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Anal Fistula

W. A. Hockett, D.O.

During the last twenty years, the study of Proctologic Fistula has revealed new facts. The interpretation of these facts has been sufficient to revolutionize the terminology, the classification, and the treatment.

Fistula of the terminal portion of the alimentary tract with its complicating abscess formation in the peri-anal, peri-rectal and ischio-rectal areas has been reported in Medical literature now for almost 4,000 years. Only in the last twenty years has there been any material advancement in successfully managing the condition. These new facts which have thrown a new light upon the subject of Proctologic fistula have been discovered by men making a special study of Proctology.

It was formerly thought that the cause of fistula was an abscess in the peri-anal or peri-rectal area which, under pressure, formed infective tracts, thus in some other area produce another opening which united the abscess which usually had an opening. When no other opening could be found, it was convenient to say that the case was "blind fistula," or simply refer to it as "abscess." If the probe reached an area within the rectum from the external opening because of probe efforts too forceful, the diagnosis was within all probability "rectal fistula." If several fistula channels were discovered, then the term "multiple" or "complex," "simple," "internal blind," "external blind," "ischio-rectal," "rectal" and "anal" have all been used in describing the malady. Because of the interpretation responsible for the terminology, a parallel was also made in the treatment of the condition.

Incisions were made from the external opening toward the anus and rectum. Peri-rectal and peri-anal "abscesses" were "lanced." It is an old story to a

Proctologist for a patient to tell of having had several anal "boils" lanced.

It is now generally conceded that well over 90% if not all proctologic fistulas have their origin within a diseased crypt. Fistula formation is now known to have four stages in its development:

- I. Cryptitis; the tissues react locally, edema of the mucosa and hypertrophy of the adjacent papillae. An exudate may seal the mucosa and the papillae or it may close the crypt with the development of a nidus from which the fistulous process extends.
- II. Extension of the infection from the primary infection of the involved crypt to one or more directions via the lymphatics.
- III. The infected tissue breaks down into an abscess with redness, local heat, swelling, tenderness, and pain.
- IV. Rupture or incision of the abscess. This is the point at which the term "fistula" can properly be applied because it is not until now that there are two openings united by a channel.

Therefore, the primary opening is in the crypt (stage I) and the secondary opening, whether it be single or multiple, peri-anal, peri-rectal, or ischio-rectal, is the opening mentioned in stage IV.

Early in the surgical treatment it was learned that it was not wise to make the incision from one opening to another diagonally through the sphincter. This was the cause of incontinence which was formerly suffered by so many victims of fistula. Or should we say victims of surgical treatment? It was then decided to incise the sphincter at right angles. Not so many years ago, one Proctologist said that he had statistics to prove that 115 suicides during one year were directly attributable to incontinence due to surgery of fistula. Now that we know the opening within the crypt to be the primary opening, we open the fistula from primary to secondary openings, laying all tracts open. This

can usually be done in one operation. Since the initial incision is at the crypt it is not always necessary to completely incise the sphincter nowadays. The incision is, of course, at right angles to the sphincter by virtue of the anatomic relationship of the crypt. Therefore, incontinence today is a rarity. We do not nowadays find so many "blind fistulas," "simple peri-anal" or "peri-rectal abscesses." Making the incision from the crypt out to the secondary opening of the abscess and laying open all tracts has solved a large percentage of the problems in the treatment of fistula.

The one remaining problem is complete diagnosis of fistula. The correct diagnosis and location of all tracts requires care. The diagnosis of the involved crypt and the finding of the primary opening often constitutes a real problem. Dr. Salmon gave to us a principle that has become a law named after him. "If the external (secondary) opening of a fistula is posterior to a line transversely bisecting the anus, the internal (primary) opening will usually be found in the posterior-midline; if the external opening is anterior to this

line, the internal opening will be found directly opposite the external opening. A fistula may have more than one internal opening but this is not usual."

While Salmon's rule has been invaluable in the past, there have been far too many complicated cases in which the rule did not suffice. One of the most enlightening studies of fistula has been made by a member of the osteopathic profession, Frank Stanton. He has greatly added to Salmon's law and given us a new and practical classification for fistula. Stanton's classification now enables us to more quickly discover the primary opening and the involved crypt, to more accurately diagnose the fistulous channel, and to be more properly forewarned and therefore, forearmed about the exact nature of the condition with which we are dealing. Stanton classifies Anal Fistula topographically: five types are described:

Class I.—Anterior quadrant: The diseased crypt is in the anterior quadrant and constitutes the primary opening; the secondary opening being in the perianal or perineal area usually in a direct line. This type may extend several inches in some

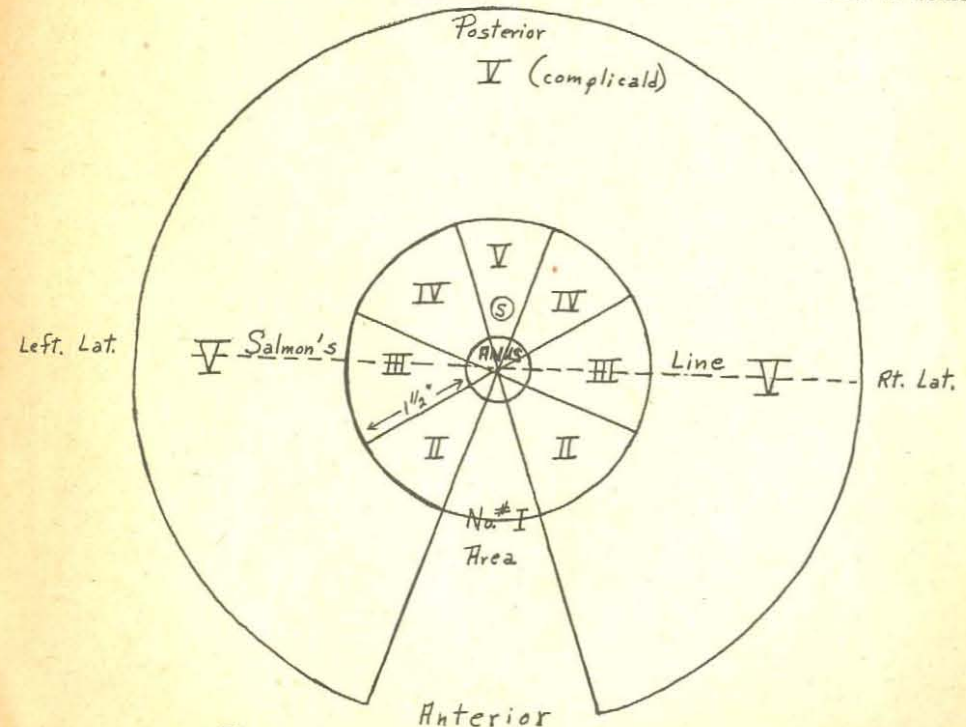


Fig. 1—Diagram of Stanton's Classification

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cases with the secondary opening in the scrotal or labial region.

Class II.—Anterior-lateral area is the location of the diseased crypt and internal opening with the secondary opening in a direct line and within 1½ inches of the anus.

Class III.—Lateral area: with the primary opening and diseased crypt or on Salmon's Lines and the secondary opening in a direct line and within 1½ inches of the anus.

Class IV.—Posterior-lateral area: diseased crypt and site of internal opening with the secondary opening usually in a direct line and within 1½ inches of the anus.

Class V.—Posterior quadrant: two types are classified here: 1. Simple which typifies the secondary opening within 1½ inches of the anus and in a direct line with diseased posterior crypt and primary opening.

2. Complicated which typifies the fistulae with the internal or primary opening in the posterior crypt and the secondary opening beyond 1½ inches from the anus and in any perianal area surrounding the anus with the exception of area No. 1 or the Anterior Quadrant.

These Type V complicated fistulas sometimes almost completely circle the anus.

It is the type V Fistula (complicated) that has caused so much trouble to both doctors and patients. The type V complicated can have its internal opening in the posterior crypt with the channel directly posterior, then right or left lateral and circling the anus or perianal area through area No. 1 and having the secondary opening almost anywhere in the lateral perianal area.

If these Complicated V Fistulas are not thoroughly diagnosed and the exact course and nature of all tracts involved given the proper surgical treatment, recurrences are almost certain. This careful investigation and diagnosis can best be done when the perianal area is completely anesthetized with a regional type of anesthesia. Many operators are satisfied to do all or most fistula surgery under local infiltration type of anesthesia, but according to proctologists in highest authority today, infiltration type of anesthesia is not recommended because of tissue distortion and also because of incomplete relaxation of the entire per-anal area. This incomplete relaxation will not permit the proper probing and investigation of all

tracts involved because of tension and spastic state of the sphincters and tissues in the peri-anal area in general. The injection of dye, paste, or air is also nowadays considered superfluous. Under a regional anesthesia (spinal or caudal) all tracts can usually be diagnosed, layed open and given treatment in one operation. Only in the very most complicated cases is more than one operation necessary today.

While it has been most interesting and gratifying to achieve the thoroughness that has been made possible by the Stanton topographical classification and interpretation of Fistula, a question that has presented itself to me, being osteopathically minded is this: Why will a diseased crypt in the lateral areas usually be a short tract in a direct line to an external opening with 1½ inches of the anus and why will an infected crypt in the posterior area have such far reaching possibilities and potential complications? Also, why will one crypt become infected in preference to another?

In a review of the anatomy of the anus, rectum and peri-anal and perirectal areas several theories present themselves. It is most interesting to note that the rectum and the circulatory vessels to the rectum are supplied by both the autonomic nervous system while the anus is supplied only by the parasympathetic (cranio-sacral). Therefore, the anus is evidently deprived of an anatomical feature which may be very important physiologically. The circulatory balance and the tissue resistance may become critical if any condition disturbed the mechanism which controls the function of the autonomic nervous system to adjacent or related organs such as the colon, sigmoid and rectum. Through laboratory research and the test of time in Osteopathic Clinical Research the vital importance of the structural integrity to the functional balance of the autonomic nervous system is an accepted fact. Therefore, it is my present theory that structural lesions, either organic or functional, can play an important part in the etiology of Fistula. A study of the nerve distribution to the anal area when superimposed upon the diagram of Fistula classification helps to clarify this point. (See Fig. 2.) At the present time, I am personally making a clinical study in the comparisons of Fistula types with associated structural findings and I invite my colleagues to participate so that in the future we may add another important contribution to the management of Fistula.

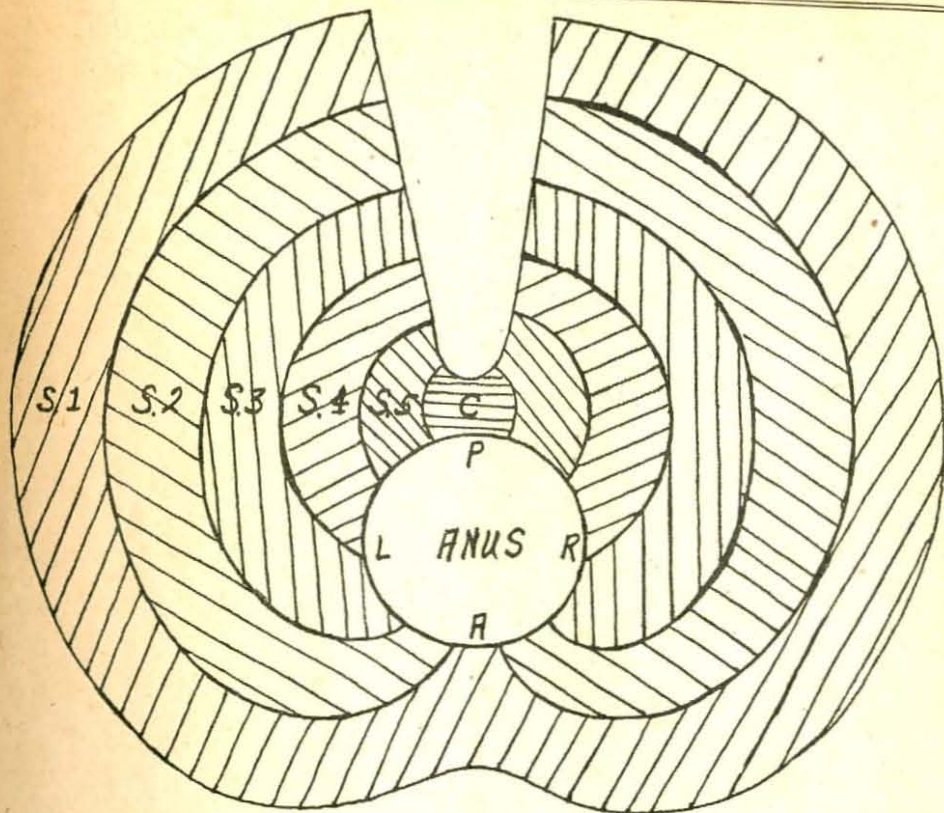


Fig. 2—Diagram of Nerve Supply to Anus and Peri Anal Areas

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 (Editor's Note: Dr. W. A. Hockett of
 Kansas City, Missouri, is a member of
 the American Osteopathic Society of
 Proctology, Surgical Staff of Proctology,

Kansas City College of Osteopathy and Surgery, and a Staff Member of the Hospitals of the Kansas City College.)

Convergent Strabismus

By Floyd W. Best, D.O.

Part III
 CHOICE OF OPERATION

From a purely surgical standpoint, that is determined by the angle of deviation, the presence or absence of amblyopia, and the state of the fusion faculty. For reasons which are difficult to understand, tenotomy of one of both interni has held sway in the past and is even practiced by many today. The operation has nothing to recommend it, unless it is that a minimum of surgical skill is required in its execution.

To offset this advantage, if it can be considered as such, is first, the danger of converting a convergent esotropia into a divergent paralytic squint. If the

patient escapes this disaster, he may be confronted with an equally serious consequence, namely, inability to sustain convergence at the near point. A third objection to this form of surgery is the creation of hyperphoria which, in many instances, is of considerable degree. Therefore, complete tenotomies are no longer done, but partial tenotomies are of value in mild cases.

The constructive surgical procedures to which the surgeon may resort are resection, with or without advancement, tucking and recession.

ALTERNATING ESOTROPIA

In the alternating type of convergent squint the patient, at will or unconsciously, fixes with either eye. The fusion faculty is absent, or so defective that training does not improve it. It begins at an earlier age than does the monocular type. Squint is evident in some cases at birth or during the first few weeks of life. Most cases are well established before the child is a year old. Amblyopia does not develop since the patient uses both eyes alternately.

Refractive errors may or may not be predisposing factors but in most cases the refractive error is so moderate that it can in no way be considered as a cause. In other instances, the error may be considerable, from 2 to 4 diopters. Unequal errors are rare. On the whole, refractive errors play an indifferent role.

Hereditary influence consists in the transmission of a defective fusion faculty. The precipitating factors such as fright convulsions, and acute illness which are observed so frequently in monocular squint are not observed so often in alternating esotropia. As a rule, the onset is insidious without any such associated conditions.

An absent or undeveloped fusion faculty is the chief etiological factor. Since the hereditary influence is shown mainly in the inheritance of inability to fuse, it might be said that the causes of alternating esotropia are practically reduced to a single factor.

Treatment

The same careful methods are used in refraction as are used in monocular esotropia. When the error is sufficient to be an etiological factor, it is of extreme importance that glasses be prescribed early. A spheric error of less than 2 diopters would hardly be high enough to require correction before the child starts to school. Astigmatism of plus 1 diopter, or more, is a more serious and a correction should be worn as early as possible. All higher errors, spherical

and cylindrical, should be corrected fully. Although the minor role of refractive errors have been referred to, they are not to be ignored, but must be given the same consideration as in non-squinters. This applies to moderate errors. Higher degrees should be treated as outlined.

Amblyopia

Amblyopia, as stated before, does not occur in true alternating squint. No special measures need to be taken to prevent its development other than a careful check-up at stated intervals, on the visual acuity in both eyes.

Fusion Training

Fusion training, like amblyopia, is unimportant in this type of squint. The degree of fusion, if present, should be classified as soon as the child is old enough to treat. If it can be demonstrated that the child has "simultaneous macular preception," every effort should be made to develop even a very defective fusion faculty. The synoptophore and amblyoscope should be used as carefully as in monocular esotropia.

It is probable that any fusion which may have been present fails to develop because of the barrier of squint, since most patients squint soon after birth, and in such cases treatment may be useless. However, a fusion faculty, although undeveloped, may persist and yield to training when squint appears later in childhood. It appears that these cases tend to be accidentally alternating in character. Nevertheless, every effort should be made for improvement when even a suggestion of fusion is present. Fusion training can and should be omitted when, as in a majority of instances, it is found to be totally absent or at least unresponsive.

Suppression is nature's provision for the comfort of true alternating squinters and irreparable harm can be done in attempting to break up the habit of suppressions, and an annoying diplopia may be created. This is evident particularly after operation.

Operative Treatment

Since the physician can hold out little hope of correcting the squint without operation in these cases, each one becomes a potential surgical case from its onset. The operation is solely a cosmetic one. The important question is of time. When shall the operation be performed?

Contrary to usual custom, it is believed better to operate early, preferably between the ages of three and four, in order that the child may be spared the embarrassment which the disfigurement creates. Also, the temporary dip-

lopia which is experienced sometimes by older children and young adults after operation, seemingly does not inconvenience the young child.

Another advantage in early operation is that the first operation improves the general appearance and, in cases requiring several operations, the second operation may be postponed for a year or two.

The serious objection is the difficult management of the young child as compared with more mature people, yet in the average case, the objection is more than balanced by the advantages gained by correcting the defect before the child starts to school.

DIVERGENT STRABISMUS (Exotropia)

All phases of the treatment of exotropia are less satisfactory than the same measures are in the management of esotropia.

Refraction

The same care in estimating and correction of the refractive error should be observed in exotropia as was advised for esotropia. A squint of moderate degree may be corrected in the accommodative variety with myopia by a full correction, if supplemented by fusion training. Unfortunately, as in esotropia, the amount of deviation is more than can be accounted for the relation of the meter angle of convergence to the diopter of accommodation. Therefore, glasses rarely give sufficient relief to correct the squint.

If the refractive error is hyperopic, instead of a full correction as indicated in esotropia, great care should be observed that the spheric error is undercorrected. One is guided in this by the patient's age and occupation. The sphere may be a great deal in young people, but after the age of thirty, one should be guided by the requirements of the patient's occupation. When the character of the occupation calls for the constant use of the eyes at the near-point, the age of the patient also becomes a determining factor. A full hyperopic glass may become necessary after the age of thirty-five. Under certain conditions, the simple rules of refraction should be followed, regardless of the presence of exotropia.

Fusion Training

Classification of each case as to the state of the fusion faculty should be practiced at the beginning of the treatment. Because of the average age of the patient, this is done with greater facility than is possible in the young es-

tropic patient. If the patient belongs to the group which shows a tendency to exophoria in the adolescent period, every effort should be made to overcome the exophoria by prism training as advised in the treatment of exophoria. If squint is manifestly present, fusion training by means of the synoptophore or amblyoscope should be followed. The results are not encouraging but every effort should be made to restore a defective fusion faculty.

Occlusion of the Fixing Eye

Many cases of exotropia are alternating in type and, therefore, vision is not apt to deteriorate. In the monocular variety, amblyopia exanopsia is infrequent. Occlusion of the fixing eye, however, should be practiced as in monocular cases, unless the exotropia is due to blindness or amblyopia other than that acquired from disuse. When one eye has a low refractive error and the other a high myopia error, with an outward deviation, nothing can be done to correct the condition by any of the measures discussed.

Esotropia Combined With Vertical Disturbance

The vertical balance in exotropia, as well as in esotropia, should be determined. A hyperphoria, if present, should be corrected by prisms properly placed. A full prismatic correction should be introduced. One should measure the amount of hyperphoria for far and near, and the minimum full correction should be prescribed. The correction of the vertical balance may have considerable influence over lateral disturbance, whether there is only a tendency to lateral disturbance or a manifest squint. If the hypertropia is high in degree, diplopia tests should be made for any possible paresis of a vertically acting muscle. If present, such conditions may require treatment by surgery.

Operation

Comparatively few cases of exotropia are corrected by non-operative measures alone. Before one proceeds to operative interference, each case should be studied carefully, as to its particular needs. There are many cases of the alternating type, moderate in degree, in which the squint is neither disfiguring nor inconvenient to the patient. Some of these patients can use either eye at will, are not annoyed by diplopia and never complain of discomfort.

Inasmuch as moderate degrees of exotropia are less noticeable than esotropia of the same degree, it is often inadvisable to recommend operation. The fusion

faculty is defective and single binocular vision is not apt to follow after operation. Operative interference should be reserved for cases in which the deviation is sufficient to attract undue attention because of disfigurement, and for cases in which there is a reasonable hope of restoring single binocular vision. The latter result is obtained less frequently in divergent squint than it is in esotropia. A cosmetic operation, however, should be resorted to unhesitatingly if the deviation is markedly noticeable.

Treatment of Hypertropia

Inasmuch as vertical deviations in this group of cases are often found associated with lateral disturbance, the treatment is supplemental to the general management of lateral squint.

Refraction

Refraction is the same as in lateral squint with which it is associated.

Fusion Training

Fusion training is of no avail. Little can be hoped for, even in hyperphoria of more than 3 centrad and practically nothing in manifest vertical squint. Nevertheless, an attempt may be made on the synoptophore and with the stereoscope to reduce the hyperphoria to a minimum. It may assist, with the aid of prisms, to restore the patient to fair degree of comfort.

Surgery, if practiced at all, should be resorted to only after careful study and should be directed to the lateral deviations first, with the hope that with the restoration of lateral balance, vertical squint may be brought within the correcting power of prisms. If this is not possible, surgery of the vertical muscles may be attempted.

*Random Thoughts
of the Editor*

Now is the time for the Editor to take his feet off the desk and try to put out another issue of this College Journal. It is quite a job. Of course, a few articles sent in by the members of the Alumni, living outside of Kansas City, would help a lot. Up to date, ninety-five percent of the material has been furnished by persons residing in the Greater Kansas City area.

The Barbiturate problem is more serious today than is the narcotic problem. Osteopathic physicians should take care to prescribe only small quantities of barbiturates. Some members of the profession, we are told, are very casual about writing for fifty or a hundred

Phenobarbital tablets or prescribing a half pint of an elixir at a time. This places in the private medicine chest a means of giving painless death to any member of the family who in a moment of depression might look for an easy solution to his or her problem. We should remember that such a prescription, while it may be a passport to better health, may also be a passport to the hereafter. It is also wise to make a notation on this prescription that they are not to be refilled, even though under existing laws and regulations they are not classed as refillable prescriptions. It is the moral responsibility of the physician and of the pharmacist to see that these dangerous drugs are properly dispensed.

So far we have been unable to discover through scientific research any drug or drugs that can be substituted for brains in the human cranium. It looks as though the only way we can have intelligence is to be born with the proper biological quantity of it. Glutamic acid has been used experimentally to increase human intelligence. Some authorities report 20 percent success in this experiment but the majority of them report a failure to improve I.Q.

One of our acquaintances told me the other day that it takes 7,500 hogs to provide sufficient pancreases to make one ounce of insulin. This is something for the diabetics to think about.

Reading in the history of medicine, we find that bottles filled with vinegar were once used by physicians as "smelling bottles." Before entering the sick room, the doctor took a whiff from the bottle to protect him from contamination while attending the sick. Personally, your Editor prefers the judicious placement of Air-wick in the room.

A Latin-American student of ours told me that in some Latin-American countries the natives endeavor to cure asthma by taking a fish and breathing into its mouth, the idea being that the asthma will leave the patient and pass to the fish. Who ever heard of an asthmatic fish?

We gleaned from our reading that there are 71 pharmacies owned by doctor groups in the United States. One cannot speculate as to which of this number might be owned by osteopathic physicians, quite a few members of our profession being registered pharmacists. While this type of procedure might be profitable, and may in some instances be necessary, it does not tend to increase the amiability of the professional relationship between the physician groups

and the pharmacy groups. This condition appears to exist in all but about eleven of the states.

Now that spring is arriving, the old-timers can stop dissolving their pearl buttons in lemon juice and drinking it as a sure cure for rheumatism. Old Man Sun probably will take care of this himself.

It is interesting to note that six states have laws prohibiting the filling of prescriptions for dangerous drugs, which had been written by physicians residing outside the state. Among these states are California, Michigan, Illinois, New Jersey and Florida. Minnesota has a law which approaches this status. Physicians should notify their patients who intend to travel in those states, so that their prescriptions could be filled before leaving on their trip.

Spring is here and robins are getting settled in their new nests or at least contemplating renewing old leases from last summer, and many members of the profession appear to be following the example of these spring migrants and are going from good pastures to greener fields, we understand, where the vegetation is heavier, where housing conditions are better or for a good many other reasons. These persons will be a loss to the communities they leave and a gain to those communities where they settle. We understand that Dr. J. F. Routsong has moved to Barnsdall, Oklahoma, and that Dr. F. L. Harmon has left Kansas City to go to Wilson, Oklahoma, as his point of settlement. Rumor, also, has it that Dr. W. D. Schaeffer, one time assistant in the Department of Physiology and Pharmacology of the College, and formerly of Freedom, Oklahoma, and Edcouch, Texas, is moving to San Antonio, Texas.

With rumors flying thick and fast, we hope we have these points of destination correct, and that everyone will be very happy in the new locations.

The Basic Science Departments of the College have made considerable improvements in their physical equipment during the winter months. The Department of Physiology and Pharmacology has improved its storage and lighting facilities. Some new experimental equipment has also been added. The Department of Bio-chemistry and Bacteriology has some new storage and work space along with several excellent pieces of experimental equipment, which has been added in recent months.

The Anatomy Department has installed a number of new dissection tables, shows considerable fresh paint, and the lighting facilities have been

markedly improved.

Some improvements are reported in the Department of Pathology.

The Clinical Department has progressed through the winter and through the courtesy of the Spinalator Company and their representative, Dr. Dorland DeShong, the College has received a Spinalator for use in treating clinic patients.

Well, we believe we have wasted enough of the Journal's space so will put our feet back on the desk and hope that some ambitious member among the Alumni groups may send in an article or two for the Journal. If such a thing should happen, the Editor will endeavor to recover from the shock and get the article duly printed in the next issue.

*Announcement of Residency
In Neuropsychiatry*

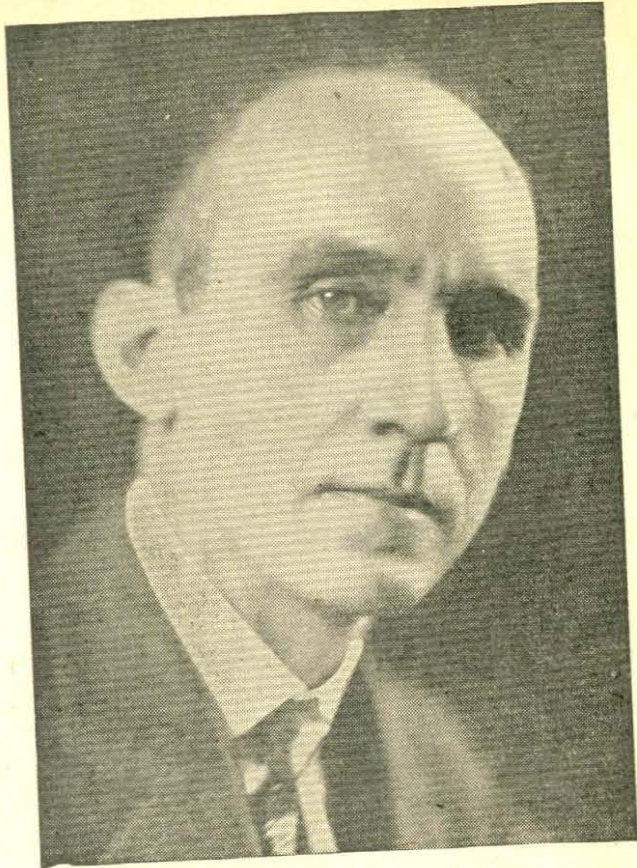
The Department of Neuropsychiatry of the Kansas City College of Osteopathy and Surgery announces one Fellowship opening for a period of one year beginning October 1, 1949. After the completion of this year, additional training time may be secured.

The requirements for admission to examination for certification as determined by the American Osteopathic Board of Neurology and Psychiatry are as follows:

1. Graduation from an approved osteopathic college.
2. If graduated after 1946—one year rotating internship. Otherwise 5 years practice suffices.
3. Three years full time residency in Neurology or Psychiatry or 5 years in both, or its equivalent (to be determined by the Board).
4. Two years specialty practice in the field of choice.
5. Membership in the A.O.A. and your state association for three years prior to the examination date.
6. A personality conducive to the practice of the specialty.

A school teacher, on a bus, smiled and nodded to a man who seemed a bit puzzled by the evidence of recognition. As she was about to leave, she said to him:

"I hope you will pardon me for seeming a bit forward, in speaking to you, sir, but it was a case of mistaken identity. I thought you were the father of two of my children."



A. A. Kaiser, D.O.

A. A. Kaiser, D.O., was born in Kansas City, Kansas, in 1888. He graduated from the local high school and in 1905 entered the Central College of Osteopathy in Kansas City, Missouri, graduating therefrom with the degree Doctor of Osteopathy.

In 1908 he went to Lone Oak, Arkansas, and entered the general practice of osteopathy. A year later he moved his office to Little Rock, Arkansas, still continuing his osteopathic practice. During this period he was Secretary and Treasurer of the Arkansas State Board of Osteopathy.

In 1910 he returned to Kansas City, Missouri, and became identified with his Alma Mater as a member of the faculty. He continued in this capacity until 1915 when he became the organizer and moving spirit in the Kansas City College of Osteopathy and Surgery. His position in the new organization was Secretary and General Manager. He was also Editor of the College Journal. He was the guiding spirit in the activities of the new college. He was the financial genius who could and did make one dollar do the work of a half dozen in less capable hands.

The school prospered. It also had many vicissitudes, many trials and tribulations, but Dr. Kaiser was always equal to all the varied emergencies.

When the college was re-organized in 1940 and came under the control of the Lay Board, Dr. Kaiser's school activities practically ceased. His job was done. All could say of him—"Well done, thou good and faithful servant."

During the major portion of his life's work, he suffered severely from an intractable brachial neuritis which manifested itself in his left arm and hand. In spite of the handicap of intense, often times agonizing, pain, he carried on to the end.

An Appreciation

A. A. Kaiser, D.O., is dead! His passing occurred at 3:00 o'clock in the morning of February 28, 1949, in the Osteopathic Hospital in Kansas City, Missouri. It closed the career of one of the most potent forces for osteopathic propaganda and perpetuation ever produced in the state of Missouri—the home, and the scene of the greatest activities as well as the permanent resting place of its revered founder, Dr. Andrew Taylor Still.

It is apropos to make mention of an editorial appearing in the College Journal, official organ of the Kansas City College of Osteopathy and Surgery, Vol. 6, January, 1934, entitled—"The 1934 College Journal." The final paragraph reads as follows: "At this time and in this place it is only fitting to acknowledge the debt and to give due credit to its founder, the general source of its inspiration, A. A. Kaiser, D.O., whose zeal, foresight, wisdom, unselfish devotion and earnestness, has made possible this great force for osteopathic perpetuity.

"To him we bend the knee."

Today we add to this: "and bow the head!"

Of Dr. Kaiser's early history, I know nothing of first hand information. My acquaintance with him began when he matriculated as a student in the Central College of Osteopathy in Kansas City, Missouri, September, 1905, from which he graduated in May, 1907. He located for general practice of Osteopathy in Lone Oak, Arkansas, and became secretary of the Arkansas State Board of Osteopathic Examination and Registration. Later on he returned to Kansas City, Missouri, and re-identified himself with Central College of Osteopathy. During a part of this period he established a lay paper for the circulation of osteopathic information which he edited and had published in Liberty, Missouri. Its existence was short.

During all this time, the germ of an idea was struggling to manifest itself. In the spring of 1916 it progressed to full fructification and the Kansas City College of Osteopathy and Surgery was born.

Dr. Kaiser was a school man, a natural. He knew intuitively of school problems and needs. He was able to postulate in advance exigencies in management, financial or otherwise, and to formulate plans to correct or to circumvent them. He had that particular genius which enabled him to make one

dollar do the work of a half dozen in other hands. Best of all, he had that sixth financial sense that permitted him in time of need, to lay his hands on that needful dollar.

His whole world was wrapped up in the Kansas City College of Osteopathy and Surgery. In it he lived, moved and had his being. In it he focused all of his desires and activities. In it lay the consummation of all of his ambitions and his osteopathic, educational altruisms.

He led the way. The new school, his dream child, was to be non-profit in every sense of the word. Incidentally his was the first non-profit osteopathic college ever to be so chartered. Its education motif was based definitely on Dr. Andrew Taylor Still's contribution to the healing art, viz., "The Natural Immunity of the Tissues" and "Skeletal Integrity as the Concomitant to Health."

When all of the osteopathic colleges were chartered as profit sharing institutions and were operated for profit, the Kansas City College of Osteopathy and Surgery alone strove for its ideal—the best of osteopathic education for the greatest number, *at cost!* There was no financial recompense to anyone associated with it. It was conceived in the love for osteopathic ideals. It was born in poverty. Its advent into the osteopathic therapeutic world was unheralded. It was an unwanted child. It met with disfavor and antagonism but rapidly outgrew into swaddling garments; waxed strong and vigorous, blazed its own trail and took its rightful place in the educational activities of the American Osteopathic Association.

The College Journal—mouthpiece of the College—issued monthly, carried no advertising, except the announcement of the College and its clinical hand maiden, the Lakeside Hospital. It was a thirty-four page issue devoted entirely to osteopathy and its problems and it was all original material. It was designed as a clinical help to men and women engaged in bedside practice. It went monthly and without price to every osteopathic physician of known address. From the Hudson Bay to the Gulf of Mexico and from the Atlantic to the Pacific Coasts. It was read in England, France, Australia, China, Japan and Mexico. This was another of Dr. Kaiser's ideas for the general uplift of the rank and file of the osteopathic practitioners the world over.

The Kansas City College of Osteopathy and Surgery, as it exists today at Independence Avenue and Highland, is the living, active monument commemora-

ting the span of his professional career in Kansas City. He leaves the impress of his being upon ever student matriculating in and graduating therefrom, and that influence will continue to spread and to bear fruit.

Those of us who worked with him and who knew him well can all subscribe to that Mantra from the Egyptian Book of the Dead, "Eternal Peace grant unto him, O God, and may light perpetual shine on him."

GEORGE J. CONLEY, D.O.

Commencement Address

By
Arthur E. Allen, D.O., Sc.D.

Commencement Exercises
of the

Kansas City College of Osteopathy
and Surgery

March 11, 1949

A Chasm, Vast and Deep, and Wide

Members of the graduating class of March, 1949, members of the Board of Trustees and Faculty of the Kansas City College of Osteopathy and Surgery and Guests.

It is a signal honor to be invited to address you, a group of seniors who are about to receive the degree of Doctor of Osteopathy, and I value that honor highly. Much time was spent in considering various subjects to discuss, trying to select one that would be equal in importance and significance to this important and significant occasion. No new "challenge" could be found which had not previously been given to others. And, also, challenges have a way of becoming discouraging if one must accept too many of them.

If this class is like most other graduating classes, several of you may not be paying much attention to me or to what I am saying. You are sitting here because it is the proper thing to do when one graduates, but your minds are on other and more pressing subjects, challenges to you. Possibly you are worrying about where you are going to locate, or how you are going to get those new clothes so that you can look prosperous and still have two nickles left to jingle affluently in your pocket. Maybe you are wondering whether you should have raised a Van Dyke to make yourself appear more professional (that's one challenge at least which will never have to be faced by any feminine graduate). Or again, you may be struggling with the age-old thought twister, trying to avoid the depressing

conclusion that two cannot possibly live as cheaply as one even though much more pleasantly. Having seen a senior myself, I was certain that you would have enough challenges by now which had already accepted you to be quite sufficient for some time, and it seemed unfair to discover any new one which might otherwise have been avoided.

Finally I came to the conclusion, that, as you were about to enter the profession of Osteopathy, probably the most appropriate subject for this evening would be the practice of Osteopathy. But first, I would like to tell you about a man, a chasm, and a bridge.

As our story begins, this man was walking along a road, purposefully, yet hesitatingly at times because in some places the road narrowed to a mere trail, and even that at time disappeared. This very uncertain pathway led through dense forests where little light could penetrate and it was easy to lose the way. It let through treacherous bogs and quick-sands where one mis-step could bring disaster. But slowly, surely, he moved forward, surmounting all difficulties until he came to the brink of a deep chasm, where the trail ended abruptly. Those who had preceded him there were gathered along the edge, some looking for a crossing, others, discouraged, were content to wait for some one else to find the way.

Our traveler, neither satisfied to wait nor to look further where others had failed, set out in a different direction and at last found a place which looked as though it might afford a way down into the gorge. Cautiously choosing his path, testing each foothold, each handhold with the greatest care, he finally reach the bottom safely. But search as he might, no way could be found to scale the opposite cliff. And so he made up his mind to build a bridge.

By this time, he had begun to attract the attention of some of those he had left behind. He called up to them, told them of his plan and urged them to come and assist him. Not only did they refuse to take the risk of the climb down the sheer granite wall but they laughed at him, told him his plan was foolish, impossible, and if he could he had better get back up with the rest of them and wait until something else developed. So he set about his task alone.

First he cleared away the sand and rubble, dead and decaying debris, all of the refuse which littered the bottom of the chasm until he found solid granite for his footings. Then stone by stone

he selected material without a flaw, piling them one on the other, binding them firmly in place with a cement of his own making. No weakness could be permitted if this bridge was to stand the test of time.

As it grew, so did the crowd of onlookers, onlookers who gathered not to help but to jeer, not to encourage but to discourage, not to praise but to disparage. Yet the work went on. Painstakingly selecting each stone, abutments, piers, and arches were completed, and the bridge was finally ready for use.

Speaking now to the gathering throng, this man of courage and determination invited them to make use freely of the bridge which he had completed, but again he received only ridicule and insults. He was told that his bridge was weak, dangerous, that anyone attempting to cross on it was risking his life, that no one of sound mind would take such a chance. But this builder of bridges knew that his material and workmanship were sound, he knew he had followed the plan of the greatest architects, and so without waiting longer, he turned and strode across the bridge. It did not collapse, it did not even sway. Calling then from the far side he urged the watchers to follow, but when no one dared to do so, with a farewell wave of his hand he resolutely set forth towards the new frontiers, the limitless horizons which his faith, his labor, and his vision had made possible.

As time went on, others gradually gained confidence enough to make use of this bridge in ever increasing numbers until it became necessary to widen and to strengthen it. All in crossing paused to do their share of the work. Some of them, it is true, without the skilled perception of the original builder, at times selected poor material, but always others were present who would detect and remove it before any weakness developed. And so the bridge from day to day grew wider and wider, stronger and stronger, until it became a fitting monument to its original builder, and a source of pride and satisfaction to those who later labored there.

I am sure it is not necessary to tell you that the bridge-builder was Andrew Taylor Still, that the winding, uncertain trail he followed was the profession of medicine as practice in his day and that the chasm which blocked his forward progress was the medical ignorance of those times. It was necessary for him to clear away the superstitions, the unsound beliefs and practices which cluttered the bottom of this chasm to get

down to the solid granite of proven scientific knowledge before he could begin his work. The boulders with which this bridge was built were his own ideas, his own conclusions, gained through study, observation, and clinical experience. The cement which held all parts so firmly together that there has never been need for repair or replacement was the Osteopathic concept and the completed structure was named OSTEOPATHY.

You are about to start your journey across this bridge. You can not pass without leaving your imprint, large or small, good or bad upon it. Widening and strengthening of the bridge goes on daily. The need for workers is urgent and your opportunities to labor will be many. But build wisely, that your work may be permanent. And how may you build?

You are now eligible to membership in your national association, and shortly in your divisional and local societies. Your Alumni Association will welcome your membership and assistance as will all of the allied societies for which you are qualified. The remarkable progress our profession has made since its inception has been due, in large part, to co-operative effort. It is a privilege, a mark of distinction to belong to organized Osteopathy. Here is your first opportunity.

After you have started practice you can become part of church, civic, and political organizations. Again important work, not only for yourself but for your profession. The practice of OSTEOPATHY today is not well understood. It is not "unheard" of, thanks to organized Osteopathy, nor is it entirely "unknown," but it may be a century before it is really known and understood intelligently by the laity. Here in your public contacts you will be carrying on one of the most important parts of the work to strengthen the science of Osteopathy. Your profession will be judged by your personal and professional ethics. It will be judged by the methods of therapy you employ fully as much as by the results you obtain. As you build good-will and respect for yourself so you will build permanently for your profession.

Keep accurate case records, make careful observations of the progress of your patients, so that your clinical results may serve as clinical research. This is most important work. At present we are too few as a profession to adequately support pure research and we are not well enough known publicly

to receive substantial private bequests, or grants from governmental sources. But such support has started within the last few years, and who knows, your thinking, your observations, your results may be the means of fully opening the doors of public and scientific recognition to your profession. These are only a few of your opportunities to build wisely and permanently.

The Osteopathic profession is an honorable profession which will bring honor and dignity to your lives if you so honor it. It is a new profession in which your achievements will be limited only by your vision and your skill, your clear vision of the Osteopathic concept and your skill in applying its fundamental therapeutic procedure, Osteopathic manipulative treatment. That concept is no long theory, it is proven, demonstrable fact. Structural adjustment is the logical and scientifically correct method to implement its principles. I realize that some of you may become specialists but Osteopathic therapy is all inclusive. There is no branch of specialization to which it does not apply. It will obtain for the specialist as well as for the general practitioner more gratifying results and will assure to the patient the best and most complete care presently known to the modern therapeutic world.

The Osteopathic profession is a dynamic profession, composed of earnest, sincere, intelligent men and women. Solely by their own efforts, the Still legion has gained scientific respectability, and a highly specialized skill, peculiar to them alone, has been developed to diagnose and treat it. The results they have secured through this method of diagnosis and treatment has changed public apathy, intolerance, and opposition, to growing interest, approval and support. Even the school of medical practice has finally admitted the existence of the Osteopathic spinal lesion and are now seeking to develop methods of structural adjustment for their own use. Surely you may well be proud that you are becoming members of such a profession.

You will not be envired with such obstacles as were encountered by our early pioneers. You will be welcomed in the community of your choice, not shunned. Your opinion will be sought and respected, not ignored and belittled. Your fields of service will be many and varied. You can make of your career what you will. The purpose of the Osteopathic profession is immense and it must begin with individual growth.

And so tonight our profession wel-

comes you to membership in its ranks and urges you to join with us immediately in the ever increasing work of widening and strengthening, so that those who follow may safely cross the chasm, vast, and deep, and wide, to new frontiers and limitless horizons, with full confidence in the strength and permanence of the bridge named OSTEOPATHY.

The Trend of Osteopathic Therapy

By George J. Conley, D.O.

During the last fifteen years of the nineteenth century, the shadow of a giant began to spread over the surgical world bringing with it new ideas and blasting outworn concepts which were hindering surgical developments. That giant was John B. Murphy, M.D., of Chicago, Illinois. His field of clinical activity was in the Mercy Hospital to which clinicians the world over beat paths to the end that they might sit at his feet and imbibe new ideas respecting clinical surgery.

John B. Murphy, M.D., became the teacher of teachers of surgery the world over. It was he who stressed sequential case history and adequate physical examination in order to elucidate the pathologies underlying the diseased conditions afflicting the patient under examination. He said many times each week in his clinical demonstrations, (and when Murphy spoke, the entire surgical world took notice): "Listen to the patient's story. She will tell you what is the matter. Your interpretation will depend upon your clinical ability together with your acuity in physical diagnosis, to detect pathological manifestations indicated by that story." And then Murphy would operate! Deftly, quickly, with an assurance born of unbounded experience, talking incessantly as he worked, he would lay open the field of operation, exposing the pathology showing it to be just as he had described it to his audience now tensely awaiting the culmination of his dissertation. Although the operating amphitheatre of Mery Hospital easily seated 500 spectators, no one ever left while Murphy worked except when impelled by dire necessity.

In 1905 Jacques Loeb, Professor of Biology at the University of Chicago, made the following prediction: "Through the oxidases one may in time be able to

control disease as the artist governs the keys of the piano. Not merely the normal course of life but also that vast gamut of diseases characterized by metabolic derangements might be controlled if we only knew how to favor or retard the action of the oxidases."

Then came Charles E. deM. Sajour, M.D., who, through his monumental work, "The Internal Secretions and the Principles of Medicine," postulated the pituitary, the thyroid gland and the adrenal glands as the defensive trinity of the body. The pituitary body being the test organ of the blood, the thyroid gland supplying the Opsonin of Sir Almroth Wright and the adrenal glands whose secretion, poured into the venous blood stream, imparted its affinity for oxygen.

January 19, 1907, at Leeds, England, Mr. A. H. Brampton in his Presidential address before the Leeds and West Riding Medico-Chirurgical Association said respecting the practice of medicine: "Scepticism is in the air. Even in this society, if any daring member has introduced a subject bearing on medical treatment, it has been with an apologetic air and humble mein, well knowing that if his remarks had any reference to the utility of drugs in the treatment of disease, they would be subjected to good humored banter and received by those sitting in the seat of the scornful with amused incredulity."

At approximately the same time, Dr. Frank Billings, in his Presidential address before the American Association said: "Drugs with the exception of quinine in malaria and mercury in syphilis, are valueless as cures." The vast majority of the practitioners of the medical system of practice were in a state of mind characterized by Dr. Osler as that of "black, hopeless, helpless therapeutic pessimism."

Dr. George W. Crile, M.D., in a series of lectures given before the Washington Post-graduate School of Medicine, 1927, entitled "Problems in Surgery," and, "Speaking on the Management of the Acute Infections" said: "Since chemical and vaccine therapy have failed, there remains only the physiologic methods of attack against pyogenic infections. The physiologic method implies, first, a recognition of the principle that the infection must be overcome by the means of defense which is inherent within the organism itself; and second, the application of measures which will remove handicaps and interferences, on the one hand, and on the other will build up the

defense."

On May the ninth, 1933, at Washington, D.C., Harvey Cushing, M.D., in his Presidential address before the Congress of Physicians and Surgeons, said in part: "As a matter of fact, it will be a great shock to laymen to learn that a great part of what is called scientific medicine is a fetish and wholly unscientific. We have instruments of precision in increasing numbers with which we and our hospital assistant at untold expense make tests and take observation, the vast majority of which are but supplementary to, and as nothing compared with, the careful study of the patient by a keen observer using his eyes and ears and fingers and a few simple aids."

The status quo of the healing art shortly after the war between the states was tersely exemplified by Skodas dictum that "we can diagnose disease, describe it, and get a good grasp of it, but we dare not expect by any means to cure it." This statement of therapeutic nihilism was challenged by our own Andrew Taylor Still, M.D., a therapeutic John the Baptist, who, working in the wilderness, alone, unaided with friendly counsel, bereft of books except the standard texts of anatomy and physiology, but skilled by the exigencies of his day in observation and deductive ability, with the bedside of the poor as his hospital, the untrained but willing assistance of kindly neighbors as nurses, he met head on the challenge of the Grim Reaper and the futile nihilistic exponents of the "law of opposites" characteristic of the practice of the healing art of his time. His clientele were not only of the poor and the lowly in the social scale but they were the failures, the incurable given up by the orthodox doctors to die. But he did not falter. Intuitively he sensed a better way of healing, one in accord with natural law. He persevered. He won out and in 1874 he was compelled to preach his teaching in the wilderness, literally on the highways, in the byways, in the homes of the sick, who were too poor to afford the services of a doctor. He carried his message, like an itinerant evangelist, to all or to any who would listen. He was at first ignored, then laughed at, reviled, persecuted and prosecuted. But he kept his eyes steadily on the "cloud of smoke by day and the shining of a flaming fire by night." He gave to the healing art his two great therapeutic aphorisms, viz., the Natural Immunity of the Tissues and Skeletal Integrity as the Con-

comitant of Health. These two innovations, the first now accepted by science the world over and the second, well on the road to universal acceptance, are destined to become the keystones in the arch of the scientific therapy of the future.

After the first world war specialism in practice of the healing art, received its first great impetus. Surgery, naturally, became the bellwether of the change with less influential and less glamorous aspects of the healing art following suit. This compelled another great change in medical practice i. e., "Group Practice." Wherein several specialists would join themselves together to participate in the examination and treatment of patients who might come their way. Laboratory methods were stressed and their findings, usually gleaned by underlings by means of instruments and gadgets of precision designed for research work, were used as a means of diagnosis by the chief clinician much on the order of one, taking the component parts of a jig-saw puzzle, and attempting to fit them together to make a diagnosis. The case history, which should be sequential and designed to bring out and emphasize important clinical facts, fell from its position of importance and became a conglomeration of unrelated clinical facts more resembling an inventory than anything else. Certainly it was nothing upon which a clinical diagnosis could be based. The idea caught on. Doctors indulging in a country practice plus the trend of our Class A medical schools to stress the mechanical side of the practice of medicine acted as a deterrent for the younger graduates who could not meet the exigencies of the changed rural conditions with the means taught to them in their courses in school. They were compelled to gravitate to the larger cities where laboratory, hospital and specialistic advantages were available. Far too many of them, in order even to obtain entrance to standardized hospitals, were practically compelled to refer the most lucrative portions of their practice to the specialistic chairs which dominate such institutions.

The trend now is reversed after a fashion. Hardly a day, certainly not more than a week, passes without urgent appeals appearing in the press counseling young doctors to locate in the smaller centers of population. At least once in a week an article appears in one or more of our metropolitan journals announcing the building of a modern of-

fice for some young doctor who will leave the city and locate in their community for the practice of the healing art.

For thirty years the field of general practice has been depleted. Comparatively few of the younger doctors ever even considered such a location, carrying with it the odium of a "country practice." The general trend was and had been unequivocally toward specialty group practice. Medical education today trains them for this type of work. So that now eighty percent or more of said doctors are striving for that ten percent of the ailments which in reality belong in the realm of the specialties while the great field of the general practice of the healing art continues to lie fallow practically neglected and certainly unnoticed.

Old Doctor Still always stressed bedside practice. He was a general practitioner. His specialty, if it could be so designated, was the diseases of men, women and children. He unerringly chose and showed to his devotees, his followers, that their greatest vantage points were to be found in the homes at the bedside of the sick. There the dominant school of medicine had failed utterly. Their secondary line of defense, the general practice of the healing art, was neglected. The field was wide open. His school of practice, Osteopathy, based upon one's ability to reason from cause to effect in terms of applied anatomy and physiology, plus skeletal integrity as a concomitant of health, supplemented with a few clinical laboratory tests met with little opposition.

His students, recruited largely from the highways and the byways of the great middle class of life, were fired by an almost religious zeal in the concept of their chosen path. They were eager, enthusiastic, militant disciples who regarded no therapeutic problem as unsailable and whose only demand was to be led to it. Pathological conditions, long considered incurable by the old school were met and overcome. Therapeutic enthusiasm was the order of the day. On the medical side of the deadening effects of a very frank and influential pessimistic nihilism threw its blight upon the rank and file of its followers.

Then the machine age of diagnosis had its inception. It was enthusiastically received. It was the long looked for panacea, the development of which would prove to be the "open sesame" for the cure of all disease. Group practice came crowding close on its heels and the entire healing art was stamped

into its acceptance, and the hegira toward the medical practice of today was on.

Osteopathic practice naturally entails physical labor. It limits the number of patients the doctor can see and treat as compared with his prescription writing brother. But the percentage of his cures is much higher and his results more quickly attained than his aforesaid brother physician.

In spite of this, the osteopathic profession swallowed specialistic trends and group practices with as much avidity as a young robin swallowing a June bug.

Dr. Still's two great aphorisms are as true today as they were in 1874. They will always occupy the major place in the arch of healing as long as time shall last. It will be as Enobarbus declared of Cleopatra in Shakespeare's "Antony and Cleopatra," "Age cannot wither her, nor custom stale her infinite variety."

Osteopathic fundamentals are here to stay but in what capacity remains to be seen. Will the osteopathic school of practice continue to develop along the lines foreseen by the "Old Doctor" or will it become a tail to the medical therapeutic kite with all the circumscriptions implied therein?

We, who are carrying on, must accept full responsibility!

Psi Sigma Alpha

The Senior Banquet was held by the Beta Chapter of the Psi Sigma Alpha Society of the Kansas City College of Osteopathy and Surgery for its graduating members at the Savoy Grill on March 2, 1949, at 7:00 p.m.

Outstanding speakers highlighted the evening's entertainment. Dr. G. N. Gillum of Kansas City, Missouri, was Master of Ceremonies and Dr. Byron Laycock of Des Moines, Iowa, Guest Speaker.

The banquet was held in honor of the following seniors graduating members who were presented certificates of Life Membership in the Psi Sigma Alpha by President J. Clement Keef:

Clayton H. Morgan, Detroit, Michigan.
Russell T. Brown, Kansas City, Missouri.

William A. Tomayko, Cleveland, Ohio.
Michael A. Calabrese, Erie Pennsylvania.

Francis A. James, Kansas City, Missouri.

The presence of a number of the Alumni greatly contributed to the evening's enjoyment.



JAMES A. DI RENNA, D.O.

1949 Alumni Meeting of the Kansas City College of Osteopathy and Surgery

The meeting this year was a marked success with Dr. James A. DiRenna presiding. The following program was carried out:

- APRIL 12, 1949
10:00 A.M.—1:00 P.M. Registration at the Administration Building, Kansas City College of Osteopathy and Surgery. Pre-Child Health Conference registration may be done at the same time.
1:00 P.M.—2:00 P.M. Free luncheon in the College Cafeteria.
2:00 P.M.—3:00 P.M. Business meeting, Kaiser Hall on the Campus; Dr. James A. DiRenna, Pres.
3:00 P.M.—5:00 P.M. Educational Films, Kaiser Hall.
8:00 P.M.—Little Theater, Municipal Auditorium. Lecture, "Painless Childbirth," Julian Lansing Mines III, D.O.
WEDNESDAY EVENING, APRIL 13, 1949
7:00 P.M. Alumni Banquet and business meeting was held at the Hotel Continental. The highlight of this meeting was the election of Dr. Howard Baldwin of Tulsa, Oklahoma, as President of 1949-50. A special entertainment which was put on for the guest laides was greatly appreciated by all persons who attended.

Uterine Cancer

F. J. CHASE, D.O.

Department of Pathology
Art Centre Hospital

Cancer is the second most frequent cause of death in this country today. No effort is too great to expend in an attempt to gain control of this death-dealing mechanism.

We have come a long way in learning WHY a cancer develops, HOW to prevent certain types of cancer, and WHAT to do in the way of treatment. The word "discouragement" must not appear in our lexicon, if we are to emerge triumphant in our battle with this terrifying scourge.

Our discussion will deal with those malignancies affecting the female uterus. We will enumerate the various factors which may contribute to the development of uterine pregnancy, differentiate malignant from non-malignant lesions, and suggest methods of investigation, now available to all practitioners, whereby that most important phase of control and cure—early diagnosis—may become a reality.

As a basis of explanation, two factors are concerned primarily in the production of cancer: the intrinsic factor—peculiarities and properties found within the cell itself; and the extrinsic factor, or those environmental influences affecting the cells from without.

Examples of the former influence are found in cases of malignant melanoma, neurogenic sarcoma, teratoma, and the like. Our major concern, however, must rest with the extrinsic factors, for we do have at our command certain means to change or greatly influence the environment of a cell, and thus, its effect upon the organisms as a whole. We can do little, in actual practice, to vary the cell's natural inherent characteristics.

Virus infections, chronic irritations, avitaminosis, hormonal imbalances, over-exposure to radio and actinic rays—in short, continued trauma—play a most important part in the production of cancer. These influences, met with in everyday practice, must be carefully searched out and eradicated.

Everything that has been said of cancer in general applies, of course, to cancer of the uterus. And when we speak of "uterus" we refer to the total organ—cervi and body, or fundus. Cancer of the cervix constitutes about 90% of the malignancies affecting the organ,

while the uterus proper is invaded in 10% of cases.

It has been stated that extrinsic factors, especially long continued irritations, apparently have a definite bearing upon the development of malignant lesions. The cervix is subjected to certain traumatic insults which, allowed to continue their effects, might be carcinogenic. Probably the commonest of these, and one with which we are all familiar, is cervicitis—an acute or chronic irritation the result of infections, injuries received during child birth or surgical procedures, excessive estrogenic influence, and others. This condition allows a break to occur in the protecting squamous epithelium covering the vaginal portion of the cervix and the much softer glandular epithelium of the endocervix. A persistence of this irritation at the junction of the squamous and glandular epithelium promotes the development of a "precancerous" lesion.

The age of the patient, and her history of parity and surgical procedures have a strong bearing upon a presumptive diagnosis of malignancy. The majority of cervical carcinomas begin in women who have borne children and who are between the ages of 30 and 36 years. Any lesion whose origin can be traced even remotely to childbirth or to a surgical procedure involving the cervix must be suspected.

Certain signs must be considered in attempting to differentiate a malignant from non-malignant lesion. Chief among these are bleeding from the cervix, particularly after coitus, an enlargement of the organ, the appearance of cauliflower growths projecting from the os, and a sense of increased hardness on palpation. Any one of these findings should make one suspect a developing squamous-type carcinoma, and further diagnostic procedures must be instituted. This latter precaution is most essential, since too often cancer of the cervix offers no visible diagnostic signs—and chronic cervicitis offers too many!

Available to the clinician are a number of methods intended to further the diagnosis of malignancy, or to differentiate the malignant from the non-malignant. Biopsy of the suspected area, for microscopical examination, is probably the most satisfactory, providing that such a biopsy is properly taken and properly preserved for study. It is our opinion that specimens obtained by electric cautery, as so frequently performed in the office, are most unsatisfactory. In a section taken in this manner, coag-

ulation may "cook" the secretion contained in the superficial glands and will burn the surface squamous epithelium. A specimen removed by this method may be so dried that proper sections cannot be made, or, if able to be made, the microscopic appearance may confuse the pathologist by its resemblance to the adeno-acanthoma or adenocarcinoma. Or an existing carcinoma may be overlooked in such a slide, and a diagnosis given which is equivalent to the signing of the patient's death warrant.

A wedge of tissues which includes portions of the squamous covering, the endocervical glands and the deeper stroma is by far the best biopsy material. This wedge is easily obtained by removing a small triangle of flesh from the os, as in cauterization, but using a sharp No. 11 Bard-Parker or similar blade. If bleeding is a problem, the cut surface may be seared with a hot cautery AFTER the specimen has been obtained.

It can be appreciated that such a piece of tissue will include that part of the cervix in which malignancy first makes its appearance—the area about the junction of the squamous-glandular epithelium. The size of such a section is sufficient to prevent its curling and twisting, and satisfactory sections for study will result. A report upon such a biopsy can be made with far greater certainty.

Another method of obtaining material for a diagnosis of cervical malignancy is that developed by Papanicolaou and other workers, in which cell-containing secretions from the cervical os, the vaginal tract and the cul-de-sac are stained and studied. By this procedure, the earliest malignant changes often can be demonstrated, in many cases even before visible evidence is apparent in the organ. The method is most satisfactory, providing the material for study is obtained properly. A full description of the technic should be obtained from your pathologist before this procedure is undertaken.

Specimens may be obtained by curettage of the uterine canal, in cases where differential diagnosis of endometrial lesions is indicated. Inasmuch as the endometrium, at certain stages of menstrual development, may simulate cancer, it is advisable to obtain a portion of the myometrium immediately underlying the endometrium, since evidence of myometrial invasion may be the deciding factor in a diagnosis of endocarcinoma. Although cancer of the endometrium constitutes but 10% of the total malignancies affecting the uterus

as a whole, it does occur with sufficient frequency to make this procedure indicated.

A rather rare find, and one in which exact symptoms are usually lacking, may be discovered at surgery during the performance of a hysterectomy. This is the uterine sarcoma, or sarcomatous degeneration of a previously existing and formerly benign myofibroma. Since it is seldom that such a malignancy is diagnosed before surgery, it shall not be discussed here.

We have attempted to discuss, rather briefly, those few signs which vouch safe a clinician in his effort to diagnose uterine cancer. No signs are certain; all signs are suggestive and warrant further careful investigation. The female patient who chooses you as her physician, places her complete, blind faith in your ability, and in your honest intention to work in her behalf. She places her life in your hands. At no time can you ignore that trust, and least of all if her condition is one involving the uterus. Your best efforts—and those of your consultants—are not too much to expend, if we in the profession of the healing arts are to reduce the incidence of—and perhaps, eventually, to eliminate—that second greatest of all disease processes to which the human body may succumb—cancer.

Footnote: This article is reprinted from the *Osteopathic Bulletin* with the permission of the author.

Faculty & Staff Committees March, 1949

1. Interne:
DiRenna, Chairman, 3 years
Swift, 1 year
Davis, 2 years
2. Program:
Zima, Chairman, 1 year
Morgan, 2 years
Margaret Jones, 3 years
3. Records:
Hoskins, Chairman, 2 years
Cook, 1 year
Steinberg, 3 years
4. Ways and Means:
Nagel
Dean Peach
Davis
5. Grievance:
Geiger
Scott
Zammer, Chairman
Hubbard
Price
8. Prof. Qual. (Ex. Com. elects 5)
1. M. Jones, Chairman

Diagnostic and Therapeutic Considerations in the Cardio-Vascular-Renal Syndrome

A CASE HISTORY

By Robert W. Shelby

Editor's Note: This case history was submitted by Mr. Robert W. Shelby in partial fulfillment of the requirements for Pharmacology V in the Department of Physiology and Pharmacology of the Kansas City College of Osteopathy and Surgery.

Mr. W. entered the out-patient clinic on 1/9/48 presenting a chief complaint of "high blood pressure." He described the symptoms a vague "sickness" in his head, dysphasia, retardation in mental processes, and a violent itching in his ears. The sick sensation in his head was described as not an ache or pain, nor was it vertigo either subjective or objective. He likened it to the nausea one feels in the stomach, only situated in his head. The sensation did not occupy any certain cranial areas but was general and diffuse. This sensation was not constant but occurred in "spells" which were irregular in periodicity and duration. They had begun four years previously following an illness of unknown and undeterminable nature—the onset was gradual and the symptoms had been moderately progressive to this time. During the sick spells, the patient experiences mental symptoms described as an inability to concentrate and the feeling that ideas are elusive. Speech is difficult to a slight degree all the time but this is exaggerated during the sick periods and is described as a thick and inflexible feeling of the tongue. No pain was present in connection with this difficulty and lingual motion was in no way disturbing to the patient.

Inventory by Systems

The patient was a white male, sixty-five years of age who appeared well nourished and not acutely or chronically ill. He was medium obese in build and had no gross deformities and exhibited no gross abnormalities of posture or gait. The face was flushed giving him a ruddy appearance. He was wearing glasses which had recently been prescribed and checked and were satisfactory to him. His temperature was 98.8, his pulse 96, respirations 16, and blood pressure 198/168. His head and neck were negative for physical findings and

extra-cranial history. He was wearing complete upper dentures and partial lowers which he said were ill-fitting and frequently fell out. When the upper plate was removed, a perforation about the size of a bean could be seen in the central-midline of the hard palate. Transillumination showed that it communicated with the nasal cavity floor and was well epithelialized with no evidence of inflammation at its circumference. He gave a history of a foul tasting sore in that area several years ago which had left the perforation in its wake.

His respiratory history is negative and examination uncovers no irregularities. The rib cage is intact and asymmetrical with no restriction in excursion.

Auscultation of the heart discloses that both sounds are loud in all areas. There was a murmur, systolic in time, at the mitral valve area and a snapping second sound in the pulmonary valve area. The PMI was dominant and located in the 6th interspace about 12 cm from the midline, well outside of the mid-clavicular line.

The patient relates a history of occasional bouts of flatulence and pain in the epigastrium which immediately follow meals. This is not severe enough to cause any dietary restrictions. He denies any nausea, emesis, or icterous. He attests the presence of hemorrhoids and an extra-departmental examination was not done at this time. The abdomen was convex, no palpable masses or areas of tenderness were demonstrated, there were no herniae, varicosities, dermal irregularities, or lymphadenopathies seen.

The urinary inventory discloses nocturia of two to three times nightly and three to four micturations daily. An examination of the external genitalia was negative.

The neuro-muscular inventory uncovered a stiffness of the entire right side which followed a stroke two years previously. Examination could uncover no flaccidity, spasticity, or atrophy. The tongue did not deviate when protruded, the facial movements were symmetrical, the right grip was weakened, and the right knee jerk was exaggerated. A negative Romberg but a doubtful Babinsky were seen. The pupils were equal and accommodated to light and distance normally. An otoscopy was done at this time and large amounts of discolored and hardened cerumen were seen. An extra-departmental fundiscopy was done with negative findings.

This man had no occupational hazards, could not recall his childhood diseases, and had never had surgery or been injured. His father had died at the age

of 45 with a stroke and his mother had died at 65 from unknown reasons.

The Clinic Specialty departments contribute the following: Urology-Surgery: Occasional nocturia, no recommendations. EENT: external canal cerumen, hypertrophied tonsils, palate perforation, left antrum block, choric-retinitis. Recommended a recheck in one month. Proctology: external hemorrhoids, slight protusion, some cryptitis. Recommend surgery. Orthopedics: normal findings. No recommendation.

The Laboratory findings were:

Blood—4,500,000	8 Juveniles
RBC	2 Stabs
6,800 WBC	35 Segs
104% Hb	51 Lymphs
	1 Mono

Urine—straw color, clear character, ph 6.7.

SG—1.009	WBC—2 to 3
Albumin negative	RBC—occasional
Sugar negative	Ep Cells—20
	Casts—1 fatty,
	1 hyaline
	Bacteria—slight
	Mucous threads

An EKG was done and the following impression reported:

This is an abnormal record. The electrocardiographic findings are consistent with the presence of a marked left ventricular strain.

Clinical Course:

A diagnosis of hypertension and hemorrhoids was made and the following therapeutic regime advanced:

- (1) Nitranital — Phenobarbital tabs grs ¼ tid
- (2) General Osteopathic Treatment —Relaxation
- (3) Rectal Surgery

The patient reported to the clinic three times weekly when the operator would apply general soft tissue and correct the upper thoracic and cervical lesions that were usually present but inconstant. Deep steady pressure was applied to the first three thoracics for a period of five minutes. The nitranital was supplied him in 24 tablet amounts.

The patient did not respond to this treatment at all. His blood pressure climbed steadily with each clinic visit and on January 15 reached a peak of 240/130. On January 26 the cranial symptoms became suddenly exaggerated and a house call was paid the patient who was in bed but recovered. It was not thought that another stroke was threatening—his blood pressure was 230/110 at this time. Two days later he came to the clinic for the last time and received his OT and had his ears cleaned again. His blood pressure measured

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220/108 at this time. He did not appear at the time of his next appointment and has not been in the clinic since. I have communicated with him several times by telephone and he has moved from doctor to doctor, has taken several mail-order courses in self-healing, and is now receiving manipulations from a doctor of chiropractic. I chanced to see this man on November 2 when he reported to me that his blood pressure had been brought down to normal. I could not help register surprise which he interpreted as doubt and challenged me to measure it for myself. Overcome by curiosity, I did—his BP was 267/127. I did not tell him the reading and he departed still believing as he did.

Summary, Discussion and Conclusions

A person in this stage of the CVR syndrome and exhibiting such momentum of the syndrome is certainly not the ideal patient to entertain in the free clinic. The proper diagnosis and differentiation between the hypertensive diseases is an expensive proposition and the therapy is non-specific and patient-dependent so that a person seeking aid at a free clinic is seldom inclined to make such an investment. We obviously did not succeed in this case and perhaps an explanation, not an alibi, is in order.

What if this man could afford all the time and money asked of him—what could have been done and how would the case have shaped up then?

This man should be placed in the hospital for a one week period and be subjected to laboratory and diagnostic procedures to determine the source of the hypertension, evaluate his endocrine and psychic status, regulate his diet, make therapeutic drug trials, and evaluate the prognosis.

I should, first of all, like to run a PsP through ureteral catheters and a mesothelial concentration test to see the extent of the nephrosclerosis that is undoubtedly attending this disease. Cystoscopic and IV pyelography could cast more light in this direction. For at least the first three days bed rest should be enforced and the BP measured every hour to determine the effect of activity. A sedimentation rate would be of great value to indicate a search for septic foci or tumefaction and to indicate the activity. Serial NPN determinations should be done to warn of an impending uremia. Competent psychotherapy should be given this patient because I have no doubt that an anxiety neurosis is one of the major aggravating factors. A closer evaluation of the cardiac status should be done and a

prognosis registered and decompensation therapy considered. I should like to see a capillary fragility test performed, although there is no doubt in my mind that the vascular system is pathological, and Ruten therapy given if indicated. Amassed, this data would tell us why this man is hypertensive and about where he is in the CVR syndrome, and, what system we could expect to give way first. As this case stands at present, we can only theorize as to etiology and station. I believe that the hypertension began as an extra-renal essential condition which has caused the cardio-renal pathology and I think that the blood pressure is out of proportion to the renal damage. The cardiac conditions is probably the most benign of the lesions as it is still asymptomatic.

The management of the ideal case should consist of a broad and general regimen which should be enforced to the letter. I would include the following:

1. Reduced activity—at least ten hours of sleep each day.
2. Reduced fluid intake and a salt-free diet.
3. Diet regulation so as to reduce protein and obesity and be as palatable as possible.
4. Psychotherapy and environmental harmony.
5. Measure fluid output—diuretics if indicated.
6. Hypotensive chemotherapy—using the drug of choice as determined by therapeutic trials.
7. Cardiac management—digitalization of decompensation threatens. Advice on acute congestive heart failure and a supply of codeine sulfate and nitroglycerine present at all time.
8. Symptomatic treatment—analgesia and sedation.
9. Frequent manipulative treatments.

One can see that even the ideal management is not specific and is just a therapeutic shotgun hoping that one pellet will score a hit. At best, the CVR disease is extremely awkward to manage and the results are oft times very discouraging.

In the case of Mr. W., who cannot and would not subscribe to all of the outlined measures, perhaps he has found what is best for him. He has been convinced that a miraculous cure has been performed on him and his anxiety is tremendously improved. This certainly can contribute to his organic as well as psychic betterment, but the last observation does not indicate any slowing down in the organic phase of his problem.

The prognosis in this case is very un-

favorable. Since one cerebral vascular accident prepares the way for another one, I hazard the opinion that the case will terminate in this manner. The time factor is dependent largely upon his activity but the accident can be expected at any time.

Announcement of Residences in Internal Medicine

The Department of Internal Medicine of the Kansas City College of Osteopathy announces residency openings for two residents in Internal Medicine for a period of two years. The requirements for certification in Internal Medicine are as follows as determined by the American Osteopathic Board of Internal Medicine:

"Section 1. To be eligible to receive a certificate of specialization from the American Osteopathic Board of Internal Medicine the candidate must meet all of the following minimum requirements, excepting as provided in Section 2 of this Article:

- "a) He must be a graduate of an approved osteopathic college.
- "b) He must be licensed to practice in the state or territory where he conducts his specialty practice.
- "c) He must have been a member in good standing of the American Osteopathic Association and of his state or divisional society for a continuous period of at least three years immediately prior to application for examination by this Board.
- "d) He must have satisfactorily completed an internship of at least one year in a hospital approved for intern training by the American Osteopathic Association or under exceptional circumstances other equivalent institutional training satisfactory to this Board. If graduated in 1942 or prior thereto, the applicant must have had experience and/or training of value equivalent to that of an acceptable internship as determined by this Board.
- "e) He must be able to show evidence of conformity to the standards set in the Code of Ethics of the American Osteopathic Association.
- "f) A period of not less than three years of training related to the specialty shall be required, after the required one year intern-

ship or its equivalent, but not necessarily immediately following the internship nor running three consecutive years, except that in the case of applicants who graduated prior to 1946, this Board may modify the requirement of three years specialty training, by allowing a credit of one year of specialty training for each five years of specialty practice for a total credit of not to exceed two years of the requirement, but in no case may such applicant graduated in 1946 or subsequent thereto be accepted for examination without at least one year of specialty training."

The training is a rounded course and follows that which is outlined by the American Osteopathic Board of Internal Medicine.

Anyone who considers himself qualified may communicate with me or Dean J. M. Peach.

G. N. GILLUM,
Chairman Department
of Practice.

17th Annual Child's Health Conference and Clinic

The 17th Annual Child's Health Conference and Clinic was held at the Municipal Auditorium, April 13-14-15. It was sponsored by the Kansas City College of Osteopathy and Surgery and the Jackson County Osteopathic Association. These organizations were assisted by other local and state osteopathic institutions and organizations. This Conference was notable because of the excellent cooperation by the various committees and organizations, its large attendance, and the quality of the exhibits.

The program was high-lighted by a number of nationally known speakers and the attendance at the various lectures was far above normal. The Conference must be considered an outstanding success and should form a basis for an even more successful one next year.

New York Gives Approval of Our College

The Department of education, State of New York, has approved the Kansas City College of Osteopathy and Surgery as a registered institution for the training of osteopathic physicians. This approval is effective as of July 1, 1948. All students graduating since that date will be recognized by the State of New York.

Kansas City College of Osteopathy and Surgery Graduation, March 11, 1949

Those receiving the degree of Doctor of Osteopathy: Russell T. Brown, Michael A. Calabrese, William T. Cooper, Francis A. James, Russell T. Land, Mary A. McClellan, Clayton H. Morgan, D. Richard Munroe, Ernest Porzsoit, Jr., John E. Scanlon, James R. Snedeker, James A. Stewart, and William A. Tomayko.

Those receiving the degree of Doctor of Science—Honorary: Arthur E. Allen, D.O., Minneapolis, Minnesota.

Dr. Allen after giving the graduation address (see page 32) was presented by Dr. C. H. Morgan, Director of Division of Graduate Education, for the conferring of the degree of Doctor of Science which was conferred upon him by President Claude Cochran.

In the past, Dr. Allen has held many positions in both his state and national organization. He was the first person to occupy the position of president-elect of the American Osteopathic Association before taking office as President in 1938. For ten years previous to his election to the presidency, he was a Trustee of the Association.

Dr. Allen has also served the Association as chairman of the following: Bureau of Public Health and Public Education; Athletics Section, at which time he planned the "Manual on the Osteopathic Care of Athletes," published by the Association; Bureau of Professional Development, and Committee on National Board of Osteopathic Examiners.

He has been a member of the Committee on Credentials, the Committee on Public Welfare, the Executive Committee, the Public Relations Committee, and the Finance Committee.

It was Dr. Allen's recommendation which started work on the standardization of specialists, and he served as a member of the committee which studied this subject. He has also held the position of Director of Research in the Association and has been a member of the Committee on Research.

Dr. Allen has held the position of President of the Minnesota State Osteopathic Association and has served as chairman of several of its committees. At present, he is vice-president of the Minneapolis Osteopathic Society.

Dr. Allen organized and drew up the constitution and by-laws for the National Board of Examiners for Osteo-

pathic Physicians and Surgeons. He was the first osteopathic physician to be a member of the Minnesota State Basic Science Board, a post which he held from 1927 until 1935. He was also a member of the Minnesota State Board of Osteopathic Examiners for three years.

Dr. Allen's other osteopathic activities include his work as trustee of the Academy of Applied Osteopathy and as a member of the Minnesota Osteopathic Clinic. He is listed in "Who's Who in America" and "Who's Who in Minnesota."

ETA Chapter of Iota Tau Sigma Reactivated

For many years Eta Chapter of Iota Tau Sigma enjoyed life and prominence on the campus of the Kansas City College of Osteopathy and Surgery, but in the latter part of 1946 the Chapter was forced to become inactive because of the war.

This winter a group of men seeking the comradeship and advantages which a fraternity has to offer approached Dr. Lee Davidson about reactivating this chapter of I.T.S. These men believed that by reactivating this chapter of I.T.S. they would have something tangible to work for and that they would leave something of their own doing to be proud of and to return when they leave Kansas City.

During rush week seven men of the Freshman class took I.T.S. as their choice. Under the energetic and enthusiastic guidance of Charles Lambert, Past-President of Alpha Chapter at Kirksville, Dr. Lee Davidson, Dr. K. J. Davis and Dr. L. S. Larimore, the chapter was quickly organized.

These seven men received their last degree on May 4 at the Hotel President. Dr. Q. L. Drennan of St. Louis, Missouri, was the principal speaker and conducted the initiation ceremonies. Dr. L. S. Larimore, Dr. John Geiger, Dr. Lee Davidson, the new Deputy for Eta Chapter, and Charles Lambert assisted in the initiation. The new initiates are Lloyd Boettger, St. Louis, Missouri; John Bullock, Seattle, Washington; Edward Feber, Cortland, Ohio; J. P. Fiest, Lawrence, Kansas; Tom Mitchell, Hollis, Oklahoma; D. L. Smith and R. W. Stuart, both of Tulsa, Oklahoma.

All I.T.S. men are looking forward to the I.T.S. banquet at the National Convention in July. The banquet will be held July 12, 7:00 p.m., in the Statler Hotel, St. Louis, Missouri.