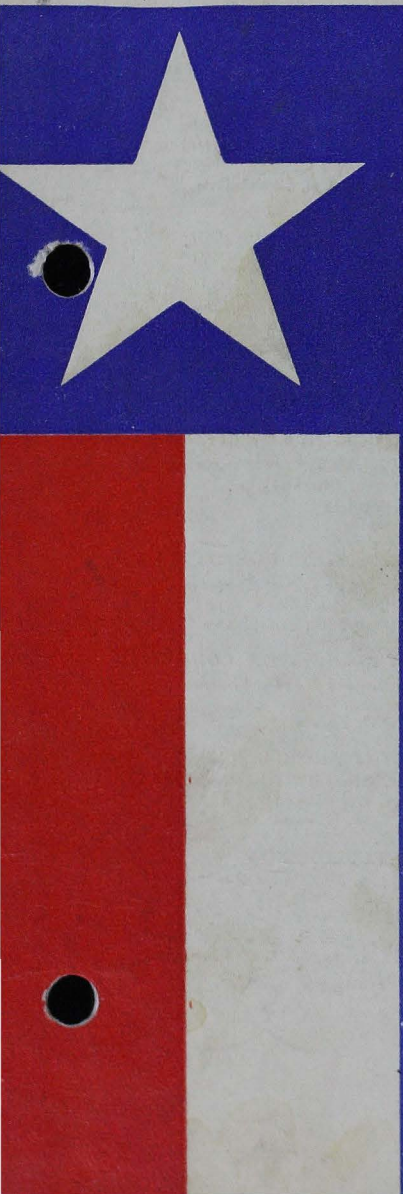


Texas OSTEOPATHIC PHYSICIANS Journal

VOLUME 2

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NUMBER 1



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VOLUME 2

DALLAS, TEXAS, JULY, 1945

NUMBER 1

FALLOPIAN TUBE PATHOLOGIES OVARIAN PATHOLOGIES

WILLIAM S. GRIBBLE, D.O.

THE FIRST consideration to fallopian tube pathologies will be given to *circulatory disturbances*. Primarily there are non-inflammatory conditions that can produce hyperemia, engorgement, hemorrhage, and necrosis of the fallopian tubes. These conditions are stasis, usually resulting from pulmonary and portal obstruction, infectious diseases such as measles, smallpox, scarlatina, and the hemorrhagic diatheses in which hemorrhage into the tissues and lumen of the tube also occurs. *Local obstruction* resulting from traction of tumors of the uterus, ovarian tumors with twisted pedicle, and rarely tumors of the fimbria *also play* a part in circulatory disturbances. *Changes in shape and position of the tube* usually are due to parovarian tumors, developing in the ligamentous leaves. Uterine displacements also cause altered shape and position of the tube. However, the lumen usually remains patent. The tubes are rarely twisted off, but constricting bands, adhesions, torsion, etc., are sometimes factors favoring detachment of the tube, at which time they may form new points of attachment and derive their nourishment by adhesions in various parts of the abdomen.

Inflammations of the fallopian tubes are by far the most common pathology, and in about 25 per cent of all gynecological operations, pelvic infection was found to be the factor which brought them to surgery. Among the lower strata of society, pelvic infections are particularly common because of ignorance, sexual promiscuity, unhygienic standards of living and poor obstetrical care. Salpingitis is *caused* by micro-organisms, and the chemical, thermal and mechanical insults that come into question merely produce a lowering of local resistance. In *Acute Salpingitis* the entire tube becomes red and swollen, and exudes pus from the fimbria, which contains bac-

teria. As the acute process subsides, the fimbria closes, and there is a nodular thickening of the tube. If the secretions within the tube continue after the fimbria is closed, there develops a pyo-salpinx. In the old cases the fluid may become watery, which is a hydro-salpinx. In association with an acute salpingitis is usually a pelvic peritonitis, and there may develop a true pelvic abscess, an ovarian or a tubo-ovarian abscess. The most important condition to be *differentiated* from salpingitis is *acute appendicitis*. *Salpingitis* is indicated by a history of primary infection, dysuria, vaginal burning, leukorrhea and perhaps menstrual irregularity. The tenderness may be more profuse and suprapubic, especially in the cul de sac and the pelvic floor. *Appendicitis* is indicated by the gastro-intestinal symptoms, including nausea and vomiting, general abdominal pain and later localized pain at McBirneys point. Muscle spasm and tenderness are usually more sharply localized in appendicitis. In both salpingitis and appendicitis the acute attack may start during menstruation. In both, leukocytosis with an increase of polys, is accompanied by fever and acceleration of the pulse. A mass is rarely felt in either case during the early stages. If appendicitis cannot be excluded, the abdomen should be opened rather than allow an appendix to rupture.

Sometimes acute salpingitis must be differentiated from extra-uterine pregnancy, ovarian cyst with a twisted pedicle, etc. In the chronic stage salpingitis is occasionally confused with an ovarian tumor, corpus luteum cyst or endometriosis. Careful examination will exclude the above conditions and allow one to arrive at a definite diagnosis.

Ectopic, or extra-uterine pregnancy exists when the implantation of the ovum is located outside of the uterine cavity. Nearly all extopic gestations are tubal, most of them in the ampulla, some in the isthmus, rarely in the interstitial tube and occasionally in the ovary or abdominal cavity. In tubal pregnancy, the ovum erodes its way into the tube exactly as it does into the endometrium, but the results are inevitably pathologic, because, the tube is entirely unsuited anatomically and histologically for the reception and development of the ovum. There is no true decidua formed in the tube, although there is a decidual reaction in the form of decidual patches, islands and more or less isolated cells. Since there is no decidua, the ovum quickly erodes its way into the muscularis of the tube, weakening the tube wall by literally riddling the muscular layers. Tubal rupture may be external into the abdominal cavity or internal into the lumen of the tube. Diagnosis is rarely made *before rupture*, inasmuch as mild cramps are usually the only symptom, but the Aschheim-Zondek test is positive at this time which materially aids in diagnosis. *During rupture* is the important time for a correct diagnosis, and the clinical picture is briefly one of impending tragedy. Pain is sharp, lancinating, and on the side involved. Vaginal bleeding is constant or intermittent, usually without clots. The cervix is extremely sensitive to movement, and the mass is usually felt at one side, behind or sometimes in front of the

uterus, and it is tense, fluctuant and extremely tender. The diagnosis *after rupture* is based on violent agonizing pain on one side, which is accompanied by severe hemorrhage, followed by nausea, vomiting, fainting, shock and collapse, with a rapid, feeble pulse, cold sweat, pallid skin and shallow breathing. Sometimes the whole abdomen is distended and tender.

The conditions to be *differentiated from ectopic gestation* and the main differential points are as follows. In *abortion*, the bleeding is usually more profuse, with clots, and the pain is caused by intermittent cramps of the uterus, which gradually increase in severity. Fetal parts and villi in the vaginal discharge render the diagnosis of abortion certain. In *Salpingitis*, there is usually a history of recent infection, positive smears, purulent discharge, gradual onset, high fever, leukocytosis, no enlargement or softening of the uterus, a hard cervix and a more or less circumscribed mass and less tenderness favor the diagnosis of salpingitis. *Appendicitis* has no menstrual anomalies, no symptoms or signs of pregnancy, and usually, no mass. *Pelvic tumors*, particularly ovarian cysts are usually larger than a pregnant tube and less tender. There is no vaginal bleeding or uterine change. The small retention cysts are the most likely ones to be confused with ectopic gestation. A Myoma in the uterine horn rarely causes confusion on account of its history and its hardness.

Tuberculosis of the fallopian tube is the most common type of genital tuberculosis found. The mode of infection is usually ascending through the vagina, due to examinations, masturbation, operation and coitus, or, there may be an entrance from some distant site due to local lesions, or entrance through a small wound in the genital tract. The pathological changes are simply those of a tuberculous infection elsewhere in the body—epithelioid tubercles, necrosis and caseation. The amount of ulceration and loss of substance depends on the acuteness and duration of the process. In over seventy-five per cent of the instances, the macroscopic appearance of a tuberculous diseased adnexa cannot be distinguished from those due to other infecting organisms. Syphilis of the Fallopian tube has been given considerable study by various investigators, and much has been published concerning it. However, none of the recorded cases can stand the test of our modern knowledge.

Actinomycosis of the fallopian tube is a secondary involvement, when abdominal actinomycosis invades the genital tract. There is marked destruction of the adnexa, and to assure the diagnosis, mycelia must be demonstrated. Neoplasms of the fallopian tubes are uncommon, and, except for malignant tumors are unimportant clinically. There may be pseudo-tumors, which are encapsulated cysts, hernia of the tube, calcifications of the tubes, and also ossification of the tubes. All of these conditions are usually followers of inflammation. The usual neoplasms are fibroma, Lipoma, osteoma, enchondroma, endothelioma, dermoids and teratoma. Primary and secondary carcinoma and sarcoma of the tube occurs, but their occurrence is very infrequent, and they usually have the appearance

of a sausage shaped enlargement of the middle third of the tube, with a very thin wall, and closely adherent to neighboring organs.

OVARIAN PATHOLOGIES

The most frequently encountered pathology of the ovary is a new growth, which may be cystic, solid or a combination of the two. They may be benign or malignant, may be associated with pregnancy or some pelvic disease, or they may occur alone as an entity. New growths of the ovary may occur with or without endocrine effects, and may be subject to many changes such as infection, rupture, torsion and malignancy.

In the diagnosis of new growths, it is important to establish the following facts: Is the growth present at repeated examinations? Is it the lone finding that is diagnostic, or are there associated conditions present? What is its size and shape? Is it movable? What is its location? What is its consistency, is it tender and to what structures is it attached? Is an ovary palpable on the side where the mass presents itself? After these facts are established, one is able to make a diagnosis of ovarian new growth. There are *many benign cystic growths*, the most common of which are follicular and corpus luteum cysts which arise from disturbances of follicular function. Also we find endometrial cysts which result from heteroplasia or transplantation. Serous and pseudomucinous cystadenomata, either simple or papillary. Dermoid cysts, arising from embryologic rests. Included in the *benign solid growths* are adrenal tumors, Brenner tumors, fibromata and fibromyomata. The *malignant cystic growths* are cystadenocarcinomata, either pseudomucinous or serous, or epidermoid carcinomas, arising from dermoid cysts. The *malignant solid growths* include all types of carcinoma and teratoma, sarcoma and melanomas, hypernephroma and chorioepithelioma. Many of the solid growths have areas of cystic change.

Parovarian cysts are often confused with ovarian cysts, but they are not the same at all. Arising from the parovarium, they are formed between the leaves of the broad ligament. The mass is usually deeper in the pelvis, and is more readily reached by the examining fingers. It is not movable as a rule, and the firm uterine body and the cystic mass may feel more like one mass, due to the close growth of the cyst to the uterus. The uterus is displaced to the opposite side. The cysts are usually tense and attempts to move them often cause pain. If a normal ovary can be palpated on the same side as the inter-ligamentous cyst, the diagnosis is certain.

I feel that two other tumors of the ovary must be mentioned, and they are Arrhenoblastoma, or the masculinizing tumor and the Granulosa Cell tumor, or the feminizing tumor. These two tumors arise from the undifferentiated sex cells which have a profound endocrine influence on the female, which may give rise to changes which may easily be seen during inspection of the patient, inasmuch as definite changes in the sexual and menstrual characteristics are seen, depending on the type of tumor that is present.

Ovarian pregnancy was formerly believed to be due to ovarian implantations occurring in the burst follicle, but we now know that they may be interstitial, suprafollicular, superficial and intrafollicular. The diagnosis of ovarian pregnancy is made at surgery, inasmuch as the physical findings are essentially the same as in tubal pregnancy.

Welcome?

THE ubiquitous chigger, that fiend in insect form, is abroad in the land. As treacherous as a Japanese sniper and as terrible as an army with banners. Those of us who time and again have furnished convention sites to gatherings of the Benevolent and Protective Order of Chiggers have reasons to remember that not altogether delightful experience.

The physician e'en though he may not encounter the gay and festive chigger face to face, will soon learn of its arrival through insistent patients demanding relief from the distressing burning, itching, and sometimes more serious developments of fever and temporary disrupting of certain nervous responses.

The belief is almost universal that chiggers are found upon the grass, upon the weeds and bushes, but according to the United States Department of Agriculture Bulletin 986, chiggers are almost exclusively found at or near the surface of the soil.

Unless one sits or lies upon the ground, chiggers are first found upon the feet. From hence they scamper to other portions of the body with utter sang froid and gay abandon. These larvae are so minute, however, that a strong lens is required to detect them.

Contrary to the practically universal belief, chiggers do not "dig in" or penetrate the skin, but attach themselves externally by their mouthparts and thus remain until engorged; then, releasing their hold, they fall off. Although they often attach at the mouth of hair follicles, they cannot enter because of the small diameter of the follicles themselves. For the same reason chiggers cannot enter normal pores of the skin.

The first signs of itching after exposure, vary greatly in length of time. It may begin within a few hours or may not be felt for 24 hours or more, depending entirely upon the period elapsing before attachment to the body takes place. The period of attachment may be five days or more.

An effective ascaricide applied soon after the chigger takes hold will greatly shorten the period of discomfort or pain.

We may reasonably expect our charming guest, the chaste and charming chigger, to remain with us from mirthful May to wan October.

DAVID GRAHAM HALL FOUNDATION

by RICHARD F. VOYER, *Director*

THE David Graham Hall Foundation was the outgrowth of three years of effort and experience of the Texas Social Hygiene Association, which was established in 1937 by a group of 25 physicians and laymen and was primarily dedicated to the promotion of a state-wide dignified but thorough venereal disease control program.

As a result of a study of the Association's three years of experience and statistical reports, Dr. David Graham Hall, M.D., of Dallas, now 87 years old, irrevocably deeded more than 100 pieces of income-bearing Dallas property to Messrs. Homer R. Mitchell, Karl Hoblitzelle, B. F. McLain, Carr P. Collins, all of Dallas, and Marrs McLean, of San Antonio, to hold in trust for the benefit of the David Graham Hall Foundation and the Texas Social Hygiene Association. These two institutions were directed to continue the sponsorship of practical programs incidental to the needs of the public's health and to assist Texas doctors in every possible way. It was anticipated that the physicians of Texas would cooperate wholeheartedly in both moral and financial support of such endeavors.

The Association has devoted its attention principally to the development of a better understanding of public health responsibilities on the part of Texas licensed physicians and by health officials as a whole. *It recognizes the fact that no successful public health program can emanate from any private endeavor unless public health officials and the physicians of Texas have joined hands in a sincerity of purpose which will back the programs one hundred per cent.*

In this respect some state and local officials and a few physicians have been found wanting. The Foundation and Association have tried to work in close harmony with all factions only to discover that extended hands of cooperation and sympathetic understanding from independent agencies were not always desired by a handful of politically minded medicos and public officials.

Since 1940 the Foundation has extended a *free* syphilis blood test mail service to every licensed physician of Texas for the use of any patient, regardless of economic status, provided, however, that commercial laboratories should be used if the patient indicates willingness to pay for same. Discretion in this respect is left entirely to the physician. The purpose of this program has been to encourage the "raising of index of suspicion of syphilis possibilities." It is desired that every physician secure a routine blood upon every patient passing through his office. We knew that untold thousands of unsuspected cases of syphilis would be uncovered and such has been the case.

We have assisted physicians in securing free drugs for the treatment of lues and have gathered up-to-date material from the

experiences of experts to be transmitted to all physicians interested in the successful treatment of venereally diseased patients. As above indicated, we make no charge for these services. Today approximately 500 medical and Osteopathic Physicians are utilizing our services. More than 9,000 unsuspected cases of syphilis have been uncovered through these good doctors.

The division of laboratories also created and adopted a custom of grouping all blood specimens received, and consequently has been in a position to report back to every physician the blood type of every patient from whom the specimen was drawn. Through this medium physicians throughout the state have been in a position to establish a blood bank in each community so that in the event of emergency they would know just where to turn for the rare type, AB-1, which is manifest in only 3 per cent of our population, or of B-3, a type carried by only 7 per cent of the white population and 13 per cent of the negro population. The same has been true of the two more common types, A-2 and O-4. There are now more than 70,000 potential whole blood donors in our files. We know that this has been a definite life-saving contribution to the peoples of all Texas as well as to cooperating physicians.

We have extended every effort to bring about harmonious relationships between all factions of the medical profession and the official agencies. Usually this has been possible without the development of animosities and hard feelings, but whenever it became necessary to carry the case to the peoples of a community or of the state or to the Legislature, we have not failed to do so.

These two institutions have been made possible only to the end that the public's medical and health needs be best served. *We recognize that such cannot be possible unless those engaged in the healing arts are fully protected from political intrigue and unfair demands.* We know from our intercourse with the 500 physicians with whom we are intimately connected that the profession as a whole realizes, and has for a long time, that the medical needs of the people have not been adequately met. We have devoted our full time to delving into the unromantic but all-essential fundamentals of medical care. We have touched sore spots and soft spots. We have delved just a little further than some of the "self-seeking" have preferred, but throughout our program we have thoughtfully withheld from the public some of our findings and have sought to deal with the leaders of the various factions in an effort to bring about the necessary corrective measures.

We have found few Osteopathic Physicians who have not been anxious to cooperate in every instance where proposed changes and programs were shown to be practical. This is not by way of an endorsement of any particular school of medicine, but is simply stated as one of the outstanding facts among our many experiences. This much, however, remains to be said—no physician, regardless of his school, can fully understand nor appreciate the scope of our activities nor the possibilities of our sympathetic interest and

assistance in behalf of his practice until he has personally investigated the two agencies.

The doors and services of the David Graham Hall Foundation and the Texas Social Hygiene Association are open at all times to every Texas licensed physician. P. O. Box 808, Dallas, Texas.

Texas Courts Ruled Without Jurisdiction in the EMIC

THE THIRD court of civil appeals, in a recent opinion written by Associate Justice M. B. Blair, reversed the judgment of the Travis county district court, dissolved the permanent injunction against the state board of health, and dismissed the case.

This litigation developed out of the rules and regulations laid down by the federal children's bureau and adopted by the Texas board of health relating to Texas' share of the \$42,800,000 federal appropriation for emergency medical care to wives and infants of enlisted men. The legislative committee of the Texas Association of Osteopathic Physicians and Surgeons instituted an action in the district court of Travis County and secured a judgment enjoining the state board of health from operating under this plan, or any other, until the plan was broadened and amended to include the Osteopathic profession.

On the state board's appeal the higher courts agreed that state courts have no jurisdiction over the suit, and held that the state board of health and the state health officers are acting as agents of the federal government.

The case will probably be carried to the Texas supreme court for final adjudication.

"DR. CHARLIE"

Dr. Charles E. Still, Kirksville, son of Dr. Andrew Taylor Still, founder of Osteopathy, was the honor guest at a luncheon given at the Dallas Athletic Club, Sunday, July 15, by the Osteopathic Physicians of North Texas. Dr. Louis H. Logan presided and Dr. Still was introduced by Dr. J. L. Holloway. Dr. Still responded in his usual inimitable manner and gave a splendid and spirited resume of the campaigns he managed near the turn of the century for legislative recognition in twenty-four states. "Dr. Charlie," beloved by the entire profession, now in

his eightieth year, is serving his eighth biennial term in the House of Representatives of the Missouri Legislature. Dr. Still is visiting his son and daughter-in-law, Dr. and Mrs. Charles E. Still, Jr., 4124 Caruth Street.

Dr. Sam L. Scothorn gave an inspirational talk stressing the importance of public relation contacts, and Dr. Ira Walton Drew, Philadelphia, and a former Congressman from that district, responded with a very timely and trenchant talk.

This testimonial dinner to "The Grand Old Man of Osteopathy" was one of the happiest events ever participated in by the Texas profession.

"Dangerous Bureaucratic Trend"

An Excerpt from the Fort Worth Star-Telegram of July 18, 1945.

• The Star-Telegram is an independent Democratic newspaper, supporting what it believes to be right and opposing what it believes to be wrong, regardless of party politics, publishing the news fairly and impartially at all times.

DECISION of the third court of civil appeals at Austin in the case of Dr. E. W. Wilson *et al.*, vs. the State Board of Health, *et al.*, is startling, almost frightening in its implications. The extent to which a federal bureau can go to control the spending of federal funds allotted to a state, cleverly circumventing the express will of Congress and blithely ignoring state laws, is brought out in the decision in bold relief. Because it highlights the threat to state's rights inherent in the centralization of government in a federal bureaucracy, the case is one of general public interest.

Evidence in the case shows clearly that wives and infants of the enlisted personnel of the Armed Forces in Texas and all but one select group of physicians in the state are the victims of rank and illegal discrimination—contrary to state and federal laws—yet a state court says it is powerless to grant relief.

The litigation arose over administration by the state board of health of funds allotted to Texas by the Children's Bureau of the United States Department of Labor under an appropriation of \$42,800,000 voted by Congress for the maternity and infant care of enlisted men, popularly known as the G. I. Baby Bill.

As passed by Congress, the law specifies that the funds are to be disbursed under "plans developed and administered by state health agencies and approved by the Children's Bureau." The law also provides that "no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order or regulation relating to the care of obstetrical cases which *discriminates* between persons licensed under state law to practice obstetrics; provided further, that the foregoing proviso shall not be so construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, *so long as state laws are complied with.*"

Despite these provisions of the law, the approved plan under which the fund is being administered in Texas contains the following stipulation: "Payment for medical care other than obstetrical care will be authorized only to physicians licensed in the state to practice medicine, and who are graduates of a medical school approved at the time of graduation or subsequent to graduation by the Council of Education of the American Medical Association."

This clause effectively bars Osteopaths and many other physicians licensed by the state from receiving any part of the appropriation for services rendered to the mother and baby more than 10 days after birth. The utter absurdity of the situation is seen in the fact that an expectant mother who needs the financial assistance Congress has tried to provide for her may have an Osteopath

or any other licensed physician of her own choice attend her before and at the birth of her child. But when the baby is 10 days old and still requires medical attention the mother is compelled to hunt up another physician—one graduated from a school approved by the American Medical Association. The practical effect of this, of course, is to restrict the mother's choice in the first place to a physician who has the blessing of AMA. This, in turn, gives those physicians so blessed a monopoly on the benefits of the G. I. Baby Bill in Texas.

When Dr. Wilson and other physicians who later joined him in the suit against the state board of health learned that this discriminatory clause had been inserted in the administrative plan, and the plan approved by the Children's Bureau in Washington, they requested that it be so amended as to remove the restriction. In response to this request, Dr. George W. Cox, state health officer, wrote a letter to the Children's Bureau which replied that it could not permit the amendment to be made because of the general policy which it had adopted. The bureau also sent Dr. Cox its "Information Circular No. 1," which set out the bureau's interpretation of the qualifications physicians must have to participate in the program.

The complaining physicians thus effectively barred from participating in the program then sought to enjoin the state health board from operating under the discriminatory plan until it could be so amended as to remove the discrimination against them and other physicians similarly situated. They won their case in the trial court, but the lower court's decision was reversed, its injunction dissolved and the case dismissed by the appellate court.

The higher court's decision was based on the premise that in its participation in this program the state board of health was not acting in its capacity as an official state body, but merely as an agency of the federal government. The court also found that the administrative plan under attack was in fact made by the Children's Bureau and not by the state board of health, as apparently was the intent of Congress.

The court further held that it was without jurisdiction in the case inasmuch as "in the absence of congressional sanction, state courts can not entertain suits against the United States or its agencies," and no such sanction was given in the G. I. Baby Bill.

All of which makes this a case which should cause Texans (*and the citizens of all other states, for that matter*) to look askance at the assurances now being given repeatedly in some quarters that federal aid for education would not result in control of our public schools passing from local and state authorities into the hands of Washington bureaucrats.

It also adds considerable substance to the fears of the medical profession that a federal health and hospitalization program would lead to the socialization of medicine wherein patients would be

deprived of their free choice of physicians, and where fees for medical services would be set, and paid, by Washington.

There is nothing in the record of the case under review to indicate that the AMA-approved physicians who are benefitting by the discriminatory plan now in effect have been active in trying to have the discrimination removed. But they would be well advised to do so. A dangerous precedent has been set. If a bureau in Washington, contrary to the express will of the people's elected representatives in Congress, can effectively discriminate against one school of medicine, it or a different set of bureaucrats could likewise discriminate against some other school of medicine. AMA-approved physicians who are the beneficiaries in this instance, may be its victims tomorrow. They should be farsighted enough to realize it.

Mirabile Dictu

IN ALL the wars prior to World War II, disease has been more deadly than bullets. Death rates from the typhoid group and smallpox have been small, while there have been no deaths at all from tetanus, yellow fever or typhus. This is the result of the development and use of toxoids and vaccines. Malaria, a major enemy in the Pacific, has been reduced to one-fourth its incidence in the early part of the war. Sulfa drugs and penicillin have cut the pneumonia rate from 24 to 6 per cent. And, marvelous to relate, by the administration of penicillin the dread syphilis can now be cured in days, instead of months, and gonorrhea in days rather than weeks. Sulfa has reduced the World War I mortality rate from meningitis from 34 to 4 per cent. At present, the over-all disease death rate in the Armed Forces is now down to a little less than a man a year for every 2,000 soldiers.—*Truly a magnificent record.*

Dr. W. L. Huetson Opens Office

Dr. W. L. Huetson, Osteopathic Surgeon, has moved to Denton from Hudson, S. D., and will take over the practice of Dr. H. E. Roberts.

Dr. Huetson is a graduate of Kirksville College at Kirksville, Mo., and for the past six years has been operating the Hudson Community Hospital at Hudson, S. D. He will be on the staff of the Elm Street Hospital and Clinic, Denton.

His wife and two daughters, Margery Ann and Judith Kay, will arrive in Denton within the next few days to make their home.

Dr. Roberts said he was retiring from practice in Denton.

GOOD ENTERTAINERS

We take this occasion to congratulate our good friend, Dr. H. B. Mason of Temple, upon the splendid service he is rendering in entertaining convalescent service men stationed at the McCloskey General Hospital. It is Dr. Mason's custom to entertain some 25 or 30 of these convalescents at his ranch near Temple over the week end, and he has been engaged in this splendid undertaking for months.

Some fifty families of Bell County and vicinity take turns in entertaining these wounded veterans from the McCloskey General Hospital. There are at present between 5,000 and 6,000 patients in this hospital, probably the largest of its kind in the United States.

An Appreciation

• *We are, indeed, glad to be favored by an article by Dr. John J. Dunning of London, England, in this edition of the Journal. Dr. Dunning is well and favorably known in Texas, where he practiced for several years following World War I, and prior to his residence in England. Dr. Dunning is the originator of the hypothesis that alteration in the shape of the intervertebral disks preceded osteopathic bony lesions. The findings of Schmorl have sustained Dr. Dunning's pronouncement, and the hypothesis advanced by Dr. Dunning is practically universally accepted. Dr. Dunning writes both wisely and well, and we are most happy to include his most excellent article.*

A COMPREHENSIVE DEFINITION OF AN OSTEOPATHIC LESION

By JOHN J. DUNNING, D.O.

NOWHERE in our literature is the disc alteration described as part of a bony lesion, yet Schmorl and others prove that the disc is illy adapted to weight bearing. One-quarter of the spine is soft cartilaginous tissue.

The pull of gravity, occupational disadvantages and trauma compresses the disc or alters its shape. These changes are most marked after 25-30 years. If falls and slight trauma were the real causes of lesions our practices would be overrun with children and youths. Yet the fact is that most of our patients come from the age group most afflicted with thin or compressed discs. In middle age, a slight jar or trauma may complete a lesion already well begun through a drying or altering disc. It is inconceivable that a mid-dorsal lesion may happen through a bump or sprain. Hardly one middle-aged person can be found without a thinned dorsal disc, rigid upper back and some cardiac difficulty or weakness. Man has not yet accommodated himself to the upright posture but Nature is already attempting to relieve the disc pressure wherever the disc seems to be thinned unduly. Almost immediately swift, growing osteophytes are formed which bridge the vertebral body edges and stop vertebral settling. It is always observed that spiny osteophytes grow exactly opposite each other and always in the area where the bony edges are likely to touch first. By bridging the narrowing gap osteophytes prolong the life of the disc and relieve the foraminal nerve pressure. Bridging osteophytes should no longer be called arthritis or considered perplexing or useless whims of Nature.

The body of the vertebra manufactures a lymph like fluid which during all vertebral movements is sucked out through holes in the top and bottom of the vertebral bodies. It is absorbed into the disc by diffusion. If the vertebral arch is removed the nutritional foramina are seen to carry a blood supply to each vertebra greater by

far than is supplied to the humerus. Thus it suggests that if a structure is composed of highly specialized tissue performing a highly specialized function and has as one of its characteristics a rich blood supply that structure is likely an organ and fulfills the definition of one. I suggest that vertebral bodies are all organs.

In the Department of Physiology of the Los Angeles College, Dr. Bell said, "that a vertebral body can well be an organ." "Certainly it functions as one. For us not to understand the mechanism of vertebral fluid production only places us in a category with the oculists who discuss the origin of the aqueous and vitreous humors." There is other splendid support to this theory.

If the annulus weakens or the disc has a lateral thinness the nucleus pulposus may move from the median line and by its pressure begin an idiopathic scoliosis. I think most nonpathological curves may start this way.

Whenever the disc alters its shape, wedge-shaped or flattened, the articulating facets migrate into the foramina. This is an example of a bony lesion provable by lateral X-rays. The click of the manipulation is likely to be the movement of the facet surfaces ripped away from its faulty position. The spinal bones inevitably follow the changes in the compressed and altering discs. This is an irrefutable explanation of an Osteopathic bony lesion.

The occipital-atlantoid joint is the only true bony lesion of the spine. Here there is no disc to complicate the definition. Slight trauma can in this district force the bony surfaces into frequent mal-alignment. But it corrects ideally, too, because there is no disc which needs to be re-created and thickened.

Simple traction employed with standard Osteopathic technique does usually restore the disc to normal position and shape. An easy proof is to measure patients before and after treating by traction. The difference in height is striking. Often one inch increase is observed and, too, very frequently $\frac{1}{2}$ to $\frac{3}{4}$ inches, are seen. I have never found the old technique of twisting, sudden cracking or soft tissue manipulation producing such evidential proof nor has any skilled manipulator ever failed to be impressed at the permanency of increased height resulting from traction and its specialized manipulation.

I have written many times to the A. O. A. requesting that they show from their files that this deduction is not original or if it has faulty reasoning, but they have never been able to give a reply to the contrary. Clinical practice for nearly twenty years has shown that specialized traction is painless, that it corrects spinal lesions quickly and keeps them in a position of correction longer than the old methods, and the old "bone out of place theory" caused by a bump or sprain. In fact, the altering disc theory proves that a spinal bone moving from its articulations with the facets does actually occur and in an understandable manner.

Conclusions.

1. The thinned disc is the beginning of a spinal bony lesion. Various mal-positions of the vertebrae can be explained by the different types of disc wedging.
2. A vertebral body is an organ.
3. The movement of an articulating facet into the foramen is a proof of a spinal lesion. It can be demonstrated by standing X-rays.
4. Height can be regained and maintained by traction and its specialized manipulative technique.
5. In a paper so short only the main statements can be noted, but full proof of these original statements has been given in many lectures in the U. S. A. and in the British Osteopathic Review, the Osteopathic Profession, Clinical Osteopathy and quotations from my articles in the journal of the A. O. A.

The Bridge Builder

SAM L. SCOTHORN, D. O. *Chm. Texas P. and P. W. Comm.*

THE Public and Professional Welfare Committee is building a bridge of recognition and prestige for those of our profession who follow.

*An old man trav'ling a lone highway
Came at evening, cold and gray,
To a chasm, vast and deep and wide.
The old man crossed in the twilight
dim.
The sullen stream held no fear for
him.
But he paused when safe on the other
side
And built a bridge to span the tide.
"Old man," said a fellow pilgrim near,
"You're wasting your strength with
building here.
Your journey will end with the pass-
ing day,
You never again will come this way.*

*You've crossed the chasm deep and
wide.
Why build this bridge at even-tide?"
The builder lifted his old gray head.
"Good friend, in the path I have
come," he said,
"There followeth after me today
A youth whose feet must come this
way:
This chasm that has been as naught
to me
To this fair-haired youth may a pit-
fall be.
He, too, must cross in the twilight
dim.
Good friend, I am building this bridge
for him."*

I hope you have responded generously to Fund Chairman Clark's recent appeal for funds. Early contributions include checks for \$50.00 from Dr. Joseph L. Love and Dr. R. H. Peterson.

Please send your check at once either to the State Office, 1234 Irwin-Keasler Building, Dallas, or to the American Osteopathic Association, 139 North Clark Street, Chicago 2, Illinois. If you send your contribution direct to the American Osteopathic Association, kindly advise so that proper credit may be given.

Radiographic Diagnosis of Pulmonary Tuberculosis

JOHN H. PULKER, D. O., F. A. O. C. R.

Radiologist, Grand Rapids Osteopathic Hospital

Before any discussion of the diagnosis of pulmonary tuberculosis is initiated, the essentials of the pathologic processes should be reviewed briefly.

Tuberculosis is a chronic inflammation caused by the tubercle bacillus of which there are three forms, the human, bovine and avian. In this discussion only the first two mentioned are of significance. Although the variations of this disease are endless, they are merely the result of the interplay of the forces of destruction and repair. In man the tendency to repair is commonly greater than the destruction process, especially if the affected part, such as the lung, can be put at rest, even though the destruction may have proceeded for some time, it may be followed by a remarkable degree of repair so that in tuberculosis it cannot be said, to quote William Boyd, "The struggle naught availeth the labor and wounds in vain".

At this point I should like to emphasize the importance of early diagnosis of tuberculosis. It is comparable to early diagnosis of carcinoma in that it affords your patient a better than average chance of becoming an arrested case. The only reliable method of early diagnosis is by X-ray films. A negative physical examination or the absence of symptoms does not rule out tuberculosis. The X-ray diagnosis is 99 per cent efficient. Examination of contacts very effective.

The pathology of tuberculosis is characterized by the formation of the so-called tubercle. The variations in pathology varies only with the system involved.

From incipency the tubercle is avascular. Two active processes are simultaneously going on, that of necrosis and fibrosis. If necrosis gains the upper hand a cavity results, if fibrosis wins out the result is encapsulation. The fibrous envelope may limit the lesion. But, even though the organisms are penned up the toxins may escape to produce typical symptoms. The toxin is an endotoxin tuberculo-protein to which the body becomes sensitized after the primary infection.

On subsequent sufficient exposure to the organism an allergic reaction occurs associated with more extensive inflammation and tissue necrosis, leading to rapidly fatal termination in some cases. On the other hand following an initial contact which usually occurs in childhood a mild tuberculosis develops which passes over. This

apparently vaccinates against tuberculosis for the rest of their lives.

There are 3 stages of spread. The primary stage occurs in infancy and childhood and is characterized as an air born infection consisting of a primary broncho-pneumonia with a lymphogenic spread. The secondary stage is characterized by a hematogenic spread which may carry infection to the apex of the lung or spread it throughout the body. The spread may be so profuse as to evoke a miliary tuberculosis. The third stage is the so-called bronchogenic stage of tuberculosis.

Primary Stage: Practically everyone is susceptible and the organism is ubiquitous. The infection is aerogenic and usually occurs in the first few years of life. After the focus of infection which varies from that of a pin point to a very large area the so-called epituberculosis is established. This is a wedge-shaped area of infiltration with the base to the periphery. Here the primary focus is set up. It may next take several courses. It may undergo caseation with a rapid breakdown, taking from a few days to a few years. It may involve an entire lobe and produce a huge caseous pneumonia which may evacuate in the center and transform the lobe into a cavity. It may become smaller and smaller until it finally calcifies, leaving a small focus which was the original tuberculous broncho-pneumonia. It may not calcify but remain as a tiny quiet focus which may flare up after 10 to 20 years. This zone or original focus is called the Ghon tubercle, usually situated at the periphery of the lung just under the pleura and supposedly seen in practically all X-rays. Associated with this primary focus there is a typical lymphogenic spread. The draining lymph nodes are involved, if in the hilar areas, may leave the calcified nodes observed in the adult. The primary complex of Ranke on X-ray reveals fine radiating lines from tubercle to the hilar glands. In our experience the Ghon lesion is much less frequently seen than has been reported in the literature.

In the second or hematogenic stage the organisms invade usually about the time of puberty, though this may shortly follow the primary infection. This stage may be divided into several groups, depending on whether the spread is malignant, virulent or bland.

In the malignant type there is a very active tuberculous spread in a person with little resistance. The organisms may enter the circulation from the tracheo-bronchial nodes to give a generalized miliary tuberculosis. The foci may rupture into larger vessels, in which case the symptoms will depend on the type of vessel entered.

In the virulent type, the patient exhibits some resistance. There are 3 general types of symptoms in this group. In the so-called typhoid type the tuberculous process mimics typhoid fever and is followed by surgical tuberculosis.

The polyserous type occurs when the organisms show a predilection for the serous membranes.

The third type is the diffuse fibroid in which there are scattered tubercles in the lungs usually in the apices depending on the vessels eroded into. In this type the patient has some resistance, though the organisms are virulent and react to a resisting process which is fibrosis.

The third or bronchogenic stage of tuberculosis is the so-called incipient tuberculosis of adult life. It is usually seen after puberty and during the early years of adulthood. The patient may suddenly have a high fever and chills due to a bronchogenic dissemination throughout the lung. The reason for this is that an individual who is sensitized inhales a huge dose of the organisms which are spread very rapidly throughout the bronchi. If the dose is large and body resistance lowered he gets what is known as galloping consumption with its typical clinical picture.

Everyone is very likely to have a tuberculous infection in the first few years of life. Questions which immediately rise are: "Why do some develop an active lesion 20 years later?" "Is the active tuberculosis endogenous or exogenous?" It is known that the organism may be harbored for years in a Ghon lesion and surrounding tissue. Therefore, it is logical to assume, it is a resistance problem.

Exogenous infection is represented by Assmann's reinfection zone. It is located just under the clavicle as a tiny focus.

However, it is surprising to note that the incidence of tuberculosis is no higher among those in charge of tuberculosis wards than in other people.

Radiologically it is more convenient to divide pulmonary tuberculosis into childhood and adult phases.

As previously explained, in the childhood phase, hilar tuberculosis is most common, characterized by a primary parenchymal nodule, increased hilar density, loss of normal contour, enlarged hilum nodes, fibroid nodulation and calcification. The next is miliary tuberculosis with wide spread dissemination of millet seed like deposits throughout both pulmonic fields. Roentgenographically, then, childhood infection is recognized primarily by enlargement of the hilar glands rather than the initial lesion of peripheral infection; any calcification present may be adjudged as evidence of a healed process.

In adult tuberculosis of the reinfective type the earliest radiographic signs are accentuation of the broncho-vascular pattern from the upper limits of the hilum to the infra-clavicular and apical regions, later spotty or flocculent infiltrative areas in the aforementioned reinfective zone. The spotty areas develop into definite tubercles and the pathology from here is one of degree, either progressive or regressive, depending on the patient and treatment instituted.

In the differential diagnosis all fevers, tachycardia, weight loss and cough should be eliminated. The following are briefly mentioned in differential diagnosis. Accessory nasal Sinus Disease, influenza, hyperthyroidism, chronic bronchitis, bronchiectosis, asthma, lung abscess, cardiac disease, fungous and pneumoconiosis.

Now we should pause and realize that tuberculosis, like carcinoma, must and should be diagnosed early for effective treatment to be instituted.

Summary—

Early diagnosis of pulmonary tuberculosis is imperative, as a negative physical examination of the absence of symptoms does not rule out tuberculosis. Roentgen examination of the lung fields is 99 per cent efficient and the examination of contacts very effective.

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Veterans' Education Benefits Under G. I. Bill of Rights

1. *What is the G.I. Bill of Rights?*

Public Law 346, 78th Congress, approved June 22, 1944, otherwise referred to as the Servicemen's Readjustment Act of 1944, Title II of which confers education benefits on eligible World War II veterans.

2. *Who administers the Law?*

The Veterans Administration through its 52 Veterans Administration field stations, one or more of which is located in each state except Delaware which is served by the Philadelphia office. Each field station is in charge of a manager under whom there is a Rehabilitation Officer who is in charge of a vocational guidance division and a vocational training division.

3. *Who is eligible for the education benefits?*

Any veteran of World War II who was not dishonorably discharged and who served not less than 90 days after September 16, 1940, or who though serving less than 90 days was discharged due to actual service-incurred injury or disability, and whose education was interfered with by reason of entrance into service.

4. *Is it necessary to prove that the veteran's education was interfered with in all cases?*

Yes, with two exceptions. The exceptions are: (1) veterans under 25 years of age when they entered the service, and (2) veterans desiring a refresher course of one year or less.

5. *What education benefits are available?*

Education or a refresher course for a period of one year. Upon satisfactory completion of the course (other than refresher course), the veteran is entitled to an additional period of training equal to the time he was in active service after September 16, 1940, and before the termination of the War. For example, if he spent two years in active service within the prescribed dates, he would be entitled to a total of three years training. Four years training is the maximum allowed.

6. *Who selects the course which the veteran shall take and the institution where he shall take it?*

The veteran himself. Of course the veteran would have to meet the entrance requirements of the institution he selects. Also, his selection of institution is confined to institutions which have been approved for the teaching of the educational course he has chosen. The educational institution chosen by the veteran need not be located in the State in which he resides.

7. *What is an "approved" institution?*

An "approved" institution is one which is listed as such by the department of education of the State in which the institution is located.

8. *Which Osteopathic colleges are listed as approved institutions?*

- | | |
|--|--|
| 1. College of Osteopathic Physicians
and Surgeons
1721 Griffin Avenue
Los Angeles, California | 4. Kansas City College of Osteopathy
and Surgery
2105 Independence Avenue
Kansas City, Missouri |
| 2. Chicago College of Osteopathy
5250 Ellis Avenue
Chicago, Illinois | 5. Kirksville College of Osteopathy
and Surgery
Kirksville, Missouri |
| 3. Des Moines Still College of
Osteopathy
720-722 Sixth Avenue
Des Moines, Iowa | 6. Philadelphia College of Osteopathy
48th & Spruce Streets
Philadelphia, Penna. |
| 7. Massachusetts College of Osteopathy
619 Commonwealth Avenue
Boston, Massachusetts | |

9. *When must the veteran make application for educational benefits?*

He should do so immediately upon discharge from the Service. He must do so

not later than two years from the date of his discharge, or from the termination of the War, whichever is later.

10. *What expenses are paid by the Veterans Administration to the educational institution?*

For each person enrolled in full-time or part-time course of education, the Veterans Administration pays to the institution involved the customary cost of tuition and such laboratory, library, health, infirmary, and other similar fees as are customarily charged, and may pay for books, supplies, equipment, and other necessary expenses (exclusive of board, lodging, and other living expenses and travel) as are generally required for the successful pursuit and completion of the course by other students in the institution, but not to exceed \$500.00 for an ordinary school year.

11. *Does the veteran receive any subsistence allowance during schooling?*

While enrolled in and pursuing the course, the veteran, upon application to the Veterans Administration, will be paid a subsistence allowance of \$50.00 per month, if without any dependents, or \$75.00 per month if he has dependents, including regular holidays and leave not exceeding 30 days in a calendar year.

12. *Where does the veteran apply in order to receive educational benefits?*

He may file an application with a field station of the Veterans Administration directly, or he may file his application with the Veterans Administrator through the approved institution which he has selected. The form of application is known as Veterans Administration Rehabilitation Form 1950. Copies of the form are available in all approved Osteopathic institutions.

13. *What is the general procedure?*

(A) When a person files an application with a field station of the Veterans Administration, it is then routed to the vocational rehabilitation and education division where his eligibility will be established and the veteran notified of the decision. If the veteran is found eligible, he will be given notification of the exact period of training to which he is entitled under the law and that he may now elect his course of training and select the approved institution. The veteran will also be informed that he may use that notification as evidence of his eligibility for training under the law when contacting the institution which he has selected. When the veteran enters training, the institution will forward to the regional office which determined his eligibility the following papers: (a) a certified copy of the notification from the Veterans Administration establishing his eligibility; (b) a certified statement showing the date the veteran commenced training in the course referred to in (c); (c) a certified statement showing (1) the name of the course, the length of the course, the length of the ordinary school year and whether course of training is full-time or part-time; (2) customary cost of tuition for an ordinary school year, laboratory, library, health, infirmary and other similar fees as are customarily charged, cost of books, supplies and equipment for an ordinary school year, other necessary expenses for an ordinary school year, itemized, as are generally required for the successful pursuit and completion of the course by other students in the institution. Board, lodging and other living expenses and travel are not to be included in the statement of the institution. Subsistence allowances are paid by the Veterans Administration directly to the veteran, upon application by him.

(B) The veteran may file his application with the Veterans Administration through the approved educational institution which he has selected and the institution may, if it is satisfied that the veteran meets the eligibility requirements, but subject to final approval by the Veterans Administration, enter him into training and promptly forward his application, together with all other necessary papers referred to above, to the field station in the territory in which the institution is located. When these papers are received in the field office, they will be sent to the vocational rehabilitation and education division where the veteran's eligibility will be established and the veteran and the institution notified of the decision.

14. *How may further information be obtained?*

(a) By writing to one of the approved Osteopathic institutions, or (b) by writing to the manager, Veterans Administration.

A Brave New World

GENETICS stands second to physics as the most fruitful department of science during the last quarter of a century. Physics has given us a new chemistry, a new thermodynamics, in fact, a wholly new philosophy as to the nature of matter. It has made possible such marvelous mechanical inventions as the aeroplane, cinema, the radio and television. The achievements of genetics are not so spectacular, but scarcely less broadly constructive. The established facts concerning variation, heredity, and development provide a new orientation in sociology.

One must possess a high degree of technical knowledge to comprehend the modern physics, but fortunately only a select few need to understand it. Relative genetics is a different matter. Every physician should learn the tenets of genetics for there is a genetic aspect to practically all problems of society; and these are problems which are not submitted to the technical expert, but are dealt with for good or evil by all who have a voice in governmental affairs. In its detail genetics is abstruse and complicated, scarcely easier to understand than the older science, but fortunately the general principles are not so difficult to grasp.

It is to be hoped that when the thoughtful members of the medical profession come to appreciate the full significance of biological determination and what it means to the physical development of the individual, which is the province of medicine, to the mental and moral development of the individual, which is the province of education, and the human evolution, which is the province of eugenics, they will wish to have a more extensive knowledge of genetic discoveries even at the cost of considerable concentration and effort.

Genetic discovery, fain would we believe, gives man the opportunity to regain his lost gift of perpetual youth—not his youth as an individual, of course, but the fast-fading youth of his race. It is a treasure, therefore, not to be lightly cast aside. You will remember the story, which comes from the ancient Greeks, who, as men of sense, judged their kind with a tolerant and humorous conceit. The tale runs that Prometheus created man out of the odds and ends of various animals held together with a little clay, and stole fire from heaven for the protection and comfort of his creature. No better in his original state than now, man immediately betrayed his creator; and the gods, greatly pleased with his dereliction, confirmed the gift of fire and also bestowed a new treasure, that of perpetual youth. Man forthwith bundled his untried bounty on the back of an ass for transportation to earth, and left the animal to his own devices. The carrier, being an animal, became thirsty; and, being an ass, exchanged his burden for a drink of water. Thus man lost his youth and became the prey of the calamities which his unbridled curiosity loosed from Pandora's vase. But he still had hope, he still had curiosity, and he still had the eternal fires of science. The combination has served him well.

Child Health Clinic Reported a Success

"The Child Health Clinic held at Amarillo, Texas, was certainly successful beyond all expectations," says Mrs. Lester J. Vick, of the First District Osteopathic Association Auxiliary. These clinics were under the direct supervision of the nationally known children's Neuropsychiatry specialist, Dr. G. N. Gillum, chief of the clinical staff of the Kansas City College of Osteopathy and Surgery.

Children from a dozen or more Panhandle towns were brought to Amarillo for examination and a number of Panhandle Osteopathic Physicians joined the Amarillo group in conducting the clinic, which is expected to be an annual event.

\$125,000 Osteopathic Hospital

Election of officers and discussion of the new Osteopathic Hospital in Houston were the highlights of the quarterly meeting of Sixth District of

the Texas Association of Osteopathic Physicians and Surgeons, at the Gardiner Clinic, Houston, on June 2.

Construction on the planned \$125,000 Osteopathic Hospital will begin in a few weeks, according to Dr. William H. Badger, retiring vice-president. The hospital will have a maximum capacity of about 50 beds and will be financed through popular subscription. The following officers were elected for the ensuing year:

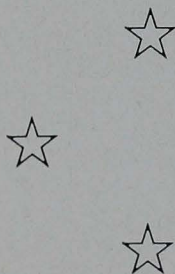
Dr. Edward S. Gardiner, Houston, president.

Dr. Julius B. McBride, Houston, vice-president.

Dr. J. Edward Vinn, secretary-treasurer, Velasco.

Drs. John M. and Claire Peterson of San Angelo were recent visitors to the Dallas-Fort Worth area.

Dr. Ted Alexander of the Archer City Hospital, has been appointed as County Health Officer for Archer County, Texas.



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flict" a NEW HORIZON
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Post-Graduate Courses

The College of Osteopathic Physicians and Surgeons of Los Angeles, California, are offering the following courses:

General Surgery and Surgical Technique, July 30 to August 24, inclusive.

General Medicine, October 1 to October 26, inclusive.

Information can be had by writing to the College, 1721 Griffin Avenue, Los Angeles 31, California.

The Editor would like for every Osteopathic Physician to appoint himself a committee of one to make the effort of sending any clipping in any newspaper they may read that concerns Osteopathy, Osteopathic Physicians or their families to this office. We know that the clipping services do not always get everything nor do they read every paper in our territory. We would much rather get two or more clippings of the same thing rather than lose out on any one.

Osteopathic Physicians Seek Admittance to Navarro County P&S Hospital

Osteopathic Physicians practicing in Navarro county requested permission to bring patients to and practice in the P. and S. Hospital, Corsicana, owned and operated by Navarro county, at the July meeting of the Navarro county hospital board Sunday afternoon. No action was taken by the board pending further study of the question. Those appearing before the hospital board were Dr. P. R. Russell, Fort Worth, member of the state board of health at one time and a member of the state medical board of examiners for twelve years; Dr. A. L. Clinch, Frost; Dr. N. E. Dunn, Blooming Grove, and Miller Reid, Blooming Grove druggist.

All members of the board were present.

The monthly collections amounted to \$4,163.22 with expenses at \$4,481.79.



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MEMBERSHIP WINNER

Dr. Robert Ellis Morgan was the winner of a \$25.00 war bond for outstanding work in the membership effort of the American Osteopathic Association during the past year. Dr. Morgan secured the greatest number of applications of any individual physician, 23. Dr. Morgan directed this campaign with the thoroughgoing enthusiasm and energy that is so characteristic of all his undertakings. 'Tis a slogan down heah in Texas: "Iffen you want a thing done right, getten Bob Morgan to do it."

Dr. J. Paul Price, Oklahoma City, Chairman of Division D, was also accorded this recognition for directing the Division obtaining the greatest number of applications. Division D includes the states of Arkansas, Colorado, Iowa, Kansas, Missouri, Nebraska, New Mexico, Oklahoma and Texas.

Congratulations, Drs. Morgan and Price!

Doctor Goes to College

Dr. E. B. Pool, who has been practicing in Sweetwater since August,

1937, left recently for Kirksville College of Osteopathy and Surgery at Kirksville, Mo., where he will take a year's residency in surgery, after which he will be in partnership with his brother, Dr. W. E. Pool, in the operation of a new 25-bed hospital in Lindsay, Okla.

Dr. Pool has been medical officer for the Sweetwater unit of the Texas State Guard for the past two and a half years, with the rank of captain. The company honored him with a dinner last week. He is a past president of Sweetwater Rotary Club. His home is in Wynnewood, Okla., and he attended the University of Oklahoma for three years before taking his degree from Kirksville College of Osteopathy and Surgery.

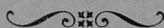
We extend a hearty welcome to Dr. Jason Grinnell, who has recently opened offices at Rockwall. Jason resumes practice in Texas after serving a hitch as Chief Pharmacist's Mate in the United States Navy and a sojourn in snow-clad hills of Michigan. Jason says that Texas is "God's own country," and we're powerful glad to have Dr. and Mrs. Grinnell locate in Texas. Success.

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P & PW PLEDGES

Those of you who have not paid their pledges of last year, please send your check in as soon as you read this item, as a report to the Central office, Chicago, has to be made. Just mail your checks to the State Office, 1234 Irwin-Keasler Building, Dallas.

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ROCKDALE MEETING

Honoring Dr. M. R. Carner and the new Carner Clinic-Hospital of Rockdale, the Fifth District of the Texas Association of Osteopathic Physicians and Surgeons held a meeting in Rockdale, Sunday, June 3, 1945. More than twenty-five physicians and their wives were in attendance. Among the guest speakers were the president of the Texas Association of Osteopathic Physicians and Surgeons, immediate past-president of the American Osteopathic Association, and a member of the Texas State Board of Medical Examiners.

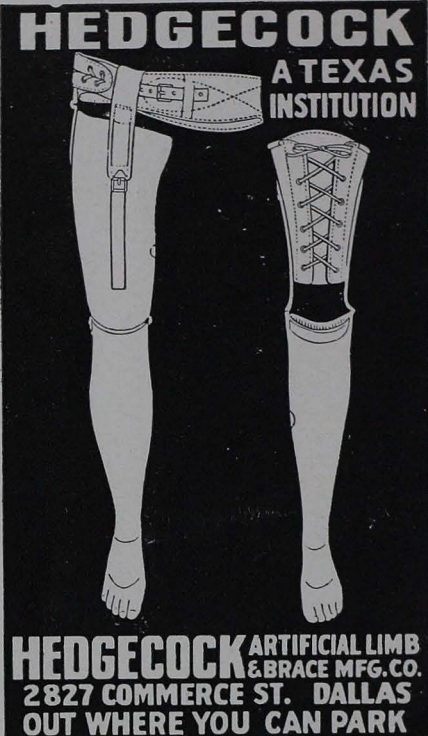
Dr. Joseph L. Love of Austin, president of the Texas Association, presided at the program meeting and gave a discussion on Heart Diseases.

Dr. Everett W. Wilson of San Antonio, recently reappointed as a member of the Texas State Board of Medical Examiners, discussed Psychosomatic Diagnosis.

Dr. M. R. Carner of Rockdale offered a paper on the cause and treatment of Asthma.

Dr. Carl J. Wieland, specialist of Austin, lectured on diseases of the eye, ear, nose and throat.

Dr. H. V. W. Broadbent of Austin, program chairman, was responsible for the program.



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Cradits, Vicks Entertain at Dinner for Graduates

Dr. and Mrs. L. V. Cradit and Mr. and Mrs. L. J. Vick were hosts and hostesses at a dinner at the Amarillo Country Club last night honoring members of the twelfth annual post graduate course and guests of the faculty.

Dr. Esther Smoot of Chicago, Ill., assistant editor of the *American Journal of Osteopathy*, was the principal speaker of the evening. Boys from Boys' Ranch, near Amarillo, provided entertainment for the evening.

We hark back to Godey Ladies Magazine of the '70's, that exquisite epistle of true refinement and etiquette, which says, "Never smoke in the presence of a lady." By following that advice at the present, the number of cigarettes you can keep for yourself is incalculable.

*Come, baby, I'm going to season your dishes
With a blend of the oils from the percomorph fishes.*

*O Xyphias Gladius, what though I shiver,
Your taste is so horrible? Lend me your liver.*

*Colossal and generous, come Thunnus Thynnus,
Cause vitamin D more abundantly in us.*

No faces, my darling! for Steriolepis Gigas, though nasty, the source of your pep is.

*You may skip your boiled rice, tapioca and sago
If you swallow your Pneumatophorus Diego.*

*What though their flavor is pretty upspittic,
So long as their action is antirachitic?*

—DEBORAH WEBSTER
in *Boston Herald*.

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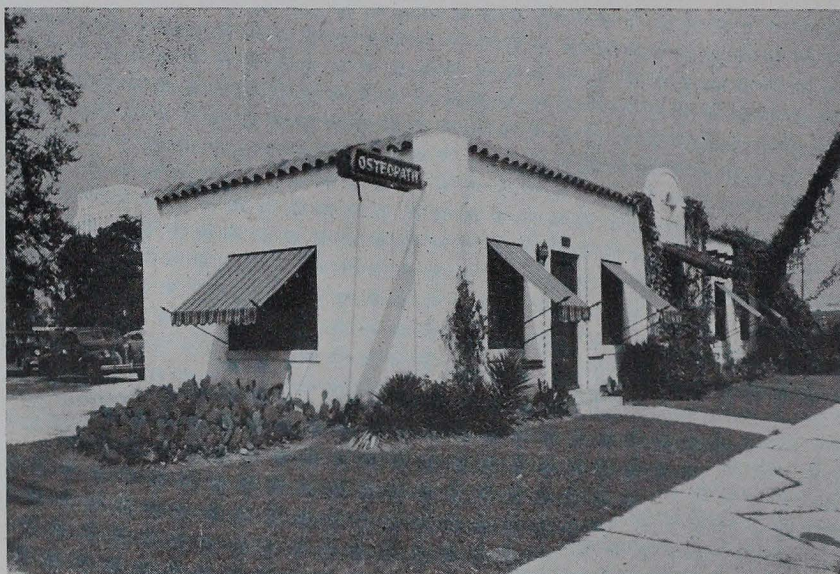
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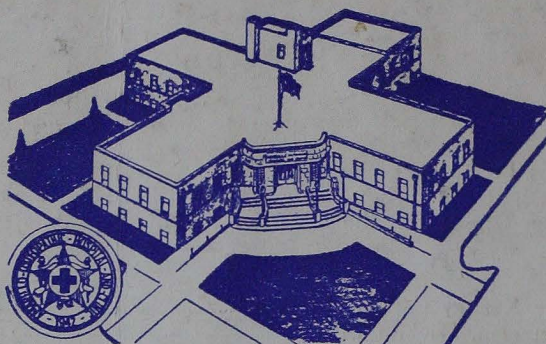
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