Movements Div.
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MONTHLY PROGRESS REPORT ★ SECTION 7

HEALTH

RESTRICTED

30 NOVEMBER 1945

3

ARMY SERVICE FORCES ★ WAR DEPARTMENT

HEALTH

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SUMMARY

RESPIRATORY DISEASE Presence of a definite outbreak of influenza type B in the civilian population of the U. S., coupled with the recently completed vaccination of the Army, lends unusual interest to the trend of respiratory disease in Army troops in the Z/I. Following the earlier rise in civilian influenza, the Army admission rate left its extremely low levels of less than 100 during October and early November and advanced markedly to about 150 for the week ending 30 November. However, the estimate for the next week is only 167. (See page 2)

MEDICAL ASPECTS OF PHILIPPINE CAMPAIGN AFTER LEYTE On Luzon, Sixth Army bed capacity was taxed by the highest disease rate in its experience, by a casualty rate roughly 80 percent of the average European level, and by a large number of civilian casualties. Nevertheless, Sixth Army returned to duty unusually large proportions of patients within the army area. Outstanding features of the campaign were the use of surgical teams in forward units, small plane evacuation, greater use of whole blood and penicillin, and front-line evacuation difficulties incident to combat in mountainous terrain. (See pages 3 to 16)

NONEFFECTIVE RATES The noneffective population of the Army is contracting rapidly not only because of declining strength but also because of exceptionally low admission rates. Evacuees in the Z/I number about half of the total throughout the Army, 150,000 during October and an estimated 120,000 in November. (See pages 17 to 18).

ADMISSION RATES Except for respiratory disease in the Z/I and for venereal disease both in the Z/I and in some overseas theaters, morbidity rates generally are very favorable. Admissions for nonbattle injuries have generally declined throughout the war and are currently very low. The Z/I rate of 31 for October is but one-fourth the average pre-war level. Admissions for neuropsychiatric disorders remain low or are falling in all overseas theaters except the Middle Pacific. The Z/I rate of 23 for October is about half those which obtained early in the year. The incidence of venereal disease, on the other hand, continued to increase in November, as was also true of the European Theater for October. (See pages 19 to 22)

HOSPITALIZATION OVERSEAS Fixed T/O bed capacity overseas is declining almost as rapidly as total Army strength but not nearly so rapidly as Medical Corps strength. At the end of October fixed T/O capacity overseas was about 65 percent of its level in all theaters on 1 May, and 60 percent in the European Theater. Only 55 percent of the T/O capacity was in operation, and 43 percent of the operating capacity was occupied. About a fourth of the mobile capacity was in operation, and a third of it occupied. Estimates of the total population of Army hospital patients for the first half of 1946 suggest a decline from about 200,000 on 1 January to 75,000 on 30 June. (See pages 23 to 26)

EVACUATION The number of Army patients evacuated to the Z/I declined further in November to about 11,000, or 6,000 below the October total. Effective 1 December Pacific resumed a 120-day evacuation policy. (See page 27)

HOSPITALIZATION IN THE Z/I Lengthening stay of general hospital patients arising from lessened use of convalescent hospitals has joined with certain other factors to prevent the general hospital population from falling to previously estimated levels for current dates. The cut-back program prepared in September is being revised accordingly. During November seven general hospitals closed and 12 others were in process of closing. (See pages 28 to 30)

DISEASE AND INJURY

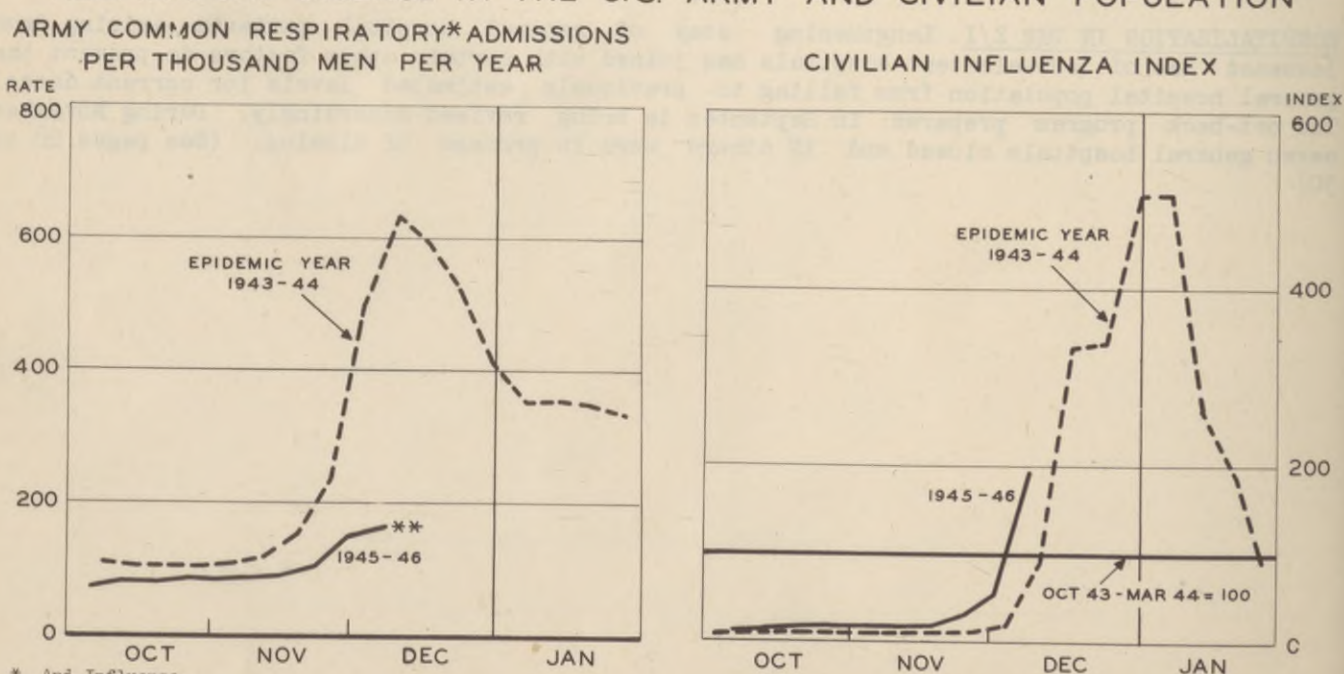
INFLUENZA IN THE ZONE OF INTERIOR

There is considerable evidence that a widespread epidemic of influenza B is under way in the civilian population of the United States and that the current sharp increase in respiratory admissions in the Army is due, at least in part, to the same disease. Through the fall the reported incidence of influenza in the civilian population fluctuated considerably but was generally somewhat higher than the median for the comparable week of the five-year period 1939 to 1943. During October the excess became greater and the reported cases doubled within a few weeks. A much sharper rise occurred in the week ending November 17. In the five-week period ending December 8, the number of cases reported weekly was 2,873, 4,146, 5,240, 13,220, and 49,694. This last figure is higher than has been reported for the first week in December in any prior year. The increase is fairly general but particularly marked in the West North Central, South Atlantic, and Mountain states with the greatest rises in the states of Kentucky, Kansas, Indiana, Virginia, West Virginia, South Carolina, and Texas. It is of interest that in 1943 the figure for the second week in December was 23,746, increasing the following week to 82,950. The accompanying chart compares the current trend with that of the epidemic year 1943-1944.

The first definite increase in common respiratory disease admissions in the Army occurred in the week ending 23 November when the rate rose from 88 to 103. The following week it was 149. There is a striking similarity between the 1943 outbreak of influenza A and that which is occurring this year, notably in the time of onset and the movement of the rate in the early phase. However, the increase has not been quite as abrupt this year. In the comparable week of 1943 the rate was 231 as compared with 149 this year, as may be seen from the chart below. A number of stations in various parts of the country have confirmed the presence of influenza virus B, either serologically or by actual isolation of the virus. Up to 7 December the highest respiratory disease rate at any station above 5,000 in strength has been 904 admissions per 1,000 men per year. In the week ending 30 November the Seventh Service Command had the highest rate, followed in turn by the Military District of Washington and the Fifth Service Command. All service commands showed a substantial increase in that week and all except the First had rates above 100. A slight increase in pneumonia was also evident, but this was largely caused by a rise in the Fourth Service Command, where the respiratory disease rate was only 121.

It is estimated that the bulk of Army personnel have now received influenza vaccine, although vaccination of many troops on furlough after returning from overseas was unavoidably delayed. It is much too early to make any statement as to the effectiveness of the vaccine, but the timing of the vaccination was nearly ideal since the civilian outbreak followed immediately thereafter. It is hoped that comparison of Army incidence of influenza with the incidence in large comparable unvaccinated groups, such as Navy personnel, will afford further evidence of the efficacy of this procedure as employed on a mass scale.

RESPIRATORY DISEASE IN THE U.S. ARMY AND CIVILIAN POPULATION



* And Influenza.
** Estimated from sample of large stations

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN

Even before the assault phase of Leyte-Samar was entirely finished (see HEALTH for June), Sixth Army had invaded Mindoro in order to secure air bases for the support of operations on Luzon, delayed by the heavy resistance on Leyte, and to protect sea routes through the Visayan waters. With Japanese air power greatly weakened by U. S. Army and Navy offensives in the air, and following three days of naval bombardment and air strikes, the Seventh Fleet moved Sixth Army into Lingayen Gulf on 9 January. The four assault divisions were organized into the I Corps, which landed on the northern beaches, and the XIV Corps, which landed on the southern. Although tactical planning had assumed heavy enemy resistance on the beachhead, virtually none developed and the bulk of the initial casualties were among the crews of combat ships hit by suicide planes and light surface craft. The troop convoys escaped damage. It is reported that Sixth Army landed about 68,500 troops on S-Day, a number in excess of the 60,000 put ashore by the First Army on D-Day in France but under entirely different tactical conditions. Other major landings are located on the accompanying map. Enemy strength was variously estimated at 160,000 to 230,000 troops. The Japanese contested neither the beaches nor the flat coastal area encompassed by the Ango River, preferring to make their stand in the mountains despite their numerical superiority in armor. This action foretold the nature of the campaign. It was to be mainly a long contest in mountainous terrain with an enemy expert in the preparation and use of elaborate defensive positions. The I Corps was soon heavily engaged as it attempted to penetrate to the north of the beachhead, but the XIV Corps drove more than a third of the way south to Manila before encountering substantial resistance. The landing at Lingayen Gulf caught the Japanese 14th Army moving its Luzon forces northward into defensive concentrations, and severance of enemy communications soon split the Japanese troops into several independent parts incapable of mutual support. They developed only two large centers of resistance, one in the I Corps area centering on Baguio in Northern Luzon, the other in the XIV Corps area in Manila and surrounding territory.

Elements of the XIV Corps reached Manila on 3 and 4 February from different directions and the city was largely liberated by 15 February. The Japanese, largely naval troops, destroyed the bridges across the Pasig River and turned the center of the city and the Intramuros into a fortress, demolishing what they could not defend in the most bitter struggle of the entire campaign. About 16,000 Japanese troops were killed before the city was finally secured on 5 March.

In the north, the I Corps met especially heavy resistance along the Villa Verde Trail in its drive toward Baguio and the Cagayan Valley in north-central Luzon. Meanwhile the XI Corps cleared the enemy from Bataan and Corregidor. By the first of June opposition to U. S. penetration of the Cagayan Valley had been broken, but 41,000 Japanese remained concentrated in two pockets on Luzon, the larger in Cagayan Valley and surrounding mountains, the smaller in the Sierra Madre mountains east of Manila. By 30 June organized resistance in these areas had been reduced to a point where Eighth Army could assume responsibility, relieving the Sixth to prepare for the assault on Kyushu.

Having relieved Sixth Army of operational responsibility for the Leyte-Samar area on 26 December 1944, and Mindoro on 1 January 1945, Eighth Army continued mopping up on Leyte and mounted a great number of lesser operations while Luzon was in progress. These landings were made by forces ranging in size from patrols to two divisions and effectively secured the sea passages among the islands and destroyed Japanese garrisons. The operational areas established on 10 February for the two field armies conducting the Philippine Campaign are shown on the map on page 4, as are the chief landings made by Eighth Army. The largest and most important of these operations was Mindanao, previously intended as the initial target for U. S. forces in the Philippines. Eighth Army landed elements of the 41st Infantry Division on Zamboanga on 10 March, and on 17 April X Corps landed the first of two divisions on southwestern Mindanao. The final surrender did not take place until 2 September.

Casualties

By 30 June, after a campaign of 255 days, all organized resistance in the Philippines had been overcome, although mopping-up continued for two months. It was estimated that only 31,000 Japanese troops remained in the Philippines on 30 June, and 22,000 on 31 July. From 19 October 1944 to 30 June 1945 it is estimated that 290,000 Japanese were killed or died. and 10,000 were captured. U. S. battle losses were 14,300 killed or died of wounds, 49,700 living wounded, and 1,600 missing. About 20 Japanese were killed for each American combat death. In relation to all U. S. forces in the Philippines these casualties are equivalent to a rate of 0.74 per 1,000 men per day, while the comparable theater rate of 0.30 is about half that which obtained in the European Theater from June 1944 to May 1945. The tabulation below summarizes the casualties for the various phases of the campaign as revealed by preliminary operational reports and radiograms to the War Department. The calendar periods

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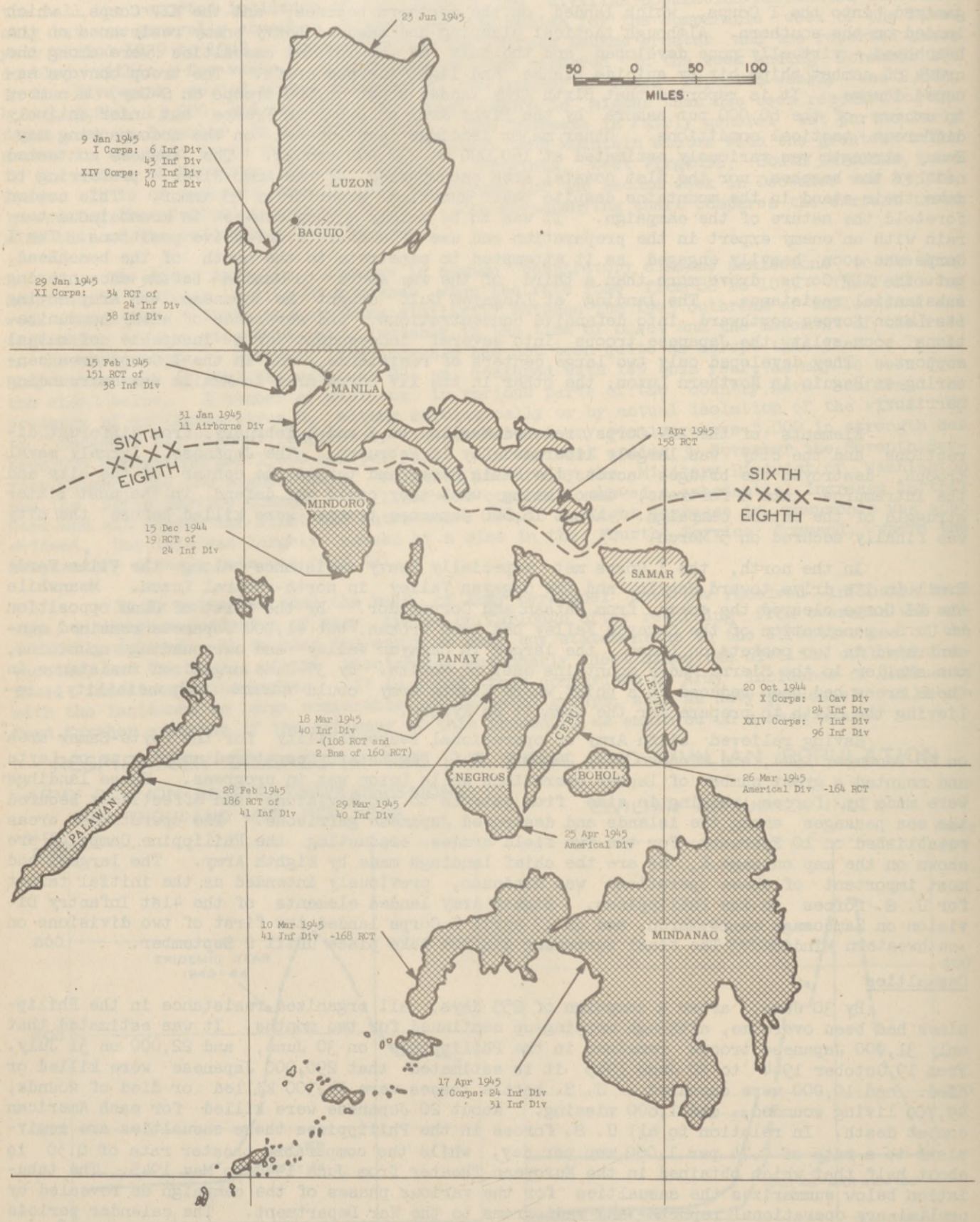
ASSAULT LANDINGS IN THE PHILIPPINE ISLANDS

19 OCTOBER 1944 — 30 JUNE 1945



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MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

tabulated do not necessarily coincide with the combat periods. Rates for the various islands are based upon average ground and service strength only, excluding air, although the casualty counts include those of all U. S. forces. Since the counts of casualties for the ground arms are probably incomplete, any error in the resulting rates is probably small. Wide variation in the size and composition of the forces employed on the different islands prevents ready

CAMPAIGN CASUALTIES IN THE PHILIPPINES

Area	Period	Average Strength	Number of Men	
	From - To		Killed or Died	Living Wounded
LEYTE-SAMAR and CENTRAL VISAYAN ISLANDS				
Sixth Army	19 Oct '44 - 25 Dec '44	140,400	2,888	9,858
Island	19 Oct '44 - 30 Jun '45	145,700	3,601	11,054
MINDORO	15 Dec '44 - 30 Jun '45	18,900	19	165
LUZON				
Sixth Army	9 Jan '45 - 30 Jun '45	180,200	8,664	29,121
Island	9 Jan '45 - 30 Jun '45	265,400	8,946	31,329
PALAWAN	28 Feb '45 - 30 Jun '45	2,600	13	55
PANAY-NEGROS ORIENTAL	18 Mar '45 - 30 Jun '45	15,100	343	1,365
CEBU-NEGROS OCCIDENTAL	26 Mar '45 - 30 Jun '45	19,500	593	1,903
MINDANAO and SULU ARCHIPELAGO	10 Mar '45 - 30 Jun '45	41,700	828	3,805
Total Philippines	19 Oct '44 - 30 Jun '45	351,000	14,343	49,676
Total Theater	1 Oct '44 - 30 Jun '45	817,100	14,645	50,171

Area	Rates Per 1,000 Men Per Day		Japanese Casualties		Enemy Dead Per U. S. Fatality
	Killed and Died	Living Wounded	Killed	Captured	
LEYTE-SAMAR and CENTRAL VISAYAN ISLANDS					
Sixth Army	0.30	1.03	-	-	-
Island	0.10	0.29	83,225	1,023	23
MINDORO	0.01	0.04	1,608	108	85
LUZON					
Sixth Army	0.28	0.93	-	-	-
Island	0.19	0.68	172,216	7,166	19
PALAWAN	0.04	0.17	791	17	61
PANAY-NEGROS ORIENTAL	0.22	0.86	5,026	306	15
CEBU-NEGROS OCCIDENTAL	0.31	1.01	9,959	390	17
MINDANAO and SULU ARCHIPELAGO	0.18	0.81	16,968	1,038	20
Total Philippines	0.16	0.56	289,811	10,048	20
Total Theater	0.07	0.22	296,129	12,183	20

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

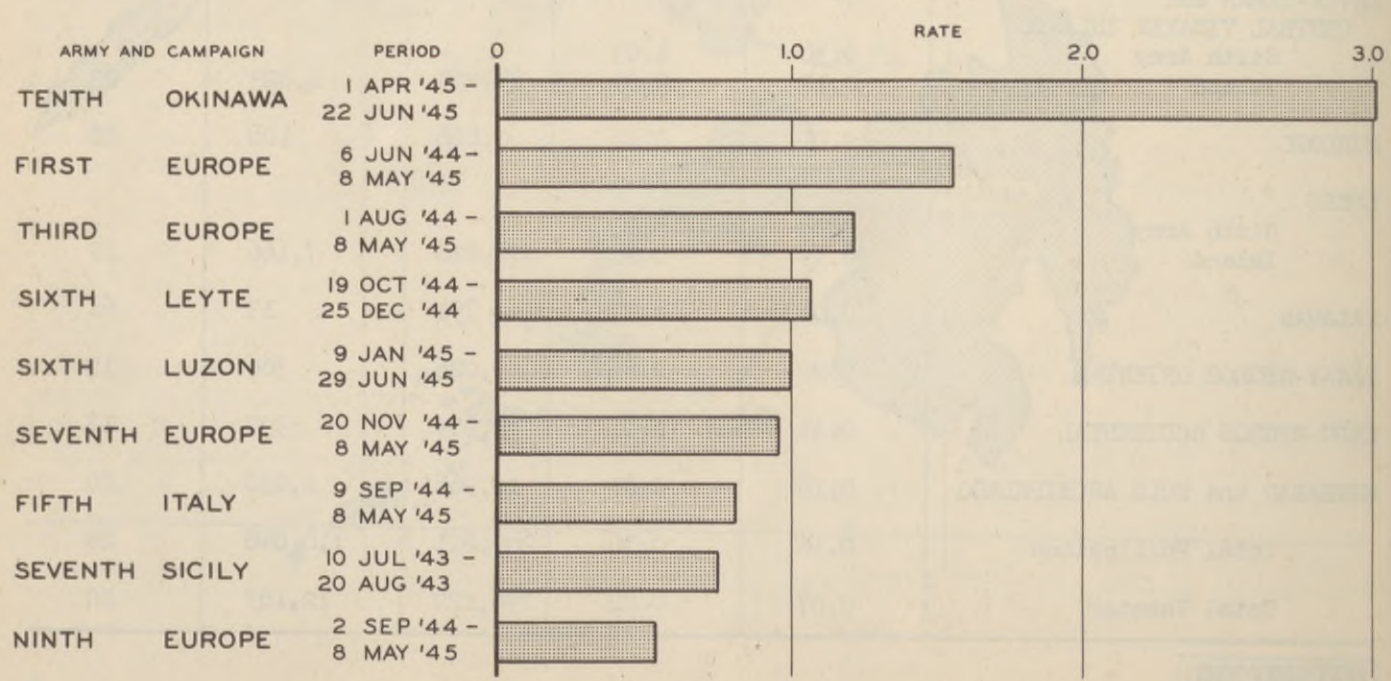
comparisons among the casualty rates for each island. However, Sixth Army rates for Leyte and Luzon may be compared directly. The rates for the other phases of the Philippine campaign may also be compared with those for previous Pacific operations where similar forces were engaged (See HEALTH for May 1945). Comparisons of the Pacific and European campaigns at the army level may be made fairly directly also, as the proportionate contributions of the combat divisions to army strength have been about the same. The chart below gives admission rates for wounded for the various armies in the major campaigns of the war. It shows again how severe was the fighting on Okinawa, for the Tenth Army rate is almost twice that for any other army. The Ryukyus campaign, however, was relatively short and the combat units of Tenth Army were almost continuously engaged. For the first 87 days of combat in Europe, First Army sustained 2.9 wounded per 1,000 strength per day, the same as the rate for Tenth Army. The Sixth Army wounded rate for Luzon was 80 percent of the average army rate for the European campaign, and in excess of those in the Mediterranean. A similar result is obtained by contrasting average rates for combat divisions. For example, the rate of 1.7 for Sixth Army divisions on Luzon is 85 percent of the European Theater average of 2.0 living wounded per 1,000 men per day. Some indication of the intensity of the fighting on Luzon may be gained from the fact that the 37th Infantry Division, in crossing the Pasig River and assaulting the Intramuros, reported average rates of 6.5 men wounded per thousand divisional strength per day for the entire month of February, and an average of 9.0 for its highest week in February. The latter value is in the area of the highest divisional rates in the European Theater, being exceeded by only 7 percent of the division-weeks tabulated for 1944. A comparison of the distributions of weekly rates for Luzon and the European Campaign during 1944 is made in the chart on page 7. The Luzon sample excludes only six percent of the division-weeks, mainly those early in the campaign. The European sample is about 99 percent complete, lacking mainly some of the early weeks of the action.

SURGERY

Although the number of surgical admissions fell far short of the medical cases during the Philippine Campaign, the load was nevertheless heavy, especially during February and March. No independent evaluation of surgical practice can be made here but medical reports make it plain that surgical services on Luzon were more highly organized than in any previous Southwest Pacific operation. The chief methods employed by consultants at theater and army level were continual indoctrination in sound surgical principles, control over the assignment of specialized surgical personnel (which was scarce), the tracing of mishandled cases, frequent inspections, and the strengthening of field and evacuation hospitals with surgical teams. Of great value in improving the lifesaving potentialities of surgery were the increased resort to whole blood in the management of shock. the more extensive use of peni-

WOUNDED ADMISSIONS TO HOSPITAL AND CLEARING STATIONS

RATE PER THOUSAND MEN PER DAY



MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

cillin, and the greatly improved evacuation facilities of the forward zone. Seventeen teams of highly qualified surgeons from base hospitals were attached to field and evacuation hospitals of the Sixth Army, and portable surgical hospitals generally cared for nontransportable patients at the level of clearing stations or even farther forward in many instances. Small plane evacuation greatly reduced the lag between wounding and surgery for the most seriously wounded, proved useful in transferring some patients to specialized hospitals, and occasionally even served to carry surgical specialists to non-transportable patients. Whole blood was used in increasing amounts as the campaign progressed, the issues being more than sufficient to permit consumption at a rate consonant with European standards. Although some was out-dated on arrival at forward installations, all unit reports confirm its value. The prevalence of gas gangrene among Sixth Army wounded declined from 1.0 percent on Leyte to only 0.1 percent on Luzon. The incidence of gas gangrene has gradually declined in all theaters with greater and better experience in surgery. Among an estimated 10,000 to 12,000 civilian casualties, however, there were about 500 cases of tetanus, 80 percent of whom died. There was no tetanus in U. S. Army personnel.

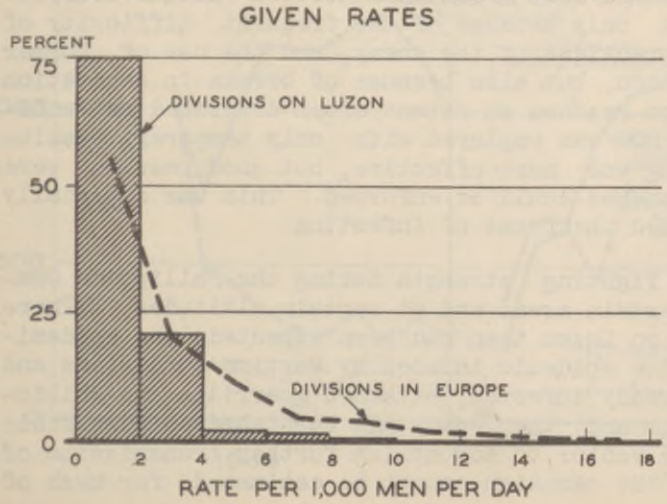
Complete information on causative agents is not available, but the reports of the 25th,33rd, and 41st Infantry Divisions and a few hospitals provide a sample of 6,700 wounded. Representing over 15 percent of all the wounded in the Philippines during the first half of 1945, this sample suggests that roughly 40 percent were injured by bullets, 58 percent by high explosive fragments, and two percent by other agents. Although the Japanese weapons encountered on Luzon are described as the heaviest which had been met in the theater up to that time, the resulting ratio of 1.4 fragment to one bullet wound is low in comparison with Iwo Jima and the Ruykyus,not to mention the European campaigns (see HEALTH for September, page 4). Two divisions provided data which permit an estimate of the proportions who were fatally hit among all those hit by the two types of weapons. Out of 3,600 men hit the average fatality was 22 percent for all weapons, 28 percent for bullets, 20 percent for shell and bomb fragments, and five percent for grenade fragments, rather close to previous Pacific experience. The same observations provide information on the proportionate fatality of hits according to region of the body. Roughly 40 percent of all those hit in the head, 44 percent in the chest, 41 percent in the abdomen, and four percent in the extremities were killed or died of wounds. These figures are fairly similar to those reported in HEALTH for May (pp. 2 to 5).

The average fatality among all wounded admitted to hospitals in the theater was only 4.6 percent up to the end of 1944, but it had risen to 6.3 percent by the time hostilities had ceased, according to figures published by The Adjutant General. Medical reports, on the other hand, which include wounded admitted to clearing stations but not to hospitals, yield 5.1 percent for all troops in the theater during the first half of 1945, and 6.5 percent for 1944. Comparison of such figures is necessarily inconclusive because of the intricacies of present reporting methods, as has been discussed previously in HEALTH (see issues for April 1944 and October 1944). However, the weight of evidence suggests that the average proportion dying of wounds has been generally greater in the Southwest Pacific than in the European combat zones, and that the 1945 proportion was materially lower than that for 1944.

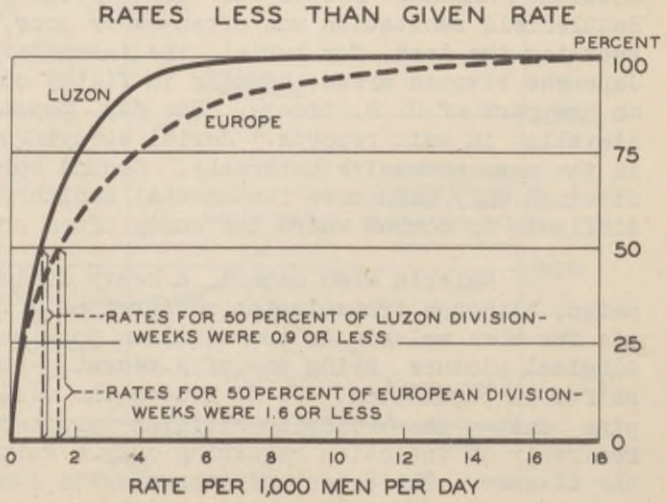
NUMBER OF MEN WOUNDED PER THOUSAND DIVISIONAL STRENGTH PER DAY

BY WEEKS

PERCENT OF DIVISIONAL WEEKS HAVING GIVEN RATES



PERCENT OF DIVISIONAL WEEKS HAVING RATES LESS THAN GIVEN RATE



MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

Disease

On Luzon, after Sixth Army had sustained disease admission rates averaging 1,154 per thousand men per year on Leyte, its weekly rate rose rapidly to a peak of 1,760 in the fifteenth week after S-Day, as may be seen in the accompanying chart, the highest they had been since that army took the field early in 1943. The seemingly abrupt drop in the disease rates for Sixth Army between the Leyte and Luzon campaigns is the result of the almost complete reconstitution of the army which had fought on Leyte. Although some divisions which had been in combat on Leyte were committed on Luzon after S-Day, when it entered combat Sixth Army was composed entirely of new divisions staged elsewhere. The XXIV Corps which had constituted about half of Sixth Army on Leyte left the western Pacific for the Ryukyus. During the Luzon campaign monthly rates for all troops in the Philippines reached their highest point, about 1,270 admissions per 1,000 men per year in May, and the corresponding theater rate was raised to about 1,140, its highest level since early 1943 before malaria was brought under control. The following table compares Sixth Army disease and injury rates on Luzon with other army rates during combat periods. Only Seventh Army in the short Sicilian operation had a higher disease rate.

HOSPITAL AND CLEARING STATION ADMISSIONS PER 1,000 MEN PER YEAR BY CAUSE
Various Armies in the Field

Theater and Army	Dates of Experience	Rate			
		Disease	Injury	Wounded	Total
Southwest Pacific					
6th Army					
Luzon	9 Jan '45 - 29 Jun '45	1,434	128	365	1,927
Leyte	22 Oct '44 - 30 Dec '44	1,154	149	367	1,670
Pacific Ocean Areas					
10th Army					
Okinawa	1 Apr '45 - 22 Jun '45	409	384	1,100	1,893
Mediterranean					
7th Army					
Sicily	10 Jul '43 - 20 Aug '43	1,464	445	274	2,183
5th Army					
Italy	9 Sep '43 - 8 May '45	892	148	295	1,335
European					
1st Army	6 Jun '44 - 8 May '45	529	181	579	1,289
3rd Army	1 Aug '44 - 8 May '45	598	162	448	1,208
7th Army	20 Nov '44 - 8 May '45	602	212	355	1,169
9th Army	2 Sep '44 - 8 May '45	375	105	198	678

Apart from undiagnosed fever, later found to be diarrheal disease, malaria, or hepatitis, diarrheal disease (of which 20 percent was reported as dysentery) was the most frequent cause of admission. Both civilians and Japanese suffered heavily from these disorders, and their poor sanitary practices encouraged the extensive fly-breeding conducive to transmission. Another factor was that troops consumed food from unauthorized native sources. Battlefield sanitation was often very poor, not only because of the frequent difficulty of reaching the dead for burial, the insanitary practices of the enemy, and the use of former Japanese bivouac areas, usually in filthy condition, but also because of breaks in sanitation on the part of U. S. troops. The fly population reached an extent often described as "unbelievable" in unit reports. Aerial spraying of DDT was employed with only temporary results in the most extensive outbreaks. Ground spraying was more effective, but good results were obtained only when more fundamental sanitary measures could be enforced. This was especially difficult in combat where the enemy often provided the focus of infection.

Malaria also caused a heavy drain on fighting strength during the Philippine Campaign, although transmission occurred only in certain areas and at certain altitudes. There was far more malaria in the civilian population on Luzon than had been expected, the epidemiological picture being one of a recent, extensive epidemic induced by wartime conditions and shifts in population. U. S. troops who were already infected, attached guerrilla and Philippine units, the Filipino civilian population, and the enemy all furnished an accessible reservoir of infection requiring only a suitable vector to accomplish further transmission of the disease. The extent of transmission during the campaign cannot be estimated, for much of

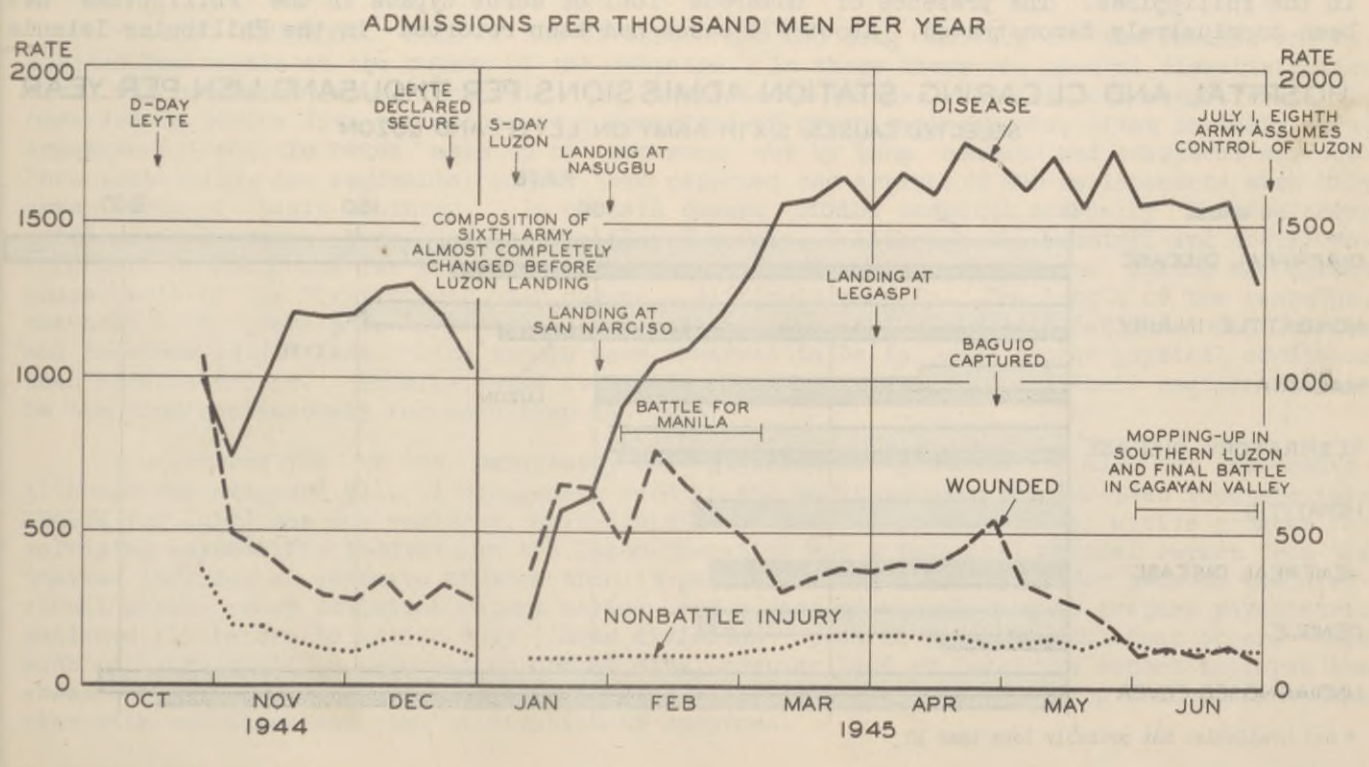
MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

the recorded clinical malaria undoubtedly resulted from previously acquired infections and many new infections were suppressed by atabrine. Basic malaria survey and control work was performed in base areas and as far forward as the divisional rear, but few unit reports allege intensive use of individual preventive methods under combat conditions. Some, in fact, reflect the view that they are impractical. Regardless of the extent of transmission, a major factor in the malaria picture was the at least occasional failure of atabrine discipline. With continuous atabrine suppression there is, of course, no sure way of knowing how heavily seeded a unit may be, but it must be assumed that most of the combat divisions were fairly well seeded, needing only a break in atabrine discipline to cause their admission rates to rise. The combat divisions experienced difficulty in maintaining satisfactory discipline among front-line troops among whom the rates were highest. A Sixth Army report includes the following significant comment: "Supervision of atabrine administration is difficult during combat, particularly when troops are tired and dispirited from long combat in inhospitable terrain. It is not unlikely that a good many troops deliberately evaded the taking of atabrine in the hope that an attack of malaria would take them to the comparative luxury of a hospital."

Hepatitis was in many ways the most serious disease problem of the campaign. Since its mode of transmission is not known, and it has an incubation period of four to eight weeks, it is difficult to incriminate specific areas or even to establish specific control measures. About 9,600 cases were reported by Sixth Army during the combat period and the total time lost by these men in the army area alone is equivalent to a constant army understrength of about 1,400 men throughout the operation. Most units confined their efforts to the isolation of known cases and to efforts to improve sanitation. Very little hepatitis was reported from Leyte before the end of 1944, but assault transports moving at least one division from Leyte to Luzon in January had cases on board, and the January rate of 63 for the Philippines as a whole is ten times that for December. Virtually all combat units reported large numbers of cases, rates of several hundred per 1,000 per year being sustained by many for several consecutive months. The peak monthly admission rate of about 200 for the Sixth Army in May exceeds any rate ever reported by the Fifth Army in Italy during the height of the epidemic season there. As late as July most of the Sixth Army divisions were still reporting admission rates in excess of 100, the army rate being 124.

Once Manila was reached venereal disease became a major cause of admission in the theater for the first time since the summer of 1942, when rates of 40 to 50 were experienced in Australia for a brief interval. From less than ten per 1,000 men per year during the first

SIXTH ARMY DISEASE, INJURY, AND WOUNDED ADMISSIONS TO HOSPITALS AND CLEARING STATIONS DURING LEYTE AND LUZON CAMPAIGNS



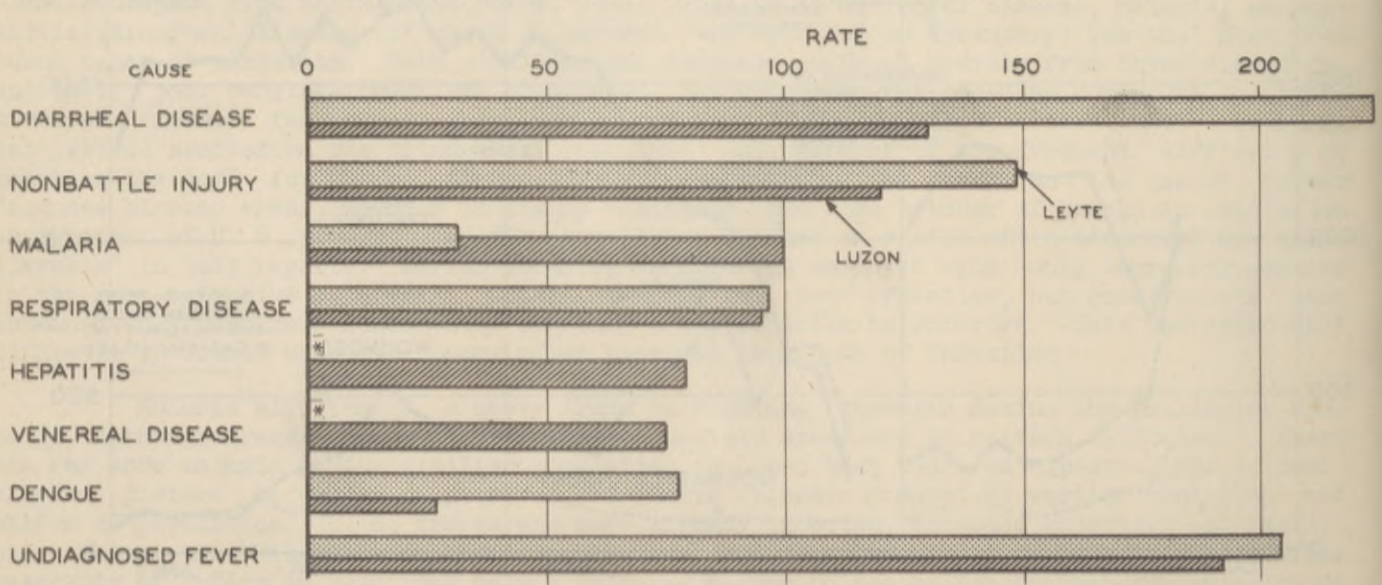
MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

five months in the Philippines, the admission rate for all troops in the Philippines advanced to 57 in March, 113 in April, and 123 in May. Thereafter it declined steadily to 99 in August and 93 for the first two weeks of September. Combat units contributed in large measure to this rise, for Sixth Army rates were almost as high as those for all troops in the Philippines, and many divisions reported rates in excess of 100 for weeks on end. It is unusual for a tactical unit to have high venereal disease admission rates during combat, but on Luzon, as elsewhere in the Philippines, contact with civilians was almost constant for many units and opportunities for sexual contact, long denied by the prior environment of most troops, were extremely favorable. Prostitution was prevalent not only because of the mores of the civilian population, inflationary prices, and widespread economic destitution, but also because most of the troops had experienced a long period of comparative continence and were willing to pay high prices. At one time it was estimated that there were 8,000 prostitutes in Manila, 75 percent of whom were infected. Prophylactic materials were not always in ample supply during the first quarter of the year, but this fact perhaps does no more than point to the degree of sexual exposure prevalent. Customarily Army and/or civilian authorities rounded up known prostitutes for examination and treatment, but this measure as usual did not lead to effective control. It was, of course, supplemented by an intensified educational program and occasionally by placing towns off limits, but recreational facilities were very poor and sexual contact too easy. Only a few unit reports mention any attempts to suppress prostitution. Others, including Sixth Army medical reports, make it plain that authority for the outright suppression of prostitution was denied by top commanders until late in June, when the theater directed that measures be taken to repress prostitution. The comprehensive control program developed at that time appears to have borne fruit, for the decline in admissions was sharp in July and August despite the fact that cessation of combat provided combat troops with more leisure for contact with the civilian population.

Other diseases of particular interest during the campaign include dengue, skin disease, schistosomiasis, scrub typhus, and poliomyelitis. There were about 2,000 cases of dengue in the Sixth Army during the first five months of the year in contrast to about 9,000 cases of diarrheal disease, the rate for the period being 27 per 1,000 strength per year. The highest incidence of dengue in the Philippines was reached in December 1944 with a rate of 49 for all forces, a gradual decline being evident thereafter. No summary statistics for skin diseases are available, but all reports speak of a lowered incidence associated with the dry season on Luzon. Schistosomiasis reached a peak early in 1945 and then declined except for a slight rise in July. It seems probable that practically all the infections were contracted on Leyte during the early stages of the campaign when men had to wade through infected water in the course of military operations. Later when the situation became more stabilized and the danger of contact with infected water was more generally appreciated, few new infections occurred. During the first six months of the year there were about 900 cases in the Philippines. The presence of numerous foci of scrub typhus in the Philippines has been conclusively demonstrated. About 275 cases had been reported in the Philippine Islands

HOSPITAL AND CLEARING STATION ADMISSIONS PER THOUSAND MEN PER YEAR

SELECTED CAUSES, SIXTH ARMY ON LEYTE AND LUZON



* Not available, but probably less than 10

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

by the end of August, a large number of which had been traced to numerous endemic foci throughout the islands. Most of the latter cases were contracted on Mindoro. There were also 123 cases of poliomyelitis with 26 deaths in the Philippines during the first five months of the year.

At the height of the fighting on Luzon the incidence of neuropsychiatric disorders in the theater reached its peak for the war with rates of 70 admissions per 1,000 men per year in February and 74 in March. For the troops in the Philippines the rates for these months are slightly lower. Only in May did the rate for the Philippines exceed that for the theater, and then by a margin of only two points. If it be assumed that enhanced combat activity caused the theater rate to rise, it is noteworthy that the rate for all troops in the theater should exceed that for the combat area, and furthermore, that the latter should exceed the rate for the Sixth Army, the major tactical command. Some part of the latter discrepancy may be explained by the apparent lack of statistical controls in the reporting of psychiatric cases which had the effect of minimizing reported admissions in tactical organizations and of increasing admissions (by change of diagnosis) in hospitals supporting the armies. Divisional data fail to reveal the clear-cut relation between combat intensity and psychiatric admissions typical of the European and Mediterranean experience. If the reporting errors mentioned by various units are typical of divisional reporting, they may account in large measure for the failure of the Pacific data to parallel the European in this respect as well as for the low rate in the major tactical command. It may be noted that Sixth Army had no consultant in neuropsychiatry until three weeks before the campaign closed, so that units were under perhaps less than the usual amount of pressure to place their psychiatric reporting on a conventional basis. Unfortunately Sixth Army medical reports on the Luzon operation make no mention of the psychiatric problem. In the absence of reliable statistics it is necessary, therefore, to rely upon the unsystematic comments made in medical reports of lesser units. Review of all available unit reports on the operation suggests, without establishing, the following general propositions about the psychiatric problem during the operation:

(1) MAGNITUDE OF THE PROBLEM. For the Sixth Army there were about 6,000 psychiatric admissions from January through June, or one-fifth the total wounded, and roughly 8,000 cases among all combat troops in the Philippines during this interval. Reported divisional ratios varied but were on the order of one psychiatric case to four to ten wounded during months of active combat. The Sixth Army admission rate reached about 100 per 1,000 men per year in February and again in April. There was a gradual rise in the ratio of psychiatric to wounded patients, ranging from about one to ten in January to one to four in April and May, Divisional admission rates varied widely, but some divisions experienced monthly rates in excess of 200 per 1,000 men per year.

(2) ETIOLOGY. Some of the divisions had had long service in the Pacific and exhibited low morale at the outset of the campaign. In these there was general dissatisfaction with the rotation scheme and with the established quotas. Admissions were frequently observed to divide into two groups, one comprised of green replacements, often in their first engagement, and the other made up of men worn out by long combat and tropical service. Parenthetically, one regimental combat team reported the arrival of 400 replacements with only seven weeks of basic training. In certain phases of the campaign unusually intense enemy artillery and rocket fire undoubtedly played a role. Although the physical and social environment on Luzon was far more agreeable than on New Guinea or even Leyte during the combat phase, much of the fighting was over rugged, difficult terrain. The length of the campaign, the heat, the prevalence of disease, and related factors combined to fatigue combat troops and to cause weight loss. Line troops were observed to be in much poorer physical condition than service troops. Finally, some divisions (but not necessarily all their regiments) were in the line continuously for more than 100 days.

Information on the management of psychiatric patients is also not extensive. Although the standard plan of management used in the Mediterranean and European Theaters (see HEALTH for July) was not employed, each division of the Sixth Army had an active program for salvaging psychiatric patients in the Luzon operation and a technical medical report from the theater includes an estimate of more than 75 percent having been saved for duty in the divisional area. Most divisions report having used a rest or casual camp to prepare psychiatric patients for return to active duty. Some divisions appeared less hopeful than others that such patients could be returned to combat duty, however, and at least one report deplored the absence of any means of reclassification within the division, necessitating evacuation to the rear with the attendant risk of fixation of symptoms.

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

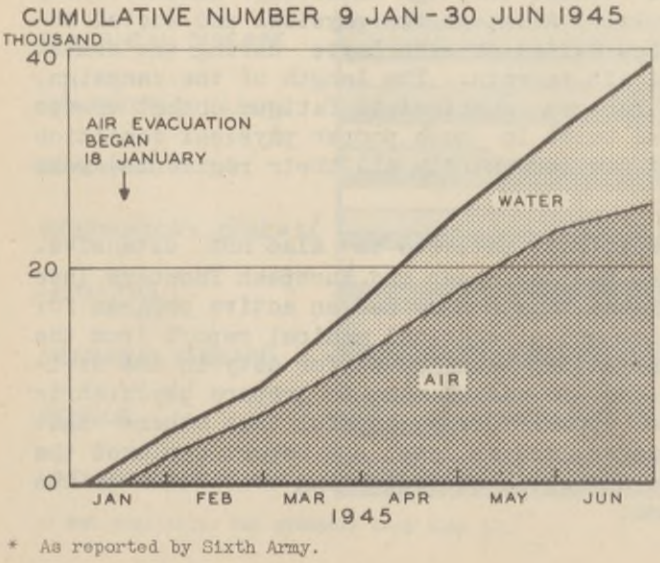
Evacuation

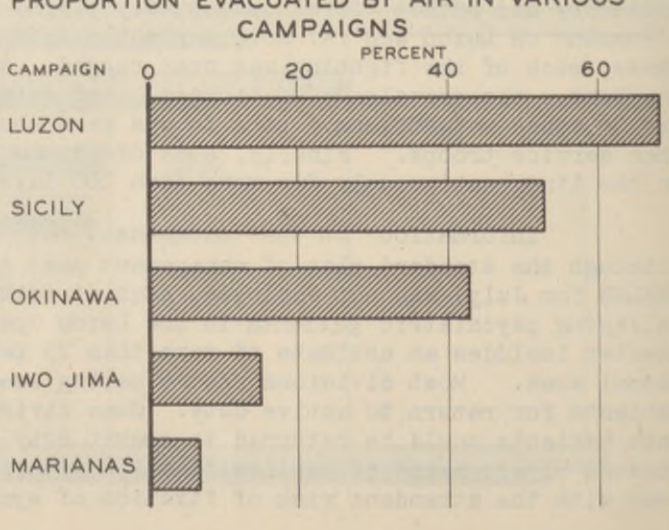
Lack of real opposition on landing at Lingayen obviated many of the evacuation problems expected in amphibious operations, permitting Sixth Army to set up adequate hospital capacity in advance of a large influx of casualties, and taking away much of the emphasis usually placed upon evacuation by water. Air evacuation was begun on D+9 and outweighed water evacuation in each month until June. Of the 38,000 patients evacuated from Luzon, 68 percent went by air. The accompanying chart permits comparison of this percentage with those of other operations. Although LST(H)'s and lesser craft were available in amphibious operations elsewhere in the Philippines, air evacuation was quite generally preferred to water evacuation. On the central plains of Luzon, or whenever excellent roads were available, evacuation by ambulance was generally easy. However, most of the combat occurred in mountainous regions where the enemy sought to exploit the full advantages of his prepared defensive positions. In consequence, evacuation from forward echelons was frequently difficult, requiring long litter-hauls over rough terrain, frequently exposed to sniper fire. Although most of the Philippine fighting occurred during the dry season, enough rain fell to hamper evacuation in some areas on Luzon, and more particularly on Mindanao.

Soon after landing Sixth Army assumed responsibility for evacuation from the divisional and corps areas and assigned to a medical group the task of directing and coordinating the evacuation of division, corps, and army units, including hospitals. This mission extended to the coordination of air evacuation off the island as well as intra-island. In the most extensive and successful use yet made of small planes, Sixth Army greatly speeded up evacuation from the divisional area, especially of the critically wounded, equalized the surgical load among hospitals, and obtained a large measure of freedom in the location of hospitals. Excellent cooperation both from the Engineers, who built the strips, and from the Air Corps assured the success of small plane evacuation not only on Luzon but also on other islands in the Philippines. Of the 161,000 patients transported on the island of Luzon, 12,000 were carried by C-47 planes, 18,000 by L-5 planes, 1,000 by C-64 planes, and 129,000 or 80 percent by motor ambulance. Helicopters were used also to a small extent. Observers have suggested the inclusion of plane ambulance units in the medical service of the field army on the basis of this experience, similar to that on Okinawa.

In the main both armies operated on 30-day evacuation policies, although Sixth Army was forced to lengthen its policy in March as Leyte hospitals became so full that off-island evacuation was erratic. In consequence some Sixth Army hospitals were taxed far beyond their T/O capacity. Later, as Sixth Army hospitals were moving from Manila, delays in setting up base hospitals in the war-torn city resulted in a shortage of beds which made evacuation a serious problem. Leyte, the base hospital area supporting Luzon and other combat areas, received 26,000 patients during the second quarter in addition to 21,000 originating on Leyte. More than half came from Luzon, about 5,300 from Mindanao, 4,100 from Cebu, and smaller numbers from other islands. Leyte hospitals were too full to accommodate all the patients from the Philippines, however, and it was necessary to evacuate patients from Manila to Biak throughout the second quarter. For example, 3,300 patients were evacuated from Manila to Biak as late as June. Water evacuation to the Z/I began from Leyte in February, and

EVACUATION OF PATIENTS FROM LUZON* BY MEANS OF TRANSPORTATION





* As reported by Sixth Army.

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

on 1 May the trans-Pacific air evacuation terminus moved from Biak to Leyte. There was no considerable water lift from Manila to the Z/I between April and June, but the air evacuation terminus was moved to Manila on 1 June and several hundred patients were flown to the Z/I in that month.

Hospitalization

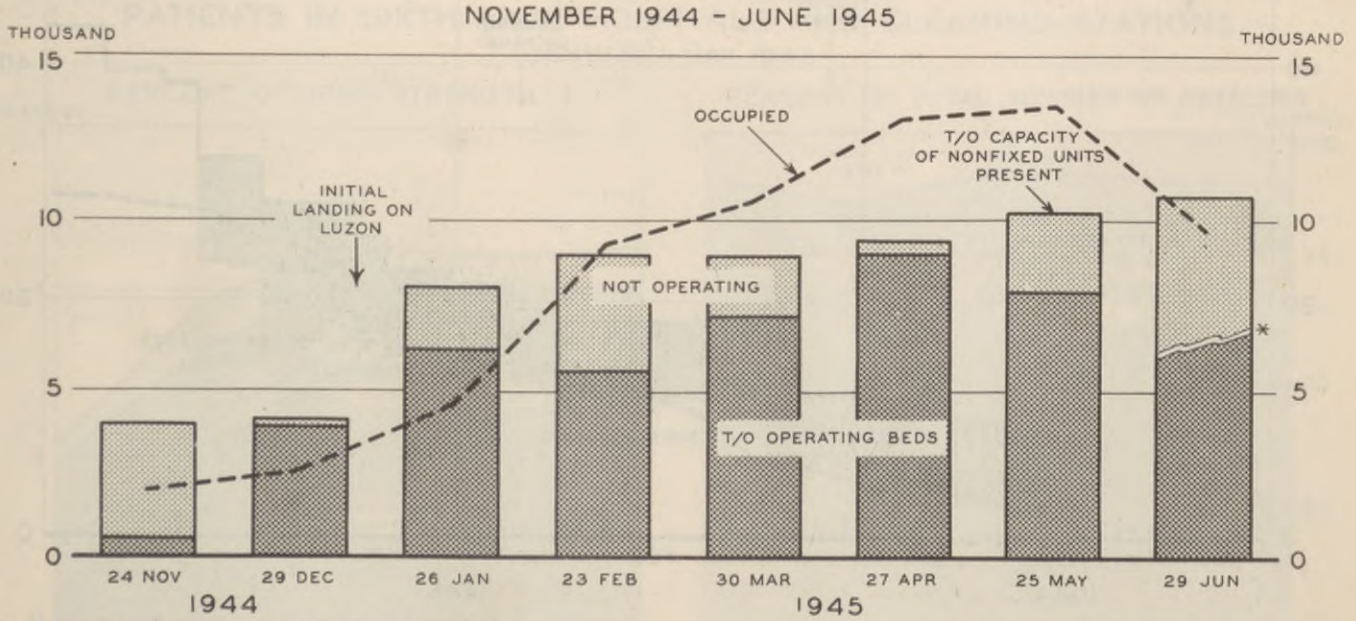
Luzon gave Sixth Army its first opportunity to operate medical services along classical lines with echelons more or less conventionally arranged in depth, but hospital facilities both in Sixth Army and throughout the Philippines became quite crowded during the campaign. The initial landings on Luzon were made with two evacuation hospitals of 750-bed capacity and three of 400-bed capacity, six field hospitals, and 17 portable surgical hospitals. In addition the Sixth Army Service Command soon brought both station and general hospitals which passed to Base M on 13 February with the establishment of the first base under the Luzon Base Section, USASOS. The two 750-bed evacuation hospitals were also detached from the Sixth Army, one remaining at Base M and the other being set up in Manila. However, other 400-bed evacuation and field hospitals, including those of the XIth Corps, were added, so that the Sixth Army had from 5,000 to 6,700 mobile T/O bed units throughout the campaign, an average of 3.2 percent of strength. Although somewhat less than was generally available to the armies in Europe, this amount of hospitalization was the best of any Southwest Pacific operation. By the end of March the Luzon Base Section was landing fixed hospitals in Manila to release army units for operations to the south.

In general, divisions had attached portable surgical hospitals on the basis of one per regiment, and all other hospitals operated directly under army control. Army hospitals were supported by the base sections on Luzon and Cebu with their fixed and mobile beds, and these in turn were backed by the fixed bed capacity on Leyte. Smaller units operating as independent task forces had hospitals attached as needed. Leyte provided up to 15,000 beds which became quite crowded with evacuees from all operational areas as the campaign progressed. All Leyte hospitals were directed to expand by 50 percent of T/O capacity. In addition to Leyte were the bases to the south, especially Biak, to which it was necessary to transfer patients throughout the Philippine Campaign because too few hospitals could be transported to the Philippines.

Suitable Sixth Army data are not available to illustrate the extent to which Sixth Army hospitals were crowded. However, the chart below provides this information for mobile hospitals in the Philippines as a whole. Fixed hospitals in the Philippines were also crowded in this period, but much less so, as is evident from the chart on page 14 which extends that shown in the report on Leyte which appeared in HEALTH for June. Comparison of admissions and mobile hospital bed capacity (including convalescent hospitals) indicates that

CAPACITY AND OCCUPANCY OF NONFIXED HOSPITALS IN THE PHILIPPINE ISLANDS

NOVEMBER 1944 - JUNE 1945



* Number of T/O beds operating is not available.

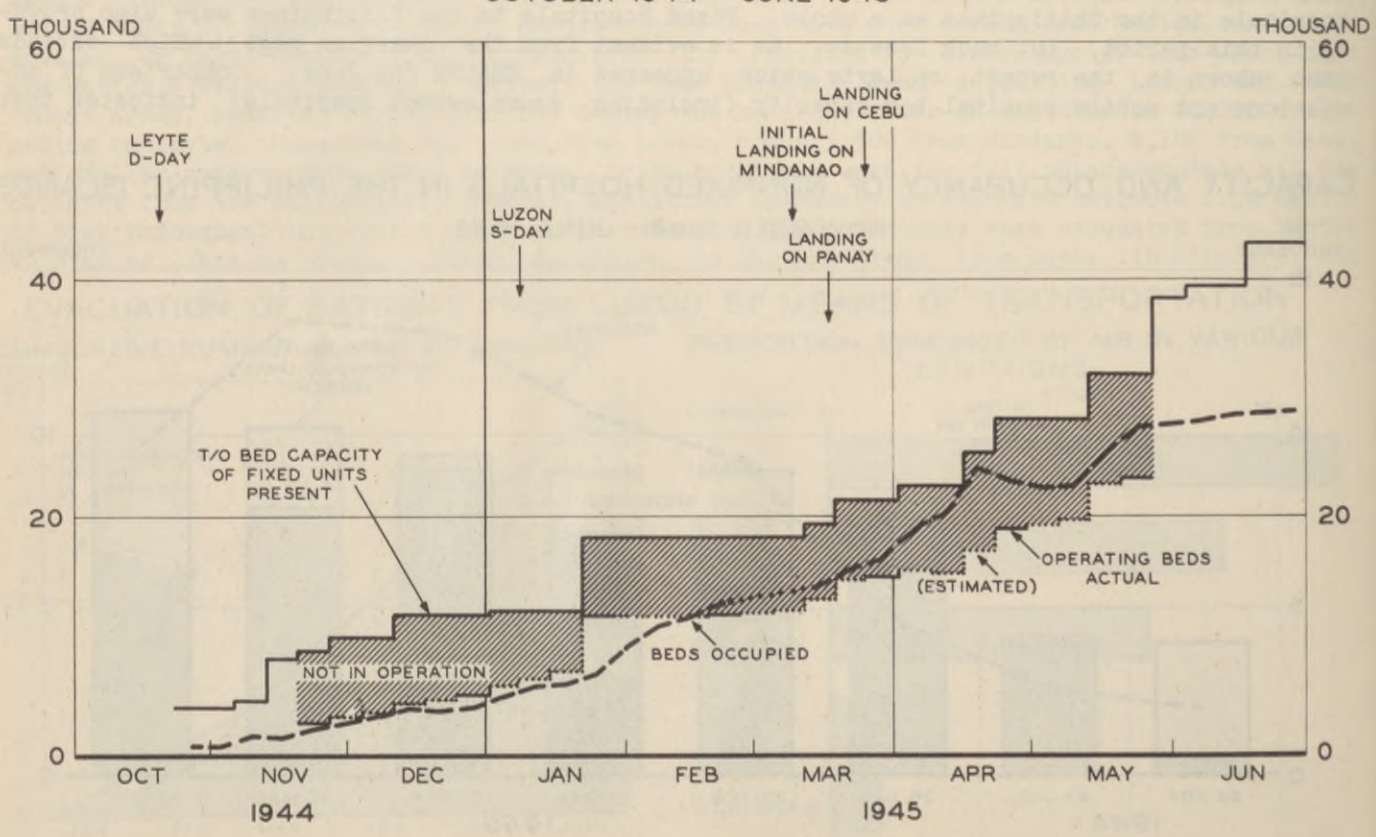
MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

Sixth Army operated at a disadvantage in comparison with the armies in Europe, as did Tenth Army on Okinawa. In the left-hand panel the chart on page 16 shows the average admissions to hospitals and clearing stations as a percentage of strength per day, and, in the right-hand panel, the average admissions per mobile bed per week for the various armies. The chart on page 15 separates Sixth Army patients in hospitals and clearing stations according to type. Army patients are distinguished from non-Army and are divided into their major components of the sick, the injured, and the wounded.

Portable surgical hospitals were employed at the level of the clearing station for the care of non-transportable patients, a function which in Europe was characteristically performed by a field hospital platoon strengthened by surgical and shock teams. Controversy over the value of the portable surgical hospital in large-scale warfare pervades the medical reports on operations in the Philippines with opponents generally favoring their replacement by surgical teams. In the main field hospitals were strengthened by two surgical teams and employed as evacuation hospitals, although they lack the personnel, the equipment, and the organic transport to render them entirely satisfactory for this purpose. The evacuation hospitals were used as such, receiving evacuees from divisional installations, and were also strengthened by the attachment of surgical teams. Station hospitals on Leyte were utilized as general and convalescent hospitals, receiving evacuees from the numerous operational areas. Those at Base M functioned more as evacuation than as station hospitals. One which landed on Bataan with the XI Corps could not be set up in the absence of a site suitable for a fixed hospital, so that its personnel were utilized to expand an evacuation hospital. General hospitals were employed as such on Leyte, although Luzon patients were also evacuated to bases in the south because of limited capacity, but on Luzon their employment was more diversified, including in part service as evacuation hospitals when combat near Manila made this seem desirable. Lack of convalescent facilities is further indicated by the frequency with which non-hospital units were employed to set up temporary convalescent hospitals. The improvisation suggested by these various facts testifies to the ready adaptability of medical personnel and units, but it also makes it plain that the mobile, convalescent, and evacuation hospitals available for employment in the army area were too few in number. Personnel shortages, especially of Medical Corps officers and Medical Department enlisted men, were considerable in the divisions and hospitals of both armies.

CAPACITY AND OCCUPANCY OF FIXED HOSPITALS IN THE PHILIPPINE ISLANDS

OCTOBER 1944 - JUNE 1945



Medical Aspects of Philippine Campaign (Continued)

Despite shortages of convalescent and evacuation hospital units, there were enough total bed capacity, and sufficient additional capacity set up on a provisional basis, to return to duty within the army area an unusually large proportion of admissions (see HEALTH for April). The following table compares the reported Sixth Army percentages with those for armies in the European combat zone.

PERCENTAGE OF ADMISSIONS TO HOSPITALS AND CLEARING STATIONS RETURNED TO DUTY* VARIOUS ARMIES

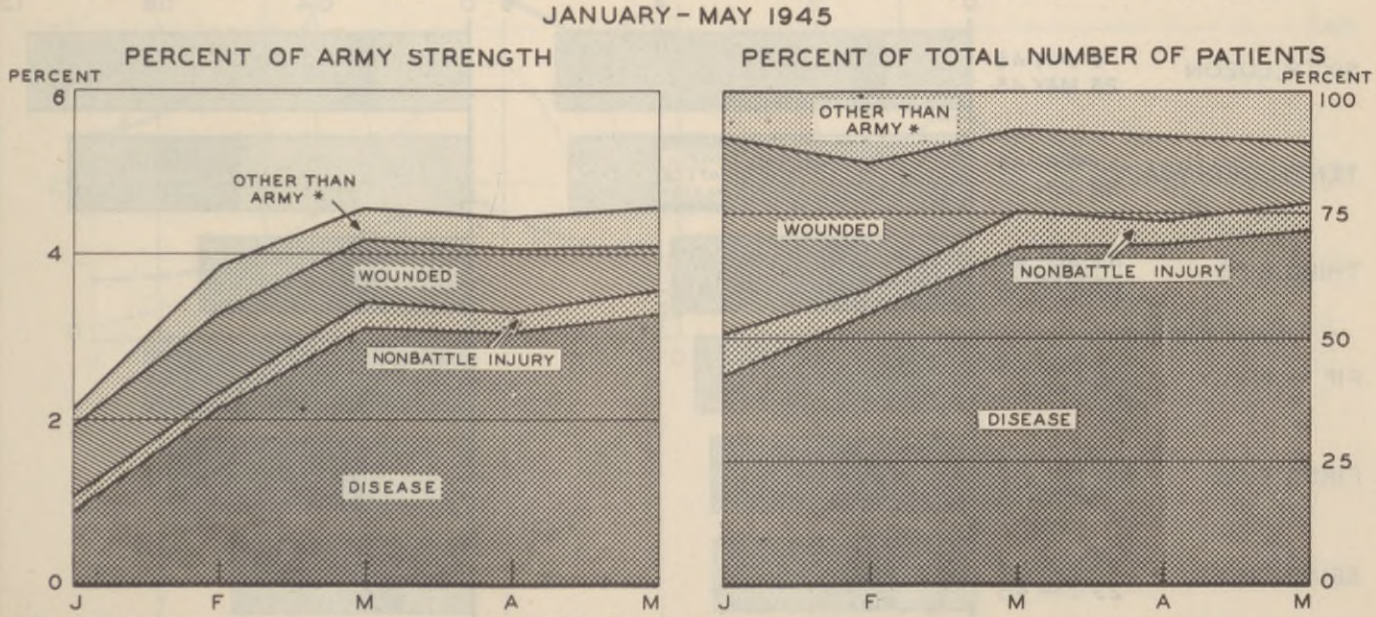
Theater and Army	Period	Percentage Returned to Duty		
		Wounded	Injured	Sick
Southwest Pacific				
Sixth Army				
Luzon	9 Jan-26 May 45	27	61	63
Mediterranean				
Fifth Army				
Italy	20 Jul 44-30 Mar 45	25	50	64
European				
First Army	6 Jun 44-8 May 45	8	28	52
Third Army	1 Aug 44-8 May 45	19	36	62
Seventh Army	20 Nov 44-8 May 45	16	33	58
Ninth Army	5 Sep 44-8 May 45	15	39	61

* Without evacuation from the army area.

Civilian Medical Care

U. S. bombardments preparatory to landings, Japanese atrocities, and the inevitable casualties incident to modern war in densely populated areas combined with a large medical problem to swell the civilian need for medical attention far beyond the capacity of the remaining local doctors and hospital facilities no matter how well organized. This was generally true throughout the Philippines but nowhere more so than in Manila where the most savage fighting occurred. In view of the relatively primitive sanitary habits of the civilian population, it is fortunate that there occurred no epidemic outbreaks of diseases more serious than dysentery. A large interned population also required medical care, and many tactical units had guerrilla or Philippine Army casualties within their areas, as is shown in the chart below. The Philippine Civil Administrative Units, attached to tactical units for staff purposes, were too few and possessed insufficient medical means to prevent the major burden of civilian care from descending upon tactical units.

PATIENTS IN SIXTH ARMY HOSPITALS AND CLEARING STATIONS
JANUARY - MAY 1945



* Philippine Army, Civilian, Guerrilla, and a few U.S. Navy and Marine patients.

MEDICAL ASPECTS OF THE PHILIPPINE CAMPAIGN (Continued)

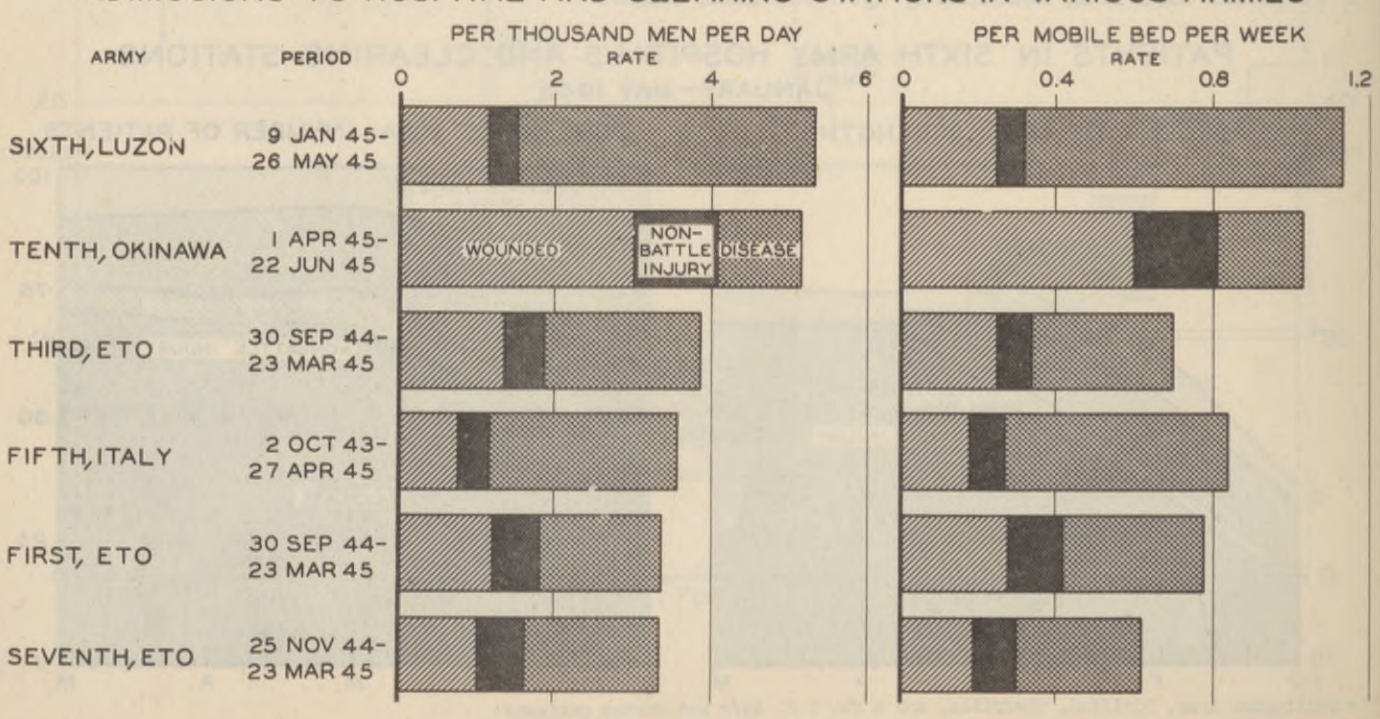
The magnitude of the problem of caring for civilians and internees in the Philippines was so large as to prompt reconsideration of the entire civil affairs plan in the Pacific with the result that a separate operating organization was planned for the assaults on the Island of Japan in order to relieve the load upon the medical facilities of tactical units (see HEALTH for July).

Supply

Medical supply was better organized and generally more satisfactory on Luzon than on Leyte, although planned dependence upon medical maintenance units for resupply during the first 60 days permitted army depot stocks to remain somewhat unbalanced during the first quarter. As at Leyte, medical units in the assault were mounted out with 30-day stocks, but within 30 days were presenting requisitions for the type of items which only a balanced stock could provide. During the first quarter, 28 block-loaded ships from the San Francisco POE arrived at Luzon with medical maintenance units for 560,000 troops for 30 days. Many blocks were unbalanced and absence of manifests and packing lists delayed warehousing. However, supplementary supplies were secured on Sixth Army operational requisitions for such items as blankets, tetanus antitoxin, litters, oxygen, penicillin, atabrine, condoms, vaccines, biologicals, and the like, as well as hospital expansion units and 24 medical maintenance units from theater stocks. On S-Day four mobile refrigerators were landed with blood, penicillin, vaccines, and the like. Whole blood was generally available at all echelons although some blood was outdated on receipt. Because of the morbidity and casualty picture, Sixth Army reported critical shortages during the quarter in boric acid, oxygen, dextrose in normal saline, prophylactics, sheet wadding, and plaster of paris bandage. During the second quarter stocks were in better balance and there were few shortages and distribution was superior. However, at the lower echelons, divisional and hospital medical supply was relatively satisfactory, although the needs of PCAU units, which failed to bring in any quantity of medical supplies, and of guerrillas and Philippine Army units, constituted a noticeable drain on tactical units and hospitals.

Sixth Army was assigned supply platoons which supported corps units at the outset but soon reverted to Army control, and some army supply points were taken over by units operating under the Luzon Base Section. The first of these were at Base M which received at first chiefly medical maintenance units, and later a wider assortment of items permitting the filling of about 70 percent of requisitions presented. Refrigeration at this base, as at some other points during the Philippine Campaign, was judged inadequate to cope with the heavy drain placed upon it. Wide dispersion of forces on Luzon made air drops essential. About 66 were made during the first quarter, 46 for guerrilla troops, totalling 27,000 pounds of supplies. A similar total was dropped in the second quarter.

ADMISSIONS TO HOSPITAL AND CLEARING STATIONS IN VARIOUS ARMIES



DISEASE AND INJURY

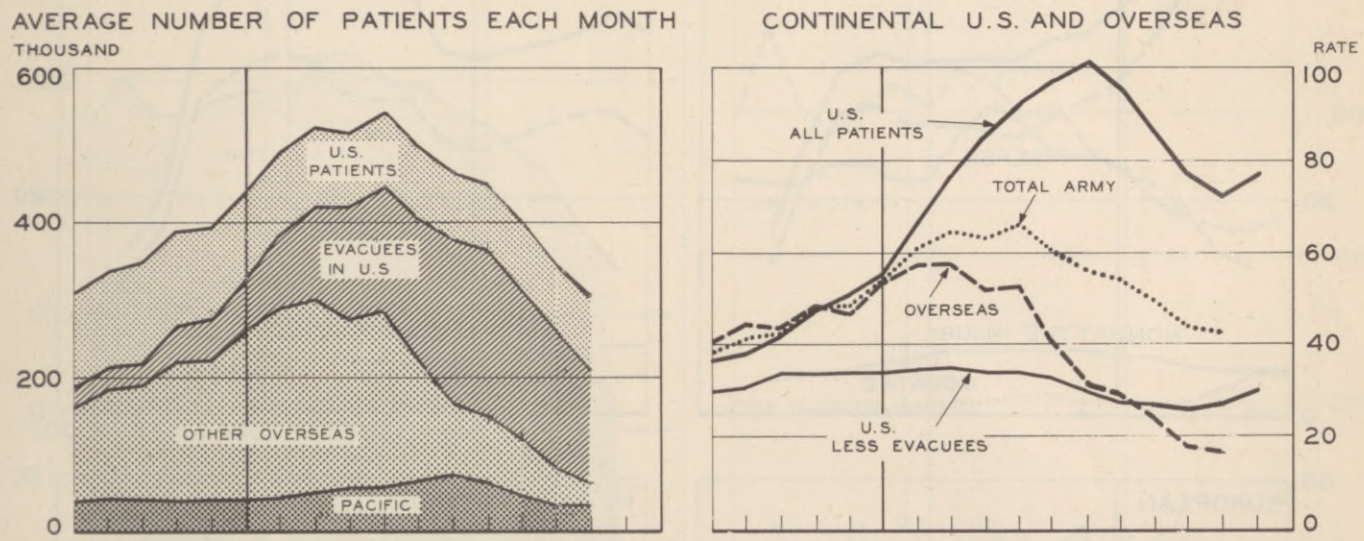
NONEFFECTIVES IN HOSPITAL AND QUARTERS

For the Army as a whole the noneffective population continued to contract both relatively and absolutely in October, but in November there was an increase in the Z/I noneffective rate associated with an increase in disease admissions and a decline in strength. The average number of men noneffective during October was about 307,000 for the Army as a whole, about ten percent below that for September. The overseas population declined almost 25 percent, the Z/I somewhat less than ten percent. Evacuees in the Z/I continued to constitute half the noneffective population of the Army, accounting for about 150,000 patients during October, fifteen percent less than September. During November there was a further reduction to roughly 120,000.

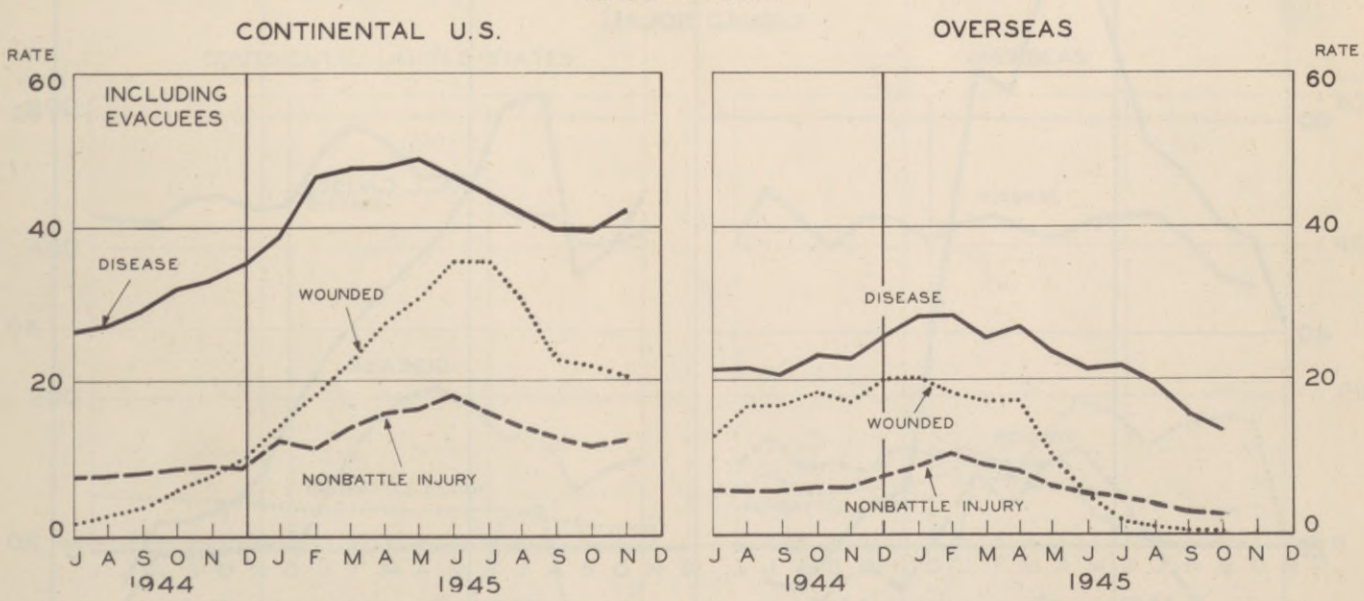
Overseas the noneffective rates for both disease and injury continued to decline in October. At 16 per 1,000 strength the total rate is the lowest of the war period. In the Z/I there was a significant advance in the rate for disease.

AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES



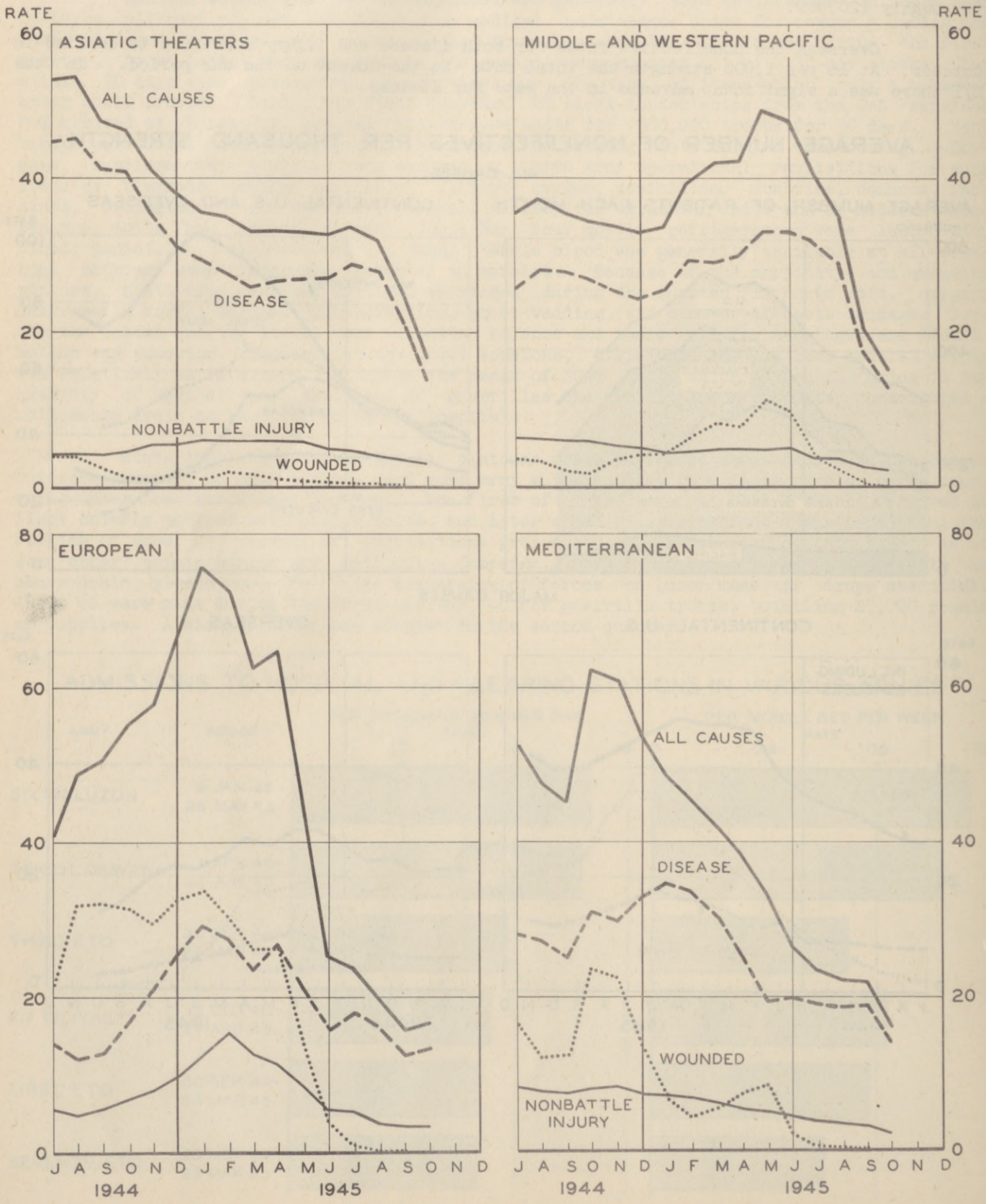
MAJOR CAUSES



NONEFFECTIVES IN HOSPITAL AND QUARTERS (Continued)

The fall in noneffectives was most marked in the Asiatic, Pacific, and Mediterranean theaters, as may be seen from the charts below. Low admission rates and the continued evacuation of patients have depressed the rates of major theaters to the lowest point of the war, about 16 per 1,000 strength.

AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH
PATIENTS IN HOSPITAL AND QUARTERS



DISEASE AND INJURY

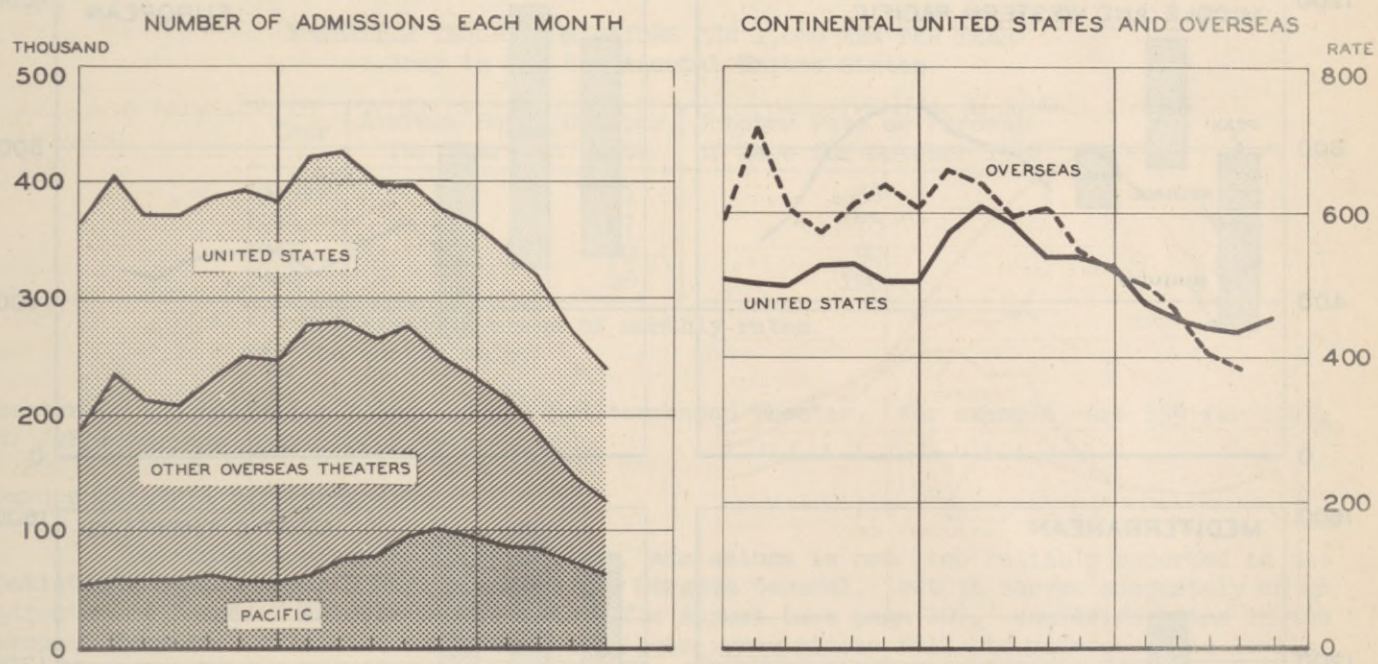
TREND OF HOSPITAL ADMISSIONS IN THE U. S. AND OVERSEAS

Preliminary radio reports from the overseas theaters reveal a further decline in the hospital admission rate for disease and all causes during October. The September rate plotted below represents a revision and is below that previously shown. Both of these rates are below any others during the war period. For troops in the U. S., however, the rate advanced about five percent during November in response to the advance in the rate for respiratory disease, and at 455 per thousand men per year is about ten percent below the rate for November 1944. During October about 239,000 Army patients were admitted to hospital, about 52 percent of them overseas.

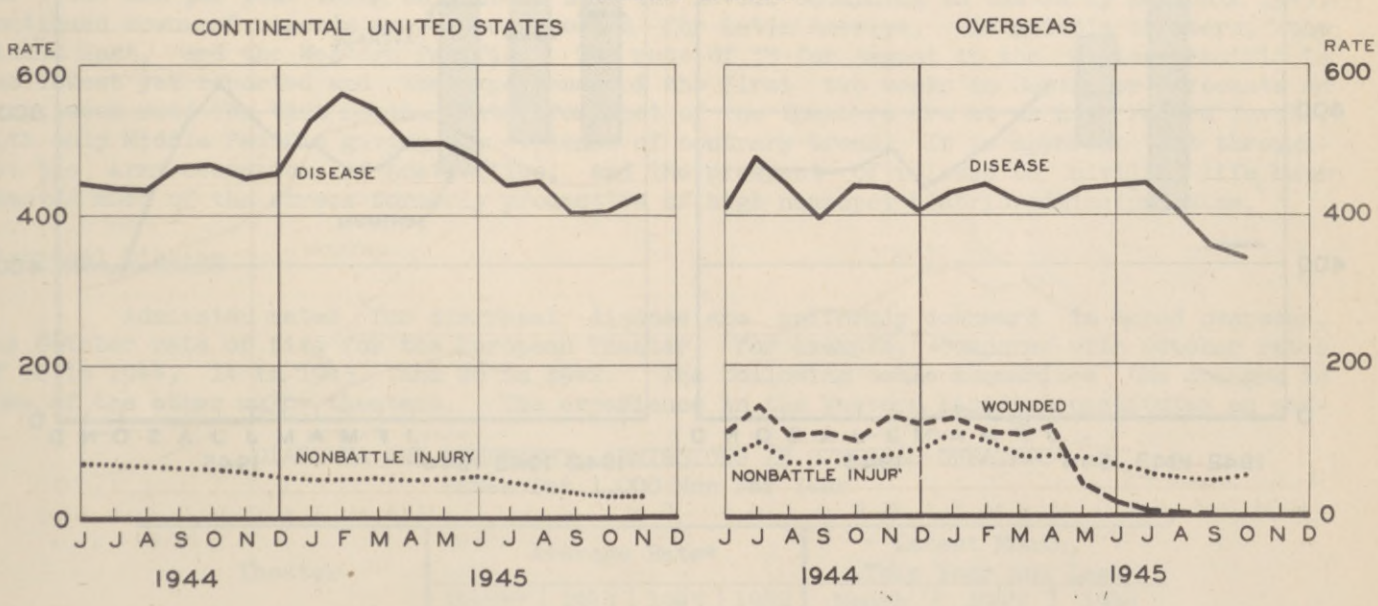
DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS

RATES PER THOUSAND MEN PER YEAR

ALL CAUSES

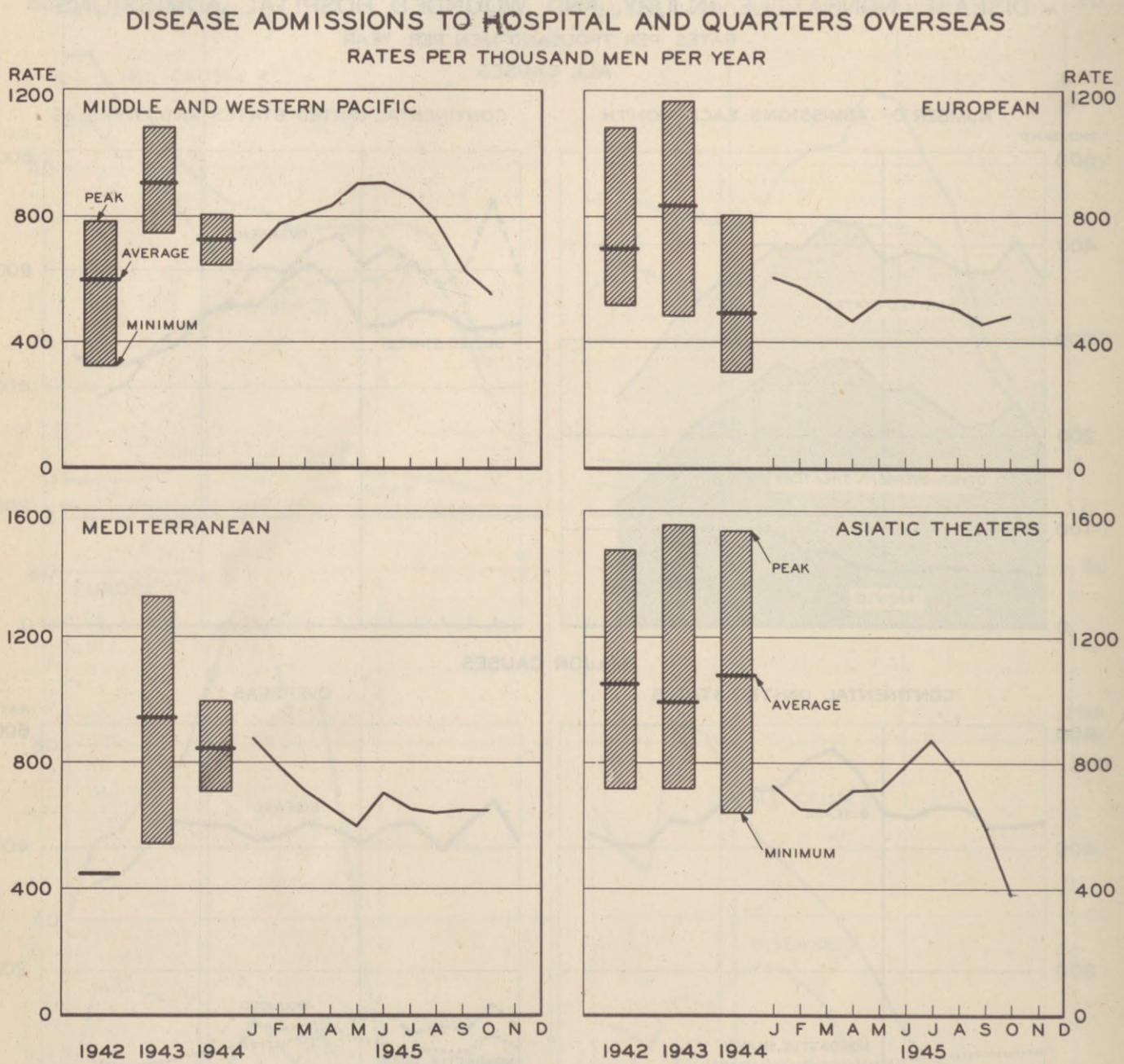


MAJOR CAUSES



DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS IN OVERSEAS THEATERS

A further spectacular decline in disease admissions in the Asiatic theaters took place in October, bringing the rate to about 385 admissions per 1,000 men per year, below that of any major theater. Although declines at this time of year are customary in the Asiatic theaters, the present low rates are unprecedented, at least partly because of superior environmental control and atabrine suppression of malaria. The admission rate also declined in the Pacific to a point below any value since 1942. The September rate for the Pacific has been revised on the basis of more complete reports, and that for October is also an advance estimate. Rates for the Middle Pacific have remained the same for three months, but those for the Western Pacific are declining.



DISEASE AND INJURY

HEALTH BRIEFS

Nonbattle Injury

With the cessation of hostilities and the reduction in related military activities, admissions for accidental injuries in the Army are falling rapidly. Beginning in September 1944 a changed method of reporting artifically depresses the rate somewhat, but the observed changes are far too great to be explained on this basis. Changes since May of this year are especially marked and independent of the method of reporting. By October, the admission rate for injury among troops in the U. S. was down to 31 admissions per 1,000 men per year, the lowest of the war period. Before the war admission rates for accidental injuries were on the order of 120 to 130 in the U. S., and the decline during the war represents the resumption of a downward trend already evident prior to the mobilization period, but at a greatly accelerated rate. The following table reveals the extent of the drop in the Z/I rate since 1942. The downtrend has been fairly continuous during this period except for a seasonal upswing during the summer months each year. Declines are also reported by virtually all overseas

NONBATTLE INJURY ADMISSIONS PER 1,000 MEN PER YEAR
Army in the Continental United States

Year	Average Rate for Year*	October Rate	October Rate as Percent of Rate for October 1942
1945**	46	31	36
1944	67	67	78
1943	80	79	92
1942	91	86	100

* Arithmetic average of monthly rates.
** Ten months only.

theaters. The September rates for the Mediterranean Theater, for example, are 139 for 1943, 137 for 1944, and only 55 for 1945.

Neuropsychiatric Disorders

The frequency of neuropsychiatric admissions is not too reliably reported in the Statistical Health Reports submitted to The Surgeon General, but it serves adequately as an indicator of trend. As reported in HEALTH for August (see page 10), admission rates in the European Theaters after V-E day continued their precipitous fall to unprecedented levels. Since May the U. S. admissions have also dropped sharply, the October rate of 23 admissions per 1,000 men per year being only about half the levels obtaining in the early months of 1945. Continued downward trends are also reported for Latin America, the Asiatic theaters, the Middle East, and the Western Pacific. The rate of 35 for August in the Western Pacific is the lowest yet reported and the experience of the first two weeks in September forecasts an even lower rate for that month. Rates for most of the theaters are at or near record levels, with only Middle Pacific giving any evidence of contrary trend. It is apparent that throughout the Army cessation of hostilities, and the prospect of release to civilian life, have removed much of the stress formerly productive of high neuropsychiatric admission rates.

Diarrheal Disease

Admission rates for diarrheal disease are uniformly downward in trend overseas. The October rate of five for the European Theater, for example, compares with October rates of 12 in 1944, 14 in 1943, and 26 in 1942. The following table summarizes the changes in some of the other major theaters. The experience in the Western Pacific constitutes an out-

DIARRHEA AND DYSENTERY, ADMISSIONS IN OVERSEAS THEATERS
Rates Per 1,000 Men Per Year

Theater	Average Rate*				Latest Month, This Year and Last		
	1945**	1944	1943	1942	Month	1945	1944
Mediterranean	22	54	132	--	Sept.	15	66
Middle Pacific	20	28	43	34	Sept.	13	23
Western Pacific	99	55	70	59	Aug.	75	57
Asiatic	98	181	146	123	Oct.	46	140
Middle East	83	115	170	196	Sept.	87	159

* Arithmetic average of monthly rates.
** Through latest month only.

HEALTH BRIEFS (Continued)

standing exception, but even there the latest rate of 75 represents a marked improvement from the peak of 138 reached in June at the end of the Philippine campaign (see page 8), and also refers to a period one or two months earlier than that for the other theaters shown.

Venereal Disease

The Z/I admission rate continues to climb in consequence of more frequent sexual exposure permitted by the slowing-down of military activities and in many cases stimulated by long overseas service. The preliminary November rate of 60 per 1,000 men per year, which excludes infections acquired prior to service, compares with rates of 43 for May and 53 for August. In Europe the admission rate resumed its rise after a temporary halt in September. October admissions yield a rate of 168, almost four times that existing prior to V-E Day and almost three times the highest level reached in 1942-1943 while troops were in the British Isles. The latest rate for the Mediterranean, 213 for September, stands as the highest rate of the war for that or any other theater, and was further discussed in HEALTH for October. Later information is not yet available also for the Western Pacific, where the August rate of 77 showed a distinct improvement over the previous months. Through September there had been no change in the admission rate for the Middle Pacific, but there was a continued decline in Latin America. No real rise in the Asiatic theaters had occurred through October, the latest month reported.

Hepatitis

It is not yet known to what extent admissions for hepatitis have risen in Italy, where the fall season brought sharp epidemics in the two previous years. However, the September rate for 1945 is lower than either of the rates for the same month in 1943 and 1944. Since the disease was most common among combat units, and since garrison-type sanitation has been possible since V-E Day, it is anticipated that the current season will produce far fewer admissions than previously. In the Western Pacific, where continuation of the Philippine campaign (see page 9) brought an epidemic of large proportions among combat divisions, the admission rate for August was down to 48 from the maximum of 82 in May, but much of the decline occurred because of the increasing strength. Figured against the June strength (on the assumption that newly arrived troops had not had time to develop clinical symptoms), the August rate is 62. In reality, therefore, there has probably been much less change in the extent of the disease than the reported rates would indicate, but the improvement is far from negligible.

Malaria

In many overseas theaters malaria admission rates seem to be rapidly approaching a minimum level. Whether such low rates will continue will depend largely upon the policy which is maintained with respect to atabrine suppression. Now that fewer troops are living under field conditions, transmission of the disease can be controlled to a very high degree, and atabrine suppression should no longer be necessary. Since the number of men overseas who are infected must still be large, rescission of the policy of atabrine suppression will temporarily elevate admission rates. A remarkable triumph for suppression and for environmental control measures is illustrated by the record of the Asiatic theaters in recent months, as may be seen in the accompanying table. July and August were the peak months of the season there in 1943 and 1944.

MALARIA ADMISSIONS IN THE ASIATIC THEATERS
Rates Per 1,000 Men Per Year

Year	July	August
1945	33	31
1944	265	310
1943	311	322

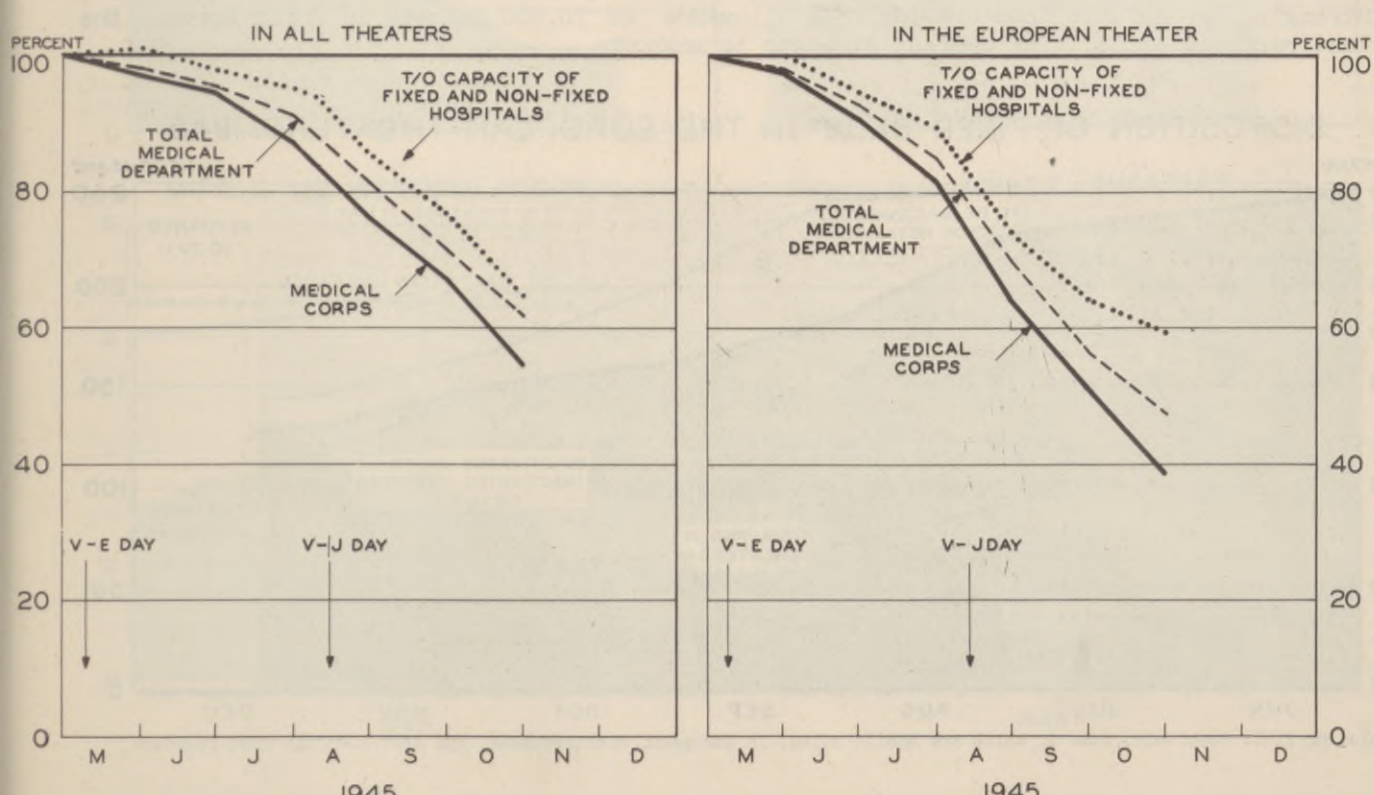
HOSPITALIZATION OVERSEAS

During October the patient census in Army hospitals overseas declined to 56,000, and at the end of the month was twenty percent below the count on 30 September, only eight percent of the patients being in nonfixed hospitals. Fixed hospital capacity present overseas dropped by fifteen percent during October. For the third successive month the decline was proportional to the decrease in strength and at the end of October 219,900 fixed T/O bed units remained overseas, 55 percent of which were actually in operation. The T/O capacity of units present in a theater no longer provides a reliable guide to the medical personnel present because so many units are entirely out of operation and have only skeleton staffs remaining. For example, in the European Theater the total number of Medical Corps officers declined by 61 percent between 1 May and 31 October while the strength of the entire Medical Department fell by 52 percent. In this same period, however, the capacity of both fixed and mobile units present in the theater decreased by only 41 percent. Decline in the number of Medical Corps officers, in total Medical Department strength, and in the T/O capacity of all hospitals in all overseas theaters and in the European Theater are shown in the panels below. The numbers of personnel or hospital capacity remaining on successive dates are shown as percentages of the number overseas on 1 May.

Operating capacity, which is now a better measure of available bed capacity than is total T/O capacity present, has in general been reduced to a level consonant with the much smaller needs of occupation forces and troops awaiting return to the Z/I. On 3 December the authorization for the Africa-Middle East was reduced from 6.0 to 4.0 percent, the level previously established for the European and the Mediterranean Theaters. Revision of fixed bed authorizations in the Pacific and Asiatic theaters is under consideration by the War Department in view of their reduced requirements. On 31 October total fixed T/O bed capacity present in all theaters amounted to 6.6 percent of troop strength, but only 3.6 percent was in operation. Forty-three percent of the operating capacity was occupied, making a hospital load of 1.5 percent of overseas strength. The chart at the bottom of the next page gives the most recent information available concerning the capacity and utilization of fixed hospitals in the major theaters. In the Mediterranean, nonoperating units were deactivated or shipped to the Z/I during October at such a rate that only operating units remained in the theater at the end of the month. The patient census in mobile units decreased by about twenty percent in October. Mobile beds were eliminated in both the Mediterranean and the Middle Pacific early in October. The tables on the following pages give the details of fixed and nonfixed hospital capacity and occupancy for 31 October.

DECLINE IN MEDICAL STRENGTH AND HOSPITAL T/O CAPACITY OVERSEAS

PERSONNEL AND BEDS AS PERCENT OF NUMBER OVERSEAS ON 31 APRIL 1945



HOSPITALIZATION OVERSEAS (Continued)

FIXED BEDS AVAILABLE AND OCCUPIED
Number of Beds, 31 October 1945

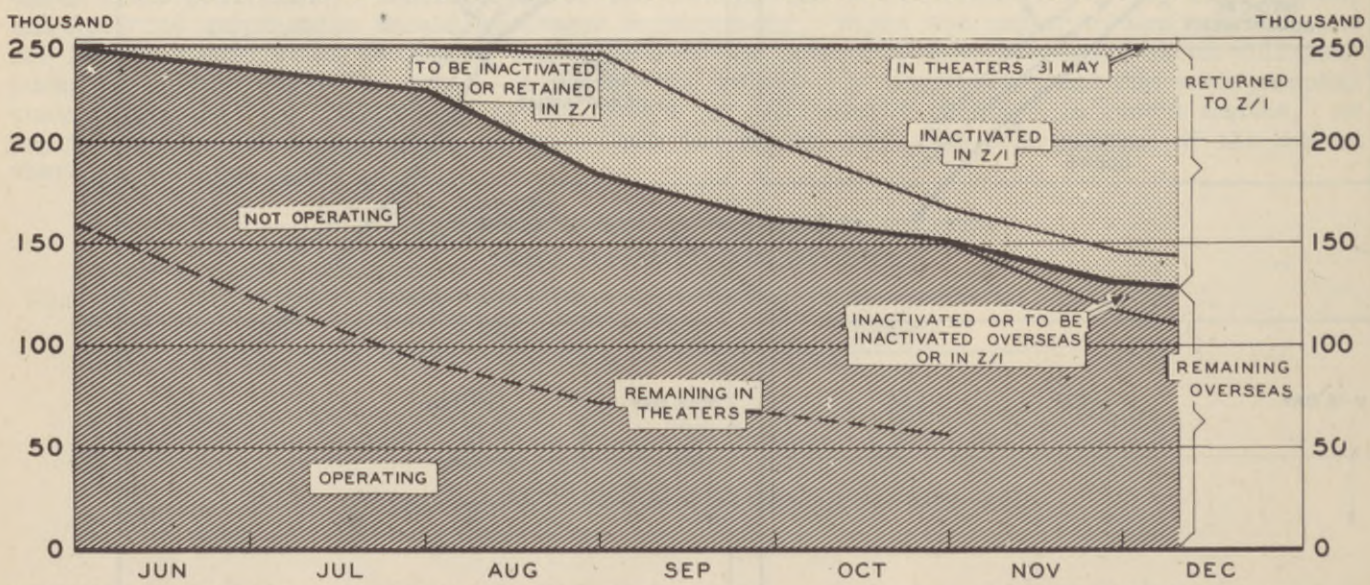
Theater	W. D. Authorization	T/O Present		Operating c/		Occupied c/
		Number b/	Percent of Authorization	Number	Percent of T/O Present	
ALL THEATERS	181,965	219,900	120.8	120,432	54.8	51,313
American a/	2,956	4,175	141.2	4,430	106.1	1,135
European	53,674	107,100	199.5	49,827	46.5	19,599
Mediterranean	4,546	5,300	116.6	5,300	100.0	3,607
Pacific	104,690	89,000	85.0	51,125	57.4	23,973
Asiatic	14,404	13,075	90.8	8,290	63.4	2,672
Africa-Middle East	1,695	1,250	73.7	1,460	116.8	327

Beds As Percent of Strength and Percent Occupied

Theater	Strength (Thousands) d/	W. D. Authorization (Percent)	Bed Capacity		Beds Occupied as		
			T/O Present	Operating	Percent of Strength	Percent of T/O Present	Percent of Operating
ALL THEATERS	3,354	5.4	6.6	3.6	1.5	23.3	42.6
American	99	3.0	4.2	4.5	1.2	27.2	25.6
European	1,342	4.0	8.0	3.7	1.5	18.3	39.3
Mediterranean	114	4.0	4.7	4.7	3.2	68.1	68.1
Pacific	1,531	6.8	5.8	3.3	1.6	26.9	46.9
Asiatic	240	6.0	5.4	3.5	1.1	20.4	49.3
Africa-Middle East	28	6.0	4.4	5.2	1.2	26.2	22.4

a/ Includes Alaskan Department and excludes Eastern Canada.
b/ T.L.O.S. dated 1 November 1945.
c/ Reported by theaters telegraphically for 26 October 1945.
d/ Geographic strength by theater, excluding personnel enroute to or from overseas theaters. Strength for Asiatic theaters includes allowance of 70,000 Chinese in India-Burma, the last reported count. The present strength is unknown.

DISPOSITION OF FIXED BEDS* IN THE EUROPEAN THEATERS, 1945



* Including field hospitals, some of which are mobile units, in European, Mediterranean, and Africa-Middle East Theaters.

HOSPITALIZATION OVERSEAS (Continued)

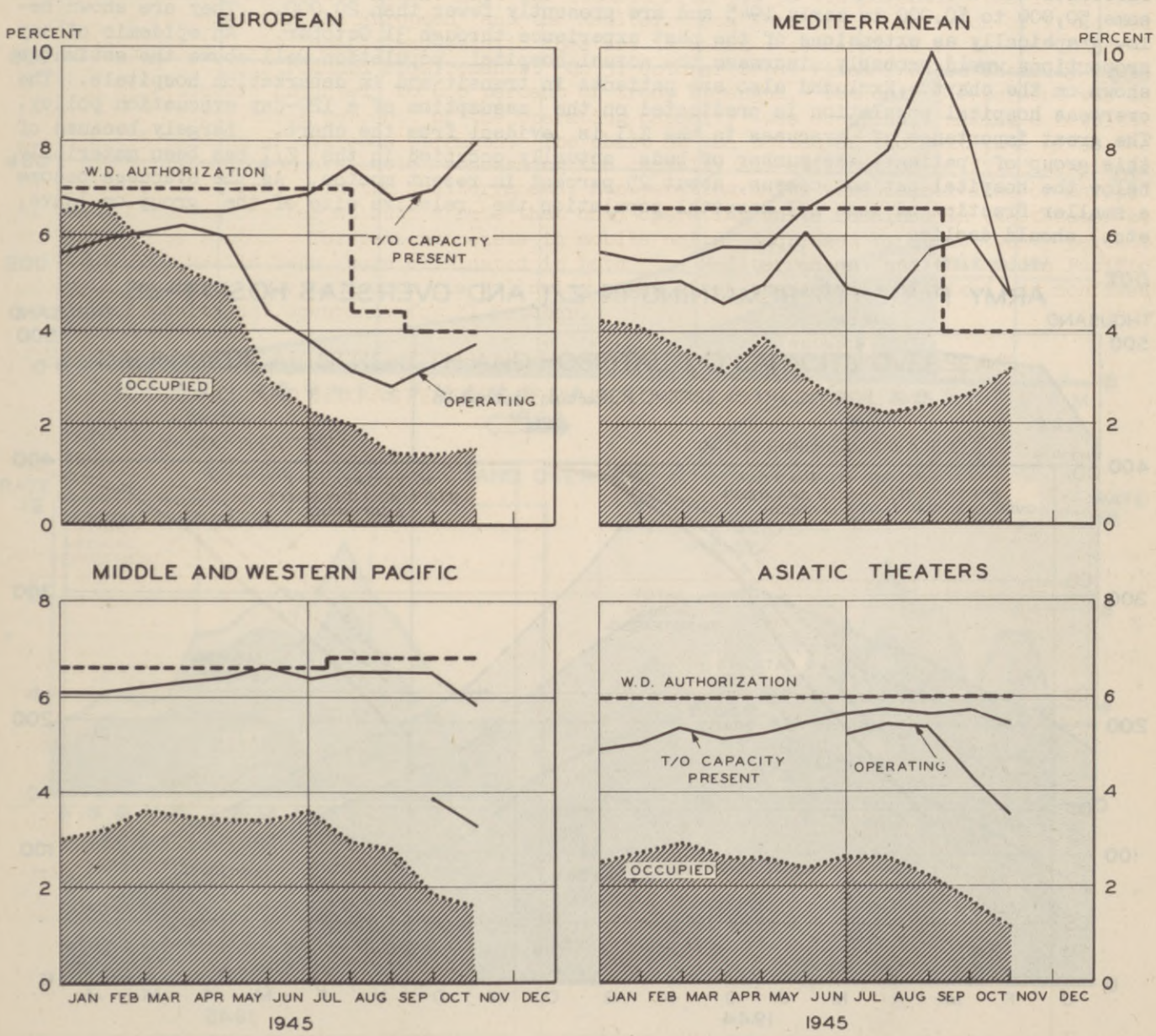
NONFIXED BEDS AVAILABLE AND OCCUPIED
Overseas Theaters, 31 October 1945

Theater	T/O Present		Operating		Total Occupied			
	Number a/	Percent of Strength	Number b/	Percent of T/O	Number b/	Percent of T/O Present	Percent of Operating	Percent of Strength
ALL THEATERS	54,425	1.6	13,923	25.6	4,659	8.6	33.5	0.1
European	46,250	3.4	11,448	24.8	3,217	7.0	28.1	0.2
Pacific	5,975	0.4	2,475	41.4	1,435	24.0	58.0	0.1
Asiatic	2,200	0.9	--	--	7	0.3	--	0.0

a/ T.L.O.S. dated 1 November 1945.
b/ Reported by theaters telegraphically for 26 October.

FIXED HOSPITALIZATION IN OVERSEAS THEATERS

BEDS AS PERCENT OF STRENGTH

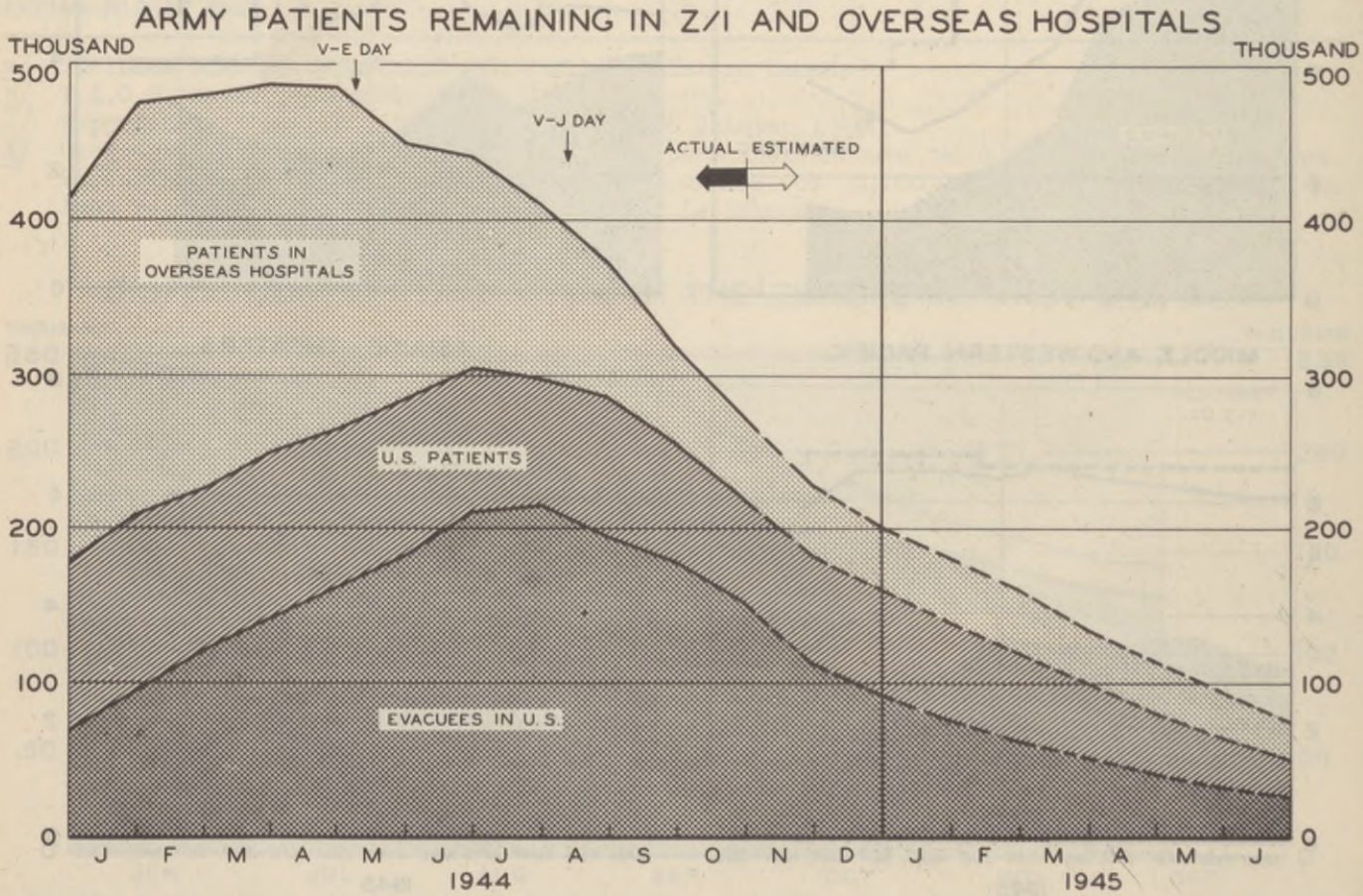


HOSPITALIZATION OVERSEAS (Continued)

By 10 December 1945, 47 percent of the 247,000 fixed T/O bed units present in the European theaters on 31 May had been returned to the Z/I, and an additional five percent had been, or were to be, inactivated overseas. Of the 117,200 fixed T/O units returned to the Z/I, 102,400 had been inactivated here, leaving only 13 percent to be inactivated or to be retained. In addition to the 117,200 already returned, and 13,350 inactivated overseas or earmarked as such, 6,150 had been marked for return to the Z/I for inactivation upon arrival. The chart on page 24 gives these data graphically. Similarly, of the approximately 108,000 fixed T/O beds present in the Pacific and Asiatic theaters on 31 May, 2,900 had been returned to the Z/I and inactivated here by 10 December. In addition 30,550 beds are scheduled for inactivation overseas, including 11,500 which the War Department had previously directed these theaters to return to the Z/I.

The decline in the hospital population since V-J Day has been even more rapid than forecast in the 31 August issue of HEALTH. Latest estimates place the year-end hospital census of Army patients alone at about 200,000, falling to perhaps 75,000 by 30 June 1946. At that time, in other words, the total Army hospital population will be but one-sixth its level on V-E Day. The largest reduction in the next seven months will occur in the number of evacuees in Z/I hospitals, of whom only one-quarter will remain. The number of Z/I patients still in hospital at that time should be about one-third the present level, while the number of patients still overseas, the smallest component of the total, will be about halved. These forecasts are necessarily very approximate and exclude non-Army patients who numbered in all some 50,000 to 60,000 in early 1945 and are presently fewer than 20,000. They are shown below graphically as extensions of the past experience through 31 October. An epidemic of any proportions would probably increase the actual hospital population well above the estimates shown on the chart. Excluded also are patients in transit and in debarkation hospitals. The overseas hospital population is predicated on the assumption of a 120-day evacuation policy. The great importance of evacuees in the Z/I is evident from the chart. Largely because of this group of patients the number of beds actually occupied in the Z/I has been materially below the hospital patient census, about 25 percent in recent months. As the evacuees become a smaller fraction of the Z/I hospital population the relative size of the group on leave, etc., should decline.

ARMY PATIENTS REMAINING IN Z/I AND OVERSEAS HOSPITALS



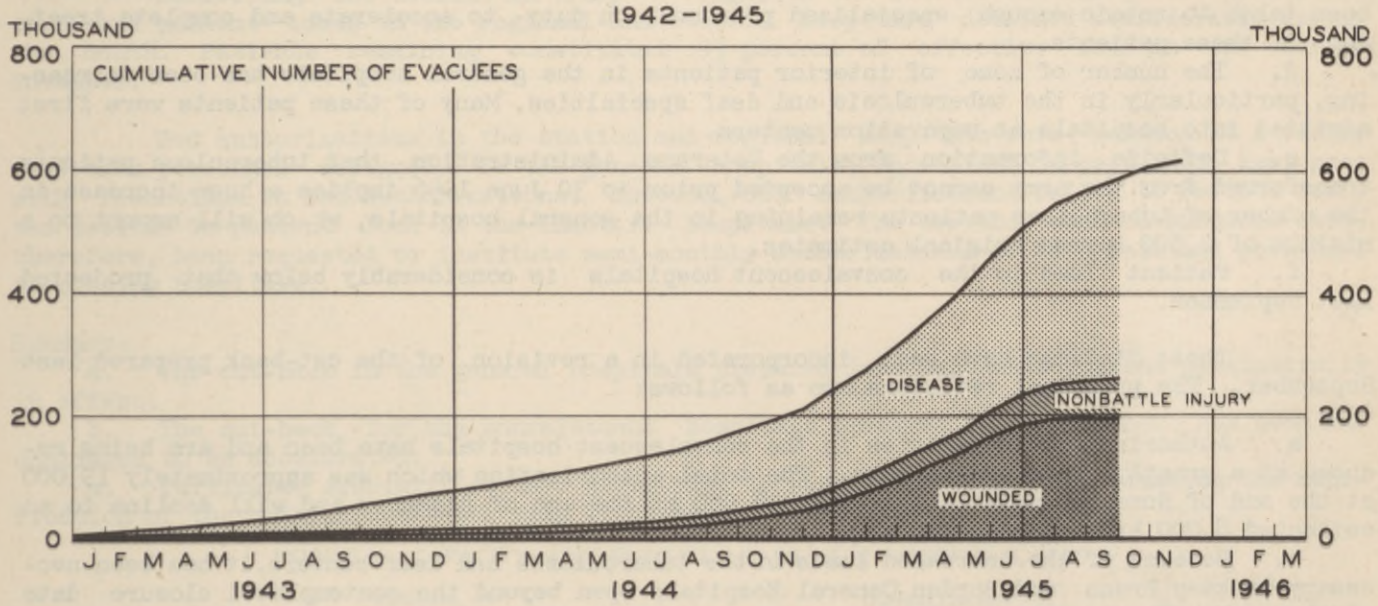
TREND OF EVACUATION FROM OVERSEAS

The volume of Army patients evacuated to the Z/I during November fell to about 11,000 from 17,000 the previous month. Both air and water lift declined, the air total of 2,000 Army patients being the lowest since June 1944. Further reductions are to be expected as the overseas strength shrinks and remaining theaters operate on a 120-day evacuation policy. Effective 1 December the Pacific increased its policy to 120 days. The November lift from the Pacific was less than 4,500, the lowest since February. The Asiatic theaters continue to evacuate patients at an unusually high rate in order to make use of all available lift without regard for evacuation policy. The November rate was about six per 1,000 strength per month.

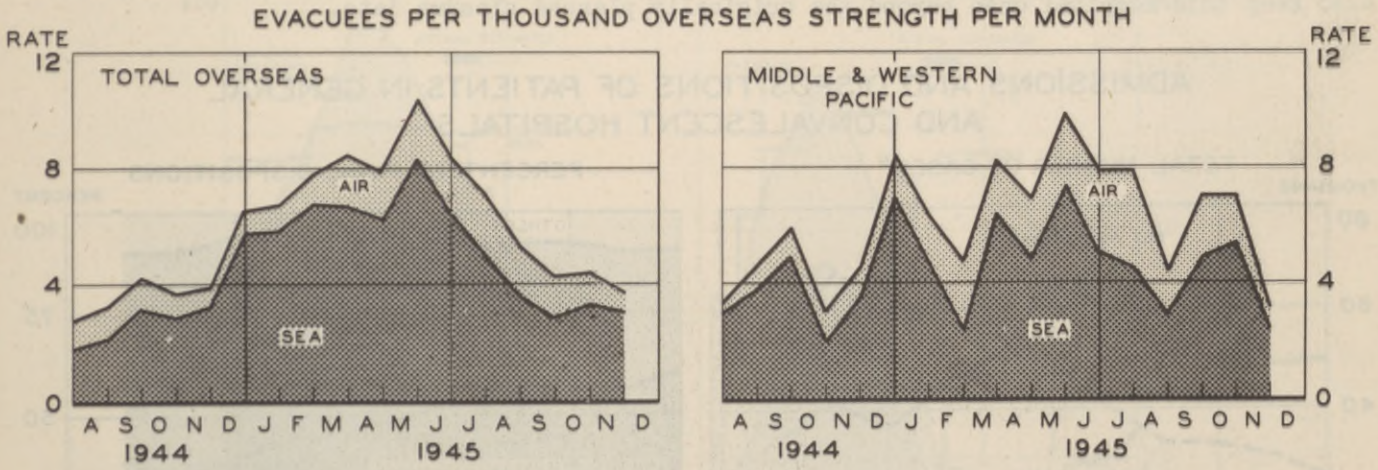
The top panel below gives the cumulative number of evacuees each month from all theaters with a distinction between battle and nonbattle patients. The bottom two panels supply similar information in rate form for all theaters and for the Pacific, except that the distinction is between air and water lift and the data are not cumulative.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS

1942-1945



EVACUEES PER THOUSAND OVERSEAS STRENGTH PER MONTH



HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR

With the first phase of the cut-back in the general hospital system near completion, a review of the plans for the second phase of the cut-back, which were initially prepared last September, has been undertaken. The findings resulting from this review are of considerable interest and significance.

a. Patient load in the general hospitals is substantially higher than was estimated in the August issue of HEALTH, page 17. This is true despite the fact that evacuations of patients from overseas theaters have fallen below expectations. The principal reason for this excess of actual over projected patient load in the general hospitals is the increasing tendency to dispose of patients directly from the general hospitals in preference to disposition through transfer to the convalescent hospitals and the consequent lengthened duration of stay of patients in the general hospitals.

b. Several specialties, principally plastic surgery and to a lesser extent blind, have shown higher actual patient loads than were projected because of the increasing significance of treatment of patients for secondary diagnoses upon completion of treatment for primary diagnoses.

c. Backlogs have appeared in certain specialties: plastic surgery, due to a shortage of surgeons; and amputations, due to a lag in the operation of limb shops. Measures have been taken to retain enough specialized personnel on duty to accelerate and complete treatment of these patients.

d. The number of zone of interior patients in the general hospitals has been increasing, particularly in the tuberculosis and deaf specialties. Many of these patients were first admitted into hospitals at separation centers.

e. Definite information from the Veterans Administration that tuberculous patients transferred from the Army cannot be accepted prior to 30 June 1946 implies a huge increase in the number of tuberculous patients remaining in the general hospitals, which will amount to a minimum of 2,500 beyond original estimates.

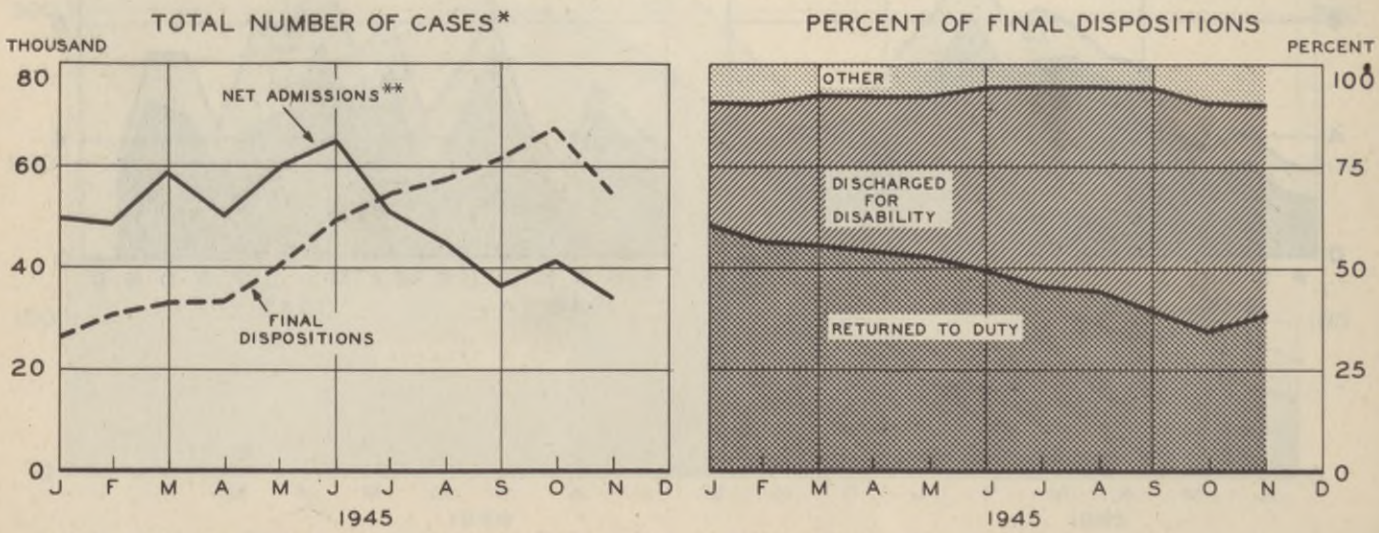
f. Patient load in the convalescent hospitals is considerably below that projected last September.

These findings have been incorporated in a revision of the cut-back prepared last September. The principal revisions are as follows:

a. Authorized bed capacities in the convalescent hospitals have been and are being reduced at a greatly accelerated rate. The total authorization which was approximately 19,000 at the end of November will be less than 15,000 at the end of December and will decline to an estimated 8,000 by the end of March.

b. Because of the increased loads in the tuberculosis and deaf centers, it has been necessary to keep Bruns and Borden General Hospitals open beyond the contemplated closure date of 31 March. The establishment of a third tuberculosis center at Moore General Hospital will also keep this hospital open beyond the originally planned closure date.

ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



* Adjusted to four-week months. ** Total admissions less dispositions by transfer.

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

c. The retention of Moore permits the closure of Butner General Hospital at the same time that Camp Butner becomes inactive in February. In addition, the rapid decrease in the neuropsychiatric load permits the closure of the Edgewood Annex of Mason General Hospital at an early date.

d. The volume of the plastic surgery load projected for the second and third quarters of 1946 will very likely require the retention of a larger number of plastic centers than was originally planned.

During November, seven general hospitals with a capacity of more than 11,000 beds were actually closed and twelve general hospitals with a capacity of 25,000 beds were in the process of closure. Patient load in the closing hospitals had dwindled to 6,300 by the end of the month. For the convalescent hospitals, only 600 patients remain in the closing hospitals. In the entire general hospital system, patient load declined by approximately 29,000 during the month of November, 23,000 in the general hospitals and 6,000 in the convalescent hospitals. More than 3,000 of the decline in patient load in the general hospitals was accounted for by the repatriation of German prisoner of war patients.

Reflecting the decline in troop strength in the zone of interior, bed authorizations and patient loads in the regional and station hospitals declined considerably during the month. Patients remaining constituted 93 percent of effective beds at the end of November.

Bed authorizations in the station and regional hospitals were reduced at a faster rate than personnel assigned. In the general hospitals, reductions in personnel kept pace with reductions in bed authorizations. However, bed authorizations failed to reflect fully the decline in patient load in the inactive hospitals. The service command surgeons have, therefore, been requested to institute semi-monthly authorizations of both beds and personnel in closing hospitals.

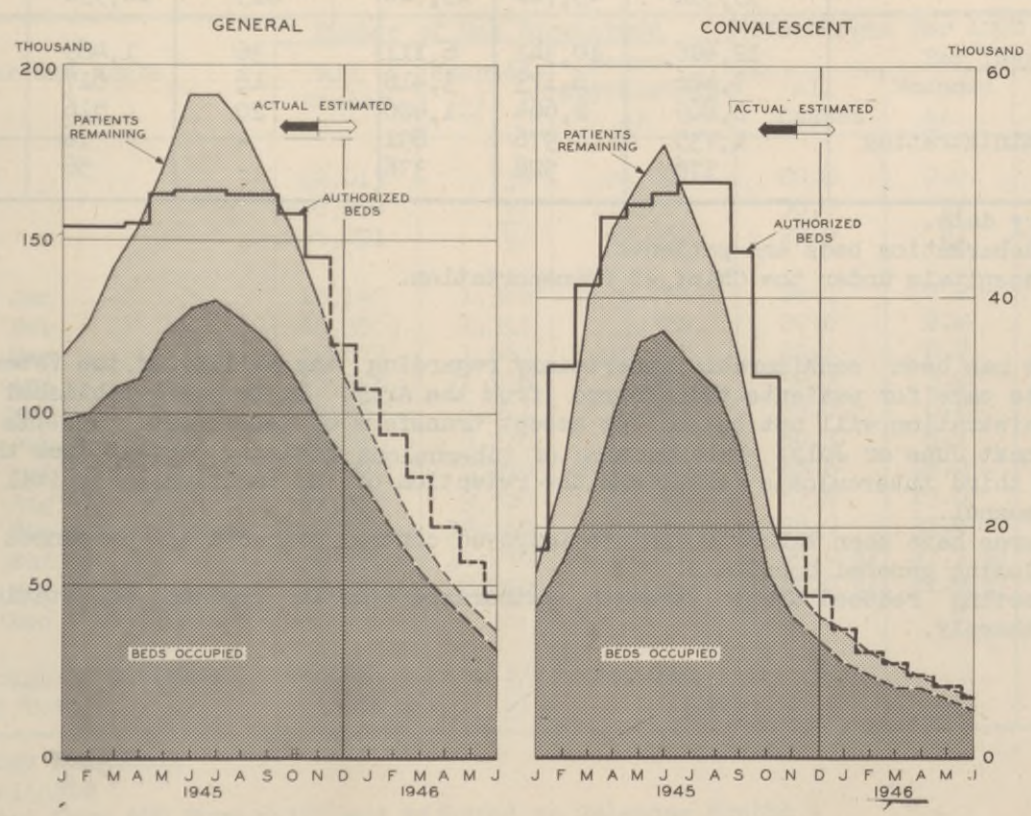
Summary:

a. The cut-back in the general hospitals prepared last September remains substantially in effect.

b. The cut-back for the convalescent hospitals prepared last September has been and continues to be accelerated.

c. Particular specialities have given rise to special problems necessitating the modification of the original cut-back plan with respect to individual hospitals.

HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITALS, 1945



HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR a/
End of November 1945

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages e/		
	Authorized	Effective b/	Number c/	Percent of Effective Beds		MC	ANC	Total
Total	217,257	197,518	183,295	92.8	145,338	-956	-473	-5,323
General	145,172	137,852	130,093	94.4	98,068	-311	145	4,754
Convalescent	19,190	19,190	15,473	80.6	11,649	- 6	- 12	-2,485
Regional	24,505	19,604	20,155	102.8	18,443	-303	-408	-4,252
Station d/	28,390	20,872	17,574	84.2	17,178	-336	-198	-3,340

a/ Preliminary data.
b/ Less debarkation beds and 20 percent for dispersion in regional and station hospitals.
c/ Data exclude patients in triage at debarkation hospitals
d/ Includes hospitals under the Chief of Transportation.
e/ Overages are denoted with a minus sign (-) in all columns.

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS
BY TYPE OF CARE AND TYPE OF HOSPITAL a/ b/
End of November 1945

Type of Patient	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station c/
Total	207,637	183,295	130,093	15,473	20,155	17,574
General-Convalescent Care	131,625	119,371	104,147	15,224	-	-
Evacuees		106,882	92,297	14,585	-	-
Z/I		12,489	11,850	639	-	-
Regional-Station Care	63,606	53,583	19,835	213	18,690	14,845
Regional	10,014	9,861	4,107	-	5,754	-
Station	53,592	43,722	15,728	213	12,936	14,845
Non-Army	12,406	10,341	6,111	36	1,465	2,729
POW	7,426	6,173	3,418	16	817	1,922
Civilians	2,869	2,664	1,426	20	516	702
Veterans Administration	1,735	976	891	-	76	9
Other	376	528	376	-	56	96

a/ Preliminary data.
b/ Excludes debarkation beds and patients.
c/ Includes hospitals under the Chief of Transportation.

d. There has been considerable uncertainty regarding the ability of the Veterans Administration to care for patients transferred from the Army. It is now established that the Veterans Administration will not be able to accept transfers of tuberculous patients from the Army before next June or July. This backlog of tuberculous patients necessitates the establishment of a third tuberculosis center and the retention of an additional hospital and the requisite personnel.

e. Measures have been taken to achieve improved control over bed and personnel authorizations in closing general hospitals.

f. Reflecting reduced troop strength, authorized beds in regional and station hospitals dropped sharply.

STATISTICAL TABLES

Admission rates for selected diseases and for nonbattle injury in the United States and in overseas theaters are shown in the tables on the following pages. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from AGO Form 8-122 (formerly MD Form 86ab), both regular and telegraphic, submitted to The Surgeon General by each overseas theater or lesser command, and by posts, camps, and stations in the United States. Only the major overseas areas are shown separately, but the total overseas rates are based upon complete consolidations. The rates for each month average the experience of either four or five weeks depending upon the number of Fridays in the month. In each case they apply to all Army strength in the particular area: air, ground, and service. Rates computed from incomplete reports and those derived from the weekly telegraphic reports are distinguished from those based on final monthly reports. Admission rates for wounded in action, previously published on this page, are no longer shown. In their place appear separations of enlisted men for mental and physical disqualification under AR 615-361, covering disability, AR 615-368, covering undesirable habits and traits of character, and AR 615-369, covering inaptness, lack of required degree of adaptability, and enuresis. The series pertains to month of separation and is derived from reports of The Adjutant General through May 1945, and thereafter upon preliminary reports submitted to The Surgeon General weekly on AGO Form 8-122. The latter have been adjusted to calender months to conform with those reported by The Adjutant General.

The series shown for nonbattle injury is not entirely comparable throughout. In September 1944 a change in reporting provided that all readmissions for nonbattle injury be classified as disease admissions. The venereal disease rates derived from AGO Form 8-122 are generally higher than those based on the Monthly Venereal Disease Statistical Report. Venereal infections contracted prior to service have been excluded from the rates. Tentative neuropsychiatric admission rates are presented for 1944 and 1945. Not systematically reported on AGO Form 8-122 until late in 1943, these rates may not be as firm as those for communicable diseases. Malaria rates for the continental United States reflect only infections acquired in the United States; rates based on all admissions are much higher. They also measure diagnosed malaria only, but include both primary attacks and recurrences insofar as these are reported as malaria. A variable amount of malaria, differing from theater to theater, is at first reported as fever of undetermined origin. Many of these cases are later correctly diagnosed and enter into the rates. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, some duplication between malaria and fever of undetermined origin continues to exist.

DISCHARGES OF ENLISTED MEN FOR DISABILITY

Year and Month	Number of Men Discharged			Discharges Per 1000 Enlisted Men Per Year		
	All Causes	Wounded a/	Neuropsychiatric a/	All Causes	Wounded a/	Neuropsychiatric a/
1942	62,013	30	26,091	20.8	0.0	8.8
1943	348,964	b/	138,609	56.2	b/	22.3
1944	205,091	b/	97,860	29.0	b/	13.8
1945 Jan	15,143	1,346	6,751	24.7	2.2	11.0
Feb	15,356	1,311	7,369	27.6	2.4	13.3
Mar	19,873	1,663	10,028	32.1	2.7	16.2
Apr	18,278	1,916	8,441	30.3	3.2	14.0
May	24,457	3,911	10,624	39.0	6.2	16.9
Jun c/	30,510	5,270	12,460	50.3	8.7	20.5
Jul c/	37,740	7,570	13,280	60.6	12.2	21.3
Aug c/	41,390	9,550	12,620	67.6	15.6	20.6
Sep c/	44,750	12,160	13,160	78.9	21.4	23.2
Oct c/	49,190	14,270	12,450	94.0 d/	27.3 d/	23.8 d/
Nov c/	33,730	8,850	7,800	80.0 d/	21.0 d/	18.5 d/
Dec						
Total Through 30 November	946,485	b/	377,543			
Percent of Total	100.0	b/	39.9			

a/ Discharge Diagnosis
b/ Not Available
c/ Estimated from AGO Form 8-122 and Adjusted to Calendar Months.
d/ Based upon Preliminary Strengths.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
ALL DISEASE										
1942 Average	669	679	671	823	700	452	494	832	1,048	1,356
1943 Average	739	860	624	670	837	943	971	1,046	991	1,107
1944 Jan-Jun	619	695	566	528	578	812	600	902	967	949
Jul-Dec	495	623	351	536	440	880	513	804	1,152	842
Average	563	654	478	531	492	846	561	840	1,077	896
1945 Jan	603	656	363	529	605	878	420	799	728	658
Feb	626	649	363	587	577	790	526	905	652	554
Mar	592	612	384	546	530	714	412	973	647	631
Apr	543	587	411	523	469	657	414	1,058	710	573
May	541	633	658	515	531	600	436	1,144	712	582
Jun	515	651	435	629	532	704	475	1,128	788	532
Jan-Jun	569	631	426	562	538	726	448	1,006	707	587
Jul	471	650	381	572	528	654	539	1,038	875	577
Aug	478	621	346	531	501	645	466	891	796	620
Sep	442	(539)	288	465	456	649	465		587	539
Oct	443	(510)	268	467	482				385	
Nov	472 b/									
Dec										
NONBATTLE INJURY										
1942 Average	91	125	152	107	110	96	104	178	80	162
1943 Average	80	133	182	105	100	149	114	171	84	140
1944 Jan-Jun	69	114	145	75	85	145	118	151	95	107
Jul-Dec	66	112	100	61	105	131	102	132	97	92
Average	67	113	127	68	97	138	111	139	96	99
1945 Jan	55	141	110	60	174	103	92	104	105	69
Feb	50	105	94	67	114	88	84	103	99	73
Mar	49	102	109	61	104	89	71	128	105	69
Apr	48	108	100	62	113	98	92	115	104	64
May	49	108	84	57	112	97	105	119	91	59
Jun	53	91	92	59	87	85	98	113	83	62
Jan-Jun	51	108	97	61	115	93	90	114	98	66
Jul	48	80	89	54	71	72	95	104	80	53
Aug	44	73	90	50	56	62	83	107	68	71
Sep	36	(64)	78	40	50	55	72		55	35
Oct	31	(65)	77	43	54				42	
Nov	31b/									
Dec										

a/ Excluding Iceland.
b/ Based on Incomplete Reports.
( ) Telegraphic Reports.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
ALL VENEREAL DISEASE										
1942 Average	29	32	7	74	38	36	12	32	64	86
1943 Average	26	34	3	56	43	56	5	15	52	68
1944 Jan-Jun	30	37	3	33	26	96	6	9	53	60
Jul-Dec	37	45	7	33	40	125	4	6	50	62
Average	33	42	5	33	35	111	5	7	51	60
1945 Jan	47	46	6	29	48	124	4	5	54	80
Feb	43	42	8	29	45	105	3	8	57	75
Mar	43	47	10	27	48	94	3	40	51	74
Apr	43	51	8	26	46	85	3	84	43	84
May	43	63	8	25	62	94	3	97	40	63
Jun	44	88	12	20	105	110	5	97	38	69
Jan-Jun	44	57	9	26	60	102	3	57	47	74
Jul	46	105	7	21	136	128	5	94	42	79
Aug	53	111	8	17	155	142	4	77	40	73
Sep	57		7	18	154	213	4		40	77
Oct	56		9	20	168				42	
Nov	60 b/									
Dec										
DIAGNOSED MALARIA										
1942 Average	0.6	33	0	99	0	11	12	52	165	136
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Jan-Jun	0.1	43	-	16	10	61	67	75	113	66
Jul-Dec	0.2	34	-	12	8	63	13	41	216	52
Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan	0.1	14	0	7	5	19	8	27	74	11
Feb	0.2	14	-	7	5	16	6	43	49	9
Mar	0.1	18	-	7	8	21	4	62	28	10
Apr	0.2	23	-	9	11	28	5	75	29	11
May	0.1	23	0	11	11	31	6	72	23	9
Jun	0.1	20	0	12	9	26	4	65	28	14
Jan-Jun	0.1	19	0	9	8	23	5	58	37	11
Jul	0.1	16	]	12	6	24	4	46	33	14
Aug	0.1	12	-	8	3	15	2	29	31	13
Sep	0.1		-	9	1	8	3		29	12
Oct	0.1		-	9	1				21	
Nov	0.1 b/									
Dec										

a/ Excluding Iceland.
b/ Based on incomplete reports.
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
COMMON RESPIRATORY AND INFLUENZA										
1942 Average	243	163	244	113	291	151	89	149	152	202
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Jan-Jun	198	174	245	84	225	185	97	90	177	254
Jul-Dec	85	100	105	77	92	138	70	78	176	132
Average	147	132	188	81	142	162	85	83	176	219
1945 Jan	167	146	106	67	166	190	70	95	135	180
Feb	192	144	135	71	157	182	60	128	135	149
Mar	167	122	115	65	125	152	54	125	131	164
Apr	122	99	143	70	93	106	56	131	130	127
May	124	97	417	75	87	79	55	139	136	92
Jun	101	89	182	193	63	70	90	145	163	88
Jan-Jun	145	115	177	95	112	132	65	128	139	132
Jul	77	93	90	150	56	61	99	180	182	108
Aug	79	96	85	105	66	69	91	151	157	115
Sep	72		68	117	63	66	60		123	116
Oct	79		47	140	72				84	
Nov	100 b/									
Dec										
DIARRHEA AND DYSENTERY										
1942 Average	8	30	5	19	17	33	34	59	123	196
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Jan-Jun	9	35	3	13	11	41	28	58	182	101
Jul-Dec	10	40	3	12	14	67	28	54	180	129
Average	9	38	3	13	13	54	28	55	181	115
1945 Jan	8	30	1	11	17	20	17	76	69	56
Feb	8	36	2	14	20	21	27	99	68	31
Mar	6	34	2	21	13	19	14	119	83	45
Apr	6	33	3	13	15	18	18	90	116	81
May	6	34	2	14	16	22	21	88	110	135
Jun	7	44	0	16	14	31	30	138	128	90
Jan-Jun	7	35	2	15	16	22	22	104	98	73
Jul	6	45	1	15	20	30	24	106	151	120
Aug	8	38	1	11	17	25	12	75	122	106
Sep	7		1	10	9	15	13		79	87
Oct	4		0	7	5				46	
Nov	4 b/									
Dec										

a/ Excluding Iceland.
b/ Based on Incomplete Reports.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	ETO a/	MTO	POA	SWPA	Asiatic	ME and PGC
FEVER OF UNDETERMINED ORIGIN										
1943 Average	c/	52	0	64	1	75	19	166	71	21
1944 Jan-Jun	c/	35	1	37	1	57	26	102	69	16
Jul-Dec	c/	40	0	31	3	85	13	80	174	37
Average	c/	38	1	34	2	71	20	88	131	27
1945 Jan	c/	24	0	20	4	39	5	70	87	12
Feb	c/	26	-	10	4	43	9	95	60	24
Mar	c/	29	0	10	6	41	3	117	56	31
Apr	c/	29	-	9	8	43	8	104	59	33
May	c/	31	0	10	9	38	10	113	70	35
Jun	c/	29	0	10	6	50	8	98	89	29
Jan-Jun	c/	28	0	12	6	42	7	100	70	28
Jul	c/	30	1	7	5	57	10	86	102	50
Aug	c/	22	0	6	5	58	5	38	91	59
Sep	c/		-	8	3	41	3		76	49
Oct	c/		-	10	2				52	
Nov										
Dec										
NEUROLOGICAL AND PSYCHIATRIC DISORDERS										
1944 Jan-Jun	29	29	11	21	24	37	26	48	23	27
Jul	32	59	10	16	84	52	27	58	16	31
Aug	36	50	12	18	76	28	25	48	17	21
Sep	46	41	13	25	40	50	32	53	16	19
Oct	48	56	13	23	65	82	32	39	21	21
Nov	47	60	13	27	85	47	28	41	23	16
Dec	47	56	12	22	72	39	29	53	20	26
Jul-Dec	45	53	12	22	69	50	29	49	19	22
Average	36	43	12	21	52	43	27	48	20	25
1945 Jan	50	43	14	25	51	32	35	43	19	20
Feb	49	39	9	27	36	31	25	70	20	15
Mar	50	40	13	29	39	31	25	74	22	20
Apr	45	36	13	24	31	41	34	60	24	11
May	49	24	9	20	15	13	19	67	22	8
June	43	20	14	20	13	13	20	49	26	13
Jan-Jun	48	33	12	24	30	27	26	60	22	15
Jul	39	18	11	23	10	12	25	38	25	10
Aug	37	17	16	18	8	14	21	35	22	12
Sep	26		10	15	7	12	30		18	7
Oct	23		8	11	6				17	
Nov										
Dec										

a/ Excluding Iceland. b/ Based on incomplete reports. c/ Not available.
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.