

— The —
JOURNAL
 OF THE
PHILIPPINE MEDICAL ASSOCIATION

VOL. XXX

FEBRUARY, 1954

No. 2

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Published Monthly by the Philippine Medical Association
 Philippine General Hospital, Manila
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Each member of the Association is entitled to receive a copy of the Journal every month. Articles are accepted for publication on condition that they are contributed solely for this Journal. Manuscripts should be typewritten, double-spaced, and the original, not the carbon copy, submitted. Advertising matter must be received not later than the 20th of the month immediately preceding the month of issue.

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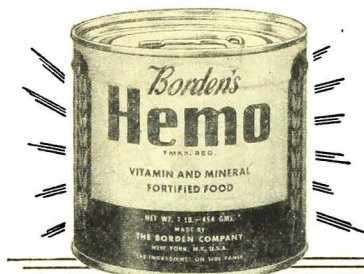


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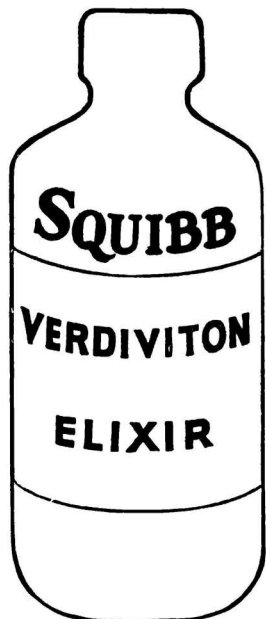
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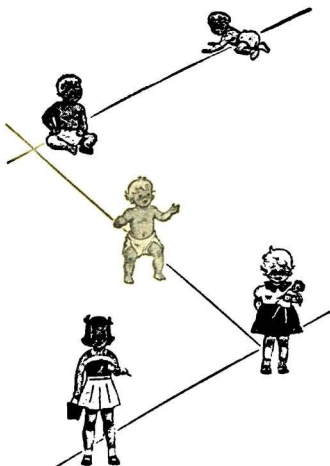
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Medical profession in the Philippines
Manila, Philippines*

VOL. XXX

FEBRUARY, 1954

No. 2

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Original Articles

PSYCHOSOMATIC ASPECTS OF OPHTHALMOLOGY*

GEMINIANO DE OCAMPO, M.D.

De Ocampo Eye Clinic, Manila

and

University of the Philippines



G. DE OCAMPO, M.D.

There are many ocular conditions and manifestations which we can not explain fully by optics, anatomy and physiology, pathology, somatic medicine and surgery. Some of these can be understood, explored and managed by considering their psychosomatic background. Our standard textbooks and ophthalmological journals deal very meagerly with this subject.

I wish to invite and stimulate thought and study on this phase of our specialty. I believe that the ideal ophthalmologist should be, not one who knows more and more of less and less, but one who is a "Jack of all trades, and master of one."

The problem may be stated as follows:—In a particular patient, is the trouble in his eyes, or is it partly or wholly in his brain; and if so, what can we do about it? From a review of my clinical records, with a diagnosis of psychosomatic factors among other things, I have found that the following are highly suspicious of a psychosomatic patient:

(1) *Inconsistencies*, obvious or subtle, in complaints, manner and behaviour, history and physical findings. For example, a very strong complaint of photophobia, but absence of it during examination.

(2) *Exaggeration*, consciously or unconsciously, deliberate or not, of ocular complaints or reactions. For example, without signs of inflammation, an undue avoidance of light.

* Read before the 7th Annual Meeting of the POOS, Nov. 24, 1952.

(3) *Multiplicity* of symptoms, complaints, glasses, and doctors.

(4) *Non-cooperation*, deliberate or otherwise, during the examination, or during history taking.

(5) *Psychosomatic appearance or complaints*. An anxious facies, a worried look, an over-meticulous appearance, a countenance showing fear. Complaints as "cannot concentrate" or "cannot absorb what one reads."

(6) *Changeableness of findings*: In retinoscopy, muscle testing, subjective refractions, etc.

(7) *Vagueness of one's complaints*: Blurring of vision, discomfort, pain, dizziness, all mixed up and ill-defined.

In general, psychosomatic symptoms are brought about by changes in circulation, secretion, tonicity and motility. In the eye, the most frequent manifestations of psychosomatic origin are those from the intrinsic muscles, especially the muscle of accommodation.

Ciliary or accommodative spasm must be suspected under the following conditions:

(1) A minus glass with normal distant vision.

(2) Subnormal distant and near vision in a young individual, improved by pinhole, with negative findings in the media, fundus, or visual fields.

(3) Symptoms of momentary blurring when looking from near objects to distant objects.

(4) Complaints of micropsia in the absence of scotoma or organic findings in the macula.

(5) In retinoscopy, if the dynamic findings for distance with good fixation gives minus values, but normal distant vision is present, or a high positive lens is obtained, most of which cannot be tolerated subjectively. At times, one can actually notice variable position, or appearance and disappearance of the retinoscopic band of light. (Streak retinoscopy)

(6) A variable and changing brightness of the different lines in the astigmatic chart in manifest or fogging refraction, or even in incomplete cycloplegia, is suggestive of incoordination or spasm besides astigmatism. Except in children, the presence of one or more of these manifestations calls for a breaking up of the spasm by deep cycloplegia, and in the absence of other obvious extra-ocular or systemic sources of irritation, a psychosomatic inter-relationship is worth investigating.

A weak accommodation is easier to suspect and ascertain, but somatic systemic causes should first be exhausted before thinking of psychosomiasis. A slow accommodation may, in fact, be really due to ciliary spasm. Some believe that pupillary spasm (spastic mydriasis or spastic miosis) can have psychosomatic inter-relationships, and may by itself cause complaints of undue glare, or slight disturbance of vision in subdued light.

The intrinsic ocular muscles are directly under the vegetative nervous system, and can be disturbed by emotional tension. Although the extra-ocular muscles⁴ have striated structure, they can manifest changes

of tonus and motility because of psychosomatic factors. It is well known that the degree of phorias and the prism duction values, even under standard technique of examination by the same examiner, is often variable in the same person at different times of examination; and they have to be repeated at least once, if they are to be interpreted rightly.

Likewise, the degree of trophias has to be frequently repeated and rechecked, because of muscle tonus changes. I have seen a baffling case of spasm of the extra-ocular muscles parading under intermittent esotropia, with a definite psychosomatic background. It is the case of a boy (J.A.) 6 years old, first seen in consultation on June 28, 1950, with alternating internal squinting of both eyes. A year before, he had had two successive falls in 3 weeks; and a few days later, he had developed the squint.

It was peculiar that, for a year, the boy's eyes squinted regularly only on alternate days. The child wore glasses of plus 1.00 D. on both eyes.

When first seen, the degree of squint was 55° by perimeter, and equal for distance and near. The esotropia was alternating (fig. 1 & 2). The E.O.M. was normal, and there was no definite difference in degree of squint with either eye fixing. He preferred to occlude his left glass (fig. 3), because he claimed he had some diplopia for distance which could not be elicited at near.

The squint was more concomitant than paralytic. But when seen the next day, as the mother predicted, the eyes were perfectly straight (fig. 4) without impairment in motility. I then thought of spasm, but why did it occur regularly on alternate days.

I was told by the mother that operation had been advised by two of our colleagues, while a third had advised exercises. I examined the child a third time after a week under atropine on a squinting day and found he had a hyperopia of O.U. plus 1.50 D.

The child was an Ateneo student and quite good in class. I referred him to a child psychologist. Unfortunately, he neither came back nor consulted the psychologist.

Two years later, the mother came back with another patient; and when I asked her about her boy, she told me that he was perfectly normal. His eyes were straight. But in February, 1951, he had again suffered a fall for which he was confined at the N.O.H. There the eyes became straight, until he was discharged.

When his boy companion called his attention to it, his squinting came back, but upon being reprimanded by his mother, his eyes became straight and had remained so.

I can not unravel the psychosomatic inter-relationships between the accidents and the regularly intermittent esotropia, but I believe the trouble was not in the neuro-muscular mechanism of the eye but in the child's mind. I have looked up the literature available, but I cannot find a similar case.

The so-called "innervation" to the extrinsic and intrinsic ocular muscles needs further investigation, but it seems that psychic factors definitely influence them to a great extent. It is for this reason that, in alternating hyperphoria, surgery is not advised; and one should be very cautious with prisms. They have to be probed psychosomatically. I have seen several such cases.

As I mentioned earlier, circulation and secretion under the influence of the vegetative nervous system are disturbed in psychosomiasis. Such new concepts of glaucoma as central thalamic regulatory mechanism of intra-ocular tension, and social service in glaucoma clinics, must take psychosomatic medicine into account. We all know that glaucoma patients are a class in themselves. An article on the personality aspects of glaucoma patients' stress this point. Even the concepts of circulatory and secretory aspects of the glaucomatous crisis may have psychosomatic factors in many cases.

Let us take a case. Dr. R. C., a male dentist, 37 years old, was seen on June 15, 1950, complaining of dimness of vision and of seeing halos every morning. He had come from one of our colleagues who had advised operation for glaucoma. Pilocarpine and furmethide did not suit him. Having seen him previously, I knew he had myopia and marked exophoria. He had brought three pairs of glasses when I first saw him eight months before, and he had seemed worried about something.

This time he was definitely afraid of getting blind from glaucoma. I examined his ocular tension, fields, and fundus on three successive days at different times of the day, and could not be convinced of glaucoma. I found that he had severe ciliary spasm after pilocarpine 1% t.i.d. which he had previously used for 3 months. I stopped all miotics and made provocative tests, using homatropine 2% and the water test. Still I could not elicit an abnormal rise of tension. I even checked my tonometers.

Knowing his background I tried to convince him to stop all miotics and to rest assured that he had no glaucoma. I sent him to a psychiatrist, Dr. Paras. After several interviews, he reported to have uncovered some psychosomatic problems. He was a dentist who did not practice, but who was in a rice mill business. He was not in good terms with his wife, and was dissatisfied with his work.

After these interviews, he came back a better man, without the ocular complaints. With more assurance, but without miotics, he left for Jolo.

After six months, his brother, a physician, happened to drop in at my clinic and informed me that the dentist was doing all right, without complaints, halos, and miotics. The physician showed a similar personality pattern as his brother. This dentist might have had rises of tension when seen by our colleague, but I think that a psychosomatic factor was involved; and this was aggravated iatrogenically. A few interviews with the psychiatrist did him much good.

I reviewed 30 cases of nervous blinking in my private files, and I found out the following: While the sex distribution was almost even, two-thirds were below 11 years. The blinking was noticed from a few weeks to many months and years in one or two cases. Pertinent findings were a few fine conjunctival follicles, with or without discharge, in about a third of the cases; but some psychosomatic factors were present, such as blinking in the playmate, chauffeur, or other housemate; poor showing in class; scolding by mother or father; and father's prohibition from going to shows. One had a fight with another boy, and was afraid to pass by a certain road. Some showed such nervous symptoms as sucking the lips or twitching of the face. Almost all were scolded for blinking. In fact, the majority of them stopped blinking after the parents has been told of the condition, and had been asked to ignore it and to refrain from scolding the patients. One stopped blinking only after being made to live with the grandfather instead of the mother. A few had low error of refraction; but in the majority of them, drops, surgery, or glasses were not so important as psychotherapy.

Improving the lighting, general health, and ocular hygiene should go hand in hand with stopping the scolding of the child and ignoring the symptoms. It would be better if some emotional factor could be discovered.

There is another very common condition: *musca volitantes*, which seems to have some psychosomatic aspects, not in its pathogenesis, but in its therapy. I have reviewed 58 such cases. After excluding under mydriasis, such organic conditions as Mittendorf dot and other congenital lens opacities, vitreous floaters, central retinopathies, or retinal detachment, reassure the patient that it is harmless and give proper ametropic correction. Colored glass is not necessary if one can overcome the fear of the patient by gaining his confidence. The less the patient tries to look for the spots, the better.

I have reviewed 30 cases, noting down some psychosomatic factors, in addition to other ocular diagnosis. The most frequent complaints are headache (the so-called tension headache)⁶ and dizziness. The most common site of the headache is the occipital and upper nuchal, and it is vague and non-characteristic. The dizziness is vague and difficult to describe, including as it does faintness with occasional transient blurring of sight. No less than ten of them have I referred to a psychiatrist.

Among the psychosomatic factors I have observed are:

1. Marital unhappiness:—hatred for, and quarrels with, the husband; habitual abortion; idleness as a society matron; absence of husband; too unhappy marriages.

2. Scholastic difficulties:—School truancy, frustrated desire to study in the U.S.; dislike for the course being taken; alibi for scholastic failure to escape studying; frequent changes in courses taken and universities attended.

3. Family resentments:—headaches resulting from week-end visits to hated relatives.

4. Frustrations in business or career.

5. Nervous tension brought about by election problems, disappearing after the polls.
6. Pressure of business.
7. Fear of blindness instilled by relatives, acquaintances, or physicians.
8. Dislikes for the use of glasses.
9. Lack of emotional gratification.

Let me restate the problem. Can the symptoms, at least the ocular, be satisfactorily and fully explained by ocular findings? Ocular findings may be negative or non-organic. This would depend on the examiner, his ability, his thoroughness, and his criterion for normal. In the presence of organic findings, a psychosomatic factor may still have to be sought for.

It is frequently stated in the literature^{1,2,3} that psychosomiasis should not be diagnosed on negative findings. In a suspected patient (after proper and careful refraction, muscle examination, and correct lens fitting) if the complaints remain, or the ocular findings are not sufficient to explain the symptoms, one has to probe further. Is there anything wrong with the brain to account fully or partly for the unexplained symptoms?

Is it necessary that such a patient be referred to a psychiatrist? This has many aspects. There are not enough psychiatrists in this country. Our society still looks down upon a person who consults a psychiatrist. Some patients complain that their psychiatrists give them only "talking therapy" or "shock therapy." I believe our group should at least know how psychosomatic probing should be done.

The following may be of some help. Try to gain the patient's confidence. In addition to your personality, office set-up, reputation, and thoroughness of physical examination, set up a "private interview room" where the patient is not likely to feel embarrassed to talk openly of his emotional problems. Sometimes the nurse or the receptionists, given the right tips, may get points in the personal and family history after the first visit, or while waiting for a subsequent consultation. Little bits of information about a suspected patient may be uncovered by asking him disconnected questions while he is being given a physical examination without letting him feel that he is being investigated.

It would be of some help to have a sort of questionnaire to be given to the patient on his first visit for him to fill out at home. The filled-out questionnaire may then be attached to the chart on his second visit. This would save time, save the patient from embarrassment, and give you an inkling of what to probe when you next meet the patient—his heredity, his constitution, his bringing up, his home life, his marital and extra-marital relations, the conditions under which he works, his business, his scholastic environment, etc. At least, you will be in a position to decide whether to attempt contact or to refer him to a psychiatrist.

Even before reaching such a decision, you should never make the patient feel that his symptoms are imaginary but although real, do not have any serious import or organic basis. At this point you should at-

tempt a clear, short and appropriate explanation of how ocular symptoms may be brought about by worry or fatigue. Some examples as "blind with rage" may help.

The assurance that there is nothing organic should be backed up by a very thorough and careful somatic and laboratory check-up and follow-up. I am reminded at this juncture of a recent case, Mrs. D.A., 50 years old, female, nurse, married to a businessman, and herself in business. She consulted me on January of this year, complaining of pain, discomfort, and blurring of vision once in a while. She brought many glasses, saying that she had consulted many doctors.

I saw her regularly for 6 months, tested her refraction with and without cycloplegia, her muscles and fields and fundi. I changed her glasses two or three times. She had compound hyperopia, presbyopia and ciliary spasm at times. I once found right hyperphoria but often orthophoria.

After ten consultations, I referred her to a psychiatrist, who interviewed her five times and who reported to me personally about her real emotional problem. This problem consisted of some resentments and conflicts connected with her only daughter, who had married against her will.

She seemed to improve a little, especially after a trip to the South. Then I advised her to go abroad for relaxation.

Two months later, a neuro-surgeon referred her to me after a big right temporal lobe tumor had been removed. It turned out that, after our last meeting, she had gone to a gynecologist, who could not explain all her symptoms by menopause; and that gynecologist referred her to the neuro-surgeon who made an arteriogram which was negative. It was only a few days before exploration that papilledema appeared and a positive arteriogram was obtained. This was a case of temporal lobe tumor with a psychosomatic overlay and vague ocular manifestations.

Whether one could or could not uncover a psychosomatic factor in a very suspicious patient, or whether the patient has been referred to a psychiatrist, some sort of psychotherapy within an ophthalmologist's limitation is worth trying. After much reading^{1,3,5,7,8,10,11} and some personal experience, I would suggest the following:

Psychotherapy would be futile without first gaining the *confidence* of the patient and convincing him that, although his symptoms are real, there is no organic or serious condition in his eyes. One should never irritate a psychosomatic patient. *Assurance* and *reassurance* that his symptoms are partly or wholly caused by a tired and worried brain should be followed by making him *understand* and *recognize* how fatigue, worries, anxieties, fears, and emotional conflicts can cause his ocular and non-ocular complaints.

A philosophy of life which embodies *reconciliation* within one's resources and *resignation* to one's limitations and failures should be driven home to the patient. A "change of attitude" is often better than a change of glasses.

Case of Regularly Intermittent Alternating Internal Squinting with Psychosomatic Background



Fig. 1. Right eye fixing



Fig. 2. Left eye fixing



Fig. 3. Left glass covered to avoid diplopia



Fig. 4. On a non-squinting day

Sometimes I give my patients a copy of Dr. W. Alvarez's series of articles on "How To Live With Your Nerves." A passage in this series is inculcating in the patient, "Oh Lord, grant me the serenity to accept the things I can not change, the courage to change the things I can, and the wisdom to know the difference."

Concluding Remarks

I have not mentioned hysterical blindness, or malingering, which has definite psychosomatic tie-ups, because they are well covered in our textbooks. I have discussed the less obvious but more frequent psychosomatic aspects of ophthalmologic practice in this country. I think that ophthalmologists should at least know how to spot a psychosomatic patient; and if he has the time, he should develop an inclination and sufficient knowledge to handle them, before referring him to a psychiatrist.

With all the interest we can develop in, and all the information we can gather about, psychosomatic medicine, we must follow up our patients if we are to gain in knowledge of this aspect of ophthalmology.

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DIAGNOSIS AND TREATMENT OF MYASTHENIA GRAVIS

Report of a Case in a Child

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Myasthenia gravis is a rare entity in children. In 1949 Nilsby¹ claimed that only 35 cases under 17 years old and only 8 cases under 8 years had been reported in the literature. During the last few years, true congenital myasthenia^{2,3,4} and neonatal myasthenia, born of myasthenic mothers^{1,5,6,7,8,9,10} may have increased the number of cases. Yet the number so far recorded is still very insignificant.

One of us had the opportunity to study a case of myasthenia gravis in a ten-year old child, with mental retardation in crisis.¹¹ The purpose of this paper is to present a case of myasthenia gravis in a four-year old child, probably the first case reported in this country, and to outline the present trends in the diagnosis and treatment of this disease.

Case Report

L.S., 4 years old, female, Filipino, was seen at the Legasto Eye Clinic and at the Lim Children's Clinic on July 15, 1953. The mother complained that the child could not open her eyes well.

Present illness had started about four weeks before, when mother noted that the child's left upper eyelid drooped. One week later, the right eye was similarly affected. This was not accompanied by photophobia, lacrimation, discharge, swelling, or injection. Mother said that the child had not had any recent attack of chills, fever, jaundice, vomiting, convulsions or trauma.

The child entered the Manila Children's Hospital a week later, on July 22, 1953, for work-up. Prior to the present illness, she had been active, but her appetite had been quite impaired.

Birth History—Child was delivered spontaneously at full term at home. Birth weight: not known. Neonatal period: normal.

Feeding History—Breast fed up to 1 year 1 month. Tiki-tiki was started at 6 months. Child was a poor eater.

Development—Smiled at 3 months, sat up at 7 months, stood up at 1 year, walked at 1 year 3 months, and uttered words clearly at 2 years.

Immunization—Had smallpox vaccination, but no DPT or BCG.

Past Diseases: Child had had frequent coughing spells since she was 1 year of age. Mother was told by a physician that the child had a primary complex. She had had measles the previous year. Denied having had varicella, mumps, diphtheria, pertussis, or rubella.

Family History: Two siblings living and well. Mother never had any abortion or miscarriage. Father also living and well, but separated from the mother. Denied any member of the family having muscular weakness,

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respiratory, mental, or metabolic disorder. RH of parents not known. No consanguinity.

PHYSICAL EXAMINATION: Poorly developed, poorly nourished, conscious, and cooperative female child, with both upper eyelids drooping. Afebrile, wt. 20-1/4 lbs., height 33", pulse 120/min., respiration 32/min., blood pressure—90/54.

Eyes—O.D. Drooping of upper eyelid. Interpalpebral fissure: 2.5 mm. at its widest diameter. Weakness on elevation of eyeball. Pupil: normal size and responding normally to light and accommodation. No appreciable weakness of orbicularis oculi muscle. Visual acuity and fundus: normal. O.S. Drooping of upper lid. Interpalpebral fissure: 1.5 mm. at its widest diameter. Exotropia 35°—40° (Hirschberg). Limited adduction of eyeball. Pupil: normal size and reacting normally to light and accommodation. Visual acuity and fundus: normal. No evidence of facial weakness. No rigidity of the neck, no headdrop, no palpable masses. Lungs clear and resonant. No rales. Heart: strong and regular, no murmurs. Abdomen: soft, liver and spleen: not palpable. No other palpable masses. The extremities were soft and flabby. There were no evidences of paralysis or paresis, no deformities or ankylosis.

Reflexes: Gag and swallowing reflexes were intact; abdominal reflex was present; no ankle clonus; negative Babinski; knee jerks: exaggerated; Kernig: negative, Brudzinski: negative.

LABORATORY EXAMINATIONS:

Blood count—RBC 4,440,000 Hemoglobin 70%
WBC 14,400 Differential Seg—60%, E—4%, S.L.—
26% LL—10%

Urine—Normal Tuberculin Test—5 T. U. + + +

Stool—Ascaris ova + + +; Trichiuris + +

Muscle biopsy of gastrocnemius—Some round cell interstitial infiltration. Spinal Fluid—normal

X-ray: Skull—No evidence of osseous pathology, no separation of sutures, Sella turcica appear normal.

Long Bones—No evidence of bone destruction however there is evidence of generalized demineralization with disturbance of growth lines. No evidence suggestive of rickets, scurvy, syphilis or lead lines.

Chest—Supracardiac shadow appears widened presumed to be thymus. Heart and lungs are essentially normal.

HOSPITAL COURSE: Child was admitted on July 22, 1953. Appetite fair; afebrile; could move about like any other child, except for the ptosis of both eyelids. A test dose of prostigmine methylsulfate,[†] 0.3 cc. of 1:2000 solution was given.

With the above procedure there was improvement as shown below:

Before injection	(O.D. 2.5 mm
	(O.S. 1.5 mm
After injection	(O.D. 3.5 mm
	(O.S. 4.2 mm

Mobility also improved.

Since the improvement was not clear-cut, it was decided to do another test on the 4th hospital day, with 0.5 cc. prostigmine methylsulfate and 1/500 gr of atropine. Within 20 minutes there was marked improvement; and within 30 minutes the eyes were widely open, almost simulating normal. (See figure) Prostigmine bromide 7½ mg. was started on 7th hospital day; but was immediately discontinued after two doses, due to abdominal pains.

[†] Prostigmine has been kindly supplied by Jose Angeles, M.D. Inhelder, Inc., Philippine Representative for Hoffman LaRoche.

(Since this child has heavy ascaris infestation, as shown by the stool examination, we were afraid that we might produce intestinal obstruction, as there were loops of intestines that felt like cords).

In the meantime the mother was given quinine sulfate (0.6 Gm) to elicit any latent myasthenia. The mother vomited the pills after one hour, and she refused to take other pills subsequently.



A

B

Tested with 0.5 cc. prostigmine methylsulphate and 1/500 gr. atropin sulphate subcutaneously. A—Before. B—30 min. after.

On the 11th hospital day, prostigmine bromide (5 mg) did not produce any appreciable effect on the ptosis. Eyes reexamined at this time, showed O.D. interpalpebral fissure 1.5 mm (widest diameter). Almost complete external ophthalmoplegia, no exophthalmos. Pupil normal; size and normal reaction to light and accommodation. Visual acuity and fundus: normal. O.S. Interpalpebral fissure 2.5 mm Exotropia 35°-40° (Hirschberg), increased on looking down. Limited adduction. Optico-kinetic nystagmus. Able to fix with left eye. Pupil normal size.

The next day prostigmine was increased to 7½ mg tid, with little effect. At this time it was noted that the child was having an upper respiratory infection. This dose was not increased until the 17th hospital day, when the prostigmine was given every four hours at 6 a.m., 10 a.m., 2 p.m., and 6 p.m. with a half teaspoonful of syrup ephedrin for every dose of prostigmine. At this point the child responded remarkably.

The next day (18th hospital day) prostigmine was again reduced to tid; but syrup ephedrin was discontinued, due to abdominal cramps, loose bowel movements, and vomiting. Child passed out five alive ascaris both by mouth and by rectum. She was sent home to continue prostigmine 7½ mg. tid on the 20th hospital day, well maintained at this dose.

FOLLOW UP: Child was well maintained on prostigmine bromide 7½ mg. three times daily for 2½ months after discharge from the hospital. The child has gained weight and appeared more sociable. She was given antihelminthic treatment and about 70 adult ascaris were expelled. At this

point prostigmine was discontinued and there was no appreciable ptosis. The patient was in remission for 3 months until last December 11, 1953 when ptosis of both eyes again reappeared following an upper respiratory infection.

DISCUSSION

The actual cause of the disease is not definitely known; but it has been postulated that the weakness of the skeletal muscle is due to the imbalance of the acetylcholine and cholinesterase, an enzyme system at the neuromuscular junction. Dale, Felberg, and Vogt¹² have shown that acetylcholine is essential in the transmission of nerve impulses through the neuromuscular junction. It is believed that in myasthenia gravis, there is an excess of cholinesterase, preventing the normal action of acetylcholine, or the amount of acetylcholine liberated is reduced to such an extent as to effect a muscular response.

It has also been thought that there is a curare-like substance at the neuromuscular junction that blocks the stimulus, or that the threshold of the muscle is increased to the effects of acetylcholine. Jones and Stadie¹³ showed that there is no distinct difference in the cholinesterase content of serum and muscle between myasthenic and normal individuals. Wilson and Stoner⁶ verified that the cholinesterase activity is not increased, and they demonstrated in the blood of myasthenic patients a substance partially soluble in alcohol which is capable of neuromuscular blocking.

McEachern¹⁴ thought of the muscle-inhibiting properties of the thymus, but he was not able to demonstrate this relationship by thymic extracts. In 1949, Constance and associates¹⁵ by using a special technique, were able to show the inhibiting properties of the thymic extract from normal and myasthenic patients, both postmortem and surgical specimens.

Torda and Wolff¹⁶ have shown that the serum from myasthenic patients are capable of reducing the acetylcholine synthesis *in vitro*. Trethewie and Wright¹⁷ have corroborated that thymic extracts from myasthenics are also capable of inhibiting acetylcholine synthesis, while extracts from normal thymus increases.

DIAGNOSIS—In infants, early diagnosis is not easy, especially during the neo-natal period. But if the mother is myasthenic, the possibility of neonatal myasthenia should always be borne in mind. The baby should be watched carefully. There may be masklike faces, weak cries, inability to open eyes, weakness in sucking breast or formula, and loss of activity. There may be periods of cyanosis and irregular respiration.

These symptoms usually do not appear immediately after birth, but usually do on the second day of life. The recognition of congenital myasthenia is even more difficult, but again the history of delayed quickening or poor foetal motility is suggestive.

In older children the onset may be either slow or sudden. There may be a history of previous infection. The mother usually complains that there is ptosis in one eye, then in the other eye. Some children

who know how to complain may first claim to have blurring of vision or diplopia.

About 50% of cases of myasthenia gravis go to the ophthalmologist on account of ptosis, or diplopia secondary to paresis of one or more of the extra-ocular muscles.⁹ The symptoms are permanently exaggerated by fatigue, and appear later in the day. In a few cases, the eye muscles alone are involved for a long period; and it seems likely that purely "ocular" myasthenia gravis may persist indefinitely.

The ocular type commencing with diplopia and ptosis is commonest.¹⁰ The involvement of extra ocular muscles follow no definite rule. Usually upward movements are first restricted. The ocular palsies at first are fleeting. All or any of the extra-ocular muscles may be affected. The result is paralysis of conjugate movement, which may be confused with the effect of supranuclear lesion.

The internal musculature of the eye is usually not involved, but scattered reports of such an involvement are found in the literature. Accommodation has been reported diminished, proven by administration of prostigmine. As the disease progresses, the external ophthalmoplegia may become complete and permanent. Exophthalmos is occasionally observed in the absence of thyroid activity.

Marcus Gunn noted retraction of the lids, so that Von Graefe's sign (elevation of upper lid with defective following) was present. This suggests that the fibers innervated by the sympathetic are not involved in the process. Cases are cited wherein an apparent exophthalmos and Von Graefe's sign are present.

Optico-kinetic nystagmus is present in myasthenia gravis, disappears completely, and returns after a period of rest. Aside from ptosis, there are cases which show weakness of the orbicularis oculi; but this weakness may be difficult to demonstrate. It is extremely unusual that the orbicularis muscles are obviously excessively weak. In such instances there is a likelihood that an erroneous diagnosis of progressive bulbar palsy may have been made.

Aside from the ocular symptoms, muscles of the face may be involved, as shown by masklike facies, and by the disappearance of the nasolabial fold. In severe cases, the mouth may drool. Eating may be easy at the beginning of a meal; but a little later swallowing may become difficult, so that even water may be regurgitated through the nose. Talking may be easy at the start, but after a while words are spoken very slowly, muffled and inaudible, with a nasal twang. In the early part of the day, the child can hold his lower jaw; but after some attempts to chew, fatigue sets in. The jaw relaxes as if the child were breathing through the mouth. Due to weakness of the skeletal muscles, the child has frequent falls, even when walking on level ground.

The symptoms of myasthenia gravis are frequently exaggerated by infection, but recovery comes after some rest. Because of this peculiarity, it is difficult to evaluate the efficacy of therapy.

Willis, in 1685, described the disease as follows, "Patients are able at first rising in the morning to walk, move their arms this way and that or lift up a weight with strength but before noon the scores of the spirit

which influence the muscle being spent they are scarcely able to move hand or foot. I have now a prudent and honest woman in cure who for many years has been obnoxious to this kind of bastard palsy, not only in the limbs but likewise in the tongue. Sometimes this person speaks freely and readily enough but after long hasty or laborious speaking presently she becomes mute as a fish and cannot bring forth a word. Nay, and does not recover the use of her voice until after many minutes".¹⁸

The following diagnostic procedures have been used by various workers:

Veits and his coworkers^{19,20,21} recommended 3cc. of prostigmine with 1/100 gr of atropin, to be given intramuscularly to an adult patient. The patient is then observed for objective and subjective improvements. Score is given every 10 minutes with an interval of one hour.

In myasthenia gravis, there is almost immediate relief of symptoms, lasting for two hours or more. In other diseases no improvement of objective and subjective symptoms is to be noted. To a newborn, 1-2 mg. of neostigmine bromide in water may be given by mouth as a test dose. However, 0.07-0.1 mg of neostigmine methyl sulfate has been tried¹⁹ intramuscularly. In our particular case, we used 1/2 cc. 1;2000 neostigmine methyl sulfate with 1/500 gr. atropine.

Tethar²² tried to modify the above mentioned procedure. He gave 0.5 mg of the neostigmine intravenously to adults. He claimed that this procedure is superior to that of Veits in that the improvement of muscular tone is immediate and clear-cut. This procedure is especially useful in mild cases which improvement is complete. We would be afraid to try this procedure on children.

Bennet and Cash²³ suggested the use of curare only in mild and questionable cases. The dose used for adults 1 mg. per kilo body weight produces mild curarization. One tenth of this amount is injected intravenously in a minute's time. Positive sign is shown by exacerbation of symptoms. This procedure is terminated in two to three minutes by injecting atropine and prostigmine intravenously. It should never be employed unless there is some prostigmine ready, for it is potentially dangerous. Mackey¹ used 0.03 mg of a tubocurarine per kilo body weight as a test dose. Eaton²⁴ attests to the great value of this test, but warned that it be not used on patients who are seriously weakened, since further weakening may result in death, in spite of artificial respiration and administration of massive doses of prostigmine.

Harvey and Whitehall²⁵ described the use of quinine sulfate 0.6 Gm. 4 times daily. A positive sign is shown by exaggeration of symptoms. This test is terminated by giving prostigmine. We have tried this test to the mother but she vomited the pills.

Recently another test was described by Osserman and Kaplan,¹¹ involving the use of 10 mg. edrophonium (tensilon) chloride intravenously in adult. A positive sign is shown by increased muscular strength and absence of fasciculation. The maximum effect occurs within 1/2 to five minutes after the injection.

We would also like to mention other tests. One is the quantitative measurement of the hand grip exhaustion by means of an ergograph. The Jollys reaction is brought about by stimulation of an individual muscle by Faradic current. Normally a normal muscle will remain contracted for a minimum of five minutes, but in a myasthenic muscle it is less than this. The electromyogram is also used to measure the onset of fatigue by stimulating the ulnar nerve. In normal patients no decrease of the amplitude of the action potential is noted within two minutes. If the muscles involved are confined to those innervated by the cranial nerves, testing the muscles of the extremities will not give any clue unless the muscles involved are included in the test. Retention of barium in the mouth, as observed under fluoroscopy after prostigmine administration, rules out myasthenia in cases with dysphagia. Muscle biopsy, based on the findings of Buzzard,²⁶ shows the presence of lymphorrhage or collection of lymphocytes in between the muscle fibers.

DIFFERENTIAL DIAGNOSIS—Bulbar poliomyelitis should always be considered, especially if the onset is sudden and seen during a polio season.¹¹ However, lumbar puncture will give the clue. In amyotonia congenita, the involvement is in the muscles of the trunk and extremities; while in myasthenia, the muscles supplied by the bulb are more frequently involved. In progressive bulbar paralysis, there is atrophy of the muscles of the lips and tongue; and there is retention of barium in the mouth even after prostigmine. In myasthenia there is no barium retention after prostigmine. Bulbar tumors are usually unilateral with progressive sensory changes.

There may be other changes in skull x-ray or on fundoscopic examination. There is no improvement after prostigmine in bulbar tumors. Pseudomeningitic beriberi has to be entertained; but again, in this condition, there is no response to prostigmine. Muscular dystrophy that occur in children is frequently familial as a rule with little tendency towards spontaneous remissions. Myasthenia, on the other hand, is usually not familial with no atrophy of muscles, and the muscular weakness varies from time to time.

Other conditions that produce muscular weakness and paralysis should be considered in the differential diagnosis, as in potassium intoxication and potassium deficiency. In both of these conditions, the paralysis is of the ascending type, rarely involving the muscles innervated by the cranial nerves, except in severe cases. Muscular weakness may also be produced in conditions like hyperthyroidism, castration, and adrenal insufficiency.

TREATMENT—No specific drug has yet been found that may be used in the treatment of this disease. Many drugs have been tried—ephedrin, potassium, choline, guanidine, and glycol—but none of them has proved superior to neostigmine in the control of the symptoms.

Margaret Walker,²⁷ an English physician, thought that the symptoms produced in curare poisoning is similar to that of myasthenia gravis. Since physostigmine is an antagonist of curare, she tried to use

physostigmine on a myasthenic patient in 1934. To her amazement, the patient responded almost instantly. The next year, she used neostigmine, and again it responded with more remarkable results.²⁸

Since then neostigmine has become the drug of choice for the control of the symptoms of this disease. This drug is believed to inhibit the cholinesterase from destroying the acetylcholine, and from exerting its nicotinic action.

Stone and Rider⁷ claimed that 85% of the cases can be controlled by oral medication alone; but in more severe forms, parenteral and oral medications are necessary. In crises, large doses are required and are given hourly by intravenous routes. According to these scientists, the discovery of neostigmine for myasthenia gravis can be compared to the discovery of insulin for diabetes.

Odon and his coworkers²⁹ found that neostigmine causes a marked fall of cholinesterase in the serum. The fall corresponds to the period of clinical improvement, and is parallel to the dose of neostigmine. The myogram remains normal even after the serum cholinesterase has risen to preinjection levels.

The disadvantage of neostigmine is that it has to be given in large doses, and at frequent intervals day and night. In severe cases, after they have received the drug for sometime, patients seem to become irresponsive to this drug. Because of this disadvantage newer drugs have been tried.

The insecticides used during the last war were found to possess cholinesterase-inhibiting properties. The first to receive clinical application was DFP or Diisopropylflourphosphate. Comroe and his coworkers,³⁰ in 1946, reported seven cases treated with DFP. Two patients showed little or no improvement. Two showed considerable improvement. One showed marked improvement. And two gave obscure results, due to peculiarities of the natural cycle of the disease.

DFP is capable of reducing the plasma cholinesterase to zero. Yet the muscular strength obtained in myasthenic patients is not of the same degree as that obtained with the use of neostigmine. According to Comroe and his coworkers, this difference may be due to the physiochemical properties of DFP, which is highly lipid soluble, while neostigmine is highly aqueous. This may account for DFP's predilection to nervous tissues, and for neostigmines selective action on the myoneural junction.

The human plasma cholinesterase is more susceptible to the effects of DFP than the brain or muscle cholinesterase. If neostigmine is given a few hours previous to DFP administration, it will not be able to exert its full effect. DFP, however, has a distinct advantage over neostigmine in that it has more prolonged action.

From the experiences of Buchtaal and Engback,³¹ two out of the three cases could manage without prostigmine; while in the third, prostigmine could be reduced. Gaddun and Wilson³² tried DFP on three cases, and all had very encouraging results. Harvey and his coworkers³³ studied the effects on both normal and myasthenic patients, and found

that normal patients develop muscle weakness and numerous spontaneous fasciculations and no changes in the voltage of muscle potentials; while in myasthenic patients, there is an increase in muscle strength and no fasciculation. In addition, the myogram is likely to become normal. The return of strength remains detectable for 8-10 days. Due to its toxicity, like the unpleasant nervous symptoms and the gastrointestinal complications, it should be used in limited amounts, if it is to produce adequate therapeutic effects.

Dejong and his coworkers¹⁴ described the properties of hexaethyltetraphosphate, HETP, as unstable but so potent that it has to be diluted 100 times before it can be used for injection. The maximum dose given to a human is 0.86 mg per kilo. This drug is effective only if the cholinesterase is free to bound. Therefore neostigmine should not be given a few hours before HETP administration.

The injection is usually repeated at intervals of three or four days. The toxic symptoms like nausea, vomiting, abdominal cramps, salivation, sweating, bradycardia, weakness, muscle twitchings and confusions are of central origin. Westerbrug and Luros¹⁵ trial on 4 cases gave very encouraging results.

Tetraethylpyrophosphate, or TEPP, is a colorless liquid, miscible in water, acetone, alcohol, glycerine, or propylene glycol. Its action is twice as long as that of neostigmine, and is only 1/3 to 1/2 as potent. It is administered orally in 1% solution in peanut oil or propylene glycol. When the maximum dose is reached after the appearance of toxic symptoms, the maintenance dose of 2 to 4 cc. daily is given. The toxic symptoms are easily relieved by atropine.

The maximum depression of plasma cholinesterase occurs within 1 hour, after administration of the compound; and the relief of symptoms is sustained for 12 hours, gradually declining over a period of 72 hours. But the plasma cholinesterase depression continues for 16 days. If neostigmine is to be given in combination with HEPP, it should be given at least one hour ahead. Burgen et al¹⁶ in 3 cases, Harvey¹⁷ in 7 cases, and Stone and Riders⁷ in 8 cases, all reported favorable results.

Octamethylpyrophosphoramidate, OMPA, has a distinct advantage over the other phosphate mentioned above, in that it is less toxic and more stable. From the experiences of Rider and his coworkers¹⁸ with this compound, six cases in adults showed four cases in which complete replacement of neostigmine was possible. One case succumbed, and one case was a failure.

These workers observed that the neostigmine requirement begins to diminish when the serum cholinesterase level approaches 60% of normal, and maximum improvement in strength is achieved when the serum level reaches 10 to 20% of normal. The toxic symptoms are practically the same as those of other organic phosphates, and can be relieved quickly by atropine.

Thymectomy—As has been mentioned, the thymus was first implicated in this disease in 1901.¹⁹ Since then, more and more evidences that the thymus may play an important etiological factor have come to

light. Partial thymectomy was done as early as 1912; but the procedure did not gain favorable acceptance until Blalock,⁴⁰ in the United States, showed encouraging results in his first six cases. By 1944, the number thymectomized had increased to 20. Of these four died, three essentially got well, five improved considerably, five improved moderately, and three improved slightly. Blalock found that the best result was obtained in cases who had had the disease for a short period.

Other authors seem to agree that thymectomy should be confined to severe cases and to those that do not respond to prostigmine.^{41,42,43} Eaton and Clagett,⁴⁴ however, are of the opinion that thymectomy should be done only in those cases where the thymic shadow can be demonstrated by X-ray, where the tumor has not yet invaded the surrounding structures like the great vessels, where there is no implantation in the pleura at a distance; and where the patient's age and condition are such not to make it risky for him to undergo an operation.

Thymectomy by X-ray has been recommended by Aring⁴⁵. In the three cases he treated, the symptoms of myasthenia gravis seemed alleviated. He said that in experienced hands, it is a harmless procedure and should be tried first before surgery is contemplated.

The use of ACTH⁴⁶ in myasthenia gravis is based on sound physiologic observation. In vitro studies, ACTH increases acetylcholine synthesis; and in vivo, it reduces the size of the thymus and lymphatic tissues. Removal of the pituitary in rats induces changes in the electromyogram that closely resemble the abnormality noted in patients with myasthenia gravis. In pregnancy it is associated with increased release of ACTH and is often followed by remission.

Torda's and Wolff's experience with five cases showed very encouraging results. These patients were still in remission three months after therapy. Shy et al⁴⁷ had one case treated with cortisone, but failed. Ritter and Ebstein⁴⁸ also failed with ACTH therapy in a 9-year old thymectomized child.

SUMMARY

A four year old Filipino child with symptoms of myasthenia gravis is presented. The child responded to a test dose of prostigmine, and was maintained fairly well on oral medication. A short review of the pathogenesis, diagnosis, and treatment of the disease is presented.

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FOR AN INTEGRATED PROVINCIAL GOVERNMENT HOSPITAL, PUERICULTURE CENTER, MUNICIPAL MATERNITY AND CHARITY CLINIC SERVICE

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The present medical relief and provincial hospital set-up in the Philippines is woefully short of equipment, buildings, and other facilities. This is mainly due to the lack of coordinated financing and of willingness on the part of some appropriating bodies to give the Bureau of Hospitals adequate financial backing with which to integrate an efficient, satisfactory government medical relief and hospital service throughout the Philippines. At present, we have 34 provincial hospitals financed under the provisions of Act 3114, as amended by Act 3168. The financing of provincial hospitals under this Act may have been tolerable twenty-five to thirty years ago. But the continually changing times have made the provisions of this Act, as amended, obsolete; and they have plunged our medical relief agencies and provincial hospitals into near chaos.



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The Manila Times in a recent editorial stated:

"Next to not having a hospital, there is probably nothing worse than having one that cannot render full or satisfactory service to the community it is intended to serve. Recent reports that many hospitals throughout the Islands faced closure were very disturbing and gave the impression that we were not as gravely concerned with the people's health as we were over other aspects of the national life.

To date the people have not learned to fully appreciate the boons of medical science. Many are still bound by superstition. In the rural areas where the major portion of our people live, the hospitals are the show-windows for the modern ways of combatting disease. If these are operated shabbily for lack of either personnel or the requisite facilities, it will be difficult to convince the great mass of our people to depend less on the ministrations of quacks than on those of the trained men of science.

In the release of funds for provincial hospitals our concern for the people's health gets a fresh and heartening demonstration."

Not only are municipal contributions to our provincial hospitals woefully inadequate; provincial participation has also lagged so far behind as to render even the semblance of a sub-standard hospital service a myth. Moreover, since some provincial capitals like Legaspi, Naga, Cagayan, Bacolod, Cabanatuan, and Dumaguete have been converted into cities, whose charters have no specific provisions for any regular aid to the provincial hospitals within their boundaries, the situation has become even worse. Finally, to be able to give a fairly adequate hospital service, in accordance with modern trends of hospital management,

the sum of ₱3,000.00 per-year-per-bed for maintenance is needed; but our present provincial hospitals have to make the best of the meager sum of from ₱1,000.00 to ₱1,200.00 per-year-per-bed, for maintenance.

Another factor that has contributed to the almost chaotic financial condition of our provincial hospitals is the fact that the sources of funds for maintenance are so varied, so vague, and so inconsistent that the chiefs of provincial hospitals and the authorities of the Bureau of Hospitals find themselves unable to pursue a definite plan or policy to be adopted from year to year. At the same time, the population of our country has increased by leaps and bounds so that, whereas in 1918, we had a population of only 14,000,000, today, we have a population of over 20,000,000; whereas, in 1918, we had a population that was indifferent to hospital service, now-a-days, because of rapid strides in education and in health consciousness, our people have overcome that indifference and are now making outright demands on their government for more and better hospital facilities. This rapid increase in population, plus the increasing demand of our public for hospital service has not gone "paripassu" with the increase in appropriation for organized hospitals, because appropriations have remained practically stationary for the past fifteen or twenty years.

In order to improve hospital service and hospital accommodations, the writer has endeavored to make a study of present hospital facilities, compared them with those of twenty years ago, and made efforts not only to better actual conditions but also to propose a systematic, coordinated, and centralized method of financing hospital construction and maintenance with the end in view of making facilities adequate to the needs of the general public. In this endeavor, the writer has placed emphasis on a proposed method whereby the municipal, the city, the provincial, and the national government, plus whatever aid may be obtained from charitable institutions and hospital income, may make the system more wieldy and yet flexible enough to make it consistently adaptable to ever-changing conditions.

In a similar vein, one may also cite the almost confusing situation, because of inadequate financing of puericulture centers; municipal maternity and charity clinics; and dental services, both field and institutional. Municipal maternity and charity clinics are almost exclusively financed from national funds; puericulture centers are partly financed from local funds raised by local associations, plus sweepstakes aid and other forms of aid these local clubs can beg from sympathetic municipal councils and provincial boards. Dental services get funds from sweepstakes aids and from meager hand outs from provincial hospital budgets.

Thus the sub-standard, inchoate services rendered by these field medical relief agencies of the Bureau of Hospitals are far below similar services in other countries of the world. Here, hospital and medical relief authorities spend most of their time begging for funds with which to meet their needs, thus leaving them very little time to attend to actual constructive duties. Our government can be better regarded and can best serve the bulk of our population by integrating all funds destined

for medical relief under a central agency administered by the Bureau of Hospitals, in budgets approved by the Department of Health, similar to the disbursement of funds by the Departments of National Defense, Public Education, and Public Works.

This article will deal with the method which I am advocating, to impiment this central idea.

TABLE I—Showing Provincial, Municipal, National, City and Sweepstakes Aids to Provincial Hospitals

Name of Provincial Hospital	Provincial Aid	Municipal Aid	National Aid	City Aid	Phil. Charity Sweepst. Aid
1. Albay	₱ 11,000.00	₱ 14,000.00	—	₱ 10,000.00	₱ 3,000.00
2. Antique	7,030.00	13,000.00	—	—	8,000.00
3. Bataan	4,400.00	13,000.00	—	—	5,831.00
4. Batangas	14,500.00	40,000.00	—	—	18,000.00
5. Bohol	16,500.00	34,000.00	—	—	2,936.00
6. Bulacan	20,839.00	43,058.00	—	—	3,273.00
7. Cagayan	10,000.00	22,000.00	—	—	3,822.00
8. Camarines N.	3,626.68	10,884.14	₱ 16,910.00	—	—
9. Camarines Sur	16,000.00	20,000.00	—	₱ 19,000.00	4,740.00
10. Capiz	12,500.00	19,000.00	—	—	2,000.00
11. Ilocos Norte	6,500.00	15,000.00	—	—	6,832.00
12. Ilocos Sur	7,000.00	23,000.00	—	—	2,725.00
13. Iloilo	26,185.00	37,547.00	₱ 6,324.00	—	—
14. Isabela	10,000.00	16,410.00	—	—	8,603.00
15. Laguna	23,000.00	49,320.00	—	—	10,000.00
16. La Union	8,000.00	21,000.00	—	—	12,832.00
17. Leyte	26,000.00	40,000.00	₱ 2,436.00	—	12,000.00
18. Marinduque	5,400.00	8,866.92	3,800.00	—	—
19. Masbate	13,700.00	18,000.00	—	—	5,832.00
20. Misamis Occ.	14,000.00	20,000.00	—	—	4,500.00
21. Misamis Or.	16,000.00	19,000.00	770.00	₱ 10,000.00	—
22. Mindoro	6,000.00	19,000.00	—	—	18,832.00
23. Negros Occ.	42,500.00	58,000.00	—	30,500.00	2,000.00
24. Negros Or.	15,000.00	18,000.00	—	6,000.00	5,000.00
25. Nueva Ecija	21,000.00	27,500.00	4,000.00	7,000.00	—
26. Pampanga	22,500.00	43,000.00	—	—	35,000.00
27. Pangasinan	37,000.00	29,500.00	—	3,000.00	7,500.00
28. Rizal	43,000.00	83,000.00	—	—	32,324.00
29. Samar	10,000.00	29,590.00	3,876.00	—	—
30. Sorsogon	6,000.00	10,000.00	—	—	10,000.00
31. Surigao	8,000.00	20,000.00	3,939.00	—	—
32. Tarlac	12,000.00	30,000.00	—	—	—
33. Quezon	21,650.00	58,600.00	—	—	—
34. Zambales	8,769.30	9,283.00	—	—	50,082.30
	₱525,599.98	₱942,559.06	₱ 41,955.00	₱105,300.00	₱295,674.00

FINANCES:

Table I shows the present financing of 34 provincial hospitals from various funds. It also shows that these provincial hospitals, with a total

approved capacity of 1,875 beds, are working under the following appropriations:

National aid	₱ 41,955.00
Provincial aid	525,599.98
Municipal aid	942,559.06
City aid	105,300.00
Philippine Charity Sweepstakes aid	295,674.00
Total	₱1,910,788.04

This total gives an annual "per-year-per-bed maintenance" of ₱1,019.00, which is much below the estimated ₱3,000.00 per-year-per-bed standard set by the Bureau of Hospitals. Even this standard is way below that of the United States and England, where the per-bed-per-year maintenance is placed at ₱5,000.00 or ₱10,000.00.

Our municipal maternity and charity clinics are maintained at an average of ₱1,500,000.00 per year appropriation; and the approximately 500 puericulture centers receive a ₱100,000.00 yearly national aid for their maintenance. Dental services are financed largely from sweepstakes doles from time to time as funds become available.

For purposes of this study, government hospitals under the Bureau of Hospitals may be divided into the following categories:

- a. *Provincial Hospital*—A hospital established, or proposed to be established, in the capital of a province, or in a city, which used to be the capital of a province.
- b. *Congressional or Sub-provincial Hospital*—A hospital established in the most centrally located municipality of a congressional district—taking into account geographical location, number of inhabitants, and accessibility by road from surrounding municipalities, as well as the capital of the province.
- c. *Special Hospital*—A hospital that has been built and was functioning heretofore.
- d. *Regional Hospital*—A hospital financed heretofore from national funds almost exclusively, and dedicated as a sort of base hospital for the region in which it is located.

In order to cope with adequate financing of all provincial, sub-provincial, special, and regional hospitals, as well as other medical relief organizations under the Bureau of Hospitals, it is hereby proposed that the following sources of funds be made available to a centralized agency:

<i>Sources of Income</i>	<i>Estimated Yearly Income</i>
(1) 5% of general funds of all municipalities	₱ 2,000,000.00
(2) 3% additional to the above 5% from general funds of municipalities in which hospitals are located	300,000.00
(3) 10% of general funds of all cities, except Manila	1,200,000.00
(4) 5% of general funds of all provinces	2,000,000.00

(5) National Government contribution (fixed amount)	10,000,000.00
(6) National Charity Sweepstakes contribution	2,500,000.00
	<hr/>
Total available for appropriation	₱18,000,000.00

With eleven million pesos available for expenditures for hospitals, municipal maternity and charity clinics, puericulture centers, and dental services, the following expanded, well-financed, and increasingly efficient medical relief activities can be effectively undertaken:

(1) For a fixed appropriation corresponding to national & sweepstakes aid for 500 puericulture centers	₱ 2,000,000.00
(2) For maintenance of about 500 municipal maternity and charity clinics, and dental services . . .	3,000,000.00
(3) For construction and maintenance of: 34 provin- cial hospitals; 12 national aid hospitals to be converted into provincial hospitals; 7 emer- gency hospitals to be converted into provincial hospitals; 1 existing city hospital; 3 existing regional hospitals; and 47 proposed congressional and provincial hospitals	13,000,000.00
TOTAL	₱18,000,000.00

The ₱13,000,000.00 that could be made available for PROVINCIAL, REGIONAL AND CONGRESSIONAL HOSPITALS could be utilized in maintaining existing ones, in putting up new buildings, and in the purchase of equipment for the proposed PROVINCIAL AND CONGRESSIONAL HOSPITALS. Details of this plan may be worked out later. Since the proposed PROVINCIAL AND CONGRESSIONAL HOSPITALS are not functioning at present, the funds destined for their maintenance, which may average ₱80,000.00 yearly, could be used for construction purposes in the meantime. Later, as the hospitals are finished and fully equipped, the ₱80,000.00 yearly appropriations may be used in maintaining 25- to 30-bed hospitals. With this arrangement, every province will have a STANDARD PROVINCIAL HOSPITAL; and every congressional district, a STANDARD SUB-PROVINCIAL OR CONGRESSIONAL HOSPITAL. The present REGIONAL AND SPECIAL HOSPITALS, maintained directly with national and local funds, may continue functioning as usual under this proposed set-up.

Table II shows the proposed distribution of PROVINCIAL, REGIONAL, CONGRESSIONAL, AND SPECIAL HOSPITALS.

Thus, with a little more effort on the part of our municipalities, cities, and provinces, plus a reasonable aid that Congress may make available, hospital service will not only be rapidly expanded; its maintenance will also be under what may be considered a STANDARD HOSPITAL SERVICE for the Philippines. Likewise, puericulture centers and municipal maternity and charity clinics will receive direct fixed aids,

which will enable them to render better service to the public and to make long-range plans for more comprehensive and efficient service. There is no gain-saying the fact that, through a systematic, efficient, and well-planned medical relief service, our government may reach the most remote confines of our island republic, and thus bring the government closer to the people.

SUMMARY

1. A detailed study of the present set-up of our special, provincial, and national hospitals is made.
2. A study of the set-up of our municipal maternity and charity clinics, puericulture centers, and dental services is also made.
3. A proposed classification of government hospitals is suggested.
4. A study of proper financing is made, giving sources of funds.
5. A system of expenditures from a centralized agency is analyzed.

TABLE II—Showing the Proposed Distribution of Provincial, Regional and Congressional Hospitals

Province	Location	Provincial	Congressional	Bed Capacity	Regional
1. <i>Abra</i>	Bangued	Existing as Emergency	—	30	—
2. <i>Agusan</i>	Butuan City	Existing as National	—	25	—
3. <i>Albay</i> :					
1st Cong. Dist.	Tabaco	—	Proposed	25	—
2nd Cong. Dist.	Legaspi City	Existing as Provincial	—	35	—
3rd Cong. Dist.	Ligao	—	Proposed	25	—
4. <i>Antique</i> :	San Jose de Buenavista	Existing as Provincial	—	25	—
5. <i>Bataan</i>	Balanga	Existing as Provincial	—	25	—
6. <i>Batanes</i>	Basco	Existing as Emergency	—	20	—
7. <i>Batangas</i> :					
1st Cong. Dist.	Nasugbu	—	Proposed	25	—
2nd Cong. Dist.	Batangas	Existing as Provincial	—	60	—
3rd Cong. Dist.	Lipa City	—	Proposed	25	—
8. <i>Bobol</i> :					
1st Cong. Dist.	Tagbilaran	Existing as Provincial	—	100	—
2nd Cong. Dist.	Carmen	—	Proposed	25	—
3rd Cong. Dist.	Ubay	—	Proposed	25	—
9. <i>Bukidnon</i>	Malaybalay	Existing as National	—	25	—
10. <i>Bulacan</i> :					
1st Cong. Dist.	Malolos	Existing as Provincial	—	60	—
2nd Cong. Dist.	Baliuag	—	Proposed	25	—

Province	Location	Provincial	Congressional	Bed Capacity	Regional
11. <i>Cagayan:</i>					
1st Cong. Dist.	Tuguegarao	Existing as Provincial	—	60	—
2nd Cong. Dist.	Ballesteros	—	Proposed	25	—
12. <i>Camarines Norte:</i>	Daet	Existing as Provincial	—	20	—
13. <i>Camarines Sur:</i>					
1st Cong. Dist.	Naga City	Existing as Provincial	—	50	—
2nd Cong. Dist.	Lagonoy	—	Proposed	25	—
14. <i>Capiz:</i>					
1st Cong. Dist.	Capiz	—	Existing as Emerg.	25	—
2nd Cong. Dist.	Mambusao	—	Existing as Emerg.	25	—
3rd Cong. Dist.	Kalibo	Existing as Provincial	—	35	—
15. <i>Catanduanes</i>	Virac	Existing as Emergency	—	25	—
16. <i>Cavite</i>	Cavite City	Proposed	—	25	—
17. <i>Cebu:</i>					
1st Cong. Dist.	Bogo	—	Proposed	25	—
2nd Cong. Dist.	Opon	—	Proposed	25	—
3rd Cong. Dist.	Carcar	Proposed	—	25	—
4th Cong. Dist.	Argao	—	Proposed	25	—
5th Cong. Dist.	Samboan	—	Proposed	25	—
6th Cong. Dist.	Toledo	—	Proposed	25	—
7th Cong. Dist.	Bantayan	—	Proposed	25	—
<i>Cebu City</i>	Cebu	—	—	150	Existing as National
18. <i>Cotabato</i>	Cotabato	Existing as National Aid	—	30	—
19. <i>Davao</i>	Davao City	Existing as National Aid	—	50	—
20. <i>Ilocos Norte:</i>					
1st Cong. Dist.	Laoag	Existing as Provincial	—	30	—
2nd Cong. Dist.	Badoc	—	Proposed	25	—
21. <i>Ilocos Sur:</i>					
1st Cong. Dist.	Vigan	Existing as Provincial	—	40	—
2nd Cong. Dist.	Candon	—	Proposed	25	—
22. <i>Iloilo:</i>					
1st Cong. Dist.	Miagao	—	Proposed	25	—
2nd Cong. Dist.	Iloilo City	Existing as Provincial	—	60	—
3rd Cong. Dist.	Janiuay	—	Proposed	25	—
4th Cong. Dist.	Pototan	—	Existing as Emerg.	25	—
5th Cong. Dist.	Passi	—	Proposed	25	—
23. <i>Isabela</i>	Iligan	Existing as Provincial	—	40	—
24. <i>Laguna:</i>					
1st Cong. Dist.	San Pablo City	—	Existing as City Hospital	35	—

Province	Location	Provincial	Congressional	Bed Capacity	Regional
25. Lanao	2nd Cong. Dist. Sta. Cruz	Existing as Provincial	—	105	—
	Dansalan City	Existing as National Aid	—	25	—
26. La Union:	1st Cong. Dist. San Fernando	Existing as Provincial	—	45	—
	2nd Cong. Dist. Agoo	Existing as Emergency	—	25	—
27. Leyte:	1st Cong. Dist. Leyte	—	Proposed	25	—
	2nd Cong. Dist. Baybay	—	Existing as Provincial	25	—
	3rd Cong. Dist. Malitbog	—	Proposed	25	—
	4th Cong. Dist. Tacloban	Existing as Provincial	—	60	—
28. Manila:	5th Cong. Dist. Burauen	—	Proposed	25	—
	1st Cong. Dist. Tondo	—	Proposed	25	—
	2nd Cong. Dist. Sta. Cruz	Existing as Provincial	—	300	—
	3rd Cong. Dist. Sampaloc	—	Proposed	25	—
29. Marinduque	4th Cong. Dist. Malate	—	Proposed	25	—
	Boac	Existing as Provincial	—	25	—
30. Masbate	Masbate	Existing as Provincial	—	35	—
31. Mindoro Occ.	Mamburao	Proposed	—	25	—
32. Mindoro Or.	Calapan	Existing as Provincial	—	40	—
33. Misamis Occ.	Oroquieta	Existing as Provincial	—	40	—
34. Misamis Or.	Cagayan de Oro City	Existing as Provincial	—	40	—
35. Mt. Province:	1st Cong. Dist. Bontoc	Existing as National Aid	Proposed	30	—
	2nd Cong. Dist. Lubuagan	Existing as National Aid	—	20	—
	3rd Cong. Dist. Kiangnan	Existing as National Aid	—	20	—
	Baguio	—	—	100	Existing as Regional
36. Negros Occ.	1st Cong. Dist. Escalante	—	Proposed	25	—
	2nd Cong. Dist. Bacolod City	Existing as Provincial	—	150	—
	3rd Cong. Dist. Kabankalan	—	Proposed	25	—
37. Negros Or.	1st Cong. Dist. Dumaguete	Existing as Provincial	—	40	—
	2nd Cong. Dist. Siquijor	—	Existing as Emerg.	25	—
38. Nueva Ecija:	1st Cong. Dist. Cuyapo	—	Proposed	25	—

Province	Location	Provincial	Congressional	Bed Capacity	Regional
	2nd Cong. Dist. Cabanatuan	Existing as Provincial	—	100	—
39. Nueva Vizcaya	Bayombong	Existing as National Aid	—	25	—
40. Palawan	Pto. Princesa	Existing as National Aid	—	25	—
	Special Hosp. Cuyo	—	—	25	Special Hosp.
41. Pampanga:					
	1st Cong. Dist. Angeles	—	Proposed	25	—
	2nd Cong. Dist. San Fernando	Existing as Provincial	—	60	—
42. Pangasinan:					
	1st Cong. Dist. Lingayen	—	Proposed	25	—
	2nd Cong. Dist. San Carlos	Existing as National Aid	—	25	—
	3rd Cong. Dist. San Fabian	—	Proposed	25	—
	4th Cong. Dist. Urdaneta	—	Proposed	25	—
	5th Cong. Dist. Tayug	—	Proposed	25	—
	Dagupan City	—	—	80	Special Hosp.
43. Quezon:					
	1st Cong. Dist. Lucena	Existing as Provincial	—	110	—
	2nd Cong. Dist. Lopez	—	Proposed	25	—
	Special Hosp. Baler	—	—	25	Special Hosp.
44. Rizal:					
	1st Cong. Dist. Quezon City	—	Proposed	25	—
	2nd Cong. Dist. Pasig	Existing as Provincial	—	100	—
45. Romblon	Romblon	Existing as Provincial	—	25	—
46. Samar:					
	1st Cong. Dist. Calbayog City	—	Proposed	25	—
	2nd Cong. Dist. Catbalogan	Existing as Provincial	—	50	—
	3rd Cong. Dist. Borongan	—	Proposed	25	—
47. Sorsogon:					
	1st Cong. Dist. Bulan	—	Proposed	25	—
	2nd Cong. Dist. Sorsogon	Existing as Provincial	—	60	—
48. Sulu	Joló	Existing as National Aid	—	30	—
49. Surigao	Surigao	Existing as Provincial	—	25	—
50. Tarlac:					
	1st Cong. Dist. Camiling	—	Proposed	25	—
	2nd Cong. Dist. Tarlac	Existing as Provincial	—	65	—
51. Zambales	Iba	Existing as Provincial	—	30	—
52. Zamboanga Norte	Dapitan	Existing as National Aid	—	30	—
53. Zamboanga Sur	Pagadian	Existing as Provincial	—	30	—
	Zamboanga City	—	—	100	Existing Regional

SUMMARY

		<i>Total Bed Capacity</i>
Number of Existing Provincial Hospitals	34	1,875
Number of Existing National aid Hospitals	12	335
Number of Existing Emergency Hospitals	7	150
Number of Existing City Hospitals	1	35
Number of Existing Regional Hospitals	3	350
Number of Existing Special Hospitals . . .	3	130
Number of Proposed Provincial Hospitals .	3	75
Number of Proposed Congressional Hospitals	41	1,025
	<hr/>	<hr/>
Totals	104	3,975

Special Article

ADDRESS *

PAULINO J. GARCIA, M.D.
Secretary of Health

Mr. Master of Ceremonies, President Fernando, Physician Members of Congress, University Presidents, Distinguished Guests, and my dear friends—

There are times, rare though they may be, when a man believe, as I do, that he has the right to ask his comrades to hear him. Tonight, I feel I can claim that right, if only to tell you that, more than the honor you have given me with this invitation, you have pleased me inordinately with your magnificent show of unity! That is as it should be. That is how we should always stand—single in purpose, one and indivisible.



PAULINO J. GARCIA, M.D.

It is not my intention to make a statement of the policy which will guide the actions of the Department of Health during my incumbency. President Magsaysay has already done that; our job is to carry out that policy to the best of our ability.

I shall, however, touch on points which may not be our primary concern, but which are of vital interest to all of us nevertheless.

The various professions which you represent have definite contributions to make to the three aspects of public health—preventive medicine; curative medicine, including preoperative and rehabilitation measures; and health promotion.

We are immediately concerned with the health of our barrio people who are the main preoccupation of the present Administration. In the rural areas, for one thing, there are no doctors, no dentists, no nurses, no midwives. For another thing, the insanitary conditions of these places are a threat to the people's health.

Why is it that doctors, nurses, dentists, midwives, and other health officials do not seem to find private practice in these areas attractive? The reason, obviously, is economic. The financial returns are not so gratifying as in centers of population, and the facilities for the effective performance of their work are woefully inadequate.

The steps that should be taken to remedy this deplorable situation are definite and clear. The government should encourage private practitioners to stay in these areas by offering them a reasonable subsidy, and

* Delivered at the Testimonial Dinner honoring the Secretary of Health and Physician-Congressmen held Jan. 26th, 1954, at the Manila Hotel.

by providing them, at strategic places, with the physical and other facilities which they need in their work. This means expansion of hospital services. Although we may not yet be in a position immediately to put up hospitals which meet modern standards, we could at least attempt to put up modest ones in as many strategic places as our funds would permit. In this way, emergency problem cases could be minimized.

With respect to the specialists needed to man these hospitals, our immediate problem is training. Towards this end, we should develop our Manila hospitals. And we should avail ourselves of the training facilities of the Philippine General Hospital, the U.S.T. Hospital, and other such institutions.

This is, of course, a very ambitious program; and we do not intend to carry it out on a national scale at once. We intend to begin with pilot projects in one or two hospitals. If these projects prove successful, we shall, as fast as we can within our means, develop and train the necessary technical personnel, and extend the program to all the hospitals. In this way, we hope to raise the provincial hospitals to the category of competent medical centers, and provincial patients need not come to Manila for specialty care.

The Department of Health has the cooperation of the United States Operations Mission in the Philippines, formerly FOA; WHO; and UNICEF. The assistance which we have received from these agencies have been truly remarkable and enormous. With the help of USOM, for example, we are giving special emphasis to projects tied up with economic development; and aside from improvements in environmental sanitation, we are launching a concerted attack against mass' diseases, like malaria, tuberculosis, malnutrition, yaws, schistosomiasis, and others, which are great deterrents to national economy.

I cannot overemphasize the vital and important role which the people themselves should play in this health program. Every effort should be exerted to make them conscious of personal health information. It is only by teaching them hygienic ways of living that we can hope to succeed. For we shall need their support, even financial support, for many of our undertakings. It is gratifying to note the extent to which civic-spirited citizens and groups in rural communities are contributing financially in carrying out both local and national health programs and services, such as the puericulture centers and the construction of artesian wells.

How do the private practitioners of the various professions fit into this ambitious program of the Department of Health? You yourselves can answer this question. All you need is initiative. You can, for example, initiate supplementary health program to support government action. You can put up private hospitals and clinics, either individually or in cooperation with one another. You may even devise a system of voluntary or pre-paid health and medical insurance, to suit people of the various income groups. And you can utilize government

facilities which you can not provide yourselves, but which you need in the practice of your professions.

At this juncture, I should like to mention our growing concern with regards to the increasing cost of medical care. Every one of us knows why the cost of medical care has gone up. The advances in medical techniques, and the variety of new and expensive gadgets which are used in the diagnosis and treatment of diseases—these are the main reasons.

But the great majority of our people are not in a position to bear the additional expenses. They are not in a position to bear any expense. This is no exaggeration. Ask those who practise in the barrios and remote rural areas.

Are we going to deprive these people of the best of medical care simply because they cannot pay for it? Most governments have accepted their responsibilities for the health of their people—responsibilities which they can fulfill only with the provision of adequate health measures. This is clearly stated in the Constitution of the World Health Organization, of which the Philippines is a member. But you would not want the government to take the full responsibility with regards to this problem. I know that the medical profession in this country is averse to even the slightest idea tending to socialized medicine.

As a private practitioner, and as Secretary of Health, I am against Socialized Medicine. But the problem is with us, and something must be done to give all the people, irrespective of their ability to pay, the best and the most effective medical care. This is the essence of democracy which all of us have freely embraced, This is our pledge to serve humanity!

The President has made clear in his speech to Congress that "the Spirit of Justice, not persecution, will guide us in our undertakings. The innocent, the honest, and the efficient need not fear, and that the Government will protect and defend their rights by enforcing impartiality and without political bias our civil service rules and regulations. We will not permit anyone to exact political vengeance on honest and efficient employees by dismissing them without cause. The victory we have won is not a license for political persecution!"

I should like to say one thing more before I go. Professional jealousy and intolerance, whether in one profession or among the allied professions, is never conducive to healthy professional growth. They breed suspicion and distrust. They harm the solidarity among the members of the profession and diminish the respect of the public for them.

Let it be our solemn obligation to keep the people's trust and confidence in our profession. There is a very simple expedient by which this can be done. We have only to observe—to observe religiously—our professional code of ethics.

I wish also to state in unmistakable terms that, as long as I am the Secretary of Health, I will refrain from running for any position in our Medical Association, thus giving absolute freedom to any member of the

Department of Health the free exercise of his suffrage in the choice of our medical leaders.

I should like to reiterate once more what I said at the beginning of my remarks about the various professions which you represent making their definite and distinct contributions to the conduct of our public health.

Your guest this evening, ladies and gentlemen, is bound to meet scores of difficulties and problems. During my incumbency, I shall draw heavily on your professional and technical advice. But above all, please know that your unity and cordial professional relations will be a constant source of inspiration to me in the performance of my work as Secretary of Health.

THE JOURNAL
OF THE
Philippine Medical Association

Published monthly by the Philippine Medical Association under the supervision of the Council.
Office of Publication, Philippine General Hospital, Manila, Philippines

Devoted to the progress of Medical Science and to the interests of the
Medical Profession in the Philippines.

VOL. XXX

FEBRUARY, 1954

No. 2

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Signed editorials express the personal views of the writer thereof, and neither the Association nor the Journal assumes any responsibility for them.

·:~:| **Editorial** |~:·

THE PHILIPPINE VETERANS MEMORIAL HOSPITAL

The sick veterans now confined at different hospitals in the Philippines should feel happy with the knowledge that in the near future the Philippine Veterans Memorial Hospital, now under construction, will soon be completed and placed at the disposal of the Philippine Government.

The Philippine veterans know that the hospitalization benefits granted by the U.S. Government will automatically terminate on 31 December 1954. And it is the Philippine Government which will continue fulfilling this responsibility. However, our Government has recently had an exchange of notes with the Representative of the U.S. Government in the Philippines regarding the extension of Hospitalization benefits from 5 years (as embodied in the Rogers Act) to 12 years.

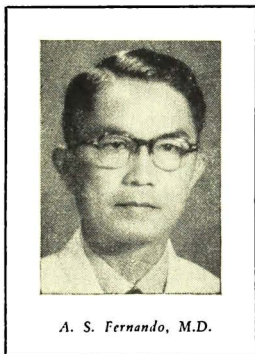
There are at least two reasons for this. First, the Rogers Act did not take effect until 1 January 1950, pursuant to an Executive Agreement between the United States and Philippine Government. And second, very few veterans entitled to the benefit had a chance to apply for it in 1950, because they did not even know about it.

Up to the present time, out of 6,503 Filipino veterans eligible for the hospital benefit, only 1,657 have taken advantage of it — leaving 4,846 still unhospitalized. This number will be further augmented, when the 4,289 pending claims are finally adjudicated. Besides, the U.S. Veterans Administration has been receiving an average of 350 claims a month since August 1, 1953.

Whether the extension of hospitalization benefits will be granted or not will depend, of course, on the Congress of the U.S., now in session. But it is likely that America will take into consideration her position, not only in the Philippines, but also in the entire Far East; and the chances are that she will look with favor on the plight of Filipino disabled veterans, who fought for democracy side by side with her own sons.

I, therefore, enjoin the officers and men in active service, the members of all veterans associations in the Philippines, the patients now confined in different contract hospitals, and their relatives to band together and put up a solid front for the common cause — to give the soldiers what is due them. Let us lend a hand to our comrades-in-arms who fought and suffered so we may enjoy our democratic way of life. — R. T. SALACUP.

President's Page



PRIVATE PRACTITIONERS IN THE P.M.A.

The Philippines Medical Directory (8th Edition, Golden Jubilee, 1953) — a publication which the PMA takes pride in presenting to the public — contains such important data on medical and health matters as lists of officers and members of the different medical organizations, particularly those affiliated with the P.M.A.; names and addresses of non-members of the P.M.A.; Philippine hospitals; Philippine medical and manufacturing houses; medical schools; and medical journals published in this country.

We believe that in assessing the progress of medical and health services of a country, reliable information on the different branches of the service is essential. Likewise, before any proposal to change the existing set-up, we must analyze carefully the significance of the data available.

With regard to the number of physicians engaged in private practice, and those in the employ of the government, we have compiled the following data, based on the short biographies of the members of the P.M.A. appearing in the Directory. In 1953, according to these data, there were 3,439 private practitioners and 851 physicians in the employ of the government — or 80.1% and 19.9%, respectively, out of a total membership of 4,294. The members of the P.M.A., therefore, are predominantly private practitioners.

This is as it should be. We are absolutely against complete government control of the practice of medicine — as is in vogue in some countries, notably Russia. We want to preserve inviolate that intimate and confidential patient-physician relationship, as well as the patient's right to choose any physician he wants. At the same time, however, we are strongly for the encouragement of medical research sponsored by the government to advance our knowledge of medicine, and for giving adequate medical care of the truly indigent patients by our government physicians.

Our Directory shows that these government physicians are distributed in the Department of Health, the College of Medicine, U.P.; the Medical Corps of the A.F.P.; and semi-government medical institutions. Some of these physicians are entitled to the privilege of private practice.

The P.M.A. is expected, in all its decisions, to give proportionate concern to the professional interests of both the private practitioners and the government physicians, with the main objective of advancing the frontiers of medical knowledge, the raising of standard of medical practice, and the welfare of all classes of people.

Antonio G. Serrano, M.D.

Miscellaneous

ABSTRACTS FROM CURRENT LITERATURE

ABSTRACTORS

Honorio Acosta-Sison, M.D.
Mariano M. Alimurung, M.D.
Jose R. Cruz, M.D.
Felisa Nicolas-Fernando, M.D.
Trinidad P. Pesigan, M.D.
Porfirio M. Recio, M.D.
Antonio M. Samia, M.D.

DOES MENSTORIAL BLOOD CONTAIN A SPECIFIC TOXIN?—By B. Zondek. *Am. J. Obst. & Gynec.* 1953, 65: 1065.

It has been claimed that menstrual blood contains a toxin, an atypical euglobulin identical to nocrosin. And this toxin is supposed to be the cause of such abnormal symptoms as premenstrual tension and primary dysmenorrhea. It is supposed also to stimulate the production of gonadotropins and adrenocorticotrophins and is responsible for the endometrial debridement.

According to Smith and Smith it is this toxin in the menstrual blood which, when injected to infantile rats, causes 95% mortality.

The author failed to confirm the findings of Smith & Smith. Zondek was careful to avoid bacterial contamination of the menstrual blood by making collection for one to three hour periods. With prolonged collection periods, Zondek found that animal mortality to be 60% suggesting bacterial contamination. Zondek stated that when cultured, the menstrual blood contained in great quantities staphylococcus albus, staphylococcus aureus, an hemolytic streptococcus, streptococcus fecalis, escherichia coli, klebsiella pneumoniae, and lactobacilli, with the bacterial count increasing proportionally to the increased time and contact between the blood and vagina. These organisms were recovered in the cardiac blood of animals which have appeared to die from toxic injections of menstrual blood. When the animals were given penicillin and streptomycin one hour before the injection of menstrual blood, the animals did not die.

Zondek also failed to confirm the contention of Smith and Smith that penicillin neutralizes the menstrual toxin and that penicillin and terramycin are good for treating toxemic patients. Zondek believes that the value of these drugs lies in their antibiotic properties. They have no anti-toxic property unless the source of the toxin is the bacteria.

Comment.—The Smiths claim to have isolated from the decidua of women suffering from the toxemia of pregnancy a toxic substance which when injected subcutaneously is lethal to immature rats. This toxic material is said to be akin to the lethal material obtainable from the menstrual blood.

Since Zondek failed to confirm the existence of lethal material from the menstrual blood after closely guarding it from bacterial contamination before injecting it to immature rats, I wonder if the result of Zondek's experiments can also apply to the postulated existence of a toxin in the decidua of women affected by the toxemia of pregnancy.—H.A.S.

THE MANAGEMENT OF TOXEMIA OF PREGNANCY. By Dr. B. T. Mayer, *Med. J. Australia*, 1952, 2:352.

In the toxemias of pregnancy we meet preeclamptic chronic hypertension, or a combination of both. Chronic hypertension, is a disease of the first 12 weeks. Pre-

eclampsia is a disease of the last 12 weeks. It is not infrequent that chronic hypertension is complicated in the last 12 weeks of preeclampsia.

One early sign of toxemia is excessive gain in weight. If this is removed by the modification of the patients' diet, the development of other signs of toxemia may not appear.

When the excessive gain in weight is not corrected edema will appear which means considerable retention of water in the tissues. Edema interferes with function. Edematous liver, kidney or brain, cannot properly function and may give rise to serious consequences.

Blood pressure above 120/80 Hg. is a sign of toxemia. But the blood pressure in pregnancy should be related to the blood pressure of the patient before the onset of pregnancy.

The presence of albumin in a catheterized urine combined with a rise of blood pressure is a sign of toxemia.

The principles of treatment are: rest, diet, sedation, magnesium sulfate, intravenous glucose, mercurial diuretics and delivery.

Rest is a diuretic. There is perhaps better blood supply to the kidneys in the recumbent position. The change in the diet is the reduction of the salt intake and to eschew the highly conditioned foods.

For sedatives the author gives 1/4 gr. phenobarbital 3 times daily at home. In the hospital, when stronger sedatives are necessary, he adds to the above one or two tablets of 1 1/2 gr. pentobarbital sodium and 10 gr. chloral hydrate in the morning. In more severe cases, he gives intramuscularly 3 cc. of 50% magnesium sulfate solution and 4 cc. every 4 hours until 32 cc. have been given or the blood pressure has fallen below 140/90.

The author gives also 20 cc. of glucose in 50% intravenously by syringe every 2 hours for 24 hours. This raises the blood sugar level and stimulates diuresis without the risk of introducing too much fluid.

The author is against mercurial diuretics but has used mersalyl on occasion with safety.

With the above treatment, most of the patients can be carried to 36 weeks and a viable child. In preeclampsia when the systolic pressure is over 160 and there is much albuminuria with the patient at rest in bed, pregnancy should be terminated. Further delay is injurious to the mother and offers no advantage to the fetus. In chronic hypertension, if the patient has developed albuminuria, pregnancy should be interrupted at the end of 36 weeks. When there is no albuminuria, pregnancy may be allowed to continue until after 38 weeks. In cases of chronic nephritis, pregnancy should be terminated at the end of 36 weeks. The danger of concealed hemorrhage in the last 4 weeks is great in this disease.

In a multipara or in a primigravida with "ripe" cervix, he provokes labor by rupturing the membranes. In a primigravida with a "unripe" cervix, the author strips the membranes then administers 3 hypodermic injections of 3 minims of pitocin at short interval. If labor is not definitely established within 24 hours, he performs low cesarean section after giving prophylactic injection of penicillin and streptomycin to forestall infection.

Comment. On the whole, the above management of the toxemias of pregnancy is sound, specially the idea of rest as being diuretic and educational. There is no doubt that rest must have a sedative effect on the nervous system. We have not found necessary to use mercurial diuretics to stimulate the kidneys to excrete. Intravenous glucose was enough to do the work. We believe that mercurial diuretics are irritant to the kidney cells. We do not subscribe to the idea of giving pitocin to induce labor specially with the strong dose of 3 minims given 5 times. So far, we have succeeded to induce labor merely by rupturing the membranes. Pitocin may increase the blood pressure which is already high. In one case, it gave rise to convulsions which ended in death.—H.A.S.

ORGANIZATION SECTION

ANNOUNCEMENT

FIRST POSTGRADUATE REFRESHER COURSE

The First Postgraduate Refresher Course will be offered by the Philippine Medical Association free of charge to all its members in good standing. This will be held in the three big hospitals in Manila—P.G.H., U.S.T. and N.G.H., from April 15-24, 1954, or the week preceding the Annual Meeting. The course will be mainly in the form of bedside conferences to be given daily from 9:00 to 12:00 noon and 2:00 to 4:00 p.m. The number of applicants will be limited to 20-25 for each conference depending upon the facilities of the particular hospital concerned. Tickets will be issued to applicants. There will be five evening sessions on subjects of general interest to be held in the Science Hall of the P.G.H. If you have any particular subject to suggest, the Committee on Scientific Assembly will appreciate your sending your suggestions for consideration.

Those interested in taking the course, please communicate with the Secretary-Treasurer of the P.M.A., Dr. Manuel D. Peñas, at the U.S.T. Hospital, or with the Chairman of the Committee on Scientific Assembly, Dr. Jose Villanueva, at the P.G.H.

First Come, First Served.



ANNOUNCEMENT

Scientific exhibitors must submit the subject of their exhibits and their outlines before the end of February. All exhibitors are requested to submit mimeographed copies of the description of their exhibits to be distributed to the members during the coming Annual Meeting.



ANNOUNCEMENT

Third call for titles and abstracts of papers for the Scientific Meeting of the 47th annual meeting of the Philippine Medical Association, April 26-30, 1954. Submit all titles and abstracts to the Chairman, Committee on Scientific Assembly, Dr. Jose Villanueva, at the Philippine General Hospital, or to the Secretary-Treasurer of the Association at the University of Santo Tomas Hospital.

·❧· SOCIETY ACTIVITIES ·❧·



Testimonial Dinner honoring Secretary of Health, Dr. Paulino J. Garcia and others given by the P.M.A. and allied medical organizations. From left to right are Dr. Juan Salcedo, Jr., former Secretary of Health; Dr. Paulino J. Garcia; Dr. Antonio S. Fernando, P.M.A. President; Senator Jose C. Locsin; Dr. Rafael Tumbokon, Undersecretary of Health; Dr. Regino G. Padua, former Undersecretary of Health, and Dr. Tomas M. Gan. Standing before the microphone is Dr. Rodolfo P. Gonzalez introducing the physician-congressmen of the Third Congress of the Philippines, and Dr. Manuel D. Peñas, Sec.-Treasurer of the P.M.A., and Master of Ceremonics.

P.M.A. GIVES TESTIMONIAL BANQUET.—The Philippine Medical Association with its component medical societies, affiliated sections, women's auxiliaries and other medical organizations gave a Testimonial Banquet in honor of the Secretary and Undersecretary of Health and the Former Secretary and Undersecretary of Health and the Physician-members of Congress in the evening of January 26, 1954, at the Fiesta Pavilion, Manila Hotel. The honorees were Hon. Paulino J. Garcia, Secretary of Health; Hon. Juan Salcedo, Jr., for Secretary of Health; Hon. Rafael Tumbokon, Undersecretary of Health; Hon. Regino G. Padua, former Undersecretary of Health; Hon. Jose C. Locsin, Senator of the Philippines; Hon. Emilio Cortez, Representative from Pangasinana; Hon. Nicolas G. Escario, Representative from Cebu; Hon. Ricardo Gacala, Representative from Ilocos Sur; Hon. Mateo S. Pecson, Congressman from Masbate; Hon. Gregorio B. Tan, Representative from Samar; Hon. Pedro G. Trono, Representative from Iloilo; and Hon. Lorenzo P. Ziga, Representative from Albay.

The Secretary-Treasurer of the Philippine Medical Association, Dr. Manuel D. Peñas, acted as the master of ceremonies. Dr. Romeo Y. Atienza, President of the Manila Medical Society, introduced the presidents, past presidents and representatives of component medical societies, affiliated specialty societies and other medical groups. Dr. Rodolfo P. Gonzalez introduced the physician-congressmen, while Dr. Ramon R. Angeles, introduced former Secretary of Health Dr. Juan Salcedo, Jr. Dr. Salcedo gave brief remarks and urged cooperation with the new Secretary of Health and offered a toast to his health. Dr. Fernando, President of the P.M.A., introduced Secretary of Health Dr. Paulino J. Garcia, who responded with a toast to former Secretary Salcedo and delivered his message to the medical profession (published elsewhere in this issue). More than 600 guests were present representing almost all regions of the Philippines.

A short musical interlude was rendered by Miss Juanita R. Javier who sang "*Love is Where You Find It*" and "*Sa Libis ng Nayon*," with Miss Julie D. Veloso on the piano.

In connection with this testimonial banquet letters of congratulations were received from the Abra Medical Society, Agusan Medical Society, Zamboanga del Norte Medical Society, Misamis Occidental Medical Society, and Camarines Sur Medical Society. Also, telegrams congratulating the honorees in the testimonial banquet were received from Bataan Medical Society, Bohol Medical Society, Camarines Norte Medical Society, Davao Medical Society, Iloilo Medical Society, and its Women's Auxiliary, Lanao Medical Society, Leyte Medical Society, Misamis Occ. Medical Society, Negros Occ. Medical Society, Sulu Medical Society and the Zamboanga Medical Society.

MANILA MEDICAL SOCIETY HOLDS SCIENTIFIC MEETING.—With Dr. Agerico B. M. Sison, Dean of the College of Medicine, University of the Philippines as main speaker, the scientific meeting of the Manila Medical Society was held February 16 at the Library Science Hall of the Philippine General Hospital. The meeting was called to order by Dr. Romeo Y. Atienza, President of the Society followed by a welcome address by Dr. Jose M. Barcelona, Assistant Director of the Hospital. Dr. A. B. M. Sison presented "Abdominal Manifestations of Malaria" with Dr. Francisco Diy, Lt. Col. Conrado Icasiano, and Dr. Hermogenes A. Santos as discussants. An open forum was held immediately after this.

MANILA MEDICAL SOCIETY INDUCTS OFFICERS.—The newly elected officers of the Manila Medical Society headed by Dr. Romeo Y. Atienza were inducted into office in a brief ceremony held at the Officers Club, Philippine Navy, on Dewey Blvd. on the evening of January 19, 1954. After the call to order was made the program was opened with remarks from the Society's out-going President, Dr. Heraldo del Castillo, followed by a musical interlude rendered by Prof. Remedios Corpus Moya, Soprano. After this interlude the induction ceremony was held with the Honorable Secretary of Health, Dr. Paulino J. Garcia, administering the oath of office to the new officers. Upon assumption into office Dr. Romeo Y. Atienza delivered his inaugural address. The second portion of the program is a social interlude offered by the Council for 1954 of the Manila Medical Society.

The other officers inducted into office were Dr. Antonio M. Samia, President-elect; Dr. Antonio O. Gisbert, Vice-President; Dr. Ruben Apelo, Secretary-Treasurer. The Councilors are: Drs. H. del Castillo, V. Ramos, A. Ayesa, H. A. Santos, J. R. Cruz, B. Barrera, C. P. Jacinto, R. Alfonso, and S. Y. Maceda, Jr.

GENERAL MEETING OF THE P.A.O.M.—The Philippine Association of Occupational Medicine held a General Meeting at the Conference Room, Sharp & Dohme, on Isaac Peral, Manila, on the evening of January 27. The program started with an opening remark by the Association's President, Dr. Enrique S. Reyes followed by the exhibition of medical film by Sharp and Dohme. New members were then inducted followed by the reading of a scientific paper on "Industrial Medical Practice in National Development Company" by Dr. Antonio de la Fuente, Medical Director, N.D.C. Discussions were led by Drs. Trajano Bernardo, Victorino de Dios, and Enrique S. Reyes.

A proposal to grant a yearly award in the form of plaque to a physician for outstanding contribution in the field of industrial medicine was discussed by the members assembled. The usual business meeting was also held.

CAVITE MEDICAL SOCIETY IN FORTY-SECOND MEET.—The 42nd scientific meeting of the Cavite Medical Society was held at the Seven Seas Hall in Cavite City January 31. The installation of new officers was also held. The program was opened with remarks by the out-going President, Dr. Jose N. Rosal. The new officers were then installed into office with Dr. Dominador I. Mangubat, City Mayor, administering the oath of office. After his induction the new President, Dr. Pacifico T. Arca, delivered an inaugural address. Dr. Teodorico A. Jimenez, Councilor, introduced the Society's Guest Speaker, Dr. Dominador I. Mangubat who spoke on "Medical Ethics." Luncheon was offered and three prizes were donated by Mr. Jim Boo Chan, proprietor of the Pagoda Kitchen. These prizes were given away by raffles.

The other inducted officers for 1954 were Dr. Lazaro Udasco, Vice-President; Dr. V. R. Borromeo, Sec.-Treasurer; and Councilors are Drs. J. N. Rosal, J. Alejo, C. Bellafior, J. Elises, J. Tranquilino, and S. Chan.



When the officers of the PHILIPPINE FEDERATION OF PRIVATE MEDICAL PRACTITIONERS made a courtesy call and pledged their full support and cooperation to the new Secretary of Health, Dr. Paulino J. Garcia, Jan. 8, 1954 at the Office of the Department of Health.

Photo shows: (left to right): Drs. Antonio M. Samia, Romeo H. Gustilo, Olimpio L. Villacorta, Ramon R. Angeles, PFPMP president, Health Secretary, Dr. Paulino J. Garcia, (seated), Dr. Ramon Atienza, Jr., secretary-treasurer, and Dr. Pablo Anzures, vice-president, PFPMP.

P.O.S. IN NINTH INAUGURAL PROGRAM.—The ninth inaugural program of the Philippine Ophthalmological and Otolaryngological Society was held January 29 at the Aristocrat Pavilion on Dewey Boulevard. Dr. J. Eusebio made an opening remark. The new officers were inducted into office by the President of the Philippine Medical Association, Dr. Antonio S. Fernando. Also the new Fellow of the Specialty Society was inducted by Dr. Edmundo Reyes, Chairman, Qualifying Board. After his induction Dr. Carlos Y. Yambao, President, delivered an inaugural address. Dr. Yambao stated that specialty practice is affected by scientific, economic, political and social factors and that the area of community service has shifted from one that has been predominantly urban to another that is decidedly rural. Of the 12-point program enunciated

by the Secretary of Health which is designed to implement the health program of President Magsaysay, Dr. Yambao gave especial mention to points 1, 2, 8, 10 and 11 which call for reassignment of government physicians to places without physicians, to subsidize doctors . . . who are willing to practice in rural areas, to encourage community participation in health problems, to give special attention to diseases that take a heavy toll in lives and cause widespread ill-health and non-productivity, to safeguard the health of school children, and to carry out an intensive health education program, respectively. He urged positive collaboration between the P.O.O.S. and the Department of Health to determine in what way EENT services might be brought not merely within the reach of, but to the very doors of rural population especially the children of pre-school and school ages. He suggested ways for study. Firstly, periodic direct and/or consultative curative services to rural areas; secondly, intensive health education of the masses in this particular field; and thirdly, a revision or redirection of certain aspect of medical education so as to prepare graduates for service to rural areas. Dr. E. Reyes introduced the guest speaker, the Secretary of Health, who delivered an address. The usual business meeting was held.

P.F.P.M.P. HOLDS GENERAL BUSINESS MEETING.—The Philippine Federation of Private Medical Practitioners held a general business meeting and a visit to the Arguz Pharmaceutical Products in Washington Ave., Manila, on the evening of January 23, Discussed in this meeting were the proposed medical legislations to be presented to the Secretary of Health and indorsed to the Fourth Congress of the Philippines, for approval. Among these are (a) Amending Republic Act No. 546 regarding the appointments to the Boards of Examiners and other matters; (b) A new Medical Law to supersede the existing obsolete provisions in the Administrative Code; (c) Amendments to existing Labor Laws regarding the employment of physicians and the provisions of Medical Services in industry; (d) A law converting all Public Hospitals into indigent or charity hospitals, especially in areas where private hospitals exist. These proposals were made by Dr. Pablo Anzures, LL.B., M.D.



Photo taken during the 4th anniversary celebration of the Misamis Occidental Medical Society held at Ozamis City last Jan. 9 with the Director of Hospitals, Dr. Tranquilino Elicaño, as Guest Speaker. May be seen above is Dr. Elicaño together with the officers and members of the Society. At the reception and ball given in honor of Dr. Elicaño the newly elected officers of the Society were inducted into office. The new officers are Dr. Jesus Sanciangco, President; Dr. I. Almonte, Vice-President; Dr. N. S. Villanueva-Bernandez, Sec-Treasurer; Dr. J. Dignum, Asst. Sec-Treasurer; Dr. G. Engracia, Librarian. Members of the Board of Directors are Drs. J. Libunao, E. Herrera, S. Clarete, J. Feliciano, F. Luansing, and H. Ramiro.

PHILIPPINE HEART ASSOCIATION IN ANNUAL MEETING.—The Philippine Health Association held its annual meeting on Valentine's Day, February 14, at the Philippine Columbian Association Bldg., Library. This Association now under the presidency of Dr. Jose M. Barcelona, had the Secretary of Health, Dr. Paulino J. Garcia, as its guest of honor. The complete program follows: (1) Call to order; (2) Reading of minutes and financial report by Dr. C. Dayrit, Sec.-Treas.; (3) Announcement of the Winners of the Burke Award with Intern Benigno Aldana, Jr. for U.P., and Intern Aurora S. Padolina for U.S.T. as recipients; (4) Distribution of Manila Medical Society Postgraduate Seminar Certificates; (5) Announcement of new regular members; (6) Address by Dr. J. M. Barcelona, President; (7) Introduction of the Guest of Honor by Dr. Antonio M. Samia, Vice-President; (8) Address by the Guest of Honor—Hon. Paulino Garcia; (9) Election of officers and the Executive Committee; (10) Induction of officers and the Executive Committee, 1954-1955 by Dr. Antonio G. Sison, Honorary President, Philippine Heart Association.

LA UNION MEDICAL SOCIETY HOLDS ELECTIONS.—The 1954-1955 officers of the La Union Medical Society were elected in a meeting held February 7 at San Fernando, La Union. The following were the new officers: Dr. Marcelino T. Viduya, President; Dr. Oscar Madamba, Vice-President; Dr. Asuncion C. Ocampo, Sec.-Treasurer; and Councilors, Drs. Bruno Gaerlan, Francisco Padua, Bienvenido Nebres, and Fidel Lopez. Dr. Antonio Encarnacion is the Press Relation Officer. This is the third time that Dr. Viduya holds the presidency of the La Union Medical Society.

PANGASINAN MEDICAL SOCIETY HOLDS 49TH SCIENTIFIC MEETING AND ELECTION OF OFFICERS.—With Dr. Quintin Gomez, Chief Anesthesiologist of the Philippine General Hospital, as guest speaker, the 49th scientific meeting of the Pangasinan Medical Society was held December 20th last year. In conjunction with this scientific meeting the annual election of officers was held with the following elected to hold the helm of the Society for the year 1954 to 1955: Dr. Francisco Q. Duque, President; Dr. Alfredo Tenganantos, Vice-President; Dr. Braulio M. de Venecia, Sec.-Treasurer, Dr. Lydia Urgena, Sub-Sec.-Treasurer; Dr. Pedro E. Sevidal, Auditor, Dr. Abelardo W. Tan, P.R.O.; and Drs. P. Castelo, M. P. Posadas, A. Domagas, M. Martinez, M. Bravo, and P. de Venecia, Councilors for first to the fifth District and Dagupan City, respectively.

NEW OFFICERS FOR PAMPANGA MEDICAL SOCIETY.—The annual election of officers of the Pampanga Medical Society was held in Bacolor, this province, during a whole day social affair January 2. The elected 1954-1955 officers are as follows: Dr. Mariano D. Bayani, President; Dr. Feliciano L. Pacia, Vice-President; Dr. Pedro G. Banzali, Secretary; Dr. Rose Catap, Treasurer; Dr. Carlos Pangan, Ass't Treasurer; and Drs. B. R. Roa, P. de Guzman, M. Mercado, F. Garcia, P. Pineda, Councilors. Luncheon was served through the courtesy of Squibb and Sons. After the luncheon speeches the program was enlivened by the presentation of Moro Folk Dances, songs and others performed by the Children of the members.

NEW OFFICERS FOR THE BATAAN MEDICAL SOCIETY.—In a recent letter to the Secretary-Treasurer of the Philippine Medical Association the following officers of the Bataan Medical Society were reported elected sometime last October, 1953: Dr. Mariano Bamba, President; Dr. Melanio Banzon, Vice-President; Dr. Leoncia Wambango, Sec.-Treasurer; and Drs. F. Pascual, M. Sta. Maria, N. Gabaya, and B. Casimiro, Councilors.

COTABATO MEDICAL SOCIETY GETS NEW OFFICERS.—In an election held December 19, 1953, by the Cotabato Medical Society the following were duly elected: Dr. Vicente J. Capistrano, President; Dr. Leonardo C. de Guzman, Vice-President; Dr. Jose F. Serrano, Sec.-Treasurer; Drs. Samuel Rayola, Esteban Eliazo, Eulogio Ladores, Bienvenido Hizon, Kararula Balhaman, and Sergio Morales, Councilors.

TARLAC MEDICAL SOCIETY ELECTS NEW OFFICERS.—In a recent election held by the Tarlac Medical Society the following were elected for the year 1954: Dr. Trinidad Esguerra, President; Dr. Adela Espinosa, Vice-President; Dr. Juan Talon, Sec.-Treasurer; and Drs. T. Santos, S. de los Santos and M. Corpus, Councilors.

THE BAGUIO MEDICAL SOCIETY held its annual election of officers last January 23, 1954, at the Patria Building, Session Road, Baguio. The newly-elected officers are: President, Dr. Dominador R. Narvaez; Vice-President, Dr. Hector T. Lopez; Secretary-Treasurer, Dr. Antonio H. Adorable; Councilors: Dr. Fernando D. Manalo, Dra. Jacinta Acena-Abando, and Dr. Lazaro P. Ricafort. The outgoing officers are: President, Dr. Fernando D. Manalo; Vice-President, Dr. Dominador R. Narvaez; Secretary-Treasurer, Dr. Floro T. Bongco; Councilors: Drs. Josefina A. Gorospe, Dr. Teodoro C. Arvisu and Dr. Efrain Montemayor.

At the same time the society honored Dra. Jacinta Acena-Abando and Dr. Emilio Reyes, two of its members who had just successfully passed the recent bar examinations.

THE PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL SOCIETY HOLDS INDUCTION CEREMONIES.—Meeting at the Philippine Columbian at Taft Avenue, the Philippine Obstetrical and Gynecological Society held an induction of officers of the year 1954, with the Hon. Paulino J. Garcia, Secretary of Health, as administering officer. The program was opened with an invocation by the Rev. Fr. Jesus Diaz, O. P. Regent, U.S.T., followed by a short remark by Dr. Jose Villanueva, Outgoing President of the Society. New Fellows of the Society were inducted and diplomas were awarded. The recipients were Drs. Rosario Isidro-Gutierrez, Pedro M. Cajipe, Marcelo D. Cruz, and Diego C. Valenzuela. The newly elected officers were then inducted into office with the Hon. Paulino J. Garcia, Secretary of Health, officiating. Dr. Alfonso Ayesa, new President of the Society delivered an inaugural address followed by an address by the Secretary of Health. The other inducted officers follows: Dr. Noe Espinola, Vice-President; Dr. Gloria T. Aragon, Sec.-Treas.; and Dr. Julita Ramos-Jalbuena, Asst. Sec.-Treasurer.

NEWS ITEMS

DR. PABLO J. NAÑAGAS of Lucena, Quezon, Philippines has registered for two courses in Ophthalmology at the Post-Graduate Medical School of New York University-Bellevue Medical Center.

The first course which he has already completed, was a part-time course of five days' duration—consisting of differential diagnosis of diseases of the anterior segment of the eyeball and different mediums of the eye. It was given under the direction of Dr. Girolamo Bonaccolto.

The second course is a nine months' course from September 28, 1953 through June 18, 1954. It deals in the basic sciences as applied to ophthalmology and is followed by a residency in a hospital approved by the school. The course is given under the direction of Dr. A. Gerard DeVoe, professor and chairman of the Department of Ophthalmology.

Dr. Nañagas is on the staff of Quezon Memorial (Provincial) Hospital in Lucena, Philippines. He is also a Fellow in the Philippine Ophthalmological and Otolaryngological Society.

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VOL. XXVI NO. 39
SIDNEY, OHIO, DECEMBER 7, 1953
Whole Number 1368

Medical Association Is Honored



DENMARK'S 1953 CHRISTMAS SEALS. Line for your collection of Danish Christmas seals will need a entire sheet of fifty to have the issue complete. Each seal is different in design and in its position to every other seal on the standard picture children of various of the world's nations. There is a design. The background color throughout is a dark green which the seal and its text from the top downward, and the descriptions on the right, left and bottom, are in gold. The top border has a silhouette portrait of King Nicolaus, Danish postmaster who conceived the world's first Christmas seal, and the anniversary of which is being celebrated this year, at the left. The left inscription translated reads, "Postmaster Nicolai Nicolai's Christmas Seal idea is every day a benefit for memorable children all over the world." The right inscription, translated reads, "This year honors the 50th Christmas Seal."

**Philippine Islands Plans
2 Stamps December 16 For
Group's 50th Anniversary**

A forthcoming set of stamps from the Philippines, which has a fair amount of American interest connected with it, will be released December 16 and collectors will be given the opportunity to obtain the stamps first day covers and of buying the issues at face value, except postage. According to an official announcement from the Philippine Bureau of Posts the set will recognize the Philippine Medical Association. One variety of stamps with Medical or Doctor themes will find the doctor a most acceptable one for their collections for it features a doctor listening through a stethoscope to a boy on an examination table.

Also incorporated in the stamp package is the symbol of the Philippine Medical Association, the working 50th Anniversary, and the dates 1903 and 1953.



**German Stamps For
Schubert, Patriots**

Those who like their Masterpieces on Stamps will have the appearance of a man who has had that philatelic honor on a number of previous occasions. It is Franz Schubert who occupies the design of a 4-cent issue commemorating November 13 by the East State of Germany.



Denominations, colors and quantities are 5c purple (5,000,000) and 10c blue (600,000) indicating that only 100,000 complete sets are possible. Printing will be in sheets of fifty.

The American fan is given from the fact that the association was founded by a group of doctors.

Also from the Post Office

Front page of the Linn's Weekly Stamp News describing the issuance of a special commemorative stamp of the Philippine Medical Association commemorating its Golden Jubilee.

Post-Graduate Medical School is part of the newly developed Medical Center of New York University which proposes to serve the community and the nation through an integrated program of medical research, training and care.

PAN-PACIFIC SURGICAL ASSOCIATION SIXTH CONGRESS, Honolulu, Hawaii, October 7-18, 1954.

Doctors are cordially invited to attend the Sixth Congress of the Pan-Pacific Surgical Association to be held in Honolulu, October 7-18, 1954, and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program with over 100 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

The Association office has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information, please write to F. J. Pinkerton, M.D., Director General, PAN-PACIFIC SURGICAL ASSOCIATION, Suite Seven, Young Building, Honolulu, Hawaii.

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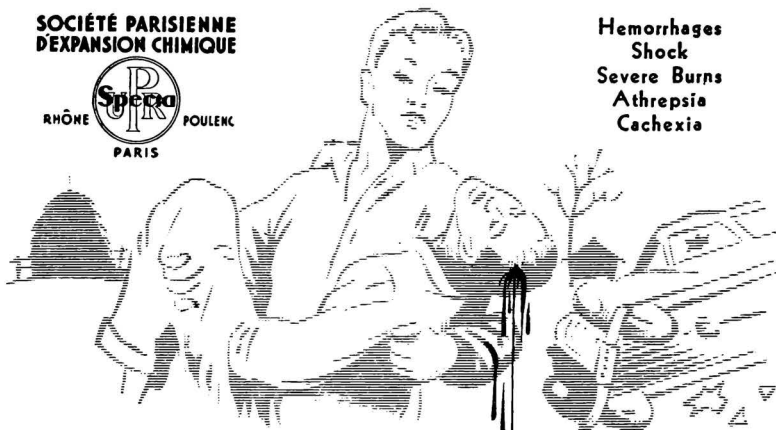
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Antibiotics & Chemotherapy 3:299 (March) 1953.

Improvement in 113 of 124 Patients*		
Diagnosis	Number of patients	Improved
Chronic catarrhal rhinitis	11	11
Chronic allergic rhinitis	26	25
Right maxillary sinusitis	2	1
Chronic naso-pharyngeal catarrh	6	6
Chronic suppurative sinusitis	3	3
Coryza, Head cold, Catarrhal rhinitis	58	51
Influenza	2	1
Acute catarrh	4	3
Hypertrophic rhinitis	12	12
TOTAL	124	113 (91.1%)

* Eye, Ear, Nose and Throat Monthly 32:512 (Sept.) 1953.

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