Texas
OSTEOPATHIC PHYSICIANS Journal

Volume VI AUSTIN, TEXAS, JULY, 1949 Number 3

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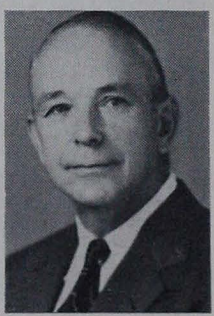

Phil R. Russell, D. O.
Executive Secretary

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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Volume VI | AUSTIN, TEXAS, JULY, 1949 | Number 3

Dr. Phil R. Russell of Fort Worth New Executive Secretary

The following article and abstracts from letters are printed at the request of Dr. L. C. Edwards, President of the Texas Association of Osteopathic Physicians and Surgeons, and does not necessarily express the opinion of tthe editor.

"WE'LL KEEP ON GOING"

L. C. EDWARDS, D. O., President

The other day, checking through the many publications that pass across my desk, my eye caught a short sentence that gave me a chuckle. It read, "Even if you are on the right track, you'll get run over if you just sit there." That little sentence struck me as a gem of humor, and maybe it was meant to be only that. But even as I chuckled, its deeper significance flashed into my mind. I read it again, this time not with amusement, but with thoughtfulness.

"Even if you are on the right track, you'll get run over if you just sit there."

In other words, we've got to keep going. We've got to keep going if we are to achieve anything during our short span of years, if we are to fulfill our purpose in this therapeutic and legislative life. We can't stop, we can't just sit there, because if we do, we will be crushed into oblivion by a rapidly moving modern world, and we will have failed in our mission in life.

My next thought was that true though this clever saying may be, it certainly did not apply to the Texas Association

of Osteopathic Physicians and Surgeons. Our state organization has progressed far since its organization forty-nine years ago.

Never has Winston Churchill's famous quotation been more applicable than at the present in regards to your state association. "Never have so many owed so much to so few." We have had too few working day and night both legislatively, professionally, and in a public relations manner in ratio to our total membership. Your Trustees and Committees through the years have seen the growth of a small professional group pass through adolescence practically over-night into an adulthood of a well-respected ethical professional group who hold the confidence of the public. This respect and confidence accumulated through the years has been at the expense and efforts of a meager few.

The Board of Trustees has voted unanimously that the results over the years now demands the full time services of an executive secretary for your state association. The problem at hand was the selection of the most qualified person to serve in that capacity.

Ten individuals were investigated by a special committee and ironically, the man selected unanimously by the committee and Board of Trustees was not even an applicant for the position, but only allowed his name to be submitted at the insistance of some members of the profession because of his long years in both state and national organization work within the profession.

The unanimous selection of the committee and the Board of Trustees was Dr. Phil R. Russell. Dr. Russell finally accepted the position at a relatively small salary from the Association compared to the large practice accumulated over twenty-five years in Fort Worth. This will result in a fairly large loss in revenue for Dr. Russell over which his practice now brings.

His unanimous selection was on the basis of his extreme loyalty to the profession and his background in organization work.

He served as President of the North Texas Association; member of Board of Trustees of Texas Osteopathic Association; youngest elected President of the Texas Osteopathic Association; member of the Board of Medical Examiners and the Board of Public Health of Texas for years; member of the Legislative and Public Health Committee of the Texas Osteopathic Association for twenty-five years.

Nationally, he has been a Delegate for the Texas Osteopathic Association to the American Osteopathic Asociation for twenty-five years; having served as a member of the American Osteopathic Association Board of Trustees longer than any other individual, four elected terms of twelve years, one year each as American Osteopathic Association President Elect, President and Past-President for a total of fifteen years; member A.O.A. Legislative Council for seven years; and directed the A.O.A. central office building fund.

Your Board of Trustees felt that the wealth of those years of organizational experience should not be lost to your state association with Dr. Russell's announcement of retirement from the national committees to devote his time to private practice. With this individual's background the Trustees felt that only a five year contract would justify his acceptance of the office of full-time executive secretary and permitted him to retain some few of his patients for the benefit of your state association and also to bridge the gap in financial loss from retirement from an exceedingly active practice of twenty-five years.

He has continually fought for certain policies to advance the profession and in accepting the office of executive secretary he will be entirely subject to the administration of policies as set down by the House of Delegates and Board of Trustees of the Texas Osteopathic Association.

Our progress as an association proves that we have been on the right track, didn't stop, and didn't get run over. The action of the Board of Trustees is evident that they are determined to sustain that progress.

When good fortune comes to someone, it is usual for friends to offer congratulations. This time congratulations are in order for the Texas Association of Osteopathic Physicians and Surgeons entire membership in securing Dr. Phil Russell as their Executive Secretary.

Dr. Phil's entire life has been devoted to the profession. His interest in osteopathy dominates his every action. His sincerity, enthusiasm and energy has been the driving force in many projects that have been undertaken, both at the state and national levels for the advancements of our school of medicine.

I have had the pleasure of serving with Dr. Phil on many bureaus and committees in our national organization. I have watched his influence for the good of Osteopathy make itself felt on individuals and groups in many different circumstances and professional problems. His honesty plus a firm conviction of the future of his profession, has been a stimulating and inspiring experience to me and to all who know him. His fearless and uncompromising attacks upon all who would destroy or limit the scope of application of the osteopathic concept in the diagnosis and treatment of disease has won for him the respect of all who know him.

His character and unwavering devotion to duty regardless of the sacrifices demanded, have won for him the everlasting affection of the osteopathic profession.

Congratulations to all of you in Texas on your choice of Phil R. Russell, D. O., as your Executive Secretary.

ROBERT B. THOMAS, D. O.
Immediate Past President, A.O.A.
Huntington, West Virginia

Word has just reached this office of the employment of Dr. Phil R. Russell of Fort Worth as the full time Executive Secretary of the Texas Association of Osteopathic Physicians and Surgeons. I will appreciate it very much if you will convey to the members of your Association my heartiest congratulations on this selection, and particularly upon their success in obtaining Dr. Russell's consent to take the position.

Texas has always been known as one of the outstanding States in organization and there now is no question but what they will soon develop into the model Divisional Society with this executive leadership.

It has been my privilege and pleasure to work with Dr. Russell in Osteopathic organization for the last ten years. Only one who has had this opportunity can begin to appreciate the sterling character and devotion to principle and duty of this man. In all his activity Dr. Russell has been a champion of and adhered strictly to the Osteopathic concept and principles as announced by Dr. Andrew Taylor Still. This type of strong leadership and zeal has accounted for an inestimate amount of the advance made by this profession, always on a firm foundation.

Leaving general practice is a severe loss to the people of Fort Worth. However, his new work will give opportunity to serve the citizens of Texas and, therefore, a greater segment of your population will be benefitted. Wherever Dr. Russell works it will always be a sincere and capable effort to advance Osteopathy for the ultimate benefit of the health of the public.

S. M. PUGH, D. O.
President, A. O. A.
Everett, Washington

I would like to extend my most sincere congratulations to the members of the Texas Association of Osteopathic Physicians and Surgeons upon selecting

Dr. Phil R. Russell as Executive Secretary of the Association.

This is one of the times when words cannot adequately express the feeling in one's heart. It has been my privilege and pleasure to have worked and played with Phil Russell for a considerable number of years. Whether it was in work or play he has never deviated from his sincerity of purpose. That purpose has always been and I am sure always will be, the development and the protection of the Osteopathic profession. If Phil has one outstanding characteristic, it is the unselfish devotion to his profession.

I am quite confident that this devotion and his natural enthusiasm will make a most valuable contribution to the Osteopathic profession in Texas in his capacity as Executive Secretary.

Congratulations are also due Dr. Russell for this latest evidence of his desire to be of service. To really know Phil is to love him. I feel I really know him.

H. DALE PEARSON, D. O.
President-Elect, A. O. A.
Erie, Pa.

Congratulations were also received from David E. Reid, D.O., Trustee of the A.O.A; Floyd F. Peckham, D.O., chairman of the Bureau of Hospitals, American Osteopathic Association; H. N. Tospon, D.O., trustee of the A.O.A.; C. A. Pavlovich, D.O., trustee of the A.O.A.; Allen A. Eggleston, D.O., trustee of the A.O.A.; Rose Mary Moser, treasurer of the A.O.A.; Donald V. Hampton, D.O., trustee of the A.O.A.; C. N. Clark, D.O., business manager of the A.O.A.; J. W. Mulford, D.O., trustee of the A.O.A.; Vincent P. Carroll, D.O., trustee of the A.O.A.; John P. Wood, D.O., Past-President of the A. O.A.; Robert J. Grunigen, D.O., First Vice-President of the A.O.A.

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SACRUM LEVELING

LESTER L. HAMILTON, D. O.

FORT WORTH, TEXAS

Anatomical Short Extremity is a term which I would prefer to leave out of this discussion but it probably must be used since it is a familiar term and many would not guess what was to be discussed if the first title, sacrum leveling, were used alone. The short leg is only one of a group of factors which may give us an unlevel sacrum or an unlevel foundation for the spine. Of course, if we understand that we are discussing Anatomical Short Extremity in its larger sense, all will be clear. However, this term has so confused our thinking that it is not uncommon to see one standing pelvis X-ray after another whereon the physician has meticuously measured the exact difference in the levels of the femur heads yet no attempt had been made to see how much of this difference was transmitted to the top of the sacrum. It is the sacrum which is the base or foundation of the spinal column and if this foundation is not level there tends to be a corresponding curve in the spine above, since the spine tends to leave its foundation at a right angle, and a spinal curvature is necessary to return the head to the mid-heel line. This occurs regardless of which leg is short and many of us have treated cases wherein it was necessary to place the lift under the long leg in order to level this sacrum.

In this paper I hope to present the more accepted facts about this subject and avoid the more controversial matters. There are some who disapprove of, and others who entirely disregard the possibility of an unlevel sacrum (or short leg) as being a major factor in

LESTER L. HAMILTON, D. O.

back troubles. To me it seems as logical to look to the foundation of the spine for levelness and stability when one has a recurring back ailment as it does to look to the foundation of a house for levelness and stability when the house has repeated cracks in the plaster. It is only the relatively infrequent case of unlevel sacrum which involves the controversial parts of this problem, so we can all care for the big majority of these cases by use of accepted treatment.

The first step in treatment is a reliable pelvic X-ray. Kerr, Grant and MacBain of the Chicago College have shown that even they could not be accurate in

their diagnosis of the short side by palpation and inspection until the shortness had exceeded 3/8 of an inch. Yet it is not uncommon to find someone experimenting with a ¼ inch lift under what they believe to be the short side "to see if the patient is benefited," and then if no benefit is obtained deciding that using a lift is of no value for that case.

It is well to remember that a standing pelvic X-ray taken at the time we most desire it, that is when the patient is having the most pain, may be of no value for judging the levelness of the sacrum. This is due to the presence of distorting muscle spasm, especially psoas spasm. This muscle spasm may give the illusion of an unlevel sacrum when in reality it would be level if the muscle spasm were relieved. Chronic fibrositis in muscle groups may produce somewhat the same illusion. I imagine that every osteopathic physician doing referred standing pelvic X-rays has taken many such pelvic pictures and wondered if a recheck would ever be taken to see if the apparent shortness on the "acute" film would be present on a later film.

Lateral lumbar views are an absolute necessity, yet there are some physicians who continue to work from A-P views alone, at least on part of their cases. Fully as much pathology will be found on lateral views as on the A-P. Such things as early arthritis, tumors or disease of the vertebral bodies, disintegrated discs, unstable lumbosacral angle, lordosis, etc., may be missed entirely on the A-P view, yet be clearly present on the lateral view.

Follow up X-rays are also an absolute necessity. These tend to recheck on our original diagnosis as well as to show us if treatment is getting the desired response. Spines do not always respond in the expected manner to attempts at leveling the sacrum, and one may find some unexpected and undesirable rotation or lateral flexion taking place on the follow up plates. Quite often one finds that considerably less "lift" is needed than was originally judged necessary. These follow up X-rays are probably the most important part of treatment for our entire program may be changed by what is found on them.

In passing it might be stated that better detail can be had on a reclining plate with good fixation, and sometimes it is wise to insist that the patient have one or more reclining spot films.

After one has a standing A-P and Lateral plate one must decide how much sacral tilt is present and how much lift will be required to level the sacrum. We first draw line connecting the highest points on the femur heads; second, erect a vertical line through each of these points; third, draw a horizontal line through the more superior of these two points, and note the point where this line intersects the opposite vertical; fourth, choose symmetrically located

points on the right and left halves of the sacrum and through them draw a line noting points where this line intersects the two verticals; fifth, draw a horizontal line through the more superior of these two points, and note where it interesects the opposite vertical. Now the amount of our short extremity is of relatively little importance to us. The important measurement is that which gives us the amount of lift necessary to level the sacrum, *at least in theory.*

Generally speaking, the lift should go under the low side of the sacrum. The case which brings up controversy is the one in which the lumber convexity is to the high side of the sacrum.

Some men prefer to place the lift temporarily under the high side of the sacrum, in this case, and switch it to the opposite side when the lumbar curvature is corrected or perhaps overcorrected. Other men who are equally capable are very hesitant to use this measure and prefer to place the lift under the low side in this case also and depend upon manipulation and corrective exercises to straighten the lumbar curve. Regardless of the procedure used the final decision as to what is best treatment for each individual case must be decided from the follow up X-rays and the results obtained for the patient. A change in plan of treatment to suit the individual case is as sensible here as in any other therapeutic procedure.

A few statements about lifts might serve to help the novice. Lifts of ¼ inch or less can be placed on one heel, usually; lifts of ¼ to ½ inch should be handled by reducing one heel and adding to the other or by using a heel pad or insole in one shoe and reducing the other heel; lifts of over ½ inch will usually require custom built shoes which provide two factors of importance in this group of cases:

(1) Additional thickness on the sole as well as on the heel,

(2) Equalization of the weight of the two shoes to prevent errors of locomotion.

It is wise to start with not more than a ¼ inch lift and add more as it seems advisable. Especially should this be true in "old spines" and in arthritic spines. One should seldom add the entire theorectical amount of lift which appears to be necessary on the original X-rays. Many factors may combine to make a less amount of lift sufficient for leveling the sacrum in actual practice. Among these factors are rotation changes in the pelvis, release of muscle spasm, correction of sacroiliac lisions, correction of unilateral broken down tarsal arch, and in children under eighteen to twenty years of age there is the possibility of additional growth on the short side.

The physician should always check the shoes of his patients, after the lift is in place, with a pair of outside calipers, measuring from the outside center to the inside center of the heel. Obstetrical calipers are ideal for this purpose. There is another reason for this other than that of checking on the accuracy of the added lift. That is to check on the boxing of the shoe itself. I have seen shoes that presented identical outside heels yet, when measured as stated above, showed 1/8 inch difference in lift value.

All shoes should be fixed at one time and the patient should not make a habit of strolling about the house in the evening in bare feet or in house slippers which do not have the lift. This is an item often overlooked by both physician and patient.

After the lift is in place, a long range problem of corrective exercises, osteopathic treatments, and X-ray check ups must be planned. It is next to impossible to keep these patients under treatment as long as they should be and the physician must emphasize that since their back has been growing in this undesirable position for many years, it may take at least a few years to correct it.

Many of the gross structural irregularities can be corrected by home exercises. However, rib lesions and sacroiliac lesions are prone to develop during this program of gross correction and may not only be very annoying to the patient but also one must consider that since the sacrum is the foundation for the spine, sacroiliac lesions may affect our whole corrective process by introducing rotation and lateral flexion effects. These lesions should receive particular attention and if they tend to recur I find it very beneficial to inject the sacroiliac ligaments with a proliferating agent such as Sylnasol or Neo-Plasmoid. Pelvis leveling to obtain a *level* spinal foundation plus sacroiliac ligament injection to obtain a *secure* foundation makes an excellent combination for combating low back ailments.

My personal pet opinion is that every painful low back deserves the shock-absorbing value of rubber heels. Those of us who wear a lift ourselves because of a low back problem, can vouch for the fact that every time a hard leather heel hits a hard floor or pavement a certain amount of trauma is transmitted to the low back. These rubber heels should be replaced as soon as they begin to "run over" to any degree.

I give two simple exercises for home use. I believe these must be simple and few in number or the patient will not use them. The first is the "broom handle" exercise. The patient stands on a wide base and places a broom handle behind the back and grasps it either in the hands or the flexed elbows. Then by visualizing the AP X-ray plate he trys to undo the side bending and the rotation that is present. First he side-bends to the convexity of the lumbar curve; then, secondly, he derotates the lumbar spine. This he does by placing the broom handle over each lumbar vertebra in succession and using that point as a fulcrum.

The second exercise is simply a relaxed hanging from a horizontal bar and then side bending to the convexity of the lumbar curve.

SUMMATION:

1. The basic fundamentals of lift therapy have been presented.
2. It has been shown that it is not necessarily the femur heads that should be leveled but the base of the spine; or, namely, the top of the sacrum.
3. Standing pelvic X-rays have been shown to be a necessity both for diagnosis and treatment. Diagnosis of short leg by palpation and inspection has been shown to be unreliable by Kerr, Grant and MacBain except as stated.
4. Lateral as well as AP views have been shown to be a necessity.
5. Standing X-rays taken when the patient is in acute pain have been shown to be unreliable for judging amounts of shortening.
6. Follow up X-rays are shown to be an absolute necessity since the "expected" does not always occur when lifts are added.
7. A logical system of film marking for determining the amount of lift needed is presented.
8. The importance of checking lifts in situ on the shoes with an outside caliper to catch errors in shoe boxing is stated.
9. "Around the house" walking in bare feet or in house slippers is suggested as a factor which may retard corrective progress.
10. Hard heels on hard floors is blamed as a method of repeatedly and constantly traumatizing an ailing back and the shock-absorbing value of soft rubber heels is emphasized.
11. The combination of pelvis leveling to obtain a level spinal foundation plus injection of sacroiliac ligaments to obtain a stable spinal

foundation is suggested as an excellent combination in low back work.

12. Two simple corrective exercises for home use have been presented.

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OSTEOPATHIC SPIRIT

WM. H. VAN DE GRIFT, D. O.
Chairman, Membership Committee
AUSTIN, TEXAS

Four score and ten years ago . . ." — a great nation was but a nebulae in the vast wilderness of an uncharted world — BUT THERE WAS A SPIRIT!

It was a spirit of loyalty and self sacrifice and of visions necessary to make a future of this neophite. For this neophite was isolated by its independent thought of a new freedom. There was a great need for planning the course of this new freedom with the ultimate goal of expansion. This is our great land today — so be it!

Today the neophite that is closest to our hearts is a comparatively small band of physcians with minds of a spirited independent nature. The very essence of this independent thought caused each one of the members of our profession to enter this field because they knew the courage and self reliant ruggedness that would be necessary to propagate this profession in its past, present, and future forms. Added to that independent nature was a great lust and desire to be skillful in the application of the profession to gain the just recognition that it deserves.

THIS IS THE DEMAND OF THE INDIVIDUAL MEMBER — TO BE HEARD AND RECOGNIZED.

One man or a small group of men cannot accomplish this goal in the present functional set-up of the world we know today. It requires a collectivism to fulfill their desire.

The settlers of old found that in order to gain their end that they had to gather in the meeting houses of hamlets, villages, towns, and cities to determine the procedure best suited to acquire and put to work this blueprint of accomplishment. It was virtually assured that if they did not unite that it would not be long before forces interested in absorbing them and ruling them would recognize their weakness and take the weak under their wing. This would have destroyed that sense of independence that for many years had been, and still is, the heritage of Americans.

WE ARE AMERICANS, ARE WE NOT?

Join your Association today! Let's present a united group! Let's maintain and cherish our independent spirits!

EARLY DIAGNOSIS OF THE COMMON ACUTE ABDOMINAL CONDITIONS

GEORGE F. PEASE, D. O.

FORT WORTH, TEXAS

There is a growing tendency to rely upon laboratory and other auxiliary reports for a diagnosis. The history and physical methods of examination must always remain the main channels by which a diagnosis is made.

I am bringing to your attention a number of physical methods of approach which will aid in early diagnosis. A high pinnacle of importance may be attached to these signs when properly elicited and correctly interpreted. Frequently an urgent and all important diagnosis may be formulated by their aid alone.

In deciding the momentous question, "Is this an acute abdominal condition?" there are two signs which may prove helpful in a general way.

1. The Rising Test—The patient is instructed to place his arms by his side and then to raise himself in bed by means of the abdominal muscles alone. The sign is positive when the patient fails to rise or complains of great pain in attempting to do so.

2. Altered Abdomino - Thoracic Rhythm. Normally, during inspiration, when the chest rises the abdomen rises also. If, however, when the chest rises, the abdomen is sucked in, it is highly probable that a diffuse leak is present and general peritonitis is imminent. Disregard the first three or four respirations to allow the patient to overcome his self-consciousness.

GEORGE F. PEASE, D. O.

Never examine a patient in Fowlers position. It is impossible to correctly interpret his reactions in such a position.

In the average case of appendicitis the diagnosis is established by the history and such physical maneuvers as palpation to determine the presence of rigidity overlying the appendix. McBurneys sign when positive registers the maximum abdominal tenderness. The Pointing Test and the test for the presence of Epicritic Hyperesthesia may well be used in appendicitis.

The "Pointing Test" when positive, is of the greatest possible diagnostic significance. Ask the patient where the pain began; he usually places a finger near the umbilicus. Now ask the patient where the pain is now; the pointing finger passes to the right iliac fossa.

Now as to the hyperesthesia of the abdominal wall; this may be found to be present in the majority of cases of appendicitis. It is best tested by Ligat's method. This consists of picking up between the finger and thumb a portion of skin and subcutaneous tissue and lifting off the abdominal musculature. The portion of skin is picked up as in pinching but it should be noted carefully that the skin is not pinched. In order to elicit hyperesthesia by Ligats method, we begin in the left iliac fossa pass to the left, then to the right hypochrondium, ultimately picking up the skin in the right lower quadrant, or what is called Sherrens triangle.

When the diagnosis is doubtful, and in about one out of four cases, the history and physical signs are a typical further examination is required.

Tests to be taken advantage of under such circumstances are:

1. Rovsing's sign.
2. Rectal Examination.
3. Testicular Retraction test.

A typical acute appendicitis is the most difficult of all abdominal emergencies to diagnose. The stage of illusion is really worthy of the name: it occurs a few minutes after an obstructed appendix has ruptured. The patient will say that he feels better, the hyperesthesia disappears, the rigidity to a large extent passes off; but fortunately the pulse begins to rise, or we should probably be mistaken more than we are.

For the real case of doubt and difficulty there are the following signs which sometimes prove helpful.

1. A confirmatory test for retroceal appendicitis.
2. The Obturator Test.
3. The Psoas Test.
4. The Thoracic Compression Test.

It is well not to forget to abide by the old maxim, "Always examine the right lung and the right kidney (urine)".

Screaming children too young to cooperate in the search for physical signs, sometimes can be placated by the following expedient. The abdomen is palpated with the child's own hand guided by the hand of the examiner. When the point of maximum tenderness is approached the child pulls its hand away. This method, if carried out patiently, will often succeed in elucidating the area of maximum tenderness when other methods are inconclusive.

The signs elicited in a case of perforated gastric or duodenal ulcer—

Pulse—for the first six hours the pulse rate is often practically unaltered. The gravity of the prognosis varies directly with the pulse rate. This basic fact should constantly be born in mind. Shock is imminent, the temperature is subnormal, but because the pulse remains normal the diagnosis is often fatally delayed. The majority of patients operated upon while the pulse is still under 100 recover, while almost all those who are delayed until their pulse rate has reached 120 or more die.

Retraction of the epigastrium is present early. As time elapses the sign is lost.

Respiration is of the thoracic type and often of a peculiar grunting character and altered abdomino-thoracic rythm is present.

If board like rigidity is present, shifting dullness is not usually demonstrable. As the pain and rigidity pass off, percussion may be of great value.

Reflexes—the examination should include testing of the knee jerks and reaction of the pupils to light to rule out the presence of a gastric crisis of tabes.

Diaphragmatic pleurisy and coronary thrombosis are the conditions most likely to be confused with perforated gastric ulcer. When there are no physical signs to be found in the chest, as may happen in diaphragmatic pleurisy, differential diagnosis becomes exceedingly difficult. Ordinarily a patient with diaphragmatic pleurisy prefers to be propped or sitting up in bed, while if the lesion is below the diaphragm he prefers to lie flat. In pneumonia with abdominal pain the skin is hyperesthetic, but pressure affords relief and there is little, if any, restriction of respiratory movements of the abdominal wall.

When rigidity is of thoracic origin it will often be found that there is some relaxation of the upper abdominal wall when the patient is told to hold his breath, with his mouth open, at the end of expiration.

Perforated duodenal ulcer is more common than perforated gastric ulcer. The physical features are all identical except that when a duodenal ulcer perforates, the escaping fluid passes to the right iliac fossa by way of the right para-colic gutter. In differentiating this condition from appendicitis, Rovsing's sign is useful.

A perforated duodenal ulcer partially sealed by omentum is a problem. The patient can move about, may walk to the hospital, vomiting is absent, rigidity is very high.

Acute Cholecystitis

There may or may not be jaundice. Ask the patient to show you where she gets the pain. She will point to the right hypochondrium. Now ask where the pain goes to and she will run her finger round the right side, saying that it passes to the back or between the shoulders.

Three signs of importance in examination of a gall bladder case are:

1. Murphy's sign (Moynihan's method).
2. Tender rib cartilage.
3. Boa's sign.

Intestinal Obstruction

In intestinal obstruction examine the hernial sites first, inguinal femoral and umbilical before proceeding to other physical signs. Inspection, palpation and percussion may all be of value. Distension is early in obstruction of the large gut and late in the small gut. Ladder patterns are characteristic of small bowel obstruction but indicate late diagnosis. Visible peristalsis requires patient watching. Gently flipping the abdominal wall or dropping of ether on the abdominal wall may initiate waves of peristalsis which may tell a story.

Auscultation should be carried out while watching and with practice becomes important. There are many sounds to be interpreted between the borborygmi of acute mechanical obstruction and the death-like silence of paralytic ileus.

Rectal exmination may reveal a carcinomatous stricture or a distended loop of small intestine. At least, if the rectum is completely empty it is suggestive of obstruction.

Other methods of examination should be taken advantage of. In doubtful cases an enema should be given, but the second enema is more important because by absolute constipation is meant that after the second enema no feces and, above all, no flatus is passed. A tape measure may be used from hour to hour to note the distension but as a rule, in doubtful cases, laparotomy should be performed.

Uremia may be confounded with obstruction and it should be remembered that the urine is scanty in both conditions.

Internal Hemorrhage

The classical signs of internal hemorrhage are:

1. Increasing palor.
2. Increasing pulse rate.
3. Restlessness.
4. Air hunger.

All of these signs are unreliable and should be checked at half hour intervals to determine change. The peritoneum does not tolerate blood well so pain and distension should be a part of the picture. Left shoulder pain is experienced with massive hemorrhage that irritates the under surface of the diaphram.

There are five principles of diagnosis in acute abdominal disease.

1. The first principle is that of the necessity of making a serious and thorough attempt to diagnosis. Spot diagnosis is impressive but unsafe. The very terms "acute abdomen" and "abdominal emergency" which are constantly applied to such cases, signify the urgent need for prompt diagnosis and active treatment.

2. The second principle is the importance to diagnose early. There is a strong temptation to temporize and "see how things are in the morning." The general rule can be laid down that the majority of severe abdominal pains which ensue in patients who have previously been fairly well, and which last as long as six hours, are caused by conditions of surgical import. There are exceptions, but the generalization is useful if it serves to call attention to the need for early diagnosis.

3. The third principle is that of making a thorough routine examination of every acute abdominal case. The order or method of examination is a matter of individual choice, but everything should be covered.

4. The fourth principle is to apply your knowledge of anatomy in physical examination. It is the rational approach.

5. The fifth principle is that of excluding medical diseases as many medical disease often cause doubt in abdominal diagnosis.

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Rovsing's Sign—Even pressure is exerted over the descending colon. This forces gas into the cecum. If, when pressing the left iliac fossa, pain is appreciated in the right iliac fossa the case is probably one of acute appendicitis.

Rectal Examination—Take particular care to introduce the finger slowly with a rotary movement. If the finger can be placed within the rectum without causing pain, not only can a much more thorough examination be made, but the discovery of a tender area becomes a real diagnostic significance. The best method of procedure is to first palpate the left side of the recto-vesical pouch; then palpate the right

side. If there is any doubt as to the relative tenderness, repeat the process, at the same time asking the patient if there is any difference in the two sides. In early cases of pelvic appendicitis, tenderness on the right is often the crucial point in an all-important diagnosis. In later cases the finding of a tender lump, or cystic swelling (pelvic abscess) when perhaps there are few if any signs on abdominal examination, brings home the cardinal importance of rectal examination in suspected pelvic appendicitis.

Testicular Retracting Test—In cases of gangrenous appendicitis, if even pressure is exerted over McBurney's point the right testis is drawn upwards. As long as the pressure is maintained the retraction commonly persists. When the pressure is released the testis drops back into its usual position.

A Confirmatory Test of Retrocecal Appendicitis—The finger locates the most tender spot in the flank. Pressing lightly, but just enough to produce a little pain, ask the patient to lift his right leg a few inches off the bed, keeping the knee stiff. If the patient promptly complains of an increase in pain, or drops the leg with a distinct outcry, the test is positive. (Baldwin).

The Obturator Test—Flex the right thigh, rotate the hip joint internally. This puts the Obturator Internus on the stretch. An inflamed appendix in contact with and adherent to this muscle will be irritated by this movement and pain will be experienced in the hypogastrium.

The Psoas Test—Place the patient on his left side. Fully extend the hip joint and abduct the thigh. If the psoas muscle is in a state of irritation from its proximity to an inflamed appendix, this maneuver will bring pain.

The Thoracic Compression Test—When it is difficult to decide whether a young child has acute appendicitis or basal lung envolvement, compression of the lower thorax from side to side elicits obvious distress when the lesion is above the diaphragm, whereas in appendicitis it has no effect.

Murphy's Sign (Monynihan's Method)—Place the left hand on the costal margin in such a manner that the thumb lies over the fundus of the gall bladder. The thumb exerts moderate pressure. Ask the patient to take a deep breath. The sign is positive if the patient "catches her breath" when the descending diaphragm causes the inflamed gall bladder to impinge against the pressure of the thumb.

Tender Rib Cartilage Sign—The sign is sought for with the hand flat upon the abdomen. Beginning on the left side, the pulp of the finger is brought into firm contact with the costal margin. Inch by inch the costal margin is examined in this way, saying nothing, but watching the patient's face. On the right, in cases of cholecystitis, a single tender spot, indicated by the patient's expression, is often found. Generally this is upon the 8th rib edge but is sometimes a little higher or lower.

Boas's Sign—In cholecystitis there may be an area of epicritic hyperesthesia posteriorly. The tenderness extends from about one inch lateral to the spines of the vertebrae to the posterior axillary line, and vertically from the level of the 11th dorsal to the 1st lumbar spine. Itching in this area is sometimes noted in recurrent cholecytitis with gall stones and it is not completely relieved by scratching.

FEDERAL SUBSIDY AND THE OSTEOPATHIC PROGRESS FUND

You've been reading in the newspapers that the Federal government is going to subsidize medical schools. Seven bills are pending before Congress for the purpose. Perhaps you think osteopathic schools are included in these bills. They are not. An eighth bill, that offers long-term loans does include osteopathic schools but this is not introduced by a member of either the Senate or House health committees.

Why shouldn't osteopathic schools be included? Senators will ask, why should they? Every dollar invested in medical schools would be for training physicians capable of unlimited practice in all the States. A physician, as popularly conceived, is one who can practice the healing art in all its branches. We would qualify under that definition in about half the States. In the other half we would not. Therefore, the Senators will reason that in subsidizing osteopathic schools the government would only be getting a full return on 50% of its money.

The only way we can overcome that handicap of diminishing returns on Federal investment is to demonstrate such a spirit of performance of self help as to command consideration under the adage that those that help themselves deserve help. That calls for an accelerated OPF.

There is another important consideration. In order to lay a basis for this legislation the medical schools asked the Federal Security Agency (Public Health Service) to survey their economic needs. So did the dental schools. If we were to have any chance at all, we would have to ask for a similar survey. So we did. The medical school survey has been extended over several months and is about completed. Then comes the dental survey. After that, if we have our way, comes the osteopathic survey.

AUXILIARY

Mrs. Roy Russell entertained the Auxiliary to the Tarrant County Association of Osteopathic Physicians and Surgeons with a luncheon at the Fort Worth Boar Club late in June. At this meeting officers for the ensuing year were installed in a program patterned after a radio quiz program.

The following officers were elected: Mrs. J. R. Thompson as president, Mrs. Hugh Ranelle as president-elect, Mrs. C. E. Everett as secretary, Mrs. George J. Luibel as treasurer, Mrs. J. O. Carr as corresponding secretary, and Mrs. R. B. Beyer as public relations chairman.

The retiring president, Mrs. Roy Fisher, was presented with a Past President's pin as a gift from the Auxiliary for her service during the past year.

STAFF MEETING

The regular clinical conference at the Gafney Hospital was held July 7, 1949 in the Hospital Staff room.

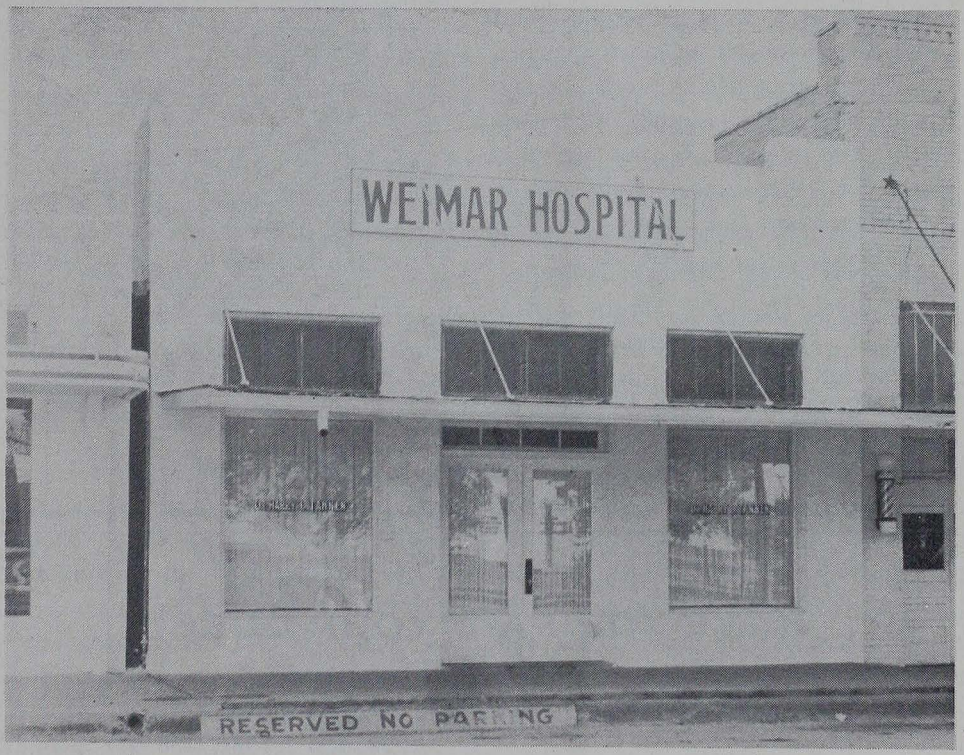
Diseases of the Gall Bladder was the subject for the days study and discussion.

Color motion pictures, "Newer Techniques of Bile Duct Surgery," were shown.

Guest speaker at the conference was Dr. Grover Stukey, Pathologist, from Kirksville, Missouri, chairman of the Department of Pathology of the Kirksville College of Osteopathy and Surgery. He spoke on the subject of "Tumors of the Liver and Gall Bladder."

Dr. Milton V. Gaffney gave a paper the subject of which was "Modern Thinking in Gall Bladder Surgery and Diseases of the Biliary System."

Texas Osteopathic Hospitals



WEIMAR HOSPITAL AND CLINIC

On June 25 when the Weimar Hospital opened its doors to the public with an open house, the townspeople were anxious and extremely pleased to be able to visit their city's first hospital.

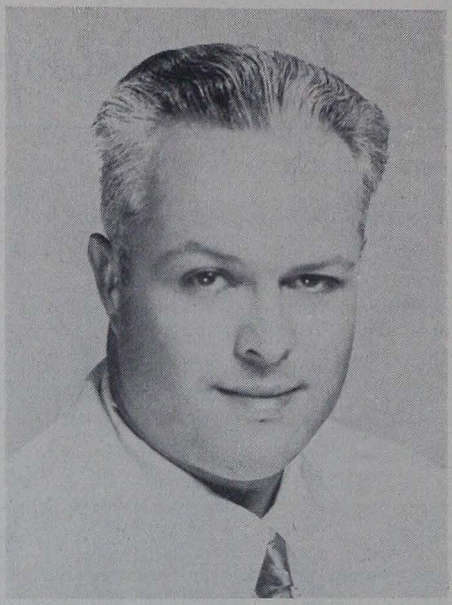
Dr. H. L. Tannen of Weimar and Dr. J. V. Money of Schulenburg will comprise the hospital's staff.

The hospital was built as an addition to the offices of Dr. Tannen and is centrally located in the business section of the city. It is an air-conditioned brick and tile fireproof building with wall coverings of a washable plastic material. There are six patient rooms and eleven beds. Each room has its individual decorative scheme devoid of the drabness and monotony of a constant witness. There are also thoroughly equipped laboratories, X-ray rooms, surgeries, delivery, nursery, drug and linen rooms as well as a modern kitchen.

TAVEL CLINIC - HOSPITAL

The Tavel Clinic and Hospital of Franklin which was built by Dr. Lester I. Tavel was ready for occupancy on June 30, 1949. It is a complete unit, fully equipped with fifteen hospital beds, six bassinetts, incubator, major operating room, delivery room, X-ray, laboratories and physiotherapy department. The hospital is designed primarily for the treatment of diseases of the anus, rectum and colon.

Members of the staff include Dr. Lester I. Tavel, Dr. J. U. Smith of Bremond, Dr. Myron C. Atkins of Jewett, Dr. John B. Riggs of Groesbeck, Dr. Nelson E. Dunn of Mart, Mrs. Aurelia Bristow, R. N., and Mrs. Lester I. Tavel.



LESTER I. TAVEL, D. O.

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TO THE PROFESSION

PHIL R. RUSSELL, D. O.
FORT WORTH, TEXAS

To Osteopathy and the Osteopathic Profession I owe everything that I possess. I have progressed from a poor barefoot boy to a man who possesses some of what the above average American citizen does in worldly possessions, professional standing, and the confidence of his community. All this and more I owe directly to the benefits secured from Osteopathy and to the leaders of former years in the profession, who made it possible for me to reach my present position. The debt that I owe to Osteopathy and to the leaders of the profession in years gone by, I feel is one that I can never repay.

For thirty-two years I have given of my time and money to the fullest extent of my ability that those who follow in the profession may have better advantages than I enjoyed. Yet no one knows better than I that what I have done is not sufficient.

Now the officers of the Texas Association of Osteopathic Physicians and Surgeons have appointed me as Executive Secretary of the Association. I am appealing to each individual member of the profession for help — the help that is essental if I am to be Executive Secretary. But far more important than my success as Executive Secretary is the success of your organization. This organization will fold up along with your schools and your practice rights unless there is a complete cooperation between individual members of the Association and the members of the Association with the Executive Secretary. This is the help that I appeal for.

The Executive Secretary position is one of administraton. He is the hired man of the organization. Since he should not be and is not a policy maker, it is up to the officers and the membership to set the policies of the organization and to point out the jobs that are to be done. When these directions are given, I assure you that every hour in every day will be utilized by me until the assignment is completed.

There will be many requests from me, as Executive Secretary, for help in setting up local contacts in each district, city, and community in this state. The success of these objectives will depend upon the individual member called upon. There is a big job to be done. I am ready and willing to do the leg work. Let us get started with this new set-up with a big bang. Make Texas the outstanding osteopathic state. Let the people of this state know that in the healing arts the Osteopathic profession is second to none — not as good as — but better than.

President-Elect George J. Luibel and Mrs. Luibel of Fort Worth, Texas. Mrs. Luibel is active with the Auxiliary work in the state.

LOOK FOR BIG THINGS FROM THE LUIBEL FAMILY IN 1950-51

DR. THOMAS L. RAY

President of the Texas Osteopath Association 1901-1902

Classified Ads

FOR SALE: Thirty-five year established practice in Texas town of 12,000 population. Only Osteopath in town. Practice and equipment for less than cost of equipment. Am retiring. Write, care of Journal.

WANTED: Young D.O. intrested in general practice in new hospital. Opportunity unlimited. Contact Dr. Lester I. Tavel in Franklin, Texas.

Two excellent locations open in Smith County, Texas, one in city and one in small town unopposed. Will stand closest scrutiny. Nothing for sale. Each will require that you have your own equipment. Come look 'em over. Write Dr. H. R. Coats, Coats-Brown Clinic and Hospital, Tyler, Texas.

Active practice and office available to enterprising D.O. in Corpus Christi. Local D.O. leaving for health reasons. Equipment optional. Write or call immediately Dr. Joseph Schultz, president of local society, 1007 Santa Fe, Corpus Christi, Texas.

Ready for immediate occupancy. Take over lease and furnishings. Completely equipped doctor's office. Write or call Mrs. F. W. Hall, 219 Royality Building, Ponca City, Oklahoma.

GOODBYE

As this Journal goes to press I will turn a page in my life — one where there will be no turning back — one where there will be no rereading. However, as I look back now and read that page I can say maybe there were others who could have done a better job, but there was no one who would take it. There was no one who wanted to be successful any more than I. I went into this job ignorant but willing to learn. Well, I learned — the hard way through trial and error.

I want to say that I have thoroughly enjoyed working with you and for you. I have made a lot of friends — friends that I shall remember and cherish through the years — friends that I would not have made had it not been for this job. These friends have made a hard job a pleasant one. They have been the ones that have given encouragement — the same kind of encouragement that a football team gets when the going gets tough and they hear the familiar yell — a yell that tells them to keep on trying. I have had no yells but have had a good many pats on the back and hand clasps with words saying "Buck up. You are doing all right."

I have tried to make this Journal the best in Osteopathic publications and have had a certain measure of success. It was classed as one of the best at the A. O. A. convention. A lot of the credit goes to Dr. C. R. Nelson who got the Journal underway — a lot goes to the editorial staff composed of Dr. George Grainger, Dr. J. W. McPherson and Dr. Kenneth Ross — also to my office staff Lady Jack Yett and Raymond Walther — and last, but by no means least, the girl that sat up many a night to help me proof read copy — my wife — Clara Nell. I want to take this opportunity to thank each and everyone of you for the cooperation you gave me.

Now I must turn the page and let someone else take it from here.

H. V. W. BROADBENT, D. O.
Editor

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