# Staff Meeting Bulletin
# Hospitals of the » » »
# University of Minnesota

## Athletic Injuries

Volume XII | Friday, April 18, 1941 | Number 22

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume XII | Friday, April 18, 1941 | Number 22

# INDEX



Published for the General Staff Meeting each week during the school year, October to May, inclusive.

Financed by the Citizens Aid Society

William A. O'Brien, M.D.

I. LAST WEEK

Date: April 4, 1941

Place: Recreation Room
Powell Hall

Time: 12:15 to 1:15 P.M.

Program: Movie: "The New York Hat"

Hemolytic Anemia
C. J. Watson
Wm. O. Clarke

Discussion
Arild Hansen
Owen H. Wangensteen

Present: 135

Gertrude Gunn
Record Librarian

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II. MOVIE

Title: "Good Scouts"

A Walt Disney Short

Released by: R-K-O.

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III. ANNOUNCEMENTS

1. ELIAS POTTER LYON MEMORIAL LECTURES

The second annual Elias Potter Lyon Memorial Lectures in the Physiological Sciences will be delivered at the University of Minnesota Medical School, May 1 and 2, at 8:00 p.m. by Professor Ernst Gellhorn of the Department of Physiology and Psychiatry of the College of Medicine of the University of Illinois. The lectures will be given in the Medical Sciences Amphitheater.

Professor Gellhorn's lecture subjects will be "The Neurophysiological Basis of Some General Adjustment Reactions," and "Investigations on the Central Excitation of the Autonomic Nervous System and Their Significance for the Problem of Schizophrenia."

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2. WILLIAL ROOT LECTURE

Dr. Arno B. Luckhardt of the Department of Physiology at the University of Chicago, will deliver the William Root Lecture, sponsored annually by the Alpha Omega Alpha medical fraternity, in the University of Minnesota Medical Amphitheater, Tuesday, April 29, at 8:15 P.M.

The subject of his lecture will be "Dr. William Beaumont and the Medical Epoch of the Northwest Territory."

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3. UNIVERSITY OF MINNESOTA MEDICAL SCHOOL LECTURE

Dr. Lucien Brouha, physiologist on the Grant Foundation at Harvard University and Professor of Human Biology at the University of Lieges, Belgium, will lecture at the University of Minnesota Medical School, April 22. He will give an illustrated lecture on the functions of the autonomic nervous system.

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4. MINNESOTA PATHOLOGICAL SOCIETY

The program for the meeting of the Minnesota Pathological Society, April 22, follows:

"Pathologic Physiology of the Kidney"
Dr. E. T. Bell

"Vitamin $B_1$ Deficiency from Fish Diets"
Drs. R. G. Green and C. A. Evans.

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5. THE ANNUAL JOURNAL-LANCET LECTURESHIP

"Vulnerable Structures of the Bacterial Cell" - by Dr. Rene J. Dubos of the Rockefeller Institute for Medical Research. Monday, April 21, 8:00 P.M., Medical Sciences Amphitheater.

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## IV. ATHLETIC INJURIES

George W. Hauser

"The student in athletic competition formerly assumed his own responsibility for medical care when he was injured. As the popularity of competitive sports developed, the sponsoring departments of athletics found resources to employ physicians to care for injuries. Later this work was extended to include physical examination of participants. In most institutions this service antedated student health services. In some colleges even now there is little relation between the work of athletic departments and student health services. An increasing number of student health services, however, are absorbing the functions of the team doctor.

"In the present study, physicians connected with the student health service conduct the physical inspection of athletes in two-thirds of 290 colleges reporting competitive athletics. Three-fourths of these colleges report that some care is provided for athletic injuries in the health service by health service physicians. Emergency treatment only is given in less than half the colleges reporting, continuation of medical care of injured students being undertaken by private physicians. One of the staff physicians in the health service is delegated to care for these injuries and calls in consultants when required. His salary is usually derived jointly from the health service and athletic department budgets, and he is usually employed as a full-time member of the health service staff.

"The cost of treatment or hospitalization for these injuries is borne by the department of athletics in 60 per cent, shared by the health service in 21 per cent, and is carried largely by the students in 19 per cent of the colleges reporting. In a number of colleges no distribution of such expense is made, and the cost of athletic injuries is therefore difficult to determine. It is interesting to note that several colleges take out accident insurance on athletes, and these schools find that the cost of care for athletic injuries is materially reduced under this plan. When the care of athletic injuries is included as a function of the student health service, the cost of injuries to the college is reduced and usually the injured student receives very satisfactory attention."*

From this survey it can readily be seen that the health service may play a major or minor role as regards athletic injuries. The feeling in the majority of colleges both as to the administrative and athletic staffs is that the proper place for treating injuries pertaining to athletics is in the health service. However, to maintain the confidence and cooperation of the athletic group it is necessary that the health service render as efficient service, or better if possible, than can be obtained elsewhere.

Friction between the health service groups and athletic people is not uncommon. The most common cause of this friction usually develops from what athletic people call "over-conservatism." When a coach has an injured player, he is naturally anxious to get him back into competition as soon as possible. The physician in charge of the case is naturally concerned in having the injury completely recovered before allowing further competition. The coach always has a tendency to feel that the physician is overly conservative. So friction results. It is evident that the individual treating athletic injuries should have the complete confidence of the athletic group. The best solution has been found in having someone treat the athletic cases who has had athletic experience and understands athletic injuries. When this cooperation exists, there is seldom any trouble between the health service and the athletic staff.

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*The Health of College Students: H. S. Diehl, M.D., and C. E. Shepard, M.D.; American Council of Education, 1939. Pp. 169.

As an example as to what may develop when this cooperation is lacking, the University of California at one time employed its own full-time doctor-nursing staff and established its own hospital ward in the gymnasium. We cannot without argument say that all athletic injuries should be treated in the health service unless the health service by its efficiency and cooperation can justify this statement.

Athletic injuries as such should be considered as injuries from whatever the source. There is one marked difference, however. An athlete wants to get well as soon as possible. Youth and splendid physical condition are in his favor. There are no compensation, lawsuits, or insurance companies involved. Therefore the days in the hospital and time of recuperation are usually much less than the same type of case seen by the average practitioner. For this reason experience in treating these cases is very necessary in order to evaluate properly the time element as regards recuperation.

Thorndyke, of Harvard, has tabulated the frequency of athletic injuries according to the sport involved--an injury is considered such when the athlete is compelled to miss at least one day of practice. Exposures are considered as one practice session.

| | No. Out | No.Exposures | No. Injuries | Avg. No. Exposures Before Injury |
|---|---|---|---|---|
| Football | 140 | 7,680 | 232 | 33.10 |
| Soccer | 50 | 2,400 | 55 | 43.63 |
| Hockey | 73 | 5,262 | 40 | 131.55 |
| Basketball | 48 | 4,320 | 5 | 864.00 |
| Wrestling | 50 | 4,500 | 2 | 2,255.00 |
| Boxing | 42 | 3,780 | 1 | 3,780.00 |
| Swimming | 64 | 5,760 | 0 | 5,760.00 |
| Track | 176 | 6,336 | 5 | 1,267.00 |

It is obvious that football as to injury hazard ranks first with soccer a close second, swimming being the least hazardous.

The most common athletic injuries are contusions due to direct trauma and injuries to joint areas. The joints most frequently involved are the knee, ankle, and shoulder; frequency occurring in this order.

Contusions may occur anywhere, but they occur most frequently on the thigh. These are commonly called a "Charley horse." They are due to a direct blow when the muscle is in contraction. The muscles involved are usually the rectus femoris or vastis lateralis or sartorius. In this condition there is always a separation of some of the muscle fibers with subsequent hemorrhage into the muscle sheath. This is followed by clotting and a hardened area is easily palpable.

Treatment: An ice pack is applied for one to two hours following injury, after which a pressure bandage is applied. After twenty-four hours the accepted treatment is application of heat. Early

massage is contraindicated as thrombosis or embolism might follow. If the clot does not absorb with the above treatment, surgery may be necessary with opening of the area and removal of clot. If this is not done, the clot may organize and result in a permanent hard mass in this region.

Myositis ossificans may be an accompanying complication. This is a condition in which bone develops in the muscle. This complication occurs when at the time of injury some of the periosteum is torn from the bone along with some of the bone-forming cells. These cells still maintain their blood supply and continue to lay down bone cells in the muscle. These are usually found when a contusion does not heal normally and an x-ray is taken, when these spicules of bone are found in the muscle.

The accepted treatment is rest, compression of the muscle against the bone by bandaging, and daily treatment with diathermy.

The most common shoulder injury is a separation at the acromio-clavicular joint. The distal end of the clavicle is forced upward, with the accompanying tearing of the acromio-clavicular ligament and coraco-clavicular ligament. This injury is usually the result of a fall on the elbow or extended arm, in attempting to break a fall. The accepted treatment is to place a felt pad over this joint and tape down tightly with two-inch tape, anchoring the tape first over the scapular area, bringing up over the shoulder and anchoring again on the chest. Considerable tension must be put on the tape to force the clavicle as near to its normal position as possible. In making this diagnosis an x-ray should be taken of both shoulders, as normally the distance between the acromium and clavicle varies in different individuals.

Dislocation of the shoulder joint is not common. When it does occur the head of the humerus is either pushed forward or downward below the glenoid fossa. The difficulty arises in that when a shoulder is once dislocated, it is apt to recur. The recurrence nearly always happens when the involved arm is raised over the head. For this reason an orthopedic appliance is often used to prevent the arm from being raised too high. For surgical repair, one of the most satisfactory operations devised is known as the Nicola operation. In this operation the long head of the biceps tendon is separated in the bicipital groove. A hole drilled through the head of the humerus and the cut tendon passed through this hole, reattaching it again in the groove. Our experience with this operation is confined to one case, as far as football is concerned. However, in this case the operation was entirely successful, and the athlete is playing football at the present time without any protection from an orthopedic appliance.

The ankle and knee, due to the fact that they are weight-bearing joints, are extremely important in athletics. Dr. Evans will discuss the knee, so I shall leave that subject to him.

The ankle has ceased to be the problem that it once was in athletics. This is owing to the fact that we have learned to tape it more effectively. The increase in quality and decrease in price of tape has also been a factor. It has become routine procedure to tape the ankles of all members of the squad for each practice session and for each game. I have never seen a severely sprained ankle when this precaution was used and the tape properly applied.

Every sprained ankle should be x-rayed. This is necessary in order to determine the extent of bone injury, if any, that is present. A fracture of the lower third of the fibula occurs quite frequently to complicate an ankle sprain. There is nothing more embarrassing to one treating a sprained ankle by routine methods than to discover, two to three weeks after injury, when the ankle does not respond as it should, that there is a fracture also of the fibula. The tip of the malleolus may be torn off at the ligament attachment in a severely sprained ankle. This is treated as a sprain, but one more severe in nature,

usually doubling the time necessary for complete recovery. The severity of an ankle sprain is difficult to determine when it first occurs, and judgment as to severity should be withheld until an x-ray has been taken and observation has been made for twenty-four hours after injury to determine how much swelling has taken place.

Treatment is a good deal similar to that for severe contusions: ice-packs for one to two hours immediately following injury, and then heat after twenty-four hours. The treatment with immediate ice-packs causes a vaso-constriction and decreased hemorrhage. The heat causes a vaso-dilation and has a value in hastening the removal of blood in the tissues after hemorrhage has stopped.

The injury to teeth occurs entirely too frequently in athletics. Usually it happens in one of two ways. First, when the jaws are closed the athlete may receive a blow on the chin, with the result that some of the enamel may be chipped off the teeth. Second, there may be a direct blow on the teeth, particularly those in the front of the mouth. This usually results in one or two teeth being broken completely off. The old type of tooth protection used by boxers has not proved satisfactory. In the first place, it is too bulky and necessitates that the athlete keep the protection in place by biting down on the mouthpiece. In athletics the athlete breathes largely through his mouth, and for that reason he keeps his mouth open and the mouthpiece will not remain in place. At the present time we are experimenting with some new plastic material and attempting to make a protective covering that will fit directly over the teeth, an individual set for both the upper and lower teeth. We are attempting to make them thin and light enough and also of such fit that they will remain firmly attached to the teeth when the mouth is opened. If we are successful in this one of the very prominent hazards of football can be decreased, if not entirely eliminated.

Tooth repair is one of the very definite items of expense as regards the athletic budget. We try to hold this expense down to actual damage done. The case in question is always seen by the dentist and Health Service physician together and an estimate made as to the work to be done and its cost. We have found that if this is not done the athlete attempts to get all his dental work taken care of at the expense of the Athletic Department.

Many athletes come to us from high schools throughout the state with chronic disabilities as a result of no treatment or improper treatment that the athletes received at the time of the original injury. For this reason the University Athletic Department has felt for some time that an educational campaign of some type carried on throughout the state would be helpful.

Realizing that cases treated in rural high schools are usually handled by individuals with limited training in this field, we are attempting to help this condition in the following way. First, at the time of the meeting of the Minnesota State Medical Association we are planning on having a booth demonstrating protective appliances, taping on models and a 16 mm. movie in operation demonstrating proper taping technique and treatment of injuries. Second, we plan to send each high school in the state a letter telling them we have such a film at the University that they can secure free for a local showing in their community to those whose duty it is to prevent and care for these injuries. From my contact with state high school people I feel that there will be a demand for such a film, and that it is probable a great deal of benefit may result to both the athletic programs of the high schools throughout the state and also to the athletic program at the University.

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## V. INTERNAL DERANGEMENT OF THE KNEE IN THE ATHLETE

Edward T. Evans

There are, of course, many injuries sustained in modern athletic competition. Most of these are minor and usually result from a lack of thorough conditioning or hardening or in many institutions, reflect a lack of proper protection. Apropos of this group I might state that I have been somewhat worried regarding the large number of trivial hand and foot injuries we have here in our unorganized touchball, so frequently played by fraternity and ball groups.

The other more serious injuries, such as fractures and dislocations, are readily recognized and receive early and adequate treatment as a rule.

There are, however, injuries of the knee which seem almost unavoidable and which may easily occur despite all training and protection.

It is a common saying in the British Isles that no man is a professional soccer player until he has had one or both of his knees operated upon for cartilage injuries. Mr. McMurray, Sir Robert Jones' associate in Liverpool, was in 1927 when I was with him, in his 1500th series of cartilage operations, many as consultant to the professional soccer teams.

Our conditioned football player is not so likely to get knee injuries, yet notwithstanding, we usually have from four to ten football or basketball squad members each year. Knee injuries of this type fall into four groups or may be combined:

1. Simple sprains with effusion (water on the knee).
2. Torn lateral ligaments.
3. Torn crucial ligaments.
4. Torn semilunar cartilages (usually the internal in 8:1 proportion).
5. Recurrent disability from an old injury.

There are, of course, other injuries such as fractures, loose bodies, etc. which I will not consider here. My plea is that these injuries be recognized and treated, and my hope is that I may dispell a bugaboo regarding knee surgery so that these boys may be rehabilitated to full activity.

In strenuous sport, the chances are 100 to 1 that a rapidly developing effusion post trauma is blood. Put this boy to bed immediately with ice packs (not heat) and after 24 hours when the bleeding has certainly stopped, aspirate the knee joint of all blood and apply a compression dressing. Recovery time is 5 to 10 days when aspirated as against 5 to 10 weeks without aspiration, with less likelihood of complicating recurrences. Several years ago we ran alternating cases at the University which warrant this conclusion.

Torn lateral ligaments are not uncommon. The injury is usually serious enough to warrant immediate treatment. They are always associated with effusion and initial treatment should be as in simple effusion followed by careful examination at the time of aspiration and fixation plaster for a period of time sufficient to allow beginning repair of the torn ligament and then rehabilitation of the joint.

Ligament tears are often associated with semilunar cartilage injuries. Torn crucial ligaments occur in more serious dislocations and fractures though they may be masked in an apparently less serious injury. We find them in about 42% of our football cartilage cases as an incidental result.

Stability of the knee in crucial ligament tears is usually not seriously impaired if the supporting lateral ligaments are intact or have fully recovered and if there is sufficient rehabilitation postoperatively.

The most common and most troublesome, if not most disabling, lesion is the torn semilunar cartilage. Unless recognized and properly treated it is

productive of intermittent locking, "catching," knee throwing, recurrent effusion and often late and serious joint changes due to mechanical irritation.

It is most important to recognize the initial "locking" or lack of full extension or painful weight bearing in extension or lack of other ranges of motion before effusion occurs. I wish I could impress every coach, team physician, trainer or handler in the country with the importance of this point. "A history of initial locking means mechanical derangement within the joint, which in the absence of a loose body or fracture, almost certainly means a torn cartilage." The locking may be only very temporary or may last hours or days.

Treatment is immediate bed rest, cold packs, and after 24 hours aspiration of the joint of its bloody contents. If locking is present or persistent, traction should be applied and morphine given for complete relaxation. I believe manipulation to "unlock" is dangerous and even though successful does not solve our problem. Traction is safer and manipulation is to be tried only if circumstances preclude more logical treatment at the time, as, for example, the necessity of returning a boy to school or postponing operation.

If the knee "unlocks" under the above regime, the condition is treated as a simple effusion, with a positive diagnosis tagged to the patient.

His days of dependable participation in competitive sports are over, however, unless the torn cartilage is surgically removed. The cartilage will not heal and remains a potential source of danger to him.

All our cases are offered and advised surgery. If a boy elects to leave active athletics we can temporize if locking is not persistent or frequent. But if competitive athletics are to be continued the operation is imperative.

There is, of course, a risk in any surgery. There is also a grave risk of further trauma to the knee and late changes if surgery is not done.

We will, over a period of years, presumably have an unfortunate case. To date every case has returned to active sports and under a careful rehabilitation regime, we have had no residual disabilities.

Average hospital stay is 10 - 14 days. Quadriceps exercises are begun immediately. Patient is allowed up without crutches in one week. On discharge from the hospital the case reports to training quarters for daily heat and muscle massage. Stationary bicycle riding is begun at 3 weeks and gradual increase in mileage strengthens the thigh muscles and gives increased stability of the knee capsule. Jogging or dog trotting is carried out for 3 months before allowing pivots, sudden stops and starts and normal athletic participation. Swimming is encouraged as a safe and excellent exercise.

We prefer to operate in Christmas vacation so as to return our boys to moderate activity in Spring practice. Given three months, however, we feel we can satisfactorily rehabilitate our case, but I believe our results reflect the cooperation of all.

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## VI. TAPING

Lloyd Stein

One of the biggest tasks in athletics today is the problem of keeping athletic injuries at a minimum. In guarding against injuries, we must depend a great deal on adhesive tape strappings or "taping" as it is more frequently called. Regardless of the sport, there is always a need for taping. Adhesive strapping is used for prevention of injuries, support, fixation, and compression. Once a player has had a sprain or strain, it is necessary to give him some sort of support by applying an adhesive strapping to the injured part. This applies not only to new injuries but also to old ones. Taping of old injuries or taping as a preventive measure gives the athlete mental as well as physical support. An athlete with a psychological fear of a weakened joint is given, in the majority of cases, a mental strengthening of the joint so that he may continue his athletic competition.

In a good percentage of cases, the question of an athlete's being able to play lies in the application of adhesive strapping. We must try to prevent new injuries and guard against old ones.

Every doctor, trainer and coach has a favorite or pet way of taping. The following methods of taping are described to you possibly not as the best methods of taping, but simply the types used at the University of Minnesota training room. It has been said that we use an amazing amount of tape, but in my mind it has been justified by reducing considerably the number of injuries to our athletes. Our first aim is to prevent injuries and secondly we try to heal them as quickly as possible.

In taping an injury, one must ask the following questions:

1. What am I trying to prevent?
2. What was the position of the part when it was injured?
3. Can I tape it to prevent it from reaching that position?

In other words, in taping you try to prevent the strain that caused the injury.

Before describing the methods used, there are a few fundamental rules to taping that we adhere to.

1. We always shave the hair from the part to be taped. Short hair actually helps the tape to stick, but long hair must be removed.

2. After shaving the part to be taped, it is painted with tincture of benzoin. The alcohol in the tincture evaporates and leaves a benzoin coating on the skin which not only acts as an antiseptic and protects the skin but also helps make the tape stick.

3. We strive for cleanliness and neatness in our taping, knowing that a bandage put on haphazardly or "any old way" is useless and that wrinkles in the tape or skin that is folded or creased underneath the tape causes blisters to form.

4. The manner of removal of adhesive tape from the skin is important. The best method is to free the ends and draw it back upon itself gently pressing the skin down away from the adhesive surface. Always pull the tape downward or parallel to the skin, never upward, as you may pull pieces of skin off with the tape.

### Figure of 8 Ankle Wrap

Because of the expense of adhesive strappings, many schools use some sort of cloth ankle roller bandage to support the ankles. Muslin, gauze, canvass, or special webbing rollers are favored. The length of the bandage varies naturally with the size of the ankle, from 70 inches up.

Have the foot at right angles to the leg. Start on the ridge of the foot arch, carrying the wrap along the inside of the foot, under the arch, up on the outside of the foot, crossing diagonally toward

the leg, just above the ankle joint. Circle around the leg once and start backwards over the same route you have covered, overlapping the first layer about a quarter of an inch. Continue this "figure of eight," looping until you have attained the desired strength of support.
Caution:--Be sure the bandage is not too tight so that it shuts off the blood circulation.

Double Figure of Eight

The "double figure of eight" ankle wrap is said to give as much support as actually taping the ankle. It can be put on the ankle directly or over the sock. This wrap is used as a preventative wrap and also for an injured ankle. The effectiveness of the wrap is based on the idea of immobilizing the calcaneus which makes it difficult to turn the ankle.

With foot at right angles to the leg, start your wrap on the top of the arch, then around underneath the arch and then up with pressure diagonally across the foot, around, and across the ankle bone on the inside, then downward across the heel high, down to the edge of the heel, below the heel, then diagonally across the bottom of the foot, up over the arch, and diagonally across the foot again, and over the outside ankle bone down diagonally across the heel again, down diagonally across the foot and finish up with a figure of eight around the ankle. The number of times you duplicate this wrap depends upon how strong you wish the wrap.

Double Football Strapping

Foot at right angles again, using two-inch tape, start on inside of arch, down under the foot at such an angle that you will come up on the outside parallel to the tendon of Achilles and over the fibula, ending about four inches above the external malleolus. Another strip the same as the first slightly overlapping should be applied. The third and fourth strips of tape are exactly the reverse of the first two, started on the outside and under the arch, up to about four inches above the internal malleolus. The support is fixed with circular layers of tape, one just above the ankle joint and the other where the longitudinal layers end.

Gibney or Basket Weave

This is supposed to be the best ankle support devised. The narrow strips of tape (1 inch) can be made to fit every nook, hollow, and crevice of the joint, forming a staunch corset.

With the foot at right angles, possibly everted and flexed slightly, start the first strip of adhesive on the inside of the leg about four inches above the malleolus. Run the strip parallel and close to the tendon of Achilles, under the heel, and up the outer surface of the leg. Pull the tape snug and fasten opposite the starting point. Press the tape down to make it adhere firmly. This completes the first perpendicular layer.

Now the first horizontal -- start at the base of the big toe, run the tape along the lower border of the foot, around the back of the heel, then along the outside border of the foot, ending at the base of the little toe.

Repeat the alternations of the perpendicular and horizontal strips, overlapping each succeeding layer about one-quarter inch. Use four perpendicular strips and enough horizontal strips to go up above the ankle itself. The horizontal layers should not meet in the front -- there should be about a three-quarter inch open in the front. This allows for ankle swelling.

Diamond Knee Strapping

With the patient standing with the knee slightly flexed, using two-inch tape, start at the calf of the leg on the inside, over the inside of the knee joint just missing the knee cap, continuing

diagonally across the leg to the outside of the thigh about eight inches above the knee. Your next strip starts on the outside of the leg at the calf muscle and goes diagonally across the tibia and just below the patella, ending on the inside of the thigh. The third strip is the same as the second but to the outside of the patella, and the fourth is the same as the first except to the outside of the patella. Using about three strips each way (12 in all), overlap each about one-half inch on each succeeding strip. When finished, the tape leaves a diamond shaped opening through which the patella protrudes -- hence the name "diamond knee bandage." This taping gives support to the lateral ligaments of the knee and does not prevent flexion and extension of the knee joint.

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VII. GOSSIP

The following letter has been received from Jack Sagel, '27, radiologist in Gary, Indiana: "Minnesota scores again! This time it was medicine instead of football, but the effect on the spectators was the same. The occasion was the monthly meeting of the Chicago Roentgen Society at which Drs. Paine and Rigler talked on the well-known Minnesota special 'Intestinal Obstruction" (pardon me, 'Stasis," since John Paine says: 'roentgenologists can go only that far in diagnosis'). The formal talks went over well but the clinic really knocked 'em dead. I heard many very favorable comments on it. It did much to establish here the high standard of medical practice at the University Hospitals. Everything is rolling along here in good shape. Regards to all the boys."....This is Cancer Control Month. The Women's Field Army of the Minnesota Society for the Control of Cancer is collecting memberships at $1.00 apiece. The money will be used to further the educational program. With the large increase in the age groups where cancer is prevalent, there is more need for adult education along these lines. The Cancer Society now has headquarters in the Lowry Medical Arts Building, St. Paul, and appears to be a "going" organization. Special attention will be given to cancer of the uterus in Minnesota during the coming year. Speaking of cancer, a three-volume set on the "Treatment of Cancer and Allied Diseases" by George T. Pack, and Edward M. Livingston has 147 author contributors. There are sectional editorials by the editors. The reviewers are giving this series very favorable comments....A letter in the mail this week from Robert E. McDonald, '26, Milwaukee, states that he and his wife have just returned from a three-weeks' trip to Florida and Cuba. He recommends the Clipper trip to Cuba....At the course in Roentgenologic Diagnosis of the Chest, to be given at the Center for Continuation Study, May 22, 23, and 24, the guest faculty members will be Leroy Sante, St. Louis, and Felix Fleischner of Boston. Registration will be limited to physicians with special training in radiology...A recent report on what children think of their parents indicates that in only a small percentage of homes did the father and mother share the responsibility for discipline and management. In a larger number of homes, the mother was solely responsible, and in a smaller number the father ran the show. Over half the youngsters reporting from homes where the mother was in charge wished the father also had something to say. There was no suggestion for change in the other homes....The Medical Six O' Clock dinner will be Wednesday, April 23. Dr. John L. McKelvey will be toastmaster. The program includes brief remarks by Drs. Barron, Rea, Platou, Schiele, and Bell. Everyone is invited to attend. A good time is guaranteed....There was a meeting at Litchfield last evening to discuss the tuberculosis roundup. According to plans, every man, woman, and child in Meeker County will be given an opportunity to secure a tuberculin test. This will be followed by x-ray examination of the chest of positives. The project is being developed by the Minnesota State Medical Association with assistance of several organizations including welfare units and insurance companies. This plan of case finding is being started in Meeker County as this county was the first to conduct an eradication program in cattle....Did you know that the Minnesota Department of Health has a Division of Industrial Hygiene in charge of Leslie W. Foker, '34? Dr. Foker was an engineer before he went into medicine. Had his graduate training at Harvard and has already developed quite a program for Minnesota. Minnesota ranks twenty-second among the states with 992,847 gainful workers, 210,299 of which are employed in manufacturing, mechanical and mineral industries. The number of special industrial workers in Minnesota is only 32,000 less than the state in the 15th place. Most of the demands made upon the department have had to do with problems related to occupational diseases (environmental conditions). A survey of the state's industry has been completed and some very interesting facts have been revealed. Dr. Carl Peterson, Secretary of the Council on Industrial Health of the American Medical Association, is also a Minnesota graduate, class of '27. A three-day course for all those interested in industrial health (medicine, surgery, employee welfare) will be given at the Center for Continuation Study, Aug. 4, 5, and 6, 1941.....