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Quote: *Cont'd from page 1.*

the efficient small businessman generally has a better percentage of earnings on sales than big business." *Henry H. Heimann, executive vice president, National Association of Credit Men.*

The plus factor . . . . "Business men can take advantage of the present lull by looking ahead 'at the plus factors in the economic picture' and planning for the upsurge that lies ahead. This is the time to accelerate research, eliminate loss items, get costs under control, drive for new markets, improve production scheduling, review purchasing policies and resist uneconomic wage demands. This is not 1929. It is only realistic to say that anyone who is in the stock market today feels poorer than he did a few months ago, but hundreds of thousands of our people are not up to their ears on margins as they were 28 years ago. There is the Federal Deposit Insurance Corporation . . . . Our deposits are safe. The factory worker who is temporarily laid off draws unemployment compensation . . . . Although I sometimes shake my head in wonder at the uneconomic extremes at which we have progressed with the various kinds of subsidy programs . . . . the farmer is at least protected from the natural hazards that have always surrounded agriculture . . .

"The most important plus factor . . . . is the movement toward easier credit availability and declining interest rates . . . sensitive commodity prices have already reached an eight year low, and producers are bringing production into line with demand at these lower levels in a number of commodity markets." *Philip M Talbott, President of the U. S. Chamber of Commerce.*

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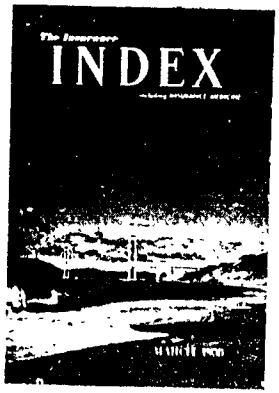
THE INSURANCE INDEX

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The Insurance INDEX including INSURANCE MEDICINE

MARCH, 1958

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The shoreline with the world famous Golden Gate Bridge in the background is Berkeley, California photographer Mike Roberts' offering for the Index's March cover. To us it is a very beautiful and striking example of just one of the many thousands of engineering accomplishments that the insurance industry has played a major role in.

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which was called asymptomatic. Yet, when finally conclusive evidence came, the reason was perforation of the appendix or generalized peritonitis.

Suicide in Children and Adolescents[1]

Suicide is the fifth most frequent cause of death in the age group 15 to 19 years in the U. S. Seasonal distribution is highest in spring, paralleling that of adults. Reasons for suicide among teen-agers include feelings of inferiority, fear of punishment, feelings of guilt, anger, economic difficulties in the family. Twin studies do not point to a hereditary factor. In the age group 10 to 14, 35 to 60 children take their lives each year. Suicide among children under 10 years of age is rare although threats and attempts are frequent. While these threats and attempts do not result in suicide, these children should be carefully examined. In a study of adult suicides, 75% had made threats of self-destruction. Parents and friends may tease and ridicule the already unhappy child. His next suicidal attempt may be successful. Any child who is markedly depressed, often insomniac, unstable, and displaying violent temper outbursts should be suspect, and given special attention.

Chest injuries[**]

Authors report on 365 patients with chest injuries in the period from January 1948 through August 1954. The ratio of simple (closed chest wall) injuries to complex (rib fracture with or without visceral involvement) injuries has reversed between 1923 and 1937 to 1940. The rather persistent mortality rate of complex injuries from 1910 through 1956 was 10 to 24.5%. The male to female ratio was 3 to 1. Of the 365 patients, 75% sustained one or more rib fractures. The complications in 97.3% were due to hemothorax, pneumothorax and subcutaneous emphysima. Head injury was an additional factor in many cases and was one of the primary causes of death in 45% of this series. 32.8% of the injuries were due to automobile accidents. Falls at home or at work accounted for the majority of the injuries. Yet, the automobile injuries were the cause of 75% of the deaths. An over-all mortality rate of 13.9% was recorded. Of the patients who died, 61% had either a head injury or crush injury of the chest. The time interval between moment of injury and death ranged from a few minutes to 29 days. The duration of hospitalization averaged 8 days. The greater use and speed of the automobile is primarily responsible for the increasing number and severity of chest injuries. If there is a combination of head injuries and crush chest injuries, there is less than a 60% chance of survival.

Height, Weight and Essential Hypertension*

The accelerated (malignant) form of hypertension is characterized by the presence of pathological changes indicative of widespread necrotizing arteriolotis. Separation of the accelerated form from other types was made by Vollhard and Fahr in 1914. The present study of certain constitutional factors expects to lead to further differentiation of the accelerated form of primary hypertension. 30 men and 30 women with primary hypertension of the nonaccelerated form and the same number with the accelerated form were selected. All 60 with the first variety were 60 years of age or older, had developed hypertension prior to age 50, and had no present or past endocrine disorders. All 60 patients with accelerated hypertension gave a history of at least 4 years of elevated blood pressure and had proteinuria, retinopathy, and papilledema. Primary renal disease was excluded. Only patients between 35 and 50 years of age were included. The ponderal index (height divided by cube root of weight) was recorded in men and women with primary hypertension, with and without the accelerated form, there being 30 subjects in each group studied at a comparable age with weight measurements made prior to modification by their disease. The women with accelerated hypertension were found to have a significantly higher ponderal index than the women with nonaccelerated disease, the former being taller and the latter heavier than a control sample of normal women. These results suggest that host factors may contribute to the susceptibility of some persons to the accelerated form of primary hypertension No significant difference in the height-weight ratio was apparent in men, whether or not they had the accelerated form of the disease.

Folie à Deux*

The term folie à deux is generally reserved for the appearance of a similar type of psychosis in two or more people living in close association. These may be twins, husband and wife, siblings, parent and child, etc. The dominant partner or one with the stronger personality, develops the psychosis first. This is usually a paranoid type of psychosis, characterized by persecutory delusions. The weaker partner soon acquires the same psychosis. A. Gralnick in 1942 reviewed 103 cases of folie à deux and the entire English literature prior to 1942. He found that it occurs more frequently in females than in males in a ratio of 4:1. It is especially prominent in sister combinations and next commonest in mother-and-daughter pairs. J. G. Oatman in 1942 stated that in a large majority of cases of folie à deux, the syndrome presents itself as a paranoid psychosis, with both patients entertaining almost identical systematized, plausible delusions, but not the bizarre, primitive beliefs of schizophrenia. Adequate history will reveal that one member of the pair exhibited psychotic symptoms earlier, if only by a matter of days. Author presents a report of the simultaneous occurrence of psychotic episodes in a pair of 21-year old monozygotic twin girls. Both Slater and Shields in 1953 and Kallmann in 1952 and 1953, stressed the importance of blood relationship as a factor predisposing to psychosis.

Occupational and Environmental Cancer*

Some of the environmental cancers, such as those elicited by coal tar, arsenicals, and ionizing radiation, display etiologic-specific epidemiologic and symptomatic patterns in regard to their regional distribution, population groups affected, exposure stigmata, pre-cancerous lesions, and site of cancer. Such patterns are almost as well defined as those available for some infectious diseases. The target organ of cancer formation may differ for some environmental cancers with the route

*H Bakin Suicide Under 20. J. Pediat. 50:749, 1957.

**T. W Jones Chest Injuries An Analysis of 365 cases Northwest Med., 56:431, 1957.

*G. A. Pereira and A. Damon. Height Weight, and Their Ratio in the Accelerated Form of Primary Hypertension. Arch. Int Med. 8 263, 1957.

*H Benjamin Simultaneous Occurence of Psychotic Episodes in Monozygotix Twins. Arch Neurol & Psychiat. 2: 197, 1957.

*W. C Hueper Newer Developments in Occupational and Environmental Cancer. Arch. Int. Med. 3 487, 1957.

of introduction of the carcinogen. The great majority of the at present known environmental carcinogens and carcinogenic exposures were discovered during the last 75 years. Although the total number of environmental, and particularly occupational human cancers observed in circumscribed population groups is relatively small, there can be no doubt that the actual number of such cancers which have occurred in these restricted populations is considerably higher because many have not been reported as being of environmental origin. The great bulk of worker groups having in some form contact with known occupational carcinogens has never been surveyed for the presence and incidence of occupational cancers. The data on hand suggest that environmental agents of known and still unknown nature apparently play an important part in the direct or indirect causation of a major portion of human cancers involving various organs and tissues. Environmental factors appear to be active especially in the production of cancers of organs and tissues furnishing the epidermal and mucosal covers of tissues (cutaneous, respiratory, digestive) with which the environmental carcinogens have primary contact or which become exposed to them during the process of excretion (urine) or in which they may be retained and stored (skin, liver, bone, bone marrow). During the last century a rapidly increasing number of new recognized, suspected, or potential industry-related carcinogens have been introduced in the human environment, so that the opportunities, intensities, and sources of human exposure to the agents have risen considerably. Thus, growing numbers of persons are becoming exposed to the new carcinogenic constituents. The increasing number of deaths from cancer demands that adequate measures be taken to keep the number of environmental carcinogens and the degree of exposure to them to the practicably attainable minimum

Current Literature

E. Todd, Jr. Cancer of the Gallbladder. Kentucky Med. J., 55 419, 1957.

219 patients who had been found to have gall stones, during a 5-year period, either refused operation or operation was thought to be unadvisable. It can be expected that 13 (6.1%) of those over 70 years of age will develop carcinoma of the gallbladder.

W. A. Thomas, J. O. Blache and K. T. Lee. Race and Incidence of Acute Myocardial Infarction. Arch. Int. Med., 3.423, 1957.

The incidence of acute myocardial infarction for each decade of life, for each sex, and for each race has been determined among 17,067 autopsied adults (8003 Negroes and 9064 white persons) from each of three widely separated geographic areas (St. Louis, Washington, D. C., New Orleans). The over-all incidence of acute myocardial infarction is much higher among whites than among Negroes in both of the periods studied (1910-1939 and 1940-1954). The incidence was similar in all three localities. The incidence rose steeply among whites in the period 1940-1954 over the period 1910-1939, but this rise did not occur in the Negroes. The incidence in the two races, expressed as a percentage of those who survive to a given age) is not significantly different in the age-group 20-39, but is significantly different between the two races in all older age groups. Among Negroes the over-all incidence of acute myocardial infarction is similar in the two sexes in each period studied. Among whites the incidence was significantly greater among men than among women in the period 1910-1939, but they were less significantly different in the period 1940-1954.

G. Hayward. Paroxysmal Tachycardia. Clin. Med 8:993, 1957. (from Brit., M. J. 4958: 105, 1956.

The essential feature of paroxysmal tachycardia is abrupt onset of the attacks. Attacks starting under age 40 are commonly supraventricular while auricular flutter or ventricular tachycardia are more common after age 50. In supraventricular tachycardia the rate is between 160 and 220 and does not vary from minute to minute. In ventricular tachycardia the rate is within the same limits but less constant. Supraventricular tachycardia occurs often in patients without organic heart disease. Ventricular tachycardia is rare except in patients with serious heart disease, such as congestive heart failure, recent myocardial infarction, etc. In supraventricular tachycardia, carotid sinus pressure will either stop or influence the rate. There is no evidence that even frequently recurrent paroxysms, with a normal heart, will shorten life.

I Starr. Heart Disease and Death. Circulation, 16:1, 1957.

The statistical conclusion that the tuberculosis mortality rate is falling and the cardiac mortality rate is rising depends entirely on death certificates. The diagnosis in tuberculosis is generally correct. The author asks under what conditions establish physicians heart disease as cause of death. While rheumatic, thyroid, and syphilitic heart disease are not being found more frequently than some years ago in death certificates, arteriosclerotic and coronary heart disease are. The author suspects that the physician who has not made thorough studies on his elderly patient, who finds him with a weak pulse and failing heart function prior to death might write in the death certificate "arteriosclerotic heart disease" although this statement in these cases is confusing. "It is my strong impression . . . that doctors often diagnose heart disease in elderly people . . . (as) they do not know what else to call it." Dr. Starr stresses that the frequency of reported deaths from arteriosclerotic heart disease "excites my suspicion that the data are being contaminated . . . The reported increase in the number of deaths from arteriosclerotic heart disease seems to me difficult to interpret with confidence."

M. Makin. Friedreich's Ataxia. Hunterian Lecture, Royal College of Surgeons, London, 1957 (Scope Weekly, 35:9, 1957).

34 of 37 patients who had surgery and who had been followed for periods up to 10 years regained full functional activity. The average age was just over 10 years, but many of the patients were not treated at the time of the diagnosis. The procedure followed was subtotal arthrodesis with correction of deformity by wedging of resections. The most common deformity was symmetrical pes cavus and claw toes. Equinus was present in over half and pes varus in under half of the cases.

W. E. Holliday and A. C. Witham. The Tetralogy of Fallot. Arch. Int. Med., 3:400, 1957.

Authors report on 32 cases. Contrary to widespread belief these patients are not necessarily cyanotic from birth. Onset is quite variable and usually reflects the severity of the malformation. Cyanosis becomes manifest only when the child begins to crawl or walk. Only 50% are syanotic at 5 months of age, and approximately 20% may still be cyanotic by 2 years. The over-all incidence of the non-cyanotic tetralogy is of the order of 10%. The prognosis