Texas Osteopathic Physicians Journal

Volume XVIII FORT WORTH, TEXAS, APRIL, 1962 Number 12

STATE CONVENTION

FORT WORTH
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HOTEL TEXAS

Convention Program
Pages 2 and 3—Auxiliary Page 30

Don't Miss This Convention

Texas Osteopathic Physicians' Journal

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TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

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EDITOR PROFESSIONAL ARTICLES - - - C. RAYMOND OLSON, D.O.

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VOLUME XVIII FORT WORTH, TEXAS, APRIL, 1962 NUMBER 12

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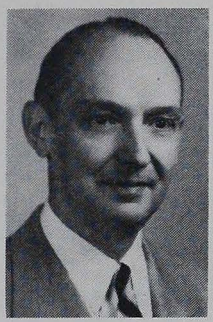
1962 CONVENTION SPEAKERS

Hotel Texas, Fort Worth, Texas — May 3, 4, 5, 1962

COME—SEE—HEAR

CHARLES L. NAYLOR, D.O.,
President AOA
Ravenna, Ohio



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JOSEPH F. DEPETRIS, D.O., F.A.C.O.I.
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Fort Worth, Texas

Annual Convention Program

BUSINESS SESSIONS

Monday, April 30, 1962

9:00 A.M.—Board of Trustees, Shorthorn Room ..... G. W. Tompson, D.O., President, T.A.O.P.S.
5:00-7:00 P.M.—District 2 Press Party ..... Press Club, Westbrook Hotel

Tuesday, May 1, 1962

9:00 A.M.—Board of Trustees, Shorthorn Room ..... G. W. Tompson, D.O., President, T.A.O.P.S.

Wednesday, May 2, 1962

9:00 A.M.—House of Delegates, Junior Ballroom (A) ..... Charles C. Rahm, D.O., Speaker
9:30 A.M.—Auxiliary Executive Board, Shorthorn Room ..... Mrs. John H. Burnett, President, A.T.A.O.P.S.

Thursday, May 3, 1962

2:00 P.M.—Auxiliary House of Delegates, Shorthorn Room ..... Mrs. George G. Clark, Mistress of Ceremonies
Invocation ..... Mrs. M. G. Holcomb
Welcoming Address ..... Mrs. J. O. Carr, President, Aux. Dist. 2
Response ..... Mrs. John Boyd, Pres.-Elect, A.T.A.O.P.S.
Guest Speakers ..... G. W. Tompson, D.O., President, T.A.O.P.S.
Charles L. Naylor, D.O., President, A.O.A.
Mrs. William B. Strong, President, A.A.O.A.
Business Meeting ..... Mrs. John H. Burnett

Saturday, May 5, 1962

8:00 A.M.—New Board of Trustees, Shorthorn Room ..... New President to preside
9:30 A.M.—New Auxiliary Board, Gold Room ..... New President to preside

GENERAL SESSIONS

Exhibits—Grand Ballroom No. 4-5
Educational Programs—Grand Ballroom No. 3
Press Room—Executive Room, Third Floor

Appreciation is expressed to Eli Lilly & Co. for its grant of $250 toward the educational program.

Thursday, May 3, 1962

8:00 A.M.—Registration ..... Grand Foyer
8:30 A.M.—Visit the Exhibits
9:30 A.M.—"Impaired Hearing—Its Detection and Present Day Management" ..... Lloyd A. Seyfried, D.O., Detroit, Michigan
10:00 A.M.-12:00 Noon—Auxiliary "Get Acquainted Coffee" ..... Jr. Ballroom (A-B)
(Sponsored by Mission Pharmacal Co.)
10:30 A.M.—Visit the Exhibits
11:00 A.M.—"Is Our Profession Worthwhile?" ..... Charles L. Naylor, D.O., Ravenna, Ohio President, A.O.A.
12:15 P.M.—Luncheon (Doctors, Auxiliary and Guests) ..... Grand Ballroom No. 2
Master of Ceremonies ..... George J. Luibel, D.O. Chairman, Entertainment Committee
Invocation ..... Dr. N. Quentin Grey, First Christian Church of Ft. Worth
Welcome ..... John Justin Mayor of Fort Worth
Response ..... L. G. Ballard, D.O. President-Elect, T.A.O.P.S.
Address ..... The Honorable Price Daniel, Governor of Texas
Subject: "Texas—Your State"
2:00 P.M.—Visit the Exhibits
2:30 P.M.—"Modern Management of Burns" ..... Lloyd A. Seyfried, D.O., Detroit, Michigan
C. Raymond Olson, D.O., Fort Worth, Texas

3:30 P.M.—Visit the Exhibits
4:00 P.M.—"Masculinizing Tumors of the Female" ..... Joseph F. DePetris, D.O., F.A.C.O.I., Dallas, Texas
5:00 P.M.—Visit the Exhibits
7:00 P.M.—Cocktail Party (For Registrants) ..... Ridglea Country Club
(Courtesy of Baker Laboratories, Inc.)
8:00 P.M.—Dinner, Dancing and Entertainment ..... Ridglea Country Club

Friday, May 4, 1962

7:00-9:00 A.M.—SPECIALTY GROUP MEETINGS
General Practitioners Breakfast ..... Longhorn Room
OB and Gyn Breakfast ..... Jr. Ballroom (C)
Radiological Breakfast ..... Directors Room
Surgical Breakfast ..... Jr. Ballroom (D)
Texas Academy Breakfast ..... Shorthorn Room
(Clinical Applications of the Findings by the K.C.O.S. Research Group ..... Ira Rumney, D.O.), Kirksville, Mo.
8:00 A.M.—Visit the Exhibits
9:30 A.M.—"The Chronic Discharging Ear—Clinical Importance and Treatment" ..... Lloyd A. Seyfried, D.O.
10:30 A.M.—Visit the Exhibits
11:00 A.M.—"Cancer of the Male Genitourinary System" ..... L. Raymond Hall, D.O. Kansas City, Missouri
12:15 P.M.—College Luncheon (Doctors Only) ..... Grand Ballroom No. 1-2
Invocation ..... Rabbi Isadore Garsek Congregation Ahavath Sholom of Ft. Worth
12:30 P.M.—Auxiliary Installation Luncheon ..... Shady Oaks Country Club
Invocation ..... Mrs. J. J. Schultz
Welcome and Introductions ..... Mrs. George G. Clark, Vice-Pres., A.T.A.O.P.S.
Installation of Officers ..... Mrs. William B. Strong, Pres., A.A.O.A.
2:30 P.M.—"Cancer of the Breast" ..... L. Raymond Hall, D.O.
3:30-4:00 P.M.—"Laboratory Parameters in Present Day Diagnosis of Thyroid Disease" ..... M. E. Johnson, D.O., Fort Worth, Texas
5:00 P.M.—Visit the Exhibits
7:00 P.M.—President's Reception ..... Grand Ballroom No. 1-2
(Doctors, Auxiliary, and Guests)
8:00 P.M.—President's Banquet ..... Grand Ballroom No. 1-2
(Doctors, Auxiliary, and Guests)
Invocation ..... Monsignor Lawrence M. DeFalco St. Patrick's Co-Cathedral of Fort Worth
Toastmaster ..... Loren R. Rohr, D.O., Houston, Texas

Saturday, May 5, 1962

7:30-9:00 A.M.—ALUMNI BREAKFASTS:
College of Osteopathic Medicine and Surgery ..... Directors Room
Kansas City College of Osteopathy and Surgery ..... Longhorn Room
Kirksville College of Osteopathy and Surgery ..... Santa Gertrudis Room
8:00 A.M.—Visit the Exhibits
8:00 A.M.—Auxiliary Past Presidents' Breakfast ..... Hotel Texas Coffee Shop
9:30 A.M.—"Bronchogenic Carcinoma" ..... L. Raymond Hall, D.O.
10:30 A.M.—Visit the Exhibits
11:00 A.M.—"Shock: Pathophysiology and Changing Attitudes in Treatment" ..... C. Raymond Olson, D.O.
12:00 Noon—Luncheon for Incoming District Presidents and Secretaries ..... Jr. Ballroom (A)
(Sponsored by Board of Trustees)
12:00 Noon—Luncheon—Texas Academy of Applied Osteopathy ..... Jr. Ballroom (C)
1:00 P.M.—Academy Teaching Technique Session ..... Ira C. Rumney, D.O.
Subjects: "Shoulder and Upper Thoracic Arc"
"Lower Back Problems"

Assisted By:
George J. Luibel, D.O. H. G. Grainger, D.O.
Catherine K. Carlton, D.O. Elbert P. Carlton, D.O.

Anemia In Chronic Congestive Heart Failure

J. F. DePetris, D.O.*
Dallas, Texas

In the patient who is in the abnormal physiological state of congestive heart failure, the metabolic demands of the body tissues become inadequately maintained, because of the impaired circulatory hemodynamics. When anemia is superimposed upon this deficient transport mechanism, not only does a further reduction of maintenance of metabolic demand occur, but also the dynamic demands of the myocardium are increased. When myocardial insufficiency and anemia occur in the same patient they act as a common denominator in the pathologic alteration of cellular metabolism, known clinically as congestive heart failure. Therefore, constant effort should be maintained in detecting and correcting anemia in the cardiac patient.

The supply of oxygen to the tissues depends on the oxygen carrying capacity of the blood and the ability of the cardio-respiratory system to aerate and to transport the blood to each cell of the body. When the oxygen carrying capacity of the blood is diminished in the patient with anemia, two mechanisms are available to maintain an adequate supply to the tissues. These are (1) an increased delivery of blood to the tissues consequent to increased cardiac output, and (2) a more complete abstraction of oxygen from the blood as it passes through the capillaries. In the anemic patient a variety of methods by several investigators have shown that there is a rise in minute output of the heart roughly paralleling the decrease in hemoglobin. (1-10) Generally the velocity of blood flow has been reported to be increased. (2, 10,11,12,13,14,15,16,17,18) At basal states only 30% of the oxygen is removed from arterial blood as it passes through the capillaries. The remaining 70% may be regarded as reserve oxygen which can be called upon during increased metabolic demand, when arterial oxygen content is lowered, or when arterial transport is slowed, to prevent asphyxia of the tissues. In severe anemia even with an increased cardiac output, increased absorption of oxygen by the capillaries cannot always prevent tissue hypoxia especially if metabolic demand is increased by abnormal physiological states. This has resulted in precipitating marked cardiac and renal pathologic physiology in an otherwise normal patient.

Clinically, the following cardiopathies have been repeatedly demonstrated in patients with anemia but without organic heart disease. An increased intensity of the first heart sound, (19,20) often accompanied by apical and, less commonly, basal systolic murmurs, is heard. (19,21,22,23,24) In severe anemia diastolic murmurs may be present. (22,23) Roentgen signs of cardiomegalia have been repeatedly demonstrated, (19,20,22,25) and this is thought to be due to dilatation. If anemia is of long duration hypertrophy also exists. Dyspnea on exertion, fatigue, and edema occur. Pain characteristic of angina pectoris (19,26,27,-28,29) with concomitant electrocardiographic changes representative of myo-

*Attending Physician, Dallas Osteopathic Hospital

cardial hypoxia (21,22) have been reported; these disappear with relief of the anemia.

In any given case of anemia the manifestation related to the cardiovascular system will naturally depend on many factors, namely: the degree of anemia, the rapidity of development of anemia, the age of the patient, and the capacity of the cardiovascular system for adjustment. It is readily appreciated that if organic cardiac disease is also present, the compensatory changes described will be greatly limited.

Bradley and Bradley (30) have recently demonstrated that in chronic anemia changes in the kidneys similar to those seen in congestive heart failure occur. A reduction of absolute renal blood flow in the face of an increased cardiac output is accompanied by a lowered glomerular filtration rate. Maximal tubular excretion of diodrast is diminished while maximal tubular glucose reabsorption remains unchanged. In view of the above study, the edema which often occurs in severe anemia is thought to be secondary to renal retention of water and salt, possibly attributable to a glomerulo-tubular imbalance indicated in the reduction of the filtration rate/glucose Tm ratio.

Since the original hypothesis in 1893, by Miecher (31), it has been generally accepted that the stimulus for the production of hyperplasia of the erythroid partition of the bone marrow is anoxia. Hemoglobin synthesis is a specific function of erythroid cells. In-vitro studies of the ability of the bone marrow to synthesize heme under various oxygen tensions failed to demonstrate a stimulating effect from any level of reduced oxygen tension. (32,33,34) Decreased oxygen consumption and increased glycolysis also occur in bone marrow with reduced oxygen tension. (35) This data suggests that anoxia is not a direct stimulant of the bone marrow. Furthermore, a number of studies of serum from anemic animals and humans have demonstrated directly (36,40) or indirectly (41,42) the existence of an erythropoietic serum factor capable of stimulating red blood cell production. Consequently, the stimulus to erythropoietic function must depend on the tissue tension of oxygen in a hypothetical erythropoietic center rather than on the oxygen content of arterial blood. Hedlund (43) found only a minimal decrease in arterial saturation in decompensated cases and practically no decrease in compensated cases of congestive heart failure when compared to normal variations. No correlation of arterial oxygen content to the total red cell volume was observed. In the patient with congestive heart failure a great variance in the reticulocyte response occurs with arterial oxygen unsaturation. (43) Usually the response is normal, unless the more severe grades of failure are encountered. Hyperplasia of the bone marrow has been demonstrated with an increase of the mitotic figures in the younger forms of the erythroblasts (43,44) and also an increase in the number of the more mature erythroblasts (45,46,47,48), reverting to normal following compensation. (43,49) Therefore, it is suggested that in congestive heart failure, under moderate control and lacking in extensive pulmonary edema, arterial oxygen content will be normal or only moderately decreased, from impaired alveolar-capillary oxygen diffusion. Tissue hypoxia due to slowed circulation may be compensated by more complete oxygen extraction from capillary oxygen surplus, so that a constant stimulus to erythropoiesis would not necessarily exist in chronic congestive heart failure.

Granick in 1946 (50) and Moore and Dubach in 1955, (51) from a review of the literature, summarized that the total iron content of the body was not controlled by unlimited absorption and excretion of excess, but rather by limiting the intake of iron. Iron once absorbed remains in the body, no significant amounts being excreted. The

body has comparatively little capacity to lose iron except through hemorrhage. The mucosal cells of the duodenum and jejunum regulate iron absorption, by maintaining a balance of ferrous iron in equilibrium with ferritin (storage form of iron) and with the circulating plasma iron. According to this hypothesis a lowering of the plasma iron would result in more rapid movement of iron out of the mucosal cells, depleting the stores of ferritin iron and finally lowering the concentration of ferrous iron in the mucosal cells below the "physiological saturation" level. At this time increased absorption of iron from the gastro-intestinal tract would be observed.

Reducing substances in food, especially ascorbic acid, cysteine, and compounds possessing the sulfhydryl groups play a large part in converting ferric iron of food to ferrous form for the best absorption. From the standpoint of gastrointestinal function, iron absorption is influenced by the secretion of hydrochloric acid, by the emptying mechanism of the stomach, by intestinal motility, and by the extent and integrity of the absorptive surface. Several diseases of the intestinal tract which interfere with the above functions have long been known to produce anemia. (53) Moore (54) has recently shown that a narrower margin of iron balance than was formerly believed occurs in healthy patients, so that nutritional factors are of greater importance in the production or prevention of iron-deficiency anemia than previously has been recognized.

Plasma iron is therefore influenced by the quantity of iron absorbed from the intestine, the adequacy of the tissue iron reserves, the capacity of the bone marrow to utilize iron for hemoglobin synthesis, and the activity of the hemopoiesis. Plasma iron levels have been found to be significantly lowered in uncontrolled congestive heart failure, rising markedly during control of same. (43) A correction factor was used for plasma dilution present. Studies of autopsy material of decompensated heart diseases have demonstrated the iron quantity in the liver and spleen to be much lower than normal (55). This information suggests that gastro-intestinal edema may interfere with normal iron absorption and regulation of plasma iron levels. Adequate intake of iron containing foods and reducing substances are often lacking in the anorexic cardiac patient, which may further hinder utilization of iron. That chronic and recurrent infectious diseases (56) and degenerative diseases known to produce anemia are common complications in particularly the elderly cardiac is readily appreciated. It is therefore felt that anemia from decreased iron absorption in association with secondary iron loss or bone marrow inhibition from associated disease in the debilitated cardiac is probably a more common precipitating and aggravating factor in congestive heart failure than is generally appreciated.

It has been repeatedly demonstrated that hepatic abnormalities, i.e., biochemical alterations (57-63), pathologic physiology (64-67), and abnormal histology (65,68-72), occur in the liver of patients in congestive heart failure. Of interest at this time is the frequent finding of lowered total plasma protein and plasma albumin values in these patients. (57,60,61,62,66,69,73,74) Several sources now conclusively demonstrate that when weight loss occurs in the patient with chronic debilitating disease, with resulting loss of total body protein, a reduction in

the total blood volume occurs. (75-82) A reduction in plasma protein concentration is not necessarily present. When this occurs the commonly used total protein determination, erythrocyte count, hemoglobin concentration and hematocrit will not reveal deficits in the total circulating protein, red cell and hemoglobin volumes. Thus a "masked anemia" may not be detected. It is readily recognized that the debilitated patient in chronic congestive heart failure may fall into this class, with a reduced blood volume resulting from loss of total body protein. Anorexia limiting available protein for absorption, edema interfering with absorption, hepatic disease interfering with protein formation, loss of excessive protein and proteinuria and therapeutic drainage of ascites and pleural effusion are not uncommon in these patients. Weight loss from associated degenerative disease in the elderly cardiac is also commonly seen.

In the past the concept that the blood volume is considerably increased in patients with congestive heart failure has been widely accepted. (43,83-90) At the present time controversy exists as to the state of the blood volume in the patient with congestive heart failure. Certain studies have indicated that a hypervolemia exists due to an increase in either the circulating red cell mass, the plasma volume, or both. (43,83-90) However, recent investigations using radioactive tagged red cells and/or radioactive serum albumin indicate that there is little or no increase in the total blood volume, plasma or red cell volume in most cases of congestive heart failure (90-94) over control cases.

A more critical survey of the investigations revealing an elevated blood volume indicated that these determinations were done in patients, usually in an uncontrolled state, with probable pulmonary edema and lowered oxygen content of arterial blood and abnormally low tissue tension oxygen levels. Even so, a great number of these cases were below the mean elevation of total blood volume. No significance of this has been correlated. Most of the authors report a reduction in the plasma and red cell volumes with compensation; a disappearance which has never been satisfactorily demonstrated by pigment excretion studies or other means. It is felt from the evidence existing that the clinician should not consider all cases of congestive heart failure to be hypervolemic. Emphasis of this should be considered in the chronic cardiac with long standing, difficult to control, congestive failure with weight loss. That a constant stimulus to erythropoiesis from lowered tissue tension is not always present in these patients has been discussed. This should accentuate the fallacy that all patients in congestive failure should have absolute polycythemia.

The feeling that anemia, not discernible with concentration measures, might be present in the patient with chronic congestive heart failure and a lowered blood volume, from the causes previously discussed, led to the study of

twenty-four cases of congestive heart failure with blood volume determination. All of the patients studied were predominantly vascular rather than valvular heart disease, and were in the fifth to seventh decades. They were given digitalis, low sodium/high protein diets, diuretics, electrolyte study and replacement as indicated to maintain an edema free state. The edematous phase varied from a few months to four years. Venous oxygen content and capacity determinations were found to be normal unless pulmonary edema, anemia, or severe uncontrolled congestive heart failure existed. This correlated with normal reticulocyte and bone marrow counts unless lowered venous oxygen content was present. Apparently, then, tissue extraction of oxygen is adequate to maintain normal tissue tension so that a stimulus to erythropoiesis does not occur unless marked pathological changes are present. Marked anemia was discovered in eight cases but was not readily noted with concentration tests, since the total blood volume was lowered. It is to be emphasized at this time that these cases were studied as office cases under partial control of the chronic edema, although hepatomegalia was constantly present in a large group of the patients, in contradistinction to most of the cases studied in the literature which were in uncontrolled failure. When correction of the anemia was possible, it resulted in prolonged relief and better control of the patient than had been previously obtained. Results have been encouraging enough to warrant the further use of blood volume study as a diagnostic aid in the patient with chronic congestive heart failure rather than a research tool.

Summary:

1. A review of the literature has emphasized the marked changes produced on the cardiovascular and renal systems by chronic anemia. Compensation ability of the normal heart and aggravation of existing organic heart disease was discussed.

2. From available evidence the mechanism of increased erythropoiesis is produced by a lowering of tissue oxygen tension of a hypothetical erythropoietic center rather than a reduced arterial saturation of blood at the level of the bone marrow. The ability of increased oxygen extraction of reserve capillary oxygen content or transport is described. The finding of a normal reticulocyte and erythroblast count and venous oxygen content in chronic congestive heart failure under moderate control is considered to be indicative that a constant stimulus to erythropoiesis is not always present in this disease state. Therefore, hypervolemia due to absolute polycythemia should not be considered a constant finding in chronic congestive heart failure.

3. It is postulated that functional changes in the mucosal cells of the upper gastrointestinal tract regulating iron absorption, as in the presence of gastrointestinal edema, indirectly aggrevate and impair treatment of anemia in congestive heart failure.

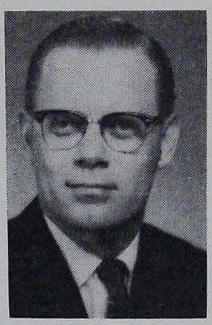
4. An analogue of the congestive heart failure patient is compared with patients who have other types of debilitating disease marked by loss of total body protein. The loss results in a reduced total blood volume, due to a change in the ratio of plasma to interstitial fluid. Such anemia may be masked if only concentration tests are used.

5. The assumption that all cases of congestive heart failure are hypervolemic has been contested. A preliminary report of blood volume study in twenty-four cases of congestive heart failure has been presented. The use of total blood volume determination as a diagnostic aid rather than as a research tool in congestive heart failure in the detection and correction of anemia has been suggested.

Bibliography available on request.

1717 North Garrett St., Dallas, Texas.

Case Report: Post-Partum Hemorrhage Due to Hypofibrinogenemia



TOM W. WHITTLE, D.O.*
Fort Worth, Texas

A twenty-eight year old gravid female at term was admitted to Fort Worth Osteopathic Hospital at 11:05 A.M. on August 15, 1960. She was admitted thirty-five minutes after spontaneous rupture of the amniotic sac, and contractions of the uterus were occurring, reportedly at five minute intervals. Obstetrical examination upon admission revealed an apparently normal uterine pregnancy at term, with contractions of moderate intensity occurring at the rate reported by the patient. The fetal head was engaged and lay in an LOA position. The patient did not complain but, on questioning, mentioned mild discomfort in the low back area and in the lower abdominal quadrants. The fetal heart sounds were regular at a rate of 138 per minute, were strong, and located in the lower left abdominal quadrant. Sterile vaginal examination revealed a cervix dilated three to four cm., effaced 50% and in contact with the fetal head. The amniotic sac had ruptured.

During the prenatal period there had been absolutely no complications. She had been seen at two week intervals from the third through the eighth month of pregnancy. During the final month she was seen at weekly intervals. During the third month her complete blood count was reported as follows: R.B.C. 4,340,000; W.B.C. 8,200; Differential, 2 stabs, 75 segmenters, 23 lymphocytes; Hemoglobin 11.0 gms.%. The red cells appeared slightly hypochromic. Luetic serology (Kline) was negative. The RH factor was: C—positive, D—positive and E—negative. Blood type was A (Landsteiner). Throughout pregnancy the patient took *Natabec* prenatal supplement and *Mol-Iron Panhemic* for the anemia. Urine examinations, blood pressure readings, weight increase and fetal growth and development were all normal throughout the prenatal period.

The patient had experienced five previous pregnancies, one of which ended in spontaneous abortion at three months gestation. All other pregnancies were normal, except that she had developed urinary cystitis during the last. She had four living children who were all normal. Their birth weights were: 7 lbs. 5½ oz.; 9 lbs. 10 oz.; 8 lbs. 5 oz.; and 8 lbs. 2½ oz. Her history was in no way unusual.

Following our examination of the patient she was prepared for delivery. *Demerol,* 100 mg. and atropine sulfate, grs. 1/150 were administered parenterally. Labor progressed rapidly and normally, and she was taken to the delivery room at 12:50 P.M. Saddle block analgesia was administered, using 2 cc of 0.25% heavy *Nupercainal.* Her blood pressure declined from 128/80 to 98/60 and *Drinalfa* was administered to correct the developing hypotension.

With the cervix completely dilated and effaced, the fetal head progressed to lie on the perineum. At this stage, the fetal heart tones disappeared and outlet forceps were applied to effect

*Chairman, Department of Obstetrics and Gynecology, Fort Worth Osteopathic Hospital.

an immediate delivery. A wide midline episiotomy was made, and the stillborn infant was delivered immediately followed by an already separated placenta and an estimated 600 cc gush of blood. A moderate amount of vaginal bleeding persisted in spite of the intramuscular administration of 1 cc of pitocin and methergine followed by an intravenous cc of pitocin. Through inspection of the vagina and cervix as well as manual exploration of the uterine cavity failed to reveal trauma or other cause for the hemorrhage. Firm packing of the uterus resulted in nothing but blood soaked packs through which the bleeding continued.

Laboratory studies were ordered at this time to determine if there might be a defect in the clotting mechanism of the patient's blood. While waiting for these studies to be completed, intravenous *Dextran* and blood plasma were started. The blood fibrinogen was reported "subnormal."

The administration of fresh whole blood and 3 gms. of human fibrinogen was accompanied by remarkable improvement. Bleeding stopped and three uterine packs were carefully removed singly over a twenty-four hour period of time. A total of five units of whole blood and six grams of human fibrinogen were required to bring these levels to normal. The hematocrit reached a low of 24% but was restored to 38% by the fifth post-partum day when the patient was dismissed.

COMMENT

It has been known for over fifty years that clotting defects may be associated with complications of pregnancy, resulting in hemorrhage from the uterus. It was not until 1936, however, that a decrease in blood fibrinogen was specifically inplicated as a causative factor in such cases. Moloney, Egan and Gorman were the first to employ fibrinogen replacement as a method of treating these patients.[1]

Among the causes of decline in fibrinogen to hemorrhagic levels are abruptio placentae, amniotic fluid embolism, retained dead fetus and severe toxemia.[2] In cases where there is known retention of a dead fetus or where severe toxemia is complicating pregnancy, serial fibrinogen level studies are indicated. Surgical shock and other as yet unknown conditions may also lead to depletion of blood fibrinogen.

Hypofibrinogenemia should be suspected in any case where a pregnant patient bleeds subcutaneously or from the mucous membranes, and in every pregnancy complicated by one of the conditions known to be associated with decreased fibrinogen levels.

The diagnosis can be made by one of several laboratory studies: quantative fibrinogen determination, the clot observation test and determination of fibrinogen titer. The simple clot observation test is useful and the results closely parallel those of the more complicated studies. Even more reliable, and specific for fibrinogen deficiency, is the method of Bowman and Yelito.[3] It gives immediate results, requires no special equipment and can be done by untrained personnel.

A study of reported cases of afibrogenemia and hypofibrogenemia reveals certain facts which have clinical application.[2]

Eli Lilly Makes Program Grant

The Texas Association of Osteopathic Physicians & Surgeons expresses its appreciation to Eli Lilly and Company for its grant of $250 toward the professional education program at our 1962 annual convention.

It is gratifying to have a pharmaceutical company so express its belief that eduaction is paramount to good patient care.

1. Serious bleeding rarely occurs before the onset of labor, no matter how low the fibrinogen level may fall.

2. Many patients who suffer this complication have had some manipulative procedure, such as manual removal of the placenta, prolonged vigorous massage of the uterus, uterine packing, hysterotomy or Caesarean section. It has been hypothecated that some "antifibrinogen" substance may be liberated by the uterus or placenta when these are manipulated or traumatized.

3. In almost all the fatal cases of afibrogenemia, the patient had a prolonged period of arterial hypotension due to uterine hemorrhage. Blood pressure must be maintained at adequate levels.

4. When hysterectomy was performed before the patient's condition had seriously deteriorated, the results were uniformly good.

5. Since the administration of fibrinogen is not without danger, the obstetrician should use the minimum amount necessary to achieve hemostasis. The absolute minimum is theoretically calculated to be three grams.

SUMMARY

1. A case of hypofibrogenemia is presented; treatment consisted of replacement of fibrinogen.

2. A knowledge of the causative factors and a high index of suspicion when a patient begins uterine hemorrhage in the delivery room are necessary for diagnosis.

3. Fatalities result primarily from prolonged hypotension.

4. Accepted treatment is replacement of the blood fibrinogen or early hysterectomy.

1305 E. Seminary Drive

BIBLIOGRAPHY

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3. Bowman, H., Yelito, M., *American Journal of Obstetrics and Gynecology*. 74:670, 1957.

Hospital of the Month

Doctors Hospital . . . Groves, Texas

This month's HOSPITAL OF THE MONTH column features Doctors Hospital in Groves, Texas. Located at 5500 39th Street, this progressive 50-bed, 7-bassinet hospital is administered by Mr. Bennie Bearden.

The hospital was founded in 1954 by Dr. Grover Stukey and Dr. R. O. De Witt. It operates as a private corporation, the stock of which is owned by seven staff physicians. Remodeled in 1957, the building will be enlarged again by summer, 1962, with an extension of the west wing. This enlarged wing will include new surgical suites, obstetrical area, laboratory and radiology suites. Approximately 5000 square feet will thus be added to the hospital.

Seventeen physicians and surgeons comprise the active staff of Doctors Hospital. Certified or Board-eligible specialists are found in the departments of surgery and anesthesiology. In 1961 almost 400 major surgical procedures were performed; 234 babies were delivered, and 1258 patients were admitted on medical service. The institution has over 70 non-physician employees.

Located in the Golden Triangle Area of Texas, the city of Groves has over 17,000 inhabitants. The hospital, however, draws from an enormous trade area of 250,000 persons, including the inhabitants of Port Arthur, Beaumont, Orange, Bridge City, Port Acres, Nederland and Port Neches. All of these cities are within a twenty-mile radius of Groves. Excellent opportunities for practice are to be found in all of these urban areas. Information concerning practice possibilities in North Orange (pop. 7,000) may be secured from Dr. A. L. Garrison, 420 Stadium Road, Port Arthur; in Port Arthur (pop. 65,000) from Mr. Bennie P. Bearden at Doctors Hospital; in Bridge City (pop. 4,677) from Dr. J. E. Barnett, P.O. Box 636, Bridge City.

This East Texas Gulf Coast Area has a relatively warm, moist climate with an average annual rainfall of 66 inches. Although winters are mild, the summertime temperature rarely exceeds 100 degrees. The area boasts itself to be a sportsman's paradise, with excellent facilities for boating, fishing, hunting and swimming.

The principal industry in the Golden Triangle relates to petrochemical products. The major companies are: Gulf Oil, Texaco, Koppers, DuPont, Jefferson Chemical, Magnolia, Neches Butane, and Texas-U.S. Chemical companies. With such heavy employment

sources, the economy of the Groves area remains stable.

Mr. Bearden, the hospital administrator, cordially invites all interested physicians to visit the city of Groves and Doctors Hospital to discover for themselves the advantages of practice in the Golden Triangle.

Texas Physician to Appear On Arkansas Program

H. G. GRAINGER, D.O.
Tyler, Texas

Dr. George Grainger, Tyler, along with A O A President C. L. Naylor, are scheduled to present the body of the Convention program of the Arkansas Osteopathic Association of Physicians and Surgeons at their annual meeting at Little Rock April 29 and 30.

Six "spots" have been assigned Dr. Grainger on the two day program. The accent is to be on "Fun in General Practice." Four of the talks will be: *"Fun with Ethyl (Chloride)", "Fun With Novocaine", "Fun With Ten Fingers", "Fun With Neurology."*

Each talk will be accompanied by clinical demonstrations.

The other presentations will be illustrated lectures on certain fundamentals of neurophysiology, and osteopathic diagnosis.

Exhibitors Annual Convention

Hotel Texas, Fort Worth, Texas
May 3, 4, 5, 1962

	BOOTH
Warren-Teed Products Co.	1
Savage Laboratories, Inc.	2
Dome Chemicals, Inc.	3
Pfizer Laboratories	4
Lanpar Company	5
Roche Laboratories	6
U. S. Vitamin & Pharmaceutical Corp.	7
Inland Pharmacal Company	8
The Spinalator Company	9
Dorsey Laboratories	10
Mead-Johnson Laboratories	11
Sid Murray "Pays in a Hurry"	12
Merck, Sharp & Dohme	13
Mission Pharmacal Co.	14
Pharmafac, Inc.	15
J. A. Majors Company	16
Professional Foods	17
Stanley Supply Co.	18
The William A. Webster Co.	19
Testagar & Co., Inc.	20
Riker Laboratories, Inc.	21
Mills Pharmaceuticals, Inc.	22
First Texas Pharmaceuticals, Inc.	23
Mercury Pharmacal Co.	24
Breon Laboratories	25
A. H. Robins Company, Inc.	26
Smith, Kline & French Laboratories	27
Owen Laboratories, Division	28
E. Fougera and Company, Inc.	29
Emerson Laboratories	30
Medco Products Co., Inc.	31
The National Drug Co.	32
Ciba Pharmaceutical Products, Inc.	33
Kay Pharmacal Company	34
Merit Pharmaceutical Company, Inc.	35
Baker Laboratories, Inc.	36
Smith, Miller & Patch	37
A. S. Aloe Company	38
X-Ray Sales and Service	39
The Cary-Taylor Company	40
E. R. Squibb & Sons	41
The Torrance Company	42
The Upjohn Company	43
R. J. Lindquist Co.	44
Vitamin Products Co. of Tex.	45

The California Situation As of March 21, 1962

Despite assurances from the Governor's office that the "merger" matter would not be an item for the Special Session of the California Legislature, the Special Call issued on March 6, 1962, did include the subject as the 41st on the list.

The many years of close rapport by the COA and CMA with members of the Legislature, and their office staffs, has been very evident in the movement of the necessary implementation bills presented to the Senate by Senator Stephen Teale, D.O. Representations to the members of both Houses are being made by O.P.S.C. people, but the advantages of years of work by the COA and CMA are making it difficult to secure effective results.

On March 20 the Senate Committee heard the five bills in the package, gave short shrift to O.P.S.C. testimony, and sent them on toward the Senate with a "Do Pass" recommendation. The next battleground will be the Assembly.

Concurrent with this, the results of a survey of representative samplings of the people of California indicates that 62.3% of those interviewed are opposed to the termination of licensing of D.O.s in California . . . and that of the 34.9% of those interviewed who approve of the merger, 75.7% are opposed to the termination of licensing of D.O.s in this State.

The survey indicates a favorable ground upon which to wage the public education program for the vote of the people if the Amendment of the Initiative Act of 1922 goes to the November, 1962 ballot. This public recognition is most welcome — and lends strength to the embattled members of O.P.S.C.

Ft. Worth Writer Wins AOA Journalism Award

Mr. Blair Justice, science editor for the Fort Worth *Star-Telegram,* was named one of three winners of the 1961 Journalism Awards competition sponsored by the American Osteopathic Association. Mr. Justice won the award for an article describing the use of synthetic materials in surgery of blood vessels.

Other winners were Miss Jeanne Franke, staff writer for the Chicago *Tribune,* whose story described the development program of the Chicago College of Osteopathy; and Ross Gelbspan of the Philadelphia Evening and Sunday *Bulletin* who wrote about a Philadelphia alcoholic rehabilitation clinic operated by osteopathic students and physicians.

Each of the three winners will receive a certificate and $100 for an outstanding story about osteopathic medicine.

What's Your Score?

(Answers on Page 24)

1) Strict low-purine diet is no longer prescribed for most patients with chronic gout, because:

a) Nutritional experts are not certain which foods contain purines

b) Uric acid is derived as much from internally-produced purines as from dietary purines

c) Chronic gout is now known to be related to low rather than high uric acid levels

2) States other than gouty arthritis in which uric acid levels may be elevated are:

a) Renal insufficiency, leukemias, malignancies, severe infections

b) Acute rheumatoid arthritis, systemic lupus erythematosus and polyarteritis

c) Mumps encephalitis, tertiary lues, primary hyperparathyroidism

3) The sex distribution of gouty arthritis is:

a) 75% males and 25% females

b) Approximately equal between males and females

c) 95% males and 5% females

4) The cardinal clinical findings in acute gouty arthritis are:

a) History of previous attack; abrupt onset; red, angry swelling of joint; dramatic response to colchicine

b) Usually no previous episode; gradual onset over weeks; joint pain without edema or erythema; dramatic response to Benemid

c) Abrupt onset; multiple joint involvement; necrotic ulceration of skin over first metatarsophalangeal joints; no response to therapy other than opiates

5) Serum uric acid levels in the patient with acute gouty arthritis are often normal or low because:

a) High uric acid levels are observed only in chronic tophaceous gout

b) most patients have been pre-

treated with salicylates, ACTH, steroids or Benemid, all of which are uricosuric agents which lower uric acid levels

c) Most laboratories employ outdated methods of determining uric acid levels, all of which fail to measure all the uric acid present.

6 The roentgenographic finding most sugestive of gout is:

a) Radiopaque shadows in the interarticular spaces due to urate deposits

b) Demineralization of bone substance adjacent to gouty joint

c) Well defined, punched-out areas commonly observed at bases or head of phalanges

7) The majority of gouty patients die from:

a) Uremia, due to high incidence of calculi, tubular deposit of urates, and involvement of renal vasculature

b) Causes other than those associated with gout

c) Cerebral dysfunction due to intracranial urate deposits.

9) Colchicine is the most effective drug for the relief of acute attacks of gout in the majority of patients and is best prescribed:

a) 0.5mg orally every hour for 5 doses, followed by 0.5mg every 2 hours, until relief or gastrointestinal upset

b) 2.0mg four times daily

c) In conjunction with Benemid, salicylates and ACTH

9) Benemid has no place in the treatment of acute gouty arthritis because:

a) As a uricosuric agent it mobilizes uric acide and may provoke further gouty crisis unless used in conjunction with colchicine

b) It has been proven ineffective in either acute or chronic gout

c) While being second only to colchicine in the treatment of acute gouty arthritis, it is far too expensive to be used in such cases

10) Mainstays in treatment of chronic gout are:

a) Long-term colchicine therapy, strict purine diet, cobalt-90 irradiation

b) Uricosuric agent such as Benemid, moderate dietary restriction of purine, heavy fluid intake and alkalinization of urine to prevent calculi

c) Surgical excision of tophi (urate deposits), uricosuric agents such as Benemid, moderate purine restriction and intermittent steroids

by IATROS

DUAL MEMBERSHIP

TO: DIVISIONAL SOCIETY SECRETARIES

As you know, at its meeting in Las Vegas in January, the A.O.A. Board of Trustees took action postponing the dual membership requirement until June, 1963. However, in order to eliminate any possible confusion, we wish to point out that this *does not apply to new applicants for A.O.A. membership or applicants for reinstatement of A.O.A. membership.*

Beginning February 1, 1962, all those applying for A.O.A. membership have been, and will continue to be, required to have divisional society membership. This requirement was not enforced prior to that time if the application was endorsed by the divisional society secretary.

Sincerely yours,

True B. Eveleth, D.O.
Executive Director
American Osteopathic Association

SYLLABUS OF CONTINUING EDUCATION FOR TEXAS PHYSICIANS

1962

APRIL 12-15—New Mexico Association of Osteopathic Physicians and Surgeons, annual meeting, Western Skies Hotel, *Albuquerque.* Program Chairman, George C. Widney, Jr., D. O., 1125 Kent Ave., N. W., Albuquerque.

16-18—NATIONAL OSTEOPATHIC CHILD HEALTH CONFERENCE, Municipal Auditorium, *Kansas City, Mo.* Exec. Sec.: Stan J. Sulkowski, D.O., 1601 Belmont Ave., Kansas City 26, Mo.

MAY 3-5 —TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS annual meeting, Texas Hotel, *Fort Worth.* Sec.: Phil Russell, D.O., 512 Bailey St., Fort Worth.

5 —TEXAS ACADEMY OF APPLIED OSTEOPATHY semi-annual seminar, Texas Hotel, *Fort Worth.* Sec.: Catherine Carlton, D.O., 815 W. Magnolia, Fort Worth.

29- —Basic Course in Electrocardiography conducted by David W. Boone, D.O. at Kirksville College of Osteopathy

JUNE 2 —and Surgery. 36 hrs. of postgraduate credit. Fee $150.00 including advance registration of $50.00. For information, contact Dean R. McFarlane Tilley, KCOS, *Kirksville, Missouri.*

27-30—Society of Nuclear Medicine, ninth annual meeting, *Dallas, Texas.* Gerard K. Nash, D. O., 2200 Memorial Drive Extended, Farrell, Pennsylvania.

AUGUST 6-9 —MEMORIAL CARDIOVASCULAR FOUNDATION annual clinical assembly, Grove Park Inn, *Asheville, North Carolina.* Chmn.: George F. Pease, D.O., 1001 Montgomery St., Fort Worth 7, Texas.

SEPTEMBER —TEXAS OSTEOPATHIC RADIOLOGICAL SOCIETY annual meeting, *Dallas, Texas.* Sec.: Charles Ogilvie, D.O., 1141 N. Hampton Rd., Dallas 8, Texas.

28-29—TEXAS ACADEMY OF APPLIED OSTEOPATHY semi-annual meeting, Villa Capri Hotel, *Austin, Texas.* Sec.: Catherine Carlton, D.O., 815 Magnolia, Fort Worth.

OCTOBER 7-13—WORLD CONGRESS OF CARDIOLOGY annual meeting, Medical Center, *Mexico City, Mexico.* Write: I. Costero, M.D., Instituto N. De Cardiologia, Avenida Cuauhtemoc 300, Mexico 7, D.F.

28- —American College of Osteopathic Surgeons, annual clinical assembly with American Osteopathic Hospital Asso-

NOVEMBER 1 ciation, American Osteopathic College of Anesthesiologists, American Osteopathic College of Radiologists, American Osteopathic Academy of Orthopedics, and American College of Osteopathic Hospital Administrators, Americana Hotel, *Bal Harbour, Fla.*

1963

JANUARY 28-31—American Osteopathic Association, 67th Annual Convention, Fontainebleau Hotel and the Barcelona, *Miami Beach, Florida.*

Consultant's Corner

QUESTION: *Is spinal anesthetic contraindicated in metastatic carcinoma of the lumbar spine?*

ANSWER: Yes. Metastatic carcinoma of the lumbar spine usually relates to the growth of tumor in the vertebral bodies with extension into the epidural space. The hazards and contraindications to spinal anesthesia obtain from this feature of epidural extension of the secondary tumor mass. Theoretically, the spinal needle may pierce the epidural tumor mass, and advance tumor cells into the subarachnoid space for free dissemination in the spinal fluid. The spinal needle may release spinal fluid which is under marked pressure, because of the obstruction created by the tumor within the spinal canal. This sudden release of fluid under pressure may cause herniation of neural structures through the dural puncture. This same obstruction could interfere with the normal spread of anesthetic agent and be responsible for an incomplete inadequate anesthesia which would then require supplementation with local or general anesthesia.

Four cases are recorded where intraspinal tumors were diagnosed after spinal anesthesia had accentuated the symptoms. In two of these cases the condition could have been diagnosed prior to injection of the anesthetic agent—in one by noting the marked increase in pressure, in the other by noting discoloration of the fluid.

P.A.S.

QUESTION: *What can be done manipulatively and structurally to improve lumbo-dorsal scoliosis?*

ANSWER: Treatment will depend upon the etiologic factor. If there have been organic changes, such as lateral wedging of the vertebrae due to disease or trauma and the symptom complex does not warrant surgery, treatment must be directed toward maintaining a compensated balance of structural mechanics. This will entail soft tissue manipulation to maintain muscle tone and to reduce fibrositic changes in the areas of stress. Bony manipulation must be gentle and only sufficient to maintain the degree of motion in the spinal articulations, as it is limited by the existing pathology. Should the basic etiologic factor lie below the sacral top and there has been no organic bony change above, the opportunity for improvement is greater. Anatomical deviations in the shape of the sacrum, long-standing sacroiliac strains, anomalies of the ilium and the anatomic short leg are some of the causes of lateral tilting of the spinal base of support which will produce a functional lumbo-dorsal scoliosis. They can be diagnosed by careful physical examination and verified by the use of the X-ray, particularly films made in the standing position. Correction by the judicious use of heel lifts will level the sacral base and remove the scoliosis. This correction can be confirmed by films made after the lift has been applied. The sacroiliac strains can be corrected by manipulative treatment.

R.P.

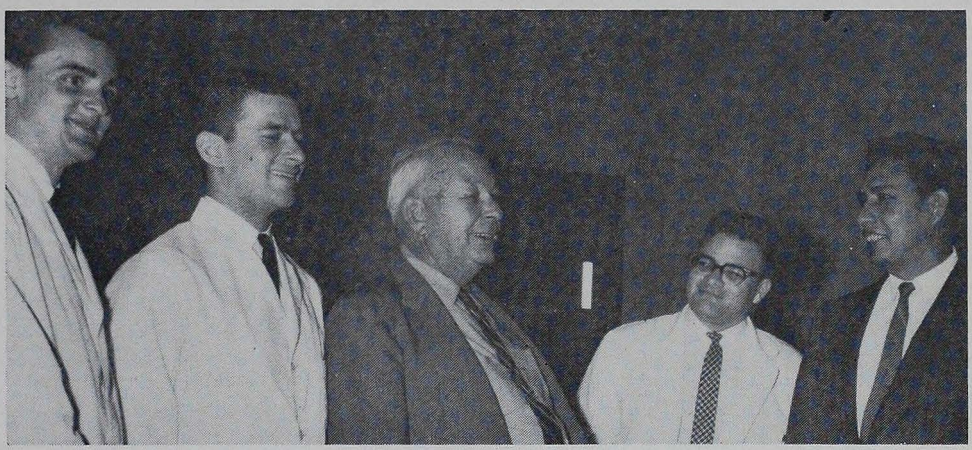
Osteopathic Physicians' Assistants to Meet

An invitation is extended to all Osteopathic Physicians' Assistants to meet in Ft. Worth August 25, 26, 1962, for the purpose of forming The Association of Osteopathic Assistants.

All assistants, who are interested, are asked to contact—Mrs. Billie L. Runnels, 4916 E. Belknap St., or Mrs. Gloria Cook, 825 N. Sylvania St., Ft. Worth, Texas.

DOCTORS! Please note and remind and encourage your ASSISTANTS to attend.

Executive Secretary's Travelogue



The executive secretary visits with four of the six Texas students enrolled in the College of Osteopathic Medicine and Surgery, Des Moines, Iowa. Pictured left to right: John Sartori, Ft. Worth, Freshman; Jerold Lynn, Dallas, Freshman, Dr. P. R. Russell, Executive Secretary, TAOP&S; Richard Lane, Dallas, Sophomore, and Oscar Guiterrez, San Antonio, Junior. The two Texas students not pictured are Rex E. Ollom, New Braunfels, instructor in anatomy department and Bernard Feigelman, Houston, Freshman.

March was a terrifically busy month so far as the office was concerned, preparing for the annual convention, getting out the annual reports according to the instructions of the House of Delegates which was an almost impossible task but we were successful in spite of the complications. Then, of course, we travelled!

On March 1st the executive secretary made a trip to Dallas, stopping first at Stevens Park Osteopathic Hospital, next at Continental Life Insurance Company and National Security Life Insurance Company, and then to Dallas Osteopathic Hospital. Finally, after a hard day's work in the interest of the public, the executive secretary had dinner with Mr. H. G. Mann, administrator of the Dallas Osteopathic Hospital and with Dr. G. LeRoy Howe a surgical resident who we hope will locate in Texas after he completes his residency in July. The entire day was most interesting and productive and the executive secretary concluded his activities about 11:30 p.m.

He left Fort Worth again on March 8th, going to Amarillo to attend the Regional Meeting of the American Osteopathic Hospital Association called "The Hospital Triad." The executive secretary was warmly welcomed at the airport by Dr. Glenn R. Scott, Dr. J. Francis Brown and Mr. W. L. Davis, administrator of the Amarillo Osteopathic Hospital. After a lengthy discussion of the affairs of the profession, he was entertained at dinner by Doctors Scott, Brown, Ersal W. Cain and Mr. Davis.

Following dinner, the executive secretary returned to the hotel where he met with Dr. Robert F. Weissinger, who is completing a residency in surgery in Des Moines. He is a close friend of Dr. Eakin in Amarillo and desires to locate either in that city or somewhere in Texas. We hope we were successful in convincing Dr. Weissinger that osteopathy in Texas has a great future.

Friday and Saturday, March 9-10, were spent attending the very enlight-

ening meeting of the AOHA. The morning program was a general session with all in attendance. The afternoon program was divided into three Group Sessions: (1) Board of Trustees, moderated by James A. Hamilton, Director, School of Hospital Administration, University of Minnesota; (2) Chiefs of Staff, moderated by Mr. Hamilton's Associate; (3) Administrators, moderated by Mr. Reno of Kansas City, Missouri.

On Saturday, the actions of the three sessions were correlated into a final summary of all sessions. It is certainly regrettable that this meeting did not receive more publicity and that it was not better attended by representatives of the larger hospitals which have boards of trustees, administrator and general staff organizations. These men were experts. They were not dogmatic, yet they knew what they were doing. It was indeed a wonderful educational program and one that should have been heard by everyone connected with a hospital.

Medical Board to Meet

The next meeting of the Texas State Board of Medical Examiners when examinations will be given and reciprocity applications considered is scheduled for June 18, 19, 20, 1962, at the Texas Hotel, Fort Worth, Texas.

Completed examination applications must be filed with the Board thirty days prior to the meeting date.

Completed reciprocity applications must be filed sixty days prior to the meeting date to be given consideration.

The executive secretary felt fortunate that he knew Mr. Hamilton, having met him on a previous occasion. On Saturday he had lunch with Mr. Reno and received an invitation to spend time at his well known institution in Kansas City.

The executive secretary returned to Ft. Worth on Monday, March 12.

On Wednesday, March 14, he was visited in the state office by Mr. Mike Bickel and Mr. Earl Gorrell, representatives of Provident Life and Accident Insurance Company of Houston. After some two-hours discussion, they had lunch and then the executive secretary took them on a tour of the Fort Worth Osteopathic Hospital as they had expressed a desire to view some of the osteopathic hospital facilities.

On Thursday, March 15, he spent some two hours with a prospective student from Arlington State College . . . a man who seemed determined and properly motivated to enter one of our institutions.

The executive secretary left Ft. Worth again, Saturday, March 17, to visit the midwest osteopathic colleges. He arrived in Chicago that evening and on March 18 visited with a loyal old benefactress who has given much financial aid to our profession . . . Mrs. Zetta Carter. He entertained her at dinner and enjoyed a wonderful visit with her. His visit culminated in another gift of $15,000 to the Kirksville College of Osteopathy and Surgery and a promise of additional help to the profession in the future.

Mrs. Carter is 82 years old and has been in the hospital with a broken hip, most of the past two years. We wish her a speedy recovery. She has a wonderful mind and is enthusiastic about our profession. This latest gift makes a total of $135,000 which she has given to the osteopathic profession within the last 10 years . . . $100,000 of which went to the Ft. Worth Osteopathic Hospital and the balance to the schools.

It certainly behooves us to take care of our friends.

On Monday, March 19, the executive secretary was at the Chicago College of Osteopathy where he visited for some two hours with President R. N. MacBain and Dean Kistner. At 10:30 a.m. he spoke to the seniors and juniors, in assembly, his subject being "The Future of This Profession." Following his talk, the executive secretary visited for an hour and a half with various students and then went directly to the American Osteopathic Association office where he had a lengthy discussion with Dr. True B. Eveleth and Dr. George W. Northup and others in the national office from whom he desired information.

That evening, he left Chicago for Des Moines, Iowa, arriving there about 10:30 p.m. He was met at the airport by Dean John B. Shumaker and taken directly to the hotel where they had a two hour discussion in reference to the College of Osteopathic Medicine and Surgery and the profession, in general.

On March 20, after an enjoyable breakfast with Dean Shumaker, the executive secretary went directly to the college where he met with President Merlyn McLaughlin. At 10:30 a.m. he addressed a general assembly of COMS. His talk was well received, and for approximately an hour following the talk, he was answering the many questions propounded by the students.

He was then taken to the Des Moines Club for lunch, as the guest of President McLaughlin and then returned to the college where he conferred with various students. At 7 p.m. he met with Dr. Leininger and his preceptor, Dr. Weissenger and their wives for dinner in a private club. There, he was introduced to some 10-12 other osteopathic physicians and their wives. This was a most enjoyable occasion, arranged by Dr. Leininger in order to bring the executive secretary up to date on his last hospital inspection (which was in Florida) and to bemoan the fact the executive secretary was not with him to share his latest escapade.

You will remember that on his first inspection trip with Dr. Leininger in Texas, the executive secretary was robbed of $150 which he never recovered. Then on his second trip, Dr. Leininger lost $1,000 which was recovered. Now, on Dr. Leininger's recent trip to Florida, due to the fact he flew in and out in a private plane, the police department put him through the 3rd degree

to find out what he was doing and to clear him of suspicion in connection with large jewel thefts that have been going on in Florida. The executive secretary informed Dr. Leininger that this would never have happened if he had been there as he certainly didn't look like a jewel thief.

On Wednesday, March 21 the executive secretary had breakfast with Dean Shumaker and then went directly to the College for another hour's visit with President McLaughlin. From there he went to visit Mr. Kenneth Barros of Bankers Life Insurance Company with whom our Insurance Committee has had a great deal of correspondence. He then rushed to catch an 11 a.m. plane to Kansas City.

The executive secretary arrived in Kansas City at 12:05, had lunch and went to the Kansas City College of Osteopathy and Surgery where he had a lengthy conference with President Joseph M. Peach and Dean Kenneth J. Davis. He later visited with various students in the college who were interested in Texas. At 7 p.m. he met Dr. Povlovich, and several students, and gained considerable information of value.

On Thursday, March 22, he was again at the College at 8:30 a.m. where he met with Dean Davis and talked at length with a student from Denton, Texas who is making application for admission to the College in the September 1962 Freshman class. From 10-11 a.m. he addressed the Senior and Junior students in assembly and at 12 Noon rushed to the Union Station to catch a train for La Plata, Missouri.

The train ride to La Plata almost ended in a catastrophe! The executive secretary was riding in the dome of the observation car, watching the beautiful Missouri scenery and fell asleep. Something suddenly wakened him, just as the train was pulling out of La Plata. He made a wild dash through three cars, using his Texas voice and made it understood he wanted to get off. He finally made it! If he hadn't had good lungs, he would have ended up in Ft. Madison, Iowa.

He was met at the station by Mr. Louis W. Handley, Business Manager of the Kirksville College of Osteopathy and Surgery, who took him to the new country club in Kirksville for some resurrecting buttermilk. They then when to the Travelers Hotel where the executive secretary found a call waiting for him from Prsident Morris Thompson.

Again, the executive secretary made a technical error! He called the number and assuming the woman who answered the phone was Miss Selsor (with whom he is well acquainted) he asked to speak to the "Janitor." There was a good deal of sputtering on the other end of the line and finally dear old Morris answered, stating, "3rd Assistant Janitor." The executive secretary will be more sure of who he's talking to before he makes this kind of "bust" again. He left immediately for President Thompson's office and after a lengthy discussion they went to Dr. Thompson's home where the executive secretary paid his respects to Mrs. Thompson and family and then they went to dinner.

On Friday, March 23, the executive secretary was at the Kirksville College at 8 a.m. where he met with Dean R. McFarlane Tilley for approximately an hour. He then spoke to the Junior class for another hour and was introduced to the class by President Morris Thompson. Following his talk, he was kept busy answering questions propounded to him by the Junior students and then had lunch with several members of the staff.

The afternoon was spent at the hospital and in the Dean's office and in consultations with Senior students until well after 4 p.m. He then visited

with Dr. Denslow for an hour and at 6 p.m. went to dinner with some six students from Texas.

At 9 p.m. he met with the Rev. Mason who is the son of the late Dr. H. B. Mason of Temple, Texas, discussing the osteopathic philosophy. Rev. Mason is to deliver the graduation address at the college. At 9:45 he was at ITS House for their initiation of new members, of which there were some 40-50 students and their wives. It was indeed an enjoyable evening and the executive secretary managed to get to bed about 1 a.m.

On Saturday, March 24 he met with Mr. Lewis F. Chapman, secretary of the Kirksville Alumni Association, for breakfast during which time they discussed the alumni situation in general. Following this, Dean Tilley took the executive secretary to the out-patient department for a visit with Dr. Ira Rumney over the new program sponsored by the money donated by Mrs. Rockefeller. At 12:15 p.m. he was met by President Morris Thompson. They had lunch and he was then taken to La Plata to catch the afternoon plane.

On Monday, March 26, the executive secretary was back in the office. That evening there was a meeting of the local convention committee. Everything seems to be shaping up well for the 1962 Convention which promises to be unusually good this year.

On Wednesday, March 28, the executive secretary spent some two hours at the Hurst General Hospital and then spent another 2½ hours at the Mid-Cities Memorial Hospital in Grand Prairie. Both visits were highly profitable to both the hospital and the association.

The executive secretary spent most of Thursday afternoon, March 29, at the United States Public Health Hospital in conference with the director, Dr. Razor and with a patient in the institution. Those who have never visited this institution and seen it function, have truly missed something. It is a wonderful institution.

As we close the travelogue, the executive secretary is preparing to leave for Western Hills Inn, Euless, Texas where at 4:30 p.m. he will deliver the welcoming address for the meeting of the American Academy of Orthopedics which starts today, March 30.

See you next month!

O.P.F. News

Congratulations were extended to Dr. Phil R. Russell, executive secretary of the Texas Association of Osteopathic Physicians and surgeons, for securing a lay gift of $15,000 to the Kirksville College of Osteopathy and Surgery, this year.

Dr. Russell will be presented a 69 CLUB membership certificate and pin at the Founder's Banquet in Kirksville, October 1962.

Answers to "What's Your Score?" Questions, Page 13

1)—B	6)—C
2)—A	7)—A
3)—C	8)—A
4)—A	9)—A
5)—B	10)—B

Texan Named to College Board

COL. D. H. BYRD
Dallas, Texas

Col. D. H. Byrd, Dallas, Texas industrialist, pioneer, geologist, oilman, aviator, investor, financier, philanthropist and sportsman, has been named to the corporate Board of the College of Osteopathic Medicine and Surgery, Des Moines, Iowa, by Dr. Merlyn McLaughlin, president.

He is the first lay person from Texas to be elected to one of our college boards.

Col. Byrd is a descendant of the famed Virginia Byrd family and a cousin of Admiral Richard Byrd, polar explorer.

Good Locations

SEGUIN, TEXAS (pop. 9,733) 30 miles N.E. of San Antonio needs qualified general practitioner to take over practice. Office space available. If interested call or write Homer C. Parker, City Pharmacy, 110 North Austin Street, Seguin, Texas. Phone: FR 9-1450.

SEGUIN, TEXAS — Eye, Ear, Nose and Throat specialist needed to fill vacancy left by specialist who has retired. If interested call or write Homer C. Parker, City Pharmacy, 110 North Austin Street, Seguin, Texas. Phone: FR 9-1450.

Reports On Tenth Annual Child Health Conference

FORT WORTH, TEXAS

by LESTER L. HAMILTON, D.O.

CONFERENCE SUMMARY

We feel the following facts are worthy of note:

1. We examined a total of 280 children between the ages of newborn and eight years. Out of this number only 66 cases came to us as having one or more recognized problems. Through our clinic we picked up well in excess of 200 problems of one degree or other in these 280 children. In addition to this we found that a great number of these children had inadequate immunizations and inadequate dental care, as we shall note later.

2. Physicians and parents are failing to get their children properly immunized against diphtheria, whooping cough and lock-jaw. Children in the 3 to 5 year group should already have had a minimum of four D.P.T. shots. Five shots are preferable. There were 101 children in this group of ages 3 to 5, and only 25 of these children had received 4 shots or more.

3. Physicians and parents are also failing to get their children immunized against poliomyelitis. Children in this 3 to 5 year group should already have had a minimum of 4 shots of poliomyelitis vaccine. Five shots are preferable. Only 41 out of this 101 children had received 4 shots or more.

4. Our dentist stated that every child should have visited a dentist by 3 years of age. Note that in the 3 to 5 year group 87 out of 101 had not been to a dentist; Note also that 48 out of this 101 needed definite dental attention.

5. Note also, that 7 out of this 280 children had general structural problems; 26 had definite orthopedic problems; 4 had heart problems; 2 were cerebral spastics; 2 were mentally retarded; 8 had definite speech problems; 46 had enuresis; 4 had skin problems; 6 had gynecological problems; 50 had eye problems and 66 had definite physiological problems.

It is of particular interest, I believe, that 66 out of our total of 280 children had definite physiological problems. We did not classify any child under this heading, unless he had two major indications, such as temper tantrums and night terrors or any other equally two important indications.

I believe it is also worthy of note that 50 out of our total of 280 children had eye problems. This takes on even more importance when we realize that the

younger age groups cannot adequately be evaluated in reference to vision.

6. Sixty out of our total of 280 children were border line anemias with Hemoglobin ranging from 10.6 gms. to 11.9 gms. Seven children out of this 280 total were frank anemias, with hemoglobin 10.5 gms. or below.

7. Female patients were carefully examined for gynecological problems and we found 6 problems in this category. This takes on added significance since about 50% of these 280 children were boys. Two of these gynecological problems occurred in the 3 to 5 year group and four in the 6 to 8 year group.

8. All children were carefully screened this year for phenylketonuria however, no cases were found. In addition to the above problems we discovered one case of nephrosis, one hemiplegia of undetermined etiology, one hydrocephalis, one cleft palate, one Mongoloid, one possible duodenal ulcer, one hearing problem, one hydrocoele, one undescended testicle, one chronic brain problem unclassified. We questioned all parents concerning convulsions in their children at any time since birth, and 8 reported convulsions.

REPORT FROM GENERAL CHAIRMAN

MRS. JEAN WHITTLE

The Tenth Annual Child Health Clinic, sponsored by the Auxiliary to the Fort Worth District 2 Association of Osteopathic Physicians and Surgeons, on March 16-17, 1962 convened at the Hotel Texas Exhibit Hall in downtown Fort Worth.

A total of 280 children, from infancy to 8 years of age, were given physical examinations. The clinic was privileged to have on its staff this year Drs. Nelson D. King, Kirksville; Ralph I. McRae, D. E. Marinelli, Robert L. Moore, Dallas; Armen Marouk, Tulsa; Miss Bennie Ann Smith, Speech Evaluationist from the Fort Worth Society for Crippled Children and Adults, 8 dentist, 9 optometrists and 41 D.O.s from District 2 and surronding areas.

Many volunteer workers on committees included Gray Ladies from the Tarrant County Red Cross Chapter, Kappa Delta Sorority members from T.C.U., Fort Worth Osteopathic Hospital Guild workers, nurses from Mid-Cities Hospital, Arlington and Fort Worth Osteopathic Hospital.

All chairmen and workers are to be complimented for their time and effort, which made the Tenth Annual Child Health Clinic a success.

Texas Academy to Meet In Fort Worth, May 5

The Texas Academy of Applied Osteopathy will hold a meeting Saturday, May 5, 1962 in the Hotel Texas, Fort Worth, immediately following the close of the state convention. The meeting will start with a luncheon at 12:00 Noon, followed by a short business session.

Teaching Technique Sessions will begin at 1:00 P.M. under the capable direction of Dr. Ira C. Rumney of Kirksville, Missouri. Subjects: "Shoulder and Upper Thoracic Arc" and "Lower Back Problems." He will be assisted by Dr. H. G. Grainger of Tyler and Doctors Catherine K. Carlton, George J. Luibel and Elbert P. Carlton, all of Fort Worth.

Dr. Rumney is a Perrin T. Wilson Professor of Osteopathic Theory and Practice in the Kirksville College, Rockefeller Foundation Fellowship Award.

The Academy will also hold a breakfast meeting in the Hotel Texas, Friday, May 4, from 7:00-9:00 A.M., at which time Dr. Rumney will speak on "The Clinical Applications of the Findings by the K.C.O.S. Research Group."

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Chairman: Council on Federal Health Programs
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March 7, 1962

Washington News Letters

Occupational Safety

"Safeguarding Human Worth" was the theme of the eighth biennial President's Conference on Occupational Safety held in Washington, March 6-8. The AOA delegate was the Chairman of the Council on Federal Health Programs. Preliminary figures show that accidents last year cost the nation some 91,000 lives and nearly $14 billion. The rate of improvement in occupational safety performance has slowed during the last few years. Off-the-job injuries are 8 to 10 times as high as on-the-job. In 1961, there was a fatal on-the-job accident every 38 minutes. But off-the-job *at home* someone was killed every 19 minutes, just twice as frequently. The health profession has been contributing to the prevention of industrial accidents since the English Factory Acts of 1832. Physicians and nurses must maintain an active interest in possible causes and sources of industrial and non-industrial accidents and should make regular plant inspection designed to study the working conditions of the plant's employees. There should be preplacement examinations leading to correction of impairments before employment. There should be periodic health evaluations with appropriate orientation in health factors which can cause accidents. Medical societies should stress a safety program among their members rather than sticking purely to the therapeutic approach.

Hospital House Staffs

A Public Health Service Health Manpower Source Book entitled, Hospital House Staffs, the thirteenth in a series on health manpower, presents data on the number of internships and residencies offered and filled in hospitals with various characteristics. See enclosed excerpt dealing with osteopathic hospitals. The Source Book also includes data on number and distribution of foreign medical school graduates serving as interns and residents in U. S. hospitals.

March 28, 1962

Medical Education Aid

On March 24, 1962, the House Committee on Interstate and Foreign Commerce favorably reported the Health Professions Educational Assistance bill, H.R. 4999, with amendments.

The reported bill deals with medical and osteopathic schools and students on the same basis. The Committee Report, however, while granting the need for the liberal long-term low-interest loans with forgiveness features

to osteopathic students, remarks on our minimal contribution in the limited states and suggests there *may be* some question as to our immediate need for school construction assistance (but see Test of Expanded Enrollment page 9) when several of our existing schools are having difficulties in filling their classes with qualified applicants.

The Health Research Facilities Act under which we participate is extended to June 30, 1966 by the bill.

The bill should pass the House next week, if it survives threatened anti-segregation amendments, after which it goes to the Senate.

AEC Proposes Exemptions for Medical Use

The Atomic Energy Commission has given notice of proposed rule making to exempt the use for diagnostic purposes by unlimited physicians of iodine 131, cobalt 58, cobalt 60, and chromium 51 in specified forms and relatively small quantities. A general license would be established for the medical use of iodine 131 and phosphorus 32 in specified forms and limited quantities sufficient for certain therapeutic and diagnostic uses. A general license would be established also for needles and tubes containing cobalt 60. Cobalt 60 needles and tubes would be generally licensed for use by an unlimited physician who has at least three years of experience in the interstitial or intracavitary use of sealed sources containing radioactive materials, and who certifies to the Commission that he is familiar with the hazards and appropriate precautions associated with such sealed sources. Under an Act of 1959, AEC was authorized to enter into agreements with states whereby the states would take over the licensing in lieu of the Commission. The California legislature now has under consideration such an agreement.

April 3, 1962

Kerr-Mills Program

On March 15 Secretary Ribicoff sent to the House Ways and Means Committee a report on the first year's experience in providing medical care through public assistance programs under Public Law 86-788, popularly known as the Kerr-Mills legislation. The report showed that as of October 1, 1961, 19 states had set up MAA programs, as follows: Arkansas, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Washington and West Virginia. All 19 states provided some hospital care, and all but Tennessee included practitioners' services. A chart accompanying the report showed that the services of doctors of osteopathy were included in the following 11 states: Idaho, Kentucky, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Washington, West Virginia.

AUXILIARY NEWS

AUXILIARY PROGRAM

Annual Convention of Texas Association of Osteopathic Physicians and Surgeons

Hotel Texas—Fort Worth, Texas

May 3-5, 1962

Wednesday, May 2

9:30 A.M.—Auxiliary Executive Board, Shorthorn Room ..... Mrs. John H. Burnett, President, A.T.A.O.P.S.

Thursday, May 3

10:00 A.M.-12 Noon—Auxiliary "Get Acquainted Coffee" ..... Jr. Ballroom (A-B)
(Sponsored by Mission Pharmacal Co.)

12:15 P.M.—Opening Luncheon ..... Grand Ballroom No. 2

2:00 P.M.—Business Meeting, House of Delegates ..... Shorthorn Room
Invocation ..... Mrs. M. G. Holcomb
Welcoming Address ..... Mrs. J. O. Carr, President, Aux. Dist. 2
Response ..... Mrs. John Boyd, Pres.-Elect, A.T.A.O.P.S.
Guest Speakers ..... G. W. Tompson, D.O., President, T.A.O.P.S.
Charles L. Naylor, D.O., President, A.O.A.
Mrs. William B. Strong, President, A.A.O.A.
Business Meeting ..... Mrs. John H. Burnett

7:00 P.M.—Cocktail Party ..... Ridglea Country Club
(Courtesy of Baker Laboratories, Inc.)

8:00 P.M.—Dinner, Dancing and Entertainment ..... Ridglea Country Club

Friday, May 4

12:30 P.M.—Installation Luncheon ..... Shady Oaks Country Club
Invocation ..... Mrs. J. J. Schultz
Welcome and Introductions ..... Mrs. George G. Clark, Vice Pres., A.T.A.O.P.S.
Installation of Officers ..... Mrs. William B. Strong, Pres., A.A.O.A.

7:00 P.M.—President's Reception ..... Grand Ballroom No. 1-2

8:00 P.M.—President's Banquet ..... Grand Ballroom No. 1-2

Saturday, May 5

8:00 A.M.—Past Presidents' Breakfast ..... Hotel Texas Coffee Shop

9:30 A.M.—New Auxiliary Board Meeting, Gold Room ..... New President to preside

NEWS OF THE DISTRICTS

DISTRICT 10

Jo Mann is now home from the hospital and apparently getting along well on the road to a long recovery. Her leg will be in a cast yet for quite some time. I am sure she would appreciate your good wishes.

Dr. G. G. Porter returned last week from a three day meeting of the Texas State Board of Medical Examiners at the Rice Hotel in Houston. This meeting was for the purpose of hearing seven doctors who were cited to appear before the Board.

Dr. E. S. Davidson and Lee Baker, administrator of Lubbock Osteopathic Hospital, spent last Saturday and Sunday in Amarillo attending a meeting of the A.O.H.A.

Dr. Mel Wisby reports that his hearing has improved markedly since his recent ear surgery.

Dr. Ben Souders and Dr. Harlan Wright just returned from attending the Tenth Annual Pediatric Seminar in Fort Worth and reported a very excellent meeting. Dr. Souders is taking to the air like a duck to the water.

DISTRICT 11

District 11 had a special called meeting Friday night, March 29, at the Skyrider's Club. Dr. Harlan Wright of Lubbock, Texas presented a program on the "California Situation," which consisted of a tape recording by Dr. Eby and added comments by Dr. Wright. The program was indeed enlightening and informative. It is gratifying to see men in our profession, like Dr. Wright, who are so dedicated to the cause and philosophy of osteopathy. We heartily concur with his feelings, that those who are not with us, are against us.

Dr. and Mrs. Wright were accompanied to El Paso by Dr. and Mrs. B. C. Johns of Olton, Texas. The Johns' were the house guests of Dr. and Mrs. J. E. Holcomb.

We of District 11 are looking forward to seeing many of you at the State Convention.

M. A. CALABRESE, D.O.
Reporter

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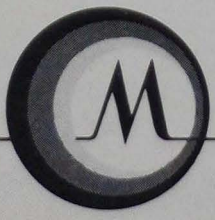

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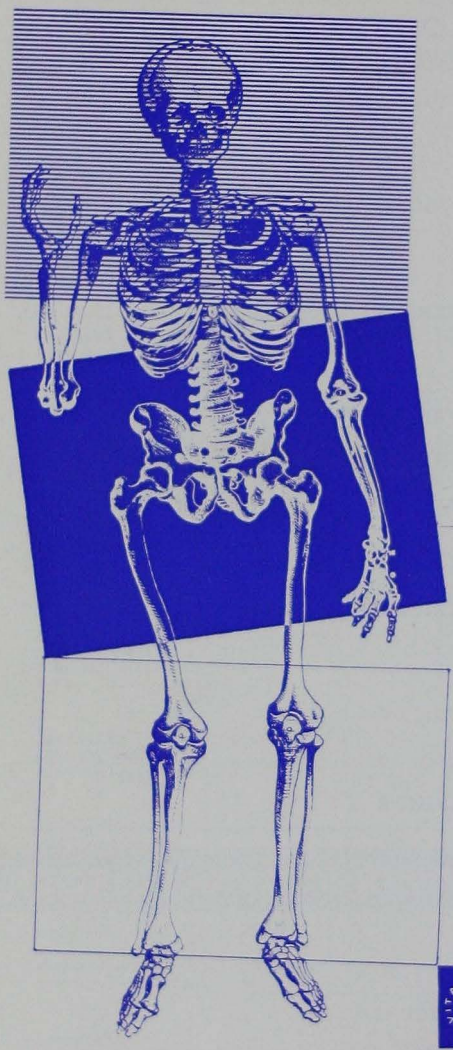

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