Texas
OSTEOPATHIC PHYSICIANS Journal

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EDITORIAL PAGE

As a physician and citizen of the United States, a democracy and a free country, you have an obligation that should not be shirked. You enjoy the opportunities and advancements offered by our government, namely: To maintain and protect the constitution of this government and the rights of citizens to live in a healthy, prosperous and free land.

Physicians who are charged with the duty of maintaining good health, which is paramount to prosperity, happiness and freedom, are known to be derelict in their participation in the vital machinery of a democratic government; the politics, in the end, is what protects or destroys the constitution and our American way of life.

Health of the people is dependent upon good medical care as rendered by the physician. The physician should realize that his failure to participate in the politics of his government may lead to the destruction of the principles for which he stands.

Doctor, come down from your smug feeling of safety. Participate in the machinery of your party that sets the policies which in the end will maintain or destroy the constitution and the laws of this country. It is important that you attend or participate in your precinct and party conventions, be they Democrat or Republican. Give them the benefit of your advice and counsel. There is no one better qualified to give advice and help than the physician, who by his training and education, is better able to understand the mind and body of his fellow citizen.

You, as a physician, should interview each and every candidate for political office. Know his objectives and his principles. Be sure they are such that will maintain the constitution and laws of our country and will protect the greatest majority of the people. Ask no special favors. Keep in mind at all times that the government is run for the people and not for special interests. LASTLY, DO NOT FAIL TO EXERCISE YOUR RIGHT TO VOTE.

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
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VOL. XIII FORT WORTH, TEXAS, JULY, 1956 NUMBER 3

A Review and Correlation of the Literature on Carcinoma of the Colon and Anorectum

ROBERT H. NOBLES, D. O.

Cancer of the colon and anorectum accounts for[1] 16 per cent of the cancer deaths each year, and ranks[2] second only to cancer of the stomach in the incidence of gastrointestinal malignancy. Eighty per cent[3] of the malignancies of the colon involve the left half, and seventy-five per cent[4] of these are within reach of the index finger. Ninety-five per cent[5] of the carcinomas of the colon are adenocarcinoma in type, and are classified as: (a) medullary, (b) scirrhous, (c) colloid and (d) papillary. The remainder are usually squamous cell type. The most common type growth exhibited by an adenocarcinoma of the colon is the lesion which either projects into, or completely encircles the lumen of the bowel. Carcinoma of the right colon is usually manifested as a large, bulky, ulcerating, fungating lesion which projects from one wall of the colon into its lumen, while carcinomas of the left colon characteristically manifest themselves as fibrotic scirrhous or papillary lesions which completely encircle the lumen of the bowel. The most common precursor to carcinoma of the anorectum and colon is the polyp.

Before discussing the pathological physiology of carcinoma of the bowel, it is necessary to review briefly the anatomy, physiology, and the symptoms of large bowel malignancy. The large intestine embryologically originates from the mid and hindgut, and is divided into the appendix, cecum, ascending, transverse, descending, iliac and sigmoid colons, the anus and rectum. The large intestine is unique in that it is thought of anatomically as one organ but physiologically it behaves as two separate physiological units. Actually, the colon can be divided both anatomically and physiologically into the right and left colon; the transverse colon being divided so that its proximal half is considered as part of the right colon, and its distal half as part of the left colon. The right colon then will be composed of the appendix, cecum, ascending colon, and the proximal half of the transverse colon. The left colon will be considered to be composed of the distal half of the transverse, the decending, iliac and sigmoid colons. The right half of the colon is derived from the midgut embryologically and has the same nerve and blood supply as the jejunal and ileal segments of the small intestine. The blood supply to the right colon is furnished by the superior mesenteric vessels through the intestinal, ileocolic, right colic and middle colic branches. The left colon receives its blood supply from the inferior mesenteric vessels. The branches of the inferior mesenteric vessels which supply the left colon are: the left colic, sigmoid, and superior hemorrhoidal vessels. The innervation

of the colon follows the same anatomical pattern. The sympathetic nerve supply to the right colon is derived from the superior mesenteric plexus, which is a continuation of the lower divisions of the celiac plexus. The fibers from the superior mesentric plexus surround the superior mesenteric artery, accompany it into the mesentery and divide into numerous secondary plexuses which are distributed to all parts which are supplied by the superior mesenteric artery, namely, the right colon. The sympathetic nerve supply to the left colon is furnished through the inferior mesenteric plexus, which is derived chiefly from the aortic plexus. These fibers follow the course of the inferior mesenteric artery and divide to innervate the same structures which are supplied by the inferior mesenteric artery, namely, the left colon. The parasympathetic or motor nerve supply to the right colon is furnished by fibers of the vagus nerve, while that of the left colon is supplied by fibers from the pelvic plexus. Other anatomical differences between the right and left colon are the size of their lumens and the degree of the development of their masculature. The lumen of the right colon is 2½ to 3 times greater in diameter than that of the left colon, and the musculature of the right colon is poorly developed in comparison to that of the left colon. These anatomical differences will be better understood as we review the physiology of the colon.

As stated earlier, the colon behaves physiologically as two organs. The principal function of the right colon is that of absorption, or a continuation of the work which is initiated by the upper gastrointestinal tract. Thus we are able to understand the close anatomical relationship of the terminal small bowel and the proximal large bowel. They have the same nerve and blood supply because their function is the same. The principal elements which are absorbed by the right half of the colon are[6] water and inorganic salts. The contents of the ileum and the right half of the colon are fluid in nature.[7] The amount of fluid which passes through the ileocecal valve in 24 hours averages 400 grams. The amount of feces evacuated in the same period of time averages 150 grams, leaving 250 grams of water and inorganic salts to be absorbed by the colon every 24 hours. Most of this material is absorbed by the cecum and ascending colon, with a small amount being absorbed by the transverse colon and a negligible amount being absorbed by the left half of the colon. The functions of the right colon are those of storage, and as stated before, a negligible amount of absorption. By studying the physiological behavior of the two halves of the colon we are able to understand their anatomical differences. The main function of the right colon is that of absorption, thus explains its larger lumen which allows more surface area for absorptive purposes. The contents

of the right colon are fluid in nature, and they are propelled slowly in order to allow more time for absorption. Thus explains the poorly developed musculature of the right colon. In contrast, the main function of the left half of the colon is that of storage of material to be eliminated. It must handle 250 grams less material daily than the right colon so its caliber is less. It must propel solid to semisolid material for elimination, thus its well developed musculature is needed. The force of gravity also exerts its influence upon the physiology of the colon. The right colon is anatomically so arranged that it must propel its fluid content against the force of gravity, thereby allowing more time for the absorption of those elements necessary for the body's economy. The left colon is aided by the force of gravity in the elimination of the body's waste. These are well planned conveniences.

Keeping in mind these anatomical and physiological differences between the right and left colons, and the types of lesions of the colon with reference to their locations and method of growth, let us review the symptoms produced by carcinomas of the colon and anorectum. According to Bacon,[8] the first symptoms noted by the patient in a series of 1995 patients with carcinoma of the colon and anorectum are as follows: 1819 patients of the series reporting;

Bleeding	574
Change in Bowel Habit	
Constipation	289
Diarrhea	269
Frequent or urgent desire for stool	195
	753
Pain	
Discomfort	101
Pain or tenesmus	391
	492
Total	1,819

The signs and symptoms which must arouse the physician's suspicion for carcinoma of the colon and anorectum are as follows:

(1) *A change in bowel habits*— any change in the bowel habits from those to which the patient in accustomed is a warning sign to the physician for the possibility of gastrointestinal malignancy. The change may be toward constipation or diarrhea. Constipation is a frequent complaint of patients and must be considered serious until proved otherwise, particularly if it grows progressively more severe. Diarrhea is many times cancerous in origin. In tumors of the right colon,[9] the change in bowel habit is toward a loose stool, while in tumors of the left half of the colon, the change is toward constipation. This is explained by the structure and contents of the two halves of the colon and the types of growth exhibited by lesions invading the right and left colon. When a patient complains of a change in his bowel habits the physician must be on the alert for carcinoma of the bowel.

(2 *The passage of blood from the anus,* bright or dark red, intermingled with, or apart from the stool, is a frequent finding in carcinoma of the colon and anorectum.[10] The most common cause of anorectal bleeding is hemorrhoids, the most important cause is carcinoma of the gastrointestinal tract. Bleeding from the anorectum must be considered to be carcinomatous in origin until proved otherwise.

(3) *A change in the caliber of the stool* is commonly caused by tightness of the anal sphincters but it is also produced by cancer of the rectum encroaching upon the lumen of the ampulla thereby producing a stool which is smaller in size than that which is normal for the patient.

(4) *Vague dyspeptic complaints* are usually reflex in nature but they may be caused by carcinoma of the bowel. Dyspesia, associated with abdominal fullness, and the need to increase catharsis, is one of the early symptom com-

plexes of carcinoma of the colon and anorectum.

(5) *Unexplained weight loss* is a latent finding of cancer of the colon and anorectum. The weight loss is usually more severe and occurs more frequently in cancer of the upper gastrointestinal tract but occurs late in cancer of the colon and anorectum.

(6) *An intestinal obstruction,* or a mass discovered by the patient or physician on abdominal or rectal palpation should be considered to be cancer until proved otherwise.

(7) *Unexplained severe anemia* is a frequent finding of carcinoma of the stomach and right colon. 25-50 per cent[11] of the cancers involving the right colon produce a profound secondary anemia. The cause of the anemia is not known.

(8) *Pain* is a latent finding in carcinoma of the anorectum and colon, and is produced by direct extension of the lesion or by partial bowel obstruction.

(9) *Tenesmus* and the desire for frequent evacuation of the rectum are frequently associated with cancers of the rectal ampulla.

We have reviewed the signs and symptoms which are produced by carcinoma of the colon and anorectum in general, now let us discuss the signs and symptoms which are produced by carcinomas of the right and left colons specifically. By far the most common cancers of the left colon are the papillary and scirrhous[12] adenocarcinomas, These scirrhous lesions characteristically encircle the lumen of the bowel. They are small in size, as compared with tumors of the right colon, and are hard, fibrotic, and contain a small ulcerative surface. The earliest symptom produced by carcinoma of the left colon is a change in the patient's bowel habit, which is produced by the encroachment of the tumor mass upon the lumen of the bowel. The left colon is smaller in diameter than the right. The walls are thicker and the contents are more solid than those of the right colon. These anatomical factors render the left colon the most likely area for the development of an obstruction of the large bowel. To add insult to injury, the most common type of growth exhibited by carcinomas of the left colon is the lesion which encircles the lumen of the bowel, thereby narrowing its lumen further. As one would expect from these considerations, the first symptoms to be produced by cancer of the left colon are obstructive in nature. The patient's first complaint is usually that he has had a change in his bowel habit. He complains that he is experiencing increasing difficulty in obtaining an elimination of his bowels, and that he is having to take cathartics in order to move his bowels. The cathartics pro-

duce enough hyperperistalsis to force the stool by the constricted area of the bowel, and the patient is relieved for a few hours. The patient further finds that he must progressively increase the amount of cathartics from day to day, until finally he is taking so much that each elimination of the bowel is followed by diarrhea for a few hours. Thus is produced the so-called alternating constipation and diarrhea, the constipation being produced by the constricting tumor of the bowel and the diarrhea by catharsis. As the tumor continues to grow and encroach more upon the lumen of the bowel, the constipation grows progressively worse and the signs and symptoms of a partial bowel obstruction ensue. These are: fullness of the abdomen, abdominal cramps, and gastrointestinal upset. The symptoms are produced for the most part by the hyperperistaltic waves trying to force the stool past the constricted area of the bowel. Weight loss becomes a prominent sign late in carcinoma of the left colon and is produced by the prolonged insult to the gastrointestinal system.

Carcinomas of the anorectum produce other symptom complexes. As we progress distally in the left colon to the rectal ampulla, inferior to the rectosigmoid junction, the lumen of the bowel abruptly increases in size to about ¾ times the diameter of the sigmoid colon. The same type carcinomas are found in the rectum as occur in the right colon. The type growth exhibited by lesions of the rectum differs greatly from that of the sigmoid colon. Instead of the scirrhous lesion as is found in the sigmoid, the large, bulky, ulcerating, fungating lesion is found invading the rectal ampulla, growing from one wall and projecting into the lumen of the ampulla. The large ulcerative surface of these cancers is constantly exposed to the hard stool of the rectum, and thus is produced anorectal bleeding, which varies from frank hemorrhage to blood intermingled with, or around the stool. Another symptom complex that is produced by carcinomas of the rectum is the so-called "bloody diarrhea". This symptom complex is actually the frequent elimination of bloody mucous, and it is not unlike the bloody diarrhea of ulcerative colitis or dysentery.[13] A careful history and sigmoidoscopic examination will enable the physician to make an accurate diagnosis in approximately 90 per cent of the cases. In any patient who complains of frequent elimination of bloody mucous, whose rectal mucosa appears to be normal thru sigmoidoscopy, carcinoma of the anorectum must be considered to be the etiological agent until proved otherwise. Carcinomas of the rectum very frequently produce tenesmus. The patient complains of a constant urge to defecate. Defecation is a reflex act,[14] which is normally initiated by the presence of feces in the rectum. The distention of the rectum as it becomes filled with

feces acts as a stimulus to the afferent nerve endings in the rectal wall. The impulses set up are conveyed to a center in the sacral portion of the spinal cord and act of defecation is initiated. In carcinoma of the rectum, the presence of the large tumor mass in the rectal ampulla acts as a constant stimulant to the afferent nerve endings in the rectal wall, and the patient is bothered with a constant urge to evacuate his rectum although there may be no stool at all in the rectum to be eliminated. As the lesion in the rectum continues to grow in size and encroach more upon the ampulla of the rectum, the stool becomes smaller in caliber and the signs of partial bowel obstruction again become prevalent. Signs and symptoms which arouse the physician's suspicion for malignancy of the left colon and rectum as discussed are: (1) the feeling of incomplete evacuation after bowel movements (2) increasing constipation with an increasing need for catharsis (3) frequent elimination of bloody mucous (4) abdominal or rectal pain (5) anorectal bleeding (6) a decrease in the caliber of the stool.

The most common early symptom of cancer of the anus is itching.[15] Other symptoms are: a slight discharge, pain on defecation, and anal bleeding. A biopsy speciman should be taken and sectioned from every ulcerative lesion of the anus. Remember 75 per cent of all carcinomas of the anorectum and colon are within reach of the index finger.

As stated earlier, carcinomas which invade the right colon are characteristically the large, bulky, ulcerating, fungating lesions which invade one wall of the bowel and project into its lumen. The types of adenocarcinoma which invade the right colon are the colloid and medullary types.[16] Carcinoma of the right colon rarely produces a partial bowel obstruction since tumors in this area do not encircle the lumen of the bowel, and since the contents of the right colon are fluid in nature. Thus the symptoms of partial bowel obstruction are not usually produced by carcinomatous lesions of the right colon. Patients with carcinoma of the right colon characteristically do not experience anorectal bleeding. Although the lesions are the large ulcerative type, the liquid content of the right colon causes no mechanical irritation, thus no bleeding. Melena is a rare finding in cancer of the right colon, as in a positive occult blood examination of the stool. Although anorectal bleeding and melena are charactistically absent in cancer of the right colon, the most common finding in carcinomas of the right colon is a profound secondary anemia, which occurs in 25-50 per cent of the patients.

The cause of the anemia is unknown. It is possible that the anemia is due to an interference with the intrensic factor and its utilization, but a deficiency of this factor should give rise to a pernic-

ious type anemia, rather than a secondary anemia. Carcinoma of the right colon ranks second to carcinoma of the stomach as the cause of unexplained secondary anemias.[17] In any patient with an unexplained secondary anemia carcinoma of the right colon and stomach must be considered and ruled out. In subjecting these patients to a GI series and barium enema, it is wise to perform the barium enema first, and if it is negative, subject the patient to the upper GI series. If a tumor is located in the large intestine, and is producing a partial bowel obstruction, an upper GI series will convert the obstruction into a complete one, and the barium will be trapped proximally to the lesion, increasing the surgical risk of the patient considerably. Occasionally it is the patient who becomes worried about the possibility that he might have cancer. He may have noted an abdominal mass or may state that he has become aware of the right side of his abdomen "feel ing unusual". He may present vague gastrointestinal complaints or the irritable bowel syndrome. There are two exceptions to the general rule of the symptoms produced in carcinomas of the right colon and these involve lesions which invade the hepatic flexure and medial wall of the cecum. Carcinomas which involve the right colon at these two areas may give rise to obstructive symptoms since the lumen of the right colon is narrowed considerably by the angulation of the bowel at the hepatic flexure, and tumors of the medial wall of the cecum grow to invade the ileocolic valve thereby producing obstructive symptoms. In addition, carcinomas of the right colon have been known to be so massive as to completely occlude the lumen of the bowel, and of course obstructive symptoms are produced in these incidences. A profound secondary anemia is the most constant finding associated with carcinomas of the right colon. Vague non-specific gastrointestinal complaints are the earliest symptoms to be produced in carcinoma of the right colon.

The only hope for the patient with a carcinoma of the colon or anorectum is that of an early diagnosis and prompt surgical intervention by his physician. In the diagnosis of carcinoma of the colon and anorectum, the physician's most valuable aide is a high index of suspicion for the presence of carcinoma. With a high index of suspicion, supplemented with the index finger, anoscope, proctoscope, sigmoidoscope, and the use of barium enemas and air contrast studies of the colon, the diagnosis of carcinoma of the colon and anorectum is easily ascertained in most cases. Remember, 75 percent of the carcinomas of the colon and anorectum are within reach of the index finger, and this is one instrument which is in constant attendance to the physician.

SUMMARY AND CONCLUSIONS

1. Carcinoma of the anorectum and colon accounts for 16 per cent of the cancer deaths each year, and rates second only to carcinoma of the stomach

(Continued on Page 16)

The next meeting of the Texas State Board of Medical Examiners will be December 6, 7, 8, 1956 in the Hilton Hotel, Fort Worth, Texas for the purpose of giving examinations and considering applications for licenses by reciprocity.

Applications for reciprocity to be considered at the December, 1956 meeting must be complete and on file at least 30 days prior to the December meeting date.

Applications for examinations for the December meeting, must be complete and on file at least ten days prior to the meeting date.

Stevens Park Holds Interns' Graduation

Dr. Harold I. Magoun receives presentation from Dr. J. Natcher Stewart, as Mrs. Magoun watches from the left.

The Stevens Park Osteopathic Hospital of Dallas, Texas, held its Fifth Annual Interns' Graduation on the terrace of the Baker Hotel on Tuesday, June 21. Over 200 physicians and their guests attended the banquet and graduation ceremony. The interns honored were: Dr. S. Stevon Kebabjian, Dr. Joel M. Messina, Dr. David H. Hale, and Dr. George B. Powell.

The Speaker of the evening was Dr. Harold I. Magoun of Denver, Colorado. The topic of Dr. Magoun's address was "The Responsibility of the Physician to His Community." Dr. Magoun was introduced by Dr. Robert McCullough of Tulsa, Oklahoma, president-elect of the American Osteopathic Association. A congratulatory message was delivered to the graduates by Dr. John L. Witt, President of the Texas Association of Osteopathic Physicians and Surgeons, after the certificates were presented by Dr. Ross M. Carmichael, Chairman of the Interns Committee. Dr. John W. Drew served as toastmaster of the evening and the Reverend Frank E. Jarrett of St. George's Episcopal Church gave the Invocation and Benediction.

Highlight of the evening was a presentation of an engraved desk set to Dr.

Magoun in recognition of his many years of service to the osteopathic profession. The presentation was made by Dr. J. Natcher Stewart, Chairman of the Department of Surgery.

Following the ceremony, a graduation ball was held. The music was furnished by Dick Webster and his orchestra.

Good Locations

CORPUS CHRISTI, Nueces County Texas: Available a clinical building for several osteopathic physicians at Six-Points shopping center. An excel lent trade area and would be advantageous to any physician beginning practice. If interested, contact Merle Griffin, D.O., 1122 Third St., Corpus Christi, Texas.

SAN ANTONIO, Bexar County, Texas: A good general practitioner is urgently needed to take over the practice of Dr. I. T. Stowell who is taking a year's residency. A ready made practice for the right man, located in the clinic of Drs. Beckwith & Beckwith, 120 West Ashby Place, San Antonio. If interested, contact Gordon Beckwith, D.O., at that address.

DAWSON, Navarro County, Texas: Needs good general practitioner immediately. Population 1200, centered in a trade territory of 2500, and located on Texas Hwy. 31 between Corsicana and Waco. Only doctor there retiring because of ill health. Several good office locations available. If interested, contact Howard T. McClain, McClain Pharmacy, Dawson, Texas.

Two Important Staff Changes Made in Division of P&PW

Klobnak Named Ass't Director; Geannopulos to Head CCO PR

Two important staff changes have been made within the Division of Public and Professional Welfare, it was announced by D. David Darland, Director.

Robert A. Klobnak, AOA press representative the past three years, was named Assistant Director of P&PW, and Nicholas G. Geannopulos, special writer, will assume public relations activities at the Chicago College of Osteopathy.

Klobnak, who is well-known throughout the profession for his handling of state PR programs, will assume his new duties July 6th. He succeeds Richard Thorne, whose resignation is effective on that date.

Darland said that Klobnak will continue to handle the press, radio and TV relations of requesting societies, but in addition will assume many new responsibilities.

Geannopulos, who joined the Division last March, will take office as director of public relations at CCO August 15th. He was hired with the approval and recommendation of Darland.

The college took this action in order to strengthen its public relations activities to complement its overall developmental program.

A more comprehensive story on the two promotions will appear in the August *Forum*.

General Practitioners Clinical Conference

The Iowa Division of the American College of General Practitioners in Osteopathic Medicine and Surgery announces that the second annual Midwestern Clinical Conference for General Practitioners will be in Des Moines, Iowa, November 12, 13 and 14.

The conference is sponsored by the American College of General Practitioners and will be open to all Osteopathic physicians.

Watch for further news as to program and speakers.

Good Public Relations

FROM LONGVIEW, TEXAS, MORNING JOURNAL, JUNE 26, 1956

Young Dr. Fisher Dreams Of Hospital For Ore City

By STAFF WRITER

ORE CITY—Dr. Sue Fisher, like all young enthusiatic doctors, has a dream of the furture—a vision of a beautiful and efficient clinic first of all and later a hospital to accommodate the people of the fast growing Upshur county town of Ore City.

Her dreams and visions are not new ones for doctors. They are made of things which are part of a doctor's life and success. Dr. Sue, as she is affectionately known by the people of Ore City, has been practicing medicine in this town for a little more than two years. She has an office located on the main highway through the city, an office which is almost always crowded.

Dr. Sue is the only doctor in Ore City and her territory extends in all four directions. House calls are numerous and the nearest hospital is not always close enough.

By early 1957, Dr Sue hopes to be able to build a small clinic in Ore City that will serve as sort of an emergency hospital and later when the city has grown even more, she hopes to see the erection of a hospital in the town whether or not it is hers.

Ore City, with a current population exceeding 1,000, has been constantly growing and its strategic location to the 30-mile-long Ferrell's Bridge and Reservoir gives the people of this locale hope that Ore City will continue to grow by leaps and bounds. It is the closest incorporated city to the reservoir.

This is another of the reasons why Dr. Sue visions the great need of a clinic and hospital in the city. She, too, looks forward to the day when the population of the city will draw more physicians and medical people to the city.

"Sometimes the need is too great for me to handle and we all realize that the day is soon approaching when our little town will be a big one and we will

be in serious need of more people in the medical profession," Dr Sue said.

Dr Sue's husband, Dr. Allen, practices in the town of Lone Star. Both use a small clinic in this city for minor surgery and take most of their hospital patients to Mount Pleasant.

Ore City's 28-year-old woman doctor was born in Abilene and moved to Amarillo in 1948 where she graduated from high school. In 1948, she was graduated from Hardin-Simmons in Abilene. She took her professional training in Des Moines, Iowa, at the Des Moines College of Osteopathy. She received her diploma from this college in 1952.

Dr. Sue served her internship in Amarillo at that city's Osteopathic hospital.

She was married to Dr. Allen in 1949 and they have one son, Scott Allen who is three years old.

Early in her lifetime, even before she finished high school, Dr. Sue had made up her mind to become a doctor. She started to work toward this goal before she got out of high school. Today, she enjoys general practice and says that she has no desire to be a specialist.

Dr. Sue's receptionist and assistant is Mrs. Lee Kennon.

EDITORS' NOTE: This article carried a picture of Dr. Sue Fisher.

Physicians' Desk Reference Available to DOs in 1956

CHICAGO (AOA)--PHYSICIANS' DESK REFERENCE will be sent to all recognized osteopathic physicians this year, according to Mr. J. P. Folsom, Oradell, N. J., PDR general manager.

In a letter to Mr. David Darland, Director of the Division of Public and Professional Welfare, he states that copies will be forwarded to all DOs along with a return request card.

If a doctor does not return the request card for next year's edition, his name automatically will be taken off the list to receive PDR.

Folsom further explained that these requests will be handled exactly the same as members of the medical profession.

(We strongly urge all DOs to take advantage of this opportunity.) Eds.

Plea Made to Rehabilitate Asian, African Handicapped

CHICAGO (AOA)—A plea for a program to rehabilitate the physically handicapped in the newly free countries of Africa and Asia was sounded last month by The World Confederation for Physical Therapy.

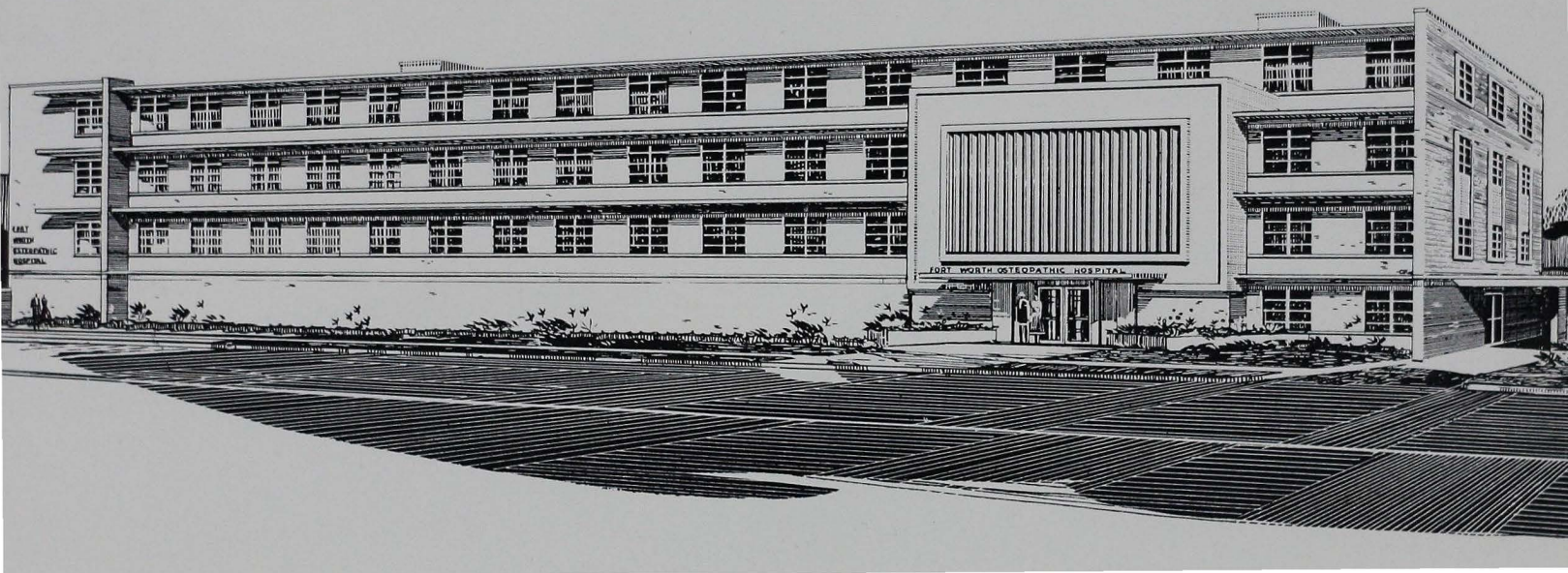
In line with the type of program that the Russians are currently engaged, a comparable activity by the U. S. was envisaged as including four equipped mobile shops for artificial limbs, each with a qualified American technician and physical therapist.

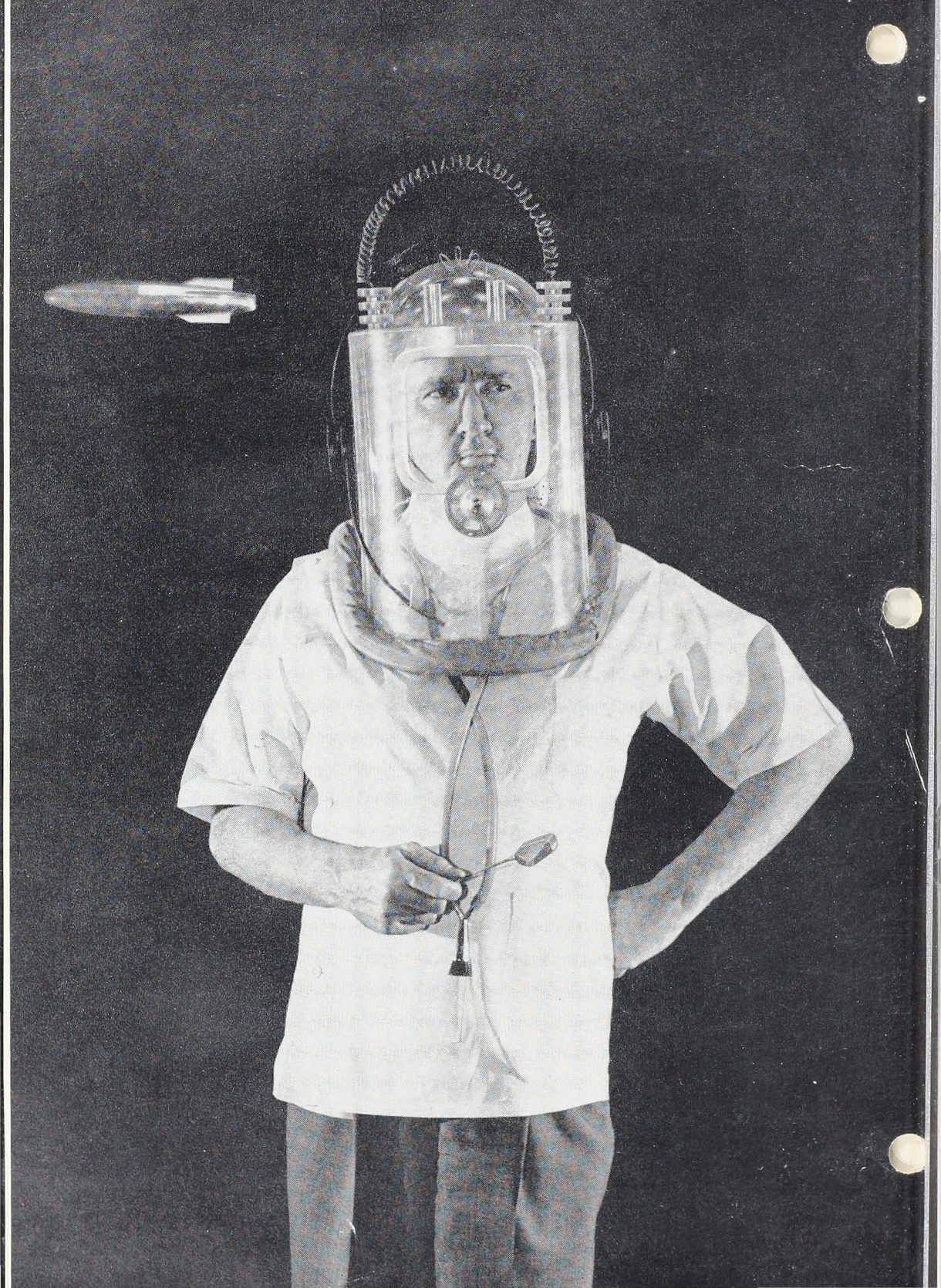
New Fort Worth Osteopathic Hospital to Hold Open House July 29, 1956

This new Fort Worth Osteopathic Hospital is the most ambitious project to date, and is the culmination of years of planning and dreams. It is located at 1000 Montgomery Street, and commands a majestic view of downtown Fort Worth. Here in a modern four story cream brick building, every attempt is being made to provide adequate hospitalization for the sick. This new hospital has been made possible by the generosity of the Greater Fort Worth Hospital Fund, Inc., Texas State Department of Health, Amon G. Carter Foundation, Mrs. Zetta Carter, Amon G. Carter, Sid W. Richardson and additional contributions from Osteopathic physicians and their friends. The completed plant represents an investment of $1,250,000.00 and will total 78 adult beds and 15 bassinets to th health facilities of Fort Worth. The fourth floor of the hospita building remains unfinished at this time, and provisions have bee made to expand bed facilities without enlarging the structure itsel

The Board of Trustees and the Staff of the Fort Worth Osteo pathic Hospital are proud to present this new health facility to th people of Fort Worth and Tarrant County.

A preview for the Tarrant County Medical Society and personne of all Fort Worth hospitals will be held July 28, 1956 at 4:00 t 8:00 p.m. Open House for the general public will be July 29, 195 at 10:00 a.m. to 10:00 p.m.





MODERN MEN OF MEDICINE PREFER TRĪVA...

he MODERN 12-day treatment for all 3 types of vaginitis

TRIVA effectively annihilates vaginal microorganisms, restores mucosal integrity and accelerates healing for rapid recovery.

Non-irritant, non-toxic, non-staining, TRIVA is a safe vaginal douche . . . even during pregnancy. Effective in any pH medium. Most cases of trichomonal, monilial and non-specific vaginitis become asymptomatic and organism free in 6 to 12 days. For complete data see Physicians' Desk Reference, 1956, page 427.

AVAILABLE AT ALL PHARMACIES, *in convenient packages of 24 individual 3 Gm. packages, each containing 35% Alkyl Aryl sulfonate, (surface-active, germicidal and detergent), 0.33% Disodium ethylene bis-iminodiacetate (chelating agent), 53% Sodium sulfate, 2% Oxyquinoline sulfate (bactericide, protozoacide) and 9.67% dispersant.*

Full treatment package and literature on request.

BOYLE **BOYLE & COMPANY** · Bell Gardens, California

Missouri Auxiliary Promotes Health in Conclusive Way

CHICAGO (AOA)—High schools, colleges, and libraries in Missouri will soon be receiving complimentary subscriptions to *Health:* AN OSTEOPATHIC PUBLICATION, Mr. Paul Adams, executive secretary-treasurer of the state association, announced recently.

The September issue, stressing the back-to-school program, will inititate a concerted effort by the Auxiliary to promote *Health* throughout the country's schools and libraries.

Carcinoma of the Colon And Anorectum

(Continued from Page 8)

in the incidence of gastrointestinal malignancy.

2. 80 per cent of the malignancies of the colon involve the left half and 75 per cent of these are within reach of the index finger.

3. 95 per cent of the carcinomas of the anorectum and colon are adenocarcinoma in type.

4. The colon is anatomically and physiologically two separate organs.

5. The following signs and symptoms should alert the physician for the presence of carcinoma of the colon and anorectum:

a. A change in bowel habits.

b. The passage of blood in any form from the anorectum.

c. A reduction in the caliber of the stool.

d. Vague dyspeptic complaints associated with a feeling of abdominal fullness.

e. Unexplained weight loss.

f. Abdominal or rectal mass.

g. Intestinal obstruction.

h. Unexplained profound secondary anemia.

i. Abdominal or rectal pain of unknown origin.

j. Tenesmus or the desire for frequent elimination.

6. The cause of the profound secondary anemia in carcinoma of the right colon is not known.

7. The diarrhea usually complained of by patients with carcinoma of the anorectum or lower segment of the left colon, is not a true diarrhea but the frequent elimination of bloody mucous.

8. The only hope for the patient with cancer of the colon or anorectum lies in an early diagnosis with prompt surgical intervention by his physician.

9. The most valuable aide to the physician in the diagnosis of carcinoma of the colon and anorectum is a high index of suspicion for the presence of malignant growth.

10. With the benefit of a good history supplemented with the index finger, anoscope, proctoscope, sigmoldscope, and barium enema and air contrast studies of the large intestine, the diagnosis of carcinoma of the colon and anorectum is easily ascertained in most cases.

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Treatment of Snake Bite and Black Widow Bite

RICHARD M. MAYER, D. O.

The general practitioner occasionally comes in contact with a case of either snake bite or black widow spider bite. Other such venomous types are similar. Such reactions from the injected toxins cause varying reactions from light fainting to heavy reactions consisting of shock, abdominal pain and death.

Those of you who have witnessed such reactions will recall that most of the symptoms of the process are those of shock; i.e., fainting, weakness, pallor, sweating, elevated pulse, lowered blood pressure, and convulsions on occasion.

Most literature on the treatment of the condition leaves one much in doubt as the process of the reaction is not explained.

It is my opinion, having treated both conditions, that this shock syndrome is more than just shock alone but should be treated as an "ANAPHALACTOID SHOCK". Such snake bites, black widow or other venomous type of insects injecting their venom into the tissues creates swelling and blanching of the tissues. The venom is then picked up through transference through the tissues and then through the venous system and into the general circulatory system. Accordingly, to the individuals general make up, the reaction varies from mild to severe and accordingly to the amount of venom having been injected, absorbed and the concentration. This reaction is anaphalactic in character and this should be kept in mind while treating the condition.

The following is a suggested outline of treatment for an average male and variations should be made dependent upon the severity of the case and the sex and weight:

TREATMENT:

1. ADRENALIN 1:1000, ½ to 1 cc I.M. stat.
2. OXYGEN.
3. HYDROCORTISONE hemisuccinate sodium 50 to 100 mg. I.V. to sustain any adrenal insufficiency which will have a long lasting effect to prevent the shock and control the histimine like reaction.
4. TOURNIQUET application to the limb above the site of the bite and suction applied through longitudinal incisions over the bite into the suspected tissue where the venom would be deposited. Suction is to be applied with a tonsil suction tip, if possible, and later with a breast type pump. Usual tourniquet precautions should be watched.
5. CALCIUM gluconate I.V. 10 cc injected slowly will prevent the abdominal pain and therefore alleviate the use of narcotics, which are to be avoided. The calcium should be injected slowly to avoid heart block.
6. d-TUBOCURARINE CHLORIDE

20 to 60 units may be used either I.M. ar I.V. to eliminate abdominal pain, suppress anxiety or eliminate convulsions.

7. GLUCOSE, DEXTRAN, SALINE, PLASMA OR BLOOD is very useful to combat the usual shock.
8. ANTIHISTIMINICS i to ii cc I.M. are helpful to prevent the histimine like anaphalactoid reaction.
9. ANTIBIOTICS should be instituted to alleviate possible localized infection as necrotic sloughing is common around the location of the bite.
10. ANTIVENIN of either the Meartic Protalidae or Black widow as indicated may be used; however, caution should be used as such antivenins may also produce anaphalactoid reactions.
11. Other symptomatic therapy as indicated.

Hyper-Wordiness of AMA Code Slated for Surgical Trimming

CHICAGO (AOA)—The American Medical Association is considering slashing by almost 90 per cent its code of ethics, it was announced recently.

If finally adopted, it will make possible hanging the code on the physician's office wall and serve as a ready reference. The present code of 48 sections is bound in a booklet.

The revision will be up for adoption at the AMA's December meeting in Seattle.

"If the new principles are approved," said Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, "their brevity will make it possible to hang the code and the age-old oath of Hypocrates on the wall together."

The new code removes many of the encumberances on the old one but it retains ethical principles, Dr Camp said.

It has two sections, most of them one sentence long and none more than three.

Long on Words— Short on Secretaries

CHICAGO (AOA)—A new idea was currently given as to why there was such a rapid turnover among stenographers for doctors and hospitals.

It seems when the girls with the pencils and pads have to toss around words like hepatocholangiocystoduodenos they are likely to come down with all kinds of psychosomatic symptoms. And some get frustrated enough to quit their jobs.

The University of Oklahoma medical center in fact, is taking steps to remedy the situation by offering on-the-job classes in medical terminology to head off the rapid resignations.

The classes at Oklahoma are aimed at helping the secretary who takes dictation from a man who figures anybody should know how to spell cholecystoduodenostomy and otorhinolaryngology.

Weather and Stress Held No Link To Common Cold

CHICAGO (AOA)—Two researchers at Cornell University reported today that wet weather temperature changes or mental and physical stress did not seem to have much to do with catching a cold.

Dr. Ralph W. Alexander, physician, and Dr. John Summerskill, a psychologist, kept track of colds caught by one class of students during their four years in college.

The patterns were nearly the same every year, they said. Peaks were reached after vacation periods, with the high number of colds occurring at the beginning of the school year when the weather usually was good, they added.

They suggested that students lost their immunity to cold viruses during vacations and become more susceptible to viruses that other students brought back. Afterward, they build up immunities to these immigrant viruses, the report said.

Washington News Letter

OASI

The current Social Security law exempts from OASI coverage a self-employed "physician . . . osteopath" and the Internal Revenue Code grants concomitant exemption from OASI taxes to a self-employed "physician . . . osteopath". H. R. 7225 as it passed the House continued these exemptions for a self employed "physician", but discontinued the exemptions for a self-employed "osteopath", and provided for OASI payments at age 50 to insured totally and permanently disabled persons.

During our testimony on H. R. 7225 before the Senate Finance Committee on February 22, 1956, we requested three amendments. One, restoration of the osteopathic exemptions from OASI coverage and taxes, pursuant to action of the AOA House of Delegates. Two, removal of the M. D. preemption of the term "physician" in the exemption phraseology. Three, deletion of the provisions of disability payments at age 50, pending a realistic study. See copy of our testimony furnished with our Washington News Letter of February 23, 1956.

The Committee, on April 24, 1956, tentatively agreed to restore the osteopathic exemptions, but without change in the terminology of the current law. In other words, an M. D. would continue exempt as a self-employed "physician" and a D. O. would continue exempt as a self-employed "osteopath". We were told that the Committee was unwilling to amend the current law merely to effect changes in form, and furthermore that there was overriding opposition to tampering with the term "physician" or otherwise disturbing terms of differentiation already established in common usage under the laws involved. We renewed and pressed our point, and I am happy to say, successfully.

On June 5, 1956, the Committee reported H. R. 7225 to the Senate with amendments. As so amended, the professional self-employed OASI coverage and tax provisions of the bill exempt:

> The performance of service by an individual in the exercise of his profession as a doctor of medicine, doctor of osteopathy or as a Christian Science practitioner; or the performance of such service by a partnership.

We are hopeful that these provisions will survive passage by the Senate and the House and Senate conferees.

The reported bill also deletes the provisions for disability payments at age 50, but there is certain to be a fight in the Senate to restore this feature to the bill.

The Committee added provisions to the bill to earmark limited medical care payments for Social Security public as-

sistance recipients on a Federal-State 50-50 matching basis.

* * *

S. 849

The Rules Committee is expected to clear the right of way for early consideration by the House of the Health Research Facilities Act of 1956, S. 849. The bill is a rewrite of the Medical Research Act of 1955, which passed the Senate on July 18, 1955. The revised version, which adds a new Title VII to the Public Health Service Act, authorizes a three year grant-in-aid program on a matching basis of $30 million for each of the three years to assist public and non-profit institutions in constructing and equipping facilities for the conduct of research in the sciences related to health. Grants will be made by the Surgeon General on the recommendation of an Advisory Council. No grant may exceed (1) 50% of the necessary cost of construction or (2) in the case of a multi-purpose facility, 50% of that part of the necessary cost of construction which is proportionate to the contemplated use of the facility for research in the sciences related to health.

Osteopathy is expressly recognized as a *"science"* related to health. The bill defines the terms "sciences related to health", "construction", and "cost of construction" as follows:

The term "sciences related to health" includes medicine, osteopathy, dentistry, and public health, and fundamental and applied sciences when related thereto.

The terms "construction" and "cost of construction" include (A) the construction of new buildings and the expansion, remodeling and alteration of existing buildings, including architect's fees, but not including the cost of acquisition of land or off-site improvements, and (B) equipping new buildings and existing buildings, whether or not expanded, remodeled, or altered.

Applicants who do not have available the matching funds required as a condition of Federal grants-in-aid may have their applications approved upon condition that the applicants give assurances within a reasonable time thereafter. Such conditional approval will give the applying institutions a better chance to secure the needed matching funds. This procedure is intended primarily to assist institutions located in areas which are less privileged with regard to health research facilities. It should stimulate contributions from private citizens, industry and voluntary organizations.

The covering of multi-purpose facilities in the bill is intended to take care of situations where specific facilities are needed in part for research and in part for other purposes. In such cases, the grant would be 50% of that part of the necessary cost of construction which is intended for research use.

Water Fluoridation Reduces DMF Rates

CHICAGO (AOA) — A ten year study published by the American Dental Association conclusively demonstrated the effectiveness and the safety of water fluoridation as a public health procedure.

The recently released report states that rates (decayed, missing and filled teeth) for children subject to water fluoridation were considerably smaller than those for children not subject to fluoridation.

"Results of this study may be far-reaching," the authors state. "Despite the fact the United States has better trained, and more dentists in ratio to population than other countries, dental caries in the past presented a problem beyond the capabilities of our present dental personnel and facilities."

Controlling the concentration of fluoride in water at an optimum level is, on the basis of available evidence, an effective agent in the reduction of dental caries, and a public health measure with a wide margin of safety, the article concludes.

KCOS Receives $100,000 Bequest From Riley Estate

Receipt of the major part of a benefaction provided in the will of the late Dr. George W. Riley of New York City was announced recently by the Kirksville College of Osteopathy and Surgery. The college was the major beneficiary of the estate of its late distinguished alumnus, and it is expected that final settlement of the estate will bring the amount of the gift to the college to a figure slightly in excess of $100,000.

Dr. Riley provided in his will that the benefaction to the college, which was named as his residual beneficiary after specific bequests to members of his family and other institutions, should be unrestricted and "used as the Trustees of the College see fit". The Trustees have applied the gift to nonmortgage obligations of the college which were accumulated during the period of rapid expansion of the hospital and clinic facilities completed in 1951.

Dr. Riley is permanently memorialized in the college with an excellent bronze likeness which was the gift of a grateful patient and close friend, photographer-artist-sculptor, H. I. Williams of New York City. The bust was presented to the college by Mr. Williams in a ceremony in Chicago in 1953 as a part of the annual banquet of the Kirksville Osteopathic Alumni Association, at which Dr. Riley was present. It is now in the waiting room in the outpatient section of the Kirksville Osteopathic Hospital, having been installed and dedicated on Founder's Day in 1954.

Urge More Tests For Executives

CHICAGO (AOA) — Health examiners of 600 top-bracket executives disclose why the ranks of the nations top administrators are being raided by premature death.

None of the conditions—some 25—had been known to exist before the examination. Some of them detected were serious enough to be considered a hazard to normal longevity.

A surprising number of those examined had hypothyroidism—a deficiency of the thyroid hormone. As might be expected a significant number (48) had high blood pressure. Arteriosclerosis was found in 37.

There were 112 hernias, 4 goiters, 7 inflamed prostates, 4 with polyps in the stomach or colon, and 2 with ulcers.

KCOS Graduates 73, Honors Two Osteopathic Leaders

A class of 73 seniors was graduated from the Kirksville College of Osteopathy and Surgery and two leaders in osteopathy honored in graduation ceremonies June 2. The honorary degree of Doctor of Science in Osteopathy was conferred upon Dr. Allan A. Eggleston of Montreal, Quebec, Canada, a past president of the American Osteopathic Association and now chairman of the AOA development program; and Dr. C. C. Reid of Denver, Colo., founder of the Denver Polyclinic and Post-graduate College and one of the founders of the American Osteopathic Society of Ophthalmology and Otorlaryngology. Dr. Eggleston was graduated from Kirksville in 1929 and Dr. Reid in 1899.

Those appearing on the program during commencement week included the Rev. Keith Kreitner, rector of the Trinity Episcopal Church in Kirksville, who delivered the doctorate sermon at the First Methodist Church Sunday evening, May 27; the Hon. Dewey Short, United States Representative from Missouri, who delivered the principal address at the Commencement Banquet at the Rieger Armory Friday evening, June 1; Dr. Wallace M. Pearson, chairman of the department of structural diagnosis at the Kirksville Osteopathic Hospital and Adair County Representative in the General Assembly of Missouri, who presided at the banquet; and Dr. Eggleston, who delivered the address at graduation ceremonies Saturday morning, June 2, at Kirk Auditorium.

Senior awards for 1956 were presented at the commencement banquet to the following: Salvadore J. DeVito, Lockport, N. Y., the Psi Sigma Alpha award for attaining the highest scholastic average for four years; Lynn R. Strobel, Toledo, Ohio, the PSA certificate for the higest average for the senior year; Jules Abolofia, Philadelpha, Pa., the President's Prize of $50 for the best case history presented by a senior student in which distinctive osteopathic concepts and methods are central, and the Dr. Roy S. Irwin Award, a scholarship award for having the highest average in the senior comprehensive examinations; Charles E. Callahan, Boise, Idaho, the Sigma Sigma Phi most valuable senior award; and Robert E. Madsen, Paxton, Ill., and Lewis M. Brickler, Danielsville, Pa., certificates for having served as president and vice-president, respectively, of the Student Council during the past year.

AOHA Stresses Health Insurance Education

CHICAGO (AOA)—Education of personnel in its member hospitals on the basic principles of voluntary and other pre-paid hospital insurance will be a prime objective of The American Osteopathic Hospital Association, it was revealed in Chicago at the group's annual midyear Board of Trustees meeting.

Mrs. Alixe P. Nuzum, Des Moines, Iowa, AOHA president, said "one of the serious problems facing hospitals is that of developing means of intelligent cooperation with voluntary prepaid hospital and medical care plans designed to provide adequate service; while simultaneously preventing abuses of present service contracts."

"In the interests of the health care of the American people we propose, through a vigorous education program of hospital staffs and all hospital personnel, to establish more adequate controls designed, (1) to prevent unnecessary diagnostic admissions to hospitals; (2) to eliminate overlong patient stay in hospitals; (3) to exercise careful control of any excessive use of drugs and, (4) to eliminate superflous use of laboratory facilities," Mrs. Nuzum continued.

According to Mrs. Nuzum, the educational program proposed by the AOHA will re-emphasize its program

of exchange of ideas, plus initiating concrete educational activities in all member hospitals. Said Mrs. Nuzum, "we must secure maximum economic efficiency to hold hospital costs at a reasonable level consistent with optimum medical care."

First Two Mental Health Clinics at KOH Successful

The first two Mental Health Clinics conducted at the Kirksville Osteopathic Hospital on May 3 and June 12 received such a positive response, that Dr. Fleda M. Brigham, chairman of the department of neuropsychiatry, who was in charge, has announced that a third clinic will be held in the fall.

The examination program, conducted by Dr. Brigham and members of the hospital staff, included a psychiatric interview, physicial examination, neurological examination, basic-routine laboratory work and life history. Psychological screening tests included "Draw a Person" test, Booder-Gestalt, Minnesota Multiphasic Personality Inventory, Cornell Medical Index and handwriting analysis from response to Thermatic Apperception Cards. At the end of the day, Dr. Brigham saw each patient to explain the arrangement for a summary of the findings at a later date, when a report will be made to the patient and the family physician.

KCOS Faculty Member Elected Treasurer of State Anatomical Board

Dr. George E. Snyder, chairman of the department of anatomy at the Kirksville College of Osteopathy and Surgery, was elected treasurer of the State Anatomical Board at the annual meeting of the organization held May 16 at the University of Missouri Medical School at Columbia. Also in attendance at the meeting was Dr. Grover C. Stukey, chairman of the department of pathology, who has served as vice-president for the past ten years, and who has been a member of the Board for twenty-seven years.

AUXILIARY NEWS

Auxiliary District Five

(Dallas Osteopathic Hospital Guild)

The annual Interne Party was held Friday, June 29 at Wylie's Dude Ranch with a good crowd in attendance. After dinner there was varied recreational facilities available such as ping pong, swimming and dancing.

In addition to our staff we had as guests, Dr. Phil Russell of Fort Worth and Mr. and Mrs. J. D. Weatherly. Mr. Weatherly is administrator of Stevens Park Hospital.

Dr. and Mrs. Lionel Burton are the proud parents of Scott Richard born June 27—weight 8 lbs and 4 oz.

Dr. and Mrs. Robert Morgan, Dr. and Mrs. Patrick Philben and Dr. and Mrs. George E. Miller are attending the A.O.A. Convention this year.

Mrs. Wilbur Baldwin is visiting relatives in Philadelphia and Mrs Tom Hobart is visiting in Missouri.

EDNA M. KRATZ
Publicity

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Auxiliary District Twelve

Our auxiliary is about to give birth to a Hospital Guild—well, it will in a couple of years or so anyway. Nine doctors from the Groves-Port Arthur area have purchased the Stukey-DsWitt Hospital, now "Doctors' Hospital," and eventually the wives of said doctors will form a guild. (There's one for the textbooks—only two years old and going to give birth.) The ladies who will be involved are: Nanalee Barnett, Elaine Eitel, Janet Davis, Florence Garrison, Betty Montgomery, Lorr Shields, Erma Sorenson, Nita Taylor and Norma Watkins.

Speaking of Lorr Shields, was it mentioned last time that she is not only the wife of Port Acres' leading physician, but also the wife of the recently elected member of the school board? I realize that sounds as if she has two husbands, but she doesn't really. That's just a long drawn out way of saying that Bob was elected.

And speaking of school boards, as President of the Vidor Board of Education Dr. Tyra Morgan passed out the diplomas this year while Modene looked on with pride.

Archie and Florence Garrison came to the last district meeting dressed fit to kill; not that this is anything unusual, you understand, but I'm just trying to lead into the fact that Archie's daughter had just gotten married. She married Bob Boylen from Centralia, Missouri, and both are attending Lamar Tech in Beaumont this summer.

Our sympathy is extended to Dr. and Mrs. Jack Taylor on the very recent death of Jack's father.

By this time, Ruth Ensign will be home from her visit home to North Dakota and Minnesota. I know she was having a grand time, because she called her husband about staying an extra week.

We decided at our last meeting to present a loving cup to the person earning the most money for the treasury. Earning, not donating. The idea snowballed along, and the first thing we knew we had decided to make it really worthwhile and have it retired only after the same person won it three years in a row. It's a shame, but we need to stimulate interest—it saves money too.

Dr. and Mrs. David Matthews and son of Denison visited recently with Dr. and Mrs. Ken Watkins at Groves.

Someone mentioned at the last meeting that Dr. D. W. Davis has been practicing in Beaumont now for fifty-four years. I don't imagine that is a record, but it seems like a whale of a start toward one.

Carolyn and Ralph Clarke have just returned from a vacation visit to Detroit and Port Huron, etc. It's good to have them back again. The Sorensons are on their vacation now, and I believe the Shields are too. Paul and Jo Siefkes have left our fold to go to Waynesville, Missouri, with Ralph and Anna May DeWitt. We shall miss them. Actually this is kind of silly, but gee, Betty Montgomery looked pretty at the last meeting.

That's about the size of it.

FRITZI GIFFEN, *Secretary*

KCOS Has Two New Faculty Members

Two new members joined the faculty and staff of the Kirksville College of Osteopathy and Surgery during June. Dr. Arthur A. Martin of Maldin, Mass., is assistant professor in the department of eye, ear, nose and throat, and Dr. Roy L. Fischer of Dallas, Texas, is a resident in the department of obstetrics and gynecology.

Dr. Martin was graduated from the KCOS in 1940. He served an internship at Massachusetts Osteopathic Hospital in Boston. Following several years of practice in Malden and Boston, he returned to the college for work in EENT. and in 1950 completed the clinical requirements for certification. Since then he has been chief of the EENT department in M.O.H. Dr. Martin has held important offices in district and state professional societies. He is a member of the Episcopal Church, the Masonic orders and the Shrine. In 1946, Dr. Martin married Miss Melva Rae Gingerich, dean of women at Northeast Missouri State Teachers College. Mrs. Martin will join her husband in Kirksville in the near furture.

Dr. Fischer received the B.S. Degree from Trinity University, San Antonio, Texas, and was graduated from the Kirksville College of Osteopathy and Surgery in 1954. Following his internship at Dallas Osteopathic Hospital, he entered general practice in Dallas for a year. From 1944 to 1946 he served in the United States Navy in the Pacific. While at the KCOS he was a member of the Student Council and was very active in the Atlas Club, having served as treasurer, secretary and president. Dr. and Mrs. Fischer, the former Miss Donna Leah Lamb of Hurdland, reside at 810 South Baltimore.

NEWS OF THE DISTRICTS

DISTRICT ONE

Dr. and Mrs. John Witt and children are spending their vacation in Honolulu.

Dr. Jim Longhagen of Claude is in McCook, Nebraska, visiting his mother, who is ill.

Dr. Robert Clayton is associated with Dr. Ed Rossman. Dr. Clayton recently completed his internship at the Amarillo Osteopathic Hospital.

Dr. and Mrs. Earle Mann recently visited his sister in Arkansas.

Dr. William Ballard recently entered the Huber Golf Tournament.

The Amarillo Osteopathic Hospital has completed its remodeling program.

Most all of the doctors in the district are telling some fabulous stories regarding their fishing while on their vacations. Pictures prove same.

Dr. Nobles recently completed his internship at Amarillo Osteopathic Hospital and has located in Lorenzo, District 12 gains. Lots of success, Doctor!

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DISTRICT TWO

Some of us are on the long awaited vacation, others have all our plans made—just waiting the eventful day to come, and still others have no plans and expect no vacation. Every one of us should take some time off—away from our job—just as most every one does, or we grow stale and unable to cope with the many situations with which we come in contact. It helps us and I know it will aid our patients.

Dr. Virginia Ellis is on her way to New York where a tough assignment awaits her, that of taking tests for her certification in pediatrics. Good luck, Virginia! Dr. Noel, along with their son and daughter, are also vacationing in New England.

Our new hospital will soon be ready and the many plans for its opening are progressing wonderfully. Anyone interested in seeing this beautiful building is invited to attend on our opening day—which will be announced later—the latter part of July.

Dr. and Mrs. Butch Miller are grandparents—congratulations M. S.!

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DISTRICT THREE

Summer activities are progressing at a rapid pace in East Texas. Drs. H. R. and W. H. Coats, accompanied by Dr. Lynch, and presumably their wives, went fishing in the Gulf July 6 and 7. Several large Red Snappers were landed.

Dr. Jones has returned from a trip to Iowa where he took his parents to their home. They had spent the winter at the Mineola summer resort. As soon as the Joneses rested up from the trip, they went on another one, this time through Colorado, where they could test out Mrs. Jones' new Studebaker that she received as a Mother's Day gift. Mr. and Mrs. Tom Castloo, of Mineola, accompanied them on the trip.

Ex-President Wayne Smith and Pearl are rapidly returning to normal living, and are fixing up the Lake house. They took a Saturday night off recently and accompanied the Rahms to a dance in Tyler, where a very good time was had by all, including the Jerry Smiths, who are vacationing from school in Kirksville, where Jerry is in his second year at K.C.O.S.

Dr. Sue and Allan Fisher report that Lone Star Lake is rapidly becoming a favorite summer resort. Dr. Sue has recently made the headlines. See else-

where in the Journal this month for a full account.

Dr. K. E. Ross, the East Texas Surgeon and Diplomat, repaired a fractured patella at the Hensley Hospital in Franklin June 27. Dr. Hensley's Model T is temporarily disabled due to tire trouble. He will repair it some more, and equip it with deluxe wire wheels and balloon tires soon. (4.40/4.50 x 21). Not much has been heard from Dr. Rahm's Model T since he spent $96.00 for two brand new 30 x 3 tires custom made just for pre-1918 Fords by the Firestone Co. Expensive hobby? No, not at all. The correct adjective is "prohibitive". Drs. H. R. Coats, Wayne Smith, C. C. Rahm and wives attended the Interns' Graduation ball last month.

Dr. E. H. Owen, of Kirkwood, Missouri, has joined the staff of Coats-Brown Clinic and reported for duty July 15. Dr. Coats says only 6 D.O.'s took the Medical Board this last time, a marked reduction compared to former times. He says reciprocity accounts for this fact to a large extent.

Dr. List and wife have returned from a long trip somewhere, but he hasn't had time or the inclination to report same for benefit of the news column. We cannot report news unless it is reported to us.

Dr. Lynch has a new air-conditioned DeSoto. His daughter (don't know which one—he didn't report any news either) will compete in the swimming meet at Houston this month.

Coats-Brown Clinic is drawing up plans for the addition of some new rooms. This rumor has been hot and cold for years now.

The Mt. Pleasant Hospital and the Currey Clinic and Hospital are taking applications for their third course in Vocational Nurses training which starts in September.

Dr. and Mrs. McCorkle spent a recent week-end in Texarkana visiting his parents.

Ross McKinney has been elected to a 4-year term on the Board of Stewards of the First Methodist Church of Texarkana.

Dr. Paul Filkill, formerly from East Texas, now of Deerfield, Michigan, was visiting in this area several weeks ago. It is rumored that he took some Texas money back to Michigan with him, as a result of his attendance at a special meeting of the Thanatopsis Literary and Inside Straight Club.

Plans are rapidly being completed for one of the best meetings ever held in East Texas. It will be in Jacksonville September 30 at 2 p.m. It isn't too early to start planning to attend. More details later.

Drs. C. C. Rahm, C. H. Bragg and others attended the regular meeting of district 12 in Port Arthur July 19. Nice meeting, and a very active group down there in district 12.

No news again this month from Drs. Bone, Bowden, Bragg, Cline, Coldsnow, Duphorne, Grainger, Hagen, Hamilton, Hensley, Kennedy, Kinzie, Kull, Lacey, List, Miller, Schwaiger, Taylor, Turner, Wolfe, Woodrow, Stuart, Speak or Rowlett. The mystery is what do they do with those postage-paid cards I send them every month?

CHARLES C. RAHM, D. O.
Secretary

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DISTRICT EIGHT

The Valley Osteopathic Association met in Weslaco on the evening of June 7, 1956.

After a dinner at the Cortez Hotel, we adjourned to the home of Dr. Mabel F. Martin.

Dr. Martin and Dr. Lloyd Davis gave a report of their attendance at the State Convention.

RALPH H. MOORE, D. O.
Secretary

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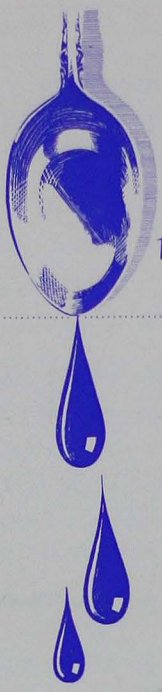

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