-RESTRICTED-

VOL III-NO 11

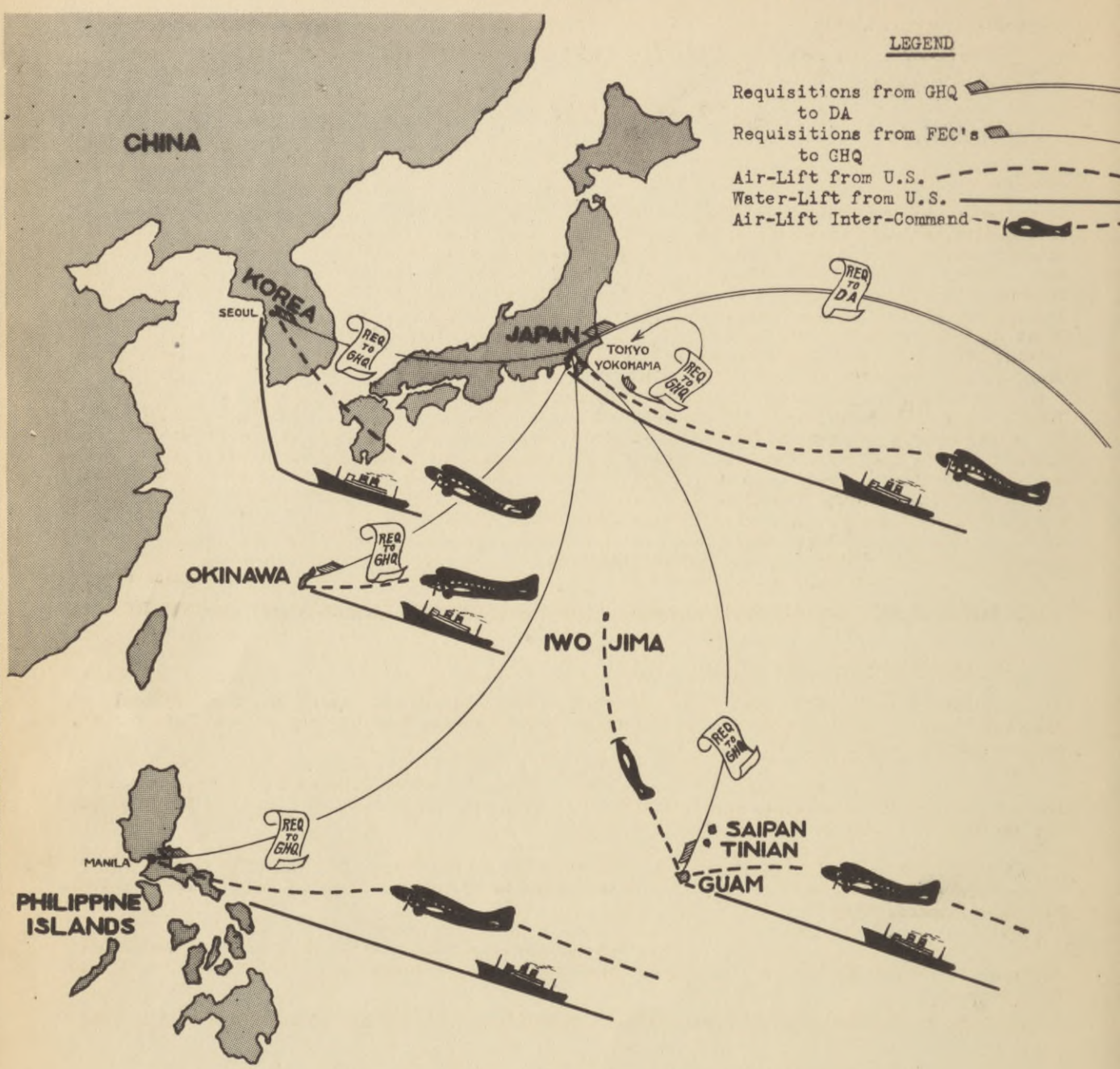
SURGEON'S CIRCULAR LETTER

1 NOV 1948

MED SEC GHQ FEC

-RESTRICTED-

PIPE LINES FOR MEDICAL DEPARTMENT PERSONNEL, FEC



Medical Department personnel (officers on a five-month and enlisted on a three-month basis) are requisitioned monthly from The Adjutant General, Washington, D.C., for direct shipment to the various major commands within the theater, dependent upon the personnel needs as forseen at time of compilation of requisition.

Upon arrival at major commands within the Far East Command personnel are screened by representatives of the Surgeon's Section concerned, and are assigned according to their qualifications.

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER APO 500

NUMBER. . . . . .11 1 November 1948

PART I

ADMINISTRATIVE

SUBJECT SECTION

I. Organization of the Medical Section

Departures. Major John V. Painter, MSC, Chief, Supply and Fiscal Division, Medical Section, General Headquarters, Far East Command, completed his tour of duty and has left for his new assignment in the zone of interior.

Major Sam A. Plemmons, MSC, Deputy Director, Personnel Division, Medical Section, General Headquarters, Far East Command, completed his tour of duty and has left for his new assignment in the zone of interior.

Arrival in Medical Section. Colonel Melville A. Sanderson, DC, formerly with Headquarters, Eighth Army, has been assigned as Dental Consultant, Medical Section, General Headquarters, Far East Command.

Lt. Colonel Harlan H. Taylor, MC, arrived from the zone of interior to assume the duties of Surgical Consultant, Medical Section, General Headquarters, Far East Command.

II. Shortage of Medical Personnel

The severe shortage of Medical Department personnel is one of the most critical problems confronting the Army today. As the Army expands, it will become even more serious. At the present time, the Medical Corps is operating with only 80% of the personnel it requires, and by the end of February it will be down to 78% with a further marked reduction prior to June 1949.

At the present time the Army is dependent on procuring medical personnel by means of the

draft from men between the ages of 19 and 26, and from voluntary offers of assistance from the American Medical Association, the American Dental Society, and other professional groups.

The most economical use must be made of doctors and dentists. Information published by the Office of The Surgeon General states that "they will not be utilized for any purpose other than that of professional care of personnel; the numbers serving on boards will be reduced to the bare minimum; and only necessary physical examinations will be given." All commanders are urged to make the best use of this scarce personnel under their command, and to insure that they are used only for types of work which require trained personnel.

However, by the end of June 1949, the Medical Department plans to substantially increase its officer strength.

As a basis of accomplishing this aim is the likelihood of introducing before the special session of Congress new legislation to secure adequate medical personnel for the Armed Forces.

While no official word has been given as yet, it is anticipated that legislation may call for active military service of doctors who received their medical training during the war under the auspices of the Army and the Navy Programs, and who have not previously served on active duty.

III. Women's Medical Specialist Corps

As an inducement to secure additional personnel, the Army has lifted the requirement of prior military service for young women seeking commissions as dietitians, physical therapists, or occupational specialists. Applicants must be under 28 at the time of commissioning, unmarried, and physically qualified for general duty. The first will be commissioned in the Reserve Corps and may apply for appointment in the Regular Army after 6 months of extended active duty. Those wishing to apply should write to the Office of The Surgeon General, Department of the Army, Washington 25, D.C., Attn: Chief, Women's Medical Specialist Corps.

IV. Medical Service Corps Vacancies

There are upward of five hundred vacancies in the Medical Service Corps in the grades of first lieutenant and captain. An urgent requirement exists for personnel trained in supply, administration, pharmacy, optometry, sanitary engineering, entomology, parasitology, bacteriology, psychology, nutrition, and psychiatric social work. It is suggested that personnel bring this information to the attention of their friends in the service or in the Reserve or who formerly held commissions. Further inquiries by those interested should be directed to The Surgeon General, The Pentagon, Washington 25, D.C.

V. Parachute Duty Physical

The Army Medical Department has published certain changes in physical examinations for parachute duty. Under the provisions of the new change, disqualifying defects are: weight - less than 120 lbs.; visual acuity - distant uncorrected vision less than 20/60 in either eye; feet - symptomatic pes planus; or a medical history of recurrent acute or chronic sinusitis. (Change No. 5, to AR 40-100)

VI. Rescinding SGO Streptomycin Report No. 34

The following is a copy of a letter sent to Army General Hospitals authorizing the rescinding of the requirement for submitting SGO Streptomycin Report Form No. 34:

"1. Reference is made to letter from this office of 7 January 1948 entitled 'Streptomycin.'

"2. Subject letter is rescinded insofar as paragraph 1b, 'Submission of Clinical Histories,' is concerned. Since sufficient information on streptomycin has been compiled, it is no longer necessary to fill out and transmit to this office the SGO Streptomycin Report Form No. 34. However, this form may be used locally if desired."

VII. Eight Ills Added to VA's List

Eight tropical diseases have been added to Veterans Administration's list of ailments which war veterans may be assumed to have caught in service.

Those added are loiasis, black water fever as a complication of malaria, onchoceriasis, oroya fever, dracontiasis, pinta, plague and yellow fever.

Already on the list were yaws, leprosy, dysentery, filiarisis, leischmaniasis, malaria and schistosomiasis.

VIII. Initial Distribution of Professional Medical Films, FEC

Initial distribution of the following professional medical film is being made available to installations in the Far East Command:

PMF 5087 - Neurorrhaphy of Ulnar; Neurolysis of Median In Arms (running time 10 minutes, 3 - 16mm print).

Distribution of the film is made in accordance with recommendations from the Office of The Surgeon General, for showings to interested medical personnel.

IX. Changes in Prevention and Control of Communicable Diseases of Man and Immunization of Typhoid - Paratyphoid Vaccine

Pending revision of AR 40-210, 25 April 1945, paragraph 10d (2) of those regulations is changed to read as follows: (Reference DA Cir 228, 2 Aug 48.)

"Typhoid Fever and Paratyphoid Fever. - Revaccination of all personnel will consist of a single stimulating dose of triple typhoid vaccine. Personnel referred to in paragraph 9 a and b will be revaccinated annually except as provided in paragraph 9 f. If there is a record of an initial series of three doses of triple typhoid vaccine having been given at any time, no further initial three-dose series need be given."

Pending revision of TB MED 114, 28 February 1947, paragraph 6 b of that bulletin is changed to read as follows: (Reference DA Cir 228, 2 Aug 48.)

"b. METHOD OF VACCINATION.

(1) The initial vaccination consists of a subcutaneous injection of three 0.5 cubic centimeter doses of the triple vaccine administered at intervals of 7 to 28 days. In order to insure accuracy, a syringe of 5-cubic centimeter capacity or less will be used. Care will be taken to make the injections into the superficial subcutaneous tissue.

(2) Revaccination or stimulating doses are accomplished by -

(a) The subcutaneous administration of 0.5 cubic centimeter of the triple vaccine annually.

(b) Intracutaneous administration of 0.1 cubic centimeter of the triple vaccine annually. This procedure may be used as an alternate if accomplished by a medical officer who is experienced in the technique of intracutaneous administration."

X. Inactivation of Medical Depot, Binghamton, N.Y.

The Medical Department at Binghamton, N. Y., has been placed on inactive status. The Depot comprising 120 acres of government land has been transferred from the jurisdiction of The Surgeon General to that of the Chief of Engineers.

XI. White Uniforms for Nurses and Women Specialists

The return to the wearing of a white uniform in hospitals by Army nurses and members of the Women's Medical Specialist Corps has been authorized. The new uniform is an improvement over that formerly worn. The white cap is of the same design worn with the present brown and white seersucker uniform. Because these uniforms will not be available through Quartermaster channels until 1 July 1949, their wear is not made mandatory until that date. They should, however, soon be available through civil manufacturers and distributors of uniforms, and until 1 July 1949 their wear is optional.

XII. White Coats for Medical Officers

Port Medical Supply Information Letter No. 606 published by the Office of The Surgeon General contains the information that The Surgeon General feels that medical officers in hospitals should ordinarily wear white coats while on duty. Accordingly attention is invited to the following items which are available for issue:

Stock No.	Nomenclature
7-159-005	Coat, Ward, Clinic and Laboratory Officers, Extra Large
7-159-010	Coat, Ward, Clinic and Laboratory Officers, Large
7-159-015	Coat, Ward, Clinic and Laboratory Officers, Medium
7-159-020	Coat, Ward, Clinic and Laboratory Officers, Small

XIII. Newly Standardized Items

Port Medical Supply Information Letter No. 608 published by the Office of The Surgeon General contains the information that T/A is being revised to include the following allowances for Stock No. 9-597-050, Tool Kit, Maintenance and Repair, Medical Department:

1 per Medical Equipment Maintenance Officer (4890)
1 per Medical Equipment Repairman (1229)

This port letter will be authorization to issue Stock No. 9-597-050 on the above basis pending publication of revised T/A-20.

XIV. Fibrin Foam and Thrombin, Human

The dating period for Fibrin Foam and Thrombin, Human (Medical Item 1-604-785) has been established by the National Institute of Health to be 3 years from the date of manufacture. This represents an extension of 1 year over the period formerly set. Accordingly, authority is given to use Fibrin Foam and Thrombin, Human, now in stock with expiration dates in 1947 and 1948, for 1 year after the stated expiration date.

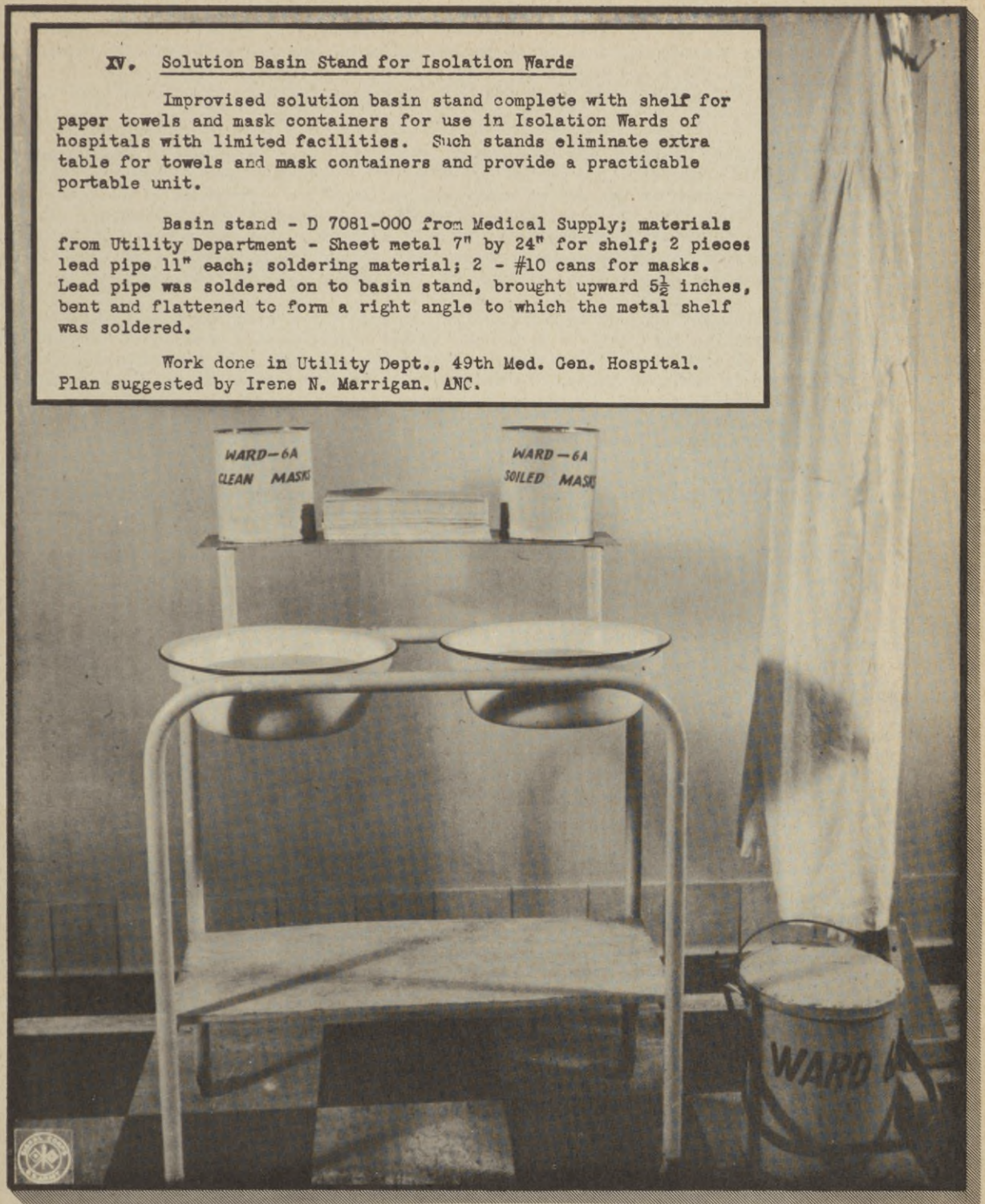
Fibrin Foam and Thrombin, Human, bearing expiration dates later than 1948 will not be used beyond the dates shown, since such dates will represent the maximum permissible expiration period. (Reference DA Cir 273, 9 September 48, Sect IV.)

XV. Solution Basin Stand for Isolation Wards

Improvised solution basin stand complete with shelf for paper towels and mask containers for use in Isolation Wards of hospitals with limited facilities. Such stands eliminate extra table for towels and mask containers and provide a practicable portable unit.

Basin stand - D 7081-000 from Medical Supply; materials from Utility Department - Sheet metal 7" by 24" for shelf; 2 pieces lead pipe 11" each; soldering material; 2 - #10 cans for masks. Lead pipe was soldered on to basin stand, brought upward 5½ inches, bent and flattened to form a right angle to which the metal shelf was soldered.

Work done in Utility Dept., 49th Med. Gen. Hospital. Plan suggested by Irene N. Marrigan, ANC.



XVI. Chest for Dental Operating, Set, Field

The following is the substance of advice received from The Surgeon General in reply to query by the Surgeon, Eighth Army, requesting verification as to whether the quantity of one (1) each item 9-141-625, Chest, Field, 28" long by 16¼" wide by 14½" deep, Empty; is correct, as it is not believed that one (1) chest of the above dimensions will hold all of the published components as listed in the new JAN Catalog of Medical Materiel under item 9-180-100, Dental Operating Set, Field, No. 60; since many bulk items such as Motor Dental Engine, each one (1); and Lamp, Dental Operating, Field Type, each two (2), have been added as components of subject item:

"The Medical Research and Development Board, SGO, and personnel of the Dental Division desire that the components now listed for Stock No. 9-180-100 Dental Operating Set, Field, Number 60, be furnished in the set of equipment and supplies. However, it is agreed that it is questionable as to whether the chest will accommodate all components now listed. The Louisville Medical Depot has therefore been requested to pack a chest, using the present list of components, and forward prompt information and recommendations in connection with findings. It may develop that two (2) smaller chests or a supplementary container will be necessary.

"A development project to standardize a complete new item has been undertaken. For this reason, no specific instructions have been issued regarding the packing of subject item with the present list of components. It is now believed the new item will not be available prior to 30 June 1949 and it is realized that it is necessary to adopt a practical method for packing Dental Operating Set, Field, No. 60, in the event the presently required chest will not accommodate the listed components.

"Advice upon receipt of reply from the Louisville Medical Depot will be furnished."

XVII. Recent Department of the Army and FEC Publications

AR 150-5, C 4, 10 Sep 48, Par 17, "Enlisted Reserve"

AR 615-367, 13 Sep 48, "Enlisted Personnel - Discharge"; par 7 - "Effect of Disability upon Resignation"

CIR 216, DA, 19 Jul 48, Sec IV, "Army - Navy Catalog, Medical Materiel" - "Standard Price Supplement"

CIR 217, DA, 21 Jul 48, Sec VII, "Organized Reserve Corps, Except General Officers" - Pertaining to Medical Corps Reserve

CIR 218, DA, 22 Jul 48, "Army Safety Program - Accident Reporting Procedure" - Certain parts pertaining to Medical Department

CIR 222, DA, 27 Jul 48, Sec I, "AR 35-2020" - Pay & Allowances of Army Nurses and Other Female Personnel of the Medical Department - Rescinded Sec VIII, "Rescission - T/BA 8, 15 Jul 42"

CIR 225, DA, 29 Jul 48, Sec III, "Officers and Warrant Officers of the Army of the United States without Component" - Hospitalized

CIR 226, DA, 30 Jul 48, Sec VI, "Rescission" - Several ASF Catalogs of MED-7 Series

CIR 228, DA, 2 Aug 48, Sec I, "AR 40-210" - Changed. Sec II, "TB MED 114, Immunization" - Changed

CIR 231, DA, 3 Aug 48, Sec I, "Character Guidance" - Pertaining to Venereal Disease

CIR 234, DA, 5 Aug 48, "Application by Medical Officers for Certification as Specialists by Interim Board of Preventive Medicine"

CIR 240, DA, 10 Aug 48, Sec II, "Advancement on the Retired List" - Amends AR 40-20 and 40-25.

CIR 254, DA, 19 Aug 48, Sec II, "Officers" - Chaplain, Medical and Dental Corps; Sec IV, pars 1 and 2, Pertaining to Medical Publications

CIR 259, DA, 23 Aug 48, Sec I, "AR 40-21, Army Nurses Commissioned in the AUS - Rescinded"

CIR 264, DA, 27 Aug 48, Sec V, "Circular", pars 1 and 2 pertaining to Medical Department

CIR 265, DA, 25 Aug 48, Sec IV, "Officer Candidate School" - par 8 DA Cir 136, 1948, amended, pertaining to Physical Qualifications; Sec V, "Rescission"

CIR 267, DA, 30 Aug 48, "Restrictions on Issue of Rodenticide Sodium Monofluoracetate"

CIR 273, DA, 9 Sep 48, Sec IV, "Fibrin Foam and Thrombin, Human (Medical Item 1-604-785)"

CIR 279, DA, 14 Sep 48, "Disposition of Exposed X-Ray Films", Rescinds par 1 b, DA Cir 35, 1948

MEMO 305-15-10, DA, 15 Jul 48, "List of Recurring Reports Authorized for Preparation" - page 34, Medical Department

MEMO 600-900-1, DA, 4 Aug 48, "Character Guidance Program"

MEMO 305-15-10, C-1, DA, 6 Aug 48, "List of Recurring Reports Authorized for Preparation" - page 34, Medical Department

MEMO 700-38-1, DA, 9 Aug 48, "Replacement Factors Test - Notice of Change in Use (Reports Control Symbol CSGSP-188)" - par 3 a, "Medical Items"

MEMO 40-1705-2, DA, 13 Aug 48, "Responsibility for Hospital and Similar Medical Assemblages"

MEMO 30-2205-1, DA, 23 Aug 48, par 5 d, "Food Service Program - Installation Food Service Report"

T/O&E 8-16N, C-1, 9 Aug 48, "Headquarters and Headquarters Company, Medical Battalion"

T/O&E 8-76N, C-1, 9 Aug 48, "Headquarters and Headquarters Company, Armored Medical Battalion"

T/O&E 8-16N, C-1, 9 Aug 48, "Clearing Company, Medical Battalion"

T/O&E 8-77N, C-1, 9 Aug 48, "Company, Armored Medical Battalion"

T/A 11-100-8, 30 Jul 48, "Allowances of Signal Corps Expendable Supplies for Medical Department Activities and General Hospitals

CIR 27, GHQ, SCAP, 13 Aug 48, "Control of Entry and Exit of Individuals, Aircraft and Surface Vessels into and from Japan" - par 3 c, amended pertaining to Medical Examinations

PART II

TECHNICAL

XVIII. Professional Consultants Reports, FEC: Amos R. Koontz, M.D., Consultant in General Surgery; Lenox D. Baker, M.D., Professor of Orthopedic Surgery, Duke University

Extract from letter of Amos R. Koontz, M.D., Consultant in General Surgery, to The Surgeon General, dated 2 September 1948, on his recent visit to the Far East Command:

"In only three of the hospitals visited were there senior surgeons

present as Chiefs of the Surgical Service. One of these was away at the time of my visit. The other two were doing excellent work, were conducting their services well, and were giving proper instruction to the younger men on their services."

"In the other hospitals the Surgical Services were being conducted by young men with only one or two years hospital training after graduation from medical school before entering the service. These youngsters were doing excellent work considering their limited training. They realized their limitations, were anxious to take advantage of every opportunity to learn, and were careful not to go beyond their depths surgically speaking. Their morale was excellent, and the encouraging thing about them was that they had not begun to feel that they "knew it all" simply because they had been given responsibilities somewhat beyond their training and maturity. A great many of these men will make excellent surgeons some day. When the proper opportunity presented itself, I encouraged them to stay in the service and take their training in it."

Extract from letter of Lenox D. Baker, M.D., Professor of Orthopedic Surgery, Duke University, dated 16 September 1948, on his recent visit to the Far East Command:

"First, I want to say that on the whole I saw an excellent orthopedic program in practically every hospital visited. This was particularly true of those stations in Japan proper and in Korea. All in all, I thought the men were handling their fracture cases more efficiently and with better results than I have seen in hospitals in the States. I want to take this opportunity to specially commend Colonel Peterson in Osaka; Colonel Hakala at the 49th; Colonel Ward in Korea; Colonel Cox at Clark Field; Colonel Gaines at the 10th General in Manila, and Colonel Boyce in Kyoto."

"With rare exception I have nothing but praise for the orthopedic work that is being done. The principles of fracture treatment are being carried out in an excellent manner and the patients are getting close personal supervision. On the whole, I felt that if the work demonstrated was being done in our clinic that I would be proud of our service. In two of the hospitals I felt that too much traction was being used. This was bringing about distraction of the fragments. . . . . ."

XIX. General Surgical Seminar Conducted at the 49th Medical General Hospital, Tokyo, Japan. Comments were made by Dr. Amos Koontz, Civilian General Surgical Consultant

Case #1: "Regional Ileitis"

Patient presented who was operated upon with a pre-operative diagnosis of acute appendicitis. At operation a regional ileitis was found involving the terminal ileum and cecum. The appendix was not removed and the abdomen was closed.

Question:

Dr. Koontz, how would you have handled this case? What is your concept of regional ileitis? What is the treatment? When in your opinion is surgical interference indicated in regional ileitis?

Answer:

Every surgeon has encountered this same situation. More often tenderness on physical examination is closer to the midline than at McBurney's point. If I find ileitis, I close the abdomen as you did in this case. Some surgeons do not. Some surgeons do a resection. I do not think this is a good procedure. Some of these cases will clear up if left alone. No one knows the cause of regional ileitis. There is no specific treatment. The only treatment is resection if you have to do it. I believe it advisable to see if the disease will clear up. If it does not, one prepares the patient for colon surgery and performs the operation with much less danger. When you do resection you will have to perform an ileo-transverse colostomy if terminal ileum is involved. Ileitis is sometimes apparent on x-ray through the "string-sign". I have seen cases in which one resects the bowel involved to find later that it occurs at some other segment higher up. This is another reason for conservative treatment in this condition. If the cecum is not

involved in the regional ileitis I remove the appendix so that you are not confronted with this possibility when patient has recurrent abdominal pain. I had a case similar to this one presented in which the distal 9 inches of ileum was involved. I did not take out the appendix in this case for fear of fecal fistula postoperatively which you mentioned.

Case #2: "Appendicial Abscess". "Postoperative Ruptured Appendix Cases".

Patient presented who was admitted with a large appendicial abscess in whom a barium enema was performed at another hospital and diagnosed as carcinoma of the ascending colon. Three cases of post-operative ruptured appendicitis were also presented.

Question:

Dr. Koontz, what are the operative indications for interference in appendicial abscesses. We have had several appendicial abscesses transferred into this hospital in the past year and in each instance the abscess has resolved under chemotherapy and Levine Suction, the latter being used to place the bowel at rest.

Answer:

The use of the Levine Tube and Wangeensteen Suction has made the practice of surgery much simpler. Ten years ago, we used drains for an abscessed appendix. I think that Dr. John Finney of Baltimore stopped draining the peritoneal cavity fifteen years ago. He pointed out that any peritoneal drain was sealed off within a few hours. The drain does not drain the peritoneal cavity. Years ago before Wangeensteen Suction and chemotherapy these individuals would "blow-up" and die from peritonitis secondary to ileus. The Wagensteen Suction keeps the bowel in good tonus by keeping the gas out. I was happy to hear that you use chromic catgut and not silk in all cases of ruptured appendicitis that have been operated upon. You invite trouble if you use silk in a contaminated wound.

Case #3: "Perforated Peptic (Duodenal) Ulcer, Three Hours Duration".

Case presented of a young soldier with classical history and physical findings included pneumoperitoneum indicating perforated peptic ulcer, operated upon within three hours of the perforation.

Question:

Dr. Koontz, will you discuss briefly your opinion of surgical vs medical treatment of perforated peptic ulcer?

Answer:

About a year ago an article was published that brought out figures regarding mortality in operated perforated peptic ulcer. The figures from most of the clinics all over the world showed a 25% mortality. In England, however, the figure was an 8% mortality. These figures must be approximately right but one does not get that impression from personal experience. Dr. Lane of the Marine Hospital reported a series of 47 cases in which he had treated perforated peptic ulcer by non-operative methods with only one death, a mortality of about 2%. In all of his cases he used the Levine Tube, continuous suction, parenteral fluids, transfusions etc., until the ulcer healed. Dr. Lane pointed out that very often when you operate upon perforated peptic ulcers you find fibrin closing the perforation so that you have to remove the fibrin before you close the perforation. His only complications were localized pelvic abscesses. Dr. Lane's figures are certainly better than operative methods and I am inclined to think that if you get a perforated ulcer which has been ruptured for 12 hours or longer that non-operative treatment is the best.

Question:

Dr. Koontz, would you operate a perforated peptic ulcer if received early, that is less than 12 hours old?

Answer:

Yes, I would.

Case #4: "Volvulus Ileo-Cecal Area". "Volvulus Rectosigmoid Area".

Two cases presented. One, a two year old child in whom there was a fibrous band from an old emphalomesenteric duct with incomplete volvulus of the ileum, cecum and ascending colon. Two, a soldier, age 35, in whom there was a volvulus of the recto-sigmoid area with infarction and early gangrene.

Question:

Dr. Koontz, I have presented two cases of volvulus, one involving the right colon and the other the left colon. What would have been your operative approach in these cases if gangrene of the bowel had occurred in both instances. In other words, how do you treat obstruction lesions of the right and left colon?

Answer:

The most common situation in a child with obstruction involving the ileal region is ileo-intussception. If the intussception cannot be reduced resection with side to side anastomosis of ileum to ascending colon is what I would do. In the volvulus involving the recto-sigmoid I would do just what you have done. Resection anastomosis is not good for left colon. Colostomy is procedure of choice.

Case #5: "Postoperative Gastric Resection for Gastric Ulcer".

An important civilian radar expert of the air corps presented who had a persistent gastric ulcer that did not respond to conservative medical treatment. A subtotal, 3/4 gastric resection, with short afferent loop was performed at this hospital.

Question:

Dr. Koontz, what is your opinion regarding surgical exploration in all cases of gastric ulcer that do not respond to medical treatment within a reasonable period of time?

Answer:

What to do with duodenal ulcer is quite simple. Everyone has agreed that it is better to try medical treatment before resection unless there is obstruction. The treatment of the gastric ulcer is different. The incidence of carcinoma in gastric ulcer is higher, in duodenal it is practically nil. At a recent surgical conference a paper was presented in which the doctor showed that if you have an ulcer as big as a fifty cent piece, the chances of it being malignant are high, if size of a twenty-five cent piece, percentage of malignancy less and if size of ten cent piece still less. Apparently if the gastric ulcer is small the chances of it being malignant is slight. In a recent comparison of operative figures on both duodenal and gastric ulcer I was shocked at the mortality rate. The over-all mortality rate for partial resection is about 3% if performed for gastric ulcer. If performed for gastric and/or duodenal ulcer the mortality rate is about 8%. In this comparison the cases were operated upon by everyone, all types of cases, and variable techniques. If you get a small gastric ulcer you are certainly justified in using medical treatment. Most ulcers occur on the lesser curvature and are less malignant in this area. Gastric resection is by no means necessarily safe procedure and must not be undertaken lightly.

Question:

Dr. Koontz, what is your opinion of vagotomy?

Answer:

Of course, you have all heard of Dr. Dragstedt and his work. He is so sure that vagotomy is the answer. He made a talk about a year ago and his opening statement was: "In a few years, the operation of partial gastrectomy for peptic ulcer will be of historical interest only." He performs vagotomy for gastric and duodenal ulcer. He has made the statement that gastric ulcers heal up in a very short time following vagotomy, and the duodenal ulcer takes a longer time to heal. The operation certainly does give relief from ulcer pain. It is a simple procedure to do especially transabdominally. At a meeting in Quebec, Dr. Kolp of New York pre-

sented a paper on partial resection plus vagotomy for peptic ulcer. It sounds like a logical procedure. One of the complications you get following vagotomy is silent perforation. Dr. Walters of Mayo Clinic claims in about 10% of cases you can get all of the fibers of the vagus from the abdominal approach. Most surgeons disagree with this. The abdominal approach is the method of choice.

Case #6: "Duodenal Diverticulum".

Patient was that of a white female, with recurrent attacks of nausea, indigestion, and abdominal pain. X-ray examination showed a small diverticulum, diameter 1 cm. in second portion of the duodenum.

Question:

Dr. Koontz, it is my opinion that duodenal diverticulae rarely cause symptoms. Am I correct? What are the indications for operative interference and what is the surgical approach?

Answer:

Certain types of duodenal diverticulae are symptomless. Most of them are congenital and the patient has had them all of their lives. When pain occurs, as a rule, there is some change in the diverticulum - an ulcer, a torsion of the diverticulum, malignancy in the diverticulum, etc. I think it is important in these cases to examine the stools for occult blood. This patient is suggestive of possible regional ileitis. I think she should be very carefully studied before operative interference is attempted for diverticulum. I do not believe her diverticulum is causing her symptoms.

Case #7: "Hypertrophic Pyloric Stenosis".

Patient presented was a 49 year old white female with symptoms of gastric retention, vomiting, and loss of appetite. X-ray GI series is very suggestive of hypertrophic pyloric stenosis.

Question:

Dr. Koontz, will you discuss the surgical treatment of this condition?

Answer:

X-ray picture is suggestive of hypertrophic pyloric stenosis. There is the "umbrella picture". The Heinike-Mikulicz operation will allow you to explore the stomach and take a biopsy to rule out malignancy. By this procedure you can explore the stomach and if negative the incision can be repaired transversely relieving the obstruction. Dr. Finney pyloroplasty (Sub-pyloric gastro-duodenostomy) although not used in recent years is another method of treating this patient and relieving the obstruction. In this latter method the only difficulty is that the duodenum must be mobilized and one cannot always do this. With the Finney procedure you can see the inside of the pylorous. This condition occurs more in females, about 4 to 1. I have seen this case with Colonel Anderson and the method of operation will depend upon what is found at operation. A partial gastrectomy, posterior gastroenterostomy, Heinike-Mikulicz operation or Finney pyloroplasty must be considered. Scirrhous carcinoma, pre-pyloric cannot be ruled out. This patient has a palpable mass in the pyloric region. I do not see why you cannot palpate a hypertrophied pylorous in an adult just as in a child. There are some who say it cannot be palpated in the adult.

Case #8: "Persistent Intractable Diarrhea, Following Ileosigmoidostomy".

A 28 year old white female was presented who was operated upon for an ovarian cyst, while in college, developed fecal fistula, had bowel resection and ileo-sigmoidostomy for unknown reason. She has gained 15 pounds on Varco diet and liver shots.

Question:

Dr. Koontz, you have seen the x-rays in this case and there is a definite anastomosis of small bowel to sigmoid. What would you do in an operative way?

Answer:

It sounds like loose stools are the result of ileal contents being dumped into the sigmoid. It might be worthwhile to try pectomate product to solidify the stools. Pectate will take the water out of stools. We use it when ilcostomics are required to reduce the number of liquid stools. If you operate I expect that you will have great difficulty with many intestinal adhesions. I would continue treating her conservatively as you have been doing first. You may have to operate and detach ileum from sigmoid.

XX. Compilation of Army Regulations and Other Directives Pertaining to Department of the Army's Policy in the Elimination of Inapt and Unadjustable Enlisted Personnel, by 1st Lt. James W. Keenan, MSC, Clinical Psychologist, 28th Station Hospital, Neuropsychiatric Section *

The problem of a high disability rate from psychiatric disorders is often considered to be of importance only during periods of active combat. This belief is entirely erroneous. The experience with armies of occupation after the last war clearly demonstrated that the rate of occurrence of psychiatric disorders was approximately 40% higher 10 months after the armistice than it had been during the peak combat period. There is every reason to believe that this same difficulty is occurring in the present widespread occupation forces, and for this reason it is imperative that every possible counter measure be taken by command to prevent the repetition of this experience.

Malingering, correctly defined, is the intentional, calculated attempt to produce or simulate illness or injury for the purpose of evading duty or responsibility. Therefore, in its true form, it is an act or behavior which is entirely conscious and premeditated. Numerous behavior disorders arise as the result of unconscious (nonvolitional)motivational factors, which cannot be controlled by the individual's conscious mind or will. The differentiation between normal socially acceptable behavior and abnormal behavior often is explainable only upon the basis of such unconscious motivation. Many commanding officers have failed to differentiate properly between the conscious and unconscious factors involved in abnormal or asocial behavior and as a consequence they tend to consider all such behavior as conscious or "Malingering". A better understanding of the complicated structure of the personality and the significance of unconscious motivation would lead such commanding officers to agreement with the incontrovertible scientific evidence that true malingering, is relatively rare even among combat troops. A very real danger lies in the failure to differentiate the mentally ill soldier from the deliberate malingerer. Not only may gross miscarriage of justice result but also unit morale may suffer serious damage from the subsequent loss of confidence in leaders who erroneously prosecute or label mentally ill soldiers as malingerers.

Most commonly, malingering is apt to be confused with the various types of psychoneuroses. These psychoneuroses are a definite type of mental illness, psychologically dependent upon unconscious factors and beyond the individual's voluntary control. Malingering, on the other hand, is a voluntary and conscious process which is neither a medical diagnosis nor an illness. Psychoneurosis is never a type of malingering, although it is quite possible that the psychoneurotic individual may over-emphasize and consciously attempt to capitalize upon the symptoms resulting from his illness. On the basis of psychiatric knowledge and practice, all personality deviation or misbehavior may be regarded as the result of maladjustment. In the Army, however, for the sake of justice and morale, sharp distinction must be made between those individuals whose socially-abnormal ideas, emotions, and behavior are the result of illness and those individuals in whom such deviations are deliberate and voluntary. It is obvious that such distinction, involving as does medical and psychiatric considerations cannot be made adequately without proper professional advice.

There are still in the Army certain unsuitable enlisted personnel whose retention in the service hinders the development of an efficient postwar Army. Technological developments, together with the necessity of economy in expenditure of funds, require that personnel who cannot be trained economically be eliminated.

Individuals with a minimum of 3 months service who are found to be incapable of rendering useful service to the Army should be separated from the service under the provisions of AR 615-369 and should be denied the opportunity of re-enlisting. Such individuals are those who lack the minimum qualifications in terms of abilities, aptitudes, interests, and habits necessary to become

suitable soldiers. Individuals whose general mental ability is definitely below average may still render useful and faithful service, provided that their interests and habits insure proper attention to duty and adjustment to normal group activities without requiring special instruction or supervision.

Continued effort and attention will be given to the screening and elimination of inapt and unsuitable personnel, and AR 615-369 will be more generally applied wherever appropriate. Those individuals who are found to be so lacking in abilities and aptitudes as to require frequent or continued special instruction or supervision, and those individuals whose interests and habits frequently require corrective or disciplinary action, should be identified as soon as possible after enlistment and should be brought promptly before boards of officers convened under the provisions of AR 615-369 in order to avoid uneconomical use of funds and overhead personnel.

In implementing the above, action will be taken to eliminate individuals who have a minimum of 3 months of service and who have demonstrated any of the following:

a. Inaptness
b. Inability to absorb profitably further military training
c. Inability to adjust and conform to group living by - (1) repeated minor disciplinary infractions and (2) habitual intemperance or recurrent instances of other personal misconduct which affect detrimentally the performance of duty of the individual concerned and his usefulness to the service.

Low AGCT scores alone will not be considered adequate justification for discharge of individuals.

BASIC DEPARTMENT OF THE ARMY MEDICAL POLICY

Board of Medical Officers - By whom convened: purpose.-- When any officer having discharge authority believes an individual to be unfit for military duty he will convene a board of medical officers to examine critically the individual. The board of medical officers will be composed of three members if that number is present for duty; otherwise of the lesser number present for duty.

Duties of Board of medical officers.-- The board of officers will be governed by the principle that no individual will be separated from the military service because of disability if he can satisfy current minimum physical and mental standards. In interpreting evidence and regulations the board will be guided by a painstaking sensitiveness to the interests of the Government and equally to those of the individual. Questions of doubt which cannot be factually decided will be resolved in favor of the individual. In every particular the actions of the board will be complete and thorough.

In determining disposition of cases, it must be clearly understood that there are many causes for noneffectiveness other than sickness. Among these are: habits and traits of character, including psychopathic personality, as manifested by antisocial or amoral trends, criminalism, chronic alcoholism, drug addiction, pathological lying, sexual misconduct (homosexuality), in the service, inaptness, inadaptability, and enuresis when the underlying cause is mental deficiency, psychopathic personality, or lack of juvenile training. Lack of adaptability may be because of lack of physical stamina, transient personality reactions due to acute or special stresses, such as acute situational maladjustment, the character and behavior disorders of schizoid, paranoid, cyclothymic, inadequate and asocial personalities; immaturity reactions involving emotional instability, dependency or aggressive reactions, mental deficiency, apathy, misassignment, defective attitudes and unwillingness to expend effort. Those who are ineffective by reason of any of these causes will be disposed of under AR 615-368 or AR 615-369.

There has been a tendency to attribute noneffectiveness to coexistent medical defects such as flat feet, back pain, or mild psychoneurosis, when actually these defects were not in themselves significantly disabling and the primary cause noneffectiveness was nonmedical, e.g., inaptness, inadaptability, defective attitudes, etc. A medical defect does not in itself constitute adequate cause for medical discharge unless the defect in itself is genuinely disabling for military service.

When, after careful medical evaluation, including psychiatric examination, it is the medical opinion that an individual has a condition which warrants consideration for discharge under provisions of AR 615-368 or AR 615-369, and no condition is present which warrants discharge for disability, a certificate to this effect will be executed and forwarded by the psychiatrist to the

individual's commanding officer, through medical channels. The certificate will include a statement specifying and describing the nonmedical condition in detail. Coexisting medical defects which do not warrant disability discharge will not be mentioned.

The diagnosis of any type of psychoneurosis implies sickness and disability of some duration. It is not to be applied for reasons of expediency in order to effect a disposition. It will be applied only when its use is justified by the existence of a clinical picture which satisfies the criteria for psychoneurosis as established by good medical practice. The mere presence of psychoneurotic symptoms which do not significantly impar the individual's efficiency or the presence of a predisposition to psychoneurosis does not warrant the diagnosis of any type of a psychoneurosis. Such individuals if otherwise sound will be considered as having no disease.

Basic Department of the Army policy to be observed.-- A. General.-- An individual will not be discharged from the service under these regulations until it is definitely established that for any of the causes mentioned he cannot be rehabilitated to the extent where he may be expected to become a satisfactory soldier. Action will not be taken under these regulations in lieu of disciplinary action.

b. Homosexuals.

(1) Homosexual offenses are included in the criminal denunciation of Article of War 93. However, it is a concern of the Department of the Army whether the maintenance of discipline and the interests of the military establishment are best served by trial by court martial or by prompt elimination of the offender from the service under these regulations.

(2) The policy of the Department of the Army in dealing with active homosexual offenses and attempted offenses is as follows:

(a) The true or confirmed who commits a homosexual offense or attempts an offense and whose misconduct does not involve additional aggravated factors will be discharged under these regulations unless he demands trial by court martial or resists separation from the service under these regulations in which case he will be tried by court martial.

(b) If the homosexual offense or attempted offense is aggravated by other offenses, as for example, use of force or violence or commission of the act with a minor, the offender will be tried by court martial.

(3) The policy of the Department of the Army in dealing with homosexuals or personnel who it is determined have homosexual tendencies but who have not committed active homosexual offenses or attempted offenses while in the service is as follows:

(a) Enlisted personnel who are to be discharged because of homosexual tendencies, but who have not committed a homosexual offense or attempted offense while in the service, will normally be discharged as undesirable unless the individual has been on active duty over a considerable period of time and during such entire period has performed his duty in an honest and faithful manner without having committed any offense of a nature related to his homosexuality. Where these conditions exist a general discharge may as a matter of discretion be given, or an honorable discharge in cases in which the man's military record is especially meritorious.

(b) This policy should by no means be interpreted as implying that all confessed homosexuals should be discharged merely on the basis of a confession of homosexuality. There should be adequate evidence of an existing psychological maladjustment resulting from homosexual tendencies which render the individual inadaptable for military service. In those relatively rare instances where homosexual tendencies constitute symptoms of a psychiatric disorder such as psychoneurosis and psychosis, disposition should be based upon the underlying psychiatric disorder.

(4) The disposition of any particular case is left to the discretion of the officer exercising general court-martial jurisdiction thereover except as indicated in paragraph 1e(3) of AR 615-368. Nothing in these regulations will preclude bringing any homosexual to trial before a court martial if the officer exercising general court-martial jurisdiction considers that circumstances make such action essential in the interests of the military establishment.

THE PROPER USE OF MEDICAL CHANNELS:-- Some unit commanders still fail to see that proceedings under AR 615-369 are clearly an administrative problem. As an additional task falling to Medical Officers assigned to evaluate soldier material for AR 615-368 and 615-369. Too often unit commanders attempt to give the medical and the hospital the burden of proof in demonstrating inaptness in a soldier instead of demonstrating by testimony before 615-369 boards specific instances of military inefficiency. Too much emphasis is still placed on the Psychiatrists Certificate used

in lieu of proper testimony whereas this has never been the intent of Army policy. Too much is still expected of the Medical Officer in the way of supplying facts for boarding the soldier and little is supplied to him for proper evaluation. These and related duties in connection with work-up of military inefficient soldiers converts a simple matter into a complicated one especially since soldiers of this type are behavior problems. These cases demand extensive administrative attention which of necessity must be individualized and in addition is time consuming for the Ward Officer preparing the case.

The unit commander and the dispensary medical officer should collaborate in providing the essential information for proper evaluation by the psychiatrist. Such information should contain the following:

(a) Statements concerning past and present behavior of the subject soldier.
(b) His efficiency and character ratings.
(c) Any abnormalities of behavior including his habits as to the use of drugs and alcohol.
(d) When available an extract copy of his form No. 20 (Soldier's Qualification Card).

This information should be forwarded as expeditiously as possible directly to the Neuropsychiatric Section of the hospital where the Neuropsychiatric Examination is to be held. When this is promptly accomplished the unit commander would have the benefit of the following:

(a) Review of facts for use later in directing testimony at 615-369 proceedings.
(b) Positive information as to whether the case will be a fit subject for AR 615-369 proceedings or one requiring other type of management, such as transfer to another unit, change of assignment, court martial, etc.
(c) Psychiatrists Certificates made out at time the soldier is evaluated, for consideration of 615-369 board and reviewing authorities.

Administrative effort now wasted by present methods would be reduced, shortening the time required to discharge inapt soldiers to civilian life.

Procedure. -- Report required; when and by whom made. -- When an individual gives evidence of habits or traits of character (except when discharge for physical or mental conditions is indicated as provided in Sec. I, AR 615-361), including psychopathic personality types, manifested by antisocial or amoral trends, criminalism, chronic alcoholism, drug addiction, pathological lying, or sexual misconduct in the service which serve to render his retention in the service undesirable, and his rehabilitation is considered impossible after repeated attempts to accomplish same have failed (except where attempts at rehabilitation are impracticable as in confirmed drug addiction, confirmed homosexuals, etc.), his commanding officer will report the facts to the next higher commander and recommend that the individual concerned be required to appear before a board of officers convened under the authority contained herein or that he be transferred to another organization.

Board convened by commander exercising jurisdiction.-- Boards of officers convened under this authority will consist of three officers, one of whom shall be a medical officer. Care will be exercised in the selection of officers designated to serve on boards convened under this regulation to insure that:

(a) The Board is composed of experienced officers of mature judgement.
(b) The Board is composed of unbiased officers duly cognizant of applicable regulations and policies pertaining to cases of this nature.
(c) The officer making the report required by unit commander, or any intervening officer who has direct knowledge of the case is not a member of the Board.
(d) In the case of an enlisted member of the Women's Army Corps, the non-medical members of the board will include an officer of the Women's Army Corps.
(e) In cases involving psychiatric considerations, the medical member of the board will be a qualified psychiatrist, if practicable.
(f) The Board is provided a competent reporter (or stenographer).

Report required by commanding officer. -- The Commanding Officer's report will include:

(a) Name, grade, serial number, age, date of enlistment or induction, length of term for which enlisted (if applicable), and prior service.

(b) Brief statement as to reasons for the action recommended.
(c) AGCT score, and MOS.
(d) Statement as to the attempts made within the organization to make a satisfactory soldier out of the individual.
(e) Character and efficiency rating.
(f) Individual's record of trials by court martial.
(g) Record of other disciplinary action taken against the individual, including company punishment.
(h) Abstract of WD AGO Form 5 (Daily Sick Report).
(i) Report of psychiatric examiner or medical officer.
(j) Any other information pertinent in the case.

Board Procedure. --

(a) Rules of procedure and evidence - See AR 420-5.
(b) Witnesses sworn. - AR 420-5.
(c) Entitled to have counsel. - See AR 420-5.
(d) Proceeding of the board will be set forth on WD AGO Form No. 37 (Report of Proceeding of Board of Officers).

Authorized Recommendations. -- The board will recommend that the individual be under the provisions of AR 615-369:

(a) Given a WD AGO Form No. 55 (Honorable Discharge), or
(b) Given a WD AGO Form No. 53-58 (General Discharge), or
(c) Referred for consideration by a board of officers convened under AR 615-368, or
(d) Retained in the service.

A recommendation that the individual be discharged will be made when it has been shown that he cannot be developed to the extent where he may be expected to absorb military training. If it is recommended that the individual be retained in the service, a further recommendation will be made indicating the type of duty which it is believed he can perform successfully.

Only in exceptional cases will an individual being discharged under AR 615-369 be entitled to an honorable discharge and the criteria established in paragraph 1c, AR 615-360 should be used as a guide in recommending an honorable or general discharge.

In those instances where it is apparent from inconsistent entries in the service record that furnishing a General Discharge would cause an injustice to an individual who has rendered honest and faithful service over the greater period of his enlistment, discharge authorities specified in paragraph 7, AR 615-360 are authorized to deviate from the criteria in paragraph 1c, AR 615-360 and furnish such individual an honorable discharge. Likewise, where it is definitely indicated by the records that an individual is not entitled to an honorable discharge but should be furnished a general discharge, such authorities are authorized to deviate from the criteria and furnish such an individual a general discharge. Doubt in any case should be resolved in favor of the individual and an honorable discharge furnished.

Authorized recommendations. -- The board will recommend that the individual be under the provisions of AR 615-368:

(a) Given a WD AGO Form 53-59 (Undesirable Discharge), or
(b) Given a WD AGO Form 53-58 (General Discharge), or
(c) Given a WD AGO Form 55 (Honorable Discharge), or
(d) Retained in the service.

An honorable discharge may be recommended in exceptionally meritorious cases only.

A general discharge may be recommended if mitigating circumstances and the character of service rendered so warrant. Such circumstances would apply where the misconduct evidencing the undesirable habit or trait of character has been minor relative to the length of any efficient service or where there has been a reasonable effort at self-control.

When effecting a discharge of any type, discharge authorities should bear in mind the fact that the type of discharge may significantly influence the individual's civilian rights and benefits provided by law. The effects of an honorable discharge or a general discharge are identical and entitle an individual so discharged to full rights and benefits. The undesirable discharge may or may not deprive the individual of veteran's benefits and will require determination by the Veterans Administration in each individual case. A dishonorable discharge deprives the individual of all veteran's benefits and may operate to deprive him of civil rights.

CONCLUSION:--The proper evaluation and use of the administrative and medical channels for the rapid elimination of inapt, maladjusted, untrainable, and anti-social personalities will insure an alert, dependable fighting force that will be ready to fulfill its mission.

Nowhere in the regulations written or unwritten is the personal responsibility of the commander for his troops eliminated. It relies upon the commander to utilize every possible force for his leadership to insure that the moral, social, physical, mental and military standards of his men are the highest attainable.

REFERENCES

Regulations, Circulars and Directives used in compiling report:

AR 615-360	dated	14 May 47
AR 615-361	"	14 May 47
AR 615-365	"	14 May 47
AR 615-368	"	14 May 47
AR 615-369	"	14 May 47
AR 615-369 C-1	"	25 May 48
AR 420-5	"	20 May 48
WD Cir. No. 93	"	3 Apr 47
WD Cir. No. 298	"	23 Sep 45

* (ED NOTE: This "paper" will acquaint the Medical Officer with the necessary knowledge of the various types of Administrative Discharges, and give him a working knowledge of Board procedure. It will enable the field Medical Officer to better understand the various psychiatric problems that are the basis for maladjustment of enlisted men in their units.)

XXI. A Discussion of Trachoma, by Wm. C. Caccamise, Capt, MC-AUS, Public Health Officer of Chiba Prefecture, Honshu, Japan

The following paper represents an attempt to present a few of the more salient features of trachoma, a disease of the eyes that is all too prevalent in the Far East but is only very occasionally seen in the United States.

Definition: Trachoma is an infectious disease of the eyes which is caused by a filterable virus. The disease is rarely acute - usually insidiously chronic.

Pathology: The palpebral mucosa shows an increase in the lymphatic elements together with hyperemia and perivascular infiltration. There is swelling of the tarsal conjunctival papillae. In the fornices, especially the superior fornix, the mucosa forms prominent folds. These follicles consist chiefly of mononuclear cells - those in the periphery resemble plasma cells. The center of the follicle - the site of proliferation - presents large mononuclear cells and mitotic figures. There is very little stroma in the follicle.

In more advanced cases there may be pannus formation. The acute superficial trachomatous pannus presents a vascularized dense plasma cell and lymphocyte infiltration which progresses from the superior limbus downward between the corneal epithelium and Bowman's membrane. In more advanced and severe cases the connective tissue elements in the infiltration zone increase, Bowman's membrane is destroyed, and vessels and infiltrations appear within the corneal parenchyma. Epithelial ulceration may result.

The Clinical Picture: The onset of trachoma is usually a subacute or insidious one. The course

is chronic. Almost from the very onset the infection is a bilateral one.

The development of trachoma can be so insidious that often only after months or years of having been infected will the patient seek a physician - perhaps already with the complete picture of the disease. Indeed in certain individuals if corneal involvement has not occurred, the entire disease may remain unnoticed until the stage of cicatricial formation. During this latent period however the individual can spread the disease to others.

Catarrhal symptoms are directly related to the degree of follicle formation and inflammation. The upper lid may become pendulant. The palpebral skin is swollen only in very severe cases. In many cases there is conspicuous reddening and swelling of the caruncle and the plica semilunaris.

Initially the conjunctiva shows a follicle formation which is most evident in the superior fornix, moderate inflammation, and swelling of the tarsal conjunctival papillae - so-called stage I. In examining a suspected trachoma case, one must visualize the fornix areas.

Gradually the follicles become more widespread, larger in size and denser - so-called granule formation of stage II. They arrange themselves columnarly on the swollen and markedly inflammed fornix fold. The tarsal conjunctiva becomes granular and inflammed.

The follicular and granular stages may persist for years. Usually however there is a gradual diminution in the follicles, the granules, and the papillary formations together with a reduction in the swelling and injection. Cicatricial formation - so-called stage III - occurs, often with considerable contraction which may result in tarsal distortion and entropion.

Corneal involvement - pannus trachomatosus, which may be a phase of stage II or stage III - developes in approximately 50% of all untreated cases. A falciform superficial gray cloudiness progresses downward from the superior corneal border. The overlying corneal epithelium is irregular. Numerous superficial blood-vessels which develop from the adjacent conjunctival vessels enter into the formation of the pannus. Soon the pannus may cover the entire cornea. In addition to the pannus formation the cornea may show ulceration in the form of Hebert's pits.

The subjective complaints are those of photophobia, foreign body sensation, discharge, itching, burning, heaviness of lids, diminution of visual acuity, and bleparospasm.

Diagnosis: In endemic areas trachoma should be suspected in all cases of conjunctivitis. The clinical symptoms that should strongly suggest trachoma as a possible diagnosis are as follows:

a. uncomplicated follicular conjunctivitis
b. follicular conjunctivitis with cicatricial formation
c. follicular conjunctivitis with a characteristic corneal involvement

The diagnosis is confirmed when the Prowaczeki trachoma bodies are demonstrated in the conjunctival scrapings. These cytoplasmic inclusion bodies which supposedly represent aggregates of the causative virus are best demonstrated in Giemsa stained preparations.

Differential Diagnosis: The following are the more usual conditions which must be considered in the differential diagnosis of trachoma:

a. Simple Acute Conjunctivitis: Bacterial infection is the common etiological factor. The Koch-Weeks bacillus and the pneumococcus are most frequently involved. Follicle and pannus formation are not usual. Stained preparations will not show inclusion bodies.

b. Vernal conjunctivitis : In this disease papillary irregularity appears predominantly on the tarsal conjunctiva, not on the superior fornix fold. Other important points are flattened polypoid formations and a characteristic thickening of the limbus. Stained preparations will reveal many eosinophils, not the mononuclear cells and inclusion bodies of the trachoma.

Other more remote possibilities are diphtheria conjunctivitis, gonorrhoeal conjunctivitis, tuberculous conjunctivitis, swimming pool conjunctivitis, Parinaud's conjunctivitis, and reactions to eyedrops such as penicillin, atropine, etc.

Treatment: American texts most frequently make the bald statement that sulfonamides offer satisfactory therapy against trachoma - usually no further elaboration of treatment is made. Trachoma is such a rare disease in the United States that many physicians have had little clinical experience with it.

It was in an attempt to evaluate and demonstrate the efficacy of sulfadiazine in the treatment of trachoma that a series of cases were treated by this medical officer in the Eye Clinic of the Chiba Medical College. Although the total number of cases treated - 10 - is small, the results were such that certain definite impressions were obtained. Each stage of trachoma was represented. The clinical impression of trachoma was verified in these cases by demonstration of cytoplasmic inclusion bodies in Giemsa stained smears of conjunctival scrapings. Full doses of sulfadiazine by mouth were employed. Adults received 2 gms. stat. and 1 gm. q 4 h. Children received 1 gm. stat. and 0.5 gm. q 4 h. Sulfathiazole 5% ophthalmic ointment was instilled locally.

Within 24 to 72 hours after initiation of treatment there was a marked decrease in subjective symptoms. Concomitantly there was a decrease in objective symptoms - a decrease in follicle and granule size, in swelling and in inflammation. Visual acuity increased where there had been a decrease due to pannus formation.

Stage I cases - the stage of follicle formation, edema, and inflammation - showed complete response to sulfonamide therapy.

Stage II cases - the stage of marked granule formation, edema, inflammation, and beginning pannus formation - showed marked improvement but a persistence of granules, though even these decreased in both number and size.

Stage III cases - the stage of cicatrization and marked pannus formation together with the inflammation of the other two stages - responded in that there was a disappearance of congestion and edema and a moderate regression of pannus vascularity.

It is felt that sulfonamide therapy alone is the treatment of choice in stage I trachoma. In stages II and III sulfonamide therapy combined with surgical evacuation of persistent granules is indicated. Chemotherapy will eliminate the activity of the trachoma infection but will not correct irreversible pathological changes in ocular structures.

Public Health Aspects of the Trachoma Problem:

Fortunately trachoma has become a rare disease in the United States, but it remains an ubiquitous problem in Japan.

The trachoma surveys which have been carried out in Japan have revealed that 5%--10% of the population are infected with this disease. Trachoma must be a reportable disease. Infected children should not be permitted in school. Routine examination of the eyes should be done on all school children. Although the isolation of cases is not practicable, each patient should be instructed in precautions against spread of secretions of the eye to others by common use of articles. Concurrent disinfection of discharges should be carried out.

Investigation of the source of infection should be undertaken by examination of the family and intimate contacts of the patient. The use of public towels or toilet articles should be eliminated. Individuals should be informed of the importance of personal cleanliness and the avoidance of direct or indirect contact with the discharges of patients. Unhygienic habits and trachoma go hand-in-hand.

The public and the medical profession must be made to realize that the early diagnosis and the early treatment of trachoma are both of the utmost importance in any plan to eliminate this disease.

PART III - STATISTICAL

Evacuation

During the period 31 July to 27 August 1948, the following number of patients were evacuated from the several major commands:

	AIR	WATER	TOTAL
JAPAN	75*	5*	80*
KOREA	80**	1	81**
MARBO	29	3	32
PHILCOM	20	4	24
RYCOM	10	1	11

Evacuations of military personnel per thousand strength for the period 31 July to 27 August 1948 were as follows:

JAPAN	1.2
KOREA	3.0
MARBO	1.6
PHILCOM	.69
RYCOM	1.5
FEC	1.5

* Includes air evacuees from Korea ** Patients evacuated to Japan for onward Evac.

Hospitalization

1. The bed status as of 27 August 1948 was as follows:

	Total T/O Beds Auth	Total T/O Beds Establ	Total T/O Beds Occupd
JAPAN	4,450	4,428	2,237
KOREA	1,900	1,096	639
MARBO	825	525	340
PHILCOM	1,600	1,520	822
RYCOM	750	500	290
FEC	9,525	8,069	4,328

2. The percent of T/O beds and established beds occupied as of 27 August 1948 were as follows:

	Percent Auth T/O Beds Occupd	Percent of Establ Beds Occupd
JAPAN	50	51
KOREA	34	58
MARBO	41	65
PHILCOM	51	54
RYCOM	39	58
FEC	45	54

3. Admission rates per thousand troops per annum for the four (4) week period ending 27 August 1948 were as follows:

	THEATER	JAPAN	KOREA	MARBO	PHILCOM	RYCOM
All Causes	609	752	771	245	450	351
Disease	556	688	719	204	413	314
Injury	53	65	52	41	37	37
Psychiatric	19	17	35	24	11	3.7
Common Respiratory Disease	54	59	99	14	55	8.7
Influenza	.67	1.2	0	.51	.55	0
Primary Atypical Pneumonia	7.2	8.6	11	6.1	1.6	1.9
Common Diarrhea	15	4.1	55	.51	15	8.7
Bacillary Dysentery	2.3	.15	3.7	4.1	7.1	1.9
Amebic Dysentery	2.3	0	3.0	3.6	10	.62
Malaria	18	2.5	53	0	10	29
Infectious Hepatitis	3.1	2.9	5.6	.51	3.8	1.2
Mycotic Dermatoses	8.9	9.0	21	0	3.8	2.5
Rheumatic Fever	1.0	.58	.74	0	1.6	1.9
Venereal	95	130	105	22	45	77

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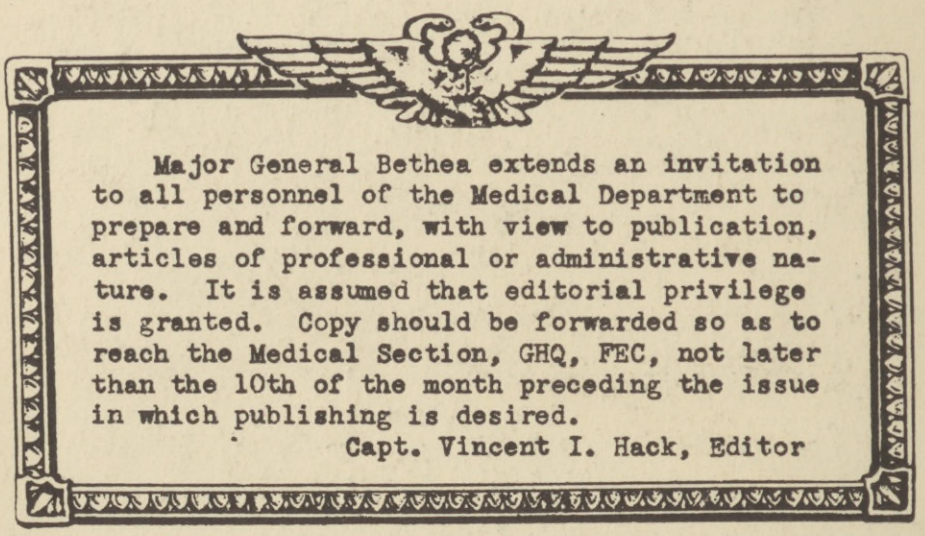

Major General Bethea extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor