



NAVY DEPARTMENT

## BUMED NEWS LETTER

a digest of timely information

Editor - Captain F. W. Farrar. (MC). U.S.N.

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Low-Sodium Diet and Free Fluid Intake in the Treatment of Congestive Heart Failure: Despite the assembly of clear-cut evidence (in laboratory and clinic) that restriction of common salt and of sodium in any form is much more important than is restriction of water in the treatment of congestive heart failure, the use in general medical practice of this therapy in effective form has been of extremely limited application.

The important factor in the successful application of this treatment in many cases is not merely the use of a low-salt diet which may contain anywhere from 3 to 6 grams of sodium chloride but the use of a low-enough-salt intake which may need to be as low as 2 grams or even less. Because a low-salt intake alters the tissue osmotic balance in favor of the elimination of fluid and salt, a low-enough-salt diet makes it possible to permit or even encourage free intake of fluids. The increase in fluid intake when accompanying an adequately lowered salt intake is handled effectively by the heart, and permits a more favorable dilution factor through the kidneys. Low-enough-salt and free fluid intake, then, tend to effect relief of edema and satisfaction of the patient's thirst. It is not necessary to carry out this treatment in the hospital in all cases, although it is usually best to begin the treatment there; ambulatory patients can follow the regimen at home if properly instructed and if able to secure such an important item in the diet as salt-free bread. The amount of salt in ordinary bread alone, especially in the case of habitual bread eaters, is apparently sometimes great enough to make the difference between the persistence and the clearance of edema. Treatment employing salt restriction should not be delayed until the development of dropsy or even slight grades of systemic edema, but started early, because the relief from dyspnea depends mainly upon the effectiveness of the control of pulmonary edema.

In the fall of 1944 this type of therapy was instituted at the Massachusetts General Hospital, and its effect in 64 patients with congestive heart failure was studied. The usual digitalis and diuretics were administered simultaneously.

The diet employed contained about 700-1000 mg. of sodium (equivalent to 1.75-2.63 grams of sodium chloride) in an amount of food equivalent to 1800 calories. If the food tasted too flat, patients were allowed ammonium chloride in the salt shaker in the place of sodium chloride. The diet has yielded a neutral ash, although its reaction probably has little significance, since ammonium chloride is given. In the body the ammonia forms urea and the chloride is set free to neutralize the excess sodium. No attempt was made to balance alkaline-forming and acid-forming foods.

No salt or soda was used in cooking or at the table, and no salt substitute containing sodium in any form was allowed. Unsalted butter or butter washed free from salt was used. Bread and salad dressing were prepared salt free.

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Drugs for the relief of disturbances of the digestive tract did not contain sodium; calcium salts were found to be helpful substitutes.

The authors state that the optimal amount of water in 24 hours on such a regimen has not been established, and that the subject has not yet been adequately investigated by them so they are not as yet in a position to confirm Schemm's belief that a water intake of from 5,000 to 6,000 c.c. a day is more beneficial than one of from 2,000 to 3,000 c.c. There are strong indications that under certain conditions, notably in cases in which there is a diminished renal function and the kidneys can no longer concentrate the urine to a specific gravity great enough to eliminate the waste products of metabolism in the normal volume of urine, a daily intake of water higher than 1500 c.c. is essential. Cardiac patients frequently have diminished renal function, and, if a given renal mechanism can only concentrate urine to a specific gravity of 1.010, a far greater amount of fluid per day will be required to eliminate the metabolic waste products than if the renal mechanism could concentrate to 1.030 or above. Should the patient develop an intercurrent infection, even larger amounts of fluid will be required to take care of fluid loss through evaporation from the skin and lungs.

Of the 64 patients studied while on this diet, 17 obtained much help, 15 moderate benefit, 8 slight benefit, and 7 no benefit. In the remaining 17 cases, either the patients were uncooperative or insufficient data regarding their response to the diet were available.

The chief disadvantages of this low-sodium treatment are (1) the difficulty of following such a diet, especially for those who eat at boarding houses or restaurants, and (2) the flat taste of the food, particularly during the early stages of employing the diet.

Although these disadvantages are difficult to overcome, they are outweighed by (1) the marked relief from distressing cardiac symptoms, notably dyspnea and insomnia, and (2) the freedom from frequent mercurial injections, advantages which are often obtained by these patients because of low-sodium intake.

This form of treatment frequently makes possible the control of edema that cannot be controlled with the usual measures, namely, rest, digitalis, and acid-forming and mercurial diuretics. In those patients in whom this therapeutic measure proves successful, the frequency with which mercurial diuretics must be given is diminished or the need for them entirely eliminated. This form of therapy enables patients to take more water than they otherwise could. (New England J. Med., May 2, '46 - Bridges, Wheeler and Paul D. White)

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Blood Plasma Proteins in Patients with Heart Failure: The recognition of oligoproteinemia, and more specifically hypoalbuminemia, and successes in their correction when significantly abnormal are now commonplace in modern scientific medical practice. Blood plasma protein determination has become practically a routine procedure in diagnostic studies in medical clinics and in the cardiovascular service of the author.

Whipple has summarized the data on the production and utilization, interrelations and modern concepts of plasma protein metabolism. He pointed out that food proteins, after digestion, yielded amino acids which were absorbed from the intestinal tract and carried to the liver. The liver is strategically situated and of sufficient size to perform most of the work of protein synthesis. Some other body cells may perform the function, but most of the plasma proteins seem to emerge from the liver cells and can be utilized in the body for all or most of the protein requirements.

Liver cells can store protein or release fabricated protein. The reserve of plasma protein forming material is considerable, one to five times the circulating mass. The reserve can be reduced by fasting, low protein diet, poor absorption, inadequate rebuilding of plasma proteins or depletion by blood loss. Body protein stores, plasma protein levels, protein production and protein utilization are in a state of dynamic equilibrium.

Blood plasma proteins seemingly can pass readily, according to Whipple, from plasma into cells and the reverse without the loss of nitrogen. The proteins need not be reduced to amino acid constituents as formerly thought, but seem to penetrate by preliminary adsorption and ultimate penetration into cells. The whole protein on the cell membrane is considered to be modified by contained ferments. The membrane is thought to be composed of a bimolecular layer of lipid molecules between two layers of protein molecules.

Protein on its way out or into the cell is designated as transition protein, which by cleavage and reassemblage will be on its way either to become cell protein or to become plasma protein. Once a cell protein can not be removed it is called indispensable. Any parenchymal cell or tissue can act to store, to utilize, to release, and perhaps to fabricate plasma proteins in a small way.

Realizing many years ago that there were several factors concerned in the disturbed water balance in congestive circulatory failure with edema formation, the author undertook studies on venous pressures, electrolyte levels, and blood serum proteins in the presence of edema, and during and after the dissipation of the edema. He has recently reviewed the data in 100 completely studied cases of congestive heart failure, the records of which were selected at random from the files.

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Analysis of the blood plasma protein studies showed slightly but definitely subnormal albumin levels with slight compensating increases in globulin values.

After the dissipation of the edema the blood proteins did not immediately rise to normal levels but there were gradual accretions. It is suggested that the lag may well be due to and evidential of liver dysfunction. Time is required after diuresis and reestablishment of circulatory equilibrium for liver function to be restored and normal protein anabolism to become effective.

The lowest blood protein levels were noted in patients who had had congestive failure for many months and especially in those who developed evidences of cirrhosis of the liver. Still lower blood serum albumin values are observed in cases with advanced cirrhosis.

Feedings of high protein, acid or neutral ash as well as sodium-free, diets are indicated in most patients with congestive heart failure and edema. Proteins of good biological character may be supplemented with protein hydrolysates, amino acids, yeast, or choline. (Ann. Int. Med., May '46 - George R. Herrmann)

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Salt-Poor Concentrated Human Serum Albumin Solution in the Treatment of Chronic Bright's Disease: The authors summarize the results of studies carried out in the Departments of Medicine and Physical Chemistry of the Harvard Medical School, and the Medical Clinic of the Peter Bent Brigham Hospital. A brief note on this work appeared in the Bumed News Letter of 17 August 1945.

Salt-poor concentrated human serum albumin was administered intravenously for periods varying between 1 and 30 days at a dosage of 50 grams a day and a rate of 10 grams an hour to a group of 7 patients in several stages of chronic nephritis maintained on a diet adequate in calories, containing 80 to 125 grams of protein daily, and low in sodium chloride.

The therapeutic value of salt-poor albumin varied with the stage of the disease. In patients with edema, low serum proteins, and absent to moderate hypertension and nitrogen retention, albumin in this dosage was a safe agent in increasing the serum albumin level and in inducing positive nitrogen balance.

The diuretic effect of salt-poor albumin administration was most striking in the severe nephrotic state with massive edema. Control studies both with amino acid mixtures administered by mouth and intravenously in comparable quantities and with mercupurin, yielded no diuresis under these circumstances.

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Unlike the diureses that have been reported as initiated by a wide variety of therapies and which resemble the spontaneous diureses of the nephrotic state, the diureses following albumin proceeded at a constant rate during the period of administration only and stopped at the end of it.

Following short periods of therapy (10 days or less), the ability to maintain weight loss was roughly related to the slope and direction of the patient's weight curve on basal regimen. In the one instance of prolonged (30-day) therapy in nephrosis, a previously rapidly ascending weight curve became flat following diuresis of 20 kgm. although the patient was still edematous. In that such a change in basal weight curve is consistent with the spontaneous course of the disease, the significance of this observation as related to salt-poor albumin therapy can only emerge after far wider clinical use.

In contrast to its effect on nephrotic anasarca, the diuretic effect of salt-poor albumin in the presence of minimal edema was slight. Although control studies showed that both amino acid mixtures in comparable quantities and urea (20 grams daily) were likewise ineffective, massive doses of urea (90 grams a day), when tolerated, appeared to induce further diuresis and weight loss of a transient character.

Albumin administration in the presence of severe hypertension, and nitrogen retention, and in the absence of edema appeared contraindicated owing to its efficacy in rapidly increasing blood volume beyond the tolerance of the cardiovascular system.

Although in this study salt-poor albumin appeared to have no influence on the natural history of the disease process, in a condition as variable as chronic glomerulonephritis, observations far more extensive, both in duration and in range of clinical material, are necessary to determine this point. The symptomatic benefits here reported in the nephrotic state well warrant such observations. (J. Clin. Invest., Nov. '45 - Thorn et al.)

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(Not Restricted)

Effect of Weight Reduction on Course of Arterial Hypertension: The result of weight reduction on the course of arterial hypertension was studied in a group of fifty-four patients in the years 1940-1941. The average course of dietary treatment was 8.2 months; the average loss of weight during this period was 23-1/2 pounds. The loss of weight was associated with a decreased blood pressure in 72 per cent and with no change of blood pressure in 28 per cent of the cases.

Fifteen patients of the original group were re-examined in 1944. With due consideration of individual variations, the course of arterial hypertension was

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more favorable in those who maintained their weights at reduced levels than in those who increased in weight during the three-year interval. Overweight is apparently only one of many conditioning factors for the development of arterial hypertension.

Loss of weight and the return of blood pressure to lower or normal levels had practically no effect on the vascular changes of the ocular fundi. (J. Mount Sinai Hosp., Jan.-Feb. '46 - Adlersberg et al.)

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Prognostic Significance of Overweight in Relation to Hypertension: A statistical analysis was made of the medical records of 22,741 officers of the United States Army to determine the prognostic significance of overweight noted in the course of annual physical examinations. The method of person-years was employed in the analysis. The indices chosen to demonstrate the influence of overweight on the subsequent state of health and cause of death were the later development of sustained hypertension, and retirement or death with cardiovascular-renal diseases. The experience with overweight alone showed significantly higher rates for later sustained hypertension and for retirement with cardiovascular renal diseases than did the control group. When, in addition to overweight, transient hypertension and transient tachycardia were present, the rate of the later development of sustained hypertension was 12 times as great as in the controls. In the case of retirement with cardiovascular-renal diseases, the rate was 4 times as great. (OEMcmr-272, Levy et al., Columbia Univ., MS. for publication - CMR Bulletin #77)

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Capillaries in Neurocirculatory Asthenia: In the nail fold of 48 patients with neurocirculatory asthenia there were significantly more capillaries of complex form than in 44 normal controls. The percentage of complex forms in each class of subjects was: normal controls, 21; convalescent controls, 35; acute neurocirculatory asthenia, 53; chronic neurocirculatory asthenia, 56.

The mean number of normal hairpin-shaped forms for the neurocirculatory asthenia patients was 4.5 out of 10, while for the controls it was 7.2 out of 10. (OEMcmr-157, Cobb et al., Mass. Gen. Hosp., MS. for publication - CMR Bulletin #75)

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Effect of Bleeding and Repeated Blood Donation on Serologic Tests for Syphilis: Because several directors of Red Cross Donor Centers and other

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interested observers had gained the impression that successive bleedings as such are capable of producing in some donors a nonsyphilitic positive reaction in recognized serologic tests for syphilis, the V-D Subcommittee of the National Research Council initiated studies designed to furnish data that would support the impression or prove it to be invalid.

The investigation was carried out on 164 male prison inmates whose ages ranged from 18 to 60. Forty-three of these subjects made more than 10 donations each. The others made from one to 10 donations.

Quantitative flocculation and complement fixation tests were run on blood specimens taken before and at varying intervals up to 15 days following blood donations. From an analysis of the results, the authors conclude that it certainly cannot be said that their data reveal the existence of a nonsyphilitic positive reaction due to multiple blood donations, or to bleeding as such, and that neither can it be said that such a possibility is totally excluded. The authors further state that no statistically valid data are yet known to them which support the hypothesis that successive bleedings are capable of producing in some donors a nonsyphilitic positive reaction to recognized serologic tests for syphilis. (Am. J. M. Sc., May '46 - Boerner, Nemser, and Stokes)

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(Not Restricted)

Report on Use of Dees's Technic for Removing Small Renal Calculi: In 1943 Dees described a new technic for the operative removal of small stones from the kidney.

As described by Dees, following a prolonged, traumatizing and apparently futile exploration of a kidney for a small elusive stone, a blood clot was removed from the renal pelvis, within which the small calculus was entrapped. Impressed by this fortunate accident, he searched for a suitable coagulum to fill the renal pelvis and calices. Fibrinogen from human plasma fulfilled the requirements of a substance that would completely fill the interior of the kidney, clot quickly and firmly, not be harmful to the kidney, and dissolve spontaneously. Fibrinogen solution is converted into a fibrin clot by adding thrombin. The thrombin used is a fraction of globulin derived from rabbit plasma. The coagulum formed is said to dissolve spontaneously in human urine at 37° C. within eighteen to twenty-four hours. At operation the upper ureter and renal pelvis are exposed. The ureter is gently occluded and a small incision is made in the renal pelvis. A No. 12 French urethral catheter is put into the pelvis, and any urine present is aspirated. The pelvis is washed with normal salt solution and then with fibrinogen solution. The pelvis is filled with fibrinogen through the catheter while simultaneously one-tenth as much of 2 per cent clotting globulin is injected through the wall of the catheter with a syringe and



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needle. After five minutes, a firm cast of the pelvis and calices forms. This is removed by enlarging the pyelotomy incision. The coagulum frequently extrudes itself or may be removed by forceps, and brings with it all small stones that lie free within the kidney. Animal experiments conducted by Dees showed that no harm was done to the kidney by the retained coagulum or its introduction, and the procedure was carried out in 21 patients without demonstrable ill effect.

The author reports use of the coagulum technic in a patient with multiple small stones in the kidney pelvis. The clot extruded itself intact on opening the pelvic wall, forming a perfect cast of pelvis and calices. All the calculi, including several small stones unsuspected in the preoperative x-ray films, were enmeshed in the clot.

Air pyelograms assist greatly in determining beforehand whether this method is suitable, since unless the air surrounds all the stones in the calices of the kidney, the calculi are apt to be adherent and are not removed by the clot. Although this procedure has limitations, it has considerable value, and trauma to the kidney is minimal.

It is pointed out by the author that since the recurrence of stones after pyelolithotomy is frequent and is due in many cases to failure to remove all small calculi at the time of operation, a method that helps to clear the kidney completely is of considerable importance. Dees's contribution may be regarded as a significant advance in the problem of renal calculi. (New England J. Med., April 25, '46 - Fletcher H. Colby)

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Prevention of Fungous Infections of the Feet - Noneffectiveness of Foot

Baths: Foot baths of 1.5 per cent hypochlorite or 15 per cent hyposulphite have been widely used for the purpose of preventing or reducing the transmission of athlete's foot in shower rooms and swimming pools. In accordance with the prevalent belief in their effectiveness a number of naval activities installed such foot baths. The question of whether or not these devices should be used is still frequently raised by naval medical officers.

The present consensus of those who have studied the problem is that the use of foot baths has little effect on the incidence of fungous infections of the feet. Bumed News Letter, Volume 4, Number 2, July 21, 1944, reported the following opinion which resulted from the conference on Fungous Infections of the Skin, held by the Division of Medical Sciences, National Research Council, on June 20, 1944, in response to a specific question by the Army: "Foot baths for the prevention of 'athlete's foot' are not prophylactic, not necessary, and their use should be discontinued by the Army."

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Instead, for prevention of fungous infections of the feet, general cleanliness of decks and showers and measures devoted to care of the feet must be relied upon. Measures for care of the feet include careful drying between the toes with the removal of excess nonviable epidermis, the use of loosely enough fitting socks and shoes to permit maximum ventilation and promote foot dryness, frequent changes of socks and shoes, and the use of fungicidal foot powders between the toes and in the shoes when indicated.

Recent screening and field tests of the most promising antifungus agents indicate that undecylenic acid and zinc undecylenate are the most effective of such agents currently available. They have been added to the supply table as Stock No. 1-204-050 Foot Powder, zinc undecylenate, 2 ounce, in sifter top container, and No. 1-209-180 Fungicidal Ointment, undecylenic acid, 5 per cent, and zinc undecylenate, 18 per cent, 1 ounce tube. The powder is more convenient for prophylaxis and is also effective in treatment.

In line with current thought, the State of New York has recently amended the Sanitary Code regulation enacted in 1932 which required the use of fungicidal foot baths in the shower rooms of public swimming pools and beaches. The New York State Department of Health reports April 29, 1946, "experience has disclosed that the fungicidal properties of such solutions (foot baths) were not effective and that it was difficult to insure the proper use and maintenance of such foot baths." The modified regulation requires only that "all floors of dressing rooms, toilet rooms, passageways and walks at every pool and public bathing beach where dressing rooms are available shall be maintained in a clean condition at all times."

The above statements cast considerable doubt on the advisability of recommending the purchase of foot baths, and leave the medical officer without much ground for insisting on their use, if already installed. It would appear that a theoretical advantage would accrue to a naval activity from the use of properly maintained foot baths through the partial elimination of those staphylococcal and streptococcal secondary invaders which produce the sick days in severe cases of fungous infection of the feet. However, without tireless supervision to assure cleaning and refilling or refreshing the foot baths several times a day when use is heavy or temperatures high, the foot bath will fail even to accomplish this mission, and if neglected, may be worse than useless.

Satisfactory control of fungous infections of the feet is obtainable through the preventive measures of good general sanitation and good foot hygiene including the use of fungistatic foot powder when indicated, and through the prompt treatment of cases. (Preventive Med. Div., BuMed)

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Studies Regarding Operation of Messes Aboard Naval Vessels: Pursuant to recommendations resulting from studies on the operation of messes aboard naval vessels, the Chief of Naval Operations requested the Bureau of Supplies and Accounts in conjunction with the Bureau of Medicine and Surgery to carry on a program of research on problems of nutrition, menus, and methods of preparation and cooking of foods. In this connection it is expected that some sort of an experimental galley (the plan and development of which is now under study) will be set up at a large naval establishment for study of the various phases of the messing operation, as applicable.

In studies to be undertaken by the Bureau of Supplies and Accounts special attention will be given the development and testing during peacetime operations of methods for battle messing.

The Navy is studying with a view toward adopting a proposed Federal Specification for frozen boneless beef which provides for a better distribution of the fat and also requires that less fat be included with the stewing beef component.

The matter of a recommendation for the addition of special items of cake or doughnut flour for shipboard use has been appraised. Because of reasons of practical expediency and because the standard Navy issue flour is considered satisfactory in all respects for cooking and baking operations, the addition of these special items has been looked upon as undesirable.

The storage of white potatoes has been studied. Based upon the planned content of potatoes in the Navy diet, 978 cubic feet of chill space are required for potatoes for 1,000 men for a period of 30 days. This cubage represents 44 per cent of the total required chill space of 2,222 cubic feet. The practice of allowing potatoes to remain at a higher temperature than chill prior to use, although useful in the case of seed potatoes to permit the reduction by natural means of excessive sweetness, is not necessarily applicable to other types of white potatoes. It must also be pointed out that under certain conditions, topside storage of potatoes is impossible, as for example, in operations where very high or very low temperatures commonly prevail. The problem of contamination by warfare agents of foodstuffs stowed topside must also be considered.

Action is being taken by the Bureaus concerned to include in the new training manuals the recent advances in concepts and practices pertaining to food and nutrition.

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Abstracts of Reports on Research Projects:

X-473  
(Report No. 2)

A study of the Inhibitory Effect of Analogues of  
P-Aminohippuric Acid on Penicillin Excretion.

Five compounds closely resembling p-aminohippuric acid in chemical structure were studied for efficacy in inhibiting penicillin excretion in dogs. The elevation or decline in the serum penicillin level at given intervals of time following administration of the drug was utilized as an index of penicillin excretion.

Compounds of the anilinoformylglycine series were found to inhibit penicillin excretion. However, the renal tubular damage caused by these compounds renders them unsuitable for possible clinical use. (Nav. Med. Res. Inst., NNMC, Bethesda, Md.)

X-265  
(Av-153-c)  
(Final Report)

Comparative Reaction Times to Signal Lights with Respect  
to Color Deficiency.

A submarine hull opening indicator board (a panel of from 30-60 small jewel-shaped lights) was wired so that observers' reaction times to the red and green light signals could be measured.

After tests it was concluded that color-blind individuals are able to read the red and green signals at full brightness nearly as rapidly as those with normal vision. As the voltage supplying the lamps is dropped, the color blind may be expected to show progressively greater hesitancy in discriminating the red from the green jewels.

The use of bluish-green glasses would be expected to decrease the confusion effect for the color blind. (Med. Res. Dept., U. S. Sub. Base, New London)

X-492 (Av-262-p)  
and  
X-614 (Av-316-k)  
(Progress Report  
No. 1)

A Study of the Physiological Blind-Spot of the Dark-Adapted  
Fovea.

The object of this study was (1) to study the size and shape of the physiological blind-spot corresponding to the cone area of the dark-adapted retina; (2) to evaluate results

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X-492 (Av-262-p)  
and  
X-614 (Av-316-k)  
(Progress Report  
No. 1)  
(Cont.)

obtained by the Livingston method with results obtained by the Diaphragm Shutter Scotometer; and (3) to evaluate each of the above devices as a test of night vision by comparing results obtained with those resulting from the use of the Radium Plaque Adaptometer.

The results of an experiment administered to 24 men of the U.S. Navy appear to indicate that:

1. The Livingston method of rod scotometry is too exacting in technic, and too demanding in terms of fatigue and cooperation of subjects to be of great value as a screening test for night vision. However, it has undoubted value in capable hands as a reliable confirmatory measure for doubtful cases, and possibly, as a diagnostic aid. Its correlation with the Radium Plaque Adaptometer at varying distance seems to be satisfactory.

2. While the Korb Diaphragm Shutter Scotometer at the present time is not as reliable as other tests, it has the following advantages: (a) it is simple to operate and easily comprehended, (b) it can be administered with some rapidity, and (c) the data obtained agree very well with the results from the Livingston test.

Certain mechanical difficulties with this device can be remedied.

Its correlation with the Radium Plaque Adaptometer appears to correspond with that of the Livingston test.

3. The Radium Plaque Adaptometer at five feet distance seems to provide a satisfactory measure of night vision on a pass-fail classification. Pearson coefficients of reliability and intercorrelation for this small population are adequate.

4. The Radium Plaque Adaptometer at seven feet distance seems to provide a wider classification of night vision than the prescribed procedure at a distance of five feet. From the data of the present experiment, the seven-foot technic appears to be slightly more reliable. There is little indication that test results at seven feet correlate well with scotometric measures. (Med. Res. Dept., U.S. Sub. Base, New London)

Note: Those interested in seeing copies of the complete reports may address their request to the Research Division, BuMed.

(Not Restricted)

Sixteen Medical Consultants Appointed to Assist in Graduate Training Program:

The Surgeon General has announced the appointment of 16 doctors as members of the Reserve Consultants Board to the Bureau of Medicine and Surgery.

The consultants are officers of the Naval Medical Reserve Corps with the exception of the consultant representing the Council on Medical Education and Hospitals of the American Medical Association. All are outstanding specialists in their respective fields. They will assist the Bureau of Medicine and Surgery in furthering the graduate medical training program.

This program, in addition to increasing professional proficiency and improving the standards of medical practice, is designed to afford naval medical officers the opportunity to train in medical specialties and to qualify for American Board certification, fellowship in one of the American Colleges, or other marks of distinction in the same manner as doctors engaged in civilian practice.

The Reserve Consultants Board will aid in establishing the residency training program in nine U.S. naval hospitals located as follows: Bethesda, Maryland; Chelsea, Massachusetts; Great Lakes, Illinois; Long Beach, California; Oakland, California; Philadelphia, Pennsylvania; San Diego, California; Seattle, Washington; and St. Albans, New York. Other naval hospitals will be utilized for training as the program expands.

The Board will meet and confer at the Bureau of Medicine and Surgery, visit and survey U. S. naval hospitals in respect to the graduate medical training program, confer and advise with the Medical Officers in Command and with the chiefs of services, and assist in the choice of reserve consultants to the staffs of naval hospitals.

At the present time the residency-type training program offers courses in the following specialized fields: neuropsychiatry, dermatology and syphilology, radiology, anesthesiology, internal medicine, urology, obstetrics, orthopedic surgery and pathology. As the program develops, it is planned to organize courses in other specialties. Medical officers are also receiving training in civilian institutions in recognized specialties.

The following are members of the Reserve Consultants Board:

Dr. Joseph S. Barr, Instructor, Orthopedic Surgery, Harvard Medical School, Consulting Orthopedic Surgeon, Eye and Ear Infirmary.

Captain F. J. Braceland, Medical Corps, U.S.N.R., Secretary, American Board of Psychiatry and Neurology.

(Not Restricted)

Dr. E. N. Broyles, Associate Professor of Otolaryngology, Johns Hopkins Medical School; Assistant Visiting Laryngologist, Johns Hopkins Hospital.

Dr. Winchell M. Craig, Professor of Neurosurgery, University of Minnesota; Neurological Surgeon and Neurosurgical Consultant, Mayo Clinic.

Dr. Arthur M. Culler, Associate Professor of Ophthalmology, Ohio State University; Consulting Ophthalmologist, University, Mt. Carmel and St. Francis Hospitals.

Dr. Howard K. Gray, Associate Professor Surgery, Mayo Foundation Postgraduate School, University of Minnesota; Head, Section in Surgery, Mayo Clinic.

Dr. Paul Greeley, Associate Professor of Surgery, Illinois College of Medicine; Chief, Division of Plastic Surgery, Illinois College of Medicine.

Dr. Clark Johnson, Associate Clinical Professor, University of California; Visiting Urologist and Chief of Service, San Francisco County Hospital.

Captain George M. Lyon, Medical Corps, U.S.N.R., Pediatrician, Huntington, West Virginia.

Commodore Alphonse McMahan, Medical Corps, U.S.N.R., Associate Professor of Medicine, St. Louis University School of Medicine; Associate Physician, St. Louis University Group Hospitals.

Dr. J. Roscoe Miller, Dean and Associate Professor of Medicine, Northwestern University School of Medicine.

Dr. Wendell Scott, Associate Professor Clinical Radiology, Washington University School of Medicine; Assistant Radiologist, Edward Mallenckrodt Institute of Radiology.

Dr. Marion Sulzberger, Associate Clinical Professor of Dermatology and Syphilology, New York Postgraduate Medical School; Associate Director, New York Skin and Cancer Unit, New York Postgraduate Medical School.

Dr. Paul Titus, President, Advisory Board for Medical Specialties; Head, Department Obstetrics-Gynecology, St. Margaret Memorial Hospital, Pittsburgh.

Captain Shields Warren, Medical Corps, U.S.N.R., Assistant Professor of Pathology, Harvard Medical School; Pathologist, Huntington Memorial, New England Baptist, New England Deaconess and Pondville Hospitals.

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Dr. M. G. Westmoreland, Council on Medical Education and Hospitals,  
American Medical Association.

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(Not Restricted)

Applications for Transfer to Hospital Corps of Regular Navy in Commis-  
sioned Officer Status: See Alnav 222 on page 34.

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Transfer to the Regular Navy: Alnav 252 of 21 May 1946 (revised) having  
to do specifically with transfer to the regular Navy follows:

Uncertainty of enabling legislation may have been a deterrent to many officers considering the Navy as a lifetime career. The passage of Public Law 347 on 18 April (described in Alnav 189-46 and the May issue of "All Hands") removes this uncertainty. Attention is invited to the fact that a deadline for requesting transfer to the Regular Navy for officers on active duty has not yet been set.

Reserve and temporary USN officers of the line (general service, aviation, and all categories of EDO) and particularly each of the staff corps are urged to submit their applications at the earliest opportunity. The high standards required have not and will not be lowered and officers capable of meeting them have the same opportunity of being selected now as they would have had weeks or months ago. The age tables listed in BuPers Circ Ltr 288-45 (revised) of 15 November 1945 are in effect and have been approved by the President in the regulations governing transfer. No changes will be made therein nor will waivers be granted.

Twenty-nine thousand, eight hundred and thirty-one (29,831) applications for transfer to the Regular Navy under the provisions of BuPers Circ Ltrs 288-45 (revised) of 15 November 1945 and 303-45 have been received from reserve and temporary USN officers in all grades and ranks of the line and staff corps. About 24,500 of these meet all transfer requirements and are being considered by the selection board as rapidly as possible. About 2,300 applications have not been submitted to the selection board because certain necessary information required by the board has not yet been received. Officers concerned have been sent air mail letters and are urged to take immediate action to complete their application. Four thousand, four hundred and ninety-one (4,491) have already been recommended for transfer in Alnavs 167-46 and 206-46 and may expect appointments in the Regular Navy in the near future. This list will be continued in subsequent alnavs.

--SecNav. James Forrestal



Waterproof Liner for Medical Stores: Waterproof liners for cases, boxes and crates and waterproofing of individual items of medical supplies and equipment minimized damage during landing operations under adverse weather conditions. When not so protected, the damage and loss of valuable supplies and equipment was heavy.

The following is an excerpt from a report dealing with the condition of medical materials received by a hospital during the later stage of the war:

All of the material for the hospital was off-loaded under trying conditions, the sea was rough, the weather rainy, the distance from ship to shore long and the supplies had little protection while en route from ship to shore. After receipt ashore, the materials had to be tugged from 5 to 15 miles and placed in open storage dumps. The ship-to-shore trip, the wind, the daily rains and two devastating typhoons subjected the waterproofing of supplies to a severe test.

Supplies which were protected by waterproofing suffered little damage while those materials not so protected were frequently damaged to such a degree as to be utterly useless. Bandages, gauze, cotton, and muslin were well preserved; camouflaged bandages seemed to be less affected by mildew; paraffin-dipped compressed bandages were not affected in any way even when cases were not supplied with a waterproof liner. Plaster of Paris bandage in hermetically sealed tins was in perfect condition, as was also the plaster in 25 lb. metal pails. Items covered by cellophane envelopes, such as surgical instruments, etc., came through in excellent condition. Wooden tongue depressors, crutches, etc., manufactured from well seasoned wood suffered not at all. Field blankets which had been baled in units of 25, wrapped in a paper blanket, covered with waterproof paper and sewed up in a burlap bag, when opened, were found to be dry and in excellent condition.

After the cessation of hostilities and after having been exposed to the elements for many months, some of the materials supplied this hospital were returned to the continental U. S. On opening these waterproof containers, the contents were found to be in excellent condition. (U.S.N. Med. Supply News Ltr., June 1, '46)

\* \* \* \* \*

New Films Available: MN-5059-Advanced Bases and the Functional Component System (Sound - Black & White - 20 minutes). This film, for all hands, explains the use of the Functional Unit Catalog System in supplying fleet or advanced bases. It shows how to order and how bases were set up by Group Unit System.

(Not Restricted)

MN-1966-Sciatic Pain and Intervertebral Disk (Sound - color - 28 minutes). This film, intended for medical personnel, shows how sciatic pain is frequently caused by traumatic injury to an intervertebral disk in the lower lumbar region. In some injuries the annulus fibrosus is ruptured, and the pulpy center of the disk becomes herniated. This produces localized pressure on roots of the sciatic nerve. Different manifestations of the injury are shown, and both conservative and operative treatment are demonstrated.

\* \* \* \* \*

(Not Restricted)

American College of Physicians Clinical Fellowships and Postgraduate Courses: For the purpose of assisting in bringing potentially useful information to medical officers who have been or soon will be released from active duty, the following announcements are made:

The American College of Physicians states that all Clinical Fellowships sponsored by the College for the year 1946 have now been awarded, and no funds are available to continue this program during 1947.

A preliminary list of the tentative schedule of A.C.P. postgraduate courses starting September 1946 follows:

<u>Dates</u>	<u>Subject Title</u>	<u>Director</u>	<u>Location</u>
Sept. 16-21	Internal Medicine*	Dr. R.R. Snowden	Pittsburgh, Pa.
Sept. 23-28	Cardiology	Dr. Frank Wilson	Ann Arbor, Mich.
	Psychosomatic Medicine	Dr. Franklin Ebaugh	Denver, Colo.
Oct. 7-12	Clinical Neurology	Dr. Bernard Alpers	Phila., Pa.
	Internal Medicine*	Dr. Homer Rush	Portland, Ore.
Oct. 14-19	Metabolism and Nutrition*	Dr. M. A. Blankenhorn	Cincinnati, Ohio
	Cardiovascular Disease	Dr. Roscoe Miller	Chicago, Ill.
Oct. 21-26	Hematology	Dr. Charles Doan	Columbus, Ohio

(Not Restricted)

<u>Dates</u>	<u>Subject Title</u>	<u>Director</u>	<u>Location</u>
Oct. 28-Nov. 2	Internal Medicine*	Dr. Wallace Yater	Washington, D.C.
Nov. 4-9	Allergy Cardiology	Dr. Robert Cooke Dr. Paul White, & Drs. Bland & Sprague	New York, N.Y. Boston, Mass.
Nov. 11-16	Gastroenterology	Dr. Walter L. Palmer	Chicago, Ill.
Nov. 18-23	Internal Medicine* Physical Medicine	Dr. Joseph Hayman Dr. G. Morris Piersol	Cleveland, Ohio Phila., Pa.
Nov. 25-30	Internal Medicine*	Dr. J. C. Meakins	Montreal, Can.
Dec. 2-7	Chemotherapy	Dr. W. Barry Wood, Jr.	St. Louis, Mo.
Dec. 9-14	Growth and Tumors	Dr. E. L. Bortz & Dr. Stanley Reimann	Phila., Pa.

\*It is hoped that all courses in Internal Medicine may be extended to include two weeks of instruction. Announcements will follow later.

\* \* \* \* \*

(Not Restricted)

Changes to be Made in Copies of Manual of the Medical Department: Certain changes in the Manual of the Medical Department have been directed, as specified in:

Circular Letter 46-85, page 21  
Circular Letter 46-87, page 22  
Circular Letter 46-90, page 25

\* \* \* \* \*

(Not Restricted)

Public Health Foreign Reports:

<u>Disease</u>	<u>Place</u>	<u>Date</u>	<u>Number of Cases</u>
Cholera	Ceylon, Eastern Prov., Batticaloa District	Apr. 1-17, '46	3 suspected (fatal)
	China		
	Hunan Province	Mar. 1-31, '46	1
	Hupei Province	Feb. 19-28, '46	52 (fatal)

(Not Restricted)

Public Health Foreign Reports (Cont.)

<u>Disease</u>	<u>Place</u>	<u>Date</u>	<u>Number of Cases</u>
Cholera	China		
	Kwangtung Prov.	Apr. 1-30, '46	21 (3 fatal)
	Canton	Jan. 1-Apr. 6, '46	466 (138 fatal)
	India, Calcutta	Apr. 6-13, '46	149 (54 fatal)
Plague	British E. Africa, Kenya	Apr. 6-13, '46	5
	Burma, Rangoon	Mar. 23-30, '46	8 (7 fatal)
	China		
	Chekiang Province	Apr. 9, '46	3
	Fukien Province	Feb. 1-Mar. 6, '46	298 (fatal)
	Kwangtung Province	Apr. 4, '46	1
	Egypt, Alexandria	Apr. 20-27, '46	7
Union of So. Africa	Apr. 13-20, '46	1	
Smallpox	Burma, Rangoon	Mar. 23-30, '46	64 (35 fatal)
	French Guinea	Apr. 1-10, '46	107
	Togo (French)	Apr. 1-10, '46	80
Typhus Fever	Mexico	March '46	127
	Morocco (French)	Apr. 11-20, '46	204
	Turkey	Apr. 20-27, '46	35
Yellow Fever	Colombia, Caqueta Territory, San Vicente del Caguan, La Danta	Mar. 1, '46	1 fatal
	Nigeria, Ibadan	Apr. 13-20, '46	1 suspected (fatal)

(Pub. Health Foreign Reps., May 24, '46)

\* \* \* \* \*

(Not Restricted)

Treatment of Early, Latent and Relapsing Syphilis: In the Bumed News Letter of May 10, 1946, it was announced that new schedules of therapy for early and latent syphilis would be forthcoming. These recommended schedules are contained in Circular Letter 46-91, page 31 of this issue.

\* \* \* \* \*

Circular Letter 46-85

28 May 1946

(Not Restricted)

To: All Ships and Stations.

Subj: Rental Report for Nurses (NavMed-727), preparation and submission of.

Encl: 1. (HW) Sample of subject report. \*

1. Subject report replaces the present report, Subsistence and Rental Report (NavMed-727). The revised report, NavMed-727, shall be submitted in duplicate monthly from all activities having Nurse Corps Officer personnel.

2. An initial supply of NavMed-727, Rental Report for Nurses, is being forwarded to activities having Nurse Corps personnel and will be available at naval supply activities as follows:

<u>Stock No.</u>	<u>NavMed Form No.</u>	<u>Item</u>	<u>Unit</u>
14-320-550	NavMed-727	Rental Report for Nurses	Sheet

3. The Manual of the Medical Department shall be modified as follows:

(a) Add new paragraph 1435 ---

1435

Rental Report for Nurses (NavMed-727) -- This report shall be prepared at the end of each month by all activities having Nurse Corps personnel and shall be forwarded in duplicate to the Bureau of Medicine and Surgery. No instructions are necessary for the preparation of NavMed-727.

(b) Page 479, add under heading "Reports Added Since 1 Nov 1945" --

NavMed-727 -- Rental Report for Nurses - BuMed - Monthly - Par 1435 --  
Place "X" mark in Column 14.

(c) Corrections and additions to the subject index of the Manual will be made in the page changes which will be issued in the near future.

--BuMed. Ross T. McIntire.

\* Because of self-explanatory nature of report a copy of it is not included but appears in the Navy Department Semimonthly Bulletin of 31 May 1946.

Circular Letter 46-87

3 June 1946

(Not Restricted)

To: MedOfsCom, NavHosps.

Subj: Report on Interns and Internships (NavMed-1048), establishment and submission of.

Ref: (a) Essentials of Internships and of Residency-Type Training in Naval Hospitals (NavMed-762).

Encl: 1. (HW) Supply of subject forms. \*

1. The Bureau of Medicine and Surgery must maintain close supervision of internship and residency-type training in naval hospitals in order to meet the requirements of the Council on Medical Education and Hospitals of the American Medical Association.

2. The report required by ref (a), page 4, is hereby discontinued. It will be replaced by NavMed-1048, Report on Interns and Internships, which shall be submitted in accordance with par 3 by all naval hospitals approved for intern training. NavMed-1048 will be stocked at Naval Medical Supply Depots as follows: Stock No. 14-336-750; NavMed No. 1048; Item, Report on Interns and Internships; Unit, sheet. The first report shall be made prior to 15 July 1946.

3. The following additions shall be made to the Manual of the Medical Department:

Add new paragraph 5129(C) as follows:

5129(C)

NavMed-1048 (Report on Interns and Internships) - 5129(C).1.  
NavMed-1048 (Report on Interns and Internships) shall be prepared by all naval hospitals approved for intern training, annually prior to 15 July and shall cover the preceding period 1 July through 30 June.

--BuMed. Ross T. McIntire.

\* \* \* \* \*

Circular Letter 46-88

3 June 1946

(Not Restricted)

To: MedOfCom, NavHosps and NavSpHosps (Continental).

\* Because this enclosure was forwarded with advance copies to the addressees, it is not printed here.

(Not Restricted)

Subj: Streptomycin, report of use of.

Ref: (a) BuMed ltr BUMED:WM:GAH, Pd-2/P3-1(022-41) dtd 23 March 1946.

Encl: 1. (HW) Supply of NavMed forms 982. \*

1. Reference (a) requested that a report be made to BuMed of each case in which streptomycin is used.
2. An insufficient number of reports has been received to enable the Bureau to make a satisfactory analysis. It is therefore directed that a report be made to BuMed, on NavMed-982 (single copy only), of each case in which streptomycin is used until the supply of forms NavMed-982 enclosed herewith is exhausted.  
--BuMed. Ross T. McIntire.

\* \* \* \* \*

Circular Letter 46-89

12 June 1946

(Not Restricted)

To: DMC's, ONE, THREE, FOUR, FIVE, SIX, SEVEN, EIGHT, NINE, ELEVEN,  
TWELVE, THIRTEEN, SEVERN RIVER COMMAND, POTOMAC  
RIVER COMMAND  
MedOfCom, NavHosps, and NavSpHosps (in above commands).

Subj: Hospital Patients, Transportation of via the Naval Air Transport Service.

Ref: (a) BuMed Circular Letter No. 46-58 of 27 March 1946.  
(b) NATS Atlantic Wing Memo No. 3-46 of 8 March 1946.

Encl: (1) Schedule of Hospital Flights effective 15 June 1946.

1. Ref (a) is hereby modified as regards routes and schedules stops.
2. On 15 June the Naval Air Transport Service will inaugurate the post-war hospital plane service within the continental United States. This service will include three (3) weekly coast-to-coast round trip express flights, utilizing four-engine R5D airplanes with a capacity of twelve (12) litter patients and twenty-four (24) ambulatory patients.
3. The new service (see Encl. (1)) will operate over the "U"-route through southern United States and will include stops at San Diego, Corpus Christi, Pensacola, and Washington. Patients destined for hospitals in central United States, except the Chicago area, will be transferred to twin-engine R4D shuttle

\* Because this enclosure was forwarded with advance copies to the addressees, it is not printed here.

(Not Restricted)

planes at Corpus Christi for transportation to destination hospital. Patients will no longer be accepted for delivery to Naval Hospital, Chicago. However, mental and rheumatic cases originating in Chicago area for hospital Fort Worth and east coast destinations may be considered for air transportation when the number is sufficient to justify a special flight for this purpose. Request for such transportation from Naval Hospital, Chicago, will be addressed to BuMed for consideration and approval by NATS.

4. Patients bound for hospitals, east coast, will be transferred to R4D shuttle planes at Patuxent, Md., for final transportation to destination.

5. The basic procedures as set forth in Ref (a) for transportation of patients by air shall remain in effect and hospitals are requested to continue cooperation with NATS in the screening and processing of patients for air transport.

--BuMed. Ross T. McIntire.

\* \*

ENCLOSURE (1)

HOSPITAL FLIGHTS

Transcontinental

Eastbound - Read Down

Westbound - Read Down

VR-3 R5D 0326V

VR-3 R5D 0325V

	<u>MON</u>	<u>WED</u>	<u>FRI</u>
Oakland lv.	1900		
San Diego arr.	2125		
San Diego lv.	2225		
	<u>TUE</u>	<u>THR</u>	<u>SAT</u>
Corpus Christi arr.	0630		
Corpus Christi lv.	0745		
Pensacola arr.	1115		
Pensacola lv.	1215		
Washington arr.	1720		
Washington lv.	1750		
Patuxent arr.	1810		

	<u>MON</u>	<u>WED</u>	<u>FRI</u>
Patuxent lv.	1650		
Washington arr.	1710		
Washington lv.	1850		
Pensacola arr.	2220		
Pensacola lv.	2320		
	<u>TUE</u>	<u>THR</u>	<u>SAT</u>
Corpus Christi arr.	0300		
Corpus Christi lv.	0415		
San Diego arr.	0855		
San Diego lv.	0955		
Oakland arr.	1225		



(Not Restricted)

Central United States  
Shuttle Service

<u>VR-3 R4D 0330V</u>	<u>TUE</u>	<u>THR</u>	<u>SAT</u>
Corpus Christi	*F		
Fort Worth	F		
Memphis	F		
New Orleans	F		

<u>VR-3 R4D 0329V</u>	<u>TUE</u>	<u>THR</u>	<u>SAT</u>
New Orleans		F	
Memphis		F	
Fort Worth		F	
Corpus Christi		F	

EAST COAST  
Shuttle Service

Southbound - Read Down

<u>VR-1 R4D 0121V</u>	<u>WED</u>	<u>FRI</u>	<u>SUN</u>
Boston		F	
Rochester		F	
New York		F	
Philadelphia		F	
Washington		F	
Quantico		F	
Patuxent		F	
Norfolk		F	
Cherry Point		F	
Charleston		F	
Dublin		F	
Jacksonville		F	
West Palm Beach		F	
Miami		F	
Key West		F	

Northbound - Read Down

<u>VR-1 R4D 0122V</u>	<u>WED</u>	<u>FRI</u>	<u>SUN</u>
Key West		F	
Miami		F	
West Palm Beach		F	
Jacksonville		F	
Dublin		F	
Charleston		F	
Cherry Point		F	
Norfolk		F	
Patuxent		F	
Quantico		F	
Washington		F	
Philadelphia		F	
New York		F	
Rochester		F	
Boston		F	

\*F - Flag Stop

Times given are local times.

\* \* \* \* \*

Circular Letter 46-90

11 June 1946

(Not Restricted)

To: All Ships and Stations.

Subj: NAVMED 582 (Monthly Morbidity Report); reporting of transient personnel on.

Ref: (a) Paragraph 35D3, Manual of the Medical Department 1945, Revised.

(Not Restricted)

Encl: 1. (HW) Revised paragraph 35D3, Manual of the Medical Department.

1. Under the present system of reporting morbidity on a monthly basis by means of subject report, some confusion has arisen regarding the reporting of morbidity of transient personnel. At present it is impossible to segregate and establish the differences between rates of morbidity which have developed in (a) personnel permanently attached to naval activities and (b) personnel who are transients (i.e. remaining at activities for a temporary period of time and not permanently attached). A number of activities are reporting morbidity and mortality of transients together with that of the personnel permanently attached, while only reporting the average strength of the permanently attached personnel. This results in local morbidity rates which are artificial and too high for the activity.

2. In order to establish exact admission rates for the two types of personnel above mentioned, it is directed that hereafter all activities in which there are 25 or more transient personnel attached during the month, shall prepare and forward two types of monthly morbidity reports (NAVMED 582). The first shall report only on personnel of the Navy and Marine Corps permanently on duty at the individual activity. The second shall record morbidity on all transient personnel (members of the Navy and Marine Corps who are in a temporary status awaiting separation, reassignment, undergoing treatment, etc.). This latter copy shall have the words "TRANSIENT PERSONNEL" typed into the heading of the report, and it shall be completed in full in accordance with the instructions for preparation of the form. Average strength for the latter report may be calculated in the usual manner (reference (a)), from the transient personnel records.

3. Submission of the "Transient Personnel" report shall be made in particular by activities such as naval receiving stations, separation centers, recruiting stations, naval hospitals (all types), naval dispensaries, and other activities handling large groups of non-permanently attached personnel.

4. The instructions for preparation and submission of NavMed 582 as outlined in ref (a) are cancelled and replaced by those outlined in enc. 1.

--BuMed. Ross T. McIntire.

\* \*

(Not Restricted)

## 35D3

**MONTHLY MORBIDITY REPORT - 35D3.1 GENERAL. - NAVMED 582** (Monthly Morbidity Report) is designed to provide the Bureau with current information for planning and coordinating the program for the prevention, control, and treatment of morbidity.

**35D3.2 PREPARATION AND ROUTING. - NAVMED 582** shall be prepared at the end of each month by all Navy and Marine Corps activities having Medical Department personnel attached. Activities having 25 or more transients attached (i.e. personnel not permanently attached) during the month shall prepare two types of this report. The first of these types, (subsequently herein referred to as Type 1), shall be the usual one, routinely submitted by all activities and shall pertain only to personnel of the Navy and Marine Corps permanently on duty at the individual activity. The second type (herein referred to as Type 2), shall pertain to all transient personnel. For the purpose of this report "transients" are defined as Navy and Marine Corps personnel who are attached to the activity in a temporary status (e.g. all patients on the sick list undergoing separation in a Medical Activity; all personnel awaiting separation; all personnel awaiting assignment; personnel temporarily attached to recruiting activities, etc.). This second type of report shall be marked "Transient Personnel" following the title at the top of the report form. The original of each type report shall be forwarded promptly to the Bureau and a copy retained on file. An additional copy of either or both types shall be forwarded to the cognizant senior medical officer, ashore or afloat, whenever required by him. The form shall be submitted as above for the portion of the month in operation whenever an activity is established or disestablished, commissioned or decommissioned.

**35D3.3 CONSTITUTION OF AVERAGE STRENGTH. - I. For** personnel permanently attached. (Report only on Type I Report). Each reporting activity shall include all permanently attached personnel on duty with or on detached duty from that activity, including: (a) for tenders and other similar ships of the fleet, the crews of attached craft

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(Not Restricted)

which carry no Medical Department personnel, (b) for shore based activities other than district headquarters, the crews of all yard craft attached, (c) for naval district headquarters; those on duty away from Medical Department personnel, including the crews of district craft which have no Medical Department personnel, (d) for central recruiting stations, all permanently attached personnel. II. For transient personnel (Report only on Type II Report). All naval activities having 25 or more transient personnel, who, individually, are temporarily attached for any period during any one month, shall report these as average strength only on the special "Transient Personnel", NavMed 582, as directed in Paragraph 35D3.2. Transient personnel shall include those active-duty personnel who are undergoing treatment, awaiting separation, awaiting assignment or in any status not permanently a part of the complement of the reporting activity.

35D3.4 CALCULATION OF AVERAGE STRENGTH. Average strength for enlisted personnel shall be computed by dividing the total number of daily rations issued and consumed during the month, or part of the month covered by the report, by the number of days in that period. The average strength for officers, (including officers of the Nurse Corps, and of the WAVES), and additional personnel listed in paragraph 35D3.3, for whom data on daily rations is unobtainable, is computed by dividing the total number of personnel days by the number of days of the month. Ships and stations shall not include in their average strength any personnel attached to the staff of a naval hospital. Naval hospitals and dispensaries (having 25 or more beds) shall report on their regular Monthly Morbidity Report (herein referred to as Type 1) only personnel attached to the staff (whether in duty or in sick status), except that the U.S. Naval Hospital, Bethesda, Md., shall include all personnel attached to the staff of the National Naval Medical Center. Naval hospitals and dispensaries shall report in the average strength of their "Transient Report" (herein referred to as Type 2), the patients on the sick list undergoing treatment during the month who are not permanently attached to their respective staffs. Average strength for the special "Transient Personnel", NavMed 582, shall be computed in a similar fashion by using transient personnel records.

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(Not Restricted)

**35D3.5 PERSONNEL TO BE REPORTED - I.** Reporting of permanent personnel (Report on Type 1 Report). Each reporting activity shall include all personnel permanently attached to that activity. For reporting personnel in special categories reference should be made to paragraph 35D3.6. **II.** Reporting of transient personnel (Report only on Type 2 Report). Report all personnel not permanently a part of the complement of the reporting activity.

**35D3.6 REPORTING OF PERSONNEL IN SPECIAL CATEGORIES -** Special categories of active-duty personnel of the Navy and Marine Corps, regular and reserve, and the methods of reporting them, follow:

(a) Personnel admitted to the sick list while on leave, temporarily away from command, or while on duty away from Medical Department personnel, shall be reported as A (NEW ADMISSION) on NavMed 582 of the Medical Department of the activity to which they are permanently attached. When taken up on the sick list by the Medical Department of a naval activity other than the one to which permanently attached, they shall be reported by that activity as FT (FROM TRANSFER) on the "Transient Personnel" (herein referred to as Type II report), and not as a new admission.

(b) Personnel on duty in yard craft shall be reported on the NavMed 582 of the activity to which the yard craft are attached.

(c) Personnel of ships of the fleet which have no Medical Department personnel shall be reported on the NavMed 582 of the ship (tender or other vessel) to which such craft are attached.

(d) Personnel on duty in submarines (exclusive of V-boats) shall be reported as in categories (a) and (c) of this paragraph. Personnel on duty in V-boats shall be reported on the NavMed 582 of such V-boats.

(e) Personnel on duty in district craft which have no Medical Department personnel attached shall be reported on the NavMed 582 submitted by the Medical Department of the district headquarters.

(f) Personnel on recruiting duty shall be reported on the NavMed 582 of the central recruiting station to which they are permanently attached.

(g) Personnel on isolated or other independent duty away from Medical Department personnel shall be reported on the NavMed 582 of the command to which they are permanently attached.

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(Not Restricted)

(Not Restricted)

(h) Personnel on duty in the Navy Department, Washington, D.C., shall be reported by the U.S. Naval Dispensary, Washington, D. C.

(i) Death occurring while on leave shall be reported only on the NavMed 582 of the activity to which the individual was attached whether permanently or in a transient status, at time of death.

(j) When intervening disabilities occur while on sick leave, they shall be reported on the NavMed 582 of the medical activity from which sick leave was granted.

(k) When intervening disabilities occur while on convalescent leave, the first medical activity which takes up the individual on the sick list shall include the case in its "Transient Personnel", NavMed 582.

(l) Patients first admitted to hospitals other than naval hospitals shall be reported on the NavMed 582 under the proper method of taking up on the sick list of the respective activity to which the individuals are permanently attached.

(m) Whenever a patient becomes the responsibility of the Medical Department of a naval activity other than the one to which he is permanently attached, he shall be reported as an FT (FROM TRANSFER) on the "Transient Personnel", NavMed 582, of the activity taking the patient up from transfer.

(n) A patient admitted to a hospital, other than a naval hospital, shall be reported on the NavMed 582 of the activity to which the individual was last attached (permanently or as a transient). If such a patient is attached to an activity not having Medical Department personnel, the procedures directed in categories (a),(b),(c),(d),(e), and (g), of this paragraph shall be followed.

(o) The U. S. Naval Hospital, Bethesda, Maryland, shall submit a NavMed 582 (Type I) to include all of the personnel except those reported in Type 2, "Transient Personnel", attached to the National Naval Medical Center.

(p) Transient personnel who become patients of the Medical Department of naval activities having 25 or more transient personnel temporarily attached during the report month, shall have their morbidity and mortality reported in the special "Transient Personnel", NavMed 582, as directed above in Paragraph 35D3.2.

This page may be removed and inserted in the Manual.

Circular Letter 46-91

11 June 1946

(Not Restricted)

To: All Ships and Stations.

Subj: Therapy of Early, Latent and Relapsing Syphilis with Penicillin and Metal Chemotherapy; recommended schedule of.

- Refs: (a) BuMed Cir Ltr 44-73, 5 May 1944.  
(b) BuMed Cir Ltr 45-127, 18 May 1945.  
(c) BuMed Cir Ltr P3-5/P3-1, 30 Oct 1945, (N.D. Bull, Item 45-1545).  
(d) AlNav 158, 5 Apr 1946 (N.D. Bull, Item 46-732).  
(e) BuMed Cir Ltr 46-63, 10 Apr 1946 (N.D. Bull, Item 46-767).

1. References (a), (b), and (c) are herewith modified.
2. As a result of recent developments, indicated in references (d) and (e), the following treatment schedules are recommended for subject syphilis cases:

- (a) Primary seronegative; 60 intramuscular injections of penicillin, 100,000 units each, every 3 hours day and night for 7 1/2 days - total dosage 6 million units.
- (b) Primary seropositive; secondary and latent; 80 injections of penicillin, 100,000 units each, every 3 hours day and night for 10 days - total dosage 8 million units.
- (c) First relapse or reinfection of previously treated syphilis cases; 80 intramuscular injections of penicillin, 100,000 units each, every 3 hours day and night for 10 days - total dosage 8 million units. Concurrently intravenous injections of mapharsen 60 mgm (0.06 Gm) each twice weekly for 5 weeks - total dosage 600 mgm, and intramuscular injections of bismuth subsalicylate in oil 1 1/2 c.c. (200 mgm) (expressed as subsalicylate NOT as bismuth metal) each week for 5 weeks - total dosage 1,000 mgm.
- (d) Second relapse of previously treated syphilis cases; 26 weeks mapharsen-bismuth schedule. This consists of 10 weeks of mapharsen injections given twice a week followed by 6 weeks of bismuth given once a week and another 10 weeks of mapharsen given twice a week. During the first 5 weeks, also during the final 5 weeks of treatment, bismuth is given once weekly along with mapharsen. Dosage of mapharsen should be approximately 1 mgm per kg. of body weight;

(Not Restricted)  
 minimum single dose, 50 mgm and maximum single dose, 70 mgm.  
 Dosage of bismuth subsalicylate in oil is 1 1/2 c.c. (200 mgm) (ex-  
 pressed as subsalicylate NOT as bismuth metal).

3. The medical officer shall be on the alert for evidence of reaction or toxicity in the treatment of all cases involving penicillin and chemotherapy.
4. It is emphasized that it is important to make monthly serological examinations for one year and a spinal fluid examination between the 3rd and 6th month following completion of treatment. The results of these examinations shall be recorded on Form NavMed H-7.

--BuMed. Ross T. McIntire.

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Circular Letter 46-92

12 June 1946

(Not Restricted)

To: All Ships and Stations.

Subj: Medical Department Property, Proper Supervision, Safeguarding and Accountability of.

- Ref:
- (a) Chapter 32, Navy Regulations.
  - (b) Chapter 49, Section 3, Navy Regulations.
  - (c) Part VI (Chapter 20 of 1938), Manual of the Medical Department, 1945.
  - (d) Art. 194, Treasury Department, Bureau of Narcotics, Regulations No. 8, dated 1 June 1938.

1. Large quantities of Medical supplies and equipment have been reported by survey on SandA Form 154 as "Missing" without adequate statement of circumstances involved in order that losses may be justified. It is the responsibility of all officers charged with custody of Medical Department property to comply with references (a) through (d), relative to custody, accountability and safeguarding of Government property. It is mandatory that every effort be made to safeguard medical stores, with special emphasis being placed on narcotics and other poisonous drugs.

2. Although lack of experienced property and accounting personnel and rapid demobilization may have been the reason for the apparent laxity in the proper safeguarding of, and strict accountability for, Medical Department Property, such laxity can no longer be countenanced. Supplies and equipment surveyed in the future as "Missing" shall be accompanied with an adequate statement of circumstances.

--BuMed. Ross T. McIntire.



Circular Letter 46-93

12 June 1946

(Not Restricted)

To: MedOfCom, All NavHosps.

Subj: Survey and Inspection of Motion Picture Equipment.

1. The Bureau of Ships as a part of discharging its responsibility for providing motion picture equipment for the various naval activities has made available a unit of technically qualified personnel to inspect and advise local activities as to their projection equipment.
2. This unit is authorized to perform the following functions in accordance with established procedure:
  - a. Recommend adjustments of motion picture projection booth installations to insure maximum safety factors and revise operating technics to minimize film damage.
  - b. Direct local distribution of motion picture projection and related equipment for maximum operating efficiency.
  - c. Advise in establishing major and minor equipment repair centers at the various Naval Shipyards and Naval Repair Base, San Diego.
  - d. Investigate local civilian equipment repair companies to assist in establishment of an equipment maintenance program.
  - e. Direct Distribution of excess equipment to repair centers for repair and restocking or for transfer to Surplus Material Salvage and Disposal Units.
  - f. Assist Activities to establish procedure to procure spare parts.
3. Naval hospitals shall take this opportunity to improve plans and channels for the procurement, operation and maintenance of motion picture projection equipment on a scale commensurate with the importance of these audio-visual aids in the Medical Department's post-war training program.

--BuMed. Ross T. McIntire.

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(Not Restricted)

officers who have not graduated from a recognized school of pharmacy or who have not received a degree in a science allied to medicine other than pharmacy. Physical requirements same as stated in BuPers Circular Letter 288-45 (revised), of 15 November 1945, and Alnav 271-45. Age requirements same as for Medical Corps, and in addition ensigns must not have attained 32 years of age on 1 January 1945.

Part 3. This is change No. 5 to BuPers Circular Letter 288-45 (revised), of 15 November 1945. Paragraph 14, add new subparagraph as follows:

“(e) Hospital Corps—same as for line and supply corps officers (see par. 13 above) or, graduation from a school of pharmacy recommended by the American Council on Pharmaceutical Education or, graduation from an accredited school or college with a degree in science allied to medicine other than pharmacy, to include optometrists, podiatrists, chemists, bacteriologists, and entomologists. Officers will be selected from the above three groups in the ratio of 65 per cent, 20 per cent, and 15 per cent, respectively.”

Add new column to the age table in enclosure (A). Under heading “Hospital Corps” list the ages shown under the Medical and Dental Corps table and in addition, age 32 opposite the three dates of rank for ensign.

Part 4. Applications previously made which meet the provisions of BuPers Circular Letter 288-45 (revised), of 15 November 1945, and change No. 5 thereto, need not be resubmitted. Eligible applicants who may now desire to transfer in commissioned-officer rank instead of commissioned-warrant or warrant grade as previously requested should so inform BuPers by letter via commanding officer or reporting senior, referring to their original application and this Alnav. Officers who will be required to take the equivalent general-background and mental-capacity test should do so at earliest opportunity.

--SecNav. James Forrestal.

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To:	All Ships and Stations.	(Not Restricted)
		Pers-67-jmp
		P17-2/MM
Subj:	<u>Change of Rating-Enlisted Personnel, Re: Changes to Hospital Corps Ratings.</u>	13 May 1946
Ref:	(a) BuPers Circ. Ltr. 190-43; N. D. Bul. Cum. Ed. 1943, 43-1449, p. 864.	
	(b) Art. D-5114, BuPers Manual.	

1. Reference (a) is hereby canceled.

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2. It is desired that all enlisted personnel, prior to change to a Hospital Corps rating, undergo a basic course of instruction at a Hospital Corps School, insofar as is practicable.

3. Effective immediately, no further changes to Hospital Corps ratings shall be effected without prior Bureau approval except as authorized under the provisions of reference (b). Recommendations for changes to Hospital Corps ratings shall be submitted to the Chief of Naval Personnel, via the Chief of the Bureau of Medicine and Surgery.

--BuPers. T. L. Sprague.

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