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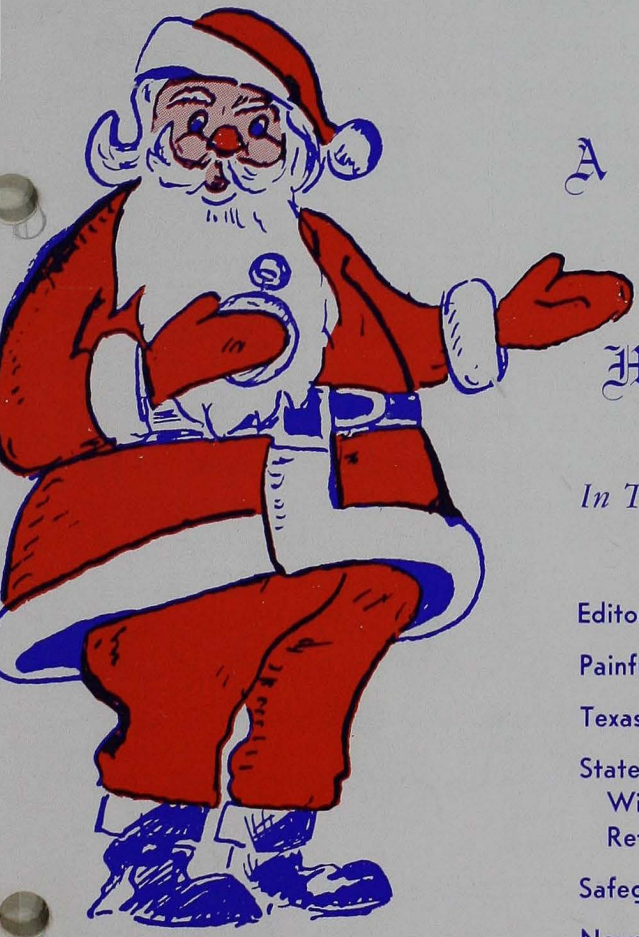

Wishing You A Merry Christmas and Happy New Year

In This Issue—

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EDITORIAL PAGE

Merry Christmas

To each and every osteopathic physician, the auxiliary and all fellow men we wish a Merry Christmas and the happiness and satisfaction each unto himself has earned.

Christmas represents the birth of Christ. It is the symbol of faith—faith in God and fellow men.

The osteopathic school of medicine holds that the human body is the temple of God, a creation that science has been unable to attain. Physicians are entrusted with the preservation of God's temple and all physicians should recognize the following facts:

1. The laws of nature are all powerful.
2. The body contains within itself all of the necessary elements to resist disease if that body is structurally and chemically in balance.
3. The body is a unit and must be cared for as such.
4. Structure and function are inseparable.
5. To unbalance function or structure is dangerous to the temple of God.

Let us recognize that there is only one reason for Christmas, which has sustained for centuries, a belief that there is a supreme power that governs the universe—call it what you will.

Let us, as physicians, recognize this fact and dedicate ourselves to join our forces with this power, preserve the normal and allow function and structure to function as a normal unit. Let us put no stumbling blocks in the path but assist in every way possible.

MERRY CHRISTMAS AND A HAPPY NEW YEAR!

from the

EXECUTIVE SECRETARY AND STAFF

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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VOL. XII FORT WORTH, TEXAS, DECEMBER, 1955 NUMBER 8

Painful Hip In Adults

A. ROLAND YOUNG, D. O.

Painful hips in adults comprise a large percentage of the practice of the orthopedic specialty and we as osteopathic physicians have occasion to see many of these people pass through our portals in their search for help with their malady.

In the light of advances in the surgical treatment of the past 12 years, even more attention is being directed to this major point. The problem is not small, even when only one hip is involved. With every step, virtually the entire weight of the body is carried through the hip joint. Imperfections in development, previous disease, injury, as well as normal aging, all may contribute to the early downfall of this joint.

Anatomically, the hip joint is an enarthrosis, a ball and socket joint, with gliding, rolling, rotating motion. It is well surrounded by a strong, ligamentous reinforced capsule which is lined by synovial membrane. To operate properly, the socket must be sufficient and the spheroid ball congruous, so as to give smooth action and skeletal support. The motivating power about the hip joint consists of a powerful and well-balanced set of muscles, which must not only drive the joint, but maintain the entire pelvis and trunk in equilibrium.

For convenience, and to emphasize the major pathologic defect, this paper has been divided into a section on the head and neck of the femur, one on the acetabulum, one on the synovia, and one on the entire unit of the hip joint. It is entirely understandable that disease in one part of a joint, the whole of which needs to be so mechanically perfect, will lead to secondary and adaptive pathologic changes in the other units of the joint. The end result is a degenerative process in the entire joint which may cause limp, deformity, pain and considerable disability.

Disease in the Head of the Femur:

The spheroid shape of the head of the femur can be distorted by congenital defects, development processes and by trauma. The distorted head eventually leads to changes in the acetabulum.

Congenital Coxa Vara

Coingenital coxa vara consists in a decrease in the normal angle which the neck of the femur makes with the shaft of the femur. This disturbs the normal anatomic relationship of the head of the acetabulum, resulting in a flattening of both. It is usually first observed early in childhood. It is often bilateral.

Clinical Picture: There may be weakness and stiffness, plus an awkward gait or a definite limp. When the condition is bilateral the "duck waddle" may be present. Abduction and internal rotation of the hip as a rule are restricted whereas external rotation and abduction may

be increased. There is shortening of the extremity. Pain often is referred to the medial part of the thigh or to the knee.

Roentgenologic Aspects: The decrease of the angle of the head and neck with the shaft of the femur is noted. Generally, there is a demarcation of a triangular area of bone on the lower side of the femoral neck, close to the head.

The head of the femur is situated low in the acetabulum. The acetabulum is often shallow and wide. When the condition is of longer duration there is usually a marked upward prominence of the greater trochanter.

Treatment: When the deformity is minimal, protection from weight-bearing may be all that is necessary. In later life a reconstructive procedure often is required for the relief of pain.

Legg-Calve-Perthes Disease

Legg-Calve-Perthes disease is a condition of unknown cause developing in children from 4 to 10 years of age. It is more common in boys than in girls.

The head of the femur undergoes degenerative changes similar to those seen in aseptic necrosis. If unprotected weight-bearing is allowed in this degenerative phase, flattening and roughening of the head occur.

Clinical Picture: Limp is the most prominent early sign. Muscle spasm is present. Pain may or may not be a feature. As in congenital coxa vara, internal rotation and abduction of the hip are definitely limited. However, in Legg-Perthes disease there is slight limitation of the other hip motions. There may be some shortening of the extremity. Symptoms regress as the head undergoes repair. However, later life the hip may present the picture of malum coxae senilis.

Roentgenologic Aspects: Early there is flattening of the head of the femur, with fragmentation. The femoral neck becomes broad and short. The acetabulum changes in shape, at least in part to correspond with the shape of the head. As healing occurs, the fragmented epiphysis coalesces. The deformed head may project beyond the borders of the acetabulum.

Treatment: Weight-bearing should be prevented during the active phase of the disease. A reconstructive procedure often is necessary in later life because of the hypertrophic changes which have resulted from the incongruity of the head in the acetabulum.

Slipped Capital Femoral Epiphysis

This condition usually is of unknown cause, but can occur as the result of severe trauma. The slip may be so slight as to cause minimal symptoms. However, slipping may be gross and cause complete disability. It usually occurs between the ages of 10 and 17 years. Here again the normal relationship between femoral head and acetabulum is disturbed, and degenerative changes in the hip may develop at any time.

Clinical Picture: The symptoms may be minimal. The early symptoms are fatigue, slight pain, stiffness and limp. When the slipping of the epiphysis is marked, the lower extremity assumes a position of flexion, abduction and external rotation. At first the pain may be referred to the knee; later it is located in the hip.

Roentgenologic Aspects: Shands described 4 stages of the condition; preslipped quiescent and residual. In the first stage the epiphyseal line is abnormally wide. When slipping occurs, the epiphysis is displaced downward and backward in relation to the neck. If it is not corrected, new bone forms between the femoral neck and the head. This produces an abnormal relationship of the head of the femur with the acetabulum. Eventually, this incongruity results in hypertrophic changes with attendant pain.

Treatment: In the pre-slipping or early slipping stage the hip can be pinned with a Smith-Peterson nail or Knowles pins. If the slip is more pronounced but recent, reduction may be accomplished by gentle manipulation.

When new bone has formed between the neck and the slipped epiphysis, osteotomy is indicated, followed by immediate pinning. Aseptic necrosis of the head of the femur may follow this procedure. When the condition is of long standing, a reconstructive operation often is necessary.

Osteochondritis Dissecans of the Femoral Head

Osteochondritis dissecans of the head of the femur occurs in adolescence or early adult life. The cause is not definitely known, although it is thought to be some disturbance in the blood supply. A portion of the articular surface, along with some of the subchondral bone, separates off, causing a roughened head and potential trouble.

Clinical Picture: The clinical picture is that of a loose body in a joint; namely, pain, weakness, fatigue and locking.

Roentgenologic Aspects: the roentgenogram will show a loose body or bodies, if they contain bone.

Treatment: The treatment is to remove the loose body or bodies. A reconstructive procedure may be necessary later, because of the abnormal wear and tear resulting from the incongruity of the relationship between the femoral head and the acetabulum.

Changes in the Head of the Femur Due to Trauma

A great number of problems which are seen in degenerative disease of the hip are of traumatic origin. Fractures of the head of the femur disturb the nice relationship of the joint components. Injuries at a distance in the neck or even in the intertrochanteric region may cause degeneration of the joint because of union in malposition, nonunion or aseptic necrosis with or without union.

Clinical Picture: Early symptoms may be aching in the hip region, slight stiffness and pain referred down the medial aspect of the thigh to the knee. Activity intensifies the symptoms. As muscle spasm develops, the hip flexes and adducts. External rotation deformity develops. Pain increases and may even be present at night, interfering with the patient's rest. As the hip becomes stiffer, increased strain is placed on the lumbar part of the spinal column and back pain may become troublesome. As flexion and adduction of the hip increases, the apparent shortening increases.

Roentgenologic Aspects: The joint line narrows: Cystic changes may become evident in the head of the femur and in the acetabulum. Spur formation is seen at the junction of the head and neck of the femur and along the edges of the acetabulum. Sclerosis of the bones is a common finding.

Treatment: Treatment is either paliative or operative. Paliative treatment includes the use of such things as heat, aspirin, cortisone, elevation of the heel, a cane and neurectomy. The definitive operative treatment includes arthrodesis or some form of arthroplasty. The operative treatment will be considered in detail in a subsequent presentation.

Acetabular and Synovial Changes

Primary acetabular pathological changes are caused by congenital subluxation or dislocation, fracture, and arthrokatadysis (Intra - Pelvic - Protrusion) while degenerative changes resulting primarily from synovial changes are due to rheumatoid arthritis, synovial osteochondromatosis, and villonodular synovitis.

Acetabular Changes

Congenital dislocation of the hip occurs because shallow, triangular acetabulum is filled with fibrous tissue, and the irregular femoral head, attached to a short, thick neck, rides upward and outward from the acetabulum. If dislocation is reduced, either by manipulation or operation, and adequate retention is maintained, the joint may develop normally; otherwise instability persists. With each step the head slips upward, irritating joint cartilages, and by the third or fourth decade of life,

medical advice is sought for degenerative arthritic pain.

Fracture of the acetabulum will cause degenerative changes unless treatment is prompt. Even an initially undamaged femoral head will eventually deteriorate.

Arthrokatadysis—In contrast to the unstable hip of congenital dislocations and acetabular fractures is the bound and tight hip of arthrokatadysis. In this condition the femoral head protrudes into the pelvis, and eventually the greater and lesser trochanters may rest against the pelvic wall. This condition may be congenital or caused by osteoporosis, osteomalacia or injury. There is early limitation of rotation and abduction of the hip; eventually pain is caused. The patient usually seeks medical aid in the third or fourth decade of life because of pain and limited motion.

Synovial Changes

Rheumatoid Arthritis is a generalized disease which in the early phases involves only the synovial membrane. In this phase there are exacerbations and remissions of symptoms, but finally the cartilage of the joint becomes involved and pain and limited motion of the joint develop. The roentgenogram reveals a loss of joint space and later even ankylosis.

Synovial Osteochondromatosis of the hip is a rare lesion, but it accounts for a small percentage of degenerative lesions.

It is characterized by multiple pedunculated and loose bodies in the joint space. The constant mechanical irritation may lead on to pathologic changes resembling those of trauma or osteoarthritis. The synovia of the involved joint is thickened and many synovial projections contain cartilaginous bodies in various stages of production. Eventually, these bodies become loose in the joint and mechanically obstruct its free motion. If they are allowed to remain, irreparable damage is done to the joint, with eventual damage to the articular cartilage and a degenerated hip.

Villonodular Synovitis probably is one of the metabolic diseases. Whether it is inflammatory or neoplastic in origin it is not known. It probably develops secondary to trauma or infection in the presence of a coexisting disturbance in cholesterol metabolism.

The condition as a rule is monarticular, and is characterized by pain and limited motion of the joint. The roentgenogram reveals a narrowed joint space, with cystic changes in the femoral head and acetabulum.
and acetabulum. At the time of operation an olive-green and yellow thickened synovial membrane is found, together with xanthomatous deposits in cystic cavities of the femoral head and acetabulum.

Entire Joint

The use of chemotherapeutic and antibiotic drugs have almost eliminated "septic arthritis" due to micrococci,

streptococci, and gonococci, brucellar infections are more common than before.

Septic arthritis of the hip may occur after measles, scarlet fever, or meningitis or may spread from distant foci such as furuncles. Penetrating wounds or osteomyelitis of the femur shaft may be the responsible factor. In most cases onset is abrupt. Effusion into the joint causes painful tension; fever and systemic reaction ensue, and the leg is ordinarily flexed, abducted, and externally rotated. Early roentgenograms may demonstrate only widening of the synovial sac, but purulent exudate contains proteolytic enzymes that soon destroy parts of the joint. The weight-bearing portion narrows and, as subchondral bone deteriorates, the entire joint space disappears. The femoral head and neck may be destroyed and pathologic dislocation result. Before roentgen change, childhood infection can be controlled by a few days of therapy and rest in bed. More often the result is painful limited hip motion if not complete bony ankylosis in later years.

Osteoarthritis

Osteoarthritis is a poor name for the most common condition affecting the function of the hip, one that has been written about and studied since the time of Hippocrates. Such synonyms as hyperthrophic arthritis, arthritis deformans and malum coxae senilis are commonly used to denote this condition. At present practically all students of pathologic changes in joints agree that the changes seen in this condition are the result of "wear and tear" and the normal attrition of life.

The American Rheumatism Association has officially adopted the term "degenerative joint disease".

Ample evidence shows that degenerative changes appear in normal joints early in life, the weight-bearing joints being affected somewhat earlier and to a somewhat greater extent than are those which do not bear weight. With advancing age, these degenerative changes become more prominent; according to some authorities, they are universally present after the age of 40. However, it is estimated that only about 5% of persons have important clinical manifestations as the result of such changes. These effects are much more extensive in some persons than in others. It is known that trauma accelerates the appearance of degenerative changes; this may take the form of a single traumatic incident, repeated trauma incident to certain occupations or that imposed by imperfections of the joint, such as result from congenital dysplasia or osteochondritis. Many times, however, it is not known why some people have clinical manifestations of degenerative disease of the joints relatively early in life any more than it is known why some people grow old early in other respects.

The publicity attending the discovery and use of cortisone has awakened a

fear of arthritis in many persons akin to the cancerphobia seen so frequently. This same publicity, however, has not as yet clarified the thinking of those who insist on a label of "arthritis" for any condition in which aches and pains are associated with spurs or some other objective evidence of degenerative changes noted in roentgenograms. "Osteoarthritis" is no better, for the patient soon forgets the "osteo" and, remembering the "arthritis", eventually falls prey to quacks and charlatans who have fed at this trough for so long.

Degenerative disease of the hip joint begins with a softening and fibrillation of the articular cartilage. Although mild stiffness and aching may be present, no roentgenographic abnormalities are detectable at this time. As the degeneration progresses, the articular cartilage wears away completely, exposing the subchondral bone, which becomes polished in appearance and extremely hard. Roentgenograms at this time show great narrowing or complete loss of the joint space; cysts appear eventually in the cancellous bone of the femoral head and also adjacent to the acetabulum. Marginal proliferation occurs and the synovial membrane presents a shaggy appearance due to an increase in the number of villi. By this time there is extensive interference with the function of the joint. The hip is flexed and abducted and the leg appears to be shortened. Rotary motions are greatly restricted or absent and flexion may be so limited that the patient cannot dress the foot of the affected leg. Pain is variable in degree and is generally proportional to the amount of weight-bearing activity of the patient. Symptoms are always more severe than usual when patients are obese. Effusion into the joint space is rarely present and spontaneous bony ankylosis does not occur in osteoarthritis.

Traumatic Dislocation

Traumatic dislocation results from a powerful force directed along the flexed and adducted thigh, as for example, in automobile accidents when the knee strikes the dashboard. The femoral head may be fractured or part of the acetabulum broken off. Anterior dislocation is less common. The most frequent complication, seen in 40% of instances, is avascular necrosis of the femoral head, caused by tearing of thrombosis of vessels in the ligamentum teres. Bone may disintegrate a few weeks or several years after dislocation. Other possible complications are paralysis of the sciatic nerve, subperiosteal hematoma, and myositis ossificans.

Principles of Therapy

At all ages, pain is the major symptom of hip disease and the chief reason for surgery. Instability, deformity, and limited movement are also important in youth. Elderly people, if comfortable get around well enough with a crutch or cane. The orthopedist must judge how much pain is felt and how well

disability can be accepted. Many hip disorders, especially in the initial stage, are tolerable if a certain level of activity is not exceeded. During a flare-up or pain and stiffness, stress and strain should be diminished by a support, rest periods, and reduction of body weight. Increasing or unbearable pain necessitates surgery.

Arthrodesis is ideal for the active young man with unilateral disease who works outdoors. Disadvantages are difficulty in sitting comfortably and lumbosacral strain from the immobolized joint.

Osteotomy moves the weight-bearing line of the femur nearer to the body midline and thus limits motion.

Arthroplasty procedures, including use of an artificial femoral head, are the best treatment for bilateral involvement, combined hip and back trouble, for elderly patients, or for individuals with sedentary occupations. The candidate for arthroplasty must have patience, insight, and persistence to carry out postoperative exercises, endure setbacks and perhaps repeated surgery or manipulation. Unaided weight-bearing may never be possible, even if pain is practically abolished and some motion is regained.

Repair of Head and Neck

Degeneration of the femur may deform or destroy the head, demolish the head and neck, or cause varus angulation.

Reconstruction, which rearranges existing parts to better mechanical advantage, may be done by the technic of Brackett, Whitman or Colonna. Arthroplasty recreates a smooth, congruous joint surface by interposing fascia, plastics, or metal. The Vitallium cut of Smith-Peterson or metal prosthetic head, Judet's stemmed or Austin Moore intramedullary type, are satisfactory for this procedure.

Osteotomy is done by 3 methods: neck, the McMurray high, or the Shantz low. Arthrodesis insures painless stability while preventing motion. After avascular necrosis of the femoral head, for example, a Colonna reconstruction with cup arthroplasty may relieve pain, restore stability, and permit 50% of normal hip motion. The Brackett operation may be useful after fracture, nonunion, and absortion of the femoral neck.

Bilateral congenital subluxation with degenerative changes may be corrected by Vitallium mold arthroplasty on the left and Austin Moore prosthetic arthroplasty on the right with end results of stable mobile hips and practically no pain.

Whatever the pathologic state of the femoral head and neck, the acetabular condition must also be considered and the joint treated as a unit.

It becomes apparent that many of these entities of the painful hip in adult life may be avoided by prompt childhood care of acute infections, congenital dislocation or dysplasia, slipping of the capital femoral epiphysis, and Legg-Perthes disease. However, arthrodesis will remain useful for severe infectious damage with extensive scarring and loss of muscular control. Osteotomy will continue to serve for some types of coxa vara and femoral malalignment near the hip joint. As a rule, procedures that preserve motion will be favored, but cases must be selected wisely. Effective arthroplasty demands sufficient bone, muscles, and ligaments, as well as patient's cooperation.

The best choice of prosthesia or interposing material is still unsettled. At least 25 devices are now in use, and others are available. Some replace the head only, others the entire head, neck, and trochanter. Plastics are either acrylic or nylon and metals are chiefly stainless steel and Vitallium. The Vitallium mold is by far the oldest and produces many good results. A modified form developed by the late Dr. Smith-Petersen may eventually be on the market.

Plastics probably will not hold up well under long and constant wear. Apparently, the prostheses most likely to withstand strain are inthamedullary

types that replaces tthe head and all or part of the neck, with fixation to the shaft.

Prostheses substituting for the femoral head, neck, and trochanter leave nothing to work with in case of failure. If tissue under a prosthesis or cup becomes infected, a serious problem must be met. Usually, the more bone remaining, the better the method of repair.

Surgery for Acetabulum

Acetabular defects are of 3 types:

1. The socket may be shallow, affording poor or no stability, as with congenitally dislocated hips.
2. The acetabulum may be irregular, causing jerky, painful, incomplete movements because of tuberculosis, old fractures involving the femur, or other disorders.
3. Occasionally the socket is too deep, motion is limited by abutment of the femoral neck on the rim, and pain is caused by degenerative changes.

Arthrodesis is almost imperative for tuberculosis of the hip. By Ghormley's technic, a bone graft is transferred from the iliac crest to a slot fashioned in the femoral trochanter and neck across the joint line and into the body of the ilium. Postoperatively a double and later a single spica plaster-of-Paris cast is required, and immobilization may be necessary for six months or more. After unilateral repair, however, patients may walk with hardly a limp and stand daily for hours.

Shelf operation is done for a young adult with shallow or deficient acetabulum. A ledge of bone constructed

over the upper weight-bearing part of the femoral head may prevent or delay degeneration.

Mold Arthroplasty supplements the shelf operation for a shallow socket with misfitting head. A Vitallium cup is supplied.

Colonna's procedure creates an acetabulum for children with congenital dislocation. In place of a Vitallium mold, an elongated joint capsule is interposed between the joint surfaces.

Acetabuloplasty is done for malformation due to injury or nontuberculous disease. A Vitallium mold is inserted between raw surfaces of the reshaped ball and socket.

Reconstruction for an intrapelvic protrusion uses a prothesis. The unusually deep pocket is buttressed with a semilunate part of the femoral head, in hope of fusion.

The best solution to the problem of acetabular lesions is prevention. Good function is generally assured if a shallow acetabulum is corrected in the first six months of life.

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Community Hospital

This institution is again expanding. During 1954 they constructed a new wing which gave them considerably additional beds.

Now they are just completing another wing to this institution which will expand their services. This new wing will provide a complete new x-ray set up, consisting of two dianostic x-ray units, a deep therapy unit, dressing rooms, and x-ray office. It will also provide new laboratory facilities and, in addition to this, the rear of the wing provides an adequate staff meeting room.

We are proud of the progress being made in the development of Community Hospital. We prophesy that another wing of additional bed space will be added within a year.

Of Interest to the Profession

MEDICAL ECONOMICS, Incorporated, announces that beginning with the January 1956 issue, MEDICAL ECONOMICS will be available on request to all doctors of osteopathy in private practice who are members of the American Osteopathic Association.

Careful study in the field of osteopathy has convinced MEDICAL ECONOMICS of its value to advertisers and to the vital interest of doctors of osteopathy in the subject of Medical Economics.

MEDICAL ECONOMICS anticipates a circulation for April 1956 of 148,000.

Life Span

The horse and mule live 30 years,
With nothing known of wine or beer;
The goat and sheep at 20 die,
Having never heard of scotch or rye.
The cow drinks water by the ton
And at 18 is mostly done.
The dog at 15 cashes in
Without the aid of rum or gin.

The cat in milk and water soaks
And then in 12 short years it croaks.
The sober, modest, bone-dry hen
Lays eggs for nog and dies at ten.
All animals are strictly dry—
They sinless, live and swiftly die.
But sinful, gin-full, rum-soaked men
Survive for three-score years and ten!
(While some of us, though mighty few,
Stay pickled 'til we're '92!)

—Author Unknown

Dr. Beckwith Receives Degree

Left: EARLE H. MANN, D. O.
Right: GORDON S. BECKWITH, D. O.

Dr. Earle H. Mann of Amarillo, sponsored Dr. Gordon S. Beckwith of San Antonio for the Degree of Fellow in American College of Osteopathic Surgeons at its annual meeting held in Washington, D. C., October 31, November 1, 2, 3, 1955

Dr. Mann is congratulating Dr. Beckwith following the presentation of the degree.

Find New Drug Aids In Treating Colic

CHICAGO (AOA)—A synthetic drug said to be helpful in treating colic in babies was reported by a Chicago team of physicians.

The new drug, which produces relief of symptoms in 24 to 48 hours, is known as Piptal. Apparently working on the nervous system, it blocks the nerve impulses and thus the pain and seizures.

Dr. H. A. Price, Osteopath, Is Dead, Age 73

Dr. Houston A. Price, 73, a retired Houston osteopath and an invalid for 16 years, died Wednesday in the home of his son at 1748 Alta Vista Drive after a heart attack.

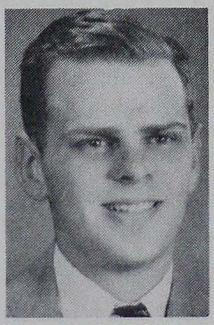
He had practiced in Houston from 1917 to 1937 when he suffered a nervous breakdown. After recovery he returned to his practice until 1939 when he had a paralytic stroke that kept him in a wheel chair for the rest of his life.

Dr. Price was born in Jackson, Miss., and came to Houston in 1890. A graduate of Baylor Medical School, he continued his study at the School of Osteopathy in Kirksville, Mo., where he received a degree in 1908.

From 1908 until returning to Houston in 1917, he practiced in Alexandria, La.

He was a charter member of the Houston Central Lion Club.

Funeral services were held at 3 p.m. Friday in the Earthman Funeral Home chapel with the Rev. Travis Berry officiating. Burial was in Forest Park Cemetery.



HENRY I. BENNER, D. O.
HURST, TEXAS

Dr. Benner is the 1955 president of Midcity Kiwanis Club, Hurst, Texas.

Phil R. Russell, D. O., executive secretary, spoke to the Midcity Kiwanis Club, Hurst, Texas, at a luncheon at the Amon Carter Airport, Amon Carter Field, Tuesday, November 29, 1955, on socialized medicine.

Clinic Named for KCOS Registrar

Miss Marie A. Johnson, Registrar at the Kirksville College of Osteopathy and Surgery, has been signally honored for service by having an osteopathic clinic named for her. The Marie A. Johnson Clinic has been opened at 5004 Broadway in St. Louis, Mo., by Drs. Glenwood Fowler and J. W. Giesler, '49 graduates of the KCOS.

Miss Johnson has held the post of registrar since 1938. She was graduated from North Park College in Chicago and also attended Northeast Missouri State Teachers College in Kirksville and Colorado State Teachers College in Greeley. Before accepting her present position, she was a teacher in the public schools at Bucklin, Marceline and Kansas City, Mo. Miss Johnson is a past president of the Kirksville chapter of the Business and Professional Women's Club and at present is coordinator. She is immediate past director of District 5. She is President of Chapter I.G. of P.E.O., and a past president of the First Contemporary Club of Kirksville.

Miss Johnson visited the clinic October 1 and 2. It is a modern eight-room structure, housing waiting room, office, treatment room, minor surgery, recovery room, x-ray room and pediatric room. Over the outside entrance is a bronze plaque with the inscription, "Marie A. Johnson Clinic".

Casner Vice-President of Missouri Association

Dr. V. H. Casner, chairman of the department of public health and director of rural and special clinics at the Kirksville Osteopathic Hospital and Clinic, was elected first vice-president of the Missouri Association of Osteopathic Physicians and Surgeons, at the 55th annual convention of the group held in Kansas City the end of September. Dr. Casner, who has served as trustee of the association for several years, is now the ranking delegate to the annual convention of the American Osteopathic Association to be held in New York City in July.

Journal Appreciated

October 29, 1955

Phil R. Russell, D. O.
512 Bailey St.
Fort Worth, Texas

Dear Dr. Russell:

I wish to thank you for remembering to send the Texas Journal. Personal attention, such as that, is very much appreciated.

It is representative of an attitude that has caused your association to prosper, and you as a man to be held in the kindest regard by his fellows.

Thanking you again, I am,

Fraternally,
S/ S. C. LYSTER, D. O.
LeClaire, Iowa

How to Kill Your Association

1. Don't come to any meetings.
2. If you do come, be sure to come late.
3. Hold back your dues, or don't pay them.
4. Never ask a friend to join.
5. Don't have anything to say if called on, just gripe after the meeting.
6. If too wet or too dry or too hot or too cold, don't think of coming to a meeting.
7. If you do come to a meeting find fault with the proceedings and the work done by others.
8. Kick if you are not appointed to a committee and if you are appointed, never attend any committee meetings.
9. Don't do anything to help your association, then when a few others take off their coats and do something, be sure to howl that a clique is running the association.

—W. Va. Conservation

Texas Students in Osteopathic Colleges

Kansas City College of Osteopathy and Surgery

Mr. William Bailes
San Marcos, Texas
Mr. Roy Bobbitt
New Boston, Texas
Mr. William Boone
Dallas, Texas
Mr. Frank Bradley
Dallas, Texas
Mr. Ray Harper
San Antonio, Texas
Mr. Raymond Hughes
San Antonio, Texas
Mr. James Peak
Dallas, Texas
Mr. Donald Peterson
Dallas, Texas
Mr. Ernest J. Sachse
Fort Worth, Texas
Mr. Billy J. Sealey
San Angelo, Texas
Mr. Robert Taylor
Lewisville, Texas
Mr. Ted E. Zachary
Richardson, Texas
Mr. James A. Byrd
Houston, Texas
Mr. William Clark
Trinidad, Texas
Mr. Clarence Cogburn
Graham, Texas
Mr. Raymond Liverman
Waco, Texas
Mr. Denzil Truitt
Ionna, Texas
Mr. Jack Gramer
Fort Worth, Texas
Mr. William Johnson
Pampa, Texas
Mr. William Masters
San Antonio, Texas
Mr. Ted B. Thompson
Austin, Texas
Mr. Carson Todd
Dallas, Texas
Mr. Kennith Gregory
Comanche, Texas
Mr. Jessie Hall
Fort Stockton, Texas
Mr. Robert Ling
Pasadena, Texas
Mr. William Morrison
Cisco, Texas
Mr. Maurice Priddy
Blanket, Texas
Mr. Robert Rose
Irving, Texas
Mr. Loy Sanders
Tyler, Texas
Mr. Joe Wolpmann
San Antonio, Texas

Kirksville College of Osteopathy and Surgery

Mr. Anthony T. Mendicino, Jr.
San Antonio, Texas
Mr. Jerry W. Smith
Jacksonville, Texas
Mr. John C. Knox, Jr.
San Antonio, Texas
Mr. Ralph C. Merwin
Port Arthur, Texas
Mr. Robert Lee Peters, Jr.
Austin, Texas

Des Moines Still College of Osteopathy and Surgery

Mr. Herbert L. Chambers
Address unknown
Mr. Robert E. Whittemore
Address unknown
Marcia Jean Ollom
San Marcos, Texas

Assumes Residency at KOH

Dr. Hyman Kahn of New York City assumed his duties as a resident in the department of anesthesiology at the Kirksville Osteopathic Hospital and Clinic October 6. Dr. Kahn, a 1951 graduate of the KCOS, served an internship at the Osteopathic Hospital, Kansas City, Mo. He received his pre-professional training at City College of New York and Brooklyn College. While at the KCOS he was a research assistant in the department of physiology.- He was a member of Alpha Tau Sigma and Alpha Phi Omega.

After completing his internship, Dr. Kahn engaged in private practice in New York City for three years. There he was also house physician at the Henry Hudson Hotel and physician for the El Al-Israel Airlines. Dr. Kahn is married and has two daughters, Lisa, 2½ and Isabel, 8 months old.

Complete Residencies at KOH

Dr. William R. Mallery of the department of pathology of the Kirksville Osteopathic Hospital and Clinic, and Dr. Edward M. Rooney of the department of eye, ear, nose and throat of the KOH, completed residencies in their respective specialties the end of August.

Dr. Mallery, a native of Struthers, Ohio, received his pre-professional training at Westminster College, Fulton, Mo., and was graduated from the Kirksville College of Osteopathy and Surgery in 1951. He spent the next year as an intern at the KOH, and then began his specialty training. Dr. Mallery is now affiliated with Normandy Osteopathic Hospital, St. Louis, Mo.

Dr. Rooney attended Bowling Green State University, Bowling Green, Ohio, and was graduated from the Kansas City College of Osteopathy and Surgery in 1952. After completing an internship at Bay View Hospital, Bay Village, Ohio, he came to Kirksville for a two-year residency. Dr. Rooney and his family returned to his home town of Cleveland, Ohio, where he planned to enter practice.

Missouri Alumni Again Donate $200 to KCOS Rural Clinic Program

A gift of $200 for use in the program of the Rural Extension Clinics was presented to the Kirksville College of Osteopathy and Surgery by the Missouri Chapter of the Kirksville Osteopathic Alumni Association at the annual luncheon meeting of the chapter in Kansas City in September. For several years the Missouri Chapter has presented a similar gift to the college in support of the unique training program under the Rural Extension Clinics in which special attention is given to preparation of the student for small-town general practice.

Osteopathic Physicians Take Medical Examination

The following osteopathic physicians took the medical board examination held in Galveston, Texas, December 1, 2, and 3, 1955.

Dr. John L. Rutherford
Des Moines College of Osteopathy and Surgery

Dr. Howard Weinstock
Kirksville College of Osteopathy and Surgery

Dr. Robert E. Clayton

Dr. Jacob Gordon Banister

Dr. Lowell Schupback
all from the Kansas City College of Osteopathy and Surgery

Dr. Pearson Named to Legislative Study Group

Dr. Wallace M. Pearson, chairman of the department of structural diagnosis at the Kirksville Osteopathic Hospital and Clinic, and Adair County Representative in the General Assembly of Missouri, has been named to a special group of six legislators whose duty is to study the problems of training and education for mentally-retarded children of the state. The group constitutes a subcommittee of the permanent legislative research committee of the House of Representatives of which Dr. Pearson is a member. He is serving his fifth term in the legislature.

Three Special Events at KCOS Founder's Day This Year

The best Founder's Day ever was the general appraisal of the 1955 annual observance at the Kirksville College of Osteopathy and Surgery October 18 and 19 in which three special events were integrated with those making up the traditional celebration of the founding of the first osteopathic college in Kirksville in 1892.

The first of the special events was the post-graduate course offered by the Academy of Applied Osteopathy at the college October 17-22, which dealt with with osteopathic principles and technics relating to the soft tissues and extremities. A membership of twenty-four was attracted to the course, which employed the facilities and personnel of the college.

The second special event was the dedication of the Ohio floor, the fourth or pediatrics floor, representing a special gift by Ohio alumni. The dedication was made on the morning of October 19 with a short address by Dr. Morris Thompson, president of the college.

And the third special event was the presentation at the Founder's Banquet October 18 of the Certificate of Honor to Judge Roy D. Williams of Booneville, Mo., eminent Missouri jurist and counsel for the Missouri Association of Osteopathic Physicians and Surgeons for his contribution to osteopathic education and the osteopathic profession. It was Judge Williams who developed the

argument and directed to a successful presentation the widely-known Audrain County Case, sustained by the higher courts to allow patients in public hospitals in the state to have the services of osteopathic physicians. Also honored at the banquet were members of the classes of 1905, 1930 and 1945.

Other Founder's Day activities included the ceremonies at the grave of Dr. Andrew Taylor Still in the Llewellyn Cemetery and at the Cabin in which Dr. Still was born, the convocation at which the speakers were President Thompson, giving his annual report on the affairs of the college, and Dr. Keineth E. Little of Kansas City, Mo., speaking on "A Need and a Challenge". A luncheon at noon attended by the college trustees, administrative counsel, officers of the Kirksville Osteopathic Alumni Association and other special guests, a picnic at Brashear Park in the afternoon and an All-College dance in the auditorium in the evening completed the program.

Postgraduate Course In Physical Medicine

The American Osteopathic College of Physical Medicine and Rehabilitation Postgraduate Course will be held at the College of Osteopathic Physicians and Surgeons from Monday, January 16 through Friday, January 20, 1956. There is a registration fee of $10.00, but no tuition fee for members of the ACOPM&R. Anyone interested in becoming a member should write to Dr. John Schuck, Secretary and Treasurer, 1721 Griffin Avenue, Los Angeles 31, California. The schedule for the course follows.

The Academy of Applied Osteopathy is giving a Postgraduate course January 9 through 14 at COP&S, preceding the course given by the American Osteopathic College of Physical Medicine and Rehabilitation. The Academy's course will be in basic osteopathic principles, and featuring a practical physiologic approach to the manipulative management of important practice problems. For further information please contact Dr. Kenneth E. Little, 3829 Troost Avenue, Kansas City 9, Missouri.

Next KCOS Clinical Conference Announced

"Referred Pain and Associated Clinical Phenomena" is the subject for the Clinical Conference to be held in the Auditorium at the George A. Still Memorial Building at the Kirksville College of Osteopathy and Surgery Wednesday evening, January 5, 1956.

Appearing on the panel will be Drs. Olwen Gutensohn, Max T. Gutensohn, R. McFarlane Tilley and I. M. Korr, moderator. The conference takes the place of the monthly educational staff meeting which is customarily held on the first Monday evening of each month.

Statement on Oxygen Administration With Reference to Retrolental Fibroplasia

Reprinted from CLINICAL OSTEOPATHY

A statement on oxygen administration and retrolental fibroplasia, including policy recommendations, has been developed during the past two months by a special Ad Hoc Advisory Committee to the California State Department of Public Health. The physicians serving on this Advisory Committee represented the five leading medical schools in California, and also, as you will note, the special fields of pediatrics, obstetrics, ophthalmology and pathology.

Evidence for a casual relationship between oxygen therapy and retrolental fibroplasia (RLF) now appears to be beyond reasonable doubt. Moreover, the available data indicate that limitation of oxygen treatment does not increase neonatal mortality. Infants weighing 2000 gms. or less appear to be more susceptible to this syndrome. The incidence of retrolental fibroplasia appears to increase with each additional day of exposure to oxygen during the first seven to ten days of life.

It is strongly urged that the following policies with respect to oxygen administration be adopted at once by all hospitals caring for the newborn:

1. Oxygen should be administered to premature infants only on the specific order of a physician.
2. Oxygen should not be administered in concentrations exceeding 40 per cent, and should be discontinued as soon as the infant's condition permits. Cyanosis and respiratory distress may occasionally require oxygen concentrations exceeding 40 percent for short periods of time.
3. The prescription for continued oxygen therapy should be renewed daily by the physician.
4. The actual concentrations of oxygen during administration should be checked with an oxygen analyzer at least every eight hours.
5. When oxygen is administered for periods longer than three days, the oxygen concentration should be measured more frequently to be sure that it never exceeds 40 percent.
6. The continuous administration of oxygen for periods in excess of three days should be prescribed only in exceptional circumstances.

—MALCOLM H. MERRILL, M.D.
Director of Public Health

Osteopathy In Paradise

Just a few days ago Chet Wyman and I were having a cup of coffee, (I paid, as usual) and he said something that started me thinking. (Entirely possible!) He was describing a bump on a log. (How the conversation got from who was going to pay for the coffee to a bump on a log, I'll never know.) Anyway, he commented on the fact that it neither added nor detracted from the log—that it neither strengthened nor weakened it—that it did absolutely nothing for the log. It was just there—Just a Bump on a Log.

How true this is of many people! People who are only interested in taking from their professions, their communities, their friends, and who give absolutely nothing in return, are without a doubt bumps on the log of humanity.

I think that the thing that would hurt me most, professionally speaking, especially, would be to be regarded by my colleagues as a bump on a log.

J. M. STELLA, D. O.

Safeguards in Rectal Anesthesia

By HELEN K. GAMS, D. O.

Adequate preoperative preparation of surgical patients is today recognized as one of the fundamental principles to be carefully observed if morbidity and mortality are to be kept at a minimum. Today's anesthesiologist, whether he be a qualified specialist in anesthesiology per se, or a proctologist administering his own local anesthetics, must determine what modality is best suited to the individual patient by evaluating the findings brought forth in the physical exanination, the X-ray and laboratory reports. He must take into consideration the weight of the patient, his age, and his blood pressure. Selection of the anesthetic is further determined by the urgency and seriousness of the operation to be performed, the position in which the patient will be placed, the degree of sphincter relaxation required, the skill and dexterity of the surgeon and anesthesiologist, and the pharmacological action of the drugs in question and their relationship to any underlying disease.

Patients who are victims of chronic debilitating diseases, extensive neoplastic disease, cardiac disease, suppurative diseases of the chest, severe metabolic disease and asthma deserve individual case evaluation, attention and management preoperatively, as well as during surgery and postoperatively.

The patient should be carefully interviewed prior to anesthetization to determine whether he has been previously anesthetized, and if so, what agents were used and what results were obtained. He should be further questioned regarding any idiosyncrasies which he might have toward premedicant drugs. If any untoward reactions can be recalled, it will be well to eliminate the usage of such agents on successive anesthetizations.

Since by far the largest majority of proctological surgery is of an elective nature, abnormal physical findings should be corrected or improved as far as possible before anesthetization or surgery is performed. The blood count should show a hemoglobin of at least 75% with a red cell count of at least 3,500,000, albumin and sugar should be absent from the urine and the heart

and lungs should be negative to auscultation and X-ray examination.

Preoperative medication should always be given before any type of anesthetic is administered. It allays fear and apprehension of surgery, reduces the amount of anesthetic required by raising the pain threshold and lowering the metabolic rate; it decreases the amount of oropharyngeal and bronchial secretions during general anesthetics, and prevents toxic reactions from anesthetic agents. The average adult patient undergoing rectal surgery in the office is usually adequately medicated after receiving 1½-3 grains of Delvinal or Nembutal sodium by mouth one hour prior to surgery. An opiate and/or belladonna derivative may be used if additional medication is required. Under no condition should the previously medicated and anesthetized (altho locally) patient be permitted to leave your office unaccompanied by a responsible person, or be permitted to drive his car.

The hospitalized patient is best medicated with 1½-3 grains of Delvinal or Nembutal sodium 1½ hours prior to surgery, and Demerol 100 mg. with Scopolamine gr. 1/200th 45 minutes prior to surgery. Because Demerol tends to cause less post operative constipation, and has a slight bronchial dilating effect it is preferred over Pantapon or Morphine in this regard.

The practical surgeon will find infiltration fully satisfactory for simple proctological surgery such as hemorrhoidectomy, cryptectomy, pectenotomy, fissurectomy and simple fistulectomy; however, since it necessitates the administration of an anesthetic, not completely without danger, the afore-mentioned minimum requirements for elective surgery should be rigidly adhered to in scheduling your patient for either office or hospital procedures. When the patient realizes that you are attempting to minimize the risk of elective surgery for him he will be pleased and confident to follow your method of preparing him for this event.

At best local anesthetic agents can be mildly toxic, and when administered injudiciously can cause severe cardio-respiratory embarrassment and death. It is of paramount importance, then, that the smallest amount of the least toxic agent be used. Since death following the administration of a local anesthetic is always the resultant of respiratory failure, it is never completely safe to administer a "local" unless a resuscitative gas machine is immediately at hand. It is highly improbable that such emergency equipment will be part of the general equipment found in your office; therefore, precautionary measures will have to consist of a means of securing a patent airway and supplying positive pressure oxygen if necessary by the use of a face mask and oxygen tank.

Prophylactically, the anesthetic solution should be injected slowly, with care being taken to prevent intravascular injection by frequent aspiration of the syringe for blood. At the first signs of toxicity to the drug such as dizziness, faintness, syncope, nausea, palpitation, excitation, muscular twitchings, convulsions, pallor, cyanosis, diaphoresis, marked changes in pulse or blood pressure, and air hunger, injection of the anesthetic solution should cease, and oxygen by face mask should be administered. If the reaction is severe enough to cause a drop in blood pressure and a change in the quality of the pulse to a weak and thready one, a vaso-pressor such as Neosynephrine, Ephedrine, Methedrine, or Vasoxyl should be given at once. Intravenous fluids and intravenous barbiturate medication may be required to control a severe reaction. The patient's head should be lowered and his body kept warm.

The use of 1:1000 Adrenalin in the amount of 8mx. to the ounce of local anesthetic solution will delay absorption and thus lengthen the anesthetic's dura-

tion. Obviously this procedure should not be adopted in the hypertensive patient.

Pentothal, as far as the patient is concerned, is the panacea of anesthesia. He undoubtedly has been told by his friends or relatives how easily it is administered and how pleasant it is to take. It is difficult for him to understand why it cannot be used to the best of his advantage for all types of operative procedures. It is difficult too for some doctors to realize and accept its disadvantages and contraindications. Pentothal is not an analgesic, but a short-acting hypnotic, and as such must be given in quantities sufficient to place the patient in a state of anesthesia before he is subjected to any painful stimulation.

The most unfavorable action of Pentothal in its effect on anorectal anesthesia is its tendency to increase the sensitivity of the laryngeal reflex and, therefore, to predispose to laryngospasm which in itself can be precipitated reflexly by dilatation of the rectum. Laryngospasm is spasm of the adductor muscles of the vocal cords causing obstruction to respiration. It may be partial or complete. If partial, there will be crowing, grunting or wheezing especially on inspration. If complete, apnea occurs, there is inability to inflate the lungs and the patient rapidly becomes markedly cyanotic. The best treatment for laryngospasm is prophylaxis. Once present, however, it must be treated promptly and effectively. Stimulatory and dilatation must immediately cease, and the administration of the Pentothal be discontinued. An attempt should then be made to force pure oxygen thru the spastic cords by squeezing a bag full of oxygen attached to a tightly fitting face mask. If oxygen can be forced past the adducted cords in this manner, the relief of anoxia causes relaxation of the spasm and the patient soon resumes voluntary respiratory activity. The mask and bag should be left in place until it is certain that complete relief of anoxia has been accomplished.

If the spasm is severe, endotracheal intubation should be performed under direct vision laryngoscopy, 100% oxygen being supplied by positive pressure on the bag. At times it will be impossible to forcibly insert a tracheal catheter between the spastic cords. One of the curare products should then be given intravenously immediately, and intubation once more attempted. Little time should be spent in unsuccessful attempts at intubation, and trachectomy should be promptly performed followed by oxygen therapy and artificial respiration.

It might be well to recall at this point that manual methods of artificial resuscitation are ineffectual in the presence of a severe laryngospasm. Pressure on the chest during spasm will evacuate the little remaining oxygen and air will not enter the lung on release of the chest wall pressure.

Pentothal sodium, in spite of its simplicity of administration, should not be used in office procedures because many patients are unaable to walk without staggering for some time after the anesthetic effect has worn off. For utmost safety it should only be used if expert anesthesiology service is available to secure a completely patent endotracheal airway and supply positive pressure oxygen if necessary.

Pentothal should never be used with the patient in the prone or jack-knife position, or where any respiratory restriction is present unless a patent airway is guaranteed by means of an endotracheal tube. Because it decreases the oxygen carrying power of the blood stream, its use is contraindicated in the presence of anemia or shock.

While it was formerly believed that Pentothal sodium was destroyed in the liver, and that the presence of parenchymatous damage in that organ contraindicated the use of the drug, newer studies have cast some doubt on this concept

and the administration of Pentothal sodium is not contraindicated in the presence of moderate degrees of liver damage.

Both the Parke, Davis and Abbott Laboratories have had on the market for some time a rapid, ultra-short acting intravenous anesthetic called Surital sodium which, while it does not differ materially from other preparations of a similar nature has the added advantages of requiring smaller doses to give comparable anesthesia and relaxation, produces less respiratory depression, pharyngeal and laryngeal reflexes are less hypersensitive, and recovery is more rapid. For these reasons, it is now my intravenous anesthetic of choice, being used in concentrations of 2.5% for intermittent injection and 0.2-0.3% for continuous drip.

Surely the previous discussion has convinced all of us that neither Pentothal sodium nor Surital sodium can, under any condition, be used as the sole anesthetic agent for ano-rectal anesthesia. In conjunction with local infiltration *with the patient in the lithotomy position,* intravenous anesthesia becomes a relatively safe adjunct for patient and surgeon alike by eliminating the painful sensation of the placement of the local anesthetic.

It is not within the scope of this paper to consider the complexities of conduction analgesia when used in proctological surgery, since the proctologist should under *no* circumstances utilize this means of anesthetization in his office practice. Judiciously administered by a *qualified* hospital anesthesiologist, any of the conduction analgesia methods such as caudal, lumbar epidural, and spinal (utilizing either a hypobaric or hyperbaric agent) will safely permit placing the patient in any necessary position to enhance surgery, and will produce lasting and profound analgesia and relaxation of the operative site.

In closing, let me emphasize once again the imperative need for individual evaluation of each patient preoperatively, and the necessity of using adequate preoperative medication, followed, in the office by no more extensive anesthesia than that afforded by local infiltration, and, in the hospital by whatever method or combination of methods best fulfills the patient's individual requirements with the greatest degree of safety.

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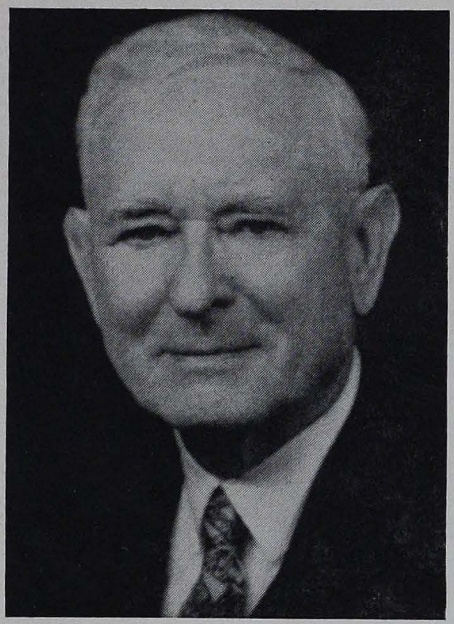
Health Features Special Edition

CHICAGO (AOA)—In an effort to provide the readers of HEALTH: AN OSTEOPATHIC PUBLICATION with the latest information, leading authorities were contacted to express their frank and down-to-earth opinions on important health problems for the special 40-page Christmas issue.

Such well-known, national figures as Mr. Jerry Voorhis, Executive Secretary of the Cooperative Health Federation of America, Rev. C. F. McCall, Jr., Associate Superintendent of the Congregational Christian Conference of Illinois and Dr. Luther W. Swift are some of the contributing authors.



Dr. Thomas L. Ray, Honorary Member TAOP&S, Dies

Dr. Thomas L. Ray, 84, who brought the practice of osteopathy to Fort Worth 56 years ago, died at 2:30 p.m. Wednesday in a rest home. Dec 7 1955

Dr. Ray, who was suffering from arterial sclerosis, entered the home several weeks ago.

He hadn't maintained his office since January 1955, but patients still continued to visit him in his home at the Westchester House until his illness necessitated the move.

Dr. Ray was the state's second osteopathic physician. He brought the practice here just two months after Dr. D. L. Clark began manipulative treatments at Sherman in 1899.

Long Standing Practice.

At the time of his death, Dr. Ray claimed the state's longest practice of osteopathy.

By 1900 the state's osteopathic profession listed 15 members, and the Texas Osteopathic Association was organized in Sherman with Dr. Clark as its first president, and Dr. Ray the second.

Paid Tribute.

Dr. Ray was first president of the North Texas Association of Osteopathic Physicians and Surgeons, which was formed in 1917.

He was a member of the Fort Worth Osteopathic Association, the Tarrant County Osteopathic Association, River Crest Country Club and the Fort Worth Club.

He was a member and deacon at Broadway Baptist Church.

Tribute was paid to him at Hotel Texas in 1948 when, at 77, he was honored by his colleagues in the North Texas association.

Survivors include his wife, and two brothers, both osteopathic physicians, Drs. A. D. Ray of Cleburne and Cyrus Ray of Abilene.

Ethics of Mailing Professional Announcements

By WALTER V. GOODFELLOW, D. O.
Director, Department of Ethics and Censorship, California Osteopathic Association.

During the past year, this Department has received several examples of the publicity used by certain members of our profession to announce their type of practice, or location or removal of offices, by means of a card sent through the mails, not to a restricted mailing list but to everyone on the mail route. These cards are usually addressed to "Patron" giving the box number and the route number.

From a standpoint of contents and general appearance, many of these cards seem to conform to the requirements of our Code of Ethics but it is, however, unethical to use this type of *Mailing.*

During the meeting of the Board of Trustees of the C.O.A. last December a resolution was passed as follows: *"That it be the policy of the C.O.A. that the use of so called residential type*

of notification for advertising on the part of any members is unethical."

It should also be noted that the Post Office Department frowns upon this type of mailing and has recently put a restriction on the acceptance of such items. This information is being given to the Profession so that they will not fall into the error of using this unethical procedure. Such announcements may be properly printed in a local newspaper, provided they are not "boxed in" and that no black display type is used. A good example of ethical publicity can be found by turning to the Directory of Clinical Osteopathy.

Reprinted from CLINICAL OSTEOPATHY

Another 40-Page Health Due

CHICAGO (AOA)—Because of the fine support *Health: An Osteopathic Publication* has been receiving by the public, the magazine's editors recently announced that it will be financially possible to continue a 40-page publication in January.

Among well-known contributors in that issue will be: Martha Eliot, M.D., Chief of Children's Bureau, U. S. Department of Health, Education and Welfare; Thomas F. Santucci, D.O., Philadelphia pediatrician and Munish Feinberg, D.O., Los Angeles heart specialist.

Religious Group Gives Nursing Scholarships

CHICAGO (AOA)—The presentation of six $1,000 scholarships for nurses' training at both the Chicago Osteopathic and Illinois Masonic Hospitals was announced by the Order of the Eastern Star of Illinois at the organization's annual meeting in Oct. The scholarships also will be used for college study for one member from each of the following four youth organizations: Order of the Rainbow, Daughters of Job, Boy Builders and the Demolays.

Fourth Annual Child Health Clinic To Be Held March 23, 24, 1956, Fort Worth

Dr. F. L. Reed of Tulsa, Oklahoma, has accepted the invitation to serve as Pediatric Coordinator for the Fourth Annual Child Health Clinic. Those who heard Dr. Reed lecture at the Kansas City Child Health Conference this last spring will remember well the enthusiastic acceptance of his presentations. We feel very fortunate to announce Dr. Reed's association with our clinic.

Specialists are being procured at this time to serve in the various fields of specialty practise. It is the intent of the clinic to offer consultants in all fields. Please remember that physicians over the state will be invited to bring problem cases into the clinic for diagnostic evaluation.

Dr. John M. Andrews Attends Stanford University Workshop

Dr. John M. Andrews, Professor and Executive of the Department of Physical Medicine and Rehabilitation, and Director of the Rehabilitation Center at the College of Osteopathic Physicians and Surgeons, was selected to attend the Stanford University Workshop on Rehabilitation Facilities at the invitation of the Office of Vocational Rehabilitation and the Public Health Service. The Workshop was held at Rickey's Studio Inn, Palo Alto, California, November 28 to December 2nd.

The purpose of the Workshop was, "To provide a meeting for representatives of State Health Departments, State Rehabilitation Agencies, and Selected Rehabilitation Center directors to discuss in general the broad implications of rehabilitation and rehabilitation facilities, and specifically the most efficient and beneficial utilization of government funds recently made available for construction and development of rehabilitation centers".

Dr. Andrews also attended the Kirksville Postgraduate Course on Osteopathic

Manipulative Technique, given by the Academy of Applied Osteopathy October 17 to 22, 1955.

The A.O.A. Seminar on the Teaching of Osteopathic Principles and Techniques was also attended by Dr. Andrews. It was held at the Des Moines Still College of Osteopathy and Surgery on November 9 and 10, 1955.

Doctor Sues Medical Group; Charges Restraint of Trade

CHICAGO (AOA)—A physician last month sued the Los Angeles County Medical Association for $2,500,000 damages, charging it is a corporation in restraint of trade.

In the Superior Court suit, Dr. Sylvan O. Tatkin charged that organized medical groups had refused him membership and barred him from hospitals because he would not charge more than $3 an office call.

The complaint further stated that the association and other groups have combined to fix fees for patients and the number of hours and days a physician may work.

According to the plaintiff's attorneys, the restraint of trade charge was unprecedented, the first time a physician has challenged the power of such an organization on such grounds.

Journal Article Rates Editorial

CHICAGO (AOA)—When an article is so excellent that it merits an editorial, we feel duty-bound to call its attention to the profession.

"Obesity; Some Considerations on a Rational Approach to a Problem," is such an article and heads our list of recommended reading. Authored by George W. Northup, D.O., Livington, N. J., it is the opening feature in the November JOURNAL.

A tribute-paying editorial, as JOURNAL readers, know, is the exception rather than the rule. But Dr. Northup's treatment of a problem affecting 40,000,000 Americans, and YOU too, doctor, is worthy of such attention.

KCOS Receives Third Heart Teaching Grant

CHICAGO (AOA)—A third grant of $25,000 by the United States Public Health Service for extension of training in diseases of the heart and arteries was awarded recently to the Kirksville (Mo.) College of Osteopathy and Surgery.

A unique feature of this grant is that it was awarded with an extension for an additional year, meaning that the college will receive this amount without application the following year.

In reporting the grant, college officials also announced the visit to the institution on Nov. 9, by President Eisenhower's personal physician, Dr. Paul Dudley White, executive director of the National Advisory Heart Council and the National Institute of Health.

He conferred with officials concerning the training program and addressed special meetings on the latest advances in heart and artery diseases.

Missouri Governor Appoints First DO to State Council

CHICAGO (AOA)—Dr. James D. Hicks, staff member of Normandy Osteopathic Hospital in St. Louis, recently became the first osteopathic physician to be appointed to the State Advisory Council by a Missouri governor.

Gov. Phil M. Donnelly, in confirming the appointment, asserted that Dr. Hicks will be of great value to the seven-member council which advises on the distribution of federal aid in Missouri.

The governor pointed out that Dr. Hicks had worked with the division of health in 1954 in the drafting of a new hospital licensing act and made a valuable contribution to that program.

NEWS OF THE DISTRICTS

DISTRICT ONE

Looks like the Panhandle was well represented at the recent Public Health Seminar held at the Adolphus Hotel. The Osteopaths attending from District One were: John Witt of Groom, Harold Gorrie, Maurice Mann, Ed Mayer, Jr., John Kemplin, Roland Beck and J. Francis Brown of Amarillo.

We are happy to report that Dr. Raymond Beck, a graduate of K. C. 1954, interned Stevens Park Osteopathic Hospital is locating an office here in Amarillo. Welcome Doctor Beck.

Dr. John Kemplin attended the Rocky Mountain conference held at the Broadmoor in Colorado Springs on November 11, 12 and 13.

Dr. John Chandler attended a meeting of the Texas Craninal Society in Dallas recently.

Ground has been broken for the new clinic building for Drs. Mann and Vick at 9th and Adams here in Amerillo. Drs. Raymond and Maurice Mann will be associated with Dr. Earle H. Mann and Dr. W. R. Ballard with Dr. Vick.

A Xmas party for the staff and wives wil be held at the Amarillo Club. This is an event that is looked forward to each year at which time small gifts are exchanged and they in turn are given to the Children's Home.

Dr. L. V. Cradit was one of two past Potentates of Khiva Temple who were honored at the Shrine Ceremonial held recently in Lubbock.

Dr. and Mrs. Cradit were guests of the Potentate and Divan members at a banquet and were accorded additional hoonrs.

Dr. Cradit has completed 35 years of service in Khiva Temple and was the Potentate in 1939.

DISTRICT SEVEN

Dr. and Mrs. William Mosheim are proud of the newest member of their family — Michael Warner Mosheim, born Nov. 10.

Drs. I. T. Stowell, H. H. Edwards, and G. S. Beckwith attended the Post-Graduate lectures in Dallas this week-end.

The Staff meeting this past month was held at the home of Dr. Schaefer. We had some very excellent colored movies on Peptic Ulcer. Everyone thoroughly enjoyed them and we are indebted to Wyeth for their use.

Dr. I. T. Stowell was on the sick list the first of the month and spent some time in the hospital. He is still convalescing. We all wish you a speedy return to work.

Mr. and Mrs. Herbert Simpson, the Drs. Beckwith's mother and stepfather, are visiting here from Evanston, Ill.

After three weeks of deer season, I have yet to hear of anyone getting one. What's the matter?

This month's staff meeting is under the direction of Dr. Billy Schoch. He has arranged with the Ballard Surgical Supply Company to give a demonstration and talk on the use of ultra sonic equipment.

This has been a very quiet month down here. No real news.

WALEDMAR D. SCHAEFER, D. O.

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DISTRICT ELEVEN

A meeting of District 11 was held at the Delgado Hospital, Ysleta, at 8:00 p.m. The subject and object was Ethics. After routine business was carried out, an audio digest was heard and appreciated by all. Following audio digest, a discussion was launched on the general

and specific points in the code of Ethics of the association. A minimum renumeration schedule was set up for the district. The attendance was excellent and the discussion was lively. Present were Drs. Valdivia, Smith, Delgado, Holcombs, Land, Calabrese, Reznikov, Vowell, and Wm. Hall.

R. T. LAND, D. O.
Secretary-Treasurer

Hospitals, Colleges, State Groups Aid Seal Campaign

Distribution Ahead of '54

CHICAGO (AOA)—The old saying that "everyone wants to get into the act" certainly can be applied to this year's 25th annual Christmas Seal Campaign.

Hospitals' drives, aided by their guilds of laywomen, are in full swing, getting seals into the hands of staff members and patients. Spirited campaigns under student council or fraternity supervision are being conducted in the colleges.

But the most significant developments of the silver anniversary campaign, according to Dr. E. H. McKenna, Muskegon Heights, Mich., is the "intensified activity of state committees."

The Christmas Seal chairman explained that the formation of state committees in 1954 has rapidly become a pivotal force, carrying the drive to district and local organizations and increasing public distribution of seals.

Dr. McKenna stated that distribution-wise, this fund-raising program, which helps support student loans and research, is running well ahead of last year. He pointed out that 110,000 sheets of seals are now in circulation as compared to 1954's total of 85,000.

Florida Honors Deceased Members

CHICAGO (AOA—Members of the Florida Osteopathic Medical Association who passed away during 1954-55 have been honored by their collegues through a memorial gift to the Osteopathic Progress Fund.

"We know no better way to pay our respect to our deceased members," stated Dr. George S. Rothmeyer, St. Petersburg, President, "than to make this gift in their memory to the Osteopathic Progress Fund for the future of the profession they have served so well in the past."

Deceased physicians of Florida in whose memory the gift was made included Dominic A. Argenzio, Oakland Park; O. S. Bingham, Hollywood; E. B. Decker, Daytona Beach; A. T. Hoffman, Pensacola; A. J. Little, Lake Worth; B. E. Walstrom, Dunedin and Avis M. Withers, Jacksonville.

The gift was the first from the Memorial Fund established recently by the Board of Trustees of the FOMA.

Officers of the District Associations of the

TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, Inc.

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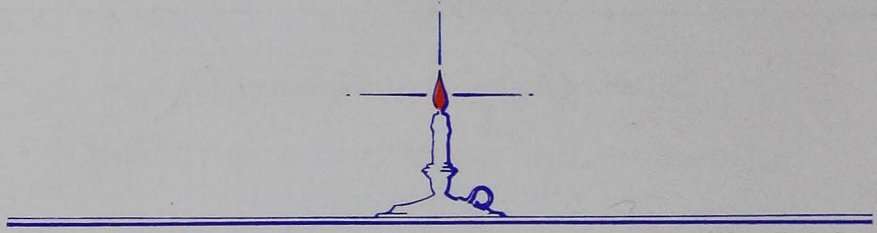

The Shining Light of Christmas

The star that guided the Wise Men of the East on the first of all the Christmases is symbolized by the Christmas Candle.

The mellow rays of this Christmas symbol help to dispel the darkness of despair, the gloom of doubt, the murk of uncertainty, and it becomes a beacon of joy and hope for all within the circle of its cheerful radiance.

To all our Doctor friends, it is our heart-felt wish that the radiance of your Christmas candle will glow merrily upon a scene of Christmas happiness and that it will foretell for you a new year of good health, contentment and prosperity.

GLENDALE 1

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