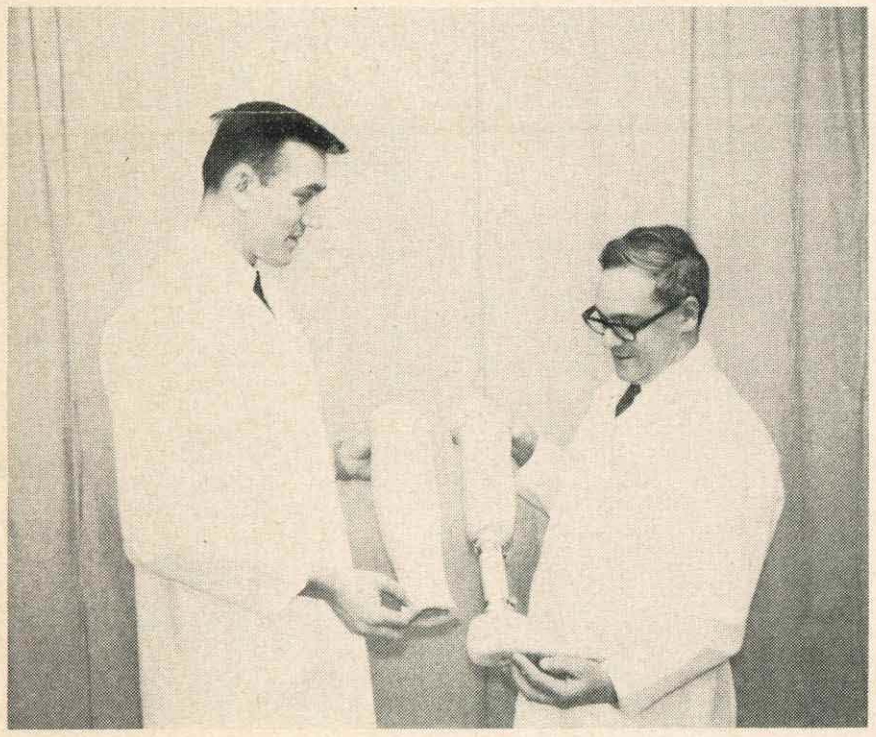
news bulletin

The Sanatorium Board of Manitoba

VOL. 8, No. 2 PUBLISHED BY THE SANATORIUM BOARD OF MANITOBA, WINNIPEG FEBRUARY, 1967



Douglas Hobson, left, mechanical engineer, displays the newly developed polyurethane cosmetic cover which gives a soft, inexpensive, pleasant to touch "skin" for the pylon shank prosthesis held here by James Foort, chemical engineer and technical director of the Prosthetics and Orthotics Research and Development Unit. (Photo by J. J. Zayshley).

IMMEDIATE PROSTHESES

Find Merit in Early Walking

The term "instant prosthesis" was coined three years ago by the Sanatorium Board's Biomechanics Laboratory to mean the speedy assembly of an artificial limb.

Recently in Winnipeg — and at other research centres in Canada and the United States — surgeons and prosthetics engineers have started to talk about "immediate prostheses" — or the fitting of "instant" artificial limbs to patients a day or two after surgery.

During the past two years many amputees at the Manitoba Rehabilitation Hospital have stood and walked on temporary "instant" prostheses from two to four weeks after surgery. In the past few months, in line with developments at other rehabilitation centres, some 10 patients have been put on "immediate post-operative walking" with considerable success.

Surgeons have discovered that encasing the stump in a well padded pressure dressing and getting the patient up on his artificial leg soon after surgery offers some merits. The snug support, for example, reduces pain and swelling. And the early walking seems to stimulate blood circulation and hasten the healing process.

But the greatest advantage, of course, is the psychological benefit to the patient. Early walking helps lessen his depression over losing a limb. He knows that when he wakes up the lost limb will be immediately replaced by an artificial one and that very soon he will be able to walk again.

"Immediate post-operative walking" stems largely from research carried out by two surgeons — Dr. M. Weiss of Warsaw, Poland, and Dr. E. Burgess, of Seattle. Both men have also had a lot to do with changing the surgeon's attitude towards amputation, and they have introduced forward-thinking surgical techniques that are geared toward helping the amputee operate his prosthesis more successfully.

In the words of the medical director of our own prosthetics unit: "They . . . and others . .. have made surgeons realize that the stump is not just an anatomical remnant, but a dynamic structure."

The amputee's ability to operate an artificial limb successfully is dependent upon the condition and power of his stump, he said. The surgeon should never needlessly sacrifice portions of the stump that could be useful in increasing the patient's ability to walk on a prosthesis.

Engineers Develop New Skin For "Instant" Artificial Limbs

Ever since it was organized three years ago, a chief aim of the Sanatorium Board's Prosthetics and Orthotics Research and Development Unit has been to develop simple, light-weight, prefabricated parts that can be assembled quickly into comfortably fitting, highly functional, near normal looking limbs.

In 1964, PORDU introduced the first "instant tinkertoy" prosthesis: pylon prosthesis designed for the various levels of lower limb amputations, consisting of prefabricated parts which fit together much like tinker toys and are easy to adjust or replace as patients progress through their rehabilitation programs. For above-knee amputees, the system was further developed to incorporate a pneumatic swing-phase unit in the knee joint to help patients attain an easy, controlled walking gait.

One of PORDU's next objectives was to provide a good "skin" for the pylon limbs, and last month our engineers happily announced the development of a polyurethane cover which they think fills the bill.

At the moment this new "skin" has been perfected for the pylon shank prosthesis. By the time this issue is off the press, similar covers will likely be ready for the knee and thigh segments.

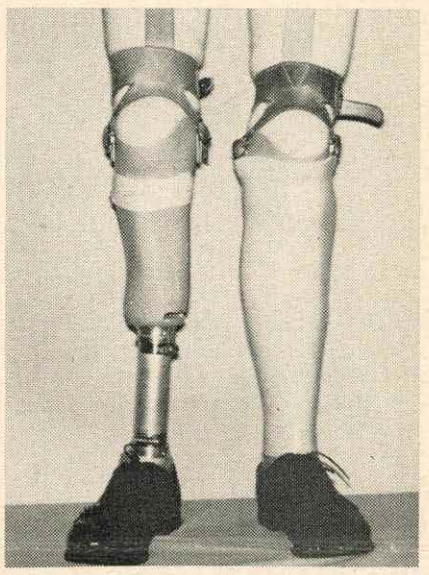
The polyurethane covers are light, silent and pliable. They have no tell-tale seams, they are pleasant to feel and they are quick and easy to install.

Because they are soft and "silent", the new covers considerably diminish the noise of any object hitting against the limb. And being soft and quite opaque, they are not as shiney as older artificial limbs with hard plastic laminate covers.

Above all, polyurethane covers are inexpensive to produce. In very simple terms, the material is poured in liquid form between an outer and inner mold or contour, and when the substance has set, the molds are carefully removed.

According to James Foort, chemical engineer and technical director of the Sanatorium Board's Biomechanics Laboratory, it will be possible to mass produce polyurethane covers in a wide range of sizes for both right and left artificial limbs. The unit's research group will turn over the designed items to local manufacturers who in turn will produce the required quantity of covers for treatment services.

(Continued on page 2)



Close-up of pylon prostheses on bilateral amputee, one with new cosmetic cover on.

Address all communications to:
THE EDITOR, SBM NEWS BULLETIN,
800 Sherbrook Street, Winnipeg 2, Manitoba
Authorized as second class mail, Post Office Dept., Ottawa
and for payment of postage in cash.

ANNUAL REPORT

Provide 117,558 Free Tests

By J. J. Zayshley

The year 1966 was a challenge and a milestone in survey work with the incorporation of free blood tests for diabetes in the tuberculosis preventative program. This combined program was confined to 25 municipalities in the western part of Manitoba and included the city of Brandon. The Associated Canadian Travellers, Brandon Club, financed the blood tests; Christmas Seal funds helped pay for the tuberculosis tests.

There were 18,569 blood tests for diabetes given in 1966. A total of 69,529 tuberculin skin tests were administered in surveys of 26 municipalities and in industrial and school screening programs. A total of 15,426 chest x-rays were made in connection with the community tuberculin surveys, and 14,069 Indians were x-rayed in surveys conducted in co-operation with the Medical Services branch of the Department of National Health and Welfare.

Of those who received tuberculin skin tests, 4,801 or 6.9% were positive. A total of 7,115 or 12% did not return for a reading, an improvement of 1.8% over the previous year.

To provide the combined detection tests, we required two additional licensed practical nurses, bringing our total LPN's on field work to six. Other extra equipment included six specially made containers for shipping blood samples, a dual propane-electric refrigerator in the mobile unit, unopettes to hold the blood samples, labels and so forth.

The blood samples were shipped by bus daily from the field and taken to the University of Manitoba Metabolic Laboratory for processing. With our refrigeration facilities and a speedy bus-courier service, we did not have one single case of spoilage.

We averaged about 250 diabetes blood tests per day, but on many occasions, in larger communities, we were able to test 425 per day. The blood tests were given on the day when people returned for tuberculin test results . . . to those 21 years of age or over and to children (with permission) if there was a history of diabetes in the family.

To plan and arrange this year's work required 36 municipal council meetings, 120 general meetings and 112 educational film meetings. Tuberculin skin testing, test reading and chest x-rays were given at 276 locations. The combined tuberculosis-diabetes detection service was carried out at 66 locations.

During the earlier part of the year much of our time was also devoted to supervising the construction of our new $35,000 mobile detection unit. This unit is a semi-trailer type, equipped with 70mm Odelco camera.

The x-ray equipment was not originally designed for a mobile unit and required special modification. The unit has been designed so that registration, chest x-rays and blood testing for diabetes could be provided right in the unit.

Engineers Develop —
(Continued from page 1)

In that way, says Mr. Foort, it will just become a matter of the prosthetist reaching up to the shelf for the cosmetic covering most closely resembling the size and contour of the patient's leg, slipping it over the pylon prosthesis, and fitting the whole system to the stump.

Later, as changes to the prosthesis become necessary during the patient's rehabilitation program, the cover is just as easily removed to allow the prosthetist to make adjustments to the leg length and alignment.

Like "tinkertoy" prostheses, which can be assembled from prefabricated parts in less than half an hour, the mass production of polyurethane covers will save precious time for both the patient and the hospital.

"It is both humane and economical to expedite the care of amputees of all ages," says PORDU. "The limitations of hospital space, facilities and personnel demand that they be used efficiently, and the expeditious handling of patients will result in real economy as well as extension of service to more patients.

"The child belongs at home or at school; the father at work; the mother in her home. And the elderly, too, should be allowed to enjoy their remaining days in the home environment. Old age is not an excuse for delay or for withholding prosthetic care. It is a cogent reason for realistic speed.

"Time is a precious thing .. . and this is true both for the amputee and those who deal with the amputee."

Report 214 New Active TB Cases

Still on a Frustrating Plateau

New active cases of tuberculosis reported in Manitoba in 1966 remained the same as the number reported in 1965, according to the Central Tuberculosis Registry.

In both years the totals were 214.

In 1966, 160 of the new active cases were whites; 54 were Indian. In 1965, 158 were whites; 56 were Indians.

A total of 45 reactivated cases of tuberculosis were reported in this province last year, compared to 49 the previous year.

Across Canada new active and reactivated cases of tuberculosis reported during the first 11 months of 1966 showed a slight dip — 4,347 as compared with 4,878 during the first 11 months of 1965.

Need More Public Support

The fact that the number of new cases of tuberculosis reported from year to year has shown little variation strengthens the conviction of tuberculosis workers that we have reached a frustrating plateau in the effort to conquer the disease.

To make further progress, it is absolutely necessary for the entire public to join the campaign and bring out into the open all cases of tuberculosis for treatment and cure.

FAST GROWING GROUP

Canada's Indians are the fastest growing ethnic group in the country, having increased at the rate of 55 percent since 1949, says Walter Currie, a Toronto teacher who is also an Indian.

Yet Indians still have the highest infant mortality rate in Canada, with eight times the national rate for pre-school children.

About half the Indian families earn less than $1,000 per year, he said. Another 25 percent are below the $2,000 mark. According to sociologists, $3,000 is the poverty line.

Everybody — young and old, rich and poor — should take the few minutes required to have a tuberculin skin test and or chest x-ray regularly.

Dr. G. J. Wherrett, former executive secretary of the Canadian Tuberculosis Association, summed up the problem this way

"Somehow we must convince the public that victory is not to be taken for granted, that it is equivalent to abandoning a fire because the flames have died down, and ignoring the fact that embers are still aglow underneath.

"As far as tuberculosis is concerned," he said, "public health personnel of all disciplines are the fire department . . . which does not turn off the water and leave the scene just because the crowd disperses when the fire dies down.

"Our business is to keep ourselves and the public aware of the fact that tuberculosis control and eradication are still a long way off."

SUPPORT TB PREVENTION — ANSWER YOUR CHRISTMAS SEAL LETTER — Christmas Seal financed tuberculin and X-ray surveys are the basis for the early detection and control of tuberculosis in the community. Although these screening programs have done a great deal over the years to reduce the tuberculosis problem, the germ still stubbornly hangs on in the bodies of nearly one-fifth of our population, and causes over 200 new active cases each year. Your Christmas Seal contribution will help continue important preventive work. If you haven't answered our November letter, won't you please do so today?

A Big Thank - You To Our Volunteers

In 1966 the volunteers at the Manitoba Rehabilitation Hospital contributed 11,384½ hours of their time to providing special services for patients and staff, according to Mrs. W. E. Barnard, director of the Volunteer Services Department.

Throughout the year our volunteers operated the hospital's gift shop, provided special services to patients on the wards, ran the patients' library and hospital information desk, arranged patient entertainment, helped operate the elevators at peak periods and for special events, helped provide tea service in our Occupational Therapy Department, assisted with preparations for the Christmas Seal Campaign and did a fair amount of clerical work, typing and filing for our office staff.

That's quite a record of service, and the Sanatorium Board is extremely grateful to the many women and high school students who so cheerfully donated all this time. Some, we note, offered their help individually; others as members of local organizations volunteered their services as a group.

The latter include the Pi Beta Phi, the Ladies Auxiliary of the Associated Canadian Travellers of Winnipeg, St. Boniface Inner Wheel, The B'nai B'rith and the Aviva Chapter of the B'nai B'rith (who have undertaken a special project to arrange twice monthly entertainment for the patients), the Humpty Dumpty Girls Club (who work on the wards Saturday mornings) and the members of two women's curling groups.

Ex-patient Reminisces about the "Good Old Days"

Tuberculosis patients who bemoan their fates now should take a good look at what happened to their counterparts 50, 40 or even 25 years ago. In those "good old days" the miracle drugs and surgical techniques that are the basis of modern treatment did not exist. "Chasing the cure" consisted primarily of strict bed rest, fresh air (even when temperatures zoomed down to 25 below), nourishing food and for far advanced cases, certain forms of rather crude and deforming collapse surgery.

Some patients who entered sanatorium were prepared to die there. Others were determined to live; and it was probably their indomitable courage that proved in the long run to be the most effective weapon against the disease.

Jim Zayshley, who for many years has organized the Sanatorium Board's tuberculin and x-ray surveys, recalled some of his experiences as a tuberculosis patient at Manitoba Sanatorium in 1942 and 1943.

"I am going away to die," was Jim's only thought when eventually he was told that he had tuberculosis and should enter sanatorium. He had had a chest x-ray when he joined the RCAF in the fall of 1942, but, reluctant to tell him that they suspected the shadows on the film were tuberculosis, the Air Force doctors sent him home to Flin Flon to wait further word. Finally, a local doctor gave him the news and suggested he go to the Central Tuberculosis Clinic in Winnipeg for confirmation.

Even as late as the 1940's, a great many people knew very little about tuberculosis. They were terrified of it and both patients and their families often did everything they could to conceal the disease. For a large proportion of the public, catching TB meant death.

"Anyway, I felt this was the end for me," said Jim. "And to save them worry . . . and perhaps shame . . . I decided not to tell my relatives and friends that I was going to the san, but rather let them think I was missing in the war. I packed a small grip, put one dollar in my pocket and boarded the train for Ninette."

Jim recalls the train trip from Winnipeg to Ninette took nine hours. It was the local run that began early in the morning, meandered down through southwestern Manitoba (making all the milk stops) and at one point, backing up 11 miles to pick up passengers, parcels and milk cans at Notre Dame de Lourdes.

The train had a special car for TB patients going to and from Ninette; and the station at Ninette, where Jim was deposited that evening, was known as "Sputum Depot". The stigma attached to tuberculosis was evident everywhere!

Ralph, the sanatorium's driver, met Jim at the station and drove him up to the administration building. After being checked in, he wandered alone over to the infirmary where he stood about hopelessly until a nurse found him and took him to a ward occupied by three other men.

The men said nothing until Jim got into bed; after that they became quite vocal, asking questions and offering friendly advice.

"You should go outside and run around the building several times, because you're going to be in that bed a long time," suggested one of his room-mates.

Jim turned to him and asked, "How long have you been here?"

"Nine years."

Jim slumped down under the covers.

"And you?" he whispered to the second man.

"Eleven years."

Jim closed his eyes.

"Hey buddy! If they suggest pneumo to you, refuse!"

Jim opened his eyes to see his third room-mate pull off his pyjama top to display a chest that Jim remembers as "all cut up and caved in".

Mass tuberculosis surveys have helped a great deal to educate the public about this communicable disease, says Jim Zayshley, Sanatorium Board surveys organizer. "Back in 1942 I and a lot of other people knew hardly anything about TB . . . except that it was a frightful, killer disease."

With patients like these around, Jim figured that Manitoba Sanatorium would be the last hospital in the province to close.

Jim was worried about his fate . . . and he was also anxious about paying for his treatment. He had had one dollar; now he was left with 35 cents, having doled out money for a glass, thermometer and the like.

It was not until four days after his arrival that Jim became more hopeful. On the third day he had been called down for a chest x-ray, and on the fourth day he was summoned for a consultation. In the viewing room his x-ray had been set up and five doctors and a secretary were ranged around it. Jim sat in the middle of the circle.

His first reaction was that of surprise that so many doctors should be concerned about him. Together they talked about what would be his best program of treatment, and towards the end of the consultation the sanatorium medical director came over to Jim and gently put his hand on the back of his chair. "We are all here to help you as much as we can," he told him. "But getting well is mostly your fight."

Jim never forgot the warm feeling that welled up in him during this interview, nor the utter surprise and delight he felt when he was also informed that treatment for tuberculosis was free. His attitude began to change. He had been given a small blue book of instructions and he read it diligently. And despite the teasing and taunts of some of the other patients, he decided to follow instructions to the letter.

He was put on strict bed rest: the only exercise permitted him was to sit on the edge of his bed once daily for one of his meals. He stubbornly stuck to the plan, and at night slept outside on the balcony (even during the frigid winter months), tucked in tightly under a mound of blankets after the 10 p.m. "milk time".

"Sometimes we'd wake up in the morning to find frost on the blankets around our nose and mouth," he laughingly remembers. "But we felt great!"

Jim had not been at Ninette long before a nurse appeared at his bedside bearing knitting needles and yarn. The idea that he should knit seemed, to say the least, peculiar, but he soon learned that making beenies, socks and scarves for the "war effort" was popular on all the male wards and patients competed with other patients to see who could turn out the most in one day. Jim joined in, and pretty soon, he proudly remembers, he could knit one sock in one day.

He gained more confidence when three months after his arrival his x-ray showed some improvement. He was allowed to go to the dining room for a meal once a day, as part of a stepped-up exercise program. And three months after that, as he continued to improve, he was moved into a single room in the King Edward Pavilion and was permitted to walk to the main building for all meals.

He took up bookkeeping and typing by correspondence, and to improve his typing he spent two hours each day typing envelopes in the Christmas Seal office.

At this time, he also became interested in x-ray work and in the late summer of 1943 he was invited to accompany an x-ray technician and doctor on a travelling clinic. When he returned he wrote to his friends and relatives for the first time and enrolled as a trainee in the Ninette x-ray department, continuing treatment at the same time.

Over the next year Jim learned x-ray technology the hard way.

(Continued on page 4)

The Cure Is Easy - - If You Remember It

One of the most difficult problems in the control of tuberculosis is getting patients to take drugs as prescribed. The TB drugs **can work if they are taken regularly;** disease can be checked and health restored. It sounds so easy . .. but it isn't.

Anne Grant, health education consultant for the Canadian Tuberculosis Association, claims that taking drugs looks easy only to those who have never had to take them regularly.

Anyone who has had to take them knows that unless one devises some help for the memory it is hard. There is the nagging question of whether one has taken them or not. Did I, didn't I?

Miss Grant suggests that patients on chemotherapy at home establish some kind of routine check. One way to do it, she says, is for the patient to set a time in the week when he measures each day's quota into a little bag, bottle or box labelled Monday, Tuesday and so on through the week.

If the pills aren't gone for that day, the patient knows he hasn't taken them . . . and had better do something about it.

Patients need to be reminded of the tremendous importance of taking drugs as prescribed. If they do not take them regularly, do not return to the tuberculosis clinic for a check-up and a fresh supply, they will likely find themselves back in sanatorium for a much longer stay.

And for some of these patients it might just as well be 1940, for the haphazard use of drugs has caused the tubercle bacilli to become resistant to the miracle drugs that are the mainstay of modern treatment.

Here and There With Our Staff

REHABILITATION MEETING — The medical staff of the Manitoba Rehabilitation Hospital are extra busy these days lining up the program for the 15th Annual Meeting of the Canadian Association of Physical Medicine and Rehabilitation which will be held here in Winnipeg August 23 to 25. It is planned that the scientific sessions of this important meeting will be held in our hospital auditorium.

* * *

THE SBM "ABROAD" — With respect to other meetings and conventions, a number of our staff have been flying here and there attending them. Miss Mary Gray, Christmas Seals Supervisor, attended a special workshop on IBM procedures (related to the conduct ing of Christmas Seal Campaigns) in Seattle, Washington, February 12 to 14, and J. J. Zayshley, organizer of our tuberculosis surveys, has flown to Washington, D.C., this month to attend a two-week institute arranged by the National Tuberculosis Association. This is an intensive training course, limited to about 30 persons, and, in addition to a review of tuberculosis and other respiratory diseases, includes special sessions on planning control program for the community, on the role of tuberculosis organizations, public relations and the Christmas Seal Campaign.

Other staff members who have been taking part in meetings include Dr. L. H. Truelove, chief of medical services of the Manitoba Rehabilitation Hospital, who flew to Toronto late last year for the Conference on Rheumatic Disease Units (Documentation Objectives and Methods), and James Foort, technical director of the Prosthetics and Orthotics Research and Development Unit, who was in Washington, D.C., at about the same time to take part in a national prosthetics and orthotics conference. On December 14 and 15, Mr. Foort lectured on new developments in the prosthetics field at the University of Virginia, Charlottesville.

* * *

NEW STAFF MEMBERS — A hearty welcome is extended to all new members of the Sanatorium Board staff. Among the newcomers are James Breakey and Edward "Ted" Gibbs, both physiotherapists who are training to become prosthetics specialists in our Prosthetics and Orthotics Research and Development Unit. Mr. Breakey was born in Souris, Manitoba, and is a graduate of the University of Manitoba School of Medical Rehabilitation. Mr. Gibbs comes from England and received his training at Southern Hospital School of Physiotherapy at Liverpool.

Miss Margaret Ann Moore has come all the way from Brisbane, Australia, to join the Department of Communicative Disorders at the Manitoba Rehabilitation Hospital. Miss Moore recently graduated in speech therapy from the University of Queensland.

A recent addition to the M.R.H. Occupational Therapy Department is Miss Jane Elizabeth Peacock, a graduate of St. Loyes School of Occupational Therapy in Exeter, England. And the latest newcomer to the M.R.H. registered nursing staff is Miss Mary Grace Voisey, a graduate of Grace Hospital School of Nursing who recently spent some time nursing at Eskimo Point, a well-known community to tuberculosis workers. It is interesting to note that Miss Voisey was born in the Northwest Territories.

* * *

FAREWELL TO DR. MARI — Over 60 members and former staff members of the Central Tuberculosis Clinic, Central Tuberculosis Registry and Sanatorium Board executive officers gathered at the Paddock Restaurant on Friday evening, February 10, to honor Dr. and Mrs. Paul Mari who left this month for Vancouver where Dr. Mari has a new post with the Willow Chest Centre and the Pearson Hospital.

Following the dinner, Dr. Mari — a member of our Sanatorium Board staff for the past 15 years — was presented with two handsome medical books and an engraved silver tray.

As principal speaker, Dr. E. L. Ross paid tribute to both Dr. and Mrs. Mari for their many contributions to our professional, cultural and social life. Mrs. Mari, he noted, has attained distinction as a fine soprano, both in Canada and the United States. And Dr. Mari, apart from his contributions to medicine, is recognized as a very good artist and the best in Canada among the medical profession.

Dr. Ross also spoke about Dr. Mari's thorough knowledge of tuberculosis treatment and control and of his special interest in drugs. He will be greatly missed not only by the Central Tuberculosis Clinic staff, he said, but also by the hundreds of patients in whom he always had a devoted and kindly interest.

"This year almost everything has a Centennial flavor and the fostering of good interprovincial relations," Dr. Ross concluded.

"So let us consider that the Mari's are Manitoba's Centennial contribution to British Columbia."

* * *

Smaller, but no less successful, was the surprise party thrown in Dr. Mari's honor by the members of his art class on January 30. The table in the O.T. Conference Room was piled high with good things to eat and drink, and in the course of the evening the students tearfully presented their instructor with a crystal decanter, an engraved bracelet to go around the decanter, a basket holder for serving wines . . . and, of course, a special something for the basket.

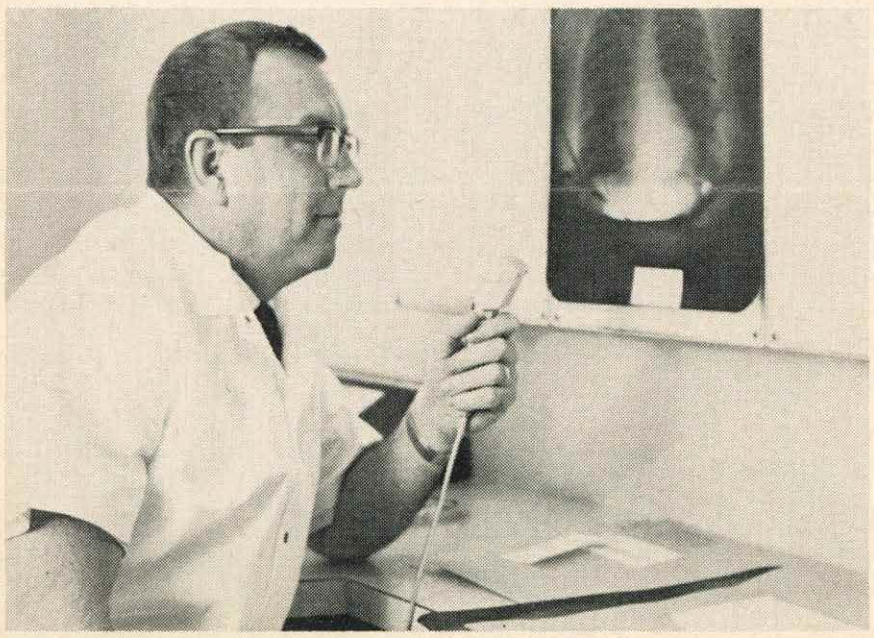
The art class plans to continue the Monday evening sessions . . . struggling along on their own.

* * *

MISS DAMEN RESIGNS — In all, the Board has experienced a rather sad month of saying goodbye to a number of valued staff members. Among those who will also be greatly missed is Miss Marie Jeanne Damen who at the end of January resigned from her position as chief speech therapist at the Manitoba Rehabilitation Hospital to return to her home in The Netherlands.

Miss Damen joined our staff soon after the opening of the Rehabilitation Hospital in 1962. During her stay here she made many fine contributions to the rehabilitation of patients with speech and hearing difficulties and she also did much to bring their problems and needs to the attention of the public.

We miss her . . . but we also wish her happiness and success in her future career.



RUSSIAN-BORN DR. PAUL MARI, who has been with the Sanatorium Board staff since his escape from Shanghai to Canada in 1951, resigned his post at the Central Tuberculosis Clinic this month to take up residence in Vancouver. Dr. Mari speaks several languages, is a talented artist and has been a fine "family" physician to both Sanatorium Board patients and staff. He and his wife Nona were honored by staff members, former staff and friends at a party on February 10.

Ex-Patient

(Continued from page 3)

Very often, when the sanatorium was short of staff, he was left without an instructor and had to feel his way along. "I made some awful messes," he said, "and I became so discouraged I was ready to quit. I decided to give it one last try. I paid $35 for a book on radiology, read it from cover to cover, and began to get the idea. I wrote the examinations in the fall of 1944 and was graduated as a fully qualified x-ray technician."

Over the next few years, Jim worked for the City of Winnipeg Health Department, taking x-rays and helping to organize industrial X-ray surveys. He took a year's course in public health work and became a public health inspector in 1952. Soon after he rejoined the staff of the Sanatorium Board to take over the organization of both industrial and community tuberculosis surveys.

Jim was never desperately ill with tuberculosis. He was not a very far advanced case. But 25 or more years ago there were patients like him who did die . . . probably because they stuck to the idea that they were fighting a losing battle. Others, far sicker, lived and rejoined the community because in spite of the odds they were determined to get well.

Today the cure of tuberculosis is comparatively fast and easy. Most patients spend less than a year in hospital, then continue on drugs at home and at work.

Yet, just as it was in Jim Zayshley's day, a speedy, long-lasting cure still depends primarily on the patient's attitude. On remembering to swallow the proper number of pills each day, on returning to the clinic for a check-up at the specified times . . . and on the patient's own determination to get well and stay well.

---

1. In those times surgical procedures were done to produce "collapse", a pressure on the diseased portion of the lung. Pneumothorax was one of two types of collapse surgery. A small needle was inserted through the chest wall between the two layers of pleura and through this, air was injected which caused the lung to collapse . . . and thus, rest. The other type of surgery, thoracoplasty, involved the removal of a certain number of ribs so that the chest wall became flaccid and compressed the diseased lung. Neither type of surgery is used today.

* * *

PUTTING OUT A BULLETIN

If we print jokes, some say we are silly;
If we don't, some say we are too serious.
If we print original matter, we lack variety;
If we don't, we are too lazy to write it.
If we print news, some say we are nosey;
If we don't, some will be offended.
If we print contributions, they are full of junk;
If we don't, we don't show appreciation.
Like as not someone will say we swiped this
. . . well we did . . . from another bulletin . . .
No telling where they got it!