bacteria in at least 30 per cent of patients.

HISTORICAL REVIEW

The present interest in this problem of sudden fatal enterocolitis began with the
report by Kramer⁹, in 1948, concerning the case of an infant who died from persistent diarrhea after several days treatment with oral streptomycin. The stools were cultured frequently but no staphylococci were found except at post-mortem and then only in the lower small bowel. Inasmuch as this baby had a staphylococcus infection of the eye also, Kramer posed the question of the possible effect of small absorption of streptomycin from the gut, permitting the organisms in the eye to become resistant to the drug prior to their entrance into the gastrointestinal tract and proliferating to produce the diarrhea.

The next case of staphylococcus enterocolitis reported was that of Kischka in 1950. In this instance the infection followed the oral administration of sulfaguanidine. The paper which first gave the medical profession real concern, however, was that of Jackson and his colleagues⁷ which appeared in the *Annals of Internal Medicine* in 1951. In this report on the use of Terramycin(R) in the treatment of pneumonia, it was pointed out that the good effects ofTerramycin were frequently compromised by super-infections with resistant strains of *Staphylococcus aureus*. Gastrointestinal symptoms, including diarrhea, were noted to occur frequently and in many cases the normal fecal flora was replaced by the pathogenic *Staphylococcus aureus*. Seven of 91 patients died. In five of these, the gastrointestinal symptoms were thought to have contributed in large measure to the fatal outcome.

RESISTANT STRAINS

Since 1953, a large number of papers have appeared reporting small series of patients in which sudden, fulminating and often fatal diarrhea has followed the administration of antibiotic drugs. When the feces of such patients are properly cultured, a pathogenic *Staphylococcus aureus* has been recovered in the vast majority of cases. The basic cause of all this difficulty is the notorious and unequaled ability which the *Staphylococcus aureus* has to continue to develop strains that are resistant to the effects of one antibiotic after another. In 1945, ninety to ninety-five per cent of all strains of *Staphylococcus aureus* were sensitive to penicillin. At the Buffalo General Hospital, of the last 100 strains of *Staphylococcus aureus* cultured, only 20 were sensitive to penicillin and many of these only slightly so. As other drugs have come into use they also have rapidly become less and less effective, with the passage of time, against the staphylococcus. During the month of December, 1957, in one 30-bed ward of the Buffalo General Hospital, 6 patients died of drug resistant staphylococcal tracheobronchitis and pneumonia.

The exact means by which the staphylococcus has been able to develop its resistant strains is not known. More than one mechanism may be involved. The following have been suggested:

1. Mutants are formed which are resistant to the antibiotic and reproduce themselves as a true strain.

2. Resistant mutants are formed and survive as such only as long as the antibiotic drug is employed.

3. Resistant organisms are already present in the original bacterial population and over-grow the less resistant forms.

4. Small quantities of an antibiotic drug may be absorbed from the intestinal tract and by enzymatic action produce resistance in distant organisms within the patient before they gain entrance into the gastrointestinal tract.

Whatever the source of the resistance may be, it has been amply demonstrated that the incidence of resistant strains of staphylococci is much higher in our hospitals at the present time than anywhere else in the country. The majority of patients seem to acquire these strains as the result of cross-infection from other patients or from hospital personnel. The reservoir of these bacteria will most likely be found to be in the upper respiratory tracts of the doctors, nurses, and orderlies.

Most, but not all, of the cases reported with staphylococcus enterocolitis have occurred in postoperative patients. With very rare exceptions the only prerequisite is that the patient has received an antibiotic drug which has decreased the normal intestinal flora sufficiently to allow the resistant staphylococcus to proliferate uninhibitedly.

CLINICAL PICTURE

The onset of this disease is usually sudden, on the second to fourth postoperative
day in surgical patients, and is characterized by a diarrhea which quickly becomes fluid, copious, and constant. The watery fecal discharge is greenish or brown in color and contains shreds of mucus and desquamated mucous membrane. In a few of the reported cases diarrhea has been absent or slight but the gut has been found at autopsy to contain large quantities of the typical thin fluid. Associated symptoms are fatigue and exhaustion, anorexia, nausea and vomiting. In most instances the abdomen becomes moderately distended and, if examined roentgenologically, presents the picture of a paralytic ileus.

If energetic therapeutic measures be instituted promptly, some patients will recover. In others, however, after a variable period of time measured in hours or a day or two, the temperature rises to as high as 106° or 108° F. and the patient becomes restless and confused. Further progression of the disease leads to profuse sweats, circulatory collapse and shock. Seventy-five per cent of patients die of shock within 24 hours of the onset. The similarity of this clinical picture with that of patients dying of Asiatic cholera has been noted by several observers.

Cultures of the stools at the beginning of the diarrhea, when made on selective media, usually show the presence of the hemolytic Staphylococcus aureus, coagulase positive, in variable numbers. As the diarrhea continues, almost pure cultures are obtained. In a few cases, cultures have been reported as negative even up to the time of death but with many organisms demonstrated at autopsy in the fluid bowel content, on the membranes, or on the wall of the gut. Blood cultures taken prior to death are almost invariably negative. Death does not occur as the result of a septicaemia or metastatic infection. How much of the symptomatology may be due to toxemia is not known. A large number of strains of Staphylococcus aureus are known to produce potent exotoxins which produce severe prostrating intestinal symptoms, but up to the present time such toxins have not been convincingly demonstrated in staphylococccie enterocolitis. Death can easily be explained as the natural result of the tremendous fluid losses that occur from the gastrointestinal tract with resulting dehydration and circulatory collapse. In some instances fluid losses as great as 16,000 cc. in twenty-four hours have been measured.

PATHOLOGICAL FINDINGS

The pathological findings at post-mortem examinations of patients with staphylococcus enterocolitis, other than the changes secondary to shock, are confined to the gastrointestinal tract. An intense inflammatory reaction is found involving primarily the small bowel but frequently also involving the colon to some extent. In a few cases the entire colon, small bowel, stomach and even the lower esophagus have been found involved. The lumen of the bowel is filled with a murky discharge containing mucus, shreds of intestinal mucosa or complete casts of certain segments of the gut. These casts are composed of necrotic mucosa combined with mucus, fibrin, leucocytes, and bacteria. Those areas of bowel wall from which these casts have been shed appear as raw shaggy surfaces from which there is a remarkably small amount of bleeding. With proper staining techniques, masses of bacteria frequently can be found on the histological slide both in the casts and in the intestinal wall.

PATHOGENESIS

The pathogenesis of this condition is the subject of a great deal of discussion at the present time. There are those who still doubt the dominant role of the Staphylococcus aureus and question whether or not there is any distinction to be made between pseudomembranous enterocolitis and staphylococcus enterocolitis. Admittedly the clinical picture and pathological findings in these two conditions are so similar that some writers believe the only way to distinguish between them is by determining the presence or absence of staphylococci in the bowel content or affected tissues. Penner, studying a series of cases of postoperative enterocolitis at Mount Sinai Hospital in the pre-antibiotic era, concluded that the only common factor in all of them was shock occurring prior to the onset of the diarrhea. He postulated the theory, therefore, that the pathological changes seen in the bowel were secondary to an ischemia occurring as the result of a compensatory arteriolar constriction during the period of shock. Edema and interstitial hemorrhage in the villi of the intestine would follow and this in turn lead to necrosis of the mucosa with secondary bacterial invasion. Such an explanation is certainly not acceptable for most of the cases.
of staphylococcus enterocolitis since most of the patients have not experienced any shock prior to the onset of their symptoms. Shock, when it does occur, follows the beginning of the diarrhea by a matter of hours or even days, depending upon the severity of the process.

The most generally accepted theory of pathogenesis is as follows: The administration of a broad spectrum antibiotic drug upsets the balance in the normal bacterial flora of the intestinal tract. The most important change is the elimination of the gram-negative organisms. With the bowel thus prepared, a strain of Staphylococcus aureus which is resistant to the drug being used gains entrance to the gastrointestinal tract from the nasopharynx, from ingested food or by means of a contaminated intestinal tube. Here this particular strain proliferates and spreads without hinderance to finally invade the mucosa. Certain patients no doubt have small numbers of resistant staphylococci in the feces from the beginning, which are able to multiply and invade as soon as the gram-negative bacteria are diminished in numbers by the antibiotic drug.

To some observers this appears to be too simple an explanation because of the suddenness of onset and rapidity of progress of the disease in severe cases as well as the paucity of organisms occasionally recovered by culture. Jonassen has suggested the possibility of this condition being an example of the Schwartzman phenomena and Prohaska has suggested that it may be an antigen-antibody reaction. The possible role of an exotoxin in the production of some or all of the clinical picture has been alluded to already. The uniform absence of bacteria from the blood associated with the marked temperature elevation and general toxic state of the patient supports such an idea. Fairlie believes that the antibiotic drug may even stimulate the production of toxin by the bacteria.

**TREATMENT**

If this disease is to be treated successfully, treatment must be begun early and pursued energetically and persistently. At the present time, diarrhea occurring in any hospitalized patient, which cannot readily be explained, is sufficient reason to suspect the development of a staphylococcus enterocolitis. A smear of the fecal discharge as well as a culture should be made. In many instances an immediate examination of the smear will reveal the existence of a significant enough number of gram-positive cocci to confirm the diagnosis, at least tentatively. A soon as further confirmation is furnished by the culture, the sensitivity of the strain to various antibiotic drugs should be determined. On the basis of this information, appropriate medication can be prescribed. In the past it has been our practice to stop all antibiotics being given at the onset of diarrhea and give erythromycin in 250 mg. doses every four hours. Up to the present time the majority of strains of Staphylococcus aureus in Buffalo are still sensitive to erythromycin but this will probably not remain the same for long. Both Austrian and Williams have advised the oral administration of bacitracin, at least until the results of sensitivity tests are available. So far we have not used this drug but are prepared to do so in the future when the need arises. The oral administration of neomycin has also been recommended but this delays the highly desirable return of a normal bacterial flora. In our own cases in which death did not occur within a day or two, we have administered lactobacilli by mouth as soon as the patient was able to retain fluids taken orally. The importance of reestablishing the normal fecal flora early and rapidly cannot be over emphasized.

The most essential part of treatment of the severe cases is the replacement of the large amounts of fluid and protein which are lost in the diarrheic stools. In some cases, fluid losses have been estimated to be as high as 16,000 cc. or more in twenty-four hours. In any event, measurements of the quantities of fluids vomited or expelled by rectum must be recorded. In desperately ill patients, the administration of plasma and electrolyte fluids in sufficient amounts may well require the use of canulas in two extremities with fluid running in almost continually.

If circulatory collapse with shock occurs, norepinephrine should be given in an attempt to sustain the blood pressure while the rapidity of fluid administration is increased. Corticotropin (ACTH) or cortisol in moderate doses is probably indicated for 48 to 60 hours but should not be continued over a prolonged period. Some men have criticized the use of steroids in this condition, but others feel, as Spink does, that
the benefits to be derived in the way of reducing inflammation, lowering of fever, and inducing a state of well being are more than worth the possible risk of spreading the infection through the tissues during a short period of administration.

The use of an indwelling gastro-duodenal tube to keep the stomach empty and prevent, as far as possible, distention of the involved bowel is advisable.

PROPHYLACTIC MEASURES

Several measures can be taken in an attempt to prevent enterocolitis and should at least minimize the number of patients so affected. Probably the most important thing to be done is to use the broad spectrum antibiotic drugs with a fine sense of discrimination. The routine use of these drugs prophylactically following surgical procedures must be reconsidered. Such a practice may well produce more difficulty than it obviates. If, as seems likely, the prevalence of resistant strains in our hospitals is largely due to cross infections, all practical means should be taken to isolate patients with any staphylococcal infection. Pharyngeal airways, intratracheal tubes and gastro-duodenal tubes should be sterilized after use. Thorough washing is not sufficient. In surgical patients in which the bowel is to be prepared prior to an operation on the gastrointestinal tract, the use of the nonabsorbable sulpha drugs is to be preferred to the more commonly employed quicker acting broad spectrum antibiotics. Extremely few cases of staphylococcus enterocolitis have been alleged to follow the use of the nonabsorbable sulpha compounds. At operation, if the bowel is opened, it would seem to make sense to routinely take a culture of the contents to determine the presence or absence of pathogenic staphylococci. Such information will thereby usually be available in time to forestall serious trouble, since the majority of cases of enterocolitis following operation show their initial symptoms on the third to fifth postoperative day while receiving penicillin and streptomycin. This patient’s death occasioned a great deal of concern inasmuch as during the preceding ten days three other patients in the same four bed ward had been ill with severe but nonfatal diarrhea developing in the postoperative period. The proof of the bacterial nature of the condition was found in the histological sections of the bowel obtained at post-mortem. On the basis of this information, slides and sections on two other patients that had died one and four years previously were restudied and large masses of proliferating staphylococci identified in the tissues of the bowel that had been disregarded at the time of the previous post-mortem examinations.

Up to the present time, a total of 19 cases have come to autopsy at the Buffalo General Hospital in which staphylococcic enterocolitis has been the cause of death or an important contributing factor. The large majority of these patients have been frail, chronically ill patients in the 60’s or 70’s. Only two have not developed the condition after operation. Penicillin alone or in combination with streptomycin has been the antibiotic most frequently being given prior to or at the beginning of the diarrhea. Death has occurred as soon as 12 hours after the first symptoms, but usually after two to four days.

DISCUSSION

The question remains: Are there two separate clinical entities, such as (1) acute pseudomembranous enterocolitis, and (2) staphylococcic enterocolitis, or are they one and the same condition which we are now seeing more frequently than in former years? Several competent observers have claimed that the clinical pictures and pathologic changes in the gut are exactly the same. Childs believes that the only difference lies in the presence or absence of an overgrowth of the Staphylococcus aureus in the intestinal tract. Certain it is that staphylococcus enterocolitis has been reported as occurring in the adult without the prior use of any antibiotic drugs and certain of the fatal infant diarrheas are due to the staphylococcus. Reports of cases of acute pseudomembranous enterocolitis prior to the antibiotic era such as have been made by the Mayo Clinic cannot be taken without question as proof of the existence of two separate pathologic entities. No bacteriological studies have been reported in the ma-
majority of these cases. Even if made, their value would be very questionable. Only since the 1940's have we had effective technics of culturing feces to detect the presence of staphylococci. For the present, I think the question must remain unanswered until a well controlled series of cases with adequate bacterial studies furnishes the answer.

REFERENCES

Nebraska 4-H Clubs
PIONEER
Modern Health Techniques For Lay Groups

In a previous article entitled "The 4-H Clubs and the Doctors of Nebraska," (Nebraska M., 43:341), Doctor Bancroft discussed the relationship of our doctors to the 4-H Clubs, pointing out specifically the value of this relationship to public relations. In this article he discusses the fallacies and possible harmful effects of the methods of examination used in the past and enunciates the philosophy and probable benefits of the newer methods now being pioneered in our State.

—EDITOR

Our public school system is more than 300 years old; the educational activity of the church is much older; the Boy Scouts, Camp Fire Girls, the 4-H Clubs and other youth organizations have been active for fifty years or more. All of these groups have a legal and moral obligation to stimulate interest in health. Since the programs of these groups are largely developed by laymen and since they antedate the very recent scientific interest in normal growth, development, and physical fitness, it is not surprising that professional groups should feel dissatisfied with some of the methods of health instruction long in use. This is not a criticism of the pioneers who deserve great credit for initiating these movements and utilizing methods available to them. It is a recognition of the need for progress.

Among its many activities in behalf of the welfare of young people the 4-H Clubs have sought to arouse interest in personal health. The founders were laymen of broad experience in agriculture. Since competitive livestock shows at county and state fairs have been so effective in creating interest in better livestock, it was logical for them to develop competitive health contests for boys and girls believing that the same beneficial effect could be secured. Throughout the forty-eight states health contests were intro-
duced at county fairs, the winners of which competed in the state contest and finally in a national contest. Doctors, acting in the same capacity as livestock judges, selected winners on the basis of physical perfection. Over the years it has become increasingly obvious that although the motives were good the effects of this method of selection at times, were decidedly injurious.

**Violation of Privacy**

It is interesting to talk to adults who, as children, participated in health contests. Many recall their embarrassment when required to disrobe in a public place for the purpose of having their bodies examined. Even though properly gowned, the strange place, the numerous examiners, the intimate association with other young people with whom they were not well acquainted, and finally the knowledge their bodies were being examined for physical defects, made this a painful experience for many.

**Emphasis on Defects**

Livestock judges can identify the best animal in a group by deducting points for physical defects. In the same manner children were examined for their defects. Such trivial defects as acne, birthmarks, moderate flat feet, bowed legs, and peculiarities of the genitals were noted and commented upon. Worse still, a functional heart murmur, which the family physician had elected not to discuss with a sensitive child, was discovered and unintentionally or intentionally revealed. The enumeration of physical defects in an adolescent child, at a time when he is most sensitive about his physical person, may be extremely traumatic, creating needless anxiety, and arousing new fears or feelings of inferiority. Participating physicians have frequently felt guilty because of the violation of sound principles of medical practice.

**Awards for Physical Perfection May Be Harmful**

It is questionable whether it is good to reward a child for something which he possesses through no effort of his own. Furthermore, the very act may be injurious to the personality if it contributes to conceit in the winner and feelings of inferiority in the loser.

**Children Cannot Be Compared**

In animal judging we deal with pure blood-lines. We compare animals only if they are of the same breeding. But, of all the animals the human is the worst genetic mongrel. This is particularly true in the great American racial melting pot. How can we compare the Scandinavian with the Spaniard? Is the comparison of children who have blood of four or more different racial groups flowing in their veins in any way different from choosing the best in a class of alley kittens or mongrel pups?

**Awards Have Frequently Gone to Those of Early Sexual Development**

It is true that many of our most promising young people, because of later sexual development, are in their “teen” years, tall, gaunt, awkward, poorly coordinated, and equipped with oversize hands and feet. Because of their immaturity they are socially ill at ease and shy. The boys make one think of Ichabod Crane. And yet in their very physical makeup we see the promise of a great physical and intellectual future. Indeed, it is from such as these that some of our finest leadership has come. At the moment of the contest, however, the well proportioned, well coordinated individual who has poise and social grace is the boy or girl who by accident of racial origin or glandular precocity has attained early sexual maturity.

The average age at onset of the menses in the women of the United States is 13.5 years. Of twenty-three women who had been 4-H champions for Nebraska the onset of the menses occurred at 11 years in 6, at 12 years in 9, and the over-all average was 12.2 years. These were early maturing girls. It was apparent from the development of other physical traits that the boys who won were also early maturing boys as a rule.

We all recall our high school days when we felt jealous of the few boys and girls who matured early and were decidedly masculine or feminine when most of us were physically and socially immature. Is it a laudable thing to reward those of early sexual development to the humiliation of those who develop more slowly?

**Modern Methods Acceptable to the Professions**

1. The 4-H Clubs of Nebraska have adopted the following in the modernization
of their program. The participants will be examined individually in the privacy of the office of the local physician when possible. This assures privacy, an examiner with whom the child and his family are familiar, as well as all the physical, emotional and spiritual advantages that grow out of the traditional doctor-patient relationship.

2. Instead of emphasis on demerits which disqualify, emphasis will be placed on credits for those things the child has done to improve himself. He is to be rewarded for positive constructive activity. With this emphasis the crippled child could be a champion, the blind child, a winner.

3. Instead of comparing the developmental characteristics of a child with that of any other child, the growth of each will becharted on a modern graph. This at once emphasizes the individuality of growth. A large boy has no advantage over the boy of small build. Early sexual maturity will give no advantage over late development. Racial differences will no longer be a factor. Finally, the assessment of physical fitness will become thoroughly scientific.

4. Finally, emphasis is placed on the fact that physical fitness is not an end in itself; but rather an aid to the productivity of a life.

CONCLUSION

These changes, pioneered by the 4-H Clubs of Nebraska, should be known to and appreciated by the many professional groups interested in health. They should be the concern of the educator, and the clergymen, as well as the physician.

REFERENCES


IMPROVEMENT of

Hearing Acuity in Ear Diseases*

Doctor Smith's theme is presented in the first sentence of this paper: "Maintenance of improvement of the hearing acuity is of prime importance in the treatment of diseases of the ear." He stresses the use of fundamental surgical procedures in addition to the use of antibiotics. While prevention of deafness is of prime importance, the author describes the various means of recovery of useful hearing in instances where infection has already damaged this function.

—EDITOR

MAINTENANCE of improvement of the hearing acuity is of prime importance in the treatment of diseases of the ear. Until recently, the feared serious complications and sequelae of middle ear suppuration necessitated that treatment be directed solely toward eradication of the disease. Little or no attention was paid to the functional status of the ear with the result that useful hearing was often irretrievably lost. The gradual up-surge of resistant strains of bacteria, especially the staphlococcal groups, is again increasing the number of such problems. Another factor also affecting this increase is the tendency toward sole dependence upon antibiotic therapy with the omission of the simple surgical procedure of myringotomy in the treatment of middle ear suppuration.

PREVENTION OF DEVELOPMENT OF HEARING DEFECTS

It is obvious that the first consideration in the maintenance of the functional integrity of the ear should be preventative in nature. This involves particularly the care of acute middle ear infections. Every effort should be made to avoid necrosis and loss of large segments of the tympanic membranes. Care should be taken that the ossicular chain is preserved as a functional unit and that residual intratympanic fibrosis is avoided. It is especially important that the development of chronic low-grade destructive middle ear infection is prevented.

The destructive pathological processes can be avoided in practically all cases by adequate treatment. Specific antibiotic therapy is invaluable and will control infection in most cases if combined with proper surg-
ical management. Generally, a prompt response is to be expected if the proper antibiotic is given in sufficient dosage over a sufficient period of time. However, even with adequate antibiotic coverage, hesitation and delay in providing satisfactory drainage will often result in severe damage to the middle ear. The ischemia associated with the suppurative process in the middle ear most often results in the permanent loss of a large portion of the tympanic membrane. Thus, adequate, early myringotomy in the acute infection with bulging ear drum not only allows drainage of the exudate but also allows the reestablishment of the blood supply to the ear with increased antibiotic effectiveness.

Early myringotomy is also valuable in securing a culture directly from the middle ear with the resultant better clinical management.

In the inadequately treated, resistant, nonresponding acute ear infections, careful attention must be given to the bony structures in the middle ear and mastoid area. Osteomyelitic foci should be surgically excised promptly while confined to the nonhearing portions of the ear. In these, an early simple mastoidectomy generally will result in an infection-free normally functioning ear within seven days. Neglect or delay in carrying out this procedure will almost certainly result in a low-grade destructive osteomyelitis which will lead to ultimate destruction of the entire hearing apparatus.

In other cases in which the infection has been fairly well controlled by antibiotics, failure to provide drainage results in the long-term retention of a transudate-like material in the middle ear. This retention ultimately produces an adhesive otitis media with the final loss of hearing. In these, adequate myringotomy and the reestablishment of eustachian aeration will result in rapid clearing with the restoration and preservation of hearing.

Recurring and acoustically destructive infections in the ear are frequently due to the failure to recognize and treat the primary foci in the areas of the nasopharynx or paranasal sinuses. In all ear infections, careful attention must be given to the orifices of the eustachian tubes. The adenoid, particularly, should be carefully evaluated. Large masses of inflammatory adenoid tissue are usually self-evident. However, small masses located in the immediate tubal area, especially in Rosenmüller's fossae, are frequently overlooked. Careful surgical removal of these masses will result in rapid clearing of the previous nonresponding and recurring ear infections.

Purulent secretion from a suppurating sinus bathing the tubal orifice also will result in continuing and recurring ear infection. Adequate care of this underlying sinus infection will, likewise, be followed by prompt, favorable response of the ear infection.

Uncontrolled allergic phenomena involving the nose and nasopharynx also result in defective eustachian aeration and so predispose to persisting and recurring ear infections. In these, antibiotic therapy will be largely ineffective unless the allergy is controlled sufficiently to allow aeration of the eustachian tubes and middle ear.

**IMPROVEMENT OF HEARING IN ACOUSTICALLY DISEASED EARS**

It is, however, quite a different and far more difficult problem when, for one reason or another, ear infections have not been completely cleared but allowed to continue on as low-grade destructive processes. In these, resistant organisms remain actively infectious and are, on the whole, nonresponsive to all of the known antibiotic or chemotherapeutic agents. These low-grade infections gradually involve and destroy a greater portion of the tympanic membrane and ultimately destroy the ossicles as well. Over a period of time, the hearing function will thus be largely destroyed. In these, the only successful treatment is surgical in nature. Medical treatment, including all known antibiotics, at best gain only temporary quiescence. Use of antibiotics should be limited to that in the combination with corrective surgery and in the treatment of complications.

Until recently, the fear of serious complications plus the knowledge that any small residual area of infection would cause persisting aural drainage has resulted in the surgical treatment being directed solely at the complete surgical excision of all the possible infected tissue. This meant that the best surgical procedure resulted in the surgical removal of the entire middle ear structure, leaving a completely nonfunction-
ing ear. The entire drum membrane, the ossicles, and even the entire periosteal covering of the inner wall of the middle ear were removed. Resultant scarring about the oval and round windows completely destroyed any chance of regaining hearing. It is in this type of middle ear disease that surgical techniques have improved tremendously. The remaining hearing-structures are carefully evaluated for their preservation as a functioning conductive mechanism. Only the actual diseased processes are removed. Magnification has been of tremendous help. By enlarging the visualized area five to twenty times, the entirety of the delicate structure is studied, making it possible to separate the pathological processes from them. This better visualization has also created a more familiar anatomical knowledge of these complicated hearing-structures. This allows the removal of granulation tissue, fibrous bands, osteomyelitic foci and cholesteatomatous masses from around the oval window and the foot plate of the stapes. The round window is also carefully cleansed under magnification to allow functioning of the hydraulic system.

The tympanic membranes and the ossicles, which frequently are severely damaged by the prolonged diseased process, can often be preserved, at least in part, and utilized to improve hearing. After being certain that the middle ear is free of infection, a thin skin graft can be applied to the surface of the drum to repair large perforations with the result that it will again become a good sound-receptor.

If the ossicular chain has been destroyed or is undergoing osteomyelitic change, the procedure will necessarily have to be altered. Each problem must be considered individually. It is desirable to salvage a portion of the tympanic membrane to form an air-containing cavity. Frequently, a portion of the tympanic membrane can be utilized by attaching it directly to the head of the stapes — tympano-stapediopexy. Hearing will then be achieved by direct vibration from the reconstructed drum membrane directly to the stapes. This, incidentally, is similar to the normal acoustic apparatus in birds and functions remarkably well in carrying sound to the cochlear structures. In any case, an air pocket connected to the eustachian orifice is formed over the round window. This creates a phase difference in the sound waves striking the oval and round window areas and so allows the hydraulic system to operative with improvement in hearing.

Low grade chronic infectious processes in the epitympanic area are a particularly dangerous and troublesome result of inadequate treatment of acute middle ear processes. The patient is usually symptom-free except for a scant malodorous drainage. At first glance, the tympanic membrane seems intact. However, more careful study shows that drainage is from a small perforation in the attic or in the marginal posterior area. Investigation shows a low-grade infection usually with an associated gradually expanding cholesteatomatous mass located in the epitympanic area. Hearing at this stage is generally unaffected and the patient has little discomfort until a sudden complication of labyrinthian irritation or a meningeval flareup occurs. In these, the serious life-endangering complication necessitates immediate care. Usually, the meningeval labyrinthian complication can be controlled by antibiotic therapy. When this type of pathologic change occurs, surgical eradication should not be delayed. Antibiotics are used to control the complications and to quiet the infection. By using an endaural approach, which allows direct visualization of the epitympanic area, it is possible to surgically expose the middle ear and remove the pathologic material without disturbing the sound-conducting apparatus. After carefully removing the skin of the external canal together with its underlying periosteum, the tympanic membrane is carefully separated from its sulcus. The bone is removed by means of small dental burrs to give adequate visualization. Then under direct visualization through an operating microscope, the middle ear cavity and ossicles are inspected. The cholesteatomatous deposits, broken down bone, granulation tissue, are all carefully removed. The facial nerve can safely be cleansed without danger of paralysis. After removal of all diseased tissue, the pars tensa portion of the tympanic membrane is packed back into position with restoration of the normal sound conducting mechanism. The epitympanic area is left open. This procedure has proved successful in preserving good hearing as well as removing the dangerous chronic infectious process.

Another hearing-defect that can be rectified by surgical procedures is that due to
otosclerosis. This condition affects approximately one per cent of all white adults. The etiology is not known but it does seem to simulate bone dyscrasias. It is characterized by islands of growing, vascular, osseous tissue. Frequently, these islands affect the foot plate of the stapes and soon begin to produce a purely conductive loss of hearing. There is considerable variation in the periods of quiescence or activity in the growth of the otosclerotic focus with the same variation in the rate of development. Virtually nothing is known concerning the factors responsible for the growth or inactivity of the otosclerotic focus. The gradual perfection of surgical techniques has proven very successful in restoration of hearing if the cochlear function remains good. It is possible to inspect the middle ear and examine the stapes directly by a procedure somewhat similar to that just described. The skin and peristium are elevated and the tympanic membrane separated from the sulcus. Adequate bone is removed to allow inspection of the stapes and its foot plate. It is possible in a large percentage to loosen the stapes and regain function of the ossicular chain system. Under the stimulus of Rosen, with the added technical improvements of Shambaugh, Goodhill, House, and Kos, improved techniques have made it increasingly possible to loosen the fixed stapes and thus restore normally functioning ossicular chains. The use of the improved operating microscope, which allows magnification up to twenty or thirty times, has proven to be of inestimable value. Unfortunately, in many, the otosclerotic process is so active the stapes again become fixed. In others, it is so far advanced that it is impossible to again re-establish stapedial mobility. However, in these, fenestration by the Lempert technique offers the most consistent result. In our hands, in approximately six out of ten otosclerosis mobilization can be considered successful for at least a period of six months. In fenestration-surgery, which is a more complicated and more temporarily disabling procedure, nine out of ten patients with satisfactory cochlear function can expect permanent, satisfactory hearing-improvement.

Another condition in which it is possible to improve the hearing-acuity is that of congenital abnormality of the ear. In these, the inner ear is usually intact. The drums, ossicles, and external ears are either not developed or are abnormal. As a rule, there is no bony external canal present. The drum is completely absent with only a bony shell in its normal location. The surgical technique in these cases varies somewhat, depending on the type of anomaly. In some, fenestration is carried out similar to that done in otosclerosis. After carefully removing the mass of bone overlying the area, a thin split skin graft is used to line the prepared external auditory canal and held in place over the fenestra by temporary packing. It has been possible in cases of bilateral congenital aplasia with marked defect in hearing to improve the hearing to approximately the twenty-five or thirty decibel area. This means that the child can develop normally, socially and intellectually. In other cases, a procedure designed by Pattee has been quite successful. In these with a mobile stapes, a thin skin graft is placed over the head of the stapes and held in contact with it by packing. This results in a functioning drum attached directly to the stapes.

Certain locally malignant tumors of the middle ear can be removed without disturbing the acoustic apparatus. This, of course, is true only if the tumor is limited to the middle ear and has not involved the ossicles themselves. Unusually locally malignant tumors of the middle ear, known as glomus jugulare or chemodectoma, are serious fatal neoplasms in this area, if untreated. In that the tumor usually begins in the lower portion of the middle ear, an approach is made from this area as described by Shambaugh. The skin with its periosteal layer is elevated with the attached drum. This allows adequate visualization of the lower two-thirds of the middle ear. The tumor is removed and the base thoroughly electrocoagulated. Although these tumors are relatively rare, they do occur sufficiently often to warrant this special attention. In our limited experience with this tumor, we have not had recurrence.

SUMMARY

It is emphasized that all treatment of ear disease should be directed toward the maintenance or improvement of hearing acuity. Adequate care of acute middle ear disease will prevent the development of acoustically destructive diseases. Early myringotomy in the suppurating ear with bulging drum and prompt simple mastoidec-
tomy in suppuration with bone necrosis, are essentials in the care of acute, middle-ear infections. Hearing can be salvaged in the severely damaged ear by a combination of improved surgical techniques under magnification, careful asepsis, and proper antibiotic therapy. Certain tumors can be removed from the middle ear without disturbing the hearing-apparatus. Congenital abnormalities can often be corrected to give satisfactory hearing. Conductive hearing loss in otosclerosis can be corrected by either mobilizing the stapes or by fenestration of the labyrinth itself.

A STUDY OF THE
Antibody Response
to an
Intradermal Booster Inoculation of
Asian Influenza Vaccine*

These authors begin, in this presentation, to furnish us reliable information we have wanted and needed; namely, facts about the efficiency of intradermal administration of Asian influenza virus as compared with the subcutaneous route. Obviously, more such studies are needed about various phases of this subject. The advice we received via the Public Health Service had to serve as our guide. Surely this was based upon a background of reliable opinion but it came to us on a basis that permitted no opportunity to formulate our own opinions or to evaluate those we received gratuitously.

—EDITOR

THE threat of Asian influenza in epidemic form throughout the country, during the summer of 1957, incited efforts for the production of an effective vaccine. Recommendations to physicians by the Special Committee on Influenza of the American Medical Association, in September, 1957, included the preferable subcutaneous injection of 1.0 ml. of monovalent Asian influenza vaccine prepared from chick allantoic fluid. An alternate intradermal inoculation of 0.1 ml. of the vaccine was also suggested by the Committee in lieu of the former. This route of inoculation is favored by some since the severity of allergic manifestations is thus minimized.

Later in the year, it became evident that Asian influenza was attaining epidemic proportions. As a result, booster inoculations were administered in many instances to bolster the antibody level in the previously inoculated population. In view of this practice, this study was undertaken to determine: (1) The overall effect produced on the antibody level two weeks after the intradermal inoculation; (2) the anamnestic response to an intradermal booster injection of a polyvalent vaccine; (3) the correlation between the ages of the group of people studied and their antibody level as titered two weeks after the intradermal vaccination.

Previous reports are conflicting regarding the efficiency of intradermal inoculation of influenza vaccines with respect to antibody production. In 1947, Van Gelder and associates showed that initial intradermal inoculation of 0.1 ml. of types A and B influenza vaccine was just as effective as a subcutaneous inoculation of 1.0 ml. in producing high levels of antibody to both of these influenza types. A second intradermal inoculation administered two weeks later did not increase the titer appreciably. On the other hand, Boger and Liu reported in 1957, that when 0.1 ml. of Asian influenza

*This investigation was supported in part by a research grant, H-2827, from the National Heart Institute, Public Health Service.
vaccine (50 CCA units) was administered intradermally in patients 70 or more years of age as an initial inoculation, only a feeble antibody response was produced when compared with a subcutaneous inoculation of 1.0 ml. of the vaccine (500 CCA units).

MATERIALS AND METHODS

A group of 60 adults, 19 through 63 years of age, consisting of students, faculty, and employees of the University of Nebraska College of Medicine were inoculated subcutaneously with 1.0 ml. of commercially prepared monovalent Asian influenza vaccine† containing 200 CCA units per ml. This initial inoculation was given during the last week in September and the first week in October, 1957. Approximately three months later the same individuals received intradermal injections of 0.15 ml. of a polyvalent influenza vaccine containing 500 CCA units per ml. of a combination of influenza Types A and B as well as Asian. It should be emphasized that 200 CCA units per ml. of the vaccine were attributable to the Asian type; consequently, 80 CCA units of the Asian virus were inoculated intradermally.

Blood samples were taken from all 60 persons just prior to the intradermal injection in order to determine the residual circulating antibody titer three months after the initial subcutaneous inoculation. A second blood sample was taken from 25 of the 60 individuals three days following the booster inoculation for the purpose of detecting any sudden rise in the antibody titer to the Asian strain virus. The entire test group was again sampled two weeks after the intradermal booster injection in order to determine the over-all rise in Asian type antibodies present.

The serum was removed aseptically from all blood samples and stored at —35° C. until tested. Just prior to serological examination, 0.5 ml. of each serum sample was treated with 1.0 ml. of potassium periodate and held overnight at 4° C. for the purpose of destroying nonspecific inhibitors present in the serum. The next morning, 1.0 ml. of 1 per cent glycerine in normal saline was added to each serum sample to inactivate the periodate. As a result of this treatment each serum sample was diluted 1:5.

Antibody titers were determined essen-

†The monovalent vaccine was prepared by Merck, Sharp and Dohme. The polyvalent vaccine was a product of Eli Lilly Company.

itially by means of the hemagglutination-inhibition test as described by Jensen.‡ A series of serum dilutions were prepared in Kahn tubes. A 0.25 ml. volume of the initial 1:5 serum dilution was added to the first tube. Another 0.5 ml. of the original 1:5 serum dilution was added to the second tube containing 0.5 ml. of 0.85 per cent saline resulting in a 1:10 dilution. A 0.25 ml. quantity of the 1:10 dilution was transferred to an empty tube and another 0.5 ml. of this dilution was added to a second tube containing 0.5 ml. of saline resulting in a 1:20 dilution. A continuation of this procedure resulted in a series of duplicate twofold dilutions of serum ranging from 1:5 through 1:640. Four hemagglutinating units of Asian influenza virus (A/Asian/ Japan/305/57 EMFE strain) were added to each tube in 0.25 ml. quantities. Racks containing the tubes were shaken vigorously and then allowed to stand at room temperature for 30 minutes. A 0.5 ml. volume of 0.5 per cent chicken erythrocytes was added to each tube and again mixed by shaking. Necessary controls were included with each test. The tests were incubated at room temperature until the red cell control tube settled to a distinct button (45 to 60 minutes). The titer was read as the reciprocal of the highest initial dilution of antiserum which demonstrated complete inhibition of the agglutination of the red blood cells by the virus. All serum samples from each individual were titered simultaneously in order to maintain constant laboratory conditions.

RESULTS AND DISCUSSION

Initial examination of the results (Table 1) shows that 34 (57%) of the 60 individuals receiving intradermal booster injections demonstrated some rise in antibody titer after a two week period. The question immediately arises, however, as to how many of these titers are indicative of immunity to the Asian influenza virus. It is very difficult to determine with certainty the minimal titer representative of immunity without challenging the entire group with active Asian virus. Even under these supposedly ideal conditions, Salk et al. found that some of those previously immunized with influenza A vaccine became ill following infection with the same strain of virus although they demonstrated high hemagglutination-inhibition titers. At the other extreme, a certain number of individuals showing low antibody titers escaped infection. These au-

October, 1958
thors demonstrated, however, that a minimal initial hemagglutination-inhibition titer (1:32) had to be attained before the majority of the vaccinated individuals were reasonably assured of immunity. Other workers\(^6\)\(^7\) performing similar experiments with various influenza virus strains arrived at similar conclusions.

Since it was not feasible to expose the 60 test individuals to the Asian influenza virus, it was thought that the level of hemagglutination-inhibition titers as detected in the

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**TABLE 1**

**INDIVIDUAL ANTIBODY RESPONSE TO AN INTERDERMAL BOOSTER VACCINATION**

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<tr>
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*Expressed as the reciprocal of the highest serum dilution.

-5 indicates a titer less than 1:5.
serum of persons convalescing (about two weeks following illness) from Asian influenza might serve as a measure of protective immunity. It is generally accepted that the majority develop immunity to a given influenza strain following frank illness with that particular strain. Therefore, the geometrical mean titer (1:34) of the convalescent phase sera from 16 individuals proven by isolation and identification of the virus to have been ill with Asian influenza was used as an index of immunity (Table 2). When the mean titers of the acute and convalescent phase sera are compared, a definite rise from 1:7 to 1:34 or almost a 5 fold increase is shown. It is also of interest to note here that a mean titer of 1:22 is obtained upon examination of the data presented by Meyer, et al concerning convalescent phase serum in seven cases of Far Eastern influenza. Furthermore, Bell and associates upon challenging a group of volunteers who had been vaccinated previously with Asian influenza vaccine found that only 25 per cent of those with titers of 1:40 or higher became ill whereas 43 per cent of those with titers ranging from 1:10 to 1:20 developed influenza. It is to be kept in mind, however, that although 1:34 seems to be a good mean titer above which a high percentage of those vaccinated should demonstrate immunity to Asian influenza infection, it is entirely possible that a certain percentage of individuals whose titers were raised to 1:20 as a result of the booster inoculation are also immune.

If a titer of 1:34 or above is taken to be indicative of immunity to Asian influenza, closer examination of the results in Table 1 reveals that 21 (35 per cent) demonstrate a titer greater than 1:34. It is also noteworthy that only 8 or 13.3 per cent of the total number of individuals examined show a rise from below to above 1:34 following intradermal injection. Also a comparison of the mean titer (1:15) two weeks after the booster inoculation (Table 3) with that (1:34) obtained in influenza patients two weeks after the onset of symptoms indicates a titer of less than half of the latter. On the basis of these findings, it can be seen that in most instances an intradermal booster injection of 30 CCA units of vaccine after a period of approximately three months from the time of the initial subcutaneous injection does not augment the titer sufficiently to indicate immunity. It would be interesting to determine the effect on the antibody level of an intradermal booster inoculation of 0.15 ml. of the newer commercially prepared Asian monovalent vaccine containing 400 CCA units per ml.

Data are presented in Tables 1 and 3 showing the effect on the antibody titer three days after the booster inoculation. Only two individuals showed a rise in titer, whereas the titer in two other cases actually decreased. The majority of the 25 sera examined showed no change in titer which is reflected in the comparison of the mean titer before (1:8) and three days after (1:9) the booster inoculation. Under the conditions presented in this study, it can be concluded that it is not possible to produce an anamnestic reaction of Asian influenza antibodies by intradermal inoculation.

No attempt was made to follow the persistence of antibody titer in the group of 60 individuals until they received their booster inoculation; nevertheless, it is interesting to note that 21.6 per cent demonstrated a titer higher than 1:34 over a period of 10 to 13 weeks (Table 1). Apparently the booster

**TABLE 2**

**DISTRIBUTION OF THE HEMAGGLUTINATION-INHIBITION TITERS DURING THE ACUTE AND CONVALESCENT PHASE OF 16 ASIAN INFLUENZA INFECTIONS**

<table>
<thead>
<tr>
<th>Antibody Titer*</th>
<th>Acute phase</th>
<th>Convalescent phase (2 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Per Cent</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>2</td>
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<tr>
<td>80</td>
<td></td>
<td>2</td>
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<tr>
<td>160</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>320</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>640</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Geometric Mean</td>
<td>7</td>
<td>34</td>
</tr>
</tbody>
</table>

*Expressed as the reciprocal of the initial serum dilution.
injection increased the antibody level in only four of these persons.

Since this study was conducted during the months of the year when the Asian influenza epidemic was at its peak, it is possible that subclinical infections could have influenced the antibody titer in certain individuals; however, there is no record of any of the members of the group having been ill with respiratory disease during the period between the booster inoculation and two weeks later when the last serum sample was obtained.

A question might be raised as to the correlation of the age of the individual with his antibody titer to influenza as a result of intradermal vaccination. The group examined in this study included 60 individuals between the ages of 19 and 63. As indicated previously, this group as a whole did not respond satisfactorily to the dose used as an intradermal booster inoculation. It was thought that a difference might be noted if the group was divided into a young adult group, 19-30 years of age, and an older adult group, 31-63 years of age. Of the 42 individuals in the young adult group, 11.4 per cent demonstrated a rise in titer from below to above 1:34. Although only 18 sera were tested in the 31-63 age-group, two or 11.1 per cent had titers greater than 1:34 as a result of their booster injection. It appears then that there may be no difference between these two age-groups with respect to antibody response following booster injection. Since intradermal influenza vaccination has been recommended for children, it would be interesting to study antibody levels in various pediatric age groups both after initial and booster inoculations.

approximately three months after the initial subcutaneous inoculation, did not augment the titer sufficiently to indicate immunity.

There was no evidence after a period of three days of a sudden antibody response to the booster inoculation upon examination of 25 serum samples.

A residual titer indicative of immunity was found in 21.6 per cent of the persons investigated two to three months after having received a subcutaneous vaccination.

The separation of the 60 individuals studied into two age groups, 19 through 30 and 31 through 63 years of age, showed no differences between the two groups with respect to antibody response to the intradermal injection of the Asian vaccine.

**REFERENCES**


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**TABLE 3**

DISTRIBUTION OF HEMAGGLUTINATION-INHIBITION TITERS BEFORE AND AFTER INTRADERMAL VACCINATION

<table>
<thead>
<tr>
<th>Antibody Titer</th>
<th>Prior to intradermal inoculation</th>
<th>3 days after booster inoculation</th>
<th>2 weeks after booster inoculation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Per Cent</td>
<td>No. Per Cent</td>
<td>No. Per Cent</td>
</tr>
<tr>
<td>—5</td>
<td>25 42</td>
<td>11 44</td>
<td>8 13</td>
</tr>
<tr>
<td>5</td>
<td>8 13</td>
<td>2 8</td>
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<td>3 12</td>
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<td>2 7</td>
<td>5 12</td>
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</tr>
<tr>
<td>640</td>
<td>--</td>
<td>--</td>
<td>1 2</td>
</tr>
<tr>
<td>Totals</td>
<td>60 100</td>
<td>25 100</td>
<td>60 100</td>
</tr>
<tr>
<td>Geometric Mean</td>
<td>8</td>
<td>9</td>
<td>15</td>
</tr>
</tbody>
</table>

*Expressed as the reciprocal of the initial serum dilution.

**SUMMARY**

A study was made of the antibody response to an intradermal booster inoculation of polyvalent Asian influenza vaccine among a group of adults 19 through 63 years of age.

In most instances, an intradermal booster injection of 30 CCA (chick cell agglutinating) units of the Asian vaccine administered
Refinements in the Electrophoretic Test for Chorionic Gonadotropin

Many laboratory procedures have been devised over the past years to detect the pregnant state. Whereas a few are quite accurate, many have proven to be of little value. Some of these tests do not become positive until pregnancy has proceeded approximately six or more weeks. Most have been bioassays; a few have been of a physicochemical or purely chemical nature.

The need for a test accurate at an early period of gestation, has led to the electrophoretic test for chorionic gonadotropin, most recently investigated by Stran and Jones. These workers subjected urine specimens to analysis by electrophoretic techniques. In nineteen of twenty pregnant women in their first trimester of pregnancy, a component, protein in nature, was seen to migrate toward the cathode under the conditions of the test.

In a later paper, Stran and Jones found that commercially purified Human Chorionic Gonadotropin (HCG) obtained from Squibb and designated "Follutein," Squibb, if subjected to their purification process and subsequent electrophoresis, did not yield a bromphenol blue stainable component. However, if these areas where one would expect to find HCG were eluted, positive Friedman tests were obtained. As they have postulated, this might represent denaturization of the carrier protein by the second alcohol precipitation, and, in the light of the positive Friedman tests, it also suggests that the specific residue is the active hormone which apparently is resistant to the purification procedure. These excellent papers should be consulted in regard to the details of their findings.

Unfortunately, Stran and Jones have found that urines from patients with high pituitary gonadotropin titers also contain components which behave in the same fashion as HCG. In their most recent paper, separation of these two entities was unsuccessful.

Lorraine and Brown, investigating the claims of Crooke and Butte that tricalcium phosphate columns could differentiate Follicle Stimulating Hormone (FSH) from Interstitial Cell Stimulating Hormone (ICSH), found that their "G.A." fraction, purported to be relatively pure FSH, contained also a luteinizing element. Their "G.B." fraction, said to be ICSH, was found to be the hormone of pregnant women (HCG). Later work by Loraine and Brown demonstrated how tri-calcium phosphate suspensions adsorbed HCG at pH 6.5, and

From the Endocrine Department of the Hastings and Lincoln Medical Laboratories, Foote Building, Hastings, Nebraska; and Stuart Building, Lincoln, Nebraska.

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that Human Menopausal Gonadotropin (HMG), which consists of both FSH and ICSH, remained unadsorbed in the solution. The HCG was then eluted from the phosphate at pH 11.0. This separation has been shown by them to be virtually complete.

We felt that by utilizing this method of separating the gonadotropins of pituitary from those of placental origin, it would increase the specificity of the electrophoretic test, and that this might then result in a sensitive pregnancy diagnostic procedure.

**METHOD**

Fifty milliliters (or one hundred if the patient might be in the very early stages of gestation) of first morning urine specimens, specific gravity 1.012 or higher, were adsorbed onto kaolin (acid-washed) as in the method described by Stran and Jones. The gonadotropins were then eluted at pH 11.3 (2.5% NaOH), the material centrifuged, and the supernatant fluid adjusted to pH 5.5 (10% CH₃COOH). Five volumes of acetone, C.P., were added, the mixture stirred for five minutes on a magnetic stirrer, and the material was refrigerated for one-half hour (4° C.). It was then centrifuged and the supernatant acetone decanted. The tube was inverted over filter paper for ten minutes and allowed to drain. Five ml. of distilled water were added, along with three ml. of tricalcium phosphate suspension prepared according to the method of Swingle and Tiselius. The pH of this mixture was adjusted to pH 6.5, and the material mixed on the magnetic stirrer for thirty minutes, then centrifuged. The supernate was adjusted to pH 5.5, five volumes of acetone were added, the material mixed for five minutes as previously mentioned and refrigerated for one-half hour. Again the acetone was decanted after centrifugation and the remaining precipitate was presumed to contain anterior pituitary gonadotropins (Loraine and Brown). These substances will form the subject of a future paper.

To the sedimented tricalcium phosphate (see above), five ml. of water were added and the pH adjusted to 11.0. This material was mixed for thirty minutes on the stirrer, centrifuged, and the supernate adjusted to pH 5.5. Five volumes of acetone were added and the mixture stirred for five minutes, then refrigerated for one-half hour. It was then centrifuged and the acetone decanted followed by inversion and drainage as before. This precipitate contains the HCG, if present.

To this precipitate, 0.1 ml. of barbital buffer, pH 8.6, ionic strength 0.005, was added and precipitate dissolved in it by means of the stirrer and a small mixing bar. Of this extract, (0.025 ml.) was applied to a pencil line marking the starting point on a strip of Whatman No. 3 MM or No. 1 filter paper which had previously been placed in a Durrum-type electrophoresis apparatus containing the barbital buffer solution mentioned above and which set-up had been permitted to equilibrate for approximately ten minutes before spotting the extract and turning on the current. Approximately 430 volts (16-20 volts/cm.) were applied and the current was slightly under one ampere. The current was allowed to flow for one hour and fifteen minutes. The strip was immediately dried after electrophoresis, in a hot-air oven. Staining and fixing were as described by Henry, et al.¹.

**RESULTS**

Urine specimens from fifty patients have been subjected to this procedure. Nine non-pregnant patients did not show any component moving toward the cathode. In three menopausal patients (one hundred fifty ml. urine processed), there was a component moving toward the cathode from the pituitary fraction, but none from the HCG fraction. Thirty-five specimens from patients known to be in the first trimester and one from a patient in the second trimester (approximately the fifth month) without fail revealed components moving toward the cathode which were from the HCG fraction. The pituitary fractions of several of these were also run, and of five cases (using fifty ml. urine), two demonstrated traces of components moving toward the cathode. One positive HCG test was obtained in a patient twenty days pregnant, and one was positive in a patient close to fifteen days pregnant.

**SUMMARY**

An electrophoretic test for Human Choriionic Gonadotropin which appears to be reasonably specific has been described, and the results of analyses of urine specimens from fifty patients both pregnant and nonpregnant have been given. Included are specimens from three menopausal patients from
which pituitary gonadotropin studies were made. Positive HCG tests were also obtained on specimens from two patients in very early stages of gestation.

We wish to acknowledge the help of Mrs. Katherine Swanson and Mrs. Luetta Findley in the collection of specimens for this study.

REFERENCES

An estimated 42 million work days are lost each year because of allergies, yet a “substantial number” of allergy sufferers do not receive medical attention. This fact is revealed in the current issue of the publication “Patterns of Disease” prepared by Parke, Davis & Company for the medical profession. Results of a study in California showed that almost one third of asthma and hay fever victims were not medically attended, according to “Patterns.”

Internal Revenue Service has ruled that physicians on full-time staff basis with hospitals do not have to include in their U.S. income tax returns money received from patients, when the checks are indorsed over to the hospital.

Job injuries disabled about two million workers last year, “Patterns” states. Of these, less than one per cent were killed and slightly over four per cent “suffered permanent physical impairment.”
IT has been with keen anticipation that I have looked forward to the pleasure of attending this session of the Medical Section of the American Life Convention ever since, some months ago, your Chairman paid me the high compliment of asking me to participate in your program. I always enjoy the opportunity to meet with members of the medical profession. Perhaps the psychiatrists among you will interpret this as an attempt to compensate for a latent and obviously frustrated desire to practice medicine. I shall have to admit that by assiduous study of Time, Reader's Digest, and other leading medical journals and by keeping an attentive ear cocked to absorb some of your lingo I have achieved the dubious status of a thoroughly convincing self-diagnostician—the type that makes the most wretched sort of patient.

In a somewhat less personal vein, knowledge of at least the rudiments of anatomy and medical nomenclature became important to me when I went to work in the health insurance business charged with the duty of paying claims. It took only one summer for the highly suggestible teen-ager to become an expert on symptoms. I had them all. Three exophthalmic goitre claims in a row resulted in at least two basal metabolism readings. A couple of claims for disability due to herpes zoster and urticaria had me scratching like mad. I am only grateful that in those early days we didn't extend coverage to pregnancy, miscarriage or abortion. So, gentlemen, you see that perforce I have had to learn something about your profession. And now it seems that through an exciting series of developments you are having to learn something about my business.

It was your Chairman, not I, who selected the title of these remarks: "Are You Meeting Your Responsibility in the Field of Accident and Health Insurance?" The title implies that you have a responsibility in this field. If perhaps you have been only vaguely aware of it, I would like to suggest that as a doctor of medicine, particularly one who is versed in insurance matters, you have an enormous personal obligation to make voluntary health insurance successful.

I would not presume on the patience of so well informed an audience to delineate all of the pressures, influences, and developments, economic, political, social, and scientific, that have conspired to require of America's medical profession a profound interest in and vigorous action to solve many of the problems that are confronting voluntary health insurance. Within the professional lifetime of most of you a veritable revolution has occurred not only in medical techniques but in the methods by which healthcare costs are financed. When my grandfather established his medical practice in a small Nebraska country town, in 1883, medical knowledge was limited, and the facilities needed in the practice were simple and inexpensive. Then, uncomplicated family and community arrangements sufficed to meet the costs of health care. Between that day and this our nation has changed from a rural, pastoral country to a mighty industrial power. Our population has moved to the cities. The old, close family-circle on whom the aged and infirm could depend for care no longer exists. The forward sweep of scientific medicine that has meant so much for all of the American people has engendered many of the problems of medical economics that concern us today. The old family doctor has largely given way before

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E. J. FAULKNER
President, Woodmen Accident & Life Company, Lincoln, Nebraska

Nebraska S. M. J.
burgeoning specialization. Modern medical practice requires the use of expensive equipment and therapeutic agents. The hospital, formerly a place to go to die, is now a usual and accepted part of the treatment of many illnesses. While all of this change has paid enormous dividends in longer life and better health for our people, a part of the price of progress has been a great increase in the cost of health-care services. Coincident with this increase the capacity of the average family to meet those costs out of current income or savings has declined. The burdensome income taxes of the past twenty-five years have prevented, for most, the accumulation of liquid savings out of which to meet unexpected health expense. Our penchant for mortgaging current income by installment purchases has vitiated the ability to pay medical and hospital bills out of the monthly pay check. In these circumstances, the need of a socio-economic mechanism for financing health-care costs was and is obvious. Happily for America when the need for insurance against the costs of ill health first became acutely apparent in the early thirties the tradition of individual initiative and private enterprise was still strong in our country. Unlike foreign lands where the government assumed the responsibility either for providing or for financing the costs of Medical care, Americans turned to private enterprise. Our great and growing system of voluntary health insurance has been the result. This system is now on trial as never before. Because it has become the instrument of choice of the vast majority of all Americans for financing their health-care costs, its capacity to meet all of the problems in this field is of surpassing significance. In a sense, today all private enterprise is being tested against the unusual problems of a world harassed by international tensions in a time when our traditional social, political, and economic philosophies are being assailed by the advocates of collectivism. The private practice of medicine and the voluntary health insurance system are by no means exempt from attack. As a matter of fact, the American health-care complex is in the forefront of the struggle to stay the dead hand of government from further destruction of the rights and responsibilities of the individual citizen. No area of social concern is of more intimate importance to more Americans than is health. Everyone desires good health and long life. Everyone, informed or otherwise, is an expert in health-care matters. Politicians knowing the vote-getting appeal of measures that seem to hold out the prospect of better health care at low or no cost to the individual are almost uniformly interested in legislation that vitally affects private practice of medicine and the voluntary health insurance system. The problems of financing health care have become increasingly acute in the decade since the war because health-care costs have risen so sharply. The Bureau of Labor Statistics Cost of Living Index is based on the average of costs in the two-year period 1947-49. This Index reveals that the overall cost of living now stands at 123.5 per cent, but health-care costs at 142.3 per cent have risen more sharply than any other element in the Index. Health-care-costs have the dubious distinction of being the only element in the Index that has risen every single month for the past ten years. Many people now are widely concerned that the excellent health care that the American people receive is being priced beyond the reach of the average family. As health-care costs rise, it follows that the cost of voluntary health insurance must rise. You are all familiar with the plight of many service-plan type insurers that have had to seek successive increases in premium — a more spectacular reflection of the impact of rising health-care costs than the more moderate adjustments that insurance companies have found necessary. While it is true that physicians' fees have risen less than the composite cost of living and that the high price of health care is primarily attributable to the precipitous increase of hospital and drug costs, nonetheless the doctor, as quarterback of the health-care team, bears the onus of blame in the eyes of the public for the growing cost of health care. It should be obvious that if the cost of health-care, whether financed through voluntary health insurance or otherwise, should reach levels above the reach of the mass of Americans, pressures for government subsidies would become inevitable. Such subsidization would necessarily lead to the socialization of medical practice and the nationalization of insurance.

The partners in the American health-care complex, the doctors, hospitals, and the voluntary insurers, must accept the responsibility for containing the rising costs of health care and solving to the satisfaction of the majority of Americans the problems that now afflict us in the private provisions and
financing of health care. The chips are down and unless doctors, hospitals, and insurers can provide sound answers to these problems compulsory health insurance and socialized medicine may well be the wave of the future. I leave to your imagination the tremendous attrition of all of the values that we cherish—not to mention the adulteration in the quality of health-care and the tremendous increase in its cost, should the government intervene further.

I give way to no layman in my respect for the medical profession which has served the American people so well. I subscribe to your guiding principles of free choice of physician, fee for service, and insistence on freedom from lay domination. I know full well the proper resentment of medical men of any attempt by lay people, individually or collectively, to supervise the judgments of the profession in health-care matters. Nonetheless, I am deeply concerned lest the majority of physicians through an understandable preoccupation with their private practices fail to exert the kind of leadership that will alone preserve the kind of medicine that we know today. Because I would not wish to intrude in any area that is a proper prerogative of the medical profession, I want to talk to you today more as fellow insurance men than as doctors of medicine. You who are the Medical Directors of the nation's insurance companies are in a unique position — one of especial advantage for making a constructive contribution to the preservation of our American health-care complex. You are the members of the profession who by reason of your special knowledge and contacts can best bring about a better mutual understanding between doctors and insurers. This you can accomplish only to the degree that you inform yourselves of the social, political, and economic issues involved in the attack on private practice and voluntary health insurance. You, better than any others can rally the profession behind the enlightened leaders of organized medicine to resist the rising clamor for lay interference with medical practice. Are you familiar with the many fronts on which your profession is defending itself against these assaults? The battle is being waged not only in Congress and the state legislatures, but truly in every city, hamlet and town. Witness the growing effect on private practice of such instrumentalities for the provision and financing of health-care as the United Mine Workers Health and Welfare Fund. But recently the Executive Medical Director of that organization proscribed the payment of medical fees from the Fund except to specifically designated practitioners. His asserted justification for abrogating free choice of physician was that only by so doing could he protect the Fund against profligate over-charge and abuse. Witness also in the Commonwealth of Pennsylvania a recent Adjudication by the Honorable Francis R. Smith, Commissioner of Insurance, of issues involved in the request of three Blue Cross plans for increases in the schedule of rates charged subscribers. In Commissioner Smith's orders pursuant to the Adjudication, he asserted jurisdiction not only over the charges of the hospital service plans but over premium rates of health insurance companies. Of extraordinary portent are the Commissioner's orders requiring Pennsylvania to adopt certain practices that he delineates intended to alleviate over-utilization and abuse of health-care. Compliance with his order is a condition precedent to Insurance Department approval of hospital contracts with the service plans. While none of us can argue with the worthwhile purpose the Commissioner seeks to serve, we must have serious reservations about his assumption of dictatorial authority over the operation and management of the hospitals. Because the Insurance Commissioner of Pennsylvania has the authority to approve arrangements between medical service plans and participating physicians, it takes no stretch of the imagination to visualize the potential extension of this kind of third party intervention to the practice of medicine itself. Witness further the establishment of the Community Health Association in Detroit under the sponsorship of the United Automobile Workers to provide a very broad prepaid medical service under conditions that severely delimit the freedoms of the medical practitioner and his patient. Listen, if you will, to the words of a leading spokesman of organized labor who in his recent address to the Health Insurance Association of America, was critical of the insurance business because of its attempt to control costs in what he described as — and I quote him: "—the old non-intervention pattern imposing (controls) primarily on only one of the parties concerned, the patient, and relying mainly on economic rather than direct medical controls. Generalized warnings to medical societies not to kill the goose that lays
the golden eggs are too far removed from the actual setting of the fees. It is not that labor resents having the controls put on the patient's back, but that whatever economic incentives are put on him, the patient cannot effectively police health care."

The same speaker sums up his argument for the imposition of controls on the doctors and hospitals by saying, "If physicians are not really ready to accept such controls, then in spite of the best intentions of third party carriers, in spite of the soul-searching meetings with medical societies and in spite of the strongest motivations that may be placed on the insured, voluntary health insurance probably cannot succeed in providing adequate protection at reasonable cost."

Here is an expression of the ostensible fear of organized labor—a fear oft repeated, that the providers of health-care, the doctors and hospitals, will neither institute the measures that can restrain the rising costs of health-care nor enforce the self-discipline that will eliminate the abuses that are adding quite substantially to the cost of that care today. As you contemplate the pressures on private medical practice, recall the ominous fact that on January 1, 1959, hospital care just across the border, in Canada, will become a responsibility of the Dominion and provincial government. While the nationalization of hospital care in Canada was triggered by a political accident, its popular acceptance may be laid squarely to the historical supine indifference of most Canadian doctors and insurers. In our own Country, even though, in 1949, we rejected an obvious plan of national health insurance proposed by the Truman Administration in the Wagner-Murray-Dingell bills, the sophistication of our people is not such that they comprehend that socialized medicine can be foisted off on them a bit at a time. Note, in this connection, the apparently popular approval of the inclusion of permanent and total disability benefits in the Old Age and Survivors Disability Insurance system, the continuance of free medical care to veterans suffering from non-servicce connected disabilities, and the dozen other programs through which government is assuming more and more responsibility for the health-care of a larger and larger part of the population. Typical of proposals now pending for further socialization of health-care is the so-called Forand Bill. This legislation would increase present OASDI benefits, expand the taxable wage base from $4,200 to $6,000 per annum and pay most hospital, surgical and nursing home expenses for all who are eligible to receive OASDI benefits. No matter what appealing emotional gloss may be put upon this proposal by organized labor and its other supporters, it would effectively destroy the minimum-floor protection theory of the Social Security system and would establish an out-and-out program of socialized medicine for a substantial and growing segment of our people. As is inevitably the case, the proponents' cost estimate of an initial one billion dollars per year to provide the enumerated health care benefits is grossly inadequate. Independent actuarial studies lead us to believe that first-year costs would be at least 2½ times what the proponents claim and this would be but a beginning. The divisive bureaucratic impact of this legislation on the practice of medicine is well illustrated by the proviso of the Forand Bill that recipients of benefits "may with respect to the surgical services for which payment is provided by this section freely select the surgeon of his choice provided the surgeon is certified by the American Board of Surgery or is a member of the American College of Surgeons........." The subtlety of the proponents' argument is illustrated by their suggestion to the voluntary insurers that they support the Forand Bill because, by relieving voluntary insurance of any responsibility for protecting the aged, the measure would strengthen the voluntary insurance system. One wonders if these people think that the nation's doctors and insurers are so naive as to believe that it is possible to remain just "a little bit pregnant." It is true that much of the political appeal of these programs lies in the something for nothing delusion which is in reality nothing but a morally indefensible shifting of today's costs to our children who will be tomorrow's taxpayers. It is necessary in our relationship with the general public to do much more than we have to inform them about the positive advantages of voluntary health insurance contrasted with the excessive cost, inferior care, and personal degradation of any system of socialized medicine. In this broad educational effort, the interest and participation of every physician is indispensable.

Yes, gentlemen, the chips are down. Your profession and our business are challenged to provide the leadership that will preserve private practice and voluntary insurance.
What can we do to stay the onslaught of collectivism in the health-care field? Doctors, insurers, and hospitals all have their part to play. Practicing physicians can largely prevent over-utilization whether of medical treatment or of hospital occupancy. They must resist the pressures that patients sometimes put on them to authorize unnecessary hospitalization or undertake treatment of questionable necessity or through an adjustment of fees charged to circumvent the deductible provisions in the insurance contract. While the vast majority of doctors hold fast against these pressures in the highly ethical tradition of the profession, yet each of us can recall instances in which the total cost of health-care has risen because of a failure by the doctor to be vigilant against abuse. Medicine can attack rising health-care costs aggressively by encouraging the development of more economic methods of treatment including the use of less costly facilities, particularly for the aged and chronically ill. Costs can be reduced by moving patients out of general hospitals and placing them in nursing homes or geriatric facilities. More effective scheduling of patients in and out of the hospital can result in substantial savings. Medicine, can continue to emphasize early diagnosis to prevent later costly disability and can perfect rehabilitation techniques to restore patients to economic usefulness. Medicine must police its own ranks not only against gross over-charge but against a tendency of a minority of physicians to add slightly to the usual fee when insurance benefits are payable. Unless medicine enforces vigorously self-imposed standards, the lay controls now advocated by vocal minorities in our society may very well be fastened on your profession.

Hospitals, for their part in our cooperative effort to reduce costs, can seek out and employ methods that are less wasteful of the time and attention of skilled, highly trained and necessarily expensive personnel. They can profitably introduce all manner of labor-saving devices. They can seek a better understanding and control over their costs through the introduction of sound cost-accounting methods. They can continue the process of up-grading the professional qualifications of their administrators. They can allay much criticism of their charges by elimination of discriminatory rates and discounts. Our sense of equity is affronted when some patients are required to pay higher rates for the same care and accommodations than others simply because of preferential arrangements enjoyed by some segments of the population. Hospitals can more aggressively seek adequate compensation from local government for care furnished the indigent. Far too often today the paying patient subsidizes the cost of the indigent care.

Insurers, irrespective of type, can do their part to abate rising health-care costs. We can expand more widely coverage that employs the deductible and coinsurance as effective deterrents to extravagance in care. We can promote major medical expense coverage that does not encourage the patient to seek hospitalization for care that could be provided equally well on an out-patient basis. We can reduce and simplify the burden of paper work placed on doctors and hospitals because of the multiplicity of claim forms. We can cooperate with doctors and hospitals to develop a more uniform pattern for the payment of charges for the services of the medical specialties. We can do much to expand the protection offered the patients who suffer from mental or nervous disorders if psychiatrists will assist us with definitions and standards to distinguish between elective and required treatment. We can seek to work more cooperatively with other types of voluntary insurers. Past misunderstandings between the insurance companies and the service plans, stemming largely from personal, petty, shortsightedness can be overcome. You must remember that in the eyes of the public all voluntary health insurance is the same. All voluntary health insurers have a common goal... the adequate financing of health-care costs within the structure of private enterprise. Neither the insurance companies nor service plans can or should monopolize the field. Healthy competition is a spur in the public interest. We should seek and find ways to develop with the service plans answers to such common problems as abuses stemming from over-insurance, duplication of coverage, over-utilization, and extravagance in treatment. While we have grave fears for the future prosperity of the service plans, because of their continuing disinclination to embrace such proved insurance fundamentals as the deductible, coinsurance and experience rating, we are heartened by evidence that the old missionary zeal so characteristic of the earlier years of the service plans is giving way in their management to a more
enlightened point of view — a recognition that the service plan essentially is an insurer and as such cannot successfully violate the fundamentals of risk bearing.

Specifically, what can you in your dual capacities as doctors of medicine and insurance executives do to contribute leadership to the solution of the problems that beset the American health-care complex? First of all, it seems to me that you can and must become active in your local and state medical societies and in the American Medical Association if you are to utilize your unique opportunity to interpret the insurance aspect of common problems to your fellows in the profession. Your voice will be listened to by your peers with a respect to which no layman could aspire. You can and should familiarize yourself with the policies and programs of organized medicine in these areas of joint insurance-medical concern. I can venture no suggestion for more effective action by doctors than that they close ranks behind the informed, able and devoted leaders of their profession in vigorous support of the wise and practical measures that organized medicine espouses to preserve the American health-care complex. Further, you can and should play an extremely active part in the program now being carried forward by the Health Insurance Council to effect a closer working arrangement and better understanding among doctors, hospitals and insurers. The finest sort of cooperative effort and mutual understanding exists at the national level between doctors and insurers. To propagate this understanding at the grass roots where alone many of the problems can be solved, the Health Insurance Council, with the encouragement of the officers and Board of Trustees of the American Medical Association, has established state committees to meet with doctors and hospitals to overcome misunderstandings that may develop at the local level and to weld into an effective team every single individual practitioner and insurer. This program of state committees is already under way in more than forty states. It deserves and demands your personal vigorous support. Through it we can supply the answers to many of the questions that doctors have. Through it we can tell them our program of standardized claim forms to ease their burden of paper work. Through the state committees we can assist them in the development of Relative Value Fee Schedules and Advisory Fee lists that permit us to underwrite benefits more closely conformed to the real needs of our insureds. The state committees can do much to cement the inherent partnership among doctors, hospitals and insurers. Because I hope that each of you will rise to the challenge of participation in this program of the Health Insurance Council, I ask that you become familiar, if you are not already so, with the material about the Council and its program which will be distributed to you at the end of this meeting. As Medical Directors you can forward the research and experimentation insurers are carrying forward to add additional luster to our already promising progress in the extension of voluntary health insurance to special categories such as the aged, the impaired, and the remote risk. Because I assume that you are generally familiar with much that is being done by our business to spread coverage more rapidly and improve the quality of the protection provided, in the limited time I have available to me, I have not touched upon these matters. But, I am sure that you recognize that they constitute important aspects of your daily responsibility.

The quality conscious American public that has the right to give us their patronage or withhold it, to encourage or restrict our opportunity for service through the laws that govern our operations, is impatient of any performance that falls short of the well-nigh perfect. The time is short in which we can satisfy the American people of the inherent capacities of private practice and voluntary insurance to solve the problems now pressing in the area of health-care. You and I who know the private practice of medicine and voluntary insurance best are confident of their ability to do just that. In the process, yours is the challenge and the responsibility for providing significant leadership. May each of you have the burning desire and the vigor and unswerving determination to make a substantial personal contribution. The way ahead is not easy; but, the course is clear. Let us not be discouraged — recalling the words of the late Dr. Peter Marshall: “Oh, Lord, when we long for life without work, without trials, without difficulties, let us remember that oaks grow strong in contrary winds and diamonds are made under pressure. If we are pessimistic, we will see disaster in every opportunity; but, if we have stout hearts, we will see opportunity in every disaster.”
Comments From Your President

The negotiating team of the Nebraska State Medical Association has just returned from Washington, D.C., where new contracts were signed for Medicare.

Your State Association as Contractor, and Blue Shield as Fiscal Agent have been operating under the original contract since the inception of Medicare in 1956.

I was accompanied to Washington by Dr. Paul Maxwell, Chairman of our Fee Schedule Committee; Dr. Arthur Offerman, President of Blue Shield, and Mr. M. C. Smith, Executive Secretary of the Nebraska State Medical Association. Mr. Ed McDermott, Legal Counsel for Blue Shield also was present and aided us in that field. Everyone of these men labored long hours for two days to accomplish a good contract for you. My thanks go to them on your behalf as well as mine. I can assure you they had your interests at heart.

As before, a schedule of maximum allowances was negotiated. Again we were able to enter into agreements with the Federal Government and yet retain your position with your patient as a private physician. In other words you will again submit your own bill for your usual fee for your cases. In very few cases will your usual fee be questioned. In those few instances you have the right to appear before the Policy Committee of the Nebraska State Medical Association and justify your fee. Within a very short time each physician of Nebraska will receive a complete list of procedures to enable you to better prepare your statements.

I have the highest regard for the military personnel with whom we worked. Colonel Floyd E. Wergeland and Colonel Earl C. Lowry, both physicians, at all times were fair, and cooperative in our deliberations. We signed a good contract. For that I am thankful as I doubt not we will have to live with it for considerable time.

As you know, Medicare services have been cut back in a large measure. Whether or not they will be restored in whole or in part remains for Congress to decide next January.

The program of Medicare is not for the doctors or the Government; it is for the dependents of our service men. Nebraska is one of the leading states in the efficient and honest administration of this program. I beg of every doctor in Nebraska that he make every effort to maintain that enviable position.

While Medicare is a big program of your association it is only one of many. Your Nebraska State Medical Association is a fairly good sized, going business. Everyone of these programs is carried out, not only for you, but technically, by you. I know that there are many things done in your name regarding which you have no information. May I urge that during the coming winter months you ask some one of your state medical officers to come to your county society meeting and explain the work of your association and attempt to answer some of the questions I am sure you have?

FAY SMITH, President.
Organization Section
Coming Meetings

Crippled Children's Clinics—
October 11, Ogallala, Elks Club
October 25, Lexington, High School
November 8, Norfolk, Norfolk State Hospital
November 22, Grand Island, St. Francis Hospital

MID-STATE CLINIC ON DIABETES MELLITUS—Fort Kearney Hotel, Kearney, November 25, 1958. For information, write Dr. O. R. Hayes, Kearney.

OMAHA MID-WEST CLINICAL SOCIETY—26th Annual Assembly, November 3-6, 1958, Omaha, Hotel Sheraton-Fontenelle.

TWENTY-SECOND ANNIVERSARY, NEBRASKA HOSPITAL ASSOCIATION—October 23-24, 1958, Omaha, Hotel Sheraton-Fontenelle. The program includes talks by a number of Nebraska physicians. Banquet speaker will be F. J. L. Blasingame, M.D., General Manager of the American Medical Association.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA — 43rd Annual Scientific Assembly, Cleveland, Ohio, November 10-13, 1958.


INTERNATIONAL COLLEGE OF SURGEONS — 24th Annual Congress of North American Federation (United States, Canadian and Mexican Sections), Palmer House, Chicago, September 13-17, 1959. Write Dr. Ross T. McIntire, Executive Secretary, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

DELEGATE'S REPORT ON MEETING OF HOUSE OF DELEGATES OF AMERICAN MEDICAL ASSOCIATION IN SAN FRANCISCO, CALIF.

The 107th annual meeting of the A.M.A. House of Delegates was held at the Sheraton Palace Hotel in San Francisco, California from June 23 to June 27, 1958.

The House of Delegates opened its first session on Monday morning with the usual procedure of speeches by the President, President-elect, and the Speaker-of-the-House.

Then the Chairman of the Board, Dr. Ed Hamilton read the nominations by the Board of Trustees for the various awards.

The seventh Goldberger Award of a Gold Medal and $1000 went to Dr. Virgil P. Sydstricker, Professor Emeritus of Medicine, of the Medical College of Georgia.

Mrs. Charles W. Sewell of Olterbein, Indiana, and Bogind Behari Lal, Science Editor of the Los Angeles Examiner, were cited for Distinguished Service, an award presented to laymen for advancing the ideals of American Medicine.

Dr. George W. Corner of the Rockefeller Institute of Medical Research received the $5000 Passano Foundation Award.

The Hektoen Gold Medal for original investigation was presented to Dr. Alvin W. Watne and Associates of the University of Illinois in Chicago, for their exhibit on cancer cells in the circulating blood.

The Billings Gold Medal for excellence of correlation of facts was presented to Dr. C. H. Hodgson and Associates of the Mayo Clinic and Foundation, Rochester, Minnesota, for their exhibit on misleading thoracic roentgenograms.

Dr. Frank H. Krusen, Professor of Physical Medicine and Rehabilitation of the University of Minnesota, Mayo Clinic Foundation, Rochester, Minnesota, became the 21st winner of the Distinguished Service Award.

Dr. Louis M. Orr of Orlando, Florida, Vice-Speaker of the House of Delegates, was named President-elect; Dr. W. Lenwood Ball of Richmond, Virginia, Vice-President; Dr. Norman A. Welch of Boston, Massachusetts, Vice-Speaker; Dr. Warren Furey of Chicago, Illinois, and Dr. R. B. Robbins of Camden, Arkansas, Trustees. Re-elected were Dr. Vincent Askey of Los Angeles, Speaker-of-the-House, and Dr. Raymond M. McKeown of Coos Bay, Oregon, Trustee.

The House of Delegates voted to have the 1960-meeting at Miami Beach instead of Chicago. The 1959-meeting will be held in Atlantic City and the 1961-session will be in New York City.
The total registration at the San Francisco Meeting was 43,555, which included a physician registration of 13,218; of this physician total, 189 were from United States Possessions and Foreign Countries.

Among the subjects of great interest to the House of Delegates were the American Medical Association's position in relation to the United Mine Workers of America, Medical Care Programs, and the Voluntary Health Agencies disagreement with United Fund.

The reference committee's recommendation to further delay an all-out educational campaign to explain the position of the A.M.A. in relation to the United Mine Workers Medical Care Programs was voted down in the House. The A.M.A. contends that the United Mine Workers, through its Welfare and Retirement Fund, has gone into the business of Hospital and Medical Care in competition with Community Hospitals and the Private Practice of Medicine.

The A.M.A. has contended that the medical interests of the Miner and his family have been subordinated to the financial interests of the fund, which now covers 250,000 workers and their families and owns 10 hospitals staffed with salaried doctors.

There were three resolutions introduced asking the House of Delegates to go on record approving the activities of the National Voluntary Health Agencies and that they should be free to conduct their own campaigns of fund raising, public education and programs of research. These resolutions were given to the reference committee on Hygiene, Public Health and Industrial Health for consideration and recommendations. It was my privilege, as a member of this reference committee, to hear those who appeared before us with arguments for the resolution and in one or two instances against them.

It was emphasized that agencies concerned with health vary widely in organization, objectives, means for attaining objectives, fund raising methods, membership and relationship of groups at local, state, and national levels. It was brought out by those who appeared in behalf of the resolution that there is a definite fight between the Voluntary Health Agencies and the United Fund. It was the feeling by those who supported these resolutions that United Fund is out to destroy the Voluntary Health Agencies.

The reference committee expressed the feeling that the Voluntary Health Agencies and the United Fund Organization should have a top level conference in an effort to iron out their differences. With this in mind our committee brought out a substitute resolution recommending a top level conference of all interested parties. This, of course, provoked considerable discussion on the floor of the House and the substitute resolution was voted down which in effect amounted to the endorsement of the Voluntary Health Agencies.

Our Committee was sympathetic to the Voluntary Health Agencies, but had the feeling that some understanding should be reached, if possible, with the United Fund. Since adjournment of the House of Delegates, I have had the opportunity to study and gather additional information, concerning the United Fund and have come to the conclusion that the United Fund is purely a fund-raising organization, and is not fundamentally concerned with health.

A preliminary report from the Committee on preparation for General Practice was received by the House. A definition of General Practice adopted by the Committee states it is "that aspect of Medical Care performed by the doctor of medicine, who assumes comprehensive and continuing responsibility, commensurate with his professional competence for the patient and his family." Future general practitioners should be prepared to actively and directly provide the services to patients, irrespective of age, over broad areas of medicine and to coordinate specialty, consultation and care, according to the particular needs of their patients. For this purpose a new graduate-educational program should be developed. A one-year internship is inadequate, the report maintained. At least two years of formal hospital training are needed — eighteen months in diagnostic, therapeutic, psychiatric, preventative and rehabilitative aspects of internal medicine and pediatrics and six months in obstetric training. Throughout the two-year period there should be experience in emergency room service, outpatient work that includes medical or diagnostic gynecology, and experience in care of the new-born. For any physician planning to undertake obstetrics, other than uncomplicated obstetrics, or surgery other than minor
surgery, the Committee underscored the need for additional training.

Support for Jenkins-Keogh legislation to permit self-employed persons to establish their own retirement programs with proper tax deferments again was approved with opposition expressed against Compulsory Social Security Coverage of Physicians and against Forand type of legislation.

The use of specialty board certification as the sole requirement for hospital appointments was opposed by the delegates, who also were displeased with reports that hospitals are making compulsory assessments of medical staff members for building funds and requiring audits of staff members finances as a requisite for continued staff appointments. They called for a study to determine whether the trend by hospitals to encourage staff members to conduct private office practice within or adjacent to hospitals constitutes a move toward practice of medicine by hospitals.

There were sixty-four resolutions in all introduced in the House, but the ones mentioned above were the most important.

During this session Dr. Russell Best, who is the alternate delegate for Dr. Pemberthy from the Surgical Section, was seated as a delegate from that section, as Dr. Pemberthy was in Europe.

I would like to take this opportunity to express my gratitude to the Members of the Nebraska State Medical Association for electing me as one of the delegates to the American Medical Association. I can assure you that Membership in the House of Delegates of the American Medical Association carries many responsibilities and makes one extremely conscious of the problems that face American Medicine.

The day has long since passed when the physician can just practice medicine and be oblivious to the community, state, and national problems which surround him. If American Medicine is to beat down the socialistic trend, it becomes the responsibility of every physician to give of his time and efforts to aid in the improvement of human welfare and to convince the American people that this is our goal.

Earl F. Leininger, M.D.,
Delegate.

MEDICARE IN OPERATION
Changes October 1, 1958

This article is designed to present the detailed revision of Medicare and elaborate on the article titled, "Current Comment," published in the September edition of The Nebraska State Medical Journal and the Special Bulletin issued on August 11, 1958.

To assure optimum utilization of uniformed services medical facilities, and to effect economy while providing care authorized by Public Law 569, the following changes in the current operation of the Dependents' Medical Care Program are effective on and after October 1, 1958.

Spouses and Children Residing Apart From Sponsors

Spouses and children residing apart from their sponsors will continue to be allowed selection of either uniformed services medical facilities or civilian medical sources for care authorized under the Program.

When DA Form 1863 shows, "Residing apart from Sponsor—Yes," in Item 4 of the claim form, the designation of this fact on the claim form by the person signing Item 14 will be sufficient, and authorized care rendered will be payable provided the person or entity providing the care has no actual knowledge to the contrary.

Restrictions on Spouses and Children Residing With Sponsors

Spouses and children residing with sponsor will be required to utilize uniformed services medical facilities if available and adequate as determined by the commander of the medical facility. When uniformed services medical facilities are not available, a Permit will be furnished such dependents by the appropriate commander. This Permit will entitle them to receive authorized care from civilian sources at Government expense if such care is authorized under Public Law 569 and the Joint Directive, as amended.

When DA Form 1863 shows "Residing Apart from Sponsor—No," to allow payment for authorized care, a Permit is required, as noted in the preceding paragraph, to be attached to the original copy of the attending physician's and the hospital's claim form; except in the following circumstances:
(1) When a spouse or child residing with sponsor is hospitalized for care authorized under the Program for a bona fide acute emergency, e.g., serious injury following an accident or illness of sudden onset requiring immediate treatment at the nearest available medical facility to preserve life, or to prevent undue suffering. In such cases, a statement is required by the attending physician on the DA Form 1863 or attachment thereto, in lieu of a Permit stating, “This case was a bona fide acute emergency.”

(2) Where a spouse or child is residing with sponsor, but is away from the area of the sponsor’s household on a trip, care authorized under the Program may be provided from civilian sources without a Permit. The statement “On Trip” in Item 3 or 4 of the DA Form 1863, by the person signing Item 14, will suffice, providing the person or entity providing the care has no actual knowledge to the contrary.

(3) A maternity case (residing with sponsor) under the care of a civilian physician on or before October 1, 1958, may be continued by that physician provided the patient has reached the second trimester of pregnancy on or before that date. In these cases a statement by the attending physician on the DA Form 1863, or attachment thereto, will be submitted by the physician and the hospital to the effect that the patient was under his care on or before October 1, 1958, and that her pregnancy had reached the second trimester on or before that date. This statement will suffice to authorize this care for payment without a Permit and will apply only to maternity cases where the wife resides with her sponsor. No restriction as to freedom of choice has been placed on those eligible dependents who reside apart from their sponsor.

(4) Spouses and children residing with a sponsor who are receiving authorized care from a physician and who are admitted to a civilian hospital prior to midnight September 30, 1958, will be authorized care by a civilian physician without a Permit, provided the physician shows the date of admission to a civilian hospital on his claim form, and this date is prior to October 1, 1958.

Permits, where required, must be attached to the original copies of DA Form 1863 on claims submitted by other than attending physicians or hospitals, e.g., Assistant Surgeon, Radiologist, Pathologist, Anesthesiologist, Dentist (when not in capacity of the attending physician), Consultant, Psychiatrist, Private Duty Nurse, Anesthetist, and Physical Therapist, will be authorized for payment without a Permit. However, claim form (DA Form 1863) must contain a statement by the person executing this certification in Item 14 that a Permit was furnished to the attending physician, identified by name.

Care No Longer Payable Under the Dependents’ Medical Care Program

Effective October 1, 1958, the Joint Directive has been amended so that the following care and services, if commenced on or after that date will NOT be payable by the Government under the Dependents’ Medical Care Program:

(1) Treatment of fractures, dislocations, lacerations, and other wounds on an outpatient basis.

(2) The termination visit. This refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient.

(3) Outpatient pre- and post-surgical tests and procedures.

(4) Neonatal visits. Formerly authorized on an outpatient basis not to exceed two visits during the first sixty days.

(5) The treatment of acute emotional disorders, except for care of an acute condition which is a threat to the life, health or well-being of the patient and adjunctive to other authorized care and then only for the period necessary for care of the primary diagnosis for which admitted.

(6) Elective surgery. The description of such as follows: “Medical or surgical care that is desired or requested by the patient which in the opinion of the cognizant medical authority can be planned, subsequently scheduled, and effectively treated at a later date without detriment to the patient, e.g., diagnostic surveys, cosmetic surgery, reconstructive surgery, tonsillectomies, uncomplicated hernias, and interval appendectomies.”

Surgical Procedures Authorized For Payment

(1) Surgical emergencies requiring hospitalization. Bona fide surgical emergencies, which cannot be handled on an outpatient basis, will continue to be honored for payment under the program. Such pa-
tients will necessarily be acutely ill and in need of immediate hospitalization and treatment. Examples include perforated duodenal ulcer, hemorrhage with shock, bowel obstruction, and similar recognized emergencies.

(2) Acute surgical conditions. It is well recognized that many acute surgical conditions develop which, while requiring prompt treatment in a hospital, are not considered emergencies under the Program. Under such circumstances the patient is acutely ill and must receive treatment without delay as time will not permit the patient to anticipate or plan for the care required. The procedures required for the treatment will of necessity be carried out at the earliest practicable time compatible with sound surgical judgment and proper preparation of the patient for surgery. The spirit of this requirement is that the ill patient is in clinical need of hospitalization without delay with a view to surgical correction of the basic condition. Examples are acute appendicitis, empyema of the gallbladder, twisted ovarian cyst, strangulated hernia, pelvic abscess, and renal or ureteral calculi with colic. When the charge physician so indicates that an acute requirement existed, payment will be authorized. Suspected or proven malignancy, requiring hospitalization, will be payable only if the case qualifies under this or the preceding paragraph.

(3) Injuries requiring hospitalization. Injuries of such clinical severity as to require hospitalization will continue to be payable. Hospitalization is authorized only for the treatment of the acute phase. Readmission for treatment of chronic stages or sequelae of the injury would not be payable unless an acute medical or an acute surgical requirement is shown, such as, osteomyelitis, with acute exacerbation.

Surgical Procedures Not Authorized for Payment Under the Medicare Program

(1) Elective surgery as previously described. Examples of such are: Tonsillectomy, Dilatation and Curetage, Hysterectomy (routine), Ligation of Fallopian Tube, Heart Surgery, Submucous Resection, Rhinoplasty, and Reconstructive Orthopedic and Plastic Procedures.

(2) The provisions of the Joint Directive pertaining to the treatment of acute medical conditions remain unchanged. However, the admission of patients not acutely ill for diagnostic surveys will not be payable.

(3) The provisions of the Joint Directive pertaining to dental care remain unchanged. However, adjunctive dental care is now payable only when it is an integral and necessary part of surgical or medical care now authorized as surgical emergencies requiring hospitalization, acute surgical condition, and injuries requiring hospitalization.

Administration of Treatment of Patients Who Commenced Receiving Care Before October 1, 1958 Where That Care Has Been Deleted From the Program, Effective That Date

(1) Hospital patients. A patient will be deemed to have commenced receiving such care if admitted to the hospital prior to midnight September 30, 1958. Care is authorized during that period of hospitalization if the claim form shows an admission date earlier than October 1, 1958. The care referred to here includes the termination visit and outpatient pre- and post-surgical tests and procedures associated with this admission.

(2) The two neonatal visits previously authorized will be payable if the birth occurs prior to midnight September 30, 1958, and if the physician’s claim form contains a statement to that effect.

(3) Outpatient injuries will be deemed to have commenced prior to midnight September 30, 1958 and, therefore, payable if the patient contacted a source of care prior to that time, and if the source of care so states on the claim form.

In view of the fact that hospital claims will now require careful completion to meet legal requirements for payment, charge physicians are urgently requested to assist hospitals in every way they can in this regard by providing a specific diagnosis, and where indicated, a clinical statement which will assure payment where proper under the Program.

The military services are instituting an extensive program to apprise military personnel and their dependents of the changes in Medicare. In addition, the military services have the responsibility of issuing the Permit to spouses and children residing with their sponsors where uniformed service medical facilities are inadequate or not available.
The Month in Washington—

When the Congress that is elected in November goes to work next January 7 it will have before it a half dozen important health-medical issues that the last Congress took some interest in but didn't resolve. They include hospitalization under social security, tax-deferment on annuities, loans and mortgage guarantees for hospitals and nursing homes, aid to medical schools and amendment of Veterans Administration's hospitalization procedures.

The issue of hospitalization under social security — the Forand bill principle — will come into the spotlight shortly after the new session starts. Under instructions from the House Ways and Means Committee, the Department of Health, Education, and Welfare will complete a study on the problems of financing hospital care for the aged before next February 1. Some study of medical costs may also be included.

Decision to move ahead with a study of medical care costs for the aged was reached by the committee at the same time it excluded the Forand idea from the social security bill enacted during the summer. H.E.W. was told to pay particular attention to the possibility of increasing O.A.S.I. taxes, and with the money purchasing health insurance (nonprofit or commercial) to take effect upon retirement or disability. This would differ from the Forand plan in that health care would be financed through insurance, and not paid for directly by the Federal government.

The Keogh bill to allow doctors and other self-employed to defer income taxes on money put into retirement funds passed the House with very little opposition, but encountered difficulty in the Senate. It was defeated there in the closing days, and under unusual circumstances. Policy committees of both parties decided to oppose the bill as too costly, and the vote came in the course of a complicated legislative maneuver that could not be used as a test of whether individual Senators favored or opposed the bill itself.

Keogh bill sponsors, however, are encouraged that 32 Senators resisted official party instructions and stayed with the pension plan. They are confident that next year under more favorable legislative circumstances the measure will clear the Senate.

An effort was made late in the session to authorize grants to medical schools for building and equipping teaching as well as research facilities. The bill extending the research grants program also would have allowed use of the grants for "multi-purpose" structures (teaching and research) if emphasis were on research. However, for fear this change would hold up the simple extension bill, it was dropped off before the bill reached the House floor. Sponsors of aid to medical education will be back next year and campaign on this issue alone.

Legislation for U.S. guarantee of nursing home mortgages, strongly supported by the American Medical Association, fell by the wayside in the House during the closing hours of the session, after having cleared the Senate with no trouble whatever. This also will be pushed next year, and may have a better chance of passage because of the growing emphasis on need for solving the problems of the aged.

Far too late for passage, Chairman Olin Teague's House Veterans Affairs Committee reported out a bill that would make a number of changes in VA hospitalization procedures, liberalizing some and tightening up on others. The bill also would require V.A. to open 5000 beds over which Mr. Teague and V.A. Administrator Whittier have been squabbling for months, the latter maintaining that the beds aren't needed. That issue still is unresolved, inasmuch as the bill didn't pass.

Congress did roll out a sizeable list of medical-health laws. It ordered the calling of a 1961 White House Conference on the Aging, gave Food and Drug Administration authority to enforce its pre-testing standards on foods to which chemicals and other substances have been added, authorized loans as well as grants under the Hill-Burton program, authorized grants for the country's schools of public health and for civil defense purposes, raised military and V.A. physicians' pay, and required labor and management health and welfare plans to make reports and open up their books for inspection by members.

American Medical Association was able to persuade the Department of Defense and the administration to retain the post of Assistant Secretary (health and medical) in the reorganization of the department. In legislation passed by Congress to bring about the reorganization, one of the assistant secretary
posts would have been eliminated, and the medical assistant was marked for downgrading. However, Secretary McElroy eventually announced that the position would be continued.

Even before Congress adjourned, it was clear that trouble was in sight for Medicare because of inadequate appropriations and instructions from Congress not to exceed the appropriation. To keep within the limitation, if possible, Defense Department was channelling many thousands of service families to military facilities, and at the same time limiting the scope of care permitted in civilian facilities. (From Washington Office, A.M.A.).

Better Patient Care: A Radical Change in Hospital Service—

A new organizational pattern for care of patients in hospitals is the subject not only for discussion by hospital administrators, but the subject of an article in Changing Times, the Kiplinger magazine. Cited as a new system of handling patients that promises better care and more economical operation, "Progressive Patient Care," provides for three zones within the hospital where care is tailored to the patient's needs, as determined by his private doctor.

A patient, following surgery, will be placed in an area of the hospital known as the intensive care zone. There, he receives constant attention from highly trained nurses and other medical personnel. Close to his bedside is all the emergency equipment he might need.

When improvement becomes apparent, and less careful watching is required, the patient can be moved to another zone, termed the intermediate care area. There normal hospital service is available, some of which can be met with nurses' aides or practical nurses, supervised by registered nurses. Much of the expensive emergency equipment can be omitted from this area of the hospital.

When even more improvement is apparent, the patient in the latter stages of convalescence may be moved into a self-help unit of the hospital where quarters are rather like hotel or motel rooms and where he is expected to wait on himself and may go to the hospital cafeteria for his meals.

The procedure can also be reversed. A patient, admitted to the self-help area of the hospital may, if indicated, be transferred to one of the other two areas of more intensive nursing service.

This plan is said to be the first really radical change in hospital procedure in more than 100 years.

Some of the advantages found in the experimental application of this plan include the fact that on an average, the patient can expect to spend less time in the hospital with a plan of this sort. This is because of the amount of attention given to patients in the acute stage of their illness and because the self-help units ease the transition from hospital to home.

It may also be possible to lessen hospital costs, because of the lesser expense of maintaining the less intensive care zones of the hospital. It may be possible, if this plan is widely adopted, to decrease construction costs of hospitals. The concentration of expensive equipment and facilities in one area of the hospital may lessen the investment per bed in the hospital.

The plan has been put into full effect in the Manchester, Connecticut Memorial Hospital and private physicians are said to have expressed approval of the plan on the grounds that under it, they have better control of the type of treatment available for their patients.

Meet One of Our New Members

Leonard Eugene Alkire, M.D., was born in Lexington, Nebraska, on April 25, 1928, where he obtained his elementary education. He attended the University of Nebraska for his premedical education and graduated with the degree Doctor of Medicine, in 1958. He interned at the Madigan Army Hospital in Tacoma, Washington from 1953 to 1954, and he took a residency in General Practice at the Sacramento County Hospital, Sacramento, California.

Doctor Alkire's military service included duty with the Medical Corps of the Army.

His wife, Anne, and two children, Steve, 3, and Bruce, 1, reside in Ainsworth, Nebraska.

For recreation he enjoys fishing, golfing, and hunting.
Hall of Health — 1958

HALL OF HEALTH HAS SUCCESSFUL YEAR AT STATE FAIR . . .

The fifth annual Hall-of-Health exhibit at the 1958-Nebraska State Fair has closed its doors after a record attendance of 56,150 persons who viewed the numerous health exhibits.

Fair visitors had the opportunity of viewing 17 different exhibits displayed by voluntary health organizations. Those organizations participating in the exhibit under the sponsorship of the Nebraska State Medical Association were as follows:

- Nebraska Hospital Association
- National Foundation
- State Department of Health
- Nebraska State Nurses Association
- Nebraska Civil Defense Agency
- Nebraska Diabetes Association
- American Cancer Society, Nebraska Division
- Blue Cross-Blue Shield
- Nebraska Heart Association
- Nebraska Tuberculosis Association
- Nebraska Society for Crippled Children
- Nebraska Society of X-ray Technicians
- University of Nebraska College of Medicine
- Nebraska Pharmaceutical Association
- Nebraska State Dental Association

Continuous health movies were also shown in the air-conditioned theatre. A total of 5,392 persons attended the movies during the week.

The people visiting the exhibit showed a great deal of interest in the displays and participated in several free tests which were available.

The Hall of Health will again display many educational and informative exhibits at the 1959 Nebraska State Fair. The accompanying pictures show the public interest in this project.
MEDICINE IN THE NEWS

From the Omaha World-Herald—

The Nebraska State Department of Health has designated the Poison Control Center at Children's Memorial Hospital as the master poison control center for the state.

Dr. E. A. Rogers, Nebraska health director, informed the National Clearinghouse for Poison Control Centers that the unit at the Omaha hospital “is equipped to function, and in fact has been functioning, as both a poison information center and a poison treatment center.

It meets “all the criteria for designation as a poison control center,” said Dr. Rogers.

“This, together with the strategic location and wide acceptance of the center, makes it ideally suited to serve the needs of the state as the master control center,” Dr. Rogers declared.

Dr. Rogers praised the “foresight and effort” of the Childrens Memorial Hospital board of trustees and staff for establishing and equipping the center.

Edward Shafton, chairman of the poison control committee of the board of trustees, said poison control and treatment data have been furnished to patients and physicians in Omaha and throughout Nebraska and surrounding territory, primarily by long distance telephone.

From the Lincoln Journal—

An interprofessional seminar on diseases common to animals and man, the first of its kind held in the Great Plains, was held at the University of Nebraska College of Medicine in September.

The Nebraska State Department of Health and the department of microbiology of the University of Nebraska College of Medicine sponsored the meeting.

From the Omaha World-Herald—

Creighton University School of Medicine has received the first of five annual grants from the Office of Vocational Rehabilitation. Over-all value of the award is $74,405, according to Dr. Frederick G. Gillick, dean.

The grant under the direction of Dr. Harold N. Neu, will be used for personnel needed to help train medical students and residents of the modern concepts of rehabilitation.

From the Lincoln Journal—

Three Bryan Memorial Hospital board members have visited Manchester, Connecticut, to view the nations first progressive-care-hospital. Those making the trip were Drs. M. D. Frazer and Everett Angle and Mr. Harry Simon.

The progressive-care-program is designed to give the patient the type of treatment he needs from intensive care to self-care.

From the Omaha World-Herald—

A delegation of doctors inspected Omaha's open sewers along the Missouri River in August.

Dr. Maurice Grier, president of the Omaha-Douglas County Medical Society, headed the delegation.

Purpose of the trip was to allow the doctors to familiarize themselves with the public health hazards of the open sewers.

Nebraska Hospital Association Annual Meeting—

The annual meeting of the Nebraska Hospital Association will be held October 23, 24, 1958, at the Sheraton-Fontenelle Hotel in Omaha.

The theme of the first day's program will be “Looking Into the Future” and will include a number of talks and panel discussions by hospital and medical personnel. Nebraska physicians participating in the meeting are Drs. Fay Smith, Imperial; John Schenken, Omaha; F. G. Gillick, Omaha; J. D. McCarthy, Omaha; Harold Neu, Omaha. Principal speaker for the Thursday evening banquet will be F. J. L. Blasingame, M.D., General Manager, American Medical Association.

DOCTORS IN THE NEWS

Doctor and Mrs. D. B. Mullikin—

We see by the Chester Herald that Doctor and Mrs. D. B. Mullikin were honored at an open house, on September 7, in commemoration of the doctor’s completion of fifty years in the practice of medicine. Thirty-eight of these years were spent in Chester. The first years of practice were spent in Munden, Kansas, where calls were made travelling by horse and buggy, on horseback, or by other means of transportation. It was
not until 1911 that the doctor bought his first car, a Ford coupe. Doctor Mullikin and his wife recently celebrated their Golden Wedding anniversary.

Doctor and Mrs. P. O. Marvel—

The Grand Island Daily Independent for August 28th, carries a long article by Jack Bailey on the more than fifty years of service to the community and its people, and to the State and society in general, by Doctor and Mrs. P. O. Marvel. The doctor and his wife have resided in Giltner since 1914. The story of Doctor Marvel’s fifty years in the practice of medicine, the object of respect and affection of his community, is well matched by the life-long activities of his wife. Schools, churches, women’s organizations, Red Cross, War Bond sales, musical activities, and others too numerous to dwell upon at length, have felt the impact of Mrs. Marvel’s ability and enthusiasm.

News and Views

A.M.A. to Survey Legal Profession—

A survey of attorneys on various subjects of mutual interest to physicians and lawyers will be conducted early this fall by the A.M.A.’s Law Department. Approximately 10,000 lawyers will be asked to answer questions on interprofessional relations, medical professional liability and expert medical testimony. The need for such a study is evidenced by the fact that as high as 80 per cent of all cases tried today require medical testimony and that seven out of 10 personal injury cases are decided on medical rather than legal considerations. The medical profession should be aware of the problems of attorneys and the role of medicine in the judicial system. It is hoped that this information can be used to promote good working relations between physicians and attorneys.

A.M.A. Nomenclature Institute in Philadelphia—

The third in the 1958-series of regional Nomenclature Institutes will be conducted by the American Medical Association November 3-5 at the Benjamin Franklin Hotel in Philadelphia. This short course on the use of the Standard Nomenclature of Diseases and Operations is offered as a special service to medical record librarians and others working with the Nomenclature in the hospital, doctor’s office or clinic. Lectures will again be given by Dr. Edward T. Thompson, Nomenclature editor, and chief, intermural research activities, division of hospital facilities, U.S.P.H.S., Washington, D.C. Persons wishing to attend should write to the A.M.A. for application blanks.

A.M.A. Plans Group Practice Roster—

The A.M.A.’s Council on Medical Service has been in the process of compiling information on group practices throughout the country and eventually plans to publish a directory of these groups. To date, the Council has information on 989 such groups located in the United States, Hawaii and Canada. Verification sheets have been sent out to those groups already on file. Physicians who practice in groups of two or more—who have not received a check sheet—are invited to send the following information to the Council: Group practice name, address, office building (indicate whether rented or owned), number of physicians, and the specialties represented.

Old Friend of the Medical Profession Dies—

Claude E. Donley died on September 4th at the age of sixty-nine. Claude was born at Seward, graduated from Seward high school and the University of Nebraska. He began his career as a pharmacist at a Seward drug store. In 1920, he and Charles Stahl founded the Donley-Stahl Drug Company in Lincoln, a firm dealing in medical and surgical supplies of all kinds. After the death of Charles Stahl, in 1935, the company continued under the same name until recently it was changed to the Donley Medical Supply Company, Ltd. The son, Leon, and other members of the firm will continue to operate the firm, an institution known to many Nebraska doctors. Claude and his supply house have grown up with the profession in our state and the founder will be missed.

Public’s Hunger for Medical News Is Great—

The following, taken from Secretary’s Letter No. 443, is quite enlightening. If true, and it probably is, we have the explanation for the mass of “medical” science news and articles published in popular magazines. The facts that a great number of the articles are beamed at those who have an avidity, somewhat like that of a child, for anything deal-
ing with sex; and that the selection of other material seems often to be based on the emotional impact upon the reader, rather than upon what the reader should be taught, imply that most "science writers" are more interested in themselves (a quick buck) than in their readers.

Public's Hunger for Medical News Is Great. A monumental nationwide study, sponsored by the National Association of Science Writers and supported by a grant from the Rockefeller Foundation, strongly indicates that the American public has a big appetite for science news, especially medical.

But the surprising conclusion is that because of space limitations all "mass media are transmitting only a microscopic part of the mountainous supply of science information potentially available to them."

The study is entitled: "The Public Impact of Science in the Mass Media." It was conducted by the Survey Research Center, Institute for Social Research, University of Michigan.

Much of the study, which deals with nine specific objectives, was concerned with medical news and the reading public.

The study revealed, for example:

—Medical reading is more prevalent among women than men.

—Medical reading increases with age, but there is a sudden drop in the group 65 and over.

—The west leads in the percentage who read all medicine, and the south and northeast trail.

—The science consumer (the reader or TV viewer) retains a lot of what he reads and hears.

—Medical stories center around the major diseases.

—Information that can be applied in everyday life is largely of the medical type.

—Almost one third of the newspaper audience want more science news, and almost one half want more medical news.

—The science consumer prefers to receive science and general news via the written media.

—Based on newspaper readers only, 41 per cent reported that they read all medicine and health news, 35 per cent said they read some, 13 per cent said they glanced at it, and only 10 per cent said they skipped over it.

"Standards" for a Blood Transfusion Service—

The Scientific Committee of the Joint Blood Council and the Standards Committee of the American Association of Blood Banks have prepared a booklet entitled "Standards for a Blood Transfusion Service" and have made this available upon request directed to Joint Blood Council, Inc., Chairman, Scientific Committee, 1832 M Street, N.W., Washington, D.C., or American Association of Blood Banks, Chairman, Standards Committee, 30 North Michigan Avenue, Chicago 2, Illinois.

Nebraska College of Medicine Names
New Faculty Members—

The Departments of Microbiology and Internal Medicine at the University of Nebraska College of Medicine have named four additional staff members, as follows:

—Frederick F. Paustian, M.D., full time faculty member in Internal Medicine.

—Mrs. Helen Reihart, Research Associate, Microbiology.

—Robert L. Zaayer, bacteriologist, Microbiology.

—Robert F. Thompson, M.D., part time, Instructor in Internal Medicine.

"Our Biggest Privileged Class"—

John E. Booth, in Harper's Magazine, July, 1958, under the title "Veterans: Our Biggest Privileged Class," says "How the most powerful lobby in Washington is bleeding every taxpayer to subsidize veterans who neither need the money nor deserve it—while the seriously disabled who do need it get short-changed." Copies of a reprint of Booth's article may be obtained from the Council on Medical Service, American Medical Association, 535 North Dearborn St., Chicago 10, Illinois.

"It Could Be You"—

This title, "It Could Be You," brings to mind a television program devoted to helping some of those who are in distress. Here, it has the opposite connotation. In Pennsyl-
vania, Blue Cross officials went before the Insurance Commissioner, Mr. Francis R. Smith, asking for a rate-increase of 53 per cent. He refused the increase and indicated there would be no further rate-increase until it was obvious that doctors and hospitals were doing something about overutilization. This can happen to Blue Cross and to Blue Shield in our State. Overutilization is probably the greatest enemy of these organizations. If we come to the point reached by Blue Cross in Pennsylvania, we will have forced our organizations to price their products out of the market so far as the ability of the lower-income groups to buy is concerned. It will be a great loss to our people, and a greater loss to us as physicians. The doctors can help avoid overutilization. Why not do it?

"Postgrad," a Guide to Current Opportunities—

Those who wish to know the opportunities available for postgraduate work in 1958-59, will find a reasonably complete listing in a booklet available from Wallace Laboratories, New Brunswick, N.J. Its title is Postgrad.

New Equipment for Nebraska College Of Medicine—

A grant of $28,652 to the University of Nebraska College of Medicine by Nebraska Division, American Cancer Society, made possible the purchase of an electron microscope. This and adjunct equipment were installed during July.

Bell System to Telecast Science Show—

The Bell System Science Series will present its second television program devoted to the working of part of the human body in "Gateways to the Mind," the story of the human senses, over the NBC network on Thursday, October 23, at 8 p.m., EDT. "Hemo the Magnificent," an earlier program in the same series, was devoted to the story of the blood and the circulatory system.

Nebraska Association of Pathologists Elects—

New officers of the Nebraska Association of Pathologists for the year 1958-1959 are as follows:

—Harold B. Miller, M.D., president (Lincoln).

—Morten Kulesh, M.D., vice president (Omaha).

—Donald Max Fitsch, M.D., secretary-treasurer (Omaha).

President Smith Banquet Speaker in Chicago—

President Fay Smith, a member of the Board of Trustees of the Mississippi Valley Medical Society, was "guest speaker" at the banquet of the Society during its 23rd Annual Meeting. The meeting and banquet were held at the Hotel Morrison, Chicago, September 25th.

Localized Polio Outbreaks Reported (From Secretary's Letter No. 441)—

"Dr. John D. Porterfield, deputy surgeon general of the U.S.P.H.S., informed us a few days ago that localized outbreaks of polio occurred in a number of communities.

"For the week ending July 26, he said, at least six states, Hawaii and Puerto Rico had reported more polio cases so far this year than in the corresponding period of 1957..."

The same source said, however, that the overall picture was good. The localized outbreaks serve to emphasize the need of pushing for more complete coverage by vaccination.

State Medical Journals Receive a "Thank You"—

The Annual Conference of Blue Shield Plans, meeting in Chicago, April 27-May 1, 1958, unanimously adopted the following resolution:

"BE IT RESOLVED, That Blue Shield Medical Care Plans express their appreciation to State Medical Journals for the space they have devoted to Blue Shield articles of interest and value to practicing physicians."

Views of the A.A.P.S. Concerning Freedom For Doctor and Patient—

It is the opinion of the Association of American Physicians and Surgeons that compulsion is a most serious menace to our American way of life and free enterprise. Compulsion in any one segment of our Society leads inevitably to compulsion for all, or SOCIALISTIC DICTATORSHIP. ("What is everybody's business is nobody's business." In other words, where no one is responsible, a dictator must take over).
Every individual is responsible for himself, and he alone can and must decide what he will do in every matter pertaining to his own welfare. He must be free to choose his own doctor, who in turn is responsible to the patient to give the most competent advice and care. Every individual must be free to decide what treatment or drugs he will take under the advice of a practitioner of his own choosing.

Medicare Shutdown a Possibility—

Washington Letter No. 85-88 informs us that:

"Medicare officials, after another look at the account books, see the possibility of a shutdown of the civilian phase of the program early in 1959. The reason is relatively simple: the $72 million appropriated by Congress for the fiscal year will not be adequate. And Senate and House conferees agreed that the armed forces should not spend more than that amount . . . ."

A Free Ride, or a Free Nation?—

A "Newsletter" from Blue Shield Medical Care Plans, discussing the subject "A Free Ride vs. a Free Nation," contains this statement:

"Everything has its price and it is the people who must pay it. Inevitably a choice must be made between the promised bounty of more paternalism on the part of government and the preservation of individual initiative and self-reliance which are the cornerstones of freedom. No nation can have both, for as people become more reliant on government for personal security, they necessarily cede some measure of their personal freedom . . . ."

"Do Not Destroy Those Originals"—

The following significant statement is from Reader's Digest, January, 1958, p. 161: "Something in our modern society operates against the production of ‘character.’ The Welfare State, for one thing is by its very nature bound to set a premium on conventionality; social security is its watchword. Whenever a government becomes certain that it knows what is best for the citizens, those citizens become more and more like citizens and less and less like characters."

Americans Needed to Stand Guard—

Voicing the concern of many thoughtful citizens, Denton Kerr, M.D., president of the Texas Medical Association, concluded an address to the Association of American Physicians and Surgeons, with a reference to George Washington. His application of this reference to present times and present problems is truly a Current Comment.

"Just before one of the crucial battles of the American Revolution General Washington was so concerned about the possibility of disloyalty and sabotage that he left strict orders to ‘allow only Americans to stand guard tonight.’ Now, over 175 years later, let us expand this historical statement to say, ‘Let every loyal American stand guard day and night until the last of the atheistic conspirators is banished from the earth.’ If we do less we shall hand over for their ruthless destruction our priceless heritage, our children, our grandchildren and the greatest Christian nation ever conceived.

Heart Association Booklet Outlines Road to Careers in Medical Research—

Young people are vitally needed as scientific investigators if we are to conquer the major diseases and approach closer to the goal of universal good health, according to The American Heart Association which announced publication of an eight-page booklet entitled "Decision for Research."

Publication of the booklet is part of a Heart Association campaign to recruit many more “young, capable, energetic minds” for research in the medical and biological sciences. The shortage of young people entering medical research has been termed critical by Heart Association officials.

The booklet points out that many great questions in medicine are still unanswered.

"We still do not know,” it notes, “what makes the blood clot . . . or the heart beat . . . or why cells run wild and become cancerous . . . or why some babies are born imperfect.

“These and many other problems can and will one day be solved,” the booklet stresses, “by people—and not by machines . . . by people who have learned there is no more glorious mission than to take part in this struggle for life.”
The booklet, copies of which are available on request to local Heart Associations, urges science-minded teen-agers to take stock now and consider whether they are cut out for research careers. Students are counseled to ask themselves whether they like to learn things for their own sake; whether they are patient, persistent and original in work, and whether they can accept failure in experimentation as well as success.

Students who can answer “yes” to these questions have the basic qualities needed for scientific investigation, according to the booklet. An active curiosity, a liking for hard work, and a concern for others are also characteristics of good investigators, the booklet notes.

If, after examining his own capabilities and personality, the young student makes his own “decision for research,” he should follow a methodical plan of study, leading through graduate studies and beyond, the booklet advises. While science should be emphasized, the humanities should not be overlooked.

The booklet was prepared and published by the American Heart Association with assistance from E. R. Squibb & Sons. A unique feature is a pull-out chart showing the recommended progress of a research-minded student through high school, college, graduate or medical school. The booklet also contains a listing of sources of information on scholarships, career guidance and ideas for student science projects.

Announcements

Postgraduate Courses in Obstetrics Are Offered the Generalist—

The Woman’s Hospital in New York City is offering two courses in Obstetrics, to general practitioners only. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled “Ante-partum Care” and “The Conduct of Labor and Delivery.” They will be given from October 16-31, 1958.

These are full time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this postgraduate instruction will please address Mr. Carl P. Wright, Jr., Woman’s Hospital, 141 West 109th Street, New York 25, N.Y., and an application blank and prospectus will be forwarded.

A Course in Reconstructive Nasal Surgery by Two Los Angeles Universities—

The department of otolaryngology of the College of Medical Evangelists and the department of otolaryngology of the University of Southern California School of Medicine, Los Angeles, jointly will present an intensive postgraduate course in “Reconstructive Surgery of the Nasal Septum and External Nasal Pyramid” at White Memorial Hospital, Los Angeles, in January 1959.

Outline of Sectional Meetings for A.C.S. for 1959—

All members of the medical profession are invited to attend any of the 1959 Sectional Meetings of the American College of Surgeons. Cities and dates are:

Charleston, South Carolina, January 19, 20, 21;
Houston, Texas, February 2, 3, 4;
Vancouver, British Columbia, February 26, 27, 28;
St. Louis, Missouri, March 9 through 12 (Four-day meeting; Joint Nurses Sessions);
Montreal, Quebec, April 6 through 9 (Four-day meeting; Joint Nurses Sessions).

Mid-State Clinic To Be Held at Kearney, November 25—

The Annual Mid-State Clinic, sponsored by the Buffalo County Medical Society, Dr. Dan A. Nye presiding, will be held at the Fort Kearney Hotel, Kearney, Nebraska, November 25, 1958. Registration will begin at 9:00 a.m. The registration fee will include the price of the banquet to be held in the evening. The topic for the day will be “Diabetes Mellitus and Its Treatment.”

October, 1958
Human Interest Tales

Dr. Nancy Catania, Omaha, was married to William Aloysius McDermott in August.

Dr. Fay Smith, Imperial, was one of the principal speakers at the dedication of the new Cambridge hospital in August.

Dr. H. D. Myers, Schuyler, attended a 3-day course on athletic injuries in Denver, in August.

Dr. and Mrs. B. W. Pyle, Gothenburg, spent several weeks at Yellowstone Park in August.

Dr. John L. Beattie, formerly of Omaha, has joined the staff of the Slagle Clinic in Alliance.

The estate of the late Dr. E. B. Bradley, Spencer, has been willed to the Spencer Carnegie Library.

Dr. and Mrs. Ralph E. Paul, Sterling, journeyed to Rochester, Minnesota for their vacation in August.

Dr. and Mrs. Richard DeMay, Grand Island, spent their vacation in Estes Park, Colorado, in August.

Dr. L. E. Hudgel, Scottsbluff, has moved to Casper, Wyoming, where he will resume his medical practice.

Dr. R. A. Underwood, Delta, Colorado, brother of Dr. G. R. Underwood, Lincoln, passed away in August.

Mr. Don Warren of Lexington has assumed his duties as administrator of the new 26-bed hospital at Cambridge.

Dr. B. N. Greenberg, York, was the guest speaker at the annual Business-Education-Day luncheon held in Beatrice.

Mrs. Charles W. Hickey, Bennington, wife of Dr. Charles W. Hickey, passed away in an Omaha hospital August 24th.

Dr. and Mrs. W. J. Reeder, Cedar Rapids, spent their vacation touring Minnesota and neighboring states during August.

Dr. B. H. Baer, Ashland, has been crowned king of the 1958 Stir-Up Friday, an annual event held in that community in August.

Dr. W. K. Wolf, Gordon, was flown to Denver for emergency surgery in August. He is reported progressing satisfactorily.

Dr. R. N. Ochs, Lincoln, has been appointed by the county commissioners to the panel to care for public assistance medical cases.

Dr. Kenneth McDermott, Grand Island, attended the August meeting of the Western Association of Railway Surgeons in Seattle.

Dr. Walter Gysin, Norfolk, talked before a group meeting of the Licensed Practical Nurses of Division 6 held in that city in August.

Dr. E. A. McNulty, Alliance, has joined the staff of the Copsey Clinic in that city. He was formerly associated with the Slagle Clinic.

Drs. F. F. Paustian and Robert F. Thompson, Omaha, have been promoted to faculty rank by the University of Nebraska College of Medicine.

Mr. Richard F. Drozda has been appointed comptroller and Dorothea Hyde as operating room supervisor at the Lincoln General Hospital in Lincoln.

An exhibit from the Nebraska Psychiatric Institute was shown at the World Federation of Occupational Therapy at Copenhagen, Denmark, in August.

Dr. Richard B. Koefoot, Broken Bow, received word that he has qualified for the Founders Group of the American Board of Abdominal Surgery.

Dr. J. D. McCarthy, Omaha, headed a conference on medical problems of the aged put on by the American Medical Association in Chicago in September.

Dr. Morris Margolin, Omaha, presented an informal talk to diabetic patients and their families at the Cornhusker Hotel in Lincoln during August.

Dr. C. U. Bitner, Sidney, received a certificate of appreciation from President Eisenhower for his long service to the local Selective Service Board.

Drs. D. E. Wilkinson and Raymond Olson, Sidney, have announced that they will join Drs. A. G. Burnham and J. L. Beattie of the Slagle Clinic in Alliance.

Dr. R. A. Sitorius, Cozad, attended a postgraduate course on the treatment of athletic injuries presented at the University of Colorado Medical Center in August.

Dr. Akira Kutsunai is the new resident
surgeon at Nebraska Orthopedic Hospital in Lincoln. Dr. Kutsunai comes to Lincoln from Detroit Receiving Hospital.

Dr. Leo A. Hrnicek, Bayard, was the principal speaker at the commencement exercises for graduating nurses from West General Hospital in Scottsbluff, in August.

Dr. and Mrs. J. Raison Wells, Grand Island, were the guests of honor at a recent farewell dinner given by personnel of the Veterans Hospital. Dr. Wells is retiring.

Dr. Stephen Wallace, Wahoo, has received a certificate of appreciation from the Nebraska Heart Association for his work as leader of the 1958-Heart-Fund Drive in Wahoo.

Dr. Charles Wilhelmj, Omaha, has received a 33 hundred dollar grant from the American Heart Association. Dr. Wilhelmj will use the fund for studies in hypertension.

Dr. V. S. McDaniel, Sargent, has been awarded a certificate of appreciation by President Eisenhower in recognition of 15 years service as medical advisor to the local selective board.

Dr. and Mrs. Harley Anderson, Omaha, spent a month and a half touring Europe this summer. Dr. Anderson also attended the meeting of the American College of Surgeons in Stockholm.

Dr. B. J. Koszewski, Omaha, faculty member of the Creighton University School of Medicine, presented a lecture in Rome, Italy, at the Seventh Congress of the International Society of Hematology in September.

Dr. Donal H. Morgan, McCook, has been awarded a certificate of appreciation by President Eisenhower in grateful recognition of five years of service as a medical advisor of the local selective service board.

Dr. Richard Gray, assistant superintendent at Lincoln State Hospital, has resumed his duties in Lincoln after completing an 18-month professional advancement program at the Nebraska Psychiatric Institute in Omaha.

Dr. John D. Reid, Pilger, has reason to believe that he is the oldest person born in the county. Dr. Reid was 84 on September 23rd and has been a physician in this community since 1903. He was born in Boone county in 1874.

Know Your Blue Shield Plan

The Kentucky State Medical Journal, in a recent issue, contained an editorial by Dr. J. Duffy Hancock, president of Kentucky Blue Shield. The aptly put and pertinent vives voiced by Dr. Hancock deserve to be reported in detail.

“No doctor,” Dr. Hancock wrote, “is unaware of the struggle that has ensued for so many years between voluntary or private health plans and proposed government control of medicine. What we may not have realized fully is that each of us, every day, can play a vital part in this struggle of ideas . . . a vital part that will retain for us the most workable, worthwhile system of medical practice known. The Blue Shield Plan is our own answer to the clamor from some quarters for socialized medicine. It must be protected—not abused.

“IT is often said by some, in complacency, that the stresses existing a number of years ago are no longer with us; that socialized medicine is no longer a possibility here in the United States. It is true that we have made great progress in demonstrating the workability of voluntary health prepayment plans, but there is yet much more ground to be covered ... and it can only be covered by us, the members of the medical profession.

“There are many ways in which we, as doctors, can help Blue Shield grow and consolidate its strength. Basically, we must constantly sell and re-sell ourselves on the philosophy of Blue Shield, and on its advantages to the public. One way that we can begin to do this is to 'take our own medicine' ... to enroll ourselves and our entire families, and our employees in Blue Shield, so that we know whereof we speak when we talk to our patients of Blue Shield protection, security and peace of mind.

“The public will have faith in Blue Shield so long, and only so long, as it knows we, the doctors, have faith in it, and continue to endorse it. This enthusiastic endorsement is one of the reasons that the Blue Shield Plan has reached its present stature. We must gird ourselves to carry it further.
long as our faith is evident, no third party can prevail.

"It is easy," Dr. Hancock continued, "for a doctor to 'sell' Blue Shield to a patient. He comes to you for medical advice and you have the power to dispel his doubt and fear. Recommend Blue Shield ... just a word, and a Blue Shield information card, is all it takes. The main thing is that the patient knows you endorse your own plan."

Dr. Hancock concludes by indicating that the profession is committed to the role of preserving the practice of medicine "for the greatest good of the greatest number without outside interference." And he added, "Our strong right arm is Blue Shield. With our individual and collective help, it shall prevail."

Dr. Hancock neither overstates nor understates the case. The issues, as he puts them, are clear and his appeal for more medical leadership in securing both the future of private medical practice and the growth of Blue Shield Plans as a part of medicine's future security represents an appealing and sincere call to action.

The Woman's Auxiliary
Dear Publicity Chairman:

This coming year let us be "good-publicity conscious." This is of importance for better public relations. Let each publicity chairman see that the public is made aware of the useful activities of his organization. Stress meetings which feature the American Medical Education Foundation, Safety, paramedical recruitment, and other civic projects.

"By their deeds shall you know them" should be our motto. Give the public a chance to know us and our deeds. Help them to learn to judge the medical profession by our acts rather than by the words of others.

Also, will you please send reports of your meetings and civic projects to me by the 8th of the month. These items will then appear in the Nebraska State Medical Journal. It is through the dissemination of this knowledge other auxiliaries may profit.

Mrs. H. V. Munger, 3024 Sheridan Ave., Lincoln, Nebraska.  

Auxiliary Wins Award of Merit—  
Nebraska Woman's Auxiliary wins Second Place in top ten States with the highest per capita contributions to the American Medical Education Foundation.

The national chairman for A.M.E.F. presented an "Award of Merit" to the Nebraska representative at the A.M.A. and Auxiliary Convention in San Francisco in June, 1958. We received the same distinction last year when we were in third place and were eligible in fourth place the year before but the practice of making awards was not then established.

The final figures on A.M.E.F. contributions in support of the nation's medical schools are herewith submitted following the close of the fiscal year on June 30th:

State and County Auxiliaries contributed ..............................................$113,889.44
National Auxiliary contributed..................................................5,000.00
Members' "Absentee Ballot" contributions ............................................7,577.24

1957-58 Grand Total .................................................................$126,466.68

Nebraska State Auxiliary mailed its check for $2,318.06 on May 15 but the amount was increased to $2,463.56 through the direct mail ballot with a "yes vote and a money gift for tomorrow's doctors"—a special project of the national chairman. Based on the membership total for the preceding year this contribution averaged $4.16 per member.

At this point I think it fitting to emphasize that contributions from the State and County Treasuries are highly representative of the membership since the gift is paid from the sums collected in dues after all other obligations of the budget are met. This much support, through the loyalty of members to the Auxiliary, is still not enough help to give to A.M.E.F. The ever-increasing costs of operating Nebraska's two class A, accredited medical schools are relieved and augmented by the moneys returned through the A.M.E.F.

Dean Gilleck acknowledged $10,596.69 in donations by individuals and organizations which were specifically designated for his school in 1957-58. He wrote in part: "It is with great appreciation that we note the Auxiliary contributions in this category. Please extend our thanks to the members for their assistance to the Creighton University School of Medicine."
Dean Tollman of the University of Nebraska College of Medicine wrote in part: that in 1957-58 there were $18,591.00 allocated from the Foundation and continues: “We are most appreciative of the continuing and consistent support of the Auxiliary. I hope you will relay our thanks at any appropriate time.”

It is very commendable that of the 15 recognized duly organized county auxiliaries for the past year 10 of them participated in this as a priority project. Benefit projects were promoted in 7; use of the memorial cards by members brought credit to 6 auxiliaries; a cash gift by an individual increased her auxiliary’s total gift. In Douglas County generous contributions were received by two allied groups — Creighton Circle of St. Joseph’s Memorial Hospital and Doctors’ Wives’ Club.

Greater individual participation through the use of Sympathy cards is very much desired. Instead of the customary flowers, members of the Auxiliary may make contributions to the Foundation as Memorials. On receipt of a check and directed information the A.M.E.F. Chairman will mail a card, specially printed and in good taste, to the family of the deceased. The card tells them that a contribution has been made by you to the cause of medical education to honor the memory of your friend. The gift may be designated for the school of your choice and in this way you will be helping the medical schools maintain their present high standards.

Our “Award of Merit” for continued interest in A.M.E.F. and increased support for our country’s medical schools was, in truth, rather effortlessly won. We need to work together for a cause which is so deserving. Each of us needs to feel the obligation to which the Auxiliary is committed—“to give aid to our medical schools.” Let’s not make another “Award” our goal for the coming year—instead, let every member support a project for A.M.E.R. in every Auxiliary. This united and organized effort will make our gift greater to the medical schools and will lessen the threat of necessary Federal intervention. I repeat here what one Dean of a medical college said, “Every school is stronger because of A.M.E.F.”

Mrs. James P. Donelan, Nebraska A.M.E.F. Chairman.

The regular fall meeting of the state board of the Nebraska Medical Association Auxiliary was held Monday, September 8, 1958, at the Hotel Cornhusker, with Mrs. George Covey of Lincoln presiding.

Attending were state committee chairmen, district counselors and county auxiliary presidents who discussed plans for the auxiliary’s projects of: (1) assisting the Medical Education Foundation; (2) encouraging youth in medical careers; (3) extending the circulation of Today’s Health, and (4) promoting the health of the nation through the observation of safety procedures.

Mrs. George Covey, Lincoln, is state auxiliary president; Mrs. Chester Farrell of Omaha is president-elect; Mrs. Wayne Wadell, Beatrice, is first vice president; Mrs. O. A. Neely, Lincoln, corresponding secretary; Mrs. R. E. Garlinghouse, Lincoln, recording secretary; Mrs. Robert Hillyer, Lincoln, treasurer, and Mrs. Frank Tanner, second vice president.

Mrs. George Covey, Lincoln, state auxiliary president, was the guest speaker at the Adams county auxiliary meeting held in Hastings September 3. On September 9, Mrs. Covey attended the Douglas county auxiliary meeting in Omaha as guest and speaker.


The Woman’s auxiliary to the Gage County Medical Society entertained at a recruitment tea in the Homemaker’s Room of the high school. All junior and senior girls in Gage county interested in nursing, medical social work, medical technology, or physical therapy were invited to attend.

Local representatives were there to speak with the girls and to answer their questions.

Mrs. Elmer Penner was chairman, assisted by Mrs. C. R. Brott and Mrs. L. Dwight Moell.
The Cheyenne-Kimball-Deuel County Medical Association and Auxiliary held a dinner meeting at the Sidney Country Club with 14 members present.

Hosts for the evening were Dr. and Mrs. Don Wilkinson.

After the dinner the doctors were shown a movie on “Glaucoma,” and the auxiliary met socially.

The Dawson county auxiliary met in Gothenberg at the home of Mrs. Sam Perry, one of the State Directors for the Nebraska Medical Auxiliary. She read her report of last year’s Dawson county activities.

Sgt. Lee Oberg, Nebraska Safety Patrol, presented the program on Highway Safety, which he illustrated with slides.

A highlight of a testimonial luncheon for Surgeon General Burney was the first public appearance of Dr. Gunnar Gundersen as new A.M.A. President. Dr. Gundersen praised Dr. Burney as a public health officer and as a government official who did not lose contact with the private medical community. The affair was in recognition of Dr. Burney’s election as president of the World Health Assembly.

New diagnostic and treatment methods have played a vital role in saving cancer victims, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession.

“If fifty years ago a diagnosis of cancer was a sentence of death,” says “Patterns,” but prompt and adequate treatment has saved 800,000 persons who are still alive today, five years after treatment. Moreover, an additional 700,000 who have been receiving medical care for cancer during the last five years, are expected to remain alive after five years.

Cancer, the second leading cause of death in this country, will strike an estimated one out of every four Americans now alive unless “new preventive measures are found,” according to the publication “Patterns of Dis-

ease” prepared by Parke, Davis & Company for the medical profession.

If you’re a man, your chances of developing the disease are one in five declining after the age 50; and of dying from it, one in eight, declining after the age of 55, says “Patterns.” If you’re a woman, your chances of being hit by cancer are one in four, declining after 30; and of dying from it, one in seven, declining after 35.

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NOTICE TO ALL CONTRIBUTORS

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.

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Today’s Health
FOR THE AMERICAN FAMILY

A Good Buy in Public Relations

* Place it in your reception room

Today’s Health is published for the American Family by the American Medical Association, 535 N. Dearborn St.—Chicago 10, Illinois

Give your subscription order to a member of your local Medical Society Woman’s Auxiliary, who can give you Special Reduced Rates.
In Biliary Distress

**ZANCHOL®**

Improves Flow and Color of Bile

Zanchol (brand of florantyrone), a distinct chemical entity unrelated to the bile salts, provides the medical profession with a new and potent hydrocholeretic for treating disorders of the biliary tract.

The high degree of therapeutic activity of this new compound and its negligible side reactions yield distinct clinical advantages.

- Zanchol produces a bile low in sediment.
- Zanchol enhances the abstergent quality of bile.
- Zanchol produces a deep, brilliant green bile, regardless of its original color, suggesting improved hepatic function.
- Zanchol improves the flow and quantity of bile without increasing total bile solids.

Bile with these qualities minimizes biliary stasis, reduces sediment and debris in the bile ducts and discourages the ascent of infection.

For these reasons ZANCHOL has shown itself to be a highly valuable agent in chronic cholecystitis, cholangitis and care of patients following cholecystectomy.

**Administration:** One tablet three or four times a day. Zanchol is supplied in tablets of 250 mg. each. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.
Current Comment
The Physician and the Federal Budget—

Louis M. Orr, M.D., Vice Speaker of the A.M.A. House of Delegates, speaking of the physicians’ concern with the fiscal policies of the Federal government stated in part: "Each year our budget is a little higher, a little broader. Each year the Federal government gets a little deeper into more programs which should be locally organized and administered. For part of each year the United States government, the government of the richest nation on earth, lives from hand to mouth, with only enough money in its treasury to pay next month’s expenses.

"Almost every year, Congress debates raising the statutory debt limit.

"But this is only the beginning of the rocket’s flight. Each new Federal program starts out small — and then the rocket will really take off!!!

"Our country has gotten so big that we tend to forget that we’re supposed to be running it. Most of the time what goes on in Washington seems so far away from us that we either lose track or treat the Washington news like it doesn’t concern us.

"I expect my patients to take an interest in their treatment — after all, it’s their health that will primarily be affected. And I feel very strongly that every taxpayer should take a personal interest in the actions of his government.

"After all, it’s our incomes they’re operating on.

"I’m sure most of you have, at one time or another, run into the notion that doctors should stick to medicine — and leave running the country to the self-styled ‘experts.’

"Well, strictly within my own field of competence, I know that it is unhealthy for a man to keep living beyond his physical means. No man can go on, year after year, getting less sleep than he needs, less food than he needs, without serious deficiencies.

"Psychologically, too, as a doctor, I know that it is unhealthy for a man to live in a state of constant debt, spending more than he is making. If he worries about his debts constantly, the strain is bound to affect him.

"And if he doesn’t worry about his debts, that’s even worse.

(Continued on page 38-A)
all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic
...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks
...an expectorant to augment demulcent fluids
...the specific antipyretic and analgesic effect of well-tolerated APAP
...the prompt and prolonged activity of timed-release medication

Each Tussagesic Tablet contains:

Triaminic® . . . . . . . . . . . . . . . . . . . . . . 50 mg.  
(phenylpropanolamine HCl . . . . 25 mg.;  
pheniramine maleate . . . . . . . 12.5 mg.;  
pyrilamine maleate . . . . . . . 12.5 mg.)

Dormethan (brand of dextromethorphan HBr) . . . . . . . . . . . . . . . 30 mg.

Terpin hydrate . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 180 mg.

APAP (N-acetyl-para-aminophenol) . . . . 325 mg.

Tussagesic Tablets provide relief from all cold symptoms in minutes, lasting for hours.

Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

Also available—for those who prefer palatable liquid medication—

Tussagesic suspension

Smith-Dorsey • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada
The Physician and the Federal Budget—
(Continued from page 36-A)

“Our government is living beyond its eco-

nomic means; it has already accumulated a

good deal of excess fat in the form of pro-

grams which either should not be govern-

ment responsibilities at all or should be han-

dled at the local level.

“Even if my voice is not heard as a tax-

payer, as a physician I say this is an un-

healthy state for our Nation to be in.

“I am not going to try to cover all the

economies possible in our Federal Gover-

ment. Instead, I am going to talk about the

 savings possible in just one agency of the

government — the Veteran’s Administra-

tion. And how much could be saved by

merely taking the VA out of programs

which are really not its proper field?

“In the next 40 years we could save over

80 billion dollars.

“As you are well aware, medicine is in-

timately involved in welfare programs. You

might say that we have a vested interest.

This welfare may be as simple as the giving

of a relief check to a man because he’s too

sick to work or it may include full hospital

and medical assistance.

“Federal agencies acknowledge medical

care as an integral part of welfare — so

much so that medical care programs for the

indigent now receive special support and en-

couragement.

“So the medical profession has an inter-

est, a very special interest, in federal wel-

fare spending a professional interest, in ad-

dition to our interest, as taxpayers, in how

our money is spent.

“The medical profession views with a par-

ticularly jaundiced eye the constantly in-

creasing Federal intervention into the pri-

vate lives of our citizens. We must be free

to practice our art and science to the limit

of our own ability — not to a set of rules

and regulations compiled in Washington.

This is why the medical profession keeps a

constant and watchful eye on Federal spend-

ing in the health and medical care fields.

“I happen to be chairman of the Amer-

ican Medical Association’s Committee on

Federal Medical Services, a committee of the

Council on Medical Service. This commit-

tee is only one of several A.M.A. depart-

(Continued on page 44-A)
HE NEEDN'T BE HIGH-STRUNG

WEIGHT REDUCTION: Obese patients may resist dieting because they fear losing the emotional security often involved in overeating. AMBAR helps them hold the diet line by giving them a more alert, brighter outlook. WITHOUT JITTERS; Methamphetamine, a potent CNS augmenter, produces less cardiovascular effect than amphetamine. In AMBAR it is combined with just enough phenobarbital to prevent overstimulation. AMBAR EXTENTABS provide 10-12 hours of appetite suppression in one controlled-release, extended-action tablet: methamphetamine hydrochloride, 10.0 mg.; phenobarbital (1 gr.) 64.8 mg. AMBAR TABLETS for conventional dosage or intermittent therapy contain methamphetamine hydrochloride, 3.33 mg.; phenobarbital (1/3 gr.) 21.6 mg. A. H. ROBINS COMPANY, INC., Richmond, Virginia, Ethical Pharmaceuticals of Merit Since 1878

WEIGHT REDUCTION WITHOUT JITTERS AMBAR

Now available NEW AMBAR #2 EXTENTABS (methamphetamine 15 mg., phenobarbital 1 gr.) for patients who require higher methamphetamine dosage
The Physician and the Federal Budget—
(Continued from page 38-A)

ments which keep track of new developments in Federal medicine.

"In recent years, we have found the Veterans' Administration welfare and medical program to be one of our greatest causes for anxiety. For the past five years, the American Medical Association, the state associations, and the individual physicians have been saying, 'It is time to call a halt, time to consider where we are heading — and whether we really want to go there'."

Can Voluntary Health Agencies Survive—

Much has been said, sometimes with considerable ill will, for and against the inclusion of the fund raising activities of Voluntary Health Agencies, in United Fund campaigns. An editorial in California Medicine, quoted in the Omaha-Douglas County Bulletin, contributes a logical analysis of this argument as follows:

The genesis of the controversy is simple. United Funds have been created to put an end to multiple fund drives for worthy causes. The argument that one might contribute once — and be done with it — appears attractive, particularly to those whose knowledge of the functions of the organizations involved is limited.

These organizations fall into two principal categories. One group consists of local welfare agencies. The other is composed of national health agencies, among which are such highly respected bodies as the American Cancer Society, the American Heart Association, the National Tuberculosis Association and the National Foundation for Infantile Paralysis. These have contributed significantly to the health and medical welfare of the American people. All have state and local subdivisions.

It is worth while to examine the functions of the two groups of agencies. Both are devoted to meeting human needs and are therefore admirable. They have certain points of similarity but greater differences.

The local welfare organizations were established to care for the needy in their own communities. The needs of one community may vary from those of another and may include providing employment, food, shelter, clothing, transportation, medical and hos-
more potent and comprehensive treatment than salicylate alone
... assured anti-inflammatory effect of low-dosage corticosteroi'd... additive antirheumatic action of corticosteroid plus salicylate brings rapid pain relief; aids restoration of function ... wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis
more conservative and manageable than full-dosage corticosteroid therapy—
... much less likelihood of treatment-interrupting side effects ... reduces possibility of residual injury ... simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED
ac... conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.
subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.
precautions: Because Sigmagen contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of Sigmagen.

in any case it calls for Sigmagen® tablets

Composition
Methocorten® (prednisone) .................. 0.75 mg.
Acetylsalicylic acid ........................ 325 mg.
Aluminum hydroxide ......................... 75 mg.
Ascorbic acid ................................ 20 mg.

Packaging: Sigmagen Tablets, bottles of 100 and 1000.
Can Voluntary Health Agencies Survive—
(Continued from page 44-A)

hospital care, recreation facilities and other services.

It may be laudable for a community group to survey the overall requirements for these strictly local services, to raise funds in appropriate amount and to distribute them on the basis of a generally acceptable formula.

The situation with the Voluntary Health Agencies is quite different. The primary purposes of these agencies are to support research, to conduct programs of public education and to assist in professional education. The service aspects of most agencies are limited and constitute a minor portion of their activities. The principal exception is the National Foundation for Infantile Paralysis. As important, however, as the service program of the Foundation may be, it pales into insignificance when compared with the research which led to the development of the Salk vaccine.

The reduction of the death rate of tuberculosis can be attributed in part to the efforts of the Tuberculosis Association. It becomes progressively more apparent that the conquest of cancer and cardiovascular diseases will be accomplished through research into the causes of these conditions and into improved methods of prevention and treatment. Progress is being made in these fields, but much more remains to be done.

Public education is a prime function of the Voluntary Health Agencies and is particularly important in the field of cancer. The annual crusade of the American Cancer Society in April does more to inform the public of the necessity of early diagnosis and early effective treatment than the year around educational activities of the Society. Thousands of dedicated volunteer workers disseminate important information about cancer while soliciting contributions. The solicitation of funds and the education of the public are inextricably linked.

The individual Voluntary Health Agency must be judged on the basis of its announced objectives, the effectiveness and fidelity it displays in pursuing those objectives and the soundness of its budget. A reasonable overhead and economy of operation are important items.

(Continued on page 62-A)
in all diarrheas

CREMOMYCIN®

Succinylsulfathiazole—Neomycin Suspension with Pectin & Kaolin

regardless of etiology

You can enhance the value of your own Journal by patronizing its advertisers
Can Voluntary Health Agencies Survive—
(Continued from page 62-A)
recognized that local service demands tend to take precedence over broader programs. The end result has been less well financed research and injury to the public education endeavor.

A.M.A. Plans Civil Defense Conference
In November—

More than 175 physicians and others interested in civil defense will gather November 8-9 in Chicago for the ninth annual County Medical Societies Civil Defense Conference. The two-day meeting at the Morrison Hotel, Chicago, is being planned by the A.M.A.'s Council on National Defense. Dr. F. J. L. Blasingame, executive vice president, will welcome the conferees on behalf of the American Medical Association, and Dr. Gunnar Gundersen, A.M.A. president, will speak on "The Profession's Responsibilities in Civil Defense." Officials of the newly-created Office of Civil and Defense Mobilization will report on the expanding role of the federal government’s defense program and the medical and health aspects of civil defense as they pertain to the new program.

As in past years, the group will divide up into workshop sessions to consider various phases of civil defense: organization and training; reception, evacuation and emergency care; hospital disaster planning; supplies, transportation and communication. In an effort to promote test operations dealing with simulated disasters, the program will feature reports on several field tests conducted this year. "Test Exercise Star"—based on a mock earthquake of severe intensity—was conducted by the Alameda-Contra Costa (California) Medical Association in cooperation with local civil and military authorities. "Operation Prep Pitt"—dealing with a theoretical jet airplane crash into the Pitt Fieldhouse—was conducted by the Allegheny County (Pennsylvania) Medical Society in cooperation with local authorities. "Operation AFTA"—based on a simulated airplane crash on the Tulane University campus—was sponsored by the Committee on Medical Education for National Defense (MEND) of the Tulane School of Medicine to provide a realistic situation for the instruction of medical students in the principles of disaster medicine.
Safe, too: 
Bonadoxin doesn’t “stop” the patient. It is free of side effects commonly associated with overpotent antinauseants. Goldsmith, reporting on 620 controlled cases, states that “toxicity and intolerance [are] zero.”

Now available in tablet or drop form.

Dosage: usually one tablet or one tsp. (5 cc.) at bedtime. Severe cases may require another dose on arising.


Each tiny pink-and-blue Bonadoxin tablet contains:
- Meclizine HCl (25 mg.) ...for symptomatic relief
- Pyridoxine HCl (50 mg.) ...for metabolic action and prompt antinauseant effect.

Infant colic?
Non-narcotic Bonadoxin Drops stop colic in about 85% of cases.

Each cc. contains:
- Meclizine Dihydrochloride...8.33 mg.
- Pyridoxine Hydrochloride...16.67 mg.

Dosage:

<table>
<thead>
<tr>
<th>Age</th>
<th>Dosage (cc.)</th>
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<tr>
<td>under 6 months</td>
<td>0.5 cc.</td>
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<tr>
<td>6 months to 2 years</td>
<td>1.5 to 2 cc.</td>
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<td>2 to 6 years</td>
<td>3 cc.</td>
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<tr>
<td>adults and children over 6 years</td>
<td>1 teaspoon (5 cc.)</td>
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2 or 3 times daily, on the tongue, in fruit juice or water

Supplied: fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Let Us Help You With Your Brace and Artificial Limb Problems.

1000 So. 13th St., Lincoln, Nebr. Phone 21644

PHYSICIANS’ EXCHANGE

Advertisements in this column are at a rate of six cents per word with a minimum of $2.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 40 words. Advertisements from members of the Nebraska State Medical Association will be accepted without charge for two issues. Each advertisement will be taken out following its second appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska State Medical Journal, 1315 Sharp Building, Lincoln 8.

FOR RENT: Residential office suite with 2 examining rooms, laboratory, reception room and private office. New building, ground floor, office parking area. Contact Drs. Seberg & Seberg, 515 West 9th Street, Hastings, Nebraska.

FOR SALE — 15 MA Proflex X-ray Unit with radiographic Fluoroscopic unit; X-ray illuminator, dark room equipment and general office equipment. Contact Mrs. O. C. Ehlers, Ravenna, Nebraska.

POSITION WANTED — Ophthalmologist — semi-retired, board eligible, desires association in Lincoln or vicinity doing refractions and some external diseases. Write Box 7, Nebraska State Medical Journal, 1315 Sharp Building, Lincoln 8, Nebraska.
IN VITRO SENSITIVITY OF STAPHYLOCOCCI FROM THREE FOCI OF INFECTION TO CHLOROMYCETIN FROM 1953 TO 1957*

**JANUARY-JUNE, 1957**

- Skin (75 strains): 96.7%
- Upper respiratory (84 strains): 86.9%
- Ear (39 strains): 97.5%

**OCTOBER, 1955-MARCH, 1956**

- Skin (113 strains): 99.2%
- Upper respiratory (137 strains): 97.8%
- Ear (45 strains): 97.8%

**JUNE-DECEMBER, 1953**

- Skin (150 strains): 92.0%
- Upper respiratory (50 strains): 86.0%
- Ear (70 strains): 90.0%

*Adapted from Boyer.*
Current Comment

BOOKS RECEIVED


BOOK REVIEWS

“The Eternal Search” by Richard Mathison (G. P. Putnam’s Sons, N.Y.) is packed with historical data about the history of drugs and medicines. The author stresses the capitude of the human beings of all times and the ease with which credulity has been played upon by charlatans in all ages. At the same time, he shows that by “break throughs” valuable information has come to light, much of which has come to us as highly worthwhile.

In spite of the mass of materials treated in his book and the long period of history covered by the story, the author has written in a style that grips the reader’s attention like a novel or a good short story. The worst that can be said is that the author has not fully documented the facts, but to have done so might have spoiled the book.


This booklet has been prepared to help the doctor show what can be done for the stroke patient at home to help prevent or keep to a minimum the disability that often develops after a stroke. It is well illustrated and is meant to be given to those caring for the patient; to be used at the direction of the physician.

Who is the “hidden” diabetic? Weight, heredity, and age are all implicated, according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. An estimated 38 per cent of persons who have positive diabetes screening tests are overweight; 44.5 per cent have a positive family history of diabetes; and 62 per cent are over 40 years of age.
the clinical results are **positive** when

**NILEVAR** restores **positive nitrogen balance**

The anabolic effects of Nilevar are quickly manifest both to the patient and to the attending physician.

When loss of nitrogen delays postsurgical recovery or stalls convalescence after acute illness and in severe burns and trauma, Nilevar has been found to effect these responses:

- Appetite improves
- Weight increases
- The patient feels better
- The patient recovers faster

Similarly Nilevar helps correct the "protein catabolic state" associated with prolonged bed rest in carcinomatosis, tuberculosis, anorexia nervosa and other chronic wasting diseases.

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent in appropriate dosage.

Nilevar (brand of norethandrolone) is supplied as tablets of 10 mg. and ampuls (1 cc.) of 25 mg. The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

*Research in the Service of Medicine.*

G. D. SEARLE & CO., CHICAGO 80, ILLINOIS

You can enhance the value of your own Journal by patronizing its advertisers.
Current Comment

The Month in Washington—

For many years a number of students of government have been searching for some way of checking the growth of the Federal bureaucracy and returning certain functions to the states.

Two particularly vexing problems are involved. Because the Federal government has moved into so many taxation areas, states complain that even if they wanted to regain control over certain programs, they would have no way of paying for them. Also, a fool-proof mechanism would have to be devised to insure that the programs didn’t break down during the transition and that the states would in fact keep up the activities after U.S. dollars stopped coming.

If the administrative details could be worked out, and if Congress would agree to reverse the trend, a number of U.S. Public Health Service grants programs presumably could be turned over to the states.

President Eisenhower is deeply interested in attempting to turn the tide, and last year the Administration came up with a concrete proposal. It was to make the states completely responsible for the water pollution control operation ($50 million annually in U.S. grants) and vocational education ($35 million a year). So the state would have money to finance the work, the U.S. would drop part of its tax on telephone service, inviting the states to levy their own tax.

Congress was cool to the idea. Besides, after giving it more consideration, the then Secretary Folsom of H.E.W. decided it wouldn’t work because the low-income states couldn’t realize enough from the telephone tax to meet the extra expenses.

But the Administration hasn’t given up hope. Supported by the federal-state joint action committee, Secretary Flemming (Folsom’s successor) is proposing a new method, one that he thinks will meet the problem of the low income states.

He would shift to the states the same two programs—water pollution control and vocational education. At the same time the U.S. would forego 30% of the present tax it imposes on telephone service and permit the states to levy this amount. In addition, (Continued on page 20-A)
if you were
in the rheumatoid arthritic’s shoes,
Doctor...

wouldn’t you want a steroid
with a proved record
of safety and success?

METICORTEN®

prednisone

you can count on rapid relief from pain, swelling and stiffness followed
by functional improvement and maintained on an uncomplicated,
low-dosage regimen with minimal chance of side effects†
and without unexplained weight loss, anorexia, muscle cramps
as reported with certain other corticoids†

The Month in Washington—
(Continued from page 8-A)
to take care of the poor states the U.S. would allocate among states an amount equal to 10% of the present telephone tax, distributing relatively larger shares to the low per capita income states.

In dollars, as explained by Secretary Fleming, the states would be losing $85 million in U.S. grants, but they would have an opportunity to collect a total of about $109 million on telephone service and receive $36 million in the new grant arrangement.

In announcing that the Administration was going to try again to have this idea adopted, Mr. Fleming emphasized that both programs were of great value and shouldn’t be allowed to “drop through the cracks in the floor” during the period of transition. He noted that under his proposal the U.S. could step in and make a state use the money for the specific purpose if it showed an inclination to collect the tax but spend the money somewhere else.

The question now is whether Congress will show any enthusiasm over the plan. At any rate, it will be opposed vigorously by the telephone industry and vocational education interests. The latter are fearful that their programs might suffer under all-state operation.

NOTES:

H.E.W. is giving careful study to the Bayne-Jones report which proposed a doubling of U.S. medical research spending and early construction of 14 to 20 medical schools. Secretary Flemming told a press conference that final estimates of the cost of carrying out some of the report’s proposals are due to be finished in December.

Social Security Administration reports a sharp rise in volume of appeals from applicants denied social security benefits, mostly under the disability section enacted two years ago. The administration’s staff of referees has been increased four-fold in two years to handle the work load. Three times as many hearings are held on disability claims as on all others combined.

Social Security Commissioner Charles I. Schottland, back from a month’s tour of Russia, reports that nurseries and old people’s homes in Russia appear to be “excel-

(Continued on page 26-A)
Symptomatic relief ... plus!

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The Month in Washington—
(Continued from page 20-A)

lently” staffed with one employee for about every three old persons and one for every two and a half children. He points out that a comprehensive social security program is a must in Russia, inasmuch as wages are about the only source of income. When wages halt, the people have only social security to fall back on.

With President Eisenhower’s appointment of General Elwood R. Quesada as administrator of the new Federal Aviation Agency, the American Medical Association is renewing its plea for an Office of Civil Aviation Medicine manned by a Civil Air Surgeon.

Mounting protests from medical and other groups have pursuaded the Post Office Department to drop its plan to ban the airmail shipment of etiological disease agents. Airlines felt there was a threat of breakage and possible danger to crews and plane passengers. P.H.S., the A.M.A. and others argued that proper packaging could control this problem. (From A.M.A. Washington Office).

Antibiotics—A Two-Edged Sword—

No one questions the tremendous value of the antibiotics in the practice of medicine, but an editorial in the Wisconsin Medical Journal emphasizes the unfavorable results that may sometimes come from these same antibiotics.

A questionnaire is cited which indicates that of 2,500 penicillin reactions, 901 were considered life-threatening and these resulted in a fatality rate of 9 per cent. The vast majority of reactions to penicillin were due to intramuscular administration.

The next most important severe reaction was one of superinfections, of which enterocolitis was the most frequent and had a mortality rate of 34 per cent. There were 27 cases of blood dyscrasias reported, of which 16 were due to chloramphenicol, of which 23 reactions were fatal. A common, but less serious reaction was angioneurotic edema and urticaria.

A plea is made to use care in the administration of antibiotic drugs. The antibiotics, in particular, should be used only when indicated, and their use curtailed when the desired effect has been produced.
EDITORIAL

EDUCATION OF THE DIABETIC PATIENT

(Guest Editorial)

Diabetes is a disease that requires the utmost in patient cooperation. The diabetic patient actually manages his own problem under supervision of the physician. It is for this reason that the diabetic patient should be as well informed about his problem as his intelligence will allow.

Education of the diabetic requires time, patience, and enthusiasm on the part of the physician. Only as the physician imparts this enthusiasm for knowledge to the patient will the patient himself become enthused about studying his disease. Education will dispel the fear a patient has of his disease. It is the unknown that produces fear; knowledge imparts a feeling of confidence in the management of any problem. And only as knowledge is present will the patient intelligently cope with his problem.

Teaching of the diabetic patient must cover the following subjects as thoroughly as the intelligence of the patient will permit:

1. The defect in diabetes and how insulin controls this defect.
2. Dietary instruction.
3. Testing urine for sugar and acetone.
4. Complete knowledge of the insulin used; how to measure; how to inject; sterile technique.
5. The effect of activity, stress, and infection on diabetes.
6. The complications of diabetes, how they are recognized and treated.

This poses quite a problem to the busy physician; however, success in treatment will depend entirely on the knowledge the patient has concerning these facts.

Fortunately, many aids are available to the physician in teaching these facts. Many good texts are available to help the patient answer his countless questions. These texts should be read through first much as one reads a magazine article, and then reread with the intent to master the information present. The physician can answer the questions the patient cannot derive for himself. The dietitian of a hospital can teach the diet. The office nurse can supervise the problem of giving the insulin—sterile technique, and measurement of the insulin. However, in the early visits, the physician must unhurriedly discuss with the patient the nature of diabetes, and the importance of proper care. This must include introduction to the above subjects, instilling a desire in the patient to make full use of the aids mentioned above.

Additional aids lie in the lay groups associated with diabetic organizations. Through lectures to these lay groups, discussions on diet, care of feet, types of insulins, management of insulin shock, and many other relevant subjects are presented. There is also an element of group psychotherapy present in such meetings; the diabetic realizes he is not alone with his problem, and, seeing how others have managed this seemingly difficult enigma, generate enthusiasm and courage to face their own problem. The American Diabetes Association also publishes a small magazine every two months which imparts screened information and encouragement to the diabetic—the ADA Forecast.

Lastly, a marvelous teaching aid for the juvenile diabetic is the Diabetic Camp near Nebraska City conducted yearly by the Nebraska Diabetic Association.

Genuine enthusiasm and interest of the physician in training the diabetic patient, and the use of training aids mentioned, will better prepare the diabetic both mentally and psychologically to manage his disease.

C. R. HANKINS, M.D.

DOCTORS BY ADOPTION OR ADSORPTION—

Not too many years ago a committee of the A.M.A., called the "Cline" Committee,
went to great lengths to have the American Medical Association recognize osteopaths as physicians; to give them, as far as possible, the same status as doctors of medicine; to declare that osteopathy is no longer a cult; and to permit members of the A.M.A. to teach in osteopath schools. Of course, declaring osteopaths to be not cultists but, in fact, physicians of equal standing with the rest of us would permit intimate (and perhaps profitable) association with them as consultants and brothers in the great profession of medicine. After about two years of effort and preparation this proposition was finally brought before the House of Delegates and defeated.

Among other questionable benefits would have been, the committee pointed out, the acquisition of half a dozen medical schools now belonging to the osteopaths. These schools were said to be in a class the A.M.A. would label “Class B,” but, it was contended, if they were supplied with good teachers from the regular medical profession, they could be converted into “Class A” schools. Little credence was given to the declaration by a great many doctors that they considered osteopathy to be still a cult, and that little that is comparable with true medical education was adequately taught in any of these schools.

At the recent session of the House of Delegates of the A.M.A., in San Francisco, it is said a group of doctors was prepared to bring this affair back to life, but, finding the atmosphere of the House somewhat cool toward such a move, they delayed the matter. It is said, also, they now plan to reopen the propositions formerly advocated by the Cline Committee in the House when it meets in December.

It seems almost unbelievable that our House of Delegates will concur in a scheme to raise osteopaths from cultism to equality with Doctors of Medicine by mere declaration, but strange things have happened and could happen again. There would arise, also, the matter of doing something with half a dozen schools that would be “Class B” at best. We are not able to support the high class medical schools we now have. Ways and means are constantly being scrutinized to raise more money for them without accepting subsidy by the Federal Government with its inevitable governmental control. If any attempt were made to build needed buildings, buy necessary equipment, employ adequate faculties, and arrange for proper teaching affiliations for any or all of these osteopathic schools, who would pay the bills unless it be “The Great White Father”?

While the doctor who sits and contemplates the matter discussed above probably says to himself “Such a ridiculous thing could not happen here,” sober reflection tells him it is not impossible. “Horse trading” is not unsuspected even in our A.M.A. House of Delegates. Assume, for example, that a large delegation from the West Coast, itching for support for the movement to become brotherly with the osteopaths (who may be especially numerous and who may have large practices in their state), should decide to trade votes with some large delegations from the Eastern Seaboard who want the A.M.A. to change its policy on Social Security for doctors. It is not difficult to foresee victory for both if these two matters could be brought to a vote.

Unless we want our profession sold down the river in this matter we should be giving it some serious thought and proper preliminary work. Some of the older members of the House who could be relied upon to consider every question of policy in the light of ethical action and in the light of what their hearts told them was the best for the most in the medical profession are no longer members. This does not reflect upon the newer members but emphasizes that the group mentioned formed a “hard core” of leadership.

SLIGHTLY USED CONSULTANTS

Radiologists and clinical pathologists are consultants we employ almost daily but only half use. These consultants provide information that often is of significant or even indispensable aid to the attending physician and patient. Accurate diagnosis, astute and successful treatment, and intelligent prognostication may depend largely upon data provided by X ray or laboratory.

These useful consultants often are treated like proverbial country cousins. Who else among us would be willing to be as helpful as he can when he has little or no contact with the patients and the least possible information about the problems the attending physician is trying to solve? The requisition slip from the attending doctor to the

(Continued on page 512)
The TREATMENT of

Diabetic Coma

Doctor Koszewski herein restates the principles and technique of management of one of our major emergencies — diabetic coma. While the author dwells largely upon treatment of the emergency, he restates the known facts about cause and prevention of this complication that carries such a grave prognosis and that demands the most prompt and skillful management.

—EDITOR

DESPITE an intensive educational and therapeutic program for diabetics, acidosis or coma, or both, still presents a relatively frequent complication of the disease. It is true that the introduction of insulin has changed the outlook for diabetics since at the present time only one patient in ten experiences an episode of coma, while previously the frequency had been six in ten. Nevertheless, the prognosis of coma, once it develops, is still grave, and proper treatment is of extreme importance.

Basically, diabetic coma is caused by a primary or secondary deficiency of insulin. Lack of this hormone impairs the utilization of carbohydrates and causes increased destruction of protein and fat with accumulation of intermediary metabolic products in tissues and blood. Certain of these products, the ketone bodies, are acids and, while a small fraction may be excreted unconjugated in the urine, the major portion must be neutralized by ammonia or by fixed body base, chiefly sodium, before excretion. This excretion of base leads to acidosis. The accumulating ketones themselves interfere with the already limited utilization of carbohydrates and further accentuate the negative balance of nitrogen and mobilization of fat. Hyperglycemia and polyuria are intensive and cause marked loss of both fluid and electrolytes. The clinical picture of hemoconcentration, dehydration, shock, anoxia, and coma occurs.

Proper use of insulin and diet should in most cases prevent this chain of events. Whereas some patients, particularly young individuals, are especially prone to acidosis, most episodes result from ignorance on the part of new diabetics and the failure or inability of more experienced patients or their relatives to cope adequately with stressful situations such as infections, gastrointestinal disturbances, or cardiovascular accidents. Again and again one hears the story of a patient who had an upper respiratory infection or upset stomach with anorexia, which made him discontinue his medication in the foolish belief that without food there is no longer a need for insulin. Instructions to the patient that in those situations the requirements for insulin persist, and that they should take at least half of the prescribed insulin dose to cover the basic body needs, would slow down the progress of ketosis and make the patient more amenable to medical treatment. Neglected comas with loss of consciousness always have a bad prognosis, and even the most optimistic clinical reports show a mortality rate of 30-40 per cent. Simple ketosis, or impending coma, has a better prognosis and diligent therapy may reduce the mortality rate to as low as 1 per cent.

Before any treatment of coma is started, the diagnosis should be made with some degree of certainty. This means short history and physical examination to elicit the cause of ketosis, to find complicating diseases, and to exclude conditions which may be confused with coma, such as severe hypoglycemia, cerebral vascular accident, myocardial infarction, shock due to trauma or hemorrhage, uremia, poisoning by barbiturates or salicylates, and overwhelming infections. The urine should be examined for sugar and acetone. Laboratory tests will include, in addition to routine blood counts and crossmatching, the chemical tests for blood sugar, ketones, amylase, urea nitrogen, carbon dioxide combining power, sodium, potassium, chlorides, and phosphorus.

The classical picture of diabetic coma with unconsciousness, areflexia, Kussmaul’s breathing, acetone odor of breath, soft eyeballs, dry tongue, low blood pressure, high blood sugar, and strongly positive ketone bodies in blood and urine is usually easily recognizable. However, there are many cases of hyperglycemia which show no impair-

BOHDAN J. KOSZEWSKI, M.S., M.D.
Department of Medicine
Creighton University School of Medicine
Omaha, Nebraska

November, 1958
ment of sensorium or only slight drowsiness but who are nevertheless ketotic. Joslin et al\textsuperscript{1} pointed out repeatedly that the term diabetic coma is loosely described and should be replaced by the more convenient definition of acidosis. He has chosen a plasma carbon dioxide combining power of 20 Vol. per cent or 9 mEq/l as the dividing line between the "comatose" and the "non-comatose" patients, and maintained that there is a marked difference in the mortality rate between those two groups. Baker\textsuperscript{2}, Owens and Rockwern\textsuperscript{3}, Rabinowitsch et al\textsuperscript{4}, Collen\textsuperscript{5}, and Koszewski et al\textsuperscript{6} failed to find any relation between the degree of acidosis and the mortality rate. Age, state of sensorium, degree of hyperglycemia, and severity of complications were the main factors which seemed to determine the clinical course\textsuperscript{6}. The degree of acidosis could not be correlated with the depth of the coma and did not influence the outcome of a particular case. Some patients become deeply comatose at a carbon dioxide level of 15 mEq/l, while others have clear sensoria at levels of 4.5 mEq/l or less. These examples are extreme, but generally speaking, it would be more advantageous to set the limit of acidosis at 15 mEq/l of carbon dioxide combining power\textsuperscript{7}. The cases with clouded sensorium and overt dehydration could be defined as coma while the others would represent simple ketosis. Fortunately, the clinical differentiation is not very important since untreated diabetic acidosis will end in coma and the management in each instance is similar. It consists of high doses of insulin, intravenous fluids, measures to counteract shock, and treatment of complications. However, the rules which govern those principles are not that simple and more detailed explanation is necessary.

For practical purposes, the treatment of diabetic ketosis may be divided into three phases: The immediate emergency therapy; the management of the hyperglycemic stage; and the conduction through the recovery period. The emergency stage may be defined as the time from the admission until the moment the patient shows a significant decrease in the blood sugar. In the event that only urine tests can be used for management (which is undesirable) this phase ends when the urine shows less than 2 per cent of sugar. The duration of this period is of utmost importance to successful therapy and should be kept as short as possible. There can be no delay in treatment by differential diagnostic speculations or search for complications. In unconscious patients, an indwelling catheter must be inserted and the urine checked for sugar and acetone. If the reactions are strongly positive, appropriate treatment will be started immediately.

Insulin is given at once, in high doses to correct the disturbed intermediary metabolism. The initial dose should be at least 100 units intravenously, and, as soon as the blood sugar is known, the original dose will be supplemented so that the total amount of insulin given in the first two hours is numerically equal to half the admission value for blood sugar. Following this, regular or crystalline insulin in doses of 50-100 units is given intravenously at hourly intervals until the blood sugar begins to fall. If this fails to occur within the first four hours, the amount of insulin must be increased dramatically. The only exceptions to this rule are children and older individuals who are rather sensitive to insulin and who may react to doses higher than 50 units with hypoglycemia or cardiovascular complications. Hourly determinations of blood sugar, or urine tests done every 30 minutes, will prevent overdosage of the hormone. The total amount of insulin may vary but it is seldom lower than 200 units in 4 hours and may go as high as 1800 units\textsuperscript{1}.

Some clinicians prefer to gauge the dosage of insulin by the level of blood ketones, determined by a modified Rothera test\textsuperscript{8}, but this method is inaccurate; there is also no good correlation between the mortality rate and the level of ketone bodies, whereas the mortality does correlate well with the initial blood sugar values\textsuperscript{6}.

Replacement of salt and water is the next step during the emergency state. The degree of dehydration and electrolyte depletion determines the outcome of coma to much the same extent as does the degree of insulin deficiency. The more shocky and dehydrated are the patients, the worse is the prognosis and the more imperative is immediate correction.

At first, the fluids are given in the form of physiological saline solution. One thousand ml, are administered during the first hour and another one thousand ml. in the next two hours. This amount of fluid presupposes good renal function. If there is anuria,
electrolyte estimation will be necessary before one proceeds with further replacement. Anuria may respond to hypertonic saline solution and 50-150 ml of 10 per cent saline can be injected directly into the tubing, if indicated. Alkaline solutions are not necessary at this time unless the patients are in profound acidosis with hyperpnea and carbon dioxide combining power below 9 mEq/l. In such instances one thousand cc. one-sixth molar sodium lactate may be given intravenously in place of the physiological saline. An exogenous source of glucose is not needed as the hyperglycemia itself supplies adequate carbohydrate for combustion. The judicious use of 5 per cent glucose in saline is even contraindicated, because the solution is hypertonic and will preclude accurate blood sugar estimations.

The third step in the treatment of the immediate emergency status is the management of shock. Kety et al9 demonstrated that there is a striking fall in the rate of oxygen consumption by the brain in diabetic acidosis. Persistent shock and anoxia will contribute to brain damage and hasten fatal outcome. All cases with low blood pressure and rapid, fleeting pulse should, therefore, have catechol amines added to the infusion. This medication has to be maintained at such a level that the systolic blood pressure is at least 100 mm. of Hg. If the blood pressure does not rise in two hours then the question arises of blood transfusion or plasma expanders, or both. Five hundred or 1000 ml of 6 per cent solution of dextran R should be given routinely. Blood transfusions will be considered if there is a deficit in hemoglobin and serum proteins. Some caution is indicated again in elderly individuals where hypovolemia may be detrimental to the already impaired cardiovascular system. However, by the time that this decision presents itself, the cardiac status and the electrocardiographic findings will be known, and an overloading of the circulatory system can be avoided.

The treatment of complications should also start as early as possible. Infections are by far the most common cause of diabetic coma, and, as long as there is no history of hypersensitivity, penicillin or wide spectrum antibiotics should be administered routinely to such patients, even if there is no obvious evidence of infectious complications. Later, when necessary clinical and bacteriological examinations are completed, a more direct etiologic approach will be possible. A decrease in the incidence of infectious complications is without doubt the main factor responsible for recent decreases in the mortality from coma1,7.

The patient should be out of shock and respond with fall of the blood sugar within four hours. By this time, the accumulated clinical and laboratory data will have rendered the etiology and pathogenesis of the ketosis evident, and the second phase in the therapy of coma i.e. the management of hyperglycemic stage can be begun at a more casual pace.

Insulin is not given as indiscriminately as before. Twenty units of regular insulin by subcutaneous injection, at hourly intervals, will usually suffice. The doses are continued until the blood sugar reaches the vicinity of 200 mg/100 ml. or the urine becomes sugar free. Rehydration therapy will be continued, but at a slower rate. Intravenous glucose is now needed to further the antiketotic action of insulin, to replenish the glycogen in liver and muscles, and to prevent possible hypoglycemic reactions. Five per cent glucose in saline may be employed, but a physiological mixture of electrolytes would be more appropriate. Butler's solution of 5 per cent glucose with 57 mEq/l sodium, 25 mEq/l potassium, 5 mEq/l magnesium, 49 mEq/l chlorides, 13 mEq/l phosphate, and 25 mEq/l lactate is the best commercially available preparation. The solution is hypertonic once the contained glucose is utilized, and can be used until full rehydration is achieved. The total amount of fluids may vary considerably according to cardiac status, but, ordinarily, between 5 and 10 per cent of the patient's weight will be given in fluids.

Study of electrolytes becomes valuable if the patient is not responding properly to the therapy. Holler10 pointed out that death from respiratory failure or vascular collapse, after apparent recovery from coma, may be attributed to hypopotassemia. Significant deficiencies of potassium may occur without manifesting any symptoms, but vascular collapse which does not respond to blood transfusions, or persisting nausea and vomiting, should suggest this diagnosis. The prevention of hypopotassemia is more logical than treatment, and infusions of fluids containing potassium, such as that of Butler, should be given routinely in the

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second stage so long as renal function is adequate.

Repeated search for complications will be made during this period. Infections and cardiovascular complications can be easily recognized at this time and a specific treatment may be instituted.

The transition to the recovery period will be gradual. As soon as the patient is out of shock and the electrolytes corrected, his sensorium will clear. Insulin may be unnecessary for some time, but the infusions should be continued until complete rehydration is achieved. If the patient is able to take fluids without nausea, hourly feedings of fruit juice or broth to which potassium has been added can be initiated. Lavage of an atonic stomach, often mentioned in the literature, is not recommended as it may cause aspiration pneumonia. Gastric atony seldom occurs when potassium has been used prophylactically in the infusions.

The third or convalescent stage of the treatment of diabetic coma is characterized by great variability. Diabetic ketosis is a catabolic episode which is marked by an excessive loss of nitrogen, phosphorus, and vitamins. The prescribed diet should compensate for these losses, i.e. it should be rich in minerals and vitamins and contain an extra amount of protein for a period of several weeks. The previously used doses of long acting insulin will seldom be sufficient and it is better to cover the body demands by regular insulin for a few days. The treatment of precipitating factors should also not be neglected. Special attention will be directed toward hidden infections or cardiovascular complications which may lead to relapse.

The treatment of diabetic coma presents a real challenge to the house staff and the attending physicians. Even the most skillful management will not be successful in all cases. However, correction of the basic metabolic derangements and alertness on the part of a team will save a great many lives.

**SUMMARY**

The outcome of diabetic coma depends upon the speed and adequacy of treatment. Employment of large doses of insulin, correction of fluid and electrolyte derangements, and proper handling of the complicating conditions such as shock and infec-

tions will lower the overall mortality rate. For practical purposes the treatment of diabetic ketosis is divided into three stages: the immediate emergency therapy; the management of the hyperglycemia stage; and the conduction of the recovery or convalescent period. The principles involved in handling the different phases of therapy are discussed.

**REFERENCES**


**Current Comment**

The Viewpoint of An Industrialist—

The president of the Autopoint Company, Mr. Jules W. Lederer, stated that the most significant change in business today is the consistency of change. Industry is confronted by a dilemma in an area of increasing costs and uncertain markets. Mr. Lederer predicted that there will be increased participation of government in medical care provision and that the medical profession should do a better public relations job to acquaint our people with the advantages of our voluntary system as opposed to other system of providing medical care.

**NOTICE TO ALL CONTRIBUTORS**

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.
MECHANISM OF ACTION of the
Oral Antidiabetic Agents
A Review

The following paper constitutes a review and coordination of known facts about the mechanism of action of oral antidiabetic agents, as revealed by an extensive literature. It seeks to summarize and coordinate our present knowledge of these agents with only indirect clinical application. Deficiencies in known facts about insulin are placed in highlight by attempts at comparison.

—EDITOR

In 1926 Frank introduced decamethylene-diguanidine (fig. 1) as an effective oral hypoglycemic agent in the treatment of human diabetes mellitus. Because of the manifest cytotoxicity of this and related compounds, however, and perhaps more important because they were introduced only shortly after the isolation of insulin by Banting and Best, investigation into this phase of antidiabetic therapy was shortlived. Diabetes was recognized as an insulin deficiency state; insulin at last was available and specific treatment at hand. Interest in the curious hypoglycemia of unphysiological and certainly toxic compounds was understandably slight.

However, the ensuing 32 years of clinical and research experience with diabetes mellitus have demonstrated that the human disease is anything but the simple insulin-deficiency state which exists in pancreatectomized animals. Evidence from a variety of sources now points to the existence of an underlying, poorly characterized defect of intermediary metabolism, which, under appropriate circumstances, may be complicated by insulin deficiency. Many of the puzzling clinical features of diabetes may ultimately be explained by such a basic metabolic derangement. The finding of diabetic vascular changes of the conjunctival vessels in non-diabetic children of diabetic mothers is indirect support for such a concept, as is the notoriously poor correlation between the incidence and severity of diabetic complications and the control or severity of the diabetic state.

Thus, the recent investigation of oral hypoglycemic agents has taken place and been reported in an atmosphere of dissatisfaction with existing concepts of diabetes and its control. It is this dissatisfaction, rather than the relatively minor convenience of oral therapy, which seems chiefly responsible for the extraordinary number of studies published on this subject in the last three years.

This review will attempt a synthesis and correlation of the welter of confusing and frequently contradictory reports concerning the mechanism of action of the currently important oral hypoglycemic agents. The structural formulae of several of these are given in figure 1. They fall into two rough categories: the sulfonylurea derivatives and the guanidine derivatives. The bulk of the clinical and experimental data accumulated to date deals with the sulfonylureas, particularly two sulfonylureas, tolbutamide and carbutamide. Since tolbutamide is the only one of these agents currently in wide clinical use, a consideration of its action will occupy the major portion of this review.

Sulfonylurea Derivatives. The ability of certain of the sulfonylureas to produce hypoglycemia was first appreciated in 1942, by Janbon and Loubatieres working with isopropylthiodiazole. In the ensuing four years, and despite the difficulties associated with the German occupation of France, Loubatieres published the results of a careful series of studies characterizing certain aspects of the mechanism of this hypoglycemia. A large fraction of the studies recently reported by investigators in this country has served only to confirm, for tolbutamide or carbutamide, what Loubatieres had established for IPTD a decade earlier. Without attempting an overly detailed analysis of the many published studies, the essential facts may be listed briefly as follows:

1. The sulfonylureas exhibit no primary insulin-like activity: They fail to produce hypoglycemia when administered to untreated pancreatectomized or alloxan-diabetic
mammals; and they have no influence on glucose utilization by distal tissues when injected into a peripheral artery. It was first concluded from these observations that the presence of an intact pancreas was required for hypoglycemic effect, but it now seems certain, both from experience with human diabetes and from animal studies, that the requirement is for insulin, per se, and that with a source of exogenous insulin definite lowering of the blood sugar is produced by the sulfonylureas, both in pancreatectomized animals and in human diabetics previously shown to be unresponsive to sulfonylureas alone.

2. In the presence of an intact pancreas, the sulfonylureas stimulate an acute release of insulin from the beta cells of the islets. This effect is demonstrated both by selective perfusion of the pancreatic artery and by cytologic studies revealing degranulation of the beta cells. This action has been held by Loubatieres to be primary, but the role of such stimulation in effective treatment of human diabetes is at best uncertain. The decreased pancreatic secretory reserve of most diabetics would seem to preclude this mechanism. This conclusion is further suggested by the fact that sulfonylurea responsive diabetics fail to show the rapid fall in blood sugar after intravenous administration of the drug that is found in normal subjects, and exhibit instead only a gradual fall over a period of 1-5 hours.

3. The fall in blood sugar after intravenous injection of the sulfonylureas is associated with little evidence of increased peripheral glucose utilization. Whereas there is perhaps more disagreement on this point than on any of the others, it is generally agreed that those evidences of increased glucose utilization which may be found are quantitatively much smaller than those observed with insulin-induced hypoglycemia of comparable extent. Thus, whereas insulin usually produces all of the following effects, most investigators have found little or no increase in peripheral A-V glucose differences, no increase in glucose disappearance rate, no increase in respiratory C14O2 derived from C14-labeled glucose, no increase in blood pyruvate or lac-

![Structural formulae of orally active hypoglycemic compounds.](image)

**Figure 1.** Structural formulae of orally active hypoglycemic compounds.
tate\textsuperscript{21-23}, no increase in uptake of C\textsuperscript{14}-labeled glucose from blood\textsuperscript{24, 25}, and little or no effect on the metabolism of insulin sensitive pentoses\textsuperscript{26}. A notable exception to these observations is the report of a fall in plasma nonesterified fatty acids\textsuperscript{27}, suggesting an increased glucose uptake by adipose tissue.

4. The acute fall in blood sugar following sulfonylurea administration is associated with a decrease or cessation of hepatic glucose production. This is indicated by the studies of C\textsuperscript{14}-glucose disappearance previously alluded to\textsuperscript{24, 25}, by the finding of a fall in hepatic V-A glucose difference and a rise in hepatic venous pyruvate after sulfonylurea administration\textsuperscript{9}, by in vitro studies which demonstrated a fall in glucose output by liver slices obtained from animals pretreated with tolbutamide\textsuperscript{8}, and by the demonstrated protection of liver glycogen reserves\textsuperscript{7}. From inhibition of the hyperglycemic responses to galactose and fructose loads\textsuperscript{29, 28, 29}, and from enhanced incorporation of C\textsuperscript{14}-glycine into liver slice protein\textsuperscript{9}, it is suggested that the sulfonylureas produce an increase in glycolytic activity and a diminution of both glycogenolysis and gluconeogenesis. Despite the decrease in glucose output, the hyperglycemic responses to glucagon, epinephrine, and the adrenal glucocorticoids remain normal\textsuperscript{21, 23, 30}. The effects of the sulfonylureas on the principal enzymes concerned with glucose release is uncertain: There is evidence both for decreased phosphorylase activity and decreased glucose-6-phosphatase, but it has usually been difficult to correlate these effects with hypoglycemia\textsuperscript{36-38}. It is highly significant that insulin itself produces qualitatively similar effects on hepatic glucose metabolism. Both the mechanism and quantitative significance of hepatic insulin action are still obscure, and thus more exact comparison between sulfonylurea and hepatic insulin effects remains impossible.

These four effects, each fairly well established, appear on the surface to contradict one another. In the fasting state, glucose is produced solely by the liver, and removed at an equal rate by peripheral tissues; thus hypoglycemia can result only by virtue of increased peripheral utilization or by decreased hepatic output. It is argued, therefore, that if stimulation of beta cell insulin release is the primary action of the sulfonylures, why cannot unequivocal evidence of peripheral insulin effect be regularly found; and, conversely, if inhibition of hepatic glucose release is the primary mechanism, why is there a requirement for the presence of insulin?

There is, however, no essential contradiction in this paradox. If careful distinction is made between peripheral and hepatic effects of insulin it becomes possible to fit virtually all of the known facts concerning sulfonylurea action into a single hypothesis. Thus, whereas peripheral insulin action is associated predominantly with increased glucose utilization, hepatic insulin action is characterized by decreased glucose production. The result in either case is hypoglycemia. Insulin released from the pancreas is delivered into the portal circulation and may be expected to produce a predominantly hepatic effect; only that insulin escaping clearance during its initial transit through the liver is available for peripheral action. Conversely, insulin injected into peripheral tissues or veins will be distributed to, and fixed principally by, peripheral tissues.

Thus, it is grossly inadequate to compare the effects of stimulation of beta cell insulin release with the effects of peripherally administered insulin. Indeed, the predominantly hepatic effects on glucose metabolism noted after sulfonylurea administration are precisely what would be anticipated from mild stimulation of pancreatic insulin secretion. It is probable that those peripheral effects which have been observed\textsuperscript{35, 34} are determined by the proportion of the released insulin escaping the liver. This latter assumption is in accord with the observation of Levine and co-workers\textsuperscript{35} that hepatectomy in dogs with an intact pancreas does not abolish the hypoglycemic response to tolbutamide. Presumably beta cell stimulation occurs as usual, but with the liver by-passed the effect is predominantly peripheral.

Whereas this hepatic-insulin effect following upon beta cell stimulation may prove to be a satisfactory explanation of the acute hypoglycemia produced in normal subjects, it does not explain the potentiation of exogenous insulin, the effectiveness of prolonged therapy, or the slow hypoglycemia observed in sulfonylurea-responsive diabetics. Observations dealing with these effects are not as complete as might be desired, but the available evidence is again compatible with a predominantly hepatic effect. This, together with the obligatory requirement for
insulin, suggests that the sulfonylureas, in addition to stimulating beta cell insulin release, potentiate hepatic insulin action.

The precise mechanism of this potentiation, if indeed it exists, is unknown; but it has been suggested by Mirsky and others that the sulfonylureas may inhibit the hepatic insulinase system, thus prolonging the effective contact of insulin with its receptor sites within or upon the hepatic cell. The sulfonylureas have repeatedly been demonstrated to be non-competitive inhibitors of this system in vitro, but the concentrations required have uniformly been considerably above therapeutic blood levels, and attempts to detect such inhibition in vivo, using the crude technique of insulin degradation have met with failure. Neither result serves to disprove the suggestion, however, both because there is never any assurance that in vitro conditions adequately duplicate conditions of intracellular enzymatic activity or that blood levels are representative of local concentration at the effector site, and because insulin degradation measures only proteolysis of insulin and is incapable of indicating nonproteolytic denaturation. An additional and very important limitation of insulin degradation is the fact that hepatic uptake of the peripherally injected labeled insulin may be estimated to be of the order of only 10-20 per cent, and therefore, even a 25-50 per cent inhibition of hepatic insulin degradation would probably be undetectable.

The significance of the insulinase system itself to mammalian carbohydrate metabolism has not as yet been definitely established, and thus the importance of sulfonylurea inhibition, if it exists, is even more uncertain. This does not, however, detract from the very reasonable possibility that the sulfonylureas do somehow exert a considerable and significant potentiation of hepatic insulin action.

In connection with the possibility of hepatic insulinase inhibition, it has been objected that if these agents inhibit insulin degradation, then they ought to produce clear-cut evidence of peripheral insulin-like action; and as has been seen, such action is not uniformly found. Such a position, however, is plainly untenable. Despite many uncertainties concerning insulin metabolism, there is no evidence to suggest that the liver is responsible for hormonal denaturation of insulin delivered to peripheral tissue; such insulin is rapidly bound to the cells concerned, cannot be removed by repeated washing, and is probably denatured in situ. Inhibition of hepatic insulin degradation should result solely in hepatic insulin effects, e.g. decreased glucose output, and not increased peripheral glucose utilization. So far as is now known, these "hepatic" effects are, in fact, observed with sulfonylurea administration to insulin-treated pancreatectomized and alloxan-diabetic animals and may reasonably be invoked to explain at least a portion of their therapeutic efficacy in diabetic humans.

**Biguanides.** The biguanides, of which the PEDG (fig. 1) is representative, are potent hypoglycemic agents and are active at considerably smaller dosages than the sulfonylureas. Perhaps chiefly because of associated gastrointestinal irritation, they are not yet in common clinical usage. The biguanides do not produce the cytotoxicity of the Synthalins, and, except for the possession of a terminal guanidine configuration, they are structurally unlike the latter compounds. However, since guanidine itself possesses hypoglycemic propensities, and because of common effects on respiratory enzymes, it is probable that their mechanisms of action is, in fact, similar to that of the Synthalins.

This mechanism seems altogether different from that of the sulfonamide derivatives. Unlike these latter, the guanidine derivatives accelerate peripheral glucose uptake, even in the total absence of islet tissue or exogenous insulin, and exhibit such activity even in vivo. Their action is unlike that of insulin in that tissue oxygen uptake is depressed. Steiner and Williams have shown that these effects are probably due to interference with electron transport in the cytochrome system, with a resultant shift to anaerobic metabolism and a greatly increased cellular demand for glucose.

**DISCUSSION**

Since the basic derangement which characterizes human diabetes mellitus is not yet understood, it remains impossible to define rational therapy or prevention. Whether or not the actions of these hypoglycemic agents can be explained, it is still not possible to relate these actions to the disease itself. In its simplest terms, the therapeutic effectiveness of these agents remains an empirical observation.
It has been proposed by Mirsky and others that diabetes may result from increased hepatic insulin destruction and thus decreased hepatic insulin effect for a given degree of islet cell activity. If this be the case, then the sulfonylureas, with their potentialization of hepatic insulin action, may well represent more rational therapy than the customary peripheral injection of insulin.

The fear that stimulation of beta cell secretion in a pancreas that has an already decreased secretory capacity may result in islet exhaustion is apparently not justified, at least in animals. Chronic administration to rabbits has produced no islet damage or deterioration of carbohydrate tolerance. More significant, Loubatieres and others have reported that IPTD exerts a curative effect in a small percentage of alloxan-treated animals which would otherwise have become irrevocably diabetic.

It is more difficult to relate biguanide action to the uncertain metabolic derangements of diabetes. The decrease in cellular oxidative metabolism produced by the biguanides corrects no known preexisting oxidative defect; and yet the increased peripheral glucose utilization represents, at least superficially, an insulin-like action.

Whatever the ultimate fate of the presently useful hypoglycemic compounds it now seems probable that agents of this general sort will find increasing usefulness, not only in the treatment of mild non-ketotic diabetes, but also in the control and possibly even prevention of the severe diabetic state.

SUMMARY

Two major classes of oral hypoglycemic agents, the sulfonylureas and the biguanides, are currently being employed clinically or undergoing investigation. The hypoglycemia produced by the sulfonylureas is associated with stimulation of beta cell activity, does not occur in the absence of insulin, and yet is associated with, at best, only slight evidence of peripheral insulin-like activity. Liver glucose production is decreased, glycogen stores preserved, and glycolytic metabolism enhanced. Perhaps these observations may be reconciled best by postulating a dual action for the sulfonylureas: mild pancreatic islet stimulation together with enhancement and prolongation of hepatic insulin action. The relative importance of each in the treatment of the diabetic human is uncertain.

The biguanides, on the other hand, produce increased peripheral glucose uptake in the absence of insulin and, at the same time, reduce aerobic metabolism. These effects have been attributed to inhibition of cytochrome activity.

It is impossible at this time to relate with certainty the effects of either class to the altered biochemistry of the diabetic state. The possible relationship of the sulfonylureas to abnormalities of hepatic insulin metabolism is discussed.

REFERENCES


**Current Comment**

**Blood Transfusions in Time of Disaster**

An effective blood transfusion program on a national scale must be established if blood is to play its ultimate role in the saving of lives during a national emergency, according to an article in the September, 1958, issue of *Military Medicine*.

Col. B. Kendrick, the author of the article, lists a number of requirements that must be met before a satisfactory blood transfusion program can be set up to cope with the mass casualties resulting from manmade or natural disasters. Some of these are an adequate donor population, facilities for a nationwide blood collection, and sufficiently trained personnel to collect blood in large quantities immediately after the development of the disaster. Also necessary is an organization to process and deliver the blood to the point where it is needed. In a nationwide emergency, centralized control would be necessary, according to the author, in order to insure the proper use and equitable distribution of blood and blood derivatives on a national scale.

Colonel Kendrick points out that this problem is important, not only for natural disasters, which might involve a hundred or a thousand casualties, but is essential for national survival if casualties due to enemy action should total as many as a million or more.
PRESENT STATUS of the

Oral Hypoglycemic Agents*†

THIS morning I want to tell you my ideas as to the present status of the new drugs for diabetes—the oral hypoglycemic agents. They are no longer entirely new, many of you have used them with your patients, but it may be of some advantage to give you a rundown on our experience which dates back now to December, 1955, when we first started using the drug which was known by the code name of BZ-55 or carbutamide, sponsored by Eli Lilly & Company and withdrawn by them somewhat less than a year later because of untoward toxic side effects. In late February 1956, our experience began with tolbutamide known by the trade name of Orinase and now available on physician’s prescription in any pharmacy in the country. I will mention them briefly at least two other drugs which have been and are being used.

We will review, for just a moment, the background of all of this. Ever since the discovery of insulin, patients have wanted something that could be taken by mouth. You all know the difficulties we have had with certain patients to persuade them to take advantage of the benefits of insulin. Insulin, however, is destroyed when taken into the stomach, and efforts along that line have proved futile.

Back in 1942, when the sulfonamides were being introduced for their antibacterial action, pharmaceutical houses carried out routine studies which showed that some of them were hypoglycemic agents; they lowered the blood sugar. Papers were published, for example from the laboratory of Eli Lilly & Company, and at the University of Montpellier in France, headed by Jabon and Loubatieres, studies were carried on over the years regarding these drugs. Nobody paid much attention to this until, in Berlin in 1954 and '55, extensive experiments with BZ-55 were carried out on patients and all you have seen since has developed.

It is worthwhile to take inventory of the present status, because items are appearing in the public press, in newspapers, magazines, and more recently in Reader's Digest with its vast world circulation; so it is doubly important that we all know exactly the status of these drugs.

We will consider, briefly, the chemical structure of the compounds that can be used as oral insulin substitutes. The first is carbutamide, now discarded in this country but used elsewhere in the world. It has the typical conformation chemically of a sulfonamide. There is a benzene ring, which is characteristic of the sulfonamides, and on the end are four carbon atoms. This is a beautiful compound—a four-carbon compound. It has an —NH₂ in the amino group. It is probably because of the presence of that —NH₂ group that this compound was found to be toxic. When, however, the same identical chemical is taken and instead of —NH₂, a —CH₃ group is substituted, one has Orinase or tolbutamide which differs from carbutamide in three important particulars: (1) it is less toxic, as I have suggested, probably because of this simple substitution in exchange for the nitrogen group; (2) it is somewhat less hypoglycemic; it does not cause quite as marked a fall in the blood sugar as carbutamide does; and (3) tolbutamide has no effect as an antibacterial agent.

Before going on to the third preparation in this particular group I would like to call attention to a third sulfa-like drug which is now being investigated and which perhaps some of the doctors in the audience are trying, a drug known as chlorbutamide. It is being sponsored in this country by Pfizer & Company and now recently named Dia-benase. A trade name has been chosen, but chlorbutamide is the chemical. It is like Orinase in chemical structure, a sulfa-like drug, except in place of the —CH₃ — the methyl group—it has a chloral group, a

ALEXANDER MARBLE, M.D.
Assistant Clinical Professor of Medicine.
Harvard Medical School
Boston, Massachusetts

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CL, and instead of four carbons it has only three. If you were writing the formula it would be CH$_3$ taken twice, CH$_2$. Those differences then indicate the composition of chlorbutamide or Diabenase about which you may soon be given literature from the drug companies on the three drugs, only one of which is available on the open market today.

The fourth compound is an entirely different compound. It is not a sulfonamide; it is not a sulfa-like drug at all; it bears no relationship to them. Thus far, it has not produced any important toxic effects. It goes by the code name of DBI because its chemical name is too long to say: N'-beta-phenethylformamidinyliminourea. This drug is being used in certain places over the country. In our group Dr. Krall has been responsible for the study of DBI for the past fifteen months, and he has perhaps 100 patients who have taken it for almost a year. It is hypoglycemic, does lower the blood sugar, and there are some patients in whom diabetes, or the blood sugar at least, can be controlled by its use. However, it is quite irritating locally and a sizable dosage is prevented because of nausea, vomiting, diarrhea, etc. Dr. Krall thinks that perhaps it smoothed out the course of unstable diabetes, particularly in children. This leads me up to my first point, namely, a 30-second summary of the German experience prior to our obtaining oral hypoglycemic drugs in this country.

You may recall that the Germans found these things:

1. That carbutamide and tolbutamide were effective in certain middle aged and elderly persons with diabetes of a mild nature;
2. That these drugs were not effective with children or in adults with the juvenile or the unstable type of diabetes;
3. They were not effective in ketoacidosis or coma;
4. They were likely not to be effective during and immediately following major surgery.

Those points still hold and we have added nothing to them. Those are the basic facts regarding the sulfa-like oral hypoglycemic agents, whether we are talking about carbutamide, tolbutamide, or chlorbutamide.

Since even amongst middle aged and elderly diabetics not all of them will respond, there must be some way of selecting patients. One common way is simply to take a patient who has diabetes, whether he is on insulin or not, start giving one of the drugs and see what happens. That sometimes leads to disaster, however, particularly if one has stopped giving insulin in order to try oral therapy, a procedure which I certainly do not approve. At this point it may be well to state that the danger in the use of Orinase will not come from the toxic effects of the drug itself but from the diabetic condition of the person on whom the drug may be unwisely used. Consequently, we have tried to establish a plan whereby we can select patients who may be responsive.

**Sulfonylurea Response Test**

We select a patient who has had no insulin for two days prior to the test day. On test day, with no insulin or breakfast, Orinase in a 3-gm. dose is given and the fall in blood sugar is noted after 2 hours and 4 hours. The fall in blood sugar after 4 hours is important.

If the fall in blood sugar following the dose of tolbutamide or Orinase was more than 40 per cent we used to think that that was a good indication that the person would respond favorably to the drug. Later on we found this was not a reliable guide; we had too many failures. So now, we insist that the test be considered satisfactory only if, in 4 hours, the blood sugar falls to normal. Regardless of how high the blood sugar is, if it is 200, it must fall to 110 or below in 4 hours; otherwise we consider the test unsatisfactory. That is a very simple way in which to judge whether or not the patient may be responsive.

In our hands this test has proved to be very useful, particularly for out-patients. We can have patients come to our office, have the test and wait until we know the blood sugar values. If the blood sugar does not come down or, as in some cases, it rises following a test dose, we give them insulin, their regular dose, or start them on insulin before they leave the office so that we know they are protected and we are not a party to producing ketoacidosis or coma which may result if patients are placed willy-nilly on these preparations without adequate protection and the use of insulin if necessary.
What may be regarded as proper control? We have divided our results into “Good,” “Fair” and “Poor.” These are for maintenance over weeks and months of time. For good results the majority of the blood sugars must be 110 or below in the fasting state and for 3 to 4 hours after eating; for fair results, 130 mg. or below at fasting and 3 hours or more after eating. All others would be considered poor control.

The intermediate values we will not discuss now because of time, but I think this is important: the physician treating a patient with Orinase or any other oral hypoglycemic agent must have adequate blood sugar control. It isn’t enough to have sugar-free urine tests because in the age group concerned, people in their 60s and 70s, the renal threshold for sugar often is elevated and it is not difficult to secure a sugar-free urine in elderly patients whose blood sugars may well range in the 200 mg. area. That is not good control. One must have adequate blood-sugar control as determined by periodic determinations and insist that the values are at a satisfactory level.

I will briefly give our experience as of just a very few months ago. At that time we had given the drug to somewhat over 1,000 patients and had actually started Orinase treatment in almost 800. But, after weeding out various groups that I will not go into at this time, there were 594 who had been treated for one month or longer and in some instances well over a year. Out of these there were 31 secondary unexplained failures and 9 due to lack of dietary control, a total of 40 out of this group who once having seemed to be controlled then slipped out of control. The name that has been given to this is “secondary failure” and is common parlance amongst those who are working in this field.

The Germans and others had reported, in some instances, very high numbers of secondary failures. However, I believe that if one selects his patients carefully, first confining his attention to middle aged and elderly diabetics with a low insulin dosage, say 20 units or less, or to people who ordinarily would take that much; and if he then carries out a response test; and only if the test is satisfactory you place the people on tolbutamide as maintenance treatment, his secondary failures will be relatively few. Indeed, you see that ours were somewhere between 5 and 10 per cent. On the average it runs around 6 or 7 per cent.

Out of this group then there was a total of 18.5 per cent with fair control and 52.6 per cent with good control — a total of about 70 per cent satisfactorily controlled. But, mind you, this does not mean 70 per cent of all diabetic patients. It is not true that the majority of diabetics can be controlled with an oral hypoglycemic agent, nor is it true that 70 per cent of them can. That is not what we are saying. Seventy per cent in this particular series of carefully selected patients did respond well on maintenance doses.

You may ask about what percentage of all diabetics might respond, and nobody knows because that would be a rather difficult study to set up. Just taking one person right after another, including children and everyone, would involve a great deal of useless labor, because you know in advance that many of these tests would be negative. My guess would be perhaps 15 or 20 per cent, but that figure has no validity. Certainly the majority of diabetics do not respond and in any percentage-statements made one must keep in mind the types of patients which have been chosen.

If we correlate the good control and the failures with the age at onset of diabetes, it is quite obvious that the successes which we had were in people in the age group of over 40 at the time of onset of their diabetes. One must keep in mind that the age at onset of diabetes is more important than the actual age of the patient. A patient that is now, let us say, 45 who has had diabetes for 20 years, therefore had the onset at age 25. This patient certainly will not be a good candidate for Orinase; but the person at age 45 who has just acquired his diabetes might be a suitable candidate. So it is the age at onset of diabetes that is much more important than the actual age of the patient. The younger person will have unstable diabetes, an easy tendency to acidosis, and probably will be entirely unsuited for the pills.

Those patients with the smaller insulin doses, certainly below 40 units per day and particularly below 20 units a day, are the ones in which one secures good control with the oral agents.

We encounter very, very few untoward effects with Orinase or BZ-55: skin rash,
nausea, vomiting, jaundice, hypoglycemia, and so on are seen on rare occasions.

In the case of hypoglycemia the question is often asked: Do patients who take Orinase truly have low blood sugar values? Yes, at times they may, but we have had a very, very low incidence of symptomatic hypoglycemia, therefore, from the practical point of view, with the usual dosage of Orinase it is not an important consideration. It is certainly uncommon. The usual maintenance dose is one or two tablets, that is to say, 0.5 to 1 gm. of Orinase daily, and usually if as much as 1 gm. (2 tablets) daily, before breakfast, does not suffice for control of the blood sugar and urine sugar, higher doses will not. As you well know, there is no advantage in the taking of Orinase if one gives doses higher than 2 gm. a day, and I certainly would not keep any patient on doses higher than 2 gm. a day for any extended period of time.

How do these drugs work? We cannot go into all of this this morning but will call your attention to the commonly held idea regarding the mode of action of oral hypoglycemic agents. There is a great deal of evidence to suggest that they act by stimulating the release or the production of insulin through the pancreas. That means, of course, that the person concerned must have a pancreas capable of producing insulin. The drugs do not work in depancreatised men or animals. They do not work in most children because diabetic children, after 4 or 5 years, come to the stage in which they can make little or no native insulin.

The other site of action is probably the liver. The drugs probably act by cutting down on the output of glucose from the liver by inhibiting enzyme activity. As you all know, one of the characteristics of diabetes is the over-production of glucose from both carbohydrates and noncarbohydrate sources in the liver and that this process is controlled by enzyme action. There is a good deal of evidence to suggest that these drugs work, at least in part, by inhibiting such enzyme activity.

A study was made that illustrates the point I have tried to make about children. This was a study in which the one-dose response test was carried out with a group of diabetic children. On a given day they had no breakfast or insulin, were given a certain dose of BZ-55 or Orinase, and 4 hours later another blood sugar determination was obtained and the type of response tabulated. Those children who had had diabetes for just a short period 90 per cent had a rather decent fall in blood sugar. Of those with diabetes of over 5 years duration, a mere 6 per cent, a negligible number, had a satisfactory fall in this one-dose test. This again suggests that the drugs may act by stimulating the production or release of insulin through the pancreas because, in these children with diabetes of rather recent onset, there is every indication they have a significant capacity to produce insulin, whereas after 4 or 5 years of diabetes that capacity has been lost.

Before speaking of the summary, and that will take me just a moment, I want to emphasize a few "DON'TS" for the practicing physician.

1. DON'T use the drugs in patients whose age, type of diabetes, and insulin dosage suggest that the drugs will not be satisfactory. Try to limit the group of people whom you start the drugs.

2. DON'T use the drugs if a restricted diet alone will suffice. Very often if you will just take the time and keep after the patient to stick to his restrictive diet he can get along very well and his diabetes will almost disappear without insulin, drugs, or anything else. For such a patient it would be an unwarranted effort and expense to use oral hypoglycemic agents.

3. DON'T neglect the blood sugar control. Carry out periodic determinations of the blood sugar, not only at fasting but at other times of the day.

SUMMARY

In summary, the statements are on the whole much as I have previously made them:

1. The drugs are effective in many but certainly not all middle aged and elderly diabetics.

2. The drugs are not effective in children or in adults with the unstable type of diabetes.

3. The drugs are not effective in ketoacidosis or coma, or during or immediately following major surgery.

4. A single dose response test gives a very good idea as to whether the drug will be effective, and this test affords the physician
a means of keeping close watch on the patient during this brief transition period and protects against ketoacidosis and coma in the patient who otherwise might be an unwise choice.

5. The incidence of untoward effects in therapy with Orinase is very low.

6. The mechanism of action is not clear; may act by stimulating production or release of insulin in pancreas or by inhibiting action of enzymes in liver.

You may ask: Over twenty years of time may there not appear toxic effects from these drugs which are not apparent after just a few months or years? Yes, that is possible. We have to live through those years to find out.

Second, you may ask: Will the drugs protect the diabetic from the complications over the long pull? Will they protect against retinopathy and nephropathy? We don’t know.

You may ask: Does the simple fact that the blood sugar and urinary sugar clear up mean we are controlling diabetes, basically and fundamentally? We don’t know that. There are many uncertain areas. All one can do is work one’s way along with preparations which seem effective and which seem to provide, in the ordinary sense of the word, good control of diabetes and whatever the action of these drugs may be, whatever the site of action, and whatever their eventual place may be in the treatment of diabetes, certainly they have stimulated a great deal of productive activity in this field and already the dividends, in terms of results of research work, have been tremendous.

The USE and MISUSE of the

Sulfonureas

in Diabetes

Doctor Henn relates, succinctly, when and how to use and when not to use oral hypoglycemic agents in treatment of diabetes. She makes clear the means of selecting cases that may be treated by oral medication and the proper manner of management of patients to whom we give the sulfonylureas. A case is cited to illustrate their misuse.

—EDITOR

In 1922, when Banting and Best first successfully extracted insulin from the pancreas, a whole new world opened up for unfortunate patients suffering from diabetes mellitus. Prior to the discovery of insulin, patients with diabetes were considered to have a dread disease and few lived very long after its onset. With insulin, the entire outlook changed. However, patients, clinicians, and research workers have not been content to stop and accept the daily insulin injections, but rather have continued to search for an effective oral agent which would be hypoglycemic in its effect and helpful to patients with diabetes mellitus.

Many compounds were tried and discarded primarily because of their extreme toxicity and then, in 1942, M. Janbon noted hypoglycemic effects of certain sulfonamides being tried in the therapy of typhoid fever. Following this, Loubatieres, working in France with an isopropyl thiazolozed noted hypoglycemic effects and at about the same time German scientists looking for soluble sulfonamides similar to Gantrisin, likewise noted hypoglycemic reactions in some of their patients. Their attention was then turned to intensified research in diabetics with one of these known as BZ-55 or Carbutamide, and very soon after this to a second compound D-860, tolbutamide or Orinase. After clinical trial in approximately 10,000 cases, here and abroad, Carbutamide was withdrawn from further clinical testing, early in 1957. Such action was deemed advisable because of an incidence of side effects of at least 5 per cent. Orinase had proved to be less toxic and was therefore released for general prescription purchase. Reported side effects from Orinase have been milder and probably have an incidence of less than 3 per cent.

Currently, there are several other compounds under intensive scrutiny. One which shows a great deal of promise is chlor-
propamide. Much more clinical testing will be done before this drug will be released for general use, but it is an additional hopeful for it is reported to have, potentially, a somewhat wider range of usefulness than the earlier drugs.

It is not within the scope of this paper to discuss all of the voluminous research regarding the mode of action of the sulfonureas, specifically Orinase. Several facts should be made clear, however. While the exact mechanism or mechanisms of action are not known, for certain, there is evidence that Orinase stimulates the beta-cells of the Islets of Langerhans to produce more insulin. Animals without a pancreas show no hypoglycemic effect of a dose of Orinase. Others have shown that in contrast to the pancreas it does not appear essential for the animal to have a liver and the sulfonureas are still active in the absence of adrenals, gonads, the hypophysis, and the thyroid. It appears that endogenous or exogenous insulin at certain dosage levels is necessary for the action of these compounds. The drugs do have at least one known activity in the liver, that is, it has been shown that they may lower blood sugar by blocking the output of glucose into the blood stream. This refers to glucose stored in the liver.

INDICATIONS FOR USE

It should be kept in mind that oral hypoglycemic agents, while convenient, are not insulin but a type of sulfonamide drug and have little more than a superficial resemblance to the action of insulin. Because of this, they cannot be called upon to substitute for insulin if no insulin is available to the body. As noted above, the presence of some functional islet-cell tissue is necessary or no hypoglycemic effect can be produced. Under these conditions, it becomes obvious that only certain diabetics will respond in a satisfactory manner to their administration. It has been shown that the patients who have acquired their diabetic state as adults usually have variable amounts of insulin present in the pancreas, in contrast to the juvenile diabetic who has little or none. Specifically, the most likely candidates for therapy with the sulfonureas are diabetic patients who have acquired diabetes at forty years of age or older, who are not excessive-ly overweight, whose diabetes is of the stable type, who have no acute complications, and who require insulin in limited amounts to control the diabetes if they are to maintain adequate nutrition. There are other instances where oral hypoglycemic agents may be considered a likely boon; this would be especially true for the stable type of diabetic who is handicapped. One particularly frequent handicap might be visual impairment of such an extent as to preclude accurate measurement and administration of insulin. Another segment would include patients whose level of intelligence would preclude proper self insulin therapy.

CONTRAINDICATIONS

Nearly 80 per cent of adult diabetics are obese. Obesity is, in itself, not an absolute contraindication to the use of oral hypoglycemic agents, but such use is a definite abuse of these drugs. For these patients, the drugs may be used as a temporary measure until such a time as weight reduction achieves control of the diabetes, and the drug can then be discontinued. Physicians should not yield to the temptation to give the drugs rather than encourage weight reduction. Obesity is known to contribute to the development of degenerative changes and, therefore, should be discouraged actively rather than ignored. One author has described this practice as “powdering the dirty face rather than washing it.”

Although not a contraindication to institution of therapy in the proper type of patient, it is important to mention that, once begun, patients should be followed carefully for the development of so-called tolerance or resistance to earlier effectiveness. A number of reports are appearing from time to time of patients who have had to return to insulin therapy after an initial, seemingly favorable, response. Such cases appear to develop in approximately four to ten months after initiation of therapy.

There are several very definite and absolute contraindications to the use of hypoglycemic agents currently extensively studied. First of all, the juvenile, labile diabetic. Diabetes of this type is considered to be very nearly or completely insulin deficient and, due to this, no hypoglycemic effect will be noted by using sulfonureas. There is hope that future agents may have effectiveness in these people not possible with the drugs presently available. A second group would be patients who are diabetic following pancreatectomy or pancreatic disease. Further, one must include patients
with acute infections, and those prone to ketosis. Patients who have previously been controlled on sulphonurereas should be returned to insulin therapy before surgery and the period of early convalescence. Tolbutamide has been found by some to be ineffective for the hyperglycemia of hyperadrenocortic-ism and acromegaly, but others have reported satisfactory control.

Given a patient who seems to be a likely candidate for oral therapy, according to criteria outlined above, and one who has no serious contraindications, a trial of therapy may be instituted. There have been sulphonurea-response tests divised by Dr. Garfield Duncan and others wherein the drug is given in one full dose followed by blood sugar determinations over a period of several hours. These are useful tests, but it has since been shown that there is a delayed response in some patients, and, therefore, these people would be eliminated by such a short test. It would perhaps be more reasonable to continue medication for a period of one to two weeks before considering the response a failure. During such time, frequent fasting and postprandial blood sugars should be checked and careful regular tests for glycosuria and ketonuria should be made. Increasing ketonuria would be a definite warning to resume insulin therapy at once.

**ILLUSTRATIVE CASE**

The following case illustrates the misuse of Orinase.

Mrs. Margaret W., a 45-year-old white woman, was admitted to the University Hospital December 10, 1957. Her chief complaints were loss of weight, weakness, fatigueability, increased thirst and output of urine of one month duration.

Mrs. W. had been a known diabetic since 1951. She stated she had been getting along very well since her initial regulation on diet and 50 units of insulin daily. She checked her urine daily by Clinitest and would only have positive tests occasionally, if she were careful to follow her diet.

Approximately one month prior to her admission, her local physician placed her on Orinase, one tablet three times daily. Her insulin was discontinued. Within a very few days her Clinitests became increasingly positive and in the two weeks prior to admission had been 4+ daily. At about the same time she had noted increasing thirst and frequency of urination. In the week prior to admission, thirst, weakness, polyuria, nausea, and some vague abdominal pain became increasingly more marked. Her weight had fallen from 128 pounds, two weeks prior to admission, to 108 pounds at admission. A blood sugar done in her home community was reported to be 250 mg per 100 ml. the week before coming to the hospital.

At the time of admission, her physical examination was essentially negative, except for signs of dehydration and recent weight-loss. She was friendly, cooperative, and well oriented. Her blood pressure was 110/80, pulse 80/min., temperature 98.6° F., and respirations 20/min. No diabetic retinopathy or neuropathy could be demonstrated. Slight tenderness to palpation was noted in the R.I.Q. of the abdomen, but no abnormal masses were felt.

**Laboratory Data on Day of Admission.** The urine was straw-colored and clear; its specific gravity was 1.017; it contained albumin graded 1+, sugar, 4+, and acetone. Chemical examination of the blood revealed a carbon di-oxide combining power of 11.6 mEq/L.; chlorides, 104 mEq/L.; sodium, 150 mEq/L.; potassium, 4 mEq/L. and glucose, 315 mg, per 100 ml.

On the ward, therapy was begun to rehydrate her and she was put on regular insulin. She rapidly improved on this regimen and was again regulated on 50 units of N.P.H. insulin daily. She was dismissed to her home physician with the recommendation that she be continued on insulin therapy because, in our opinion, she was not a suitable candidate for Orinase therapy.

**SUMMARY**

It is hoped that in this brief paper pertinent features of oral therapy for diabetes have been stressed. These can be summarized as follows:

1. Sulphonureas are not insulin, nor do they act like insulin.
2. They are not cures for diabetes mel- litus.
3. They are most effective in controlling diabetes in older, stable, diabetic patients, and are not effective in juvenile diabetics or older patients who acquired diabetes when they were young.

4. When diabetes can be controlled by diet alone they are unnecessary and should not be used.

5. Sulfonureas are ineffective during acute complications such as acute infections, surgical procedures, and ketosis.

6. In some patients, the drug seems to lose its effectiveness in four to ten months.

7. The use of such oral agent does not reduce the need for strict attention to diet and frequent urine tests for sugar and acetone. The latter are of special importance in the first week or so of oral therapy.

8. It is well to caution all physicians to see their patients frequently in the early weeks of treatment to ascertain also, if the patient is developing any signs of drug idiosyncrasy.

PALLIATION OF METASTATIC

Breast Cancer*

Doctor Davis emphasizes the possibility and need for palliative therapy, rather than "anodynes" to control pain, in incurable cancer of the breast. With proper selection of such palliative treatment, life may not only be prolonged but made much more comfortable. The author enumerates the methods that may be used in palliation and urges the consideration of them all rather than the special procedure of greatest interest to the physician who happens to be in charge of treatment.

---EDITOR

INTRODUCTION

Breast cancer is the leading cause of death among women in the mid-period of life and represents 21.7 per cent of all cancers in females. It is, therefore, factual that the palliative treatment of far advanced, recurrent, and metastatic breast cancer has become a problem of major magnitude in clinical practice.

Until a few years ago women with far advanced carcinoma of the breast were given anodynes to control their pain and were advised to get their affairs in order. These unfortunate women often had lingering, painful terminal illnesses with long periods of invalidism often in a hospital causing immeasurable mental anguish and financial burden to their loved ones.

Today, even though there is no cure for these patients, there are a number of mechanisms by which they can be palliated. By palliation is meant the relief of painful and disabling symptoms and the prolongation of useful life expectancy, saving mental anguish and financial burden.

In discussing the various modes of palliation, reference is often limited to the one with which the author is primarily interested; thus, the radiologist refers only to radiation therapy, the internist to drug therapy, and the surgeon to surgical therapy. Since each case presents different findings, no one form of therapy should be uniformly applied.

The purpose of this presentation is to outline the various modes of palliative treatment known at this time and to indicate their particular uses and advantages. It is not my intention to burden you with statistics, historical background information, or ultra-scientific data which is readily accessible to all of us in the current literature. The only conclusion I will attempt to draw is that there is much we can do at the present time to achieve worthwhile palliation of disseminated breast cancer.

OUTLINE

In discussing the problem of palliation of breast cancer, the various available procedures can be grouped under three clinical headings: Irradiation (external and radioactive isotopes); Drug Therapy (hormones and chemotherapeutic agents); and Surgery (ovariectomy and adrenalectomy, and hypo-
physeotomy). I will attempt to discuss each of these separately using illustrations wherever possible. In many cases the illustrations will not come from my clinical material and in those cases I will give credit to the appropriate source.

IRRADIATION METHODS

External Irradiation

In brief, external irradiation has its primary usefulness in healing ulcerating lesions and in controlling local bone-pain.

Small doses of external radiation to breasts containing large malignant masses, or to large internal mammary lymph nodes visible para-sternally often prevents ulceration of the skin by delaying their growth.

If the patient presents with already ulcerating lesions, moderate doses of external radiation in conjunction with hormone administration is effective in aiding re-epithelialization and healing of the ulcer. The drainage, odor, and pain are thus controlled.

Healing of pathological fractures, particularly of long bones, is hastened with external radiation and often converts a bedridden patient to an ambulatory one.

Radioactive Isotopes

The serosal application of colloidal isotopes has proved to be of value in the treatment of pleural and peritoneal effusions that are the result of metastatic breast (and other) tumors. The principle is to irradiate the serosal surfaces with beta particles producing an intense layer of ionization over a large surface area. The two most commonly used radioactive isotopes are gold (Au$^{198}$) and phosphorous (P$^{32}$).

Beta particles penetrate to a maximum tissue depth of about 5 mm. with about 90 per cent of the ionization occurring in the first millimeter. The gamma rays, present in radioactive gold, penetrate farther, but their contribution to serosal radiation is negligible. Radioactive phosphorus has the advantage of being a pure beta emitter, but without the gamma rays to check its distribution it often clumps and flocculates, giving less ideal distribution.

Radioactive phosphorus may be given intravenously and, since it is metabolized in bone and actively reproducing tissue, can often cause temporary palliation of bony and soft tissue metastases. The usual dose is four millicuries for the average adult weighing 120-175 pounds (50-80 kg.).

Radium may be used as interstitial implants, in the form of needles, grains, and seeds, to control local recurrences of the tumor in skin and subcutaneous areas.

DRUG THERAPY

Hormone Therapy

In 1896, Beatson removed the ovaries in some women with advanced carcinomas of the breast. He reported marked improvement in the carcinomas, and this was the beginning of our concept that certain tumors of the breast in younger women depend upon ovarian secretion of estrogen. When the male sex hormone became available to clinical medicine it was found antagonistic to estrogen in several particulars and has also been found, in certain cases, to help control carcinoma of the female breast in the premenopausal age.

In recent years numerous investigators have experimented with the hormones, estrogen and testosterone, in the palliation of advanced breast cancer. The results can in no way be referred to as spectacular, but in many cases gratifying palliation is obtained.

At present the feelings are that estrogens should not be used in women less than five years past the menopause. When properly used the estrogens are found to be somewhat superior to the androgens in their objective effects on lesions in soft tissues and visera. The androgens are somewhat more potent by subjective criteria, often affording relief of bone-pain in cases where X-ray therapy has failed. Regression of the tumor sometimes occurs, also, upon the discontinuation of hormone therapy that has been ineffective or has ceased to maintain an initial improvement.

The usual dose of estrogen is stilbestrol 5 to 50 mg. four times daily. Testosterone propionate should be given in doses of from 100 mg. three times weekly up to 300 mg. daily.

Chemotherapeutic Agents

(Alkylating Agents)

Cancer results from the ability of bodily components to grow, divide, and invade without regard to ordinary restraints. This
is a property of the individual cells concerned and one which is hereditary, being passed from parent cell to offspring. The inherited cellular properties derive largely from the nuclear material of the cell and are complex chemicals known as the nucleic acids.

The so-called alkylating agents have a selective toxicity for rapidly proliferating cells, possibly by producing enzyme inactivation. The cellular damage resembles that caused by radiation.

The most commonly used alkylating agents today are nitrogen mustard and triethylene thiophosphoramide (ThioTEPA), and TEPA and triethylene melamine (TEM) are also being used.

Nitrogen mustard can be administered intravenously or intracavitarily. The former route is indicated to attempt to palliate diffuse disease whereas the latter is used to control ascites and pleural effusions.

ThioTEPA may be given intravenously, intramuscularly, intracavitarily, or directly into a tumor mass. In many cases dramatic objective improvement occurs as evidenced by regression of enlarged nodes and tumor nodules and healing of ulcerating recurrent lesions in the breast scar with relief of pain.

Nitrogen mustard has been most effective in controlling pleural and peritoneal effusions when given intracavitarily, diluted in saline. ThioTEPA has been most effective in controlling recurrent lesions in the chest wall and lymphatic metastases.

The dosage schedule for nitrogen mustard is 0.1 mg./kg. body weight intravenously for four doses making a total of 0.4 mg. nitrogen mustard/Kg. body weight. When given into the pleural or peritoneal cavities the total dose is two times the systemic dose (0.8 mg./kg.) diluted in 100 to 300 cc. of saline.

ThioTEPA is dissolved in physiological saline and prepared in concentration of 10 mg. to each milliliter (cc.). In general, 1 mg. of ThioTEPA is given intravenously for every 1000 white blood cells in the peripheral white blood cell count. The maximum dose for any single daily injection should not exceed 10 mg. If the leukocytes number 3500 or less, no drug is to be given. When given directly into recurrent lesions of the chest wall, undiluted amounts of 2 to 5 mg. may be given and repeated at regular intervals until the lesion completely regresses.

Since both of these drugs depress the hematopoetic system, daily leukocyte counts must be obtained and the drug discontinued if the count drops to 3500.

**SURGERY**

**Estrogen Ablation by Ovariectomy and Adrenalectomy**

Estrogens have definitely been proven to be carcinogenic and have a decided role in the production and maintenance of many breast cancers. The ovaries are the primary source of estrogen in the body and these were removed for palliative treatment of breast cancer as early as 1896. Over the years, however, it was noted that after bilateral ovariectomy there was often a remission followed, in time, by a later relapse. On the theory that the cancer was again activated by fresh hormones released from elsewhere in the body, Huggins, in 1951, performed adrenalectomy in addition to castration. This was followed by another remission in a large percentage of cases.

Not all cases benefit by this form of therapy, and, unfortunately, there is no good yardstick by which they can be chosen. In reviewing the reported cases in the literature the average operative mortality rate is 4 per cent and the average remission rate is 54 per cent.

Surgical ablation of the ovaries is superior to radiation methods for two reasons:

1. Surgery produces immediate effects, which is desirable, whereas radiation produces a delayed effect taking at least ten weeks.
2. Some ovaries are radioresistant. There have been recorded cases of pregnancy after delivering 1500 r. to the ovaries.

**Hypophysectomy**

Hypophysectomy achieves complete sex-hormone control by eliminating gonadotropic and adrenocorticotropic hormones, and dispenses with the other pituitary hormones associated with breast cancer. Pituitary ablation has induced remissions for as long as thirty-two months in patients with metastatic cancer of the breast.

Surgical ablation of the pituitary is superior to radiation methods as the pituitary
is quite radio-resistant. Five thousand to six thousand patients does not entirely suppress its endocrine function and may cause brain damage. When the hypophysectomy is complete, the patient will develop myxedema and diabetes insipidus, as well as adrenal cortical insufficiency. These patients have to be maintained on cortisone, desiccated thyroid, and pitressin. If the adrenals are not removed there is no alteration in salt balance.

Because of the magnitude of this operative procedure and the complicated post-operative management, it has been reserved as a “last ditch” stand in the treatment of disseminated breast cancer. Failure of the patient to respond to androgen or estrogen therapy or to previous ovariectomy and adrenalectomy does not mean that the patient will not benefit from hypophysectomy. It is quite possible that, in time to come, this mode of treatment will prove to be the most efficacious and that it will be performed earlier in the course of the disease.

SUMMARY

At this point we can recapitulate the various modes of palliation by listing the possible forms of treatment for several types of patients with recurrent or metastatic disease. Since each patient in each category will present his own unique problem, no effort is made to list these in order of choice.

I. Local recurrence in the chest wall—
   a. Surgical excision and skin graft;
   b. Interstitial radium implants;
   c. External radiation;
   d. ThioTEPA (I.V. or directly into the lesion);
   e. Hormones;
   f. Ovariectomy and adrenalectomy;
   g. Hypophysectomy.

II. Diffuse lymph node metastases—
   a. Hormones;
      1. Testosterone in pre-menopausal age;
      2. Estrogen in post-menopausal age;
   b. ThioTEPA—intravenously;
   c. Ovariectomy and adrenalectomy;
   d. Hypophysectomy.

III. Visceral metastases (lung, liver, etc.)—
   a. Hormones;
   b. ThioTEPA intravenously;
   c. Ovariectomy and adrenalectomy;
   d. Hypophysectomy.

IV. Inflammatory carcinoma—
   a. External radiation;
   b. Hormones;
   c. Ovariectomy and adrenalectomy;
   d. Hypophysectomy.

V. Pleural or Peritoneal effusions—
   a. Intracavitary nitrogen mustard;
   b. Intracavitary radioactive gold, phosphorus (or chromium);
   c. Hormones;
   d. Ovariectomy and adrenalectomy;
   e. Hypophysectomy.

VI. Isolated bone metastasis—
   a. External radiation;
   b. Nitrogen mustard intravenously;
   c. ThioTEPA intravenously;
   d. Hormones;
   e. Ovariectomy and adrenalectomy;
   f. Hypophysectomy.

VII. Multiple bony metastases—
   a. Hormones;
   b. ThioTEPA intravenously;
   c. Radioactive phosphorus (P32) intravenously;
   d. Ovariectomy and adrenalectomy;
   e. Hypophysectomy.

The important point is that there are a number of ways to afford palliation to each of these patients. If one method chosen first fails, one can resort to one or more of the remaining forms of palliation.

CONCLUSION

Throughout the history of breast cancer one principle remains unchanged. The ideal treatment of cancer is early, complete, surgical extirpation. It is only when the disease has progressed beyond operability that the less decisive, or palliative, measures remain as a further recourse. The most vital progress in the management of malignant disease rests with early diagnosis and forthright surgery. But, in the less fortunate cases, palliative management affords a longer period of acceptable health and freedom from pain before the patient becomes cachetic and moribund. This is much less than a cure of cancer, but to the individual patient it is still a great deal.
The SURGICAL TREATMENT of

Gallbladder Disease*

The function of the gallbladder is essentially the concentration and storage of bile secreted by the liver. The bile is concentrated to an eighth or tenth of its original volume in the gallbladder and is released into the intestine upon the stimulus of food. This concentration of bile is accomplished mainly by the absorption of water and electrolytes. Bile pigments are not reabsorbed at all.

It can be argued that the gallbladder is a nonessential organ, since many people have lived apparently perfectly normal lives, after having had the gallbladder removed. Several species of animals do not even have a gallbladder and it may be present or absent in species closely related to each other. The mouse, for example, has a functioning gallbladder, while the rat has none.

Since the human being can get along quite well without a gallbladder, as a rule, I believe there should be no hesitation about removing this organ when it has become a threat to the patient's health or to his life. Some disturbances of the gallbladder can be treated by medical means alone. For example, the gallbladder in which no stones can be demonstrated, but which appears to concentrate poorly, should be treated medically. Here is where many mistakes are made. The general tendency is to treat such patients with a low fat diet and not much else. This is not the place to go into this particular subject in detail, but thoughtful investigators of this problem believe that gallbladder function can be improved and symptoms relieved by a more physiologic approach which would include, among other things, a high fat diet.

Surgical treatment for gallbladder disease should be undertaken, of course, only on clear indications. There is an old surgical adage to the effect that the most satisfactory cures are achieved in those with the most patho-anatomy to be removed. A word of warning may be inserted here. All fair, fat, forty, flatulent and fertile females who have right upper quadrant discomfort, belching, and so forth, do not necessarily have gall-

bladder disease. If a normal cholecystogram is obtained, surgical treatment will not relieve her symptoms, and ill-advised surgical intervention will probably make her worse. These individuals can be very difficult patients, and to arrive at a diagnosis and satisfactory treatment can be very trying for physician and patient alike, since psychological difficulties, allergies, obesity, anatomic variations, and other conditions may cause the symptoms.

GALLSTONES

Stones in the gallbladder are, in my opinion, always an indication for cholecystectomy. Admittedly, conditions may exist which contraindicate surgery, such as old age, severe cardiac disease, or other disorders which make the risk to the patient too great. The so-called "silent gallstone" has been a subject of considerable debate, and internists, especially, have stood like plumed knights, arms outstretched before the castle gates, protecting the innocent possessor of a "silent gallstone" from the fiercely aggressive surgeon. I cannot help wondering at this, since carefully taken histories in such cases will reveal that these gallstones are not so silent after all, and will make themselves heard, if one will listen. In my experience, very few of them are asymptomatic, and when one considers the potential for harm in the presence of gallstones, surgery seems the lesser evil. It is a harrowing experience, which I have had many times, to operate upon patients who have been known to have gallstones for years and to find carcinoma of the gallbladder, usually far advanced and incurable, or some other serious situation which could have been prevented, had cholecystectomy been performed years before, when the patient was younger and in much better condition to withstand the operation.

ACUTE CHOLECYSTITIS

Acute cholecystitis, or the sudden onset of severe right upper quadrant pain, usually

*Read before Annual Convention Nebraska State Medical Association, May, 1955.
with vomiting, is something of a misnomer. It is almost always caused by a gallstone, impacted in the ampulla of the gallbladder and causing obstruction, followed by edema, and venous, and later, arterial occlusion. Infarction of the gallbladder wall results. Infection is seldom a factor in acute cholecystitis, except as a secondary and late occurrence. The chain of events is almost entirely on a mechanical basis. Cultures taken of the contents and walls of gallbladders which were removed early have been almost uniformly sterile. Here, again, the culprit is the gallstone. Perforation of the gallbladder occurs fairly frequently; I have seen gallstones present in adhesions at a distance from the gallbladder, on several occasions, indicating previous rupture and spontaneous healing.

Early operation for acute cholecystitis is, in my opinion, the treatment of choice. By early, I mean within the first twenty-four to seventy-two hours following the acute onset. If operation is done early, it may be technically quite easy, because planes of cleavage can be opened with facility due to the edema, and the gallbladder and cystic duct may be dissected from adjacent structures with little difficulty.

However, if five or more days have elapsed since the beginning of the attack, the edema and fibrinous exudate will be organized and the planes of cleavage obliterated and densely adherent. Operation at this time is obviously much more difficult and it would be better to wait several weeks or months, if this is possible. Early operation does not necessarily mean soon after admission to the hospital, since the patient may not have been admitted until several days after the onset. Early operation for cholecystitis, then has the advantage of being technically easier, of saving the patient days of severe pain, of preventing depletion of the patient by long illness; the result is that he undergoes the operation in good condition, and a definite cure results in most cases. As for cholecystostomy, I consider it most unsatisfactory and do it only rarely, in a few situations where it is absolutely necessary. It should also be said that the operator who is inexperienced in gallbladder surgery, when faced with a very sick patient, especially one with other complicating disorders such as cardiac disease, would do well to drain the gallbladder under local anesthesi, thus making the best of a bad situation.

**JAUNDICE**

When faced with a patient who has jaundice, the physician naturally asks himself at once, “Is this jaundice due to intra- or extra-hepatic disease?” “Will surgery be necessary?” The old aphorism that jaundice is never a surgical emergency should probably be remembered by all of us. There is time to study the patient thoroughly and then decide on the proper treatment. Chemical blood tests may help in differential diagnosis. On the other hand, they may prove confusing — the virus of hepatitis may attack the liver in different areas. If necrosis of the liver parenchyma occurs, the cephalin flocculation will become positive quite early, and the thymol turbidity becomes positive.

With a patient who has a positive cephalin flocculation and jaundice, it is not wise to rush into operation. On the other hand, the hepatitis virus may attack the cholangioles, the small collecting biliary tubules, causing swelling and producing intrahepatic obstruction, which can mimic extrahepatic obstruction in every way. In these cases, the cephalin flocculation may be negative, and the elevated alkaline phosphatase and serum cholesterol point to an obstructive process.

I feel strongly that needle biopsy of the liver, especially on a patient with jaundice, is dangerous. Bile peritonitis and bile embolization may result. Besides, the needle biopsy of the liver may well be inconclusive, since the lesion in the liver, swelling and infiltration of portal triads, is found in both extrahepatic obstruction and viral cholangitis. It is, therefore, better to observe the patient, employing repeated tests, and if the degree of jaundice continues to increase, the alkaline phosphatase continues to rise, the urine continues to show bile, and the stools show the absence of urobilin, the indications point more and more toward surgical exploration.

In hepatitis, there is never complete absence of bile in the stool for longer than two or three weeks. Repeated chemical analysis of the stool for urobilin is most helpful, and completely acholic stools over a period of several weeks is a serious finding which indicates obstruction. Stones in the common duct and cholangitis may cause intermittent biliary obstruction, which makes
it difficult to rule out partial obstruction from cholangiolitic hepatitis.

If the gallbladder becomes large and palpable, obstruction of the biliary ducts is indicated, and surgery is mandatory. This finding is worth more than all the liver function tests known.

EXPLORATION AND DRAINAGE OF THE COMMON DUCT

Exploration of the common bile duct should be done when stones are present in the gallbladder and the cystic duct is definitely dilated. Dilatation of the cystic duct indicates the likelihood that stones have passed through it into the common duct. However, the presence of a dilated common duct with a cystic duct of normal calibre does not indicate common duct exploration. If the cystic duct or ampulla of the gallbladder have been obstructed by stones, the common duct will dilate. This is a physiologic compensatory phenomenon and does not necessarily mean the common duct has been obstructed. In exploration of the common duct it should be palpated very carefully to detect the presence of stones, especially the distal portion; to facilitate this, the peritoneum lateral to the duodenum may be incised and the duodenum rotated to the left. The distal end of the common duct may then be palpated and stones felt if present. Stones occasionally become impacted in the wall of the distal portion of the duct, and a pseudo-diverticulum forms. Probes and catheters may pass these stones and traverse the ampulla of Vater, giving a false impression that the lower duct is clear. To remove stones such as these, it is occasionally necessary to open the duodenum and approach the duct through the ampulla, slitting it open and removing the stones from below.

A very thorough search of the common and hepatic ducts should be made, using a catheter and irrigating the ducts with copious quantities of saline. The “T” tube drainage of the duct should always be carried out following exploration.

Following cholecystectomy, with or without common duct exploration, drainage should always be employed. Very often, bile will drain in large amounts, either from accessory bile ducts, or from slipping of the cystic duct ligature. If drainage is not provided, a bile-cyst or bile-peritonitis will result. Recently, in the Queries and Minor Notes section of the AMA Journal, an answer to a question stated that drainage need not be employed if the gallbladder bed is dry. This is very dangerous advice and should not be followed. Drainage should always be provided.

Finally, I would like to stress that surgery of the gallbladder and biliary ducts is major surgery and fraught with danger. The anatomical arrangements of the ducts and blood vessels in this region have many variations, and anomalies are frequent. Expert anaesthesia, good lighting, and competent assistance are imperative. Operations should be undertaken only by surgeons who are adequately trained and who are experienced in this type of surgery. The increasing number of biliary-duct injuries and other complications of ill-advised or poorly executed gallbladder surgery is a serious indictment of our profession; it is in the power of each of us to help eliminate this reflection on our ability. The expression “a routine gallbladder” like a “routine appendix” or a “routine delivery” should be stricken from our vocabulary, unless and until the patient is fully recovered — and even then, the prudent doctor will not use these terms.

Current Comment

A Congressional Viewpoint—

The Honorable Thomas B. Curtis, Congressman from the Second Missouri Congressional District, noted three economic factors in current American life as suburbanization, an economy of plenty, and a fast growing population.

Better medical care and longer life were noted as results of an increase in the quality and standard of living. Mr. Curtis stated that people receive much more for their dollars in medical and hospital care today than ever before. Older citizens have an economic problem resulting from our continuing inflation. Their dollars of savings are therefore less effective in purchasing the increased amount of medical and hospital care that they need. The construction of modern nursing homes was suggested as one method of approaching this problem. Physicians were urged to play a greater part in political activities and therefore in the affairs of government in order to preserve the two-party system in America.
Organization Section

Coming Meetings

CRIPPLED CHILDREN’S CLINICS—
November 8, Norfolk, Norfolk State Hospital.
November 22, Grand Island, St. Francis Hospital.
December 6, Alliance, St. Joseph Hospital.

MID-STATE CLINIC ON DIABETES MELLITUS—Fort Kearney Hotel, Kearney, November 25, 1958.

OMAHA MID-WEST CLINICAL SOCIETY—26th Annual Assembly, November 3-6, 1958, Omaha, Hotel Sheraton-Fontenelle.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA — 43rd Annual Scientific Assembly, Cleveland, Ohio, November 10-13, 1958.


MEDICARE IN OPERATION

Changes October 1, 1958

This article is designed to present the details of revision of Medicare and to elaborate on the article, “Medicare in Operation,” published in the September issue of the Nebraska M. J., page 415, and in the “Special Bulletin” issued on August 11, 1958.

To assure optimum utilization of uniformed services medical facilities, and to effect economy while providing care authorized by Public Law 569, the following changes in the current operation of the Dependents’ Medical Care Program are effective on and after October 1, 1958.

Spouses and Children Residing Apart From Sponsors

Spouses and children residing apart from their sponsors will continue to be allowed selection of either uniformed services medical facilities or civilian medical sources for care authorized under the Program.

When DA Form 1863 show, “Residing apart from Sponsor—‘Yes,’” in Item 4 of the claim form, the designation of this fact on the claim form by the person signing Item 14 will be sufficient, and authorized care rendered will be payable provided the person or entity providing the care has no actual knowledge to the contrary.

Restrictions on Spouses and Children Residing With Sponsors

Spouses and children residing with sponsor will be required to utilize uniformed services medical facilities if available and adequate as determined by the commander of the medical facility. When uniformed services medical facilities are not available, a Permit will be furnished such dependents by the appropriate commander. This Permit will entitle them to receive authorized care from civilian sources at Government expense if such care is authorized under Public Law 569 and the Joint Directive, as amended.

When DA Form 1863 shows “Residing Apart From Sponsor—‘No,’” to allow payment for authorized care, a Permit is required, as noted in the preceding paragraph, to be attached to the original copy of the attending physician’s and the hospital’s claim form; except in the following circumstances:

(1) When a spouse or child residing with sponsor is hospitalized for care authorized under the Program for a bona fide acute emergency, e.g., serious injury following an accident or illness of sudden onset requiring immediate treatment at the nearest available medical facility to preserve life, or to prevent undue suffering. In such cases, a statement is required by the attending physician on the DA Form 1863 or attachment thereto, in lieu of a Permit stating, “This case was a bona fide acute emergency.”

(2) Where a spouse or child is residing with sponsor, but is away from the area of the sponsor’s household on a trip, care authorized under the Program may be provided from civilian sources without a Permit. The statement “On Trip” in Item 3 or 4 of the DA Form 1863, by the person signing Item 14, will suffice, provided the person or entity providing the care has no actual knowledge to the contrary.

(3) A maternity case (residing with sponsor) under the care of a civilian physician on or before October 1, 1958, may be continued by that physician provided the
patient has reached the second trimester of pregnancy on or before that date. In these cases a statement by the attending physician on the DA Form 1863, or attachment thereto, will be submitted by the physician and the hospital to the effect that the patient was under his care on or before October 1, 1958, and that her pregnancy had reached the second trimester on or before that date. This statement will suffice to authorize this care for payment without a Permit and will apply only to maternity cases where the wife resides with her sponsor. No restriction as to freedom of choice has been placed on those eligible dependents who reside apart from their sponsor.

(4) Spouses and children residing with a sponsor who are receiving authorized care from a physician and who are admitted to a civilian hospital prior to midnight September 30, 1958, will be authorized care by a civilian physician without a Permit, provided the physician shows the date of admission to a civilian hospital on his claim form, and this date is prior to October 1, 1958.

Permits, where required, must be attached to the original copies of DA Form 1863 on claims submitted by attending physicians and hospitals. Claims submitted by other than attending physicians or hospitals, e.g., Assistant Surgeon, Radiologist, Pathologist, Anesthesiologist, Dentist (when not in capacity of the attending physician), Consultant, Psychiatrist, Private Duty Nurse, Anesthetist, and Physical Therapist, will be authorized for payment without a Permit. However, claim form (DA Form 1863) must contain a statement by the person executing this certification in Item 14 that a Permit was furnished to the attending physician, identified by name.

Care No Longer Payable Under the Dependents' Medical Care Program

Effective October 1, 1958, the Joint Directive has been amended so that the following care and services, if commenced on or after that date will NOT be payable by the Government under the Dependents' Medical Care Program:

(1) Treatment of fractures, dislocations, lacerations, and other wounds on an outpatient basis.

(2) The termination visit. This refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient.

(3) Outpatient pre- and post-surgical tests and procedures.

(4) Neonatal visits. (Formerly authorized on an out-patient basis not to exceed two visits during the first 60 days). Except that in the case of home or office deliveries, necessary infant care may be provided on an out-patient basis during a period not to exceed 10 days following date of delivery.

(5) The treatment of acute emotional disorders. Except, however, the treatment of acute emotional conditions during the period of hospitalization of a spouse or child who has a condition that does qualify for authorized treatment in a hospital.

(6) Elective surgery. The description of such as follows: "Medical or surgical care that is desired or requested by the patient which in the opinion of the cognizant medical authority can be planned, subsequently scheduled, and effectively treated at a later date without detriment to the patient, e.g., diagnostic surveys, cosmetic surgery, reconstructive surgery, tonsillectomies, uncomplicated hernias, and interval appendectomies."

Surgical Procedures Authorized for Payment

(1) Surgical emergencies requiring hospitalization. Bona fide surgical emergencies, which cannot be handled on an outpatient basis, will continue to be honored for payment under the program. Such patients will necessarily be acutely ill and in need of immediate hospitalization and treatment. Examples include perforated duodenal ulcer, hemorrhage with shock, bowel obstruction, and similar recognized emergencies.

(2) Acute surgical conditions. It is well recognized that many acute surgical conditions develop which, while requiring prompt treatment in a hospital, are not considered emergencies under the Program. Under such circumstances the patient is acutely ill and must receive treatment without delay as time will not permit the patient to anticipate or plan for the care required. The procedures required for the treatment will of necessity be carried out at the earliest practicable time compatible with sound surgical judgment and proper preparation of the patient for surgery. The spirit of this requirement is that the ill patient is in clinical need of hospitalization without delay

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with a view to surgical correction of the basic condition. Examples are acute appendicitis, empyema of the gall bladder, twisted ovarian cyst, strangulated hernia, pelvic abscess, and renal or ureteral calculi with colic. When the charge physician so indicates that an acute requirement existed, payment will be authorized. Suspected or proven malignancy, requiring hospitalization, will be payable only if the case qualified under this or the preceding paragraph.

(3) Injuries requiring hospitalization. Injuries of such clinical severity as to require hospitalization will continue to be payable. Hospitalization is authorized only for the treatment of the acute phase. Readmission for treatment of chronic stages or sequelae of the injury would not be payable unless an acute medical or an acute surgical requirement is shown, such as osteomyelitis, with acute exacerbation.

Surgical Procedures Not Authorized for Payment Under the Medicare Program

(1) Elective surgery as previously described. Examples of such are: Tonsillectomy, Dilation and Curettage, Hysterectomy (routine), Ligation of Fallopian Tube, Heart Surgery, Submucous Resection, Rhinoplasty, and Reconstructive Orthopedic and Plastic Procedures.

(2) The provisions of the Joint Directive pertaining to the treatment of acute medical conditions remain unchanged. However, the admission of patients not acutely ill for diagnostic surveys will not be payable.

(3) The provisions of the Joint Directive pertaining to dental care remain unchanged. However, adjunctive dental care is now payable only when it is an integral and necessary part of surgical or medical care now authorized as surgical emergencies requiring hospitalization, acute surgical condition, and injuries requiring hospitalization.

Administration of Treatment of Patients Who Commenced Receiving Care Before October 1, 1958 Where That Care Has Been Deleted From the Program, Effective That Date

(1) Hospitalized patients. A patient will be deemed to have commenced receiving such care if admitted to the hospital prior to midnight September 30, 1958. Care is authorized during that period of hospitalization if the claim form shows an admission date earlier than October 1, 1958. The care referred to here includes the termination visit and outpatient pre- and post-surgical tests and procedures associated with this admission.

(2) The two neonatal visits previously authorized will be payable if the birth occurs prior to midnight September 30, 1958, and if the physician's claim form contains a statement to that effect.

(3) Outpatient injuries will be deemed to have commenced prior to midnight September 30, 1958, and, therefore, payable if the patient contacted a source of care prior to that time, and if the source of care so states on the claim form.

In view of the fact that hospital claims will now require careful completion to meet legal requirements for payment, charge physicians are urgently requested to assist hospitals in every way they can in this regard by providing a specific diagnosis, and where indicated, a clinical statement which will assure payment where proper under the Program.

The military services are instituting an extensive program to appraise military personnel and their dependents of the changes in Medicare. In addition, the military services have the responsibility of issuing the Permit to spouses and children residing with their sponsors where uniformed service medical facilities are inadequate or not available.

Reasons for Medicare Reports Being Returned to Physicians

A vast number of Medicare Reports (DA Form 1863) are constantly being returned to the physicians because of incomplete information. Foremost among the many reasons why a report is returned is for incomplete information in Item 29. As previously stated in the article, "The Medicare in Operation," which appeared in the June edition of the "Nebraska State Medical Journal," the private physician will receive an amount established in the local schedule of maximum allowances or his usual charge, whichever is less. It specifically points out in the terms of the contract that payment by Medicare shall be payment in full for services rendered by a physician. This fact is further stipulated in the second paragraph.
“a” of Item 29 of DA Form 1863. The second paragraph “a” of Item 29 must be completed, or a special letter should accompany the report, before it can be processed for payment.

If additional payment for an allowable condition, is desired by a physician for extraordinary services rendered a patient for abnormal complications, the charge physician should submit a letter of justification for his fee. The letter of justification shall provide the basis for the charge-physician’s report to be submitted to the Policy Committee of the Nebraska State Medical Association. The Policy Committee will then review the case, taking the complications into consideration, and make a recommendation. The report is then forwarded to the Contracting Officer in Washington for final approval and adjudication.

The second major reason for returning the reports to the physicians is the omitting of pertinent information in Item 6 (the medical authorization card number) and Item 7 (the expiration date of the card). The primary means of identification continues to be the DD Form 1173. When this identification card is not available and treatment is required under emergency conditions and similar circumstances (to mean those instances in which treatment is necessary for the preservation of life, health, or wellbeing of the patient, including in general, bodily injuries, medical or surgical conditions, and obstetrical and maternity care) one of the following forms of identification will be acceptable:

(A) Statement of a local commander having knowledge of the sponsor’s status that the patient is a bona fide dependent.

(B) Other official uniformed services documents and/or identification cards signed by an official reflecting the patient as being a dependent eligible for civilian care under Medicare.

(C) Statement of the physician that he has personal knowledge of the identification of the patient, of her dependency status, and eligibility for civilian care under Medicare.

With reference to Item 7, undated or expired cards are not considered acceptable and, in these instances where expired cards are presented, the same provisions apply as if no card were presented. Identification cards containing the word “Indefinite,” or abbreviation thereof in lieu of a specific date, are considered acceptable.

In view of the revision of the Medicare Program October 1, 1958, it is extremely important for the correct present address of the patient to appear in Item 3. It is of equal importance for the complete current official duty station of the sponsor to appear in Item 18. The correct information inserted in these items will avoid returning the reports for additional verification.

Although the main causes for the reports to be returned to the charge physician are set forth in this article, it is mandatory that all items be completed. The Nebraska Blue Shield is merely the Fiscal Agent and all necessary information must be furnished before a case can be paid. All claims are audited by the government.

HOW OUR CANDIDATES FOR CONGRESS
WILL VOTE ON STATE MEDICINE

Candidates for Congress in both parties were contacted by letter and certain questions as to their views were asked. The candidates who received the editor’s letter and answered were: Mr. Don McGinley, Congressman Glenn Cunningham, Congressman Bob Harrison, Mr. Francis M. Casey, Congressman A. L. Miller, Senator Roman Hruska, and Mr. Lawrence Brock.

Two of the key questions were:

“If elected, will you consistently oppose any legislation that: (causes) any further intrusion of Federal Government into the private practice of medicine by any route, as exemplified by the Forand-type of bill?

“. . . will you be dedicated to promotion and strengthening of freedom and self-government and will you support medicine’s position against proposed legislation calling for hospitalization and medical care benefits for Social Security beneficiaries?”

Only one, Mr. Don McGinley, gave me no answer though his secretary acknowledged receipt of letter. The reason for no answer was given as “Because of the pressure of the last weeks of the campaign . . . .”

Congressman Glenn Cunningham sent, as his answer, his latest issue of his “Washington Report,” which fails to answer these specific questions.
Each of the others gave an unqualified "Yes" in answer to those specific questions.

Senator Bricker Lauds World Medical Association—

Before the Senate of the United States adjourned, Senator John W. Bricker of Ohio noted that "not enough recognition has been given to the role of voluntary and private associations in promoting international understanding and in keeping the free world free . . . (and) individual effort is often more potent than collective action."

Senator Bricker continued: "Only the World Medical Association is working at the international level for free enterprise in medicine; for the freedom of a patient to choose his own doctor. The success of the World Medical Association makes it possible to compare standards of medical care in countries A, B, and C, where doctors are civil servants, with those prevailing in X, Y, and Z, where free physician-patient relationships exist. The fact that we can make such comparisons is the best reason for believing that socialized medicine will be abandoned as inferior and unworthy of a free people."

He presented the 6 points differentiating the World Medical Association and the World Health Organization and observed that: "The World Health Organization has done excellent work in combating and containing contagious diseases. It would be pointless to compare on a purely quantitative basis, the work done by an organization with a $13 million budget and that done by a private organization with an annual budget of $165,000. Nevertheless, the size of W.H.O.'s campaign against disease should not be allowed to obscure the World Medical Association's fight for medical freedom or its ability to provide almost instantaneous medical assistance in emergency situations."

(From W.M.A. Newsletter No. 14).

Protect Your Medical Credentials—

Attention has been directed in your Journal, a number of times, to the advisability of protecting your medical credentials. Loss of them has been catastrophic to many doctors. Such losses could happen here and leave you forever unable to prove you are a qualified physician. It is for this reason we publish the following letter from the A.M.A.:

Mr. M. C. Smith, Executive Secretary
Nebraska State Medical Association
1315 Sharp Building
Lincoln 8, Nebraska

Dear Mr. Smith:

The World Medical Association has initiated a program which the American Medical Association commends to your attention.

On July 1, 1958, the services of a Central Repository for Medical Credentials became available to doctors of the world. During war and national uprisings, medical records are often lost or destroyed. Because of this, many doctors are today unable to utilize their professional skills because of the loss or destruction of their original credentials and a lack of a protective service in which authenticated copies could be deposited. Therefore, The World Medical Association has undertaken a program to assure that the doctor will always be able to prove himself medically trained and fully accredited to practice medicine.

In the United States, the lifetime cost of the service on a one-payment basis to the newly graduated doctor is approximately $60.00. An actuarial schedule has been established for doctors in the various age groups. A 10-year service rate is also available.

Repository officials suggest that the credentials deposited include official medical school record, medical diploma, and specialist credentials. American doctors should not send their original credentials, but should send photostatic, microfilm, or notarized copies of their original credentials.

Requests for forms and additional information in regard to the Central Repository for Medical Credentials is available from The World Medical Association, 10 Columbus Circle, New York 19, New York.*

The American Medical Association suggests that you may wish to publish in your state medical association journal or other publications information with respect to this worthwhile service which is now offered by The World Medical Association.

Most sincerely,

Frank W. Barton, Secretary.

*Information and application blanks also may be obtained from Doctor W. H. McFadden, Jr., at the University of Nebraska College of Medicine or from your editor)

November, 1958
Nebraska Doctors Please Take Note—

September 26, 1958

Dear Sirs:

I am enclosing a check for $2.60 as a gift to the Heart Fund in memory of Mr. Jack G. Nagele, my father, a lifetime resident of Nebraska, who passed away recently.

The money was collected from one of our teen-age girls' clubs here at Neighborhood Association, one of eleven social group work agencies in St. Louis.

No matter how small the gift, I know the money will be gratefully received.

Sincerely yours,

Jacqueline Nagele Hamm,
Girls' Director
(Neighborhood Assn.,
St. Louis, Missouri)

MEDICINE IN THE NEWS

From the Lincoln Journal—

Omaha: Discovery that a common antibiotic, tetracycline, concentrates in tumor tissue is being studied by a resident physician and a Creighton University medical professor for possible use in cancer detection.

Dr. John F. McLeay, and Dr. Benedict R. Walske, are conducting their studies under a 3-year $20,000 grant awarded the Creighton University School of Medicine by the U.S. Public Health Service.

The doctors hope to learn if tetracycline can be used in diagnosing and treating tumors.

From the Alliance Herald—

Dr. E. I. Whitehead has announced that he is retiring from practice after 59 years, the last 32 of which have been in Alliance.

Dr. Whitehead came to Alliance from Holdrege in 1926. He started his practice in Gillespie, Illinois, on May 1, 1889. During W.W. 1 he was a captain in the ambulance corps overseas.

He is one of the charter members of the Alliance Kiwanis Club and served the organization as a district lieutenant governor at one time.

Dr. and Mrs. Whitehead plan to continue making their home in Alliance.

From the Lincoln Journal—

The office of Governor Anderson has announced the re-appointment of two members of the State Board of Health.

The re-appointees are Dr. W. W. Webster, Lincoln dentist, and Dr. Maurice Frazer. The appointments became effective on September 14 and will expire September 14, 1961.

From the Omaha World-Herald—

Two new grants totaling $70,479 have been made to the Creighton University Polio Rehabilitation Center at St. Joseph's Hospital.

The awards were announced by the National Foundation as part of one million dollars given for 19 projects.

Creighton will receive $56,974 for continuing studies in the prevention and treatment of polio crippling.

Another $13,505 is for one of seven "after effects" studies to determine the effects of polio paralysis on a long-term patient. The Creighton study will be for research on bone changes in patients immobilized by polio.

From the Lincoln Star—

A full 3-year residency program in obstetrics and gynecology has been approved for St. Elizabeth Hospital allowing a physician to complete his entire residency at the hospital.

Previously doctors wishing to specialize in gynecology and obstetrics in Lincoln could receive only one and two-year approved courses and were required to finish their residencies elsewhere.

Hospital officials said that the American Medical Association had made a survey of the facilities and teaching procedures provided by the hospital earlier this year and had notified the hospital of approval of the new 3-year course.

From the Omaha World-Herald—

(Public Pulse Column): Congratulations on Hollis Limprecht's recent series on the abuses and misuses of health and accident insurance. This is a subject that needs to be aired.
If socialized medicine ever comes to the United States, doctors will have no one but themselves to blame.

The first question a new patient usually hears when entering a doctor's office is: "Do you have any insurance?"

If your answer is negative you may expect a modest bill, but if you are honest enough to say yes, your insurance company may take a beating and your rates may go up.

I witnessed a case in which a patient received a bill of $30 from an anesthesiologist.

The patient then told the doctor that she was covered by insurance. A few days later the patient received in the mail an insurance form from the doctor.

The doctor enclosed a note asking for the patient's signature and added: "You may notice the difference in the amount of this claim and the first bill sent to you. I am charging the insurance company $70 because that is what they allow for anesthesia for your type of operation." CONCERNED.

From the Hastings Tribune—

Dr. and Mrs. Frank Brewster of Holdrege were among the hosts at a Skyriders Club meeting held in Holdrege in September. Dr. Brewster, who at 85 is the oldest licensed pilot in Nebraska, spoke. He said that even in Bible times people tried to get as far off the ground as possible and cited the Tower of Babel as an example. He traced the history of aviation, relating that in 1783 the French filled paper bags with hot air from furnaces and put them in flight. Dr. Brewster also told of Benjamin Franklin's interest in balloons and his prediction they would revolutionize the world. At that early date, however, people thought of flying just as people today think of the satellites, he said.

From the Hastings Tribune—

The annual meeting of the Nebraska Heart Association was held in Omaha in September.

The conference emphasized diagnosis and treatment of rheumatic fever and rheumatic heart diseases, a heart problem among youngsters and teenagers.

Dr. Stephen L. Magiera of Omaha, outgoing president, reported on Nebraska's battle against heart disease.

He said the heart fund drive collected a record $230,000 in the state last year.

The seven living past presidents of the group received medallions at the annual awards dinner.

There were Drs. O. A. Kostal of Hastings and F. W. Niehaus, E. M. Walsh, F. Lovell Dunn, F. G. Gillick, W. D. Wright, Stephen L. Magiera, all of Omaha.

An Editorial Viewpoint on Socialized Medicine—

The following editorial from the Journal, Firibury, Nebraska, Sept. 11, 1958, seems to accept, too readily, the statement of one English general practitioner and a similar viewpoint taken from the Manchester Guardian, as to the Socialistic practice of medicine in England, but the writer (Mr. L. K. Cramb) looks at the situation in the United States with acute understanding. He proceeds to point out our weakest spots and to rub salt in some of our open wounds, such as $500 for an operation that takes an hour or less. Let us read what he has to say:

HEALTH PROGRAM IN ENGLAND

An English general medical practitioner said recently in Omaha that the big majority of his medical colleagues are no longer hostile to the British government's health program. "We are now pretty much convinced that it's a good service, even though it has some rough spots, Dr. Alexander Marshall said.

An article in a recent number of The Manchester (England) Guardian under the title, "Health Service Achievements," is along the same line. "After 10 years the National Health Service is taken for granted; its achievements receive less attention than the vague suspicions that it costs too much, that too much is spent on drugs, and that it is exploited by foreigners. All this is erroneous," the article says.

The vast majority of people in this country are opposed to a national health service, which many refer to as socialized medicine. This so-called socialized medicine has been adopted by nearly every civilized country in the world, there being only a few exceptions. Yet that does not prove it is best for this country.
There are two factors that could bring on socialized medicine in this country. One is the increasing cost of hospital service, and the other is the high charges by many physicians and surgeons, especially in larger cities. A charge of $500 for an operation that can be performed in less than an hour seems excessive, especially when the surgeon performs several such operations in a day.

The various health insurance plans have gone a long way to prevent the adoption of socialized medicine in this country. Under these plans when a severe illness strikes or an operation is necessary there is money to pay the cost.

Yet these health programs in this country are limited. They do not provide for prolonged illnesses, and they are not in most cases obtainable for the aged. When the present Chief Justice of the Supreme Court was governor of California he proposed a program for those with prolonged illness, but the physicians of the state at great expense opposed the program and it was defeated.

SLIGHTLY USED CONSULTANTS
(Continued from page 480)

radiologist or the clinical pathologist is woefully inadequate even when used to the limit of its possibilities. The information is limited to one or two brief sentences. Even this is preferable to a mere order for examination with no information in many instances, the order sometimes being accompanied by instructions on how to carry out the examinations.

It should occur to those of us who use these consultative services that to treat the radiologist and the pathologist as doctors whom we are calling in consultation often might lead to more accurate examinations at lesser cost and with greater yield of helpful information. These experts certainly can view any problem requiring the services of their specialties with an eye to answering the questions involved by proper choice of procedure at the least cost and with the greatest chance of finding out what we need to know. We have all seen long lists of reports on laboratory and X-ray examinations that have added uselessly to the cost and have omitted the very data that might have helped where help was needed. How much better it could be if we would outline our problems to the radiologist or to the pathologist, as the case may be, and to accept his help and advice as if he were, in fact, a consultant. The attending physician, the patient, and the consultants would gain, not only in saving time and money, but in acquiring more useful information and in raising the slightly used consultants to the status which they so well deserve—doctors practicing a useful and often indispensable specialty.

DOCTORS IN THE NEWS

Nebraska Doctors Negotiate Medicare Contract—

A special committee of the Nebraska State Medical Association composed of Drs. Paul Maxwell of Lincoln, A. J. Offerman of Omaha, Fay Smith of Imperial, and Mr. M. C. Smith, our executive secretary, negotiated and signed a contract with the Defense Department in the matter of Medicare, the early part of September. The contract became effective on October 1. (Lincoln Star, September 18).

F. P. Suegang Medical Building Completed—

From the Alliance Herald of September 8 we see that Doctor F. P. Suegang of that city has completed a new medical building. Over 1000 people from the surrounding country and towns visited the new building on September 7th. The building is to house a number of offices and is described as ultramodern.

Colonel Benford Named Director of Armed Forces Medical Publication Agency—

Colonel Robert J. Benford, USAF (MC), a specialist in aviation medicine and former newspaperman, has been named director of the Armed Forces Medical Publication Agency and editor of the U. S. Armed Forces Medical Journal. He succeeds Captain Bennett F. Avery, MC, USN, who has been appointed national coordinator of the Medical Education for National Defense (MEND) program.

Colonel Benford served as Staff Surgeon of the XX Bomber Command in World War II. He recently
completed a tour of duty in the Office of the Assistant Secretary of Defense (Health and Medical).

Since 1955 Colonel Benford has been editor of the Journal of Aviation Medicine, official publication of the Aero Medical Association. He is also a member of the editorial advisory board of Aero/Space Engineering—monthly journal of the Institute of Aeronautical Sciences.

A native of Omaha, Nebraska, Colonel Benford is a graduate of Creighton University and the University of Nebraska College of Medicine. Before studying medicine, he was a reporter for the Omaha World-Herald. He is the author of Doctors in the Sky, a history of aviation medicine, and other publication in this specialty.

News and Views

Honors Awarded by American Medical Writers' Association, 1958—

At its recent annual meeting held in Chicago, the American Medical Writers' Association bestowed the following honors:

Dr. Charles W. Mayo of Rochester, Minn., received the 1958 Honor Award for his work in teaching, writing, and editorial work.

Dr. Theodore R. Van Dellen of Chicago, was given the 1958 Distinguished Service Award because of his service as editor, teacher, and dean (Health-editor, Chicago Tribune; Assistant Dean and Associate Professor of Medicine, Northwestern University School of Medicine; and Associate Editor, Illinois Medical Journal).

Honor Awards for Distinguished Service went to the following medical journals:

1. Cleveland Clinic Quarterly.
3. The Bulletin of the Fulton County Medical Society.
4. The Medical Record.

Health Insurance Association of America

Position on Forand Type Legislation—

Mr. E. J. Faulkner of Lincoln appeared before the Ways and Means Committee on June 24, 1958, for the Health Insurance Association of America, to testify as to the Association's position on hospital, medical, nursing home, and dental care proposals of H.R. 9467 "and similar pending bills." The statement Mr. Faulkner made to the Committee contains a wealth of information. It should be read by every doctor, in view of the likelihood that we will almost certainly have similar legislation to consider during the next Congress. His entire statement will be published in a future issue of the Journal, but the following summarizes his conclusions:

"We express to you our firm and complete opposition to H.R. 9467 and similar bills proposing socialization of the provision and financing of health care because (1) such measures if enacted would impair if not destroy the present Social Security System; (2) they would fail to alleviate the only real problem, that of the presently aged who require assistance to meet their health care costs; (3) such proposals would impose new, uncertain, growing and crushing burdens on an already heavily taxed citizenry; and (4) such measures are unnecessary because voluntary health insurance has the capacity to provide the aged as well as other segments of our population with a sound and economical means of paying health care expenses. . . ."

The U.S. Committee Member (WMA)

Defends Medical Freedom—

The World Medical Association is the only voice the practicing physicians have at the international level. Therefore, membership in the United States Committee of W.M.A. is essential to us as doctors because:

1. We must strengthen that international voice to protect the freedom of medical practice.
2. Only in this way can the viewpoint of free medical practice be presented and receive respect nationally and internationally.
3. We are combating the socialistic influences of I.L.O. and other organizations intruding into health and medical affairs.
4. We encourage physicians oppressed by the yoke of government controls to continue their struggle for freedom.
5. We assist in raising world standards of medical care and education.
6. It offers professional and personal contacts with physicians in other lands.
7. Annual meetings of W.M.A. may be attended.
8. Official recognition is granted to foreign lecture tours and exchange visits.
9. The World Medical Journal alerts us to problems confronting physicians in other countries.

10. Through it, meaning is added to "M.D." — Medical Diplomat — our role in building peace in the hearts and minds of all men.

Are you a Medical Diplomat? You need freedom of medicine and the freedom of medical practice needs and deserves your full support!

Continuing Education Center on Ag Campus—

The Kellogg Foundation has offered $1.5 million toward construction of a building to be used as a Continuing Education Center. The University will have to raise $1,142,000 in matching funds. Meeting rooms appropriate to the purposes, dining facilities, and hotel-type facilities will be available. One section will be a youth-activities wing for high school science clubs, Future Farmers, Future Teachers, 4-H clubs, etc. It has been rumored that this institution will be located on the Ag Campus.

Doctors Get Czech Ruling—
(From Omaha World-Herald, 8-19-58)

Vienna (UPI) — The Czechoslovak Communist Government has decreed a ban on the private practice of medicine by doctors effective next January 1, Czech newspapers disclosed recently.

The decree, issued by the Prague Health Ministry, will abolish one of the last vestiges of capitalist economy in Czechoslovakia.

Prague newspapers said the Health Ministry had ordered all doctors to close down their private practices by the end of the year.

The decree said that no new licenses will be issued for setting up private practices.

The decree granted a limited exemption to a few university medical professors and lecturers "who in some cases will be granted permission to maintain their private work provided that they also work in the State Health Service."

Routine Proctosigmoidoscopy Could Save Many Lives—

The employment of proctosigmoidoscopy as part of the routine physical examination of the 7,500,000 employees of businesses which have industrial medical departments would drastically reduce the incidence of rectal and colonic cancer, according to Thomas G. Rigney, M.D., senior physician, Standard Oil Company of New Jersey.

Dr. Rigney and John R. Hill, M.D., section of proctology, Mayo Clinic, were the principal speakers at a conference in New York City on "Proctoscopy in Industry" called by the New York State Society of Industrial Medicine to discuss the feasibility of increasing the use of proctosigmoidoscopy by industrial physicians. The meeting was made possible through a grant by the C. B. Fleet Company, Lynchburg, Va.

Infections of Urinary Tract in Children Dangerous—

Urinary tract infection in childhood "is a potentially fatal warning sign," according to Stuart S. Stevenson, M.D., research professor of pediatrics, University of Pittsburgh School of Medicine. These infections constitute one per cent of hospital pediatric practice and have an ultimate mortality of from 2 to 20 per cent, yet urologists do not see most cases, he said.

Frequently the infection goes unrecognized. In later life if chronic infection is not obliterated, "though pus and bacteria are gone, all that remains is a scarred, shrunken, lobulated kidney . . . and (the patient) dies, with growth of time, of renal failure, perhaps years after the original neglected infection has been forgotten," he points out in the Journal of the Louisiana State Medical Society.

Dosage of Asian Influenza Vaccine Again Question—

Scope carries a report (September 10, 1958) that Dr. Howard K. Edwards, medical director of Eastern Airlines in Miami, has stated that two injections of 0.1 cc of vaccine spread over a period of two or three weeks will produce higher antibody levels than one larger injection. This point has been a matter of mild controversy in the past, and, no doubt, will be argued again. There would be quite distinct advantages to the smaller dosage, one of which is lessened chance of allergic reaction to the smaller dose. Previously we were advised by the U.S. Public Health Service that we should use the larger doses. Further information
will be helpful to the practitioner now that we are probably facing a recrudescence of Asian influenza.

News From Our Medical Schools—

Creighton University School of Medicine has received, recently, a number of grants to be used in research. The following is a partial list:

Studies of bone changes that take place in patients paralyzed and immobilized as a result of polio will be conducted at Creighton University.

This study will be supported under a grant of $13,505 provided by March of Dimes funds. Work on the project will be directed by Dr. Robert P. Heaney, assistant professor of medicine in the Creighton School of Medicine.

Serious consequences can result for patients immobilized by paralytic polio. Calcium lost from bones leaves the body in the urine after passing through the kidneys. Here it may cause formation of kidney stones large enough to require surgery.

Dr. Heaney will investigate the mechanism of these bone changes in polio patients. To accomplish this, he will give doses of radioactive calcium to polio patients and trace its distribution in the body with a Geiger counter.

Creighton University School of Medicine has received the first of five annual grants from the Office of Vocational Rehabilitation, Washington, D.C. Overall value of the award is $74,405.

The grant is to be directed by Dr. Harold N. Neu, professor of medicine and co-ordinator of the teaching and rehabilitation at the School of Medicine. It will be used to implement personnel needed to help train medical students and residents of the modern concepts of rehabilitation.

A National Science Foundation Fellow from the University of Oklahoma has joined the faculty of the Creighton University School of Medicine. He is Dr. Joe M. Dabney who will be an assistant professor in the Department of Physiology and Pharmacology.

A native of Monett, Mo., Dr. Dabney received his Bachelor of Arts Degree from the University of California at Berkeley in 1947. He holds a Master of Science from the University of Oklahoma and this month received his Ph.D. from that University.

A March of Dimes grant of $56,975 has been made for the support during the coming year of the Poliomyelitis Respiratory and Rehabilitation Center, at Creighton Memorial, St. Joseph's Hospital. Work of the Respiratory and Rehabilitation Center at Omaha has a dual purpose:

To develop and apply improved methods for caring for severely involved polio patients, and to teach and demonstrate these methods to doctors and other professional workers so that they can use them elsewhere.

Action Against the Food Faddist—

A nationwide educational campaign to alert the public to a billion dollar food-faddist racket will be a cooperative effort of the American Medical Association, the Federal Food and Drug Administration, and the National Better Business Bureau. It is hoped that it will be implemented locally by state and county medical societies.

The director of the A.M.A.'s bureau of investigation states they are selling at high cost their inexpensive and ineffective combinations of peppermint tea, herbs, vegetables, vitamins and minerals. Absurd health claims are made for everything from sea kelp to irradiated peat moss. The products may themselves be harmless but great harm can result if the salesman leads the purchaser to believe that they have the power to cure disease and, as a result, needed medical care is postponed.

Despite the high educational level of the American people, quackery and spurious schemes still thrive in all parts of the nation and the acceptance of the faddists and their products is at the highest level in history.

The approach in the attack against faddists will call for a vigorous public education campaign and more and better law enforcement to overcome this spreading blight.

There are 108 local bureaus of the National Better Business Bureau whose objective is to promote truth in advertising and to protect the public from fraud. The National Better Business Bureau maintains a volume on advertising to guide the various media, agencies and advertisers in accepting advertisements for health products. The cooperation of advertisers, and especially the media of newspaper, radio and television is needed.
Physician-Pharmacist Relations—

What pharmacists think of physicians and physicians of pharmacists is the subject of an article in the Journal of the American Association. The results, obtained by a questionnaire, indicate that 85.4 per cent of physicians’ fees were considered reasonable by pharmacists and 12.3 per cent were considered to be excessive. Prescription prices, when rated by physicians, were considered reasonable in 76.8 per cent of cases, and too high in 22.9 per cent. The number who thought the other profession’s fees were too low were a small minority.

A great problem noted by physicians was the price discrepancy between drug stores, which 68 per cent of the physicians said they observed at least occasionally. It was also noted that some drug stores apparently do not have consistent prices within the store.

Over half of the pharmacists said that customers occasionally complained to them about physicians’ fees. When physicians were confronted with the possibility that pharmacists would receive such complaints, 90 per cent of the physicians requested that the patient be referred to the physician for discussion of the complaint.

Each group felt that the other could be very helpful—and, in fact, was usually helpful—in giving the patient a better understanding of the charges made by the other group.

Over half of the pharmacists noted that items on the prescriptions such as the patient’s name, address, directions or the physician’s registry number are often omitted. Eighty per cent of the pharmacists stated that physicians often fail to give refill information on the original prescription. It may not be a surprise to learn that pharmacists sometimes have difficulty in deciphering the physician’s handwriting.

From the survey came a suggestion that physicians and pharmacists meet together on both a local and national level in order to further develop their interprofessional relations.

Attacks on the Medical Profession—

The strength of the voice of criticism of the medical profession will depend on how we solve our own problem, according to Dr. George W. Slagle, president of his State Medical Society. Doctor Slagle, in the President’s Page of his State Journal, noted that health directors of labor organizations, meeting as the National Conference of Labor Health Services, said that group plans for the mass purchasing of doctor care are necessary to protect the public from “incompetent physicians.”

Doctor Slagle stated that it was impossible to sit back in the face of such attacks and state: “We are the only ones who can practice medicine and we will decide how it is to be practiced.” Such a statement, if it is possible, would indeed be foolish.

The health directors of these organizations represent powerful consumers of medical care, and whether we like it or not, according to Doctor Slagle, they will have something to say about how medical care is rendered and paid for.

The problems which concern labor are also the problems which must be solved by the medical profession. According to Doctor Slagle, this requires an active State Medical Society, with the confidence of its members and a membership that is willing to work out, within the structure of that society, the difficulties and differences that are bound to exist in any new program.

A.F.L.-C.I.O. Opinion—

Mr. Leo Perlis, director of Community Service activities for the A.F.L.—C.I.O. in New York, stated that a more health-conscious public has created many medical economic problems. Other factors contributing to these problems are the growth of collective bargaining and the extension of trade unionism, the acceptance of responsibility for the workers beyond the plant gates by both labor and industry, as well as population increases, moves to the suburbs, and added leisure time.

It was stated by Mr. Perlis that even though tremendous gains have been made in extending insurance coverage, labor is not yet satisfied with what has been accomplished.

Mr. Perlis expressed faith in the future of the voluntary approach to the problem of providing adequate insurance prepayment plans but declared that the real issue is to keep our minds open to all possibilities for making this system work effectively.
Labor has great respect, Mr. Perlis said, for the medical profession's know-how and devotion but expressed the view that all people concerned with medical care such as labor, industry, and others, should serve on boards of those organizations providing medical care, with all groups participating and no groups dominating. A plea was made for continuing constant experimentation in the economic laboratories in order to make voluntary plans work better. It was suggested that this experimentation include an attempt to provide home care, dental care, psychiatric and nursing care, as well as the more usual medical and surgical care, with voluntary health insurance.

Announcements

Mid-State Clinic To Be Held at Kearney November 25—

The Annual Mid-State Clinic, sponsored by the Buffalo County Medical Society, Dr. Dan A. Nye presiding, will be held at the Fort Kearney Hotel, Kearney, Nebraska, November 25, 1958. Registration will begin at 9:00 a.m. The registration fee will include the price of the banquet to be held in the evening. The topic for the day will be "Diabetes Mellitus and Its Treatment."

National Institute of Mental Health Offers Training Grants to Physicians—

The National Institute of Mental Health is offering grant support for a training program for general practitioners and other physicians engaged in the practice of medicine other than psychiatry. Funds are available during the current year (fiscal year 1959) for these grants and training institutions may submit applications at any time.

The program has two purposes:

1. To foster the development of postgraduate training in psychiatry for the practitioners who wish to increase their psychiatric knowledge and skills in order to be able to deal more effectively with the emotional aspects of illness generally and in order to play a more effective role in the treatment and prevention of mental illness. These courses will be designed for the physician who plans to continue practicing in his own field.

Grant support is being offered to medical schools, hospitals, clinics, and medical and psychiatric societies for the development and expansion of such postgraduate training in the form of courses, institutes, and seminars. This support does not include fees, subsistence, or travel for the physicians who attend.

Support of this type of training may be for a particular professional group over a given period, or for training offered regularly as part of the postgraduate curriculum of a medical school, hospital, or clinic, or as part of the educational program of a medical or psychiatric society.

Physicians interested in obtaining this type of training should apply to medical schools, hospitals, clinics, and medical or psychiatric societies which have, or are developing, such training opportunities.

II. To provide support at an adequate level for psychiatric residency training for physicians in practice who wish to become psychiatrists. Training stipends up to a maximum of $12,000 a year are available. The level of payment will be determined by the training institutions who will also make the award to the individual physicians. The National Institute of Mental Health will make awards of grants for this purpose to training institutions and not to individuals.

Physicians interested in support for this type of training should apply to training institutions which are approved for psychiatric residency training.

Inquiries about the program should be sent to Dr. Seymour D. Vestermark, Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Maryland.

Essay Award — American Congress of Physical Medicine and Rehabilitation—

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award, annually, a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest is open to all doctors, but is beamed especially to internes, residents, and graduate students. For all details write, if interested, to American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.
International Authorities to Meet on
Bacterial Resistance Problem—

A world-wide picture of the clinical problem of bacterial resistance and methods of dealing with it will be presented at the International Colloquium on Resistant Infections at the Plaza Hotel, New York City, on November 20 and 21. The conference is being sponsored jointly by the United States Committee, World Medical Association, and Eaton Laboratories, Norwich, N.Y.

Physicians from Argentina, Canada, England, France, Germany, Puerto Rico, Sweden and the United States will describe the results of their investigations and their experiences in treating resistant infections.

Particular emphasis will be placed on the control of staphylococcal infections in hospitals, a grave concern to physicians today. The role of drugs, both as contributors to the development of resistance and as a means of helping to solve the problem, and the need for more rigid aseptic technics to control the spread of infectious organisms will be thoroughly discussed.

All the medical disciplines concerned with the resistance problem will be covered in conference sections dealing with systemic, respiratory, topical and urinary tract infections. A final session will be devoted to the role of the hospital environment in disseminating infection.

Bahamas Conferences, November, December, And January—

Serendipity — Peace of Mind — Not to have to watch the clock; Nassau. This coming winter, there will be three Conferences: The Sixth Bahamas Medical Conference, November 28th until December 18th; The First Bahamas Surgical Conference, December 29th until January 17th; The Serendipity Session, January 18th until January 31st, 1959.

All sessions will be held at the British Colonial Hotel, Nassau. Anyone wishing to attend must make reservations now. For full details, write to Dr. S. L. Frank, Organizing Physician, 23 East 79th Street, New York 21, N.Y.

American Goiter Association Again Offers
Van Meter Prize—

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association, at the Drake Hotel, Chicago, Ill., April 30, May 1 and 2, 1959.

The competing essays may cover either clinical or research investigation, should not exceed 3000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, must be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Ave., Albany 10, N.Y., not later than Jan. 15, 1959.

A New Journal—Health Education—

Volume 1, Number 1, of a new journal was published in April, 1958. The International Journal of Health Education will be devoted to Health Education, Health Propaganda, Health Teaching, and Public Relations. Editorial Office: 3, rue Viollier, Geneva, Switzerland.

Post-Doctoral Scholarships Available—

The Sister Elizabeth Kenny Foundation announces continuance of its program of post-doctoral scholarships in neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of neuromuscular diseases.

The Kenny Foundation scholars will be appointed annually. Each grant will provide a stipend for a five-year period at the rate of $5000 to $7000 a year depending upon the scholar’s qualifications. Candidates from medical schools in Canada and the U.S. are eligible.

For details, write to Dr. E. J. Hueneckens, Sister Elizabeth Kenny Foundation, Inc., 2400 Foshay Tower, Minneapolis 2, Minn.

Human Interest Tales

Dr. D. L. Fletcher, Orchard, underwent eye surgery at an Omaha hospital in September.

Dr. Floyd Ring, Omaha, spoke at the September meeting of the Lincoln Ministerial Association.

Dr. Donald Purvis, Lincoln, has taken over
his duties as president of the Nebraska Heart Association.

Dr. Gerald Kuehn, Hastings, has been re-elected president of the staff of Mary Lanning Memorial Hospital.

Dr. L. D. James, McCook, was a guest speaker at a recent meeting of the McCook Professional Women’s club.

Dr. A. J. Merrick, Fremont, attended the September meeting of the Southwest Clinical Society at Kansas City, Missouri.

Dr. Marvin F. Hill, LaGrande, Oregon, has been appointed to the faculty of the Creighton University School of Medicine.

Dr. C. M. Murphy, Omaha, is the new president of the Nebraska Chapter of the American Academy of General Practice.

Dr. and Mrs. Ben Bishop, Crawford, were hosts at a recent dinner party given for the clinic staff and hospital nurses of that city.

Dr. R. F. Sievers, Blair, has been elected president-elect of the Nebraska Chapter of the American Academy of General Practice.

The Buffalo County Medical Society and the Auxiliary held their first joint dinner meeting of the year in Kearney in September.

Dr. Donald Ritter, Lincoln, presented a paper on heart disease at the September meeting of the Sixth Councilor Medical Society.

Dr. John Aita, Omaha, presented a talk at a recent meeting of the Women’s Fellowship of the First Central Congregational Church of Omaha.

Dr. and Mrs. Alfred Brown, formerly of Omaha, have returned to this city to live after residing for several years in Asheville, North Carolina.

Dr. Morris Margolin, Omaha, has been appointed for a 3-year-term as Governor for the State of Nebraska, by the American Diabetes Association.

Dr. J. S. Bell, York, was recently awarded an attractive lapel pin in recognition of his 15 years of service to the Selective Service System of Nebraska.

Dr. Theo Koefoot, Jr., Broken Bow, presented a paper at the September meeting of the American College of Obstetricians and Gynecologists at Des Moines, Iowa.
The Woman's Auxiliary

GEMS Program of the Woman's Auxiliary to the Adams County Medical Society—

A course in "Good Emergency Mother Substitutes" was given by this Auxiliary in cooperation with the Y.W.C.A. this summer during the latter's annual two-weeks program in July.

Using suggestions sent previously by the National Safety Council, a rather extensive course was developed.

The fields covered were: Infant and child care, conducted by a nurse; First Aid, Artificial Respiration, conducted by a Red Cross First Aid Instructor; Pediatrics, by a doctor; Child Psychology, by a psychologist; and "What the Parent Expects and What the Sitter Expects," covered by a baby sitter and her mother in a panel discussion.

During each session, a review was conducted, by a member of the auxiliary of the previous day's lesson. At the end of the two weeks period an examination was given. Those having attended the required number of sessions and receiving a passing grade were awarded certificates. These were billfold size cards bearing the student's name and signed by the Y.W.C.A. president and by the chairman of the GEMS Committee.

Our course was very successful. We stressed, in all our lessons, safety, both to the sitter and to her charges.

Some very gratifying reactions were heard from parents of the potential sitters, as well as from mothers who employed these sitters. Many mothers stated that their daughters received invaluable training, not only for baby sitting "jobs," but for taking care of their younger brothers and sisters, as well as their own children some day.

We took particular care in the selection of qualified people who were dynamic speakers and could instruct children on this level.

Literature, including "You're in Charge," "To Parents of Baby Sitters," "What Our Baby Sitter Should Know," was distributed.

The regular meeting of the Adams County Medical Auxiliary was October 1. A dinner with the doctors was held at Meadowbrook Club after which Dr. Russell McIntire spoke on "Child Health Problems."

Plans were made for a paramedical recruitment tea to be held November 15.

Mrs. Donald Steinberg of Aurora and Mrs. L. F. Percelik of Hastings were guests.

Dawson County—

The Dawson County Medical Auxiliary announced two recipients of the annual Scholarship Loan Fund at its September meeting at the home of Mrs. A. W. Anderson in Lexington.

Phyllis Brooks, Cozad, has begun nursing training at Bryan Memorial Hospital, Lincoln. Phyllis Saulsbury, Lexington, has enrolled at St. Catherine's Hospital in Omaha.

Mrs. Sam Perry, Gothenburg, reported on the State Board of Directors' meeting which she attended in Lincoln, September 8.

Civic affairs discussions resulted in the following resolutions: Members will write their senators in favor of a Nebraska Juvenile Court plan, will send "Today's Health" subscriptions to all Dawson County schools, and will donate old magazines needed at the Hastings State Mental Hospital.

The following members were present: Mmes. B. W. Pyle and Sam Perry, Gothenburg; Mmes. Charles Sheets and Rodney Sittorius, Cozad; Mmes. Ray Wycoff, V. D. Norall, A. W. Anderson, and Wm. Long, Lexington.

Deaths

A. A. Larsen, M.D., South Sioux City — Doctor Larsen died at his home in South Sioux City June 26, 1958, at the age of 66. Doctor Larsen had been active in the practice of medicine up to the time of his death. Dr. L. T. Gathman was a partner with him. Doctor Larsen was born in Homer on July 2, 1891. He attended the University of Nebraska, graduating from the School of Pharmacy as well as Medicine, in 1915. He practiced medicine in Dalton and Gurley, Nebraska before locating in Homer in 1930 and in South Sioux City in 1945.

Charles Marsh, M.D., Valley — Doctor Marsh died while on vacation at Portland, Oregon, August 26, 1958, at the age of 45. A graduate of the University of Nebraska College of Medicine, he had practiced in Valley and Omaha since 1942. He and Dr. R. C. Moore made a nine-year study of auto accidents and gave talks on their findings to many groups.

Nebraska S. M. J.
George T. Erickson, M.D., Phoenix, Arizona—Doctor Erickson died in the Good Samaritan Hospital in Phoenix, July 24, 1958, at the age of 51. Born in Mora, Minnesota, on April 1, 1907, he graduated from the University of Minnesota College of Medicine. Doctor Erickson established his medical practice in Broken Bow. In 1957 a serious illness necessitated the termination of his practice and he moved to Phoenix where he succumbed.

Samuel Metheny, M.D., Lincoln—Probably the oldest practicing physician in Lincoln, Dr. Samuel Metheny died in Lincoln October 2, 1958, at the age of 94. Born in Illinois in 1864, he graduated from Lincoln Medical College of Cotner University in 1902. He taught in the same institution from 1902-15. He also taught in the University of Nebraska Dental College. He was a cofounder of a hospital in Lincoln which operated from 1903-08.

Frank T. Wright, M.D., Kansas City, Missouri—Doctor Wright died July 21, 1958, in Kansas City, at the age of 83. Born in Valparaiso, he graduated from the Lincoln Medical College in 1907. He practiced medicine at Davey for 4 years, at Cresco from 1911 to 1923, and at Lincoln from 1925 to 1951. He then located in Phoenix, Arizona, where he spent two years when he again returned to Lincoln where he practiced until his retirement in 1957.

Charles K. Gibbons, M.D., Kearney—At the age of 81, Doctor Gibbons died at a Kearney hospital, October 3, 1958. He received his degree from Northwestern University in 1902. Doctor Gibbons practiced in California for a short time before he located in Kearney, in 1903, until his retirement in 1946. He had been in poor health for several years.

Rodney W. Bliss, M.D., Oklahoma City, Oklahoma—Doctor Bliss died September 5, 1958, at the age of 80, in Oklahoma City. He had previously been a long-time Omaha physician.

Oscar W. French, M.D., O'Neill—Doctor French died at the Saunders County Hospital August 3, 1958, at the age of 66. Born at Page February 29, 1892, he graduated from the University of Nebraska College of Medicine in 1920. From 1920 to 1922 he practiced in Ewing. In 1922 he located in Page where he practiced until 1938. He then moved to O'Neill where he became associated with Dr. J. P. Brown. He has been in ill health for the past three years.

Mrs. Elias (Frances) Holovtchiner, Omaha—Mrs. Holovtchiner, widow of the founder of the old Omaha Medical Society, died at her home September 23, 1958, at the age of 87. Her husband had practiced medicine in Omaha over 60 years.

E. H. Willmarth, M.D., New Castle, Pennsylvania—Doctor Willmarth died September 19, 1958, at a hospital in New Castle at the age of 57. He was a graduate of the University of Nebraska College of Medicine.

Harvey B. Stapleton, M.D., Hickman—Doctor Stapleton died at the age of 68, in a Lincoln hospital, October 1, 1958. He had been a physician in Hickman for the past 40 years.

Alfred E. Reeves, M.D., North Platte—Doctor Reeves died at St. Mary's Hospital, North Platte, September 1, 1958, at the age of 77. He practiced medicine in Farnam, Nebraska after having graduated from Ensworth Medical College in 1904. In 1925 he built a hospital at Farnam. He located in North Platte in 1943 where he practiced for 10 years. Doctor Reeves had spent the last few years in retirement because of ill health.

L. A. Carter, M.D., O'Neill—Doctor Carter died at St. Anthony Hospital September 4, 1958, at the age of 82. Doctor Carter was born in Mills County, Iowa, November 20, 1875. He graduated from Kansas City Hanemann Medical School in 1903. He practiced in Mahaska, Kansas, until 1913 when he located in Tryon. He began practice in O'Neill in 1917, and retired in April, 1958.

Andrew D. Brown, M.D., Central City—A graduate of the University of Nebraska College of Medicine in 1912, Doctor Brown established a practice in Central City in which he was active from 1913 until serious illness forced him to retire 14 months ago. He was born at Atlantic, Iowa, May 27, 1886. He died July 30, 1958 at the age of 72.
DIABETES MELLITUS

Diabetes mellitus, the eighth leading cause of death in this country, is the "only major cause of death in which female mortality exceeds male mortality."

This fact is revealed in the current issue of "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession.

The high mortality toll exacted by the disease is graphically described in the publication. Among children and young adults the death rate of diabetics is five to ten times higher than the death rate of non-diabetics, and among middle-aged and elderly persons this ratio is at least two to one.

The death risk for women is almost 40% greater than that for men, "Patterns" reports. Chances at birth that a man will die of diabetes before reaching the age of 65 are 3.8 per 1,000. For a woman, this figure is 5.2.

Marital status, too, plays a role, "Patterns" discloses. Prior to the age of 45, the death rate in diabetes is higher for single women than for married women, but after this age, the position is reversed. Among men, the death rate from diabetes is greater for the unmarried until the age of 70.

The publication further reveals that one out of every 80 Americans is diabetic. In addition to a million diabetics, there is another million undiagnosed diabetics.

"Patterns" stresses the importance of detection drives in creating awareness of diabetes as a public health problem and discovering the unknown diabetic. A survey of more than 70 per cent of the population of a New England town revealed three "hidden" diabetics for every four persons known to have the disease.

THE "HIDDEN" DIABETIC

What are the characteristics of the "hidden" diabetic? Weight, heredity, and age are all implicated by the publication. Approximately 40 per cent of persons who have positive diabetes screening tests are overweight; 44.5 per cent have positive family heredity of diabetes, and 62 per cent are over 40 years of age.

In general, "surprisingly little is known about the cause of diabetes, but several factors have been identified," according to "Patterns." Obesity exists in 50 per cent of diabetics, a family history of diabetes in 42 per cent, and both obesity and a family history in 22 per cent.

What are some of the symptoms of diabetes? General weakness or tiredness and a sore, abscess, infection or slow-healing wound are among the most frequently reported symptoms causing a visit to a doctor's office and leading to a diagnosis of diabetics, "Patterns" reports. Other symptoms include itching, weight loss, and excessive thirst.

The onset of diabetes is sudden and dramatic in the young according to "Patterns." It may be accompanied by excessive eating and urination, and weight loss. However, in older persons glycosuria can be present for many years without other more dramatic clinical symptoms.

The disease is far commoner in older people than in the young, with 40 as the danger age at which concentration of new case findings of diabetes are begun, "Patterns" says. Among elderly persons, diabetes is a major disease.

The publication stresses that life expectancy in the diabetic has improved greatly because of the use of insulin, a better understanding of the disease mechanism and improved methods of treatment, but it is still shorter than that of the general population.

The leading cause of death among diabetics is heart disease which accounts for almost 50 per cent of all diabetic deaths. Vascular lesions of the central nervous system rank second.

The complications of the disease are also outlined in the publication. One comprehensive study showed that in diabetics who had survived from 20 to 24 years of the disease, eye damage was the leading single complaint, afflicting 82 per cent of victims, and hardening of the arteries was second, accounting for 73 per cent. Proteinuria is third and hypertension fourth. Other complications include uremia and gangrene.

COMPLICATIONS OF PREGNANCY

In pregnancy too, complications are far commoner among diabetics than among non-diabetics. For example, the incidence of congenital anomalies is about three times as high, prematurity four times, and stillbirths 12 times. Excessively large fetuses occur in 45 to 70 per cent of diabetic pregnancies and the incidence of spontaneous abortion is also greater than in non-diabetic pregnancies.
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Current Comment

Home Services in Rural Areas—

Two rural counties in Minnesota are independently developing programs for providing home nursing and rehabilitation services to the chronically ill and disabled patients. Such programs have heretofore been primarily in urban areas and it is believed they can be equally valuable in rural areas, for preventing the further deterioration of home-bound ill and disabled patients.

The program is described in the *Chronic Illness Newsletter*, issued by the American Medical Association's Council on Medical Services. It is noted that in Wright County, a citizens' committee represented the County Medical Society, the Board of Public Health Nursing and the County Welfare Board, as well as the State Medical Association's Committee on Chronic Diseases and the State Health Department. Teams of volunteer interviewers surveyed the population to determine the number of individuals confined to their homes by chronic illness. One hundred and fifty-five persons were found in this category, of whom forty-nine were previously known to the County Public Health Nursing Service or the Welfare Board. More than two-thirds of the group were sixty-five years of age or older and nearly forty per cent of all the home-bound were suffering from diseases of the heart or blood vessels. Plans of the Wright County program include a desire to establish a rehabilitation nursing service as an integral part of the County Public Health Nursing Program. A physical therapist will be employed for the Community Hospital, providing physical therapy on an outpatient basis. A roster will be compiled of registered and practical nurses, as well as Red Cross home nursing instructors and other persons available for home nursing care.

In Steele County, the County Board of Commissioners and the Public Health Nursing Board with the cooperation of the County Medical Society, have established a private home nursing care program, to give nursing and rehabilitation services to the home-bound ill on the basis of need. To be eligible for this service, a patient must be under the care of a doctor and all treatments are to be carried out only on this doctor's orders.
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Current Comment

Malpractice Suits As a Symptom—

The past two decades have seen malpractice suits increase, and although perhaps this trend has leveled off within the past year, this is still a grave problem to the entire profession.

An editorial in the West Virginia Medical Journal discusses this question, and cites other writings on this subject. The cause of the increase is attributed to two major factors.

One of these factors is a change in the philosophy of our country, which has occurred during the last 25 years. Twenty-five years ago, the generally accepted principle was that the individual owes his country and his fellow citizens service and fair play. Perhaps a newer and different philosophy has taught people that they owe nothing to anyone but themselves.

Our present generation has also been developed in an era when we have constantly shifted responsibility from the individual to the group—from local, to state, to national governments.

(Continued on page 62-A)
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blood levels of
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5-cc. teaspoonful represents
125 mg. (200,000 units) of
potassium penicillin V.
Malpractice Suits As a Symptom—
(Continued from page 54-A)

Another factor is the change in the attitude of the public toward the collective medical profession. The editorial states that it is true that some doctors may have succumbed to a new and opportunistic way of life. Fortunately, these individuals are rare among physicians, the majority of whom are primarily interested in satisfied patients. It is reiterated that the best public relations for the doctor is the doctor himself who gives good care to his patients.

The American Scene and American Medicine—

Some very thoughtful individuals believe that not all of the medical profession is aware of the changing events and shifting philosophies occurring on the American scene.

To discuss these questions Medical Society representatives recently listened to individuals representing business, the insurance industry, labor, and politics who expressed their views on the question of the adaptation of the medical profession to our present national scene. The session was sponsored by the American Medical Association’s 1958 Public Relations Institute. The Chairman asked each expert to discuss the most significant changes taking place in his field and explain how they relate to medicine.

The chairman of the Health Insurance Council, Mr. Morton Miller cited great gains in insurance coverage so that today seven out of ten persons have some protection. The view was expressed that ultimately the government may have to help those who are unable or unwilling to allocate enough of their funds for health benefits after retirement.

Mr. Miller stated that the real challenge is to find a way of providing for these individuals which will cause a minimum of disturbance to our system of private medical care and voluntary medical or health insurance.

The discussion included reference to the inevitable question of unnecessary costs which are a threat to the future of voluntary health insurance. It was noted that it is the doctor who determines the quality and quantity of the patient’s medical care and consequently controls the way in which health insurance, as a means of financing health care, works out.
IN VITRO SENSITIVITY OF PATHOGENIC STAPHYLOCOCCI TO CHLOROMYCETIN AND TO FOUR OTHER MAJOR ANTIBIOTICS

CHLOROMYCETIN 96%

ANTIBIOTIC A 75%

ANTIBIOTIC B 61%

ANTIBIOTIC C 50%

ANTIBIOTIC D 39%

*Adapted from Godfrey & Smith. Staphylococci studied were strains isolated from 28 patients in a general hospital.
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Method of Anatomy: Grant; sixth edition; The
Williams & Wilkins Company, Baltimore, Maryland;
price, $11.50.

This is a book of 879 pages, designed for the use
of the student of anatomy. In this thoroughly re-
vised edition, new material about matters of clin-
ic importance has been added together with thirty-
four new illustrations. The new international ana-
tomical nomenclature has been adopted (N.A.P.) re-
placing B.N.A. and its Birmingham Revision. The
volume is illustrated by 862 figures. It is thor-
oughly indexed, and a list of references adds to the
facility of investigative study.

Alcoholism, A Guide for General Practitioners:
Hewitt; Lea & Febiger, Philadelphia, Pennsylvania;
pdce, $3.00.

This little book of 112 pages tells the general prac-
titioner what he can do to help care for the more
than 4,500,000 alcoholics in the U.S. This work is
based on the successful results obtained from treat-
ing an average of 100 alcoholics a month in the
largest alcoholic rehabilitation center of its kind in
the western United States. Dr. Hewitt gives an
explicit guide based on establishment of a new un-
derstanding and sympathy on the part of the physi-
cian. He stresses the vital need to secure the con-


Current Comment
BOOKS RECEIVED
Method of Anatomy: P. C. Boileau Grant (Uni-
versity of Toronto); sixth edition (1958); The
Williams & Wilkins Company, Baltimore; price, $11.50.

Cold Injury, Ground Type: Colonel T. O. M. F.
Whayne, M.C. USA (Ret) and Michael DeBakey,
M.D.; under direction of Medical Department U.S.
Army; U.S. Government Printing Office, Washing-
ton 25, D.C.; price, $6.25 (Buckram).

What We Do Know About Heart Attacks: John
W. Gofman, M.D., University of California; G. P.
Putman’s Sons, New York, N.Y.; price, $3.50.

Alcoholism, A Guide for General Practitioners:
Donald W. Hewitt, M.D., Chief Medical Advisor,
Charity Alcoholic Rehabilitation Center, Los An-
ges, Calif.; Lea & Febiger, Philadelphia, Penn.;
price, $3.00.

Neurological Basis of Behavior: A Ciba Founda-
tion Symposium edited by G. E. W. Westenholme
and Cecelia M. O’Connor; Little, Brown and Com-
pany, Boston, Mass.; 400 pp.; price, $9.00.

Water and Electrolyte Metabolism in Relation to
Age and Sex: Ciba Foundation Colloquia on Aging
edited by G. E. W. Wolstenholme and Cecelia M.
O’Connor for the Foundation; Little, Brown and
Company, Boston, Mass.; 327 pp.; price, $8.50.
Now, after just 12 months, SPONTIN has become an outstanding drug of choice against resistant staphylococci, and in other serious coccal infections.

Six papers presented at the Antibiotics Symposium reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical responses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

INDICATIONS: Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularly those caused by organisms that resist all other antibiotics.

DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity. Be sure your hospital has it stocked.

Abbott

Current Comment

The Month in Washington—

The 86th Congress convenes January 7 with a top-heavy Democratic majority in both House and Senate. This, in turn, will find all Congressional committees including those dealing in health bills, with a higher proportion of Democrats.

Because legislation rarely gets to the floor for a vote unless some committee sends it there, the makeup of committees is of considerable importance in any Congress. It will be doubly so in the 86th Congress, where so many new personalities and new ideas promise to abound.

In the Senate during the 85th Congress when the line-up was 49 Democrats to 47 Republicans, committees were fairly even divided—generally only one more Democrat than Republican. With the ratio in the Senate increased to 62 to 34, committee composition may run as much as 10 to 5 or 9 to 6 in favor of the majority party. The Reorganization Act of 1946 assures each Senator of two committee assignments, which means 26 new places have to be found on Senate committees in January.

The party ratio for House committees likewise will run high in favor of the Democrats.

Each party and each branch of Congress have their own way of naming members to the many committees.

In the Senate, the Democrats make appointments through a standing 15-man group known as the Democratic Steering Committee. Its chairman is Majority Leader Lyndon Johnson and other members are Senators Mansfield, Hennings, Chavez, Ellender, Frear, Russell, Hayden, Holland, Humphrey, Pastore, McClellan, Robertson and Johnston of South Carolina.

The Republicans in the Senate make their appointments through a 5-man Committee on Committees which in the last Congress was made up of Senators Knowland, Bricker, Saltonstall, Bridges and Dirksen.

In the House, the selection of Democratic members is done by the majority members of the Ways and Means Committee which sits as a Committee on Committees. The Republicans have a different approach. When Congress convenes, each state delegation

(Continued on page 18-A)
If you were to examine these patients

could you
detect
the asthmatic on
Medrol*?  Probably not. Not without a history.

First, because he's more than likely symptom-free.
Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticootherapy.
Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.
But in your own patients, you could see the advantages of Medrol right away. Why not try it?
The Month in Washington—  
(Continued from page 16-A)

meets and names a representative to a Committee on Committees; he has as many votes on the committees as there are Republicans in his delegation. Chairman of the committee is Minority Leader Joseph Martin.

The House Ways and Means Committee which undoubtedly will be considering legislation of import to physicians (hospitalization of the aged under social security and tax deferrals on money paid into annuities) has for several years been divided 15 Democrats to 10 Republicans. This ratio may change to 17 to 8. In any event, seven members will not serve in the new Congress. One was lost through death, four through decisions not to run for re-election to the House and two to defeat at the polls.

The Senate Finance Committee, which will be handling much the same legislation as Ways and Means, has been divided 8 to 7. It is certain that three Republicans will not serve again; two retired from the Senate and one was defeated in the recent elections.

House Interstate Committee, another group of importance to the profession because of its interest in federal aid to medical schools and Hill-Burton amendments among other things, has lost the three top ranking Republicans and the only physician serving on a committee dealing with health. Either they did not seek re-election or they were defeated at the polls.

Senate Labor Committee, which has jurisdiction over most of the major health proposals in the Senate outside of social security, loses three Republican members. Its present lineup of 8 to 7 will be changed too, probably to 10 to 5.

Physician members of the 86th Congress number four. This is one less than in the 85th Congress. Returned again were Drs. Walter Judd of Minnesota and Thomas Morgan and Ivor Fenton, both of Pennsylvania. Defeated were Drs. Will Neal of Virginia and A. L. Miller of Nebraska.

One new doctor has been added. He is Dr. Thomas Dale Alford, a board opthalmologist of Little Rock, Ark., where he has been in active practice since 1948. Dr. Alford, 42, was educated in Arkansas schools and received his medical degree from the Univer-

(Continued on page 55-A)
EDITORIAL

CHRISTMAS IS HERE AGAIN

As we approach the season when men celebrate the birth of the most influential man who ever lived—Jesus of Nazareth—our thoughts turn naturally to our fellow men. It was He who bade us “love thy neighbor as thyself.” St. Paul wrote an exposition on love, the meat of which is expressed in I Cor. 13:13—”So faith, hope, love abide, these three; but the greatest of these is love.” Without love, for ourselves and for mankind, the practice of our great profession would fall by the wayside; it would sink to the level of a craft practiced for gain only—“a noisy gong or a clanging cymbal.”

As we enter this Christmas season let us review our human relationship and renew our faith, our hope, and our love for our fellow human beings. To this end we publish the following prayer. (This “Prayer of a Physician” was first published in the South African Medical Journal, reprinted in The Journal of the A.M.A., and our clipping is from the Cornhusker G.P.)

PRAYER OF A PHYSICIAN

O God, I pray that I may have absolute intellectual honesty; let others fumble, shuffle and evade, but let me, the physician, cleave to the clean truth; assume no knowledge I have not, and claim no skill I do not possess. Cleanse me from all credulities, all fatuous enthusiasm, all stubbornness, vanities, egotism, prejudices, and whatever else may clog the sound progress of my mind—those be dirt; make my personality as aseptic as my instruments. Give me heart, but let my feeling be such as shall cover me as an investment of power, to make my thoughts clear and cold as stars, and my hand skillful, strong as steel. Deliver me from professionalism, so that I may be always human, and thus minister to sickly minds as well as to ailing bodies. Give me the joy of healing. I know how far short I am of being a good man, but make me a good doctor. Give me courage but hold me back from over-confidence. Let me so discharge the duties of my office that I shall not be ashamed to look man or woman in the face, so that when at death I lay down my task I shall go to what judgment awaits me strong in the conscious-ness that I have done something towards alleviating the incurable in life.

It is with sentiments molded by such thoughts as those in this prayer that the staff of your Journal bids you Godspeed at this Christmas time.

THE TISSUE COMMITTEE

The educational value of the tissue committee and what such a committee may accomplish for the surgeon, the patient, and the hospital is graphically described and documented in an article, “The Effectiveness of the Tissue Committee at the Missouri Baptist Hospital,” by Verda and Platt, published in the Bulletin of the American College of Surgeons, 42:449, 1958.

In the words of the authors, “From such educational activities have come a reduction in the number of unnecessary surgical procedures and adoption of new surgical techniques; patients are more carefully screened for operation, and their diagnostic work-ups are more thorough; the medical records are more complete and of better quality; the use of consultation increases.”

The program leading to these results has not been a negative or inhibiting influence but a positive approach through staff discussions, panel discussions, guest speakers, and seminars—a continuing education.

These authors document their conclusions by considering five categories of operations, namely, appendectomy, uterine suspension, lysis of adhesions, hysterectomy, and biliary tract surgery.

The story of appendectomy furnishes the most vivid example of beneficial change. With a relatively constant surgical census, the number of appendectomies diminished yearly from 26 per cent to 7 per cent of operative procedures. The reports by the pathologist showed the “normal appendices” de-
increased from 42 per cent in 1952, to 20 per cent in 1956. This was not accompanied by a rise in rate of occurrence of gangrenous or ruptured appendices; and the preoperative workup and diagnosis showed "more accurate and thoughtful screening."

While the numerical results of the work of the tissue committee have been less impressive in the other categories than that dealing with the lowly appendix, the improvements in pelvic and biliary tract surgery are, perhaps, more meritorious. It is obvious that, in the Missouri Baptist Hospital, the tissue committee does not carry a big stick, but that it has paced the staff in making use of this study as an educational instrument. Furthermore, this cooperative effort has paid good dividends toward the better practice of surgery.

A BARGAIN?

The following letter provides food for a great deal of thought, and should, with a little figuring and with the information at hand as to legislative trends in these "something-for-nothing" days, give the doubter a firm foundation for a stand against the inclusion of doctors under Social Security.

George W. Covey, M.D., Editor
Nebraska State Medical Journal
Sharp Building
Lincoln, Nebraska

Dear Dr. Covey:

I wish to call your attention to a note from The New England Journal of Medicine, October 16, 1958, page 791.

The note is on Social Security and reports the poor economics of the legislation effectively: "Of the 7560 members of the Massachusetts Medical Society, 15 per cent (1155 men and women) are sixty-five years of age or over.

"If physicians were included in the Government's Old Age and Survivors Insurance Plan (Social Security), these 1155 elderly physicians might retire and collect more than $2,000,000 annually. The remaining 6405 active practitioners would be subject to an annual tax of 3.4 per cent of the first $4,200 of their earning, and would thereby contribute to the plan $914,634 each year.

"Whether one considers this a bargain or not probably depends on what ticket one's father voted when one was an impressionable youth."

Yours truly,
Keith W. Sehnert, M.D.

"FREE-CHOICE" ON TRIAL

From A.M.A. Washington Letter 85-89 we see that those in charge of the Mine Worker Fund report a saving of 2.4 per cent or $1,448,909 during the past year on total costs for hospital and medical care. Their explanation is as follows:

"The trust fund's official files and records . . . are replete with evidence showing that the primary quality and cost requirements of the trust fund regulations were not being met under the previous free-choice-of-physician arrangements whereby the fund had permitted the beneficiary free choice of physician and had paid every physician so chosen for any service he billed the fund, and had allowed him to hospitalize any beneficiary at fund expense whenever and for as long as he desired."

One can't draw any conclusions from this statement or from what the average doctor knows about the facts in this controversy about free-choice. One could conclude that some doctors may have "used" the opportunity presented by the liberality of those administering the United Mine Workers Welfare and Retirement Fund and thereby cast a shadow upon the whole profession. We know this has happened in dealing with Blue Cross and Blue Shield. On the other hand, many other explanations for such reports can easily be deduced in the light of the present trends to blacken the reputation of the medical profession at every opportunity. If anyone knows the whole truth and can tell it without rancor and with complete impartiality, the profession at large should be privileged to have the story.

NOTICE TO ALL CONTRIBUTORS

The deadline for items to appear in the following issue of the JOURNAL is the 10th of the month. The JOURNAL goes to press on the 12th.
ANALYSIS OF
Surgical Deaths
OVER A FIVE-YEAR PERIOD (1953-1957) *

The author undertakes, in the following paper, an analysis of 600 deaths that occurred among 19,864 patients admitted to the Buffalo General Hospital on the services of General, Thoracic, and Proctologic Surgery during the five years, 1953-1957. His analysis is beamed at finding and suggesting ways and means of reducing the mortality rate wherever further reduction seems possible.

—EDITOR

IN 1850, shortly after the discovery of anesthesia, and at the dawn of the modern era of surgery, the life expectancy of an infant born in the United States was about 40 years. By 1900, this figure had increased to approximately 50 years. During the past half century, however, longevity has increased at a much faster pace so that by 1952, white infants could expect an average life span of three score years and ten. Whether or not this tremendous increase in the span of human life that has occurred during the last hundred years is an unmixed blessing, I will not argue. In any event it is an accomplishment for which medicine and its allied sciences rightly have been given credit. The role of surgery in this achievement, despite its brilliant triumphs of the past few decades, has been a minor one. This prolongation of life reflects in the main the control gained over the diseases of environmental origin such as tuberculosis, the common infections of childhood and lobar pneumonia. What accolades there may be must go primarily to the underpaid bacteriologist, the taken-for-granted Public Health Officer and the overworked pediatrician.

Surgery is undertaken at the present time, however, with less risk to the patient than ever before. The mortality incidental to virtually all types of operations, even the most radical, has been reduced in recent years. Some three years ago a statistical study carried out by the Metropolitan Life Insurance Company* compared surgical mortality as reported in recent years with that of a decade or more earlier, for various types of major operations. In every instance cited, surgical mortality had been reduced by at least one-half and in some instances by more than four-fifths.

As surgery has become safer in general, it has become feasible not only to utilize more radical procedures but also to undertake operations in poorer risk patients for whom surgical therapy formerly would have been considered ill advised. The net result of these various factors, however, may well be some increase in the over-all recent surgical mortality rates in those hospitals where advanced, more or less radical surgery, is being done. Such is probably the situation in my own hospital where the patient mortality rate on the surgical service, for 1957, is 3.25 per cent—the highest it has been for any year during the past decade.

Figure 1 is a simple line-graph of the over-all mortality rate for patients admitted to the General Surgery, Thoracic Surgery and Proctology services of the Buffalo General Hospital for the years 1947 through 1957. As I remember, in 1949-51, we were learning to do cardiac surgery and pursuing a vigorous policy with respect to carcinoma of the lung and esophagus. In 1954 we began to accept poorer risks for mitral valve operations and to construct porto-caval shunts. Since 1956 we have been trying to salvage at least one ruptured aortic aneurysm. All these efforts claim their price in mortality and leave their mark on the record. The over-all operative mortality is a respectable 2.5 per cent for the past three years but is still higher than it was previously.

A periodic survey of deaths occurring on hospital services, as now demanded in all accredited hospitals, is an excellent discipline for the professional staff if it is frankly and honestly carried out. In such meet-

*Read before Annual Convention Nebraska State Medical Association, May 1, 1958.

JOHN R. PAINE, M.D.
Buffalo General Hospital and
University of Buffalo School of Medicine
Buffalo, New York

December, 1958
Figure 1. Mortality Rate at the Buffalo General Hospital, 1947-1957, for the General Surgical, Thoracic Surgical and Proctological Services.

MORTALITY OF SURGICAL PATIENTS B.G.H. 1953-1957
600 DEATHS FROM 19,864 PATIENTS

Figure 2. General Surgical, Thoracic Surgical and Proctological Services.
ings the results of the surgeon’s acts of commission and the results of the internist’s acts of omission cannot well be hidden. Embarrassment soon gives way in an atmosphere of helpful criticism and understanding. With the passage of time, medical and surgical practice is improved.

Inasmuch as the deaths of our patients are a measure of our disappointments, our failures and mistakes, they should have lessons to teach us. It was with this in mind that we began some time ago a critical study of all the deaths that have occurred during the past five years at the Buffalo General Hospital on the following services: General Surgery, Thoracic Surgery and Proctology. It was hoped that such a study might serve to indicate the most important causes of mortality in surgical patients at the present time and in what ways our efforts to reduce this mortality still further might be spent most effectively. In the belief that the experience of this hospital is fairly typical of most moderately large hospitals in the country today, the results of this study are here reported.

The Buffalo General Hospital is a 646-bed, privately endowed, voluntary hospital, with beds for both private and charity patients. All of the surgeons who work there, numbering approximately thirty, either have been certified by the American Board of Surgery or are members of the American College of Surgeons. Due to the immediate proximity of the Buffalo Children’s Hospital, there is no Pediatric Service. As a consequence, all patients here reported are over 16 years of age. On the surgical services mentioned previously, 3500 to 4000 pa-

**TABLE 1**

**SURGICAL DEATHS**

**BUFFALO GENERAL HOSPITAL**

1953-1957 (Inclusive)

| Total Patients: General Surgery, Thoracic Surgery, Proctology | 19,864 |
| Total Operations | 18,218 |
| Total Deaths (Autopsies—55%) | 600 |
| Patient Mortality | 3.02% |
| Operative Mortality (Approx.) | 2.28% |
| Mortality in Unoperated Patients (Approx.) | 11.12% |

**TABLE 2**

**CAUSE OF DEATH**

**600 SURGICAL CASES — BUFFALO GENERAL HOSPITAL**

1953 - 1957

<table>
<thead>
<tr>
<th>Patients With Malignancy</th>
<th>Patients Without Malignancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unoperated</td>
<td>Operated</td>
</tr>
<tr>
<td>Malignancy (208): 35%</td>
<td>117</td>
</tr>
<tr>
<td>Cerebral Vascular Accidents (21): 3.5%</td>
<td>4</td>
</tr>
<tr>
<td>Cardiac (68): 11%</td>
<td>3</td>
</tr>
<tr>
<td>Cardiac “Arrest” (10)</td>
<td>3</td>
</tr>
<tr>
<td>Coronary Occlusion (26)</td>
<td>1</td>
</tr>
<tr>
<td>Cong. Failure (32)</td>
<td>9</td>
</tr>
<tr>
<td>Pulmonary Emboli (24): 4%</td>
<td>11</td>
</tr>
<tr>
<td>Pulmonary (103): 17%</td>
<td>5</td>
</tr>
<tr>
<td>Atelectasis (18)</td>
<td>12</td>
</tr>
<tr>
<td>Aspiration (34)</td>
<td>9</td>
</tr>
<tr>
<td>Pneum. and Trach.-Bronch. (51)</td>
<td>4</td>
</tr>
<tr>
<td>Hemorrhage (89): 6.5%</td>
<td>2</td>
</tr>
<tr>
<td>Operative (7)</td>
<td>5</td>
</tr>
<tr>
<td>Post Operative (15)</td>
<td>4</td>
</tr>
<tr>
<td>Varices (5)</td>
<td>11</td>
</tr>
<tr>
<td>Aneurysms (12)</td>
<td>4</td>
</tr>
<tr>
<td>Shock (Not Due to Hemorrhage) (14): 2%</td>
<td>9</td>
</tr>
<tr>
<td>Renal Failure (17): 3%</td>
<td>1</td>
</tr>
<tr>
<td>Peritonitis (81): 13.5%</td>
<td>1</td>
</tr>
<tr>
<td>(a) Local: (12)</td>
<td>3</td>
</tr>
<tr>
<td>(b) Diffuse: (69)</td>
<td>26</td>
</tr>
<tr>
<td>Leaks from Suture Lines: (18)</td>
<td>12</td>
</tr>
<tr>
<td>Sepsis Other Than Peritonitis (24): 4%</td>
<td>35</td>
</tr>
<tr>
<td>(a) Lung Abscess: (2)</td>
<td>2</td>
</tr>
<tr>
<td>(b) Gas Gangrene: (2)</td>
<td>2</td>
</tr>
<tr>
<td>(c) Septicemia: (5)</td>
<td>3</td>
</tr>
<tr>
<td>(d) Mediast. and Empyema: (6)</td>
<td>3</td>
</tr>
<tr>
<td>(e) Cholangitis: (9)</td>
<td>4</td>
</tr>
<tr>
<td>Miscellaneous Causes (40): 6.6%</td>
<td>3</td>
</tr>
<tr>
<td>(a) Liver Failure: (8)</td>
<td>2</td>
</tr>
<tr>
<td>(b) Pancreatitis: (8)</td>
<td>6</td>
</tr>
<tr>
<td>(c) Burns: (4)</td>
<td>1</td>
</tr>
<tr>
<td>(d) Multiple Injuries: (6)</td>
<td>5</td>
</tr>
<tr>
<td>(e) Staph. Enteritis: (9)</td>
<td>8</td>
</tr>
<tr>
<td>(f) Odd Cases: (5)</td>
<td>3</td>
</tr>
</tbody>
</table>

December, 1958
patients are treated each year. There have been exactly 600 hospital deaths among these patients during the past five years—an average of 10 each month. Autopsies have been performed on only 55 per cent of these patients, and it is freely admitted that our conclusions as to what really happened in the unautopsied patient may be wrong in some instances. Also, forty patients have appeared to have two or more coexisting lesions, any of which may have been the cause of death. These patients have been included in more than one category. Neither of these factors, which are inherent in any such inclusive study, is large enough, we believe, to vitiate the general conclusions that may be drawn.

Certain general observations are of interest. Three hundred and seventeen of these 600 patients (53 per cent) were suffering with some type of malignant neoplasm when admitted to the hospital. Men outnumber women in our series by 84. The average age of the male is somewhat greater than that of the female. The over-all hospital mortality in patients that were operated upon was a little over 2 per cent, whereas the mortality in patients not operated upon was approximately 11 per cent.

CAUSES OF DEATH

Malignant Neoplasms

It would seem quite significant that over half of our surgical deaths are occurring in patients with cancer. In two hundred and eight patients (about 35 per cent of the total) cancer was the specific or chief cause of death. In more than one half of the patients dying from cancer, operation was not performed. In most instances these patients were suffering from recurrent or metastatic tumors and were admitted to the hospital in the terminal stage of disease. There is little hope of decreasing the mortality in cancer patients unless new nonsurgical methods of treatment can be found.

The continuing campaigns for the early diagnosis and treatment of cancer may be having some effect. Any such results would not be directly reflected in our figures which merely pose the magnitude of the problem which yet remains in this field.

Cerebral Vascular Accidents

Intracranial hemorrhage and thrombosis or embolism of the cerebral blood vessels occupy a relatively minor position as a cause of death, accounting for only 3.5 per cent of the mortality. Such accidents occurred three times as frequently in operated patients as they did in patients not subjected to operation and probably reflect the average age of the surgical patient more than anything else. Almost 12 per cent of all deaths in the United States are said to be due to such lesions. The hope of reducing our own moderate mortality in this category is not good. Improvement will depend primarily on the results of long-term research programs or the use of new methods of treatment. A development of considerable interest has been the treatment of cerebral thrombosis with anticoagulants similar to that used now in coronary occlusion.

Heart Disease

Approximately 11 per cent of our deaths were due to heart disease. In 10 patients cardiac standstill occurred. Three responded temporarily to cardiac massage or stimulation but died one, two and five days later. The remaining 58 cases are about equally divided between death due to coronary occlusion and death due to congestive failure. Two instances of coronary occlusion were due to emboli dislodged during the course of operations on the mitral valve. The increased mortality associated with surgery performed upon patients with heart disease has been recognized for a long time. There is one question in this regard which I believe is still unsettled in spite of what most of the cardiologists that I come in contact with tell me. Does preoperative prophylactic digitalization help if congestive failure is not present? It has not been our practice to do this, but I think it would be interesting to see what a large, well controlled series of cases might show. Undoubtedly the stresses, strains, hypoxia, and hypotension frequently associated with major surgical procedures may precipitate coronary artery occlusion. With the continuing improvement in technics of inducing anesthesia and the better appreciation of physiology by the surgeon, such incidents can be expected to gradually approach an unavoidable minimum. The higher incidence of death due to heart disease in patients without cancer as compared to those with cancer is striking.

Pulmonary Emboli

Only 4 per cent of our patients died as the result of pulmonary emboli. This is a
considerably lower percentage than was commonly reported some years ago. Adequate support of the circulation by transfusions during the surgical procedure and in the immediate postoperative period combined with early ambulation and the treatment of the nonfatal initial episode with anticoagulants have, no doubt, helped to reduce the number of fatal pulmonary emboli in all hospitals. There is considerable evidence, however, that the incidence of pulmonary emboli could be reduced still further by the initiation of the routine use of anticoagulants in a prophylactic manner. Two well known surgical clinics in this country have recently begun to use anticoagulants in this manner in the postoperative period in certain selected patients. At my own hospital, Dr. Elmer Milch has followed such a practice for several years and now has a consecutive series of 1900 patients who have undergone major surgical procedures in which treatment with dicumarol was started immediately after operation. No known fatal pulmonary embolus has occurred under such a regimen. However, some increase in morbidity due to an occasional postoperative hemorrhage must be expected. In Milch's series there has been one death from such a hemorrhage.

All but one of the 24 patients dying because of a pulmonary embolus were over 55 years of age. Four occurred in unoperated patients. The percentage would be greater if Dr. Milch's patients were excluded from the calculations.

**Pulmonary Complications**

Deaths due to pulmonary complications comprise the largest group, other than those due to cancer, in our study; namely, 103 patients or approximately 17 per cent of the total. As would be expected, the great majority of these deaths occurred in operated patients and for some reason the incidence was higher in the patients without cancer than in those with cancer.

It seems reasonable to assume that postoperative pneumonia in most instances develops as the result of either atelectasis due to bronchial mucus or the regurgitation and aspiration of gastric contents. Both of these occur rather frequently in the older and weakened patient. Efforts to reduce surgical mortality might be concentrated on this group of patients with some hope of success.

With modern anesthetics and methods of their use, every surgeon has the right to expect that at the end of an operation his patient's lungs will be well aerated, not filled entirely with oxygen and with an airway relatively free of mucus. Following surgery, however, the maintenance of this healthy state of affairs is the surgeon's responsibility. Even the most carefully written orders and excellent cooperation on the part of the nursing staff is frequently not sufficient to achieve the desired result. Especially is this true in the frail, elderly, emphysematic, sedated patient. Coughing is painful, breathing is shallow, and mucus production is often increased due to the presence of a nasal tube.

Dr. Theodore Noehren of our Department of Medicine has been of great help in this problem by introducing us to the benefits to be obtained by the use of a form of treatment known as intermittent positive pressure breathing which, during the past year, we have used with increasing frequency in selected patients with very satisfactory results. You will appreciate, I am sure, the difficulties in securing good controls by which the value of such a measure may be objectively estimated, but I would urge you to try it and draw your own conclusions.

Much of the mortality and morbidity of pulmonary complications associated with major abdominal surgery may well be due to the irritation of the nasopharynx and the excessive production of mucus incident to the almost routine use of indwelling nasogastric tubes used for decompression during the immediate postoperative period. A practice which Dr. Gilchrist of Chicago first called to my attention a couple of years ago would seem to have much to recommend it. I have reference to a catheter gastrostomy as a substitute for an indwelling nasogastric tube. Such a practice is peculiarly well suited for those patients undergoing abdominal surgery in which the construction of a gastrostomy requires no additional incision and only a few minutes more operating time. The patients in whom we have used this procedure—and these are increasing at the present time—have been grateful for the increased postoperative comfort afforded them. The production of pharyngeal mucus is definitely decreased.

It is indeed distressing to find so often at autopsy that the postsurgical patient has ap-
parently died from the regurgitation of gastric contents followed by aspiration of some of this material into the bronchial tree. It must be freely admitted that on occasions this occurs merely as a premortem incident in patients dying of other causes, but in our experience it frequently appears to be the principal cause of death. Certain circumstances usually obtain for its occurrence. Typically these are as follows: An elderly, somewhat frail, patient with poor respiratory reserve has been treated following abdominal surgery by continuous suction applied to an indwelling nasal tube. The sympathetic doctor, in response to the patient's complaints of discomfort, has removed the tube during his morning rounds, against his better judgment. Some degree of gastric stasis occurs during the day. In the dark of the night, the patient becomes nauseated, regurgitates, aspirates and dies either promptly or from the pneumonia which is thus initiated. Gastric decompression maintained for an adequate length of time by means of a catheter gastrostomy obviates this chain of events.

Another preventable cause of bronchial aspiration is the use of tube feedings. It must be admitted that such a procedure is at times indicated but, nevertheless, can be dangerous in an ill patient who may at any time become unable to pass out of his stomach all that is put into it. Particularly dangerous, in my opinion, is the use of the motor-driven food-pump which has recently been put on the market. At least two patients at our hospital have died during the past year because these machines worked too well. I won't let them be used on my service.

No doubt all of us are using tracheostomy more than ever before as an adjunctive procedure in the management of the patient with chronic pulmonary or bronchial disease. In selected cases, such a procedure can be employed prophylactically with profit. No better means that I know of has been suggested to assure to the patient with excessive bronchial secretions an adequate and open airway.

Until fairly recently it was difficult for me to believe that a grown adult could die from merely a tracheobronchitis. With the increasing frequency of Staphylococcus aureus infections, however, I have had to change my mind. Quite a few of our deaths in recent months have apparently been due to such lesions. These patients may or may not have an associated staphylococcus pneumonia. Death can be sudden and unexpected. In most instances the Staphylococcus aureus can be cultured as the predominant or sole organism in the scanty sputum. These patients constitute but one facet of the whole problem of staphylococcus infections which is facing the entire medical profession today and this is much too complicated in its various ramifications to attempt to discuss here. I will say only that at my own hospital we have become more acutely aware of the value of bacteriological studies in the postoperative patient than ever before; antibiotics are being used with more discrimination, and patients with staphylococcus infections are being strictly isolated.

Hemorrhage

Hemorrhage from various causes continues to be a problem for the surgeon and accounts for between 6 per cent and 7 per cent of our deaths. It should be noted that the majority of these patients were in the non-cancer group. Serious hemorrhage during operation or during the immediate postoperative period in most instances probably reflects, to some extent, on the skill and experience of the operator. Such instances can never be entirely eliminated and as long as surgeons continue to make aggressive attacks on lesions once thought of as inoperable, hemorrhage will continue to play an appreciable role in our mortality figures. The esophageal varix and the aortic aneurysm are two such lesions. Part of the price that surgeons must pay to learn this type of surgery must be paid in blood.

Shock Due to Surgery

Less than a generation ago shock loomed large as one of the most prominent causes of death in surgical patients. Many of us can well remember the trials and struggles we had doing abdominoperineal resections, thoracoplasties, and gastric resections before blood banks were invented. Adequate transfusion services, improved anesthesia, and recovery rooms have done a great deal to eliminate shock as a cause of death except in unusual and desperate circumstances.

Renal Failure

About 3 per cent of deaths are due to renal failure. The majority of such deaths on a surgical service are due to the aggra-
tion of preexisting chronic renal disease, and, under these circumstances, little or nothing can be done about it. On the other hand, the present outlook for the patient with acute renal failure such as is seen in some transfusion reactions or in the lower nephron syndrome produced by prolonged shock is somewhat brighter. For some time now at the Buffalo General Hospital we have been using the MacNeill dialyser with spectacular success in selected cases. Of the last four patients with acute renal failure due to transfusion with incompatible blood that were transferred to our hospital for treatment, three have completely recovered following dialysis for 4 to 8 hours.

**Peritonitis**

Suppurative processes in the peritoneal cavity continue to present a very serious challenge to the surgeon. This is true in spite of the great help which we have received from the whole series of antibiotic drugs. In some lesions there is little or no improvement, however, that can be credited to these drugs. As an example, the mortality in patients with perforated peptic ulcer can be cited. At two of the largest hospitals in Buffalo, the mortality associated with this condition is as high now as it was fifteen years ago.

In the critical review of any group of surgical cases dying from peritonitis, cognizance must be taken of those patients with established peritonitis prior to operation as contrasted to those patients developing peritonitis as a direct sequel of surgery. In our own series, about one-third of those patients operated upon and dying of peritonitis had the infection prior to operation. The surgeon must accept a greater share of the responsibility for the remaining two-thirds—those patients operated upon and developing peritonitis following surgery. This group numbers 49, and in 17 of them the peritonitis was caused by or associated with a leak at an intestinal suture line. In spite of the fact that the majority of such accidents occurred in patients with cancer, faulty or inadequate surgical technic must be primarily to blame. It behooves all of us to remember that success in surgery depends in large measure on doing a large number of small and seemingly unimportant things properly and carefully. Any intestinal anastomosis or closure is worthy of our closest attention and most meticulous technic. I would also question whether drainage of the operative area should not be employed more frequently in bowel surgery. I have yet to be convinced that any harm comes from draining the closure of a duodenal stump or an end to end anastomosis of the bowel. There are those, however, who believe otherwise. Whether one uses an open or closed method of anastomosis probably makes no difference if the operation is done in a proper fashion. Bowel preparation with antibiotics has no doubt lowered the over-all mortality of intestinal surgery, but it is not an adequate substitute for good technical performance. The use of large doses of antibiotics in the treatment of established peritonitis is also very beneficial but will not close a leaking suture line. That the use of these drugs may not be entirely harmless, however, I have already indicated.

**Sepsis Other Than Peritonitis**

Other forms of sepsis account for 4 per cent of our mortality. These 24 patients represent a variety of lesions. Of these, the most frequent is cholangitis occurring as a complication of biliary tract disease.

**Miscellaneous**

Miscellaneous cases number 40 — approximately 7 per cent of the total. The cases of liver failure all occurred in patients with some degree of cirrhosis. Two patients died from pancreatitis produced by trauma incurred at the time of operation. There have been 9 fatal cases of *Staphylococcus aureus* enteritis or enterocolitis.

**DISCUSSION**

Whereas heart disease is by far the most frequently recorded cause of death in the United States as a whole, death due to cancer occurs most frequently in surgical patients over 16 years of age, accounting for one-third of the mortality. Peritonitis and other forms of sepsis account for an additional one-sixth, and pulmonary complications of the original lesion or following operation for another one-sixth. These three conditions then account for two-thirds of the surgical mortality. Heart disease as a factor in surgical mortality is relatively less important.

Some answer must be given to the inevitable question: How can we improve our results in the treatment of surgical patients? No one answer, of course, can be given to
this question. I will only venture certain suggestions which seem reasonable and ask that you consider them. These are:

1. More frequent use of intermittent positive-pressure-breathing.
2. Increased use of tracheostomy as an adjunctive surgical procedure.
3. Use of a catheter-gastrostomy as a substitute for an indwelling nasal tube for purposes of decompression.
5. More careful and meticulous technic in the closure or anastomosis of the bowel.
6. More frequent drainage of intestinal suture lines.

7. Prophylactic use of anticoagulant drugs for the prevention of pulmonary emboli in selected cases.

REFERENCES


Volmer Patch Testing

IN CHILD HEALTH CONFERENCES
A Three-Year Survey, 1955-1957

It is pointed out in this article that tuberculin testing has recovered its former popularity, replacing routine X rays of the lungs, because of the present fear of excessive radiation. While the major benefit derived from testing in childhood is “case finding,” it is also an educational tool. The figures quoted show that almost fifty per cent of positive reactors in this group of 3238 children occurred in the age-group 0-3 years, a group in which knowledge of the status of the disease is most important.

—EDITOR

TUBERCULOSIS as a pediatric problem has undergone marked changes in the past decade, yet tuberculosis remains a complicated problem for the family, the physician, and the community. Medical and community management of the tuberculous child is a highly specialized field. The physician, through routine use of the tuberculin and patch tests, is the main source of case finding today.

The patch test is used in the Child Health Conferences of the Omaha-Douglas County Health Department as a means of case finding in the very young. The obvious advantage of the patch test is its simplicity. It is recognized, however, that the patch test has its limitations in that all positive reactors are not truly positive, and that some negative reactors are not truly negative. The purpose of the tuberculin skin or patch test is twofold. First, it is an important means of case finding, and, second, such testing has value as an educational tool. During the 1950’s the skin testing programs were very popular; masses X-raying through mobile units gained ascendency in the 1940’s; at present the skin testing program once again is favored because of the concern over radiation, especially in young children and youths.

The Child Health Conferences offer only child health care and treat no illness of any kind. Their main purpose is to keep well children well and to prevent disease. When a positive patch is discovered, every effort is made by the public health nurse to have the family seek medical care. Repeated home visits are made until this is accomplished or until the family ultimately refuses follow-up care.

On July 1, 1956, the Child Health Conferences began tuberculin testing each child once a year. Prior to that time tuberculin

MATILDA S. MCINTIRE, M.D.
Director, Division of Preventable Disease Control,
Omaha-Douglas County Health Department

DELANNE SIMMONS, R.N.
Assistant Director in Nursing Service,
Visiting Nurse Association

BEATRICE ADAMS, R.N.
Preventable Disease Control Officer
Omaha, Nebraska
testing was done once on admission and then only at five years of age. Positive reactors are not skin tested again in the Child Health Conferences.

A three-year review of this program is presented below:

**VOLMER PATCH TESTING IN CHILD HEALTH CONFERENCE DURING 1955, 1956, 1957**

<table>
<thead>
<tr>
<th>Location of Clinics</th>
<th>Number Tested</th>
<th>Positive Reactors</th>
<th>Per Cent Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Omaha</td>
<td>943</td>
<td>38</td>
<td>4.3</td>
</tr>
<tr>
<td>Near North Side</td>
<td>1961</td>
<td>69</td>
<td>3.5</td>
</tr>
<tr>
<td>Benson</td>
<td>129</td>
<td>4</td>
<td>3.1</td>
</tr>
<tr>
<td>East Omaha</td>
<td>188</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Downtown</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9238</strong></td>
<td><strong>112</strong></td>
<td><strong>3.4</strong></td>
</tr>
</tbody>
</table>

Presumably there is no economic difference from one area to another, for the same eligibility requirements are effective in all clinics.

The age distribution of positive reactors is as follows:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>1955</th>
<th>1956</th>
<th>1957</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>5*</td>
<td>5**</td>
<td>7†</td>
<td>17‡</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>10</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Over 5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46</td>
<td>30</td>
<td>36</td>
<td>112</td>
</tr>
</tbody>
</table>

Many investigators are recommending the routine use of antituberculous drugs in positive reactors under 3 years of age, even though the child is X-ray negative and clinically well. For this reason, the age of the positive reactor in the past few years has been particularly important. Opinion, however, understandably is divided on this point.

Distribution by sex and race is as follows:

<table>
<thead>
<tr>
<th>MALES</th>
<th>1955</th>
<th>1956</th>
<th>1957</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Negro</td>
<td>17</td>
<td>9</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>16</strong></td>
<td><strong>14</strong></td>
<td><strong>57</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEMALES</th>
<th>1955</th>
<th>1956</th>
<th>1957</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>13</td>
<td>11</td>
<td>13</td>
<td>37</td>
</tr>
<tr>
<td>Negro</td>
<td>5</td>
<td>3</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>14</strong></td>
<td><strong>22</strong></td>
<td><strong>55</strong></td>
</tr>
</tbody>
</table>

From these figures it can be seen that white females constitute the largest group of positive reactors, followed by Negro males. Approximately one-third of the attendance at all Child Health Conferences is Negro.

A follow-up by a public health nurse is made on each positive reactor in an effort to bring the child under medical care.

Final reports on positive reactors reveal these findings:

<table>
<thead>
<tr>
<th>Disease</th>
<th>1955</th>
<th>1956</th>
<th>1957</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Chest</td>
<td>38</td>
<td>18</td>
<td>15</td>
<td>71</td>
</tr>
<tr>
<td>Primary Tuberculosis</td>
<td>3</td>
<td>9</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>No Report</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Negative Examination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46</td>
<td>30</td>
<td>36</td>
<td>112</td>
</tr>
</tbody>
</table>

*Of 17 for whom there was no report, 11 refused follow-up and 6 had moved from the City.

Tuberculosis is a communicable disease, but is comparatively less contagious than measles, chickenpox, and other childhood diseases. Transmission requires intimate, prolonged, or massive exposure. Such exposure usually occurs within the family or household environment and for that reason tuberculosis tends to remain within the family.

Of the positive reactors, the number of children with known active tuberculosis contacts was 22, or 19.6%.

The importance of finding positive contacts has been stressed by all investigators. Finding such contacts proves frequently unsuccessful as revealed below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Positive Reactors</th>
<th>Contacts With Known Tuberculosis Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>46</td>
<td>9</td>
</tr>
<tr>
<td>1956</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>1957</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

**SUMMARY**

1. Three thousand two hundred and thirty-eight pre-school children were patch tested in eight Child Health Conferences in Omaha-Douglas County from January 1, 1955 to December 31, 1957. One hundred and twelve, or 3.4% gave positive reactions.

   Fifty-four, or 48.2% of the positive reactors were in the age group 0-8 years.

2. Positive reactors were most frequent in white females.

3. Eighteen cases of primary tuberculosis were discovered in the three-year program. This means 55.6 cases per 10,000 tests resulted.

4. Only 19.6 per cent of the positive reactors gave history of contact with known positive cases of tuberculosis.
Urological Emergencies

in General Practice

Doctor Davis has recorded important data about urological emergencies. This information briefly and concisely puts at the reader's disposal the means of diagnosis, differential diagnosis, and treatment. Such a resume is always a convenient instrument to have at hand.

—EDITOR

UROLOGICAL emergencies are usually seen first by the family doctor and later by the urologist. Early recognition and management are vital, and may spell the difference between health and invalidism, life or death. A brief review of some of the more common problems would therefore seem in order. Situations demanding immediate attention are:

1. Acute urinary retention.
2. Urinary tract trauma and extravasation.
4. Reno-ureteral colic.
5. Acute urinary infection.

1. Acute urinary retention.—This is the commonest urological emergency. Predisposing factors are prostatic obstruction (benign, malignant, or inflammatory) and urethral stricture. The usual exciting cause is avoidance of the normal urge to urinate incident to long automobile rides, alcoholic bouts, or surgery. The history of inability to void, a patient in distress, and a palpably distended bladder make the diagnosis obvious. Urinary drainage must be established immediately. The first attempt at gentle catheterization should be made with a small (No. 16 French) coude tip red rubber catheter. If unsuccessful, a filiform and woven Philips' follower may often be passed and should be available to all physicians when help is not readily at hand. If all attempts at urethral catheterization fail, a suprapubic cystostomy through a small, midline, low abdominal incision is in order. Blind trochar cystostomy is dangerous and to be avoided. The emergency thus resolved, diagnostic studies to determine the exact cause of the retention, and hence the appropriate definitive management, can be carried out later.

2. Urinary tract trauma and extravasation.—Extravasation may or may not accompany trauma and is defined as the passage of urine from the normal confines of the urinary tract into the adjacent soft tissues. The escape of sterile urine results in violent tissue reaction and necrosis; if the urine is infected, tissue response and systemic effects are even more profound. Violent trauma to the pelvis or perineum or faulty urethral instrumentation are the causes of urinary extravasation commonly seen. Bladder distension and urethral stricture predispose to rupture and resultant extravasation in these respective situations.

A. Renal Trauma.—Because the kidney is anatomically well protected, serious injury occurs only with violent external trauma or a penetrating wound. Such pre-existing renal disease as tumor, calculus, or hydronephrosis predisposes to severe injury with relatively minor trauma. Degrees of renal injury vary from slight contusion to pulpefaction and vascular pedicle avulsion. A history of injury, hematuria, flank pain, tenderness, and rigidity suggest renal injury. Variables are shock and a palpable flank mass representing hematoma or extravasated urine or both. Treatment varies from bedrest and observation to immediate, life-saving nephrectomy, depending upon the severity of the

NEAL DAVIS, M.D.
From the University of Nebraska
College of Medicine
Omaha, Nebraska
injury. An early and accurate appraisal of the injury is therefore vital to proper management. An immediate intravenous pyelogram, taken while the patient is being X-rayed for other injuries, may provide all the necessary information. This simple procedure may prevent much later doubt and mismanagement. If, because of impaired function or fractional visualization, the intravenous pyelogram is not diagnostic, retrograde studies may be necessary. In addition, pyelography by either route will demonstrate the presence and status of the contralateral kidney in case the damaged kidney requires nephrectomy. Briefly, a diagnostic pyelogram by intravenous or retrograde means is vital to proper management. Acceptable emergency treatment varies from bedrest and observation to immediate nephrectomy. At one extreme, a simple contusion without disruption of renal architecture may be watched conservatively. On the other hand, a pulpefied kidney with massive hemorrhage and extravasation calls for immediate nephrectomy. Intermediate degrees of injury involve parenchymal tears of variable extent with or without massive hematuria and perinephric accumulation of blood and/or urine. Depending upon degree, these may require surgery or may be followed conservatively with close attention to vital signs, degree of hematuria and development or enlargement of a flank mass. Transfusion, intravenous fluids and antibiotics may be of great value. If surgery is required initially or later because of progression of the problem, it may involve nephrectomy or debridement, hemostasis and repair of parenchymal tears.

B. Ureteral Trauma.—Except as resultant from pelvic surgery, the ureter is rarely injured because of its size, mobility, and anatomical protection. Surgical injury may result from hemostatic crushing, ligation, or partial or complete transection and may be unilateral or bilateral. If recognized when they occur, ureteral injuries should be repaired immediately. Simple deligation of a ligated ureter may be adequate. Re-anastomosis of a transected ureter over a splinting ureteral catheter with adequate retroperitoneal drainage is the treatment indicated. More commonly, ureteral injuries are recognized postoperatively with the development of anuria in the case of bilateral ligation, or symptoms referable to the kidney if one ureter is ligated. Transection or ureteral crushing injuries may first become apparent with urinary leakage from the incision or vagina, the latter if a uretero-vaginal fistula has developed. With late sequelae cystoscopy and retrograde pyelography will reveal the site and extent of the injury as well as whether the problem is unilateral or bilateral. Appropriate surgical correction, involving nephrostomy, nephrectomy, deligation, re-anastomosis of the ureter to itself or to the bladder as the case may be, may then be undertaken.

C. Bladder Trauma. — The usual mechanism of bladder trauma is a crushing injury to the pelvis, so that associated pelvic fractures are often present. Bladder distension at the time of trauma predisposes to rupture. Bladder rupture may be intraperitoneal or extraperitoneal. If of the former type, the resultant chemical peritonitis causes generalized abdominal tenderness and rigidity. If the rupture is extraperitoneal, there will be suprapubic pain, tenderness, and swelling. A history of trauma, the regional physical findings, and a retrograde cystogram establish the diagnosis. As a rule, with the passage of a catheter, little or no urine is returned. Instillation through the catheter of 100 cc.
of a 10 per cent solution of any of the commercial urographic contrast media will confirm the diagnosis and localize the site of tear. Bladder rupture is an emergency calling for immediate surgery. The bladder should be exposed through a low mid-line abdominal incision. The peritoneum should then be opened and any tears involving the bladder's peritonealized surface, should be repaired. Finally, the bladder should be opened, and any additional bladder tears repaired with chromic "o" catgut. The wound is then closed with a Penrose drain in the space of Retzius and a cystostomy tube indwelling.

D. Urethral Trauma.—The commonest mechanisms of urethral injury are faulty instrumentation and straddle injuries. The classical findings in urethral rupture are painful, difficult urination or complete urinary retention, urethral bleeding and discoloration and swelling of the penis, scrotum and perineum. The history of trauma, these physical findings and the inability to pass a catheter help establish the diagnosis, which may be confirmed by a retrograde urethrogram. The latter may be performed by mixing equal parts of a 30 per cent solution of urographic contrast media and a water soluble jelly, such as Lubafax, to give the medium body. This material injected into the meatus with an asepto-syringe, will demonstrate extravasation from the site of urethral rupture. Urinary diversion by cystostomy, adequate incision and drainage at the site of the rupture and primary repair of the urethra as soon as practicable are important principles.

3. Hematuria. — Urinary bleeding, whether gross or microscopic, whether occurring once or repeatedly, demands complete urological study. Spontaneous cessation should not lull either the patient or the physician into false security. However, hematuria becomes an emergency only if blood loss is excessive, or clots in the bladder interfere with voiding. In either instance, cystoscopy, evacuation of bladder clots and pyelography will reveal the source of the bleeding. Appropriate control measures, which may involve transurethral fulguration of bleeding points, suprapubic cystostomy, emergency prostatectomy or renal surgery may then be carried out intelligently.

4. Reno-ureteral colic. — Colic results from distension of the renal pelvis and ureter proximal to the site of ureteral obstruction. The passage of blood clots, calculi or crystals down the ureter may cause colic. The classical picture is excruciating pain radiating along the ureteral course and down into the labia or testis. Cystoscopy and pyelography will pinpoint the exact cause and site of the obstruction. Morphine will usually afford emergency relief. Pain persistence, however, especially if chills, fever and flank tenderness supervene, demands drainage of the kidney by indwelling ureteral catheter, ureterotomy or even nephrostomy. Delay may result in the destruction of the blocked kidney or even loss of the patient.

5. Acute urinary tract infection.—

A. Acute Pyelonephritis. — Portals of bacterial entry may be hematogenous, lymphogenous, or ascending from the lower urinary tract. Intrinsic urinary disease and urinary stasis from any cause predispose to pyelonephritis. Chills, fever, renal pain, and flank tenderness suggest pyelonephritis. Associated bladder symptoms may or may not be present. There will be pyuria, unless drainage from the involved kidney is completely obstructed. Far from excluding pyelonephritis therefore, a negative urinalysis may actually be a very serious sign. Broad spectrum antibiotics, bedrest and high fluid intake should result in rapid improvement. Failure to respond and persistence of chills and fever after 48 to 72 hours suggests an
obstructive factor and demands immediate cystoscopy and pyelography. Once the type and site of the perpetuating obstruction is determined, it may be bypassed by appropriate means. This may involve an indwelling ureteral catheter, or possibly nephrostomy or ureterostomy.

B. Acute Cystitis.—As in the case of pyelonephritis, intrinsic bladder disease and urinary obstruction predispose to cystitis. Cystitic symptoms include frequency, dysuria, tenesmus, suprapubic distress, and occasionally gross hematuria. Systemic response to severe bladder infection is rarely as marked as with pyelonephritis. The urine will reveal pyuria. Antibiotics, urinary antispasmodics, and bedrest will usually suffice. If there is an obstructive factor, as in the case of prostatic obstruction with residual urine, catheter drainage is in order. As with any urinary tract infection, if cystitis is persistent or recurrent, complete urological study is indicated.

C. Acute Prostatitis.—Acute prostatitis represents a bacterial infection of the prostate gland by the gonococcus or by any one of the nonspecific urinary pathogens. In addition to marked bladder symptoms, systemic symptoms with acute prostatitis are marked. Chills and fever and prostration are common. The gland is swollen and exquisitely tender rectally, and inflammatory enlargement may cause complete urinary retention. Massage is, of course, contraindicated. Antibiotics, fluids, and bedrest usually afford quick clinical response. Failure to improve suggests a prostatic abscess which may require perineal exposure with drainage.

D. Acute Epididymitis. — Infection may reach the epididymis via the vas deferens or blood stream. Systemic chills and fever and the swollen, tender epididymis characterize this disease. Bedrest, antibiotics, scrotal support and regional icebag constitute accepted treatment. If there is associated pyuria or a significant past urological history, complete study after the acute phase subsides may be in order.

6. Anuria.—Anuria is the cessation of urinary output and may be pre-renal (shock, dehydration, hemorrhage), renal (intrinsic renal parenchymal disease) or postrenal (obstruction to urinary outflow anywhere from the collecting tubule to the external urethral meatus. Sulfas crystalluria, accidental surgical ligation of the ureter, and bilateral ureteral calculi constitute the more common causes of postrenal anuria which is distinguished from acute urinary retention by an empty bladder (catheterization). The emergency treatment of obstructive anuria is the relief of the obstructive factor. This should be accomplished before the anuric state progresses to frank uremia.

Note — More common than frank anuria are uremic states with seemingly adequate urinary volumes. However, the same considerations apply in that these problems are also prerenal, renal or postrenal in origin. The physician is obligated to exclude possible postrenal (obstructive) causes. If present, obstructive lesions may be bypassed and the uremic state reversed. The classical example is the old gentleman with uremia resultant from prostatic obstruction. Continued neglect leads to progression of uremia while simple catheter drainage results in striking clinical improvement.

Current Comment

Diabetes is the “only major cause of death in which female mortality exceeds male mortality,” according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. Chances at birth that a man will die of diabetes before reaching the age of 65 are 3.8 per 1,000. For a woman, this figure is 5.2. Women accounted for 60 per cent of the 26,340 deaths from diabetes in 1956.
Ileocolic Intussusception

IN THE ADULT (A Case Report)

This case-report concerns a relatively rare condition and serves to remind the reader of such a possibility. Ileocolic intussusception in the adult is much less frequent than in the child; its symptoms often vary from the usual; its causes differ from those of the childhood type. In the case reported, the etiologic agent was different, also, than usually found in adults.

—EDITOR

INTUSSUSCEPTION was recognized as early as 1793, when John Hunter described a case. Yet, intussusception in the adult remains an infrequent entity, and consequently the discovery of a case stimulates interest. In adults, intussusception accounts for only five to ten per cent of all intussusceptions, whereas, ninety to ninety-five per cent of the cases are seen in children under two years of age.

Further differences between the adult and childhood forms of intussusception are demonstrated by the variation in site of occurrence. In infancy and childhood ninety-four per cent of the cases are of the ileocolic or ileocecal types, whereas, only thirteen per cent of the adult cases are of the ileocolic type.

The exact mechanism for causation remains unknown, but there are well-established predisposing factors. A great majority of cases in childhood have no demonstrable cause, but in the adult the process is usually secondary to a definite lesion. In a series of 745 cases this proved to be a benign tumor in thirty-three per cent of the cases, and a malignant tumor in twenty-one per cent of the cases. In the majority of cases the condition manifests itself as being subacute or chronic in nature. The symptoms vary in duration from a few days to several years. A case is reported where surgical treatment was delayed by the patient for a period of nine months after the diagnosis of intussusception was made by barium enema. Blood is evident in the stools in thirty-eight per cent of adult cases as compared to a seventy-three per cent incidence in childhood cases. An abdominal mass is palpable in forty-nine per cent of adult cases, but is palpable in seventy-seven per cent of cases in childhood.

CARL P. TRANISI, M.D., and O. J. PARRILLO, M.D.
Omaha, Nebraska

A case of adult ileocolic intussusception is presented. This is a 53-year-old colored man, a hotel porter. In mid-August of 1950, he developed late afternoon episodes of malaise, fatigue, aching of the legs, chilliness and increasing fever, lasting approximately one hour and terminating in generalized diaphoresis. There was anorexia, and a weight loss of 12 pounds had occurred to the time of admission on October 6th, 1950.

Physical examination revealed the patient to be well-developed, undernourished, and not in any acute distress. There was minimal scleral icterus and discrete small generalized lymphadenopathy. There was no hepatospleno-megaly and the remainder of the examination was noncontributory.

Blood cultures and polyagglutination tests for typhoid, paratyphoid, brucella, Weil Felix, and the heterophile antibody were negative. The serum bilirubin rose to 7.2 mg., the thymol turbidity to 16.4 units. The bromsulfalein initially revealed 40 per cent dye-retention in 45 minutes. The cephalin flocculation was 2+ in 24 hours and 4+ in 48 hours. Total serum protein was 5.70 Gm., albumin 3.05 Gm., and globulin 2.65 Gm. Urine urobilinogen was increased.

Right supraclavicular and epitrochlear lymph node biopsies on October 26 and November 3 respectively were reported as showing a small round cell type lymphosarcoma. A bone marrow biopsy was normal.

Hospital Course and Treatment.—He had almost daily late afternoon chilliness or chills with fever to 102.8° F., diaphoresis, fatigue, and increasing icterus of sclerae and mucous membranes. He was given a course of nitrogen mustard starting on November 7th. Grati-
fying clinical improvement occurred with increasing appetite, general well-being and rapid clearing of the clinical icterus. Temporary hemopoietic suppression occurred, and all liver function tests eventually returned to normal. He was discharged and followed periodically with no evidence of recurrence.

In September 1953, and July of 1956, the lymph node biopsy sections were reviewed, the previous diagnosis of lymphosarcoma was considered questionable, and a diagnosis of marked chronic lymphadenitis was made. Scattered mitoses seen in the sections were thought to represent an early lymphocytic lymphosarcoma by one examiner, however.

Final Admission 7-29-57:

At 1 p.m. on July 25, 1957, this patient began experiencing recurrent short episodes of sharp, cramp-like, periumbilical pain radiating through the midepigastrium and at times of sufficient severity to cause him to double over. There was associated anorexia and nausea and on one occasion, vomiting. Bowel movements were normal until the day prior to admission.

Physical examination revealed the blood pressure to be 150/94, the pulse 72, temperature 99°F. An egg-sized, smooth, tender, somewhat fixed mass was palpable low in the right lower quadrant of the abdomen and there was mild general right abdominal tympany and hyperperistalsis. There was shotty generalized lymphadenopathy. During the examination there occurred two short episodes of sharp pain causing him to grimace and clutch his mid-abdomen.

Routine laboratory studies were negative including a roentgenogram of the chest. A flat film of the abdomen revealed a possible oval soft-tissue mass in the ileocecal area measuring approximately 4 x 3 cm. Examination by barium enema, on 7-30-57, revealed a partial obstruction to the passage of barium at the hepatic flexure where a cup-shaped filling defect was observed. The barium finally filling the ascending colon and cecum revealed an extensive “coiled spring” appearing filling defect seen more clearly in the ascending colon and cecum on the evacuation film. There was also a pressure defect in a portion of the ileum due to a mass.

A diagnosis of ileocolic intussusception was made, and, after proper bowel preparation, exploratory celiotomy was performed on 8-7-57, revealing a thickened edematous terminal ileum for a distance of approximately 12 inches with associated hyperplastic nodes in the mesentery of the terminal ileum and ascending colon. The intussusception had apparently reduced itself prior to surgery. A by-pass procedure was done with a side-to-side 2” luminal anastomosis between normal ileum and ascending colon. Appendectomy with purse-string inversion of the stump was also done and several mesenteric lymph nodes were removed for biopsy purposes. The postoperative course was uneventful and he was discharged from the hospital 8-16-57.

Histopathologic examination of the appendix revealed irregular mucosal hypertrophy, moderate submucosal fibrosis and focal lymphoid hyperplasia. The lymph nodes showed reactive hyperplasia.

COMMENT

Preoperatively it was thought that this represented a case of ileocolic intussusception secondary to a tumor mass, probably a recurrence of lymphosarcoma. At surgery, the terminal ileum had the classical appearance of terminal ileitis and the mesenteric nodes were reported merely as demonstrating reactive hyperplasia.

SUMMARY

A case of ileocolic intussusception in the adult, secondary to terminal ileitis, is described. Although a diagnosis of lymphosarcoma had previously been made on this patient and it was considered preoperatively to be the precipitating factor for the ileocolic intussusception, this could not be substantiated at surgery, and indeed, there was no evidence of abdominal lymphosarcoma.

BIBLIOGRAPHY

STATEMENT of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
On PROPOSED
Social Security Act Amendments*

Mr. Chairman and Members of the Committee:

My name is E. J. Faulkner. I am President of Woodmen Accident and Life Company of Lincoln, Nebraska. I appear today in behalf of the Health Insurance Association of America, an association of 264 insurers engaged wholly or in part in providing voluntary health insurance. Our member companies underwrite in excess of 80 per cent of the voluntary health insurance in force in insurance companies in the United States and Canada.

This statement is directed to the hospital, medical, nursing home, and dental care proposals of H.R. 9467 (the Forand Bill) and similar pending bills including benefits for health care. As to the other provisions of such bills we concur in the statement presented by Mr. Miller. The health care benefits proposed by H.R. 9467 would pay for up to 120 days per year of hospital or nursing home care, or both, and surgical service including oral surgery for those who are currently eligible to receive O.A.S.D.I. benefits and their dependents whether or not they are actually receiving such benefits.

We are opposed to the enactment of H.R. 9467 and similar measures for the following principal reasons: (1) The benefits proposed constitute a radical departure from the established concepts of the Social Security System, a departure that would seriously jeopardize the system; (2) the proposal fails to alleviate the only real problem, that of the presently aged who either are indigent or can become so when confronted with unexpected health care costs; (3) the proposal would levy a heavy, new, and unnecessary tax on our already overburdened taxpayers; and (4) the American system of voluntary health insurance is rapidly providing nearly every element of our society including the aged with the means of meeting necessary health care costs and should not be hampered or destroyed.

As originally conceived and as maintained despite extensive amendments, the purpose of the Social Security Act is to pay basic retirement benefits in cash to supply a floor of protection for our senior citizens without depriving them of the sense of personal responsibility upon which human dignity depends. The Act seeks to provide encouragement to supplement O.A.S.D.I. payments by individual thrift and to contribute to national productivity because of reasonable work incentives. The O.A.S.D.I. recipient has never yet been deprived of his right to determine freely and for himself how to spend his Social Security benefit. In violation of this concept, the health care provisions of H.R. 9467 are a radical and dangerous departure. They postulate that the Social Security System be used to supply services rather than cash income for O.A.S.D.I. recipients and their dependents. This would be accomplished by direct payment for covered health care services, not to the O.A.S.D.I. beneficiary, but to the provider of such services. This change in the role of Social Security raises important and serious questions.

First, do we no longer believe that the individual is capable of budgeting his income or allocating his resources to meet the several necessities of life including payment for health care or insurance to provide for it?

Second, if we feel that the O.A.S.D.I. recipient is incompetent in the health care field, would we not also be justified in con-

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*Before the Ways and Means Committee of the House of Representatives, June 24, 1948.

E. J. FAULKNER
Lincoln, Nebraska

Nebraska S. M. J.
cluding that he is equally deficient in his ability to budget for food, clothing and shelter and that the Social Security system should do this for him.

Voluntary insurers have not opposed payment of floor-of-protection cash retirement benefits by the Social Security System. Such payments have helped preserve rather than vitiate the freedom, independence and responsibility of the individual for managing his own affairs. H.R. 9467 if adopted would be an irrevocable first step in the destruction of these individual liberties and would subvert a sound, fundamental concept of Social Security.

Since evidence is lacking that any American, aged or otherwise, who has needed and actually sought health care has been denied it, we must conclude that the intended purpose of H.R. 9467 and similar bills is to ease the problem of those senior citizens who cannot pay for needed health care services, at least not without great difficulty. While available information precludes precise segregation of these people, it is reasonable to assume that the majority of Americans over age 65 are not included among them. Many people age 65 or older are receiving, in addition to or independent of O.A.S.D.I. benefits, pensions from previous employment, income from investments, from annuities and from individual or group life and health insurance policies. Many have accumulated savings, own their homes free of mortgage, or have other assets. Recent studies of the Social Security Administration show that an estimated 28 per cent of persons age 65 or older have income from employment. From these facts it is obvious that a substantial number of our senior citizens have some means from which to meet health care costs. On the other hand, we know from Social Security Administration data that there will be approximately 5,400,000 men over age 65 and women over age 62 who will not be covered by or eligible to receive O.A.S.D.I. benefits as of January, 1959, this being generally one-third of all aged persons. It is doubtful some part of this group who are the aged men and women who experience the greatest difficulty in paying health care costs. Yet H.R. 9467 and similar proposals would do nothing to ease their burden. These bills do not go to the heart of the real problem. They fail to define or to reach those who are in greatest need. Rather than the proposed measures, therefore, we urge Congress to consider favorably further and more adequate Federal financial participation for the benefit of the aged in the “vendor payments for medical care” program. This program, because it is restricted to persons qualifying for public assistance, will define and reach those aged who have the real health care costs problem. It has the advantage and economy of matching state and federal funds and of local administration on a needs and means test basis. As would not be the case with an additional permanent and constantly more expensive program, improvement of medical vendor payments for the aged indigent can be flexible, subject to contraction and elimination as the proportion of aged people with health care cost problems diminishes over the years because of the expansion and perfection of voluntary insurance.

Not only does H.R. 9467 miss the mark, as just suggested, but its proposals fail to recognize that much expense, often and erroneously considered a part of the health care costs of the aged, is in reality simply living expense. For example, the Housing Commissioner of the State of New York recently pointed out that insufficient housing for the aged is keeping many older people confined to hospitals even though they do not need constant medical care. He estimates that 20 per cent of hospital confinement of older people could be eliminated if adequate housing were available for them. Other Committees of the Congress have before them proposals to correct this type of problem. Many informed people today believe that much can be done to reduce the health care costs of the aged by developing sufficient but less expensive facilities and techniques for their treatment. Wider use of ambulatory or self-service hospital care and better use of trained practical nurses both in and out of the hospital would result in substantial savings. Enactment of H.R. 9467 would discourage sorely needed experimentation and development to cut the costs of health care now being studied and undertaken by government agencies, professional groups, and private institutions.

As a supplement (Appendix I) to this statement, I am filing detailed actuarial estimates of the costs of the health care benefits proposed by H.R. 9467. It is submitted in behalf of the Health Insurance Association of America, the American Life Convention, and the Life Insurance Association of
America. I will only summarize the estimates here.

Assuming an effective date of January 1, 1959, for commencement of payments, we estimate the first year cost of the proposed hospital benefits would be $1,370,300,000; surgical benefits $228,371,000; and nursing home care $513,929,000; for a total of $2,112,600,000. Using these first year costs as a base, our actuaries have projected the costs for future years. For hospital benefits, their conservative estimate is a 4 per cent increase each year 1960 to 1964 inclusive, 3 per cent per year 1965-1969 inclusive, 2 per cent per year 1970-1974 inclusive and 1 per cent per year 1975-1979 inclusive. Surgical costs are estimated to increase 2 per cent per year for 10 years. Nursing home care costs are calculated to triple in the next decade. All of these estimates exclude any future increase in the general cost of living which would be a further addition to the expense of these benefits.

On page 9, Appendix I, there is presented a computation establishing that the level premium cost of the health care benefits of H.R. 9467 amounts to 3.025 per cent of taxable payroll. This cost is many times greater than the one per cent of taxable payroll increase in Social Security taxes proposed by the bill to provide these benefits and all of the other benefits of the bill. Obviously, were the bill enacted, the initial increase would have to be larger than the bill provides. The level premium cost of presently provided Social Security benefits is 8.25 per cent of taxable payroll. Cost of H.R. 9467 health care benefits would push the total necessary payroll tax expressed on a level premium basis to 11.275 per cent, a 37 per cent increase. And this would be but a beginning, because there would be continuing proposals for extension of health care benefits culminating probably in an all-inclusive compulsory health insurance system. This could easily mean that the American worker and his employer would be taxed to the extent of 20 per cent of payroll for social benefits. Such a tax load could well grind down our wage-earners and crush the American private enterprise economy.

Let us not be blind to the experience of others. Although not entirely analogous to what is here proposed, the history of the Provincial Hospital Plan Saskatchewan is ample justification for estimates that the cost of health care benefits of H.R. 9467 will be very high. Saskatchewan has had a compulsory hospital insurance plan since January 1, 1947. After one year of operation it was discovered that original forecasts of cost were about 50 per cent too low. Those costs have continued to grow and, in 1957, accounted for 2 per cent of the total net general expenditure of the Saskatchewan Provincial Government. It is notable that all health and social welfare expenses including hospital care amounted in that year to 41 per cent of the total net general expense of the Province. Because there is an absolute limit to the amount of taxes that government can extract from its citizens, it is patent that the high cost of such social benefit schemes can be met, if at all, only at the expense of adequate provision for defense, education, highway construction, and scores of other needed public services.

A major reason why any compulsory health care scheme develops cost substantially greater than voluntary systems is over-utilization of the benefits and facilities provided. Appendix II to this statement presents certain data about compulsory Canadian plans. Table A contrasts hospital utilization in the United States and in Saskatchewan during 1956. The average number of days of hospitalization per capita is twice as great in Saskatchewan as in the United States because under their compulsory scheme people go to the hospital about twice as often and stay there longer. Great Britain has had an equally deplorable experience with its National Health Plan as is evidenced by the shocking difference between the original estimate of ultimate cost of 180,000,000 pounds per year and the current such estimate which is 690,000,000 pounds per year. These costs have skyrocketed even though original benefits have been curtailed, some charges to patients have been instituted, and no funds have been available for hospital construction. Thus even though our conservative actuarial estimate of the costs of H.R. 9467 is many times greater than its proponents claim, it is probable that this estimate understates the seemingly inevitable impact of progressively greater over-utilization and expansion of benefits implicit in any compulsory health care plan. We believe that it is not morally defensible for this generation, seeking to ease a temporary problem, to saddle a crushing tax on our children who must pay tomorrow's taxes.
It is unnecessary for Congress thus to mortgage the future of Americans as a free people. The problems of financing health care costs are being solved by private enterprise. Less than 20 years ago voluntary health insurance was relatively unknown to most Americans. Today, according to the Health Insurance Council, 123,000,000 people in the United States have some form of health insurance. Last year voluntary health insurers paid $4,200,000,000 in benefits. This insurance is written in many forms and by various types of insurers. These include insurance companies, service plans like Blue Cross and Blue Shield, group medical practice plans operating on a pre-payment basis, plans that are self-administered by employers, Labor Unions, fraternal societies, and rural health co-operatives. Coverage is provided on an individual, family, association, and group basis. Each type of insurer has its distinctive approach, providing the buyer of insurance the opportunity to choose the kind of plan best suited to his needs and ability to buy. Keen competition among insurers has spurred experimentation to devise new and better benefits. Competition has made voluntary insurers responsive to changing needs which is important when protecting against so volatile a hazard as that of health care costs. We of the voluntary health insurance business are proud that our institutions are making so considerable a contribution to the public good. We are confident that we can continue to improve the coverage of our insurance and extend it to even greater numbers of people.

But what has been done and what are we doing to provide health insurance for our senior citizens? In the relatively few years since their special problems became of concern, outstanding progress has been made in meeting their health insurance needs. Experience with their risk is accumulating daily. Competition has sparked the development of many methods for extending insurance to older people. Some of these approaches were unheard of even five years ago. The seven principal methods are:

1. Continuation of insurance on older active workers under group insurance plans.
2. Continuation of group insurance on workers who retire, and their dependents.
3. Continuation on an individual policy basis of coverage originally provided by group insurance, this being accomplished by conversion of the group coverage on termination of employment or membership in the insured group.
4. New issuance of group insurance on such groups of older people as associations of retired persons or employees, retired teachers and civil servants, and Golden Age Clubs.
5. Continuation into the later years of individual insurance purchased at the younger ages.
6. New issuance of individual insurance at advanced ages.
7. Issuance of insurance that becomes paid-up at age 65, thus enabling the policyholder to pay for his protection during his productive years.

(These methods are explained in greater detail in Appendix III filed with this Statement).

In addition to these approaches of insurance companies, other types of health insurers are making valuable contributions to the extension of health insurance protection to aged people.

The number of older people having some form of health insurance today is not known precisely. Estimates derived from many studies based on different samples vary, but all confirm that excellent progress is being made. We believe that at least 40 per cent of persons over 65 now have some health insurance coverage, although a study in Michigan indicated the insured proportion of the aged in that state to be 86 per cent. Since about 18 per cent of the aged are public welfare recipients under the federally aided public assistance program and, as such, eligible to receive health care, since some do not need or want health insurance and others are institutionalized or receive care from the Veterans Administration or local public or private agencies, the already achieved expansion of health insurance to so large a proportion of the aged population in just a few years time is a remarkable accomplishment. Today’s aged did not know the value of voluntary health insurance in their younger years, but their children know it and accept it as sound and necessary. This generation will see to it that their voluntary health insurance protection is maintained in their years beyond retirement. Thus, with
respect to the future aged, the proportion insured will continue to grow and the uninsured problem-aged to decline.

A system so vital, progressive, and widespread as voluntary health insurance should not be impaired or destroyed. Already the mainstay of the vast majority of Americans for meeting health care costs, its potential for solving the remaining problems of financing health care is very great. However, as Mr. Miller explained in his statement, the voluntary system and a compulsory health scheme cannot co-exist. Nor can one be superimposed on the other. If people are compelled to pay taxes to support a government health care program, as proposed in H.R. 9467, our uniquely successful and advantageous system of voluntary health insurance will be supplanted by an inflexible, cumbersome, expensive, and inferior system of state medicine and compulsory health insurance.

We express to you our firm and complete opposition to H.R. 9467 and similar bills proposing socialization of the provision and financing of health care because (1) such measures if enacted would impair if not destroy the present Social Security System; (2) they would fail to alleviate the only real problem, that of the presently aged who require assistance to meet their health care costs; (3) such proposals would impose new, uncertain, growing and crushing burdens on an already heavily taxed citizenry; and (4) such measures are unnecessary because voluntary health insurance has the capacity to provide the aged as well as other segments of our population with a sound and economical means of paying health care expenses. In the best interests of the American people, we ask you to vote against these proposals.

REFERENCES

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DOCTOR — Does your wife like to read the Auxiliary news? Then be sure and take your copy home.

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Comments From Your President

May I use this page to express my feelings which I know are those of all of you at the Holiday Season?

Our Thanksgiving Time just passed means a great deal to our profession. We are given freedom in this Land of Ours to practice medicine in our own free way. Because of that freedom we can be justly proud of the quality of care which we render. It is now our Christmas Season. May our gift to our patients be our very best efforts to care for their needs?

In return we are receiving a greater gift than any other profession ever receives. That is the God given gift of being of real service to our fellow men.

May we all be worthy of that gift?

FAY SMITH, President.
Organization Section

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
December 6, Alliance, St. Joseph’s Hospital.
January 10, Kearney, Good Samaritan Hospital.
January 31, Norfolk, Norfolk State Hospital.

SEVENTH ANNUAL SEMINAR ON CANCER — Arizona Division, American Cancer Society; Paradise Inn, Phoenix, Arizona, Jan. 22, 23, 24, 1959.

NEW ORLEANS GRADUATE ASSEMBLY—March 2-3-4-5, 1959, Hotel Roosevelt, New Orleans; followed by 15th Annual Clinical Tour of Mexico, March 6 to 21.

INTERNATIONAL COLLEGE OF SURGEONS—Southeastern Regional Meeting of United States Section; Americana Hotel, Miami Beach, Fla., January 4-7, 1959.

Medicare in Operation

THE BIG CHANGE

Undoubtedly by now, every physician is aware of the radical change in the Medicare Program. When the government tightened the purse strings on the Program, this automatically set into motion rigid standards of evaluation as to coverage for medical and surgical procedures. It is imperative for the Fiscal Agent to obtain all pertinent information concerning a case in order to render an intelligent and fair adjudication. The government auditors have the authority to recall any monies paid under Medicare up to seven years from the date of payment.

A permit is required in most cases when the patient and sponsor are residing together. Although this permit is issued by the commander of the base medical facility, the permit does not commit the government on payment for unauthorized care. The underlying cause for the appropriate commander to issue a permit is because there are no facilities at the base to care for the specific condition or the facilities are utilized to the maximum. The primary source for determining authorized care is the Fiscal Agent.

To provide effective cross-utilization of medical facilities of the uniformed services, eligible dependents, regardless of service affiliation, shall be given equal opportunity for medical care. Such dependents may request and be furnished medical care at the medical facility of the uniformed service serving the area in which they reside or in the medical facility of the sponsor’s own uniformed service depending upon the capability of the medical facilities concerned. Spouses and children are considered to be residing with their sponsor if they reside in the area to which the sponsor is assigned, in the area of his permanent duty station, or the home port or home yard of a ship, even though the sponsor may be temporarily away, by reason of temporary duty with his unit or ship, from the area to which he is assigned, the permanent duty station or his home port or home yard respectively, or by reason of the sponsor’s absence on individual temporary duty or temporary additional duty order.

The major question uppermost in everyone’s mind is “What is the reason for such drastic precautions and restrictions?” The answer is simple, Congress limited the proposed budget to run the Medicare Program. Medicare payments to physicians in Nebraska during 1957 amounted to $333,784. During the first nine months of 1958, prior to the cutback, the payments amounted to $366,981.

Blue Shield and the Aged

The following item is reprinted from Blue Shield Medical Care Plans Newsletter of November, 1958. It is not only instructional but encouraging to note the progress made along this particular line toward the proper care and management of the aging population.

The A.M.A. Council on Medical Service held an invitational meeting in Chicago last month with representatives of Blue Shield-Blue Cross and the health insurance industry to discuss the problems and current status of “Voluntary Health Insurance for the Aged.” At this gathering, the past efforts of Blue Shield Plans in covering elder citizens and the attitude of Blue Shield toward extending its efforts still further in serving the needs of senior citizens were described in a prepared statement. The complete text of this statement follows and is presented because it will be of special inter-
The provision of health care coverage for senior citizens has been a matter of continuing interest to Blue Shield for some years. Plans long ago recognized that the elder citizens would increasingly represent a segment of the community whose needs for coverage would have to be more specifically met if the objective of community service was to be effectively fulfilled as a basic aim of the Blue Shield program.

That the Plans have actually made progress in meeting the needs of senior citizens is borne out by the fact that in 1951, 5 per cent of Blue Shield enrollment—or nearly a million members—were 65 years of age or older. By 1957, about 2.5 million persons enrolled in Blue Shield were over 65. This represented 6.5 per cent of Blue Shield enrollment. And of particular interest in this regard is the fact that while total Blue Shield enrollment between 1951 and 1957 increased by about 85 per cent, the number of persons over age 65 covered by Blue Shield increased 170 per cent.

Underlining further the strides already made by Blue Shield Plans in providing coverage for elder citizens, is the conclusions which can be drawn in comparing Blue Shield enrollment of persons past 65 with figures recently reported indicating the extent to which the total aged population is covered by some form of health insurance. A study released in June, 1958, by the Department of Health, Education, and Welfare, indicated that as of 1956, 28 per cent or about 4 million persons past 65 had surgical/medical coverage. The number of persons past 65 covered by Blue Shield—roughly 2.5 million—represents about two-thirds of the segment of the aged population reported in the H.E.W. study as covered under surgical/medical programs in 1956.

The extent to which Blue Shield is already covering senior citizens has been due largely to the enrollment and conversion regulations adopted by Plans in their efforts to provide for the needs of persons reaching retirement age. For example, 65 per cent of the Plans impose no age limits on initial group enrollment. Although 35 per cent of the Plans have age limits on such enrollment, the universal practice among these Plans is to waive them on groups of reasonable size. Moreover, when Blue Shield sub-

scribers attain retirement age, every Plan provides for continuation of coverage under conversion privileges.

Of further interest is the fact that six Plans have eliminated age limits on initial non-group enrollment to meet the needs of persons previously without any coverage or those who may have had types of coverage they could not continue on reaching retirement age.

Reinforcing these accomplishments, some of our Plans, notably Arkansas and Nebraska, have recently established coverage especially designed for senior citizens. Similar efforts will undoubtedly be duplicated or paralleled as more Plans seek to fulfill the needs of a segment of our population whose numbers will increase significantly in the years ahead.

To provide constructive assistance to Plans and to assure continuing developments aimed at accelerating enrollment of senior citizens by all Plans, the Board of Blue Shield Medical Care Plans recently established a special committee to study all aspects of the problem. Specifically, this committee will be expected to:

1. Assess and define specifically the extent to which Blue Shield Plans are presently meeting the needs of elder citizens for coverage.
2. Gather pertinent information on the experience of Plans already offering special forms of coverage for persons past retirement age.
3. Define the actuarial and underwriting criteria that may be expected to have special significance in writing coverage for senior citizens.
4. Develop suggested patterns of benefits considered to be basic coverage especially for elder citizens.
5. Provide current information on the nature and extent of competitive efforts to provide coverage for the aged.
6. Consult with representatives of medical organizations who may be seeking an exchange of information on the needs and problems to be met in developing coverage of special value to senior citizens.
7. Draft and submit recommendations on the most suitable means of pro-
viding coverage for senior citizens to the Board of Blue Shield Medical Care Plans for review and ultimate presentation to all Plans for their guidance and information.

"In serving these objectives, this Blue Shield committee assumes a responsibility of basic importance not only to Blue Shield but to the future of the total concept of employing voluntary mechanisms of all kinds in solving the vital problem of financing health care costs.

"It is anticipated that the efforts of this committee will provide the motivation and the organized planning essential in stimulating Blue Shield Plans to move ahead rapidly in meeting the needs of senior citizens for the coverage they will increasingly demand as essential to their personal and economic security in retirement.

"The national attention recently given the Forand Bill is a clear-cut indication that health coverage for the aged is a question of major importance. It could, in fact, become an issue of immense political magnitude leading to legislation affecting the very future of voluntary programs for health care coverage. Blue Shield is dedicated to the preservation of voluntary systems to meet the health needs of the nation and is, therefore, determined to move forward energetically to meet the needs of senior citizens as fully and practically as possible." 

**Medicine in the News**

**From the Lincoln Journal—**

The Bryan Memorial Hospital medical staff members have unanimously endorsed the new progressive patient care concept.

At a quarterly meeting the physicians on the staff passed a resolution asking consideration of the progressive patient care plan when Bryan's expansion begins next summer.

The resolution was sent to the board of trustees which must make the decision on whether Bryan adopts the new medical care concept.

Progressive patient care, used in part by about 100 of the nation's hospitals now, places patients together in relation to the degree of illness—not by types of illness.

There are five steps to the new concept, intensive, for those seriously ill; intermediate, for those not so ill; selfcare for the ambulatory; a long term unit, and home care.

If Bryan should adopt the plan, officials believe only the first 3 steps would be in operation at the onset.

**From the Kearney Hub—**

Phyllis Saulsbury of Lexington and Phyllis Brooks of Cozad have been named as recipients of the annual Scholarship Loan Fund of the Dawson County Medical Auxiliary. Miss Saulsbury is in nurses training at St. Catherine's Hospital in Omaha and Miss Brooks is enrolled in training at Bryan Memorial Hospital in Lincoln.

**From the Lexington Clipper—**

A total of 81 new students are registered at the University of Nebraska College of Medicine. All but six are from Nebraska. Of the new students, 32 are married. Only 5 are doctor's sons, while 17 come from farm families.

**From the Omaha World-Herald—**

Creighton University School of Medicine has received its second contract for the Federal program, "Medical Education for National Defense." Value is estimated at 11 thousand dollars.

The program calls for a series of lectures on the care of mass casualties and the sending of medical faculty members to specialized meetings.

**From the Omaha World-Herald—**

Colonel Robert J. Benford, a specialist in aviation medicine, has been named director of the Armed Forces Medical Publication Agency and editor of the United States Armed Forces Medical Journal.

Dr. Benford, a graduate of Creighton University and the University of Nebraska College of Medicine, is the author of "Doctors in the Sky," a history of aviation medicine.

**From the Lincoln Journal—**

Dr. Donald F. Purvis of Lincoln was elected president of the Nebraska Heart Association at its annual meeting in Omaha in October. Doctor Purvis succeeds Dr. Stephen L. Magiera of Omaha.
Other officers chosen were Edwin Van Horne, Omaha, chairman of the board; Dr. D. A. Nye, Kearney, president-elect; Dr. Richard Egan, Omaha, first vice-president; Edwin F. Dosek, Lincoln, re-elected second vice president, and David S. Davis, Omaha, treasurer.

Named to the executive committee were Drs. L. Lowell Dunn, William Angle, S. L. Magiera, Otto Wurl, Robert L. Grissom, all of Omaha, and Dr. O. A. Kostal, Hastings.

From the Omaha World-Herald—

The Nebraska Psychiatric Institute received the 1958 Mental Hospital Service Award of the American Psychiatric Association.

The silver plaque was awarded to the Omaha institution.

It recognized the leadership of the institution in setting up a state wide Nebraska mental health program.

"Nebraska's decision to invest in a psychiatric research and training facility, rather than just adding more hospital beds, has paid dividends in a dynamic program that has benefited the entire state and also aids the Dakotas and Iowa," a citation read.

Dr. Mathew Ross, medical director of the A.P.A., made the award at the 19th Mental Hospital Institute, to Dr. Cecil Wittson, director of the institute.

The judges noted that lectures and teaching seminars in Omaha reach Nebraska institutions in Beatrice, Hastings, Lincoln, and Norfolk, and state hospitals in Iowa and North and South Dakota by a special two-way audio hookup.

The Nebraska Psychiatric Institute was the first psychiatric center to use closed-circuit television.

From the Chadron Record—

The Chadron Community Hospital fund drive launched an all-out drive on November 6th to bring its campaign to a close. Goal of this final drive is $60,000, the amount needed to bring the fund up to the total required for enlarging and modernization of the city's hospital facilities.

The hospital fund campaign was started a year ago, and up to this point has raised $90,000 in pledges and contributions. Application has been made to the state hospital board for federal assistance for the project under the Hill-Burton Act.

Tentative plans call for a modernization of present facilities and a two-story wing added to the present building.

From The Norfolk News—

The State Hospital Advisory Council is considering a complete revision of procedures for distributing federal funds in Nebraska, a State Health Department official has disclosed.

Vern Pangborn, state hospital director, said the council is considering dropping for Nebraska use one of the federal categories under which communities may apply for Hill-Burton matching funds.

Under the current system, the state recognizes three general categories of hospital construction: Rural hospitals, urban medical centers, and intermediate medical centers, or area medical centers.

It has been proposed, Pangborn said, to drop the intermediate, or area medical center category, "because of the apparent lack of need for these facilities in Nebraska."

Mr. Pangborn noted that medical specialists located primarily in Omaha, Lincoln, North Platte, Hastings, and Scottsbluff are visiting rural community hospitals on a consulting basis.

"This is a revolution in medical treatment," Pangborn said. "It's something nobody ever expected."

Pangborn said this development apparently makes it possible to consider developing only urban medical centers, in Lincoln and Omaha, and community hospitals throughout the state.

From the Lincoln Star—

Baseball player Richie Ashburn of Tilden will be the Nebraska chairman of the 1959 Cancer Crusade.

His appointment was announced at a banquet for volunteers held in Omaha in October.

Dr. Jerome Murphy of Omaha was one of the guest speakers at the meeting.
From the Department of Public Relations
University of Nebraska College of Medicine—

Dr. Roy G. Holly, Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Nebraska College of Medicine, has been elected a fellow of the American Association of Obstetricians and Gynecologists.

Another honor will come to Doctor Holly in May of 1959, when he will become an associate examiner for the American Board of Obstetrics and Gynecology, according to the group's president, Dr. Bayard Carter of Duke University.

Doctor Holly has held his faculty position at the College of Medicine since 1954. He was educated at the University of Minnesota, receiving his M.D. and Ph.D. degrees there. He is also a former faculty member of that institution.

From the Kimball Observer—

State mental health director, Dr. Cecil Wittson, feels Nebraska should have another mental health clinic.

Dr. Wittson has asked the Board of Control for some $42,000 to place a clinic in southeastern Nebraska. He preferred Lincoln as a site.

There are several other clinics in Nebraska, operated by the state, under a plan formulated by Dr. Wittson.

From the Lincoln Journal—

As many as 82 medical school graduates can serve their internships in 9 of Nebraska's general hospitals which are approved for participation in the National Intern Matching Program.

Fourteen of the 82 yearly internships are available in Lincoln's three general hospitals and the remainder at six Omaha hospitals.

Lincoln hospitals qualifying are: Bryan Memorial, Lincoln General, and St. Elizabeth's hospitals.

In Omaha the approved hospitals are: Bishop Clarkson Memorial, Creighton Memorial, St. Joseph's, Immanuel Hospital, Nebraska Methodist, St. Catherine's, and University of Nebraska Hospital.

Doctors in the News

Doctor and Mrs. E. B. Morrow Celebrate Golden Wedding Anniversary—

Doctor and Mrs. Morrow of Seward were honored, October 26, in observance of their fiftieth wedding anniversary. Many of their friends from Funk, where Doctor Morrow spent the first four years of his professional practice, attended the celebration at the Morrow home in Seward. A two-course luncheon was served.

Doctor Morrow was the first doctor in Funk, and at the end of four years he moved to Seward to enter a partnership with his two brothers. He retired two years ago.

Hosts for the occasion were Mr. and Mrs. L. A. Franzen, Ernest Franzen, and Mrs. Harvey Larson. (From Holdrege Citizen).

News From Our Medical Schools

Men of medicine and of the cloth were able to bring their professions into closer alliance because of a Postgraduate Seminar held Monday, October 20th at the University of Nebraska College of Medicine.

The common meeting ground: "Grief." Over one hundred participants from both professions attended the one-day conference which was innovated for the purpose of determining how these two groups can best comfort the dying and the bereaved.

In the first speech of the day, the Reverend Loren C. Pretty, Director-Chaplain of the Nebraska Lutheran Social Service pointed out that grief begins with the traumatic experience of birth and continues throughout life. He went on to say that death has more impact as a cause of grief because of the finality which is associated with it. From a physical standpoint, he reported, as well as from an emotional point of view, situations of grief can result in stress and actual physical symptoms of illness if the person involved takes an abnormal view of bereavement, or if he prolongs his grief.

Speaking on the possibilities of stress in grief situations, Dr. David Stephenson, morning panel member and Intern at University Hospital, emphasized two ways in which stress can be utilized in the hospital patient's outlook. He said that stress could either cause the patient to be realistic by facing up to his grief, or it could achieve
a certain fantasy if the patient were to run away from grief-like problems.

Dr. Merle M. Musselman, Chairman of the Department of Surgery at the College, listed several reasons for grief situations coming about in the hospital. Among them, loneliness, changes in routine from the home to the rigid schedule of the hospital, and poor communications between the doctor and his patients were possibilities. In cases of dread diseases or the fear of having such diseases, Dr. Musselman said, medical terms can by their very nature frighten the patient, as can the doctor's tone of voice or his personality if he seems abrupt.

In posing the question, "who knows of the patient's grief?", the surgeon pointed out that this may well be the pastor, the hospital chaplain, the doctor, or another member of the surgical team. Because it may be that only one of these team members who knows the situation, Dr. Musselman stressed the need for cooperation between members of the surgical staff and the clergyman, as each performs his duties in ministering to and treating the grieving.

A summarization of the meeting led to a list of suggestions for both the clergy and the medical profession on combating or lessening grief. Dr. Musselman presented them as follows: Listening to hear of grief, inviting conferences in which grief may be expressed, being honest in bereaving situations, and supporting the patient's beliefs.

**News and Views**

*Twelve Doctors Are Nominated for Silver Anniversary All-America—*

New York, Special — The names of 72 senior football lettermen of the class of 1934, honored by their Alma Maters with nomination for Sports Illustrated's 1958 Silver Anniversary All-America, were submitted this week to the august panel of judges which will name the 25-man roster in December. Twelve of the nominees have earned distinction in the field of medicine.

The annual competition seeks to "emphasize the pursuit of the rounded human values in which athletics and education are joined' through honoring those players who have most distinguished themselves in their chosen fields of life.

A breakdown of the list of nominees shows that twelve, the second biggest professional group, carved out successful careers in medicine. The largest segment is business and industry, with 33. Next in order came law and education with six each, military service, five, and science, farming and public service each with one representative. (From *News Illustrated*).

**Health Law Center—**

The University of Pittsburgh is establishing a Health Law Center. This is a new departure in research, going far outside the laboratory into the comparatively unexplored field of health and hospital jurisprudence.

Functioning within the graduate school of public health, the new center is an outgrowth of a two-year study in hospital law made possible by a grant of $234,528 from the National Institutes of Health. This was directed by an attorney, John F. Horty, Jr., who will direct the new center. The results of the past study will be published early in 1959. Other fields of health—public health, nursing, dentistry, pharmacy, and medicine—will be studied in relation to the law.

**Murder by Insulin Poisoning—**

The *British Medical Journal* for August, 1958, reports the details of the investigation of murder by insulin poisoning. The crime was committed by a trained male nurse who murdered his wife by injecting her with insulin. This is believed to be the first case in which the charge of murder by insulin poisoning has been substantiated, and the first instance in which human insulin has been demonstrated in human tissue, excepting the pancreas, after death.

**Forand Bill Among Labor's Major Objectives In Next Congress—**

A pamphlet just issued by A.F.L.-C.I.O. places passage of the Forand bill or similar legislation high on the agenda for the next Congress. Only overhaul of the Taft-Hartley act tops it in importance.

**Rabies Fight in Our Hemisphere To Be Helped by International Expert—**

The Pan American Sanitary Bureau is sending the world renowned research scientist, Dr. Karl Habel, for a six-weeks' con-
sultation with five Latin American governments in an effort to eradicate rabies. That rabies can be eradicated has been demonstrated by Uruguay where a successful eradication campaign was concluded 15 years ago. While only 149 deaths were reported in our hemisphere, in 1956, as due to rabies, officials are aware that there were many more and that the many thousands who had to take preventive treatment suffered from pain, misery, and economic loss.

Zoonoses Receiving Belated Attention—

A center for the study of zoonoses (diseases transmitted to man from animals). This center, the Pan American Zoonoses Center, has been set up by P.A.S.B. in Azul, Argentina. Though there are over 100 diseases included under the zoonoses, the present intention is to concentrate on the studies of rabies, brucellosis, and hydatidosis.

American Registry of Doctor's Nurses, New—

We see by G.P. that a new order has arisen, the American Registry of Doctors' Nurses. According to the announcement participants do not have to be R.N.'s or L.P.N.'s. The only requirements are that they shall have acted as “a doctor's nurse” for a minimum of six months and the application must be signed by the doctor. They get in for $2 and pay $10 yearly dues. They will receive an official pin, a cap, car stickers and metal emblems, and a periodical, The Doctor’s Nurse. The originators hope to have 100,000 members in two years. The founder, Mr. Ralph Z. Bell, has moved from Albany, Georgia, to Washington, D.C. Mr. Bell and his staff should be able to give the members quite a bit of help at $12 a head.

Secretary Flemming Wants to Shift Some Programs to the States—

According to A.M.A. Washington Letter No. 85-93, Secretary Flemming plans next year to ask Congress to shift two grant-in-aid programs, water pollution control and vocational education, to the states. A similar idea was advanced last year, but it brought no reaction in Congress and eventually was dropped. The cost to the states would be offset by the Federal Government's foregoing the collection of certain taxes which the states could collect for themselves. There would be a little outright Federal grant money to go along with this. It is predicted that Congress won't react the next time, either.

National Foundation—

The National Foundation for Infantile Paralysis has changed its name to National Foundation. The objectives of the Foundation, victory over crippling diseases—arthritis, birth defects, and virus diseases—plus a continuing battle with polio. The Foundation hopes to get $65 million worth of dimes, come the “March of Dimes” in January.

The National Foundation News for October carries a letter from the president of American Rheumatism Association welcoming the Foundation into the arthritis-field. Last summer there did not seem to be so much felicity on the part of the A.R.A. toward The Foundation’s thrusting itself into this field. It seemed that A.R.A. had been working at the problem for twenty-five years and doing quite a good job.

Everything Is Getting Better—

A quick look at the September issue of the Statistical Bulletin of the Metropolitan Life Insurance Company is quite reassuring. The following are the headlines:

“Children Growing Taller” and, incidentally, heavier; “Health in Alaska” shows mortality rate dropping rapidly, especially in tuberculosis; “Longevity of Industrial Population in 1957”—average length of life in 1879, 34 years; in 1957, 70 years; “Decrease in Homicide Rate”—has decreased in the period since World War II, about 20 per cent. Some things go ahead in spite of political parties.

The Physician and School Health—

Most communities have some form of a school health program and the best ones are found where local physicians have cooperated with school personnel in the formulation of sound principles and practices, according to an editorial in the Rocky Mountain Medical Journal.

A good school health program safeguards the pupils' health in a manner similar to that of an industrial health program, but usually neither is planned as a complete program of medical care. A good program in either field will compliment the medical care which the individual should receive from his private physician.
Health protection on the school premises is one phase of a good school health program, and is concerned with proper sanitation, lighting, ventilation, and guards against faulty or unsafe equipment, buildings, or playgrounds. It also protects the pupil against the dangers of impaired health of school personnel.

Health education is an important part of a good school program. The fundamentals of personal and community health can be taught along with other subjects if the teachers have been adequately prepared in the field and if they have adequate council and instruction from members of the health professions according to this editorial. Health literature used in distributing in the school should be carefully reviewed and approved.

Health services should be available in a limited form including a system of sensible first aid with referral for subsequent medical care. The program should detect and report any defects in vision, hearing, or personality. Such a program should include a simplified health record and should encourage parents to obtain medical care for the correction of defects. Each local medical group is encouraged to give leadership and assistance in developing a sound community school of health program.

Human Interest Tales

Dr. J. H. Calvert, Pierce, underwent surgery on the spine at an Omaha hospital in October.

Dr. M. J. Powell, Fairbury, has been elected to head the Jefferson County Cancer organization.

Dr. and Mrs. H. O. Bell, York, journeyed to Excelsior Springs, Missouri, for several weeks of relaxation in October.

Dr. John Thompson, Lincoln, has been chosen as president of the Nebraska Public Health Association for the coming year.

Dr. and Mrs. C. G. McMahon, Superior, attended the annual meeting of the American College of Surgeons held in Chicago in October.

Dr. Paul M. Scott, Auburn, was recently elected president of the Auburn Kiwanis Club. Dr. Scott will assume his duties on January 1st.

Dr. Vern F. Deyke, Columbus, presented a talk on “Heart Condition” at the October meeting of the Platte County Nurses club held in that city.

Ye auld editor was privileged to attend the county medical society meetings in Fremont and in Beatrice this past month. It was delightful and enlightening.

Dr. A. Carlton Earnstene, a former resident of Nebraska City, now of Cleveland, Ohio, has been named president-elect of the American Heart Association.

Dr. Robert C. Kelley, Lead, South Dakota, has returned to his former locale of practice at Beemer. Dr. Kelley re-opened his office in this community on November 1st.

Dr. J. B. Kozsewski, Omaha, faculty member of Creighton University School of Medicine, received a $6,944 grant from the Public Health Service for research in blood disorders.

Dr. William Lear, Norfolk, was the guest speaker at the October meeting of the Division 6, Licensed Practical Nurses, held in that city. Dr. Lear discussed the subject “The Heart.”

Dr. Paul Bancroft, Lincoln, presented a discussion on “Adolescent Behavior in the Public School” at a meeting of the Clay County Education Association at Harvard, in November.

Dr. Delbert Neis, Omaha, was the principal speaker at the Burt County Extension Clubs’ Achievement Day in October. Dr. Neis spoke on “Heart Malformations and New Types of Heart Surgery.”

Dr. M. O. Arnold, a practicing physician in St. Paul for 38 years, has closed his office in this city. Doctor Arnold has been appointed physician for the Soldiers’ and Sailors’ Home in Grand Island.

Dr. Victor E. Levine, director of the Department of Biochemistry, Creighton University School of Medicine, received a citation for service to the University at a Founders Week convocation in October.

Dr. and Mrs. Donald Nilsson, and family, Omaha, have returned home after an extended absence. Dr. Nilsson has been doing postgraduate study at the University of Michigan medical center since last June.
Dr. Louis J. Gogela, Lincoln, was the principal speaker at the October meeting of the Dodge County Medical Society, held in Fremont. Doctor Gogela presented a paper on "Diagnosis of Intra-Spinal Lesions."

Dr. M. M. Sullivan, Spalding, received a silver lapel badge in recognition of his 15 years as medical advisor of the Selective Service Board of Greeley County. The award came from President Eisenhower.

Dr. R. E. Johnson, member of the staff of the Norfolk State Hospital, was a guest speaker at a meeting of the Farm Bureau, in Creighton in October. Dr. Johnson discussed various phases of mental health.

Dr. Lee C. Holmes, Central City, closed his office in this city in November. Dr. Holmes has accepted a position with the Veterans Hospital in Grand Island. The family will continue to reside in Central City.

Dr. Wallace Vnuk and family, of Omaha, have moved to Fremont where Doctor Vnuk has opened his office for the practice of surgery. Dr. Vnuk recently completed his training at the Veterans Hospital in Omaha.

Dr. and Mrs. R. Russell Best, Omaha, traveled to Kalispell, Montana, in October for a ten-day combination vacation and business trip. Dr. Best spoke at a medical meeting in Kalispell.

Dr. M. L. Chaloupka, Callaway, recently completed the job of moving into a new addition to the Seven Valleys Clinic. Six rooms were added to the present building along with a new furnace and air-conditioning system.

Dr. Clarence Minnick, Cambridge, for his 15 years of service as medical advisor to the Selective Service Board of Furnas County, has been awarded a silver lapel badge by President Eisenhower in grateful recognition of his service.

Drs. Janet Palmer and C. K. Elliott of Lincoln and Drs. Thaddeus Krush and E. D. Lyman of Omaha, participated in the annual Nebraska Social Work Institute meeting held at the University of Nebraska in Lincoln in October.

Dr. M. M. Musselman, Omaha, has been awarded a plaque by the American Cyanamid Company. The award was made to Dr. Musselman for helping to produce movies of surgical techniques for the surgical division of the company.

Dr. D. A. Walker, Mullen, was recently the recipient of a silver lapel badge in recognition of 15 years of service as a medical advisor of the Selective Service Board of Hooker. The award was received from the President.

The University of Nebraska Board of Regents has passed a resolution approving in principle the plan whereby the University Medical College, in Omaha, will provide general medical and surgical service at Douglas County Hospital.

Dr. K. S. J. Hohlen, Lincoln, has received a silver lapel badge in recognition of 5 years of service with the Selective Service Board. The award was presented by State Selective Service Director, Major General Guy N. Henninger.

Dr. Robert M. Sorensen, former practitioner in Fremont, has returned to this city after completing a residency in pediatrics at the Hurley Hospital, Flint, Michigan. Dr. Sorensen has opened his office for the practice of this specialty.

Dr. Charles W. Wilhelmi, Omaha, has been named chairman of an All-University Committee on Research at Creighton University. The group will act as a clearing house for research and as agent in general research grants to the university.

Dr. A. H. Holm, Wolbach, has received recognition from President Eisenhower for his 15 years of service to the nation as a medical advisor to the Selective Service Board of Greeley County. Dr. Wolbach was awarded a silver lapel badge.

Dr. R. J. Smith, Albion, expects to move into the new Albion clinic about the first of the year. The clinic is being built to accommodate three doctors. It is a one-story structure with 2200 square feet of floor space. Original occupants will be Drs. R. J. Smith and Robert Westfall.

Five doctors from Nebraska were inducted as members of the American College of Surgeons at the annual meeting in Chicago in October. They are: Drs. Robert C. Smith, Hastings; Kenneth F. Kimball, Kearney; Louis W. Gilbert, Lincoln; Harold Horn, Lincoln, and Albert S. Black, Jr., Omaha.

Four Omaha physicians were honored at the annual faculty dinner of the Creighton University School of Medicine, held in Octo-
ber. They are: Drs. J. E. Courtney, William M. Dendinger, William J. Egan, Werner P. Jensen. Creighton service plaques were awarded for a minimum of 25 years teaching service.

A number of Nebraska physicians have been named to the Nebraska Board of Directors of the Nebraska Division of the American Cancer Society. They are: Drs. T. D. Fitzgerald, Alliance; Earl F. Leininger, McCook; W. O. Brown, Scottsbluff; Robert A. Hillyer, John T. McGreer, both of Lincoln, and Pierce T. Sloss, Grand Island.

Dr. James J. O'Neil, Omaha, presented two courses at the Annual Meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago in October. Doctor O'Neil discussed "Aerosol Therapy in Otolaryngology," and "Diagnosis and Treatment of External Otitis." Some of Doctor O'Neil's original work in upper respiratory allergy was also featured in an exhibit at the meeting.

Announcements

International College of Surgeons to Meet at Miami Beach—

The Southeastern Regional Meeting of the International College of Surgeons, United States Section, will meet January 4-7, in Miami Beach, Florida, at the Americana Hotel. An outstanding program is planned and speakers include many men of international reputation. Adequate provision is made for the general practitioners and for the auxiliary. For full details please contact Dr. Harold O. Hallstrand, general chairman, 7210 Red Road, South Miami, Fla., or Dr. Ross T. McIntire, executive director of the college, 1516 Lake Shore Drive, Chicago 10.

Arizona Will Host at Cancer Seminar in Phoenix in January—

A pioneer in the idea of holding an annual cancer seminar for doctors, the Arizona Division of the American Cancer Society will repeat on January 22, 23, and 24, 1959. This will be their Seventh Annual Seminar and will be held at Paradise Inn, in Phoenix. For further details contact Dr. Edward H. Bregman, Chairman of Seminar Committee, 543 East McDowell, Phoenix, Arizona.

The Woman's Auxiliary

President's Message

HOLIDAY GREETINGS TO ONE AND ALL!

Mrs. Farrell and I attended the conference for Presidents and Presidents-Elect in Chicago last month. You will find Mrs. Farrell's report on this conference in this issue of the Journal. It was a most inspiring meeting and I wish all of you could have attended.

I have had the privilege of visiting a number of our auxiliaries and have plans to vis-
it others. It is amazing and most heartening to see what our auxiliaries are accomplishing in complying with the priority projects set out for us this year. It is my hope that Mrs. Farrell and I may have the opportunity to be included at a meeting with each of our auxiliaries.

Along with our priority objectives, we have been asked by the A.M.A. to put special study on the matter of ways and means of caring for our senior citizens. It is important that the medical profession blaze the trail in programs for the care of our aging population. Having each community study and evaluate its needs is the first step in solving this problem. A number of our Nebraska communities have plans, including physical installations, which are either in operation or soon will be. I urge you to take a profound interest in this work and include it in your year’s program. Ask your medical society what you can do.

Our Auxiliary is sponsoring the A.A.P.C. essay contest this year on a state wide basis. Please do not fail to use this opportunity for a tremendous range in community service through such a medium that has no limitations in reaching the people of our state.

My best wishes for a productive year.

Sincerely,
Elizabeth Covey.

WOMAN’S AUXILIARY
ANNUAL FALL CONFERENCE
The 15th Annual Conference of State Presidents, Presidents-elect, National officers, and Chairmen of the Woman’s Auxiliary to the American Medical Association was held at the Drake Hotel in Chicago, October 6-8, with approximately 185 women present.

The theme of the Conference was “Auxiliaries in Action,” and the three-day meeting covered all phases of auxiliary activities, with plans and suggestions to help state and county officers and chairmen in their planning and programming for the coming year. It was most interesting to learn a county auxiliary in Rhode Island or Montana had the same problems as a county auxiliary in Nebraska or Mississippi.

Each phase of auxiliary work was presented by a panel of four or five state presidents, moderated by the national chairman of one of the 15 standing committees. Nebraska’s president, Mrs. George Covey, was on the Civil Defense Panel, and gave a very interesting account of the emergency action Nebraska has planned in case of an enemy or natural disaster; namely, that Lincoln has marked evacuation routes out of town and plans have been made for the state government to be moved to Columbus. Dr. Harold Lueth, former dean of Nebraska’s medical school, is Chairman of the A.M.A. Committee on Civil Defense, and he spoke to the group on the widespread need for shelters if a significant portion of the population is to survive a nuclear attack. There are no drugs available to counteract radiation—sheltering or shielding is the only protection.

Dr. Ernest Howard, assistant executive vice president of the A.M.A., spoke to the conference about the recent important activities of the A.M.A. The first of these was the new publication, “The A.M.A. News,” an interesting communication medium published every other Monday. Second, a scientific research program is to be started with funds from the A.M.A. and possibly outside sources; it is to be known as the American Medical Research Foundation. Much emphasis was put on the “Program for the Aging.” For the next two years the A.M.A. will concentrate on the problems that affect the care of the aged. Emphasis will be placed on the extension of voluntary health insurance, and development of more adequate health care facilities for this group, in every state. In January, 1960, there will be a conference at the White House, and state medical societies and auxiliaries are asked to cooperate in this conference.

One of the most important things facing the medical profession at this time, is the threat of socialized medicine. Of 21,000 bills introduced in the 85th Congress, 704 had medical implications. The most important bill is the Forand Bill, providing hospitalization and medical care for certain social security beneficiaries. Based on estimates by insurance experts, this bill alone would cost over 2 billion dollars annually, and would increase social security payroll tax over 11 per cent, or a 37 per cent increase. Though the bill was not passed, it will be reintroduced next year, and the year after for it has the support of organized labor. The A.M.A. cannot stand alone, but must have help of allied professions. Mr.
Joseph Stetler, director of the Law Division of the A.M.A., explained the A.M.A.’s stand on opposing Social Security for the medical profession. He said the doctors retire too late to derive any benefit from social security, and the survivor benefits would cost more than private insurance. The best way to fight socialized medicine is to stay out of social security.

There were nine participants on the Membership panel, and the problems of the very large auxiliary and all the way to the small county auxiliary were discussed. Much emphasis was put on welcoming the new auxiliary members, and creating a desire to be active participants in the auxiliary activities and projects. Probably the most important thing that came out of the discussion was the fact that under the new By-Laws, the auxiliary program is changed to fitting the program to the individual member rather than the member to the auxiliary program. Special badges were suggested for new members and members-at-large.

The new editor of Today’s Health magazine, James Liston, was introduced, and he reminded the members that subscriptions eligible for the professional rate of $1.50 a year, are available only through the auxiliary.

Many money-raising projects were suggested for the A.M.E.F. Several California auxiliaries have a dance or fashion show luncheon. Nevada has a 2-day rummage sale in Reno. Memorial cards, appreciation cards, and the sale of A.M.E.F. Christmas cards prove an effective way of promoting A.M.E.F. and raising money too. The $126,000 raised last year was used in providing better equipment, new projects, and higher salaries for the teachers in the medical schools. The goal for 1958-59 is $160,000.

Program, as interpreted by the national auxiliary, is the planning of each state and county auxiliary. New York state chairman, Mrs. John Kennedy, said “Nothing great is ever achieved without enthusiasm. This is especially true of program planning. A good formula is to use four parts entertainment, two parts education, one part auxiliary projects, and one part community service. Mix well. Add orderly, well-planned business sessions and administer in small amounts each month.” A good program should not exceed 30 minutes in length, and if there is a guest speaker, twenty minutes is preferable.

The name of the Public Relations Committee has been changed to “Community Service Committee.” The five main points in the program this year are: 1. Solving the problems of the aging; 2. sound nutrition versus food fadism; 3. the importance of safety belts in highway safety programs; 4. medicine as a career; 5. freedom of choice of a doctor. Mr. Aubrey Gates, Field Service Director of the A.M.A., said the key to effective persuasion is to know well the key people in your community and state, so that you may get A.M.A. information to them.

Paramedical Careers Recruitment is the new term for the recruitment program. There are approximately 150 health careers and occupations, and the shortage of personnel is general in most of them. It is thought that the panel-type presentation is the most interesting and effective way to interest teen-agers in the various careers in the health field. “Health Careers Guidebook” is a reliable source of information regarding college requirements, loans, scholarships, and so forth.

One of the highlights of the conference was the talk given by Frank Burrows, Jr., Field Service Director, Citizen’s Traffic Safety Board of Chicago. Mr. Burrows was a dynamic speaker, and illustrated his lecture on safety with magic tricks and the contents of a small envelope he called the Safety Six pack. In the pack was a grain of corn, to be carried in our billfold to remind us to perform an act of driving courtesy every day, because safety is not corny. A candy sucker—to lick the problems of safety. A piece of string to remember to string along with safety programs. A rubber band to remind us to stretch our efforts to encompass the safety program. A safety pin—a mechanical guard—keep our cars in safe working order—and a band-aid to put on the back of our hands to remember the things he said. The A.M.A. is sending posters to all state safety chairmen entitled “Testing the Drunken Driver.” Much emphasis is put on keeping the drunken driver off the road, and helping the teen-age drivers to become safe drivers. The A.M.A. is going to start a drive to put safety belts in all cars, and the publicity will start soon.

The Mental Health Panel presented a movie “Preface to Life,” one of many such
movies available to the auxiliaries from the A.M.A. Bureau of Health Education. The moderator, Mrs. Aaron Margulis, defined mental health as “Be your age.” It was suggested that any panels or discussion groups on mental health should have psychiatrists, psychologists, or psychiatric social workers as participants or in the audience, to correct any misconceptions and to answer questions. Iowa distributes the “Milestones to Marriage” leaflets in all schools and church groups.

All members of the auxiliary are urged to subscribe to the official publication of the Auxiliary, the Bulletin. It is especially helpful for all officers and chairmen.

The Conference had several informal social gatherings, namely the get-acquainted Continental breakfast on Monday morning, and the North Central regional breakfast on Tuesday morning, attended by the chairman, Mrs. Wm. Mackersie of Detroit, and the presidents and president-elects of our district — Kansas, Iowa, Michigan, Minnesota, Illinois, Indiana, Ohio, Wisconsin, North Dakota, South Dakota, Missouri, and Nebraska. Monday evening the National President, Mrs. Underwood, and the President-elect, Mrs. Gastineau entertained the members of the Conference at a sherry party, in their suite. The speaker at the Monday luncheon was Dr. F. J. L. Blasingame, Executive Vice President of the A.M.A. He spoke on the re-organization of the A.M.A. and illustrated his talk with lantern slides. Dr. Gunnar Gundersen, President of the A.M.A., spoke to the group at the Tuesday luncheon. His subject was the “World Medical Association Today.” Both Dr. Blasingame’s and Dr. Gundersen’s talks are to be published in the January Bulletin.

I very much appreciate the privilege of attending the Conference, and hope this report will be of some help to the officers and chairmen in planning their auxiliary programs.

Respectfully submitted,
Margaret C. Farrell,
President-elect.

Lancaster County—

The Lancaster County Medical Auxiliary held its November meeting at the home of Mrs. L. F. Pfeifer. Co-chairmen of the event were Mrs. A. L. Smith, Jr., and Mrs. L. W. Gilbert.

Dr. G. R. Underwood presented a talk on Geriatrics, in which he stressed the increasing number of elderly people, thereby creating the problem of providing more medical and social assistance.

Mrs. J. M. Stemper, Publicity Chairman.

Douglas County—

Mrs. G. Kenneth Muehlig, newly elected president of the Woman's Auxiliary to the Douglas County Medical Society, entertained the board members at her home on September 3rd. Plans for the coming year were discussed.

The newly elected officers are: Mrs. G. Kenneth Muehlig, president; Mrs. H. H. Brinkman, president-elect; Mrs. Leo V. Hughes, vice president; Mrs. Wilbur A. Muehlig, secretary; Mrs. George Johnson, treasurer.

The first regular meeting was a dinner which took place at the Omaha Athletic Club on September 9th. Mrs. George Covey of Lincoln was the guest speaker. Also highlighting the program was the Beaux Arts Fashion Parade with past-presidents modeling.

Four County Woman's Auxiliary—

“Four County Women’s Auxiliary” has donated to each of the four hospitals within the territory as the project for the year. These hospitals are located in Burwell, Loup City, Ord, and Spalding. The money is to be used for equipment.

Dr. and Mrs. Bob Fox and Dr. and Mrs. Karl Forster of Spalding are the parents of boys born within the last six months.

The meeting of the “Four County Women’s Auxiliary” was held in Loup City at the home of Dr. and Mrs. Bert Miller.

Dawson County—

The Dawson County Medical Auxiliary announced two recipients of the annual Scholarship Loan Fund at its September meeting at Mrs. A. W. Anderson’s in Lexington.

Phyllis Brooks, Cozad, has begun nursing training at Bryan Memorial Hospital in
Lincoln. Phyllis Saulsbury, Lexington, has enrolled at St. Catherine's Hospital in Omaha.

Mrs. Sam Perry of Gothenburg reported on the meeting of the State Board of Directors which she attended in Lincoln.

Civic affairs discussions resulted in the following resolutions: Members will write to their Senators in favor of a Nebraska Juvenile Court Plan, will send “Today’s Health” subscriptions to all Dawson County schools, and will donate old magazines needed at the Hastings State Mental Hospital.

The following members were present: Mmes. B. W. Pyle, and Sam Perry, Gothenburg; Chas. Sheets, and Rodney Sitorius, Cozad; Ray Wycoff, V. D. Norvall, A. W. Anderson, and Wm. Long, Lexington.

Lancaster County—

The first fall meeting of the Woman’s Auxiliary to the Lancaster County Medical Society was a get-acquainted tea, held at the home of Mrs. Louis J. Gogela. The co-chairmen of the event were Mrs. Schuyler Brown and Mrs. G. R. Underwood.

The new officers are as follows: Mmes. W. W. Bartels, president; L. F. Pfeifer, vice president; E. S. Maness, secretary, and O. A. Neely, treasurer.

Committee chairmen are: Mmes. L. T. Davies, Inter-Club Council; E. W. Rowe, Parliamentarian; L. D. Cherry, Legislative; J. M. Stemper, Publicity; J. W. Rogers, Historian; L. J. Gogela, Bulletin; H. L. Papenfuss, Today’s Health; M. P. Brolsma, Membership; D. F. Purvis, Public Relations; Harold E. Harvey and George Lewis, Jr., Social; J. T. Williams, Program; H. G. Ahrens, Telephone; Key Hachiya and D. G. Ritter, Health Recruitment; L. F. Pfeifer and N. R. Miller, Courtesy; H. V. Munger and F. P. Stone, Philanthropic; E. S. Maness, A.M.E.F.; and M. J. Epp, Nebraska Medical Foundation.

Respectfully submitted,

Mrs. J. M. Stemper,
Publicity Chairman.

Know Your Blue Shield Plan

The following is quoted from “The Journal of the Medical Society of New Jersey—Volume 55, Number 9, September, 1958:

THE QUIET SIDE OF BLUE SHIELD

Scandals get bolder headlines than marriages, births, or philanthropic donations. By the same rule of human perversity, we often take articulate notice of Blue Shield only when we have some fault to find with it.

Whenever four or five colleagues are gathered, some critic may take shots at Blue Shield. Often the complaint has something to do with the Plan’s payments. Perhaps the allowance for a certain procedure seemed inadequate for the particular case, or the Plan didn’t cover the diagnostic work that was needed, or the Plan has been persistently requesting a detailed operative report to explain a pending surgical claim.

What’s good about Blue Shield, anyway?

Well, for every case where the Plan’s payment has been inadequate, delayed, or refused as ineligible, there have been scores of other cases for which reasonable payment has been swiftly remitted. Actually, Blue Shield’s payment for an eligible claim, properly presented, is as fast and dependable as any source of income we have on our books.

As for the Blue Shield payment in a particular case, we have a unique recourse. The fee schedule is arrived at—and continually adjusted—with the advice or at the request of our medical society. And if the scheduled payment is out of line with the service required in a particular case, the complainant can ask for a review. Blue Shield is the only prepayment program whose medical policies are subject to our own guidance and control.

Another unique virtue of Blue Shield has to do with the economic segments of the patients whom it covers. Because of its community approach and its unmatched economy of operation, Blue Shield is the one medical prepayment plan that covers the lower income groups who most need protection. Hence, through Blue Shield, doctors are now being compensated for services ren—
dered to a considerable number of people who, were it not for Blue Shield, would still qualify for our free services in hospital wards and clinics.

Blue Shield is the Profession’s Plan, and a successful plan, too. Nationwide, some 43 million patients are now buying Blue Shield every month, and thousands more are joining them every day. In so doing, these friends and neighbors are expressing their confidence in medicine and in our American system of independent private practice.

Blue Shield merits a pat on the back from doctors, too.

Diabetes mellitus, the eighth leading cause of death in this country, afflicts one out of every 80 Americans according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. There are a million diabetics and as many undiagnosed diabetics. In addition, 4,750,000 persons are potential diabetics. Each year, 65,000 persons in the United States become diabetic, “Patterns” says. These persons were part of the group of potential diabetics, those who will develop diabetes during their lifetime. One person in four in the population is a carrier, a non-diabetic person who can transmit to offspring the tendency to diabetes.

Does marital status play a role in diabetes? Prior to the age of 45 the death rate from diabetes is higher for single women than for married women according to the publication “Patterns of Disease,” prepared by Parke, Davis & Company for the medical profession. For example, between the ages of 35 and 44 the death rate is approximately 65 per cent higher for single women. However, after the age of 45 the death rate for married women exceeds that for single women. Among men the death rate from diabetes is greater for the unmarried until the age of 70.

Normal Laboratory Values—A Service
To the Reader—

In the January issue of the Bulletin of the American Medical Writers’ Association, Doctor Edward R. Pinckney makes a plea for the publication of normal values for laboratory findings. This, he believes, should be done in connection with each article. He says:

“Due to the multiplicity, as well as the complexity, of diagnostic laboratory procedures, scientific articles and case reports are becoming more and more difficult to interpret...”

The author, using the data presented at one of the workshops presented at the 1957 meeting of A.M.W.A., cites a number of methods by which the editor or the writer of an article can include such data. The choice seems to fall upon a paragraph appended to the article and printed in smaller type.

DOCTOR — Please take each copy of your Journal home. The wives complain that they never get to read the Auxiliary column.
Nebe, F. M.  
505 Sharp Bldg.  
Noel, J. Marshall  
924 Sharp Bldg.  
Neely, Orvin A.  
824 Sharp Bldg.  
Nemours, Francis  
620 Sharp Bldg.  
Norman, Chester L.  
3560 South 45th St.  
Ochoa, R.  
3560 South 45th St.  
Oney, R. C.  
4760 “O” St.  
Owen, L. J.  
567 Stuart Bldg.  
Palmer, Janet Forbes  
343 Stuart Bldg.  
Pappenfus, Darlin L.  
1401 Sharp Bldg.  
Papson, H. O.  
508 Sharp Bldg.  
Patterson, Paul L.  
762 Sharp Bldg.  
Pfeifer, LaVern F.  
3765 South St.  
Place, George E.  
4825 St. Paul St.  
Pollenca, J. T.  
612-614 Trust Bldg.  
Pervis, Donald F.  
300 South 13th St.  
Rautten, David S.  
4725 Prescott St.  
Reed, E. B.  
3145 “O” St.  
Reese, S. O.  
816 Sharp Bldg.  
Rickman, James H.  
625 Sharp Bldg.  
Rider, Larry  
Wichita, Kansas  
Ritter, Donald G.  
3145 “O” St.  
Robers, E. A.  
2841 Woodside  
Robers, John W.  
4623 Havelock Ave.  
Rose, Forrest F.  
1203 Sharp Bldg.  
Rose, Kenneth D.  
1614 N St.  
Rowe, E. W.  
2135 “O” St.  
Ryan, Edwin R.  
3011 35th St.  
Sanderson, D. D.  
914 Stuart Bldg.  
Shaffer, Harry D.  
724 Sharp Bldg.  
Sharrar, Lynn N.  
719 Sharp Bldg.  
Smith, A. L.  
1009 Federal Sec. Bldg.  
Smith, A. L., Jr.  
1601 Federal Sec. Bldg.  
Smith, Russell T.  
Loma Linda, Calif.  
Spradling, W. F.  
State Hospital  
Stafford, G. E.  
800 South 13th St.  
Stapleton, H. B.  
Hickman, Nebr.  
(Deceased 10-1-58)  
Stein, Robert J.  
430 Stuart Bldg.  
Steinman, John F.  
4101 Walker Ave.  
Stemper, Jack M.  
805 Stuart Bldg.  
Stewart, Frank A.  
2133 Winthrop Rd.  
Stone, John M.  
2300 South 13th St.  
Stover, Lee  
800 South 13th St.  
Struder, R. M.  
430 “O” St.  
Taborsky, A. F.  
525 Stuart Bldg.  
Tanaka, Frank H.  
1835 So. Pershing Rd.  
Taylor, Bowen E.  
3145 “O” St.  
Taylor, H. A.  
4728 St. Paul St.  
Taylor, F. D.  
4728 St. Paul St.  
Taylor, F. F. (Life)  
2815 So. 57th St.  
Teal, F. R.  
2800 South 13th St.  
Thierstein, Samuel T.  
1168 Sharp Bldg.  
Thomas, R. L.  
691-605 Stuart Bldg.  
Thompson, C. L.  
107 South 16th St.  
Thompson, J. E. M.  
1000 South 13th St.  
Thorough, Paul H.  
1205 Sharp Bldg.  
Tice, Wayne E.  
Independence, Mo.  
Underwood, G. R.  
3836 “J” St.  
Walker, G. H.  
1000 Stratford  
Wallace, Robert E.  
1301 Sharp Bldg.  
Warner, Ruth A.  
609 Stuart Bldg.  
Webb, A. H.  
1614 “N” St.  
Webster, F. S.  
1000 South 13th St.  
Wegner, E. S.  
724 Sharp Bldg.  
Welch, J. S.  
New York City, N.Y.  
Wendt, Bernard F.  
784 South 56th St.  
White, H. H.  
805 Sharp Bldg.  
Wiedman, C. W.  
135 So. 14th St.  
Wiedman, J. G.  
8145 “O” St.  
Wiedman, Willard G.  
135 So. 14th St.  
Williams, J. B. (Life)  
Pasedena, Calif.  
Williams, Jon T.  
4135 South 4th St.  
Wilson, Nat J.  
V.A. Hospital  
Wood, Myranda A.  
3145 “O” St.  
Woodward, J. M.  
910 Sharp Bldg.  
Wright, F. T. (Life)  
Denver, Colo.  
(Deceased 7-21-58)  
Youngman, R. A.  
3145 “O” St.  
Zeman, E. D.  
1146 South St.  

CASS  

ELMWOOD  
Knap, Glen D.  
Liston, O. E.  

LOUISVILLE  
Worthisen, H. W.  

MURRAY  
Tyson, R. W.  

NEBANKA  
Andersen, R. R.  

PLATTSMOUTH  
Brendel, R. F.  
Dietz, Robert J.  
Pusek, L. S.  

WEPPING WATER  
Kunkel, L. N.  

OTOE  
NEBRASKA CITY  
Bonebrake, A. H.  
Burrichter, Ben E.  
Fenstermacher, R. G.  
Gilligan, W. B.  
Kenner, W. C.  
Maevean, M. M. (Life)  
Stonecipher, D. D.  
Weeks, T. L.  

SYRACUSE  
Fornanck, C. J.  
Gately, H. S.  

JOHNSON  
TUCUMAN  
Chadec, Leonard J.  
Schutt, John C.  

THIRD DISTRICT  

GAGE  

Harvey Runty, Councilor  

ADAMS—  
Waggener, J. T. (Life)  

BEATRICE—  
Brott, Clarence R.  
Brown, H. R.  
Brown, R.  
Elis, H. F.  
Friechein, C. T.  
Gillespie, Patrick C.  
Hipperlen, H. M., Jr.  
McCleary, D.  
McGirr, J. I. (Life)  

NEWMAN GROVE—  
Carlson, Emery W.  

NORFOLK—  
Brauer, S. H.  
Brush, E. L. (Life)  
Bulawa, Francis A.  
Cowell, G. D.  
Duplan, James  
Farner, R.  
Gysin, Walter  
Hille, C. G.  
Ingham, Chas. G.  

PAWNEE CITY—  
Anderson, A. B., Jr.  
Stewart, H. C.  

RAITHBORN—  
Rathbun, Sanford M.  
Taylor, R. W.  
Waddell, J. C.  
Waddell, W. W.  
Wildie, Wm. T.  

ODELL—  
Rice, C. E.  

WYMORE—  
Nelson, J. C.  
Samuelson, Myron Earle  
Thomas, C. W.  

BARNETT—  
Anderson, A. B., Jr.  
Stewart, H. C.  

CUMING—  
(Madison Six County)  

BEEMER—  
Kelsey, Robert C.  

WEST POINT—  
Anderson, A. W.  
Scherer, Robert H.  

WINAVER—  
Hansen, Warren D.  

PIERCE—  
(Madison Six County)  

OSMOND—  
Mullard, A. E.  
Rogers, C. E.  

Pierce—  
Colvert, John H.  
Devers, W. I.  

Plainview—  
Johnson, M. A.  
Kopp, Robert R.  

KNOX—  
(Madison Six County)  

BLOOMFIELD—  
Kohtz, R. H.  

CREIGHTON—  
Green, Carl E.  
Wright, W. E.  

NIORARA—  
Nelh, Stanley Roy  

WAUSA—  
Tollefson, Richard L.  

MADISON  

(Madison Six County)  

MADISON—  
Berrick, Wm. H.  

NEWMAN GROVE—  

NORFOLK—  

TILDEN—  
Barr, G. C.  
Barr, Robert E.  

JOHNSON—  

Ketter, W. D.  
Boulder, Colo.  
Lennomann, Ernest  
Medical Lake, Wash.  
Shepherd, Wm.  
Wilkinson, Dudley E.  

HUMBOLDT—  
Helm, H. S.  
Steppenbeck, A. P.  

SHUBERT—  
Shook, W. E.  

December, 1958  

563
EIGHTH DISTRICT

WILBUR E. JOHNSON, Councilor

BOYD

(Bolt and Northwest)

HOLT

(Bolt and Northwest)

GENEVA

ASHBY, A. A.

ASHBY, CHAS. F.

LYNN, VINCENT S.

FAIRBURY

CASKEL, R. L.

ATKINSON

MCKEE, N. P.

RAMSEY, JAMES E.

JEFFERSON

DAVID, JOSEPH J., JR.

LYNCH

DWAY, JOHN V.

ROCK

PANZER, H. J.

POWELL, M. J. (Life)

TROWBRIDGE

WEHMAN, A. I.

Owen, Bernard A.

SUPERIOR

LARSON, S. L.

MAHON, G. G.

TROWBRIDGE, J. A. (Life)

WEBER, A. L.

SHERIDAN

(NGWEST NEBRASKA)

GORDON

WANSEK, FRANK

WOLF, W. K.

RUDY

CRUM, H. V.

HOOK, R. L.

HAY SPRINGS

OWN

NINTH DISTRICT

B. R. BANCROFT, Councilor

WOOD RIVER

WILTON, C. E.

BUFFALO

CARIGNAN, CHAS. B., JR.

GIBSON

SALLENBACH, DONALD H.

KEARNEY

HANCOCK, R. R.

HANSON, H. C.

HARRISON, MERLE A.

HAYES, O. R.

JETER, R. F.

JOHNSON, O. D.

JOHNSON, RICHARD D.

JOHNSON, RAYMOND F.

KIMBALL, KENNETH F.

LANO, L. D.

NELSON, ROBERT A.

NUTZMAN, WM.

NYE, DAN A.

REHAL, R. F.

LONG BEACH, CALIF.

RICHARDS, F. L.

ROSENFIELD, ROBERT C.

SMITH, HAROLD W.

STALEY, SANFORD O.

STEFFENS, L. C.

WILCOX, M. B.

RAVENNA

DICKINSON, L. E., SR. (Life)

SHELTON

NORDSTROM, J. E.

SUTTON

GELWICK, RICHARD

MUSS, H. V.

DENVER, COLO.

NUTZMAN, C. L.

1942 LOCUST

CLAY

BROWN

(ALINSWORTH)

AIKINS

LEONARD E.

SHIFFERTMILLER, FLOYD

CHERRY

(HOLT AND NORTHWEST)

DENKIN, THOM. W.

FARNER, JOHN E.

JOHNSON, WILBUR E.

GREELEY

(FOUR COUNTIES)

SCOTIA

REEVES, E. HOWARD

(CUSTER CO.)

SPALDING

FORSTER, KARL M.

FOX, ROBERT K.

SULLIVAN, M. M. (Life)

WOLBACH

HOM, A. G. (Life)

(HOWARD CO.)

VALLEY

(FOUR COUNTIES)

NORTH LOUP

MARKLEY, M. E.

ORDE

LYNN, ROBERT J.

MARTIN, PAUL R.

MILLER, C. J. (Life)

MILLER, OTIS W.

GARFIELD

(FOUR COUNTIES)

BURWELL

CRAH, ROY S.

SHERMAN

LITCHFIELD

RHODES, C. A.

(CUSTER CO.)

LOUP CITY

AMOLD, G. L.

(CUSTER CO.)

BOGE, JOHN H.

(FOUR COUNTIES)

MILLER, BURELL E.

(FOUR COUNTIES)

GRANT

HYANNIS

HOVELL, W. L.

(BOX BUTTE CO.)

TEN TH DISTRICT

F. M. KARRER, Councilor

ADAMS

ANDERSON, H. F.

CAES, HENRY J.

SIoux City, Iowa

CHARLTON, GEORGE P.

DEBUCKER, L. J.

EGEN, L. F.

FESS, J. E. (Life)

FOOTE, C. M.

FOOTE, D. B.

FOOTE, C. E. (Life)

GLEN, ELMER E.

GULDNER, C. W.

HOFMEISTER, GEORGE F.

HOFMEISTER, REX

(Ross)

HOLM, CHAS. R.

INGLESIDE

GOULD, CARL

ODONNELL, H. J.

WOLFF, J.

KENSAY

MARTIN, ROBERT L.

FRANKLIN

McNEILL, L. S.

FRANKLIN

DOERING, WILLIAM THOMAS, CONRAD

KINGSLEY, D. W.

KLEAGER, CLYDE L.

KOSTAL, O. A.

KOHN, GERALD A.

LANGSTAFF, CHAS. W., JR.

MCINTIRE, ROBERT H.

MCINTIRE, R. J.

MCMILLAN, JOHN A.

MURRAY, DON E.

PINNEY, GEORGE L.

RICHARD, WARREN E.

RUTT, FRED J.

SHAW, W. L.

RENATA, CALIF.

SHRECK, H. W.

SMITH, A. A.

SMITH, ROBERT C.

WEBER, C. R.

YOST, JOHN E.

December, 1958

565
ELEVENTH DISTRICT
H. L. CLARKE, Councilor

LINCOLN
NORTH PLATTE—
Anderson, Joel (Life)
Callaghann, A. J.
Chick, Nicholas
Clarke, H. L.
Dent, T. E.
DeVol, R. A.
Drausky, Stanley
Heider, C. F.
Heider, Chas. S., Jr.
Kerkhoff, S. A.
Broomfield Heights, Colo.
Kreyenberg, O. C.
McDonald, H. A.
Niebus, Wm. B.
Pinkerton, Clifford C.

SCOTTS BLUFF
GERING—
Gentry, Harold E., Jr.
Gentry, W. J.
Gentry, W. Max
Harvey, W. C., Sr.
Harvey, W. C., Jr.
Wiley, Stuart Paul

MITCHELL—
Leffel, Edwin J.
Osme, Kenneth
Watson, C. R. (Life)

MORRILL—
Prentice, O. D.

SCOTTS BLUFF—
Baker, Ellis E.
Baker, Paul Q.
Brown, W. O.
Campbell, Stuart D.
Frank, Carl
Franklin, W. S. (Life)
Gridley, L. J.
Grubbs, Lorin C.
Hanna, Joe T.
Hayhurst, J. D.
Heineke, John P.
Herhahn, Frank T.
Holmes, Wm. E.
Karrer, R. W.
Krepl, Jacob, Jr.
Lovett, Ivan C.
Martin, Joe M.
Riddell, Ted E.
Rosenau, John A.
Sorenson, C. N.

DUNDY
(Southwest Nebraska)
BENKLEMAN—
Morehouse, G. A.
Stout, Kenneth C.
CHASE
(Southwest Nebraska)
IMPERIAL—
Hoffmeister, George (Life).
Shopp, Bryce G.
Yaw, Elwood
WAUENEA—
Carlson, C. R.
HITCHCOCK
(Southwest Nebraska)
TRENTON—
Hoyt, Melvin S.

FRONTIER
(Southwest Nebraska)
CURTIS—
Magill, Van H.
EUSTIS—
Roseau, O. P. (Dawson Co.)

FURNAS
BEAVER CITY—
Bray, Avis F.

DEUEL
(Cheyenne, Kimball and Deuel)

BIG SPRINGS—
Mullins, E. B.
Denver, Colo.
(Cheyenne-Keith-Parkins)

CHAPPELL—
Harsaw, John E.
Larson, D. L.
(Cheyenne-Keith-Parkins)

GARDEN
(Cheyenne-Keith-Parkins)

LEWELLEN—
Cowen, L. H.
(Scotts Bluff Co.)

HEMINGFORD—
Hineman, Marquis W.

DAWES
(Northwest Nebraska)

CHADRON—
Alderman, Allen J.
Coushion, A. J.
DeFlon, Eric G.
Griot, A. J.
Hoevet, L. H.
Pierce, C. M.

CRAWFORD—
Bishop, Ben

CHEYENNE
(Cheyenne, Kimball and Deuel)

CORNELIUS—
Dorwart, Clinton B.
O'Holleran, Lloyd S.
Thayer, James E.

KIMBALL—
(Cheyenne, Kimball and Deuel)

KEPLER—
Cork, Robert C.
Coro, Edwin R.
Shamberg, Alfred H.

MORRILL—

BAYARD—
Doher, T. L.

BRIDGEPORT—
Blackstone, H. A.
(Scotts Bluff Co.)
Post, George Peter

CAMBRIDGE—
Minnick, Clarence

OXFORD—
Bentley, Neil B.

PHelps—
Bert, Robert

HOLDREGE—
Best, Robert

OUGHALLA—
Chase, Robert C.

MEXICO—
Catterall, E. E.
Roberts, D. G.
Thompson, R. L.

NEBRASKA S. M. J.
The Month in Washington—

(Continued from page 18-A)

sity of Arkansas. He served in the Army Medical Corps during World War II.

Dr. Morgan, who has been acting chairman of the House Foreign Affairs Committee since last summer, is slated to become chairman when the new Congress is formally organized. He will thus be the first physician chairman in the 136 years of the committee. (From A.M.A. Washington Office).

The Same Mistake?—

An analysis of the British medical profession before and after socialization of medical practice in England raises the question of our own defense against such an eventuality. This question is discussed in the California G.P. as a report of an interview with a physician from England who, during the past year, visited in California.

It is noted that only a small segment of the British Medical Association was in favor of socialization prior to the successful effort of a coalition government to begin the program.

The British government when faced with the prospect that 83 per cent of the members of the British Medical Association were not willing to participate in the government program, proposed that they go ahead with the 17 per cent who were willing to participate. The first people signing up were given immediate seniority and their pensionable rights were calculated from that day. When the plan offered for a limited time to buy the good will of the practices of doctors who would sign up, 47 per cent of the physicians indicated their willingness to participate in the plan.

The visitor to California concluded that the government would never have gone ahead with its plan of socialization if there had been unification within the ranks of the British Medical Society. Because practitioners of medicine are individualistic it is difficult to achieve agreement. In England for the same reason it has been difficult to achieve reforms or improvements in the government program. For those physicians who have doubts as to the desirability of maintaining the private practice of medicine, a visit to England with observation of the English system is suggested.
Current Comment

A Lawyer Looks at the Medical Profession—

The above title is the subject of an article by an attorney appearing in the Journal of the Michigan State Medical Society.

Mr. Dodd, the attorney, points out that there are two principle professions, the Law and Medicine. Each is essential to the well being of a citizen in our system of government. A plea is made for an independent profession for the practice of medicine in order that our society may continue to have the benefits of good medical care. To this end Mr. Dodd reviews the means of self control and self regulation which operate in a free profession. Mr. Dodd recommends that we better acquaint the public with the mechanisms of self regulation so that the consumer of medical care may better appreciate the means by which our high quality of medical care is maintained.

The operation of a Medical Audit Committee, the Qualifications Committee of a hospital staff, the Ethics Committee and the Mediations Committee of the organized medical societies is described in detail. This is necessary in order that the public may be informed regarding the regulation of a free profession. Mr. Dodd states that if an informed public wants and is satisfied with medical care strictly regulated from without the profession, that is what it will get and that is what it will ultimately deserve.

The article further explains what the public should know regarding modern medical organization and its relation to medical progress. Along with advances in the art and science of medicine there has been advance in the provision of adequate medical care to a far greater proportion of the people. This has resulted from constantly expanding development of prepaid medical care plans conceived, organized and implemented by the medical profession itself. The most powerful repellant of any threat to a free profession and therefore to the public interest is stated to be aroused public opinion.

Football and the Physician—

On its editorial page, the Texas Journal of Medicine notes that among the big things characteristic of Texas is the largest high school interscholastic football league. The season just past has seen in excess of 900 high schools test their skill on the gridiron representing approximately 100,000 youths in an active competitive contact sport.

(Continued on page 42-A)
nasal and paranasal congestion
and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

**Oral Decongestant Action.** Through the action of Triaminic, nasal patency is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered orally, there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

**Wide-Spectrum Action.** Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

### Trisulfaminic tablets and suspension

**Triaminic® plus triple sulfas**

*Each Tablet and each 5 ml. teaspoonful of Suspension contains:*

- Triaminic® (phenylpropanolamine HCl) 12.5 mg;
- pheniramine maleate 6.25 mg;
- pyrilamine maleate 6.25 mg
- Trisulfapyrimidines U.S.P. 0.5 Gm.

**Dosage:** Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.
Football and the Physician—  
(Continued from page 36-A)

In many of these high schools the determination of conditioning and of injuries is the responsibility of the coach, along with his teaching of the fundamentals of football. Football does not allow the time which heals most sports injuries because each week presents its game requiring its players and necessitating an accelleration in the treatment of injuries.

The editorial points to the complex variables associated with the game, and notes on one side the over anxious mother who will stop her son from playing for any excuse in contrast to the aggressive father who insists that his son plays even though he may have no desire or physical ability. The coach often must win if he is to advance in his career. There is the tradition for the boy to admit of no injury or defect if he thinks that such an admission would keep him from playing.

The team physician’s position must be the unbiased and stable voice, according to the editorial, in this picture. The physician must have the confidence of the parents as well as the coach and be ready to consult with the family physician. He must know the players and their reaction to injury and when to encourage and when to restrain.

The team physician’s duties should begin with insistence upon a pre-season physical examination performed by either the family physician or by the team physician. The team physician should insist that equipment be in a good state of repair and adequate in amount. His presence is needed at every game to pass upon any injuries received. A boy playing the game or his coach is not qualified to state the extent of the injury which may be present.

The editorial concludes by pointing out that while Texas is proud of its size, its ranches and its oil it should be even more proud of the health of the 100,000 young men engaged in competitive organized sports.

Health Insurance Benefits Increasing—

Benefit payments to Americans covered by health insurance through company policies exceeded $2 billion during the first nine months of 1958, as reported by the Health Insurance Institute. This was an increase of more than 10 per cent over 1957.
the chill
the sneeze
the cough
the aches
the fever

in the common cold
and other upper respiratory infections...

the only such preparation to contain penicillin V to curb bacterial complications...

- antibacterial
- analgesic
- antipyretic
- antihistaminic
- mood-stimulating

Supplied: Capsules, vials of 36. Each capsule contains: penicillin V (100,000 units), 62.5 mg.; salicylamide, 194 mg.; promethazine HCl, 6.25 mg.; phenacetin, 130 mg.; mephentermine sulfate, 3 mg.

Pen-Vee-Cidin®
Penicillin V, Salicylamide, Promethazine Hydrochloride, Phenacetin, Mephentermine Sulfate
Current Comment

Medicine in the Changing Order—

Concern for the future of medicine prompts the New York Academy of Medicine to begin a study to develop methods of investigation of possible patterns for the future of medical teaching and practice in the face of the rapid growth of knowledge, the changing concepts of community service and the emergence of new groups of professional workers. It is estimated that the health and medical service of forty years hence may be quite different from that of today or forty years ago.

This pilot study which has been termed "Whither Medicine" is purely in the nature of an inquiry. It is stated not to be a prelude to propaganda and is without any objective other than to yield information and understanding.

Areas of exploration include a study of the economics of medical practice. It is stated the doctor to patient pattern of medical service is changing radically by a variety of new service patterns. One of these noted is the simple intercession of an insurance intermediary between the doctor and the patient. Other changing patterns include group practice, the development of health centers and hospital centers rendering services on a regional basis.

Notice will also be given to the increasing power and influence of labor unions in the field of health services. It is obvious that this is heavily weighted with economic, social and political implications.

Another factor to be observed is the role of the pharmaceutical industry in both medical research and medical practice. It is stated that the pharmacy has been all but obliterated in its ancient or traditional sense. The pharmaceutical corporation now manufactures and to a considerable extent influences treatment rather than leaving the compounding of medication to the local pharmacist. These industries are absorbing into their enterprises a good proportion of the available research manpower and with their financial influence infiltrate both university and hospital research projects.

The increasing importance of technology in Medicine as exemplified by a variety of specialists and technologists will also be considered for their possible influence on the (Continued on page 46-A)
If you were to examine these patients

could you detect the uveitis patient on Medrol*? Probably not. Not without a history.

First, because he's more than likely symptom-free.
Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?

Medrol hits the disease, but spares the patient

*TRADEMARK, REG. U.S. PAT. OFF.—METHYLprednisolone, UPJOHN
PHYSICIANS' EXCHANGE

FOR RENT: Residential office suite with 2 examining rooms, laboratory, reception room and private office. New building, ground floor, office parking area. Contact Dra. Seberg & Seberg, 515 West 9th Street, Hastings, Nebraska.

FOR SALE — A General Electric 100 milliamperes X-ray machine with bucky table, in excellent condition. Price very reasonable, $800.00. Contact John F. Campbell, M.D., 321 West Koenig St., Grand Island, Nebraska, Tel. DU 2-4500.

FOR SALE — On account of my health, I am closing my office. I wish to dispose of my equipment which includes a General Electric portable X-ray machine in good condition. Contact W. H. Hombach, M.D., 416 West Division Street, Grand Island, Nebraska.

FOR SALE — Office building, furniture, EKG, X-ray and well equipped laboratory, etc. Reasonable terms to close estate. Write or call Mrs. Charles Marsh, Valley, Nebraska.

EXCELLENT OPENING — Available for physician in Ravenna, Nebraska. This city of 1800 has only one physician who is now past 80. We are now in the process of raising 50 thousand dollars for medical center. For further information please contact, Ravenna Lions Club, c/o J. Gilmore Love, Ravenna, Nebraska.

X-RAY FOR SALE — Profex 20 M.A. in excellent condition, all accessories. P. J. Hermsen, M.D., Harvard, Nebraska.

FOR SALE — One complete office equipment for Eye, Ear, Nose and Throat, as I have retired from practice. Come and see it at my residence, 3621 20th Street, Columbus, Nebraska. The price will suit you. Charles H. Campbell, M.D.

FOR SALE — Complete office equipment including 100 M.A., Kelleket X-ray with fluoroscopic unit, Beck Lee EKG, Pelton autoclave, etc. For price and details write R. A. McShane, M.D., Box 902, Norfolk, Nebraska.

IMMEDIATE OPENING — For excellent general practice. New hospital and irrigation project started, excellent future. Five room office with heat furnished, monthly rental $85.00. I will introduce before leaving. All clinical records are available. M. O. Arnold, M.D., 806 Seventh St., St. Paul, Nebr.

FOR SALE — Complete office and surgical equipment for eye, ear, nose and throat, belonging to the late Dr. J. E. Gelow of Grand Island. All items may be checked in current supply catalogs. Will be sold at a fraction of the original cost. Mrs. J. E. Gelow, 418 S. Tilden, Grand Island. Telephone DU 4-0654.

FOR SALE — Seven rooms and utility room. Air conditioned. City of 1200 in good location in east central Nebraska. Write Box No. 6, Nebraska State Medical Journal, 1315 Sharp Building, Lincoln, Nebr.

Medicine in the Changing Order—
(Continued from page 44-A)

future practice of medicine. The probable changes in our population, both as regards the shifts in age groups and the mobility of our population will receive notice. Since medicine is designed to serve the health needs of people it is significant that medical care must be available, complete with hospital and technical facilities, within reach of our people.

A brochure describing this activity of the New York Academy of Medicine points out that in their opinion medicine is no longer the sole prerogative of the medical profession. It is stated that in recent times and specifically during the last three quarters of a century, health has come to be regarded not as a commodity but rather as a social derivative and a social requisite. In this latter respect it is considered by our population on a par with liberty and education. These forces which may be expected to alter the practice of medicine in the future result from social and economic forces of large magnitude and it is alleged that the influence of the medical profession as such has been relatively unimportant in the eventuation of these changes in our society.
**NEBRASKA STATE MEDICAL ASSOCIATION OFFICERS AND COMMITTEES**

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<td>Vice President</td>
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<td>R. B. Adams, Lincoln</td>
<td>Secretary-Treasurer</td>
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<td>M. C. Smith, Lincoln</td>
<td>Executive Secretary</td>
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Delegates—J. D. McCarthy, Omaha; Carl E. Leininger, McCook
Alternates—H. C. Morgan, Lincoln; W. C. Koner, Nebraska City

**COUNCIL ON PROFESSIONAL ETHICS**

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**COMMITTEES**

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<td>Walter Reiser</td>
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| K. P. McDermott, Chm. | Grand Island |
| L. E. Dickinson | McCook |
| E. K. G. P. Carver | York |
| Paul Scott | Aurora |

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<td>Marshall Noyd</td>
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<td>G. Paul Charlon</td>
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<td>Arthur Anderson</td>
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<td>William F. Novak</td>
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<td>W. G. Taylor</td>
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DIURIL (Chlorothiazide) given alone to 85 patients, "...caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. ... The average effective dose was found to be 1 Gm. per day by mouth. ... The usually excellent response coupled with the absence of significant toxicity and lack of development of drug resistance makes chlorothiazide ideal for the prevention and treatment of toxemia."

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...caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria...."
Current Comment

Standard Insurance Forms—

The Medical Association of Georgia has a committee on standardization of insurance forms and their report in a recent issue of this state’s journal indicates at least some success for the committee.

The committee sent a questionnaire to 48 states to survey the activity of other state associations in the field of standardizing insurance forms. The assistance of the Health Insurance Council of America was also requested.

It was the recommendation of this committee in Georgia that in cases of “pure” hospitalization the insurance data for the hospital insurance forms be provided by the hospital from the hospital chart and that it not be necessary for the physician to validate this information.

In the event of medical and surgical policies, a standard form was recommended to be used by the physician in all medical and surgical claim cases. This standard form when completed by the physician would be attached to the company form. The standard form would note that if additional information is necessary, the firm may obtain such from the doctor at a minimal charge.

The committee recommended that the Council of the Medical Association of Georgia communicate to the insurance companies their opinion that a copy of the death certificate should be sufficient proof of death for the insurance company. Further information would be available from the physician but for a special fee.

The committee further recommended that a standard industrial claim form be adopted.

Cardiacs Should Work—

Strong evidence is now available that the patient with heart disease has a better outlook if he is working than if he becomes idle, according to Dr. Leonard J. Goldwater who presented the results of his research to the Vermont Heart Association.

Prolonged periods of idleness for the patient with heart disease may result in physical and psychological damage that far outweighs any benefit which may result from rest. This is particularly true of inactivity resulting from prolonged legal proceedings which the disadvantages may outweigh any.

(Continued on page 54-A)
"Much better—thank you, doctor"

Proven in research
1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice
4. More rapid clinical response
5. Unexcelled toleration

**COSA-TETRACYCLYN**

GLUCOSAMINE-POTENTIATED TETRACYCLINE

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<th>ORAL SUSPENSION</th>
<th>NEW! PEDIATRIC DROPS</th>
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<td>(black and white)</td>
<td>(orange-flavored)</td>
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<td>250 mg., 125 mg.</td>
<td>125 mg. per tsp. (5 cc.)</td>
<td>5 mg. per drop, calibrated dropper, 10 cc. bottle</td>
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<td>(for pediatric or long-term therapy)</td>
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**COSA-TETRASTATIN**

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

**CAPSULES** (black and pink) 250 mg. Cosa-Tetracyclin (with 250,000 u. nystatin)

**ORAL SUSPENSION** 125 mg. per tsp. (5 cc.)

Cosa-Tetracyclin (with 125,000 u. nystatin), 2 oz. bottle

**COSA-TETRACYDIN**

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

**CAPSULES** (black and orange)—each capsule contains: Cosa-Tetracyclin 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.


Pfizer Science for the world's well-being

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York
Cardiacs Should Work—
(Continued from page 50-A)

financial benefits which result to the pa-
tient.

Dr. Goldwater stated that fear is an im-
portant deterrent to employment. The fam-
ilies may aggravate the situation and the
physician must encourage the patient and
counteract the pessimistic advise of well
meaning friends.

The research underlying this report was
conducted by Dr. Goldwater at Bellevue Hos-
pital. A work classification unit for cardiac
patients provided the data for Dr. Gold-
water's conclusions. It is necessary that the
work must be within the physical capability
of the patient. Along with encouragement
it is necessary that the patient receive full
benefit of our modern knowledge of effective
therapy for cardiac patients.

It is more difficult for the older patient
with heart disease to return to full-time em-
ployment, because often times the cardiac
functional capacity of patients whose heart
disease develops after 55 is diminished to a
greater degree than is the case in younger
persons. Also the employment opportuni-
ties in general are more restricted for the
elderly period.

Patients whose physical condition would
permit regular work but who lack the will
or the confidence to return to work may
need psychiatric assistance.

Dr. Goldwater made a plea for continuing
research to develop more effective, prac-
tical, and reliable methods of measuring ob-
jectively a patient's ability to meet the
physical demands of a specific job.

Public Education on How Voluntary
Health Insurance Benefits—

A coordinated program to improve public
understanding of how voluntary health ins-
urance helps finance the medical costs of
the older age population has been urged by
the Health Insurance Association of Ameri-
ca. The Director of Information and Re-
search, Joseph F. Folkmann, Jr., says: "The
entire corps of medical professional person-
nel, public health personnel, the secondary
schools, employers, labor unions, rural and
farm organizations, community organiza-
tions, and others can help in an important
way to create a better informed public."
Make new Panalba* (Panmycin® Phosphate plus Albamyacin**) your broad-spectrum antibiotic of first resort effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:
1. Panalba Capsules: bottles of 16 and 100 capsules. Each capsule contains:
   Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride .... 250 mg.
   Albamyacin (as novobiocin sodium) ... 125 mg.
2. Panalba KM-11 Flavored Granules. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:
   Panmycin (tetracycline) equivalent to tetracycline hydrochloride ....... 125 mg.
   Albamyacin (as novobiocin calcium) ....... 62.5 mg.
   Potassium metaphosphate ........... 100 mg.

Dosage:
Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.
Current Comment

Over-utilization of Insurance—

Don't kill the goose, is the title of an editorial in the Journal of the Texas Medical Society concerned with methods of preserving voluntary health insurance.

The editorial states that champions of centralized government would like nothing better than to see voluntary health insurance fail. The insurance plans have had to cover increasing medical costs. The factors causing the increase include new methods of diagnosis and treatment which have meant better care but it is also stated that at least in some instances these costs have increased because of unnecessary hospitalization, needless procedures, and confinement of patients for periods longer than required for good care.

Presidents of County Medical Societies in Texas have been urged by the chairman of the state committee on voluntary health insurance to initiate a study of the voluntary health insurance program in their own areas with particular emphasis on abuses which might have crept into them.

The editorial notes that fire insurance does not necessarily increase fires and life insurance does not increase the death rate, but the introduction of health insurance has been followed by an upsurge in the utilization of personal health services. Needless hospitalization and unnecessary use result in an increase in premiums. This abuse of service is one of the things that is so feared in government medicine when total prepaid insurance exists. The editorial concludes that to fail to solve this problem could price voluntary health insurance out of the reach of the public and "kill the goose that laid the golden egg."

Very few diabetics die as a direct result of their disease but rather from its complications, according to the publication "Patterns of Disease," prepared by Parke, Davis & Company for the medical profession. Heading the mortality list is heart disease which accounts for approximately 50 per cent of all deaths among diabetics. Vascular lesions of the central nervous system rank second with about 13 per cent. Only 1.2 per cent of deaths result from diabetic coma.
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