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 of fistula.

Fistula of the terminal portion of the alimentary tract with its complicating abscesses formed 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 have 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. If no other opening could be found, it was convenient to say that the case was “blind fistula.” The term was simply refer to it as an “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. Fistulas and peri-anal “abscesses” were “lanced.” It is an old story to a Proctologist for a patient to tell of having had several anal “bolts” lanced.

It is now generally conceded that well over 90% if all proctologic fistulas have their origin within a drainage 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 form within the mucosa and the papillae or it may close the crypt with the development of a nodule from which the fistulous process extends.

II. Extension of the infection from the primary infection of the involved crypt. The extension may be in 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 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...
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 complicated 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 directed 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 of fistula surgery under local infiltration type of anesthesia, but according to proctologists in posterior quadrant, the primary site of crypts, and disease in the lateral perianal area occurs almost anywhere in the lateral perianal area.
Fig. 2.—Diagram of Nerve Supply to Anus and Perianal Areas

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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, reference to either the iris or to the retina 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, the danger of converting a convergent strabismus 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 heterophoria. In many instances, it is of considerable degree. Therefore, complete lenotropes are no longer done, but partial lenotropes are of value.

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

ALTERNATING ESOTROPIA

In the alternating type of congenital 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 present in alternating esotropia. In most cases the refractive error is so moderate that it can in no way be considered as a cause. In all cases the condition is best considered, from 2 to 4 diopters. Unequal errors are rare. On the whole, refractive errors play an indifferent role. Amblyopia may be present. Amblyopia consists in the transmission of a defective fusion faculty. The precipitating factors such as fatigue, illness, and other factors which are observed so frequently in monocular squint are not observed so often in alternating esotropia. As a rule, the condition is not annoyed by c Hillopia and never comes to the advice of the patient.

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A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted. A hyperphoria, if present, should be noted.
Phenobarbital tablets or prescribing a half pint of an elixir at a time in the private mess, may cause a failure of giving painless death to any member of the family who in a moment of depression feels it is necessary for his or her problem. We should remember that such a prescription, while it may be a help to the patient, may also be a passport to the hereafter. It is also wise to make a notation on this prescription even though they are not placed as refillable in the regulations. 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 drug combinations that can be substituted for drugs that can be substituted for, in the human cranial. It looks as though the only way we can have intelligence is to be born with the proper biological equipment. Glutamic acid has been used experimentally to increase human intelligence. Some authorities report 20 percent increase in intelligence, but the majority of them report a failure to improve IQ.

One of our acquaintances told me the other day that he had 7,500 hogs to provide sufficient pancreases to make one ounce of insulin. This is something for the diabetics, I thought.

Reading in the history of medicine, we find that bottles filled with vinegar were once used by physicians as "Antiseptic bottles." Before entering the sick room, the doctor took a small cork from the bottle to protect him from contamination while he was in the room. 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 native endeavor to cure asthma by taking a fish, or worming their intestines into its mouth, the idea being that the fish would leave the patient and pass to the fish. Who ever heard of an asthmatic fish?

Announcement of Residency

In Neuropsychiatry

The Department of Neuropsychiatry of the Kansas City College of Osteopathy and Surgery announces one Fellowship opening for the academic 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 speciality practice in the field of choice.
5. Membership in the A.O.A. and your state association for three years prior to the examination.
6. A personality conducive to the practice of the specialty.

A school teacher, on a bus, smiled and puzzled by the evidence of recognition.

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KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY
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 the College Journal, official organ of the Kansas City College of Osteopathy and Surgery, Vol. 6, January 1907 and entitled—"The 1904 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 other than what is in the College Journal. 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 Registration and Registration. Later on he returned to Kansas City, Missouri, and re-identified himself with the Central College of Osteopathy. During a part of this period he established a law practice in the circulation of osteopathic information which he edited and published in Liberty, Missouri. Its existence was short.

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

Dr. Kaiser was a school man, a natural. He knew intimately of school problems and needs. He was able to postulate in advance exigencies in management 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 educational 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 the school. 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 grew into swelling 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 "Lakside Review of the Osteopathic Practice" 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 wisely it grew to carry osteopathic literature of known address.

From the Hudson Bay to the Gulf of Mexico and from coast to coast the College Journal was read in England, France, Australia, China, Japan and Mexico. This was another of Dr. Kaiser's ideals, the aim of which was the rank and file of the osteopathic practitioners everywhere.

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

By

ARTHUR E. AMB, D.O., Sc.D.

Commencement Exercises of the Kansas City College of Osteopathy and Surgery

March 11, 1949

A CHASM, VOAD 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 my signal honor to be invited to address you, a group of seniors who are about to receive the degree of Doctor of Osteopathy, an honor that honors you 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 previously been given to others. And, also, challenges have a way of becoming discouraging if one must accept too many.

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 how you are going to locate, or how you are going to get those new clothes so that you can look down the sheen granite wall. It is a signal honor to be invited to make use freely of the chasm which he had completed, and the bridge was finally ready for use. You can not pass across this bridge. You can not pass down the bridge. 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 without waiting longer, he started to cross the bridge. But this bridge did not collapse, it did not even sway. Calling them from the far side to come and help, but when no one dared to do so, with a farewell wave of his hand he resolutely set foot upon the chasm, and the endless 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 strengthen it. All in crossing the path, testing each foothold, each handhold with the greatest care, he finally reached the bottom safely. As he might, no one should be found to scale the opposite cliff, and so he made up his mind to build a bridge.

By this time, it had begun to attract the attention of some of those who had left behind. He called upon them, told them of his plan and urged them to come and help. Not only did they refuse to take the risk of the climb down the sheer granite wall but they laughed at him. Their foolishness was insignificant, and if he could have had his way back with them and taught them better developed. So he set about his task alone.

First he cleared away the sand and rubble, dead branches, all of the refuse which littered the bottom of the chasm until he found solid granite for his foundations. Then stone by stone he selected material without a flaw, pilings the other, binding them firmly in place with a cement of his own making. No weakness could be permitted in 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 censure, to discourage but to dishearten, to discourage, not to praise but to disparage. Yet the work went on. Painstakingly stone by stone the bridge was built, piers, abutments, and arches were completed, and the bridge was finally ready for use.

Speaking now to the gathering throng, this man made a determination to invite them to make use freely of the bridge which he had completed, but the拱s, arches, and:)r after, and in- results. 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 without waiting longer, he started to cross the bridge. But this bridge did not collapse, it did not even sway. Calling them from the far side to come and help, but when no one dared to do so, with a farewell wave of his hand he resolutely set foot upon the chasm, and the endless horizons which his faith, his labor, and his vision had made possible.

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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. 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 ability to implement a 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 you will not be able to contribute for the specialist as well as for the general practitioner more gratifying results and will yield the best and most complete care presently known to the modern therapeutic world.

The Osteopathic profession is a dynamic, forward looking profession of earnest, sincere, intelligent men and women. Solely by their own efforts, the Still brothers have created the profession of osteopathic medicine and have built up the profession in a short period of time. This was accomplished solely through their vision, their effort, and a highly specialized skill, peculiar to them alone, has been developed.

The results they have secured through this method of diagnosis and treatment have changed public thinking, public acceptance, and opposition, to growing interest, approval and support. Even the school of medical professionals, which has existed the existence of the Osteopathic spinal lesion and are now seeking to develop methods of structural adjustment for their own use. We may be proud that you are becoming members of such a profession.

You will not be envied 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. Your reputation within your career what you will. The purpose of the Osteopathic profession is immense and it is your duty to know your individual growth. And so tonight our profession welcomes you to membership in its ranks and urges you to join with it immediately in the ever increasing work of widening and strengthening, so that those who follow may safely cross the chasm, vast, and deep, to new frontiers and limitless horizons, with full confidence and strength, and to perpetuate the 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 blazing 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 Hospital to which clinicians the world over came. He took a patient's case to its end so that they might sit at his feet and imbibe new ideas regarding clinical practice. John B. Murphy, M.D., became the teacher of teachers of surgery the world over. It was he who gave the specialists case history and adequate physical examination in order to elucidate the pathologic underlying the diseased conditions afflicting the patient under examination. He said many times each week in his clinical demonstrations, and even more often in his professional world, "Listen to the patient's story. She will tell you what is the matter. Your clinical judgment will depend upon your clinical ability together with your acuity in physical diagnosis, to determine the pathological manifestations indicated by the clinical story, and then Murphy would operate!" Defly, quickly, with an assurance born of unbounded experience. As he worked, he would lay open the field of operation, exposing the pathology showing the lesion, and described it to his audience now tensely awaiting the culmination of his dissection. It was at these dramatic amphitheatres of Mercy Hospital, where seated 500 spectators, one or even less, but while Murphy worked except when impelled by distraction.

In 1905 Jacques Loeb, Professor of Biology at the University of Chicago, made the following prophetic observation: "The oxidases may in time be able to control disease as the artist governs the keys of the piano. Not merely the normal life of the body but also that vast gamut of diseases characterized by metabolic derangements might be controlled if we, he declared, "will favor or retard the action of the oxidases."

Then came Charles E. deM. Sajour, M.D., who, through research and work, "The Internal Secretions and the Principles of Medicine," postulated the pituitary, the thyroid gland and the adrenals glands as the test organ of the body. The pituitary body being the test organ of the blood, the thyroid gland and the adrenals glands which secretion, poured into the venous blood stream, imparted its affinity for oxygen.

Open January 19, 1907, at Leeds, England, Mr. A. H. Brampton in his Presidential address before the Post-graduate School of Medicine and West Ridg- ing Medical-Logical Association said respecting the practice of medicine: "Scepticism is in the air. Even in this society, if a practice were to introduce a subject bearing on medical treatment, it has been with an apologetic air and humble admission that known medicine did not have the utility of drugs in the treatment of disease, they would be subjected to the handicaps and interferences, viz., the Natural Immunity of the Tissue and Skeletal Integrity as the Con-
After the first world war specialization in practice of the healing art, received its first great impetus. Surgery, naturally, became the helmsman 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 jigsaw puzzle, and attempting to fit them together to make a diagnosis. The case history, which should be sequential and designed to bring out an organized important clinical facts, fell from its position of importance and became a conglomerate of unrelated clinical facts more resembling an inventory than anything else. Certainly it was nothing upon which a 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 practice under the conditions with the means taught to them in their courses in school. They were compelled to adapt to the conditions in the hospital, laboratory and specialist advantages available. Far too many of them, trained only to obtain entrance to standardized hospitals, were practically compelled to refer the most lucrative portions of their practice to the specialist chairs which dominate such institutions.

The trend now is reversed after a fashion. How? Certainly, but not for more than a week, passes without urgent appeals appearing in the press counseling young doctors to locate in the small cities. At least once in a week an article appears in one or more of our metropolitan journals announcing the building of a modern of cities.

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

In spite of this, the osteopathic profession with its specialized 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, as the osteopathic school of practice continue to develop along the lines foreseen by the "Old Doctor" or will it remain the medical therapeutic kife with the many encroachments implied therein? The student carrying on, must accept full responsibility!

P.S: The Alumni Banquet was held in 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. Tomonyko, 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.

JAMES A. DI RENNA, D.O.

KANSAS CITY COLLEGE OF OSTEOPATHY AND SURGERY
Cancer is the second most frequent cause of death in this country today. No effort on the part of clinicians in an attempt to gain control of this death-dealing mechanism. We have come a long way in learning Ways and Means: of cervix. We cannot overlook the above-mentioned possibilities, or to differentiate the malignancy from the non-malignant. Of the cervix, the appearance of cauliflower growths projecting from the os, and a sensation of increased discharge and irritation. Any one of these findings should make one suspect a developing squamous cell carcinoma. This latter precaution is most essential, since too often the only 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 malignancy from the non-malignant. Biopsy of the suspected area, and especially when a clinical examination fails to reveal any evidence of a neoplasm. A speculum examination is indicated. Inasmuch as the endometrium, at certain stages of menstrual development, may simulate cancer, it is advisable to obtain a portion of the endometrium immediately underlying the endometrium, since evidence of malignancy may be the only visible diagnostic sign. In a section taken in this manner, conglulation may "cook" the secretion containing the superficial islands and wills. It has been stated that extrinsic factors, especially long continued irritation, are apparently the prime causative factors leading to the development of malignant lesions. The cervix is subjected to certain traumatic influences, and if allowed to continue their effects, might result in a malignant process. Probably the commonest of these, and one with which we are all familiar, is cervical irritation-the result of infections, injuries received during childbirth or surgical procedures, or from other causes. These factors, in and of themselves, may have a strong bearing upon a presumptive diagnosis of cancer of the endocervix. The persistent irritation at the junction of squamous and glandular epithelium promotes the development of a "precancerous" lesion. The age of the patient, and her history of parity and surgical procedures, now available to all practitioners, whereby that most important phase of control and cure—early diagnosis—may become effective. As a basis of explanation, two factors are concerned primarily in the production of cancer: the extrinsic factors peculiarity and properties found within the cell itself; and the extrinsic factors, or environmental influences affecting the cells from without. Examples of the former influence are found in cases of malignant melanoma, neurofibrosarcoma, and the like. Our major concern, however, must rest with the extrinsic factors, for we have learned that such influences may change or greatly influence the environment of a cell, and thus, its effect upon the organism 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, overexposure to radio and actinic rays—in short, anyone of these may 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 cervix. And when we speak of "uterus" we refer to the total organ—cervix, body, and fundus. Cancer of the cervix constitutes about 90% of the malignancies affecting the organ, while the uterus proper is invaded in 10% of cases. 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 diagnostic procedures. A 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 the clinician afford to fail to make one suspect a malignancy, or to differentiate cancerous processes from those 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 February 24, 1949

1. Internes: DiRenna, Chairman, 3 years
   Swift, 1 year
   Davis, 2 years

2. Program: Zima, Chairman, 1 year
   Morgan, 2 years
   Mertens-Joachim, 3 years

3. Records: Houskins, Chairman, 2 years
   Greiner, 1 year
   Steinberg, 3 years

4. Ways and Means:
   Nagel, Dean Peach
   Davis, 2 years
   Greiner, 1 year

5. Publicity: Geiger
   Scott
   Zimpel, Chairman
   Hubbard
   Price

6. Prof. Qual. (Ex. Com. elects 5)
   1. J. Jones, Chairman
   2. 3. 4. 5.
Diagnostic and Therapeutic Considerations in the Cardio-Vascular-Kidney Syndrome

A CASE HISTORY

By Robert W. Shelby

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

Mr. W. entered the out-patient clinic on 1/19/48 presenting a chief complaint of "high blood pressure." He described the symptoms a vague "sickness" in his head, dizziness, retardation in mental processes, and a violent itching in his ears. The site in his head was described as not an ache or pain, nor was it vertigo either subjective or objective. He likened it to the sensation one feels in the stomach, only situated in his head. The sensation did not occupy any certain area, and it 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 nature and all associated 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 indistinct feeling of the tongue. No pain was present in connection with the sick periods and an extra-departmental examination uncovers no irregularities, or lymphadenopathies seen. The urinary inventory discloses no evidence of albuminuria. 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 warrant any dietary restrictions. He denies any nausea, emesis, or icterus.

The patient was a white male, sixty years of age. His history was submitted by Mr. Robert W. Shelby in partial fulfillment of the requirements for Pharmacology II in the Department of Physiology and Pharmacology of the Kansas City College of Osteopathic Medicine.

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Announcement of Residences in Internal Medicine

The Department of Internal Medicine of the Kansas City College of Osteopathy and Surgery announces residency openings for two residents in Internal Medicine for a period of at least one year beginning July 1, 1946. 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, as executed in the provision of Section 2 of this Article:

(a) He must be a graduate of an 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 of the American Osteopathic Association and any other local or state osteopathic institutions and organizations.
(d) He must have satisfactorily completed at least three years of the requirements, but not more than a period of five years, except in the case of a person who graduated prior to 1946, and who may have been retrained in the field of medicine.
(e) He must pass an examination without at least one year of experience from the American Osteopathic Association.
(f) He must have had experience and/or training of value equivalent to that of an acceptable internship as determined by this Board.

"Section 2. The above requirements may be modified by this Board to the extent deemed necessary to suit the educational needs of the applicant.

"Section 3. The above requirements may be modified by this Board to the extent deemed necessary to suit the educational needs of the applicant.

"Section 4. The above requirements may be modified by this Board to the extent deemed necessary to suit the educational needs of the applicant.

"Section 5. The above requirements may be modified by this Board to the extent deemed necessary to suit the educational needs of the applicant.

"Section 6. The above requirements may be modified by this Board to the extent deemed necessary to suit the educational needs of the applicant.

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

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


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 Osteopathic 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.