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MONTHLY PROGRESS REPORT ★ SECTION

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Asst. Security Officer, SMO~~

HEALTH

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U.S. Army,

OFFICE OF THE SURGEON GENERAL'S Office

HEADQUARTERS, ARMY SERVICE FORCES, WAR DEPARTMENT

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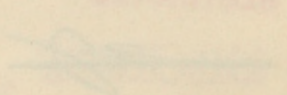


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DISEASE AND INJURY

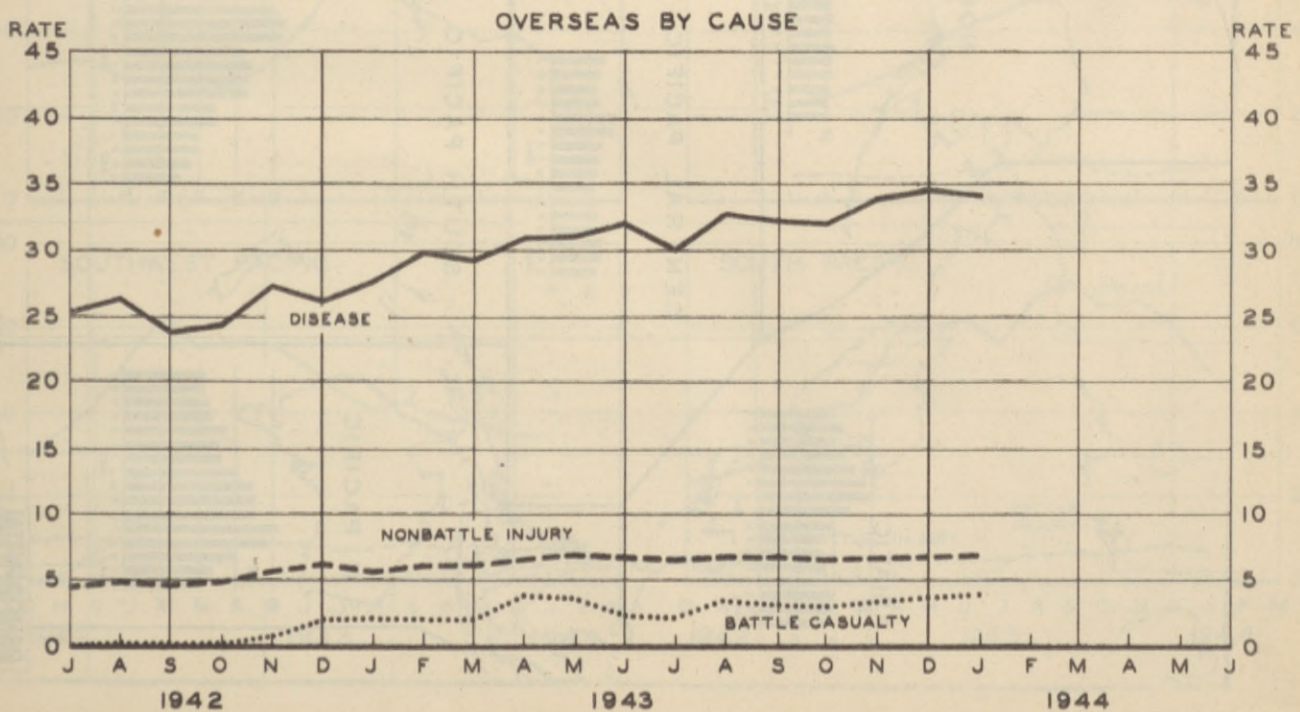
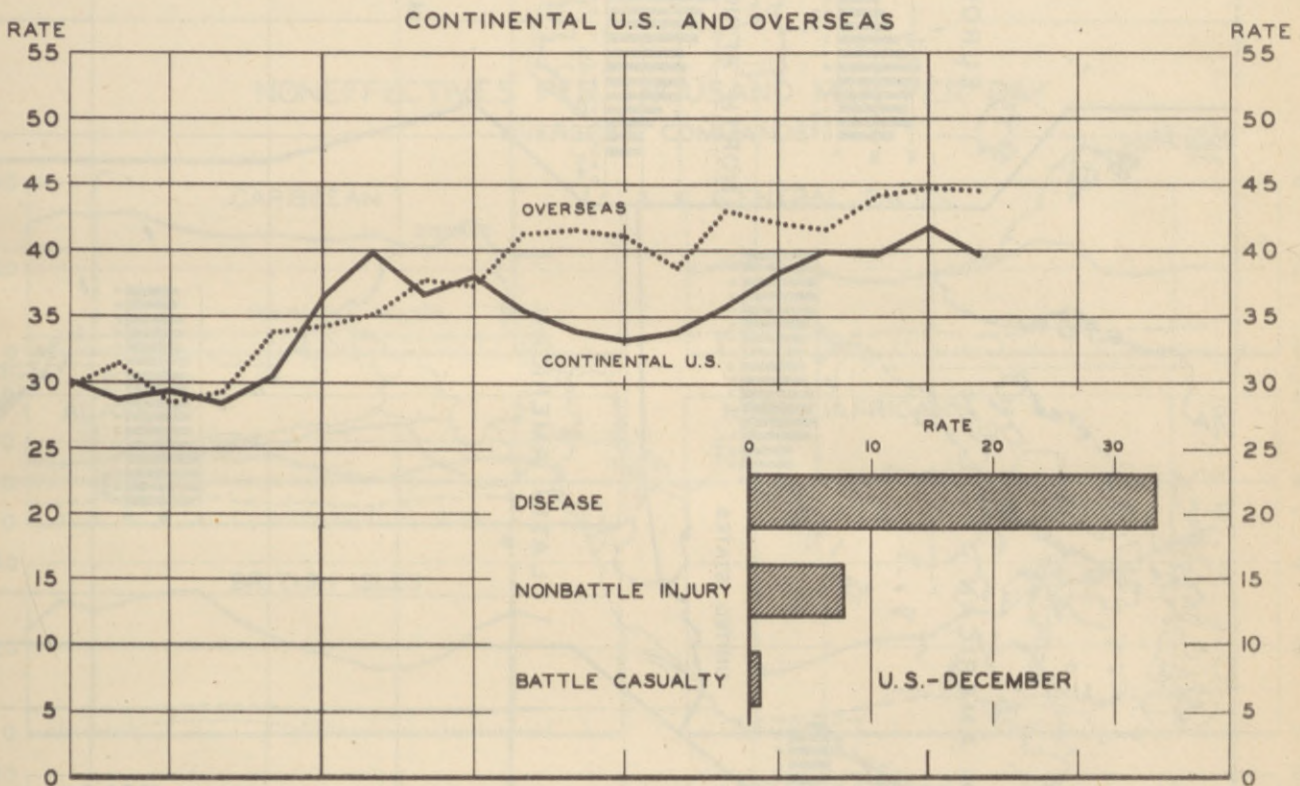
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NONEFFECTIVE RATES, U. S. AND OVERSEAS

The average daily noneffective rate for troops in the Continental U. S. declined slightly during January to reach 40 per thousand men per day. For the first time it is possible to show the major components of the U. S. noneffective rate. A tabulation for the month of December reveals that the rate of 42 breaks down into 33 for disease, 8 for nonbattle injury, and 1 for battle injury. The parallel overseas figures were 34, 7, and 4 during December, according to preliminary reports. During January there was no real change in the average noneffective rate overseas.

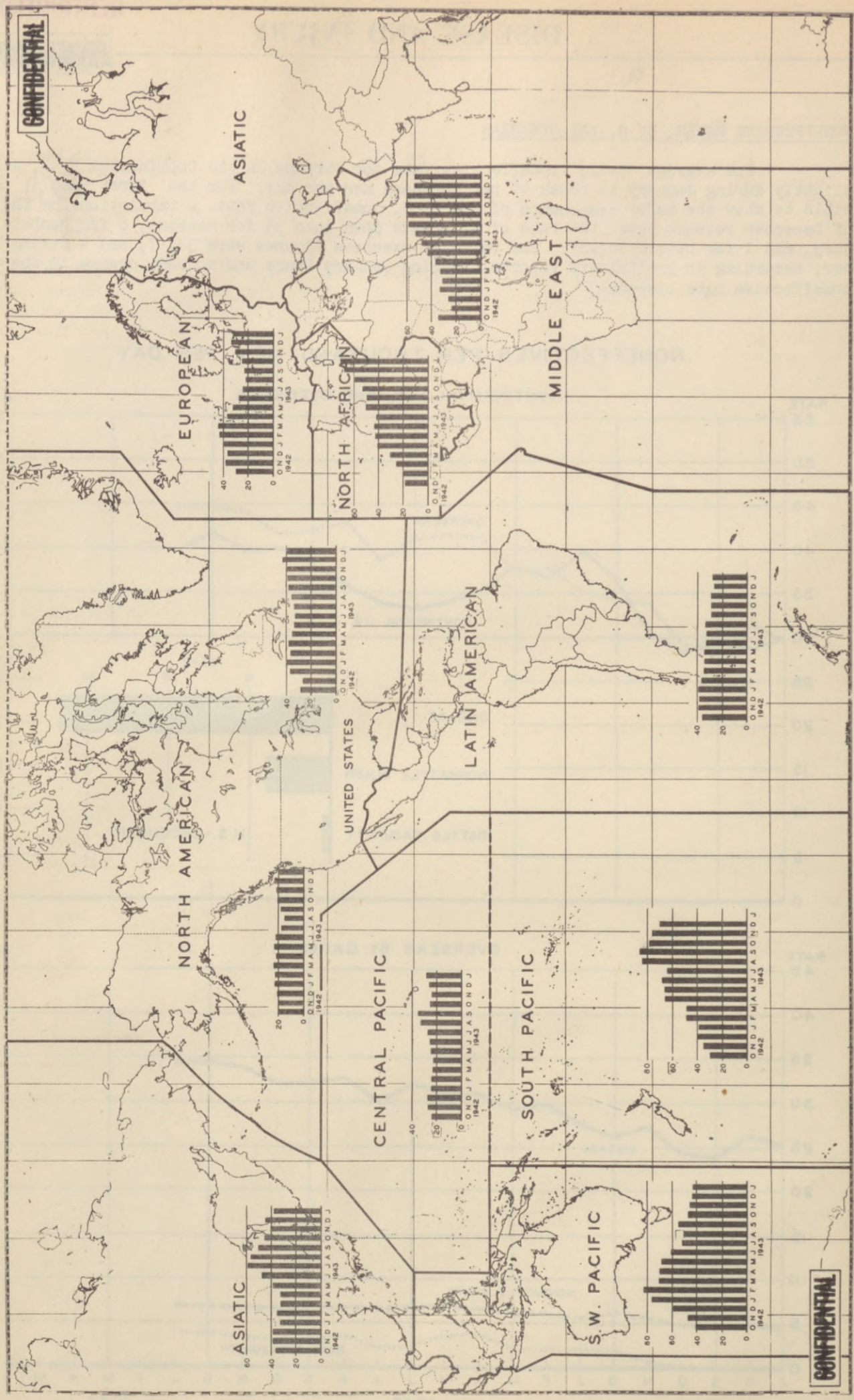
NONEFFECTIVES PER THOUSAND MEN PER DAY



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NONEFFECTIVES PER THOUSAND MEN PER DAY



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DISEASE AND INJURY

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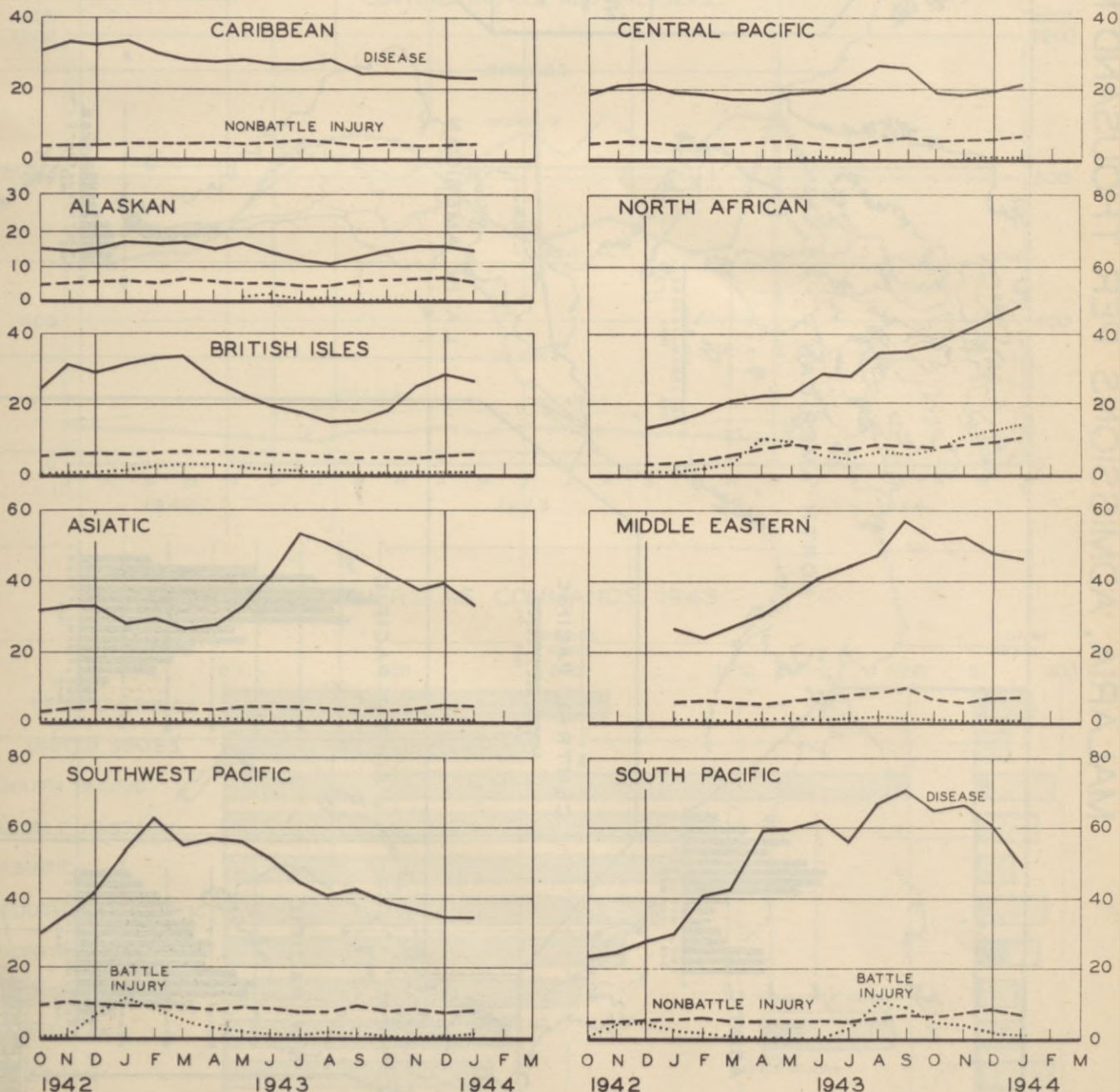
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NONEFFECTIVE RATES OVERSEAS

The noneffective rate, measuring the cumulative effect of admissions to hospital and quarters, and the length of time lost during treatment and convalescence, is the best single index to the health of the Army. In the charts below, the total rates shown on the map across the page are separated into the components attributable to disease, nonbattle injury, and battle injury. Points for the most recent months are provisional, being based on radio reports.

In most theaters or other commands the noneffective rate declined slightly during January. In North Africa, however, the rate continued to climb, the rate of 66 for December being exceeded by that of 71 for January. This rise in the total rate resulted from increases in all three components, from 45.0, 8.9, and 12.5 to 48.0, 9.5 and 13.0 noneffectives per thousand men per day for disease, nonbattle injury, and battle injury.

NONEFFECTIVES PER THOUSAND MEN PER DAY OVERSEAS COMMANDS

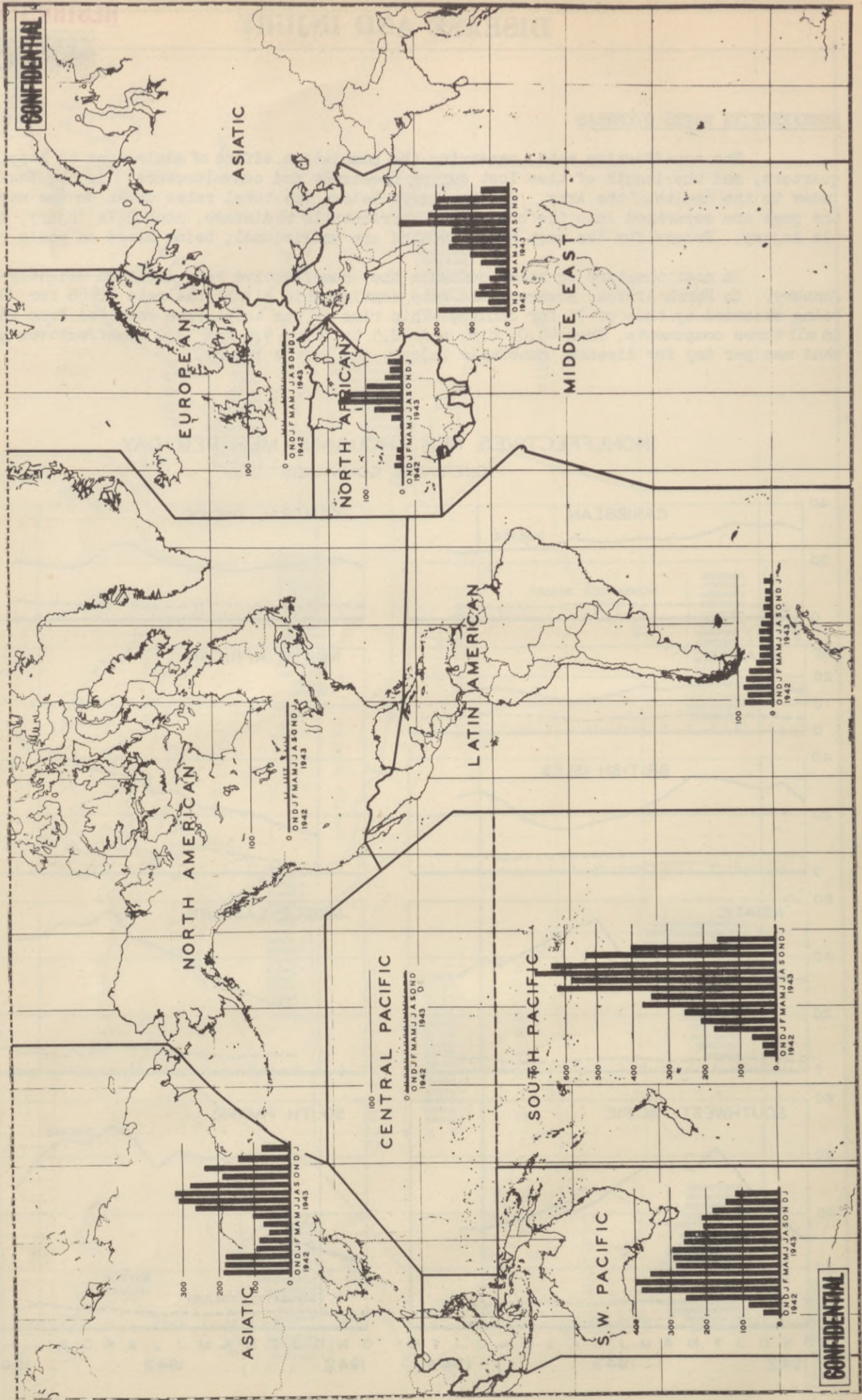


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MALARIA, ADMISSIONS PER THOUSAND MEN PER YEAR

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DISEASE AND INJURY

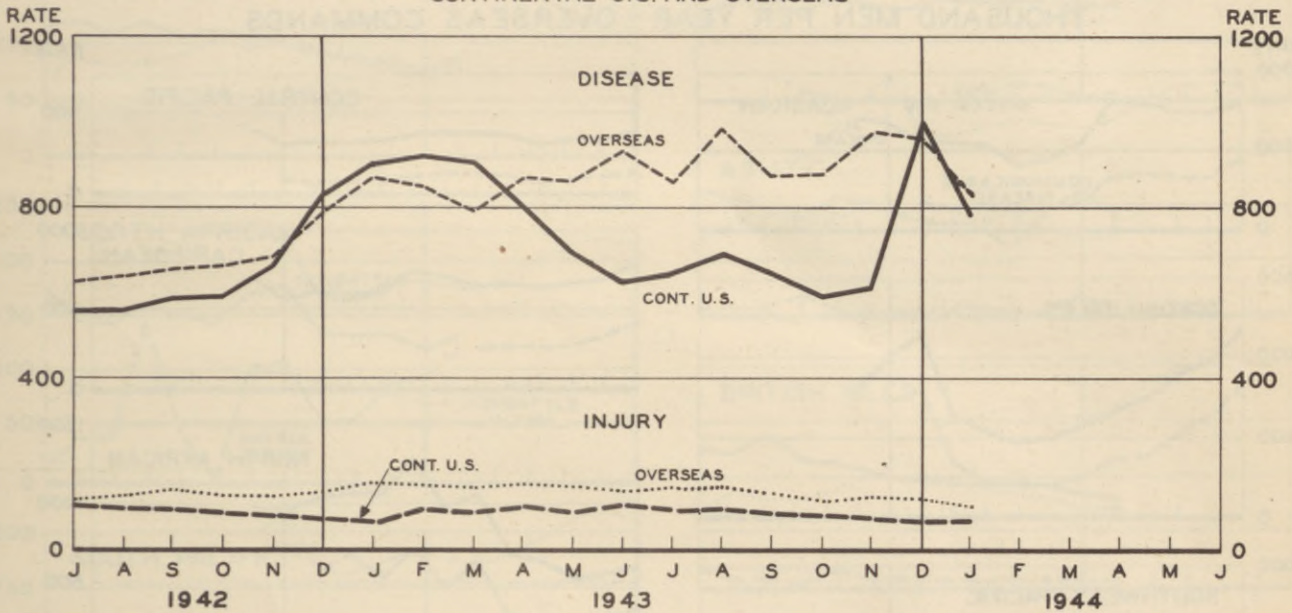
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DISEASE AND NONBATTLE INJURY

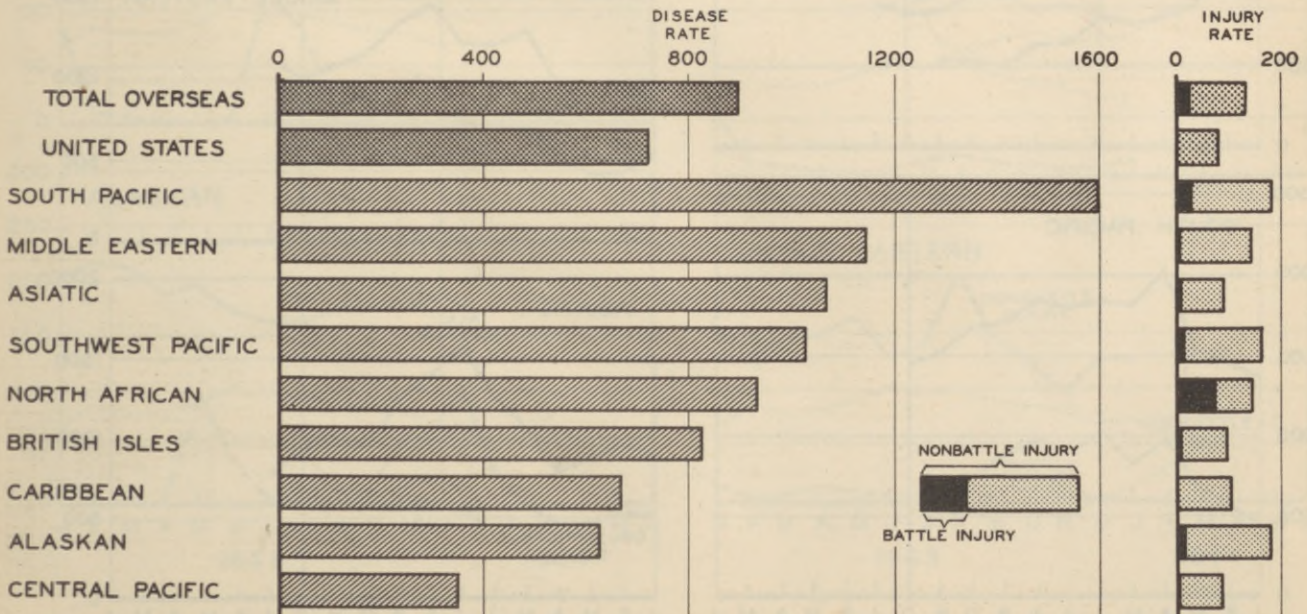
During the month of January, the provisional rate for all disease declined both in the United States and overseas as the respiratory epidemic subsided in the U. S. and the British Isles. In the British Isles the provisional January rate of 804 was 20 percent below that for December, and served to depress the total overseas rate from 963 to 836.

The U. S. admission rate for injury increased slightly to 70 while the rate for troops overseas declined about 10 percent to reach the low level of 107 admissions per thousand men per year, according to preliminary estimates. The chart at the bottom of the page compares the average 1943 incidence of all disease, nonbattle injury, and battle injury in certain overseas theaters or important commands. The theaters are ranked according to the incidence of all disease. Only the Caribbean, Alaskan, and Central Pacific commands enjoyed admission rates for disease which were lower than the 1943 average for the U. S.

DISEASE AND INJURY, ADMISSIONS PER THOUSAND MEN PER YEAR
CONTINENTAL U. S. AND OVERSEAS



OVERSEAS COMMANDS, 1943



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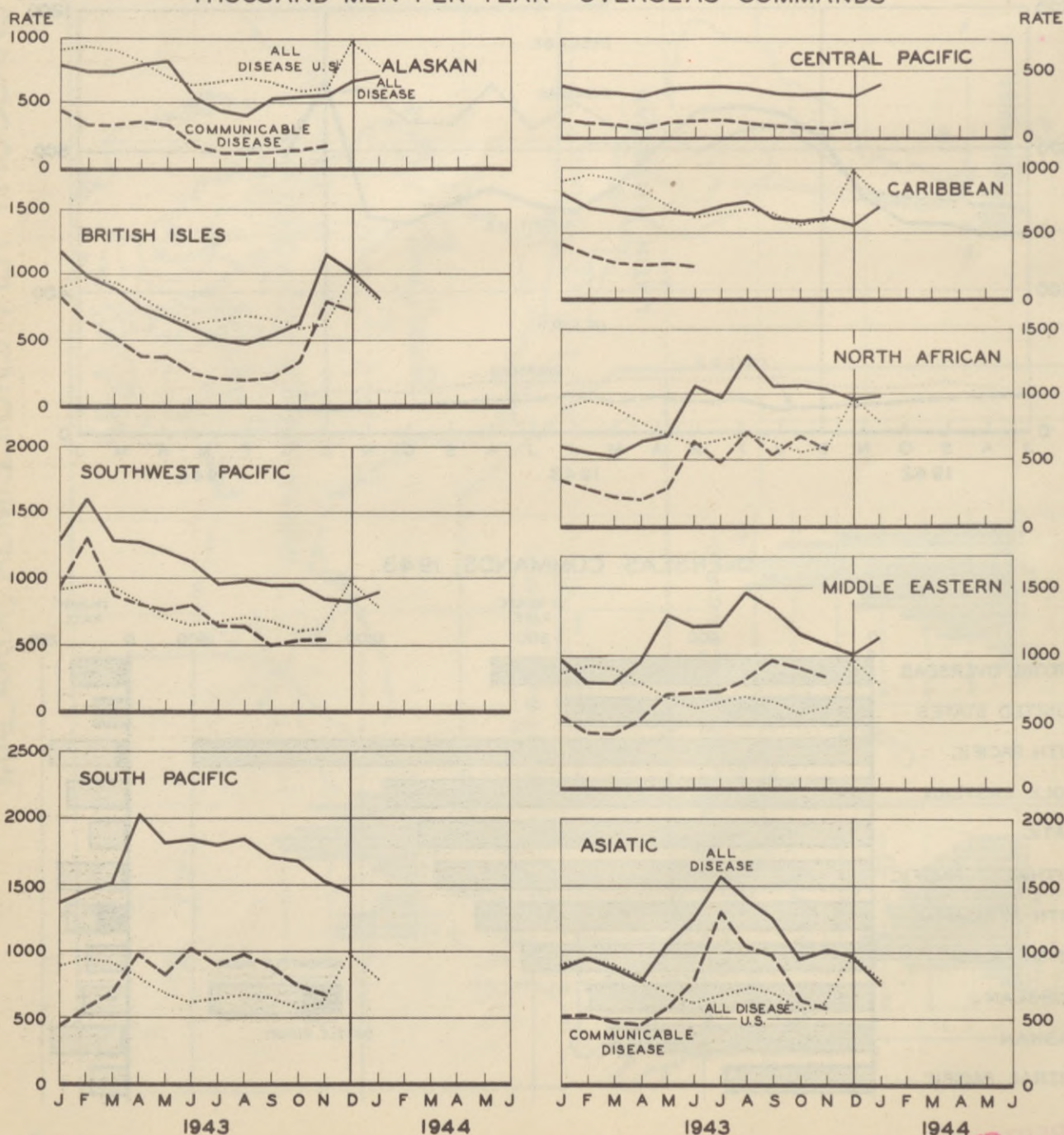
DISEASE AND INJURY

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DISEASE AND INJURY OVERSEAS

The charts below and on the following page depict the relative incidence of disease and injury in the more important overseas commands and in the United States. During 1943, disease accounted for many more admissions to hospital and quarters overseas than did battle and nonbattle injury combined. In all commands except Alaska, the Central Pacific, the Caribbean, and the British Isles, admissions for disease were consistently above those for the U. S., the greatest difference being noted for several months in China-Burma-India and the Middle East. The decline in admissions for malaria and for diarrhea and dysentery during the latter part of 1943 reduced the total disease rates in the South and Southwest Pacific, North Africa, the Middle East, and Asia. The rise in Alaska and the British Isles beginning in September 1943 was caused by the increased incidence of respiratory disease. The apparently greater incidence of noncommunicable disease in the South Pacific is considered largely erroneous because of the inclusion of some transfer cases as original admissions. The total disease rate shown below for the South Pacific is thus regarded as too high.

ALL DISEASE AND COMMUNICABLE DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR - OVERSEAS COMMANDS



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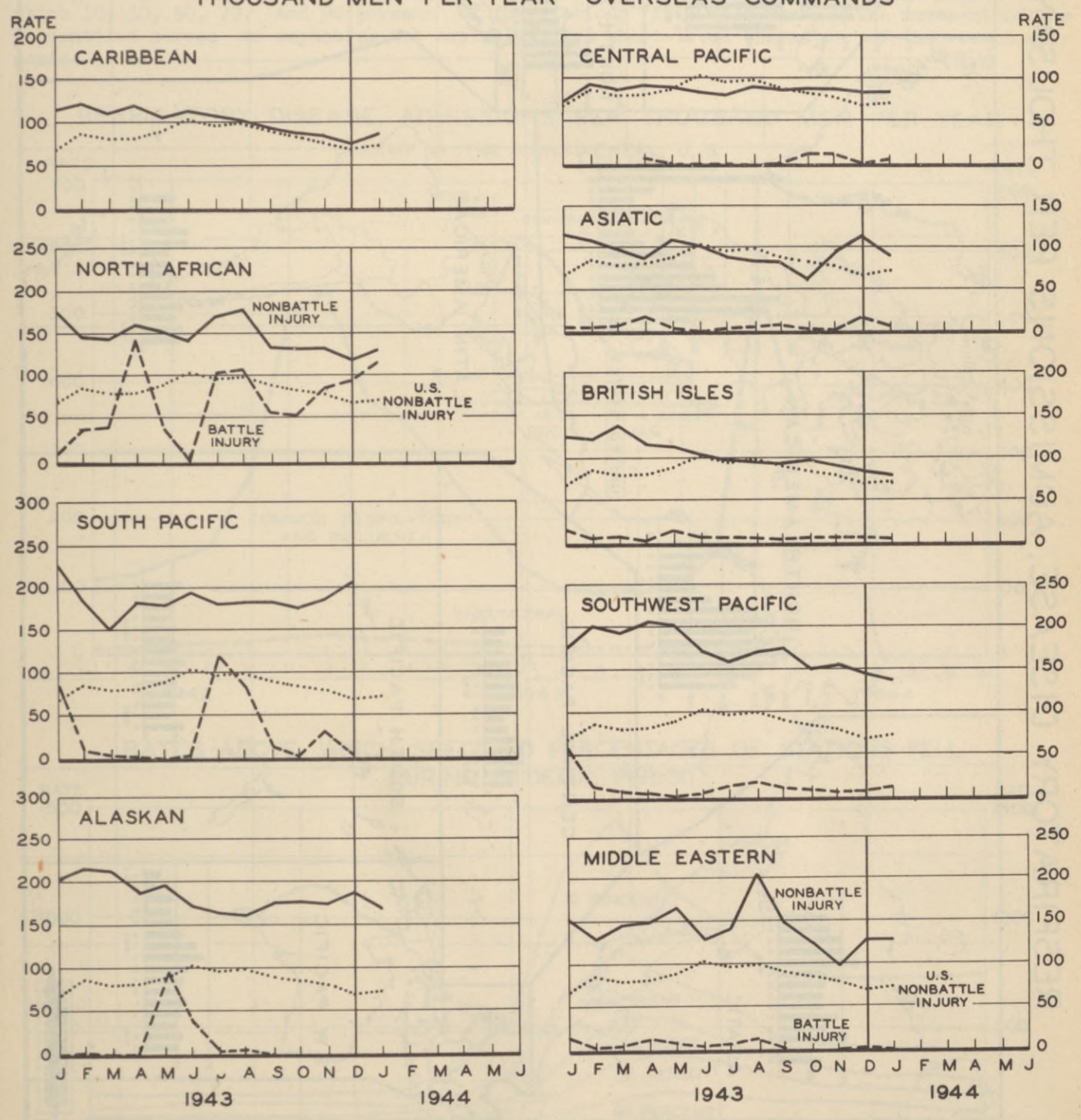
DISEASE AND INJURY

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DISEASE AND INJURY OVERSEAS (Continued)

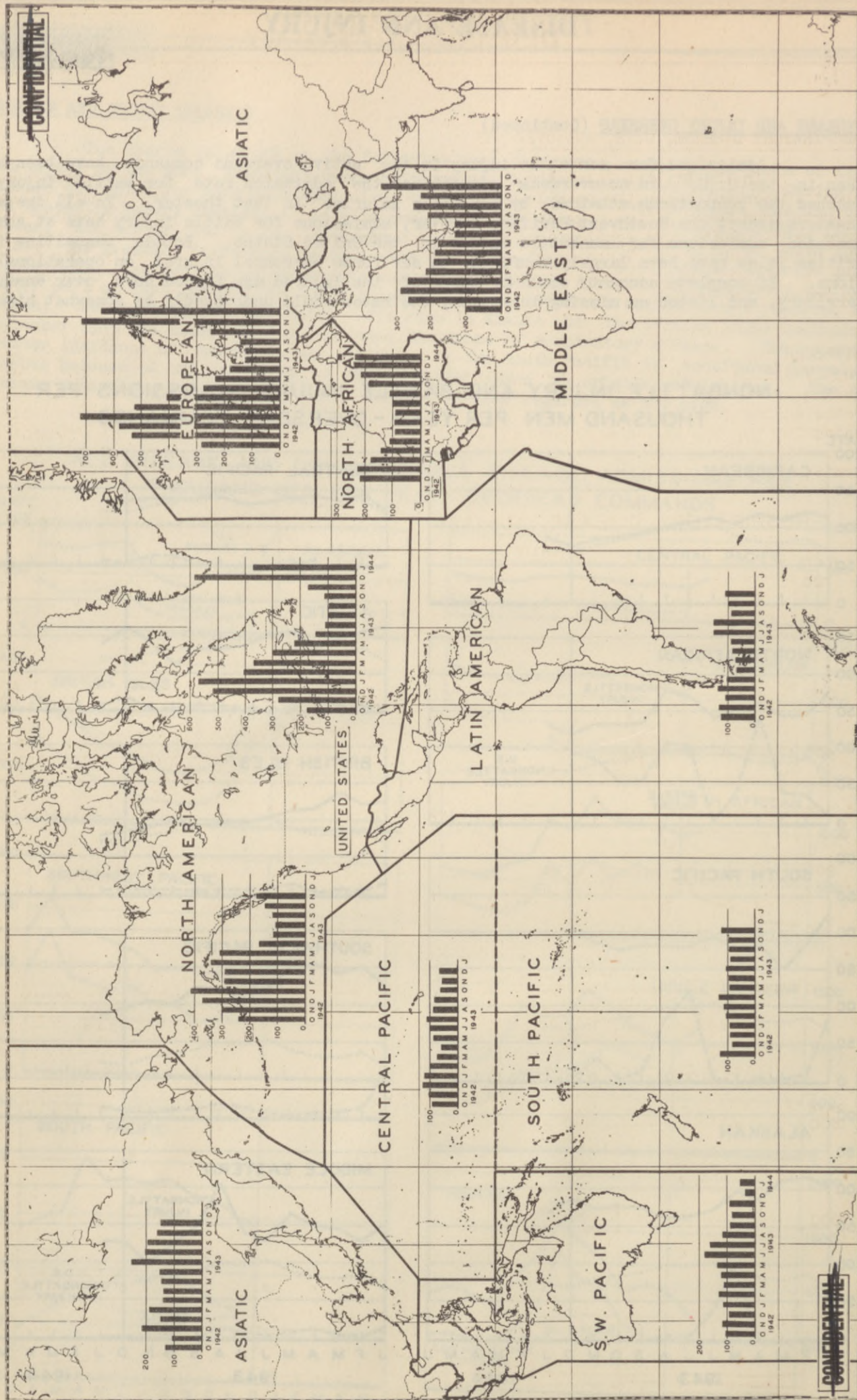
Admissions for nonbattle injury in the active overseas commands have been higher than in the U. S. In no overseas command has the admission rate for battle injury ever reached the proportions attained by nonbattle injuries in that theater. In all the active theaters except the Southwest Pacific, however, admissions for battle injury have at sometime exceeded admissions for nonbattle injury in the United States. Battle casualties in the British Isles have been largely confined to air force personnel injured on operational missions. If complete account could be taken of the injured men forced down over enemy-held territory, and listed as missing in action, the rates would undoubtedly be somewhat higher.

NONBATTLE INJURY AND BATTLE INJURY, ADMISSIONS PER THOUSAND MEN PER YEAR - OVERSEAS COMMANDS



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RESPIRATORY DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR



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DISEASE AND INJURY

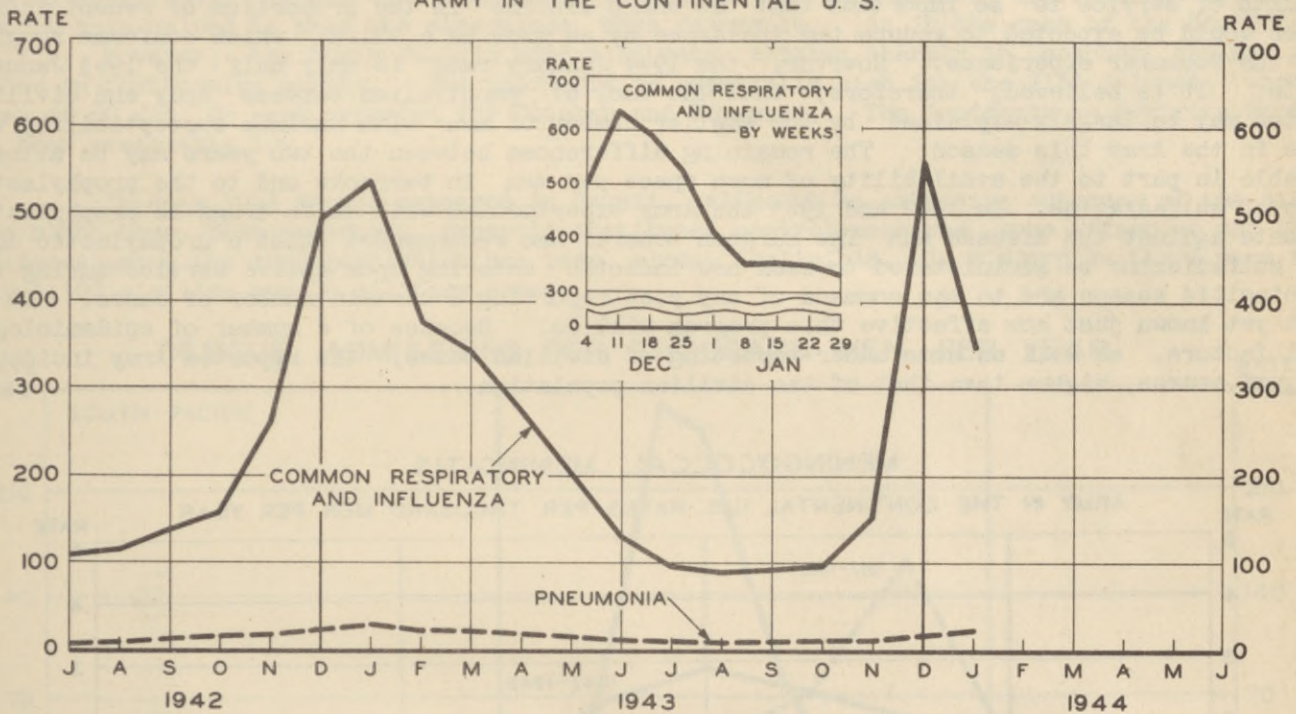
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RESPIRATORY DISEASE, U. S. AND OVERSEAS

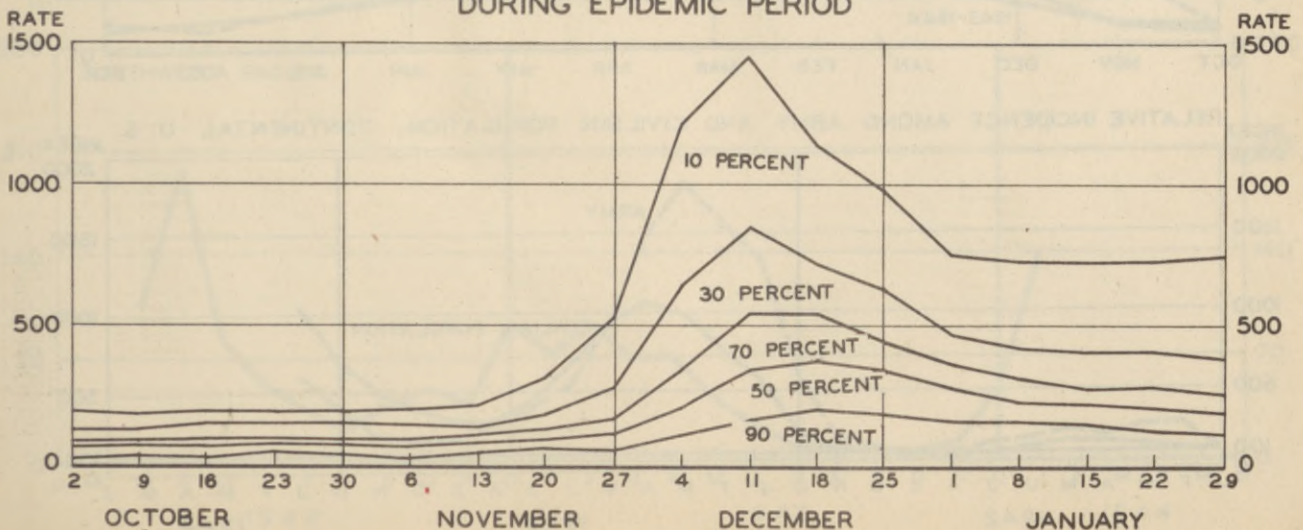
In the British Isles the December admission rate for respiratory disease declined about 10 percent below the peak level of 713 reported for November. Preliminary telegraphic reports from North Africa suggest that there was very little advance in the December respiratory rate, and a more considerable increase of perhaps 25 percent in January. Reports from the Middle Eastern and North American Theaters, where changes in the respiratory rate would also be of particular interest, were not available for December and January when HEALTH went to press. The latest information is shown on the map opposite.

In the United States the respiratory admission rate declined sharply in January, although the inset of the top chart below indicates that the weekly rates changed most abruptly during December. In the bottom chart, which is drawn to a different scale, stations having an average strength of 5,000 or more have been grouped according to their admission rates during each week of the past four months, and a line drawn connecting the points above which 10, 30, 50, 70, and 90 percent of the stations fell each week. The movement of the percentiles serves to emphasize the explosive and short-lived character of the recent epidemic.

RESPIRATORY DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR
ARMY IN THE CONTINENTAL U. S.



RATES ABOVE WHICH SPECIFIED PERCENTAGES OF STATIONS FELL
DURING EPIDEMIC PERIOD



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DISEASE AND INJURY

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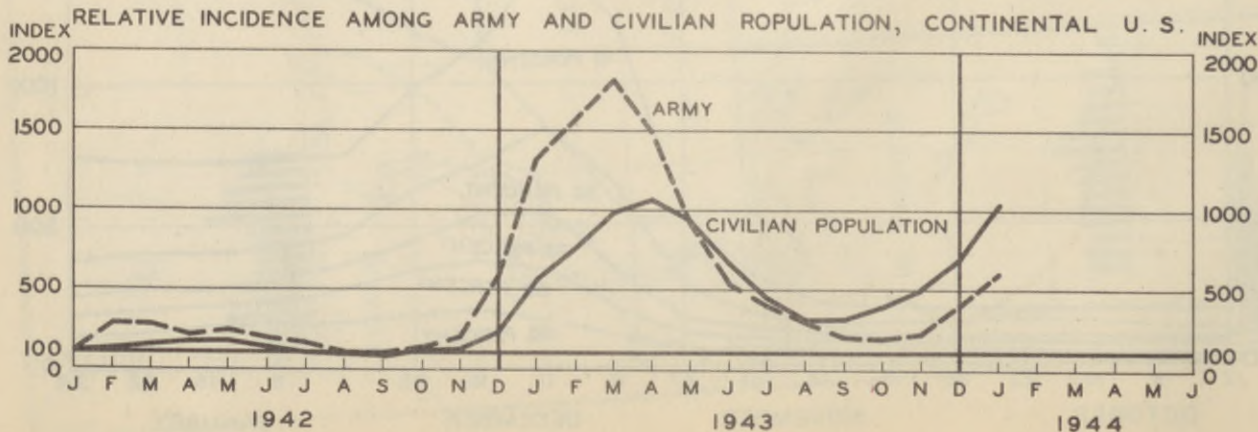
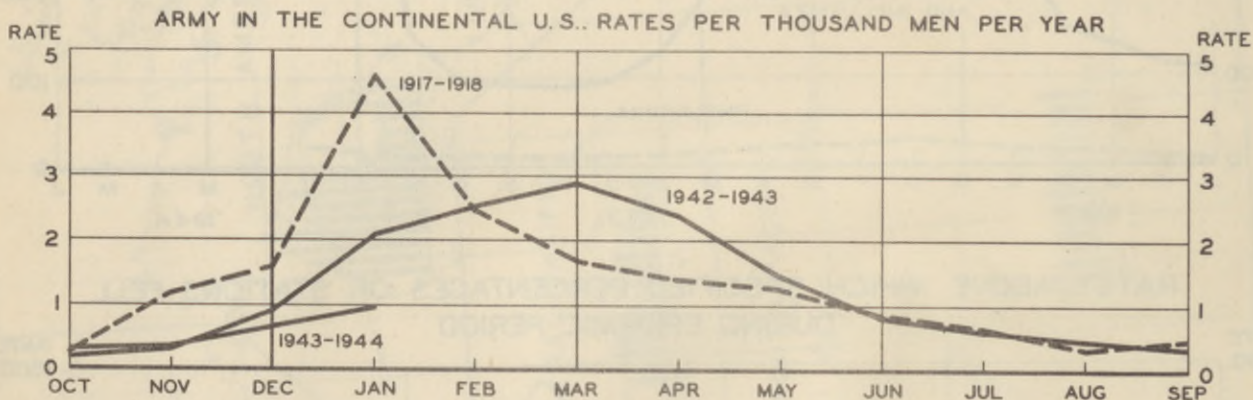
MENINGOCOCCAL MENINGITIS

Early in 1943 the incidence of meningococcal meningitis, or cerebrospinal fever, attained epidemic proportions among troops in the U. S. with the highest rates reported since the epidemic of 1918. During the late spring and early summer the rate declined to a point of almost normal incidence, but it rose very rapidly in November, December, and January, as shown in the first chart below. In relation to the epidemic period of a year ago the current experience seems quite favorable, but it is well above the average inter-epidemic incidence.

The civilian experience of the present season stands somewhat in contrast to the relative trend of the Army rate. The bottom panel shows both civilian and Army rates expressed as percentages of their respective rates for January 1942. This index clearly reveals that the Army rate reached a higher peak, proportionately, than did the civilian rate a year ago, but that the current civilian rates are even higher than last year, the January 1944 rate being almost twice the January 1943 rate. Why these differences should exist is not entirely clear, for the epidemiology of the disease is imperfectly understood.

It has been well demonstrated that new recruits are much more susceptible to the disease than are seasoned troops. During the 1942-1943 winter season, roughly 400,000 new enlisted men entered the Army each month. Since that time the number has fallen to its present level of about 120,000. Information gathered during the 1942-1943 epidemic suggests that length of service is so important that the sharp decline in the proportion of recent inductees would be expected to reduce the incidence by as much as a third, which conforms roughly to the December experience. However, the 1944 January rate is only half the 1943 January rate. It is believed, therefore, that the lack of parallelism between Army and civilian rates may be largely explained by the smaller number of men with maximum susceptibility who are in the Army this season. The remaining differences between the two years may be attributable in part to the availability of more space per man in barracks and to the prophylactic use of sulfadiazine. In 1942 and 1943 the Army experimented with sulfa drugs as prophylactic agents against the disease and The Surgeon General has recommended that a prophylactic dose of sulfadiazine be administered to each new inductee entering upon active service during the meningitis season and to the command of any post reporting a certain number of cases. It is not yet known just how effective this program will be. Because of a number of epidemiological factors, as well as some under-reporting of civilian cases, the reported Army incidence is, of course, higher than that of the civilian population.

MENINGOCOCCAL MENINGITIS



DISEASE AND INJURY

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DENGUE

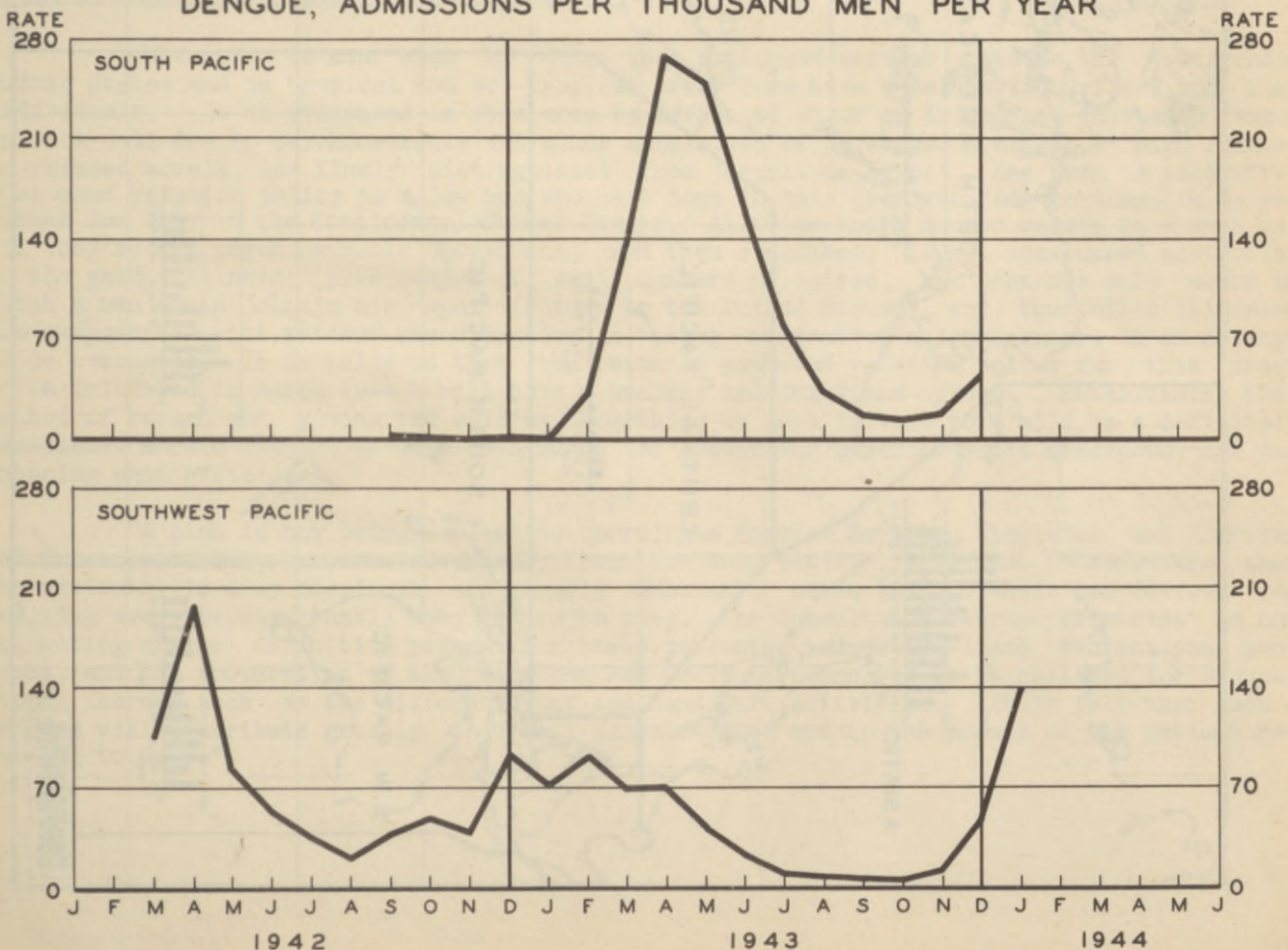
Dengue fever is widely endemic in the South and Southwest Pacific, the Asiatic, the Latin American, and the North African Theaters of Operations, and the Aedes mosquitoes which transmit the disease are distributed even more widely. Dengue is rarely fatal but it has epidemic potentialities and for a short period it can exert a marked influence upon the noneffective rate among troops without specific immunity. Fortunately, dengue is a disease of short duration and one attack usually confers immunity against subsequent attacks for one or two years.

In the spring of 1942 there was a sharp outbreak of dengue among U. S. troops in Australia, a rate of about 200 admissions per 1,000 men per year having been recorded for the theater during April of that year. During the summer season (November-March) of 1942-1943 the Southwest Pacific rate was again fairly high at almost 100 admissions per 1,000 men per year. During the past winter a very low rate obtained, but recent reports show that another summer peak is in the making. However, it is hoped that the disease may cause less noneffectiveness this year than last because of superior control measures and a more widespread immunity among troops.

Under the influence of a severe epidemic on Espiritu Santo in the spring of 1943, the South Pacific admission rate for dengue reached almost 270 admissions per 1,000 men per year in April 1943. Since that time mosquito control has been greatly improved and seasonal factors have helped to make the experience more favorable. As in the case of the Southwest Pacific, however, the South Pacific admission rate climbed sharply in December and may go higher in forthcoming months. The incidence is especially high in the Fiji Islands, where rates of 80 and 102 were reported for October and November. The incidence on Espiritu Santo has been reasonably low.

In June 1943 dengue appeared in Hawaii. Although an extensive outbreak of the disease might have been expected, promptly instituted control measures were effective and the incidence among the Army population has been almost negligible. In six months there were about 1,300 civilian and 56 military cases.

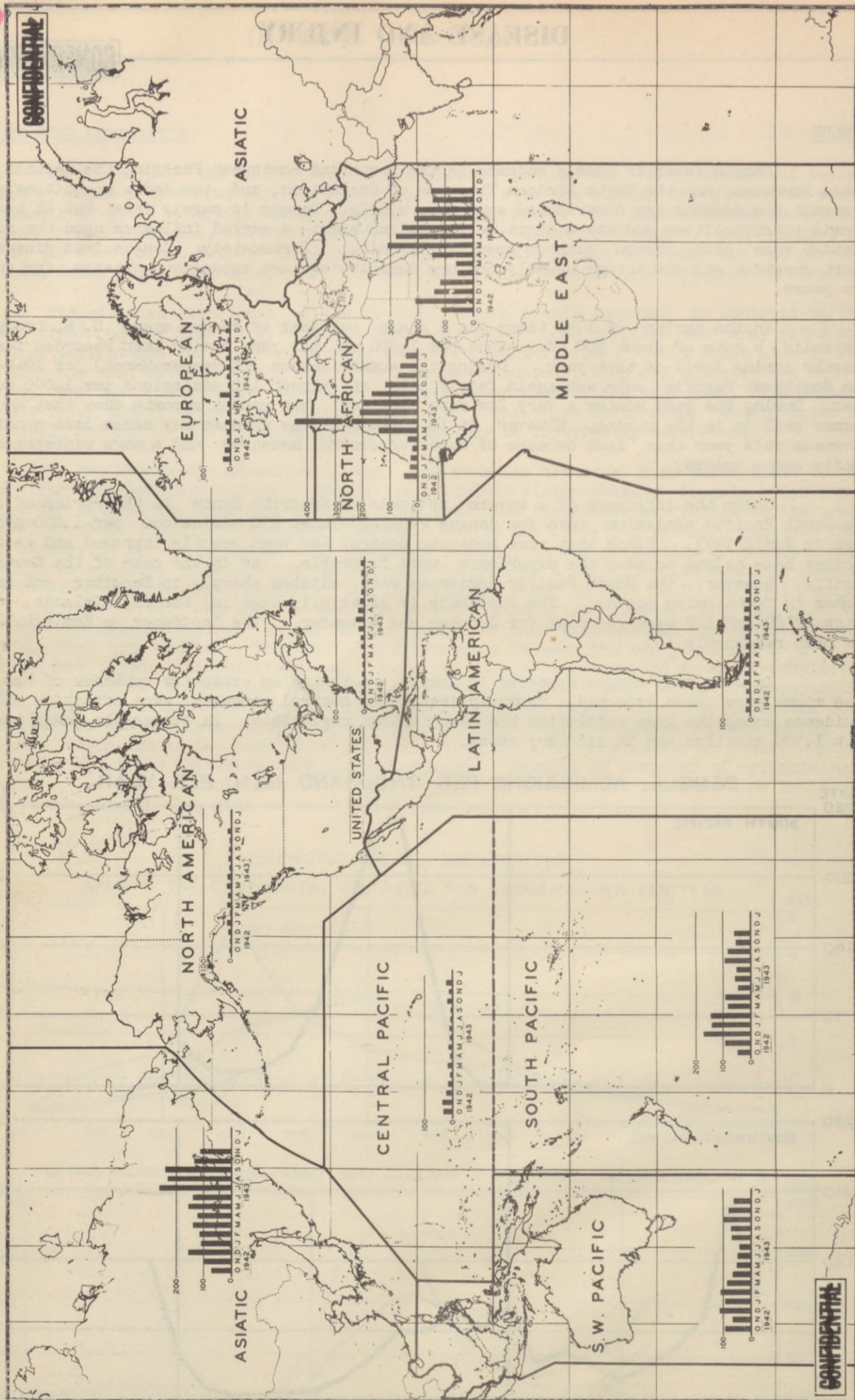
DENGUE, ADMISSIONS PER THOUSAND MEN PER YEAR



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DIARRHEA AND DYSENTERY, ADMISSIONS PER THOUSAND MEN PER YEAR

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DISEASE AND INJURY

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MENTAL HEALTH AND MORALE IN THE SOUTH PACIFIC

The following excerpt is taken from a recent technical medical report from the South Pacific Theater:

"The ultimate goal of a very high percentage of personnel is to 'get home', whether or not augmented by the thought 'to get it over, and get home'. Evacuation from an organization is one step to that goal. The overall problem of changing that goal from 'to get home', to 'to win this war' or 'to kill Japs' is a tremendous undertaking and involves changing of viewpoint in all ranks. It involves changing the trend of thinking even in the Continental United States. Mail censorship indicates that mail from home does not promote the 'win the War', 'kill some Japs for me', 'we're proud of you' note, but tends to increase nostalgia with the 'wish you could be with us', 'when are you coming home?' theme. Radio programs frequently carry the same note of nostalgic sentimentality. There is a preponderance of sentimental songs and love songs reaching popularity and being publicized and a dearth of good stimulating tunes such as marching songs for men to sing as they perform their duty. There is a great need for more education of the men by means of increased emphasis on orientation lectures. Greater emphasis should be placed on such types of moving picture as 'Divide and Conquer' and 'Why We Fight'. These latter are considered the best means at hand for education and orientation of the soldier, and their use should be extended and effort made to produce more of these films for showing to officer and soldier audiences. The soldier must know why he is fighting.

"Morale is directly in proportion to leadership; incidence of neuropsychiatric casualties is in inverse proportion to morale. Figures of neuropsychiatric casualties are high in units where the leader, be he of commissioned or non-commissioned grade, becomes a neuropsychiatric casualty. In units fighting side by side with this same unit, under the same conditions, be it squad, platoon, or company, in which leadership is good and the leader is not a psychiatric casualty, figures are disproportionately low. Good leadership is considered the most important factor in obtaining and maintaining morale. Continued emphasis is being placed on careful selection of leaders. Emphasis is also being placed upon building 'esprit-de-corps' with the unit as a command function. This must be continually emphasized, as unit commanders are sometimes prone to consider morale building a function of Special Service, which is concerned primarily with recreation.

"However, it must also be said, that prolonged service outside the Continental United States and in tropical and sub-tropical areas does have a deleterious effect upon some individuals. It is evidenced in this area by decreased vigor or drive, and increased census on sick call due to psychoneurosis and minor complaints of psychogenic origin. Also related to reduced morale, as finely distinguished from 'esprit-de-corps', has been a lack of replacement rotation policy to allow men who have been in this area for long periods, to be returned for duty in the Continental United States. Allowing these men to remain in a unit until they become psychoneurotic breakdowns, and then evacuated, is not considered advisable. In the past, illness, plus return of small numbers of cadres, has been the only means by which a man could obtain his 'goal' (return to the United States), and thus often illnesses are exaggerated, the patient uncooperative in taking medication and treatment, in an attempt to be evacuated. It is believed that the recently approved rotation policy for this area, to be initiated in March 1944, will have a healthy and immediate effect. Establishing this method of return and giving the soldier 'something to look forward to', will be a definitely beneficial morale factor, as well as a means of preventing psychoneurotic breakdown, and increasing unit efficiency.

"A plan is now being evolved to coordinate Special Service, Chaplains, and American Red Cross personnel, to more adequately treat the army patient. It must be remembered that the patients in army hospitals are largely ambulant, often left to their own devices for 'whiling away the days' until they return to duty. The Consultant Neuropsychiatrist is now organizing a more definitive program for these patients, educational and recreational programs, and the cooperation of the American Red Cross personnel is to be utilized for occupational therapy such as the different art and handcraft activities. It is felt that such a program will contribute greatly to speedy convalescence and to the morale of the patient returning to duty."

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DISEASE AND INJURY

THE OUTBREAK OF TYPHUS FEVER IN NAPLES

During December 1943 and January 1944 a relatively large outbreak of louse-borne epidemic typhus fever occurred in Naples. The disease spread rapidly and was a potential danger to military forces in the area. The outbreak has been brought under control with unusual promptness through vigorous measures instituted and carried out by the U.S.A. Typhus Commission working in association with the medical establishment of the Surgeon, North African Theater of Operations, AMG officials, and a typhus control team of the Rockefeller Foundation Health Commission. There was full cooperation from military authorities of the Peninsular Base Section and from HQ, U.S. Forces in the Middle East. All operations were carried out in constant contact with The Surgeon General and The Commanding General, A.S.F.

Whereas in January as many as 63 new cases were reported in a day, there were less than 10 cases per day by 10 February, according to a radiogram from the Field Director of the U.S.A. Typhus Commission. This message stated further that the "typhus situation in Southern Italy shows remarkable improvement" and that "the control measures have proven even more successful than anyone anticipated".

Final figures and details are not available at this time. The following is, therefore, a preliminary statistical report. The incidence of typhus among civilians in Naples by months from 1 March 1943 to 18 January 1944 is shown in the following table (mortality figures are not yet available):

<u>Date</u>	<u>Cases</u>
1943 March	1
April	3
May	6
June	0
July	2
August	11
September	18
October	29
November	55
December	341
1944 January (1-18)	<u>633</u>
Total	1,099

It is seen from this table that typhus began to increase in Naples before the entry of American forces in October and that 974 out of the total of 1,099 cases occurred between 1 December 1943 and 18 January 1944. The U.S.A. Typhus Commission was called in about the middle of December and was put in charge of the situation on 26 December 1943.

Italy had been free from typhus for many years. Outbreaks had occurred during the first world war and shortly after, but no case of typhus had been reported from Italy from 1928 to 1942, as shown by the following table:

<u>Year</u>	<u>Cases</u>	<u>Year</u>	<u>Cases</u>
1915	6	1930	0
1916	50	1931	0
1917	19	1932	0
1918	36	1933	0
1919	635	1934	0
1920	113	1935	0
1921	60	1936	0
1922	0	1937	0
1923	1	1938	0
1924	3	1939	0
1925	0	1940	0
1926	34	1941	0
1927	16	1942	0
1928	0	1943	466
1929	<u>0</u>	1944	<u>633</u> (18 Jan)

As typhus fever had not occurred in Naples for 15 years and had occurred only in small outbreaks in the preceding 13 years, the disease in 1943 was introduced into a non-immune population. This created a much more dangerous situation than is present during the

DISEASE AND INJURY

THE OUTBREAK OF TYPHUS FEVER IN NAPLES (Continued)

yearly increases of typhus fever among populations constantly in contact with the disease. All other conditions in Naples were favorable to a severe outbreak. The people lacked sufficient food. The water supply system and housing had been largely destroyed by bombing and by the Germans. Soap and bathing facilities were scarce, or non-existent. Great masses of people crowded into air raid shelters frequently--often several times a day. Medical services were disorganized. Prisoners from jails and prison camps which had been bombed were mingled with the citizens. The sick who under normal conditions would have been isolated were being cared for in any available shelters in contact with the well. Louse infestation was prevalent. It is assumed on evidence that the disease was imported from Yugoslavia in 1943, by refugees from the Balkans and perhaps by escaped prisoners of war. The figures indicate that the outbreak was definitely underway before the Allied forces occupied Southern Italy and Naples.

The typhus control program instituted by the U.S.A. Typhus Commission included five main points:

1. Case finding
2. Immediate contact delousing of persons in contact with cases
3. General contact delousing of persons in vicinity of a case
4. Mass delousing of the entire population of Naples
5. Immunization with typhus vaccine, administered first to personnel of all essential services, including doctors, nurses, hospital attendants, police, priests, officials, etc.

These measures have been carried out on the scale necessary to deal with a population in Naples and adjacent areas estimated to be between 900,000 and 1 million. The group on which concentration was focused was estimated at about 800,000. From 1 to 18 January, 769,248 persons had been deloused. The following figures show the development of this operation and the numbers handled daily:

1944 January Day	Number Deloused by Dusting with Insecticide Powder	1944 January Day	Number Deloused by Dusting with Insecticide Powder
1	5,051	10	66,225
2	8,951	11	63,210
3	14,251	12	66,476
4	22,864	13	62,600
5	28,462	14	62,800
6	32,700	15	50,696
7	38,877	16	58,344
8	43,360	17	50,760
9	41,089	18	52,532
		Total	769,248

It was possible to delouse this great number of people in so short a time because of the development by the Office of The Surgeon General, in collaboration with the Department of Agriculture, the International Health Division of the Rockefeller Foundation, the U. S. Public Health Service, the National Research Council, and other agencies, of new and effective chemical insecticides and new methods of applying these substances in the form of powders. The louse powders used were MYL (containing pyrethrins) and DDT (dichloro-diphenyl-trichloro-ethan). MYL kills quickly, but has a relatively short period of effect. DDT kills lice more slowly, but it remains effective in clothing for as long as a month. The powder is applied by hand dusters and power dusters, blowing the powder up the sleeves, down the back, inside of trousers, skirts, and other clothing. In this manner it is possible to delouse individuals without undressing them. This revolutionary and effective method of delousing reduces, and almost eliminates, the need for heat sterilization apparatus and bathing establishments as equipment for typhus control.

Dependence for immediate control was placed on delousing. As a factor for longer term control, immunization with typhus vaccine was instituted. In the new type Cox vaccine used in the Army since 1942, there is available a prophylactic agent which thus far appears to be highly effective. Supplies of vaccine were moved by air from depot in Cairo to Naples. To replenish the stock at Cairo 50,000 vials (20 cc. each) of typhus vaccine weighing 10,000 pounds were flown from the Medical Supply Depot at Kansas City to Cairo.

To date no case of typhus has been reported in an American soldier in Italy.

DISEASE AND INJURY

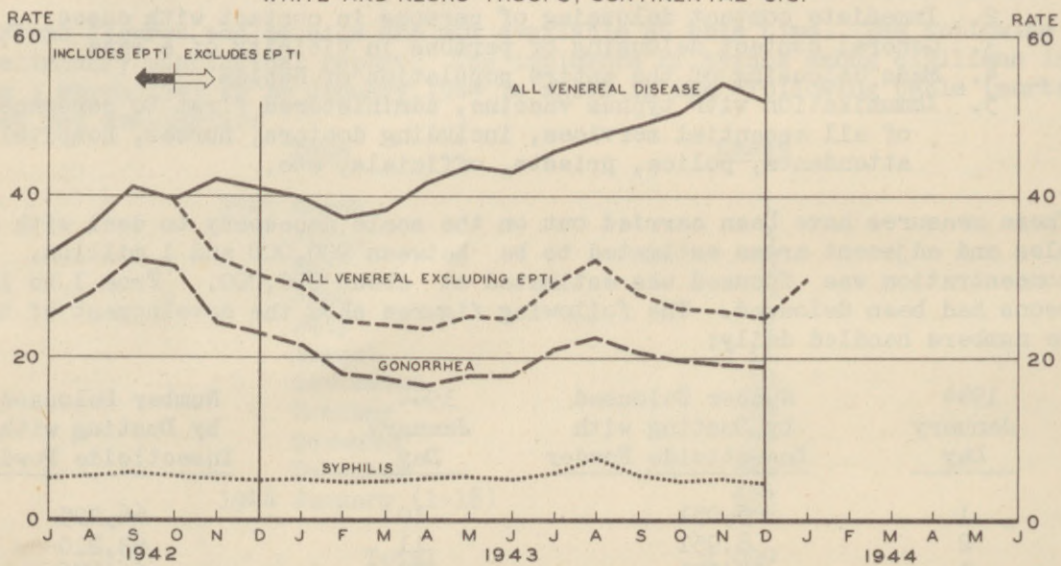
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VENEREAL DISEASE

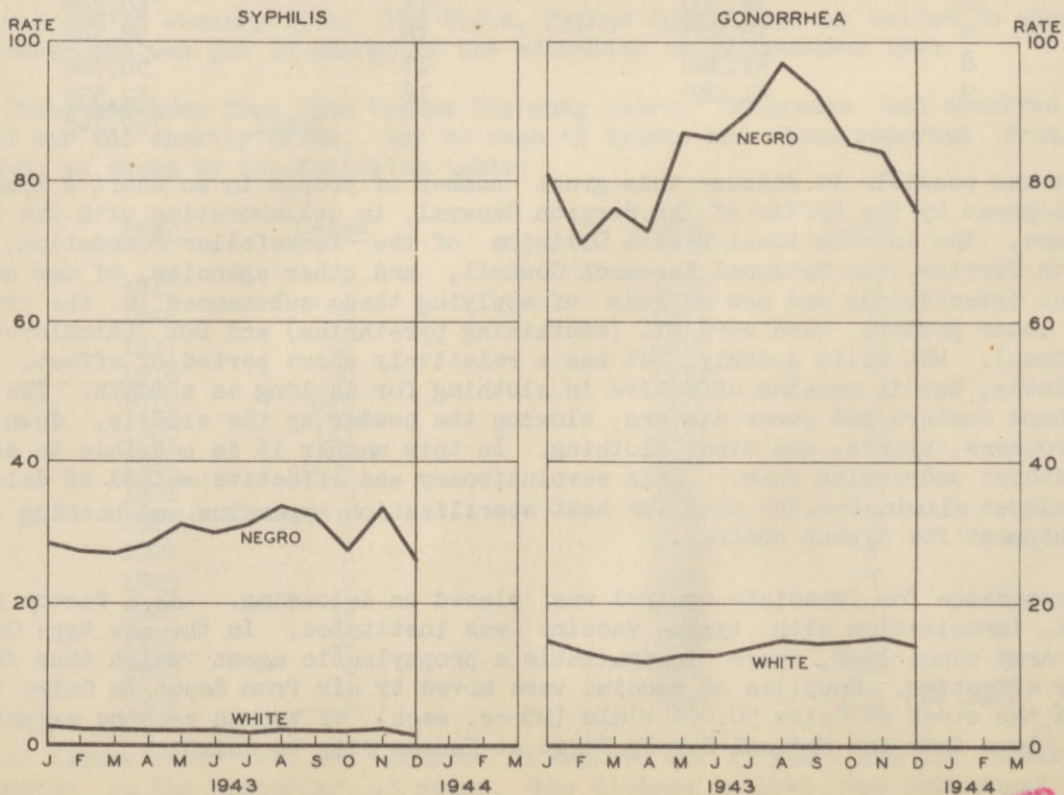
During 1943 admissions for venereal disease among troops in the U. S. increased considerably because of the policy of inducting infected men. The top line of the chart below traces the course of the gross admission rate among all U. S. personnel. The lines below it show corrected rates, derived by excluding the admissions of men infected prior to entrance into the Army, for all venereal disease, for gonorrhoea, and for syphilis. The preliminary rate for January is considerably higher than that for December.

The charts at the bottom of the page give the admission rates for white and Negro troops in the Continental U. S. They show how little change there has been in the admission rate for whites, and suggest how important are any changes in the rates for Negro troops. The syphilis rate for Negroes in December declined sharply by about 25 percent after having reached a high point of 34 admissions per thousand men per year in November.

VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR
WHITE AND NEGRO TROOPS, CONTINENTAL U.S.



BY COLOR



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DISEASE AND INJURY

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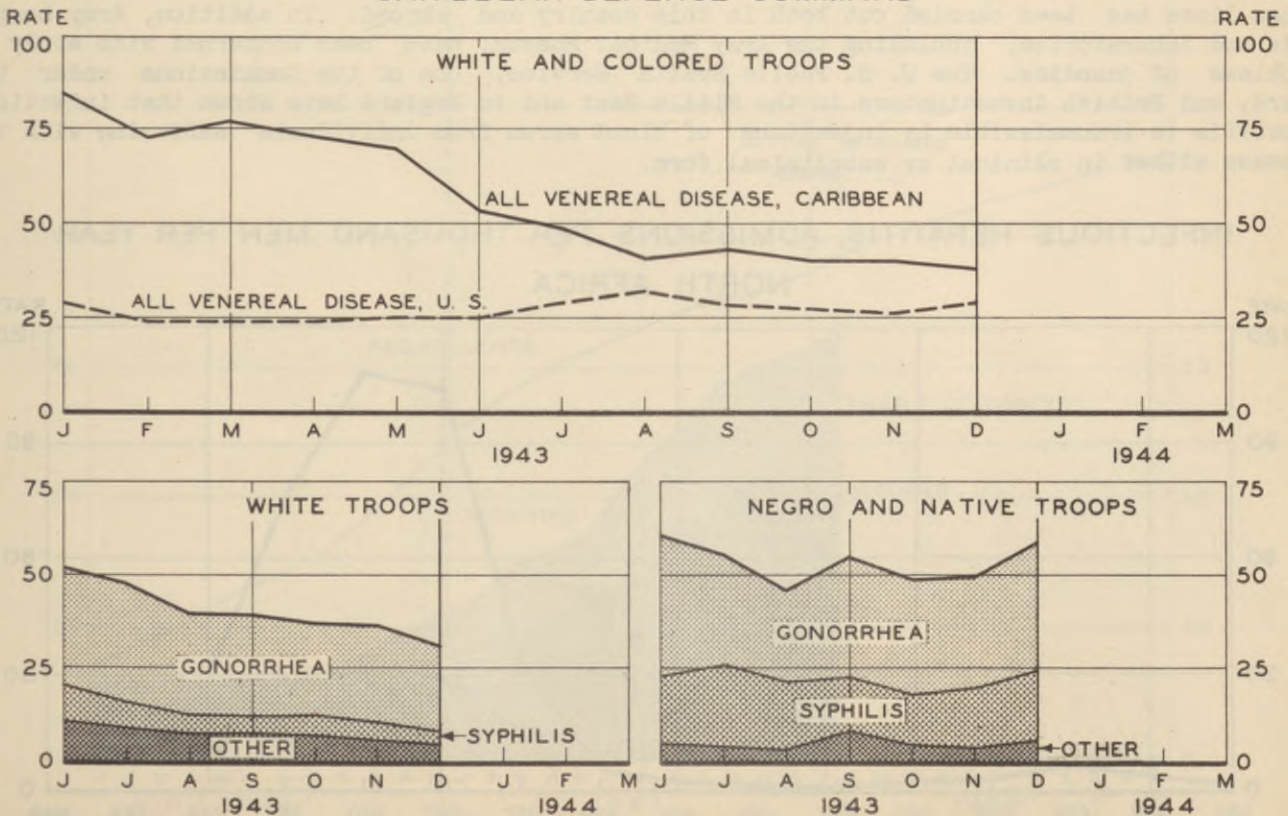
VENEREAL DISEASE IN THE CARIBBEAN

Venereal disease has been called the most important and the most difficult health problem facing the armed forces in the Caribbean area. Infection is highly prevalent among the civilian population and social and economic conditions are such as to facilitate contact with sources of infection. Throughout 1942 and early 1943 the average level of the admission rate for venereal disease among U. S. troops in the Caribbean was considerably higher than that for any other command of commensurate size. However, during 1943 the admission rate has been almost halved by the energetic prosecution of a realistic venereal disease program which increasingly represents a cooperative endeavor on the part of the Army, Navy, U. S. Public Health Service, and other official agencies.

The top chart below gives the 1943 rates for all venereal diseases among troops in the Caribbean and in the U. S. (less EPTI). From 85 admissions per 1,000 men per year in January, the rate for the Caribbean has declined to 38 for December, about 55 percent. The improvement has been fairly general, but in the last seven months of 1943 the rate for whites has maintained a steady downward trend whereas that for Negro and native troops has been rather erratic. The bottom chart gives the detailed experience by diagnosis. "Other" venereal disease shown there is chiefly chancroid. The decline in the rate for whites is seen to consist chiefly in a lessened incidence of gonorrhoea and chancroid, but the relative changes in the admission rates for chancroid and syphilis are most striking.

In one unit of almost 20,000 strength, the Coast Artillery Command of the Panama Canal Department, especially notable results were obtained by the skillful application of a control program. The January to May 1943 rate of almost 60 for this command fell abruptly in June and thereafter, reaching about 20 in November. This result has been attributed to the following measures: "a. an intensive, individualized, educational program designed to give each soldier an accurate knowledge of the true dangers of acquiring each venereal disease and of the details of proper mechanical and chemical prophylaxis with emphasis on the proper use of soap and warm water; b. specifically providing mechanical and individual chemical prophylactic kits with each pass permit and providing acceptable station prophylaxis; c. instituting a check pass system whereby every returning soldier is suitably interrogated relative to the possibility of his exposure to venereal disease and he is personally urged to take all necessary prophylactic precautions; and d. utilizing sulfa-prophylaxis to reduce the incidence of gonorrhoea - the most frequently acquired venereal disease."

VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR, CARIBBEAN DEFENSE COMMAND



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DISEASE AND INJURY

HEPATITIS IN NORTH AFRICA

During the late summer and fall of 1943 an epidemic of mild infectious hepatitis with jaundice (also called catarrhal jaundice, jaundice without known cause, etc.) occurred among United States, British, and French troops in the North African Theater and constituted one of the major medical problems in this theater. Similar outbreaks were experienced by British troops in the Middle East in 1941 and 1942. A study of the incidence of infectious hepatitis among troops in the U. S. over the past 10 years (excluding the 1942 experience, discussed below) reveals that admissions for this disease tend to increase during the late summer, reaching a peak in November and December and then falling off sharply to an average level of about 1 per 1,000 per annum. It has been noted that in the southern hemisphere, in those regions which in general have seasons reciprocal to those in this country, the peak incidence of infectious hepatitis occurs during those months which correspond to our autumn.

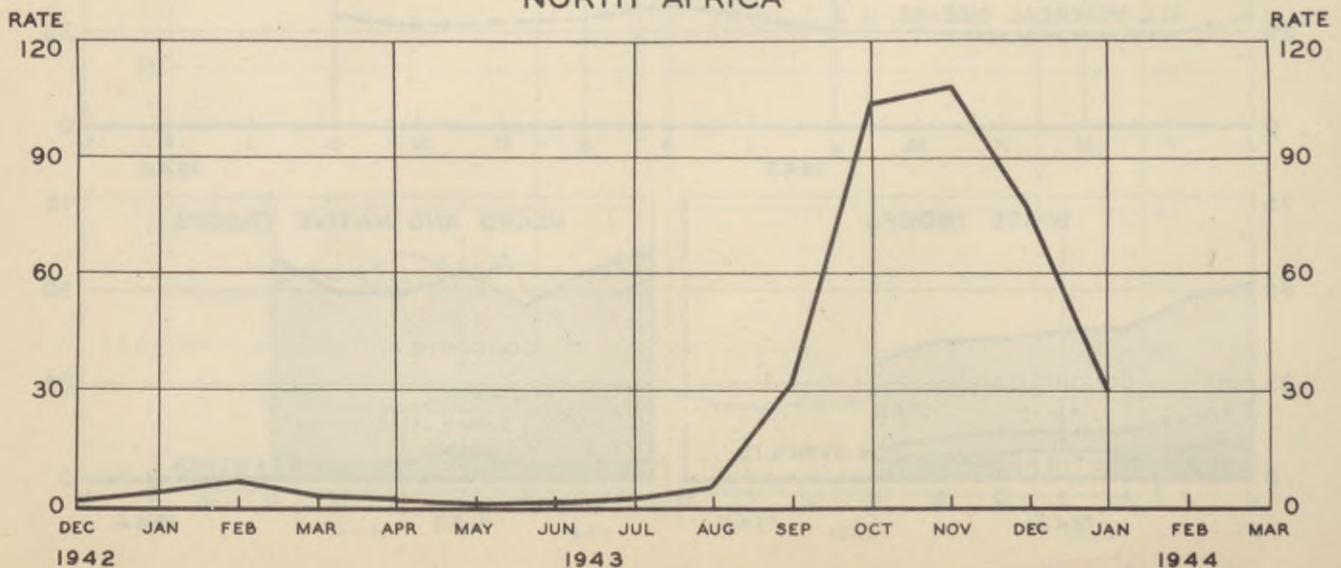
As may be seen from the accompanying graph, admissions from jaundice in the North African Theater, which has seasons corresponding in general with those in the United States, began to increase in August and September, reached a peak in November, and then began to fall off sharply. Recent reports by radio indicate that the admission rates have continued to decrease markedly during the month of January 1944.

During 1942 the Army experienced an epidemic of post-vaccinal jaundice clinically similar to the North African outbreak. This disease occurred in most instances from 90 to 120 days following protective inoculation against yellow fever, and was characterized by the simultaneous appearance of jaundice in U. S. troops all over the world, regardless of location or season of year. The outbreak of post-vaccinal jaundice began in the spring of 1942, reached its peak during the latter part of June, and was over by September 1942.

The etiology of infectious hepatitis is not known but it is believed by most investigators to be caused by a filtrable virus. The ordinary mode of infection is not known but the disease is thought to spread under usual circumstances by droplet transmission from an infected respiratory tract. The incubation period is believed to be about one month. There are no definite preventive measures at the present time. During an outbreak of infectious hepatitis good sanitation and hygiene should be practiced as well as the precautions usually taken to prevent the spread of respiratory diseases.

Intensive investigations of jaundice have been carried out since 1942 under the direction of The Surgeon General. Several Commissions of the Board for the Investigation and Control of Influenza and other Epidemic Diseases in the Army are continuing to investigate the cause, manner of spread, treatment, and control of infectious hepatitis. Work along these lines has been carried out both in this country and abroad. In addition, Army hospitals and laboratories, including the Army Medical Museum, have been concerned with study of problems of jaundice. The U. S. Public Health Service, one of the Commissions under the Board, and British investigators in the Middle East and in England have shown that infectious hepatitis is transmissible by injections of blood serum from individuals suffering with the disease either in clinical or subclinical form.

INFECTIOUS HEPATITIS, ADMISSIONS PER THOUSAND MEN PER YEAR
NORTH AFRICA



HOSPITALIZATION

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UTILIZATION OF AND REQUIREMENTS FOR BEDS IN NAMED GENERAL HOSPITALS

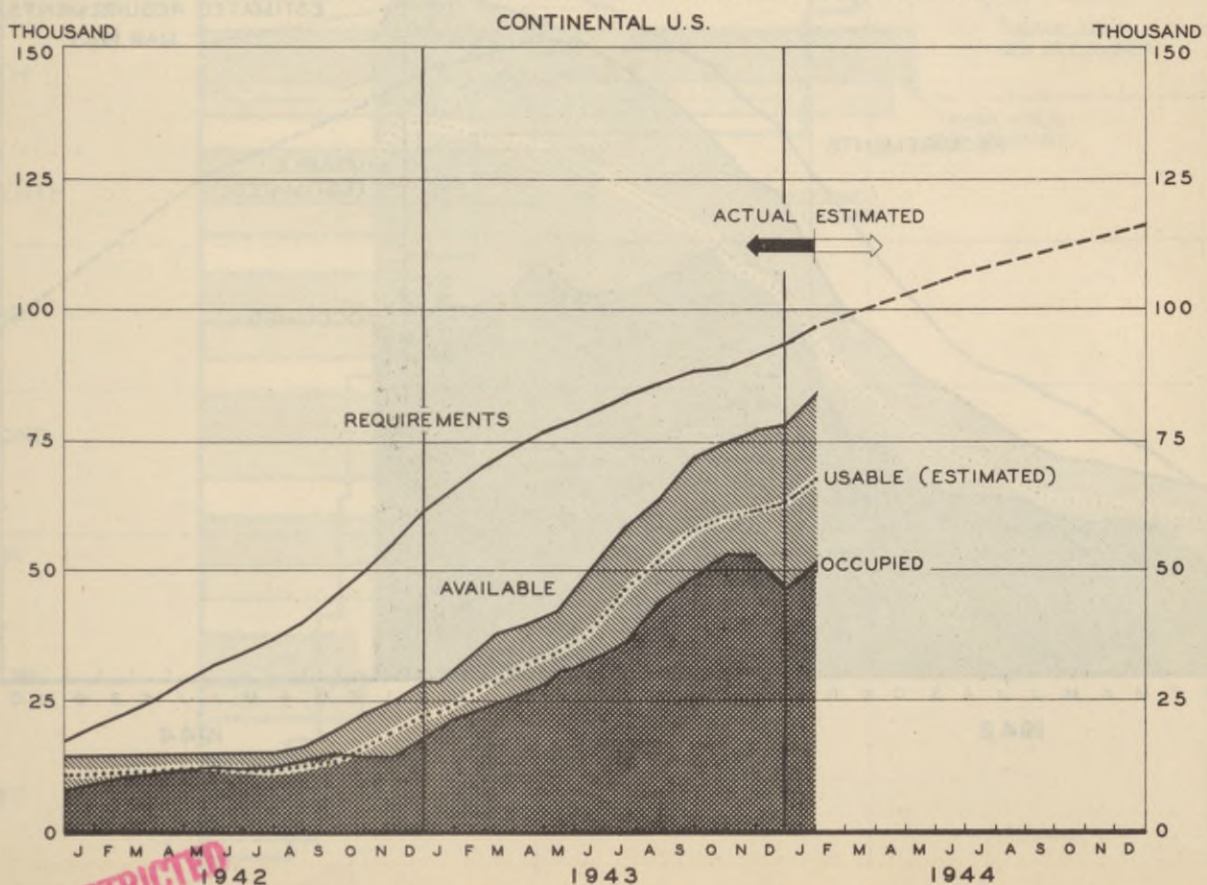
The requirements for beds in general hospitals are calculated at one percent of total Army strength plus 0.7 percent for troops overseas, but the overseas requirement factor is under study and may be increased. The anticipated needs for beds in general hospitals have not yet completely developed because the Army has enjoyed excellent health and because overseas operations have not yet required the evacuation of large numbers of patients. If overseas operations in the future increase the number of evacuees sizeably, an acute shortage of beds might result. In anticipation of this likelihood efforts are being made to provide separate hospitalization for convalescents and to convert certain permanent station hospitals to general hospitals. In order to conserve critical specialists the main effort will be directed toward increasing convalescent facilities near specialized general hospitals.

The extension of available normal beds has been omitted from the chart below because of the uncertainty surrounding future bed counts, the method of reporting having recently been changed from 72 to 100 sq. ft. per bed. The broken line close to the line of occupancy represents the average limit of normal utilization without overcrowding, since at any one time about 20 percent of the available beds cannot be used because of the importance of maintaining specialized wards, e. g. for women, surgical cases, patients suffering from contagious and infectious diseases, and the like. Under the previous space requirements the average hospital having more than 80 percent of its normal beds occupied had found it necessary to crowd beds into corridors and solaria, or to place patients in expansion barracks. Under the new space requirements expansion facilities will be obtained primarily by reducing the space allotment.

The number of available normal beds in named general hospitals increased from 77,900 for 25 December to 84,600 for 28 January. The average number of beds occupied rose slightly from 59 to 61 percent.

Although all hospitals (except Mason, not counted against the authorized total) are included in the above counts and in the chart below, certain hospitals have ceased to operate as general hospitals and should be regarded as receiving and evacuation hospitals for overseas patients. These are Lovell, Halloran, Stark, Barnes, and Letterman, and represent a loss of 7,544 normal beds.

REQUIRED AND AVAILABLE GENERAL HOSPITAL BEDS



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HOSPITALIZATION

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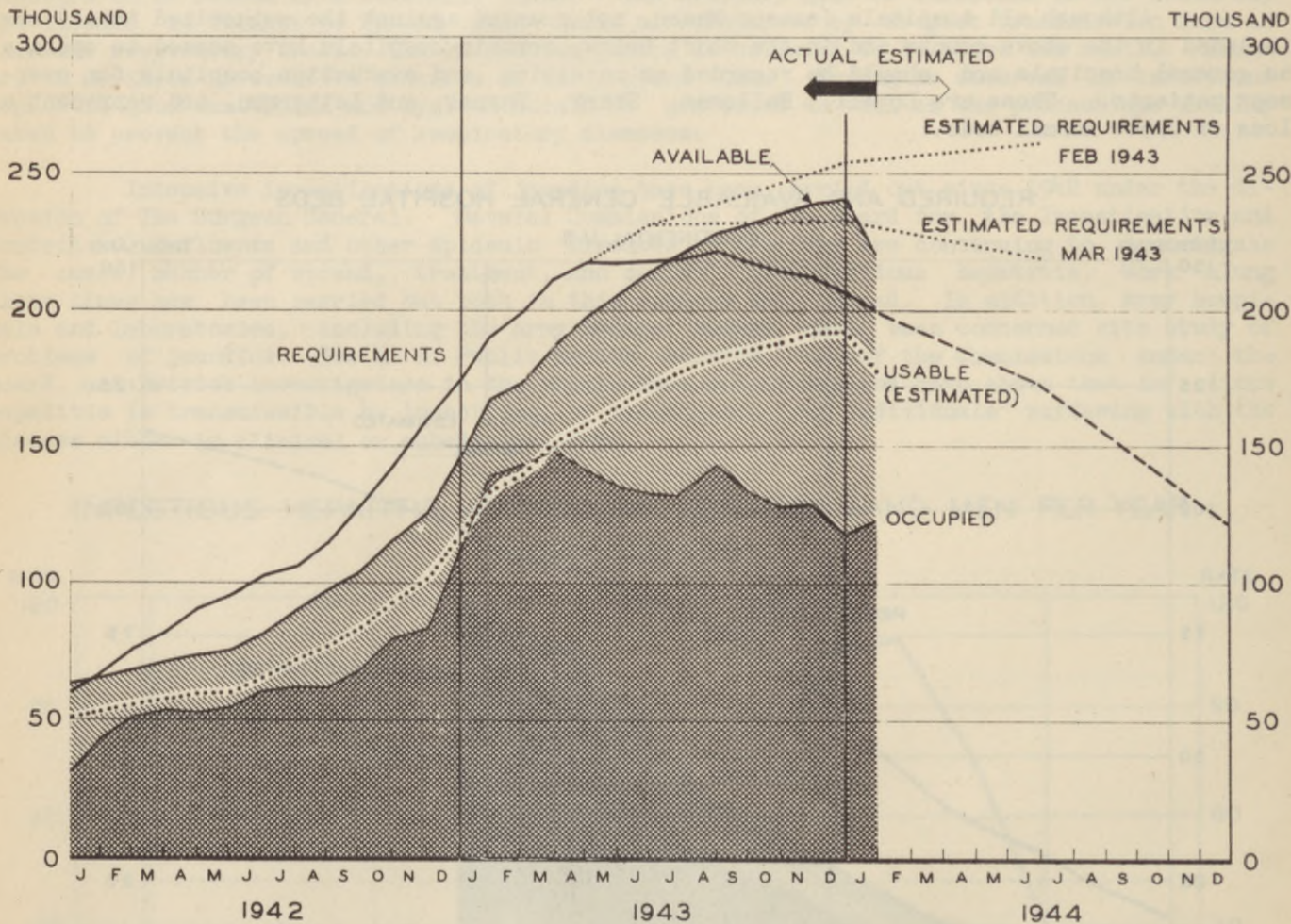
UTILIZATION OF AND REQUIREMENTS FOR BEDS IN STATION HOSPITALS

The requirements for beds in station hospitals in the Continental U. S. are calculated on the basis of 4 percent of the strength of the troops to be stationed there, with an allowance for prisoners of war which adds 7,000 beds to the calculated requirements for 28 January 1944. The requirements computed from present day strength, however, differ materially from those which furnished the objectives early in 1943. By the end of 1944, according to most recent estimates, only 122,000 station hospital beds will be required.

In addition to requirements, the chart below shows the number of occupied beds, the number of available normal beds, and the estimated number of usable normal beds (80 percent of the number of available beds) to indicate average utilization without overcrowding. The curves for available and occupied beds exclude those reported from maneuver areas since they belong chiefly to numbered units. On this basis the number of normal beds available in station hospitals was 221,000, about 19,000 less than that reported for 25 December. Approximately 55 percent were occupied.

In view of the steady lowering of estimated requirements, it is not surprising that a surplus now exists. On 25 December there was an apparent surplus of 35,000 beds, which declined to 21,000 beds on 28 January. Efforts are being made to eliminate this surplus by closing certain wards and even certain individual posts. In addition to these measures, plans

REQUIRED AND AVAILABLE STATION HOSPITAL BEDS
CONTINENTAL U. S.



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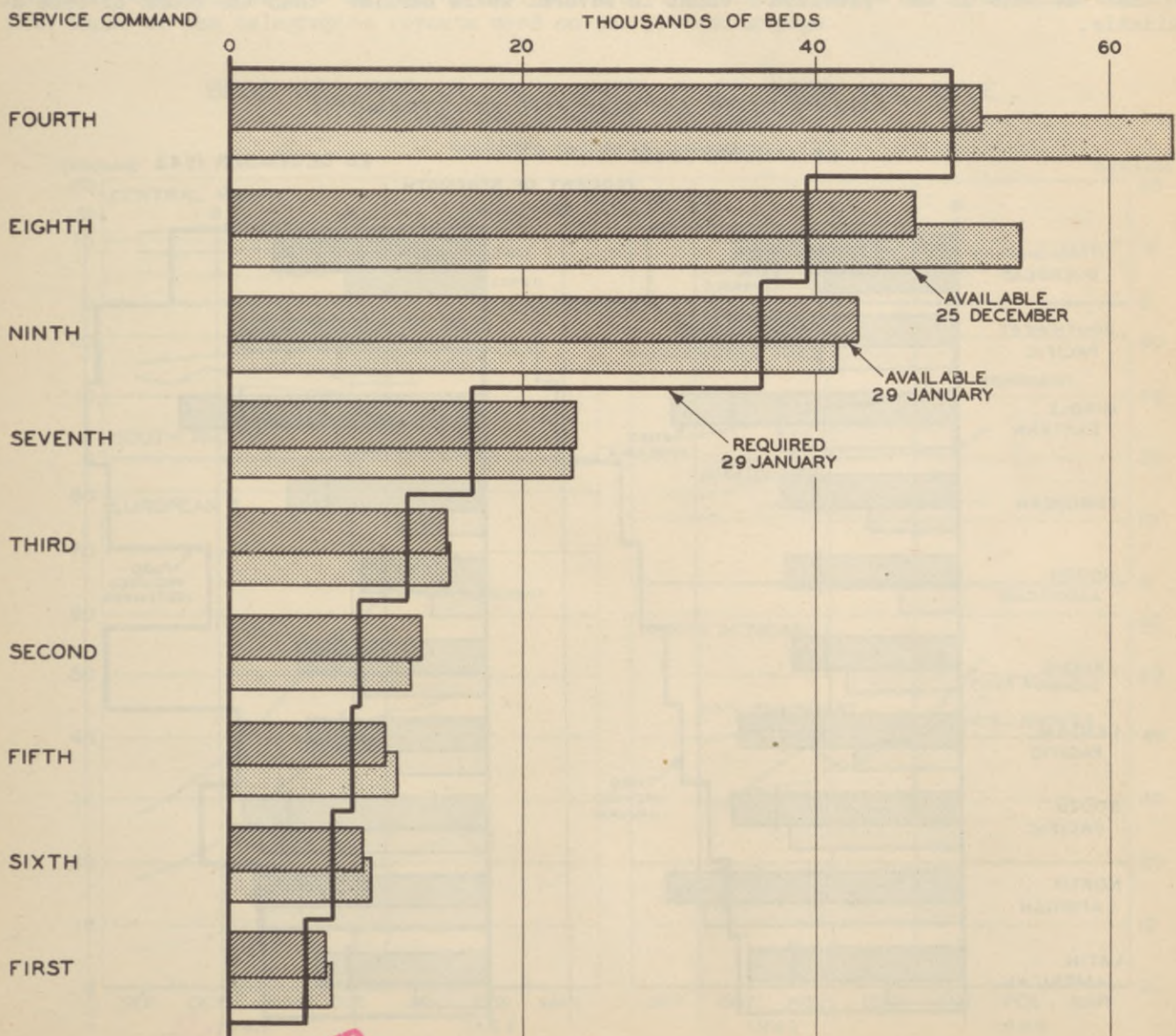
UTILIZATION OF AND REQUIREMENTS FOR BEDS IN STATION HOSPITALS (Continued)

are being made to convert certain large station hospitals into general hospitals and to release appropriate facilities to the Veterans Administration. It has become necessary to distinguish between authorized and constructed capacity, and a recent promulgation of policy will implement such actual closure as is required for the recapture of essential personnel, equipment, and supplies. War Department Circular No. 43, dated 1 February 1944, directs that only such beds as are authorized by competent authority shall remain set up, and that the authorized normal bed capacity of any post shall, with reasonable exceptions, be determined at 4 percent of the troops cared for. In January, prior to the issuance of the circular, considerable confusion arose when efforts were made to re-orient the field in the direction of reducing bed capacity so as to release personnel for numbered units and named general hospitals about to be activated. Attempts were made to limit bed capacity to 4 percent of strength but in some cases the change in reporting may not have entailed the actual closure of facilities.

The decrease of 19,000 beds during January may be largely attributed to the Fourth and Eighth Service Commands. These two commands apparently made the greatest effort to reduce the number of beds to 4 percent of strength.

The chart below shows the number of normal beds available as of 25 December and 28 January and the calculated requirements for 28 January.

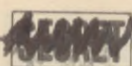
REQUIRED AND AVAILABLE NORMAL BEDS IN STATION HOSPITALS
BY SERVICE COMMAND, 29 JANUARY



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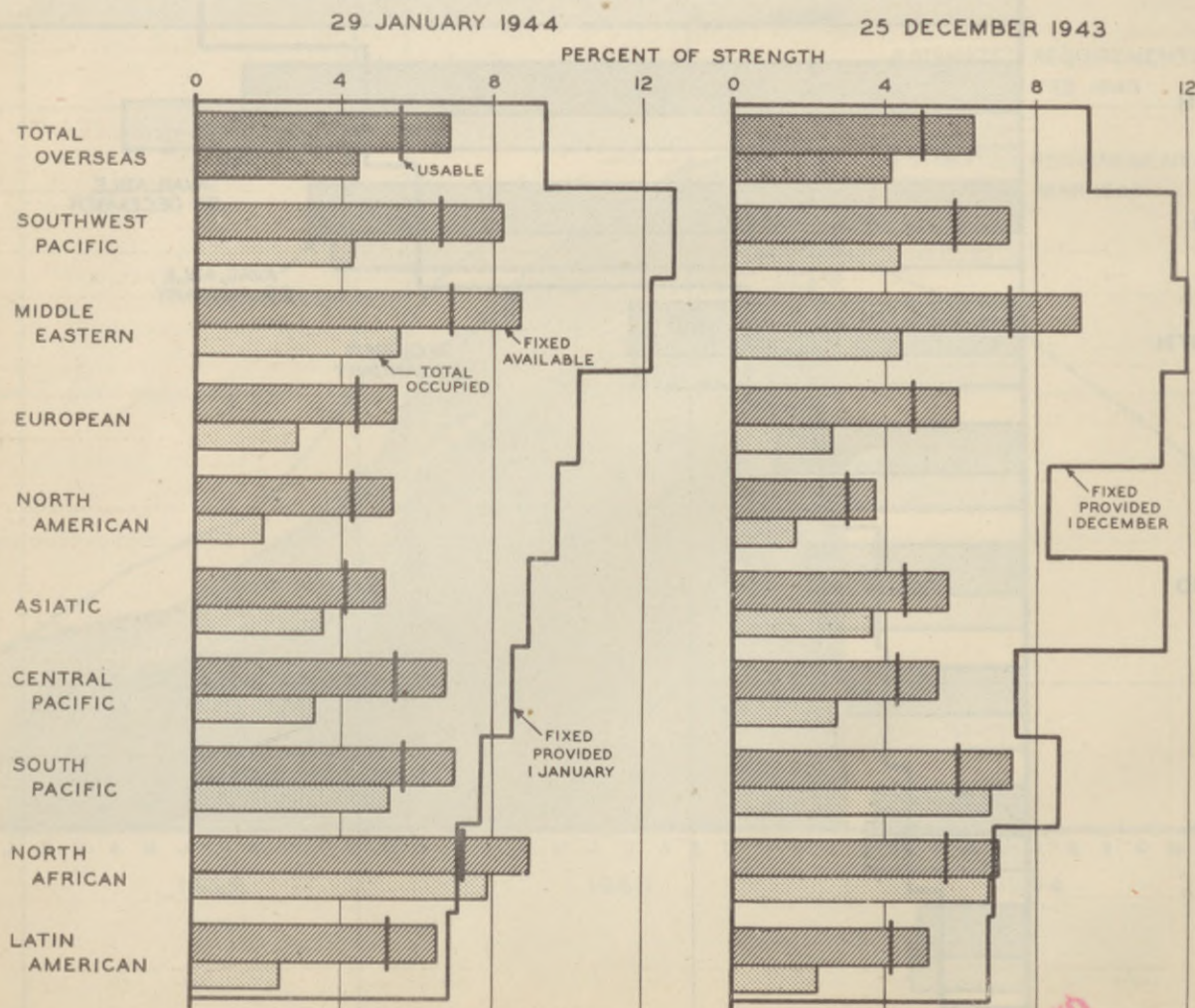
HOSPITALIZATION OVERSEAS

The chart below and to the left shows, for each theater, and as a percentage of the U. S. Army strength there: (1) the number of beds in fixed hospitals provided up to 1 January 1944; (2) the number of fixed beds reported as ready for use on 29 January 1944; and (3) the total number of patients hospitalized in the theater on the latter date. The second panel of the chart gives similar data for 25 December. Patients in both mobile and fixed units are counted because it is essential that there be sufficient fixed beds to care for each patient requiring hospitalization.

The theaters are arranged according to the number of fixed beds provided as of 1 January, expressed in percentage terms. The crowding of facilities in North Africa seems especially serious in view of the fact that more beds were reported as occupied on 29 January than there were fixed usable beds available, suggesting that it may have become necessary to use mobile units as fixed hospitals. It should be borne in mind that any particular fixed hospital will show signs of crowding when 80 percent of its beds are occupied, so that up to 20 percent of the fixed beds available should properly be discounted in planning. For this reason 80 percent lines have been drawn across the bars representing beds available. The crowding of facilities in the South Pacific abated somewhat during January and at the end of the month less than 80 percent of the fixed beds available were reported occupied. The excess of fixed usable beds over and above total beds occupied in the Asiatic Theater as of 29 January may not be as large as indicated, for the latest reports of fixed beds available may include some mobile units being used as fixed.

The term "provided" is used to denote facilities earmarked for shipment, in transit, and in storage in the theater, as well as those actually ready for use. It will be noted that the date of the "provided" count is several weeks earlier than the count of beds available.

FIXED BEDS AS PERCENT OF STRENGTH



HOSPITALIZATION

SECRET

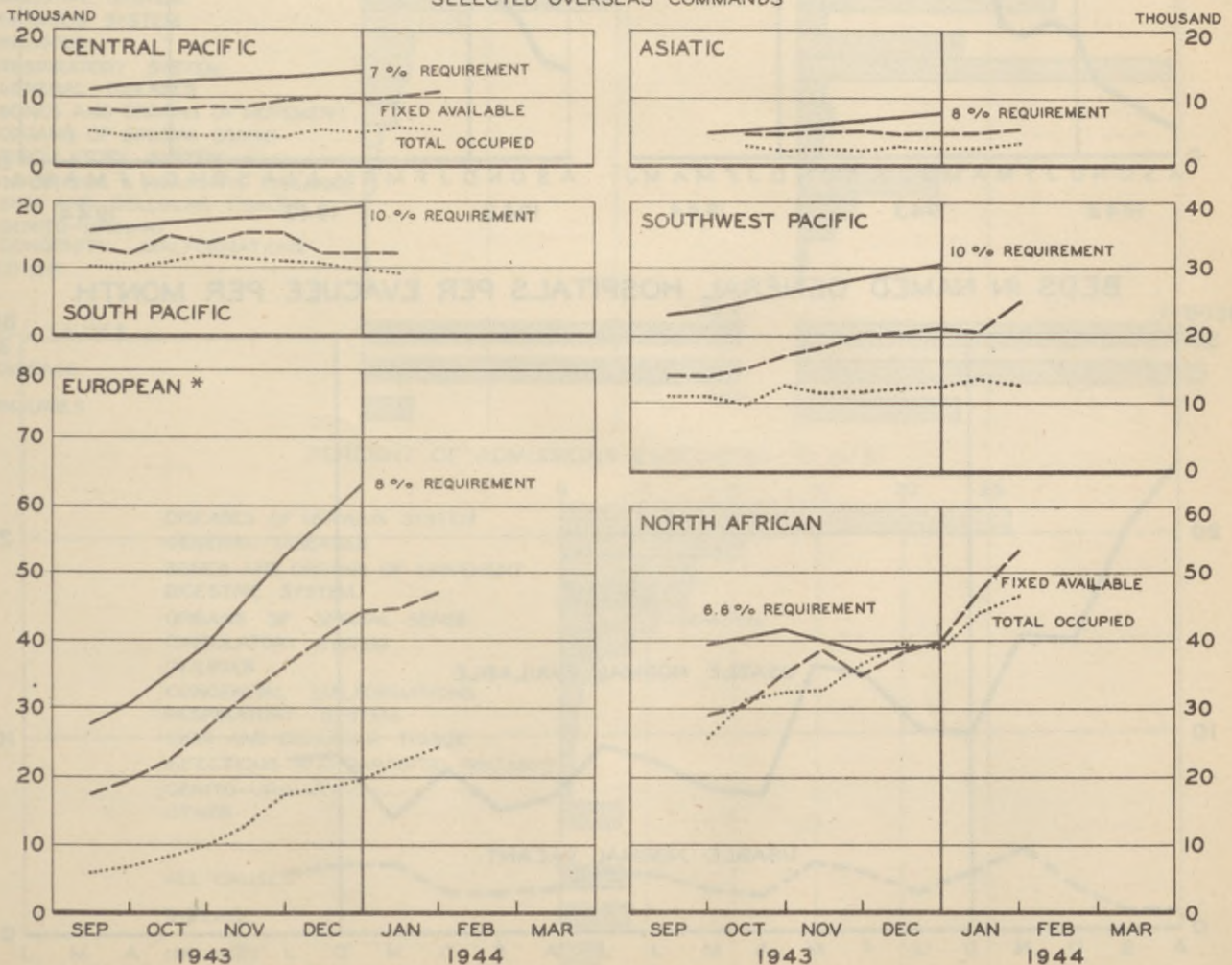
HOSPITALIZATION OVERSEAS (Continued)

In comparison with the 5 percent of strength now provided in the United States for station plus general hospitals, some overseas theaters require 10 percent or more in fixed beds alone (those in station, general, and field hospitals). Estimates of need must take into account not only combat activity, but also the probable incidence of disease and nonbattle injury, and provisions for evacuation of patients needing extended periods of hospitalization or special treatments. In the Asiatic Theater special provision is made for hospitalization in support of certain Chinese units excluded from the reported strength.

The panels below detail the recent changes in fixed hospitalization in some of the major or more active theaters. The data are given in absolute form, not as percentages of strength, and each panel carries a requirement line, based upon a strength factor of 6 to 10 percent, depending upon the current level of authorization for fixed bed units. Over and above the authorization for fixed bed units, use of expansion equipment is authorized to the extent of an additional 50 percent. However, the use of such facilities necessitates a degree of utilization of personnel not intended by tables of organization and must be regarded as an emergency measure. Crowding has been continuous in North Africa since September, when the present series starts, but it was somewhat alleviated during January as more fixed beds became available. Since bed occupancy is now almost 8 percent of strength, it seems evident that the 6.6 percent requirement in fixed units in North Africa is insufficient to provide hospitalization for all patients without continued resort to expansion equipment or the use of mobile as fixed units.

The data on available and occupied beds are drawn from telegraphic reports, while those on requirements are taken from official A.G.O. strength figures which are more complete than those of the telegraphic reports used on the preceding page.

BEDS REQUIRED IN FIXED UNITS, FIXED BEDS AVAILABLE AND TOTAL BEDS OCCUPIED
SELECTED OVERSEAS COMMANDS



* Iceland omitted from September and October points for beds available and occupied.

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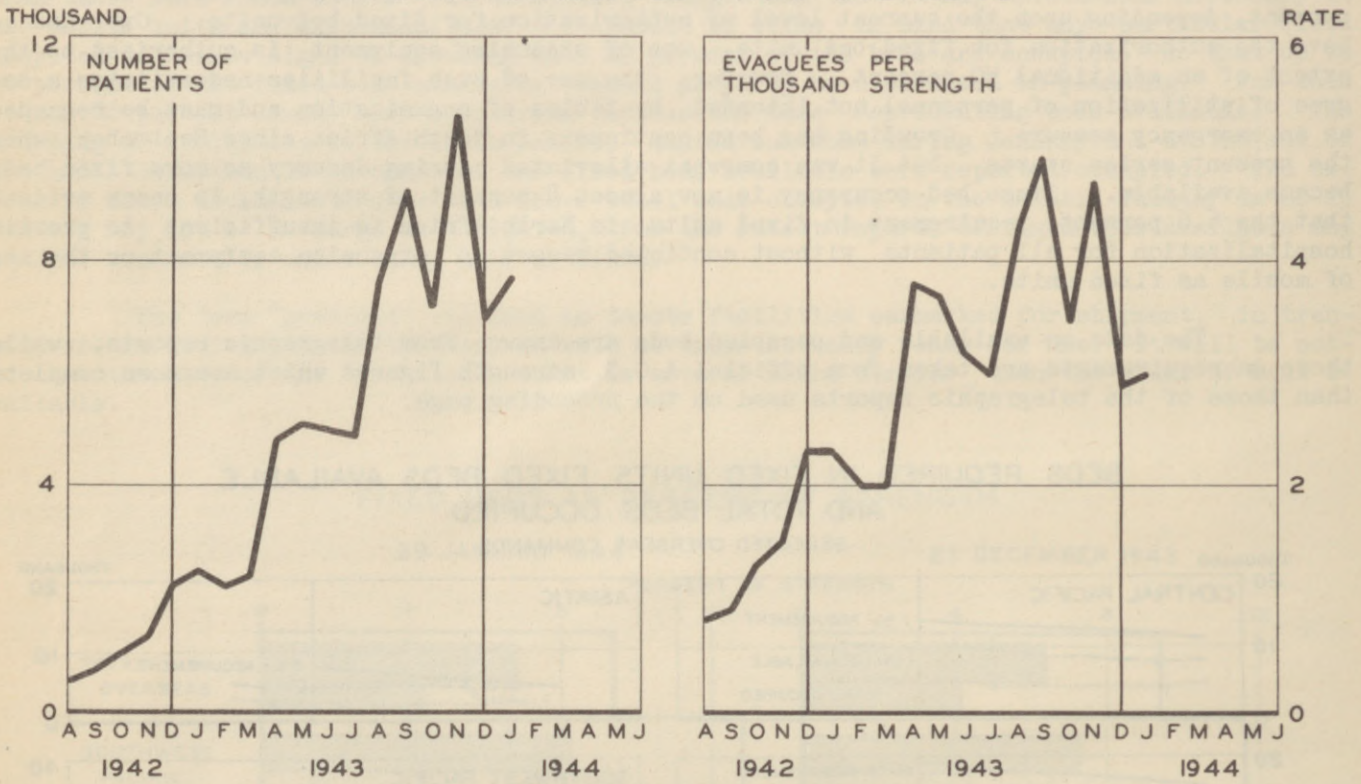
HOSPITALIZATION

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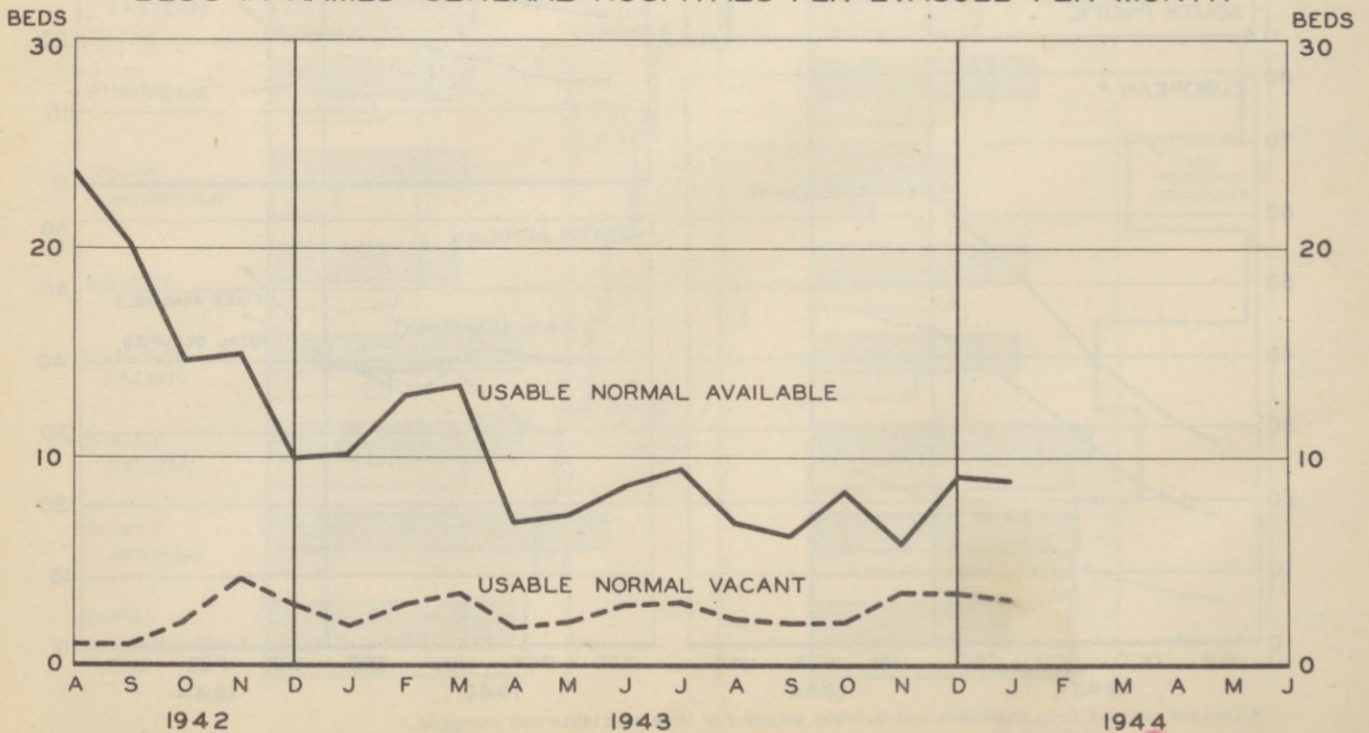
EVACUATION OF PATIENTS FROM OVERSEAS

There was little change in the rate of evacuation from overseas during January, about 7,700 patients having been received, according to preliminary estimates. The experience to date is shown below in both absolute and relative form. The lower panel shows the relationship between the number of evacuees received each month and the beds available in named general hospitals. Usable normal beds have been estimated at 80 percent of the normal beds available. Vacant usable (and normal) beds have been estimated by subtracting total beds occupied from the usable normal beds. There was no real change in the ratios of beds per evacuee during January.

PATIENTS EVACUATED FROM OVERSEAS



BEDS IN NAMED GENERAL HOSPITALS PER EVACUEE PER MONTH



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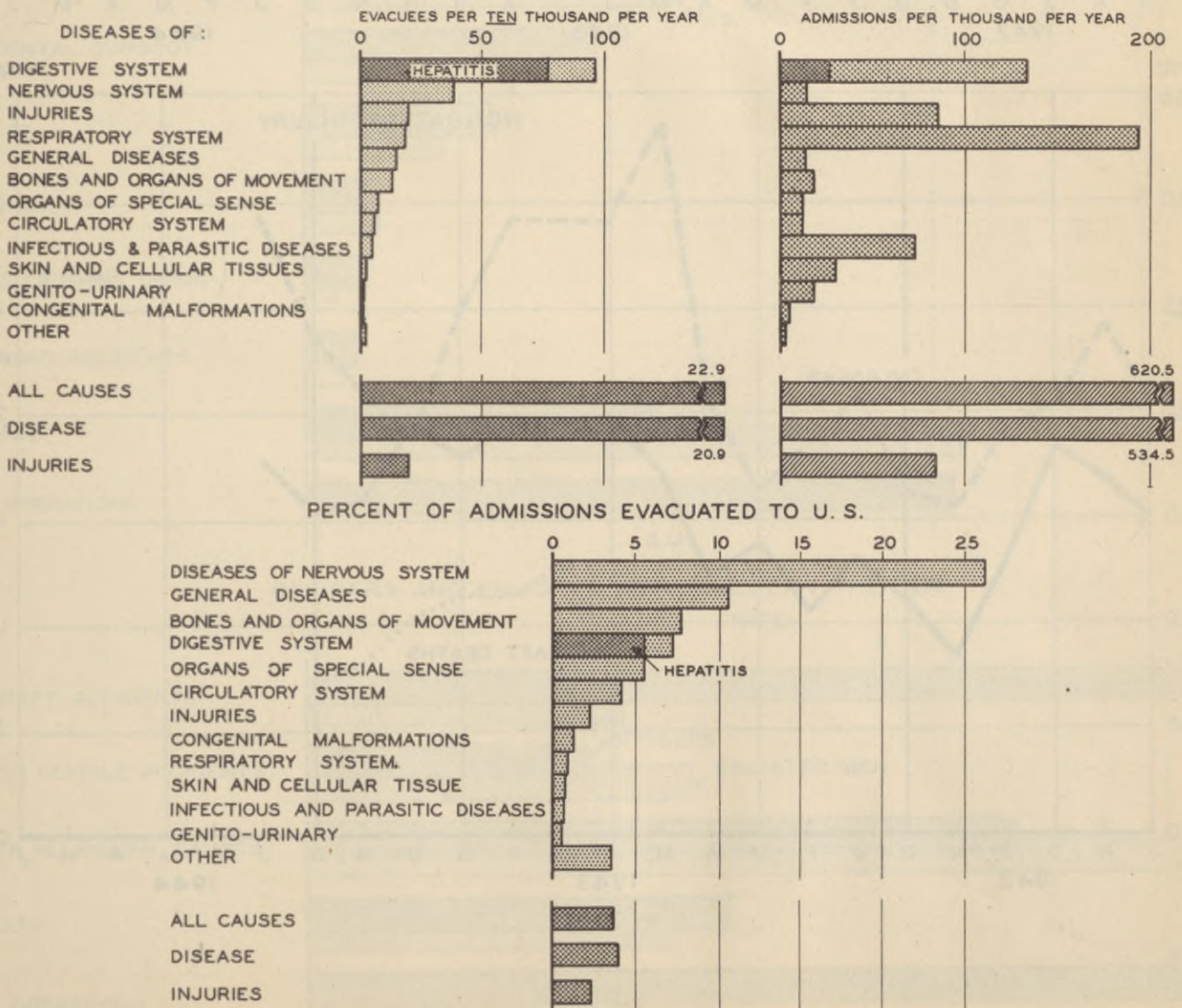
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CAUSES OF EVACUATION, EUROPEAN THEATER

The European Theater has recently forwarded a tabulation of patients evacuated to the U. S. during 1942. Combined with parallel information on causes of admission this tabulation yields valuable information on the causes of evacuation. The first two panels below give rates of admission per thousand men per year, and rates of evacuation per ten thousand men per year, for major diagnostic classifications. The three leading causes of admission are also the leading causes of evacuation, but in reverse order. Infectious and parasitic diseases, the fourth leading cause of admission, were in ninth place as a cause of evacuation. The rates of admission and evacuation for diseases of the digestive system are exceptionally large because of the post-vaccinal hepatitis which occurred in 1942. For this reason, that portion of the admission and evacuation rates attributable to hepatitis is distinctively indicated as such in the charts.

On the average, patients were evacuated at the rate of 23 per thousand strength per year, whereas the admission rate for all causes was 620 per thousand. Thus about 4 percent of all admissions, or 2 percent of the strength, was evacuated to the U. S. in 1942. For certain causes of admission the percentage requiring evacuation was quite high, as may be seen in the bottom chart below. About 25 percent of the neuropsychiatric admissions were evacuated, for example. It would be useful to have a classification of evacuees according to whether or not the disability existed prior to induction. Although a complete tabulation for 1942 is not available, one technical medical report from the British Isles indicates that among 205 patients evacuated for peptic ulcer 41 percent were adjudged EPTI, and that among 111 cases of chronic arthritis 48 percent were EPTI. The average length of service of 905 men evacuated to the U. S. prior to 1 June 1943 was approximately 2 years.

PATIENTS ADMITTED TO HOSPITAL AND QUARTERS AND EVACUATED TO U.S. BY CAUSE, EUROPEAN THEATER, 1942



MORTALITY

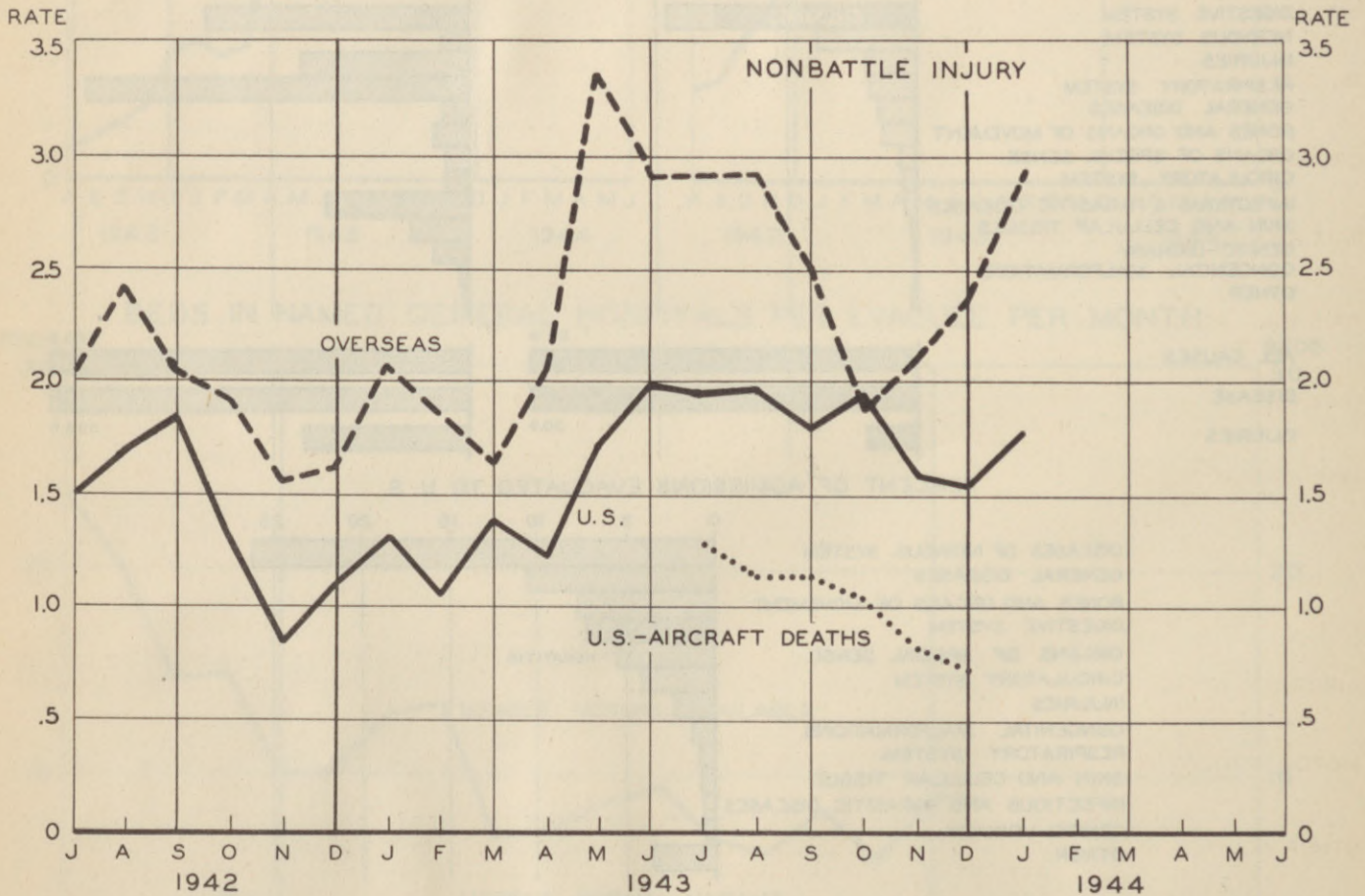
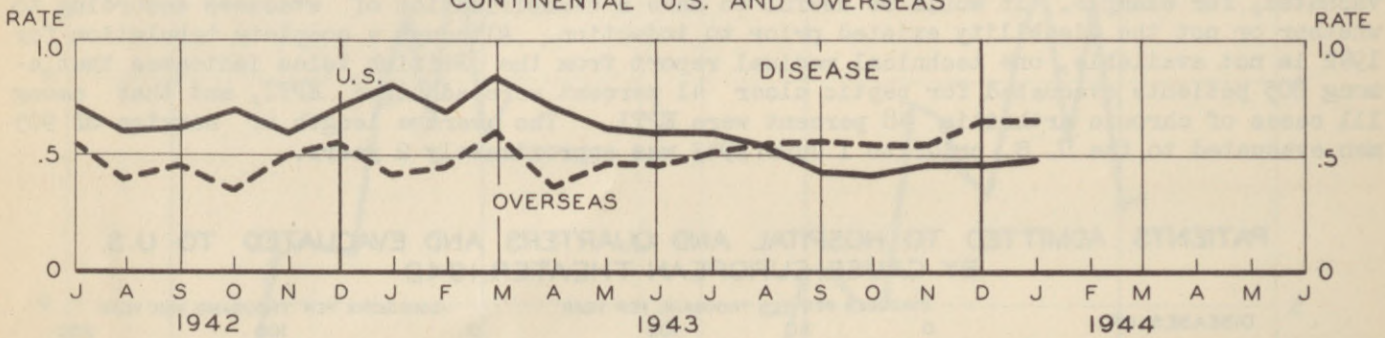
MORTALITY FROM NONBATTLE CAUSES

During January there was a rise of about 15 percent in the U. S. death rate from nonbattle injury which has followed a somewhat erratic but generally downward course since June. There has been added to the chart below a tentative line showing the relative importance of deaths from aircraft accidents, consistently half or more of the total accident death rate. In December the accidental death rate was .37 from motor vehicle accidents, .08 from railroad accidents, .07 from drowning, and .06 from gunshot wounds. There was no change in the death rate from disease among troops stationed in the Continental U. S.

The overseas telegraphic reports for January yield tentative rates of 2.94 for nonbattle injury and .66 for disease.

DEATHS PER THOUSAND MEN PER YEAR, NONBATTLE CAUSES

CONTINENTAL U.S. AND OVERSEAS



MORTALITY

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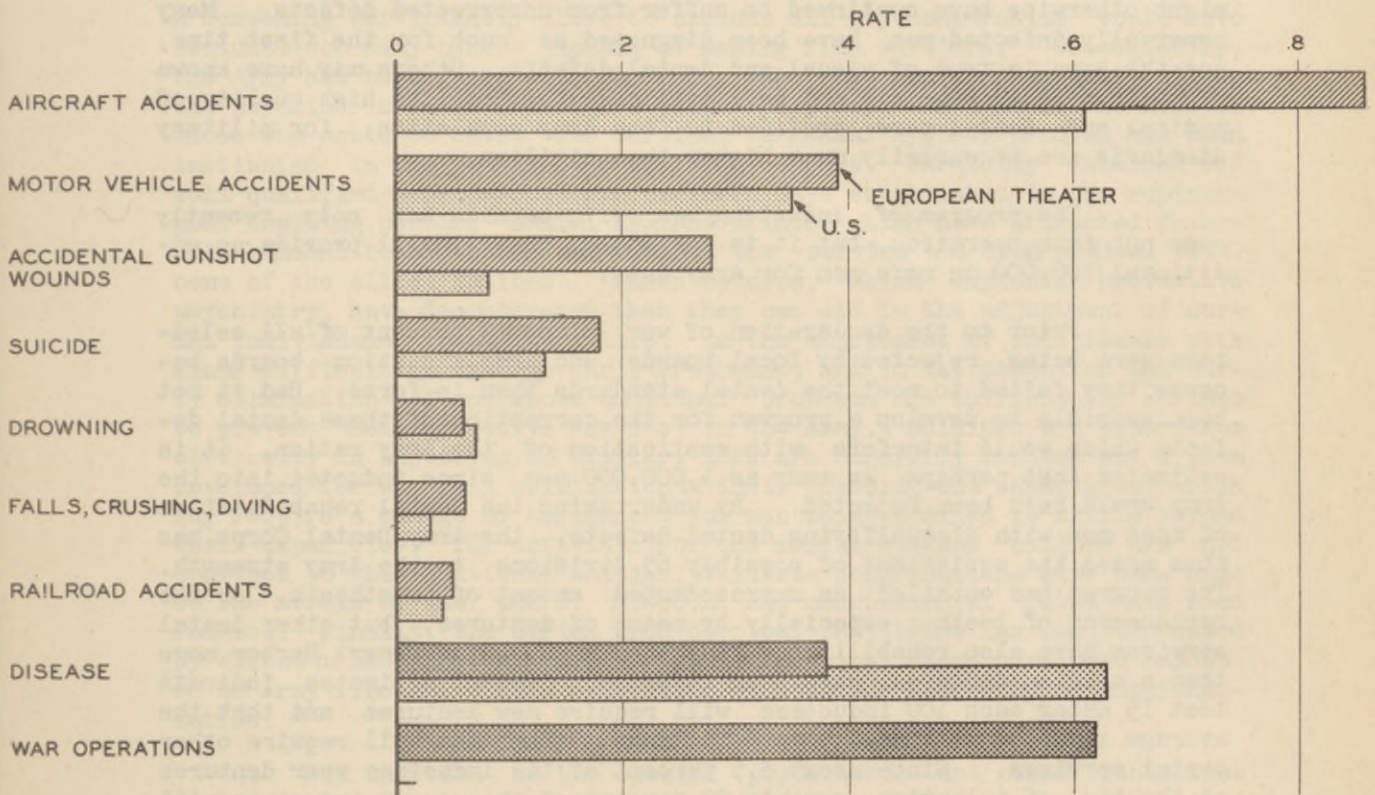
DEATHS FROM NONBATTLE INJURY, EUROPEAN THEATER

Recent tabulations made in London permit a comparison of causes of accidental death among U. S. troops in the European Theater and in the U. S. during 1942, the U.S. series being quite provisional. During this period the average death rate from battle causes was .62 for troops in the British Isles, and the death rate from nonbattle injury there was 2.17 in comparison with 1.47 for troops in the U. S. The battle component may be too low.

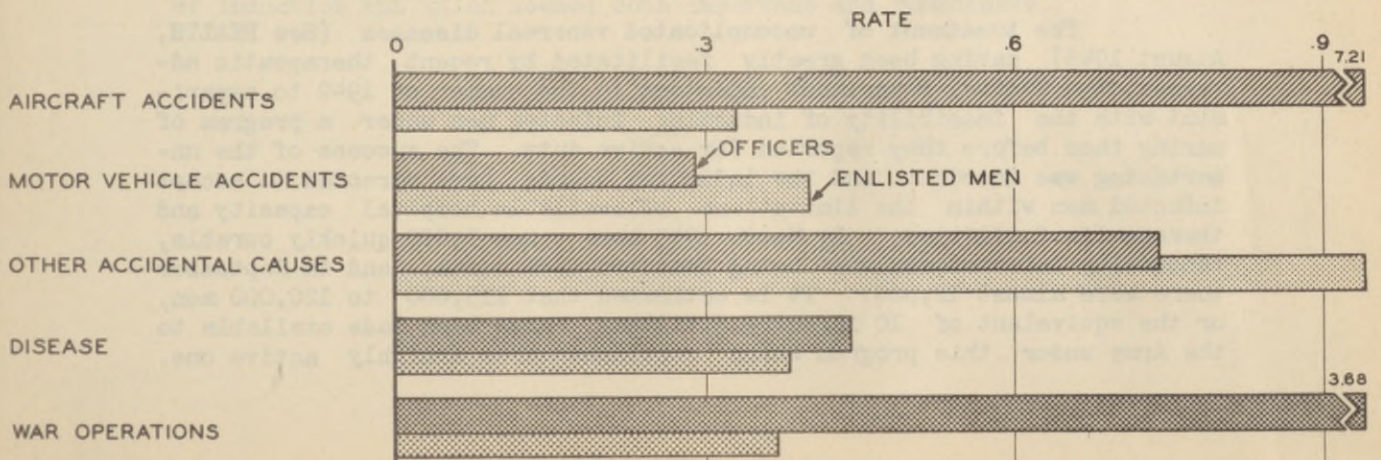
In both the U. S. and the European Theater aircraft accidents caused more deaths than any other variety of nonbattle injury, but the rate of .86 for the British Isles was significantly higher than that of .61 for the strength in the U. S. In general the important causes were the same in both groups, but the only reliable differences are those for aircraft accidents, gunshot wounds, and disease.

The tabulated data for the European Theater separate officers and enlisted men, and bring out marked differences in deaths from aircraft accidents and from enemy action which are based primarily upon the role of the air arm in this theater. The bottom chart compares officers and enlisted men from the standpoint of selected causes of mortality.

DEATHS PER THOUSAND MEN PER YEAR, EUROPEAN THEATER AND U.S. 1942 ALL TROOPS, BY CAUSE



OFFICERS AND ENLISTED MEN, EUROPEAN THEATER



CONFIDENTIAL **RESTRICTED**

MISCELLANEOUS

RESTRICTED

ARMY PROGRAM OF REHABILITATING MEN OTHERWISE UNACCEPTABLE FOR MILITARY SERVICE

The military need for manpower necessitates careful scrutiny of selectees, especially from the standpoint of mental and physical stamina and health. In the face of a potential shortage of men to meet the troop basis, physical standards for induction have been relaxed at those points where the facilities of the Medical Department are adequate to remedy certain defects to such a degree that men otherwise unacceptable could be used in military service. Large numbers of men have been accepted, therefore, under a plan of rehabilitation and correction of otherwise disqualifying defects and the number of defects is being further extended. To date this plan has embraced chiefly men with dental and visual defects and also men having curable venereal infections but certain men having hernias are now acceptable. No exact estimates are available, but it seems evident that well over a million men have been made available to the Army under this plan. In addition to the men released for military service by virtue of the remedial program of the Medical Department, no illiterates have been rejected solely for this cause since the first of June 1943, with the result that approximately 65,000 illiterates have been inducted and trained for Army service. Apart from the purely military question of extracting the utmost from a limited supply of manpower, there is the important consideration that many men have been aided who might otherwise have continued to suffer from uncorrected defects. Many venereally infected men have been diagnosed as such for the first time, and the same is true of visual and dental defects. Others may have known of their defects but did not have available to them the high quality of medical and dental care provided to the Army population, for military standards are necessarily much higher than civilian.

The program of inducting men with hernias has only recently been put into operation, but it is estimated that it will provide an additional 100,000 or more men for Army duty.

Prior to the declaration of war almost 9 percent of all selectees were being rejected by local boards and Army induction boards because they failed to meet the dental standards then in force. Had it not been possible to develop a program for the correction of those dental defects which would interfere with mastication of the Army ration, it is estimated that perhaps as many as 1,000,000 men since inducted into the Army would have been rejected. By undertaking the dental rehabilitation of most men with disqualifying dental defects, the Army Dental Corps has thus added the equivalent of possibly 65 divisions to the Army strength. The program has entailed an unprecedented amount of prosthesis, or the replacement of teeth, especially by means of dentures, but other dental services have also rehabilitated many thousands. Since Pearl Harbor more than a million dentures have been inserted. Recent estimates indicate that 15 among each 100 inductees will require new dentures and that the average inductee will need 5 to 6 fillings. Some men will require other dental services. Since about 3.5 percent of the inductees wear dentures at the time of induction, roughly 20 percent of the recent inductees will be found wearing one or more dentures.

The treatment of uncomplicated venereal diseases (See HEALTH, August 1943) having been greatly facilitated by recent therapeutic advances, the Medical Department undertook in the summer of 1942 to experiment with the feasibility of inducting infected men under a program of curing them before they reported for active duty. The success of the undertaking was immediate and the induction boards were directed to accept infected men within the limitations of available hospital capacity and therapeutic facilities. By March 1943 more than 5,000 quickly curable, venereally infected men were being inducted each month, and in September there were almost 12,000. It is estimated that 115,000 to 120,000 men, or the equivalent of 10 infantry divisions, have been made available to the Army under this program which continues to be a highly active one.

RESTRICTED

MISCELLANEOUS

RESTRICTED

ARMY PROGRAM OF REHABILITATING MEN OTHERWISE UNACCEPTABLE FOR MILITARY SERVICE (Continued)

Roughly one-fourth of these had gonorrhoea, and three-fourths syphilis. Well over half the men were Negroes.

From the beginning of the mobilization period men with certain correctible defects have been accepted, and with the passage of time the definition of a correctible visual defect has been broadened to such an extent that the rejection rate for defective eyes declined from about 6 percent in May and June 1942 to roughly 2 percent in recent months. In the past year alone such a differential would permit the induction of an additional 100,000 men, equivalent to more than 6 infantry divisions. The extent of the program to correct visual defects may be judged from the fact that roughly 2.5 millions of pairs of spectacles have been issued to approximately 1.5 millions of men in the Army since the beginning of mobilization. A significant proportion of these men did not realize their need for correcting lenses. Further changes in the standards for vision are expected to result in the availability of a significant number of men previously declared unacceptable.

Although men have not knowingly been admitted into the Army with neuropsychiatric defects, some such individuals have been inducted. A screening sufficiently close to exclude all psychoneurotics would have excluded too many others capable of making fine soldiers. Consequently, the Army has been faced with the fact that some men were actually ill in the psychiatric sense and others potentially so. To prevent the loss of those who could be saved for service, a mental hygiene program has been instituted in the replacement training centers. Carefully selected and well qualified neuropsychiatric officers have established in the replacement training centers mental hygiene clinics which have attracted favorable comment both within and without the service and from medical officers of the Allied Nations. These clinics, which emphasize preventive psychiatry, have demonstrated that they can aid in the adjustment of normal individuals to military life, in the adjustment of individuals with minor difficulties through early treatment, and in the detection and early elimination of men whose emotional problems are sufficiently serious to prevent their effective service in the Army. Soldiers who experience difficulty in adjusting to military life are carefully studied and a plan developed for the full utilization of their training and capacities, which may require a change of assignment for men being trained in skills beyond their capacities. The activities of the mental hygiene clinics are not confined to the individual soldier. Valuable contributions have been made to the morale of the posts. A.W.O.L. and court-martial rates have been reduced. Finally, the burden upon hospital facilities has been decreased by virtue of the fact that many potential hospital cases have been adjusted to Army life and others eliminated without the necessity of hospitalization.

In addition to the special psychiatric and other facilities discussed above, use has been made of the usual medical, surgical, and psychiatric facilities to remedy defects which escaped notice at the time of induction but which seemed both important and remediable.

RESTRICTED

MISCELLANEOUS

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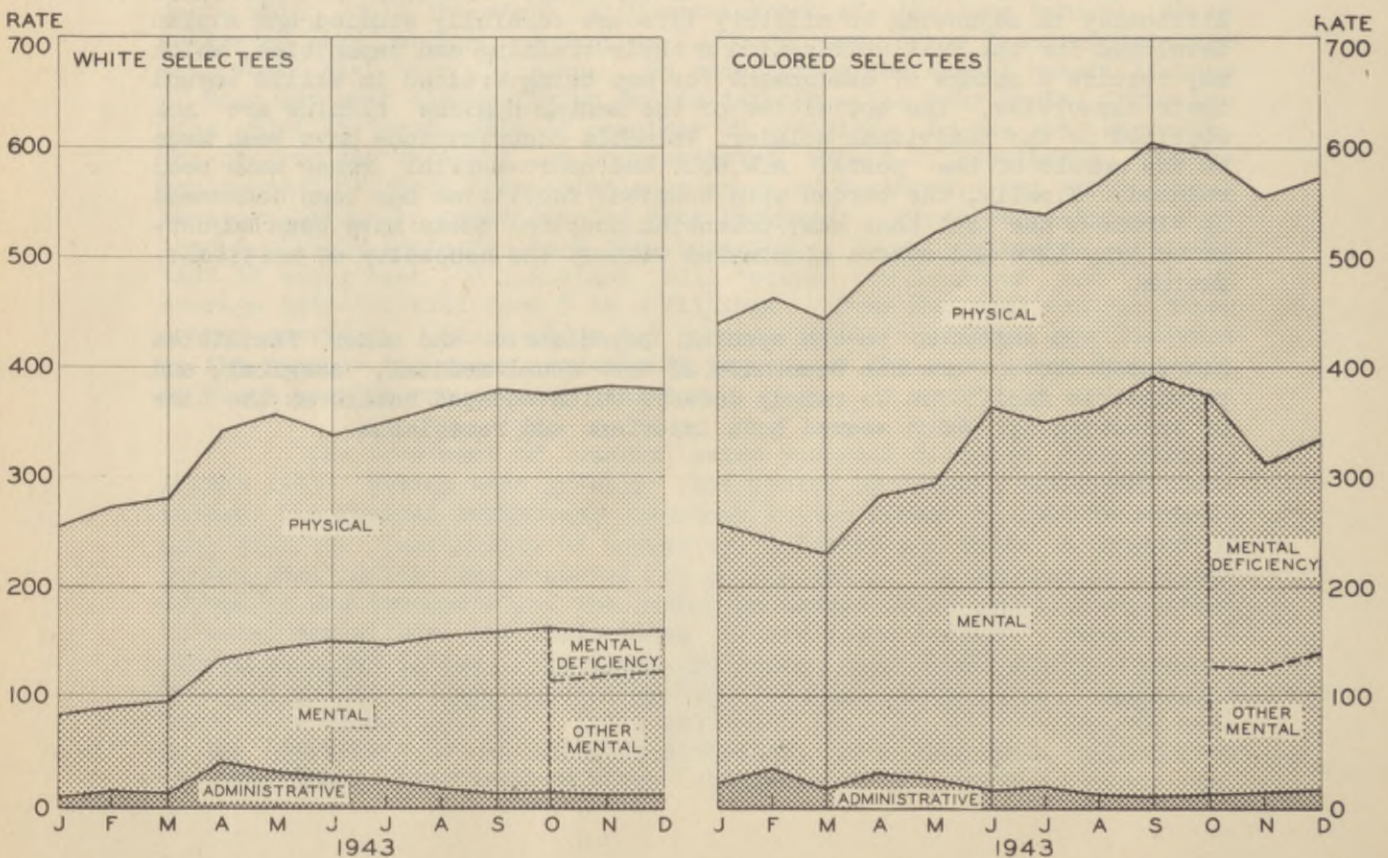
INDUCTION STATION REJECTIONS, 1943

Results of examinations of selectees at induction stations are reported monthly to The Surgeon General. These reports do not cover rejections made by local boards. Figures published by Selective Service for the first ten months of 1943 indicate that rejections at local boards have shown little change and have averaged about 6 percent of those examined. The trend of the rejection rate at induction stations during 1943 is shown in the chart below separately for white and colored selectees. The rejection rate rose markedly during 1943 for both white and colored selectees. For white and colored selectees combined, the rejection rate rose from 280 per thousand examined in January 1943 to 424 rejections per thousand in December 1943. The average rejection rate for the year was 363 per thousand.

For white selectees the rejection rate jumped sharply in April and showed a further rise from July through September, after which it became stabilized. The average rejection rate for the year was 330 per thousand. For colored selectees the rejection rate rose in April and showed a generally upward trend thereafter to a peak in September, followed by a somewhat lower rate during the last quarter of the year. The average rejection rate for the year was 532 per thousand. Some of the rise in April among both white and colored selectees was due to special restrictions placed on the induction of limited service men during part of that month, which had the effect of increasing the rate of rejection for "administrative" reasons.

For both white and colored selectees the principal factor in the rise of the rejection rate was the pronounced increase in the rate for mental rejections and, prior to 1 June, illiteracy recognized as such. Men with both physical and mental defects were always classified as mental rejections. An important factor in the rise in the rate for mental rejections was a fuller recognition of the problems caused by the induction of men having, or predisposed to, psychiatric disorders. As a result, increasing emphasis was placed on the need for careful psychiatric screening in order to exclude from military service as many psychiatric misfits as possible. Directives to this effect were issued in March, April, July, and September 1943. This fact, combined with greater experience on the part of the examiners, served to increase the rejection rates for mental reasons.

INDUCTION STATION REJECTIONS PER THOUSAND MEN EXAMINED
BY COLOR AND BY CAUSE OF REJECTION, 1943



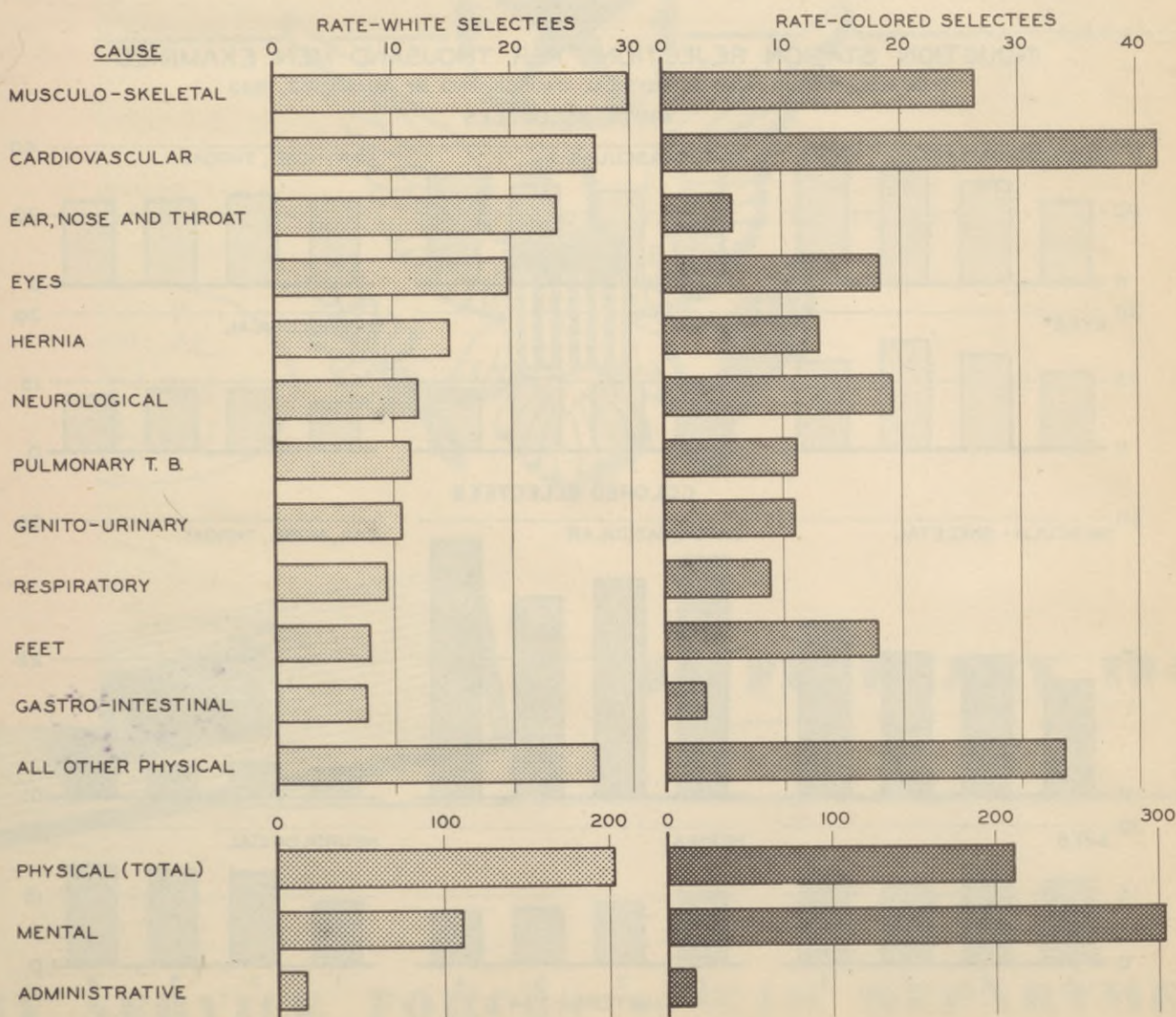
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INDUCTION STATION REJECTIONS, 1943 (Continued)

Another factor in the rise in mental rejections was the more intensive reworking of the 4-F pool on the part of local boards hard-pressed to meet their quotas. It is believed that men previously rejected for the milder psychiatric disorders may have been called up for re-examination with greater frequency than some other defect groups. Finally, some part of the increase, especially among colored selectees, reflected the removal, as of 1 June, of all restrictions on the number of illiterates who could be inducted. Prior to 1 June mental rejections included illiterate selectees who were not then acceptable because of limitations on the number of illiterates who could be inducted daily. All illiterates otherwise qualified for general service in the Army or Navy became acceptable if they passed specially designed qualification tests. Nevertheless, the mental rejection rate increased in June, particularly for colored selectees. This increase probably reflected the unloading by local boards of illiterates who had previously been rejected as such and who were again rejected, but now on the basis of qualification tests.

For the last three months of 1943 mental rejections have been reported with a distinction between "psychiatric other than mental deficiency" and "mental deficiency". Selectees who failed to pass the specially designed qualification tests were reported as rejected on account of mental deficiency just as were those who could be diagnosed as mentally deficient by the psychiatrists without recourse to the tests. During the last quarter of 1943 approximately one-quarter of all mental rejections among white selectees were reported as due to mental deficiency, whereas among colored selectees almost two-thirds of the mental rejections were for this reason.

INDUCTION STATION REJECTIONS PER THOUSAND MEN EXAMINED
BY COLOR AND BY CAUSE OF REJECTION, 1943



INDUCTION STATION REJECTIONS, 1943 (Continued)

During 1943 physical defects among white and colored selectees accounted for 56 percent of all rejections at induction stations. Among white selectees the percentage was 61 and among colored selectees it was 40. It should be borne in mind, however, that selectees with both mental and physical disqualifying defects have been reported as mental rejections. The effect of this practice is to reduce the proportion of physical rejections, especially among colored selectees. The chart on the previous page shows the relative importance of the various classes of disqualifying physical defects during 1943 for white and colored selectees separately. The trend of the six leading causes of rejection for physical defects among white selectees is shown by quarters at the bottom of this page, as is the trend of these same causes for colored selectees.

Substantial increases have occurred in the rejection rates for musculo-skeletal and cardiovascular defects among both white and colored selectees. There were certain other significant increases not shown graphically. Rejections for foot defects increased during the last quarter to 11 per thousand for white selectees and 21 for colored. Rejections for gastro-intestinal defects among whites also rose significantly to a rate of over 9 per 1,000 during the last quarter of 1943. Among colored selectees rejections for syphilis rose sharply during the latter part of 1943 to a rate of over 20 per 1,000. Paradoxically, this was because of the special effort made by the Army to induct otherwise qualified men with venereal disease, especially syphilis (other than cardiovascular, cerebrospinal, or visceral syphilis) for in conformance with this program the local boards sent to the induction stations large numbers of previously rejected syphilitics. Analogous efforts were made to review the pool of cardiovascular rejections and there was, of course, a general reworking of the 4-F classification by the local boards. In November the Army began to accept men with inguinal hernia which had not descended into the scrotum and also men having femoral hernia, so that the rejection rate from this cause has begun to shown a decline.

INDUCTION STATION REJECTIONS PER THOUSAND MEN EXAMINED BY COLOR FOR LEADING PHYSICAL CAUSES, AND BY QUARTERS, 1943

