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Cooperative efforts in health services . . . heart disease control in a county health department . . . trends in nursing education . . . problems related to fluoridation . . . responsibilities in civil defense . . . sensitivity studies in antibiotic therapy . . . advances in nutrition . . . accidental death statistics . . . fly-borne disease control . . . school lunchroom sanitation . . . next steps in child health and crippled children's programs.

This somewhat random listing suggests the range of topics considered at the twentieth annual meeting of the Southern Branch of the American Public Health Association held at Biloxi, Miss., April 26-28, 1951. On hand were more than 700 public health practitioners—sanitarians, public health nurses, county health officers, clerks, laboratory technicians, entomologists, sanitary engineers, and health educators—from 16 States and the District of Columbia. They met to discuss technical and professional problems in formal sessions and also, through a unique technique—"curbstone consultations"—to discuss common problems informally and individually with experts in specific fields.

The following much-condensed summary of some of the papers presented in the formal sessions was undertaken through the courtesy of L. M. Graves, M. D., M. P. H., director of the Memphis-Shelby County Health Department, Tenn., and newly elected president of the Southern Branch. Many papers could not be included because sufficiently detailed abstracts or texts were not available. It is the custom of the Southern Branch, however, to publish all papers in full in its official proceedings.

Cooperative Efforts in Health Services

An examination of "cooperative efforts of voluntary, official, and professional groups in health services" was undertaken by a panel of seven, led by Felix J. Underwood, M. D., executive officer of the Mississippi State Board of Health.

The Private Practitioner

Ozro T. Woods, M. D., professor of surgery and surgical pathology of the Dallas Medical College, pointed out that "we are all trying to do different parts of the same job . . . we could do a better job of working together." Practitioners of medicine were first trained by the apprentice system, he recalled, learning medicine in its relationship to the community. As the mass of medical knowledge has continually increased, he claimed, we have further isolated the medical student from the community and the other health activities. "We tell him about them and take him visiting to health departments," Dr. Woods noted, "but this academic introduction has failed to create friendship and understanding and cooperation."

"In our enthusiasm," Dr. Woods observed, "we have without intent developed a physician who thinks he is supreme in the health field. He may have learned the value of teamwork with other physicians but, in general, not with others in the health field . . . He seems often not to understand that public health medicine has also made a contribution to the progress in the health of our Nation [and that it] started in areas almost neglected by practitioners."

Dr. Woods went on to point out effects of "exclusiveness" and specialization in terms of separate training facilities, "protective" professional organization, and "special efforts to control some diseases."

"The circumstances which made us this way need to be corrected, and I think it is rather easy to do," Dr. Woods said. "We all enter the health field somewhat alike. We come out different."

The answer, Dr. Woods said, is that "we must grow up together in training. We should all be trained in a common medical center where we learn by working together . . . we would have to work in the community . . . we would stop our isolation from each other and from the community."

"At least after such training each of us would know about the other. I even think we would learn to like each other," he said, continuing: "I think it would be a very satisfying experience to learn better how to apply to sick people all of the health benefits that are known. I think experimentation in this broad field of medical care is as normal as it is in studying individual diseases." Dr. Woods concluded by

saying that "we have not changed our plans of health services to meet the revolutionary advances in medical science."

Community Health Council

Joining with Dr. Woods in discussing the private practitioner's place in the promotion of community health was F. S. Crockett, M. D., of Lafayette, Ind., chairman of the Rural Health Committee of the American Medical Association.

He described the community health council as definitely an educational program, and "a program that is learned through work." It involves two groups: (1) those who supply medical care, and the doctor is the one first thought of; and (2) the consumers of medical care who can be taught many of the rules of healthful living and thereby escape the catastrophe of illness.

"We often speak of 'health' and 'medical care' as though they meant the same thing," Dr. Crockett observed. "This is far from being correct. Better living practices for the maintenance and preservation of health can be taught in varying degrees to everyone and thereby reduce the need for medical care. We should also be able to teach people to get the most benefit from the doctors they have."

When sickness comes it calls for medical care at the hands of some good doctor, he said, pointing out that "medical care cannot be successfully taught to laymen. Consequently, it is not a part of the county health council educational plan." That belongs, he said, to the National and State health councils which have undertaken to interest medical educators and hospital executives to make the modifications and innovations needed to increase the available number of doctors and other personnel, and to provide refresher courses and other postgraduate stimuli for the profession. There is progress in this direction, he reported.

Dr. Crockett reviewed recent work of the Rural Health Committee and developments in health councils. He reported that 43 State medical societies now have rural health committees and that interest in local community health councils is increasing. As an "outstanding example of brilliant accomplishment" he mentioned Clinton County, Ohio.

Clinton County residents wanted to know "facts about the prevalence of certain diseases, sanitary conditions, immunization, and other pertinent information to be obtained simply by asking questions of everyone in the community." The people made the survey themselves, Dr. Crockett emphasized, and it "reached 5,450 families, missed 357 families, and only 98 out of 17,900 persons refused to answer. This was a 2-year effort involving 454 persons.

"Here was a wealthy, complacent, agricultural community apparently quite well satisfied with the way things were going," Dr.

Crockett said. "One would think that, if education and culture would help, here was a county that would show up well on the right side of the health ledger." Among other things "the good people of Clinton County found that they were not affording their children adequate protection from contagious disease or dental caries; that sewage disposal and water supply in both town and country were, in some cases, primitive in character; that the handling of dairy products and the incidence of brucellosis was a very real threat to health."

The report is worth reading, Dr. Crockett said, but cautioned: "In reading it, don't feel sorry for Clinton County—your own home community may not be so good—go home and look it over." Stressing the important values flowing from the voluntary participation of so many people, he said: "It had the value of being an inside job, and the Clinton County Council had excellent support from the local medical profession. It is a good example of the role of the practitioner in the promotion of the health of the community," Dr. Crockett felt.

There is an "increasingly mellow attitude" evident from the recurring conferences of the national Rural Health Committee, he said. "It is an expression of full confidence in the honesty and sincerity of all groups cooperating. We look to its rapid crystallization at the county level in the form of more health councils. We believe the local doctor is in a mood to go along."

"To my mind," Dr. Crockett concluded, "the role of the private practitioner in the promotion of the health of the community is quite clear. He should find his most effective opportunity for teaching health practices in his daily contact with his patients. It is equally important that, in all other efforts to promote community welfare, he should join with his neighbors as a fellow citizen to achieve common goals through community organization."

The Official Health Agency

The organizational form and the character and scope of duties of the public health worker are dependent upon the government of which they are a part, William W. Frye, M. D., dean of the Louisiana State University School of Medicine, reminded the members of the APHA Southern Branch in speaking of the role of official agencies.

He noted great advances in community health protection during the past 25 years and a growing awareness of the responsibilities of the official health agency. "Our responsibilities have increased," he said, "but I am afraid that in many instances the communities have moved ahead in their thinking and planning much more rapidly than our health departments."

"I believe," Dean Frye observed, "one of the biggest factors we have to overcome in the field of health is fear—fear of regimentation and control of individuals. This fear complex is in most instances

based on lack of information, or on an inability of individuals and groups to face the facts and plan for the future."

Turning to the future, Dean Frye said that progress in preventive medicine and public health will be profoundly affected by the broad swing of our concept of health. If the objective continues to be "merely the prevention of specific disease entities, little change in principles and practices can be anticipated," he felt. "If, on the other hand, the official health agency organizes the community to include and integrate all activities intended to improve health, which is always relative in degree, then we can expect progress."

The future strategy of preventive medicine must concentrate attention more and more on the problems of health in the later years of life, without for a moment forgetting youth and middle age, Dean Frye maintained. He noted, as an example, that in contrast to "well baby clinics" the idea of "well adult clinics" is virtually unknown.

"This seems to me," the dean said, "to be an area which the official health agency can no longer ignore. The prevention, retardation, or possible control of the degenerative diseases and chronic illnesses of the population can be accomplished only by such individual action."

The Broadening Concept of Prevention

In a similar vein, John B. Hozier, M. D., of the Public Health Service, Region VI, Atlanta, pointed out that there can be no sharp demarcation between preventive and curative medicine, or between activities or services provided by official and voluntary health agencies.

"There is," Dr. Hozier emphasized, "a whole man to make, or to keep, healthy. There is a community problem we must face and conquer together—the private physician, the voluntary health agency, and the official health agency." Responsibility for coordinating and directing resources of a community toward promotion of community health seems to have fallen logically to the official agency, he said.

This does not minimize, however, the importance of the contributions of all sources toward the promotion of community health, Dr. Hozier emphasized. Historically, groups of citizens—voluntary agencies—have served as spearheads for raising funds to promote specific projects, he said, noting that when the effectiveness of projects has been demonstrated and the need for continuation established, sooner or later some governmental provision is made for continuation and often expansion of the service.

Pointing to the role of private physicians, Dr. Hozier stressed that their "contribution to the over-all health pattern of the community is far-reaching and is accomplished in many ways." As a member of the community which establishes an official health agency, Dr. Hozier noted, the physician "has a part in its creation as well as in the determination of the services which it renders. In his close association with

his patients he has illimitable opportunities, by practicing preventive as well as curative medicine, to improve the health of his community.”

The Voluntary Health Agency

In no other country do we find voluntary health and welfare organizations so firmly established and so generously supported by all the people as in the United States, said Hart E. Van Riper, M. D., medical director of the National Foundation for Infantile Paralysis. As these organizations have increased in activity and scope they have interested more and more community leaders in better health for their communities, he said.

“All of us today want to be healthy, and yet when we speak of health, it is a nebulous term that seems difficult to define,” Dr. Van Riper said. “Ask the man on the street what he thinks of health, and if he answers at all he will no doubt be confused and bewildered. Ask the same man,” Dr. Van Riper continued, “what he knows about cancer, heart disease, tuberculosis, the disaster services of the Red Cross, or poliomyelitis, and his answer will no doubt be largely determined by the activity of these various agencies in his community in the time interval that has existed between the day of the question and the last annual drive of the organization.”

Speaking of the voluntary health agencies, Dr. Van Riper said that “there are those today who unknowingly are attempting to destroy this great American institution, not so much the people as the prominent community leaders and industrialists, who are saying that the multiplicity of drives is annoying and disturbing to the people; that we should have but one drive for all voluntary health and welfare agencies. I submit to you,” he said, “that we should not have fewer, but rather more, drives, for it is only by constantly bringing before the people the needs of the several agencies that we are able to keep their interest not for one single period in the year but for 52 weeks of the year.”

Dr. Van Riper noted that public health workers know “the inability to sell health as a package” and are “more aware than anyone else that we cannot legislate good health, neither can we sell local health units on a county and district basis until the citizens demand such public health units.”

The medical director of the National Foundation for Infantile Paralysis concluded by saying that “continued support by the leaders in public health will do much to stimulate, through voluntary activities, the demand for improved health for all of the people.”

Public Health and Mobilization

Manpower Reserve Possible Achilles' Heel

The lack of an increasing reservoir of trained, experienced public health personnel may well be the Achilles' heel of the defense effort, Surgeon General Leonard A. Scheele of the Public Health Service warned in a report on the role of public health in defense mobilization. He pointed out:

1. Defense production and build-up of our Armed Forces depend upon the continuous maintenance of health and sanitation services.
2. Improved health in the underprivileged areas of the world is a basic goal of our total mobilization effort.
3. The health and morale of the civilian population at home must be sustained if our basic economic strength is to withstand a long period of mobilization.

"A major factor in the maintenance of civilian welfare for the long pull is the civil defense program," Dr. Scheele stated. "We need to understand better the meaning of civil defense and to contribute fully to its development . . . We must recognize that the planning and development of civil defense, however, is only one segment of the total mobilization program. The emergency nature of civil defense must be distinguished from the present, continuous, and post-disaster responsibilities of the Nation's public health agencies."

The impact of mobilization on public health is already being felt in such matters as the construction of camps and cantonment areas and the creation of whole new communities, the Surgeon General observed. "You know, too, that at the very time these disruptions occur, State and local resources are weakened through loss of trained personnel, shortages of health manpower, and overtaxing of health and sanitation facilities," he said.

"Unfortunately, no national action is being taken to increase our reservoir of trained, experienced public health personnel," Dr. Scheele reported, and "this lack may well be the Achilles' heel of our defense effort." He pointed out that in many parts of our country today, local health resources and manpower are not sufficient to meet a rapidly developing crisis—should it occur. In other instances, local health services are completely lacking or are so poorly developed that the communities could not cope with the evacuees and other effects of enemy attack on outlying areas.

Must Improve Quality of Services

"Although the strengthening and extension of local health services has long been a common goal, the Nation is no nearer that goal than

it was 3 years ago," Dr. Scheele warned. "Unless we move forward quickly now, the Nation's health services may be found at the peak of mobilization to be too little and too late. The quality of our health services must be improved if we are to achieve the goals of mobilization. Manpower is the most critical commodity in the national economy today—and we must conserve it, so that every man and woman can make a full contribution to the mobilization effort.

"This improvement depends primarily upon the effectiveness with which we utilize our resources," he continued. "We can do better than we have been doing, and I believe that mobilization can and will hasten our understanding that we are living in a new age—an age that is supplying public health with new knowledge, new techniques, equipment, and drugs, and is supplying us also with new opportunities to work out better methods of organization and management by which to utilize our health resources to the best advantage.

"Clearly," the Surgeon General said, "we must now gear our public health programs to the new technologies. Yet very few of our existing health programs are geared to the imminent future. For example, there can no longer be excuses for setting the professionally trained nurse to tasks commonly performed by less highly trained employees. There are many other categories of trained personnel who, because of outmoded methods of administration and practices, are unable to make full contribution to the health of the people. The trained health educator, for example, has much to offer—not only in educational activities with the public but also in the organization and operation of staff education programs." Dr. Scheele pointed out that many health services, hospitals, and research projects "suffer from ineffective record-keeping and from failure to utilize the health statistician for accurate analysis and evaluation of program."

The People Are Out in Front

Dr. Scheele emphasized that "we are not utilizing fully many techniques which were shown to be effective years ago, for we in public health are sometimes a little too complacent about what we call 'cultural lag.' Today, in many parts of the country, it is we who are lagging—the people are out in front of their health services, demanding action programs in many fields and better organization of hospital and medical services."

By way of illustration the Surgeon General noted that "although the control of epidemics is a basic function of public health, nevertheless we have failed to develop and modernize one of our most effective tools—the epidemiologic team. Success in the control of many epidemic diseases has encouraged us to neglect this technique; yet, not many decades ago, epidemiologic investigation of an outbreak was routine. We must now rebuild our epidemiologic services—

not only for effective control of disease now but also for defense against biological warfare. More precise, more rapid systems of disease reporting also are needed, and progress is being made in this direction.

"It is imperative that we improve our public health laboratories in order to effectively back up our epidemiologic services," Dr. Scheele declared. Also "the streamlining and reorientation of our industrial hygiene program is a must, for the defense production program of the next few years will impose enormous and often bewildering tasks upon industrial health services and one of our first steps will attempt to place the new industrial toxicology on a sound physiological basis." He went on to point out that "Health agencies must develop cooperative activities with Federal, State, and local rehabilitation programs in order that defense industry may make the most effective use of rehabilitated workers—and that more disabled men and women may be brought to treatment and restored to productive life.

"We have barely made a start on chronic disease control," Dr. Scheele stated. "There must be rapid, well-planned development and a strong effort to stem the tide of chronic disease, or the drain on productive manpower imposed by these major killers and cripples will indeed seriously maim our national defense. More research and sound community programs must be started to mobilize public and private resources for the prevention, early detection, diagnosis, and treatment of chronic disease.

"The core of the matter, however, is that health services and increased health manpower are essential in all phases of mobilization," the Surgeon General concluded. "Eventually, the Nation will have to recognize that these health manpower shortages are national in scope and high in priority."

Health of the Hemisphere

The United States can be extremely helpful in furthering the orderly expansion of public health programs in the Americas by supplying trained technicians and the necessary tools, John R. Murdock, M. D., assistant director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization, stated in describing recent health program activities on the two American continents.

The continent-wide effort against insect-borne diseases faces a shortage of DDT and chlorine-based insecticides which the United States could help to meet, he said. Twenty-eight countries and territories in the Americas are now engaged in a battle against a common foe, the *Aedes aegypti* mosquito, he reported.

By the end of 1950, he stated, 230,670 communities had been inspected in this campaign, nearly half of them during the year. Bolivia is free of *A. aegypti*, and Brazil, Uruguay, Paraguay, and Panama are in the last stages of the work. The United States, how-

ever, needs to intensify its campaign against this mosquito, he said, since it still "abounds in southern towns and cities." In many countries the campaign against *A. aegypti* is merging into expanded programs against malaria, Chagas disease, typhus, plague, and other diseases.

Dr. Murdock reported considerable expansion of activity in rabies, hydatidosis, and brucellosis control. Demonstration programs in tuberculosis control are operating in El Salvador, and are to be instituted in Ecuador, Jamaica, and Paraguay. Mass BCG programs are operating in Mexico and Ecuador. A training scheme established by Ecuador enables doctors and nurses to carry out the programs in their own countries, he reported. The Uruguay BCG laboratory is to be converted into an international BCG production and supply center.

A similar increase in activity and progress was reported in venereal disease, smallpox, and other communicable disease programs. The lessons learned at the Institute of Nutrition of Central America and Panama at Guatemala City may well point the way to practical methods of raising nutritional standards in like climatic belts throughout the world, he said.

Dr. Murdock described the first project of the Point IV technical assistance program—the establishment of a health demonstration area in El Salvador—which embraces work in the fields of health, agriculture, labor, and education. Adjacent countries may send observers and persons for training during any stage of the program, which includes all aspects of public health.

Selected Reports

Cautions Care in Antirabic Vaccine Use

T. F. Sellers, M. D., director of the Georgia Department of Public Health, warned that antirabic vaccine is not harmless and that there is considerable danger of inducing treatment paralysis.

During the past few years mortality from rabies has declined but antirabic sensitization deaths and serious complications have increased to the point where physicians must now realize that antirabic vaccine should not be administered indiscriminately, he stated.

Two concepts have emerged from the research of the past few years. First, rabies is communicable only by direct bite into the flesh deep enough to touch nerve tissue and, second, antirabic vaccine prepared from brain tissue, if repeatedly injected over a long period of time, may induce specific brain tissue sensitization, sometimes causing treatment paralysis, a serious and often fatal complication, Dr. Sellers reported.

Standards for considering the animal as potentially infectious were outlined by Dr. Sellers as follows:

1. The animal is clinically rabid, even though post-mortem brain examination fails to reveal Negri bodies.
2. Clinical behavior before death was not rabid, but brain shows Negri bodies.
3. If the animal is not available for examination.
4. Any animal that bites without provocation and is immediately killed should be suspected even if laboratory findings are negative.

Antirabic treatment is indicated, Dr. Sellers stated when:

1. Wounds have penetrated the skin.
2. Wounds were inflicted through clothing torn by the animal's teeth.
3. It is suspected that the saliva contacted fresh, open, or raw preexistent abrasions.
4. When the exposed person is too young to give reliable testimony.

Antirabic treatment is contraindicated, he said:

1. When there is no broken skin anywhere on the body, including face or mouth.
2. If previous wounds are known to be over 24-hours old or are covered with an unbroken scab.
3. If the tooth wounds were made through untornd clothing—such wounds are usually bruises.

4. If exposure is limited to handling only the dog or objects contaminated with the saliva, or to drinking the milk of rabid cows or goats.

5. If the wounds were inflicted not less than 7 days prior to the detection of visible signs of the disease.

6. If the animal remains normal for as long as 7 days after inflicting the wounds.

Reimmunization should be avoided for borderline exposures regardless of the time elapsed since the last treatment, Dr. Sellers stated. Retreatment should be limited in any case to a short booster series of five or six injections.

Dysentery Reduced by Fly Control

In 1941, reports of isolations of poliomyelitis virus from nonbiting flies collected during epidemics stimulated public interest in flies as disease carriers. Dale R. Lindsay, Ph. D., of the Communicable Disease Center, Public Health Service, reporting on progress in the control of fly-borne diseases, said this interest was dampened by World War II and the fact that epidemics are unsatisfactory for testing the effects of fly control upon the prevalence rates of the disease.

A much better disease for such testing, Dr. Lindsay continued, was bacillary dysentery which in certain areas occurred endemically with high prevalence rates associated with seasons of fly abundance. Hence, two such areas, the Rio Grande Valley in Texas and certain communities in southwest Georgia, widely divergent in other respects, were chosen for the fly control program. A significant reduction in reported dysentery prevalence rates resulted, confirmed by an even more marked reduction in the numbers of positive *Shigella* infections as revealed by rectal swab cultures from children under 10 years of age.

The Rio Grande Valley experiment, completed in 1948, constituted the first field proof of the common, nonbiting flies as vectors of disease. These experiments were made possible through the existence of efficient residual type insecticides, which for a short time were believed to be the solution for the problem of fly control. At present, Dr. Lindsay said, the common housefly is found to be resistant to some degree to DDT, and to other insecticides as well, in nearly every community where such insecticides have been used.

Dr. Lindsay discussed other possibilities of fly control such as additions of the effective portion of metabolic end products to otherwise favorable breeding media, which, he says, would probably not harm the fertilizer value of animal excrement, for instance, and should not be toxic to vertebrates.

Since development of resistance to insecticides appears inevitable, only prevention of fly breeding by sanitary measures remains as a recommended procedure, he felt.

Sanitation Stressed in Fly Control

F. Earle Lyman, Ph. D., and George Bradley, Ph. D., also of the Communicable Disease Center, agreed with Dr. Lindsay, emphasizing that general sanitation is still the best method known for attaining adequate and permanent fly control. They stated that although it has been shown that sprayed houses do have less flies than unsprayed houses, the degree of fly control being achieved is not as high as is desired. However, they thought that present evidence indicates that lack of satisfactory control is not due in any large extent to resistant houseflies. It is more, they said, a result of an accumulation of numerous factors—an important one of which is the inability to kill enough flies in the face of extensive breeding potentials resulting in large fly populations. Residual sprays are temporary at best and are used to attack the problem after it is allowed to occur rather than to prevent the problem at the start. Prevention, they said, is a fundamental concept in all public health work.

Real Maternal and Child Health Progress

Tremendous improvement has been made in maternal and child health in the past 15 years, Edwin F. Daily, M. D., director of the Division of Health Services, Children's Bureau, reported. Maternal mortality has decreased more than 80 percent and infant mortality, nearly 45 percent. More than 85 percent of deliveries now take place in hospitals compared with less than half of them 15 years ago. Parents know much more about child health, and communicable diseases are far less serious, he said.

Citing the discovery of antibiotic drugs, use of fluorides to prevent tooth decay, new ways of treating poliomyelitis patients, and new methods for detection and treatment of hearing loss in children as among the important scientific contributions to child health, he named as the most important our realization of the part emotions play in determining the outcome of illness, pregnancy, or physical handicap.

"We know now that understanding the feelings and attitudes of people is as essential as providing immunization, diagnosis, or treatment," Dr. Daily said. In the trend toward "humanizing" hospital care for both mothers and children, more attention is given to their wishes and requests, he explained. And more attention is paid to the emotional, recreational, and educational needs of children hospitalized for long periods.

Dr. Daily stressed the need for the aid of citizen and parent groups in helping plan and apply expanded health services for mothers and children. This year, the combined Federal maternal and child health and crippled children's fund and required State matching funds are \$34,762,500, more than three times the amount allotted 15 years ago.

Although the Congress and the States recognize the needs of mater-

nal and child health to this extent, no program in a community can last without active citizen cooperation, he pointed out. Each community, calling upon professional guidance, must know what can be accomplished and what is most desirable. Each community must decide what health services will most benefit their children and mothers.

Louisiana Program for Premature Infants

Louisiana's five-point program initiated in 1945 to reduce the premature infant death rate has progressed considerably, according to S. J. Phillips, M. D., president of the State Board of Health and State health officer of Louisiana.

Prematurity—the leading cause of infant deaths in Louisiana—accounts for approximately 30 percent of all infant deaths annually, he said. A similar situation exists in other areas of the United States, particularly in the South, Dr. Phillips stated.

The five phases of the program, designed to train graduate nurses in premature infant care and supply facilities, were outlined by Dr. Phillips:

1. Establishment of a training center in premature infant care in the New Orleans Charity Hospital.
2. Establishment and staffing of premature infant care centers in outlying charity hospitals of the State.
3. Investigation of the home and provision for follow-up care.
4. Placement of incubators, loan kits, and carrying cases for premature infants in all parish health units.
5. Provision of hospital nursing consultation.

The greatest advances have been made in establishing the training program at New Orleans and in follow-up care, Dr. Phillips said. The training center entailed cooperative planning by the hospital, the pediatric staff of the medical schools of the Tulane and Louisiana State Universities, and the State Department of Health with the Children's Bureau of the Federal Security Agency.

Fourteen 6-week classes have been held and 102 nurses have received instruction and clinical training at the center since April 1949. Resident physicians receive training through work in the premature unit for two 2-month periods.

Follow-up care, consisting of three home visits by a public health nurse, is provided for both New Orleans and the outlying parishes, Dr. Phillips reported. Twice before the baby's discharge from the hospital, the nurse evaluates the facilities in the home. She makes the third visit after the baby's discharge to ascertain its progress and to help with any difficulties. Cases involving social problems are referred to the local welfare department, which also makes the home evaluation in parishes without health units.

Availability of incubators, loan kits, and carrying cases in the local health units has been vitally important in saving lives, he declared. And the hospital nursing consultant, whose advisory services on the care of newborn infants and their mothers are now available to all hospitals in the State, will stimulate hospitals to set up separate nurseries for premature infants, he believes.

Dr. Phillips hoped that work will begin soon on the premature infant care centers planned for seven outlying charity hospitals, to be staffed with personnel trained in the New Orleans hospital. Facilities would thus be brought within 90 miles of the home of any premature infant born in the State, he said.

Perspective on Rat Control

David E. Davis, Ph. D., of the Johns Hopkins School of Hygiene and Public Health, compared rat control with the whole field of wildlife management and found little difference in the principles involved. Every species, he said in speaking of a perspective on rat control, is regulated in its abundance by a variety of factors. These can be grouped under three heads: (1) environment, (2) depredation, and (3) competition.

Environment produces a mortality that is independent of the density of population. In contrast, depredation and competition produce mortality that increases proportionately to that density. Rat control, therefore, becomes a problem of intensity of action. In terms of cost, the increase of depredation rarely can be adequate, within the budgets available, to satisfy health requirements. An increase in mortality by changing the environment reduces reproduction and increases depredation. In addition, this change improves living conditions for people.

A comparison of the history of changes in rat population in Baltimore, Dr. Davis continued, shows that poisoning gives only temporary relief, but that human housing rehabilitation results in a permanent reduction of the rat population.

Ratproofing Best Method

That rat poisoning seems to increase rather than decrease typhus in rats while ratproofing sanitation acts to reduce it was the conclusion reached by N. E. Good, Ph. D., J. H. Schubert, Ph. D., and C. O. Mohr, Ph. D., of the PHS Communicable Disease Center.

There has been a very satisfying and steady reduction in the number of human cases of murine typhus in the United States during the past 6 years, but a continued decrease, they said, must be based on reduction of typhus infection in domestic rats rather than on the control of the principal vector, *Xenopsylla cheopis*, alone. DDT dusting is effective on *X. cheopis* but not against certain other rat ectoparasites.

In order to plan effective measures for reducing typhus in rats, it is necessary to know the basic factors which determine prevalence. These are classified under the three general heads: (1) environment, (2) the rat, and (3) artificial or introduced factors. The latter factors relate to the control by man of either rats or of the arthropod vectors of murine typhus.

Typhus Morbidity Reappraisal

Considerable evidence is available from areas of moderate to high endemicity for murine typhus that the disease has been under-reported, according to Griffith E. Quinby, M. D., M. P. H., of the PHS Communicable Disease Center Epidemiologic Service. Some studies, he noted, lacked complement fixation confirmation data and therefore are open to some question as to the degree of under-reporting.

During 1949 and 1950, 335 reported or reputed cases of typhus were appraised in five Southern States, Dr. Quinby said. Of these, 116, or 35 percent, were confirmed by complement fixation tests as positive cases of typhus, but at least 20 percent were appraised as other than typhus. This indicated that some degree of over-reporting exists, particularly in areas where typhus occurs sporadically, he stated. Many other cases in the presumptive, doubtful, and incomplete categories could be expected to increase this percentage.

The determination of the degree to which areas of under-reporting will balance those of over-reporting must await more intensive and extensive communicable disease appraisal, he said. If typhus continues its present decline in prevalence, relatively more over-reporting may be anticipated, Dr. Quinby stated.

Low Point for Malaria

In a review of malaria in the United States, Justin M. Andrews, D. Sc., deputy officer in charge, PHS Communicable Disease Center, stated that all malariometric evidence indicates that the present prevalence of the disease is the lowest recorded. Reported malaria deaths and cases have diminished continuously since the last epidemic wave in the mid-thirties, he reported. During the last 18 years the annual proportion of positive blood smears among some 3 million diagnostic and survey slides have decreased markedly.

Probably the strongest testimony at hand for the conclusion that malaria transmission has ceased entirely or is maintained only at low levels in isolated areas comes from the systematic epidemiologic appraisal of cases, he stated. In 1949 and 1950, 19 and 7 cases, respectively, were considered to be indigenous primary malaria. Thus, on the basis of reported malaria statistics of the results of routine diagnostic and survey blood examinations and the paucity of actual primary indigenous cases, it is contended that endemic

malaria has declined to a very low level and is probably approaching the vanishing point.

The national malaria eradication program was launched 4 years ago as a continuation of the extended malaria program established after World War II to prevent introduction of foreign malaras to this country by infected repatriated service men, Dr. Andrews said. DDT, as a residual spray, was applied on the interior surfaces of homes and privies where relatively high malaria prevalence had been reported. These operations were reinforced by supplementing the staffs of State health departments with Federal epidemiologic personnel to assist in the investigation of reported deaths and cases allegedly caused by malaria and to consult with physicians concerning diagnosis and treatment.

County Health Department Heart Program

A challenge that no county health department can afford to ignore is the fact that 9 million people in the United States have heart disease, stated Leon Banov, M. D., health officer of Charleston, S. C. As the life span increases, we may expect cardiovascular disease to take more lives, he said.

A significant beginning to the Nation-wide campaign against heart disease, the leading cause of death today, can be seen in the creation of the National Heart Institute, the heart section in the Division of Chronic Disease and Tuberculosis of the Public Health Service, and the recent expansion of the American Heart Association, Dr. Banov stated.

Charleston, S. C., following the lead of Newton, Mass., has established a heart disease prevention demonstration pilot study, financed largely by the Public Health Service, to evaluate and use various methods and techniques of heart disease prevention at the county health department level, Dr. Banov said.

He listed as present objectives: to find the early, unknown, and potential cardiac cases and send them for medical care; to provide social, nutritional, and related services to doctors for patients; to aid in rehabilitation of patients with the help of social and welfare agencies; and to develop effective programs for preventing heart disease as far as present knowledge permits.

Mosquitoes and Encephalomyelitis

Evidence, though slight, was found by Thomas A. Cockburn, M. D., D. P. H., Communicable Disease Center, to support the theory that mosquitoes initially acquire the encephalomyelitis virus by feeding on birds with viraemia. In a study of encephalitis in the Missouri River Basin, he summarized his conclusions thus:

1. Western equine encephalomyelitis was isolated six times from birds and arthropods collected in the field.

2. Three of these isolations were from nestling birds and preceded the isolations from mosquitoes by nearly 2 weeks.

3. There was only one human case and no equine case in the area.

4. It was concluded that this indicated a persistence of inapparent infection between epidemics, and also supported the assumption that the mosquitoes acquire their infection from birds.

Dr. Cockburn, however, warned that similar isolations must be repeated many times before they can be considered significant.

Mosquito Data for Missouri Basin

The density and distribution data now available on mosquitoes from the 10 Missouri River Basin States were summarized by Gordon E. Smith, Ph. D., John A. Rowe, Ph. D., and George R. Schultz, B. S., Communicable Disease Center, Public Health Service.

Records charted from 549 counties throughout the Missouri Basin showed the presence of 82 mosquito species.

Density data, obtained from mosquito light-trap records from 147 traps operated for 11,178 nights in 96 counties, were presented in detailed tabular form for 7 of the more important species while both the density and the distribution of 23 species were indicated on individual maps. Two species, *Aedes vexans* and *Culex tarsalis* accounted for 64 percent of the total catch. No attempt was made in the study to correlate these data with the various ecological factors of the region, but several new records were established and the range of many new species were clarified.

Mosquito Breeding Areas

Inadequate disposal of waste water from irrigated lands, application of water to land which has not been properly prepared for irrigation, seepage of ground water from higher land, and inadequate maintenance of irrigation distribution systems were conditions found by Marshal B. Rainey, B. S., and a team of scientists from the PHS Communicable Disease Center, to be responsible for mosquito breeding in two areas in Nebraska in 1950. Although factors responsible for mosquito breeding on areas of these types are now well defined, additional studies, the scientists believed, will be necessary in order to define them on other types of irrigation developments where soil, crops, and irrigation practices may be different from those in the areas already studied.

In another study of four dry-farm areas along the Republican River in Nebraska and Kansas in 1949, George C. Keener, M. S., John A. Rowe, Ph. D., and Gordon E. Smith, Ph. D., PHS Communicable Disease Center, presented in graphic form the seasonal summary for each plot showing (1) daily precipitation, (2) total watered area and actual breeding area, (3) average number of larvae

per dip, (4) species identified from larval samples, and (5) mosquito breeding index for the plot. Twenty-seven mosquito species were represented in the total collection for the season with four species (*Aedes vexans*, 31 percent; *Culex tarsalis*, 31 percent; *Aedes nigromaculis*, 15 percent; and *Protophthora signipennis*, 4 percent) accounting for 81 percent of the total. The two principal types of mosquito breeding places on all plots were roadside ditches and surface pools, the investigators said.

Florida Epilepsy Program

Florida is combating epilepsy through the coordinated services of all State and private agencies, according to Frances E. M. Read, M. D., director of the Florida epilepsy program.

Institutes on epilepsy meet throughout the State, she reported. One institute was timed to coincide with a meeting of the Florida Education Association so that teachers could enter into the program, she said.

During 1950, Florida purchased four new electroencephalographs. The information from the EEG's is supplied to physicians to aid them to determine treatment for any given case. In 1950, 268 encephalograms were taken at Miami, an increase of 117 over the preceding year. Of this number, 54 were diagnosed as epileptic and 21 showed cerebral damage, Dr. Read reported.

"The educational institutes sponsored by all the departments vitally concerned with the many phases of epilepsy is a new venture in public health," she said. Several States have requested information concerning the organization. Maryland and Texas are planning similar institutes during the coming year.

Improved Mortality Statistics

The Sixth Revision of the International Classification of Causes of Death provides for improved analysis of mortality statistics, and a great advance in the accuracy of mortality statistics should be seen in the next few years, according to W. Thurber Fales, D. Sc., director of the statistical section of the Baltimore City Health Department.

The increased number of categories, however, present many problems, Dr. Fales said. States will not be expected to publish according to the detailed list. The National Office of Vital Statistics, Public Health Service, has prepared 4 lists of selected causes of death; 1 of 250 causes, 1 of 64, another of 32, and 1 of 45 selected causes of infant deaths. These lists can serve as guides to State and local health departments.

At the same time the Sixth Revision was adopted, the international medical death certificate was adopted for inclusion on the standard State death certificate, he stated. NOVS recently issued a film on the

principles of correct medical certification, an area of possible weakness in mortality reporting.

Time series of death rates based on the Fifth Revision require a bridge for comparability with the new revision, particularly where diabetes and nephritis are concerned. NOVS has issued a report on comparability ratios which will help bridge the gap, Dr. Fales said.

Nurse Education

A Commission on Nursing Education appointed by the Board of Control for Southern Regional Education is expected to complete and report its study this fall, W. J. McGlothlin, associate director of the Board of Control, stated.

The Board, formed in 1949, is composed of governors and educators from 13 Southern States. It assists States, institutions, and agencies concerned with higher education to advance knowledge and improve the social and economic level of the South. The Board operates under the State legislatures which support it, he said.

Although a previous nursing study had been made (recommending arrangements to help develop graduate programs leading to a master's or higher degree in nursing), the Board was unable to follow through because of the urgency of problems in other fields, he stated.

Interstate contracts are made for medical, dental, and veterinary students. During 1950-51, nearly 600 students were being trained under contracts. The Board is considering the inclusion in the program of other graduate fields.

In another talk, Olwen Davies, R. N., Associate Director of Education, National Organization for Public Health Nursing, discussed the general trends in nursing education in the United States.

A progress report was given on the development of the first university school of nursing in Mississippi which has 15 students at present. Scholarships provided through the State legislature have been used to improve preparation of faculty members for State schools.

Incidence of Disease

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

Reports From States for Week Ended August 11, 1951

Poliomyelitis

The 1,522 poliomyelitis cases reported for the current week represent an increase of 26 percent over the 1,203 cases for the week ended August 4. Two-thirds of this increase over the previous week is accounted for by sizable increases in the East North Central and Mountain States. In the West North Central and South Atlantic States there was only a slight increase over the previous week, and in the West South Central and Pacific States there was a slight decrease in cases reported.

Since the seasonal low week, 7,152 cases have been reported in the United States, as compared with 7,602 for the same period in 1950, and 12,958 in 1949. The cumulative total for the calendar year is 8,364. For the corresponding periods of 1950 and 1949, the totals were 8,733 and 13,871, respectively.

In New York State, where 105 cases were reported for the current week, 37 occurred in New York City. Cases have not been reported in large numbers in other parts of the State. In Illinois, where the number of cases reported last week was 81 and 129 for the current week, more than half have occurred in Cook and Champaign Counties. For the current week, 37 cases were reported in Chicago. In Michigan, one-half of the cases have been in Detroit and other urban sections of Wayne County. Only 2 other counties, Macomb and Oakland, have reported more than 5 cases in any week prior to the current week for which data are not yet available for individual counties. In Wisconsin, more than one-half of the cases in the State continue to be reported from Milwaukee. A total of 34 cases was reported in Milwaukee for the week ended August 11.

Information has been received from the National Foundation for Infantile Paralysis that 11 Indians living near Hayward, Sawyer County, Wis., have been hospitalized with poliomyelitis in Duluth. The Bureau of Indian Affairs states that this outbreak has been under investigation by their medical officers since August 7.

In Tennessee, where there has been an increase in incidence in recent weeks, only a few areas have been involved—Shelby and Tipton Counties in the southwestern part of the State; while in the central part, Davidson, Hickman, Maury, and Rutherford Counties have accounted for most of the cases. In Alabama, a large proportion of the cases have occurred in Jefferson and Mobile Counties. In Mississippi, where several counties in the west central part of the State have reported a relatively high incidence, the peak has been reached according to latest reports. In Colorado, poliomyelitis incidence has been highest in Pueblo County and in the Denver area. Salt Lake and Utah Counties have reported most of the cases in the State of Utah.

Epidemiological Reports

Anthrax

Dr. Emil Kotcher, Kentucky Department of Health, reports the occurrence of one case of anthrax in a man who lives and works in an area where an epizootic has been in progress among domestic animals. He was working on a delta plantation in Fulton County and was bitten by an insect while examining an animal dead of anthrax. Dr. R. H. Hutcheson, Tennessee Department of Health, reported another case in a resident of Hickman, Ky., who was hospitalized in Memphis. This patient had been vaccinating cattle against anthrax for 2 or 3 weeks prior to his illness.

In addition to the area comprising 2 counties in southwestern Kentucky and 2 in northwestern Tennessee, anthrax has been reported recently in 3 other States, according to reports received by the Department of Agriculture. In Lyons County, Nev., 41 cattle on 15 ranches died of anthrax in recent weeks. Eighteen head of swine on 8 different premises were also lost in Nevada. Spread of infection by biting flies among the swine was suspected. Anthrax was reported to be occurring in Morton and Richland Counties, N. Dak., but no details are available. An outbreak in swine has been reported in New Jersey, and in a packing house 1 steer was found to be infected.

Gastroenteritis

Dr. A. M. Washburn, Arkansas State Board of Health, states that a local physician reported that epidemics of gastroenteritis and septic sore throat had occurred in the area where he practiced during the latter part of July. The gastroenteritis occurred chiefly among children from 6 months to 10 years of age and was characterized by rapid onset with high fever and severe abdominal cramps. Myalgia, headache, and peripheral muscle cramps occurred in many cases. Recovery in 48 hours was usual. Stool cultures did not reveal positive evidence of an etiological agent.

H. C. Clare, Idaho Department of Public Health, has reported three cases of gastroenteritis which occurred after eating soft ice cream from an ice cream stand in Twin Falls. Investigation showed that there were faulty procedures in cleaning the ice cream making machine and in the handling of the mix whereby flies and other contaminants came in contact with the materials. Both coliform organisms and staphylococci were found in the machine and the unused mix.

Whooping Cough

Dr. L. L. Parks, Florida State Board of Health, reports that whooping cough has been much more prevalent in 1951 than it was in 1950. During the first 6 months of 1951, 609 cases with 14 deaths were reported as compared with 471 cases and 7 deaths for all of 1950. More than twice as many deaths have occurred from whooping cough (14) this year as compared with poliomyelitis (6).

Malaria

The Arkansas Board of Health has received additional reports of malaria in military personnel who had been in service in Korea. Up to August 4, 104 cases have been verified by laboratory examination. It was previously reported that 79 cases had been diagnosed between May 15 and July 22. The majority have been recognized at the military establishments in Arkansas, but in several instances the diagnosis has been established by private physicians.

Comparative Data For Cases of Specified Reportable Diseases: United States

[Numbers after diseases are International List numbers, 1948 revision]

Disease	Total for week ended—		5-year median 1946-50	Seasonal low week	Cumulative total since seasonal low week		5-year median 1945-46 through 1949-50	Cumulative total for calendar year—		5-year median 1946-50
	Aug. 11, 1951	Aug. 12, 1950			1950-51	1949-50		1951	1950	
Anthrax (062).....				(1)	(1)	(1)	(1)	44	29	32
Diphtheria (055).....	52	83	137	27th	227	322	577	2, 235	3, 450	5, 187
Encephalitis, acute infectious (082).....	28	23	23	(1)	(1)	(1)	(1)	² 609	495	361
Influenza (480-483).....	232	331	331	30th	482	770	616	116, 537	139, 534	139, 534
Measles (085).....	1, 957	1, 305	1, 305	35th	³ 494, 051	304, 795	582, 899	⁴ 465, 350	285, 665	547, 953
Meningitis, meningococcal (057.0).....	38	41	45	37th	3, 777	3, 497	3, 399	2, 816	2, 584	2, 427
Pneumonia (490-493).....	451	639	(⁴)	(1)	(1)	(1)	(1)	45, 605	59, 981	(⁴)
Poliomyelitis, acute (080).....	1, 522	1, 435	1, 435	11th	⁵ 7, 152	7, 602	7, 602	⁵ 8, 364	8, 733	8, 430
Rocky Mountain spotted fever (104).....	14	23	29	(1)	(1)	(1)	(1)	233	322	382
Scarlet fever (050) ⁶	255	257	350	32d	⁷ 69, 077	56, 609	80, 210	⁷ 53, 386	40, 170	57, 666
Smallpox (084).....			1	35th	17	44	70	9	24	49
Tularemia (059).....	12	19	22	(1)	(1)	(1)	(1)	428	631	641
Typhoid and paratyphoid fever (040, 041) ⁸	84	105	138	11th	1, 139	1, 502	1, 629	1, 574	2, 012	2, 114
Whooping cough (056).....	1, 167	2, 250	2, 183	39th	68, 307	105, 588	88, 432	46, 705	84, 052	62, 414

¹ Not computed. ² Deduction: North Carolina, week ended June 16, 1 case. ³ Addition: Wisconsin, week ended June 30, 1248 cases. ⁴ Data not available. ⁵ Deduction: North Carolina, week ended July 14, 1 case. ⁶ Including cases reported as streptococcal sore throat. ⁷ Addition: Wisconsin, week ended August 4, 10 cases. ⁸ Including cases reported as salmonellosis.

Reported Cases of Selected Communicable Diseases: United States, Week Ended August 11, 1951

[Numbers under diseases are International List numbers, 1948 revision]

Area	Diphtheria (055)	Encephalitis, infectious (082)	Influenza (480-483)	Measles (085)	Meningitis, meningococcal (057.0)	Pneumonia (490-493)	Polio-myelitis (080)
United States.....	52	28	232	1,957	38	451	1,522
New England.....	2		2	195		19	62
Maine.....			2	35		7	5
New Hampshire.....				9			5
Vermont.....				14			1
Massachusetts.....	2			116			26
Rhode Island.....				6			
Connecticut.....				15		12	25
Middle Atlantic.....	4	11		566	1	52	110
New York.....	2	11	(1)	327			105
New Jersey.....	2			102	1	16	10
Pennsylvania.....				137		36	25
East North Central.....	5	7		447	5	47	390
Ohio.....	2			68	1		73
Indiana.....	1			10	1	2	16
Illinois.....	1	3		122	1	23	129
Michigan.....	1	4		49	1	22	115
Wisconsin.....				198	1		57
West North Central.....	4	1	1	78	5	38	138
Minnesota.....	3		1	18	1	11	19
Iowa.....	1			6	1		33
Missouri.....				13	1		26
North Dakota.....				25		26	2
South Dakota.....				2			3
Nebraska.....				6	1		25
Kansas.....		1		8	1	1	30
South Atlantic.....	11	1	63	167	9	44	121
Delaware.....				1			
Maryland.....	2		1	100		18	7
District of Columbia.....				6		7	3
Virginia.....	2		56	33		9	18
West Virginia.....	3	1		2	1		12
North Carolina.....	2			5	3		16
South Carolina.....	1					3	7
Georgia.....	1		6	10		7	38
Florida.....				10	5		20
East South Central.....	11	1		63	10	23	167
Kentucky.....	4			41	2		17
Tennessee.....	2	1		11	5		51
Alabama.....	2			8	1	14	71
Mississippi.....	3			3	2	9	28
West South Central.....	10	4	71	125	4	164	200
Arkansas.....			24	2		20	18
Louisiana.....	1		1	5		52	36
Oklahoma.....			46	5		12	49
Texas.....	9	4		113	4	80	97
Mountain.....	3		77	93		41	150
Montana.....	3		15	27			1
Idaho.....				14			5
Wyoming.....				4			3
Colorado.....			3	8		5	112
New Mexico.....				11		29	3
Arizona.....			59	9		7	20
Utah.....				20			34
Nevada.....							2
Pacific.....	2	3	18	223	4	23	124
Washington.....			7	7	1		19
Oregon.....			4	33		4	16
California.....	2	3	7	165	3	19	89
Alaska.....							1
Hawaii.....				55			3

¹New York City only.

Reported Cases of Selected Communicable Diseases: United States, Week Ended August 11, 1951—Continued

[Numbers under diseases are International List numbers, 1948 revision]

Area	Rocky Mountain spotted fever (104)	Scarlet fever ¹ (050)	Small-pox (084)	Tularemia (059)	Typhoid and paratyphoid fever ² (040,041)	Whooping cough (056)	Rabies in animals
United States	14	255		12	84	1,167	123
New England	18					59	
Maine.....	3					11	
New Hampshire.....	7					6	
Vermont.....						2	
Massachusetts.....	4					36	
Rhode Island.....	1						
Connecticut.....	3					4	
Middle Atlantic	1	46			5	140	14
New York.....		31			1	46	4
New Jersey.....		3			1	52	
Pennsylvania.....	1	12			3	42	10
East North Central	49				4	226	18
Ohio.....	16				2	34	2
Indiana.....	3					18	10
Illinois.....	8				2	37	
Michigan.....	16					64	6
Wisconsin.....	6					73	
West North Central	15			2	5	56	22
Minnesota.....	4					6	4
Iowa.....	3				2	19	7
Missouri.....	4			2	2	19	1
North Dakota.....						1	
South Dakota.....	1					3	
Nebraska.....	1					3	1
Kansas.....	2				1	5	9
South Atlantic	8	27		7	17	143	16
Delaware.....						1	
Maryland.....	2	2			2	10	
District of Columbia.....		3				10	
Virginia.....	3	5		1	2	22	7
West Virginia.....	1					43	3
North Carolina.....	2	11		2	2	36	
South Carolina.....	1			1	3	8	4
Georgia.....		2		3	7	6	2
Florida.....		3			1	7	
East South Central	3	21		1	10	124	22
Kentucky.....		7			5	70	15
Tennessee.....	1	9				32	4
Alabama.....	1	4			1	16	
Mississippi.....	1	1		1	4	6	3
West South Central	1	21			19	265	31
Arkansas.....		7			1	34	2
Louisiana.....		1			1	3	
Oklahoma.....	1	3			2	22	2
Texas.....		10			15	206	27
Mountain	1	8		1	6	68	
Montana.....		1			1		
Idaho.....		1			2	12	
Wyoming.....				1		2	
Colorado.....					1	15	
New Mexico.....		1				11	
Arizona.....		1			2	25	
Utah.....	1	4				3	
Nevada.....							
Pacific		50		1	18	86	
Washington.....		1			1	18	
Oregon.....		1				4	
California.....		48		1	17	64	
Alaska.....							
Hawaii.....							

¹ Including cases reported as streptococcal sore throat.

² Including cases reported as salmonellosis.

FOREIGN REPORTS

CANADA

Reported Cases of Certain Diseases—Week Ended July 28, 1951

Disease	Total	Newfoundland	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
Brucellosis	5					2	2				1
Chickenpox	434	2		11	1	23	193	33	16	89	66
Diphtheria	3					3					
Dysentery, bacillary	18					3	2				13
Encephalitis, infectious	1						1				
German measles	103					27	36	3	8	19	10
Influenza	17			10			3				4
Measles	479	16		41	2	85	99	23	6	134	73
Meningitis, meningococcal	2					1		1			
Mumps	186	13		2	1	18	68	13	26	23	22
Poliomyelitis	79	2		4	3	7	51			4	8
Scarlet fever	124			1	1	26	13	12	26	19	26
Tuberculosis (all forms)	188	28		1	7	38	23	22	6	19	44
Typhoid and paratyphoid fever	6				1	2					3
Veneral diseases:											
Gonorrhoea	373	10		6	7	105	51	27	19	56	92
Syphilis	199	1		5	4	51	18	3	195	9	13
Primary	8			1		1	1		1	4	
Secondary	8				1	2	4				
Other	183	1		4	3	48	13	3	93	5	13
Other forms	1										1
Whooping cough	101	1		3	2	20	52	4	6	4	9

¹ Includes 92 cases of syphilis discovered as a result of a recent survey.

NORWAY

Reported Cases of Certain Diseases—May 1951

Disease	Cases	Disease	Cases
Diphtheria	4	Poliomyelitis	16
Dysentery, unspecified	34	Rheumatic fever	93
Encephalitis, infectious	2	Scabies	680
Erysipelas	313	Scarlet fever	108
Gastroenteritis	3,016	Tuberculosis (all forms)	317
Hepatitis, infectious	41	Veneral diseases:	
Impetigo contagiosa	1,455	Gonorrhoea	158
Influenza	2,208	Syphilis	49
Measles	2,581	Other forms	4
Meningitis, meningococcal	9	Weil's disease	1
Mumps	143	Whooping cough	1,750
Pneumonia (all forms)	2,967		

WORLD DISTRIBUTION OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER

The following tables are not complete or final for the list of countries included or for the figures given. Since many of the figures are from weekly reports, the accumulated totals are for approximate dates.

CHOLERA

(Cases)

Place	January- May 1951	June 1951	July 1951—week ended—			
			7	14	21	28
ASIA						
Burma.....	1,433	154	35	18	7	-----
Akyab.....	7	-----	-----	-----	-----	-----
Bassein.....	348	14	-----	-----	-----	-----
Kyaukpyu.....	-----	-----	-----	1	-----	-----
Mergui.....	106	51	21	3	1	-----
Moulmein.....	215	47	-----	-----	-----	-----
Rangoon.....	32	1	-----	-----	-----	-----
India.....	42,300	10,545	¹ 122	¹ 125	¹ 103	¹ 107
Allahabad.....	-----	-----	-----	-----	-----	² 2
Bombay.....	3	-----	-----	-----	-----	-----
Calcutta.....	3,245	1,037	112	103	95	101
Cawnpore.....	-----	-----	-----	-----	1	-----
Cuddalore.....	7	-----	-----	-----	-----	-----
Lucknow.....	3	12	-----	11	2	4
Madras.....	206	100	10	11	5	-----
Nagpur.....	68	10	-----	-----	-----	-----
Negapatam.....	87	-----	-----	-----	-----	-----
Trichinopoly.....	105	5	-----	-----	-----	-----
Tuticorin.....	34	-----	-----	-----	-----	-----
India (French).....	179	72	-----	³ 48	⁴ 83	-----
Karikal.....	36	-----	-----	-----	-----	-----
Pondicherry.....	143	-----	5	9	-----	-----
Indochina:	-----	-----	-----	-----	-----	-----
Cambodia.....	⁴ 41	⁶ 11	-----	-----	-----	-----
Viet Nam.....	23	4	-----	-----	-----	-----
Cantho.....	2	-----	-----	-----	-----	-----
Haiphong.....	3	-----	-----	-----	-----	-----
Soc Trang.....	2	1	-----	-----	-----	-----
Pakistan.....	11,882	606	¹ 13	-----	¹ 20	¹ 14
Chittagong.....	42	6	3	-----	-----	² 14
Dacca.....	51	1	-----	-----	-----	-----
Thailand.....	1	-----	-----	-----	-----	-----

¹ Preliminary. ² Imported cases. ³ July 1-10, 1951. ⁴ July 11-20, 1951. ⁵ Includes suspected cases. ⁶ Includes imported cases.

PLAGUE

(Cases)

AFRICA						
Belgian Congo.....	17	1	-----	3	1	1
Stanleyville Province.....	17	1	-----	3	1	1
British East Africa:	-----	-----	-----	-----	-----	-----
Tanganyika.....	¹ 42	-----	-----	-----	-----	-----
Madagascar.....	131	1	-----	² 1	³ 2	-----
Union of South Africa:	-----	-----	-----	-----	-----	-----
Cape Province.....	13	-----	-----	2	-----	-----
Orange Free State.....	13	-----	-----	2	-----	-----
ASIA						
Burma.....	246	2	-----	3	3	3
Rangoon.....	41	-----	-----	-----	41	41
Tavoy.....	2	-----	-----	-----	-----	-----
India.....	5,954	135	29	-----	-----	-----
Allahabad.....	⁴ 126	⁴ 2	-----	-----	-----	-----
Bombay.....	41	-----	-----	-----	-----	-----
Calcutta.....	20	-----	-----	-----	-----	-----
Cawnpore.....	8	-----	-----	-----	-----	-----
Lucknow.....	⁵ 15	-----	-----	-----	-----	-----
Nagpur.....	11	-----	-----	-----	-----	-----
Indochina:	-----	-----	-----	-----	-----	-----
Cambodia.....	26	12	-----	-----	-----	-----
Pnom Penh.....	7	3	-----	-----	-----	-----
Viet Nam.....	73	6	5	-----	-----	-----
Baria.....	6	2	-----	-----	-----	-----
Cap St. Jaques.....	2	1	-----	-----	-----	-----
Phanthiet.....	42	3	-----	-----	-----	-----
Phu Kok Island.....	19	-----	5	-----	-----	-----

See footnotes at end of table.

PLAGUE—Continued

Place	January- May 1951	June 1951	July 1951—week ended						
			7	14	21	28			
ASIA—continued									
Indonesia:									
Java.....	5								
Bandoeng.....	1								
Djakarta.....	4 1								
Jogjakarta.....	2								
Semarang.....	4 1								
Madura.....	1 12								
Timbang.....	1 12								
Thailand.....	7								
SOUTH AMERICA									
Brazil.....	8	2							
Ceara State.....	6								
Pernambuco State.....	2	2							
Ecuador.....	16								
Chimborazo Province.....	10								
Loja Province.....	6								
Peru.....	3								
Chota Province.....	3								

¹ Includes suspected cases. ² July 1-10, 1951. ³ July 11-20, 1951. ⁴ Imported. ⁵ Includes imported cases.

SMALLPOX

(Cases)

AFRICA						
Algeria.....	46	39		1 1		
Angola.....	96					
Bechuanaland.....	146					
Belgian Congo.....	1, 146	190	21	66		
British East Africa:						
Kenya.....	2		2			
Nyasaland.....	40	9	3	3		
Tanganyika.....	258	80				
Uganda.....	15	1				
Cameroon (British).....	5					
Cameroon (French).....	137	51		1 6		
Egypt.....	1					
Ethiopia.....	12	8				
French Equatorial Africa.....	104	24		1 7		
French West Africa.....	2, 212	417		35	65	23
Dahomey.....	359	11		1 1	2 3	3 23
Guinea.....	9	1				
Ivory Coast.....	209	14		1 5	2 13	
Mauritania.....	13	3				
Niger Territory.....	774	101				
Senegal.....	3	1				
Sudan.....	627	255		1 28	2 45	
Upper Volta.....	218	31		1 1	2 4	
Gambia.....	1					
Gold Coast.....	337	26				
Morocco (French).....	6					
Mozambique.....	97	8	14			
Nigeria.....	5, 692	448			1	1
Rhodesia:						
Northern.....	1	1				
Southern.....	253	23				
Sierra Leone.....	23	1				
Sudan (Anglo-Egyptian).....	18	14	5		5	8
Togo (French).....	35			1 10	2 3	
Tunisia.....	7	1				
Union of South Africa.....	453	4 2				
ASIA						
Afghanistan.....	299	74				
Arabia.....	3					
Aden.....	4 2					
Oman.....	1					
Burma.....	582	28	2	5 1		
Ceylon.....	44	9	2			
China.....	5					
India.....	185, 520	22, 576	4 72	4 49	4 76	4 33
India (French).....	2, 284	155		1 9	2 51	
India (Portuguese).....	158	1	8			

See footnotes at end of table.

SMALLPOX—Continued

Place	January— May 1951	June 1951	July 1951—week ended—			
			7	14	21	28
ASIA—continued						
Indochina:						
Cambodia.....	78	23			2	
Viet Nam.....	962	347	66	47	27	20
Indonesia:						
Borneo.....	1,130	65		3		
Java.....	148	24	5	5	5	
Iran.....	239	25	7			
Iraq.....	134	26				2
Japan.....	52					
Korea.....	474					
Pakistan.....	32,835	2,717	442	431	434	443
Straits Settlements.....	1					
Syria.....		1				
Thailand.....	33		1			
Turkey.....	120					
EUROPE						
Great Britain:						
England: Brighton	15					
Portugal.....	19					
Netherlands.....	52	2				
NORTH AMERICA						
Guatemala.....	2					
SOUTH AMERICA						
Brazil.....	3	6	1			
British Guiana.....	11					
Colombia.....	25	3				
Ecuador.....	103	4				
Paraguay.....	20					
Venezuela.....	41					

¹ July 1-10, 1951. ² July 11-20, 1951. ³ July 21-31, 1951. ⁴ Preliminary figure. ⁵ Imported.

TYPHUS FEVER*

(Cases)

AFRICA						
Algeria.....	50	9		1		
Belgian Congo.....	1	7				
British East Africa:						
Kenya.....	15	2				
Somaliland.....	1					
Uganda.....	4					
Zanzibar.....	1					
Egypt.....	6	2	1			1
Eritrea.....	13		2			1
Ethiopia.....	404	180				
Gold Coast.....	3					
Libya:						
Cyrenaica.....	3	2				
Tripolitania.....	13					
Morocco (French).....	2	6				
Morocco (Spanish).....	15					
Nigeria.....	1					
Tunisia.....	15	5				
Union of South Africa.....	42					
ASIA						
Afghanistan.....	368	110				
Ceylon.....	3					
India.....	61	19		2	3	1
India (Portuguese).....	33					
Indochina: Viet Nam.....	31					
Iran.....	215	28	5	3	1	1
Iraq.....	36	9	5	2	1	5
Israel.....	2					
Japan.....	10					
Korea.....	126					
Pakistan.....	13					
Syria.....	1					
Transjordan.....	43	2				
Turkey.....	93	20	7	1	3	1

See footnotes at end of table.

TYPHUS FEVER—Continued

Place	January-May 1951	June 1951	July 1951—week ended -			
			7	14	21	28
EUROPE						
Germany (French Zone).....		1				
Germany (United States Zone).....		1				
Great Britain:						
Island of Malta.....	1					
Ireland.....						1
Italy.....	10	1				
Sicily.....	10					
Portugal.....	32					
Spain.....	1	14				
Yugoslavia.....	284	20				
NORTH AMERICA						
Costa Rica.....	37					
Guatemala.....	13					
El Salvador.....	34					
Jamaica.....	38			34		
Mexico.....	440	16	1			
Puerto Rico.....	1			1		
SOUTH AMERICA						
Chile.....	77	13	6	5	3	4
Colombia.....	32					
Ecuador.....	4374	465				
Paraguay.....	11					
Venezuela.....	310	1	31			

*Reports from some areas are probably murine type, while others include both murine and louse-borne types.

¹ July 1-10, 1951. ² Preliminary. ³ Murine. ⁴ Includes murine type.

YELLOW FEVER

(C—cases; D—deaths)

AFRICA						
Gold Coast.....C	121	2	22	23	23	21
Acera.....C	15					
Adeiso.....C	16					
Sierra Leone.....C	22					
Koinadugu District.....C	22					
Freetown.....C	22					
NORTH AMERICA						
Costa Rica.....C		1				2
Limon Province.....C		1				2
Panama.....C	1	1				
Bocas Del Torro Province.....C	1	1				
SOUTH AMERICA						
Brazil.....D	3400					
Goiaz State.....D	3400					
Anapoli.....D	41					
Goiania.....D	42					
Goiaz.....D	45					
Inhumas.....D	41					
Jaraqua.....D	46					
Mineiros.....D	42					
Niquelandia.....D	43					
Pirenopolis.....D	41					
Porangatu.....D	41					
Rio Verde.....D	42					
Uruacu.....D	42					
Matto Grosso State.....D	3					

See footnotes at end of table.

YELLOW FEVER—Continued

Place	January- May 1951	June 1951	July 1951—week ended—			
			7	14	21	28
SOUTH AMERICA—continued						
Colombia.....	D	13				
Boyaca Department.....	D	1				
Otanche.....	D	1				
Caqueta Commissary.....	D	2				
Montanita.....	D	1				
Meta Territory.....	D	1				
North Santander Department.....	D	3				
La Vega.....	D	3				
Santander Department.....	D	7				
Campohermoso.....	D	1				
Guamales.....	D	1				
Maradales.....	D	1				
San Vicente de Chucuri.....	D	1				
Tambo Redondo.....	D	1				
Venegas.....	D	1				
Ecuador.....	C	61				
Esmeraldas Province.....	D	1				
Atacames.....	D	1				
Quininde.....	D	1				
Santo Domingo de Los Colorados.....	C	58				
San Meguel.....	D	1				
Peru.....	D	4				
Huanuco Department.....	D	1				
Junin Department.....	D	1				
Loreto Department.....	D	1				
San Martin Department.....	D	1				

¹ Includes suspected cases. ² Suspected. ³ The number of deaths, Dec. 1-Feb. 20, 1951, was estimated to be 400 and the number of cases was estimated to be 2,000. ⁴ Confirmed deaths.

U. S. Marine Hospitals Renamed

The 21 hospitals operated by the Public Health Service under the name "United States Marine Hospitals" have been redesignated as "United States Public Health Service Hospitals," thus providing a uniform designation for the 23 hospitals operated by the Service.

Affected by the change in name are 18 general hospitals located in ports along the Atlantic, Pacific, and Gulf Coasts, the Great Lakes, and the Mississippi River; two tuberculosis hospitals at Fort Stanton, N. Mex., and Manhattan Beach, N. Y.; and the leprosarium at Carville, La.

A neuropsychiatric hospital at Fort Worth, Tex., and another at Lexington, Ky., opened in the 1930's primarily for treatment of people addicted to narcotic drugs, have been known as United States Public Health Service Hospitals.

Since 1798, when President John Adams approved legislation creating a medical care program for merchant seamen, Congress has increased the number of groups entitled to treatment at the hospitals, and the old designation no longer described the functions performed. Besides American seamen, the hospitals treat officers and enlisted men of the Coast Guard and Coast and Geodetic Survey, Federal employees injured at work, and other groups designated by Congress as Federal beneficiaries. Activities of the Hospital Service also include research and preventive medicine.
