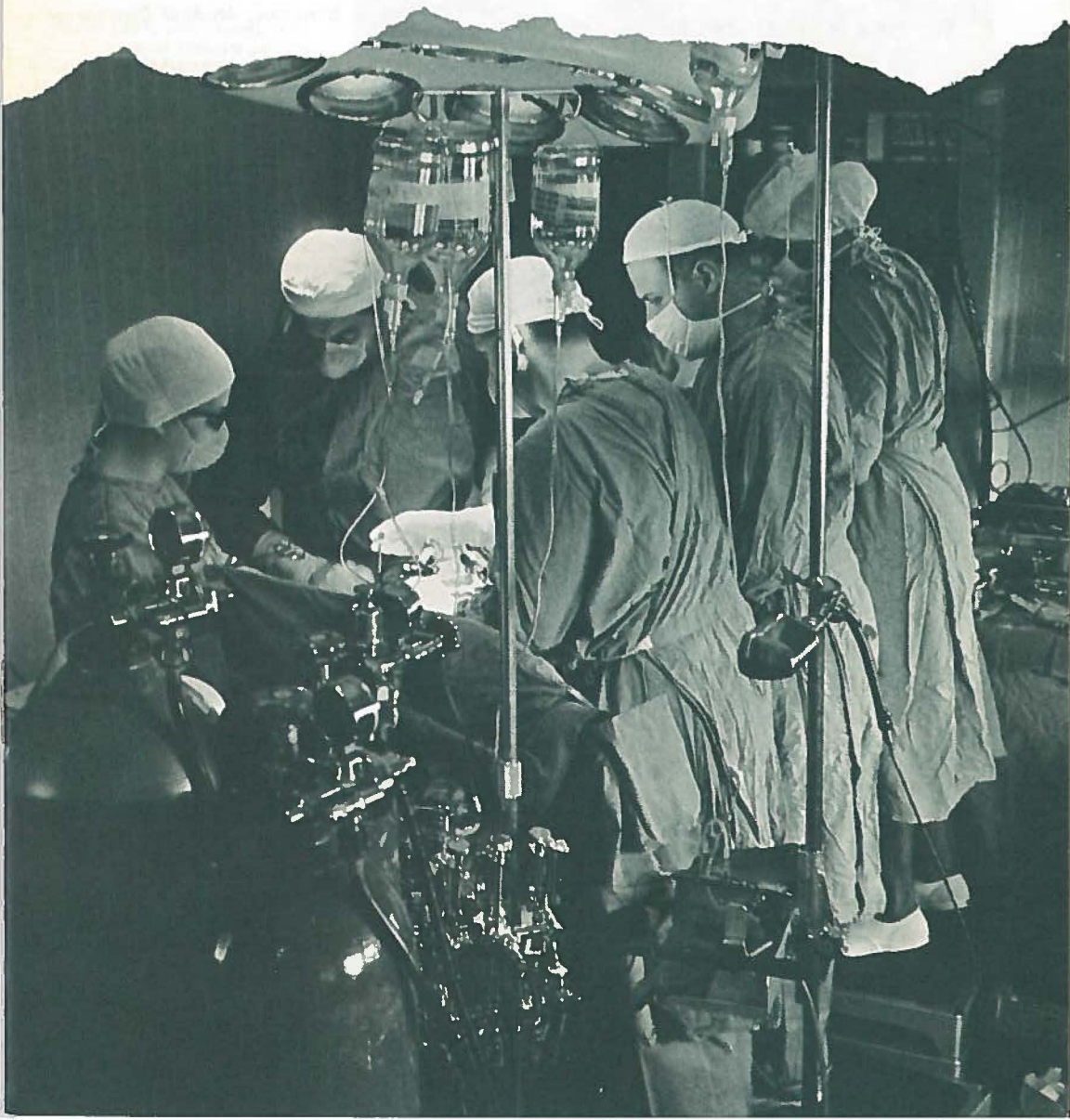


FALL 1965

# *The* **Courier** *reprints*

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL





# The Courier reprints

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SINCE 1948, when The George Washington University Hospital moved to Washington Circle, its Women's Board has told the story of the Hospital through a little magazine called THE COURIER. First it seemed important to let the community know of new and urgently needed facilities the new building on the Circle had brought to the Nation's Capital. As the Hospital and the magazine developed, it was found that readers looked forward to knowing about developments at the Hospital and keeping abreast of important findings and services of the George Washington medical staff and medical alumni. With this issue, the Women's Board inaugurates a new approach to telling the George Washington medical story, that of publishing reprints selected from many newspapers, magazines, and journals, which tell about George Washington's contributions to better health through care and study. ■

FROM LEFT, Mrs. Mason, Mrs. Carroll, Medical Director of the Hospital Clayton B. Ethridge, and Mr. Ludewig. (Reni photo for the University.)



The Washington Post and Times Herald, May 12, 1965

### Women's Board Gives Cardioverter

THE GEORGE Washington University Women's Board has presented a Lown's cardioverter-defibrillator to the Hospital as a memorial to the university's last President, Dr. Thomas Henry Carroll.

Mrs. Martin Alexander Mason, president of the Women's Board, made the presentation to Victor F. Ludewig, administrator of the Hospital. Dr. Carroll's widow was a guest at the ceremonies.

Dr. Irene Hsu, associate professor of medicine, explained that the small machine provides electrical impulse to the heart which helps restore the heart's normal rhythm in the case of certain cardiac emergencies. ■

Patients allergic to bee sting usually receive their maintenance "desensitizing" injections at monthly intervals. Some of these patients discontinue treatment too soon because of the inconvenience of reporting so often to the doctor's office.

Science News Letter, July 26, 1965

### Bee Sting Shots Given Less Often

Allergic persons who lose consciousness or go into convulsions when they are stung by a bee, wasp, yellow jacket or hornet can be cheered by a report that they may be able to take "hyposensitizing" injections at longer intervals.

Dr. Halla Brown of the George Washington University School of Medicine in Washington, D.C., reporting in Medical Annals of the District of Columbia 34:315, 1965 has found that gradually increased doses of insect extract needed can lead to taking shots every four months instead of every three or four weeks.

Twenty patients tolerated gradually increased doses of insect extract until three of them could take 5,000 protein-nitrogen units (PNU) at intervals of 16 weeks. Seven of the group tolerated this dosage at intervals of 14 weeks and 10 at 10-week intervals.

"Most patients reached the 12- to 16-week interval by the third year," Dr. Brown said.

Whether these patients are protected can be determined only by a sting, preferably in the latter part of the interval between injections. ■



## our man in Atlanta



A GLOBAL MAP covering an entire wall of his office symbolizes the medical world of Dr. James L. Goddard, chief of the U.S. Public Health Service's Communicable Disease Center in Atlanta, Georgia.

"Diseases know no boundaries; modern commerce and international travel make epidemics and infectious disease trends anywhere on the globe important to the people of the United States," Dr. Goddard told a visitor recently.

As chief of CDC, Dr. Goddard is a youthful medical man-about-the-nation and the world who heads a team of several hundred physicians and scientists responsible for assisting states with control of communicable diseases.

The energetic Dr. Goddard and the bustling Communicable Disease Center have been a good match for each other since he became its youngest chief in September 1962 at the age of 39, only 12 years after graduation from GWU Medical School.

CDC, with a staff that includes some of the nation's foremost authorities on a number of infectious diseases, moves along at a rapid pace in its programs of assistance to states. Its work includes applied research, laboratory services, in-service training to thousands of public health workers, production of audio-visuals, technical assistance and consultation to health departments, community-wide demonstration projects and epidemic aid. It began in 1942, as a wartime malaria control and training center.

Dr. Goddard directs CDC's work with zest and enthusiasm. While he relies strongly on the judgment of competent program chiefs, his desire to know gives him a remarkable mastery of detail that in turn enhances his mastery over the broader goals of the Communicable Disease Center.

Soon after becoming chief, he visited all the CDC field stations personally. In this extraordinary move he inspected the sites of schistosomiasis studies in Puerto Rico; technical development laboratories on sub-tropical Oat-

land Island near Savannah, Georgia; dysentery studies in Phoenix; histoplasmosis studies in Kansas City; encephalitis studies in Greeley, Colorado, and plague studies at San Francisco. In addition to solidifying his own understanding of programs, these visits gave a lift to the morale of field station employees.

His insistence on knowing has taken him into all corners of the vast CDC headquarters, where he is on easy speaking terms with technicians as well as supervisors. Laboratory apparatus and electronic equipment fascinate him. He is currently working with a CDC engineer on an electronic lock for use in security buildings.

Dr. Goddard talks with familiarity of such varied equipment as a microbiotank (a chrome-lined upright tank that can contain a human for measurement of viable particles shed per minute), a gas chromatograph and CDC's television videotape recording equipment.

In fact, his familiarity with the videotape equipment is part of a strong personal conviction that medical communication must be revolutionized to bridge the widening gap between discovery and application of scientific knowledge. "At CDC we are giving full support to the Public Health Service's effort to improve medical communications," he told a group of trainees recently. "We are working in three important areas: scientist to scientist, scientist to practitioner, and scientist to general public."

In scientist-to-scientist exchange of knowledge, CDC researchers rely chiefly on publishing their findings in professional journals. Scientist-to-practitioner communication is carried out through training programs, publications, consultation and through production of films and other audiovisuals. CDC communicates scientific knowledge to the general public directly through news channels, magazine articles, radio and television programs and films.

An idea sparked by Dean John Parks has

developed into a form of communication that is receiving considerable emphasis at CDC. This is the "single concept" 8mm training film suggested to Dr. Goddard by Dr. Parks, with about five to 10 minutes of instruction on one particular subject. (This project was discussed in the last issue of *GW Medicine*.) CDC has produced about 20 single concept films on subjects that include microtiter serological techniques and testing foods for botulism toxin. The films are shipped in a continuous film cartridge for use in a special desk-top projector.

Dr. Goddard's insistence on knowing, combined with a remarkable capacity for absorbing information during briefing sessions, has made him an impressive and persuasive spokesman for CDC. This is particularly evident in the hearings each February and March before House and Senate subcommittees on appropriations. In these hearings, Dr. Goddard reads a prepared statement on happenings at CDC and on plans for the coming fiscal year. Then he answers a round of very penetrating questions from committee members.

Whatever the questions, he answers them readily, citing facts and figures with convincing directness. During questioning on the 1964 budget by Congressman John E. Fogarty (D-R.I.), chairman of the House subcommittee, Dr. Goddard successfully cleared a gamut of questions on salmonella, air filtration, vaccination programs, eradication of *Aedes aegypti* mosquitoes, rabies, encephalitis, influenza vaccine, polio vaccination, standardization of reagents in laboratories and a number of others. He discussed details of bat rabies in Frio Cave, Texas, motivation of people to take vaccine and resistance of organisms to antibiotics.

There is no "typical day" in Dr. Goddard's office. Since CDC is a Division of the Public Health Service, as chief he is required to make frequent trips to Washington. These trips average about one per week. He is also in demand as a speaker, and he serves on a number of national advisory boards.



This past March he lectured at the University of Michigan School of Public Health, attended a NASA Advisory Board meeting, served on a panel in a two-day CDC-AMA meeting in Atlanta on *Aedes aegypti* eradication, testified before a Congressional budget subcommittee, testified before the New York State Senate on the importance of measles vaccine, attended a critical vaccination assistance project conference in Los Angeles, visited the Pediatric Research Department of the Lovelace Foundation in Albuquerque and lectured to medical students at Emory University in Atlanta.

The geographic coverage of surveillance and investigations at CDC is world-wide. Influenza in England, cholera in India or leprosy in the Philippines—all of these are only hours away from American ports of entry. In a typical year recently, epidemic aid was extended to 17 countries. In addition, CDC staff members traveled to 15 foreign nations to meet, consult, or observe. Since 1946, foreign trainees at CDC have totaled 2,685 from over 100 nations, CDC cooperates in international health activities with the Agency for International Development, the Peace Corps, the World Health Organization and foreign ministries of health.

In promotion of international health activities, Dr. Goddard traveled around the world last year. In Geneva he held discussions with the WHO director of communicable disease control. In India he checked on progress of the National Institute of Communicable Diseases which is being patterned after CDC.

Dr. Goddard is the eighth chief CDC has had since the malaria control days of 1942. As a Public Health Service commissioned officer, he holds the rank of Assistant Surgeon General (equivalent to Rear Admiral in the U.S. Navy).

Since his graduation from the GWU Medical School, he has served in a number of responsible positions in public health. After internship at the U.S. Public Health Service

Marine Hospital in Cleveland, he was in private practice in Kalida, Ohio, until 1951. During the next two years he was Medical Officer in Charge at the Federal Employees Health Service, Denver, where he was responsible for providing on-the-job medical care to 6,000 federal employees.

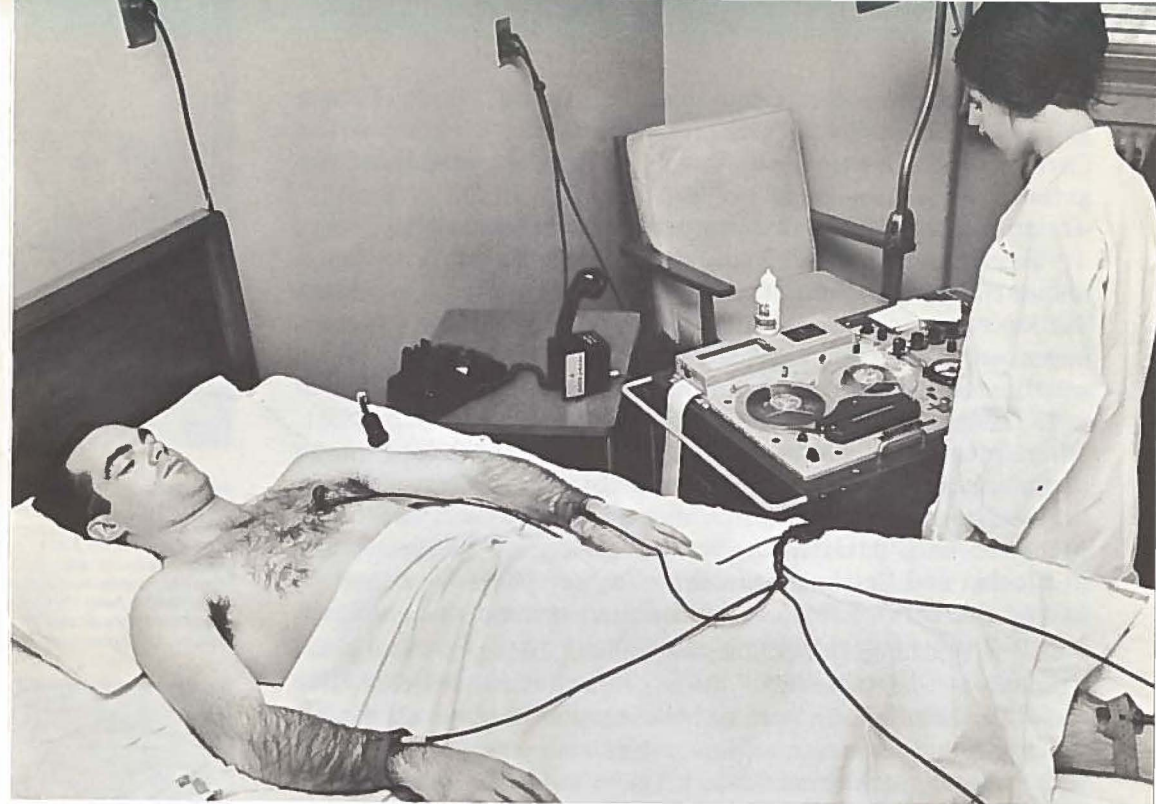
Then followed a year and a half of training in local public health administration in North Carolina. After a year at Harvard University School of Public Health, where he received a Master of Public Health degree in 1955, Dr. Goddard was assigned to the New York State Department of Health where he developed a Driver Research and Testing Center.

From 1956 to 1959, as chief of the Public Health Service Accident Prevention Program, he was responsible for developing and administering a program for reducing deaths, injuries and disabilities from all types of accidents.

The Federal Aviation Agency then borrowed Dr. Goddard for four years. As the nation's first civil air surgeon, he organized the expanded medical program of the FAA, and headed a program for the medical examination and licensure of the nation's 250,000 civil pilots. He operated the Civil Aero-Medical Research Institute at Oklahoma City, an organization involved in the human factors and medical aspects of civil aviation. He directed the organization of the FAA program of medical investigation of all fatal accidents in air carriers. The FAA awarded him its Distinguished Service Award in 1962.

Dr. Goddard holds a hot air balloon pilot's license. While with the FAA he discovered that no qualifications were required for such a license, so he applied for and received a license. This loophole in qualifications was closed soon after.

Dr. Goddard is an avid bridge player, a hobbyist in electronics, an amateur actor, a camping enthusiast and a companionable father of three teen-agers. But most of all, Dr. Goddard is a man of action, and there certainly is action at CDC. ■



ECG RECORDED on magnetic tape at George Washington University is converted to high-frequency signal for transmission.

## Computers aid ECG diagnosis

USE OF COMPUTERS in cardiac diagnosis—only yesterday the private dream of electronics experts—has suddenly entered the realm of clinical reality. There are strong indications that the massive data-processing facilities already functioning in several areas of medicine will soon be brought to the service of America's leading medical problem.

The feasibility of this development already has received limited but impressive support from a clinical pilot project conducted by George Washington University Hospital and the U.S. Public Health Service Heart Disease Control Program in Washington, D.C. At this writing, 600 ECGs are being transmitted monthly from the hospital's Heart Station to a nearby computer center, converted from analogue into digital values, electronically scanned, correlated and printed out in a matter

Roche Medical  
Image Photos—  
Bernard Cole

Roche  
Medical Image,  
June 1965



of minutes to be entered daily on the patients' charts. Future plans, IMAGE was told by Dr. John M. Evans, Director of the Cardiovascular Section, call for expanding the use of this fully automated system—capable of processing 3000 ECGs monthly—to analyze the ECGs of every patient in the hospital.

"The time- and labor-saving advantages of such a system," to quote Dr. Juan B. Calatayud, cardiologist heading the Heart Station team, "are inescapable. Consider that it takes our computer less than four minutes to 'study,' integrate and produce a printed analysis of all data in a standard 12-lead ECG."

To these gains in time and labor, Dr. Calatayud points out, "there must be added the inestimable advantage of long-range diagnostic services. Our computer center on the George Washington University campus has already received and effectively processed ECG data transmitted telephonically from hospitals in Florida and California. In three to four years we expect to extend this service to 25 or 30 hospitals around the country."

It won't be long, Dr. Calatayud predicts, before private practitioners will begin to enjoy the benefits of expanded computer facilities. Rural physicians, he believes, will be able to transmit their ECGs to leading medical centers and receive evaluations within hours, perhaps minutes.

Although many problems must still be overcome before computer technology can be broadly applied to the field of electrocardiography, five years of intensive research and experience in the computer analysis of 30,000 ECGs have convinced the members of the GWUH team that the major difficulties can be solved. They believe, moreover, that for routine ECG analysis, computers already have demonstrated a qualitative advantage in consistency of results and freedom from observer error. "By virtue of its unchanging program logic, the computer will always make the same analysis of the same kind of ECG, whereas two physicians reading the same tracing will often differ on minor points of interpretation," they say.

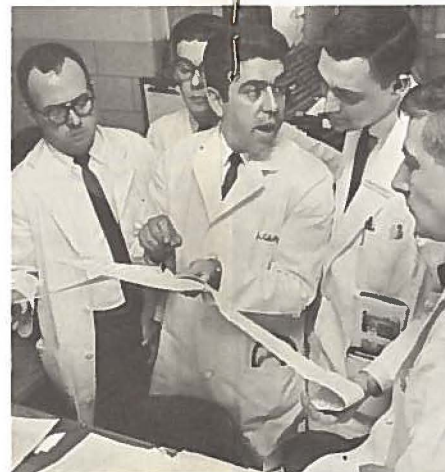
This statement is supported by some convincing statistics: in a series of 3648 measurements of wave amplitude and duration, the machine showed a diagnostic consistency of 97.3 per cent. The types of ECGs evaluated included left ventricular hypertrophy, myocardial infarction, left axis deviation, intraventricular conduction defect, left ventricular ischemia, atrial abnormality, digitalis effect and first degree A-V block. As against this figure, 500 ECGs independently evaluated by two groups of GWUH physicians revealed full agreement in only 60 per cent of the diagnoses. The results were analyzed for observer variation in PR, QRS and QT determinations. Two-thirds of the disagreements, it was found, were in the measurement and interpretation of QRS abnormalities, including those



AT COMPUTER CENTER automatic receiving device accepts ECG signal and turns on analogue-to-digital converter (above), which feeds 500 numerical values a second into the digital computer. Results are automatically printed out on electric typewriter (below) in less than four minutes. Wave amplitudes are indicated in millivolts and durations in seconds; borderline or abnormal values are shown by asterisks.



ECG TRACINGS are analyzed and correlated with computer measurements to aid diagnosis by Heart Station team, led by Dr. Juan B. Calatayud (center, below).



caused by myocardial infarction, conduction defects and ventricular hypertrophy, and ST-T wave abnormalities, including digitalis effect.

One of the root causes of divergent readings by physicians is lack of unanimity in base line estimates of the normal, contends Dr. C. A. Caceres, chief of the U.S. Public Health Service instrumentation group that designed the computer's complex operation program. Disputes over ECG diagnosis of myocardial infarction may, for example, result from different estimates of the duration of a Q wave, different criteria of diagnosis or both.

The ability of the computer center to rapidly process large numbers of ECGs with undeviating consistency rests on the conversion of electrocardiographic signals into a series of numbers—each representing a time-specific wave measurement—that comprise the raw diagnostic material digested by the computer. The ECG signal, recorded on magnetic tape and telephonically transmitted from the hospital, is measured 500 times a second by an analogue-to-digital converter, so that 500 numerical values enter the digital computer each second.

Consistency, of course, does not imply infallibility. An improperly programmed computer will be consistently wrong. Dr. Caceres cites a number of errors in the electronic readings, all of which resulted from incorrect programming or from difficulties in applying the digital approach to certain aspects of wave measurement. Wrong determinations of wave duration, he points out—important in the diagnosis of conditions such as enlarged atrium and the Wolff-Parkinson-White syndrome—have occurred "because using general mathematical expressions to identify duration points, particularly in gradually rising waves, is much more difficult than measuring amplitude, which is the difference between an easily identified peak and base line."

Even with careful programming, the GWUH unit has been able to detect only 60 per cent of the arrhythmias. The problem in tracings of this type derives from the predigital stage of data processing, when ECG signals are converted from electrical to analogue measurements. Since the analogue unit analyzes wave forms, it must be programmed so that the first small positive deflection is read as a P wave, the next larger deflection as a QRS, and the next smaller deflection as a T wave. Thus, programming becomes extremely difficult in cases where this classic sequence of small-larger-smaller positive deflections may not obtain, as in hyperkalemia (where the T wave may be larger than the QRS), in hypocalcemia (where U waves may appear) or in the arrhythmias.

Although the GWUH team is confident these barriers can soon be surmounted by programming changes, many cardiologists are less sanguine. "To program a computer to recognize ar-

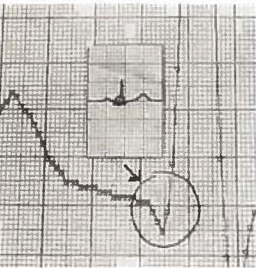


rhythmias," says Dr. Harold D. Levine, director of the Electrocardiographic Laboratory, Peter Bent Brigham Hospital, Boston, "it will be necessary to measure the auricular and the ventricular rate and see whether there's one relationship or not, or whether there's two for one. We will also have to determine whether auricular activity can be identified at all and, if it can be, whether there is a smooth consistent undulation of the base line, or is this merely an erratic sort of thing?"

Other problems of computer-ECG analysis continue to challenge the experts. "It is not at all certain the machine can be programed to pay attention to minor degrees in shift occurring from day to day that may be very significant," asserts Dr. Levine. "If there is a slight elevation of the RS-T segment, for example, the physician will usually pay more attention to it if the patient is having pain and less attention if there is no pain involved. It's questionable whether a machine can be trained to display such selective judgment."

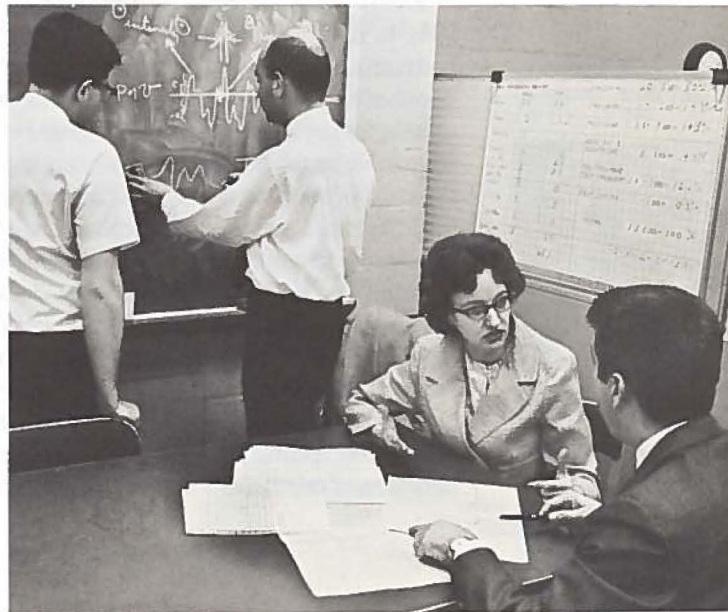
Similar reservations are voiced by Dr. Martin Dolgin, Chief of Cardiology at the Veterans Administration Hospital, New York. "The numerical data of the computer," he cautions, "must always be correlated with clinical findings—a function only the physician can perform. What the computer labels as abnormal may have little clinical significance, and, conversely, a minor determination in the computer may be clinically important. This applies especially to ST segment deviations and Q waves."

On the other hand, Dr. Dolgin believes that "use rather than abuse" of computers will eventually help to define such borderline problems as the significance of Q waves, high- or low-voltage QRS, or the reduction of T wave amplitudes—values of major importance in the diagnosis of cardiac disease." ■



**INDISTINCT Q WAVE** (inset), detected by computer, is enlarged 20 x for identification.

30,000 ECGs on magnetic tape are stored in this computerized "library" (below); automation speeds retrieval of individual patient's ECG. Electronic analysis of wave forms, it is hoped, will establish normal cardiac base lines. To resolve discrepancies of computer readings and tracings, data are analyzed daily (below, right) by Dr. Calatayud and mathematician Anna Weihrer.



## CHILDREN GET HELP

# March to Tackle Defects

BY JANE ANGEL

With Washington's sugary mass polio immunization program less than a year old, many of those who took their serum-soaked cubes may ask: "Why the March of Dimes, now that polio is licked?"

The answer is birth defects. Six years ago, after polio immunization vaccines were developed, the National Foundation-March of Dimes turned its attention to other health needs. In consultation with leading medical authorities, the decision was reached: Tackle birth defects.

A quarter of a million children are born annually with serious birth defects — one out of every 16 births.

And the percentage of victims is higher in the nation's capital than in any other city of comparable size — 1,400 out of 20,082 live births.

### Center Here

In 1962 a birth defects center was started at Children's Hospital here, supported by a \$32,500 grant from the foundation.

Last week Jane Wyatt, the television and motion picture star, visited the facility as part of her national tour as chairman of the 1965 Mothers March, to be held Jan. 29.

Miss Wyatt played with the young patients and noted the center's specialty — research and treatment of congenital defects of the nervous system.

Recognizing the distress experienced by parents of children with congenital defects of the nervous system.

*The Washington Star,*  
January 20, 1965



**ACTRESS JANE WYATT** plays with 2-year-old Franklin Keyser, a patient in the Birth Defect Clinic at Children's Hospital. Miss Wyatt toured the facility last week in connection with the Mother's March to be held Jan. 29.

the clinic differs from most conventional out-patient clinics. Screened waiting rooms, definite appointments (in order to avoid tedious waiting) and other details are noted at the center at Children's Hospital. The philosophy of the center is that privacy, special handling, and pleasant facilities lead to

greater understanding between parents and physicians.

### Work As Team

The local Birth Defects Center works on a team basis to avoid the confusion and "shopping around" to which many parents of birth defects victims often are subjected. In one and the same visit the



parent is given the opportunity to see all of the specialists involved and confusion and misunderstanding is reduced.

One-way windows for observation of children difficult to examine are provided. The "whole patient" is considered in each visit and the entire resources of the hospital are available.

The center is under the direction of Dr. Richmond S. Paine, neurologist to Children's Hospital and professor of pediatric neurology at George Washington University of Medicine. He is assisted by a staff of six. The other clinics at Children's Hospital offer consultation and treatment.

#### Children Eligible

Any child in the area is eligible for treatment at the Birth Defects Center regardless of race, color or creed. Age is restricted to 19 years or under. There are no restrictions as to residence for out-patient visits. For in-patient admissions to Children's Hospital through the Birth Defects Center, the National Capital Area Chapter of the National Foundation-March of Dimes may seek reimbursement from the local chapter of the patient's residence. Financial limitation bars no one from the clinic, although those capable of paying are asked to pay reasonable costs to the hospital. Solely supported by the National Foundation-March of Dimes, the Birth Defects Center is faced with a steadily increasing caseload of patients.

During the month of January the March of Dimes is conducted, climaxing with the Mother's March Jan. 29, and the two following nights. This commemorates the birthdate of the Founder of The National Foundation, March of Dimes, President Franklin Delano Roosevelt. ■

## THE MYSTERY

SISTER M. ANITA PETERS  
College of St. Scholastica  
Duluth, Minnesota

### INFLUENCES ON CHOLESTEROL LEVEL IN THE BODY

The cholesterol level in the body may be influenced by nutrition, age, sex, hormone balance, emotional stress, exercise, hereditary factors, and environmental factors. Many studies have been performed in relation to these factors.

A study on the low protein diet of the Trappist monk in relation to cholesterol level, carried out by Dr. Cesar A. Caceres of the George Washington University School of Medicine, showed the cholesterol level and other fats in the blood of the Trappist to be average. By this Dr. Caceres infers that a restricted diet need not be helpful to a heart patient. Although more studies need to be made to establish this fact, Dr. Caceres has stated that diet alone does not determine blood-fat levels.

Another study was made by the Georgia Department of Public Health to investigate whether Trappists develop atherosclerosis at a faster rate than men of the Benedictine religious order do, or vice versa. The research indicates that Trappist monks have less cholesterol in their blood than Benedictines. Trappists are strict vegetarians and eat sparingly of eggs and dairy products. They are withdrawn from the world, devoted to contemplation, prayer, and physical labor. Benedictines are teachers and preachers and are not prohibited from eating meat. The Trappists do not have the stresses of teaching and contact with the world that could serve to raise the cholesterol level more than the diet would.

Sex also has influence on the cholesterol level. In studies performed with mice, it was found that the

## OF CHOLESTEROL

Excerpt from an article  
in the *Journal of Home Economics*,  
December 1964

cholesterol level was significantly higher in males than in females. This is related to the fact that women enjoy natural protection against atherosclerosis through the sex hormones or estrogens.

Emotions also have a measurable effect on the cholesterol level in the blood. In a hospital it was found that even when food and exercise are controlled, cholesterol levels vary. One elderly man's cholesterol level hit its peak for his entire hospital stay when another patient called him a dirty name and threatened to start a fight. Another patient's level hit a similar peak in a row over a card game. A woman patient had a consistently high level until another doctor started treating her—she didn't like the first one.

In addition to emotions and sex, exercise also has an effect on cholesterol level. A study on 42 middle-aged white-collar workers whose average cholesterol levels were far above normal showed that after a year of strenuous exercise the average levels dropped below the average for the general population. Dr. Lawrence A. Golding, at Kent State University, Kent, Ohio, explained the program:

The men who came into the program were tested at the beginning and found to have an average serum cholesterol level of 261 mg per 100 cc. The group met as a class Monday through Friday, during the noon hour, beginning with a small work load and gradually building in intensity. When the program began, the men could only do a few sit-ups and push-ups. Now they are doing 35 or more of each. The real significance was the drop in cholesterol level of the group as a whole. The average drop of the level in the group was from 261 to 195, with a few individuals going from nearly 300 to around 150. The men were put on no dietary restrictions and, in fact, reported an increase in caloric intake soon after the onset of the program. ■

*The Washington Star*,  
December 26, 1964

## Bible From Carlson Used for Class Here

Dr. Neel J. Price, who has been on the faculty of the George Washington University School of Medicine since 1948, well remembers Dr. Paul Carlson as a medical student who was graduated in 1955.

Price delivered the first of Mrs. Carlson's two babies, Wayne Paul, on March 18, 1955. The grateful father gave Price what he correctly thought would be the most appropriate gift—a Bible.

Price, despite his busy medical practice and teaching schedule,

**Dr. Neel J. Price holds  
the Bible Dr. Carlson  
gave him.**





has been teaching the adult Bible class at the First Church of the Nazarene here for 18 years. The Carlson gift is well worn by now.

Dr. Carlson, of course, was the medical missionary slain Nov. 25 by Congolese rebels who had held him as an alleged spy.

Price brought the Bible with him to First Church last Sun-

day, when he participated in the service.

Interviewed on the telephone, he recalled that Carlson was a better-than-average student. As a senior he was president of the school chapter of the Christian Medical Society.

The Carlsons attended Wallace Memorial Presbyterian Church, located then in Northwest Washington. The mis-

sionary-to-be had, since the age of 17, been a member of the Evangelical Covenant Church—a branch of Lutheranism—which at the time had no church in the Washington area.

Still in Price's medical records is the information that the Carlsons lived at 6147 Kansas Ave. NE—and that their baby weighed 9 pounds, 1 ounce. ■

## Emphysema Called Commonest Illness

By SUE CONNALLY

A surprising 10 per cent of all Americans who consider themselves as being well have "measurable emphysema," a specialist in pulmonary diseases said here Friday.

That U.S. Public Health Service figure, said Dr. James P. Mann, makes emphysema the most common disease in the country when combined with the thousands whose cases have already been diagnosed.

Dr. James P. Mann . . . "a patch-work program," but good for emphysema.

*Dallas News,  
December 5, 1964*

Dr. Mann, Assistant Clinical Professor of Medicine at George Washington University School of Medicine in Washington, D. C., discussed emphysema and its current concepts at a Friday symposium on chest diseases at the Statler Hilton Hotel.

The symposium was sponsored by the Dallas County chapter of the American Academy of General Practice and Lederle Laboratories, a division of the American Cyanamid Co.

"In recent years, improvement in our understanding of the pathophysiology of emphysema has led to the development of a therapeutic approach that no longer requires us to view this disease with the uniformly pessimistic outlook which had in the past become almost traditional," Dr. Mann said in an interview.

He said it is important for those with undiagnosed emphysema to recognize the symptoms and seek a physician's care.

These symptoms may include "a productive cough, especially

in the morning," frequent colds that settle in the chest, progressive shortness of breath, and wheezing (a musical sound you hear when you breathe deeply).

Treatment is a "patch-work program," he noted, because of the wide variety of problems that emphysema poses. "But it's a good patch-work program." ■

*The Scope of  
The George Washington  
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MORE THAN 200 came to an art tea and tour on February 20 when the Hospital Women's Board entertained for artists whose works they exhibit and sell for Hospital charitable projects through the Hospital gift shop. Tea committee chairman was Mrs. Joseph Roe, and co-chairmen were Mrs. Jed Pearson and Mrs. Francis Kiepe.



## GW Professor Searches for "Jumping Frenchmen"

THE AMOUNT OF MEDICAL RESEARCH that exists today is astounding. In pre-clinical and clinical environments, doctors are studying today's problems for tomorrow's answers.

Reversing this trend somewhat is Dr. Harold Stevens, professor of neurology at The GWU School of Medicine. He is attempting to find "the Jumping Frenchmen of Maine."

The Jumping Frenchmen or "jumpers" made for popular studies among neurological scientists between 1880 and the turn of the 19th century. Jumpers just about disappeared from the science view until Dr. Stevens turned up three contemporary specimens.

A Jumping Frenchman is a person who gives a single violent jump when surprised by sudden touch, sound or movement. The jumper will also respond to any command given to him at the moment he is startled by senselessly repeating the command while he simultaneously obeys it—no matter how foolish or harmful.

In 1878 Dr. George M. Beard announced his intentions to investigate a group of patients known as the "Jumping Frenchmen of Maine," who lived in the Moosehead Lake region of northern Maine, the sole endemic area for this new disease.

According to Dr. Stevens' study, reported in the March 1965 Archives of Neurology, Dr. Beard observed 50 cases, including 14 in four families and reported his findings at the Sixth Annual Meeting of the American Neurological Association in 1880. Dr. Beard's re-

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port is the only one on the subject in American literature.

Dr. Beard investigated the patients, all men, and concluded that the disorder first appeared during childhood and persisted unchanged throughout life. Since "jumping" ran in families he felt it was inherited. All of his "jumpers" were of French Canadian descent and most of them were lumberjacks. Dr. Beard believed the disorder was limited to such people, but when his report was translated in publications in Europe it prompted the rediscovery of "Myriachit" among Siberian Russians and "Latah" of primitive societies of Asia and Africa.

Myriachit is "to act foolishly." The Russians maintained these jumpers surpassed the jumping Frenchmen of Maine and that the Russian scientists had discovered the disorder long before Dr. Beard found it. Latah had been known for centuries, it later turned out. When startled its victims can repeat any sound with amazing accuracy.

For many years controversy raged over the relationship among the disorders of the jumpers of Maine, the Myriachits of Russia and the Oriental Latah. However, by 1912, interest in the whole question had dissipated and no further scientific word about it had been published until Dr. Stevens discovered three jumpers in 1963. Dr. Stevens' jumpers are a 59-year-old man of French-Canadian descent, a 52-year-old woman of a Scotch-Irish-German family from North Carolina and her 20-year-old niece.

In Dr. Stevens' words, "reexamination of these three picturesque syndromes may not resolve this old dispute but will probably disclose that jumping, latah and myriachit are not as rare as implied by the paucity of medical observations and that they are probably not confined to particular ethnic groups or geographic areas." Dr. Stevens hopes that his work will stimulate interest in these three entities "or at least resurrect 'the Jumping Frenchmen of Maine.'" ■





*The Scope of The George Washington University Hospital, February 1965*

## DR. ETHRIDGE NAMED MEDICAL DIRECTOR OF GWU HOSPITAL

Dr. Clayton B. Ethridge was named Medical Director of The George Washington University Hospital and an Associate Dean of the School of Medicine earlier this month.

Dr. Ethridge will be responsible for the medical affairs of the expanding GWU Hospital with its active emergency room facilities, out-patient, and in-patient services, large house staff and educational and research programs.

Dr. John Parks, dean of the School of Medicine who up until this month also served as Medical Director of the

Hospital, said, "Dr. Ethridge is a distinguished physician and educator who has been associated with the GWU Hospital and Medical School since 1937. He is eminently qualified for the position." Dr. Ethridge will work closely with Dean Park and Hospital Administrator Victor F. Ludewig in developing a medical center at The George Washington University that will meet the future medical needs of the community and the Nation.

Dr. Ethridge is past president of the D. C. Society of Internal Medicine and past president of the Washington Heart Association. He holds membership in 20 honorary societies and professional and civic organizations. Among his awards and honors are the Certificate of Merit and Selective Service Medal presented by President Truman in 1945 and the Meritorious Service Award presented by the Federal Aviation Agency in 1964 for his "extremely competent leadership as Chairman of the Medical Advisory Panel" over a three-year period. He joined the GWU Medical School faculty 28 years ago as a clinical instructor in medicine and now is a professor of medicine. ■

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