of syphilis requires separate consideration on his part. All details of the course of the disease, length of treatment, response to treatment, physical condition at the time, possibility of relapse, etc. must be considered before a decision is made. THERE IS NO INFALLIBLE TEST, NO LANDMARK OR MILESTONE IN THE DISEASE WHICH, ONCE PASSED, WILL INDICATE FITNESS FOR MARRIAGE.

In general, repeated negative blood and spinal fuuid examinations, regular physical examinations by a physician and a prolonged sympton-free period (at least 2 years) is required. In complicated cases a much longer period is desirable.

Above all, it is unpardonable dishonesty to withhold the facts of a previous infection from the marriage partner, no matter under what circumstances or for what reasons such information is concealed.

GONORRHEA

DEFINITION

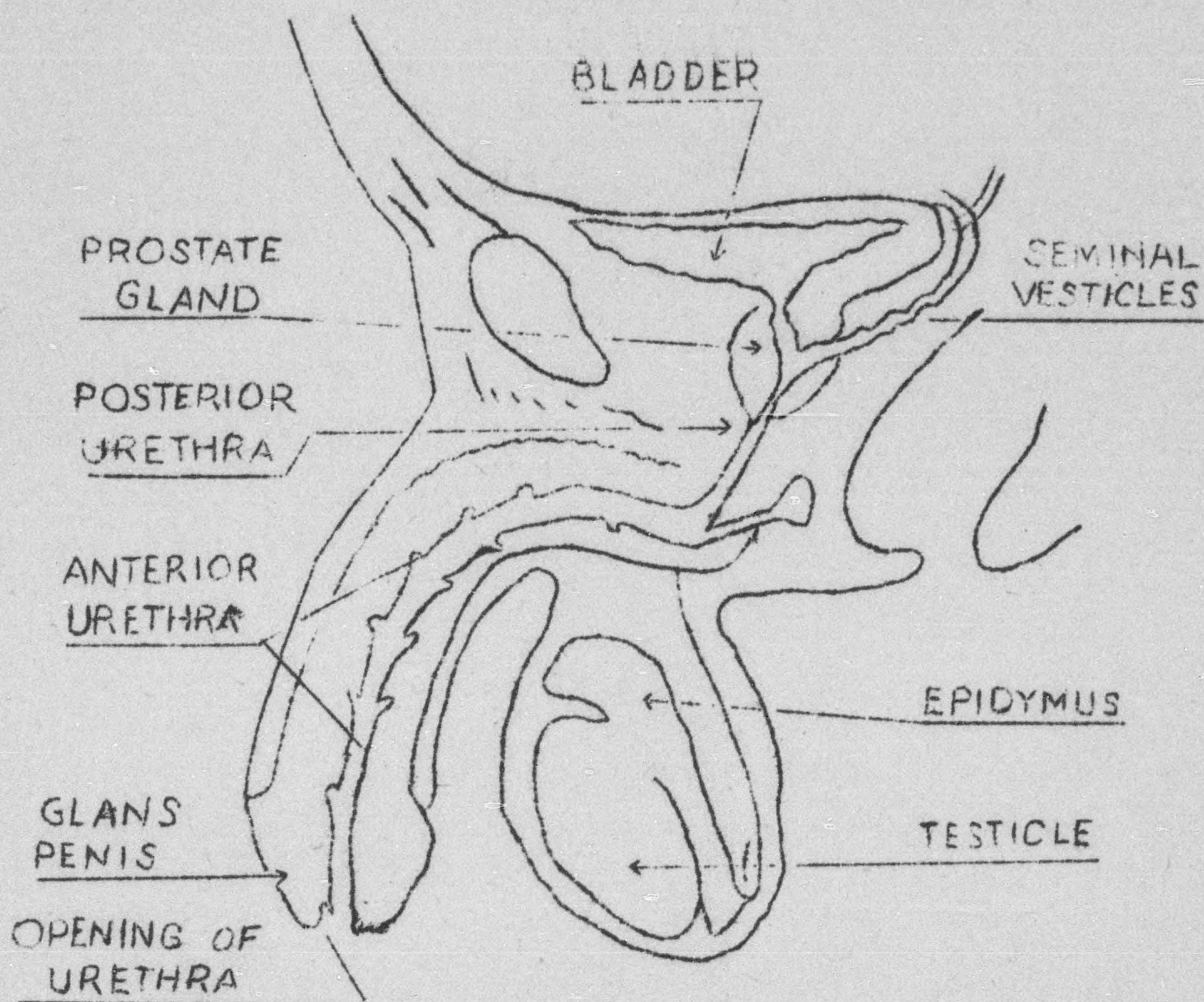
~~Gonorrhea is also known as Clap, Gleet, Running of the Range, Strain, and many other misnomers.~~ It is an infectious disease caused by the gonococcus. Predominantly, it is a mucous membrane disease and shows a decided predilection for tissues of the genito-urinary tract and the conjuctiva of the eye. Occasionally it also affects the lining of the joints, heart, and the liver. Common opinon regards it as a mild disease, that is "no worse than an ordinary cold". As a matter of fact, gonorrhea is one of the more serious infectious diseases and its complications are painful and disabling; it may invade the blood stream, attack previously damaged heart valves and produce death through septicemia - a growth of germs in the blood stream itself.

For many years gonorrhea and syphilis were thought to be one and the same disease. This was taught by John Hunter who was considered an authority on the subject until 1838 at which time a treatise was written by Philippe Ricord who established the separate indentity of the two diseases. The causative organism was discovered in 1879 by Albert Neisser and was given the name Neisserriae Gonococcae. Following this, contributions as to the treatment and complications were numerous and constant.

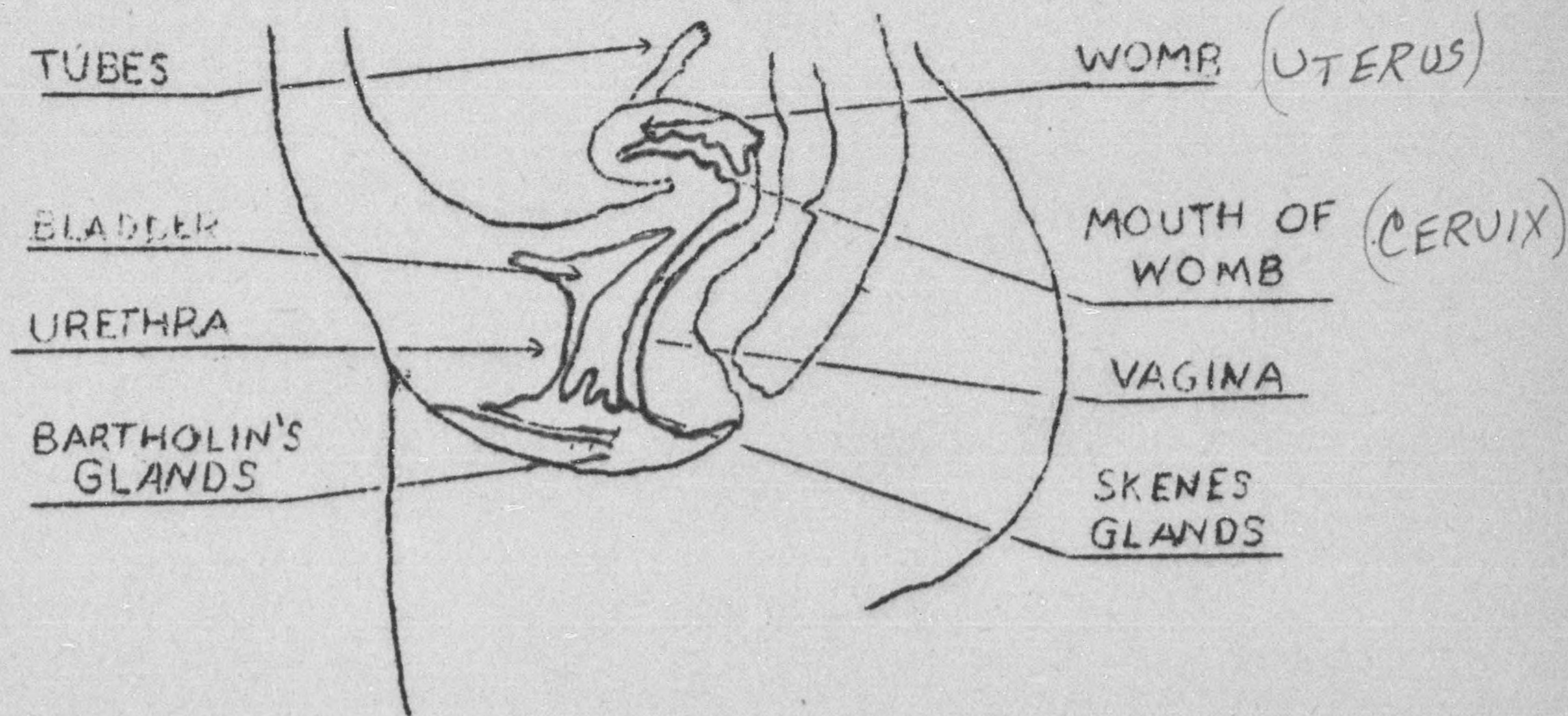
ETIOLOGY

Like the disease it produces, the gonococcus got a bad etymological start, for the meaning of its name is "a berry-like organism that causes a flow of semen". It is not berry-like and no one would mistake the discharge that it produces for semen in these more enlightened days. It appears under the microscope as a small organism likened unto the flat side of a coffee bean and it occurs in pairs.

MALE



FEMALE



Unlike most other organisms it is not quickly digested by the pus cells (white blood cells) so that it stains deeply and evenly both inside and outside of the cells. It takes the gram-negative stain and grows only in the presence of air; it can be cultivated on special media with a certain amount of difficulty. It is very frail outside the body, dies upon drying, and is easily killed by weak germicides. They are, however difficult to destroy once they have invaded the tissues of the body.

~~APPLIED ANATOMY~~

~~In no disease is it more essential that one have a knowledge of the structures involved than is the case with gonorrhea. In the following diagrammatic views the parts affected are shown. (See diagram No.1)~~

TRANSMISSION

Infection is almost invariably due to sexual contact, accidantal infections being of the rarest occurence, if it ever occurs. Occasionally fresh discharges may be conveyed to the eye by such means as contaminated towels. Among the many pecularities of the gonococcus, the one of greatest good fortune to the human race is that it dies immediately upon drying. This fact greatly limits its spread to those individuals whose susceptible mucous membranes come into contact with fresh gonorrheal discharges.

Female children, lacking the protection of pubic hair and having the more susceptible "baby type" vaginal mucous membranes, are subject to greater risk of infection by accidental contact with infectious secretions from a nursemaid, parent or guardian.

It must be borne in mind that the female may transmit the infection to a male immediately after having exposed herself to an infected male. In this case the vagina acts merely as a receptacle in which the infectious material is deposited and transmitted by direct contact. This may occur even after so-called douching is used.

The most important factor in the transmission is the asymptomatic female who, in spite of repeated sexual exposures and the indiscriminate use of alcohol, which ordinarliy exaggerates symptoms, remains asymptomatic over periods of months.

PREVALENCE

It is impossible to arrive at correct statistics, not only due to the great secrecy in which this disease is held, but also due to the activities of quacks, charlatans, and unethical druggists. It is known to be the most prevalent of the venereal diseases, occurring from three to seven times as often as syphilis. 211,000 new cases occurred in Japan last year. If all cases were reported there would probably have been 2 to 3 times as many cases. ~~It is estimated that several million new cases occur each year in the United States alone.~~ It is agreed that sexually promiscuous people are constantly in great danger of infection unless prompt and perfect prophylaxis is used. Professional

prostitutes and other very promiscuous persons almost invariably become infected.

INCUBATION

Incubation period is that time elapsing between the implantation of the infectious material and the first clinical manifestation of the disease. In gonorrhea this usually amounts to from two and a half to 10 days, usually 5. Evidences of infection over a much longer period of time are, generally speaking, mild unnoticed gonorrheal infections stirred to activity by either alcohol or sexual excitement. Likewise, attacks occurring in less than 48 hours after exposure are recurrences of an old gonorrhea or represent infection acquired by still another sexual contact at an earlier date. In such instances the last sexual partner may have been infected by the patient and does not represent the source of his infection.

SYMPTOMATOLOGY

The symptoms of gonorrhea differ in severity in different individuals. In most individuals there occurs a slight itching at the opening of the urethra (tube-like structure leading from the bladder) and burning while passing urine, followed by the appearance of a discharge. This discharge may be scanty and the burning may be very slight; it may vary from a thin watery material to a creamy yellow pus. The more severe early symptoms usually develop in those persons who consume alcohol or indulge in sexual intercourse during the incubation period.

As long as the infection is confined to the anterior portion of the urethra the symptoms are usually limited to burning, slight pain on unination, and varying amount of discharge. If the infection extends to the posterior portion, the prostate gland and the bladder become involved causing frequency of urnination, painful urination, intense back pain, and in many cases elevation of temperature (fever). During the presence of anterior urethritis alone, the urine, if passed into two glasses shows a cloudiness of the first glass, due to the presence of pus in the anterior urethra, while the second glass is clear. With the onset of an infection in the posterior portion of the urethra, the second glass of urine also becomes cloudy due to the presence of pus in the bladder and/or the numerous glands at the posterior urethra which are partly emptied when the flow of urine is stopped between the filling of the first and second glass.

Few diseases differ more widely in symptoms they produce in different individuals than does gonorrhea in the female. In many women there are no recognizable symptoms, and in 75% the symptoms would be classified as mild or moderate. Symptoms pass through all gradations from the entire absence of all symptoms to the most pronounced pain and discomfort associated with fever, profuse discharge,

and extreme pain in the lower abdomen and bladder. Uncomplicated infections in women limit themselves to the urethra, to the glands situated about the opening into the vagina, and to the cervix(mouth of the womb).

DIAGNOSIS

Diagnosis must be discussed separately for males and females. In males the diagnosis of gonorrhea should never be made on the basis of clinical signs and symptoms. ~~In the army~~ The diagnosis ~~is~~ should never be made unless the causative organism (gonococcus) can be demonstrated by microscopic examination with pus cells occurring in a smear made from the discharge. Cases of urethritis caused by organisms other than gonococcus may occur making it necessary that repeated examinations of smears be made to be certain that one does not have gonorrhea. Where cultural methods are available they should be used.

In the female the diagnosis is much more difficult. Many women exhibit no signs or symptoms from the start and it is also true that many very quickly pursue a complete cycle of acute, subacute, and chronic before they are seen by a physician. It has been demonstrated by authorities that when a woman is infected by a man whose symptoms have been reduced or obliterated by sulfathiazole (or some other sulfamamide drug) she becomes a symptomless carrier and remains so for varying periods of time. Therefore, it becomes a greatest importance that we thoroughly understand the limitations of diagonosis and the fact that health examinations of females, no matter how often and how carefully done, are of limited value. Only when well conducted cultural methods are generally used is it that the diagnosis in the female can be of definite value in the control of the spread of gonorrhea, even when they are medically examined.

TREATMENT

Prior to the introduction of the sulfonamide drugs (1937) (sulfanilimide, sulfathiazole, sulfadiazine, sulfapyridine) treatment consisted of the injection of certain drugs into the urethra. The effect of these drugs is only to cleanse and stimulate the mucous membrane to overcome the infection. Some of the drugs used are mild protein silver, strong protein silver, acriflavine, potassium permanganate, and silver nitrate. Internally urinary sedatives were given to help in giving relief to the pain and frequency of urination. Only a small part of this treatment was given in the physician's office and the bulk of the injections were left to the patient. The job was a messy one and in many instances was improperly done. Too often the use of these drugs was increased to the point where they brought about trauma and tissue damage leading to a chronic stage of the disease.

With the advent of the sulfonamide drugs revolutionary changes occurred in the treatment of gonorrhea. The details of the use of these drugs will not be explained but it must be added that there is

increasing evidence that many asymptomatic carriers are created and we should exercise great care in determining cures. Most authorities recommend ~~a combination of the~~ use of sulfonamide drugs ~~and the injection of protein silver drugs locally. This is particularly true of cases with involvement of the posterior urethra.~~ and no local treatment at all.

The use of the sulfonamide drugs caused many people to think that the treatment of gonorrhea had become a very simple matter and that it would only be a matter of each case going to the corner drug store and buying little white pills. This has caused disastrous results. Gonorrhea is still a disease which requires the careful consideration of a well-trained conscientious physician and no person should resume a normal sex life or the use of alcohol until certain tests of cure have been used.

The ~~present~~ NEWEST treatment of gonorrhea ~~by the army~~ is the use of 200,000 units of penicillin given intramuscularly in four consecutive doses at 2-3 hours intervals. This treatment is excellent, but in increasing percentages of cases it fails, for the following reasons:

(1) Failure of the patient to abstain from alcohol or sexual contact during the period of observation following treatment. <u>During this period the disease is not cured</u>. The tissues require about three weeks to heal even after the organisms (gonococci) are destroyed.

(2) The infection caused bya virulent (strong, resistant) organism may be sufficient to resist penicillin treatment. This is undoubtedly true in an increasing number of cases, and is a matter of great concern among physicians. ~~It would seem that after a period of time that all the weaker gonococcus strains may be obliterated leaving only penicillin - resistant organisms.~~

COMPLICATIONS

Complications of gonorrhea occur frequently in these cases who attem self-treatment and those cases that are badly managed. The most common are strictures (narrowing of the urethral tract); prostatis (infection of the prostate gland); abscess of the prostate; epididymitis (infection of the tube-like structure coiled at the back of the testicle); adenitis (infection of lymph glands in groin); arthritis (infection of joints); siminal vesiculitis (infection of saculated portion of tube leading from testicles); phimosis (inflammation of foreskin and inability to retract foreskin); paraphmosis (inflammation of foreskin which has been retracted and cannot be returned to normal position); balanoposthitis (inflammation of the glans penis and its apposed portion of foreskin); phlebitis (inflammation of veins of penis); lymphangitis (inflammation of lymphatics which drain penis; this is usually due to sexual intercourse or masturbation during treatment); parafrenal abscess (abscess of glands located on each side of the frenum ~~or "G" string~~).

In the female, complications are of even more serious nature. Sterility may occur in either sex. Blindness frequently results in the eyes of infants who are infected during or shortly after birth. Occasional blindness also results from infection of the adult eye with the gonococcus. When the tubes become infected it often leads to scarring and obliteration of the opening, making it impossible for pregnancy to take place.

CHANCROID

DEFINITION

Chancroid is a disease which is contracted during sexual intercourse and is characterized by ulceration of the external genital organs and inflammation of the regional lymph glands. It has been termed "soft chancre" in contradistinction to the chancres of syphilis which has been termed "hard chancre".

ETIOLOGY AND INCIDENCE

This disease is endemic in all parts of the world and there is no especial racial susceptibility. It has been described as a disease of filth. It is caused by a specific organism known as the "Bacillus of Ducrey."

INCUBATION PERIOD

The onset of chancroid occurs 3 to 5 days after exposure.

SYMPTOMS AND COURSE

The earliest symptom is the appearance of one or more pimples or blister-like sores usually on the external genital organs, but sometimes on skin areas elsewhere. These quickly break down with the formation of open sores or ulcers which tend to enlarge, burrow and destroy tissue.

Soon thereafter there is usually involvement of the glands in one or both groins, which, when inflamed, are called buboes. If untreated, these often suppurate (form pus) and require incision and drainage. The sores are indolent and slow to heal regardless of treatment. Chancroids often occur concurrently with the initial sore of syphilis and microscopic examination of the serum or pus exuding from the sore is necessary to determine the nature of the disease.

PREVENTION

Chancroid is practically always preventable by the simple expedient of properly using a condom during non-marital sexual intercourse and by thoroughly washing with soap and water immediately thereafter. The water should be hot in order to be a proper solvent for the secretions which adhere to the genitals and the soap should be of the liquid variety such as is used in the regulation army prophylaxis.

TREATMENT

Many forms of treatment for chancroid have been advocated. Formerly cauterization of the sores with strong acids or oxidizing agents was employed. Wet dressings or application of powder drugs or ointment on the lesion as well as medication by mouth is usually indicated. Occasionally the bubo must be drained by the use of the needle or even a surgical incision. Sulfa drugs used as in the treatment of gonorrhea are now the best available treatment.

Stop.

LYMPHOGRANULOMA VENEREUM

SYNONYMS

Synonyms for this disease are: Venereal lymphogranuloma, Lymphogranuloma inguinalis, Climatic bube, Tropical bube, and Durand-Nicholas-Favre disease.

NATURE AND INCIDENCE

Lymphogranuloma venereum is much more prevalent than previously realized. It is found in all parts of the world. So far as is known, it is only transmitted during sexual intercourse. This disease is found most frequently in negroes.

ETIOLOGY OR CAUSATION

The causative agent has been indentified as a virus. A virus is a disease producing agent too small to be seen by the ordinary microscope. The size of these agents is determined by their ability to pass through special filters or mechanically with the aid of centrifuges similar in design to the kind used in separating cream from milk. The presence of the agent is demonstrated by its ability to produce a typical disease in laboratory animals.

SYMPTOMS

The disease first manifests itself by the appearance of one or more pimples or blister-like sores on the external genital organs 1 to 3 months after exposure. This initial sore is not easily recognizable and may go unnoted with the first symptoms appearing in the

form of buboes [or] swollen lymph glands, in one [or] both groins. These buboes are painful, tender, andtend to break down with pus formation. The everlying skin becomes discolored and finally ruptures, usually at several points with the formation of multiple discharging sinuses.

In women an ulcerative-scarring process involves the external genitals and rectum, causing painful and incapacitating strictures.

THE FREI TEST

This test has proven to be fairly reliable. It is performed by injecting a small amount of material (known as antigen) into the skin. The resulting skin reaction indicates the presence of disease, but not its present activity.

TREATMENT

Treatment has never been satisfactory, but a combination of Frei Vaccine, fever therapy and sulfonamide administration is the treatment of choice and will undoubtedly cure many cases.

PROSTITUTION AND VENEREAL DISEASE

Whenever and wherever there is a rapid increase in population whether it be the organization of a new industry, the development of a military installation or other sudden economic boom the natural increase in pay-roll attracts almost immediately a certain group of cheap promoters or racketeers who like to refer to themselves as "the entertainment industry". This statement is not intended to include the legitimate and wholesome means of entertainment usually available in such communities; it refers to the cheap honky-tonks, taxi-dance joints, many "juke-joints", and a certain type of tourist camp - that certain "underworld fringe" which attempts to mask their activities as promoters of the profession of prostituion. There is no denying that the great pool of infection, as well as the greatest single factor in the spread of venereal disease, lies in the practice of commercialized prostitution, and no discussion of venereal disease is complete without some consideration of this profession and its effects on national health.

In many of the infectious diseases with which we have to deal such as malaria, the intestinal diseases, Typhus fever, etc. the disease is spread by an impersonal mosquito, fly or louse. We can effectively deal with these diseases by wiping out or attempt to wipe out the carriers, by actual killing of the adult, or by preventing development of the young. The carrier of syphilis or gonorrhea, however, is either a man or woman. These carriers cannot be eliminated like insects - they must be handled or controlled in an entirely different manner and it is this control which represents one of the greatest public health problems in the United States today.

Every city of any size has its problem of prostitution. Several different methods of dealing with this problem have been tried in various localities and these methods can be summarized into two general policies as follows:

1. Segregation and control of prostitution.

2. Suppression of prostitution.

SEGREGATION

In certain localities it was thought that this was the answer to the prostitution question. Prostitutes were given a "license" either legally or through extra-legal channels; they were set up in houses or rooms in segragated districts, the so-called "red-light" districts, and were examined by physicians at regular intervals in the false hope of preventing venereal disease. This was considered a very common sense attitude toward the question — this was the "no-use-trying-to-stop-prostitution, we-will-accept-the-situation-and-control-it" idea. A series of similar experiences in different parts of the United States has proven that this type of control of prostitution SIMPLY DOES NOT WORK. That is, such districts (red-light districts) actually cause an increase in venereal diseases — not only do medical statistics prove this, a little practical reasoning will show why an increase in disease incidence is to be expected.

First: MEDICAL INSPECTION OF PROSTITUTES IS NOT EFFECTIVE IN PREVENTING DISEASE. Examination of prostitutes by a physician is necessarily a superficial one. The primary lesion of syphilis, the chancre, does not usually appear until three weeks after the individual is infected. Occasionally the lesion is so small or is so located as not to be detected even on careful examination. Also the blood Wassermann does not become positive until as late as six weeks following infection. Thus, a case of primary, infectious syphilis may be easily overlooked. Also, even though a prostitute may be free from infection at the time of examination, she may become infected by the first man she has contact with following the examination, or she may act as a carrier for germs which she can transfer from one customer to another before she has clinical manifestations. PHYSICIANS ADMIT THAT EXAMINATION OF PROSTITUTES IS AN INEFFICIENT AND UNTRUSTWORTHY PROCEDURE.

Secondly: Segregation causes increased contacts which in turn mean increase in disease rates. When a prostitute is "set up" in a protected house or district her "customers" know where they always can find her; they know that they are protected against legal action and in many instances are lulled into a sense of false security because they know that she is regularly examined. As a result, the satisfying of the sex becomes a simple problem and the individual prostitute often builds up a surprisingly large "clientele". Exposures up to fifty by one woman per night are not uncommon and in certain areas there are authentic records of over seventy exposures in one evening. It needs only the application of simple grade-school arithmetic to reveal that venereal disease must be considered

an "occupational hazard" by those who practice the "oldest profession". PROSTITUTES ARE DISEASED. Medical records over a period of 25 years indicate that 50% to 90% of all prostitutes in the United States have syphilis, gonorrhea, or both.

SUPPRESSION OF PROSTITUTION

We have seen how segregation allows a great increase in the number of contacts by the individual carrier and thus increases the probability of infection. If the prostitute were to be denied a license, deprived of her "protected" house or district and the practice of her profession made illegal, she must, if she wishes to persist in her activities, seek her customers on the streets as pick-ups -- she must do her own "missionary work". This obviously results in fewer contacts per night, probably no more than four or five. Fewer contacts means less exposure to disease and therefor less syphilis and gonorrhea. Even clandestine contacts and infections from the "pick-up" or "sea-gull" type of prostitute decrease under intelligent repression of prostitution. This is true because of the difficulty in keeping prostitutes in the housed provided for them in the legalized districts -- there is, in fact, more clandestine prostitution in cities where "red-light" districts are tolerated than in cities that have adopted repressive tactics. Repression then is a much more sane and workable system than that of segregation in the public health sense.

THE "ROMANTIC MYTHS" OF PROSTITUTION

Certain popular misconceptions regarding commercialized vice have existed for many years and one still occasionally hears carelessly uttered remarks by individuals who simply do not know the facts. Here are a few of these "romantic myths"; let us examine these statements coldly and in the light of actual facts as we know them.

"Prostitutes can't afford to be diseased, it is ruinous to their business so they see to it that they stay clean". This statement is simply a stupid absurdity. A review of what has already been said in regard to frequency of exposure reveals that. Also prostitutes actually know very little about the venereal diseases, they have not been educated in the medical aspects of these diseases; furthermore a large percentage of them are mentally deficient.

"A prostitute is smart, she knows it is only good business to keep from giving her customers a venereal disease". The medical profession knows of no drug which will prevent an infection from being passed on from the female to the male. We know that prostitutes are not skilled medically; they are NOT smart. They are prostitutes not because they have planned to become prostitutes from an early age; they are in the profession as a result of failure of other aims or ideals before they actually decided to do so. Many have psychopathic personalities which accounts for them being engaged in prostitution. Should an individual of normal intelligence and good health depend on the "skill and knowledge" of a feeble-minded, psychopathic failure to protect the health? There is only one answer.

"Prostitutes make good money; they pay high fees for the best medical care." Another complete absurdity. There are a few "successful" prostitutes who, being above the average in intelligence, deal with a very limited, monied clientele -- the "kept woman" type -- but they are very few and do not represent the problem with which we are dealing. Prostitution is a poorly paid, exploited profession from which the girl realizes very little monetary reward for herself. There are madams, procurers, "contact men", and other cheap racketeers who see to that. In regard to medical care, it is very often necessary to force prosititutes to take treatments for diseases they already have contracted, EVEN WHEN IT IS GIVEN TO THEM FREE OF CHARGE. They lack the intelligence to take advantage of any possible benefit from expert medical advice.

"A man has to have sex experience in order to obtain full adult development; it is better for him to go to a licensed woman than to take a chance on a "pick-up". Continence has been, it being and will continue to be practised without harmful influence on the male. Satisfaction of the sex appetite is NOT necessary. On the other hand, excessive sexual indulgence may result in exhaustion of the testicular cells which produce the sperm and a relative or absolute impotence and sterility may occur. Such a statement as appears above is usually made by one who is attempting to justify his own sexual irregularities. In regard to the second half of the statement, there is poor choice indeed. Both are in the same profession, both are exposed to the same hazards, both contribute heavily to the venereal disease rates and, as we have already repeatedly stated, PROSTITUTES ARE DISEASED. In the words of one modern syphilologist: "As far as venereal disease is concerned, prostitutes are divided into three classes:

1. Those who have had it.
2. Those who have it.
3. Those who are going to get it.

VENEREAL DISEASE PREVENTION

Venereal diseases are preventable. Venereal Disease Control Officers and non-commissioned officers, after thoroughly acquainting themselves regarding prophylaxis, should assure their men that the procedures recommended by the Medical Department are 100% effective if used as prescribed. Records indicate that only about 50% of the men use preventative measures and we believe that if these measures were thoroughly understood more men would use them. The men who do not use them must be made to realize that a continuation of these indiscriminate exposures will eventually lead to infection.

The methods available may be classified as follows: (1) the prevention of exposure whenever possible (2) prophylaxis before exposure (3) prophylaxis after exposure.

(1) C[illegible]inence is the only absolutely [illegible]e method of preventing venereal diseases. This would reduce the rate faster than any mechanical or chemical prophylaxis known today. Unfortunately, sexual continence is not always a method on which we can solely depend. Continence is not always practised by men in civil life where they are surrounded by what might be termed the restraining influence of home, family, friends, and public opinion; and where they are provided with the contacts and amusements which make up a normal social existence. Young soldiers, then, cannot be expected to change their characters with the donning of a uniform, particularly those on duty in foreign places where restraining ties of the home are removed and recreation facilities are limited. However, this method deserves utmost consideration and an effort should be made to remind the men of their moral obligations to their families.

(2) Prophylaxis before exposure. The use of the mechanical prophylaxis, rubber condom or sheath is the only real prophylaxis, in one sense of the word, in that it is the only method that can be applied before exposure. The rubber condom is the most practical method available, if properly used, in that it is readily obtainable, cheap, easily carried, quickly disposed of, and protects both partners.

The rubber should be one of good quality and one which has been inspected and tested to see that it is intact. Generally speaking most rubber sheaths made in the United States today are satisfactory, but all stocks should be examined intermittently to be sure that those available are in good condition and an adequate supply is on hand.

The rubber should be applied before any type of sex play takes place because infectious material may be transferred by the hands from the female to the penis. The penis should not come into contact with the woman prior to applying the condom. The man's soiled fingers should be cleaned before the condom is applied. The condom should be rolled into a flat disc with a firm rolled circumference. The flat surface should be applied to the head of the penis and the condom unrolled down over the penis. This prevents entrapment of air which would expand during sexual intercourse and possibly rupture the condom. It should not be covered with vaseline or any other pertoleum product, but it is good practice to lubricate with merthiolate ointment or any type of water soluble jelly. Vaseline and petroleum products cause such rapid deterioration that the rubber may be weakened enough during a prolonged sex act to cause breaking.

After the completion of sexual intercourse the rubber should be carefully removed with one downward and outward motion, turning the rubber inside out so that the outside, which is covered with infectious material, never touches the fingers or any part of the body. The proper application and removal of the rubber should be demonstrated to the men by the use of a broom handle.

Used rubbers should be immediately discarded by throwing into a toilet or wrapping in a paper to be burned later. They should never be thrown on the street, lawn, or roadside where they might be picked up by innocent children.

Emphasis should be placed on the fact that the rubber protects only while it is in place and only the part of the penis that it covers. While most venereal diseases are contracted on the penis it must be remembered that any other portion of the body, namely fingers, lips, scrotum (the sac that contains the testicles, or balls), lower part of abdomen, and inner part of the thighs, is subjected to infectious material. Fingers will transmit infection to the eye, or this may happen following the use of contaminated wash clothes and towels.

IT MUST BE CLEARLY UNDERSTOOD THAT THE RUBBER IS THE FIRST LINE OF DEFENSE AGAINST VENEREAL DISEASE AND THAT THIS IS THE ONLY METHOD OF PROTECTION BEFORE THE INFECTIOUS MATERIAL IS DEPOSITED ON THE PENIS.

(3) Prophylaxis after exposure. Actually this is EARLY TREATMENT. DO NOT ALLOW THE MEN TO FORGET THIS. TO BE OF VALUE IT MUST BE USED AS SOON AFTER EXPOSURE AS POSSIBLE.

A. The first step is urination. This has a flushing effect and tends to wash out any organisms which may have been deposited in the urethra. The bladder should be emptied spasmodically (in jerks) and the penis should be handled as little as possible.

B. The next step in chemical prophylaxis after exposure is the use of soap and water. Plenty of soap and water - that is as hot as can be comfortably tolerated - should be used in order to remove the gelatinous material containing the infectious material. This procedure is particularly effective (only effective measures) against chancroidal infections which are so prevalent in this area (chancroid is a disease of filth). It is also helpful in preventing the other venereal diseases.

WASH THOROUGHLY

In addition to the penis (retract the foreskin), scrotum, abdomen, and inner parts of thighs; the hands, face, and lips should be thoroughly washed. It should be remembered that syphilis can be contracted on the lip by infected saliva and this washing is the only protective measure against infection on the lip. The mouth should be rinsed with some type of mouth-wash or gargle in that other types of infections such as trench mouth, epidemic sore throat, or tuberculosis may be prevented.

CHEMICAL PROPHYLAXIS

C. The next step is the injection of silver salt for the prevention of gonorrhea. At regular Army Pro Stations a solution of Protargol is used and in the V-Packette a silver picrate jelly is used. Those germicides are prepared in strength that will have a direct killing effect on the gonococci, and while they may produce slight burning and irritation they would not be effective in weaker solution. About a teaspoonful (4-6 cc; contents of yellow tube from V-Packette is injected into the urethra very gently and the end of the penis grasped and lightly clamped between the thumb and forefinger inorder to retain the solution for five minutes. LESS THAN FIVE MINUTES IS NOT EFFECTIVE. The solution should

be released and permitted to flow out slowly so that there will be no flushing effect and a certain amount of the solution will be left on the wall of the urethra. This will penetrate the upper layer of the mucosa and destroy any gonococci which may have made their way beneath the surface. The soldier should be instructed not to urinate for 4 or 5 hours so that the solution will not be washed out.

D. Thus far the use of soap and water, the chief protective measure against chancroid and to a considerable extent against the other venereal diseases, and the use of silver salt against gonorrhea has been explained. The next step is of great importance in that it offers protection against syphilis which is the more dangerous of the venereal diseases in that it requires longer treatment and carries much danger from its late complications. For this step Calomel Ointment is used. It should be rubbed gently but thoroughly into the penis (place a small amount into the urethral opening; retract the foreskin; rub well into the head and shaft, paying particular attention to the corona - rim which surrounds the base of the glans penis; this is most frequent site of chancre - scrotum; lower part of the abdomen; and inner part of thighs).

Eight to ten minutes should be devoted to thoroughly rubbing this ointment into the mucous membrane and skin as merely applying it to the surface is not sufficient. The spirochete may have penetrated the skin and it is necessary that the drug be given a chance to be effective.

The prophylactic procedures, as discussed, are used in regular Army Pro Stations and aid stations. The same principles hold true when the individual prophylactic package is used. These convenient packages (produced under various trade names such as V-Packettes) contain the same material described above.

Encourage the men to accept a rubber and a V-Packette before leaving on pass and furlough if there is any chance at all that they might have a sexual exposure. If no exposure takes place (as indicated on the pass sheet) he should turn these articles in. Also encourage the men to go to the regular Army Pro Station when the station can be conveniently reached within one hour. If this cannot be done, the V-Packette should be used immediately after exposure (early bedside treatment) and when there is any doubt that the treatment has been thorough and complete he should then proceed to an Army Pro Station and be given a regular pro by a trained attendant. This applies particularly to men who were under the influence of alcohol.

The individual chemical prophylactic kits contain a sheet of paper on which complete directions are written. There is a piece of cloth impregnated with soap. Whenever additional soap is available it should be used to be certain that thorough washing occurs.

The excuses for failure to take a pro are ridiculous and are merely the reactions of an uninformed mind. Therefore it is our duty to see that these men understand the basic principles of the pro and that they are sold on the idea of using all protective measures available against venereal disease.

ADMISSIONS FOR VENEREAL DISEASE, TOTAL ARMY
(Rates per 1,000 per year)

Year	All Venereal Diseases	Gonorrhea	Syphilis	Chancroid
1867	214.96	90.61	124,34	
1900	133,96	78.68	15.83	39.45
1915	99.33	58.18	19.73	21.42
1916	89.98	54.60	16.16	19.22
1917	107.23	77.92	15.18	14.13
1918	90.47	66.49	17.56	6.42
1925	52.25	31.08	11.70	9.46
1930	47.74	28.32	11.89	7.54
1935	35.14	22.25	7.82	5.07
1938	30.60	19.57	7.95	3.08
1939	29.61	20.19	6.59	2.82
1940	42.46	30.55	7.31	4.60

HEADQUARTERS I CORPS
APO 301 (Kyoto, Honshu)

Med Corr I/10M Unit Barber Shops

MEMORANDUM
NUMBER 60

10 May 1946

Section
Barber Shops.................................. I
Curfew In Kyoto Area.......................... II
Rescission of Numbered Memorandums............III

I. BARBER SHOPS. 1. It has come to the attention of this Headquarters that sanitary principles regulating the use of barber shops in I Corps Z/R are not being complied with.

2. No barber shop will be patronized by troops in I Corps Z/R until it has been inspected and approved by a medical inspector and the following regulations found to be complied with.

a. No barber shops will be established in any military unit area without the permission of the commanding officer thereof.

b. The unit commander is responsible for the sanitation of the unit barber shop or of one located in buildings under his jurisdiction. Exchange and other officers are similarly responsible for the sanitation of barber shops being conducted under their immediate supervision.

c. Barber shop personnel whether enlisted personnel or civilian will be examined monthly and will submit to such tests as are deemed necessary to insure their freedom of communicable disease. The results of such examinations will be conspicuously posted. Such personnel will keep their person and clothing clean and will wear a clean, washable white coat when attending patrons.

d. All attendants will wash their hands thoroughly with soap and water before attending each patron.

e. All barber shops will be kept clean. The floors will be swept at frequent intervals.

f. No medicinal applications for the hair or skin will be sold or used in any barber shop without the written approval of a medical officer.

g. Provision will be made for adequate supply of hot and cold water and for proper disposal of waste water.

h. A freshly laundered towel will be used for each patron. The head rests of each chair will be covered with a clean towel or piece of paper for each individual patron.

i. No hair brushes, or shaving brushes will be used.

j. All razors, combs, clippers and scissors will be sterilized after each separate use preferably by immersing the article in 5% lysol solution for 3 minutes after thorough washing in hot water. The sterilized articles will be stored until use in a closed cabinet or other receptacle with a tightly fitting top.

Memorandum No 60, Hq I Corps, dated 10 May 46, contd.

3. An extract copy of par 9 b, AR 40-205, will be posted in each barber shop. (S)

II. CURFEW IN KYOTO AREA. 1. All military personnel will be off the streets and in assigned billets between 2300 and 0600 hours except as provided below:

a. Personnel having authorized passes.

b. Drivers having authorized trip tickets for trips during curfew will also be issued a pass for this specific duty.

c. Personnel attending authorized night recreation, such as dances sponsored by a unit or military club, may be authorized curfew privileges by unit commanders until 0100 hours for the specific purpose of returning to proper billets.

2. Paragraph 6, Memorandum No 29, as amended by Section I, Memorandum No. 37, this headquarters, cs is rescinded. (B)

III. RESCISSION OF NUMBERED MEMORANDUMS. The following Numbered Memorandums, this headquarters, 1946, are rescinded:

#46 - Japanese General Election

#43 - Payment of Troops (Mar 46)

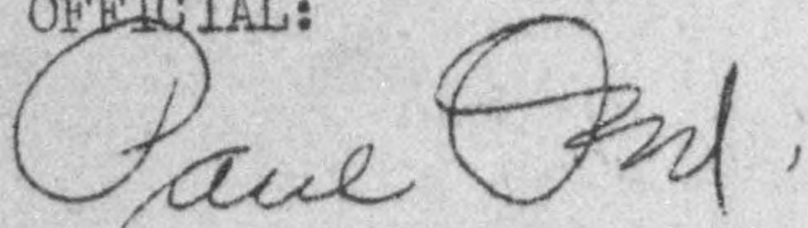
#36 - Requisitions for Wire Screen

#12 - Payment of Troops - Loss of Pistol (L)

BY COMMAND OF MAJOR GENERAL WOODRUFF:

HUGH CORT
Colonel, GSC
Chief of Staff

OFFICIAL:



PAUL OED
Colonel, AGD
Adjutant General

DISTRIBUTION
A & D

1 [illegible]
I/10a

HEADQUARTERS I CORPS
Office of the Surgeon
APO 301 (Kyoto, Honshu)

MEDICAL BULLETIN: 12 February 1949

Section I - Roster, Medical Section, Hq I Corps
Section II - Milk, Recombined, Storage of
Section III - Conservation - Coal, Electricity and Water
Section IV - Immunizations Prior to Departure to ZI
Section V - Swimming Pools and Areas
Section VI - Monthly Venereal Disease Statistical Report
Section VII - Laboratory Specimens
Section VIII - Medical Library, Establishment of
Section IX - Supplies, Safeguarding of
Section X - Narcotics for Relief of Pain, Choice of
Section XI - Insect and Rodent Control
Section XII - Records, Completion and Retirement
Section XIII - Venereal Disease Diagnosis Reports, Transmission of
Section XIV - Incoming Troops Report to Unit Surgeon
Section XV - Physical Examination Report, New Form
Section XVI - Change of Address Report
Section XVII - Indigenous Foods, Use of Prohibited
Section XVIII - Withholding Tax
Section XIX - Medical Corps Officers, Extension of Duty Tour
Section XX - Medical Service to DAC-DAFC, Report of

1. This issue Number 3 of the I Corps Surgeon's Office Medical Bulletin, published at irregular intervals, is furnished I Corps Medical Officers for their information. Comments, recommendations and/or suggestions on future issue material will be appreciated.

I. Roster, Medical Section, Hq I Corps, APO 301, Kyoto

				Telephone		
				Office		Qtrs
Bitner, Robert E	Col	MC	Surgeon	26715	26716	64053
Price, Samuel J	Lt Col	MSC	Executive	26715	26717	64005
LaCasse, Walter J	Maj	MSC	Training	26716		22176
Adrounie, V Harry	Capt	MSC	Med Insp	26716		63677
Christian, D J	Sgt 1/c		Chief Clerk	26715	26716	20180
Dumond, W C	Sgt		Sick & Wounded Report Clerk	26718		63796
Noesen, J H	Col		Records & Files	26718		63796

II. Storage of Recombined Milk
Users of recombined milk products should be advised that these items are not permanently stable but should be stored at temperatures not to exceed 40°F and for not longer than seven (7) days before use.

III. Conservation - Coal, Electricity and Water
All personnel must be made to appreciate the need for conserving these items at all times but especially during the winter months - I Corps Memo, AG 400.8E, 19 November 1948.

IV. Immunizations Prior to Departure to ZI
Attention re this item is directed to paragraph 8c, GHQ Circular #48, dated 2 March 1948.

V. Swimming Pools and Areas
See Section II, Eighth Army Circular 48 of 25 January 1949 for regulations concerning these activities.

VI. Monthly Venereal Disease Statistical Reports (RCS N-7)
Errors continue to be evident in this report from many organizations. Direct attention to Section IX, Eighth Army Monthly Medical Bulletin, dated 1 January 1949.

VII. Laboratory Specimens
Extreme care must be taken to insure proper collection, labeling, handling and delivery of laboratory specimens if full benefit of laboratory service is to be obtained. Section X, Eighth Army Monthly Medical Bulletin, 1 January 1949. Follow-up if reports are not promptly returned.

VIII. Medical Libraries
The Medical Section, Hq I Corps is coordinating the establishment of two Medical Libraries within the I Corps Z/R, one at the 35th Station Hospital and the other at the 118th Station Hospital. Request that unused copies of all medical journals be forwarded to this office for binding and distribution to above libraries.

IX. Safeguarding of Supplies
Difficulty in obtaining, increased costs, and problems in distribution in all types of medical supplies makes it necessary that every effort be made to conserve supplies, eliminate leaks, reduce waste, etc. Check should be made of all fragile supplies to note deterioration of containers, contents, stoppers, and labels. Return to dispensary, hospital, etc of clean used bottles, boxes, etc. should be encouraged.

X. Narcotics
"Morphine remains the drug of choice for most conditions requiring quick relief of pain for short periods of time. Meperidine (demerol) is indicated in cases of pain associated with spasm of smooth muscle, or in persons who do not tolerate morphine well. Metopon is limited to oral use in chronic painful diseases. Methadon (amidone) can be used in most instances in which morphine

is indicated. It is particularly useful in cases requiring pain relief for long periods of time, and for withdrawing drugs from patients addicted to the opiates." (Harris Isbell, Senior Surgeon, USPHS, Lexington, Ky. Annals of Internal Medicine, December 1948)

XI. Insect and Rodent Control
While the summer months are usually considered the insect season and the colder months the rodent season, rats and flies persist through the year and preventive measures must be employed against them at all times. See Section XVII, Eighth Army Monthly Medical Bulletin #1, dated 1 January 1949; paragraph 6, GHQ Circular #39, 9 October 1948.

XII. Completion and Retirement of Records
Attention of hospital commanders and others maintaining records is directed to the requirements of TM 12-259, AR 15-15 and AR 380-5 with reference to retirement of files and reports thereon.

XIII. Transmission of Venereal Disease Diagnosis Reports
Hospitals and dispensaries reporting venereal disease to commanding officer of patient will dispatch same to the commanding officer rather than permitting hand carrying by the patient.

XIV. Incoming Troops Report to Unit Surgeon
All unit surgeons should require all troops coming into their organization to report to their office immediately after incoming processing for physical check.

XV. New Form of Report of Physical Examination
The new form, SF88 Report of Physical Examination for use of all services, is now in distribution and may be obtained upon requisition.

XVI. Change of Address
To assure of prompt mail service all personnel experiencing change of address should complete DA AGO Form 204 and mail same to:

a. Old unit or organization.
b. All correspondents, publishers, etc.
c. Port Postal Officer, San Francisco Port of Embarkation.
d. (Officers only) Adjutant General, Personnel Information Branch, Washington 25, D.C.
e. Eighth Army Form 40, to Central Mail Directory, APO 503, c/o PM San Francisco.

XVII. Use of Prohibited Indigenous Foods
All Medical Department officers are reminded of their responsibilities in bringing to the attention of occupation personnel

the highly contaminated nature of indigenous foods and the hazards of enteric diseases resulting from the consumption thereof. The following details should be presented:

a. Diseases caused:- Common diarrheas, typhoid and paratyphoid fevers, cholera, bacillary and amoebic dysenteries, and helminth or worm infestations.
b. How these foods are contaminated by the use of night soil for fertilizer in Japan and the insanitary manner of food handling prevailing throughout the country.
c. Personnel should be advised of the regulations which directly prohibit such use by occupation personnel, ie, Circular 84, Section IV, Eighth Army, dated 18 November 1948; Annex 5, Inclosure I, paragraph 3a, Eighth Army Adm Order 21, 15 April 1948; GHQ (SCAP) Circular #11, 26 April 1948.
d. Personnel should also be advised regarding the disposition of garbage and other refuse and the dangers arising from improper techniques. See Section I, Eighth Army Circular 66, dated 6 October 1948.

XVIII. Withholding Tax

Withholding tax on salaries of enlisted men working for unappropriated Fund activities. All units employing enlisted men or others subject to U.S. income tax and payable from unappropriated funds must employ tax withholding techniques.

XIX. Extension of Tours of Duty of Medical Officers

The attention of all Medical Corps officers is directed to the fact that under present regulations they may extend their present tour of duty for any period of time beyond their theoretical date of relief from active duty. In view of the critical shortage of medical officers imminent all are urged to reconsider their plans and if at all possible extend their tours 1 to 6 months in order that occupation personnel may not actually suffer through the lack of adequate medical care.

XX. Medical Service to DAC-DAFC, Report of

Report of Medical Service furnished to Department of the Army and Department of the Air Force civilian employees will be required quarterly effective for the months January, February and March. See Eighth Army Circular #9, Section II, dated 5 February 1949 for directive and form of report.

FOR THE SURGEON:

Samuel J. Price
SAMUEL J PRICE
Lt Colonel, MSC
Executive Officer

Public Health
Kyushu MG Region

Osaka Team
Osa Team 2 Dec 48
I/10a

HEADQUARTERS I CORPS
Office of the Surgeon
APO 301 (Kyoto, Honshu)

23 November 1948

MEDICAL BULLETIN

Section I - Utilization of Medical Department Officers
Section II - Statistical Health Reports - Submission
Section III - Diagnosis, Report and Changes
Section IV - Safeguarding and Accounting for Narcotics and Penicillin
Section V - Influenza Immunization
Section VI - Syphilis Register
Section VII - Drinking Water - Chemical and Physical Characteristics
Section VIII - Venereal Disease Lecture for Enlisted Personnel
Section IX - Annual Report
Section X - Respiratory Diseases
Section XI - Medical Department Personnel Reports
Section XII - Monthly Sanitary Report
Section XIII - Report of Treatment Furnished Pay Patients, Parts A and B

1. This issue Number 2 of the I Corps Surgeon's Office Medical Bulletin, published at irregular intervals, is furnished to I Corps Medical Officers to help them keep advised on pertinent administrative and operational matters coming to the attention of the Surgeon. Comments, recommendations and/or suggestions for material for future issues will be appreciated.

I. Utilization of Medical Department Officers
Attention is directed to Section I of Eighth Army Circular #74 dated 20 October 1948 and necessary action should be taken to bring about conformance to the policy established.

II. Statistical Health Report - Submission
Attention is directed to Section I, Eighth Army Circular #73, dated 18 October 1948 and references regarding submission of the Statistical Health Report.

III. Diagnosis, Report and Changes
All changes of diagnosis of hospitalized patients should be reported to the Registrar immediately upon determination. Communicable disease should be reported immediately upon diagnosis.

IV. Safeguarding and Accounting for Narcotics and Penicillin
Attention is directed to Section I, Eighth Army Circular #75, dated 22 October 1948 and pertinent references regarding the safeguarding

and accounting for narcotics and penicillin in hospitals, units and other installations. Monthly audits must be made of all narcotics and penicillin.

V. Influenza Immunization

Immunization against influenza will not be a routine requirement during the winter 1948 - 1949. Reference: Department of the Army Circular #314, dated 8 October 1948.

VI. Syphilis Register

Attention of all concerned is again directed to the importance of proper initiation and completion of DA AGO 8-114 (Old WD MD Form 78) Syphilis Registers - Reference: AR 40-210, paragraphs 24 c & d. Syphilis Registers are to be kept by the unit Surgeon; letter or memorandum to that effect should be on file in soldier's 201 or service record. On change of station, unit commanding officer should call for record for forwarding to new station.

VII. Drinking Water - Chemical and Physical Characteristics

Physical Characteristics: Potable drinking water should possess the following characteristics: Turbidity of water shall not exceed 10 p.p.m. (silica scale) nor the color exceed 20 (standard cobalt scale). The water shall have no objectionable taste or odor.

Chemical Characteristics: Chemicals will not exceed the amounts shown in the following scale:

Lead (Pb) 0.1 p.p.m.
Fluoride 1.0 p.p.m.
Arsenic 0.05 p.p.m.
Selenium 0.05 p.p.m.
Copper (Cu) 3.0 p.p.m.
Iron (Fe) & Manganese (Mn) together 0.3 p.p.m.
Magnesium (Mg) 125 p.p.m.
Zinc (Zn) 15 p.p.m.
Chloride (Cl) 250 p.p.m.
Sulfate (SO_4) 250 p.p.m.
Phenolic compounds 0.001 p.p.m. in terms of phenol
Total solids should not exceed 500 p.p.m.

Salts of barium, hexavalent chromium, heavy metal glucosides should not be in the water.

For waters softened by the lime soda process the total alkalinity produced should not exceed the hardness by more than 35 p.p.m. (Calculated as $CaCO_3$).

For chemically treated water the phenolphthalein alkalinity (calculated as $CaCO_3$) should not be greater than 15 p.p.m. plus 0.4 times the total alkalinity. This requirement limits the permissable pH to about 10.6 at 25° C.

For chemically treated waters the normal carbonate alkalinity should not exceed 120 p.p.m.

VIII. Venereal Disease Lectures for Enlisted Personnel
The role of a Medical Officer in his participation in Venereal Disease lectures or any other type of talks of a medical nature is that of a highly skilled technician and professional person. A Medical Officer should not degrade the profession or his own position by obscene or suggestive remarks; nor should he talk over the heads of his audience. The interest on the part of the speaker to get something understandable over to his listeners should be primary. Explain any Medical terms that must be used. Many times your listeners have questions to ask but are reluctant to speak up. It is suggested that sheets of paper be distributed to your audience so questions may get to you without embarrassment to a soldier by requiring him to stand up. In your remarks on prevention, stress the timely use of soap and water, which in itself is one of the most important elements in the prevention of diseases.

IX. Annual Report
Annual Report of Medical Department Activities (Reports Control Symbol MED-41) will be required of the Surgeon I Corps, 24th Infantry Division, 25th Infantry Division, the Commanding Officer 35th Medical Station Hospital, 118th Medical Station Hospital, and 207th Malaria Survey Detachment in accordance with paragraph 4a, AR 40-1005, dated 17 November 1947. All subordinate units and sections will be prepared to submit pertinent data in time to permit submission of these reports.

X. Respiratory Diseases
An increase of individual common respiratory diseases may be anticipated with the advent of the cooler weather of fall and winter. Attention is directed to Section III, Eighth Army Weekly Directive #6, dated 16 October 1948 regarding prevention and control, and letter, this headquarters, Office of the Surgeon, dated 7 October 1948, File Surg 720, Subject: "Prevention and Control of Respiratory Disease," and Memorandum #30, Hq I Corps, dated 15 October 1948.

XI. Medical Department Personnel Reports
Reference subject report required by Circular #19, GHQ, FEC, dated 24 May 1948 - it is requested that reporting units include telephone number of office of preparation in same space provided for name and location of unit.

XII. Monthly Sanitary Report
The Surgeon of each unit will include in the Narrative Section, the following information pertaining to insect and rodent control: The effectiveness of local control measures. Reference: Par 7b, Circular 39, GHQ, FEC, dated 9 October 1948.
The Monthly Sanitary Report will have the following Reports Control Symbol: MED-3.

XIII. Report of Treatment Furnished Pay Patients, Parts A and B

Report: The report of hospitalization and outpatient treatment will be submitted on NME Form 7 (Report of Treatment Furnished Pay Patients - Part A, Hospitalization Furnished), and NME Form 7A (Report of Treatment Furnished Pay Patients - Part B, Outpatient Treatment Furnished, Reports Control Symbol MED-45.

Preparation: As prescribed by Par 2, Memo 40-590-15 (AFL 160-155) dated 10 June 1948. Further reference: Sec V, Circular 81, Hq Eighth Army, dated 5 November 1948.

Submission: British Commonwealth Occupation Force: Upon completion of hospitalization and/or outpatient treatment of a member of the British Commonwealth Occupation Force, either military personnel or civilian employee or their dependents, the medical installation concerned should forward the following by the calendar month through technical channels so as to reach the Surgeon, General Headquarters, Far East Command, APO 500, by the 10th of the succeeding month:

a. Itemized bill for each patient in quintuplicate. Bills should be computed at currently prescribed rates and should include name, rank and serial number of patient, name and address of patient's organization or (in the case of dependents) the name and address of patient's principal, inclusive dates of treatment, final diagnosis and should be signed by the patient acknowledging that enumerated items were received.
b. Report of hospitalization (NME Form 7) and/or report of outpatient treatment (NME Form 7A), in triplicate, for British Commonwealth Occupation Force Personnel.
c. For hospitalized cases, subsistence voucher (DA Forms 351-351a) in quadruplicate. (Above extracted from Letter, GHQ, FEC, Medical Section, File 705 (2 Nov 48)MD-PO, dated 2 November 1948, Subject: Medical Care of British Commonwealth Occupation Force Personnel.

U.S. Navy Personnel: Reports of hospitalization and/or outpatient treatment to be forwarded by the medical installation direct to the Surgeon General. Reference: Par 5c(1), Circular 81, Hq Eighth Army, dated 5 November 1948.

Pay Patients From Whom Collection Is Required To Be Made Locally: Forward through medical channels to Hq Eighth Army, Attention Surgeon. Reference: Par 5c(2), Circular 81, Hq Eighth Army, dated 5 November 1948.

FOR THE SURGEON:

Samuel J. Price

SAMUEL J. PRICE
Lt Colonel, MSC
Executive Officer

Capt Harrower

HEADQUARTERS I CORPS
Office of the Surgeon
APO 301 (Kyoto, Honshu)

MED BULLETIN)
)

15 October 1948

Section I - Water Examination
Section II - Respiratory Disease
Section III - Immunizations
Section IV - Treatment of Scabies
Section V - Multiple Dose Syringes
Section VI - Medical Records
Section VII - Sick Call
Section VIII - Alcohol Beverages for Occupation Forces
Section IX - Physical Standards and Physical Profiling for Enlistment and Induction, AR 40-115
Section X - Storage of Smallpox Vaccine
Section XI - Boards AR 615-368 & AR 615-369
Section XII - Dental Activities
Section XIII - Inspection of Food Handlers
Section XIV - Special Medicine
Section XV - Property Accounting and Auditing.
Section XVI - Personnel Policy - Reference VD

1. This is the first issue of "Medical Bulletin" to be published by Headquarters, I Corps, Office of the Surgeon, at irregular intervals, in an effort to keep Medical Department personnel abreast of time. Comments and recommendations will be appreciated.

2. It is the intent to make subjects published in the "Medical Bulletin" as brief as possible and in many instances giving only subject title and references.

I. Water Examination

References: TM 8-227, Chapter 10
TM 5-600, Sec VI (as amended)
TM 5-295 (as amended)
OD 68, 8th Army, 20 Jul 46, "Municipal Water Supply Chlorination"
Incl 1, Annex 5 to Adm O 21, 8th Army, 15 Apr 48
Public Health Service Drinking Water Standards, 25 Sep 42

a. All water supplies must be tested for chlorine residual once daily and bacteriologically once weekly. These tests must be done at check points on the water system which are ob-

tained from the Unit Surgeon and Engineer. The results of these tests should be available to both the Engineer and the Surgeon. (This is done by the use of duplicate copies).

b. When the test is being taken the water at the tap should be allowed to run for at least five minutes for chlorine residual testing. For bacteriological testing the tap should first be flamed then allowed to run for a minimum of five minutes before the sample is taken. Information to be sent to the laboratory with each sample is as follows:
   (1) cl_2 residual
   (2) source
   (3) date
   (4) collecting unit and address

   WD AGO Form 8-126 is used for this purpose. The bottles used for collecting bacteriological samples should be sterile and have a sterile cloth or paper tied over the bottle cap. All collections must be made carefully so as to avoid extrinsic contaminating factors. Samples of chlorinated water must be collected in bottles to which 0.02 - 0.05 gm. of sodium thiosulfate have been added. Water samples should be examined within six hours of collection for untreated water and within twelve hours for treated water.

c. A chemical examination of the water should be done semi-annually. Ph testing should be done monthly.

II. Respiratory Disease
See Letter this Headquarters, Office of the Surgeon, dated 7 October 1948, File Surg 720, Subject: "Prevention and Control of Respiratory Disease," and Memo #30, Hq I Corps, cs.

III. Immunization, GHQ Cir #8, 2 March 48
Immunizations against Typhus are due on or about 1 November 1948. All Supply Officers should see that they have sufficient stock of the vaccine on hand to complete the program. WD AGO Form #8-117 should be reviewed at this time and other required immunizations brought up to date.

IV. Treatment of Scabies
See Sec X, Weekly Directive #4, Hq Eighth Army, 2 Oct 48.

V. Multiple Dose Syringes
See Par 16, Letter, Hq 8th Army, Office of the Surgeon, 1 Oct 48, File MEDNA 300.6.

VI. Medical Records
See Par 6, Letter, Hq 8th Army, Office of the Surgeon, 1 Oct 48, File MEDNA 300.6.

VII. Sick Call
See Par 8, Letter, Hq 8th Army, Office of the Surgeon, 1 Oct 48, File MEDNA 300.6.

VIII. Alcoholic Beverages for Occupation Forces

References: SCAPIN 871, 9 Apr 46
Operational Directive #50, Hq 8th Army, 17 May 46
Operations Memorandum #1, Hq I Corps, 8 Jan 48

a. It has been found that in some places unauthorized alcoholic beverages are being sold in Japanese "On Limit" cabarets in violotion of the above directives. The Surgeon of each organization should do the following to insure that occupation personnel get authorized beverages.

(1) Publish a list every six months of alcoholic beverages by brand or trade name which are approved for purchase and consumption by occupation personnel.

(2) At frequent intervals, pick up samples of each lot from approved distilleries and producers, and have them tested in United States Army laboratories in accordance with procedures outlined in Inclosure #1 of Operations Memorandum #1, Hq I Corps, 8 January 1948.

(3) Make frequent inspections of "On Limit" installations and clubs selling alcoholic beverages of Japanese origin to insure that all bottles are properly stamped with lot number and are from an approved source.

IX. Physical Standards and Physical Profiling for Enlistment and Induction
See AR 40-115 and Weekly Directive #5, Hq 8th Army, 9 Oct 48.

X. Storage of Smallpox Vaccine
Smallpox Vaccine will be stored in the freezing compartment of refrigerators if available, or if ice is being used the vaccine will be placed or kept directly on the ice.

XI. Boards
AR 615-368 and AR 615-369 do not require Medical Corps officers to sit on these Boards. See Changes No. 1 and 2, 25 August 1948 to the above mentioned Army Regulations.

XII. Dental Activities
See Par 23, Letter, Hq 8th Army, Office of the Surgeon, 1 October 1948, File 300.6.
Attention of all Dental Officers is invited to Par 3c, AR 40-510 which requires a Dental Survey of all military personnel annually.

survey tobe completed between January and June.

XIII. Inspection of Food Handlers, AR 40-205

a. It seems that many Medical Officers consider a food handlers inspection is primarily a "short arm" for venereal disease. Giving the subject some scientific logical reasoning we find that a food handlers examination consists of the following, in order of importance:

(1) Skin eruption or open lesions.
(2) Intestinal parasites.
(3) History of recent diarrhea.
(4) Acute and chronic inflammatory condition of the respiratory tract.
(5) Venereal Disease.

b. This procedure should be used for examination of all food handlers, both occupation and Japanese personnel, a minimum of once a month. All names with results of examination to be posted conspicuously in the place of employment.

XIV. Special Medicine
Many times doctors are requested to obtain medicines that are not stocked by the Army or listed in Medical Supply Catalog. Special medicine may be obtained by sending a prescription in letter enclosing a money order to cover the cost of the medicine desired and air mail postage to the following address:

Sterling Pharmacy
Prescription Specialists
400 Kearny St. Cor. Pine
San Francisco, Calif.
Phone DOuglas 2-2849

XV. Property Accounting and Auditing
See Sec VI, Weekly Directive #5, Hq 8th Army, 9 Oct 48.

XVI. Personnel Policy - Reference VD
See Sec VIII, Weekly Directive #5, Hq 8th Army, 9 Oct 48.

FOR THE SURGEON:

Paul B Roach
PAUL B ROACH
Major, MSC
Executive Officer

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1 ea Med. Off.