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Texas Health Problems

By Geo. W. Cox, M.D.,
State Health Officer

THE recent World War fully demonstrated that our security is dependent in great part upon the health level of our citizenship. Never before has the health factor been more forcefully brought to our attention. Facing facts, as we must in this realistic world—we must come to the final conclusion that our health record in Texas is far from satisfactory. And in that record—such as it is—are many events and many shortcomings that were impossible to prevent. It is only necessary that we turn the pages of history and read the record of selective service. Of all selectees in Texas, 49 per cent were rejected by examination as unfit for military service. There were ten leading causes for the rejection of selective service registrants. Mental disease was the principal cause, followed by Tuberculosis, Cardiovascular, Venereal Disease, Mental and Educational Deficiency, Physical Defects—Teeth, Hernia, Eye and Ears. In early life, many of these conditions could have been prevented, or to say the least, could have been corrected.

Those of us more directly interested in public health are deeply concerned regarding the indifference manifested by the general public in health measures.

An epidemic of alarming proportions is required before public sentiment is fairly aroused. More concern, however, should be expressed regarding the apparent apathy within our various state-wide organizations due to their lukewarm support for an improved and expanded public health program for Texas.

Public health in Texas is fighting an uphill fight—practically single-handed, and with far too little encouragement from those who should be most concerned.

Out vital statistics records reveal too much illness from communicable disease and entirely too many deaths from preventable cause.

Tuberculosis has infected thousands of our Texas people and each year 3,000 of these die from this disease. Typhus fever continues to increase. Cancer claims in death 6,000 of our population each year, while heart disease continues the leading cause of death. The Venereal Diseases, Gonorrhea and Syphilis, actually disables many thousands of people each year, and paves the way for many of its victims into some Eleemosynary Institution, sooner or later. Infantile Paralysis and Rheumatic Heart Disease has made fatal attacks upon the life and health of our people for many years.

The State Department of Health is charged by Statute with the responsibility of reducing and controlling the continuing incidence of death and disability among the citizens of Texas. Yet, today we are endeavoring to operate on a salary schedule that existed ten years ago which has resulted in the loss of component and efficient technical and professional personnel. This was the fatal handicap that existed during the war and is a continuing barrier to the development and expansion of an adequate public health program in Texas. The 8 cents per capita appropriation for public health in Texas has placed our great State in position number 46, down the line, in comparison with the other 48 States in the Union. No public health program can survive a continuous financial handicap—and under that circumstance, can only render a limited service—and certainly limited service provokes immediate criticism and general dissatisfaction. The State Health Department has been in this awkward predicament for too many years.

This existing situation is further complicated by the continuation of earmarked appropriations for the positions of public health professional employees. This legislative practice has complicated the living and travel cost factor and made the matter of public service in this field an almost impossible sacrifice for all technical and professional employees. Qualified medical, nursing, laboratory, engineering, educational and sanitation personnel are not available at the salary schedule provided under existing line item State appropriations.

The State Department of Health has reached the full limit of its ability to carry on an adequate public health program to the citizenship of this State, and without adequate resources, further expansion will be at a standstill. At the present time, partial full-time health protection is being afforded the residents of 55 counties, and although this represents approximately fiifty per cent of the State's population, at the same time there remains the other 199 counties with no semblance of a full-time health service to act as a barrier to preventable disease and the resulting death or disability. At the moment, we have listed 65 additional counties that have requested State assistance in the formation and establishment of full-time health service, but all available money is already budgeted in existing health activities and unless additional funds become available for local distribution, it wll not be possible to increase the efficiency of existing services, much less develop new programs in those cities and counties that are now calling upon the State Department of Health for this assistance.

In like manner, many functions and activities of the State Department of Health have been handicapped and limited by a joint failure to pool our common interest—our common objective—our general understanding — into an operating procedure that would simplify and specifically contribute to the general welfare. We must remember that healthy citizens are the greatest

asset that any community can possibly have. Absence from work through physical disability and ill health is a loss to employer and to employee. Inefficiency resulting from ill health is costly to both. The worker has an economic value to the community—his incapacity reduces that value and is costly to him—his employer and his home—his death destroys that value and may result in taxation for the support of his family. The lives—the health and the hopes of our people today are depending on a better world for the future. This will not occur as the result of a miracle—but definitely through the plans—the efforts, and action of everyone concerned. Better health, better homes and better communities will contribute much in that direction. Better health can be had through the application of scientific knowledge in a preventive public health program, and this means education in methods for discovering disease—for its modern treatment—but most important of all—for its prevention.

Nobody would try to tell us that good health is a bad thing, or that bad health is a good thing. Everybody is for good health. It is a different story, however, when we begin to tell somebody just how much a good health program will cost. Then is when somebody begins to worry about money. We usually save our money in preference to our health and lives. The philosophy involved in a decision against good health on the basis of what it costs is difficult to understand. Instead of worrying about how much good health costs—it might be well that we devote some time and determine just how much poor health costs. Without counting the more important human values—we pay the cost of poor health indirectly—in the loss of manpower and productive human efficiency—and we also pay directly through relief and welfare programs to aid the victims of poor health. If we can save lives by the expenditure of money—I wouldn't think that people who have a decent respect for the dignity of mankind would prefer to save money and lose lives.

Public Health is responsible for a program of disease prevention. It is nothing more than a job of preventing the occurrence of disease—eliminating the hazards and cause of disease. It is all very simple and offers a service to each and everyone of us—when we have prepared ourselves to serve in some particular capacity. Public Health research is one of our great needs today—and should only be limited by the amount of personnel and scientific instrumentalities which can be made available. The future hope for the adequate control of such diseases as Cancer, Poliomyelitis, Diarrhea and enteritis, dysentery, heart disease, typhus fever and many others—will be contingent on research activity conducted through our laboratories. You may be interested to know that Rodents in a certain section of Texas are now infected with Bubonic Plague Microorganism and there certainly exists the potential possibility of an epidemic or outbreak of Bubonic Plague in our State at some time. We can ill afford to continue our program of neglect—we should at least provide the facilities for a research laboratory in connection with our present laboratory—and it should be second to none in the Nation.

"Public Health is the science and the art of preventing disease, prolonging life, promoting physical and mental health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections—the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and prevention of disease, the development of the social machinery which will ensure to every individual in the community, a standard of living—adequate for the maintenance of good health."

To put into effect the basic principles outlined in this definition of public health, will certainly require money. It will require the employment of competent technical and professional personnel, and adequate competative salary scale, the expansion and extension of health service to all the people, the expansion of physical facilities and the development and expansion of medical public health research.

It will require the active interest and the participation of all professional and civilian organizations throughout the State. It will require our United expression of a common faith in a worthy cause.

Osteopathy Included In Veterans Administration

WASHINGTON, Dec. 23 (AP).—The Veterans Administration announced Sunday it will add doctors of osteopathy to its department of medicine and surgery.

The number to be engaged has not been decided. No osteopaths are employed now, but their employment was authorized by the last Congress.

VETERANS ADMINISTRATION announced today that arrangements have been completed for the appointment of doctors of osteopathy to serve in VA's Department of Medicine and Surgery.

The appointments will be made in compliance with Public Law 293, 79th Congress, which authorizes VA to hire doctors of osteopathy to work with veterans.

A doctor of osteopathy, to be eligible for appointment, must:

(1) Be a citizen of the United States.

(2) Hold a degree of doctor of osteopathy from a college or university recognized by VA.

(3) Have completed an internship satisfactory to VA.

(4) Hold a license to practice osteopathy in one of the States, territories or the District of Columbia.

(5) Meet VA prescribed physical standards.

Doctors of osteopathy interested in securing positions with VA should forward applications to the Deputy Administrator of the VA Branch Office having jurisdiction over the area in which the applicants desire to work.

Junior, Associate, Full, Intermediate, Senior and Chief Grades.

Basic Requirements:

Applicants for these positions must meet the following basic requirements:

a. Be a citizen of the United States.

b. Hold a degree of doctor of osteopathy from an approved college or university and have completed an approved internship. The approved schools and hospitals for internship shall be those provisionally approved by the Administrator of Veterans Affairs.

c. Hold a license to practice osteopathy in one of the States or Territories of the United States or in the District of Columbia.

d. Preference in the recruitment and placing of doctors of osteopathy will be extended to qualified veterans including those with disabilities due to service in the armed forces which do not militate against full performance of

ther duty. Applicants must, however, meet the physical standards for Civil Service appointment until Department of Medicine and Surgery physical standards are published, except that an applicant will not be appointed if 55th birthday has been reached.

Minimum Annal Salary of Grades:*

Junior	$4,149.60	Intermediate	$7,102.20
Associate	4,902.00	Senior	8,179.50
Full	5,905.20	Chief	9,975.00

* Grade will be determined by Deputy Administrators upon recommendation of the Professional Standards Board after determination that the qualifications of the applicant are equivalent to those of doctors of medicine in comparable grades. In no case will salary exceed $10,000 per annum.

Photostat copies in lieu of original documents required in paragraphs b and c must be submitted with application.

Our Program

IN THE Adolphus Hotel at Dallas on April 3-4 and 5, there will be four or five outstanding speakers of our profession who will give us most instructive lectures on Osteopathic Medical practice. We are endeavoring to bring to you ideas and techniques that every member of our profession can use to advantage when he goes back to his office.

These lectures will cover surgical diagnosis which will include some "Do's and Dont's" for the boys in hospital practice. Osteopathic Principles and Practice will be discussed and demonstrated by one of our dynamic speakers. The Obstetrical and Gyncological problems will be discussed by one of our forceful speakers who will enumerate the early points of diagnosis in our cardiac problems.

We are trying to build a program that will have a definite benefit to everyone in our association irrespective of the type of practice that he may use.

J. R. Alexander
Chester Farquaharson
W. S. Gribble, Jr.
George Luibel
Claude Logan

Post-Operative Management of the Average Case

Milton V. Gafney, D. O.
Tyler, Texas

Prepared for Fall Meeting of
Texas State Osteopathic Association
Amarillo, Texas
October 4-5-6, 1946

THE selection of this subject on the part of the author and speaker is based on the consideration that most of those present are concerned with this important subject in one way or another, and like all things of value

constant changes for the better are always being made. Recognizing the fact that there have been many chapters written on this subject and even full volumes have appeared from time to time, the limitations of this paper are apparent and any attempt to cover the subject fully would be impossible.

It is my impression that painstaking details are essential in the care of the patient and so often the seemingly unimportant things, when neglected or overlooked, bring about a lot of apprehension, as witness the fact that if the surgeon has failed to tie or the suture has slipped on a small superficial bleeding point that seems to want to continue to bleed after the patient has returned to his bed.

I will present this subject in a semi-outline form and take up the discussion of the various phases for consideration, with no attempt to be complete in every sense or to pose as an authority, in other words, I speak only from experience and as I see it.

PREOPERATIVE EVALUATION OF THE PATIENT

Strangely enough, the postoperative care of the patient begins before the operation is done. Of prime importance to the success of any operative procedure is the ability of the patient to withstand the proposed operation. Every available bit of information concerning the general condition of the patient must be obtained and evaluated, being very sure that he is in a state of what I refer to as physiological balance. If he is to heal properly after the operation the red count and hemoglobin must be near normal, kidney function must be adequate, heart and lungs able to function under stress. These things can in most cases be corrected in the elective case and in the emergencies recognition of abnormalties and allowance for them in the kind of an operation done will pay one many times over. Transfusions are so commonplace that an anemic patient need never be operated, and if the emergency is grave enough give the transfusion while the operation is in progress.

Examine the gums and tongue and you will get a very good general idea of the vitamine intake and assimilation of the case. To me a slick red tongue suggests either an anemia of long standing or a pellegra. Gingivitis and pyorrhea mean one of two things or both, either a vitamine C deficiency or general neglect of the health and care of the body, both of which are important.

Obesity can not be overlooked and the preoperative control of it should be done where possible especially in the patient that is to have a gall bladder surgery, they sometimes present a real postoperative problem.

Evaluate, if possible, the psychiactric patient and the hysteric, these have real obsessions etc., which are not relieved by surgery, in fact very often they are made worse and a satisfactory regime of post operative care is impossible. They refuse to be cured or relieved. I think that as an aftermath of the war that we are going to see more of these kind.

If we are to have little or no trouble with gas pains etc., after the surgery care must be given to the colon as a preparatory measure. It is my routine to give all preoperative patients a colonic irrigation before surgery, except of course, the case of acute appendicitis or any other contraindication, such as shock, hemorrhage etc. It is well to avoid any purgation of the patient and if colonic irrigation is not available, a thorough cleansing with enemas will suffice. Watch the nurses though, or you will not get the results that are to be anticipated. The night before the surgery is to take place, the patient should be allowed to have an ample quantity of fluids, fruit juices, broth, milk, etc., I have seen no harm from such. It is my routine also, to order ample

citrus fruit with plenty of Karo syrup to build up the glucose reserve and Vitamine C concentration. I also give four salt tablets in order to get the chloride level up to a maximum.

CHOICE OF ANESTHESIA

As a general rule any anesthetic which will be sufficient for the operation at hand is satisfactory and it is not the place here to discuss the merits of the various agents used. After the operation one must be aware of what the patient had and see that he is cared for in the manner indicated, as after a spinal it is not wise to have the patient on a pillow for a few hours. Following all general inhalation anesthesias it is well to return the patient to his bed with the airway remaining in place and it should be left there until the patient is able to get rid of it for himself. This should be established as a routine.

WHEN THE LAST STITCH IS PLACED: THEN WHAT

As the last knot is tied the postoperative care begins, and there are several important things to look after before the patient is moved. Before the dressing is put in place be sure that bleeding is not excessive and is not of such a character that it would give any trouble. As this dressing is applied there is no reason for a big strong arm intern to put the adhesive strips in place as though he were working on a bucking horse. The tape is applied to hold the dressing in place and not to prevent hernia, etc., that was the surgeons job. Many times the adhesive is placed too high and it interferes with the movement of the diaphram and aeration of the patient plus the discomfort of constriction. While this is going on don't expose the patient's body to any more cold air than is necessary. In moving the patient from the table it is my routine to lift him with the operating tabl esheet and slide him over to the cart and this same sheet goes to his bed and he is moved from the cart to the bed in the same manner. This is a warm sheet and the patient is protected from chilling in this manner. After he has reacted from the anesthesia there is plenty of time to then change the bed and remove the recovery sheet. Of course, if the sheet has been badly soiled in the operating room, this point is omitted. Gentleness and respect for a patient is readily noticed by the relatives and appreciated by them. Of prime importance, don't let the patient get cold. Another big don't is NEVER LEAVE A HOT WATER BOTTLE OR ANY OTHER HEATING APPLIANCE IN BED WITH AN ANESTHETIZED PATIENT. It is alright to use hot water bottles to warm the bed but take them out when the patient is placed in the bed. Another thing, it is not necessary to cover the patient and close all the windows etc. It is well to avoid drafts but fresh clean air is excellent. Excessive covering with blankets etc. enough to make the patient sweat, causes him to lose a lot of fluids and electrolytes which he so badly needs at this particular time.

POSTOPERATIVE FLUIDS

How much and what kind of fluids to give is a highly controversial question and can not in my opinion be stated precisely. The size of the patient, his state of hydration, amount of preoperative vomiting or blood loss, length of time of the surgery etc., must all be taken into consideration. As a general rule, I use all solutions by venoclysis and give 1,000 to 2,000 c.c. per 24 hours of Dextrose 10% in normal saline. The most satisfactory way to judge the amount of fluid needed is by the urinary output, if the patient is passing about 1500 c.c. of urine per 24 hours, he has a proper fluid balance. In my opinion many patients are given too much fluid too fast and too often. At least an

hour to an hour and a half should be used for the injection of each 1,000 c.c. The chloride-ion of the normal saline will cause retention of fluid and edema of the sacral area which may pass unnoticed, the same being true for pulmonary edema. They need the fluid only to a physiologic degree and no more. As soon as possible get the fluid in via the normal route, i.e. per mouth, then let the thirst desire of the patient be the determining level. Usually about three days of intravenous fluids is all that is needed in the average patient. In cases of excessive vomiting, diarrhea etc., more fluids must be used to compensate for the loss.

Every now and then there appears on the market a new fluid and some of them almost amount to a vitamine cocktail, these are not needed as a rule. If the patient has a vitamine deficiency treat it specifically by the appropriate method.

Generous use of transfusions is always in order when indicated and carries with it a great stimulant to the patient. Blood is the prime essential to the maintenance of health and/or to the recovery from disease or trauma, and surgery is definitely controlled trauma. Many patients who have slow wound healing or even disrupted wounds could have profited immeasurably by a timely transfusion.

On the subject of post operative feeding, when the patient says he is hungry then is the time to begin with the liquid diet and as soon as it appears that he can manage that then shift over to a soft diet. The one thing that it is well to omit is sweet juices in as much as they seem to cause more fermentation and gas in the bowel. Carbonated drinks are good and the patient usually thinks that he has had a real break. Over feeding is to be avoided and here the family and well meaning friends sometimes need a little guidance in what to bring in, etc.

BOWEL AND KIDNEY MANAGEMENT

On the morning of the third post operative day, we usually give the patient a small enema, either a normal saline solution or a mild lactic acid solution. About a pint of fluid is enough, there have been recorded cases of a blow out of the caecum in appendectomy cases when an enema of two quarts has been given by a negligent nurse. Following this an enema every day is usually needed as long as the patient remains in bed. With early ambulation though the bowel function and the kidney function is much more nearly normal and fewer enemas are needed. If the fecal matter seems to be too firm then it is advisable to give mineral oil or occasionally a mild laxative or both.

The use of catheters must be guarded. Some authorities have serious doubts whether any routine catheterization is an aseptic procedure. Indwelling catherters are a definite menace if not absolutely necessary. If such is used measures to combat infection should be started at the same time, such as penicillin, bladder irrigations with a mild solution such as boric acid, and a mild urinary antiseptic per mouth such as hexamethylenamine and sodium acid phosphate. Watch the urine for several weeks if possible because the cystitis may appear even after the patient has left the hospital.

PROPHYLAXIS OF VASCULAR COMPLICATIONS

Thrombae, embolae and infarcts are still the bane of surgery in spite of the very great amount of research being done on the subject and some of the newer medications developed to combat this complication. Prevention is more

important than cure in this instance. Some of the things that we can do are simple yet effective, viz: make the patient turn in bed and have them flex and extend the legs. It appears that a lot of these troubles begin in the popliteal-veins and when the patient is lying in bed this is the most dependent part of the body. Ache or pain in the calf of the leg is a very ominous symptom and should be watched for and recognized. Many patients have minor troubles of this sort and recover but the occasional catastrophe is sufficient to make us constantly aware of adequate treatment and particularly of prophylaxis. Early ambulation again will surely play an important part in this condition. When the condition has fully developed then resort to vein ligation an danticoagulants should be taken.

The indescriminate use of the anticoagulate preparations is to be discouraged, they must be used under strict laboratory control where daily prothrombin levels, etc., can be obtained. Also not to be overlooked is that when this condition developes in a case that has been ambulated to some degree he should be returned to bed and the affected extremity placed in an elevated position and at absolute rest. Massage, passive motion etc., are contraindicated at this phase of the process. If and when a massive embolus turns loose in the blood stream and happens to get into the circulation of the brain, lung or heart the outcome may be suddenly fatal, no treatment being available to adequately cope with the rapid development of the process.

As an aftermath of a post operative phlebitis the involved leg is very often swollen for a long time and it is well to advise that the patient wear a well fitted elastic support, either a stocking or an elastic bandage.

DRESSINGS AND STITCHES

As a general rule, it is not necessary to disturb the dressing at all unless it tends to roll up or the tape is causing irritation. In my opinion a lot of the dressings are too large and heavy and do not allow sufficient air to get to the wound. After the first day or two there is very little danger from contamination from without and the wounds do much better when covered with a few flats. Also in applying the adhesive, air space should be left between the strips. Most of the low grade wound infections, especially in fat people, is due to the stitches being too tight, accumulation of sweat under the dressing, and no allowance for skin evaporation. In this type of patient it is often useful to remove the first dressing, expose the wound to the air and then put on a loose, light dressing.

The stitches are as a rule allowed to remain in place for ten days and are then removed. If the patient has been dismissed he can by that time return to the hospital or office for this procedure. After removal of the stitches, I usually apply two so called 'butter flies' of adhesive direct to the skin and then a light gauze dressing for another week. At the end of this time all dressings are left off and the patient is allowed to take a tub bath, which by this time he really appreciates.

In thoses cases that have been drained it is necessary to do daily dressings as a rule, removing the drain about the seventh postoperative day. Daily shortening of the drain should be carried out to prevent it becoming adherent and defeating its purpose.

POST OPERATIVE COMPLICATIONS

I will present the commonly seen complications and the treatment which is useful to me and as a general rule satisfactory when judged from the standpoint of results.

NAUSEA AND VOMITING

As a general rule we expect some nausea and vomiting and this can be attributed to the medication that the patient has received, slight pylorospasm and an accumulation of gastric juice and saliva in the stomach. For the relief of the symptom manbutal suppositories afford relief. The trouble can almost always be corrected by the use of an indwelling nasal stomach tube, used with constant suction. The use of a simple tube of this type at the right time will save the patient much discomfort and at the same time prevent the onset of a protracted vomiting ordeal. 36 to 48 hours of tube drainage is as a rule sufficient.

GAS PAINS

Nasal tube, colon tube, loosen the abdominal dressing, prostigmine per hypodermic and heat to the abdomen usually bring prompt relief. Any time this condition developes one should consider it as a mild form of paralytic ileus and treat it accordingly and promptly before it developes into a full blown case. Here again attention to details is of prime importance.

POSTOPERATIVE PAIN

As a general rule morphine or a similar narcotic will have a place in the care of the patient for the first three or four days. It should be used only in the amount necessary to relieve the pain of the patient. Morphine of itself interferes with the contractions of the intestine and causes some predisposition to ileus and it's symptoms.

BLEEDING

Watch the bleeding point carefully and take prompt and immediate action when necessary, procrastination has no place here and if necessary take the patient back to the operating room and open the wound and "find it, fix it, and leave it alone."

Calcium and Vitamine K injections will prove of value here and should be used. Gross hemorrhage, as from a suture slipping as a result of vomiting etc., must of course be treated by active surgical measures.

SHOCK

With the present day methods of doing surgery, the modern anesthetic methods, etc., postoperative shock will very seldom be seen in the average case. Too much anesthesia, poorly administered, and too much surgery done by the cut and slash method is the cause of most shock and should be corrected at the operating table, not when the patients gets back to bed.

SECONDARY INFECTIONS

This complication is usually seen in the patient that had a septic infection at the time of surgery as in the ruptured appendix, pyosalpingitis etc. If the wound becomes infected and purulent, remove the stitches in the immediate area of the infection and let it drain. One thing to watch for also is in the presence of a septic postoperative temperature and a development of diarrhea look for a Cul-de-sac abcess and if found it must be opened.

PULMONARY COMPLICATIONS

Watch the patient for cough, temperature and rales. Treatment is pretty much standard, penicillin in sufficient dosage, Osteopathic treatment, cough medication, benzoin inhalations etc. Here again, early ambulation, turning the patient, encouraging deep breathing etc., will prevent a lot of trouble.

OSTEOPATHIC THERAPY

All postoperative cases will profit if they receive routine osteopathic manipulative treatment, supplied intelligently and for a definite purpose. This thought is very much in keeping with some of the so called modern philosophy coming out of the allopathic school. The basic thought being that the circulation is to be stimulated and that no areas of static circulatory stasis be allowed to develop. A 15 minute 'hammer and tongs' 'crack and pop' treatment is out of place here. Just raise the ribs a few times, turn the patient from side to side for lumbar treatment and then flex and extend the legs a few times and the whole thing should not take more than five minutes. Along with the treatment one should familiarize the patient with the idea of what is being accomplished so that they will have an understanding of some of the advantages of being under osteopathic supervision. Leave off the "miracle stuff" and just talk common sense, they will understand.

DISMISSAL FROM THE HOSPITAL AND FOLLOW UP OF THE PATIENT

When the patient is ready to go home is a very important time to question him and his family about the services received and if there is satisfaction with all concerned. Proper dismissal is important from the standpoint of the business office, the good will of the institution and the good of the profession in general. Always try to sense anything suggestive of dissatisfaction and take immediate and prompt steps to correct these things. Many times right here is the place where subsequent legal and liability thoughts on the part of the patient or his family can be forestalled. True enough there are some patients who refuse to be satisfied, many times with an eye to getting an adjustment on his account etc., and if this is the case rational talk is in order. If one is sure that the hospital is in the clear in all particulars then one should stand his ground and not allow himself to be shoved around. There are those patients who will invariably try it and they must be dealt with by the measures most appropriate for the case in question.

Referring doctors must be very particular about their statements to the patient and not take sides with the patient before he is aware of all the particulars in the case. I have known referring physicians to side with the patient sometimes and it appeared that he would rather emulate himself in the mind of the patient than to make a little personal sacrifice of prestige for the institution which is and has served him and his patient.

Follow up of the patient is important from the academic point of view, has the operation been successful, were the symptoms relieved, are there any improvements to be made or technique changed, what is the loss or gain in weight, does the patient need other services, medical or surgical or osteopathic. If the results are not what had been expected find out why and analyze the situation with the patient so that there is an understanding between all parties concerned.

47th

Annual Post-Graduate Conference

of the

Texas Association

of

Osteopathic Physicians

and Surgeons

April 3rd, 4th and 5th, 1947

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HEADQUARTERS

The Hotel Adolphus

Dallas

Hypertrophic Pyloric Stenosis and Pylorospasm

PATRICK D. PHILBEN, D. O.

WHO has not, in acute general practice, been confronted with a child, presented by an anxious mother, suffering from irretractable vomiting and in whom you saw or thought you saw symptoms of this condition?

Since the malformation which we are about to describe is comparatively rare, this paper is written primarily to refresh the memory an dto attempt to point out that the diagnosis of this condition is not as difficult as it may seem. Fortunately the gastric upsets of infancy are most frequently traced to some error of feeding or handling, but in the first month of infancy they must be regarded with a thought of more serious implications.

Hypertrophic pyloric stenosis is a condition which has been described as a hypertrophy of the musculature of the pyloris to such an extent as to prohibit the passage of food and liquids. Macroscopically the lesion is round or slightly oblong and it is approximately the size of an olive. Microscopically it is seen to be a simple hypertrophy of the circular muscle fibres of the pyloris. Etiologically little is known of its origin except that it is thought to be a true congenital anolmalie. In many cases examination of the rest of the stomach discloses hypertrophy and dilitation, but this is thought to be due to the attempt of the stomach to compensate for the inadequacy of the lumen of the affected portion of the organ. It has not been explained why it more often occurs in boys than in girls nor why it often occurs in the first born. In at least one case it has been observed in identical twins simultaneously. Feeding seems to have no place as an etiological factor, because it occurs quite as often in breast-fed infants as it does in those artificially fed.

The diagnosis of a typical case should not prove to be too difficult if careful examination and observation is made. The presenting symptom is almost without exception vomiting, which may or may not be severe. The infant who was seemingly normal at birth does not as a rule begin the regurgitation until some time after the tenth day or second week of life. At that time the eructation of food seems to be without nausea and occurs usually immediately after feeding or shortly thereafter. As the situation progresses it is found that dietary changes and the usual routines offer no relief, and the condition steadily worsens to the stage of the typical explosive type of projectile vomiting. The vomitus is expelled with such force that if the child is lying on its side, the bulk of the fluid is seen to travel a distance of eighteen inches or more; or if on the back, can be shot into the air a foot or so. The infant itself meanwhile does not seem to suffer discomfort from the act nor does he seem to be unduly uncomfortable except from the pangs of hunger and will immediately take more food only to have the process repeat itself.

At this stage another profound symptom is the complete constipation which is in keeping with the pyloric obstruction. The stool that is seen is small, hard and extremely dry in nature. In addition the typical peristaltic waves can be seen in the upper abdomen traveling from left to right and resembling two smooth round objects rolling beneath the thin belly wall. These waves can be easily demonstrated in some cases by the use of mechanical friction such

as gentle stroking of the abdomen or the application of a cold compress momentarily. The progress of the case depends of course upon the degree of stenosis, that is, whether any of the ingested food passes from the stomach. In the average case the infant loses weight rapidly and the situation deteriorates as if the child were in the midst of a famine area. Fever of inanition at this time is very common.

While not essential, x-ray offers the means of positive diagnosis if there is any doubt in the mind of the clinician. Our method of administering the barium is by means of the Breck feeder. The desired amount of barium suspension is put in the feeder and given the infant at a regular feeding time and not following a feeding because of the regurgitation problem. In a true case the barium will be seen to remain in the stomach for a period of four or five hours after ingestion.

The management of such cases is best done under hospitalization inasmuch as case progress can be more accurately determined. The earlier the condition is recognized and placed under adequate treatment, the better the chances of the infant for survival. The routine of treatment varies with different authors and pediatricians. Some believe that surgery should be resorted to only after an attempt to rectify the condition by other means. These same authorities, however, do not delay surgery in the presence of rapidly developing debilitation. They state that even true cases of pyloric stenosis have made complete recovery under proper palliative medical treatment and produce accurate case histories to substantiate their claim. Medical management consists principally of atropine or allied drugs, parenteral fluids and proper feeding. Atropine is the most widely used drug and is prescribed in a freshly prepared 1;1000 solution or 1:10,000 solution and is begun in small doses and increased until symptoms of intolerance occur. Barbiturates are at the moment in great favor especially since infants tolerate them well and they can be used in cases of atropine sensitivity. This medication is also begun in small doses and increased gradually until twenty, thirty or even forty drops are taken depending upon the child's reaction, that is, sedation. During the course of pyloric stenosis the infant becomes so dehyrated that it is necessary to supply adequate fluids and to correct any existing anemia by means of blood transfusions. The fluid of choice is Hartman's solution or five percent glucose and saline administered in proportion to weight loss and evidence of alkalosis. Feeding or attempted feeding of such cases is accomplished by the use of thick cereal because it does not seen to be so easily regurgitated. The thick cereal effect is best produced by the use of some precooked cereal added to the formula or by the preparation of such cereal from farina, etc. If under this regimen of management, the infant does not after a week or so begin to show definite improvement it is advisable to resort to surgery. In sharp contrast to the above described routines in some pediatric and children's institutions surgery is resorted to the moment diagnosis is made. The proponents of this method point to extremely low mortality rates. The most widely accepted operation is the Fredet-Rammstedt technique which consists of incising the obstructing mass to the depth of the gastric mucosa. Preceding surgery the infant is first carefully prepared. Degree of alkalosis must be determined and corrected insofar as possible, existing anemia must be compensated for by a blood transfusion and general debilitation carefully considered. At the present time the surgery is performed more often under local anesthesia with the obvious advantage over inhalation anesthetic. Following surgery the infant is not allowed food for twenty four

hours with the exception of small amounts of Hartman's or saline. At the end of this time formula is begun in small amounts and gradually increased.

Pyloro spasm which is often confused with pyloric stenosis responds very satisfactorily to the routine of treatment prescribed under medical management in this paper. If a given case of previously diagnosed hypertrophic pyloric stenosis responds to medical treatment, it must be remembered that it might possibly have been pyloro spasm.

Dr. and Mrs. Arthur H. Clinch of Grandview are rejoicing over the advent of a delightful member of the Younger Set, Miss Sharon Ames, who arrived October 26th, 1946, weighing 9 lbs.. and "jes' as pretty as a picture."

Dr. James L. Holloway, A.S.O., 1904, a mere stripling of 87, with practically half a century spent in the practice of Osteopathy was an interested spectator of the New Years Day Cotton Bowl classic. Dr. Holloway was chaperoned by Dr. Sam L. Scothorn, A.S.O., 1908, who, if the truth be known, really wanted to leave but was afraid to mention it.

We congratulate Dr. W. H. Van de Grift on the opening of his new office, located at 1219 Parkway, Austin.

Dr. Ted Alexander of Archer City, has purchased an excellent site in Wichita Falls, and intends to open a hospital in that city on or about March 1st, 1947. Congratulations.

The initimable roving correspondent of the Dallas Morning News, Wick Fowler, devoted an article to Dr. John B. Riggs of Groesbeck and his unprecedented air flights over all that section of Texas. 87 babies delivered by plane; 44 of which were delivered right down on the farms is certainly an outstanding record.

CIVIL SERVICE MEDICAL EXAMS NOW PERFORMED BY D. O.s

Announcement has been made by Dr. C. D. Swope, Chairman of the Department of Public Relations, American Osteopathic Association, of the successful culmination of efforts to make medical examinations performed by licensed doctors of osteopathy acceptable to the Civil Service Commission. This problem has been a constant source of irritation to the osteopathic profession and its clientele.

Conferences with the Commission during the last few months finally induced the Commission to take favorable action as a consequence of added Congressional recognition of osteopathy in related fields of Government service. The Commission took favorable action in September, but due to internal processes the information was not ready for dissemination by the Commission to the Regional Directors, Managers, Branch Regional Officers, Division Chiefs and Staff Officers until the first part of November.

As a measure of cooperation with the Commission to avoid possible confusion arising from osteopathic dissemination prior to official circulation to the Civil Service agencies, Dr. Swope has deferred releasing this information until now. The Federal Personnel Manual, which will be off the press in the near future, will contain the following: "Medical certificates for use in connection with appointments under Temporary Civil Service Regulations 8 and 16 may be executed by any duly licensed physician (doctor of medicine or osteopathy)."

The Commission is operating under Temporary Regulations, but permanent regulations are to be approved by the President on or before January 1, 1947, and will likewise contain the osteopathic recognition.

The Commission's letter to Regional Directors, etc., above mentioned, stated: "On September 19, 1946, the Commission approved a recommendation that it accept medical certificates executed by osteopaths under the same conditions that the certificates are acceptable from other private physicians who have not been designated as Federal medical officers."

This recognition carries with it a responsibility which rests on each osteopathic physician that any Civil Service medical examination which he makes shall be complete, and properly executed.

THE HEALING POWER OF FAITH

Sir William Osler

A noteworthy feature in modern treatment has been a return to psychical methods of cure, in which **faith in something is suggested** to the patient. After all, faith is the great lever of life. Without it man can do nothing; with it, even with a fragment, as a grain of mustard-seed, all things are possible to him. Faith in us, faith in our drugs and methods, is the great stock-in-trade of the profession. In one pan of the balance, put the editions from Dioscorides to the last ssue of the Unted States Dspensatory; heap them on the scales as dd Euripides his books in the celebrated contest in the "Frogs"; in the other put the simple faith with which from the days of the Pharaohs until now the children of men have swallowed the mixtures these works describe, and the bulky tomes will kick the beam. It is the **aurum potabile**, the touchstone of success in medicine.

Faith in the gods or in the saints cures one, faith in little pills another, hypnotic suggestion a third, faith in a plain common doctor a fourth. In all ages the prayer of faith has healed the sick, and the mental attitude of the suppliant seems to be of more consequence than the powers to which the prayer is addressed. The cures in the temples of Æsculapius, the miracles of the saints, the remarkable cures of those noble men the Jesuit missionaries in this country, the modern miracles at Lourdes and at Ste. Anne de Beaupré in Quebec, and the wonder-workings of the so-called Christian Scientists, are often genuine, and must be considered in discussing the foundations of therapeutics. We physicians use the same power every day. If a poor lass, paralyzed apparently, helpless, bed-ridden for years, comes to me, having worn out in mind, body and estate a devoted family; if she in a few weeks or less by faith in me, and faith alone, takes up her bed and walks, the saints of old could not have done more, St. Anne and many others can scarcely today do less. We enjoy, I say, no monopoly in the faith-business. The faith which is available today in everyday life, has its limitations. It will not raise the dead; it will not put in a new eye in place of a bad one (as it did to an Iroquois Indian boy for one of the —esuit fathers), nor will it cure cancer or pneumonia, or knit a bone; but faith is a most precious commodity, without which we should be very badly off.

—Harvey Cushing, The Life of Sir Wiliam Osler (1925).

ATTENTION!

The Public Health Committee of the Texas Association of Osteopathic Physicians and Surgeons has requested the profession in Texas to make certain contacts, thereby, laying groundwork for the Committee's activities with members of the Fiftieth Texas Legislature when convened at Austin.

The duties of your Public Health Committee consists of presenting our side of the argument relative to certain Bills introduced in the Senate and House. The Committee requests but an impartial hearing on the merits of the proposed legislation.

It is but natural that the activities of this Committee have been complimented and criticized. The criticism usually arises because the Committee is unable to disseminate all the information at its command, or does not believe it to be to the best interests of the profession to openly discuss its strategy and tactics. In this connection, it is to be noted that the directing staff of an army in warfare finds this to be the best policy.

Activities of this nature require a great deal of material and information and men trained to this particular line of endeavor. To train the membership in general in all the details of handling suc ha situation, the flexibility of argument required, and the consummate strategy, would require a preparatory schooling of six months or more, in connection with an intense enthusiasm on the part of every individual attending such a course. Therefore, it can be readily understood why the situation must be handled in this manner.

The Texas Association elects its officers, who, in turn, appoint, create and empower committees for the various component parts of a functioning organization. The days and days consumed by the Public Health Committee in planning their campaign both offensive and defensive, to say nothing of the effort and expenditures, should command the cooperation of every member of the osteopathic profession in Texas. The profession is aware of the fact that any time this Committee is not complying with, or, energetically pursuing the directives of the

Association; the Board of Trustees can inugurate an entire change of policy and program.

The Public Health Committee takes this opportunity to thank those of the profession who have so conscientiously performed the tasks assigned. It has been a real pleasure to note the large number of the profession who have complied with every request of the Committee for cooperation and information.

OSTEOPATHY AT THE CROSSROADS

The Osteopathic profession in Texas has enjoyed 39 years of unexampled progress, due in a great measure to the fine group of men and women engaged in the practice of the profession in our Glorious State, and a Medical Practice Act, which is probably the fairest and best in the entire United States of America.

The Medical profession has been prosecuring and persecuring the Osteopathic profession in various States of the Union. The Medical profession has employed astute men who have devised dubious ways by which the Osteopathic profession could be limited in its scope of practice in these States. The Osteopathic profession in Texas has been especially fortunate in the broad scope of practice accorded, and, it is only natural that the opposition should wish to curb the profession in Texas. Feeling, doubtlessly, that if the Osteopathic profession could be deprived or limited of the unhounded right of practice, other States would more readily become victims of circumscribed policies.

The call to arms has been sounded in Texas. History repeats again and again. Everything worth while must be fought for. It remains to be seen whether the Osteopathic profession of the State of Texas feels that their profession and the continuance of an unlimited practice is really worth the struggle.

THE QUESTIONABLE SULFAS AND PENCILLIN

As the antibiotics, sulfa and penicillin, seem to be doing a marvelous job, rumblings are heard on the horizons: **are they really as good as we are led to believe?** The bacteria doesn't seem to be dying as fast as they are supposed to in many cases. Bacteria are certainly staging a comeback equal to none. The bacteriologists can breed germs rapidly in the laboratory and in the past few months have bred strains of pneumocci, streptococci, and other common germs which are practically immune to sulfa, penicillin, etc. Dr. Hans Molitor, Director of the Merck Institute, is the authority and was the pioneer in the development of antibiotics.

Gonorrheal infections have been found not to respond as readily as they once did. **The British Medical Journal** warns "against the idea that penicillin will necessarily continue indefinitely to cure nearly every case."

It is now evident that there are new mutations among the bacteria. A respiratory infection which hit the East in 1944 failed to respond to the sulfa drugs, although they had previously been effective against similar infections. Stanford bacteriologists traced the epidemic to a sturdy strain of streptococci which had "become more resistant by mutation."

The inexperience of physicians with the antibiotics has been partly to blame for their declining efficacy. Doctors often prescribe inadequate doses which give germs a chance to develop resistance.

Researchers hope to keep two jumps ahead of the "jump-ahead" germs.

A $200 000 ultra-modern air-conditioned 50-bed non-profit hospital "open to any licensed, reputable, qualified physician" is the plan of the Fort Worth Osteopathic Group.

The group has donated $5,000 to initiate the program and a fund raising campaign will be started early in January. Temporary quarters are at 1402 Summit.

Directors of the hospital until the contributors elect an advisory board are Dr. V. L. Jennings, chairman, Dr. Phil R. Russell, vice chairman, Dr. Roy B. Fisher, secretary-treasurer, Dr. Daniel D. Beyer and Dr. Jerry O. Carr.

THE PROFESSION'S CRYING NEED

The osteopathic profession must have representation in public health associations and public welfare movements if osteopathy is to receive widespread recognition and become eventually a guiding influence in the health programs and laws of the state.

To obtain this recognition, the osteopathic physician must realize that it is up to him to make the initial con-

tact with representatives of his board of health, sanitary commission, maternity and child care organizations, acute contageous disease department or venereal disease control office in his local area. Contacts may be brought about in several ways, one of which is given here. He should make it his business to attend "town hall" meetings or provinvial gatherings devoted to public health and welfare, as well as public assemblies of any of the above named groups. But mere attendance at periodical welfare meetings is not sufficient. The doctor must let the officers or committee chairmen handling these groups know that he is "among those present" and is prepared to co-operate to the fullest extent to help make the issue or movement in question as complete a success as possible. On occasions such as this, the individual D.O. will have the opportunity to point out that the osteopathic physicians in the area are anxious to promote preventive health measures and improve community welfare.

To substantiate his offer of help, the physician must be willing not only to contribute his time, money and professional services in these local undertakings, but also to give well-considered advice and statistical information that must, necessarily, be provided by doctors.

In short, the osteopathic physician must become a motivating factor in his community if he is to answer the "crying need" of his profession!

Dr. and Mrs. Leland S. Larimore of Kansas City, Mo., Dr. and Mrs. L. V. Cradit of Amarillo, and Dr. Keith S. Lowell of Clarendon were house guests during the New Year's at the home of Mr. and Mrs. O. Parmeter, 5448 Surrey Circle, Dallas. Mr. Parmeter was recently made General Sales Manager for the entire United States by the Farnsworth Laboratories, of Chicago.

DISTRICT GLEANINGS

Sam L. Scothorn, D.O., Chairman

Texas P. & P. W. Committee

PANHANDLE DISTRICT NO. 1

Some forty staff physicians and Auxilliary members attended the Third Annual Christmas Party at the Thomas' Dining Room the night of December 18th. A fine buffet dinner was served with turkey and trimmings. Group singing was the feature of the evening and several fine violin numbers were rendered by Mrs. Norman M. Harris accompanied by Mrs. J. Francis Brown. After the program Santa arrived and distributed gifts; each physician furnishing a gift for a gentleman and each member of the Auxilliary a gift for a lady. This was one of the most enjoyable evenings in Panhandle history.

Dr. and Mrs. James H. Kritzler of McLean are the proud parents of a bouncing baby boy.

Dr. Harold M. Gorrie recently made a pilgrimage to Denver and returned with a beautiful bride.

Drs. E. W. Cain and Homer M. Thompson will occupy their new and modern Clinic at 1620 Washington Street, Amarillo, shortly after the first of the year. The Clinic is top fllight in every way and will be a credit to the osteopathic profession in Texas and Amarillo in particular.

Dr. George W. Diver, KCSO '35 has recently returned to Amarillo and is now associated with Drs. Cradit and Vick. Dr. J. C. Jacques KC '46 is now interning at the Amarillo Osteopathic Hospital.

Dr. William M. Jackson KCOS '29, formerly of York, Pa., a Certified Roentgenologist, is now head of the X-ray and Laboratory Departments of

the Amarillo Osteopathic Hospital.

The new officers of District No. 1 took office in November, and, under the able leadership of the President, Dr. L. V. Cradit a most successful year is anticipated. Quarterly meetings of the Association will be held, as formerly, in Amarillo.

The next meeting of District 9 will be held January 8th, 1947, with Dr. and Mrs. Donald M. Mills in Victoria.

E-TEXAS YEAR

A lot of things have happened in Texas among us D.O.'s which can't be put in print. Now I don't know of a single instance personally, and I hope none of you do either, but if you do, don't print it, and if you WEREN'T THERE, don't repeat it and finally if it's about any of us East Texas D.O.'s its a damn lie, and don't you even believe it.

Then there's a lot of goings on in Texas which is really worth repeating, in fact worth recording. Most of it in East Texas, I've either forgotten about or haven't heard. But what I've heard and seen I'll try to put down here. And if you folks know of something better, that I left clean out, send it in to Mac or Sam Scothron or me or somebody, and maybe we can make a good yar out of it.

Now there's been quite a bit of shifting about I see, as I study my geography of District 3. And its been all to the better for all concerned it seems. For instance Mt. Pleasant, county seat of Titus, has developed into quite a medical center with their new Osteopathic Hospital there. That pulled RUSSELL MARTIN from Pittsburg, CHUCK OGILVIE from Troup and M. L. CLINE from Mount Vernon. Then GARNETT LOBER came from Winnsboro to take over Ogilvie's practice in Troup.

N. B. GAFFORD located this year in Sulphur Springs, and is cracking the medical ice there with that potent osteopathic wedge.

TOM KASHATA finished his internship at Coats-Gafney Hospital in Tyler, oh, about a year or more ago, and is located in the same clinic building that Larry Giffin used to have in Nacogdoches. He's doing all right too.

You take GROVER STUKEY and ELLIS L. MILLER. Miller finished at Coats-Gafney a couple of years ago it seems, went down to San Augustine. took oved a little hospital and cleaned up from the very start with his good works. Stukeq who had been over at Mineral Wells, came in with Miller, and they rapidly out shone their medical conferes in their skill and plain old desire to work. Wayne Smith and I visited Stukey and his family recently, and they showed us around their new fireproof ultra modern air-conditioned house.

ERNEST SCHWAIGER only recently moved from Winnsboro to De Kalb, which is right near Texarkana. He's working hard but takes time out for legislative matters.

BURR LACEY is not an old man in East Texas. He came down to Rusk about a couple of years ago from Pretty Prairie, Kansas, and has been doing fine work there for his patients and for you and me. Incidentally, Burr was AT our last meeting in Athens when it rained so hard. I apologize, Burr, for what I said about the absent. I expect I'll catch a lot of hell on account of this report, too. But Lacey was THERE. He wrote me a nice letter and I wrote him back and said I'd see if I could make amends.

Then another mover was Earl Stuart who sold out his hospital in Winnsboro and moved to Tyler for a spell. He recently bought a ranch back in his old stomping ground, and has retired within its confines. Last time I saw him he was buying tractors and such.

Alan Filkill and the aforementioned Ernest Schwaiger bought the hospital, then Schwaiger sold out to Filkill and now Alan's doing quite all right by himself. Alan's still a bachelor, and he's been courting a sweet Tyler girl pretty heavily it seems to me. Somebody OUGHT to catch that there guy. He's entirely too eligible to suit some of us benedicts.

I think that gives our editor, and our Public Relations chairman, at whose request this was written, a general idea as to what gives in East Texas. It shows above all other things, that we are not static, that we are at least active; that we are certainly not siftless, for we HAVE been shifting around.

H. G. G.

The Central or District No. 5 held a special called meeting at the office of Dr. V. A. Kelley of Waco, Sunday,

January 12th. The impending legislative program and future action was discussed. Dr. Ira F. Kerwood of McGregor, President of the District Association presiding and the meeting was well attended and enthusiastic throughout.

District No. 7 met Sunday, December 8, 1946, at the St. Anthony Hotel, in Sunny Sanantone.

Dr. John B. Donovan, President, acting as Program Chairman.

Dr. Kenneth R. Wolliscroft of Rockdale gave a very interesting dissertation on "Urological Problems."

Dr. William H. Van de Grift of Austin reviewed the Public Health situation at some length.

We are in receipt of the following excellent letter from Dr. C. R. Stratton, the capable Secretary of District No. 9.

"District No. 9 had their regular monthly meeting December 11, 1946, here in Cuero, Texas.

Mr. Boyer, technician of the San Antonio Osteopathic Hospital furnished us with an excellent program " Office Routine of Laboratory Work." Dr. S. J. Candas of San Antonio and Dr. W. G. Millington of Nixon gave a report on the meeting held in San Antonio, the first of the month, which opened a lively business discussion for this District; all present agreeing to stand behind the Public Health Committee in all legislative measures. A motion was passed to the effect that each member of this District Association be assessed a sum not to exceed $100.00 per capita if needed to finance any program this particular Committee chose to instigate.

At our meeting last month we voted to give $5.00 each to our Secretary who in return would mail same to the Overall Progress Fund, with the understanding that would not interfere with any individual donation.

Dr. and Mrs. T. D. Crews of Gonzales are the proud parents of a fine boy Nicholas Lossen. Date of arrival 1st, December.

Dr. and Mrs. Donald M. Mills, Victoria, are rejoicing over the delivery of a brand new convertible Ford, bright red in color and the last word withal.

Dr. Harry Tannen, Weimar, arrived in a brand new, green Buick, accompanied by a very attractive young lady from a neighboring town.

Dr. Alan J. Poage of El Campo, has been doing quite a bit of hunting this season. 'Tis reported that he brought down two deer the first day. Speaking of hunting, Dr. M. P. Ollom, New Braunfels, Dr. Willis L. Crews. Gonzales, Dr. Paul M. Pinkston, Victoria and Dr. J. V. Money, Schulenburg have been having their guns trained on Senators and Representatives."

We welcome Dr. Donald Watt, PCO '27 who has recently opened offices at 910 Duncanville Road, Cockrell Hill.

Veterans Administration Approves Osteopathic Intern-Training Hospitals

The Veterans Administration recently approved 54 osteopathic hospitals for the training of interns who are graduates of osteopathic colleges. Last summer the six osteopathic colleges, located in Chicago; Des Moines, Iowa; Kansas City, Mo.; Kirksville, Mo.; Los Angeles, and Philadelphia, were approved by the Veterans Administration as complying with the V. A. requirements for the education of osteopathic physicians and surgeons leading to the D. O. degree.

The approval of osteopathic colleges and intern-training hospitals were preliminary steps necessary under public law 293 before appointments of qualified osteopathic physicians to the Department of Medicine and Surgery of the Veterans Administration could be made.

Osteopathic Physicians Eligible For Appointment To Navy Medical Corps

Public Law 604 recently passed by Congress confers explicit and permanent authority on the President of the United States "to appoint, by and with the advice and consent of the Senate, graduates of reputable schools of osteopathy as commissioned medical officers in the Navy, in such numbers as the President should determine to be necessary to meet the needs of the naval service for officers trained and qualified in osteopathy."

Officers of the District Associations of the Texas Association of Osteopathic Physicians and Surgeons

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