The COLLEGE JOURNAL

OSTEOPATHY

Lay Members

We are proud to announce the election to our Board of the following lay individuals:

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Kansas City, Mo.

Mr. Edgar L. Evans,
E. L. Evans Printing Co.,
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Mr. Charles J. McKinley,
Vice-President, Willis & Weber Paper Co.,
Kansas City, Mo.

We are glad to have these prominent business men, all keenly interested in Osteopathy, as associates in defining the destines of the Kansas City College of Osteopathy and Surgery—The Aggressive College.

OSTEOPATHY

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OUR HOBBY—Continued

A short while back one of our graduates spoke to the writer concerning some building and loan stock that he cashed in and asked our advice as to its further investment. We suggested he reinvest it in the building and loan company. He said he had already tried to do so but the company refused to accept it—"as they had more money now than they cared to invest."

This part of the conversation reminded us of a bit of experience we had when the fall session opened. We desired to place $5,000.00 in a savings account at our bank. We were informed the bank would be glad to take care of our money but would pay us no interest—they were already paying out more money on savings accounts, at the rate of 2½% than they cared to think about. We told him of this experience.

He then asked about the Trustee's Certificates we were attempting to float at six per cent. We had to inform him that none had been issued due to lack of demand but if he wished to place his investment with us we would issue our demand note at six per cent to be exchanged for Trustee's Certificates "when, as, and if" issued.

A few weeks later came a check for $500.00 with the promise of more to follow. This young man has made a gilt edged investment—not in a concern set up with profits as its primary motive, but with the purpose of helping, without profit, in the upbuilding of the osteopathic profession. He is taking absolutely no risk, he will receive his six per cent per annum interest and his principal on demand.

He has done much, he has invested $500.00. We have done more. We have invested our very lives, our every endeavor in the strengthening of Our Hobby. He will at his will, receive his money. We cannot recall our lives nor would we. We can wish we had a dozen lives to give to this—Our Hobby.

Possibly, publication of these facts may induce others to do likewise. Our personal experience in trying to build up a fortune informed us that commercial investments are precarious at best. We have seen our real estate drop enormously in value and finally taken into the hands of the mortgage holder. We had our bonds—without exception—go into receivership and depreciate fifty to seventy-five per cent. We've had our building and loan stocks pay us back sixty to seventy per cent of our hard earned investment. How we regret now that every penny was not loaned or invested or even given to Our Hobby. It would not then have been lost. It would not have depreciated. It would have been as secure as Osteopathy itself.

We've learned our lesson when it is too late. But there can now be no investment offered us so alluring as to attract a dime from our pockets again. If we, perchance, do acquire again any of this world's goods, it is going immediately into the treasury of Our Hobby, where it may earn honest interest, serve a noble purpose other than adoration of the God Mammon, where it will help to make Our Hobby greater than ever before.

That is the thought for this month.

A. A. Kaiser, Secretary

DR. CONLEY RESUMES HIS COLLEGE ACTIVITIES

It is with pleasure that we are able to make the above announcement. Dr. Conley was taken ill May 2 last, which prevented him from finishing his school-work last session. It also made it impossible for him to attend the graduating exercises immediately following; the first occurrence of the kind since the organization of the College in 1916.

Dr. Conley was confined to his bed, without privilege of company, for 43 days and was not permitted to take on any of his professional duties for 90 days. Since then he has resumed his professional activities gradually, but was unable to fill his college assignments with the beginning of the first semester of the present session.

His general health has improved rapidly with the onset of the cooler weather so that now he is competent and able to take over all of his college and professional assignments. Beginning the second semester of the present session he will resume his clinics at the college, both general and surgical, as in the past and will have the Seniors and Juniors in Osteopathic Practice.

The burden of the responsibility for the operation and maintenance of the Lakeside Hospital having been assumed by the lay Board of Trustees with the cooperation of the newly formed professional staff, will allow Dr. Conley more freedom for the pursuance of his college activities. Not only in a teaching capacity in which his long years of clinical experience will prove valuable to the students who take his practical courses, but along administrative lines as well.

He has held the office of the President of the Board of Control since the organization of the College in 1916. He has held, and continues to hold, the Chair of Surgery in the College since its inception. His duties as President of the Board assume greater responsibility as plans are being formulated and measures perfected for the endowment of the College and the expansion of its present facilities.

The reorganization of the Lakeside Hospital permits him to give his entire time in the furtherance of his professional activities, surgical practice and consultations, both general osteopathic and surgical. He still maintains his professional interest in the Lakeside Hospital, takes his hospital cases there and affiliates with it as a member of the general and executive staff.

He has established himself in his permanent office in Suite 212 Tower Building, The Country Club Plaza where, in association with R. A. Murren, D. O., he will continue the conduct of his private practice.

It is assumed that the many friends of Dr. Conley will be pleased to learn of his restoration to health and that his services are once more available, not only in a professional capacity, but in organization work as well.

Dr. A. A. Kaiser, Secretary

Recently I met Dr. Conley in the hall of the College early in the morning. He was in excellent spirits and told me his program for the previous day. He had done two major surgical operations at the Lakeside Hospital in the morning, had attended a noon-day Chamber of Commerce luncheon, had treated several patients osteopathically in his office, and then had returned to the Conley Clinical Hospital and performed another major surgical operation. He termed it a "bully day" and certainly looked none the worse for the busy day.

Dr. R. A. Murren

THE OSTEOPATHIC MANAGEMENT OF HEART DISEASE

J. L. Jones, D. O., of the College Staff

That mechanical and manipulative measures influence the heart is a well known fact to the medical profession as shown by the following references:

Dr. Beckman in "Treatment in General Practice," p. 521, says regarding treatment of paroxysmal tachycardia, "Pressure of the vagi in the neck especially the right vagus often terminates an attack by stimulation of the inhibitory function of this nerve" and he further states that "Pressure upon the orbit is sometimes effective also."

In "Diseases of the Chest," by Norris and Landis, p. 201, we find these statements. "The vagus nerve may be stimulated directly by firm finger pressure on the carotid artery just below the angle of the jaw, or indirectly via the fifth nerve and the vagus center; by compression of the eye ball." * * * "These procedures often perceptibly slow the heart rate and increase pulse volume." "If care is not exercised in compressing the carotid immediately below the angle of the jaw, an increase in pulse rate may occur from irritation of the superior cervical sympathetic ganglion. The pulse rate may be accelerated also from psychic effects."

Cardiac hypertrophy may be the result of spinal deformity we are told by Dr. Finley in the Can. Med. Assn. J. of Oct. 11, 1921. And Dr. Goldthwait in Body Mechanics, p. 129, tells of curing decompensating and enlarged hearts without the use of any drug. Dr. Goldthwait on p. 133 quotes Drs. Gunther, Garnett and others as having "Recognized a pseudo-angina from involvement of the vertebra nerve roots from arthritis or postural deformity."

The Osteopathic Physician is conversant with these facts, and we are not attempting to deny in any way these good doctors, but let me call to your attention that is only a short step which they need to take from heart disease to disease in general. We would like to ask these good doctors why they do not give credit where credit is due for Dr. A. T. Still was teaching this sixty years ago, and by right of discovery would be given credit for his work.

In the book, "The Failing Heart of Middle Life," p. 13, by Hyman and Parsonett we find this statement, "It is a well recognized fact that the functional integrity of any organ depends upon the maintenance of a normal and sufficient blood supply. This is particularly true of the heart." This also sounds like these authors had been reading some of the works of Dr. Still, who said in 1874, "The rule of the artery must be absolute, universal and unobstructed, or disease will be the result" or in Research and Practice, p. 183, (Published in 1910) by Dr. Still we find this, "If the heart is weak or over-active the cause will be found to be in the nerve supply."

Yale Castlio, D.O. in "Principles of Osteopathy," p. 74, says in speaking of lesions of the 4-5-6 Cervical vertebra "Cardiac arythmia is not uncommon," and again on p. 84 he says, "Second thoracic lesions induce asthenia and increases excitability of the cardiac muscle." On p. 117 he says, "Upper thoracic lesions are likely to make normal function impossible and progressively weaken the myocardium."

The Osteopathic Profession not only recognizes the pathology of the lesion but also has a definite theory as to the cause of disease and a logical therapy for the cure. In both of these we are far ahead of the old school of medicine which only in a minor way recognizes the lesion as

the cause of disease, and is afraid to admit that the correction of the lesions will cure disease. For it goes without saying that if old school practitioners admit this it would automatically destroy all their old beliefs and give credit to the Osteopathic profession for something which they have tried to destroy by fair means and foul politics, slander and ridicule.

It seems necessary from the Osteopathic and Medical evidence to accept the fact that lesions in the spine will cause heart disease; it further seems necessary, upon the same evidence, to assume that the correction of the lesion by whatever name you call it (lesion, body mechanics, spinal deformity or arthritis) will affect the heart for good. That it then becomes necessary in caring for heart disease patients to go back to original Osteopathic principles and correct the lesions.

Rest is the one great therapeutic measure at our command. It takes 5% more energy to sit up in bed than it requires to lie down, and the pulse rate of the patient in bed is about 5 beats slower than if in the upright position. This seems small but will total up to about 7,000 beats each 24 hrs. and it is a well recognized fact that all extra beats of the heart take place at the expense of the rest periods of the heart, which normally total about 13 hrs. a day.

The modern physician also must take cognizance of the effect of scientific diet upon his patient. We cannot say, "Stuff a cold and starve a fever," for we know a cold should not be stuffed for it is a fever disease and a fever should not be starved. It is possible that one of the reasons for such a large percentage of the population of today are found to be heart cases is due to the fact of the misconception in the past on the part of the physician and the laity in regard to the diet. The patient with a fever has a higher metabolic rate than in health, so will require a greater caloric intake in sickness than in health. In fever diseases it is common for the patient to develop an acidosis and the heart will not stand a change in the pH as well as the skeletal muscle so will suffer first and most.

Best and Taylor in their book, "Physiological Basis of Medical Practice," p. 246, have shown that the heart muscle is seriously damaged by a 0.07 concentration of lactic acid while the skeletal muscle will continue to respond even with a concentration of 0.2. Dr. Osborne, M.D., of Yale says, "Carbohydrate starvation is inexcusable with our present understanding of the danger from acidemia." Protein foods should be consumed in quantities from 40-100 grams to meet the daily requirement and if your food does not contain sufficient protein the body musculature including the heart muscle will be called upon to furnish it. It is true that muscle and the solid parts of the body requires very little protein to replace their daily wear and tear but the blood corpuscles are being destroyed in great number and must be replaced by new, young, healthy cells chiefly composed of protein.

Other essential food elements to be considered are the vitamins and minerals. The principle minerals to be considered in heart facts are the sodium, calcium, and potassium which must be present in the blood for the heart to function. And the vitamins to be considered are A.B.C. A. is the anti-infectious vitamin and deficiency will lower body resistance to infection; lack of B. indues cardiac disfunction and causes muscular weakness of the heart and a deficiency of Vitamin C will cause shortness of breath, rapid heart action, and rapid breathing.

The proper diet for the sick patient should be largely composed of milk, fruit juices, fruit, honey, sugars of

various kinds, cereals, eggs, broths and soups. The feedings should be sufficiently frequent to give the patient the necessary caloric requirement of both carbohydrate and protein foods.

Drugs are of no great value in heart cases. There is no known drug yet devised which will improve the condition of scarred heart valves and we find in Tice's Practice Vol. 5 p. 88 under treatment of sub-acute bacterial endocarditis this statement, "There is no specific or even recognized treatment of acute endocarditis." * * * "As far as can be determined all therapeutic efforts and attempts of various kinds are simply useless or futile."

Digitalis is not a cure for heart disease of any kind but may act for good in some types of heart disease by slowing the rate and thereby giving the muscle more rest.

Other digitalis-like drugs we are told by Dr. White of Harvard Med. School in, "Heart Disease," p. 526-8 are, "inferior to digitalis in effectiveness and reliability—and all other so-called stimulants, if active at all, produce an effect not directly on the heart but on the nervous system, blood vessels or other tissues; none of them can in any way take the place of digitalis. These drugs include strychnine, camphor, caffine, theobromine, spartine, physostigmine, crataegus, cardiazol, coramine, aconitine and cactus."

When the heart muscle begins to fail treatment must be directed toward restoring cardiac function regardless of the type of lesion responsible for decompensation. After compensation is re-established it is then time to consider the original cause, i.e., infected tonsils, rheumatism, syphilis, hypertention, etc.

The most important single factor in restoring cardiac function is REST (both mental and physical). Impress upon the patient that his chief business now is to get well. He must obey orders or die, there is no half way treatment in decompensation of the heart. Explain to the patient that rest in bed (sitting up if necessary) will save the heart on the average of about 25,000 beats a day. No bath room privileges are extended and meals are to be taken in bed—the patient is not to get out of bed for any cause.

Sometimes it is advisable to postpone the beginning of the treatment for a day or two to give the patient an opportunity to prepare his business affairs so that they will not be a source of worry any more than necessary. The rigidness of the rest, the length of time it must be endured and the period of relaxation of such rest will depend entirely upon each patient, so no set rule can be established.

The nurse should be agreeable as well as efficient, visitors should be restricted to a minimum or eliminated. All food, medicine, treatment and visitors should be during the day time, the nights being devoted to rest and sleep.

The old style practice of vigorous cathartics to remove edema is out grown. It is permissable to give ½-oz. of saturated epsom salts solution in the morning before any food is taken; this is enough to be mildly cathartic and will remove some fluid, but is not drastic enough to disturb the patient by excessive elimination. In fact, it is of little importance even if the bowels move only every other day. At any rate purging is too drastic and alters the edematous condition too little to warrant its use. Diuretics are generally valueless—in congestive heart failures and if digitalis is used it will serve the purpose. Hydrotherapy is of value in cleansing the skin, and improving the circulation, warm baths are good for improving the peripheral circulation.

Massage is appreciated by the patient as is the Osteopathic treatment; both will improve the venous return

circulation and promote lymphatic drainage.

The mildest sedative that is effective is the best for the particular patient and in the beginning it is sometimes advisable to begin with a small dose of morphine. This should be diminished so that within three days a sedative by mouth will suffice such as 10-15-gr. sodium bromide, 1½-gr. of phenobarbital, El. Alurate Oz. 1 to 3; or 15-gr. chloral hydrate by mouth or rectum.

When all is considered we can sum up the treatment of the heart in a few words:

Medicine outside of digitalis is of little or no value. Digitalis is useful to help slow and strengthen the heart beat in such cases as auricular fibrillation and decompensation.

It is agreed by M.D.'s and D.O.'s that faulty mechanics will cause heart disfunction and the Osteopathy Physician has something to do about it. Rest is the most important factor in treating heart disease. The patient should receive a nutritious easily digested diet containing all the food elements; proteins, carbohydrates, fats, vitamins and minerals.

That cathartics are not advisable in cardiac disease.

Dr. Still was the first to discover that mechanical malpositions of the body would cause disease and that the correction of the lesions will cure many of them.

(The above paper was delivered before the Missouri State Convention on October 12th by Dr. J. L. Jones.)

W. McKim Marriott, M. D. says, (Recent Advances in Chemistry in Relation to Medical Practice) "In planning a diet a reasonable amount of milk, butter, green vegetables and cereals should be included, and when this is done, we need have no fears of vitamin deficiency. Vitamines should be bought at the grocery store and not at the drug store."

ADVANCED POST-GRADUATE INSTRUCTION

Dr. A. B. Crites and assistants of the College staff are again offering an intensive course in operative surgery on the eye, ear, nose, and throat the last week of February, 1939. Each student will perform the various operations upon the cadaver under supervision. The entire gamut of nasal and sinus surgery will be run, stressing reconstruction of the turbinates, submucous resection, the intranasal technique for frontals, ethmoids, sphenoids, and antra done under flaps and without mucous membrane or turbinate destruction. The operation and elementary nasal plastic procedures will be demonstrated.

Dissection from a practical surgical standpoint of the neck and entire head will clarify and crystallize the knowledge of the anatomy of the parts. Mastoid, radical, complications, Hinsberg labyrinth and Neumann apex operations together with eye surgery will be done.

To satisfy repeated requests for such work, this course is offered to those who have been doing specialty work and wish to acquire the newer things in technique. The college dissection room will be used, the facilities of the clinical hospital will be available and the class will be strictly limited. Further information will gladly be furnished on request.

Clinical Observations of the Effect of Lesions of THE LUMBO-SACROILIAC AREA AS ETIOLOGICAL FACTORS IN PELVIC PATHOLOGIES

George J. Conley, D.O., of the College Staff

It is the purpose of this article to call attention in a specific way to certain effects produced by lesions of the lumbo-sacro-iliac area for which the average gynecologist or genito-urinary specialist can find no appreciable explanation and which may vaguely be ascribed by them to endocrine dysfunction, psychical manifestations, constitutional disturbances, leucorrheal diathesis and numerous others.

It is in such cases that the specialist or the general practitioner searches vainly with the "instruments of precision" at his command for evidences of a pathology, visual or otherwise, that will account for the troublesome and oftentimes alarming symptoms for which the complaining patient consults him for relief. Among the cases that I have in mind, which are frequently encountered by the general practitioner, are persistent leucorrhea or a spontaneous type of inexplicable origin, vaginismus, vaginitis, essential hemorrhage of the womb, cystitis, hematuria, renal or ureteral spasm or colic and proctitis. There are others but these are sufficient for the purpose in mind.

In all these cases no definite pathological findings are forth coming from the use of the various diagnostic gadgets which are usually the first thought in the minds of the thoroughly up-to-the-minute specialists or wouldbe aspirants thereto. As a result, after much of examination effort, the patient is subjected to a round of experimental treatments which run the gamut from local applications and douches, the various modalities of heat, light, electricity, vitamin deficiency, endocrine imbalance and surgery, the end result being, at best, temporary improvement or failure. Understand, now, I am speaking of cases inexplicable to the medical specialist and far too often concurred in by the osteopathic specialist. Let me say here and now there is a grave tendency on the part of specialists of the osteopathic school of practice to accept the dictum of medical specialists as absolute and follow their recommendations and treatments ad seriatim. Far too often the osteopathic concept as an aetiological factor is overlooked or ignored to the detriment of the patient and the confusion of the doctor.

Naturally in the examination of the patient a sequential case history is the first and oftentimes the most important factor and this, supplemented with a careful physical examination by one trained to reason from cause to effect in terms of applied anatomy and physiology, will suffice to give the clue to the offending pathology. If at this time amplification of the findings of the case history and physical examination is indicated, then recourse can be had to the X-ray, the test tube, the microscope and other "instruments of precision." Primary reliance, as a rule, however, must be vested in the case history and the physical examination. Osteopathic physicians and surgeons should always adhere to this method of procedure, regardless of medical dictum as to aetiology.

Briefly let us consider the nerve supply to the plevis, to the end that the influence of the lesions of the lumbo-sacro-iliac area upon the pelvic viscera, may be evaluated. The sacral plexus of nerves (the largest nerve plexus in the body) is made up largely of the 5th lumbar and the 1st and 2nd sacral nerves. It is

closely connected with the hypogastric plexus of the sympathetic which lies immediately in front of the 5th lumbar and the sacral promitory. Both these plexuses have strong connections with the pudendal plexus, one of whose branches, the pudendal nerve, reaches the rectum, the base of the bladder and the vagina. "The pelvic portion of the hypogastric plexus lies close beside the rectum upon the pelvic surface of the levator ani, close to the vagina in the female and on the fundus of the bladder in the male. Together with the pudendal plexus it forms a number of smaller plexuses: the middle hemorrhoidal plexus on the rectum, the prostatic plexus on the prostate, the large utero vaginal plexus especially well developed on the lateral border of the cervix uteri, the vesicle plexus on the bladder and the cavernous plexus." (Sabotta and McMurich.)

Leucorrhea may be precipitated by lesions in this area. Any irritation to the sacral plexus of nerves reacting through its connections with the hypogastric and pudendal plexuses can influence the vagina or the entire womb, particularly the cervical portion: giving rise to congestions, either acute or chronic, which manifest as leucorrhea. True this factor is not mentioned in medical works on gynecology, but the fact remains that correction of such lesions is followed by surprising results in so-called "essential" conditions. By "essential" I mean inexplicable on any known pathological findings of medical origin. In my own experience I have relieved many cases by the simple expedient of relieving a lumbo-sacral lesion or a twisted innominate on the sacrum.

An old patient of mine from a nearby village came to me one day complaining of a severe purulent leukorrhea of nearly two years standing. She told me she had gone to another osteopathic physician for treatment "because my prices were too high." She had had douches, local applications of various sorts, lights and various modifications of heat treatments (administered by the office assistant). My examination revealed no causative pathology locally. There was deep congestion of the vaginal mucosa but no apparent reason. The history revealed a fall some two years previously wherein she hurt her back in an area corresponding to the lumbo-sacral articulation. Examination revealed a pelvis twisted on the spine, accompanied with heavy muscular contractions and severe pain. The lesion was reduced. She was asked to return in three days for a check-up examination. No other treatment of any kind was advised as the effect of the reduction of the lesions was to be noted. Imagine my surprise as well as her pleasure when she reported the cessation of the persistent vaginal discharge together with disappearance of the lumbo-sacral pain. I saw her again within a week with complete subsidence of symptons. An interval of three years elapsed before contacting her again. She came on a different mission, but questioning revealed freedom from the troublesome symptons. Examination at that later date confirmed and showed normal relationship in the lumbo-sacral articulation. This case is but one of many which yielded to the reduction of lesions of the nature referred to. I am simply calling attention to a common condition which may act as a stumbling block to unsuspecting osteopathic physicians when confronted with such cases.

Again, a case of so-called essential hemorrhage from the womb in association with a lumbo-sacral lesion and with absence of any detectable uterine pathology. Reduction of the lesion followed with adequate subsequent observation, demonstrated the cessation of the troublesome condition permanently. Under old school methods the X-ray would be used and

if it failed then hysterectomy would be resorted to. The same line of reasoning is applicable to the disturbances of the menstrual flow in the absence of detectable pathology.

Severe cases of vaginismus have been relieved permanently by giving attention to the lesions of the plevic girdle and seeing to it that they were corrected.

A lady was packing up preparatory to a change of residence. It fell her lot to pack several barrels with dishes, etc. After a long hard day of packing and unpacking barrels and boxes she finally had to give up and take to her bed on account of severe lumbo-sacral pain. Some time later she went to the toilet to evacuate the bladder and was greatly alarmed to find that she had suffered a copious hemorrhage from the bladder accompanied with a very definite urge to urinate at frequent intervals thereafter, always passing blood. In those days the use of the cystoscope was limited as only specialists of known repute made use of such an instrument and the price was out of the reach of one in modest circumstances. The pain being the immediately annoying factor, I found a lumbo-sacral lesion which was corrected. Then I decided to await developments before proceeding further. The bladder pain and the urge to urinate subsided and with it the hematuria disappeared. I made a mental note of it. Later on I found another case giving me a similar history, but with more fortunate financial conditions. A cystoscopic examination was made but no definite pathological findings were noted except extreme congestion, most marked about the base of the bladder. In such an event the expectant plan of treatment was adopted. The lumbo-sacral lesion was reduced with no other treatment recommended. The immediate result was cessation of all untoward symptoms.

Another case, a farmer was thrown across the tongue of his wagon in a runaway. The team was running in a large circle with the result that the horse on the inner side struck his hips every leap. He noticed pain in the lower reaches of his back and in the right inguinal area. A little later an intractable cystitis developed. He was cystoscoped by an outstanding urologist of our city with negative findings. Later on an enterprising surgeon concluded his symptoms were due to a chronic appendicitis. An appendectomy was done with no relief. In his search for relief he encountered another surgeon who postulated a hidden hernia on the right side and an operation to relieve was done. The symptoms still persisted. Then he journeyed to a noted clinic and after a most painstaking examination by competent specialists was told there was nothing the matter, that he had a "nervous" bladder and to go home and forget it. As a last resort he came to the Lakeside Hospital where physical examination revealed a badly twisted lumbo-sacral articulation with much pain and heavy muscular contractions. The lesion was reduced, the symptons disappeared and, altho under observation for several weeks, there was no recurrence.

Those tenesmic pains in the rectum without adequate pathological foundation, but accompanied with deep congestion of the rectal mucosa, in association with lesions of the pelvic girdle particularly the lumbo-sacral, are usually relieved permanently by reduction of the lesion.

More could be written in the way of citing experiences corroborative of the influence of these lesions, but enough has been mentioned to call the attention to their far reaching and oftentimes cataclysmic effects.

One thing more must be mentioned: in the presence of demonstrable pathology of organic nature-such as hemorrhoids, pus tubes, uterine displacements, chronic gonorrhea, lacerations

of the cervix uteri and the perineum, the reduction of the lesion, if present, palliates as a rule. The lesion tends to recur. Particularly is this true if the secondary effects of the lesion become so deeply entrenched that nature is unable to repair the damage —in which event primary recourse to surgery must be resorted to before successful reduction of the lesions can be accomplished.

As a corollary—when surgery for such secondary conditions is completed, then of necessity the primary lesions must be corrected before you can assure the patient permanent relief from all the disagreeable symptoms. If a pain persists in the pelvis following a hysterectomy for uterine fibrosis or a huge fibroid with lesions of the pelvic girdle present, don't follow the trend of the surgeons of the medical school and say, "adhesions" and advise further surgery. Remember your osteopathy, correct the lesion and send home a grateful patient. Far too often is the physician inclined to assume a complacent attitude in the fact that the successful correction of pathology by surgical means is all sufficient and that there is nothing left for him to do.

Two-thirds to three-fourths of the simple gastric ulcers can be cured or greatly benefitted by proper palliative treatment. All early and uncomplicated cases should be given the advantage of such treatment.

The presence of areas of pain associated with muscular contractions about one inch to the left of the 9th, 10th, 11th and 12th dorsal spines is significant of the presence of gastric or duodenal ulcers. Correction of vertebral lesions in this area should always be the major factor in the palliative treatment of such ulcers. Even after surgical interference such correction is not only indicated but is imperative.

ANNUAL CHILD HEALTH CONFERENCE

The Annual Child Health Conference, which is sponsored by the Kansas City Society of Osteopathic Physicians and Surgeons, will be held April 19 to 22, inclusive. This is ten days after Easter which is an ideal time.

Dr. Leo Wagner of Philadelphia will be our guest speaker on the regular program. We are indeed fortunate to be able to announce that Dr. Arthur Allen has promised to be with us as speaker at the Grand Banquet on Friday evening, April 20. We hope to have 500 people at this banquet.

Due to the fact that the Baltimore Hotel is closed for alterations, we will hold the Child Health Conference this year on the Roof Garden of the Continental Hotel (Continental Hotel was formerly the Hotel Kansas Citian).

Remember the time—April 19 to 22, inclusive.

The place, Hotel Kansas Citian.

We will be seeing you there.

CASE REPORT: RENAL ADENOCARCINOMA

L. J. Graham, D. O. and C. A. Povlovich, D. O., of the College Staff

Present History: Patient, A. H. male 56 years, on admission to the hospital complained of weakness and a loss of 26 pounds in weight in the past six months, persistent presence of blood in the urine, the patient stated that the first hematuria dated to about 4 months previous entrance to the hospital, intermittent in character, but occasional attacks were hemorrhagic in severity. At times would pass several clots, the last severe hematuria occurred fourteen days before admission. Since that time the urine cleared up, until the present attack, which was more severe than any previous attacks, the patient became alarmed and came to the hospital. At no time was there ever any pain accompanying these attacks of hematuria. In the past five or six months, the patient had noticed that he had been losing weight, and tired easily on the slightest exertion.

Physical Examination and Past History: The patient stated that he had had mumps, measles, whooping-cough, in the influenza epidemic during the World war had influenza, followed by an attack of pleurisy, which lasted for about four months, there was no diagnosis that this pleurisy was tuberculosis as there were no other symptoms suggesting it. History of any Gastro-intestinal disturbances was negative, Genito-Urinary, negative up to the present onset of his illness. Venereal diseases denied.

The patient on physical examination showed a well-nourished and muscular individual, but who showed some evidence of recent loss of weight. The eye, ear, nose and throat were negative, orally the patient was wearing artificial dentures. The chest was normal, the heart negative, blood pressure, Systolic, 155, diastolic 100, the abdomen was moderately tender to palpation over its entire area, in the left upper quadrant was a palpable rounded mass, which was movable on deep palpation. Prostate appeared negative, as did the external genitalia. Laboratory report: Kahn Reaction, negative. Erythrocytes, 4,100,000 with 10 grams hemoglobin. Leukocytes, 14,200 with 78% neutrophilic leukocytes. Urinalysis, no casts, large amount of blood cells. Phenolsulphonphthalein out-put in two hours, 50%. Roentgen-ray findings showed a normal right kidney, the left kidney showed a filling defect, which was thought to be due to a kidney tumor.

With the above present history, laboratory and roentgenologist findings a tentative diagnosis of left kidney tumor, in all probability carcinomatous type.

The patient was prepared for operation with a liberal supply of glucose per orum, in the following formula, which was first advocated by one of the authors, (CAP), glucose or karo syrup 15 teaspoonfuls, juice of 2 large oranges, ½ teaspoonful sodium chloride, qsad; tap water 1 quart, this supplies the necessary carbohydrates, water and sodium chloride to combat the dehydration post-operatively.

The immediate pre-operative orders are as follows.

Prepare patient for left lumbar incision. Saline enema at bedtime, repeat enema following A. M. Nembutal 1½ grains at bedtime, repeat Nembutal at 5:30 next A. M. Morphine Sulphate ¼ grain, Atropine Sulphate 1-150 grain at 6:20 A. M. to surgery at 7:30 A. M.

The von Bergmann oblique lumbar incision is made by one of the authors (LJG), it begins at the lateral border of the sacrospinalis muscle at the costovertebral angle, a little above the twelfth rib. The incision is carried downward and forward (mesially), midway between the last rib and the crest of the ilium, the fascia cov-

ering the sacrospinalis is now divided from without inward, next comes the latissimus dorsi, then the external and internal oblique muscles down to the aponeurosis of the transversalis muscle, now dividing the aponeurosis the perirenal fat protrudes into the incision, the lower pole of the kidney is now palpated. Difficulties are encountered by firm adhesions to the colon, which had to be separated from the kidney, the kidney was large with a short pedicle. The tumor mass appeared to occupy the upper pole extending almost down to the lower pole. In order to gain additional exposure at this stage of the operation, the twelfth rib was freed in its posterior portion upward and backward nearly to the articulation of the rib with the transverse process of the twelfth dorsal vertebra. This allowed a better exposure of the kidney, since it was difficult to bring it up into the incision because of the short pedicle, the pedicle was grasped with a large curved nephrectomy clamp, another is now placed into position, and the pedicle is divided close to the kidney, the kidney is now out of the way allowing better access to the pedicle. One ligature is applied to the pedicle on the proximal (aortic) side of the more deeply applied forceps and then the forceps is slowly removed. This leaves one forceps attached to the pedicle. A second ligature is now applied, by transfixion, then the second forceps is now removed. No bleeding in the field of operation, the incision is ready to close. Two cigarette drains are placed near the pedicle and are allowed to project from the posterior part of the incision, the transversalis fascia is now closed with continuous suture using No. 2, plain catgut suture, the muscles are now brought together with interrupted mattress sutures. The deep fascia is now closed with continuous No. 2 plain catgut suture. Skin clips were used to approximate the skin edges, which will be removed on the sixth day. At this time the anesthetist reports the patient's condition excellent, the anesthesia used was induction with ethyl chloride, then changing over to ether inhalation.

The immediate post-operative orders were as follows: Physiologic saline 1000cc by hypodermoclysis, statim, Glucose 20% 500cc by Venoclysis at 6:00 P. M. then repeat Glucose and Saline P.R.N.

Gross pathological report: A large kidney measuring 15x12x5 cm. the tumor mass appeared partially encapsulated and sharply demarcated from the surrounding kidney structure of the cortex, it showed invasion into the pelvis of the kidney, with some compression of the calyces. On section through the kidney it showed a yellowish-white mass with some areas of hemorrhagic necrosis. No apparent invasion of the blood vessels was found. The gross picture was one of a variegated appearance, which is typical of so called hypernephroma or renal adenocarcinoma.

Histopathological microscopic description of a section through the kidney tumor.

This showed a neo-plastic tissue with an attempt at the formation of glandular tissue, the cells were vacuolated, rather large and rounded. The stroma is scanty and delicate, the tissue was highly vascularized, this probably accounts for the tendency to frequent homorrhage into the tumor, and hematuria. This is a typical example of the so-called "clear-cell" type of adenocarcinoma (hypernephroma), there was no line of demarcation between the tumor and surrouding kidney tissue.

The patient made an uneventful recovery and was discharged greatly improved. Unable to follow up this case as the patient moved out of the city, the prognosis in this type of tumor is very poor owing to the tendency of metastases through the blood, yet there are cases on record of no recurrence following early removal.

BENIGN CYSTADENOMA RIGHT OVARY

CLINIC AT CONLEY CLINICAL HOSPITAL
HOME-COMING WEEK, NOVEMBER, 1938

George J Conley, D. O., of the College Staff

The patient, a married lady aged 66 years, came to the clinic complaining of an enlargement in her abdomen which she first noticed several years ago. It was painless, caused no discomfort in the early years of its presence, and which increased in size slowly. At first the enlargement was near the median line and just above the symphysis pubis. Some five months ago, as a result of the gradual enlargement, she experienced a feeling of weight and discomfort, as though her abdominal organs were being crowded. She feels as though she were pregnant and experiences discomfort when she walks. She also complains of heart burn although on questioning this symptom has been annoying since her first pregnancy some 45 years ago. She complains of pressure on the bladder.

Her familial history is negative while the early childhood history is uneventful. Her menstrual epoch is normal. She was married at 21 years. Has had two pregnancies with one normal delivery, the first stillborn and the other a hard instrumental delivery.

In the laboratory the urinalysis was negative, the blood showed 84% hemoglobin, 2,600,000 erythrocytes and 5,650 leukocytes. The systolic pressure was 150, diastolic 75.

The physical examination reveals nothing of importance, except the enlargement in the abdomen which extends upward to the level of the navel, occupies all the right abdomen and intrudes upon the left side about two inches. It is smooth in outline, tense and is freely movable. On percussion the impulse is transmitted distinctly to the finger on the opposite side indicating fluid contents. The marked circumscription of the enlargement is indicative of a cyst. The bimanual vaginal examination reveals a tense, definitely outlined mass occupying the entire right broad ligament area filling the culdesac and extending to the left across the median line. It crowds down from above in a manner which makes prohibitive any attempt to outline the uterus. To the examining finger the mass is fluid in character. Rectal examination confirms the vaginal. I must make an unequivocal diagnosis of a right ovarian cyst.

Were this patient twenty years younger I would go farther with my examination by insisting upon x-ray exposure and the rabbit test to exclude the possibility of a pregnancy. In this instance the presence of a growth recognized by the patient covering a period of years might be judged as sufficient evidence to eliminate a possible pregnancy.

Again the absence of the classical symptoms significant of pregnancy should be additional grounds against such a possibility. This may all be true and yet the fact that the enlargement was marked in the last five months might still be viewed with suspicion as a possible pregnancy in complication with a known ovarian cyst. Also one must ever bear in mind the fact that women in the childbearing period have been known to pervert the facts which may get the diagnostician in a jam. Although the patient is 66 years of age it must be remembered, as cited in the "Book of Truth," that Sarah in her ninetieth year conceived and presented Isaac (in his one hundredth year) a son and heir. We may have approached the millenium sufficiently, that occasionally men will be men and women be women, as in the good old days.

Our anaesthetic, which is the

"HMC—Chloroform Sequence," is complete under the watchful care of Dr. Ollhoff, one of our interns, and we are ready to cut down on our diagnosis. At this time I am reminded of a funny incident which occurred years ago before the x-ray laboratory test for pregnancy. A young married lady who had had a menstrual history remarkable for its long intervals between periods (from 6 months to 18 months) was taken with a painless persistent vomiting. She consulted an outstanding stomach specialist who, after getting the case history, made a diagnosis of nervous vomiting and gave treatment calculated to correct. He failed. She hunted up another specialist who made a similar diagnosis with failure to alleviate. A third was consulted with the inevitable failure. Then she consulted an osteopathic physician who, taking into consideration the standing of the specialists already consulted, accepted their diagnosis, treated her, and after exhausting all his resources, in desperation called me in consultation. Examination, bimanually, revealed a womb symmetrically enlarged with its cervix soft to the touch of the examining finger. She had vomited so long that her condition was grave. A diagnosis of "pernicious vomiting in pregnancy" was made and a therapeutic abortion recommended. This was laughed at and the aforesaid specialists again were called in. Naturally they used every argument at their command to prove that I, an osteopathic physician, was wrong. They continued their palliative measures without successful relief. When the patient was suffering six to eight fainting spells a day I was called again by phone to see the patient. "Send her to—hospital so that she may be prepared for the operation, or call someone else." I said. They said they would call the ambulance at once. When she was in the operating room under the anaesthetic and everything ready to begin the operation, the referring osteopathic physician, who was present, tapped me on the shoulder and motioned me over to the most remote corner of the operating room. He had experienced for the first time the responsibility of "cutting down on a diagnosis." He said to me in a suppressed whisper, "Doctor, what in the world will we do if it isn't that?" So this morning I am cutting down on this diagnosis without any such fears.

You will note the perfect condition of the patient as a result of Dr. Ollhoff's efforts with the anaesthetic. We will make the incision a trifle to the right of the midline so that we can avoid the navel. The incision extends from the symphysis pubis to an inch above the navel. As I enter the peritoneal cavity free fluid was in evidence. It was a light amber color with no evidence of blood. Just what significance can be drawn from this fact? It is one of Nature's methods of telling us that this growth is not malignant. The rule is that malignancy in the abdominal cavity, if accompanied with ascites in any quantity, will be bloody or blood tinged.

The growth presents itself. It is a cyst of the right ovary. Here well over on the outer aspect of the cyst is the remains of the ovarian structure. It is thickened, hard and somewhat irregular in development, suggestive of a malignant growth. As we raise the cyst out of the abdominal cavity a thin portion of its wall ruptured and chocolate-colored, fluid content escaped. Now we can see the uterus below. There are several fibroids presenting so we have a condition of multiple fibroids, in addition, with which to contend. A subtotal hysterectomy will be necessary. As both the tube and the ovary on the right side have been distorted and the ovary destroyed we must be sure, before clamping off the broad ligament on that side, that the womb has not been rotated to the right, drawing the bladder around with it. It is very easy

to make such an error. It is more than easy to cut the whole back out of the bladder. If this should be ligated as tho' it were the broad ligament pedicle, a disastrous result would ensue. If it should be cut and then recognized, a difficult and troublesome complication would be added to an already big job. I will remove the cyst first, which will render visualization of the structures of the uterus and its adnexa, together with contiguous structures, more thorough.

The orientation of the uterus and the positive location of the bladder is assured by the normal relationship of the tubes and round ligaments to the uterus. There is no difficulty in the identification of the various structures and no technical hazards in the resection of the uterus. The cervix will not be disturbed. All raw surfaces are peritonealized and the belly is closed without damage. Dr. Ollhoff reports the pulse and respiratory rate of the patient as normal with the skin dry and pink, surely an ideal condition for the patient after an operation of this magnitude.

Now we will examine the cyst. Here is the base of the original ovary. It feels thick, hard and irregular, so we will open the cyst and examine its contents and its wall. An area of about four inches in diameter around the ovarian base is covered completely with a cauliflower-like growth from one-half of one to one inch in thickness. There are other smaller areas on the cyst wall producing a similar outgrowth. While it gives a suspicious appearance to the eye suggesting malignancy the contained fluid, as well as the ascitic fluid free in the abdomen, is not blood tinged, which argues against malignancy. We will have this growth sectioned, a biopsy. No matter what the findings of the microscope prove to be I have done all that can be done from the surgical viewpoint to protect this patient's future. Should the microscope visualize malignant cells then thorough saturation with x-ray would be supplemented with this treatment. Inasmuch as the growth is well encapsulated in the cyst there is much less chance for metastasis, so I am very sure this patient, regardless of the biopsy, has a very good chance for a cure.

(Later-Patient made an uneventful recovery. Biopsy-Benign cystadenoma ovary, Ed.)

Fats burn only in the fire of carbohydrates. _____

The causes of peptic ulcer remains a mooted question. Surgery does not, as a rule, correct the primary factor, but deals with its effect. Hence it follows that the cause active in producing the first ulcer working unopposed will tend to bring about a recurrence. _____

A suitable formula for infants during the first year of life is prepared by adding three ounces of volume of corn syrup to one quart of cow's milk. This provides the proper proportions between sugar and milk. Such a mixture has a fuel value of 30 calories per ounce. For infants in the first month of life, this mixture should be diluted with an equal volume of water in order that the infants will not receive more cow's milk than they are able to digest. If all goes well the proportion of water may be decreased gradually until, at the end of the third month, the infant will be receiving two parts milk mixture to one of water. By the age of five or six months the infant's capacity for digestion will usually have increased to such an extent that the milk and sugar mixture may be given undiluted.

The mixture should be boiled in all instances. Ordinarily the bottle should not be offered more than every four hours and the infant should be allowed to take as much as desired. Five feedings a day are usually sufficient and after the fourth month many infants fed in the method described will not need more than four bottles a day. (Marriott)

MELANOSIS PROCTOCOLI

Mabel Andersen, D. O., of the College Staff

I recall in my early proctologic experience the case of a woman about fifty-five years of age who came to me for examination, giving her symptoms as hemorrhoids and constipation of some years standing. On examination I found internal venous hemorrhoids and a moderate degree of rectal prolapse. In addition to this I found the entire mucosa of the rectum, as high as I could see with the proctoscope, to have a deep reddish-brown or mahogany like color. I used the sigmoidscope and as high as I could see in the rectum and sigmoid, I found the same color to the mucous membrane.

I had examined a number of rectal cases, had read most of the late texts on proctology, but had never read, heard of or observed this condition before. I questioned the patient carefully as to other symptoms, habits, medications used, etc., and finally guessed that the condition was due to the use of rectal ointments and suppositories.

I cleared up the hemorrhoid condition, which relieved the congestion in the lower rectum, and soon stopped the use of the rectal ointments. By correction of habits and diet, the patient was soon able to get along without cathartics. I said nothing to the patient about the pigmentation of the rectal mucosa but had her return every few months during the next several years for examination. To my surprise, the color of the mucous membrane was greatly improved during that time.

I later came across several more cases with this same mucosal discoloration, and found the history, symptoms and condition to be similar. I found other proctologists asking about this condition, but found that no one seemed to have anything very definite to offer. Practically nothing has appeared on this condition in the standard proctology text books until the past year or so. Now we find a separate chapter devoted to this condition, which has been termed Melanosis Coli or Melanosis Proctocoli.

Melanosis Coli was first described about a century ago by Crueilhier. Shortly afterward, about 1847, Virchow described it. All studies of this condition up to about 1933 were based on post mortem investigation. About 1933 a report was published by Bockus, Willard and Bank based on their clinical investigation of the condition.

The condition is definitely a pigmentation of the mucous membrane. There are various ideas as to the source of the pigment and the method of entry into the mucous membrane. Some believe the pigment is derived from metals as mercury and lead. It is generally conceded that chronic constipation is a contributing factor. Many have observed the frequent occurrence of chronic constipation and the ingestion of anthracene cathartics, as cascara, aloes, etc.

Quoting from Bacon on Anus, Rectum and Sigmoid Colon, 1938, we find the following: "Pick was of the opinion that it was due to the products of protein disintegration which were acted on by tyrosinase and converted into melanin. Hueck brought forth the theory that the pigment does not belong to the melanin group but is a lipofuchsin; further, that the splitting of certain products of digestion gives rise to a "propigment" of a lipoid nature, and this is affected by ferments giving rise to the pigment. Synnott attributed the condition to the metabolic pigment melanin, which is an autochthonous substance originating in situ by transformation of pre-existing material. Obendorfer explains the pigmentation on the basis that disturbances in protein metabolism may result in excess production of waste products. At an early

date the ingestion of heavy metals, especially mercury and lead, was thought to be the cause. Lignac believed the condition to be due to hemorrhage with subsequent bacterial activity, while McFarland adhered to the theory that the pigment was formed by an enzyme which acts on the intracellular substance of the stroma of the intestinal mucosa. Lynch considers it to be due to a disturbance in the chromogenic function of the liver."

Symptoms: As far as the pigmentation of the mucosa is concerned, no symptoms will be given, but the patient will invariably mention chronic constipation and the use of various laxatives belonging to the anthracene group.

Gross and microscopic appearance: The color of the mucous membrane varies in different cases from a light brown, dark brown, reddish-brown, mahogany to an almost black. In some cases there appears to be yellowish striations here and there thruout the mucous membrane. There is seldom an inflammatory or ulcerous condition of the mucous membrane. Buie states: "Grossly, it appears that the deposit is in the surface of the mucous membrane but on microscopic examination it will be found that there is no pigment in the epithelial cells. Instead, the entire deposit of pigment accumulates in the tunica propria of the mucous membrane where it lies chiefly within the large mononuclear cells. Rarely it extends to the muscularis and lymphatic involvement has been reported."

Treatment consists of correcting other rectal pathology found, the withdrawal of anthracene cathartics, relief from constipation and restoring as nearly as possible normal circulation to the parts. It may take many months to restore the normal color to the mucous membrane in these cases, but the condition is not serious and there need be no great anxiety on the part of the patient or physician for a speedy return to normal. This is a condition where osteopathic treatment is very beneficial. I have found osteopathic treatment to be one of the most important factors in correcting constipation, and with the correction of constipation the patient discontinues the taking of cathartics and there is usually an improvement in the local condition.

Forcible vomiting in the new born, loss in weight, diminution in fecal and in urinary output plus the typical riotus peristaltic waves seen and felt over the epigastric area means pyloric stenosis, whether functional or organic.

Gastric hemorrhage may be precipitated by cirrhosis of the liver, appendiceal pathology, carcinoma of the stomach and certain diseases of the spleen. Peptic ulcer is, however, the most common cause. 90% of such hemorrhages cease spontaneously.

GENERAL RULES GOVERNING THE FEEDING OF THE WELL BABY

Annie G. Hedges, D. O., of the College Staff

In the making of a formula for a baby no rule can be followed explicitly in every case. We know approximately the requirements of the human organism in the way of calories and other tissue needs but the response is varied in different individuals so we must adapt the formula to the baby.

The average infant needs from 30 to 35 calories per pound of body weight each day for the first two or three weeks of life, then 45 calories until about eight months of age, when it should be reduced to 40. Of this, the correct proportions are: 50% carbohydrate, 35% fat and 15% protein. There are times when we have to modify these proportions and certain cases which need more or less calories.

General Rules Used As a Basis:

1. Total fluid volume per day—weight in pounds times—3 for the first quarter of the year. 2½ for the second and third quarters. 2 for last quarter.
2. Milk in the formula, weight in pounds times—1.75 for the first 3 to 4 months—then 1.5 for several months (depending on condition and other foods given).
3. Water in the formula is the difference between the total amount which can be given the baby and the milk.
4. Capacity of a baby's stomach is usually about .4 oz. for each pound of its weight (Balance of water must be given between feedings).
5. Sugar in the formula, 10 calories for each pound each day. (Amount will naturally vary with kind of sugar given).
6. No. of feeding per day 7 for the first 2 months, 6 for a few months until capacity of stomach is such that by 7 to 10 months only 5 are necessary.
7. Feeding intervals—4 hours from birth for about 3 days, then 3 hours until the stomach capacity has reached a point at which the 2:00 A. M. feeding can be discontinued, usually from 2 to 3 months then 4 hours.

Cod liver oil and orange juice may be given by the end of the first month and cereals and vegetables added by the end of the second month, with careful attention to caloric values and age of the child. The sugars used in infant feeding are dextrose with a caloric value of 60 per tablespoon; milk sugar, 40 cal. per tablespoon; and honey, 99 to 100 per tablespoon.

The addition of lemon juice to the formula is valuable when gastric digestion is imperfect. Both lemon juice and gelatine assist in breaking up the curds which ordinarily form in the stomach of a baby artificially fed on cow's milk. The Beta-lactose—lemon juice-gelatine formula is useful during mild illnesses when desirous of limiting milk for a time. The formula often used in our College Clinic is:

Water .....1 pint
Beta-lactose.....3 level tbs.
Knox plain gelatine.....2 tsp.
Lemon juice.....1 tbs.

Naturally these amounts may be varied greatly to fit the individual case. A formula similar to this except having no gelatine and only 1 tsp. of lemon juice is useful for the first three days of feeding before breast feeding is fully established and is greatly preferable to any form of a milk feeding at that time. It can beneficially be used once or more a day between feedings for the first month.

Certain things must be considered before making changes in the formula.

The appetite of the baby; rate of gain in weight; mental state (if satisfied or fretful and cross) and condition of the stool.

Interpretation of the Stool

Normally, after milk feeding is established, the stool is smooth and soft —(semi-solid) and has a slightly sour, aromatic odor due to the lactic and fatty acids contained in it.

If curds occur, either the quantity given is excessive or indigestion is imperfect.

The stool accompanying starvation or insufficient food is small, dark green, loose or pasty and has a stale musty odor.

Fat causes the stool to be sour or rancid, sugar sharply acid as of vinegar, and protein more or less foul and putrid.

The color varies with the dominance of its contents. It is pale yellow with excessive fats, gray with starch and brown with protein. A greenish tinge after exposure to the air is usually caused by oxidation and of little or no significance.

The reaction of the stool is normally acid. Excessive proteins or indigestion may cause an alkaline stool.

Summing Up:

In indigestion due to carbohydrates, the stools are loose, scalding, green, acid in odor and reaction.

In indigestion due to protein, the stools are loose or constipated, dark in color, foul and alkaline, with Gram-negative bacterial flora.

(In cases of Gluteal Erythema, treatment should not be given until determining the reaction of the stool.)

In indigestion due to fats, the stools are loose at first. Later, constipation often occurs. The presence of excess oil in the stool can usually be detected.

Either overfeeding or underfeeding will cause abnormality of the stool and sometimes our skill is taxed to the utmost to determine the real cause of the trouble.

Bibliography:

Holt's Dis. Inf. & C. 10th Ed.
Infant & Child Feeding—Wilcox
Pediatrics—Chapin & Royster

WE are listing herewith the Accredited Colleges of Osteopathy. These colleges are approved by the American Osteopathic Association, are in good standing with the various State Examining Boards and are members of the Associated Colleges of Osteopathy.

Chicago College of Osteopathy

College of Osteopathic Physicians and Surgeons (Los Angeles, Calif.)

Des Moines Still College of Osteopathy

KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY

Kirksville College of Osteopathy and Surgery

Philadelphia College of Osteopathy

A Resume of the
RECORD OF THE GYNECOLOGICAL CLINIC
at the Kansas City College of Osteopathy and Surgery

Written by Myrtle T. Moore, D. O.

It has been the privilege of the writer to be assistant to Dr. Mamie Johnston in the Gynecological Clinic at the Kansas City College of Osteopathy and Surgery during the year 1938, pursuing the fifth year post graduate course.

During the year we have made gynecological examinations upon approximately 800 women and girls. We have found diseases of the Cervix Uteri to be the most common complaint of women. By actual count, there being approximately 44% of our patients suffering from some involvement of the cervix and of this number more than one-half suffered erosions.

H. S. Crossen says: "An Erosion of the Cervix is an area on the vaginal surface of the cervix which is found covered with columnar epithelium, and consequently presents a reddened inflamed appearance."

In our clinical work we do not go into the histo-pathology of our cases, but we find this reddened inflamed appearance in many of our cases. Naturally, there are all grades of inflammation, some bleeding, while others are slightly inflamed, with every degree of inflammation and redness between these two extremes.

Our findings have been that the erosion is associated with lacerations in a vast majority of cases. These lacerations are often very slight, but due to the heavy musculature of the cervix, a slight nick is sufficient to stimulate the cervical nerves and create the disturbance necessary to cause the tissues to erode.

It is not my intention to convey the idea that none but women who have borne children suffer from erosions of the cervix. We have examined young girls and maiden women who have had very decided and extensive erosions and we have every reason to believe these girls and women to be virgins. We have also examined women long past the menopause, who have never had a pregnancy, and they, too, like the virgin girls and maiden women mentioned above, have very extensive erosions.

It has been our policy to use Schiller's Test on many of these Erosions. We are amazed at the number of positive reactions we have to this test.

We are fully cognizant of the fact that this test is not infallable. We know that when the cervical tissues are deprived of glycogen we get a positive reaction to Lugol's solution. We know, too, that glycogen is absent in cancer, and we feel that if we can hurry our patient to decide to have surgery done early, when we find a cervix that does not take the stain, we have done a good deed and probably saved our patient some very serious trouble later on.

W. Schiller (Lancet 1:1228) (5/30/36) warns that the aqueous iodine test is not specific for carcinoma but marks off only the area that does not contain glycogen. He states also that glycogen is absent in carcinomatous transformations of epithelium, hyperkeratosis of the squamous epithelium of the cervix, keratinization developing in prolapse, which may also cause the glycogen to disappear, and when the superficial layers of glycogen containing epithelium have been rubbed off by inflammation, maceration or rough handling by fingers or speculum there are different possibilities of the surface remaining white.

Schiller also states "that painting the cervix with Lugol's is very easy to carry out in an out-patient clinic." He

says "that 20 out of every one hundred women show suspicious areas of which only one or two proved to be cancer. But even if only 1% of the women examined gave a positive diagnosis the results are still very satisfactory, for carcinoma, when detected and treated at that early stage gives nearly 100% security for definite and permanent healing."

Another very common condition that we find is the hypertrophied cervix. At the present time the profession as a whole is using Theelin in wholesale quantities. The writer is of the opinion that this endocrine product is largely responsible for the great numbers of hypertrophy of the cervix which we find.

John S. Lingenfelter—Cyclopedia of Medicine, Vol. 9, Pages 412-422 has this to say: "Doisy obtained an estrus-producing hormone in a pure crystalline state and named it Theelin. This Estrin is found in the small lake of fluid found in the corpus luteum of cows and frequently in the human. When Theelin is injected into spayed test animals it will produce all of the extra ovarian histological evidences of Estrus. The uterus and vagina increase markedly in the thickness of their walls, as well as in the diameter of their lumen. The cells in the vaginal smears of spayed rats, mice and guinea pigs change from polymorphonuclear leukocytes to nucleated epithelial cells which are soon replaced by keratinized non-nucleated epithelium of Estrus. When Estrin (Theelin) is injected into the pregnant animals in sufficient quantities abortion will take place. This occurs in spite of the fact that Estrin is found normally in the blood and urine as well as in the placenta and amniotic fluid of the pregnant animal."

If Theelin has the effect of thickening the walls and increasing the diameter of the lumen of the uterus and vagina in spayed test animals, then we may presume that it will have a like effect upon a woman who has had a surgical removal of ovaries and tubes. This is exactly the condition we find when these women present themselves for examination and treatment in our clinic.

The Cystic Cervix or the enlargement of the follicles of Naboth is closely associated with prolapsus, retroflexion and retroversion. The malposed uterus being responsible for the inadequate circulation of blood to and from the cervix thus bringing about the enlargement of the Nabothian follicles and they appear as small cysts on the surface of the cervix. Our treatment of these cystic cervices has been grossly disappointing, in that they do not respond to ordinary treatment. We are not equipped to do the electrical cautery treatment on these cases therefore we must refer them to surgery. In passing, I might add that invariably these cystic cervices give a positive reaction to Schiller's test.

The lacerated cervix is another condition that we meet in our clinic all too frequently. In years gone by when the Profession was using pituitrin in obstetrics, promiscuously, gross lacerations were the very common result. Today, fortunately, we have a milder uterine stimulant in the Pituitary-Thymus preparations, and the grossly lacerated cervix is not so common.

Naturally, we offer no treatment for the lacerated cervix, except surgery, since we have proven to our own satisfaction that nothing but surgical repair or surgical amputation above the laceration is going to put the cervix in a healthful condition.

Frequently, associated with lacerations of the cervix, we find polypoid growths. These polyps vary in size from the size of a pinhead to the size of a hazelnut. In a number of these cases the menopause was not established until the patient was well past fifty years of age and then after that age, there would be a slight "spotting"

occasionally. In one of our cases of complete procidentia the patient suffered a bilateral laceration and growing out of the right laceration was a polyp the size of a large hazelnut. This patient did not establish her menopause until after the age of fifty-five.

We hear so much about cancer, these days, that one would think in eight hundred women we should find a great many cases suffering with this dread disease. I am most happy to report that we have had just two cases of cervical carcinoma. One of these cases was too far advanced for surgery and was referred to Radium treatment. The other failed to return after she was advised of her condition, so we were unable to follow these cases further. In each of these cases of carcinoma of the cervix there was involvement of the uterus. In one, the case referred to Radium treatment, the uterus was low in the pelvis and was a hard nodular mass with nothing about it that could be recognized as a uterus. In the other case, the uterus was enlarged, solid to the touch but not nodular.

There are suprisingly few cases of disease of the external genitalia. We have had some few cases of Pruritis Vulvae but this condition is brought about, largely, from drainage from the vagina. Treatment of the vaginal condition usually brings about a cure of the Vulvar Pruritis. Therefore, we direct our efforts toward curing the vaginal condition.

The writer has assisted in the Minor Surgery Clinic where several cases of early surgical menopausal pruritis vulvae have been treated by the injection of a local anesthetic in oil into the sub-membranous tissues of the vulva and the results have been very gratifying, the patients report complete relief after the injection treatment.

One case of Pruritis Vulvae which came to our clinic is worthy of mentioning. A woman, fifty years of age gave a history of extreme itching of the vulva over a period of twenty years. The vulvar membrane was white and glistening and very thick, giving the impression of leather. Either from a congenital anomaly or because of abrasions of the membrane, there was a complete adherence of the labia minora to the labia majora. The writer is of the opinion that this was a congenital condition since both sides were just alike, there being no break, whatsoever, in the line of adhesion. The membrane that is usually a loose fold over the clitoris was closely adherent. The clitoris was not papable under this adherent membrane, and was probably atrophied or absent altogether. This woman was normal in other respects. She had borne children and suffered from a retroflexed uterus and a badly eroded cervix. The secretions from the vagina and the cervical erosion were, no doubt, the cause of the extreme pruritis.

Such conditions as Hooded Clitoris, Enlarged Labia Minora, Urethral Caruncle, abscesses of Bartholin's or Skeen's glands are immediately referred to the surgical department. We make no attempt to treat any of the above mentioned conditions in our gynecological clinic. The lacerated Perineum is a very common condition and we offer no treatment except surgery in these cases.

Following in the wake of the Perineal laceration is the Rectocele and Cystocele. We have patients with protrusion of the vaginal walls in every degree of severity. I can imagine no condition more annoying than rectocele or cystocele and still we have women who have endured this inconvenience for years. We offer surgery in these cases and surgery, alone, can bring about a cure.

It is surprising how few cases of specific infection we get in our clinic. During the year we have had only two cases of active Gonorrhea, three cases of Trichomonas Vaginitis and

one case of Colon Bacillus Vaginitis. We used the prescribed treatment in the cases of acute gonorrheal infection and have cleared our two cases of discharge. We realize that we have not effected a cure of this disease in either case. In the cases of Trichomonas Vaginalis Vaginitis, we used the John Wyeth's Silver Picrate insufflation treatment preceeded by a thorough cleansing of the vaginal and cervical tissues with Peroxide of Hydrogen, as suggested by the University of Minnesota, and followed by the John Wyeth Silver Picrate suppositories. In all of our cases we had absolute cures, proven by laboratory tests.

One of our cases returned in two weeks for a check-up. Although the laboratory test was negative, we were not satisfied with the patient's condition therefore we used two insufflations, one week apart, of Beta Lactose. After these two treatments the patient was in splendid condition.

In our one case of B. Coli Vaginitis we used iodine douches and effected a complete cure. We used in these douches 10 drops of Tincture of iodine, 1 teaspoonful of glycerine and 4 oz. of water.

We have had three cases of senile atresia of the vagina, one case being very severe, the canal being constricted to such an extent that the index finger, only, could be inserted and it was impossible to use the smallest speculum. This dear lady was in her late seventies and, of course, we could offer her no relief. Our other cases were less severe but were very pronounced. We offered no treatment in either of these cases.

We found a very peculiar condition in three patients; that of an adhesion between the cervix and the vaginal mucosa. One case was a congenital anomaly while the other two were brought about by cervical lacerations at childbirth. No doubt, a badly contused vaginal mucosa courted the adhesion at the line of laceration.

We have not had a single case of syphilitic chancre of the vagina, cervix or vulva, nor have we found scars where a chancre had been at one time. We know we have many cases of Lues among our clinic patients but if they have acquired syphilis they have had their initial chancre elsewhere upon the body.

So many obese women come to us with heaviness in the pelvis—a heavy ache that does not ease. The history in these cases invariably shows that the patient has been taking "shots" to reduce her weight and upon inquiry we find the patient has been given Antuitrin S. Oliver Kamm, Detroit, Mich., Cyclopedia of Medicine Vol. 1 Pages 574-686 gives no recommendation for the use of Antuitrin S. in treatment of obesity or hypofunction of the sex organs.

This author states that there are two types of abnormal functioning of the anterior lobe of the Pituitary gland, viz., those associated with overactivity and those attributable to deficient activity. Quote: "The diseases known to be associated with excessive secretion are gigantism and acromegaly. Administration of glandular therapy is contraindicated in cases of hyperactivity of the anterior lobe. A pathological condition associated with hypofunction of the anterior lobe of the pituitary gland is Distrophia Adiposogenitalis. This condition has one striking characteristic, namely, marked obesity associated with sexual infantilism. The sexual development of an adult being no greater than that of a young child. This disease is usually due to tumors which destroy the pituitary gland. This condition is greatly benefitted by the administration of anterior lobe preparations."

According to Tucker menstrual disorders are benefitted by the careful administration of the posterior lobe or whole gland preparations if there is also skeletal or genital underdevelopment. Antuitrin S. is the sex hormone obtained from the anterior lobe of the pituitary gland. The writer believes that a member of the Profession is guilty of malpractice when he prescribes Antuitrin S. for a patient who is suffering from obesity. The disease Distrophia Adiposogenitalis. is very rare. Obesity from overeating is a very common condition.

Perhaps a connection between the above dissertation and diseases of women is seemingly far fetched but in clinical practice it is not so. We have these obese women, who have been having their Antuitrin S. "shots" regularly, come to us with an ache low in the pelvis. Invariably we find an enlarged uterus and an hypertrophied cervix and upon questioning our patient we elicit the information that this ache in the pelvis is new to them.

Our own Dr. Quintos Wilson taboos the use of Antuitrin S. He says that after using this sex hormone for a time the endometrium is built up to such an extent that a curettement must be done before relief can be had.

The following case history may bring my argument to a point. Mrs. L. aged 32 entered the general clinic; weight upon entering was 213 pounds. A diagnosis of obesity was made and besides a limited diet she was to have Antuitrin S, intramuscularly twice weekly. This patient was very faithful in coming for her treatments. After eight "shots" of Antuitrin S. she was brought to our gynecological clinic complaining with "trouble in the tubes."

Upon examination it was found that she was suffering from an hypertrophied cervix which was badly eroded. It was impossible, because of the thick abdominal wall, to get the exact position of the uterus, but judging from the position of the cervix, we could presume that the uterus was in a normal position. We could also presume that the uterus had enlarged in exact ratio with the enlargement of the cervix. There is no doubt in the writer's mind but that this patient will be brought to operation and that a pan-hysterectomy will be necessary to relieve her of the distress she is suffering in the pelvis.

Malpositions of the uterus, of course, are very common. Retroflexion and retroversion being more common than lateral and anteflexions. We can bring about cures in many of these cases of retro-displacements when we can get the patient to cooperate with us and if the perineum is intact. We use the bimanual method of replacement and have many cures to our credit. We can not say so much, however, for the extreme anteflexion and lateral displacements.

In the cases of ventral fixation that have come to us, in our clinic, invariably the patient suffers a pull upon the belly wall. Many of these women are conscious of a weight suspended from the particular point of attachment to the wall, and we can, in most cases, place a finger upon the point where the fixation is made. Unfortunately, we can do nothing to relieve these patients, there being no relief for them except through surgery. With the badly malposed uterus, if there are symptoms of nervousness and visceroptosis, the only thing we can do is to send the patient to surgery.

We have had several cases of prolapsus and three cases of complete procidentia. These cases are associated with perineal lacerations and retro-displacements of the uterus. It is gross folly to render treatment in these cases. There is nothing that will keep the uterus up in the pelvis when the perineum is torn away, therefore, we send these cases to the surgeon at once.

We have had several cases of infantile uteri. These, of course, if the patient is not too old, might develop and become normal in size and function. The cases we have had were associated with gross spinal lesions which would, of necessity, have to be corrected before one could hope for any development of the uterus.

We had one case of congenital anomaly which might be of interest. This girl, eighteen years of age, had what would seem to be a double vagina with one section below or posterior to the other. Upon examination it was found that the lower opening was a malplaced rectum. This rectum with an opening in the lower part of the vulva and anterior to the fourchette was supplied with no sphincter and still there seemed to be no lack of control of the bowel. This girl was normal in every other way. The pelvis was well formed, the vagina was normal and she was regular in her menstrual cycle. The normal site for the rectum was visible and the normal sphincter and anus could be palpated but the canal was completely closed. It was decided that so long as the patient was so nearly normal and had complete control of the bowel it would be unwise to disturb the functions and operate to open the normal anus.

Varicosities of the Broad Ligaments are very common. These are usually associated with malpositions of the uterus. Usually these varicosities are palpable and, naturally, are quite painful.

Acute pelvic inflammation coupled with diseased ovaries and Fallopian tubes is not so common as one would think when we know of the prevalence of gonorrheal infection. We have found that these patients gain a vast amount of relief when they receive the Elliott treatment.

Chronic pelvic inflammation with chronic oophoritis and chronic salpingitis is relatively common. These cases must be sent to surgery since palliative treatment only prolongs the patient's suffering.

Going hand in hand with chronic pelvic inflammation is chronic endometritis and chronic endocervicitis. These patients are extremely tender and sore over the uterus and complain at the slightest pressure. We have had no acute cases of metritis or parametritis, in our clinic.

Adhesions, either arising from an inflammatory process or following surgery, are all too prevalent, and is the cause of much pelvic distress. Many laterally displaced uteri are caused by adhesions pulling the organ into an abnormal position and fixing it there.

Fibrotic conditions and multiple fibroids of the fundus of the uterus are very, very common. Why this is true I can not say but in women past forty years of age this is too often the condition. We find these women, even at that age are beginning to suffer irregularities in the menstrual cycle, with long flowing periods and short periods between the flow. In too many cases surgery must be the treatment in order that the patient be saved from too great a loss of blood.

Subinvolution is not so common and yet, we have had a number of these cases. These are usually associated with spinal or sacroiliac lesions. We find that a correction of the lesion will bring about a cure of the uterine condition. We treat these cases osteopathically, using good stimulation to the spinal nerves from the 9th dorsal down to the end of the spine with special attention to the lumbar segments. We have had marked results in these cases in a very short time and we believe that this treatment is the very best in these cases.

I have touched upon the important cases and conditions that have come into our clinic. This work has been extremely interesting and I might add that I have been most happy in my work in the gynecological clinic and in my association with Dr. Mamie Johnston, who has, at all times, given me every opportunity to make examinations and also to express my opinion on all of the cases. I wish that other doctors in our Profession could avail themselves of the opportunity that has been mine, during the year 1938, in this clinic.

Intravenious injections of drugs took form in 1656.

INTRACAPSULAR CATARACT EXTRACTION

A. B. Crites, D. O. and D. M. Russell, D. O., of the College Staff

This case because it is typical and since it was operated before the group of visiting physicians at the fall homecoming is here reported.

Mr. C. S. H., age 72, came to the College clinic on September 22, 1938, complaining of blindness in the right eye which had been failing for several years. About two years previously the vision of the left eye became noticeably affected, glasses were changed several times with no improvement, in fact the condition progressed so that for nearly a year he has been unable to read the newspaper. Mr. H., highly intelligent is a very interesting conversationalist and relates the facts that he came to Kansas City in 1881, 57 years ago, when there was one mule car line and his first place of residence was a three room house located in what is now the center of the Jones Store.

Physical Examination:

Temperature	98.4
Pulse	70
Blood Pressure	160/88
Weight	134
Chest Cardio-vascular	negative
Abdomen	negative
Reflexes	normal
Neuro-Muscular system	normal

Laboratory Examination:

Urinalysis.

Color	yellow
Reaction	acid
Spec. gr.	1.016
Albumin	negative
Sugar	negative
Epith. cells	2 plus

Blood

Hb.	85%
R. B. C.	4,100,000
W. B. C.	9,100
Kahn	negative

Eye, Ear, Nose and Throat Examination.

Nose-anterior septal perforation

Throat-negative. Several infected teeth.

Sinuses-Frontal, negative

Antrum-Right, 2 plus, Left, negative

Ethmoid-Right, 3 plus, Left, 3 plus

Vision-O. D., Counts fingers at 12 inches, light projection good.

O. S. 12/200.

Ophthalmoscopic examination revealed an amber colored grey pupil with an absence of the fundus reflex and no iris shadow,

Diagnosis-Right Senile cataract mature, left immature cataract.

Patient was advised to have infected teeth removed and treatment for sinus infection, and then to undergo an operation for the extraction of the cataract. This suggestion was readily accepted and he proceeded to have the focal infection cleared up. On November 16, 1938, the patient reported for a re-examination and was found to be in good physical condition, so was operated on the following day for extraction of the cataract.

The operation was done with a local anesthetic, a solution of 4% cocain hydrochloride applied to the cornea. Also a few drops were injected under the conjunctiva below and above the limbus. During the operation an occasional drop of cocain and adrenalin were instilled in the eye. A corneal section was made, which comprised about two-fifths of the circumference of the cornea, and was terminated at the upper margin with a conjuctival flap. A peripheral iridectomy was then performed, after which the lens was expelled by gentle pressure upon the lower part of the cornea. The cataract was delivered with the capsule intact, the sutures which had previously been inserted after making the corneal section were tied, the eye cleansed with a saturated solution of boric acid and eserine ointment was applied to the conjunctiva. Both eyes were bandaged and the patient was

sent to his room. In two days time the dressing was removed and the patient was able to count fingers at a distance of twelve inches. The eye was then dressed every day for the next ten days, at which time the patient was discharged from the hospital, with orders to appear in two weeks time for a refraction.

Refraction was twice repeated at intervals of two days, the final correction being a plus 9.25 combined with plus 1.75 cylinder at axis 170 which gave vision of 20/20 plus 1. A plus 3.00 added in the bifocal sigment enabled him to read the 6 point type in the inside of the newspaper.

Mr. H. appeared before the senior class on December 2nd, just three weeks after his operation, with an entirely quiet eye, having a round pupil, happy in the complete restoration of his vision.

Acids stronger than carbonic acid in the blood stream cannot exist as such in the presence of bicarbonate, reacting with the latter to form neutral salts and carbonic acid.

Very few hydrogen ions exist in pure water, the amount of dissociated hydrogen ions being 1/10,000,000 gram per litre. So small are hydrogen ions that there are approximately 60,000,000,000,000,000 hydrogen ions in 1/10,000,000 gram.

"There are some things in this world that are inevitable. And it is good to think that where the inevitable is, God has something in mind which He wishes to accomplish.

That we do not understand it is a matter of minor importance." (Abbe Pierre)

In the new born and in very young children cyanosis, sudden attacks of pallor, breath holding, convulsions or slight difficulty in breathing, should suggest the possibility of the presence of an enlarged thymus gland.

Statistical Report

CONLEY CLINICAL HOSPITAL

(end of second year)

Number of patients registered to date 1325

Registration Nov. 15, 1936 to Nov. 15, 1937 572

Registration Nov. 15, 1937 to Nov. 15, 1938 753

Cases in major surgical department 345

Eye, ear, nose and throat 568

Obstetrical 102

Proctological and minor surgical. 78

Observation and Palliation 238

Fatalities 38

Comparative Monthly Registration:

	1937	1938
January	38	51
February	31	49
March	38	62
April	31	49
May	55	59
June	48	77
July	50	73
August	71	107
September	54	66
October	53	75
Average Monthly Registration	47	67

Percentage increase 42.5%

Comparative Daily Registration:

	1937	1938
January	8	17
February	7½	17
March	8	19
April	11	16½
May	14	17
June	12½	17
July	13½	14
August	13	19½
September	13	17½
October	14½	20½
Average Daily Registration	11½	17½

Percentage increase 54.5%

Average length of time in Hospital 7 days.

C. A. King, D. O.,
Resident Physician

THE LOWER BRACKET INCOME PROBLEM

Forty million people in the United States have incomes of less than $800.00 per year, according to Thurman Arnold, Assistant United States Attorney General, that cannot pay for medical care.

It would be interesting as well as illuminating to have information from this group as to the number that are maintaining automobiles, who have expensive radio outfits, up-to-date electric refrigeration and that are possessed of the various electric driven gadgets designed to make housework easier. But to narrow the inquiry let it be limited to the auto, the radio and electric refrigeration. All of these may be classed properly among the luxuries. And yet no one seems to be too poor that he feels he cannot afford an auto. He rides to work in his auto to save street car fare and to save time, disregarding or ignoring the fact that no car can make a mileage average under five cents when all expenses are calculated. To the average member of this low income bracket group, the time saved in transportation is dissipated in nonproductive effort or in diversions demanding a modicum at least of expenses. No one drawing $200.00 per month or less can afford an auto unless he can increase his efficiency to justify the expense of maintenance. And yet there are day laborers, washer women and the like who must needs maintain an auto to furnish transportation to and from work. Take any W.P.A. project and the autos parked in the vicinity almost compel the presence of a traffic cop to get them started home properly.

A man came my way who had been hurt by a fall while at work in a large industrial plant. He went on compensation automatically until he could return to work. The sum was $12.00 per week. His case was stubborn. His medical advisors were at loss to determine that seat of his ailment. Months elapsed and he was still on compensation. In relating to me the case history he spoke of the fact that he could not live on $12.00 per week. He had a little patch of ground and his residence in a suburban community. He told me how he had to eat his chickens because he couldn't afford to feed them; he had to sell his hog and finally he had to let his cow go. "Literally taking the milk out of my babies throats," he said. By that time I was almost ready to cry and to make sacrifices to help him when he finished his panegyric with "and now by God, they are going to take my automobile!"

It takes gas, oil and tires to make the wheels of an auto turn. These things are all on a "cash and carry" plan. They take all the available money (encrouching on the monthly payments on the car even) the owner has at his disposal hence the butcher, the baker, the grocer, et al, are not paid, and being not paid, they cannot meet their obligations and we have all the makings of an economic depression.

The same holds true with the rest of the household luxuries, converted into necessities by over zealous salesmen and transformed into unsurmountable liabilities by a too lax credit system on the part of far too many business houses.

It is not intended here to decry the use of labor saving devices in the home. They are fine and should be encouraged but only in so far as the budget of the family will permit. Everybody should balance his own budget and, his own being in a state of stability, the family, the community, the county and the state will automatically come into adjustment. With these in a condition of equilibrium it can be seen that the nation will likewise fall in line. This simply paraphrases the philosophy of life as outlined by Confucious some six hundred years before Christ.

And it is all hinges upon that time within one's means."

The government is greatly distressed about the medical care received by these 40,000,000 low income people. To be sure they should have adequate medical attention as an economic prerequisite. Sickness is very frequently preventable. Given a nourising diet, a warm, dry place to live and sufficient clothing to keep one warm, the natural adoptive functions of the body will furnish sufficient protection to the individual to keep him in an average state of health, one that will need the attention of a physician only at rare intervals. Although this is true they pick on the doctors as the experimental guinea pigs in the social security plans. Why not get back to the fundamentals and make such provisions as will insure the conditions that will make for health automatically? Why not see to it that food, clothing, warmth and housing with such labor saving devices as are legitimate, are insured to an individual at cost plus a reasonable profit. Minimize the number of commissions between producer and consumer so that the product is easily purchasable. Then if the health condition is beyond the reach of the average run of people, take some steps to make the product of medical schools i.e. its graduates distributable by eliminating the dead wood in the curriculum of its schools and concentrate upon the essentials of bedside practice so that the graduates will minimize time spent in school and curtail the expense thereof to a point where a reasonable fee can be charged, one that a patient in the lower income bracket can afford to pay when occasion demands. This problem constitutes more than the actual regimentation of the physicians of the country willy-nilly to care for their physical ailments. It is one of the many results accruing from departure from the path of economic rectitude; from the junking of the fundamental virtues so vital to the success of our fore fathers; from the deliberate attempt to shirk individual responsibility of self preservation; from the nihilistic philsophy that as they were not consulted as to their entrance into the world said world owes them a living; from glorifying acquisition and greed with the belittlement of the small returns accruing from legitimate vocations involving physical labor and self sacrifice.

It all resolves itself within the homely propositions of living within ones means which constitutes a balanced budget.

Blood as acid as distilled water or as alkaline as tap water is incompatable with life.

RESERVE APRIL 19, 20, 21 AND 22, 1939 FOR THE SEVENTH ANNUAL CHILD'S HEALTH CONFERENCE

Each year, since its origin, the Child's Health Conference, which is sponsored by the Kansas City Society of Osteopathic Physicians and Surgeons, has grown in numbers. Each year more doctors come to this splendid post-graduate clinic. The Clinic sponsors have the full co-operation of the Kansas City College of Osteopathy and Surgery, the Lakeside Hospital, the Northeast Hospital, the Conley Clinical Hospital and the Women's Auxiliary.

We are pleased to announce that Dr. Leo Wagner of Philadelphia, Pennsylvania, is to be our guest speaker and chief examiner this year. He is a most capable pediatrician, a popular convention speaker and his presence among us assures us a splendid meeting.

The purpose of this Conference is to give young children the benefit of a thorough physical examination by well organized groups of specialists; to give practicing physicians of Missouri, Kansas and surrounding territory four days of intensive study of the problems of childhood; and to provide parents the opportunity of acquiring much valuable information concerning the care of their children.

Kansas Citian Hotel's delightful roof garden will be our meeting place. (The Baltimore Hotel, to whose management we are greatly indebted for a fine hospitality in former years, is closed for reconstruction.)

Nothing will be omitted which will serve to make this meeting worth while for our visitors. It is already endorsed as affording adequate training to satisfy Missouri and other State Boards of Registration and Examination. Get in touch with your own State Secretary to determine if it is endorsed by your own state.

Watch the College Journal, Forum and A.O.A. Journal for further announcements. We are looking forward to greeting a record attendance.

MARGARET JONES, D.O., General Chairman.

THE A. O. A. MEMBERSHIP CAMPAIGN

1938-1939

Arthur E. Allen, D. O. is facing the most important era in his incumbency as President of the American Osteopathic Association. Frank E. MacCracken, D. O. is up against the most gruelling portion of his job as Chairman of the Special Membership Committee.

The 76th Congress convened January 4th at 12 noon. During the session legislation of vital importance to the osteopathic profession will be enacted. The question of therapeutic parity in socialized medicine will be decided. It directly concerns every osteopathic physician and surgeon in the United States. We must participate, and on a parity too, with the physician of the medical school of practice in every phase of the socialized medicine legislation.

President Allen's job is to steer or at least, to be captain of, the ship during these strenuous and stormy days of change in the relationship between patient and doctor. Not only must the general fundamentals of parity in practice be written into these new laws, but the wording must be scrutinized as to possible or probable future interpretations. All in all, Dr. Allen is in command of the osteopathic ship in the most troublesome voyage in its entire tempestuous career. This takes time, energy and money and this is where Frank MacCracken gets on the spot.

The 1938-39 directory will go to press short approximately 850 names as compared to last year's issue, a decrease of about 8%. These names were dropped for non-payment of dues. Each name represents an asset of $20. Figure it out for yourself! The Central Office needs money, needs every cent the old directory figures would have yielded. It is by rehabilitating these delinquents that the needed funds can be realized. Dr. MacCracken's committee is charged with this responsibility. That is why Frank MacCracken is sitting on a hot spot. But why should he be?

Every osteopathic physician will be affected alike by the prospective legislation, be it favorable to our interests or adverse. Every osteopathic physician should be alert in safeguarding his own individual interests. Only by backing up whole heartedly President Allen and the Central Office can our best interests be preserved. Therefore, it is your job, my job, equally, as it is Frank MacCracken's job, to get into the National Association, not only ourselves if we are out, but every other non-member of our acquaintance. Self-interest demands it. Self-preservation compels it.

A condition of insecurity confronts us all. The safe way out for all of us is to hang together and depend upon team-work and fight to secure our professional safety.

Everybody must be a member of the National NOW!

G. J. C.