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## NINETY YEARS AGO, JANUARY 1920

Murray S. Danforth, MD, in "Advances in the Surgery of the Extremities during the War," recounted: "My first recollection... is of seeing a patient lying in bed with a weight at the foot of the bed for treatment on the lower fragment of the fractured femur, and with a long board splint and coaptation splints for maintaining the fragments in position. With that method a result in a simple fracture was rated as good, when the shortening was not more than an inch or even an inch and a half. This meant a limp and subsequent back strain with a not inconsiderable disability." Post-war, therapists emphasized "not forcible manipulation" ... but "more reliance on hot and cold showers, whirlpool baths, massage, exercise..." Prewar the mortality from a fracture of the femur was 83%; post-war, it had fallen to 15%. In a comment to Dr. Danforth's paper, a Society member urged members to be cautious about applying lessons from the complicated injuries of war to civilian fractures.

Elizabeth M. Gardiner, MD, in "Child Welfare – Yesterday and To-Day," traced the Children's Federal Bureau to the 1909 White House Conference on Children's Welfare, convened by President Theodore Roosevelt. "It used to be said that once a child is born, the parents and the state must accept responsibility for its well-being. We now go a step further. The very fact that state after state... is creating new departments for child welfare... is evidence enough that the state recognizes its obligation to afford to every mother the necessary education and health facilities to insure a safely born child." The War had demonstrated the sorry state of children's health: many would-be soldiers were disqualified for health: "... a greater proportion of them represented preventable childhood diseases which we neglected to prevent."

Bennett L. Richardson, MD, in "Erythema Multiforme following Diphtheria Antitoxin," described the case of a four year-old boy, sick with diphtheria, admitted to Providence City Hospital. His brother was admitted a week later, with the same symptoms. On admission, the four year-old was given 2,000 units of antitoxin intramuscularly; two weeks later, he had a fever of 100.5 and was itching.

An Editorial, "The Encore," described the Society's decision to renew publication of the Journal: "Now that the smoke of battle is cleared away and everyone is back home again, trying to pick up the loose ends of a practice, the need of a Journal... has become more and more evident."

## FIFTY YEARS AGO, JANUARY 1960

C. Miller Fisher, MD, Assistant Professor of Neurology, Harvard Medical School, spoke on "Present Trends in the Treatment of Cerebral Vascular Disease" at the Neuropsychiatric Rounds at Rhode Island Hospital. The Journal reprinted his talk.

Orland F. Smith, MD, and Richard S. Rosen, MD, in "Colovesical Fistula: A Complication of Diverticulitis," noted that 20 years ago the surgical mortality for large bowel procedures at the Mayo Clinic was 14.7%. The authors reported on two recent cases, treated successfully.

Warren W. Francis, MD, in "Spontaneous Rupture and Herniae," described two patients – a 68 year-old man and a 2 year-old girl —where treatment called for "immediate surgical repair."

Raymond N. MacAndrew, MD, in "The Other Appendiceal Conditions," discussed the carcinoid, the mucocele, and adenocarcinoma.

An Editorial supported "A New Brown University Medical School." The *Providence Journal* had been lukewarm to the proposal.

## TWENTY-FIVE YEARS AGO, JANUARY 1985

An Editorial, "Deinstitutionalization in Rhode Island," cited an article in the *International Herald Tribune* that called de-institutionalization "a quick fix that backfired." That article had cited decreased funding, leading to an increased number of people in slum housing. The Journal editor called Rhode Island "a shining example of a successful experience," crediting Dr. Joseph Bevilaqua, former director of the state Department of Mental Health Rehabilitation and Hospitals, and his successor, Tom Romeo.

Charles E. Kaufman, MD, and Elliot M. Perlman, MD, in "Orbital Causes of Red Eye," noted: "Differential diagnosis is essential to initiate appropriate and possibly life-saving therapy."

In the "Clinico-pathological Conference: Case Report," Maurice M. Albala, MD, George F. Meissner, MD, Tom J. Wachtel, MD, and Mark Fagan, MD, editors, presented the case of a 60 year-old woman with a history of hypertension and alcohol abuse "admitted for abdominal pain." This woman, who smoked a pack a day, had been in good health until a week before admission. She was initially given 2 units of packed red blood cells. On the second hospital day "endoscopy revealed mild distal esophagitis and mild to moderate gastritis. No bleeding was seen." She was given antacids and cimetidine. On the 4th hospital days, after a barium enema, she passed bright red blood clots. On the 9th hospital day, she went into cardiac arrest and died. The anatomic diagnosis: "Aortoduodenal fistula with massive gastrointestinal hemorrhage s/p right renal artery." After 14 years, the patient showed a weakening of the suture line from an aortorenal bypass graft.