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GHQ/SCAP Records (RG 331, National Archives and Records Service)

Description of contents

(1) Box no. 2816

(2) Folder title/number: (19)
No Title

(3) Date: Apr. 1949 - Feb. 1951

(4) Subject:

Classification	Type of record
9032.2, 9751	i, k, t

(5) Item description and comment:

i) Kanto
ii) Includes "Handbook for Ito Style Trachoma Mass Treatment" by Yaeji Ito M.D.

(6) Reproduction: * (Yes) No

(7) Film no. Sheet no.

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25 September 1950

HANDBOOK

FOR

ITO STYLE TRACHOMA

MASS TREATMENT

(For "X1-10" Ophthalmologic Salve)

By Professor of Chiba University
Yaeji Ito M.D.

Published By Kyorin Shoin

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The Preface

Trachoma in Japan exists in a high rate. It is very shame to say that our country is a cultural country, having many trachoma patients among the population. A sign board like, unsanitary land, uncultural people are inserted here. So, this must be exterminated.

The necessity of extermination and prevention has strictly been advocated by speeches or words since the end of Meiji era and it is also known that it was carried out usually and zealously. Especially, the ophthalmologists are volunteered to this exterminating fight, and are doing their best to make effort. It might be said that it showed effort to some limits but it can never be said that it has decreased from the viewpoint of the whole number of patients. But only the next thing is surely the achievement of the ophthalmologists. Namely, the severe patients who might be blinded, have remarkably decreased.

A trachoma land like Japan has a great amount of epidemic source and the real situation is that the quantity if so large that it is quite hard to control the spreading.

I believe that this source extermination must depend upon mass treatment. But as the original way isn't enough and as I realized keenly that a mass treatment under some new ideas, using suitable new treating methods must be found, it has zealously been studied and the effort was announced on the Nihon Iji Shimpo last year (1949) to have it criticized.

My announcements contains both the idea and practice. The former one has the problem of how the substance of trachoma is looked, so this point is still being studied. And the latter one is the guidance of the performance of mass treatment. So this needs kindness. I have already mentioned all the important items on performance but I haven't given each detail and necessary point at the time of practice.

I wrote the literature for the doctors as an object, those days, but I have found out the necessity of writing it in detail for performance by the experience, afterward.

I have been doing my best to accomplish the purpose by supplementing the published sheet several times since last year, but I have received many questions from many zealous persons during the time, which I felt to be important and I have written answers to each of them, but I have hereby keenly felt the necessity of gathering them.

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The purpose of this book is just as I have mentioned above, so I have shortened the technical part as possible. But I have added the detail as possible on the technical items that has relations with the text. The part in small types are what I have mentioned. As the aim was to let everybody understand it, I would like you to comprehend it.

In conclusion, I express my gratitude to the self-sacrificing co-operation of assistant professors, Dr. Yoshitami Suzuki, Professor Dr. Ko Chugi and the other staffs of the laboratory at the time of the performance of Ito style mass treatment.

16 March, 1950

At the Ophthalmologic Laboratory
Medical Section, Chiba University.

Yaeji Ito, M.D.

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Preface

This book is a description that gave a systems to my method by using "XL-10" ophthalmological salve for trachoma mass treatment. I hope that the performance of the mass treatment will be done according to the inserted content. As this was made in conformity with my sufficient experience and consideration, I believe that the system is already made with the exception of completion or imcompletion.

I have also described some related items that might better be known at the time of the trachoma mass treatment in my style, so this book has happened to have the content of a trachoma text book.

As there were necessity to put the aim on the people besides the specialists as readers, the places that are specially important for the ophthalmologists were described in large types.

I have endeavoured so that the content of this book will have the newest knowledge of the ophthalmological academic circle of the world. By this, it happens that this is the most progressed book than any other newly published or revised text book in Japan, after war. This is unavoidable by the situation that scholistic interchange with the foreign countries was stopped since war, enough books, literature didn't come in even after war and that it is only one or two years since it started again. The situation has been remarkably recovered recently, but it has not become as it was before war, yet.

It is only a common sense to the Europeans and Americans that sulfa drug has remarkable effects against trachoma and though their published ophthalmologic text books are inserting the trachoma treatment that is done at the very first, the Japanese text books has been still showing doubtful attitudes. This is one of the remarkable examples, but I think that there aren't so few that are still doubting the effect of this sulfa drug salve to trachoma, done by local treatment. But these people will surely begin to recognize the value, because there aren't any reasons that of falling behind.

And I have oftenly mentioned about trachoma disease germ. It is thought to be virus. This is not done by an established assumption, but there aren't so much difference in common sense of the recent world. I will hereby describe beforehand that I am writing, relianting on this disease germ.

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Chapter 1 Prelimanary knowledge

Section 1. Ophthalmologic Sulve "XL-10"

This book was written to make the people have more understanding on trachoma mass treatment. Also, this book was written to give a more detailed account on the point of the performance.

The scientific name 'Trachoma' used in Japan, was united by the Japanese Ophthalmologist Academy that was held on the 5th of Showa (1930). The original word is 'Trachoma' and it is used in England, America, Italy and etc. It was called trachome up to this date, and it might be familiar, using this name as usual. The original word is Trachome in German and is also pronounced in the same way in France using the word Trachome. The Trachome Prevention Association, and the Trachoma Prevention Law of the Home Ministry of Japan still remains. So we should know both, the scientific name 'Trachoma', and popular name 'Trachome'. But, it should be united in the future.

The mass treatment of Trachoma, which I advocate is done by using an eye salve called 'XL-10'. During the term of this treatment, the other treatments are not used as a rule. Namely, 'XL-10' is important to my mass treatment. So, I would like to explain about this salve first.

'XL-10' contains few sulfa drugs as chief element, some other drugs asebasic elements and this mark was used in our laboratory during the examining period of this trachoma salve. This was decided after making many trial productions and putting marks on them. The formation 'XL-10' is, homosulfamine (10%) as the chief element, lanolin and vaseline as the chief elements of the basic drugs. As a special artistic excellence is needed to prepare the medicine, this is the name including the whole drugs. A year was used because there was a big difficulty to make marketing commodity salve, having the same quality. The marketing commodity's name is 'XL Homozol'.

I would like to explain about the 'XL-10' (abridged 'XL') as it appears in the whole volume.

The special feature of my mass treatment is that the other doctors or those who are not doctors, nurses, and school-nurses could be preformers of the treatment, decides the use of 'XL' salve. Even the ordinary school teachers and other people can take the place for treatment, if they can understand the technic of using the salve and annexed nurse items like the nurses. 'XL' was made under this object.

The strong point that is obtained by this, is the acquisition of many helpers in districts which are in shortage of ophthalmologist (or medical specialist) to exterminate Trachoma. And increase the members who treat Trachoma, raises the interest and eagerness of the general peoples and propel it toward the people. I think that sanitary insusceptibility against Trachoma could be cleared off; then.

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Sanitary insusceptibility against Trachoma is excessive in our country. I have explained about this oh the situation of Chiba Prefecture on the first report (Nippon Iji Shimpo, 23 July 1949, 30 July 1949, and 6 August 1949, Part 2, page 5). 90% of the presumed Trachoma patients in Chiba are the above-mentioned sanitary insusceptibilities. They don't visit doctors and are acting as the infectious source and only 10% are receiving treatment. As the latter ones aren't sanitary insusceptibility, they have connections to the destruction of Trachoma, whether they aren't perfectly cured by medical treatment or stop receiving treatments. But the above-mentioned 90% of Trachoma patients don't still have connection nowadays. Most of these non-connected patients are living in the fishermen's village and it makes me shudder. I presume that there might be a great many of non-connected groups and I think this problem will be settled by getting a great deal of help from the above-mentioned treatment performers for thedestruction movement.

As I have mentioned above, I would just like touse 'XL', namely 'Homozol'. The reason is as follows. The chief element, homosulfamine, basic drug lanolins are unsuitable for this salve. For example, lanolin according to the Japanese Pharmacopeeia is also unsuitable. There are many possibilities of manufacturing rejected goods of homosulfamin salve by freely mixing those things individually. And same possibilities to the other marketed article. The results by using these rejected goods are different. Homosulfamin vaseline also belongs to this rejected group. From these reasons, I would like to write this book by using 'XL' only.

Section 2. THE NECESSARY GENERAL KNOWLEDGE

This section is on about the distribution of Trachoma of the world and the rate of trachoma in Japan.

Clause 1. The Distribution of Trachoma of the World.

"Report on Trachoma of the World", published by the Sanitary Bureau, International League, was made by gathering the investigation papers that were sent to every country. The person in charge was N.M.J. Jitta (Netherland) and A. Lutrario (Italy) and is a reliable report.

"Social Managements and Laws against Trachoma" was a report of M. Zachert (Poland) on July, 1935 which was done at the yearly meeting of institution, of the International Organization for the Campaign against Trachoma that was held at London in 1935. And Wibaut's Trachoma Chart is recorded on it. The latter one was made and presented by Dr. Wibaut to the 13th International Ophthalmologist Academy that was held at Amsterdam in 1929. This is also an authorized one.

The above-mentioned two reports (three, if adding Wibaut's) of Jitta and Zachert are comparatively the recent world look of Trachoma. But as there are no reports since that I'm showing one which I picked out from the above-mentioned three reports (Table 1).

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TABLE DISTRIBUTION OF TRACHOMA OF THE WORLD

(Picked out of Wibaut's 1929, Jitta and Lutrario 1930, and Zachert 1935)

Group A (0-5%)	Group B (5-20%)	Group C (20-40%)	Group D (40-100%)
Germany	Australia	Rumania	Lithuania
England	Esthonia	Turkey	China
Belgium	Greece	Soviet Russia	India British Colony
Finland	Chekoslovakia	Japan	Indochina
Hungary	Yugoslavia	Argentine	Iraq
Italy	Uklaine		Palestine
Holland			Algeria
Lucksenbergh			Egypt
Canada			Tunisia
North America			
Poland			
France			

I divided it into 4 groups (A-D) and wrote down the names of the countries. The following matters are found from this.

(1) Most of the European countries belong to group A.

(2) Asia, Africa, Central Asia and etc. belongs to group D.

(3) The countries between these two groups belongs to group B & C.

(4) Japan belongs to group C.

Even in group A, especially Germany, England and America are at least under 0.5%. Even in group D, Egypt is known to be famous by her high rate Trachoma (100%), and Palestine, India British Colony, China and etc. are about 80%. It is pleased that Japan is rather good among the Eastern countries.

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It is quite interesting by changing the view point to know that the Trachoma rate becomes higher as the country becomes older.

The above-mentioned reports are comparatively reliable ones and I believe that the statistics are quite correct in England, America, Germany and the other European civilized countries that only have few Trachoma cases. But in the other countries I believe that they don't have any perfect statistics. There cann't be any in the countries which have the highest rate of Trachoma. As the datas of these three reports were presented by the scholars of every country, I think that it shows the presumption of every man's subjectivity. But there are no objections because it shows the common sense of the world.

I think we feel the same way that Japan hasn't thrown away her pride and hope to join the civilized countries of the world even after war as she did before war. But we should be shame to associate with the A Group, being in the C Group. So we should do our best to join the A Group as soon as possible by the effort of the people.

Recently, an American doctor who went back to States, said that they have above two thousand hospitals in New York, but probably there are not a single Trachoma patient. I experienced the same matter in Berlin. Even the famous eye-specialists in Berlin did not have self-confidence on Trachoma, and they brought in the suspected patients to let me see it.

But it seems that there was some change in the European countries on the rate of trachoma recently. It was caused by the interchange of Trachoma during the world war (by the movement of the occupied army, garrison, war prisoners, laborers and etc.). And suddenly the Trachoma problem raised its head in the countries which were safe from it. This matter must have made America and etc. raise caution against Trachoma. The Trachoma problem in Japan is an urgent, because the communication with America is becoming close. An army surgeon said that the spread of Trachoma in Japan is terrible.

Clause 2. The Number of Trachoma Patients in Japan.

It is very difficult to presume the total number of Trachoma patients in Japan. There are many reasons on it, but I think that the following two reasons are the biggest:

(1) The statistic of Trachoma of the Education Ministry is not reliable.

(2) The statistic of Trachoma of the young men's physical examination (that was done to the military aged men) cannot be believed.

The statistic of the Education Ministry was made by gathering the reports of every Fu, Ken, and the reports which every Fu, Ken made was done by gathering reports of the primary and middle school in which they are in charge. But the latter ones were made by the school doctor and

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most of the doctors are not eye-specialists. So the statistics of the Education Ministry are not reliable.

Sometimes I used the word "trinity" on the report of rate of Trachoma which comes from the schools. It means that the principal of the school, school doctors and the prefectural officers get together, shows a tendency to hope the rate of Trachoma to be a low one. It would be pleasant if it is really a low rate. I think that in some cases, they would give reports showing low rate, all going toward the tendency of unnoticed, or deliverated. But the Japanese text books on ophthalmology are responsible, too. Because it teaches us that Trachoma rate throughout the country is about 10% and I think that it preoccupies our mind. Or may be there are some school doctors who do only poor inspections on the conjunctive of the lower eyelid, and they only choose those which swwms to have serious illness. It is a funny talk but once an eye-specialist took place of a school doctor in a school and the principal grieved that the new doctors increases the number of Trachoma, too much. I think that the society is made by creatures so it does not move theoretically.

I never doubted the Trachoma result of the young men's examination in the past, but reflecting and examining into it nowadays, I have found out that it is not perfectly reliable. But in comparative with the statistic of the Education Ministry, it is rather correct. Probably, this has some meanings of the military government and this has effects on the report of the Trachoma rate. And also, most of the army surgeons in charge, received only a short lecture and seems to be unfamiliar in diagnosing. I know some army surgeons who I taught, and I found out a part of the situation of the militarism era by knowing that most of those demobilized ones have experience of young men's examination.

So the Trachoma rate of the Education Ministry is beyond compare with the trachoma rate of examination result of the youth. But I believe that it needs some amendment.

Excluding the case of statistic, this yearly done physical examination to the yough has rendered a great deal of distinguished services to the prevention of Trachoma. It wan not only used in Japan for the extermination of Trachoma. This important inspection was stopped after war, and those who repatriated and many who enter Japan from countries where they have more worse spreads of Trachoma, are causing a part of the spreads of Trachoma.

The whole statistic of the country has less reliance, but there are many reliable local statistics. I believe that all of the ophthalmologic departments of universities and those of the hospitals, ophthalmologic practioners in accordance with the universities, are showing conscionable statistics. These are the local ones, so this will be useful to presume the whole. I have been very friendly with many ophthalmologic practioners throughout this prefecture (Chiba) for many years. So I have tried always to ask the practioners, the number (rate) of the Trachoma patients they undertake, at the time of group discussion. But recently, I have actually found out the substance of trachoma of primary schools in various districts deciding them into many units (school). The latter one was generally

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separated from the reports of the school doctors, but I have found out that the rate was lower than I thought. There are famous schools by trachoma on the seashore districts, but I don't know all about the prefecture. I think that I have understood something about the situation of Trachoma in Chiba prefecture.

I have done some investigation on the east-north region (Tohoku Region) because I heard that there are great many cases there. I am sure that there were quite many in a village of Miyagi Prefecture, but the rate was unexpectedly low. On the other hand, I have found out that there were many school Trachoma than I expected in the villages throughout Yamagata Prefecture and near Yamagata-shi. There are some difference in each part of Tohoku Region. There are many reports on Trachoma from each part of the country in the magazines and etc. and it does a great deal of reference by looking at it minutely. So, I think that the general numbers of Trachoma in Japan can be presumed by not gathering the reports and reckoning them.

From the above-mentioned knowledge, I made a rough presumption of Trachoma distribution in Japan. (figure 2). As this is a rough presumption, there are a great deal of subjectivity, working on it so it is not a correct one. I think that there are many who have a different opinion, so I would like them to correct it.

TABLE 2

District	The Presumed Trachoma Rate
1. The six great cities	below 10%
2. The mountainous district	10 - 20%
3. The farm villages and fishermen's village	20-40%
4. The Tohoku District	30-50%
The average throughout the country (presumed)	20-30%

Remark:

1. Probably, the Trachoma of the primary schools are same to the above-mentioned one.

2. The placeswhere they have a great many Trachoma are:

   a. Fishermen's village,
   b. Mines,
   c. Farm villages by the side of big rivers,
   d. Separated islands where they do fishing.

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3. The places where they have few Trachomas are:

a. The center of great cities
b. Sanitary cities
c. Clean mountanous farm villages

The purpose that I presented this chart, is as follows. I think that the people are thinking that the rate of Trachoma in Japan is 10%, but an officer of the Civil Affairs Region who seems to be familiar with Trachoma, is wondering a great deal about the assumption. Namely, it is that every health center says that it is 10% when they are asked about the rate of trachoma, as if they made promises to say so. Every body knows that this is funny. Certainly, those who are familiar in this case will never fail to notice this funny matter. I was oftenly questioned about this, but I was puzzled because I cannot give any answer with self-confident. From this effect I made Table 2.

I think that it will be better if there is a way to reckon the local rate of Trachoma. I thought that the foundation of reckoning might be requested from the following two correlations.

1. From the rate of new Trachoma patients throughout one year, which the eye-specialists handled in the area.

2. From the perfect rate of Trachoma of the schools in the area.

The latter one is unreliable in the present situation, but I think that the rate of the former one is quite correct.

To make the rate of Trachoma clear, is the way to know the size of the infection source and is very important. As I have mentioned above, it is necessary to multiply the coefficient of separated area to the quantity of sanitary insusceptibility.

Section 3. GENERAL KNOWLEDGE ON TRACHOMA

Trachoma is an inflammatory disease and the process is chronic. If it once becomes serious, it will not be perfectly cured and if the treatment is failed to be attended, it will trouble the patient throughout his life. The patient will become nearly blind or perfectly blind.

The place where the disease occurs is the eye and the tissues and organs which is attacked by the disease are the conjunctiva of the eyelid, conjunctiva of eyeball, caruncula lacrimalis cornea, lachrymal sack and etc. But it also attacks the cartilage of the eyelid. In words, these are all called the eye region and there are no relations with the face region nor the other parts of the body.

Some of the Trachoma breaks out acutely and some of thoee are comparatively benign ones. There are some which are naturally cured. There is a disease of the women's genital mucous membran (mucosa) resembling to Trachoma and those Trachoma like diseases that are caused by this, is called paratrachoma. The relations between the latter one and

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genuine one are studied by the scholars now. This is very important to deliberate the infection of Trachoma. Some of the scholars, place limits on those which inclusion bodies are proved in the conjunctivae epithelial cells and shows the Trachoma like type, clinically.

Trachoma is a contagious disease. Most of the contagious contact tracing is done by the family, next to school, factory and the other mass lives. So, if the family is left alone and only mass treatment done, the contagious source will be left and it will decrease half of the effort. It is certainly an ideal to preform the mass treatment to the family in parallel with the village people. But I myself is still wondering, what to do to the latter one. I cannot leave this important problem unfinished.

Next, the outline of change of the disease is as follows:

The first change that happens is the inflammation of the conjunctivae, next hyperaemia, swell, granule, papilla, and at the same to me the first stage of pannus in the cornea appears. As a result of the inflammation, discharge arises and foreign body feelings, pain, lachrymation and decrease of vision and etc. appears as subjective symptoms. These symptoms, progresses by degree and keeps acting on the above mentioned tissues. This is the essential elements of Trachoma and I would like to call it inflammatory elements.

Next, the inflammatory elements does the healing crisis from one side by degree and forms cicatrical tissue as a result. When this element is called cicatrical element; these two elements progresses together during the process of the disease. If the process of Trachoma only changes into cicatrix from one act: like paper sliding picture (kami shibai), it will be easy to start. But as the inflammation keeps going on one side, and forms cicatrix on the other side just like a motion picture film, the treatment is quite difficult.

At last, all changes into cicatrix and the inflammation which is the substantial element disappears, but when it reaches this stage, it might be said that Trachoma has been cured, substantially. But, besides this, the terrible situation caused by the cicatrical element remains as a permanent sequela. During the process, the inflammation and cicatrix both exists and complicates, and accumulates the mutual subjective and objective obstructions. Thus, a so-called distress, difficult matter of Trachoma appears. Namely, as the substantial inflammation cures, the cicatrix which is originally the healing crisis, makes the process rather complicated and a cynical phenomenon like the disturbance of healing appears. The formation of cicatrix starts partially from the climax of Trachoma and a suitable treatment cannot be done without understanding this.

'XL' is effective to the above-mentioned substantial element namely the inflammatory element and is not effective to the cicatrical element as a rule. A wrong conclusion can be obtained that 'XL' is not effective to Trachoma, from those who don't analyse the above-mentioned change of Trachoma. The first stage cicatrix is done in the tissue and sometimes cannot be found out macroscopically. So the doctors must deepen his cognition on the cicatrix in the tissue and know the way to

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restore it. Most of the examples that shows that 'XL' has no reactions are caused by the above-mentioned matters.

We have originally called the effects and situations caused by the cicatrix, the complications of Trachoma, but mistakes will be made when it complicates with some other diseases, so we generally call it scquela, now. The original famous sequela are as follows:

They are:

Blepharophimosis, entropin, trachiasis,
symblepharon, xerosis conjunctivae,
xerosis corneae, pannus (the latter term) and etc.

These symptoms are the object of operation. Besides this, pyorrhaea of lachrymal sack (Dacryocyslophennorrhoea) complicates easily with conjunctivitis of Trachoma, some times it owes to Trachoma.

Pus surges back from Angulas oculi medialis, bothers the cure of Trachoma and also it makes the cause of evil natured eye incision so it must be cured.

I think that chronic dacryocystitis in Japan has relations with Trachoma, directly or indirectly. If this is true, the extermination of this disease will have an important contact with the destruction of Trachoma.

In conclusion, I would like to write on complications. As there are acute, chronic conjunctivitis, conjunctivitis vernalis (vernal conjunctivitis) etc. in Japan, there are many chances for trachoma to complicate with those diseases. At this time, the symptoms of the two disease exists, so we are oftenly puzzled to diagnose trachoma. This is the problem that hangs about on the diagnose of mass treatment, but I think that it will be better to put this case into Trachoma dubium.

I am oftenly asked about the history of trachoma, so I would like to write down the outline. Trachoma was a disease we had from the ancient age. We could find the oldest correct description in Greek age (over 2,000 years ago). A more old record is the one in Egyptian monarchic days. (over 3,000 years). There is an excellent description in Sushruta Sambita of India. In this big medical reference book, all kinds of Glaucoma are classified as it is now and are explained in details. Next, ophthalmology of the Greater Arabian Empire was almost clinically perfect; and descriptions of Trachoma, too. I feel that the treating method of Trachoma (includes the operation) hasn't made so much progress in comparative with those days. I think it was 1,000 years ago. Next appeared the ophthalmology of China. The one in the era of "Zui and To" was a pueriled one, the one in the era of "So" showed progress and it was perfect in the era of "Genmei". The one in Japan is a little bit behind this but almost the same and was formed as ophthalmology in the era of Northern and Southern Dynosties (Majima style). We can find the words like Trachiasis, pannus in the description of Trachoma.

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I would like to write a little about the recent common sense of the cause of Trachoma. It is thought to be virus by the common sense of nowadays. But we haven't reached the stage of indicating some super minute particle surely. We will have to depend on the electron microscope. 1/1 millio million m.m. is used as the unit and it is just like 100 or 300. This study is done in several places in Japan, I'm also working on it but I think that none has been led to the conclusion. But as the virus problem of Trachoma is an interested matter throughout the world, I am sure that America, England, France and etc. are working on it. It will be settled at somewhere in the near future.

Chapter II The Practical Mass Treatment (Standard Knowledge)

Section 1. INTRODUCTION OF INDIVIDUAL TREATMENT AND MASS TREATMENT

Clause 1. Individual Treatment and Mass Treatment

Individual treatment means to give each Trachoma patient a suitable treatment individually. This is the method that was done to the patients by a skillful eye specialist, generally and Trachoma was treated almost by this way. The special feature is that the doctor can choose the most suitable treatment and operation to each patient. And also that the patient can choose the doctor whom they want and receive treatment on any hour and day they like.

This is certainly an ideal way for treatment and for receiving treatments. But there is a defect as follows in Japan. Namely, there aren't enough eye-specialists in comparative with the numbers of patients, so about 1% of all thepatients nearby are really receiving treatments. And also the doctor will be very busy if he was visited by amount of patients several times larger in the number, namely, the rate of the doctors are low against the patients, in other words the number of the patients are too enormous. So, the destruction of Trachoma is quite difficult, but in America, British and etc. the patients are few so it can be perfectly restored only by individual treatment.

This defect can be found in many places where the rate of Trachoma is more higher than Japan and where they have fewer doctors than Japan. (It is a common actuality in most of the trachoma countries). It is very necessary to perform mass treatment to help this condition.

The mass treatment of Trachoma means to treat the Trachoma patients of the schools, organizations,and the society, together. The special feature

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is to concentrate treatment at once to a specific mass, but the following limit will be necessary, using my way.

Namely, from the side who treats, treatment should be performed by the general doctors, nurses, school nurses and etc. besides the eye specialists to enlarge the limit of the preformers of treatment. From the side of the patients, the treatment should be received partially compulsorily for definite days (continued for 15 days). The idea of public health should be convinced to the latter ones.

From the side of originator, it is claimed that the method of the treatment is to be the easiest one, be fixed, harmless, the effect is to be rapid, and cheap (my four principles).

The Four Standard Condition. The main point is that the doctor could treat with ease and also that the patient could receive the treatment without pain to the mind and body with joy.

(1) The method of the treatment should be easy (so that everyone can do it).

(2) It should be harmless (so that everybody could use it without fear).

(3) The effect should be a rapid one (if not, the patients will get tired and also the doctors).

(4) It should be cheap (very necessary).

These are my four standard principles of mass treatment.

Since the new powerful treatments were found by the appearance of sulfa drugs, I have examined the drugs comparing them with my four principles. Though it might be an effectable treatment, I think it is suitable for mass treatment even if these is one principle lack.

If not, there will be no possibility of success nor permanence.

As mass treatment needs a constant standard treating method to all of the patients in comparative with individual treatment, there is a defect that we cannot freely select the method of treatment as in the former one.

We aren't the first one that used the word "mass treatment" and who carried out the performance. It was originally done by some zealous eye-specialists of schools, factories, also Trachoma treatment was done before the examinations of young men (of military age); and also at time of treatments to caterers etc. There were surely some which showed excellent results. But, each of these are the treatments which the eye-specialists use, so the problem of numbers of the ophthalmologists makes the spreading difficult. In other words, the enlarging and extention of individual treatment itself will do no good in Japan.

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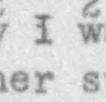
My style of mass treatment has a new idea by having some one else besides the eye-specialists to undertake the performance of the treatment. This might be the first time to be done. But MacCallan (Trachoma 1936), had clearly separated the individual and mass treatment and the latter one was done by hospital nurses, employees under the helps of ophthalmologists, but the ophthalmologic treatment room was used for the treatment and there were lacks in the plan preparations such as to spread it generally to the local districts. Namely, his method is the proceeding form of the individual treatment to my method. He has been studying on trachoma of Egypt for many years, so I think that he approached to this idea but I hope there will be more progress. But as there were no useful drugs that had revolutionary effects like sulfa drug at that time, there were no way for advance.

I am sure that I would not have thought out this method for mass treatment if there were not any appearance of sulfa drug.

Clause 2. Sulfa Drug and Revolution of the Method of Trachoma Treatment

The anti-bacterial chemical drug called sulfa-drug generally in Japan is a very old one, but the one that is said to be found nowadays is red colored ptontosil, made by Domagk (Germany, 1935). Next, white colored prontosil (1036), Sulfanilamide, Sulfathiazole Sulfapyridine (1937), Albucid (1938), and the others were composite continuously. These drugs are generally called Sulfa drugs (or Sulfonamid or Sulphonamide). Among those drugs, thiazole another name G.23 (1936) and Albucid are especially well-known as drugs for Trachoma. And homosulfamine which I use is a muriate (Prof. Ishidate Morizo) of marfanyl that was composited by Miller (1941) of Germany. Marfanyl is said to be a singular powerful drug among the sulfa drugs and the special features are as follows. The special feature is that it has a form of p-Amino-Methyl in the chemical formula (H_2NCH_2-  -SO_2NH_2). The following strong points are the incentive why I was going to use marfanyl for Trachoma in comparative with the other sulfa drugs.

(1) There are many bacillaries that are effectable. It works on aerobic bacillaries and especially anaerobic bacillaries.

(2) The virulence is very small and the stability is high.

(3) It is not rivaled by Para-Amino-Benzoic acid.

(4) It is possible to use yeast drug, procaine hydrochloric, anesthesin at the same time.

(5) It is not rivalled by blood, pus, effusion, necrotic tissue and etc.

(6) The effect will not decrease by the change of PH.

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(7) It is the best suitable local chemical treatment. Next is penicillin and streptomycin (Howes).

(8) It is effectable to diseases which other sulfa-drug and penicillin don't work.

These reasons made me think that homo-sulfamine is hopeful for the treatment of Trachoma. There is a possibility for the appearance of more effectable new drugs by giving a suitable change to the place of para in the formula. That is why we are having a new expectation on homosulfamine.

The reasons that Sulfadrug showed revolutionary effects to the treatment of Trachoma comes under the following points:

(1) Trachoma is cured by taking medicine internally.

(2) The effect is remarkable.

(3) The substance of the effect is that it works on the second infection cases, also seems to work on the pathogenic sourse of Trachoma.

First, Trachoma is a localized disease and it was originally thought that it wouldn't be cured without treating the local part. But it is a surprise that it will become better in a short time by using sulfa-drug internally. Next, from the point of effect, it is the second surprise that it has shortened the process remarkably. The third is, that it is behind the times to think that sulfa-drug is only effective to the second infection. In England and America, the way of thinking that it has rapid effects on Trachoma itself substancially, namely on the pathogenic source, has become influential. By the way mentioned above, it can be said that sulfa-drug has caused a revolution to the treatment of Trachoma. If there was any ophthalmologist who don't use sulfa-drug for the treatment of Trachoma, it can surely be said that he has fallen far behind the times.

It was an unfortunate matter to the medicine of our country that we have gone far away from their knowledge in cause that the European and American literatures ceased entirely during the war. And the development of America and Britain during that time was remarkable. Till 1942, Japan stood in comparison with Europe and America studying on the effect of sulfa-drug to Trachoma and our laboratory was working on the permeation by Iontopholyse (Katsumi) with success, (America started to devote themselves on this recently.) but the study of the axle side stopped during the war. The study on the effect of sulfa-drug to Trachoma has been continued with zeal during the war up to-day. The literatures on Trachoma which we received till the end of last year were over a hundred, but most of those were about sulfa-drug. By this, there are no doubt that this drug has a remarkable effect to Trachoma. It showed that the act was limited to the second infection in the first stage and didn't show any substantial effects to Trachoma itself. This opinion is still managing Japan nowadays, but America and Britain have become to believe from several years ago, that it might have substantial effects. And Sorsby

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(1948) declares that the original opinion is a mistake. (Modern Trends in Ophthalmology II Series).

Section 2. LOCAL TREATMENT OF TRACHOMA BY SULFA-DRUGS

At first, sulfa-drug was chiefly used for treatments by internal use. The effect by using the medicine internally, has already been recognized and nobody doubts it now. The secondary reaction by using the medicine internally shows an intensity that cann't be ignored. This is certainly a defect as a treating method of Trachoma, the local disease also. So, the way using the medicine internally is very useful for individual treatment, but it is not desirable for my method of mass treatment. If it is possible to use something like salbe in place of using the medicine internally for individual treatment, it is natural that everybody would like to choose the latter one.

So, this method is now being examined to all of the sulfa-drug and in the above-mentioned European and American literature of Trachoma, there are three groups of examinations like (1) using medicine internally (2) using medicine internally and locally (3) locally, and these three groups are mixed. There are many persons who reported, recognizing the satisfactory effect only by local use, just the same to the use of medicine internally.

By the effect, in America nowadays, the study on local treatment of eyes by sulfa-drug is done very actively.

The study can be analysed as follows:

(1) The choice of sulfa-drug.

(2) Device and invention on the improvement and manufacture of basic drugs of the salbe.

(3) The increase of penetration of the main drug in the salbe.

(4) Some way besides salve (for example, Iontopholyse).

Recently, many studies of this kind has become conspicuous.

A sentence that has a deep relation with the homosulfamine salbe which I claim was described by Mr.Steele and Mr. Leopold (Ophthalmologic Dept. of Pennsylvania University. 1948, May, Arch. of Ophth.) It says that, sulfamylon (made by the Ophthalmologic Dept. of Tulane University, it has the same formula to homosulfamine) has gathered the attention recently, and is very hopeful, but it asserts that no examinations has been done practically nor clinically against the infectous disease of eyes, yet. Still more to trachome. So 'XL' is the salve made for the

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first time in the world, using marfanyl.

The basic drug of salbe and device on making it; and etc. are technically interesting but I will not describe it here.

Section 3. THE POSITION OF INDIVIDUAL TREATMENT IN CASE OF USING 'XL' SALVE.

Clause I. The Treatment of Trachoma after the Appearance of Sulfa-drug.

As I have mentioned above, the effect of sulfa-drug against Trachoma has revolutionized the original treatment of Trachoma. So it can be said that the treatment of Trachoma has entered a new stage and the individual treatments of the specialists should deservedly conform it. It should be said that ophthalmology of America, after war, is in a position of taking the world under her leadership in case of penicillin and sulfa-drug. (There are some, besides these drugs yet). And it isn't too much to say that the cognition of the remarkable effects of sulfa-drug against Trachoma is only a common sense now. It is a remarkable fact that each text books on ophthalmology which were published or revised after war, are all putting sulfa-drug at the head of the treatment of Trachoma. By this silver nitrate, copper sulphate (blue vitriol) which were the best ones up to this time, has fallen to the next rank or have disappeared. On the other hand, some of the Japanese books which were published or revised after war, have nothing described about it or adds a little about it on the last paragraph. It is clear from this that Japan is behind the times.

I will write down some English and American books that inserts sulfa-drug as a treatment for Trachoma at the head.

(1) A Sorsby (above-mentioned, 242. 391 p. 1948)

(2) Traquair (Clinical Ophthalmology, 144. p. 1948)

(3) Parsons and Duke-Elder (Diseases of the Eye, 180 p. 1948)

(4) Neame and Willamson-Noble (Handbook of Ophth. 180 p. 1948)

(5) Adler (Gifford's Textbook of Ophthalmology. 213 p. 1948)

(6) Moffatt (Aids to Ophth. 39 p. 1948)

(7) Stallard (Modern Treatise in Ophth. 195 p. 1949)

(8) Perera (May's Manual of the Diseases of the Eye, 127 p. 1949)

The famous scholars on Trachoma are Dr. Thygeson (America) who claimed that sulfa-drug is the revolution of treatment for Trachoma, and also Lindner (Austria) who claimed "Sulfa-drug for Trachoma, and Penicillin for Blennorrhea conjunctivae."

As it has become quite easy for the universities to get foreign books nowadays, I believe that we should deservedly know the new

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current of medicine.

Clause II. Treatment of Trachoma Using 'XL'

The methods which the doctors should take, by using 'XL' salve for treatment of Trachomaare as follows:

As I have mentioned above, sulfa-drug is good for the inflammatory elements of Trachoma but not for cicatrical elements. So,

(1) Those that could be cured only by 'XL'

The disease period that the former elements is the subject, namely, the first period and the first half of the second period, can be:

The following items should be paid attention.

(1) The response of Trachoma to 'XL' is a general natured one but a few are weak.

(2) There are no cases of secondary reaction to the whole body nor to local parts if there aren't any existence of allergy. The eyeball conjunctiva oftenly becomes whiter than usual, but this is not secondary reaction by compulsion.

(3) By the complication of acute conjunctivitis and blepharitis, there were somecases when Trachoma was over sensitive to 'XL'. When the eye-lid and conjunctiva swells and congests, the use of 'XL' should be stopped and changed to penicillin.

(4) No cases of allergy was experienced on Trachoma itself. But I think there are some cases of allergy rarely in cause of constitution or temporarily.

(5) I found two cases that seems to be allergy in some cases 'XL', was used continuously over a month. And the use of 'XL' was stopped.

(6) The eye is washed by salt solution (1%) and boric acid solution (2%) but other medicines are not used principally.

Next,cicatrix becomes to be formed by degree after the last half of the second period, and the disease reaches the deep part. In a word, the two elements of cicatrix and inflammation are complicated. There will be some cases that cann't be restored by only sulfa-drug. So, operations will be required besides the drug.

The operations done are called Kaining style, Aoyama style, Compressing method, Pakrein method, scarification, and etc., but any one will do. The important matter is to operate it slightly. It will also promote roughly.

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It is as above-mentioned that the latter one will have a bad effect in its process. To use 'XL' salve soon after the operation is an attention that should not be forgotten. This is very important because this will enlarge the effect of the operation of Trachoma. And there is a suitable field for Iontophalyse here. Sulfa drug can be easily permeated from the cataode. The cicatrix will thicken, reach the deep part and many sequela will happen after the third period, so all kinds of operation (the one that are done up to this time) should be performed against it and also it is necessary to add a suitable scarification according to my experience. The latter one has the foundation of my imaginary of virus, but the detail will be abbreviated.

It is good to give sulfa-drug for internal use besides 'XL' during this time. But we should previously know how the secondary reaction happens and know the suitable way to cope with it when it happens.

Those who take the standpoint that the source of Trachoma is Prowazek corpuscule is only a part of growth of the pathogenic microbe, but I don't think that the cause is limited only by Prowazek corpuscule. Perhaps, virus is the cause, so from this assumption, it is not something that could be proved only in the epithelium like Prowazek corpuscule. And I think that the virus exists in the diseased tissue, diffused widely over it. So the main point of my claim is how to make the medicine reach the place.

Most of us assume that it is caused by virus: but I think that the meaning of Prowazek corpuscule will increase its important from some other view points in the future.

I think that it is not right to use sulfa-drug internally as the main way of treatment for Trachoma. First, let us pick up the secondary reaction for a problem.

Dr. Almer A. Vorisek (1946) of Chicago is the advocater of the standard treatment of Trachoma (Sulfadiazine for internal use. Sulfathiazole salve (10%), thiazole eye washing solution (1-10%)). He gave 12 kinds of general and 8 kinds of local secondary reactions caused by the use of diasine internally, but there are a great deal that happens to be serious. He details the attention on the use of medicine internally. I would like to describe it, because I think it is important.

(1) The use of sulfa-drug internally, needs enough quantity and time.

(2) Make sure that the urine and blood calculation are normal before using it.

(3) Keep the level of blood calculation to 5-10 mg % cc during the use.

(4) Repeat the urine and blood calculation or keep the blood and urine basic.

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(5) Take enough water.

(6) Watch the temperature.

(7) Avoid the direct rays of the sun (photo sensitisation).

Diasine is said to be the most harmless drug among the sulfa-drug. But if we have to be so careful at the time of internal use, I doubt whether it has the possibility of universality of sulfa-drug as internal use.

Next, lets take the expense for problem. The internal use of scores of gram of sulfa-drug is quite expensive. It might be quite easy for the rich peoples, but I'm afraid that Japan and the other poor races who are threated by the spread of Trachoma cann't bear it.

The above-mentioned defect is always hanging about the internal use of the drug and this is why it is not suitable as a standard treatment for the small and weak races.

Clause 3. Necessity of Cooperation of Individual Treatment to 'XL' Mass Treatment.

As I have mentioned above, the effect of 'XL' salve is limited. The mass treatment which I advocate, is done by using 'XL' once every day, so it is natural that there is a limit to the effect. It certainly shows an immediate effect to comparatively fresh cases like the primary schools or those who haven't ever received treatment. But the cases after the third stage or cases which have been receiving treatments before, will clearly show worse effects in cause of the cicatrical elements. This is a case of primary schools, but I think that the same result will appear generally on other organizations when it is used as objects.

'XL' is used for only 15 days by my method. I have the following reasons why I decided it 15 days:

(1) The effect of 'XL' is generally perfect within 15 days. (Of course, the use of 'XL' will be added in some cases when needed).

(2) By examining it again a month after the treatment is finished, we find that the rate of healing has increased.

(3) Practically, 15 days is the most suitable length for mass treatment for schools. The effect will become short if it shortened than this and there will also be difficulty on the performance, if it is done longer than this.

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While the period of treatment is 15 days, it is necessary to use it in the most useful way, so I would like the practical attentions which I have described, to be obeyed.

At the time of practice of mass treatment, there aren't so few cases which are recognized that the operations are suitable to be taken at the same time just as I have expressed in the former clause. But as I haven't permitted any treatments besides the standardtreatment by using 'XL', the performers of the treatments are told not to add original individual treatment even when they make more effects. As a matter of course, about 20% of the students will be claimed to receive the supplement of 'XL' use or individual treatment. This individual treatment mainly means operation, but the above-mentioned slight operations will be enough. By this way, Trachoma faces recovery (clinical recovery) and individual treatment must be the one which undertakes the settlement of mass treatment that is done ahead.

This extent of work will not mean the supplement of work of the ophthalmologists and only serious cases will be handled by the eye-specialists, slight ones by the general performers of treatment.

In words, the meaning of individual treatments of the eye-specialists will become more bigger. Trachoma treatment of the general public will be concluded by only the cooperation of mass and individual treatment in Trachoma countries like Japan. It is necessary to know that all of the Trachoma cases will never be healed, even we have school nurses who are skillful on mass treatments or have other treatment performers. Mass treatment of Ito style does the work of a broons when it likened to clean a room and the work of the map is always done by the individual treatments of eye-specialists.

Chapter III. Practice on Mass Treatment (Practical Knowledge).

Sectionl. THE METHOD OF ITO STYLE, TRACHOME MASS TREATMENT.

The standard form of Ito type, trachoma mass treatment is like the diagram showed in Table 1.

Namely, (1) diagnosis of Trachoma is done by the ophthalmologists who are in charge (the doctor in charge). (II) the perforance of mass treatment is done for 15 days by the performer of the treatment. (III) the decision of the effect is done by the above-mentioned doctor in charge. (IV) the supplement of 'XL' is done by the performer of the treatment.

The mass treatment is finished by this and next when a decision is made by the ophthalmologists that individual treatment is needed (III), the patient is sent in to the doctor in charge. Individual treatment is necessary to all of those who were judged to be abated and to a part of

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those who were judged to have some effects. Whel allergy is found during the performance of the treatment (II) or when it has become worser by the outbreak of some other complications, these cases will be excepted immediately from the mass treatment, so these cases will be sent in for individual treatment. This work should be prepared beforehand by requesting it to the ophthalmologic practioners, nearby.

By the result of about 30 units of mass treatments, that was done in our laboratory till now, we have found out that, the cases which can be settled only by mass treatment, are about 70%, and about 20% are wished to be recommended the individual treatment, and the rest namely 10% will have no objection of receiving suitable treatments (supplement of 'XL'), according to the average result.

I have explained about the mass treatment in fact, and about the individual treatment that should have direct connections with it. On case of performance, it will surely have relations with the environment, to make the patient receive the treatment for a fixed period, namely 15 days, almost (completely, in fact) compulsorily. So the limit which the promoter should surely consider and cooperation that should be requested, before, are wide.

Next, ophthalmologists (doctor in charge) who is the supervisor will need preliminary knowledge on the diagnosis and decision.

The main point of attention must be put on the performer of the treatment. When those who are not doctors (school nurse) are committed to the charge of the treatment, the ophthalmologists or school doctors who are supervisors of treatment should teach them, the preliminary knowledge, technique, important matters, etc. and it is also necessary to take a look on the treatment oftenly. The success of mass treatment is owing to the zealousness of the treatment performer, so the attention to this should be carefully done. The system of my mass treatment includes all of this and not only the standard form model is all of it.

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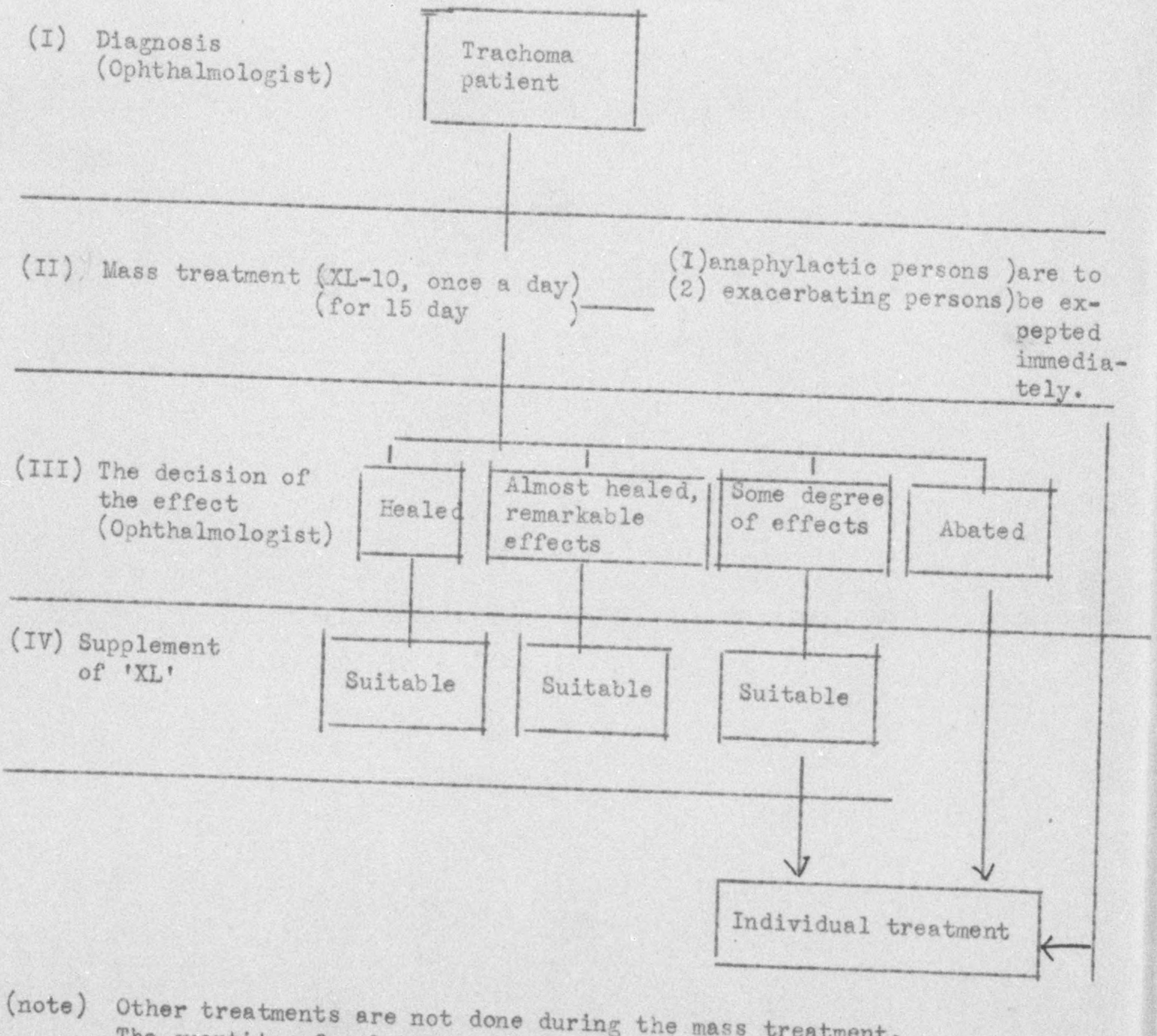
Table 1

The standard form of Trachoma mass treatment by 'XL-10'

Ito, 12 June, 1949



(note) Other treatments are not done during the mass treatment.
The quantity of salve for one eye is about 0.1 gram, per time.
(Indian beans size is suitable).

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Section 2. THE DUTY OF THE PROMOTER OF MASS TREATMENT (ATTENTION 1)

I am having the primary and middle school, as an object for a while, so I would like to described the duty of the promoter when he is going to begin the Trachoma mass treatment at schools.

It is the present condition that most of the persons who become promoters are the principals, school doctors or the local peoples who have connections with schools, but that is the most localized limited object and when it is to be performed to a wide limit, the promoter changes naturally.

The matter that should be considered when the promotor makes a plan is, that it is the matter claiming prior settlement to request for enough understanding and cooperation to the place that is thought to be important, comparing it with the next diagram showing (the school and its circumference) (attached sheet No. 1). The model diagram of attached sheet No. 1 shows what close relations the existence of the school has with the environment, and the connection the environment has with the higher rank.

I think that this diagram will not need any explanation, but it does not mean that all of these surrounding systems also have close influence power upon every mass treatment. They should have relations only with places close to all or schools according the size of the circumference of the plan. Even in the latter case, or in cases it is done generally, we must first put our minds on the relation of the school and the P.T.A.

If there are something missing on the understanding and cooperation of the environment in concern, it will be easy for some difficulty to arise finally at the beginning of mass treatment, even during the performance or even after it. So it is a secret principle to give enough satisfaction to the environment and let them cooperate positively in compare with the diagram first.

Section 3. THE DUTY OF THE CLERK (ATTENTION NO. 2)

It is necessary to choose a suitable man of ability for a manager and let him do all sorts of preparation just as the following.

(1) To know the round number of Trachoma patients.

This must surely be done with the school doctor as an adviser. It is necessary to know the round number for the necessity of preparation, letting the diagnosis take its own course at the time of the performance of Trachoma treatment. It may fairly be said that those who have discharge or hyperemia can be suspected as Trachoma in Japan to be sure of a regular shaped Trachoma. The round numbers are made clear, adding these false patients.

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The yearly report on Trachoma which the school doctors present, generally shows more lower rate than the real number. I think that this happened because only the serious cases were selected at the time of inspection. But the object of mass treatment is to control the contagious source of Trachoma; so the slight ones, and the first stage ones should not be neglected especially. So there are no necessity of being restrained by the state yearly report if the rate of Trachoma up to this time. We will need good understandings among the school doctors, schools and administrative managers on this point.

2. The preparation of furnishing 'XL' salve.

If the number of persons of the former clause becomes clear, it is necessary to find a way to secure 'XL' salve as soon as possible. The manufacturer and saler is Miyata Chemical Manufacturing Company, No. 234, 3-chome, Koenji Suginami-ku, Tokyo, so connections should be made.

The quantity needed for one person (used on both eyes for 15 days) is 4 to 5 gram (contains excessive), so it should be ordered counting the whole quantity. The name of the 'XL' salve made here is 'XL Homosol".

3. The preparation of the other needed articles.

a. Salve jar. (25g or 50g contents)

'Homozol Miya' is inside tube (85 gram), so just put the quantity needed for daily use into the jar.

b. Glass stick for salve use: The quantity needed, is bought, one for each person. It will be better if it is a non-colored one. The half coloured one is not good for hot water sterilization.

c. Eye irrigation bottle and water receptacle.

d. Hot water sterilizing equipment (wash-basin or pot can be used in place).

e. Saline (1%) or boric acid solution (2%) is to be prepared for eye washing.

f. Preparation of cotton (50 gram of absorvent cotton wool will be needed daily, when it is used once for both eyes of 100 patients).

g. Cared for each patient to receive mass treatment is prepared. (will be detailed afterwards).

h. Preparation of lizol or corrosive subtimate solution for disinfecting hands of the treatment preformers.

I have given examples of some internal and external duties which the manager undertakes, but the date of performance, the turn of treatment, and making the groups who are to receive treatments into suitable sizes, and etc. are the domestic works (school). This is a treatment continued for 15 days and the performer of the treatment is a school nurse (mostly

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one), so it is an important problem to know, how many patients are suitable to be treated per day, from the view point of the last result I think that 100 peoples, at least within 150 people are suitable, but it is to be abstaineded from increasing the numbers thinking to do the work at once. This matter will come out again afterwards but in words, it is important for the manager to think over about the treatment performer's capacity and hisphysical strength, estimate the number of the students, separate them into suitable groups to revolve the work smoothly. If this undertaking is unsuitable, it will influence the result of mass treatment (as in the following) and also make the school and P.T.A. displeased.

Section 4 THE DUTY OF THE TREATMENT PERFORMER (ATTENTION 3)

I would like to make it a custom to use the school nurses for treatment performers. It is a rule of my mass treatment to let the ophthalmologists only diagnose, judge the effects and control as doctors in charge, but don't let them undertake the treatment. The duty of this work for a school nurse is an important this mass treatment. The education from the doctor in charge will be absolutely necessary, but it is also necessary to get enough knowledge from this book, observe universities, large hospitals and etc. to look at the actuality of trachoma patients, and learn the technique (treatment by salve, etc.). Our ophthalmologic laboratory of Chiba Medical College will welcome these sort of observations. Next, I would like to describe the duty of the treatment performer.

Clause 1. Items of general attentions in the treatment room.

Situate a suitable treatment room.

Keep the room, instruments, drugs and etc. clean.

Especially, on drugs, are as follows:

(1) The salve should be sealed, put into a locker and nobody except the treatment performer should handle it. The salve must not be contaminated.

(2) The eye washing solution should be made newly everyday and the remaining solution of the day before should never be used.

(3) Same to the lizol solution, etc. for disinfecting hands.

(4) The eye irrigation bottles, glass sticks should be sterilized by hot water, every day.

(5) The number of persons for treatment, time for treatment (it would be better to perform it soon as the patients arrive and is unsuitable to perform it from afternoon or after school) should be talked over well with the above-

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mentioned manager and the doctor in charge.

(6) It is necessary to make a mass treatment book (like an attendance book) so that the absent patients can be made clear and make steps against them. It is an ideal to continue the treatment for 15 days.

(7) The treatment cards are made for each students, so it should be marked every time the treatment is done (to be mentioned afterwards).

Clause 2. The Performance on the Use of the Salve.

The doctor should perform the treatment against the patient in a grave manner.

(a) The patient and the treatment performer should sit opposite, comfortably and then start the treatment.

(b) Before the treatment with salve, the eyes will be washed. (Saline solution or boric acid solution).

(c) Put about 0.1 gram (red bean size) on both ends of a 5 minutes boiled and sterilized glass stick.

(d) Make the patient's face look upwards to some degree. When the outer side of skin of the upper eyelid is lightly pinched up after making the patient stare at his (or her) own nose, some space will be found between the eyelid and eyeball, so insert the glass stick inside as possible from below the ear-side (look at the detached sheet No. 2)

(e) Next, let the upper eyelid skin be free which was pinched up, then pull out the glass stick by degree twisting it.

(f) It is a principle to put the 'XL' salve inside the upper eyelid, but it may be used to the inner lower eyelid when it is difficult. But there are some disadvantages from the view point of the effect.

(g) The hands must be washed with 3% lizol or 1/1000 corrosive sublimate solution.

The way of using salve which is written in the ordinary books is done by using inner lower eyelid, but my above mentioned method is better than that. But, some people do not use the right way, so these people will have to use the original way. I believe that this method, using salve is one of the important element to my so-called system.

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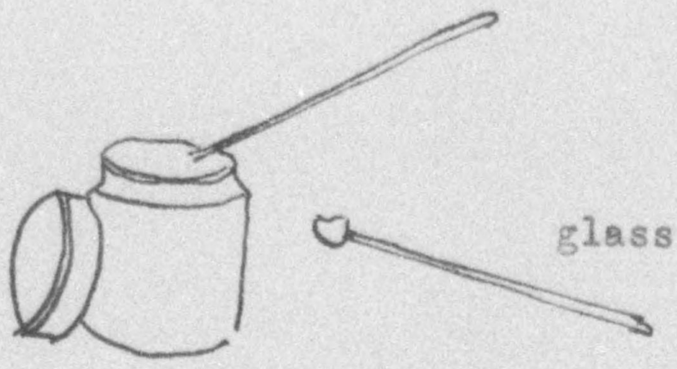
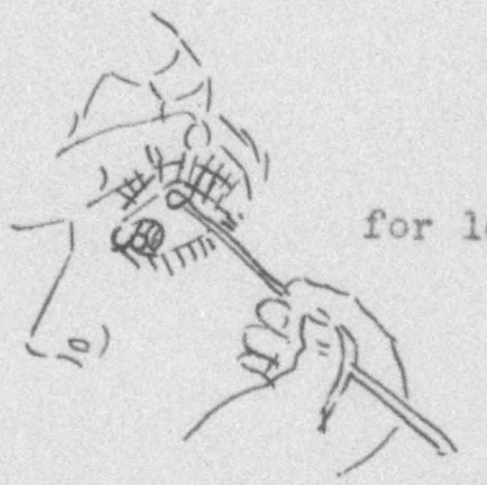
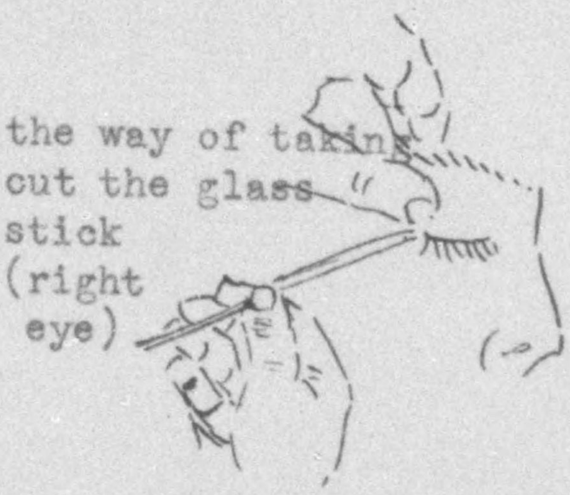
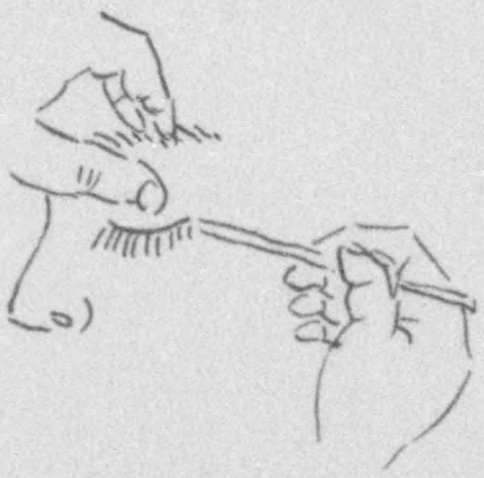
Detached sheet No. 2. The Way of Using 'XL' Salve.









Note:- (1) The glass sticks must be sterilized by boiling it each time.

(2) One stick could be use for 1 person by using both ends.

(3) A new glass stick must be used to each person.

(4) Many glass sticks must be prepared.

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Clause 3. Attentions during the Performance of Treatment.

The practice of treatment is done by the school nurse as above-mentioned. The doctor must control it sufficiently, whether the matters that demands the special attention are obeyed by the treatment performers, visiting the place oftenly.

The treatment performer must be able to manage the following items which oftenly happens during the performance. These matters should always be talked over with the doctor in charge, and should always be in preparation for suitable management. Besides this, next, I will describe the important matters that demand the special attention. In words, we must not forget that the result of mass treatment is influenced by the zealousness of the school nurse.

a. When any patient is found irritable against 'XL', the treatment should be immediately stopped. And the eye be washed well. These patient will be treated individually.

There are not so many people irritable against 'XL', but the patients will surely be found the day after the treatment.

The symptoms are, swell of eyelid, redness, redness of conjuntiva, lachrymation, increase of discharge, and besides this, subjective symptoms are remarkable. The use of 'XL' to the patient should be stopped, well washed, and sent in to the eye specialists to receive treatment by penicillin eye-washing or penicillin salve.

b. Sometimes, conjunctivit's, phlycten and etc. besides Trachoma which happens from some causes, are found. This is also one kind of the irritation or an incidental occurrence of prevalence. The treatment should also be stopped at once on these cases, wash the eyes and sent into the specialists. As there is a possibility that many people will be caught by the disease during the mass treatment, the necessity of the disinfection of hands of the treater (after each patient) and sterilization of glass sticks (after each patient) should always be attended.

c. Soon after the use of salve: It is an important thing to press the eye lightly with some cotton for about 10 minutes. The children must be told well, because they want to go out to play as soon as possible after the treatment. And still more, playing in dusty places or swimming (summer) and etc. soon after the treatment will annul the result and also be bad.

d. The patients who receive the treatment should be given the self-conciousness that they are receiving the treatment and they should be given sanitary education that their activities must be a suitable one.

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e. It is necessary to make the children who are receiving treatment be careful to keep their livings in sanitary condition and keep the wash-basin, handkerchiefs, hands and etc. clean even after going home from school. It is a very regrettable matter, receiving treatments on one hand and get domestic infections on the other. It is important to give the P.T.A. a chance to regret gravely and cooperate on the treatment on this point.

Clause 4. The Mass Treatment Cards and the Entry.

A treatment card must be prepared individually for the mass treatment. The duty of entry is done by the school, the doctor in charge and the treatment performer.

I would like to show the mass treatment card used at my laboratory. This is made suitable for use when the staff of the laboratory is the doctor in charge, Dr. MacCallan's classification is used -- and there are some notes at the bottom - I think, that will give us complicated feelings, but I think this form should be used, to keep it as a record of mass treatment and also from the point of performance to the future. The card is made so that the follow-up result could be recorded (at the bottom of the card).

The classification by the Trachoma Prevention Law could be used instead of the MacCallan's classification. It is also clever to use the one by the law.

I will explain a little about this treatment card.

1. Name, sex, date of birth, grade and the teacher in charge should be noted down by the school.

2. The entry about the family should also be noted down by the teacher in charge or the doctor in charge.

3. The entry of diagnosis is the work of the doctor in charge. Column 1 and 2 can be understood when the doctors look at it. The diagnosis confirmed will be marked by a red colored line or circle. It is same to the complication. A magnifying - glass will be used for the confirmation of pannus and entered by deviding it into (−), (±), (+), (++) and etc.

It has become clear since the invention of the slit-lamp and corneal microscope. (During the First World War).that pannus is a symptom that appears from the early period of Trachoma. Even very slight cases of pannus could be found by inspecting it by the slit-lamp and corneal microscope. It is difficult to imitate this by magnifying-glass, but it will be useful to deepen the knowledge on pannus. There are many people that think that the certification of the appearance of pannus is the key to confirm the suspected case (1) of Trachoma.

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Also, Trachoma is a disease, that is combined with conjunctivitis (by some other causes) most of the time, and some can easily be diagnosed, but there are quite many that are difficult to diagnose by the combined disease at the time of practice of diagnosis. The discrimination will surely be more easy, if the inspection equipment of the examination room and the slit-lamp could be used, but some cases are still found doubtful. I think that it is unreasonable to require such kind of high class inspection, but it will be convenient to put some marks to these doubtful cases. I have used the word "B" for such cases. This is mentioned in Item 2 of the notice of the mass treatment card.

The subjective symptoms of thepatient are written on the third column of diagnosis. A red circle is put to the (+) (++) (+++) under the doctor's judgment to the view.

So, the entry of diagnosis (1) is naturally the duty of the doctor in charge. This entry is important at the time of judging the result afterward. The reason isthat, the performance of treatment is for only 15 days, but the view of the patients' eye changes quite rapidly and there are many cases that can not be recalled without this record.

4. The entry of performance of mass treatment (II) should be done by the treatment performer (school nurse). Put down the date of the treatment and get the official seal of approval.

5. The judgment of the result (III) should be done by the some doctor and the entry in the same way. It is to be juedged to be perfectly healed, almost healed (includes the remarkable effect), to have some degree of result or no result. In this case, the record of diagnosis (I) will be useful. This card is made so that the remarkable subjective and objective symtoms at the time of the judgment could be entreed as the fundamental datas that could be served as a reference to the follow-up result. The way of the entry is same as above-mentioned.

6. Supplement of salve use, and the matter of sending the patients in for individual treatment, should also be directed by the doctor in charge. The treatment performer will do practical activities like the supplement of salve use for several days according to the direction, enter the date, get the official seal of approval, or send the patient for individual treatment.

7. The existence of responsibility should be made clear by the registered number, seals of the treatment performer, and the ophthalmologist in charge.

And the mass treatment is finished. The adjustment of the treatment card and statistic will be done by the doctor in charge and the school nurse. The responsibility of custody should be looked by the principal.

I would like to describe a very important attention here.

1. Every treatments (even eye washing) should be stopped besides the use of 'XL' once a day during the mass treatment.

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XL Salve Trachoma Mass Treatment Card

(Detached sheet)

* School name . . . . . .

* name		* sex	* Date of birth ---------years old	* class	* Teacher in charge

* Is there anybody in the family that have discharge or hyperaemia in the eye. yes (Now many ?) no

I. Diagnosis	Tr. acutum Tr. II B	Tr. dubium Tr. III (II), Tr. III (I)		Tr. I Tr. IV		Tr. II A Pannus	
	Complication: entropton, blepharo phimosis, trichiasis pterygium, xeriosis (orneal, conjunctival), corneal opacity						
	discharge + ++ +++	foreign body feeling + ++ +++	hyperaemia + ++ +++	granule + ++ +++	papilla + ++ +++	opacity + ++ +++	swell + ++ +++
II. * mass treatment	date	date	date	date	date		
	date	date	date	date	date		
	date	date	date	date	date		
III. effect judgment	discharge + ++ +++	foreign body feeling + ++ +++	hyperaemia + ++ +++	granule + ++ +++	papilla + ++ +++	opacity + ++ +++	swell + ++ +++
	cured almost (remarkable) cured no effect supplement use (times) sent for individual treatment (operation, etc.)						
	date	date	date	date	date		

number ----------	* treatment performer	doctor in charge

follow-up result: doctor in charge performed date (------days after the result judgment)

I. good result	II. no change	III. growing

Note: (1) * marked items should be entered by the responsible person at school the treatment p is to be performed. The column of mass treatment and supplement of salve use should be filled about with the date of salve use and the name of the school nurse, teacher in charge is to be entered in the column of treatment performer.

(2) At the time of diagnosis, those which might be acute conjunctivities or some other conjunctivitis on that seems to be the complication should be marked "*" just like Tr. acutum B. Tr. II A B and etc.

(3) The diagnosis of pannus should be done by the use of magoritying glass as possible and classified as -, ⁻, -, -, etc.

(4) Tr. III (I) means Tr. III which happened by Tr. I, Tr, III (II) shows that Tr. III changed from Tr. II.

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It will be better to use the salve twice a day (morning and evening) than once, so it should be done as possible on treatment by hospitalization or individual treatment. But it is unsuitable to use other eye washing solutions (even medicine for conjunctivitis) because there is a fear that it will wash away the salve. Much more, the use of irrigative medicines will cause the outflow of tears and wash away more salve. It just seems as if it will do some help to the salve because it is medicine for the same conjunctivitis, but it is a mistake. There is also a fear that a medicine which stands against the salve might be used. I prohibit the use of zinc eye washing solution.

SECTION 5. THE DUTY OF THE DOCTOR IN CHARGE (ATTENTION 4)

The doctor in charge (ophthalmologist for a while) is the supervisor of this mass treatment and not the performer of the treatment.

The allotment of the duties of the doctor in charge are as follows:

1. The diagnosis of Trachoma.

2. The watch of the performance of the treatment.

3. The result judgment, supplement of medicine use, and besides this, sending in patients for individual treatment.

4. Follow-up result and yearly report on treatment.

As I have described, most of the part of these items in the former section. (The duty of the treatment performer), I would like it to be looked at. I have just gathered it here and stated the expositions and the matter that demands special attention.

Clause 1. Diagnosis of Trachoma.

The diagnosis and classification of Trachoma can be done according to the Trachoma Prevention Law, or MacCallan's classification. The learn and performance of the latter one need not be compulsorily done, at once. But the tendency is moving toward it by degree and I think that the classification of the Home Affairs Ministry will be changed, also the latter one will be used throughout the country.

The Home Affairs Ministry, Trachoma Prevention Law was the gazetting of 1918. (26 March, 1918 Law No. 27, performed from 1 Sept. 1918).

MacCallan's classification was formally announced (October, 1934) by the request of the International Trachoma Prevention Association (found in 1930) and again the description was repeated in detail in a separated volume (Trachoma) (1936). MacCallan has been working on the clinical study of Trachoma throughout his life, he is the director of

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the International Trachoma Prevention Association at present and is still in good health though he is old. The place where the study was done is Palestine and Egypt where the Trachomarate is nearly 100 per cent. The classificating method of his, was used by himself at first, but it was formally announced as mentioned above.

His classification is used in every book nowadays. Even Gifford (1936), Berens (1938) and also May - Perera (20th Edition 1949) are only using this classification recently without inserting the other classifications. Especially May's (America) ophthalmology test book has been published twenty times since the First Edition (1900), translated into every language throughout the country and the most read ones are the ones in English, Spanish, French, Italian, Dutch, German, Japanese (Dr. Hidaka, 1909 and 1914) and Chinese, etc. It is the rare fashionable text book, but is the ophthalmologic model book to the medical students of America.

The Trachoma chapter of even these books have been entirely renewed to the MacCallan's classification from the 20th Edition (took over by Dr. Berala).

I and Dr. Tsutsui Norimitsu of Okayama were present at the above-mentioned general meeting of foundation of the International Trachoma Prevention Association (July, 1930) (Dr. Nakajima Minoru was to beat the meeting, but was absent by the cause of the period of returning). So the yearly reports were received and MacCallan's classification was received that year (1934). By this, I first introduced it in Japan as 'The Introduction of MacCallan's Classification' (Experimental Ophthalmologist Magazine 15 Oct. 1935). And it was again announced as 'The Classification of Trachoma (MacCallan's Classification)' in the 'Newest Knowledge'; especially established on European and Oriental medicine (25 May, 1936). This classificating method was first used on the out-patients of Ophthalmologic Department of Chiba University and is still used now (since August 1935).

It is a remarkable matter that Dr. Umazume Kakichi inserted this classification immediately after my announcement in his 'Foundamental Ophthalmology (1938)', which was published before war in Japan. It generally seems that there still are not anybody who tries to use this classification magnificiently, even after this war, and they are adhered to the classification of the Home Affairs Ministry. But it is remarkable that 'Clinical Ophthalmologic Summary'. (Author: Dr. Nakajima, Dr. Kurachi, 1949) is describing MacCallan's classification correctly but simply. The other books are late on this point.

So, assuming that Japan nowadays is on a gradation, charging from the classification of Trachoma Prevention Law to MacCallan's classification. I have supplemented and showed some revise added ones so that it could be used in both ofthe classifications by describing both of them and also comparing both.

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1. MacCallan's Classification

a. First Period (Tr.I) First Stage.

The crude part of the conjunctivae face appears on the other margin of cartilage of the superior pupillary margin, and a slight hyperaemia is found macroscopic. (Note: when there is a limited deseased part on a part of the conjunctivae like the Fornix Conjunctivae, it should belong to this period.)

b. Second Period (Tr.II) The Maximal Stage,
The Increasing Stage.

The term when the disease spreads over the conjunctivae, hyperaemia, secretion appears, tissue swells and the granule, papilla becomes remarkable. Those which have many granule are called Tr.IIa and those which have many papilla are called Tr.IIb. At this period, pannus can be found macroscopic. (Note: No cicatrix found macrescopic. When the inflammatory change of the conjunctivae of Trachoma is figured out by curve, this is the period till it reaches the top.)

c. The Third Period (Tr.III) Cicatrix Forming Period.

At this period, the peculiar cicatrix remarkably appears on the conjunctivae and goes on spreading by degree. The inflammatory infiltration still exists, but starts to decrease by degree. The change of the disease spreads to the deep part and the tissue nearby. The corneal pannus becomes more remarkable, opacity and ulcer appears. All kinds of complication of the eyelid happens. Namely, Entropium pelpebrae Trichiasis, Blepharophimosis, symblepharon and etc. are found.

d. The Fourth Period (Tr.IV) Cicatrix Completion Period.

This is the condition when the diseased part, all turns into cicatrix and the inflammatory infiltration decreases. This is the term of the continuation of the diseased part of the third period and when it leaves complication behind. And the most severe one is siccative trachoma. Recently, the real time of outset before the first period is being studied by the slit-lamp inspection.

2. The classification of Trachoma according to the Prevention Law.

a. Trachoma Grave.

(1) The one which is massed with granule all over the conjunctivae, those which the increase of papilla is remarkable at the sametime of the outbreak of granule, or those which the inflammation are in a high degree and which the secretion are in a flourishing condition.

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(2) Those which have occurred trachoma pannus and still in progress.

b. Trachoma Leve.

(1) This is the one which the symptoms of Trachoma just like the outbreak of granule, increase of papilla and etc.are limited on the internal, external canthus part, semilunar canal, or jornix part of the conjunctivae of the eyelid.

(2) Those which the symptoms of the conjunctivae are slight, those which do not have so much excretion.

c. Trachoma Dubium.

(1) This one has symptoms resembling to Trachoma, but cannot be confirmed to be Trachoma.

(2) Those which have cicatrix, attended by inflammation and are doubted to have passed Trachoma in the conjunctivae.

The classification of MacCallans is as above-mentioned and he is explaining about the prodromic period, but practically, there are many cases that will have to be handled as suspected case at the time of diagnosis of mass treatment. So, I would like to add trachoma dubium that will suit it to his classification.

I also would like to add Tr.III(1) as a diagnosis. This Trachoma leve which changed to the third period, passing rapidly through the second period from the first period.

The Trachoma classification by the Prevention Law, separates it into severe case, slight case and suspected case as above-mentioned, but I think that it is possible to make it resemble MacCallan's classification by dividing the suspected cases and slight cases, each into two parts, calling the outbreak period of them as suspected case (I), slight case (I) and the end period, suspected case (II) and slight case (II). By this way, MacCallan's classification can be substituted by the one of the Prevention Law and according to another way of looking at this classification. I think that it will be more reasonable when it has the general society as an object. This is why I said that this classification is an excellent one, last year. The two classifications are as follows by comparing them. (Detached sheet No.2)

These two classifications do not use acute Trachoma. I think that it is better to leave it in the mass treatment because it is the habit for a long time and is convenient to handle it. I have already described about it, at the former section, 'the entry of the treatment card'.

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As MacCallan's classification shows, the process of Trachoma is quite easy to understand from the first period to the fourth period. And the classification according to the Prevention Law will be applied to it.

The diagnosis of pannus will be convinced macroscopic, or by the use of magnifying glass using a powerful light as possible.

A slitlight and cornal microscope is needed to confirm it correctly, but I do not wish to use it for mass treatment.

The way to know the existence of outbreak of pannus (Mr. Mogi Sen) is to find the irregular boundary line facing toward the cornea of the annular part of the upper part of cornea. When it is not sure, let the patient close the eyelid several times, and then it will become more clearer. This method is an easy one and has a practical value.

Table 4. A MacCallan

Tr.I

Tr.III	Tr.II : Tr.III : Tr.IV	Perfectly healed without leaving any marks

B Trachoma Prevention Law (Ito, revised)

Tr. leve (I) and Tr. dubium (I)

Tr.leve(II)	Tr.grave : Tr.leve(II) and Tr.dubium(II)	Perfectly healed without leaving any marks

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Detached Sheet. Classification of Trachoma

(MacCallan and Trachoma Prevention Law, Revised)

I	II
MacCallan's Classification	Classification of Trachoma Prevention Law
Tr. dubium	Tr. dubium (I)
Tr. I	Tr. leve (I)
Tr. II (a, b)	Tr. grave
Tr. III (II)	
Tr. III (I) Tr. IV	Tr. leve (II)
	Tr. dubium (II)

Clause 2. The Effect Judgment and Supplement of Salve Use

The number of dates for treatment is 15 days as you see in "The standard type of mass treatment" (Table I) Treatment on consecutive days as possible are an ideal. But as there are two Sundays during this term, it is unavoidable using these days for supplement. It finally takes about seventeen days by cause of some troubles during the treatment and I think that this is unavoidable, too. But it is a principle, using 'XL' everyday and it should not be stopped during the treatment. So, when it takes about twenty days for it, the result of the effect judgment is also not good. As it is a mass treatment held with much trouble, the principal, teachers, school doctor and P.T.A. should do their best to be in good cooperation to finish it within the limited period.

The effect judgment should be done by the doctor looking at the record of the first diagnosis (the latter part of the treatment card) and must inspect the present situation calling it out to his mind. This is because, the progress of recovery during the fifteen days are quite remarkable ones. I have mentioned this in the former section.

The standard of the effort judgment is as follows:

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1. Recovery (It means clinical recovery)

   a. Subjective symptom completely gone, objective symptom of conjunctivae and cornea are not recognized macroscopically.

   b. Subjective symptom completely gone, some hyperamia left in the fornix conjunctivae, corneal pannus disappears macroscopically.

   c. The cicatrix and the other complications are left, but the inflammatory symptoms and diseased parts are gone. (The granules becomes regressive and inactive by this treatment. There are no infection is recognized namely to a safe clinically headed condition by the way it is or by some suitable supplement of salve use.

So, I have bundled up those which comes under these two items into percent of healing.

It is the discrimination of (II) and (III), that rises difficulty and doubt from the view point of judgment and on which the doctor's subjective element works. It is a problem that when two doctors look at the same material, there is quite a difference between their opinions. This influences the number of percent of healing. It can be said that there will be more than 10% of increase anddecrease to the percent of healing of the mass treatment when the doctor is changed. I think that this is unavoidable.

Next, I would like to examine the 'some effects' and 'no effect' ones. This does not mean that the patients are irretable, but it just means that the reverberation is weak. The reason I suppose is:-

1. They do not have so much response against 'XL'.

2. The cicatrix form in the tissue is in a situation disturbing the 'XL' to reach the deep part. Those that belong to this section are the patients who are influenced by the long treatment done by the eye-specialists, before.

3. When the children do not keep the sanitary rules after the use of 'XL' salve.

4. When the effect of the treatment repeats any increase or decrease by the cause of the Trachoma infected families. These cases must be restored soon as possible besides (1) and (II):

The supplement of salve use means that 'XL' is supplemented by the same treatment performer for a suitable term, and this should be done by keeping the above mentioned cause in the mind. From the point of the quality, this belongs to the individual treatment, but it is one way, using the surplus of salve. The number of times of the use is just about ten days, those which do not seem to recover, should be sent to the

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eye-specialist (individual treatment) for operation.

This section was quite a long one, but in conclusion I would like to explain the way to handle the percentage at the time of judgment.

The above-mentioned four items of judgment are each made a percentage. The denominator is the member of students who have finished the treatment, and the numerator is the number of people of each item. Namely, four (I), (II), (III), (IV) percentages are made. Next, the way to make the percentage of healing is to put the healed, almost healed and remarkable added number as the numerator.

The way to make the percentage of healing easily understood, is put them in alphabetical order like A, B, C. D by the turns of the results. The percentage of healing of A is over 80%, B is over 70%, C is over 60%, and D is below 59%.

Clause 3. The Duty After the Completion of Mass Treatment.

1. After the judgment of the doctor in charge, the patient is sent in from the view point of quality for individual treatment. At this time, special patients are ordered to receive supplement of salve use and to be sent to the eye specialists. The school nurse should undertake the former one, but there are some problems on the performance of the latter one.

2. It is easy to say to send them in for individual treatment, but hard to do. It will be as follows when it is analysed:

a. The degree of zealousness of the school nurse, school doctor, the school, parents, and of his own.

b. The economical problem.

c. The existence of ephthalmologists nearby.

Among these three, I think that the cooperation of the director of the district government and the specialist are the key of the settlement of the economical problem (II). So I think that it is necessary for the city, town, village, school, parents and etc. to make good agreements with the above-mentioned director and specialists. On the case of (III), it will be convenient if there is a doctor nearby, but if there are not any (oftenly there are not any in villages), some eye specialists should be requested to go to the place or when it is impossible, the school doctor should do it even when he is not the specialist. If the doctor is unacquainted with the management, he should ask the eye-specialist.

The other duties of the doctor in charge are, to look at the follow up result, and the problem of the yearly treatment. I will describe about this in another chapter.

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Chapter 4. The Result of Mass Treatment and Follow-Up Result.

Section 1. THE RESULT OF MASS TREATMENT.

I have started the execution of mass treatment of my style from the end of the year before last year (1948).

The execution to five schools were finished till the first half period of 1949 and the result was announced already, but the summary is as it is shown in Table 5.

Twenty schools were finished in the last half period of the year. The result is as it is shown in the detached sheet No. 2.

The range of performance is being spread this year (1950) and ten and several other places were already supplemented till present. At first, the execution was only done in Chiba Prefecture, but Tokyo, Hokkaido and etc. were supplemented from the last half period of last year and is being spread to the other Fu, Ken, this year. The result of this year is to be announced soon, but the result of 20 places of the last half period of last year, was announced by Dr. Tadayoshi Ko at the fifty-fourth general meeting of the Japanese Ophthalmologic Academy (at Kyoto), this year.

Table 5 is the result of the early time and 'XL', 'X-10' were also used besides 'XL-10".

Table 5. The Result of Mass Treatment.

(First half period of 1949)

No.	Doctor in Charge	Name of School	Treatment Performer	Number of Patient	Judgment of the Effect			Used Medicine	Note
					Healed, Almost Healed & Remarkable Ones.	Some Effect	No Effect		
1.	Suzuki Satoshi (Chiba)	Shizu Primary School (Chiba Prefecture)	School Nurse	55	63.6%	32.7%	3.6%	X- 5 X-10	1949 - 49 Winter
2.	Ito Taisuke (Labora-tory)	Togo Primary School (Chiba Prefecture)	"	38	68.4%	28.9%	3.6%	X-10	1949 early in spring
3.	Yo Kyoka	Kohitsugi Primary School (Chiba Pref.)	"	65	77.6%	20.6%	3.0%	XL-10	1949 early in spring
4.	Ichihara Masafumi (Labora-tory)	Ohara Primary School (Chiba Prefecture)	"	90	The no. of times for treatment not constant.			XL-10	1949 early in spring
5.	Yo Kyoka (labora-tory)	Yoda Primary School (Chiba Prefecture)	"	80	74.9%	18.9%	5.0%	XL-10	1949 early in spring

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The percentage of healing is as shown above and the term we were using X drug is C class in the order of merit and those which 'XL-10' were used is B class.

The result of the last half period of last year is as follows: (See detached Sheet No.3)

'XL-10' was used for all of these 20 units. According to the whole average (the lowest column), the number of patients who have finished treatment are 2,853, the result of the effect judgment is,

(1) Healed 1,071 (37.5%)

(2) Almost healed and remarkable effect 9.32 (32.6%)

(3) Some effect 549 (19.2%)

(4) No effect 301 (10.5%)

and the healing rate averages 70.2% (turn: B).

The healing rate is from 60.1% to 87.8%, but in accordance with the standard order of merit, it is as follows:

a. Order A, 6 unit

b. Order B, 7 unit

c. Order C, 7 unit

By explaining it in detail, the following points will be found.

1. Most of the doctors in charge are the staffs of the ophthalmologic laboratory, Chiba University, but some are the local ophthalmologic practioners or the general doctors. But as the aim of this result was to make it the standard result for the performance of my method, the guidance of the laboratory staffs were offered to the local practitioners in charge.

2. The treatment performers are, school nurse 11, teachers in charge 5 (but as helpers), public health nurse 5, intern student 2. From the result of this treatment, I think that the school nurses should be used as the treatment performer. I am sure that there were persons of more full legal capacity, personally among the teachers, but I think that it will take more time to popularize it. The reason was mentioned above.

3. The rate of Trachoma was 22.1% in total (2 school missed). This was fewer than I was thinking. But as there are some famous Trachoma districts on the coast, I think that the average of the Trachoma rate will become a little more higher by adding these kinds of school.

When

4. I compared with the number of Trachoma students (5,093), the number of patient who have finished treatment (2,853) was inexpectedly few.

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The reason why the treated number is small is that, at Otaru City, the first mass treatment was performed to about 1,000 persons among 2,947 persons diagnosed, and the rest was to be done on the next time. According to the chart, the latter one is about 56%. The rest, 44%, will be as follows, when it analysed. (Though there were some who were to be treated the next time like at Otaru City).

1. Those who refused to receive the treatment from the beginning (few).

2. Those who said that they are being treated by the ophthalmologist, at present.

3. Those who got sick or accident happened during the mass treatment.

4. Those who can not finish the treatment by the cause of helping their families in the farm village.

(3) & (4) are the most reasons. These mostly happen in the middle schools of the farm-villages, and they received the treatment after all, but as the treatment period took time, the results are hard to collect. Next, this is what we oftenly see at the middle schools, but especially after the war, the students are disobedient to the teachers' orders and there are students that are oftenly absent. This oftenly happen at the primary schools. The reason that I put the main point on the primary school is here. (Look at the latter part of Section 3).

In conclusion, the market sold 'XL Homozol' is to be used for the result of this year and I am watching the effect. It has been performed to ten and several units till today and by the result, I have found out that there are no differences with 'XL-10' and also that it is rather effective. I am intending to use caution to keep the quality of 'XL Homozol' in purity.

By looking at the diagnosis by the difference of the desease period, the datas on the condition of the healing rate, are all surely gathered in our laboratory. The detail will be abridged and the summary is as follows:-

a. The most many healing rate is found on the first period and the first half of the second period.

b. The most worse healing period is the first half of the third period and the proceeding period from the second period to the third period.

As most of the Trachoma of the primary schools belong to (a), the healing rate is quite good. But as the trachoma of the dwellers in the district are increasing, I think that the healing rate will become fewer in comparison with the former one.

Attached Sheet No. 3.

RESULT OF TRACHOMA MASS TREATMENT BY 'XL-10' SALVE

(The last half period of 1949)

Doctor in Charge	Performed Month	School	Examined Number	Trachoma Patient	Finished Number		Effect Judgment (%)				Healing Rate	Treatment Performance	Result in Order
							Healed	Almost Healed or Remarkable Effect	Some Effect	No Effect			
1.Kezuka Shoichi (Tokyo)	7	Iwabuchi Primary School, Tokyo	249	59	22.8	49	22(44.9%)	19(38.7%)	8(16.3%)	0(0%)	83.6	School Nurse	A
2.Suzuki Yasuhiko (Funabashi City)	6-7	Funabashi Primary School (Chiba Pref.)	1,176	509	43.2	409	155(37.8%)	125(30.5%)	107(26.0%)	22(5.3%)	68.4	School Nurse Teacher	C
3.Yamazaki Kazuo (Narita-shi)	6-7	Narita Middle School (Chiba Pref.)	974	35	3.5	32	5(15.6%)	18(56.2%)	9(28.1%)	0(0%)	71.8	School Nurse	B
4.Takeuchi Ju (Katsuyama -cho)	7	Katsuyama Primary School (Chiba Pref.)	479	182	37.9	151	82(54.6%)	44(29.1%)	21(13.8%)	4(2.6%)	83.4	School Nurse	A
5.Suzuki Satoshi (Chiyoda-machi)	Summer	Chiyoda-machi Primary School (Chiba Pref.)	-	198	-	123	20(16.2%)	61(49.5%)	20(16.2%)	22(17.8%)	65.8	Teacher	C

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Attached Sheet No.3. RESULT OF TRACHOMA MASS TREATMENT BY 'XL-10' SALVE (CONTD)

(The last half period of 1949)

Doctor in Charge	Performed Month	School	Examined Number	Trachoma Patient	Finished Number		Effect Judgment (%)				Healing Rate	Treatment Performance	Result in Order
							Healed	Almost Healed or Remarkable Effect	Some Effect	No Effect			
6. Suzuki Kiyoshi (Sawara-cho	6-7	Tsunomiya Primary School (Chiba Pref.)	351	137	39.0	128	18(14.0%)	18(14.0%)	75(58.5%)	1(0.7%)	72.6	Teacher	B
7. Ditto	6-7	Tsunomiya Middle School (Chiba Pref.)	140	58	41.3	37	3(8.1%)	24(64.8%)	10(27.0%)	0(0%)	72.7	"	B
8. Ko Tozan (Labora-tory)	9-10	Iwabuchi Primary School (Tokyo)	621	125	20.1	103	61(59.2%)	29(28.1%)	9(8.7%)	4(3.8%)	87.3	"	A
9. Ko Chugi (Labora-tory)	10	Tachibana Ishide Primary School (Chiba P.)	378	90	24.6	75	30(40.0%)	18(24.0%)	18(24.0%)	9(12.0%)	64.0	Public Health Nurse	C
10. Ditto	10	Tachinaba Ishide Middle School (Chiba P.)	191	59	31.2	43	20(46.5%)	10(23.2%)	9(20.9%)	4(9.3%)	76.7	"	B
11. Tsuchiya Haruo (Labora-tory)	10	Tachibana-Mura, Tachibana Primary School (Chiba P.)	320	68	21.0	54	23(42.5%)	21(38.8%)	10(8.5%)	0(0%)	81.0	"	A

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Attached Sheet No.3

RESULT OF TRACHOMA MASS TREATMENT BY 'XL-10' SALVE (CONTD)

(The last half period of 1949)

Doctor in Charge	Performed Month	School	Examined Number	Trachoma Patient	Finished Number		Effect Judgment (%)				Healing Rate	Treatment Performance	Result in Order
							Healed	Almost Healed or Remarkable Effect	Some Effect	No Effect			
12. Tsuchiya Haruo (Laboratory)	10	Tachibana-Mura, Tachibana Primary School (Chiba P.)	160	26	16.0	21	12(57.1)	4(19.0)	5(23.8)	0 (0)	76.0	Public Health Nurse	B
13. Ko, Yo, Saito (Laboratory)	10	Miyamoto Primary Schoo, (Chiba P.)	800	223	27.8	189	98(51.8)	44(23.2)	31(16.4)	16(8.4)	75.1	School Nurse Teacher	B
14. Asanagi Tetsuzo (Laboratory)	7	Yawata Primary School (Chiba P.)	-	85	-	74	36(48.6)	29(39.1)	6(8.1)	3(4.0)	87.8	Intern Student	A
15. Ko, Watanabe (Laboratory)	10-11	Katsuyama Primary School (Chiba P.)	364	115	31.0	103	41(39.8)	25(24.2)	22(21.3)	15(14.5)	64.0	Teacher	C
16. Ditto	"	Katsuyama Middle School (Chiba P.)	274	78	288	54	25(46.2)	15(27.7)	8(14.8)	6(11.1)	74.0	"	B
17. Ko Chugi (Laboratory)	"	Higashi Oto Middle School (Chiba P.)	238	67	287	29	11(37.9)	7(24.1)	7(24.1)	4(13.7)	62.0	Intern Teacher	C

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Attached Sheet No.3.

RESULT OF TRACHOMA MASS TREATMENT BY 'XL-10' SALVE (CONTD)

(The last half period of 1949)

	Doctor in Charge	Performed Month	School	Examined Number	Trachoma Patient	Finished Number		Effect Judgment (%)				Healing Rate	Treatment Performance	Result in Order
								Healed	Almost Healed or Remarkable Effect	Some Effect	No Effect			
18.	Ichihara Masafumi (Laboratory)	11-12	Yoshio Primary & Middle Schools (Chiba P.)	661	101	15.2	101	49(48.5)	35(34.6)	17(16.8)	0 (0)	83.1	Public Health Nurse	A
19.	Ko, Iriye (Laboratory)	11-12	Shirozato Primary School (Chiba P.)	922	214	23.2	198	47(23.7)	72(36.3)	54(27.2)	54(27.2)	60.1	School Nurse Teacher	C
20.	Otaru City Ophthalmologist Hokkaido University Ko	11-12	Otaru City Primary & Middle Schools (Hokkaido)	14,726	2,947	20.2	880	313(38.5)	257(29.2)	144(16.3)	166(18.8)	64.7	"	C
Sum Total				23,020	5,093	22.1	2,853	1,071(37.5)	932(32.6)	549(19.2)	301(10.5)	702	"	B

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Section 2. THE FOLLOW-UP RESULT.

The follow-up result has the most suitable content to investigate the existence of safety and reappearance, etc. of the patients after a fixed period, after removing malignant turnor surgically, gynaecologically, etc.

But there is a difficult point, performing something resembling this, after the mass treatment of Trachoma. Namely,

1. At the time of judgment of the conclusion of the treatment, all of them are not healed. Some have some effects.

2. There are surely enough Trachoma left in the 'some effect' and 'no effect' ones, there are possibilities of reappearance.

3. As there are some difference in the daily life of the finished students. There will be a lack of appropriateness, summing the follow-up result, indiscriminately.

4. There are some who get individual treatments and those who do not, even after the treatment is over.

5. The Trachoma of the family will be the cause of reinfection.

So it is originally difficult to use the follow-up result as it is used in surgery, gynaecology, etc.

But I believe that it is absolutely necessary to look at the follow-up result in the possible limit. Especially, as I think that probably my mass treatment is the first one in the world to be examined, and there are also relations of existence of possibility of diffusing this method, I am feeling responsibility on it.

So I have used the following way.

The one who investigates the result, must be the same doctor in charge who diagnosed and judged the effect at the time of the mass treatment, by all means. It is impossible for other doctors to undertake it.

I have made the standard of investigation as follows:-

1. Good change: Those which have shown more remarkable good change in comparative with the time of effect judgment.

2. No change: Those that are thought to be the same as the time of effect judgment.

3. Aggravation: Those which are recognized to have changed worser than the effect judgment time.

The above-mentioned items are to be entered into the last column of follow-up result of the treatment card.

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(Detached sheet No. 1 Mass Treatment Card) of each student and add it afterwards.

The base at the time of the entry of the doctor in charge is the view record, the most direct one, at the time of the effect judgment, but the matter that serves more as a reference is the memory of the doctor, also the view record at the time of diagnosis, the evidence of the school nurse and teacher in charge, etc. The zealous doctor's memory is useful, but we must be careful with the student's evidence, and use the part of the evidence that is same to the above-mentioned base.

Next, I would like to explain the result.

1. In the first half period of 1949, after six months - one school, after three months ---- five schools, and when it is summerized, it is as the detached sheet No. 4. But this time, I have made the good changed one, be contained in the "no change", ones.

2. The follow-up results in the last half period of 1949 are being investigated now, but the result we got till present are the ones of Tachibana, Katsuyama, Iwabuchi, Tsunomiya, and Miyamoto, etc. and the number of the passed dates are the one summerized from 1 to 6 months. This was also announced in detail with the result of mass treatment of the former chapter by Dr. Tadayoshi Ko at the general meeting of the Japanese Ophthalmologic Academy of this year. I would like to insert a part of it here. Now the following same points are found, by comparing follow-up result (1) with follow-up result (II).

DETACHED SHEET NO. 4. FOLLOW-UP RESULT (I) (First Half Period of 1949)

No.	Name of School	Doctor in Charge	Inspected No. of People	Inspected Time	Result		Note
					No Change (Contain Good Change	Aggrevation	
1.	Shizu (Primary School)	Suzuki Satoshi	31	About 6 months	26 (86.5%)	5 (16%)	5 (16%) changes better
2.	Togo (Primary School)	Ito Taisuke (Laboratory staff)	38	110 days	31 (81.5%)	7 (18.4%)	7 aggravated ones have Trachoma in the family
3.	Kohitsugi (Primary School)	Yo Kyoka (same as above)	58	about 100 days	54 (93%)	4 (7%)	Many changed better 7 were treated individually and got sanitary education to the bottom
4.	Ohara (Primary School)	Ichihara Masafumi (same as above)	69	"	56 (81.6%)	13 (18.14%)	80% of the aggravated ones belongs to coast trachoma district
5.	Yoda (Primary school)	Yo Kyoka (same as above)	73	100 days	61 (83.5%)	12 (16.5%)	2 conjunctivitis besides this
Total			269		228 (81.08%)	41 (18.92%)	

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Detached Sheet No.5 FOLLOW-UP RESULT (II)

Last Half Period of 1949
Inspected No. of People: 946
The Passed Term: 1-6 Month

At the time of effect judgment \ Result	Better Change	No Change	Aggravation	Note
Healed	% 0	% 317 (83.42)	% 63 (16.57)	No change exists in a high rate
Almost healed, Remarkable effect	122 (36.20)	185 (54.89)	30 (8.90)	Many better changed ones, few aggravated ones.
Some effect	68 (39.53)	92 (53.48)	12 (6.97)	Many better changed ones, the other are the same as above
No effect	9 (15.78)	35 (61.40)	13 (12.47)	Many no changed ones, unexpectedly, only few aggravated ones.
Total	201 (21.24%)	627 (66.27%)	118 (12.47%)	

a. In list (I), the "better changed" ones are contained in the "no changed" ones and the total (at the bottom of the list) is 81.08%. If list (II) is handled in the same way, the total will be 87.51% and be almost the same. The reason why (II) has a high rate is because there are some difference in the number of days after the treatment was finished.

b. The aggravation is, 18.92% in list (I) and 13.47% in list (II). This also seems to be profitable to list (II), but both are between 10-20%.

Namely, after 1 to 6 months, after the mass treatment was finished, those which aggravate are only 10 to 20% and the others show no change or better change.

Next, in list(II), the following points are found by observing them in more details.

a. "The better changed" ones are 21%(approximately), aggravated ones are 12%(apprx.) and the former one is better than the latter one. And the "no change" one is about 66 %.

b. The contents of the "better changed" ones, are surely zero on the healed one at the time of judgement but the "almost healed ones and remarkable effect" ones are 36%, "some effect" anes are 40%, and the "no effect"

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ones are 16%. It is remarkable that there are many 'better changed' ones in the latter two.

c. On the item of 'no change', each item is generally the same, as you can find it on the chart. I think that the reason of high rate of healed ones are, because there are not to be shared to the better changed ones.

d. There are quite many aggravated ones in the healed ones (17%), next is 'no change' ones (12%), and the other two are resembling. According to this, I think that the cause of aggravation has only few relations with the condition of time of judgment.

In short, it indicates that during this term, the condition at the time of the judgment was kept for about 70%, over about 10% showed aggravation and over about 20% showed better changes, the result is a better one than the one shown in Table 1. I think that it can be said that it is a satisfactory effect.

As I have mentioned above, it is impossible to get a perfect follow-up result just like in cases of surgery and gyneacology for trachoma, but when my above-mentioned inspecting method is supposed to have appropriateness, the result of my mass treatment should be satisfied. And also, each Trachoma patient is going to do their own livings till the follow-up inspection after the treatment is finished, and some will turn to a profitable way of aggravation. The real situation is that almost all of the students who have finished the mass treatment are left alone and there are only a few who receives individual treatment. Premising this fact, I think that the following matter can be said generally.

1. Those who have received mass treatment with 'XL-10', can be recognized that they are getting more than as the number of days passes after the treatment. It is already recognized that it becomes better after the treatment is stopped when it is treated with sulfa drug, but even when this salve is used for local treatment, the follow-up result of 1 to 6 months after the treatment, this fact is affirmed. But we have not done investigations on the result of one year after. But if the yearly treatment is to be done again, I believe that there will be much hope on the destruction of trachoma of the proper units (school).

b. I think that zealousness of the school nurses has an important meaning to the daily life of the trachoma patients. Especially, it is necessary to give enlightenments on sanitation to the trachoma families.

c. The school nurses must have zealousness towards the preformance of individual treatment.

d. The families that have many trachoma patients are the source of reinfection, so this counter-plan must be considered. The main cause of the aggravation of the former list is the reinfection of trachoma and I have no hesitation in saying that the cause is family infection.

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When trachoma once spreads in the family, it is very difficult to eridicate it. I am now handling a case that occurred in a family of an educated class, but it is a hard work because the re-infection happens very oftenly. The sequence of infection was first the grandchild (infant); next the mother, next the grandchild's brother, next the grandmother and at least it appeared on the father, recently. This family lodges in the wife's parent's house. I am intending to treat all of the family in the house, but I have not time to start yet. I have related these kinds of example, because I want to know the difficulty that you will face at the time of trachoma mass treatment to the regional dwellers.

The number of times of follow-up inspection.

As I have shown in the treatment card (detached sheet No. 1) which I inserted, I think that it should be done once about 6 months after the treatment. After the next 6 months, it will be the time of the yearly inspection or yearly treatment.

Section 3. THE OBJECT OF MASS TREATMENT

I have mentioned throughout this chapter, as I have said in every place, that primary schools, middle schools (especially primary schools are suitable) are better for a while as the object of this mass treatment, and that school nurses should be used as the treatment performer for a while.

1. The Object of Mass Treatment.

As the trachoma sufferers are without regards to old, young, male and female, it is sure that the plan must originally be made toward all of the population, nationally, to make the counter-plan of the preventive construction. But, as I have mentioned above, this is very difficult, practically. Especially I think that the most easiest one to handle and the most effective one is the primary schools and middle schools. I attach great importance to the point that the students of the primary and middle schools have some understandings at the time receiving treatments. From the point that the infection of trachoma is mainly done at home the treatment of the family should be done first, but we must carefully think over the way of spreading the performance. As this is a problem, keeping company with the villagers, there will be a difficult matter on deciding the doctor in charge, treatment performers and etc. like it is done at school, and I am now considering the way of controlling this work of the villages (contains cities) and how to carry out the work smoothly. The politicians might be able to find out a counter-plan, and that is the one done for each kind of preventive infection. It might be easy to go to the dispensary for injection once or twice, but when we have to go the dispensary every day for a number of days like the mass treatment of trachoma (even for 15 days), it will become a difficult problem. But as I also recognize that the treatment of the villagers are the first principle, essentially, I am considering to settle this by all means. I have started the performance to a few villages, presently, to make the experience.

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The treatment of trachoma is best within the least few days of infection. From this point, the primary schools are most suitable and next the middle schools. I have mentioned already that the high schools are not suitable presently.

As there are the signs already even at the middle schools (new system), we were led to the conclusion that primary schools are the most sutable ones. Practically, the primary school students have understandings, are obedient and zealous.

My plan is to perform it in turns, locally, first on primary schools, and next middle schools and the next step is to perform it to the villagers of the same local district. I think that it is the next step to perform it to the high grade schools like the high school, etc. and bigger regions. On cases of performance of Do, Fu, Ken, and large cities, it is a course to enlarge it by degree according to this plan. The construction of Trachoma is the work of the century as it is also said in Egypt. (Tewfic 1935) there are no reasons of hastening, but we must not be resting.

Chapter 5. Appendix.

What I have mentioned that is covered in the former four chapters is, in words, the trachoma mass treatment system which I have advocated. This is premised by using a salve called 'XL-10', namely, 'XL Homozol', and a change to the whole system will occur, if the drug to be used is changed. So, when 'XL' salve is not to be used, this book might have a value to refer, but I declare that this will not be the guide nor standard. Recently, salve which homosulfamine is used as the main drug is in a tendency being sold in markets and it will be delightful, if the quality is good. But I am not thinking so much about the possibility of using these drugs in place of 'XL'. As I have mentioned in Chapter 1, 'XL-10' was decided at last, examining all kinds of basic drugs in the salve trial producting period, so I do not feel that it is necessary now to examine the resembling salves which were abandoned.

The marketing drugs might increase in the future, but during this one year till I have become satisfied by degree recently, I was very surprised because there were so many narrow paths that are to be conquered on the condition of the country of nowadays.

I have already related about this, so I will not repeat it again, but I have found out the dangerous path which I have to pass at the time of making ophthalmologic salve. So, I have just related my small experience that there are a quite deal of difficulty in making ophthalmologic salve.

The treatment of Trachoma grave is a difficult problem to the ophthalmologists of the successive generations. No matter how specialists struggled, the better changes and aggravations always repeated and they had bitter experiences, and at last the patients and even the doctors became tired about it. There are many cases in the farm villagers, fisher-

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the trouble that extended for many years had come to naught. It seems as if these cases are giving more impressions of difficulty of the healing of trachoma. I also received the same impression. But if the treatment is performed at the beginning of the desease, these unfortunate effects can be prevented. So when the period of performing the mass treatment is done extensively in the future, these kind of patients will be eradicated by degrees.

At present, in the word I say trachoma sanitary insusceptibility, there are some that really occurs, because the method is incomplete and unprepared even when receiving the treatment of the specialist. The ophthalmologists have a duty of using the knowledge of the new age, enough, and devise a suitable scheme against this too. As I am studying to consider the way of systemalizing the treatment of trachoma, I am intending to make another manuscript of this important problem for the reference to the eye-specialist.

As I have related before, there are surely some naturally healed cases in trachoma. It is a problem whether it is a perfectly healed one or a clinically healed one. Even it is a perfectly healed one, the number is few. It should not be doubted that most of the cases aggravates more and occurs infections around it. The word that says that trachoma is a national desease, frankly expresses it. Even when a supposition like a dream is made, the real side that the infection that will be shown during the term the patient was caught by the desease and till it is healed can not be overlooked. In words, it is a problem of technical study on trachoma that there are some that are healed naturally, but it will never reduce even a list of the size of the social problem of the necessity of trachoma prevention. The same thing can be said on tuberculosis.

I have said before that the anti-trachoma drive is a problem of this century. This will be affirmed by the knowledge of the ophthalmologists of nowadays. Japan is really carrying a big duty on her back toward the future. So the necessity of mass treatment will not move for a while. The one I advocated is one of the systems, and I have no reasons of keeping an undue hope on it. I am just hoping for a new system that is passed by a more good way.

But I feel keenly that my system needs a yearly treatment to look for the perfection of the mass treatment. While repeating the performance of the above-mentioned treatment that is done once a year, I think that it should be given to the people of the region besides this, then spreaded to the advanced schools and to the wide area. I believe that my system was made, thinking about this, but I really do not know myself whether enough predictions is made on the many lanes that will be met at the time of performance. For instance, I am still wondering on the way of practice of mass treatment of the villagers.

'XL-10' is made by malfanyl as I have mentioned before (1941), but it is 9 years since the synthesis of the material. During this term, new synthesized drugs also appeared and there are no rest on this time. I can not be said that there are not any possibility of appearance of some

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effective frug better than "XL-Homozol". We are doing our best toward the realization of this prossibility. But I believe that my above-mentioned 4 provisions will never move in this case, too.

Perhaps, even when it is assumed that there are not any drugs better than malfanyl, the study on the basic drug and preparation method might be able to guide it to a salve that surposses "XL". Though I have produced by the way of experiment using many basic drug, that was all we could get in this country after war. Our hospital surely had stocks since the beginning of war. But we unavoidably had to use the marketed post-war manufactured goods. And I also know about the study on the basic drug that developed in America by magazines. So, more examinations are being done presently, to the salve basic drug of "XL Homozol".

The basic drug and also the manufacturing method has developed a great deal. So we must accept these, too. In words, I think that the future of this salve can be expected.

Next, as I have related in the introduction, the desease germ of trachoma is still unknown yet. But it stands on a opinion of a foundation that it might be virus, as the European practioners assume. And we trachoma desease germ responses it. So I declare that all of the arguments are along the line. This is not only the reason that only came out of the consideration by my literature, but by depending on the support that a part of unchangeable base is obtained by the virus study.

The virus study on trachoma has been started at several places by using electron microscope. A subject was presented from Hokkaido University and Kyoto University at the general meeting of the Japanese Ophthalmologic Academy this spring, and my laboratory is intending to make the first announcement within this year.

When the virus of trachoma is settled, I think that the problem on the effect of sulfa drug will also be settled definitely. I think that the time is not so far already. As we must think that the scholars of Europe are surely grappling with this problem already, some country in the world will aim the victory by the electron microscope soon.

In conclusion, when the virus is settled, the next problem that will occur, is vaccine and preventive injection. This is thought to happen surely and the next, the criticism will be held flourishingly, but this means that the trachoma problem will be settled and I think that it will need quite a long time for it to be finished. But at present, the academic circle of the world will rush into the race course on the settlement of the desease germ.

The Conclusion.

I believe that the duty of this book is almost finished, so I think that I would like to end it here. But I think I would like to relate a

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few points which I desire to you in conclusion.

First, all of the people must endeavour to control trachoma. The people must resolve to control it by their own hands.

As I have mentioned before, the numbers of ophthalmologists are very few in comparative with the number of trachoma patients. And also, most of the trachoma patients do not visit the doctors and do not seem to worry about their desease at all, so those indifferent patients must be urged their consciousness of the necessity of the treatment and let them understand the danger that will come up to the other peoples and this work can not be done without the effort of the whole people all marching toward the control of trachoma.

Next, it is necessary to have them understand the necessity of the right performance of the mass treatment. It seems as if those people who are unconscious against trachoma, do not like to spend even a few hours nor any expense. But, to be infected does not only make the efficiency fail but also is a terrible desease that makes the patient blind by getting worse and also occurs infections to the others, so a feeling of gladly offering some sacrifice is wanted from the view point of mutual existence, mutual prosperity of the interested people. As I have related, I attach importance, a great deal to the right performance of mass treatment. This is, because a well selected treating method and performing method is necessary. I think that there are many marketed salves using home sulfamine as the main drug, and many doctors, pharmacies using it for personal use, after I announced "the road to the construction of trachoma" (Nihon Iji Shimpo) last summer, but they are not using pure materials nor containing impurities, and most of them are unsuitable for mass treatment use by cause of the irritation. We must not perform the treatment with this imperfect medicine and method when the mass treatment is to be performed by the cooperation of the people. Recently, a sort of so-called mass treatment is seemed to be done at some places, but most of the results were unsuccessful. So, I have heard that there are some people even doubting the effect of sulfa drug itself. But by hearing the real situation, or inferior goods, or the treatment was unsuitable or the sterilization and other preparations were not done well. There are no faults that the motive of the action was on the welfare of the people and is very respectable, but it is necessary to be careful about the oposite effect.

The third is that the effect of my treating method is rapid. This owes to the progress of the modern science and the original treatment for trachoma can not be expected the result, even the ophthalmologists, too. We must not let the people think that the ophthalmologists are doing something in vain. The drugs that are to be used for mass treatment are surely going to be the regular medicines of the whole ophthalmologists from now on also many other new medicine are being deviced and especially a new operations for trachoma is being deviced and every kind of severe patients will surely be completely treated. I am sure that the mass treatment will never be able to act in the same way. So the responsibility of the ophthalmologists will become more heavy according to the performance of the mass treatment and the work will become more busy. The people should now recognize the necessity

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of the ophthalmologists, widely and deeply, and I am strictly relating here that no misunderstanding should be made even despiring the ophthalologists.

- End -

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IMMUNIZATION QUESTIONNAIRE WITH SPECIAL EMPHASIS ON TUBERCULIN TESTING AND BCG INOCULATIONS

_____ PREFECTURE

1. Have you received the following? (Check appropriate column)

Yes	No	
		Preventive Vaccination Law #68 of 1948.
		Ministry of Welfare Notification #95 of 1948.
		Ministry of Welfare Notification #96 of 1948.
		Ministry of Welfare Notification #97 of 1948.
		Yohatsu #38, 12 January 1949.
		Yohatsu #39, 12 January 1949.
		Yohatsu #341 of 11 April 1949.
		Ministry of Welfare Notification #255 of 16 November 1949.
		Ei-hatsu #434 of 23 May 1950.
		Ei-yo #114 of 25 November 1950.
		To-hatsu #13 of 11 January 1951.

List any other directive which you are at present following regarding your immunization program.

2. What are the totals of the following groups in the prefecture as of 1 January 1951? Give basis for numbers used; are these census (C) figures or estimates (E)?

Totals	C	E	
			Total population.
			Approximate number under 1 year of age (1950 births less deaths under 1 year).
			Approximate number entering primary school.
			Approximate number completing primary school.
			Approximate number 3 years to 60 years inclusive.
			Approximate number 6 months to 30 years inclusive.

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3. What is the estimated number of individuals to be immunized in the prefecture during 1951 for each of the following in order to comply with the Preventive Vaccination Law #68 of 1948?

_____ Smallpox

_____ Diphtheria

_____ Typhoid-paratyphoid

_____ Pertussis

_____ Tuberculosis

_____ Tuberculin test

_____ BCG inoculation (Does this include those with doubtful tuberculin test: Yes ( ) No ( )

4. In what form are records of inoculations first made at the inoculation stations where performed:

( ) Separate certificates or receipts for each person for each inoculation.

( ) Separate certificates or receipts for each person for each complete immunization.

( ) Lists or registers of persons actually receiving inoculations or a complete immunization.

( ) Lists of registers of persons supposed to receive inoculations with entries made for those actually inoculated.

( ) Individual record cards on which all immunizations may be entered (Form described in Yohatsu #39 of 12 January 1949)

5. Are records temporary? Yes ( ) No ( ) If temporary, how soon after inoculation are they transcribed:

At what location:

On to what forms:

6. Are the individual immunization record cards (Yohatsu #39 of 12 Jan 49) in use throughout the prefecture for recording all immunizations?
Yes ( ) No ( ) If not, are they used in:

( ) Model health center district.

( ) In some or all "urban" health center districts.

( ) In some or all "rural" health center districts.

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7. At what locations (as to type) are the individual immunization record cards filed:

( ) Health centers in cities.

( ) Health centers in rural areas.

( ) City, town and village offices.

( ) Schools.

( ) Other. (Name, if any)

8. What is the total number of individual record cards in the prefecture placed in use with names and other individual identifying data entered: _____.

9. What immunizations and how many complete immunizations of each type given in the prefecture during 1950 have been entered on the individual immunization record cards?

Immunization	How many completed	How many entered on imm. record cards
Smallpox		
Diphtheria		
Pertussis		
Typhoid-paratyphoid		
Tuberculin tests		
BCG inoculations		
Others		

10. Have all previous records of immunizations been transcribed to the individual immunization record cards? Yes ( ) No ( ) If not, how long will it take to complete the transcription?

11. Are tuberculin tests and BCG inoculations commonly performed in the

Health centers - Yes ( ) No ( )

Town and village offices- Yes ( ) No ( )

Other public buildings - Yes ( ) No ( )

Outdoors in summer - Yes ( ) No ( )

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12. Is a record made by entry on a register or card of each BCG inoculation at the time it is given? Yes ( ) No ( )

13. By what office(s) are personnel performing immunizations employed?

By what office(s) are they given detailed instructions?

14. What persons perform or record each of the following procedures at the inoculation stations? If more than one class of person is involved, please indicate:

	Doctor	Nurse	Clerk
Tuberculin inoculation			
Recording of tuberculin inoculation			
Reading of tuberculin reaction			
Recording of reading of tuberculin reaction			
BCG inoculation			
Recording of BCG inoculation			

15. Are records kept by local health offices (town, village, school, etc.) of the number of plus-minus or doubtful readings of tuberculin reactions? Yes ( ) No ( )

Are reports made to health centers of the number of doubtful tuberculin reactions? Yes ( ) No ( )

Do the health centers report these to the prefecture? Yes ( ) No ( )

Are repeat tests with stronger tuberculin performed on the "doubtful" group? Yes ( ) No ( )

Are they given BCG inoculations if doubtful? Yes ( ) No ( )

Are they exempted if doubtful? Yes ( ) No ( )

Were the "doubtful" reactions to tuberculin included:
with positives ( ) with negatives ( )

16. Did each city, town and village report regularly each month during 1950 to the health center, the total number of tuberculin tests and BCG inoculations performed even if this number was zero? Yes ( ) No ( )

17. Were special forms used for reporting tuberculin tests and BCG inoculations? Yes ( ) No ( )

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17. (Cont'd)

Yes	No	
		Did they throughout the year (1950) include the data required by Yohatsu #341 of 11 April 1949?
		Did the prefecture continue to collect the data required by Yohatsu #341 during 1950 after the publication of Eihatsu #434?
		Did reports from cities, towns and villages to health centers and from health center to the prefecture include data other than (1) total numbers of tuberculin tests read, (2) number positive and (3) number of BCG inoculations performed? If so what other data?
		Was this form the same throughout all health center districts of the prefecture?
		Blank reports forms were printed by:
		the towns and villages?
		the health center?
		the prefecture?

18. From what local records were the monthly reports of tuberculin tests and BCG inoculations prepared:

( ) From separate certificates or receipts?

( ) From lists or registers?

( ) From the individual record cards?

( ) From other records?

19. Does the Prefecture Health Department receive monthly reports of tuberculin tests and BCG inoculations from each health center? Yes ( ) No ( ) If so, do these reports indicate:

( ) Totals for the entire health center district or,

( ) List of tuberculin tests and BCG inoculations for each city, town and village in the health center district.

20. By what authority and with what funds were the "ordinary" or regular, the "extra-ordinary" and "other" tuberculin tests and BCG inoculations performed:

Type	Authority	Funds
Ordinary		
Extra-ordinary		
Other		

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21. Do these three categories as reported to the Prefectural Health Department and by them to the Ministry of Welfare include all tuberculin tests and BCG inoculations performed in the prefecture? Yes ( ) No ( ) If not, what other agencies performed tuberculin tests and BCG inoculations and to what prefectural and/or national agency were they reported.

22. Did the Prefectural Health Department send monthly reports of tuberculin tests and of BCG inoculations to the Ministry of Welfare? Yes ( ) No ( ) If so, were these sent each month ( ) or in December only ( )?

23. Was the annual report of tuberculin tests and BCG inoculations by age for 1950 prepared in the same offices (city, towns or village) as the monthly reports? Yes ( ) No ( )

24. Were the original reports by age for the year prepared directly from:

( ) Separate certificate or receipt?

( ) List or registers?

( ) Individual record cards?

25. Were these reports for individual towns and villages compiled in health centers into single reports giving totals for each age group for the entire health center district? Yes ( ) No ( )

26. Did the Prefectural Health Department receive the 1950 annual reports of tuberculin tests and BCG inoculations from each health center of the prefecture? Yes ( ) No ( )

27. Were these reports ( ) totals for the entire health center district?

( ) separate reports of each town and village?

28. Did the 1950 annual report of the prefecture include all tuberculin tests and BCG inoculations by year of age up to 30 and by age groups over 30 years performed in the prefecture? Yes ( ) No ( ) If not, what other tuberculin tests and BCG inoculations were performed; where are the records and to whom were the reports, if any, sent?

29. What records and reports pertaining to the financial aspects of tuberculin testing and BCG inoculation are made at:

City, town and village level:

Health center level:

Prefecture level:

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30. Obtain samples of all record forms and report forms used or in use which differ from those required by the directives listed in question 1 of this questionnaire.

31. What are the tuberculin testing and BCG inoculation plans for 1951 as to number of individuals and age groups to be tested and inoculated during certain months or periods of months:

Priorities to be established either by age groupings or geographical area:

Concentration or spread of the work during various seasons of the year:

32. From the most dependable data available in the prefecture, consolidated report according to the attached form is desired, giving numbers of tuberculin tests examined, number of positive reactors, number of BCG inoculations, number of free inoculations for regular, extra-ordinary and other inoculation programs by month from October 1949 to December 1950 inclusive.

Regular: Schools - at Spring and Fall seasons
Factories
Offices

~~Extra-ordinary:~~ Working in various government offices
Regulars done out of season

Others: Left-overs
Newborn

33. Have public health and school officials coordinated sufficient to develop an adequate execution of the BCG program? Yes ( ) No ( )

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_____PREFECTURE

DATE	REGULAR INOCULATIONS				EXTRA INOCULATIONS				OTHER INOCULATIONS				TOTAL				REMARKS
	TB TESTS		No. BCG Inoc.	No. Free Tests & Inoc.	TB TESTS		No. BCG Inoc.	No. Free Tests & Inoc.	TB TESTS		No. BCG Inoc.	No. Free Tests & Inoc.	TB TESTS		No. BCG Inoc.	No. Free Tests & Inoc.	
	Total Exam.	No. of Positive Reactors			Total Exam.	No. of Positive Reactors			Total Exam.	No. of Positive Reactors			Total Exam.	No. of Positive Reactors			
1949																	
OCT																	
NOV																	
DEC																	
1950																	
JAN																	
FEB																	
MAR																	
APR																	
MAY																	
JUN																	
JUL																	
AUG																	
SEP																	
OCT																	
NOV																	
DEC																	

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PUBLIC HEALTH SECTION

1. List of Indigenous Personnel That has been Given Notice as of 11 May 1951.

FUKUDA, Keishin (Dr)

FURUSHO, Akio (Dr)

HATANAKA, Kyoko (Miss)

ISHIBATA, Teruyasu (Dr)

KIJIMA, Kenshi (Dr)

MAKI, Atsuko (Miss)

NISHIDA, Sue (Miss)

NODA, Kan (Mr)

NUKAZAWA, Isuke (Mr)

OGURA, Hiroyuki (Mr)

OSHIMA, Ai (Mrs)

SAMBE, Toki (Mrs)

TAJIMA, Marie, Noriyo(Mrs)

WATANABE, Hiroyuki (Mr)

2. Those Who have Already Given Notice.

AWOKI, George, Tadashi (Dr)

KARIYA, Ichiro (Mr)

KONDO, Yasugoro (Mr)

NITTA, Ko (Mrs)

YOSHIHAMA, Tsuneko (Miss)

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CLINTON W. ALLEN

KAN NODA

ICHIKO KATIVA

CHARLES E. PEGG

DR KAJIMA

NAKAZAWA

MARGARET C. KENSEL

YOSHITOKA

MARGARET B. HAMILTON

OGURA

VITOLD JANKOWSKI, MD

~~DR GORTON~~ G.A. ~~EDELMAN~~

DR ISHIKAWA

DR TANAKA

AI OSHIMA

MRS. SAMBE
MRS. SUZUKI

CATHERINE MORTAN

MRS. KO N. TEA

DR. FUKUDA

MISS MAKI

P. HARRIS

MISS SUE NISHIDA

GAIL WILLIAMS

~~KYOKO KATAYAMA~~

TSUJI on SL;

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Sambe -	VD Reports Time Sheets, Dac & Jn Miscellaneous
Yoshihama -	Picks by Distributions Delivers CD Reports Prepares CD Reports
Tajima -	Report Typing Copy Work
Nagahisa -	All Out Going Letters Field Trip Reports Minos Concerning NPR

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5 Mar 51	Realignment of PH Program	2	Dr J.; file
8 Mar 51	TB Project, dated 7 Mar 51	2	1 - Dr J.; 1 file
20 Mar 51	List of Names of A Schools of Nursing Accredited by the Education & Welfare Branch (Last Copy 20 Mar 51)	1	Nursing
27 Mar 51	Interim Med Report for JPR, dtd 1 Mar 51.	1	Dr J.
	Interim Med Report for J.B.R, dtd 1 Mar 51	1	Dr J.
	Interim Med Report for JPR dtd 1 Mar 51.	1	Dr J.
	Interim Med Report for JPR dtd 2 Mar 51	1	Dr J.
	Interim Med Report for JPR dtd 3 Mar 51	1	Dr J.
	Interim Med Report for JPR. dtd 5 Mar 51.	1	Dr J.
29 Mar 51	Subj: Disposition of Contraband dtd 27 Mar 51.	1	Mrs J.

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DATE	SUBJECT	NO.	DISPOSITION	FILE
27 Sep 50	Correction of Immunization Deficiencies in the NPR, dated 26 Sep 50.	1	1 - Jankowski	
28 Sep 50	Japanese available for lectures, dated 27 Sep 50.	1	1 - Jankowski	
6 Oct 50	"Operation of Mothers' Class" dated 7 Aug 50	1	1 - Morgan	
7 Oct 50	Correction of Immunization Deficiencies in the NPR (not dated)	1	1 - Jankowski	
7 Oct 50	Interim Medical Report for NPR(not dated)	1	1 - Jankowski	
17 Oct 50	Conference with Gen Concerning PH&W Admin., dated 16 Oct 50. From Chief PW	1	1 - Mr. Allen	
19 Feb 51	Scapin 2142, dtd 13 Feb 51		1 - Dr. J.	
19 Feb 51	Water Supply, dtd 12 Feb 51		DR J. & MR A.	
3 Mar 51	Min of Wkly Not of #24 attached: Section II "Nursing Affairs"	1	Miss M.	
5 Mar 51	Scapin 2143, "Telegraph Delivery of Interm. Radio & Domestic Messages addressed to Army Post Offices"	1	Circulate	

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DATE	SUBJECT	NO.	DISPOSITION	FILE
5 Sept.50	Public Health & Welfare Administration	2	1 - Jankowski	
			1 - Allen	
7 Sept.50	(CE) Information Plan	4	1 - Jankowski	
			1 - Morgan	
			1 - Pegg	
			1 - Allen	
13 Sept 50	Publiv Health Information and Education Program, dated 8 August 50.	1	ADMIM-KCAR, TOKAI-HOKURIKU CIVIL AFFAIRS REGION, APO 710	
19 Sep 50	Information Concerning the Medical Examiners Law	1	Jankowski	
21 Sep 50	Partial Amendment of Public Health Nurse, Midwife and Nurse. Law No. 203	2	Morgan -1	23 Sept 50 Forwarded To Cos
25 Sep 50	Regulations Concerning Tokyo-To and Ward Activity Adjustment Council	1	Dr. J.	
12 Aug 50	Ratings of Japanese Food Outlets, dated 11 August 1950	1	1 - Pegg	
12 Aug 50	Communicable Disease Index (no date) Attached: Law #167-1948 Venereal Disease Prevention Law	1	1 - Jankowski	
16 Sep 50	Reference Manual For Nurse Administrators	1	1 - Morgan	
	(Returned from CAS, "Comment" Walter ~~Bangnoug, PH Division~~)		1 - Harris	
			1 - Jankowski	