Texas Osteopathic Physicians Journal

Volume XII FORT WORTH, TEXAS, SEPTEMBER, 1955 Number 5

In This Issue—

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EDITORIAL PAGE

Comments on Post-Graduate Education

The Committee on Professional Education and Meetings recently met and arrived at the following conclusions. There is a further need for postgraduate education especially from the standpoint of learning various techniques that are of daily practical application in the physician's office.

This phase is stressed because in the past, an exceptionally high percentage of medical education has been purely didactic instruction. The fact is further realized that there is a change in the medical education prior to post-graduate level. Due to the resident programs, the scope of the practical training of the intern has been narrowed so much as to severely limit the scope and range of practical techniques that the intern can take into general office management. It is felt that the general practitioner must keep abreast of the newer diagnostic and therapeutic modalities.

To this end, the Committee recommended the establishment of an annual 2½ day seminar sponsored by the T.A.O.P.S., for the express purpose of broadening the skills of the general practitioner. The seminar would be in the form of practical demonstrations of specific methods of diagnosing and treating the various pathologies encountered in daily practice. The demonstrators would be competent local specialists in various fields. For example, the emergency catheterization of strictural urethras, excision of nasal polyps, closed reductions of simple fractures, improved methods of episiotomies, etc., would be the type of program intended.

This seminar is not intended to replace, substitute, or compete with existing post-graduate courses of instruction which have proved to be didactic in nature and not of sufficient practical nature for some of the general practitioners.

Having presented the above facts, the Committee is of the opinion that it would be desirable to know what the feelings of the profession in general would be in regard to the suggested seminar. The Committee believes that the seminars would prove to be popular and informative, with the widespread support of the general practitioner. It is necessary that the opinions in the field regarding these suggestions be evaluated and objectively examined by the tenor of the correspondence received. Comments should be mailed to:

JOHN J. LATINI, D. O.
402 West 14th Street
Austin 11, Texas
or
NAT STEWART, D. O.
1141 North Hampton Road
Dallas 11, Texas

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

PUBLICATION OFFICE: 512 BAILEY STREET, FORT WORTH 7, TEXAS

EDITOR - - - PHIL R. RUSSELL, D. O.
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VOLUME XII FORT WORTH, TEXAS, SEPTEMBER, 1955 NUMBER 5

Geriatric Gynecology

By T. M. BAILEY, D. O.

As the number of individuals surviving the age of three score years rapidly increases, it becomes inevitable that there will be more and more geriatric gynecological problems arising in practice. The purpose of this paper will be to emphasize the gynecological problems peculiar to this aging group.

Aging is a part of living but it must be remembered that the aged and aging are not the same. The aged are people while aging is a process which may vary such as time itself varies. When waiting in the physician's office, thirty minutes seem like an eternity but, when young lovers are courting, the same time interval is but a fleeting moment. Biologic time and chronologic time are not the same. They may occasionally coincide, but this is the exception rather than the rule.

The numerical increase in the elderly is far greater than most of us realize. The total population of the United States increased 7.2% in the ten year period from 1930-1940; whereas the number of persons sixty-five years or older increased 35% at the same time. This increase percentage wise was even greater in the ten year span from 1940-1950. Certainly this relative rate of increase in those over sixty-five should constitute sufficient reason for affirming, without apology, that the problems of gynecology, and in this instance, geriatric gynecology, are of utmost importance. Since society and medicine are together fostering research to save life, they must in turn accept the responsibility of the lives thus prolonged.

Just how old is old? Since there is no complete agreement as to exactly where pediatrics ends, neither can there be complete agreement as to where geriatrics begins. To limit geriatrics to the treatment of the senile would be as illogical as to limit pediatrics to the care of the newborn. For clinical clarification and in the interest of time, we shall limit this paper primarily to the most common post-menopausal gynecological problems.

As people in general become older, there are certain usual changes that go on: namely, hypertensive and renal disease; arteriosclerotic changes in coronary, cerebral and other vessels; and increased incidence of degenerative processes such as diabetes mellitus, arthritis, malignancy, etc. In the women, to these processes must be added the very definite effects on tissue of estrogen deprivation. When this estrogen deprivation is added, the normal aging defects of muscle and ligamentous tissues become much more obvious. This factor is important in the pelvic viscera ptosis problems and the osteoporosis seen in many geriatric females.

The gynecological examination of the

geriatric patient should be as thorough or, if possible, more thorough, than in other female patients if we wish to properly diagnose and treat these patients. Slowly in most women, more rapid in other, secondary sex characteristics undergo changes which are largely atrophic in character. The mons veneris becomes less prominent. The major labia shrink and flatten as a result of a loss of subcutaneous fat. The labia minora may disappear completely and the distribution of hair becomes more and more sparse. The vaginal orifice shrinks in diameter and becomes less and less elastic and the vulvar skin becomes thin, shining and parchment like in consistency. Thorough examination of the breast should precede every pelvic examination. Cystic changes and other benign breast conditions usually disappear after the menstrual function has ceased. Any mass, however, that presents itself when the breast tissues are showing definite signs of atrophy should be treated as carcinoma until proven otherwise. The detailed discussion of a complete breast examination will not be given here since it is felt that all here are well acquainted with this procedure. If diagnosis of breast cancer is definitely established, it will be necessary to treat each patient according to her medical and physical status; as to radical surgery versus simple mastectomy and X-ray therapy.

Diseases of the vulvar skin and vagina in the geriatric patient are many. One of the most frequent complaints bringing a geriatric female to the physician's office is a vaginal discharge of some type; with or without itching or burning. -I am sure we have all had the experience of seeing the patient with irritation and edema of the external genitalia; with or without a purulent irritating discharge, prove to be diabetic. Such was my experience about two months ago while gathering the material for this paper.

For clinical discussion it is convenient to classify diseases of the vulva and vagina into four groups. These four groups are:

1. Inflammatory diseases.
2. Leukoplakic Vulvitis and Kaurosis Vulvae.
3. Benign Cysts and Neoplastic Diseases.
4. Structural Derangements.

These four classifications will be discussed with no further recognition as to their numerical arrangement.

The Vulvar and Vaginal tissues of the geriatric patient are particularly prone to Trauma and infection because of the deprivation of Estrogen. This same fact gives these tissues a poor recuperative power. In order to properly prescribe and carry out treatment, the predominant infectious organisms of the Vulvar or Vaginal infection must be identified. The simple procedures for diagnosis of Trichomonas or Monilia infection of the vagina are mentioned only to call them to our attention. These diagnostic procedures, including smears, cultures and sensitivity tests were most adequately covered by Dr. Bryson in her paper and certainly apply in all fields of gynecology. In the management of these conditions several factors are important. These are:

1. Use of Estrogen locally and/or orally to give to the tissues the proper recuperative power to combat the infection.
2. Specific chemotherapy directed at the predominant organisms. This chemotherapy should include topical vaginal creams, ointments, and suppositories, and when indicated oral and/or parenteral antibiotics. Among the topical vaginal preparations are triple Sulfa Vaginal Cream; A.V.C. Cream; Gentia-Jel; Capryllium and many others. Each physician here, I am sure, has his or her own preference and feels that his treatment is best.
3. Avoidance of over treatment with any chemotherapeutic agents. This, I feel, is very important because

it is in this Geriatric group that my percentage of drug, and especially antibiotic, reactions has been the greatest.

Often the use of Estrogen cream or suppositories alone will improve the mucosa, acidify the secretions, and correct the condition. Non-specific infection will usually respond to this aforementioned Estrogen therapy. Should the elderly female patient be receiving large doses of any of the antibiotics, the possibility of yeast infection must be kept in mind. In the management of these inflammatory vaginal conditions, I feel that, in the Geriatric group, douches are drying and irritatiig and should be used cautiously. Recently, however, I have used a preparation, chlorogiene, for douching with good success in several cases of senile vaginitis with non-specific inflamation.

At this point I wish to give special attention to that most aggravating problem, Post Menopausal Vaginitis. The physical findings of this condition have been mentioned previously as part of the normal changes in secondary sex characteristics of the Geriatric female. These changes were: loss of vaginal elasticity; narrowing of the vaginal orifice; shiny appearance of the mucosa with a pale yellowish coloor. In addition the vaginal secretions become scant and greatly altered with changes in the typical bacterial flora and a PH. of 7 or more.

The true Vaginitis develops when inflammation is superimposed upon the above physiologic factors. The inciting factor may be coitus, douching, etc. Thus the physiologic atrophy sets the stage for Trauma and infection and together the clinical picture of Senile Vaginitis is produced.

Symptoms of this condition are: vaginal discharge; itching; burning; dysuria; pelvic pain; backache; and dyspareunia. There may even be raw denuded areas which may lead to plastic or adhesive Vaginitis.

The treatment of choice is Estrogen therapy and hygenic measure. The method of Estrogen administration is controversial but I find that oral administration serves me well. 0.2 mg. to 0.5 mg. Di-Ethyl-Stilbesterol, or its equivalent, daily will adequately treat the average case. In 4 to 10 days the response is usually satisfactory but it is advisable to continue treatment for 2 to 4 months. Since recurrences are very common, it is necessary to frequently repeat the treatment. Usually however, when the inflammatory stage is quiescent, recurrences may be prevented by topical vaginal medications.

Such things as pediculosis, scabies, allergic dermatoses, neurologic dermatitis, diabetes and anemia present individually peculiar problems and must always be carefully studied and considered as possibilities in the vaginal infections.

Leukoplakia of the vulva with skin thickening and fissuring is considered by most authorities as a pre-cancerous lesion. If, however, the skin is thinned and atrophic, malignant degeneration is rare and usually the condition will respond to Estrogenic therapy. These more serious lesions will produce severe pruitis vulvae and burning and it is usually these symptoms which bring the patient to the office of the attending physician. There is a current feeling that Leukoplakia in its varied forms

(Continued on Page 19)

Thoughts on Osteopathy

By J. J. LATINI, D. O.

It is generally accepted that progressive thoughts are more often associated with chronologically youthful minds, and conservative or reactionary ideas allied with older minds. However, when ultraconservative concepts reside within a young man, that is cause for comment. Likewise, when progressive ideas stem from an older, more experienced person, that is cause for congratulations. Such congratulations should be extended to the perceptive editor of the Texas Osteopathic Journal, Dr. Phil Russell, for bringing into focus the advancing trends of the Osteopathic branch of medicine.

He might be labeled progressive because of his constant reorientation of osteopathic medicine to the realities of today, and because of his constant resistance to immobilizing osteopathic practice by static, immutable dogmas that some editors are capable of imposing. By such a dynamic attitude, he is neutralizing on an organizational level, the limitations placed on the profession at the practice level by those who voluntarily restrict osteopathy solely to manipulation. It is conceded that it is the privilege of any practitioner to limit his practice as he so desires. However, with the privilege of limiting the practice of osteopathic medicine within the profession solely to manipulation, there should be assumed by such a practitioner an obligation that is implicit in this situation.

That obligation is this. It should be pointed out to the patient that the doctor is not practicing osteopathy, but merely one phase of it, which is manipulative. Emphasis should be placed on the fact that the psychiatrists and surgeons in this profession, who may do a minimum or no manipulation at all, are not only practicing osteopathy, but may be even more inclusive and comprehensive than the doctor who solely manipulates. Thus, the osteopathic doctor who limits his practice to manipulation and fails to point out this restriction to his patients, thereby permitting his method of treatment to become synonymous with osteopathy, although exercising his privileges of voluntary limitation of practice, is not assuming his proper obligations.

Such a failure bestows an injustice

upon the entire profession, for it tends to perpetuate a sterotyped definition of osteopathy that is inconsitent with modern day osteopathic medicine. The conscientious efforts of Dr. Phil Russell have greatly tended to rectify this failure. The corrective force has to trickle down from an organizational level to the general plane and be rendered obvious to the uninformed public.

That movement is largely the concern of the physician who practices a more comprehensive type of osteopathic medicine, consistent with his using medicine and surgery in addition to manipulation. The most plausible way to force the movement is to participate more extensively in public health. In many areas, even where there is a potent representation of the osteopathic profession, and the osteopathic medical school the only school of the healing arts in a heavily populated region, there is little obvious participation by the D. O.'s in the local community health problems, such as polio, T. B. and health forums. The result is the creation of dependence by the laymen upon the local allopathic group for medical consideration and advice.

The movement is further served by those physicians who correctly apply terms and carry out proper analogies. The term "osteopath" should not be compared to the terms "M.D.", "medic", or "regular doctors", but only to "allopath". The term "M. D." is then a degree to be compared with an equal degree "D. O.", and not "osteopath". In this manner proper analogies can be made between the equal degrees, "D. O.", and M. D.", or between the adjectives, "osteopathic", and "allopathic", for the students of both schools are medically trained.

One might ask if the above point about analogies is a trivial one. If it is believed that every long journey begins with a single step, then the answer is no. For if in all osteopathic literature there is constant application of correct analogies, then there will begin a proper orientation within the profession of the osteopathic relationship to the entire medical field. In order to discern in what direction the profession is traveling, it is necessary to "fix" the present position, and the "fix" may be represented in literature by the terms used currently.

The purpose of these aforementioned efforts is essentially to raise the level of recognition of the degree "D. O." so as to convey the full significance of its meaning to the laymen. Increased significance may follow as the result of what a D. O. puts on his shingle. This is especially true in those states where there is one common licensing medical board, issuing an identical medical license to both M.D.s and D.O.s. In this state of Texas, where D.O.s are given a license to practice medicine and surgery, osteopathy being considered as one of the four schools of medicine, it seems that public relations would be served a good turn if D.O.s were to display a shingle as "John Jones, D. O. Medicine and Surgery". This brings that public's attention to the fact that D.O.s, besides M.D.s practice medicine and surgery; that the degree D.O. is equivalent to the degree M.D.; and that a D.O. is not educated to have a practice limitated by statute to manipulation, unless it is voluntarily self-imposed. Osteopathic medicine will have fully matured and realized its most complete potentials only when the degree D.O. is fully equated by the public with the M.D.

(Continued on Page 22)

Texas State Board of Medical Examiners will hold its next examination and reciprocity session December 1, 2, and 3, 1955 at the Galvez Hotel, Galveston, Texas.

Bankers Life and Loan Company Supreme Policy

The relationship of the osteopathic profession with Bankers Life and Loan Company has been unusually good.

However, during the past year they issued a supreme policy which limits hospitalization to AMA approved hospitals.

It came to the attention of the insurance committee that they had denied payment to an osteopathic hospital under this supreme policy.

Your executive secretary made a trip to Dallas over this matter and has just received the following letter which proves cooperation of the company:

August 25, 1955

Dr. Phil R. Russell
512 Bailey Street
Fort Worth, Texas

Dear Dr. Russell:

Your friendly letter and visit to our office was greatly appreciated. I am sorry I was not in for I would liked to have discussed with you some of our mutual problems.

As to the policy form in question let me assure you there was no intent to discriminate against a policyholder or group of policyholders. This is a very broad form policy and it is simply not possible to issue it without some restriction to qualified hospital.

We have long recognized the personal effort you have made to maintain and hold up the high standard of the Osteopathic Association, and we are willing as of this date to include AOA along with AMA on our Supreme Policy. That is, with you as mediator in case of a dispute or misunderstanding.

With kindest personal regards, I am

Sincerely yours,

s/M. H. Hall
M. H. Hall, General Manager
Bankers Life and Loan Co."

EDITORS NOTE: You must be a registered hospital with the AOA in order to collect on these policies.

Good Locations

GRANGER, Williamson County, Texas: Trade area 17,000 and no doctor. One of best locations in Texas for General Practitioner.

If interested contact Mr. Bill Hincir, Granger Drug Store, Granger, Texas.

EMORY, Rains County, Texas is in need of a doctor. No doctor within 20 miles. We are assured by the Nix Pharmacy that this would be a good location for any good, progressive doctor.

If interested, contact Mr. Browning Nix of the Nix Pharmacy, Emory, Texas.

Surgeons and Hospital Administrators Meet

The Texas Society of Osteopathic Surgeons and the Texas Osteopathic Hospital Association held a joint meeting at Fort Worth, Texas, August 20-21, 1955, at the Western Hills Hotel.

The feature speakers of this program were Dr. W. Donald Baker for the surgeons and Dr. Ralph F. Lindberg for the hospital association, both speakers appearing before each group.

Left to right: W. DONALD BAKER, D. O., Cardiovascular Surgeon, Los Angeles, California; RALPH F. LINDBERG, D. O., Medical Director, Detroit Osteopathic Hospital, Detroit, Michigan.

The program was truly postgraduate training and those who failed to take advantage of this opportunity were the losers, as this was the most instructive program ever held by either group.

A joint dinner meeting was held by the groups on the night of August 20, at which Dr. Ralph Lindberg was the speaker.

The dinner was preceded by a visit to the site of the new Fort Worth Osteopathic Hospital and a cocktail party was given by the Fort Worth Osteopathic Hospital at the new home of the Texas Association of Osteopathic Physicians and Surgeons.

The surgeons elected Dr. M. G. Holcomb of El Paso, president; Dr. Roy B. Fisher, Fort Worth, secretary-treasurer.

The Texas Osteopathic Hospital Association elected Mr. Earl Lock, Tyler, Texas, president; Dr. Palmore Currey, Mount Pleasant, president-elect; Mr. Hal Coker, Houston, vice president; Dr. G. W. Tompson, Houston, and Dr. Phil R. Russell, trustees.

Left to right sitting: P. R. RUSSELL, D. O., MR. HAL COKER, MR. EARL LOCK, MRS. JANE SINIARD.

Left to right standing: G. W. TOMPSON, D. O., and PALMORE CURREY, D. O.

ERROR

In the report of Dr. W. D. Blackwood reporting on the House of Delegates the mistake was made that the dues of the American Osteopatsic Hospital Association were $5 per bed.

This was an error. They were reduced from $5 to $4 per bed in 1948.

We are sorry for the error.

A Book Truly Osteopathic In Principle

Editor's Note:

Medicine will make something out of manipulation.

The osteopath has a specialist in every medical field except manipulative surgery and orthopedics. I have no answer to the ultimate outcome. We have outmediced the medic, now the medic outosteopaths the osteopath.

Dr. Jones in his lecture at Los Angeles states that he cures almost all disc cases by altering their shoes. What do you do about them?

The Postural Complex

Observations as to Cause, Diagnosis and Treatment

By

LAURENCE JONES, B. S., M. D.
Midway Hospital, Los Angeles

NOT RESERVED FOR ORTHOPEDISTS ALONE—all practitioners are equally and vitally concerned with the COMPLEX PROBLEMS OF THE NEURALGIAS considered in this book.

"This book is an unique addition to the extensive literature on *the relation of posture to neuralgic pain in various parts of the body* . . . the author describes his procedures in such detail that any interested physician can *determine the corrections* necessary for a patient and apply them in the proper shoes. The physician will find this method of treatment an effective solution to much of the problem of postural pain."—*From the Foreword by Robert T. Pottenger, M. D.*

The *strengths and weaknesses of human posture* that are the direct result of incomplete evolutionary adaptation.

The *anatomical causes and mechanisms* producing serial deviations.

Different radiographic techniques are described which measure *the exact difference of leg lengths,* and another for lateral rotatory shifts that cause changes in pelvic position.

There is a detailed description of *special methods* for history and physical examination.

Highly specialized methods of *treatment.*

The final chapters are devoted to a clinical evaluation and summary.

The final chapters are devoted to a clinical evaluation and summary.

SPECIAL FEATURE:

One chapter has special interest as it analyzes five hundred cases having chronic low back pain, with or without sciatica, derived from *the practices of the author and three independent observers.* All had been previously intractable to the usual accepted methods of treatment. The greater number (85

per cent) were given symptomatic benefit by fixed rigid postural shoe corrections and adjuvant therapy.

The entire work is *profusely illustrated* with eighty figures many of these compounded from as many serial parts.

An almost universal rotatory deviation in the feet and legs has been found to cause a series of deviational changes. *Some of these result in local symptoms as exemplified by a great variety of postural cosmetic defects and localized neuralgias.* Others are general symptoms stemming from a tension of the entire central nervous system with or without localized root tension neuralgias. When present these may occur at single or multiple levels.

CASE HISTORIES: Case histories are analyzed in which postural imbalance was a primary, and in others a secondary, aggravating factor in the maintenance of disabling symptoms.

THE POSTURAL COMPLEX, *Observations as to Cause, Diagnosis and Treatment* . . . by Laurence Jones . . . 176 pages (8½ x 11), . . . 283 illustrations . . . sent on approval, $9.75, postpaid.

Published by CHARLES C. THOMAS
Springfield, Illinois

Life Insurance Appointments

Dr. J. Warren McCorkle, Mineola, Texas has been appointed medical examiner for the Physicians Life and Accident Company, Dallas, Texas, and the Business Men's Association, Kansas City, Missouri.

Honored

C. RAY NELSON, D. O.
San Antonio, Texas

Dr. C. Ray Nelson of San Antonio, Texas, was elected president of the Academy of Applied Osteopathy in Los Angeles.

Construction Started On New Hospital

The Fort Worth Osteopathic Hospital signed a contract with Thos. S. Byrne, Inc., August 22, 1955 for the construction of the new hospital to be located at the corner of Montgomery and Mattison Streets.

Ground was broken on Wednesday, August 24, and work started. The contract calls for 350 calendar days for completion of this $1,250,000 project.

Two hundred thousand dollars ($200,000.00) worth of equipment has been selected and ordered for this new, modern institution.

It will be open for occupancy not later than August 1 1956 and assurance has been given that it will be completed by July.

Washington News Letter

September 1, 1955

To: State Officers, and Federal-State Coordinators

College Housing—The College Housing Amendments of 1955, which is Title III of the Housing Amendments of 1955 (amending the Housing Act of 1950), Public Law No. 345, approved August 11, 1955, broadens and liberalizes the College Housing Loan Program of the National Housing Act. Under the Amendments the Administrator is authorized to make loans not only for housing, but also for "other educational facilities". An eligible loan may be made unless funds can be obtained by the educational institution upon terms equally as favorable as the terms of the Government loan. The maximum terms of the loans are increased from 40 years to 50 years, and the interest rate charge to institutions is lowered. An "educational institution" is redefined to specifically include junior colleges, and to include nonprofit corporations established by a college for the sole purpose of providing housing or other educational facilties for the students or faculty. "Other educational facilties" is defined to include cafeterias or dining halls, student centers or student unions, infirmaries or other inpatient or outpatient health facilties, and other essential service facilties.

Salk Vaccine—Recently the individual members of the profession have received from the National Foundation for Infantile Paralysis copies of the pamphlet entitled "Information for Physicians on the Salk Poliomyelitis Vaccine". The questions and answers part of this publication is particularly interesting and practical. On August 12, 1955, the President approved the Poliomyelitis Vaccination Assistance Act of 1955, Public Law No. 377. The law appropriates $30 million for Federal allotments to the States, under State plans approved by the Surgeon General of the Public Health Service. $25 million is for purchase of vaccine and $5 million is for planning and conducting programs or for the purchase of vaccine. The funds are to be used by February 15, 1956. The law restricts use of vaccine purchased with these funds to pregnant women and children under 20. The Act is separate and distinct from the voluntary plan for allocation of the vaccine during the period of short supply, which went into effect on July 31, 1955, and under which the current priority group is children 5 years through 9 years old. Under the voluntary allocation plan, the Public Health Service allocates the supply of vaccine and the States have the responsibility for distribution of the vaccine through both commercial and public agency channels. All the States have designated officials to handle the problems of equitable intra-State dis-

tribution. LET ME KNOW WHETHER YOUR LIAISON WITH THIS OFFICIAL IN YOUR STATE IS EFFECTIVE. These State officials determine what proportion of the share of their State is to go to public agencies, such as local Health Departments, and what amount will be distributed by the manufacturers through normal drug channels for use by private physicians. Congress appropriated $300,000 to cover the cost of 48 special investigators of the Food and Drug Administration to prevent possible "black market" distribution of the vaccine in the States. Check-ups by these investigators will be considered complete in regard to any particular lot of vaccine when FDA has a record indicating its total distribution into legal channels; that is, when it has determined that the vaccine is in the hands of a physician, a hospital, a State or local Health Department, or other authorized person or agency.

THE TEXAS STATE BOARD OF EXAMINERS
IN
THE BASIC SCIENCES
402 PERRY-BROOKS BUILDING
AUSTIN, TEXAS

August 8, 1955

NOTICE OF EXAMINATION.

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for October 21 and 22, 1955.

The examinations will be given in Austin and in Houston, and details as to time and place may be obtained by writing to Mrs. Betty J. Ratcliff, Chief Clerk, at the above address.

All arrangements should be completed one week before examination time, and those interested should act immediately.

Very truly yours,

HENRY B. HARDT, PH.D.
President.

Good Public Relations

UNITED STATES DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE
ROOM 1801, 1114 COMMERCE
DALLAS 2, TEXAS

August 17, 1955

Dr. Phil Russell, Secretary
Texas Association of Osteopathic
Surgeons and Physicians
512 Bailey Street
Fort Worth 7, Texas

Dear Sir:

We wish to take this opportunity of thanking you and your organization for some excellent cooperation from one of your members.

Recently it was necessary that this service obtain the services of a doctor or medical attendant to assist in moving an insane alien from the U. S. Public Health Service Hospital, Fort Worth, Texas to New York City for deportation. This is not an easy matter, as we must have a competent medical attendant or doctor, and unfortunately there is practically no pay for such services. We were furnished the name and given excellent references as to his ability, but we were quite surprised to find him both willing and able to render this service to his government and we certainly feel that he deserves a lot of credit for taking his time to serve in this capacity. We hope to avail ourselves of his services in the future, as he has proven to be a most competent and trustworthy medical attendant and has indicated his willingness to cooperate with the Immigration Service in any way possible.

We have extended our own personal thanks to him but feel that perhaps his association would be interested in knowing that we do appreciate this type of splendid cooperation.

Very truly yours,

Acting Officer in Charge.

made from grade A milk*

"The first in infant feeding"

This statement is your assurance of the use of high quality, clean milk. Make a habit of looking for it on the label of the milk products which you prescribe for infant feeding.

The quality of the ingredients is reflected in the quality of the final product!

FEEDING DIRECTIONS		
	Baker's	Boiled Water
First 5 days of life	1 part	2 parts
Second 5 days	1 part	1½ parts
After 10th day	1 part	1 part

*U. S. Public Health Service Milk Code

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

MAIN OFFICE: CLEVELAND 3, OHIO — PLANT: EAST TROY, WISCONSIN

HILL-BURTON ALLOTMENTS

The Department of Health, Education, and Welfare Appropriation Act, 1956, Public Law 195, approved August 1, 1955 (69 Stat. 397), appropriates $109,800,000 for hospital construction payments under Parts C and G of the Hill-Burton Act (Title VI of the Public Health Service Act, as amended) for the fiscal year ending June 30, 1956. Part C is the basic Hill-Burton Act, and applies to aid for construction of general, tuberculosis, and mental hospitals. Part G is the amendment entitled Medical Facilities Survey and Construction Act of 1954, and is for aid for construction of diagnostic or treatment facilities, chronic disease facilities, rehabilitation facilties, or nursing homes. See enclosed chart of allotments.

The Federal share under Part C is set by the States somewhere between the limits of one-third and two-thirds. The States have not as yet set the Federal share percentages for July 1, 1955 to July 1, 1956. However, the Federal share for the past year in each State was as follows (Vermont did not set a figure): Alabama, 66-2/3%; Arizona, 50%; Arkansas, 66-2/3%; California, 33-1/3%; Colorado, 43-1/3%; Connecticut, 33-1/3%; Delaware, 34.99%; District of Columbia, variable; Florida, variable; Georgia, 33-1/3%; Idaho, 38.8%; Illinois, 38.8%; Indiana, 49%; Iowa, 33-1/3%; Kansas, 40%; Kentucky, 50%; Louisiana, 64%; Maine, 50%; Maryland, 33-1/3%; Massachusetts, variable, Michigan, variable; Minnesota, 45%; Mississippi, 66-2/3%; Missouri, 50%; Montana, 40%; Nebraska, 40%; Nevada, variable; New Hampshire, 33-1/3%; New Jersey, 40%; New Mexico, 50%; New York, 33-1/3%; North Carolina, 50%; North Dakota, 46%; Ohio, 33-1/3%; Oklahoma, 50%; Oregon, 33-1/3%; Pennsylvania, 33-1/3%; Rhode Island, 40%; South Carolina, variable; South Dakota, 50%; Tennessee, 52%; Texas, 50%; Utah, 45%; Virginia, 55%; Washington, 40%; West Virginia, 61%; Wisconsin, 40%; Wyoming, 33-1/3%; Hawaii, 50%. The Federal share under Part G is 50% unless the State specifies a variable.

The above Appropriation Act also provides $1,200,000 for use under Section 636 of the Public Health Service Act, for grants-in-aid to public and private nonprofit institutions for projects for research, experiments or demonstrations relating to the development, utilization, and coordination of hospital services, facilities and resources. Section 636 was added to the Public Health Service Act in 1949, but it has not heretofore been implemented, because this is the first appropriation that has been made available.

Procedures for projects under Section 636 are expected to be promulgated within the next four to six weeks. Osteopathic and other applicants who filed in 1949 are expected to be circularized (WNL December 1, 1949).

Osteopathic Physicians Granted Unlimited Licenses In Illinois

Twelve osteopathic physicians who took the medical examination in Illinois this year were granted a license to practice medicine and surgery in that state.

This is indeed a victory for the profession that has fought for many years to force the Department of Registration and Education of Illinois to permit our graduates to take the entire examination of Illinois and be granted unlimited privileges.

Executive Secretary Speaks

The executive secretary was privileged to speak at Mount Pleasant, Texas, to an enthusiastic lay audience at the following program:

CAPPING CEREMONY
for Students of
Mary Leigh Legg School for
Vocational Nurses
Currey Clinic-Hospital

Invocation ..... Rev. Gene Legg
Presentations of Bibles ..... Giddeons
Song ..... Dr. Gary Taylor
(Accompanist: Mrs. J. S. Kennedy)
Nightingale Pledge ..... Class
(Leader: Gilda Breedlove, R. N.)
Capping ..... Mary Leigh Legg, R. N.
Introduction of Speaker
..... Dr. Palmore Currey
Address ..... Dr. Phil Russell
Benediction ..... Rev. W. E. Bruce

Reception

We congratulate the Currey Clinic and Hospital in behalf of the osteopathic profession for sponsoring the first vocational guidance school of practical nurses in the osteopathic profession of Texas.

This is indeed a worthwhile program which we recommend that other hospitals in the profession take up.

DO's Journal Article Wins Wide Acclaim

CHICAGO (AOA)—"Suffocation or Sudden Death in the Infant," a feature article in the June JOURNAL, won author F. J. Thompson, D. O., Whittier, Calif., nationwide acclaim. The article was picked up by a major wire service and carried in newspapers throughout the country. Dr. Thompson has received many commendatory phone calls and letters from laymen and members of the healing arts professions.

KCOS Has New Faculty Member

Dr. John R. Ruffle, a 1953 graduate of the Kirksville College of Osteopathy and Surgery, joined the faculty and staff of the College July 1. He is an instructor in the division of practice of osteopathic medicine in the department of public health, where his primary assignment is to the Rural Extension Clinic program.

Dr. Ruffle served an internship at the KOH following his graduation and had been a member of the staff of the Stukey-DeWitt Hospital and Clinic of Port Arthur, Texas, since that time. He received his pre-professional training at Alma College, Alma, Michigan. He is a member of Atlas Club and Sigma Sigma Phi.

Dr. and Mrs. Ruffle live at 905 East Harrison.

Reprinted from the July issue of
CLINICAL OSTEOPATHY

Electromyography at the Rehabilitation Center

JOHN M. ANDREWS, D.O.

Professor and executive of the Department of Physical Medicine and Rehabilitation, Supervisor of the Rehabilitation Center, General Osteopathic Clinic, College of Osteopathic Physicians and Surgeons.

During recent years progress in the field of electronics has made possible the development of several diagnostic and therapeutic modalities. One of the latest of these is the electromyograph.

It consists essentially of an apparatus which amplifies to a high degree the minute electrical potentials which are produced when a muscle contracts. When the aparatus is properly calibrated, these tiny potentials can be accurately measured, photographed from the oscilloscope screen and recorded on magnetic tape. The tape may be replayed at any time to reproduce the original wave patterns on the oscilloscope screen which makes it a valuable teaching aid as well as permanent progress record.

Electromyography as used clinically, is concerned with the analysis of individual motor units. These motor units produce characteristic wave patterns and sounds. Alterations in the physiology of the neuromuscular unit produces changes which can be identified. Denervation produces fibrillation potentials which are involuntary and also produce characteristic sounds and wave patterns.

From this it may be seen that the electromyograph becomes an important examination procedure in confirming the diagnosis of neuromuscular diseases as well as being a valuable aid in the differential diagnosis of conditions such as suspected herniated intervertebral discs, muscular dystrophy and the amyotonias.

Electromyography is of particular value in localizing the area of involvement in cases of peripheral nerve damage. This is helpful in post-polio paresis both from the standpoint of diagnosis and prognosis.

Frequently, in industrial and other traumatic cases, the emotional factors have to be evaluated. It may be extremely difficult to decide whether the patient is malingering unless one resorts to electromyography.

Patients referred to the Rehabilitation Center for electromyographic studies should be directed to the General Osteopathic Clinic. Information concerning the areas to be tested should accompany the patient or be given to the Clinic at the time the appointment is made. Information relative to charges may be obtained from the Clinic Administrator.

Patient cooperation is essential in performing adequate studies with the electromyograph. Infants and young children make unsatisfactory subjects unless unusually cooperative.

Following peripheral nerve injuries or in suspected herniated disc cases, a period of at least three weeks should elapse before requesting an electromyographic examination.

Those interested in further information on electromyographic procedures will find excellent material in a book just off the press by Alberto A. Marinacci, M.D., "Clinical Electromyography," San Lucas Press, Los Angeles, 1955. It represents the conclusions of the author after study of over 8,000 cases.

1956 National Health Forum To Stress Chronic Illness

NEW YORK—Chronic illness has been announced as the subject for the 1956 National Health Forum which will meet here next spring.

The subject was selected at a meeting last month of the Board of Directors of the National Health Council, which sponsors the Forum as a part of its annual meeting. The American Osteopathic Association will be represented at this conference.

An Appeal to the Profession

This month, the profession will view a new national magazine titled, HEALTH: AN OSTEOPATHIC PUBLICATION. Actually, HEALTH is not a new magazine in the strictest sense of the word. It is an outgrowth of Osteopathic Magazine, which has served a goodly portion of the American public for 41 years.

There has been a need for an adequate modern health magazine and it is felt that HEALTH will fulfill that need. It is through your aid in the past, your suggestions, your opinions and your patience that this change has been brought about, a change that not only will serve as a better educational tool for your patients but one that you will be proud to have represent you.

HEALTH is dedicated to those people who possess some knowledge concerning health and, more important, the curiosity about how to preserve it.

It will bring your patients hundreds of practical facts on personal and family health. The articles will be non-technical, easy - to - read, authoritative. Readers of HEALTH will not only find the magazine personally valuable, but they will be better able to further the development of a sound, positive health program in their local communities—their homes, their schools, their places of employment.

AAOA to Promote HEALTH

The National Auxiliary to the AOA is making the promotion of HEALTH one of its important projects for this year, and the goal is to more than double last year's monthly circulation of 34,000 by December. The publishers of the AOA publication are convinced that the minimal yearly circulation must be increased to one million. It is not improbable or impossible. However, HEALTH will need the support that comes from the hearts of all the profession who believe in what it is doing.

It's up to YOU!

Dr. Mike Fisher Elected President Lone Star Chamber of Commerce

At a regular meeting of the Lone Star Chamber of Commerce Monday night, Dr. Mike Fisher was elected President of the organization to replace D. S. Campbell who recently moved to Ore City. The members of the Chamber also discussed the building of a street through the territory between Edgemont and Lone Star Heights so that those two centers could be connected and so that Lone Star Heights children could have an easier way to reach the school building.

Other projects relating to the efforts to be put forth to increase the population of Lone Star were discussed and committees appointed to contact the firms who will build the Ferrell's Bridge Dam and tell about the advantages of living in Lone Star.

Kansas City College Receives Mental Health Grant

First Osteopathic College to Receive Teaching Award in Undergraduate Psychiatry

Officials of the Kansas City College of Osteopathy & Surgery recently announced that the College is the recipient of a Grant Award in Undergraduate Psychiatry from the National Institute of Mental Health, a Division of the U. S. Public Health Service under the Department of Health, Education and Welfare. This is the first time such a Public Health Grant has been made to an Osteopathic College, although grants from the Heart Institute and the Cancer Institute have been provided to our Colleges for the past several years.

Funds from this grant will be used to provide material and personnel for an expanded program of teaching Undergraduate Psychiatry at the College, the officials stated. In the proposed plans are provisions for adding to the Department the services of an Assistant in Psychiatry, a Clinical Phychologist and a Psychiatric Social Worker. Purchase of Aids in Psychiatric Teaching such as a library of psychiatric tevts, films, records and recording devices will also be made possible by Grant funds.

The Grant will be under the direction of Floyd E. Dunn, D. O., F.A.C.N. Doctor Dunn has been Chairman of the Division of Neurology & Psychiatry at the Kansas City College since 1949. He is a Diplomate in Neurology and Psychiatry and is the immediate past President of the American College of Neuropsychiatrists.

Grants of this type are an indication of the acute awareness on the part of our Governmental Agencies of the rapidly increasing need for Mental Health Care, the officials added. Since the great majority of patients in need of help for their emotional and psychological problems come to their family physicians first, it is imperative that the doctor of the future be better trained in the diagnosis and therapy of these problems, and Federal Grants of this type, the officials concluded, are helping the colleges with the great burden of providing expensive training in fields which will constitute a large portion of the practice of America's doctors in the coming years.

Announcement of A New Clinic Service

The Kansas City College of Osteopathy and Surgery wishes to announce the opening September 1, 1955 of a new Clinical Service: The Human Relations Clinic, under the direction of Dr. Floyd E. Dunn. Staff personnel and other expenditures of this Clinic will be paid in part from a Grant in Undergraduate Psychiatry from the National Institute of Mental Health of the U. S. Public Health Service. The patients will be expected to pay nominal fees for services rendered, in accordance with ability to pay.

Facilities for the performance of the following services will be available:

Complete psychophysiologic and psychiatric consultation service.

Marriage and pre-marital counseling.

Vocational counseling and guidance.

Psychological testing.

Therapy in psychiatric and psychophysiologic (psychosomatic) problems.

2nd of TV Series To Be Filmed at Ottawa Arthritis Hospital

CHICAGO (AOA)—Hospital sequences for *Arthritis,* second film in the TV series "Symptoms of Our Time," was photographed at the Ottawa Arthritis Hospital the weekend of Aug. 26, 27 and 28. Production personnel and actors, six in number, stayed at the Ottawa osteopathic institution during the on-location filming.

Geriatric Gynecology

(Continued from Page 4)

and Kraurosis Vulvae should be classed as a chronic atrophic dermatitis of the vulva. In such an instance 3 distinct stages are noted. These are:

1. The acute inflammatory stage in which swelling, redness, and even superficial blebs are prominent. The vulvar tissues may be so congested that even careful palpation may produce bleeding. There is intense pain and itching. This stage may last several weeks or months but sooner or later becomes subacute or chronic.
2. The second stage is characterized by rapidly progressive atrophic changes including induration and thickening of the skin; loss of elasticity and occasionally a mottled grey color. This entire process is limited definitely to the non-hairy portion of the vulva. In its progress it may extend posteriorly to the perineum and skin to the anus but has no tendency to spread laterally.
3. The third and final stage, to which the term Krauosis Vulvae has been given as the chronic stage lasting for years. The skin over the entire vulva becomes smooth, glistening and parchment like. The vaginal orifice becomes narrowed and fissures and cracks develop easily.

A biopsy will always assist in the accurate diagnosis of the condition and, in the event of true Leukoplakia, a vulvectomy should be considered. Since recurrences in adjacent tissue are not too unusual, careful followup of these cases is necessary. There have been some authorities who feel that vitamins A and C and judicious use of Estrogenic hormones may prevent these recurrences.

The non-surgical treatment of this series of conditions has not proven successful. In selected cases, however, it should be tried. Estrogens have been used by some with mild relief and antipruritic ointments such as Quotane, Theophorin, Calmitol and others have been used in control of the severe itching and burning. X-ray has given only fair results and is rarely used as treatment.

New inclusion cysts and bartholin cysts rarely occur for the first time in the Geriatric patient. Carcinoma of these glands may occur but is very rare. It is advisable to carefully examine any nodule on the vulva in the older women. Virus warts, Senile Keratosis and Nevi are easily identified and treatment for the same may be outlined. The most common malignant lesion in the vulvar and vaginal area is the squamous cell Carcinoma. Rarely is the basal cell Epitheloma found. These lesions are

usually raised; have rolled edges; and are much more firm than the surrounding tissue. Usually the patient does not seek medical care until ulceration and secondary infection occur. At this stage, it has been said that forty-five to fifty per cent of these cases have definite extension to the inguinal nodes. The treatment of choice is wide excision of the vulva and bilateral inguinal node dissection. If the patient is a poor operative risk, this may be done in stages. In the very elderly and the very poor surgical risk patient, simple vulvectomy may provide symptomatic relief. X-ray therapy may be palliative but is rarely curative and radium has, according to most authorities, proven very unsuccessful.

I feel that biopsy of suspicious lesions should be by wide excision and not by incision. With early and adequate surgery before lymph node involvement has developed, it has been said that seventy-five percent of the cases will have a five year survival. If the nodes have become involved, this survival rate drops to about thirty per cent.

Vaginal Carcinoma is usually secondary to Cervical, Fundal, or Vulvar tumors and when this diagnosis is suspected, a careful survey must be made for a primary site. In the occasional primary vaginal carcinoma, the posterior fornix is the most likely site.

Among the structural defects noted in the Geriatric patient is Prolapsus of the Uterus plus Cystocele, Enterocele, and Rectocele. The ground work for these lesions usually occurred as a result of childbirth many years before but such is not a prerequisite to Prolapsus. With Estrogen deprivation of the postmenopause there is an increased aging of ligamentous and fascial tissue and the patient gives a typical history that following prolonged coughing; heavy lifting; unusual exercise; etc. A vaginal tumor appears. Examination at the time reveals a prolapsus of a varying degree. In addition urinary dysfunction, gastrointestinal dysfunction, low back ache and other pains and discomforts may be present.

It is my opinion that the time of merely fitting these patients with pessaries and sending them on their way is rapidly drawing to a close. Since the advent of modern anesthesia, early ambulation, blood replacements and careful pre-operative evaluation, it is possible to give more permanent relief to these patients.

For the Geriatric patient who is not going to be active, climbing stairs, etc., and who is past the likelihood of sexual activity, the Le Fort operation, or Colpoclesis, is a good procedure. On the poor operative risk patient this surgery may even be done under local infiltration anesthesia. Dilitation and curettage must always precede this operation. The Manchester-Fothergill and Watkins Interposition operations may also be used to a good advantage. I agree with most of the authorities that Vaginal Hysterectomy via one of the varied techniques with Anterior and Posterior Colporrhaphy is probably the operation of choice for the average severe procedentia. Giatric patients appear to tolerate the vaginal approach much better than the abdominal. In severe enterocele, however, it may be necessary to combine the vaginal and abdominal approach since this is the one lesion that is apt to recur regardless of the type of repair. The choice of the operative procedure will finally be determined by the life expectancy of the patient; the expectancy of physical activity of the patient; and by the surgical capabilities of the surgeon. It must be remembered that in the Geriatric patient it is very important to maintain the physical activity of the patient as long as and as comfortably as is possible. It is this sense of being valuable around the house and of being generally active

that makes life worthwhile for these patients.

A frequent complaint bringing the post-menopausal patient to the physician is a bloody discharge. With this complaint comes the necessity of careful diagnostic survey. The following are among many conditions which must be considered when faced with this presenting complaint:

1. Local Trauma by scratching or douching because of the fragility of tissue.
2. Ulcerated neoplasms of the Vulva or adjacent structures.
3. Uretheral Caruncles and Ectropions.
4. Intravesical lesions such as Polypi and/or Neoplasms.
5. Ulcers on a Prolapsed Cervix.
6. Carcinoma of the Cervix.
7. Endometrial or Fundal Carcinoma.
8. Pyometra.
9. Hemorrhoids, Fissures and Rectal Neoplastic growths.

In the interest of time each of the above causes of vaginal bloody discharge as a presenting complaint will not be independently discussed. Several pertinent facts will, however, be emphasized.

It must be remembered that carcinoma of the Endometrium is the most statistically likely neoplasm in the Geriatric group. Diagnostic Curettage is the only safe way to eliminate this possibility. Any recurrent bleeding after the menopause usually indicates an abnormal condition which may vary from a trivial polyp to an all important cancer. Again the Diagnostic Curettage is a valuable defensive weapon.

Attention should be called to the fact that in the Geriatric patient Carcinoma of the Cervix is primarily a condition responding to X-ray and radium therapy while Fundal or Endometrial Carcinoma is primarily a surgical entity. I feel, however, that a plea should be made for those physicians away from large centers to use the facilities at hand with which they are most familiar, be they X-ray, radium, and/or surgery. Quite often what has proven statistically correct in a given condition has not proven practically so in a given situation.

Summary

1. The importance of Geriatric Gynecology in light of the increasing number of Geriatric patients has been emphasized.
2. Problems peculiar to the Geriatric patient have been outlined.
3. It has been noted that by the judicious use of Estrogenic Hormones topically and/or orally many infectious and inflammatory processes of the vulva and vagina may be cured.
4. Chronic Atrophic Dermatitis with

Leukoplakia and Kraurosis Vulvae has been discussed in its various stages as to diagnosis and treatment.

5. It has been shown that every surgeon interested in surgery of the aged should realize that, properly prepared and protected, the risk to the Geriatric patient is not nearly so great as is commonly believed and that realization that the special hazards are not insurmountable has led to an extension of even radical surgery in certain conditions to those who previously were denied possible benefit. In the preparation of these patients it must be remembered to give special attention to preoperative and post-operative nutrition, replacement of fluids and blood, early ambulation, and a proper selection of surgical techniques and anesthesia by the surgeon and the anesthetist.
6. Malignancy of the Geriatric patient has been touched upon. It should be mentioned that in the older patient, because of slower growth of tumors, the actual prognosis may be better than in the younger age group. Therefore, prompt diagnosis and definitive treatment are essential.
7. It has been stated that since society and medicine are together fostering research to save life, they must in turn accept the responsibility of the lives thus prolonged.

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Thoughts On Osteopathy

(Continued from Page 6)

degree and given all the privileges residing in this equation.

What happens if such an equation is not forthcoming? The profession must resort to alternatives. Having failed to achieve full recognition and rights as a D.O., one alternative is to change the title of the degree to something more acceptable to the boards of recognition and those D.O.s demanding this fully deserved acknowledgement. Such a possibility would be an "M.D.O.", medical doctor of osteopathy, or "O.M.D.", osteopathic medical doctor. These degrees might give a better view of the osteopathic position in the medical domain, but at best are mongrel offsprings of two concepts. The second alternative is to become subservient, lose identity completely, and merge into the main stream of medicine by amalgamation. To do so suggests increased privileges at the cost of decreased identity.

At this point, it must be determined what is the most important destiny of osteopathy: the maintenance of a traditional name with its limitation, or seeking full participation in medicine under any name ascribed to it, believing that a "rose by any other name smells as sweet". If one contends that osteopathy has already served out its purpose by causing allopaths to become conscious of physical medicine, then no reasons for a separate existence may be offered. However, if one believes that osteopathy has merely scratched the surface and has many more contributions to make in the future, and these contributions would not be forthcoming if amalgamation took place, then it would be essential to continue as a distinct school of medicine, even at the expense of partial practice rights. The ideal solution would offer the D. O.'s full rights

with complete recognition as a distinctly separate entity.

Many factors, some obvious, some occult, shape the future course of this profession. One factor often overlooked is represented by the many popular phrases found in osteopathic thought and literature. These phrases perceptibly influence the future course and of necessity will require further examination. One such phrase is, "patients complain about how hard it is to get an old-fashioned osteopathic treatment anymore". Assuming this is true, the statement may be highlighted by asking if the patient is the same one who goes to a "real doctor" when he is actually sick, and then deciding if osteopathic education was intended to take care solely of that type of patient. Another phrase is "all that using drugs make us is a second rate M.D., and I'd rather be a first rate D. O. than a second rate M.D." One might assume that the doctor would be more interested in what services he could extend to his patient than that doctor's personal medical rating. The validity and implications of such a statement has to be examined and evaluated for its proper merit. It can be seen that many trite expressions and cliches abound in osteopathic thoughts, literature and conversations. It would seem profitable if these phrases were culled, examined objectively, and either refuted or brought into sharp focus with the practical daily application of the osteopathic concept in modern medicine. Dr. Phil Russell as editor of our JOURNAL, has both the knowledge and ability to do this.

Of equal importance is the necessity to discuss the "science" in our profession. There is often a failure to realize that the scientific attitude may be used unscientifically. A differentiation must be made between Galilean and Aristotlean science. Once a distinction has been drawn, it would be informative to point out which school of science has predominated and shaped osteopathic thoughts in the past. Some contend that true osteopathic science began only when Paul Rosenberg Associates were asked to consider spinal mechanics and osteopathic lesions as a problem in physics. True or not, it was in this light that Dr. Rosenberg stated ". . . it is to be hoped that we can bring a vigorous and unambiguous method of physics to osteopathic research". In the recent past, osteopathy has witnessed a movement by the researchers in the profession to bring osteopathic method of thinking from one school of science to the later school of scientific procedure. Perhaps a direct correlation exists between the degree of shifting that has already occurred and the percentage of acceptance that the D.O.s now enjoy.

All of the preceding discussion leads pointedly to the quintessence of this article. WHY HASN'T OSTEOPA-

THY BEEN MORE FULLY ACCEPTED TO DATE? Some claim lack of acceptance is due to the small number of osteopaths, only about 12,000. This knowledge is to be compared with the fact that there are only a few hematologists in the entire country, and yet their findings are accepted by the scientific world. Others contend that the osteopathic concepts are new, being 75 years old. In contrast, radio astronomy as a science is only several years old, yet experiences no difficulty in having its unique ideas seriously considered by other scientists. One may then question if acceptance as a body of knowledge is proportional to age or size. The answer is obviously no.

There are doctors who declare that D.O.s come by their unusual position because it is a "rival group". With all due respects to the allopathic group, intellectual honesty must be utilized. This honesty demands that the answer to the problem resides within the word METHODOLOGY.

As many osteopathic physicians will now eagerly state, the allopathic schools are now accepting some of the osteopathic techniques of practice and even applying similar manipulative measures. What many of these same osteopathic physicians fail to realize is that the allopaths are rejecting the *methods* by which these concepts were drawn, *the methods* of explaining the results, and the *methods* of elaborating upon those effects, even though the clinical response is satisfactory. As a result, the *methods* used by a school of medicine in developing new ideas, and the *methods* of evaluating those ideas are actually often more significant than the findings themselves as far as acceptance by the medical scientists is concerned. One wonders if it would be too presumptuous to think that if different *methods* were applied to the osteopathic concepts by the earlier investigators, as were applied by Pasteur or Koch in the same era, and that these *methods* were superimposed on the good clinical results that D.O.s have been consistently obtaining, the D.O. degree today would be the envy of the medical world. Speculation of possible past performance doesn't aid the present problems however.

Inadequate methods have been a failing in the past, but improved methods may be the saving grace of the future. The story of Cranial Osteopathy is a condensed version of the pattern of osteopathy itself, only its beginnings are still in the present tense. Whether this cranial concept is emasculated by improper methodology, and restricted to a few fervent followers, or the tremendous dynamic potentials are unleashed by unambiguous objective methods remains to be decided by the men close to this highly interesting field. It would be most unfortunate if a truth of medical science were to be carried to a blind alley and stigmatized merely because it was transported there by a vehicle of poor choice. The choosing of the proper vehicle can be aided by Dr. Russell and his editorial work.

It would be wise to close these thoughts with the hope that all of the above comments would be constructively considered, subjectively provocative, objectively evaluated, and projectively utilized.

Study of U. S. Work In Medicine Mapped

WASHINGTON, D. C.—A special committee to review and evaluate all medical research programs of the Department of Health, Education and Welfare was announced by Mrs. Hobby's successor, Marion B. Folsom, and Dr. Alan T. Waterman, director of the National Science Foundation.

The review to be completed in December by an eight-member committee, will be conducted by the foundation as an interim report on its survey of medical research in this country.

Reprinted from the July issue of CLINICAL OSTEOPATHY

Subluxation of the Head of the Radius

Its Recognition and Treatment in Young Children

By ROBERT MAGRILL, D. O.

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Subluxation of the head of the radius is a common injury in young children. But because its diagnosis is apt to be missed, many parents become apprehensive until the condition is recognized and treated by physicians attending young children. The history and findings are characteristic and the treatment exceedingly simple with dramatic, spontaneous relief.

The syndrome was first recognized and described by Fournier as early as 1671. Since that time, medical literature has been filled with accounts of this traumatic disorder. It has been called "pulled elbow," Malgaigne's sublaxation, slipped elbow of young children, Gromeyer's injury, curbstone fracture, and nursemaid's elbow.

The etiological factor is alway traction upon the extended arm at the hand or wrist of a young child—generally those under five year of age. The child is usually lifted or jerked by the hand to prevent his falling. Examples of this are: (1) lifting a child up over a high curb or streetcar step, (2) holding him when he stumbles to prevent his striking the ground, (3) pulling a toy away from a child, (4) pulling the arm through the sleeve of a dress or sweater, (5) swinging a child around by the hands. Occassionally, the injury may be incurred by a fall.

The history is usually very definite, for the child immediately cries out with pain and refuses to use his arm, which generally hangs motionless at his side. He maintains the arm limp as it hangs from the shoulder in slight adduction and internal rotation. All motion of the forearm, especially supination, is resented. The forearm is usually semipronated.

This condition is frequently unrecognized because the subjective symptoms are often misleading. They are invariably referred to the wrist, mid forearm or shoulder. Examination reveals no evidence of fracture. Tenderness on pressure over head of the radius is commonly elicited. There may be some swelling over the radial head, depending upon the duration of the subluxation. The hand, wrist and shoulder can be moved in any direction by the examiner. The elbow can usually be moved in all directions. However, passive supination of the forearm meets with a rubbery resistance and marked tenderness is elicited.

The treatment is very simple and can be accomplished by manipulation without anesthesia. Reduction is obtained by supination and outward pressure on the subluxated head. The involved elbow is gently grasped so that the thumb is placed over the radial. The patient's wrist is grasped with the other hand and the forearm slowly supinated and extended. A sharp click announces the reposition. This can be heard and felt with simultaneous disappearance of the rubbery resistance.

The response is most dramatic and satisfying to the physician, the patient and the anxious parent. The child is almost immediately symptom free and begins to use his arm with no limitation of motion and a sling is usually unnecessary. However, in some cases where the subluxation has existed for more than twenty-four hours, there is some reluctance on the part of the child to use the arm immediately following reduction.

In such patients, it would be advisable to apply a sling to the arm until the swelling and pain subsides.

Many patients probably never reach their physicians, as they reduce the subluxation spontaneously. It is not unusual for the reduction to occur while the X-ray technician is positioning the forearm for X-rays. Recurrences are not uncommon.

The radius, situated on the lateral side of the ulna, forms only a small part of the elbow joint. Ossification of the radius occurs from three centers. The center of ossification for the body of the radius appears during the eighth week of fetal life. At the end of the second year, ossification begins at the distal extremity. The head of the radius begins ossification at the fifth year. In children under five the cartilaginous head of the radius is usually smaller than the shaft. It is partly rounded and partly rectangular in shape. There is an abrupt rise from the neck to the head of the radius anteriorly, while laterally and posteriorly the rise is gradual.

Stone, working with anatomical specimen, concluded that the deformity was caused by the head of the radius slipping under the annular ligament. He demonstrated that the head could only slip out if the forearm was pronated. The annular ligment is in close contact with the radial head and neck and maintains the proximal radius in position. When strong traction is applied distally in the long axis of the radius, the radial head is displaced under the annular ligament and becomes locked.

Although this condition involves the bones and joints, it is primarily a pediatric problem. It is most often seen by the pediatrician or general practitioned. Its frequent occurrence should alert all physicians who treat young children. Renewed emphasis should be placed on this condition because of its alarming consequences. Diagnosis is readily made if the history and physical findings are kept in mind. Treatment can be performed in the office without anesthesia. Many anxious and apprehensive hours can be avoided when an immediate diagnosis is made and adequate therapy instituted.

SUMMARY

Subluxation of the head of radius is a frequent traumatic injury of children under five years of age.

History and physical findings always reveal traction on the extended arm. Examination reveals the involved extremity hanging motionless at the side. Tenderness is elicited upon pressure over the radial head.

Treatment consists of manipulative therapy and may be performed in the office without anesthesia.

All pediatricians and general practitioners should become well acquainted with this condition.

CASE REPORTS

Case I—S.M.M., a thirty-two month old male child was seen in the outpatient department of Glendale Community Hospital on December 31, 1954, with the complaint of refusal to move his left arm.

History of Chief Complaint.—Onset several hours earlier when patient stumbled and traction was applied to extend arm by parent to prevent his falling to the ground. Child cried out at once and then refused to use the arm which hung motionless at his side. Pain at the wrist and shoulder were noted.

Past History.—Full term infant delivered spontaneously, birth weight seven pounds. Roseola infantam at age six months. Fifth's disease at fourteen months. Had immunizations and vaccination by eight months of age. Booster DPT at eighteen months.

Similar episode to chief complaint at nineteen months following a fall. Left arm hung motionless for a period of about two hours. Then child suddenly

began moving left arm spontaneously with no residual weakness or pain.

Family History.—Mother living and well. Father living and well. One sibling, age eighteen months, in good health. Negative history of tuberculosis, syphilis, rheumatic disease, diabetes and allergy.

Physical Examination.—Revealed a well-nourished, well-developed male child in no apparent acute distress, very active. However, left arm hung motionless at his side.

Examination of the eyes, ears, nose, and mouth revealed nothing abnormal. The heart, lungs, spine and abdomen gave negative findings. The extremities were normal except for marked tenderness on pressure over the head of the left radius. The hand, wrist and shoulder could be moved in any direction by examiner. Supination of the forearm met with a rubbery resistance and considerable reluctance from an otherwise cooperative patient.

X-ray Examination.—Left Upper Extremity, December 31, 1954. AP and oblique views of the left shoulder area including the humerus, plus PA and lateral views of the left forearm, present no radiographic evidence of bone or joint pathology, at the present time.

Diagnosis.—Subluxation of the head of the left radius.

Treatment.—Following X-ray examination where the forearm was supinated and extended by the X-ray technician, child began to move his arm in all directions with no residual weakness or pain.

Case II.—D.C., Four year old male child was seen at my office with chief complaint of not being able to move left arm.

History of Chief Complaint.—Child had been playing out of doors and was running away from parent. While running, he stumbled and was falling when parent grasped the child's extended left hand and held the child who twisted around, but did not strike the ground. A snapping sound was heard and child cried out immediately. Child complained of pain in left shoulder and wrist. He had not moved the arm for over an hour. Arm hung motionless against his side at all times in almost complete extension.

Past History.—Spontaneous delivery, twelve hour labor, no complications, cried immediately after birth, no resuscitation required. Neonatal development satisfactory, no feeding difficulties, occasional colic during first three to six months. Had immunizations and small pox vaccination. Booster-immunization at age two.

Family History.—Mother living and well. Para III, gravida III. Father living and well. Occupation—grocery manager. Patient oldest child, has young brother age three and younger sister age eleven months in good health. Negative history of tuberculosis, syphilis, rheumatic disease, diabetes and allergy.

Past Illness.—Measles, occasional upper respiratory infection, tonsillitis with cervical adenopathy. No previous injuries recalled. No operations.

Physical Examinations.—Reveals well-developed, well-nourished four-year-old male child well adjusted, in no apparent acute distress. Patient displays great reluctance to move left arm. However, left upper extremity does move slightly while walking.

Physical findings essentially negative except for hypertrophied tonsils which are not injected and left upper extremity hanging at his left side with forearm in extension. No evidence of fracture was noted. Tenderness was illicited over the radial head and a marked resistance to passive supination and complete extension was noted. The hand, wrist and shoulder could be moved in any direction. No swellings were noted.

X-ray Examination.—Left upper Extremity. AP and oblique views of the life shoulder area including the humerus plus Pa and lateral views of the left

forearm presented no radiographic evidence of bone or joint pathology at this time.

Treatment.—Treatment consisted of reduction of the subluxation by placing the thumb behind the radial head and with the other hand, grasping the patient's wrist and slowly supinating the patient's forearm and extending.

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Research Center to Study Body's Needs

CHICAGO (AOA) — A new research center to learn about the body's needs and responses in our "world of today" has been established at the University of California at Los Angeles reports the July issue of "Science Newsletter."

According to Dr. Ben Miller, chairman of the department of physical education, four major projects that will be operated under his department are already in progress.

"It is the University's hopes," he said, "that operations of the research center will be expanded in the future as larger physical facilities become available."

Dr. Miller stated that the four research programs now in progress include: study of the body's balance mechanism; relation of muscle power to speed of movement; study of the value of warm-up in athletics, and an investigation of physical growth and performance among school children.

KCOS Announces Founder's Day Speaker

Dr. Kenneth E. Little of Kansas City, Mo., Director of Graduate Instruction of the Academy of Applied Osteopathy, will be the guest speaker at the Founder's Day Convocation at the Kirksville College of Osteopathy and Surgery October 19. Dr. Little's address, titled "A Need and A Challenge", will be preceded by the President's Annual Report of Dr. Morris Thompson.

Founder's Day activities will open on the evening of October 18 with the Banquet honoring members of the classes of 50, 25, and 10 years ago. On the morning of the 19 will be the pilgrimage to the grave of Andrew Taylor Still, with a floral tribute by the earliest graduate present; the Convocation at the College Auditorium; and the ceremonies at the Old Doctor's Cabin at which the symbolic transfer of the key from the sophomore class to the freshman class is made. On the afternoon of the 19 will be the All-College Picnic at Brashear Park, and that night, the dance at the College Auditorium, both events sponsored by Student Council.

Being held in conjunction with Founder's Day activities this year is the Academy of Applied Osteopathy Post-Graduate Course B, which is meeting at the College October 17-22, recessing for the evening of the 18 and the morning of the 19 to join in the annual observance. The course will deal with the extremities and fascial and other soft tissue technics, including myofascial reflex phenomena. Featured will be a thorough introduction to Chapman's reflexes and their use in diagnosis and treatment.

AUXILIARY NEWS

Auxiliary District Two

Here we are beginning the fall season and it seems to come as a bit of a shock to all of us and we feel a little bit sluggish after summer vacations.

First of all, if I could shout on paper I would do so right now as I announce that district 2 won National first place award for the best Year Book at National Convention this last July in Los Angeles. We surely wish to thank Mrs. J. O. Carr (Florine), Year Book Chairman, for such a splendid job.

Mrs. R. B. Beyer (Dorothy) and Mrs. C. R. Packer (Gita) were our delegates to the convention this year.

Dr. and Mrs. Phil Russell left September 2 for Europe to visit their son and family, and what a trip they will have—even "Gay Paree". Ruby says she will keep a fast hold on Phil's coattail and intends to step just as fast as he does.

The ground has been broken for our new hospital here in Fort Worth, and we can hardly wait now to see this beautiful, spacious hospital which we think will be the pride of Fort Worth, and even all of Texas.

Our first meeting will be held September 11 at the Worth Hotel. It is to be an all day meeting starting with a coffee and a short business meeting and luncheon with the Association. Dr. Morris Thompson, president of the Kirksville College of Osteopathy and Surgery will be the luncheon speaker. A book review by Mrs. A. H. Clinch will be heard in the afternoon.

That is all for now. See you next month.

Mrs. William M. Snow (Barbara)
District 2 Pubilicty Chairman.

Auxiliary District Five

The Dallas Osteopathic Hospital Guild will have their fall Rummage sale Saturday, September 3.

Dr. and Mrs. Lester Cannon and daughters recently returned from a 10 day trip to Mexico and Colorado, where they visited several interesting spots.

Dr. and Mrs. Leslie McClimans and family are visiting their parents in Greenville, Pennsylvania.

Dr. and Mrs. Robert Moore are spending a few days vacationing in Galveston.

Dr. Lionel Burton's mother from Cincinnati, Ohio, visited in the Burton home last week.

Dr. and Mrs. H. G. Swords and sons left September 1 to visit relatives in Missouri and Illinois.

Dr. and Mrs. Myron Magen and son left August 29 to visit Mrs. Magen's parents in Des Moines, Iowa.

Dr. and Mrs. Joe DePetris and Dr. and Mrs. L. C. Nystrom spent a weekend recently fishing at Texoma.

Mr. and Mrs. Floyd Collop of Kirksville, Missouri, are visiting their daughter and family, Dr. and Mrs. J. C. Williamson, and their son and family, Dr. and Mrs. Robert N. Collop and family.

Dr. Sam Morgan, who is now stationed in the armed forces, left for 12 weeks to Fort Dix, in New Jersey to help make a picture on First Aid. Mrs. Morgan accompanied him.

Mrs. H. G. Swords, *Reporter*

NEWS OF THE DISTRICTS

DISTRICT ONE

Dr. and Mrs. John Witt of Groom spent the last two weeks of August in Colorado enjoying a much needed vacation.

The district meeting was held at the Sneed Hotel in Dumas on Sunday, August 14. Dr. and Mrs. Paul Price, Jr. were the host and hostess. Mr. Charley Lummis, Safety Engineer for Shamrock Oil and Gas Company presented Mr. Byron Austin, Safety Engineer, who spoke to the Group on "Co-operation of Doctor and Employee". Wm. Ballard, D. O. had charge of the program and he introduced Dwight Cox, D. O. of Hedley, who is chairman of the Ethics Committee. Dr. Cox gave a very interesting paper on "Ethics of the Physician", which was enjoyed by all. A business meeting followed with President Lester J. Vick, D. O. presiding. Dr. Vick made a report on the A.O.A. meeting held recently in Los Angeles.

It is a pleasure to report that Archie Garrison, D. O., chairman of our State O.P.A., plans to visit us on September 24, and we hope to be able to report to Chairman Garrison that the group will be 100% at that time. Dr. Peach of the K.C.C.O.S. will also be present, and we shall be happy to welcome both of them.

Dr. and Mrs. John H. Chandler attended the A.O.A. Convention in Los Angeles. En route they detoured and stopped by Salt Lake City and Las Vegas. Their daughter, Mrs. Kenneth Moore, and children, are visiting from Roswell.

Open House was held recently at the home of Dr. and Mrs. Raymond Mann to celebrate the wedding anniversaries of Dr. and Mrs. Earle H. Mann and Dr. and Mrs. Maurice Mann.

George Bob Vick, son of Dr. and Mrs. Lester J. Vick, has been home for a visit this summer from Europe. He will return to France to complete his studies.

Now that Dr. and Mrs. Lee Cradit's daughter and husband, Captain and Mrs. Thos. P. Mason, have returned to the States after being stationed with the Army in Verdun, France for three years, the Cradits plan to enjoy four vacations instead of one, visiting them quarterly during the year at their home in Colorado Springs. A highlight of their recent visit was the "Pikes Peak or Bust" Rodeo which is held at the Broadmoor Stadium.

Joe Bob Brown, son of Dr. and Mrs. J. Francis Brown, has gone to Fulton, Missouri, where he will enter Westminister College.

We want to welcome Dr. K. C. Suderman to our district. He is now living in McLean. He interned at the Tulsa Osteopathic Hospital.

Dr. and Mrs. J. H. Kritzler, formerly of McLean, went to Dayton, Ohio, where he will specialize in X-ray. We are sorry to lose the Kritzlers, but happy to have Dr. Suderman.

J. FRANCIS BROWN, D. O.

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DISTRICT TWO

Dewayne Giles, Fort Worth, is planning on entering the College of Osteopathic Physicians and Surgeons, Los Angeles, California, as a freshman this fall.

DISTRICT NINE

A reception and banquet was given Thursday, September 8, 1955, for the District 9 members of the Texas Association of Osteopathic Physicians and Surgeons.

Dr. Edwin F. Peters, who is president of the Des Moines Still College of Osteopathy and Surgery, Des Moines, Iowa, was a special guest, Dr. A. L. Garrison, past president of the State organization of TAOP&S, was also honored.

Dr. and Mrs. Paul E. Pinkston entertained with a reception in their home preceding the banquet in honor of Dr. Peters and Dr. Garrison.

Dr. Peters, as guest speaker at the banquet, spoke on the subject of the "Needs of Present Day Education."

The women attending the reception and banquet were members of the Ladies Auxiliary to the Association.

Dr. Pinkston was host at the banquet, held at Victoria House Restaurant.

Others attending the banquet and reception were: Dr. and Mrs. T. D. Crews, Gonzales, Dr. and Mrs. C. L. Booher, Bloomington; Dr. and Mrs. H. A. Poage, El Campo; Dr. and Mrs. W. L. Crews, Gonzales; Dr. and Mrs. John H. Boyd, Louise; Dr. and Mrs. J. C. Burt, Moulton; Dr. and Mrs. R. L. Morehead, Flatonia; Dr. and Mrs. H. L. Tannen, Weimar; Dr. and Mrs. R. L. Stratton, Cuero.

The Victoria Advocate, Saturday, September 10, carried a nice write-up and quite a few pictures of the doctors and ladies of the auxiliary.

Cardiovascular Training Center for Nurses To Be Established

WASHINGTON, D. C.—Plans for the establishment of a pilot Cardiovascular Training Center for Nurses were announced recently by Surgeon General Leonard A. Scheele of the Public Health Service, U. S. Department of Health, Education and Welfare. The training center, first of its kind, will be located at the University of Minnesota School of Public Health, starting Jan. 1, 1956.

Nurses for the first group to train at the center which will offer field experience in special services for cardiovascular patients will be drawn mainly from the consultant, supervisory and instructor positions.

This is related to the Cardiovascular programs sponsored by the USPHS, in which many D. O.s and M. D.s have participated.

Meeting of Kirksville Alumni Huge Success

The Los Angeles meeting of the Kirksville Osteopathic Alumni Association recorded the characteristic continuing growth in attendance. Forty-nine representatives from twenty chapters was a record, and the banquet attendance of 259 moved right up to top the east coast gathering at Atlantic City and the record gathering in Toronto last year. Plans are already underway for the big reunion next summer.

New officers include: President, Dr. Lester J. Vick, Amarillo, Texas; President Elect, Dr. Margaret H. Raffa, Tampa, Florida; Vice-President, Dr. H. E. Donovan, Raton, New Mexico; Secretary, Dr. Kenneth L. MacRae, Cass City, Michigan; Delegates at Large, Dr. Robert N. Evans, LaGrange, Ill., and Dr. Victor J. Cervenak, Detroit, Michigan; and Past-President, Dr. Geo. E. Cozma, Cleveland, Ohio.

Dr. C. Robert Starks of Denver, Colo., was nominated to the Board of Trustees of the College to succeed Dr. Allan A. Eggleston of Montreal, Quebec, Canada, subject to the action of the Trustees at the annual meeting in October.

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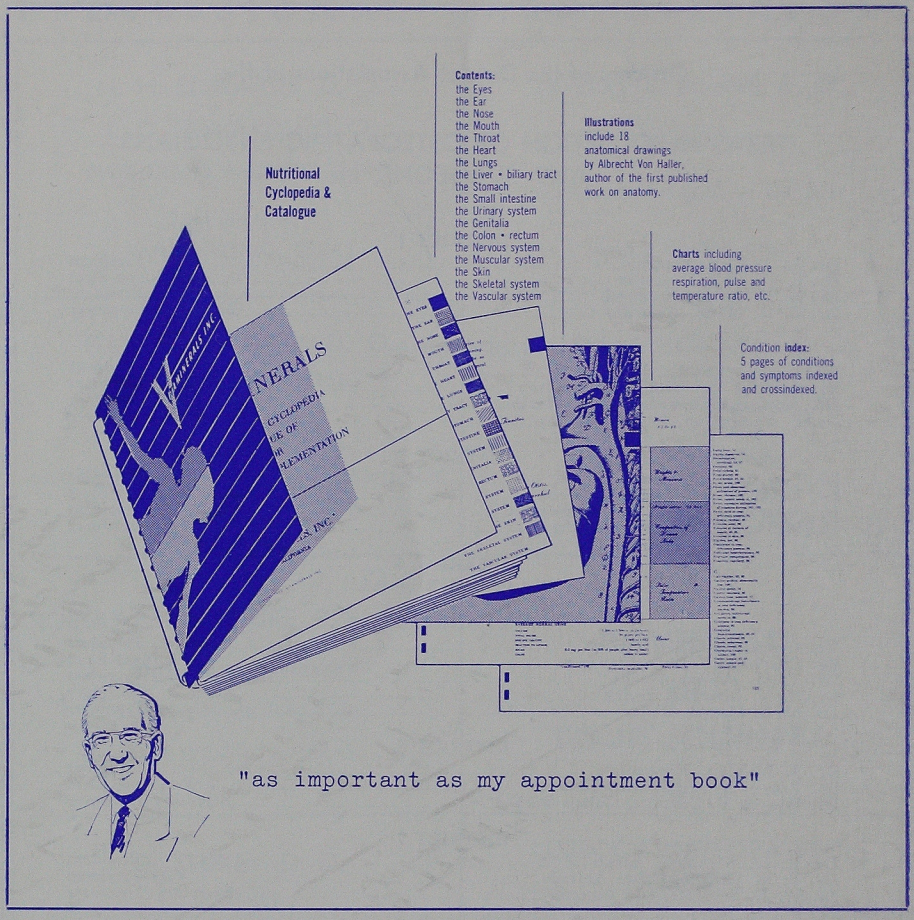

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