MONTHLY PROGRESS REPORT ★ SECTION 7

ec	Prof	
S	Med	
J	NP	
R	Surg	
Trop	Recon	
VD	Vet	
Lab	Oper	
n	Train	
	Hosp	
v-Nutr	Supp	
	Control	
	Med Stat	
	Hist	
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HEALTH

RESTRICTED

31 JANUARY 1946

ARMY SERVICE FORCES ★ WAR DEPARTMENT

HEALTH

DOCUMENT SECTION

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CONTENTS

SUMMARY

NONEFFECTIVE RATES Consonant with the increase in the admission rate during January, the Z/I noneffective rate advanced to 37 per thousand for Z/I patients only and to 82 for Z/I patients plus evacuees. The average patient load in Army hospitals and in quarters during December was made up of 100,000 evacuees in the Z/I, 79,000 Z/I patients, and 44,000 patients overseas. (See pages 2 and 3)

ADMISSION RATES In January the Z/I hospital admission rate for disease increased to 521 in response to the increased incidence of respiratory disease. During December 175,000 Army patients were admitted to hospitals, 86,000 of whom were overseas. Admission rates for nonbattle injury have been declining steadily and are now stabilized at the lowest levels of the war. (See pages 4-6)

RESPIRATORY DISEASE January admission rates suppcrt the view stated in December that the low Army incidence in the Z/I during November and December probably resulted chiefly from the vaccination program. Influenza B is now epidemic in the United Kingdom but incidence among U. S. troops in said to be low. (See page 7)

PRIMARY PNEUMONIA IN THE U. S. Since atypical pneumonia first became reportable early in 1942, the proportion of all primary pneumonia which has been reported as atypical has increased. The prevalence of the pneumonias and the correlated incidence of bacterial pneumonia and the common respiratory diseases plus influenza are discussed on pages 8 through 10.

DIPHTHERIA IN EUROPE Diphtheria is one of the major civilian health problems in Germany today. In the American Zone about 1,300 cases and 70 to 80 deaths per week were reported in November and the first half of December. Diphtheria cases among Army personnel have also increased and an immunization program has been formulated to combat the disease. (See page 11)

MEDICAL STATUS OF RECOVERED ALLIED MILITARY PERSONNEL Results of medical processing of large numbers of RAMPS in the Pacific are summarized. A conservative calculation places the death rate among those captured by the Japanese at 10 percent per year. (See pages 14 to 16)

VENEREAL DISEASE The post-holiday increase in admissions raised the January rate to 69 for all Z/I troops in contrast to 50 in December. In the Mediterranean the rate declined in December but elsewhere overseas trends were upward. (See pages 12 and 13)

HOSPITALIZATION OVERSEAS Demobilization of overseas units is progressing rapidly. In Europe T/O bed capacity dropped by 73 percent between 30 April and 31 December, and the number of Medical Corps officers by 77 percent. In the Pacific T/O capacity fell by 55 percent and the number of doctors by 44 percent between 31 August and 31 December. On 31 December there were only 95,000 fixed and nonfixed beds operating overseas. (See pages 19-22)

EVACUATION FROM OVERSEAS The total of about 6,500 evacuees received in January is smaller than any number received since July 1943. (See page 23)

HOSPITALIZATION IN THE ZONE OF INTERIOR At the end of January there were about 152,300 patients remaining in ASF station, regional, and general hospitals and 128,000 beds occupied. Blocked general and convalescent hospitals contained 29,000 patients. Negotiations are in process for a credit of 10,000 beds in Army hospitals for the Veteran's Administration. (See pages 24 to 26)

DISEASE AND INJURY

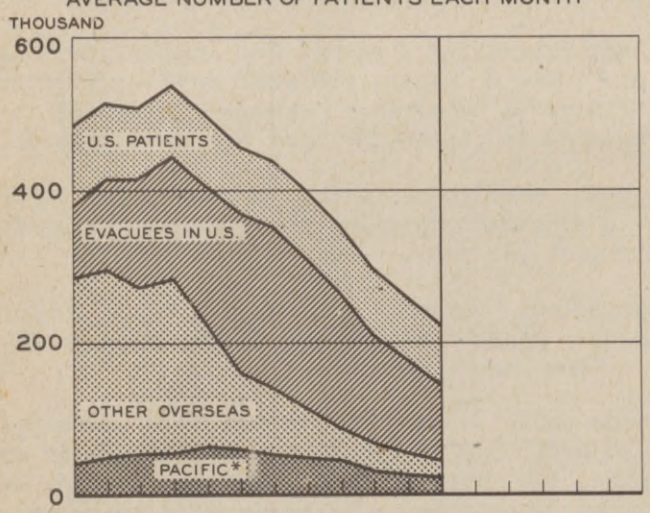
NONEFFECTIVENESS IN HOSPITAL AND QUARTERS

In response to both the rapid decline in Army strength and the increased morbidity characteristic of the winter months, the U. S. noneffective rate for patients of Z/I origin rose in January to 37.4 per thousand strength, although the average number of patients during the month dropped by about 4,500 to 74,700. Evacuees in Zone of Interior hospitals numbered about 90,000 in January, 10,000 less than in December, and when added to patients of Z/I origin yield a gross noneffective rate of 82.3 per thousand in January. Among troops overseas the most recent data place the average level of noneffectiveness at 18 during December, only slightly higher than the revised level of 17 during November. On the average 44,000 patients were under treatment overseas during the month, which is only 44 percent of the average number of overseas patients in Z/I hospitals in December.

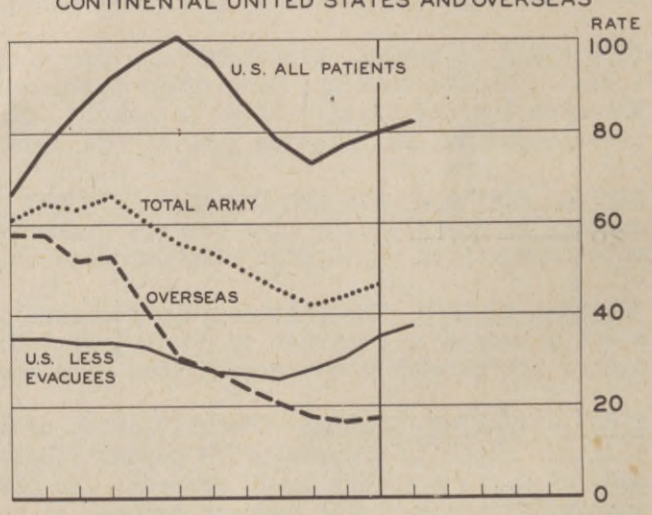
AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES

AVERAGE NUMBER OF PATIENTS EACH MONTH

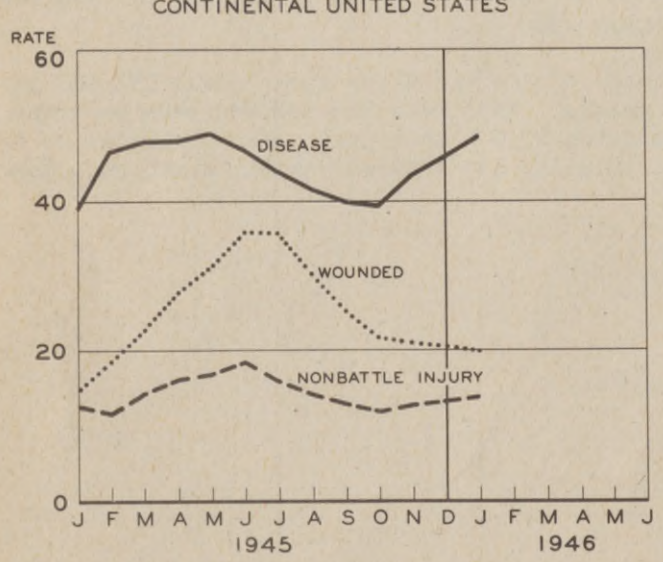


CONTINENTAL UNITED STATES AND OVERSEAS

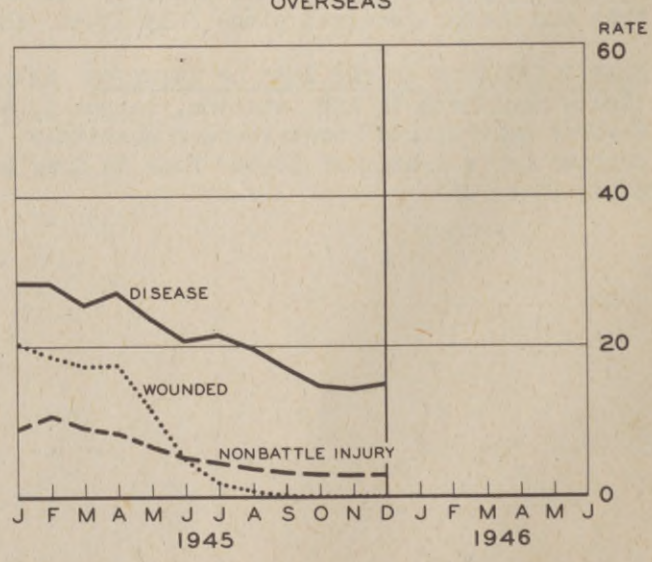


MAJOR CAUSES

CONTINENTAL UNITED STATES



OVERSEAS



* Middle and Western Pacific

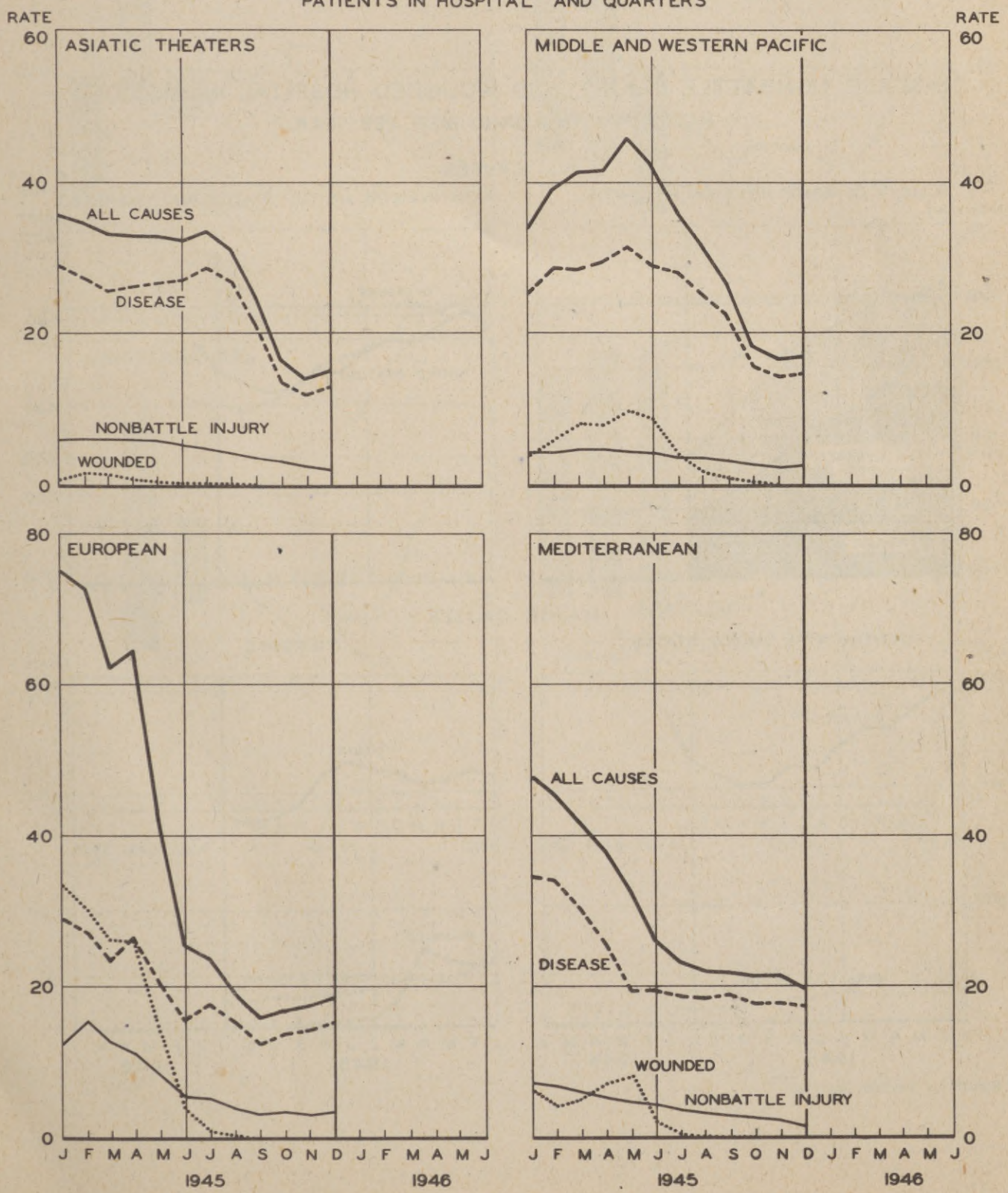
DISEASE AND INJURY

NONEFFECTIVENESS IN HOSPITAL AND QUARTERS (Continued)

In overseas theaters, as well as in the United States, falling strengths forbid too close a comparison of noneffective rates. However, in spite of the decline in troop strength noneffective rates are being kept at exceptionally low levels by the combined influence of a lower true incidence of disease and a tendency for troops to refrain from seeking treatment for lesser complaints if they are about to come home. An exception is the Mediterranean Theater where higher admission rates for venereal disease have been offset by lower average days lost per case. Some slight increase in disease noneffectiveness in Europe during December is probably the result of a seasonal increase in respiratory disease.

AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

PATIENTS IN HOSPITAL AND QUARTERS



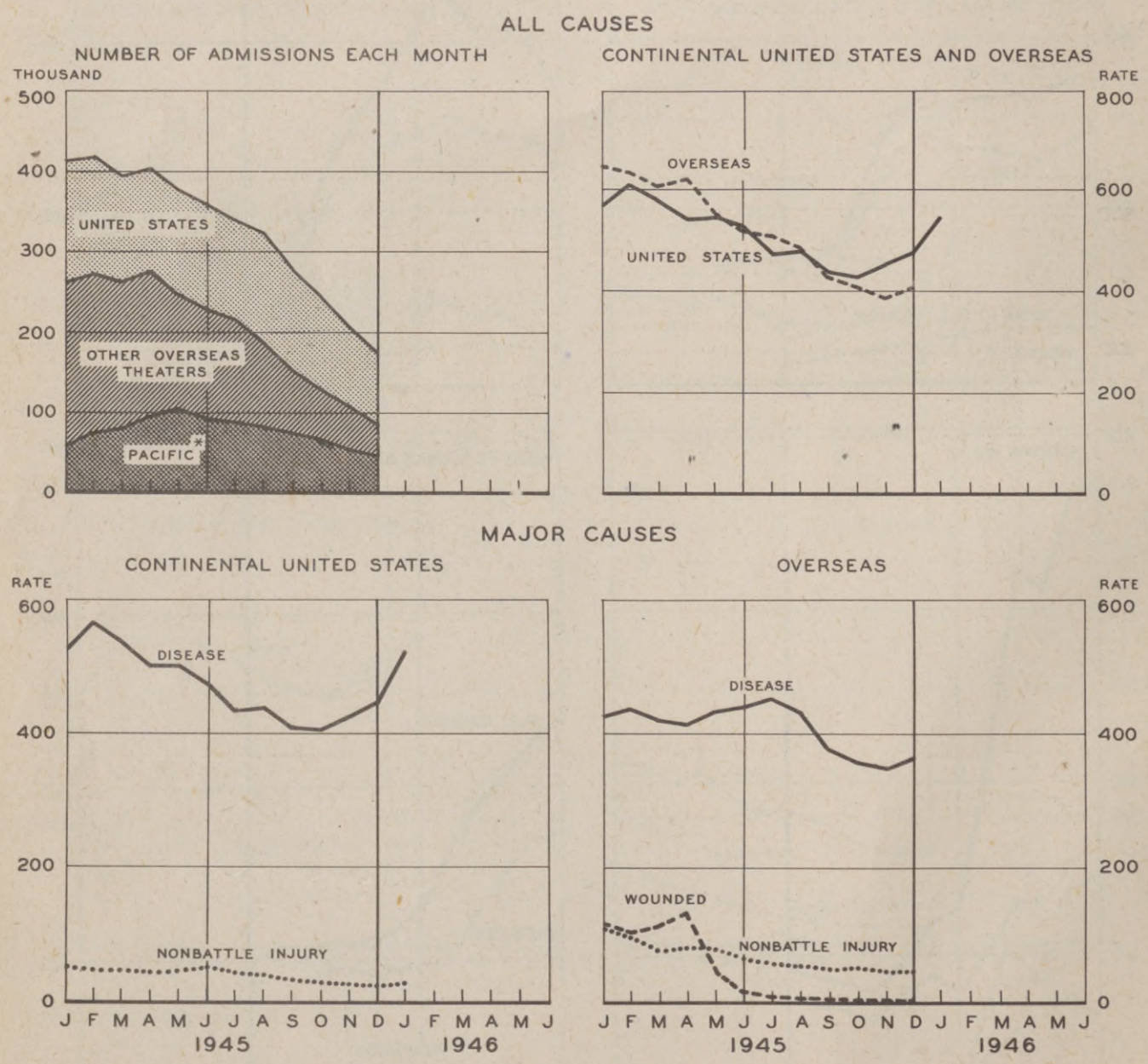
DISEASE AND INJURY

TREND OF HOSPITAL ADMISSIONS IN THE UNITED STATES AND OVERSEAS

During December about 89,000 patients were admitted to hospitals in the United States and about 86,000 overseas, 45,000 of whom were in the Middle and Western Pacific. The panels below give the admission rates to hospital for the major causes of admission both in the United States and overseas. In January the provisional U. S. rate for disease was 521, the highest since March 1945, and probably the peak for the 1945-46 winter season. The provisional December admission rate for disease among troops overseas is 362 per thousand men per year, slightly higher than that for November. Nonbattle injury admissions are low both in the Z/I and overseas, the latest rates being 27 for Z/I troops in January and 46 for those overseas in December.

DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS

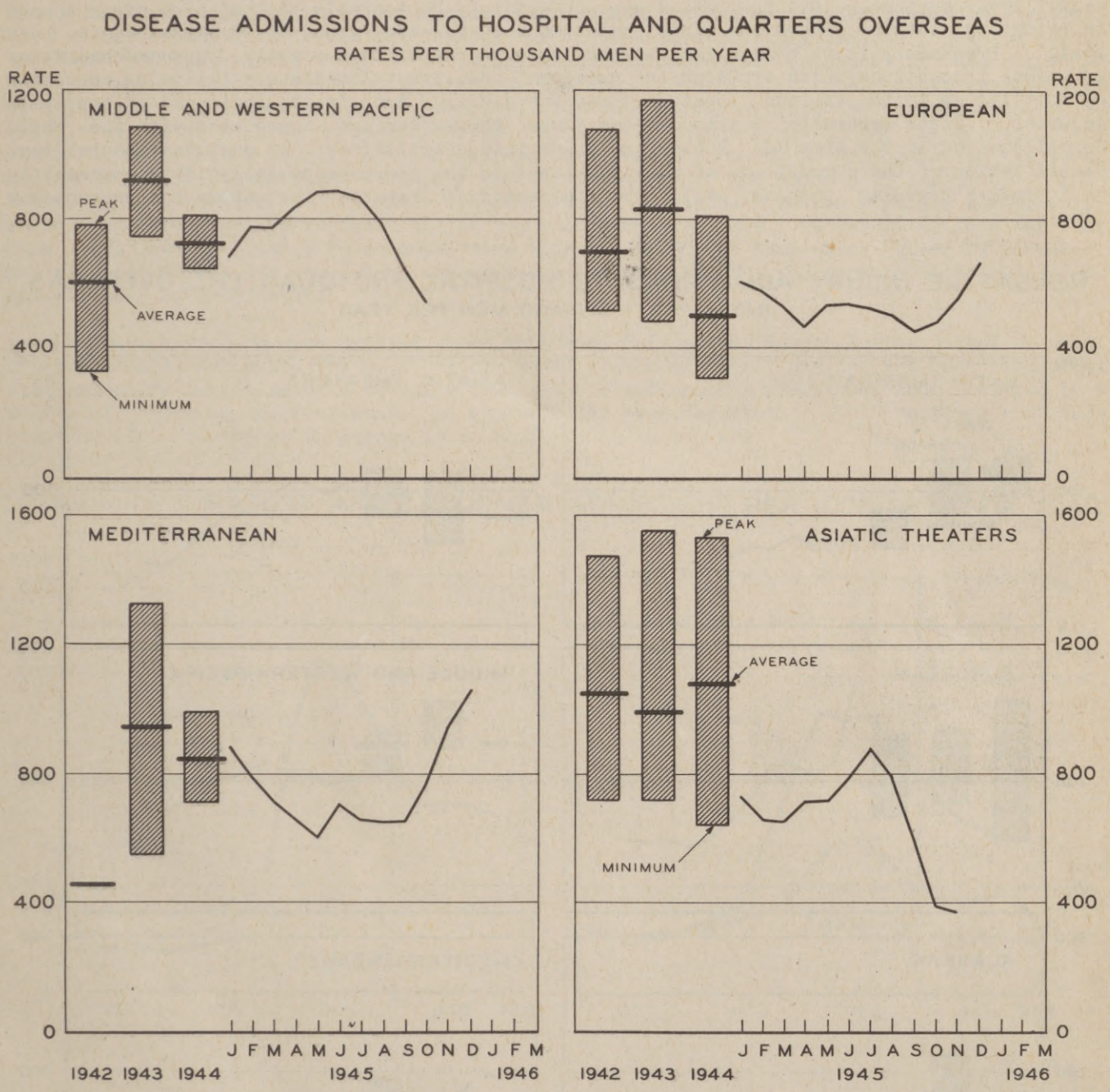
RATES PER THOUSAND MEN PER YEAR



* Middle and Western Pacific.

DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

During December admission rates to hospital and quarters increased further in the Mediterranean and European Theaters. The increase in Europe is attributable to increase in both venereal and respiratory disease, although disease incidence as a whole rose in the Mediterranean in spite of the first drop in the venereal disease rate in eight months.

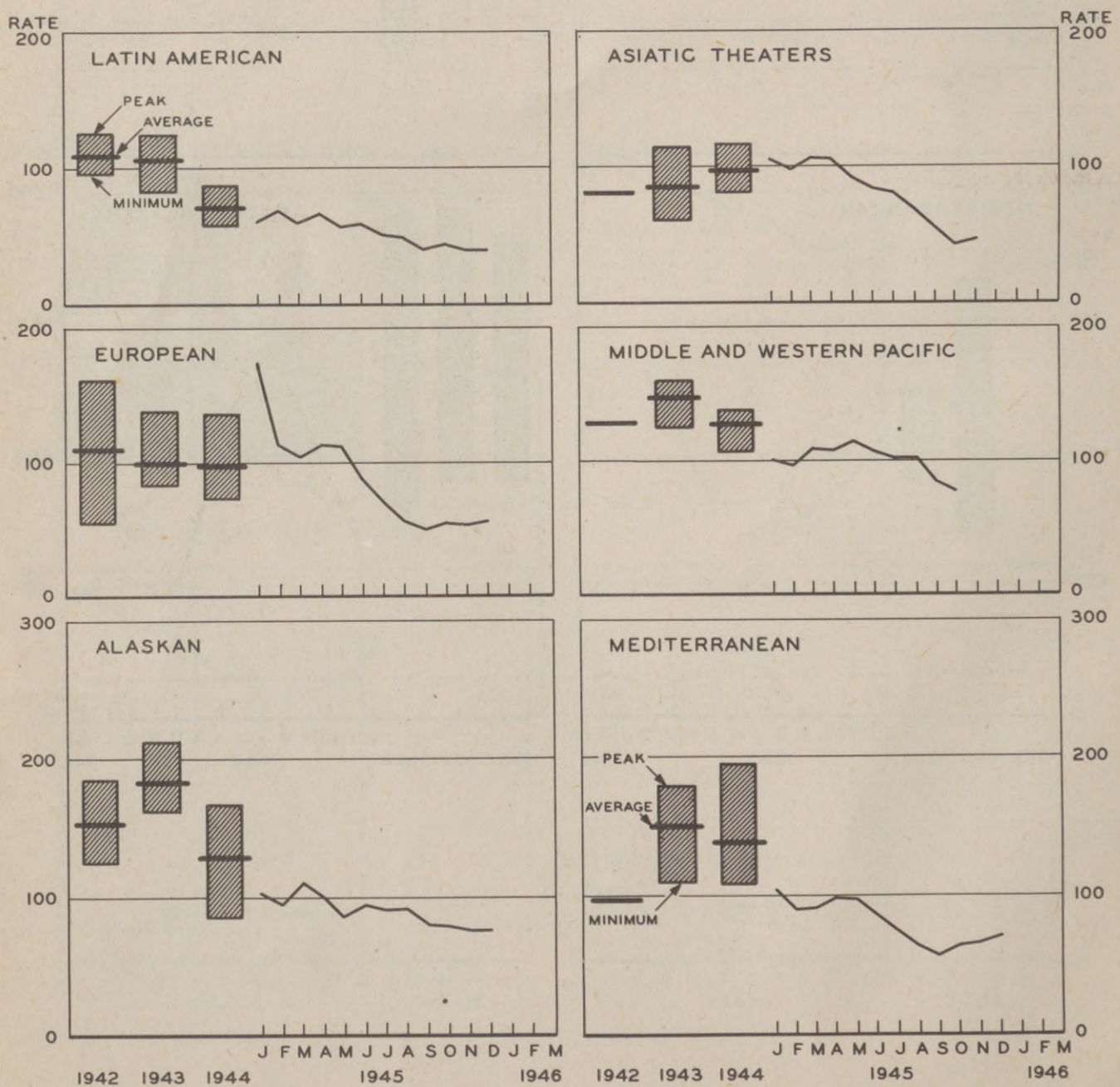


NONBATTLE INJURY

In recent months admission rates for nonbattle injury in overseas theaters have tended to stabilize at levels generally about the lowest of the war. By November all major areas had rates of 75 or less and both the Latin American and the Asiatic commands had rates below 50. Alaska continues to have the highest incidence, about 75 per 1,000 men per year. However, all these rates are well below pre-war levels for troops either in the Z/I or overseas. After September 1944 the series are not entirely comparable because of a minor change in reporting, but the reductions since that time are far too great to be explained on this basis. Presumably it is primarily lessened exposure rather than greatly improved observance of safety precautions which explains the universal decline. Immediately following cessation of hostilities in the various theaters there was a sharp drop in the incidence of nonbattle injuries. If the generally continuous decreases thereafter are associated with the rapid demobilization of the Army and lessening of training activities, it must be expected that stabilization of the composition of the Army later in the year, especially if accompanied by an intensive training program, will force the accident rate to rise above the present low levels.

NONBATTLE INJURY ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

RATES PER THOUSAND MEN PER YEAR



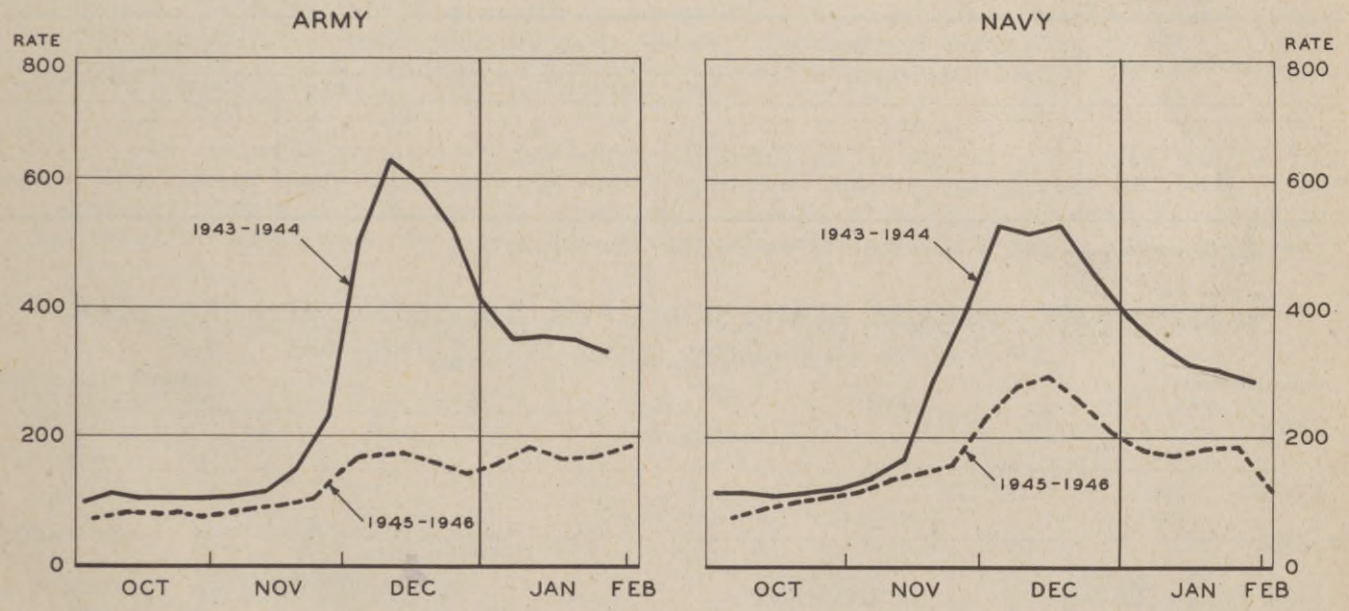
DISEASE AND INJURY

RESPIRATORY DISEASE

During January the U. S. admission rate for common respiratory disease and influenza averaged 172 admissions per 1,000 men per year, very close to the post-epidemic Navy rate of 181 for the month. The chart below continues the weekly series shown in HEALTH for December 1945, the Navy series being for catarrhal fever and influenza which parallel closely the Army categories of common respiratory disease and influenza. The approximate comparability of the Army and Navy rates of recent weeks reinforces the conclusion that most, but not all, of the observed differential in November and December probably derived from the use of influenza vaccine by the Army, although short-term differences in reporting are not ruled out. Although vaccination probably prevented a rise in admission rates above the low peak established in the week ending 14 December, it could hardly explain the sharp decline below that level in the three succeeding weeks, especially since post-holiday rates were at or above the 14 December level. It is believed that the decline in the Army rate in the weeks ending 21 and 28 December and 4 January was attributable to the absence of personnel on furlough, holiday pass, etc. Attempts are being made to secure a ration strength series which would permit appropriate revision of the reported admission rate. However, it is clear that such revision is unlikely to do much more than level off the Army rates after 14 December, and will not affect to any extent the comments made in HEALTH for December with respect to the efficacy of vaccination.

Reports have just arrived that influenza B is now epidemic in the United Kingdom. Its prevalence among the few U. S. troops still stationed there has not yet been determined statistically but is said to be quite low. While influenza B virus has been isolated in a number of places on the Continent, no epidemic has been reported. It is believed that vaccination of U. S. troops in Europe is as complete as in the Z/I.

COMMON RESPIRATORY AND INFLUENZA ADMISSIONS PER 1,000 MEN PER YEAR



PRIMARY PNEUMONIA IN THE U. S.

The pneumonias comprise infectious, inflammatory conditions of the lung caused by a variety of agents. An understanding of their incidence requires a distinction between the more recently recognized virus types, mostly atypical pneumonia, and the bacterial types. The latter carry the higher mortality which, however, has been greatly reduced by the sulfonamides and penicillin. A distinction is also made between secondary pneumonia, in which pneumonia occurs as a complication of an already existing disease (except common respiratory disease), e.g. influenza or measles, and primary pneumonia which includes all other cases.

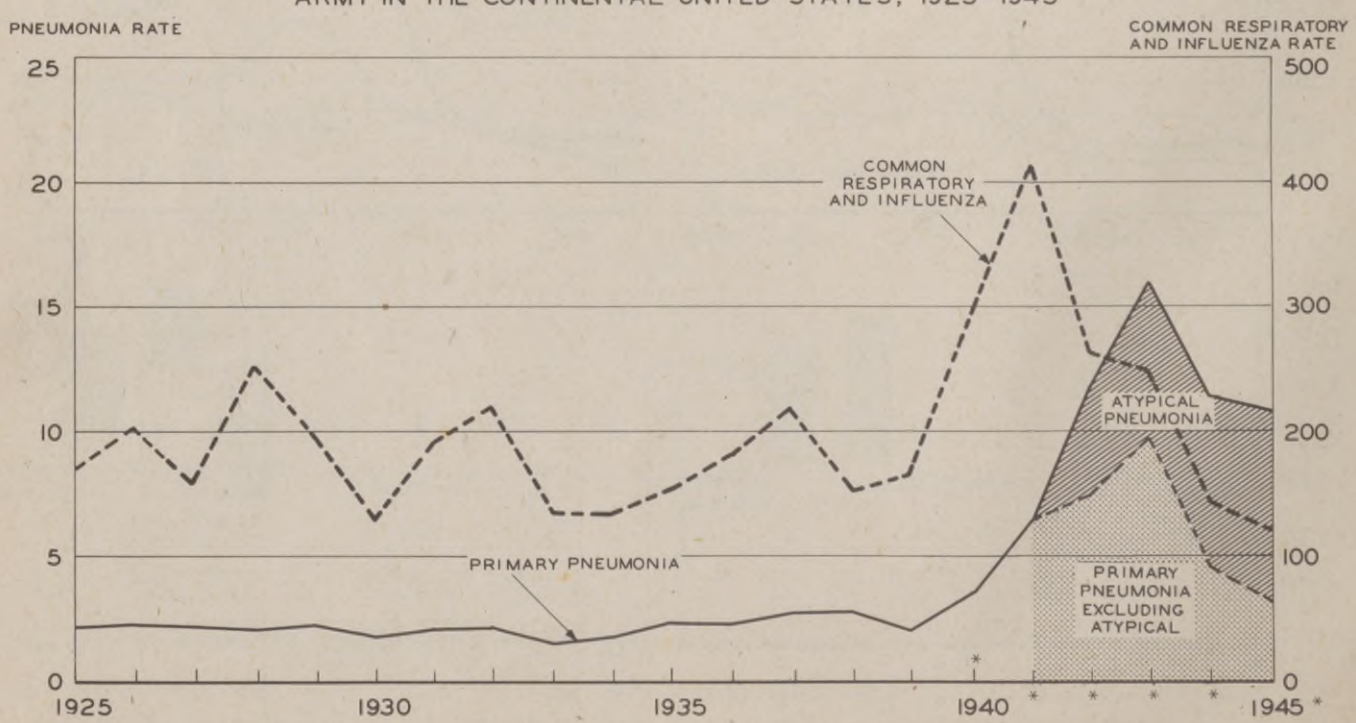
During January admissions for primary pneumonia (including atypical) averaged 15 per 1,000 men per year, or about eight percent of all respiratory disease. This rate compares with 13 in January 1945 and 22 in January 1944 following the influenza epidemic of November and December of 1943. These rates are very high according to pre-war standards, the range for the years 1925 to 1941 being from 1.9 to 9.9 for the month of January. In part the difference is caused by the better recognition and separate reporting of atypical pneumonia which began in 1942. Although some cases of this type may have been reported earlier as pneumonia, it seems certain that others were not recorded as such until after separate reporting was instituted. However, the "true" incidence of atypical pneumonia may be on the increase. In general, then, some of the large increase in pneumonia incidence during the war years, as shown in the chart below, may well arise from the improved recognition and reporting of atypical pneumonia, and it is impossible to state how much of this rise is real. The rates are for the calendar years of 1925-1945, but those for 1940 to 1945 were obtained by averaging monthly rates in order to eliminate the distortion caused by the tremendous strength changes during this period. The correction is appreciable only for the years 1940 and 1941 when the fast-increasing strength gave too much weight to high rates at the end of

PRIMARY PNEUMONIA, ADMISSIONS PER THOUSAND MEN PER YEAR*
Continental United States

Calendar Year	Total Primary (Including Atypical)	Primary Less Atypical		Atypical	
		Rate	Percent of Total	Rate	Percent of Total
1943	16.1	9.8	61	6.3	39
1944	11.4	4.5	39	6.9	61
1945	10.9	3.1	28	7.8	72

* Yearly average rates obtained by averaging monthly rates.

RESPIRATORY DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR
ARMY IN THE CONTINENTAL UNITED STATES, 1925-1945



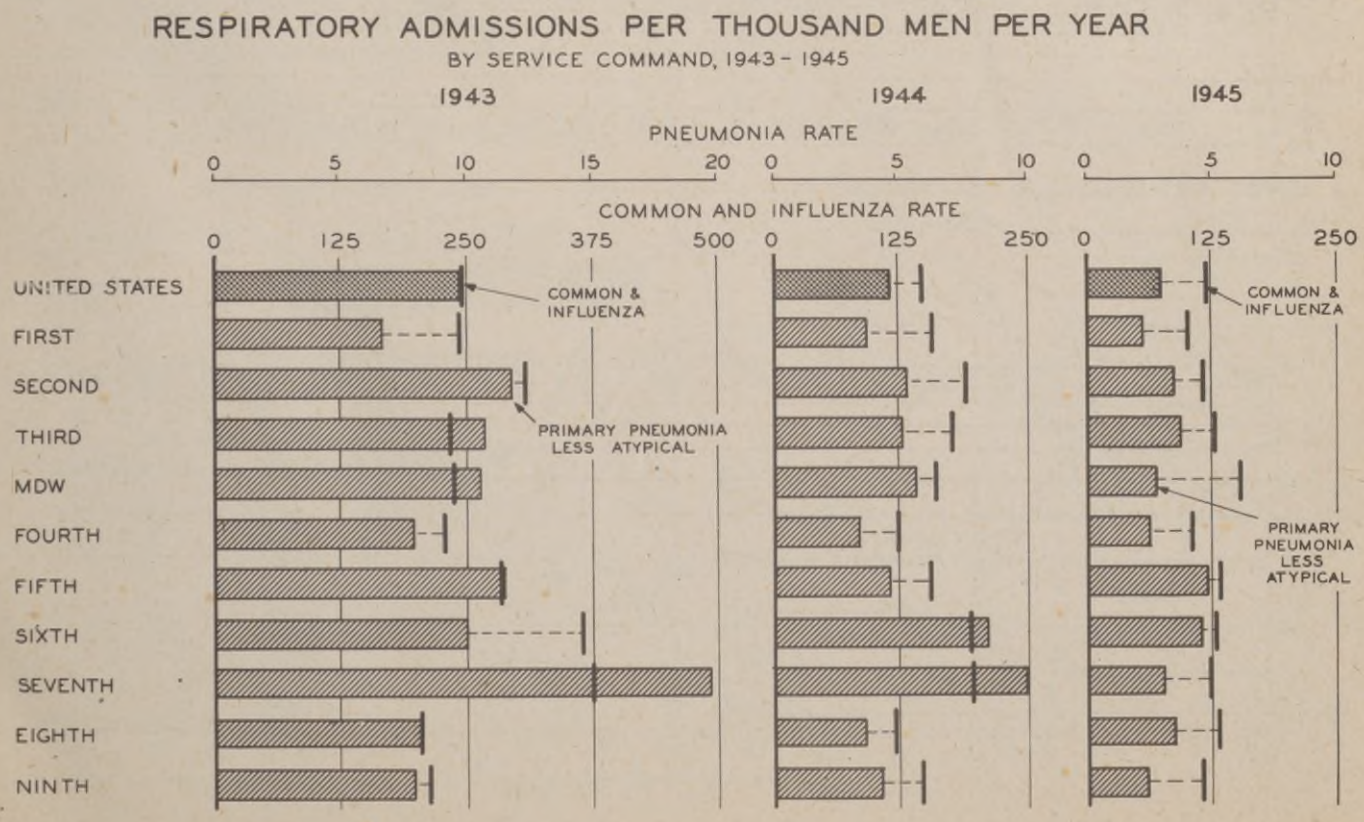
* Figures for 1940 through 1945 are arithmetic averages of monthly rates.

PRIMARY PNEUMONIA IN THE U. S. (Continued)

1940 and too little at the beginning of 1941 when influenza was widely prevalent. Essentially the same results are obtained when rates are plotted for the fiscal years which in general correspond more nearly to the respiratory cycle. It is plain that atypical pneumonia is an increasingly large portion of whatever primary pneumonia is reported, for the percentage of pneumonia classified as atypical rose from 39 in 1943 to 61 in 1944 and to 72 in 1945. During this interval the reported incidence of atypical pneumonia has risen steadily while that of other primary pneumonia has declined from 9.8 in 1943 to 3.1 in 1945. However, when computed for the fiscal years by averaging monthly rates, admissions for atypical pneumonia are remarkably constant, increasing from 6.8 in 1942-1943 to only 7.0 in 1944-1945. On the same basis the rate for other than atypical pneumonia fell from 10.4 to 3.1 admissions per 1,000 men per year during this interval. The rate of 3.1 for pneumonia other than atypical in 1945 is only 41 percent above the average reported incidence of all primary pneumonia from 1925 through 1939, although in 1943 the rate for pneumonia less atypical was 345 percent above that average.

The inclusion of common respiratory disease and influenza on the preceding chart, drawn to the different scale defined on the right-hand side of the chart, shows how weak is the apparent association between the average yearly incidence of primary pneumonia and other respiratory disease. Whatever the relation there is depends on the roughly concomitant rise and fall during the war years, when the problems of reporting were most acute. Peak rates are also not closely parallel in their variation. This is not true, of course, of the seasonal variation within years, as will be seen from the chart on page 10 covering the war years. What is perhaps even more important is that when annual pneumonia rates for the service commands and the Military District of Washington are correlated with those for common respiratory disease and influenza for the period 1943-1945, a rather close correlation exists for primary less atypical pneumonia ($r = +0.90$), but none for atypical pneumonia. This suggests that primary bacterial pneumonia more frequently follows common respiratory disease or undiagnosed influenza than does atypical pneumonia. The individual service command rates are shown below for pneumonia less atypical and for common respiratory disease and influenza. Two separate scales are employed to facilitate comparison between the two causes of admission.

The seasonal variation in pneumonia is parallel to that for other respiratory disease. For the war period 1942-1945, as may be seen from page 10, the cycles are well-defined and the last three are of decreasing amplitude. Because of the very different levels of the rates, they have been drawn on a logarithmic or ratio scale. On this scale equal percentage



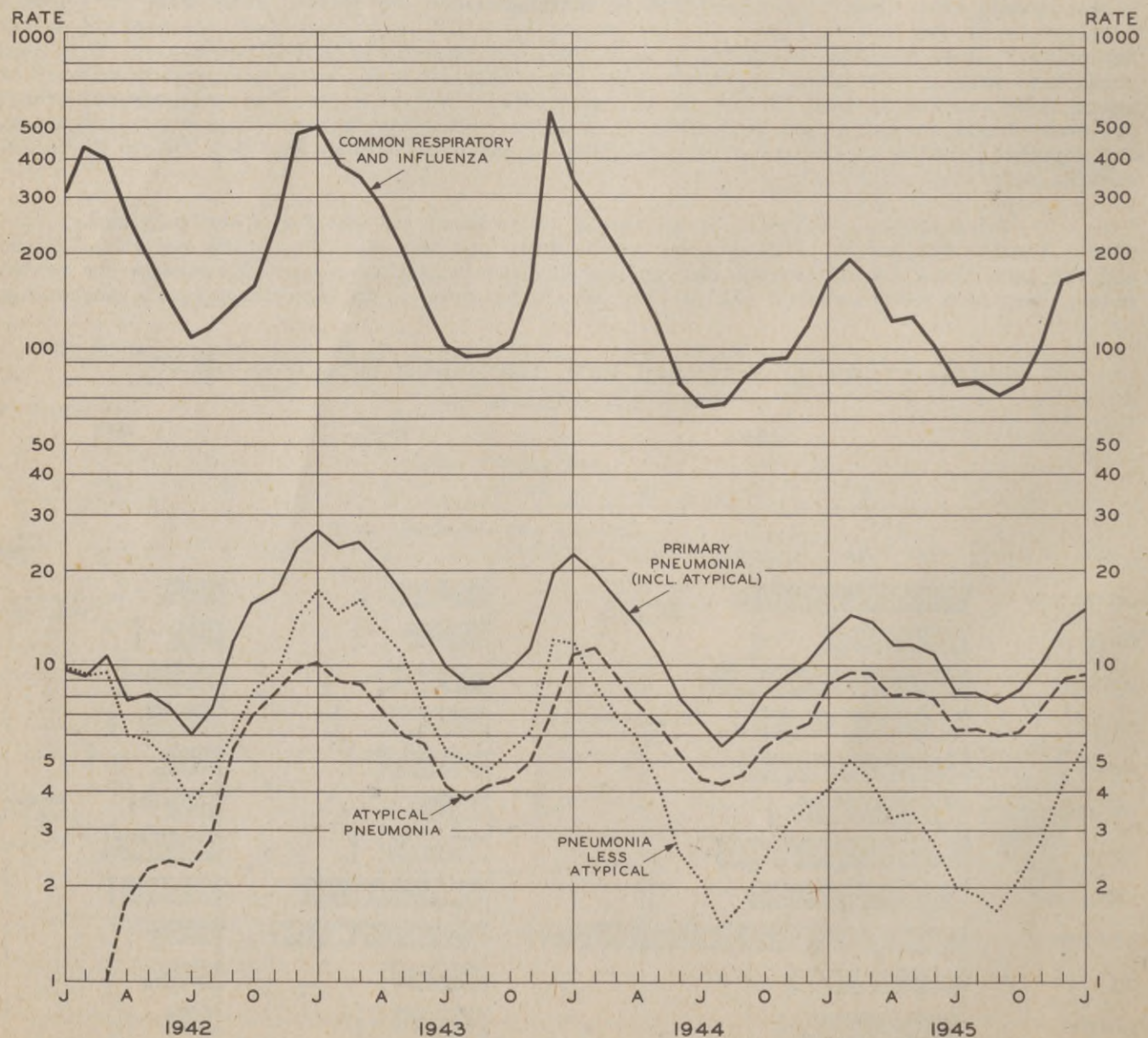
PRIMARY PNEUMONIA IN THE U. S. (Continued)

increases or decreases appear as equal vertical distances no matter what the magnitude of the rates may be, and parallel lines denote equal percentage increases or decreases. It is evident that the seasonal variation in common respiratory disease and influenza is greater than that for primary pneumonia. The peak winter rates for common respiratory and influenza are proportionately greater than the minimum summer rates than is true for primary pneumonia. However, in this sense there is about as much fluctuation in the rates for primary pneumonia less atypical as there is in the common respiratory disease and influenza. It is the lesser seasonal variation in atypical pneumonia which restricts the amplitude of variation in all primary pneumonia. For primary pneumonia less atypical the variation is extreme during 1944 as the rate moved to the lower level of the 1944-1945 and 1945-1946 seasons.

When the above facts are borne in mind, the current incidence of pneumonia is not disturbing. It is very little higher than it was during the 1944-1945 season, and distinctly lower than during the two preceding years. Most of the difference comes from the decline in pneumonia other than atypical, for the peak incidence has been relatively constant for atypical pneumonia since 1943. The higher annual rate for atypical pneumonia results chiefly from its increasing prevalence during the period between peaks in the incidence of respiratory disease. The minima moved from 3.8 per thousand men per year in 1943 to 4.2 in 1944 and to 6.0 in 1945.

RESPIRATORY DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR

ARMY IN THE CONTINENTAL UNITED STATES



DISEASE AND INJURY

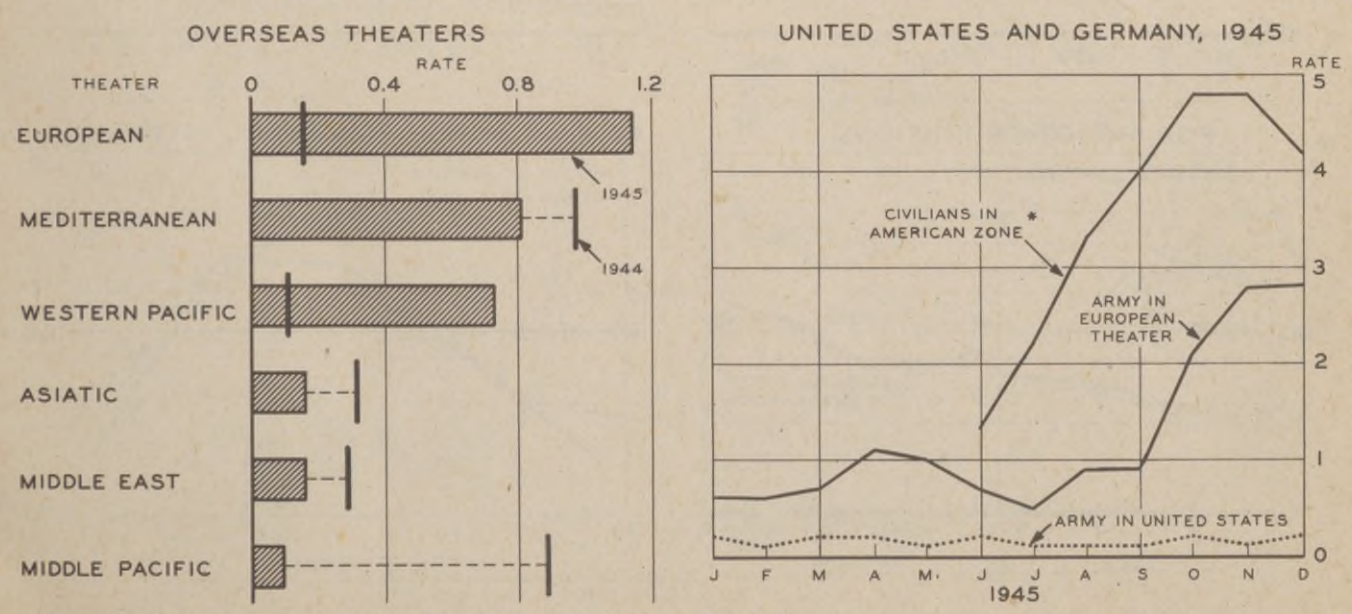
DIPHTHERIA IN EUROPE

For several years considerable attention has been given to diphtheria as a hazard to troops operating in Europe. In northwestern Europe its prevalence increased greatly during the war. In Germany, for example, immediately before the war about 150,000 cases were reported annually; by 1942 the incidence had almost doubled. No improvement had occurred by 1945 and today diphtheria constitutes one of its major health problems. In the American Zone during November and the first half of December the reported incidence among civilians of all ages averaged about 1,300 cases per week with 70 to 80 deaths. An extensive program of immunization has recently been placed in effect.

A marked increase in admissions for diphtheria has likewise recently occurred among American troops on the Continent, particularly in Germany. During October, November, and December there were from 200 to 300 cases per month, admission rates being from two to three per 1,000 men per year. This is more than ten times the current prevalence among troops in the Z/I. From 1930 to 1939 admissions for diphtheria in the total Army averaged 0.12 per 1,000 men per year, or one-tenth of the 1945 rate for the European Theater. There have been about 50 deaths from this cause in the theater during 1945, or about two percent of all admissions for the disease. Although the peak incidence is usually reached about November, for three weeks in January the rate is 4.8. In addition to the immunization of German civilians extensive efforts have been made by the theater to insure early recognition and adequate treatment of the disease among U. S. troops in order to lessen its spread and to diminish the chance of death or serious complication.

At the start of the war it was decided not to adopt diphtheria immunization as a routine procedure in the Army but to reserve it for local situations when required. This policy prevailed throughout the war and immunization was seldom necessary. Only recently has it appeared advisable to adopt this measure on any large scale. The principal reason for a conservative attitude toward immunization has been the knowledge that diphtheria toxoid, the agent used, often produces rather severe reactions in adults, although dangerous or fatal types of reactions are not encountered. However, decision has now been made in the European Theater to immunize all hospital personnel and those who frequently come into close contact with civilians. It has also been decided to immunize, before they leave the United States, all replacement troops under 35 who are being sent to the European or Mediterranean Theaters. This step has been taken only after serious consideration of the difficulties which include: a) the desirability, whenever possible, of first doing a Schick test and then immunizing only those who react positively; this makes the procedure considerably more complicated than most other immunizations; b) the advisability of modifying the usual dosage schedule so as to start with a very small dose and avoid giving further doses to those with severe reactions to this test injection; and c) the unusually long period required for completion of immunization (approximately seven weeks), which will often necessitate administration of final doses after arrival overseas.

DIPHTHERIA ADMISSIONS PER THOUSAND MEN PER YEAR



* Reporting less complete than Army. Civilians of all ages are included.

VENEREAL DISEASE IN THE U. S.

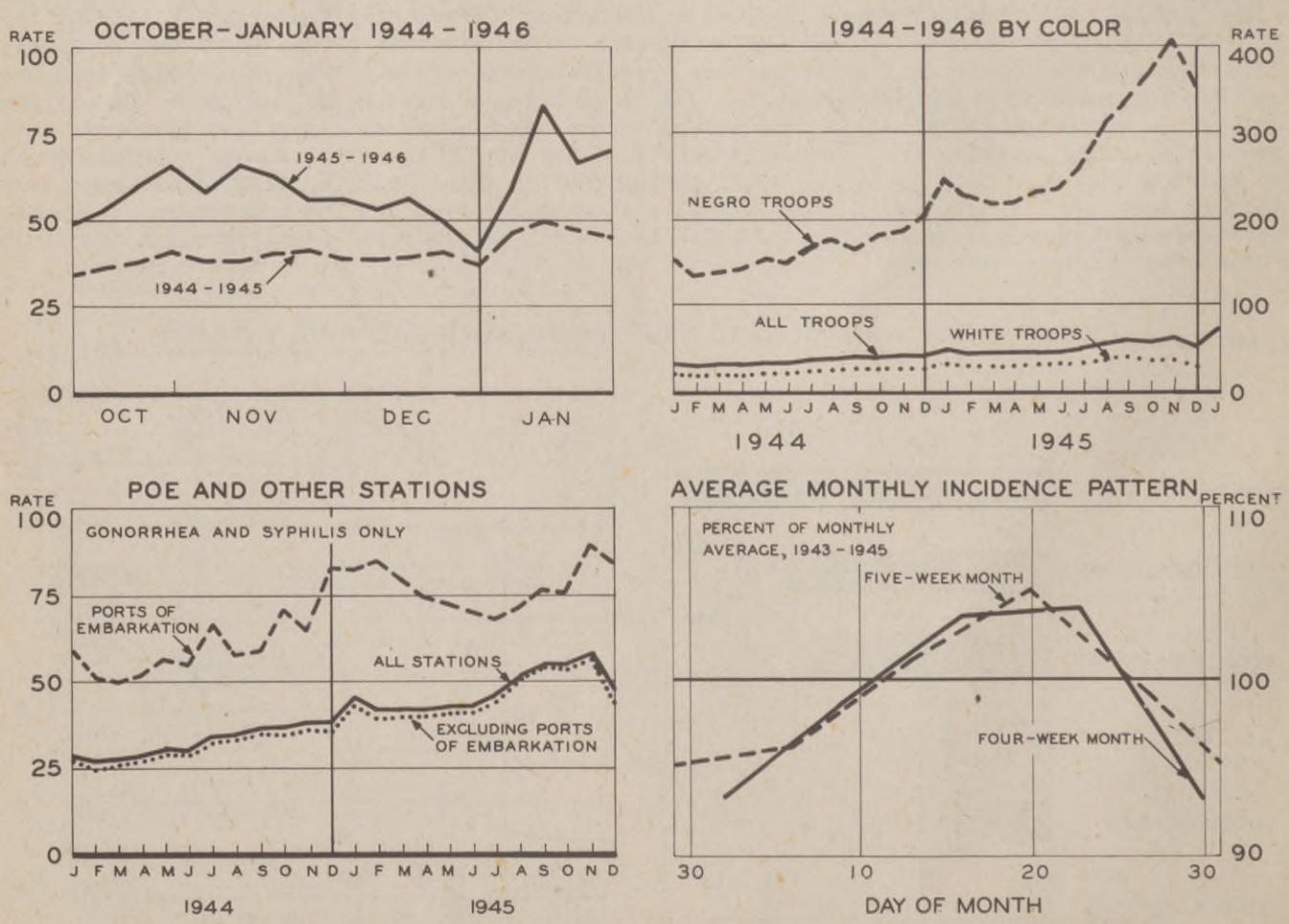
The incidence of venereal disease among all personnel in the United States has increased steadily since the beginning of 1944 to the point where the current rates are about twice those which obtained during 1943. The preliminary January rate of 69 is the highest of the war, partly because of an exceptional post-holiday increase shown by the weekly rates plotted in the top left-hand panel below. The top right-hand panel provides rates by color. The arithmetic scale is not appropriate for showing rates of change, but it is easily shown that the rate of increase is considerably greater for Negro troops than for white.

Because ports of embarkation or debarkation and their associated assembly areas have exceedingly high rates they were separated from all other stations to see how much of the recent increase might be attributable to the port areas. As may be seen from the bottom left-hand panel (restricted to gonorrhea and syphilis), their influence has been very small, and the rate for all other stations has determined the upward trend. There is evidence that appreciable numbers of infected personnel are being embarked overseas and first enter admission statistics at ports of entry in the United States.

Weekly rates for venereal disease display a rather regular pattern in the form of a monthly cycle which begins to rise after one pay-day and falls to its minimum at or before the next. Because the Statistical Health Report is rendered weekly, so that the first week of any month may end from one to seven days after pay-day, the average patterns are less precise than daily data might provide. It is usual to group either four or five weeks into one month, and averaging each type gives slightly different results, as may be seen from the bottom right-hand chart. Long-term trends in incidence have been eliminated from the monthly cycles, which are shown there in index form. The amplitude of fluctuation is about 10 to 12 percent, the peak being about the middle of the month.

VENEREAL DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR

ARMY IN THE CONTINENTAL UNITED STATES



DISEASE AND INJURY

VENEREAL DISEASE OVERSEAS

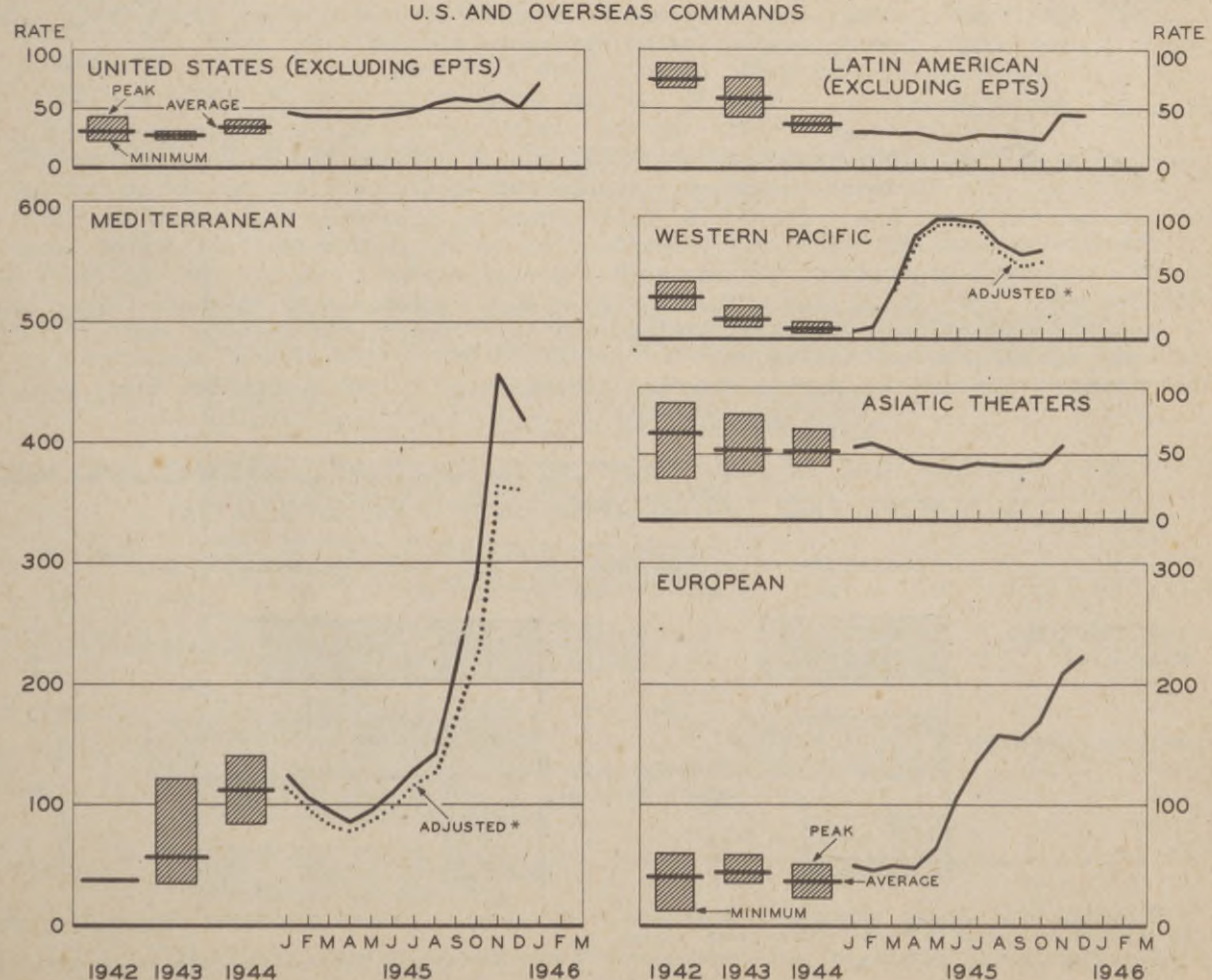
The incidence of venereal disease declined slightly in the Mediterranean Theater during December, but elsewhere overseas trends were generally upward. In the Asiatic theaters, where venereal incidence had been declining throughout 1945, a definite upturn was registered in November. In India-Burma the increase was from 39 in October to 50 in November, but in China, where the strength is small and falling rapidly, the rise was from 54 in October to 134 in December. Concentration of troops in modern Shanghai has permitted unprecedented exposure for troops previously stationed in the interior of China.

In the Western Pacific the increase in venereal infection during October was slight. However, troops in Korea reported a rise from 11 in September to 36 in October, and for the troops in Japan the rate jumped from 22 to 64. Prostitution is of course so widespread in Japan that policing is difficult and a high percentage examined have been found to have venereal disease. For the European Theater the December rate of 224 is the highest of the war. Rates for whites advanced from 156 to 165, while those for Negroes increased from 802 to 870 during the month. Rates for Negro troops are above 800 per 1,000 men per year in the European, Mediterranean, and Africa-Middle East Theaters. The Mediterranean rate of 1,843 for Negroes in December means that 15 percent became infected in that month alone. This is an exceedingly poor record even for a small force. The average theater rate declined only because the rate for whites fell from 258 to 207 in December and the proportion of Negro troops lessened.

In order to ascertain the importance of differences in proportions of white and Negro troops theater rates were adjusted to the average color composition of all overseas forces in 1944. Small differences were found except in the Mediterranean and the Western Pacific where the proportions of Negro strength have exceeded the average. New adjusted lines have therefore been added to those panels for comparison. For the European Theater the adjusted December rate is 231 while that reported is 224. For the Asiatic theaters the adjusted November rate of 53 compares with 55 reported.

VENEREAL DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR

U. S. AND OVERSEAS COMMANDS



* To 1944 average ratio of white to Negro troops overseas.

MEDICAL STATUS OF ALLIED MILITARY PERSONNEL RECOVERED FROM THE JAPANESE

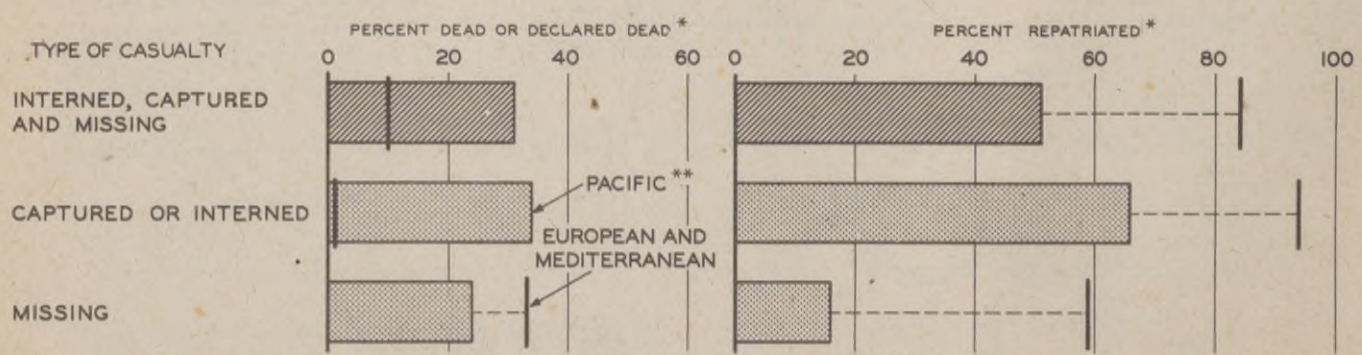
The brutal treatment accorded by the Japanese to Allied prisoners of war, their mortality while in prison, and their medical status upon recovery constitute medical and political facts of importance. According to the Adjutant General's accounting of U. S. Army casualties (as published in BATTLE CASUALTIES OF THE ARMY), one percent of those captured or interned in the European and Mediterranean Theaters died or have been declared dead as against 34 percent in the Pacific. Even if a generous allowance is made for the longer duration of imprisonment in the Pacific (perhaps 3.5 years as against one year in Europe), the ratio of deaths to the total number taken prisoner is eleven in the Pacific to one in Europe. The average death rate among prisoners taken by the Japanese exceeds 10 percent per year on a conservative calculation. The accompanying chart summarizes the facts as published 1 January 1946. The indications are that about 4,000 Army prisoners were recovered from the Japanese between 1 January and 1 June 1945, and about 12,000 between 1 June and 1 December, or 16,000 in all. It is relevant, but by no means exonerating to the Japanese, that during the war their own civilian and military personnel were often treated in a fashion judged inhumane by American standards. The difference in cultural values with respect to the care of the ill, the infirm, and the militarily non-productive is a factor to be borne in mind.

The war against Japan ended so suddenly that there existed no comprehensive plan for assessing the medical status of recovered Army personnel to provide the basis for an exact accounting. From the moment of release to their arrival in the Z/I repatriated prisoners were subject to so many dietary, therapeutic, and other environmental changes that the conclusions which may be drawn as to their condition depend upon the point where they were seen. Whether a satisfactory accounting will ever be available now seems doubtful, so that this preliminary report is based on such samples of data as are presently available. The U.S.S. HAVEN, a Navy AH, processed and screened medically 9,000 Allied prisoners of war recovered from camps on Kyushu during September 1945, 15 percent of whom were U. S. military personnel. The 42nd General Hospital processed 17,500 RAMPS between 4 and 21 September from Honshu and Hokkaido, perhaps 40 percent being U. S. nationals. A third sample pertains to 31,000 Allied prisoners received in replacement depots in the Manila area from Japanese prisons in Japan, Korea, and Manchuria. This group is said to exclude about eight percent who were handled through medical channels. A fourth sample consists of 4,600 recovered U. S. military personnel seen at West Coast debarkation hospitals from two to eight weeks after their release, when their conditon was already considerably improved.

Report of U.S.S. HAVEN

It is difficult to generalize on the health of the men on their recovery in September, but on the whole they were in remarkably good condition and only a few were in desperate condition. The Japanese prisoners, accustomed to a rice diet, had fared better than the British and the Americans. The U.S.S. HAVEN found it necessary to hospitalize for treatment or further observation about 10 percent of the total recovered. Stretcher-teams were needed, but the great majority of the men were vigorous enough to permit the efficient use of an examining maze from which they emerged with a good prognosis as to their future health, albeit needing a great deal of both physical and emotional rehabilitation and adjustment. The extreme emaciation and wasting seen in prisoners in certain German concentration camps were not found. The precise number who died subsequently is not known, but there were three

STATUS ON 1 JANUARY 1946 OF ARMY PERSONNEL CAPTURED, INTERNED, AND MISSING IN EUROPE AND THE PACIFIC SINCE 7 DECEMBER 1941



* About 25 percent of the missing (primarily in the Pacific) were still carried as such on 1 January 1946, and four percent of the captured (primarily in Europe) had not been located.

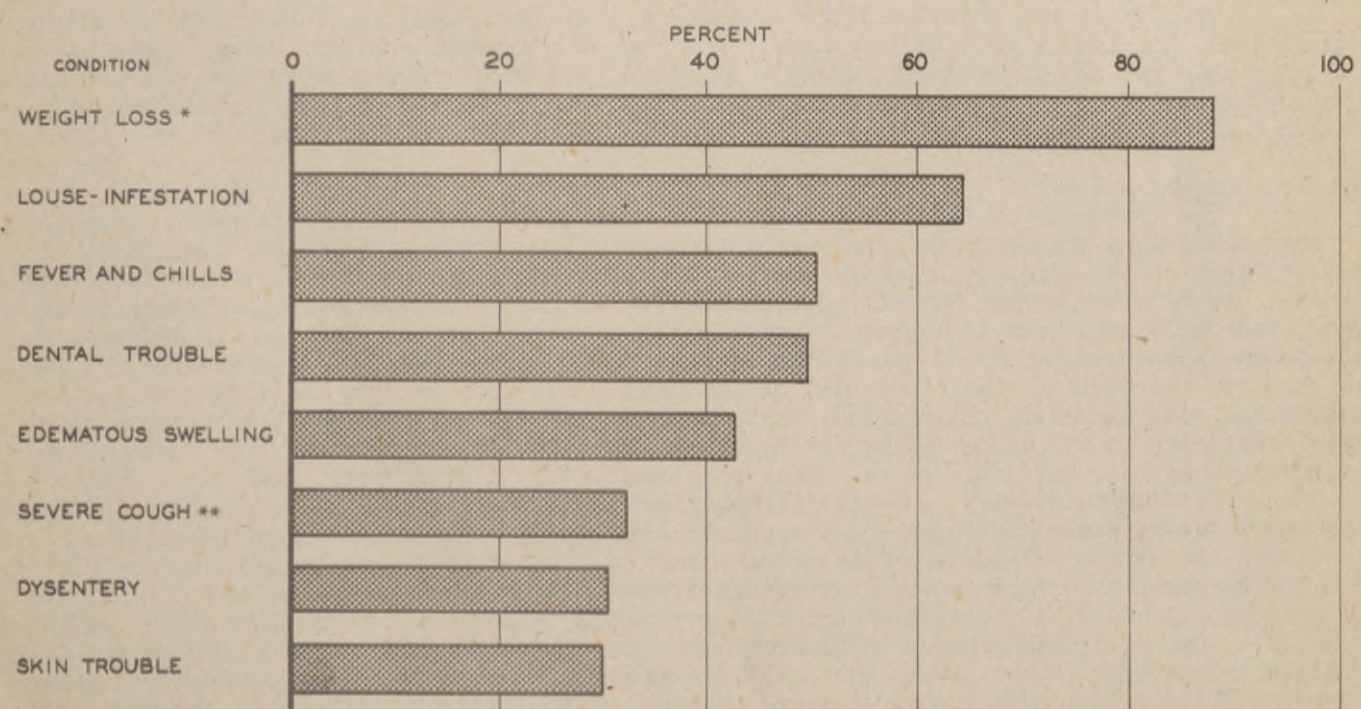
** Western and Middle Pacific commands and their predecessors. Asiatic theaters and Strategic Air Force are excluded.

MEDICAL STATUS OF RAMPS RECOVERED FROM THE JAPANESE (Continued)

deaths among patients while they were on the U.S.S. HAVEN. According to the men themselves the most common points in their medical histories while imprisoned were those shown in the following chart. In most instances the conditions noted were even more prevalent than reported and the criteria employed were such as to rule out mild conditions. For example, many men reported no dental trouble but their teeth showed evidence of neglect and decay, a considerable number of cases of mild dysentery must have been excluded, and chills and fever were recorded only if recurrent or lasting more than a few days. According to their own testimony, necessarily based on a limited understanding of their symptoms, and thus likely to be understated, the percentages of those hospitalized who had acquired various diseases while imprisoned were 66 for beriberi, 58 for dysentery, 43 for malaria, 20 for skin disorders, 19 for pneumonia, 14 for pellagra, and six for tuberculosis. Although only nine percent reported malnutrition, actually more than 90 percent of the hospitalized patients had malnutrition in some form. On the other hand, beriberi is sufficiently well understood to make its reported incidence fairly accurate. The primary cause of admission was beriberi in 35 percent, malnutrition and debility in 12 percent, and tuberculosis in eight percent.

Dental decay, weight loss, edema, and other evidence of nutritional deficiency disease were among the most prevalent findings. Respiratory infections had been very common, and both the morbidity and mortality from pneumonia had been very high. Tuberculosis had also been very prevalent. The prisoners had been subjected to the rigors of cold, damp winters without proper clothing or housing, had been debilitated by improper diet and other causes, and had in the main come from tropical or subtropical climates. One sixth had been in more than five camps. Malaria had been rife in the Philippine camps and in Burma and Thailand, but by the time of liberation it had ceased to be an important factor because of treatment and the natural tendency of the disease to die out unless sustained by repeated infection. The high percentage of louse-infestation measures the insanitary conditions of living in the Kyushu camps. Upon recovery it was plain that many individuals already suffering from nutritional and deficiency disturbances had gorged themselves on food dropped on the prisons by B-29's after V-J Day, with further aggravation of symptoms. A striking observation was the absence of psychoneurosis in the large group processed. There were only two frank psychotics requiring security accommodations. The prisoners themselves appeared to believe that the more susceptible among them had developed psychic difficulties early in their confinement when their captors were most brutal, and that they shortly fell victims to their incapacity. Death rates generally were 6 to 10 times normal expectancy in well-established camps, entirely apart from the large numbers of deaths even prior to arrival at camps.

PERCENTAGE OF 9,043 RAMPS REPORTING VARIOUS MEDICAL CONDITIONS DURING IMPRISONMENT



* Exceeding 10 pounds.

** Lasting more than three weeks and mostly caused by asthma, chronic bronchitis, prolonged irritation from dust in the mines, or pulmonary tuberculosis. Only 3.2 percent reported raising blood.

MEDICAL STATUS OF RAMPS RECOVERED FROM THE JAPANESE (Continued)

Report of 42nd General Hospital

The 42nd General Hospital was aboard the U.S.A.H.S. MARIGOLD which docked at Yokohama on 30 August, and processed 17,500 RAMPS between 4 and 21 September. Of the 11,800 whose records were complete 43 percent were U. S. nationals. The findings were generally similar to those reported by the U.S.S. HAVEN. Of the total number processed nine percent required hospitalization and 91 percent were evacuated as non-patients. About 15 percent of those hospitalized, or 1.4 percent of the total processed, had tuberculosis.

Report of Replacement Depots in Manila Area

The replacement depots near Manila received 31,000 liberated Allied military prisoners from the Japanese mainland, Formosa, and Manchuria. This number excludes eight percent handled through medical channels. According to their report fit personnel had been worked 12 to 14 hours daily with a rest-day on the 10th day when parades or humiliation parades necessitated hours of standing. Food and clothing had been inadequate, and there had been no provision for extremes of temperature. Medical supplies had been grossly deficient. Histories taken from these men showed dysentery, malaria, beriberi, and diarrhea to have been most prevalent with a significant increase in chest illness. A sample study yields the following proportions of men reporting various diseases as having developed during their confinement: beriberi 50 percent; malaria 41 percent; diarrheal disease 68 percent; and chest illness (chiefly pneumonia and pleurisy) 25 percent.

The first groups to arrive presented a picture of severe starvation, with sunken eyes, prominent cheek-bones, distended abdomens, and marked atrophy of all muscles. Nutritional edema and beriberi were very common. Succeeding groups presented a much improved picture. Vitamin deficiencies were common. Beriberi was present in all groups. Skin lesions were common. Nearly all personnel had chronic coughs. In camps where statistics were kept about 50 percent of the recorded deaths had been attributed to pneumonia. Approximately 25 percent suffered some loss of visual acuity. Parasitic infestation, e.g. hookworm, was practically universal. Impairment of hearing was often noted. Cases of psychoneurosis were rare. Only occasional cases of depression were noted. Many individuals appeared to have formed small, strongly-knit groups which shared food and the pressures of prison life. From the statements of prisoners it was inferred that early in their imprisonment a considerable number of men developed severe psychoneuroses and possibly psychoses which rendered them so unable to adjust to the hardships of prison life that they perished. Surgical conditions were judged few in number in the light of the brutal treatment and the dangerous working conditions in mines, furnaces, and factories. Most fractures had been satisfactorily treated but there were outstanding exceptions. Some of the prisoners had been burned by the atomic bomb explosions.

Upon their repatriation Allied prisoners were given rest, suitable food, vitamins, and medical supplies which started them on the road to recovery. Weight losses began to be quickly made up, the average gain being 20 pounds in the first three weeks when the men had stupendous appetites. The vast majority were felt to be in need of prolonged rest, rehabilitation, and retraining before they would be capable of full-duty assignments.

Surgeon General's Survey

The testimony of the studies made at the earlier points in the chain of evacuation is corroborated by the findings among patients seen in West Coast debarkation hospitals, although many of the signs of malnutrition and the like had been alleviated by the time they arrived there. The Surgeon General appointed a board of officers to survey the health of repatriated prisoners late in August. About 4,600 men were carefully studied. In addition to providing systematic confirmation of the earlier medical findings the observations are important for the further light they shed on the psychiatric problem. As was found earlier the men themselves expressed the opinion that the less stable among them had been eliminated by their inability to adjust to the hardships of prison life. When examined they were quiet, reserved, cheerful, and cooperative. They were definitely a group apart from other patients in being less demonstrative, awkward at mess, careless about sanitation, somewhat docile, and above average in intelligence and apparent adjustment. Their histories reveal food to have been the primary focus of their prison life, all other interests being subordinated to it. There was little spontaneous expression of hostility toward the Japanese but a tremendous hostility could be elicited on probing more deeply. Only five psychotics and 34 psychoneurotics were diagnosed among 4,600 examined. Some investigation was made of the foundations of resistance to the great emotional stress of imprisonment with its starvation, physical brutality, and constant fear of death, but only inconclusive results were obtained. It seemed, however, that men with a strong will to live survived better than others and that those who gave up just died. Examiners were of the opinion that the men might later have difficulties in adjusting to normal life, despite their general lack of anxiety when seen.

DISEASE AND INJURY

HEALTH BRIEFS

Louse-Borne Typhus

The virtual absence of louse-borne typhus in U. S., British, and French occupied zones in Germany during recent months, following upon the epidemic conditions of the previous winter season, represents a great victory for modern methods of typhus control in Allied hands. Although the incidence was declining rapidly in May and June of 1945 (see HEALTH for 30 June 1945), there was ample reason to expect that it might be serious the following winter. However, only sporadic cases have been reported through early January and it may now be assumed that this low incidence will continue to prevail. The control program which so dramatically halted the Naples epidemic of 1943-1944 now has an even more remarkable parallel.

During November outbreaks of louse-borne typhus were reported among civilians on Hokkaido, where the disease had been endemic since 1942. Except for one instance, an officer of the United States of America Typhus Commission engaged in typhus control activities in Hokkaido, no cases of typhus have occurred among U. S. troops who are immunized against this disease. Following plans laid down in the theater for prevention and control of typhus in the early fall of 1945, travelers between Hokkaido and Honshu are being routinely deloused and control measures have been instituted in the mining areas heavily affected.

Tuberculosis

In view of the extremely low incidence of tuberculosis during the war, a record made possible by the systematic x-ray screening of all inductees and others entering the Army, it comes as a surprise to many to learn that the provisional Z/I rate for December 1945 is the highest of the war, and about four times the average for 1944. However, it seems clear that the rise in the rate is largely an artifact of rapid demobilization. An analogous increase occurred after the end of World War I and a similar phenomenon had been forecast for World War II (see HEALTH for October 1944).

At induction examinations about 12 per 1,000 were rejected for tuberculosis throughout the war. This process, while excellently conceived, was admittedly imperfect in administration. If the error was one of only ten percent the screen might well pass about 1.3 cases of minimal or early tuberculosis per 1,000 inductees. If it be assumed that half of these would be found later during their military service, either on subsequent x-ray screening or on their development of symptoms necessitating medical care and thus leading to a diagnosis of tuberculosis, there would remain about 0.65 cases per 1,000 strength. If now one demobilized 1,000,000 men in a month, as was done in October, November, and December, one would expect to uncover 650 cases, which is enough to raise an expected rate of 1.0 to 4.5 on the basis of December strengths. The actual rate was 4.3 per 1,000 men per year for December.

The above illustration is hypothetical, as the true incidence of tuberculosis is unknown. However, it is known that about 7 per 10,000 examinees have been reviewed for suspected tuberculosis on the basis of x-ray findings. If one assumes that current Z/I rates should be equivalent to those of 1944 i.e. 1.0 per 1,000 per year, and computes the expected cases for 1945 on this basis, the reported number is in excess by 2,100 admissions. Known cases of suspected tuberculosis among men processed at separation points, bases, and centers exceed 2,800 for the year, a considerable proportion of which must be in the admissions. How many have been recorded as admissions to sick report, however, is not known accurately. Without such information it cannot be stated that tuberculosis is not on the increase apart from demobilization, but if any increase is occurring it probably is small. That some increase may be taking place is suggested by the known exposure of troops to tuberculosis abroad.

Hepatitis

During the combat period in the Mediterranean Theater admission rates for infectious hepatitis rose seasonally each fall to a high level, especially among combat troops. In 1944, for example, weekly theater rates of 11 to 13 during August rose to 20 to 25 per 1,000 men per year in September, to 30 to 60 in November, and to 91 for the week ending 16 December. Fifth Army troops had even higher rates, the peak being 211 for the week ending 16 December 1944. During the past fall season the increase has been very slight. For the theater the average monthly admission rates are 12 for July, 17 for August, 18 for September, 18 for October, and only 12 for November and December. Although divisional and other tactical strength in the theater has declined rapidly since 1 August, the present low rates cannot be explained solely on the basis of troop composition, but indicate substantial improvement in the environmental situation of remaining troops.

HEALTH BRIEFS (Continued)

In the Western Pacific, where admissions reached 82 in May, the rate has fallen very rapidly to 29 in September and 15 in October. In China admission rates for hepatitis have been in excess of 20 since July and rose to 56 in December, although they have not exceeded seven in the India-Burma Theater. In the Z/I the admission rate has gradually risen from 1.0 in January 1945 to 4.1 in January 1946, chiefly because of the return of large numbers of troops from overseas.

Death Rates in the Z/I

During January death rates continued to follow the trends noted in HEALTH for December. The provisional rate of 0.7 per 1,000 men per year for nonbattle injury establishes a new low for the war period, while the uncorrected rate of 1.2 for disease sets a new high. Approximate adjustment of the latter for declining strength, as explained in HEALTH for December, reduces the provisional rate to 0.7. Before the rise in 1945 the level had been about 0.6 deaths from disease per 1,000 men per year.

Neuropsychiatric Admission Rates

The declining trend in neuropsychiatric admissions mentioned in previous issues (cf. HEALTH for November) continued through November and December in overseas theaters and at home. The December rate of 21 for Z/I troops is the lowest of the two-year period recorded on the Statistical Health Report. In the European Theater the rate is down to five from its peak of 85 in November 1944 and its pre-invasion level of 20 to 30 admissions per 1,000 men per year. The latest rates are shown in the table below both as such and as percentages of the respective average 1944 rates.

NEUROPSYCHIATRIC ADMISSIONS PER 1,000 MEN PER YEAR

Command	Month	Rate	Rate as Percentage of 1944 Average
United States	December	21	58
Mediterranean	December	14	33
Alaskan	December	12	100
Latin American	December	11	50
Africa-Middle East	December	11	44
Middle Pacific	December	10	37
European	December	5	10
Asiatic	November	11	55
Western Pacific	October	15	31

Scabies

Scabies, an itching and inflammatory condition of the skin caused by the itch mite, is a distinctly minor disease under modern standards of cleanliness and personal hygiene. However, among troops in both the Mediterranean and European Theaters the incidence of this infection has been comparatively high. Admission statistics are not reliable for this infection since most cases are treated on a duty status.

It is recognized today that bodily contact is the primary means of transmission of scabies. Crowded conditions found in barracks, on transports, and on trains, especially when the temperatures are favorable to the migration of the scabies mite, lead to rapid spreading of the disease. Contact with prostitutes and "pick-ups" in Europe is also considered an important source of infection. To limit the spread of this infection among troops and civilians The Surgeon General on 9 January 1946 published WD Memorandum 40-46 on the control and treatment of scabies. This pamphlet stresses the necessity for complete treatment of the individual infected with scabies and outlines the methods for eradicating the disease.

While clothing and bedding are of secondary importance in the transmission of scabies, disinfection of such items is important. It should be done at reception and separation centers, at hospitals, and other military installations where scabies is detected.

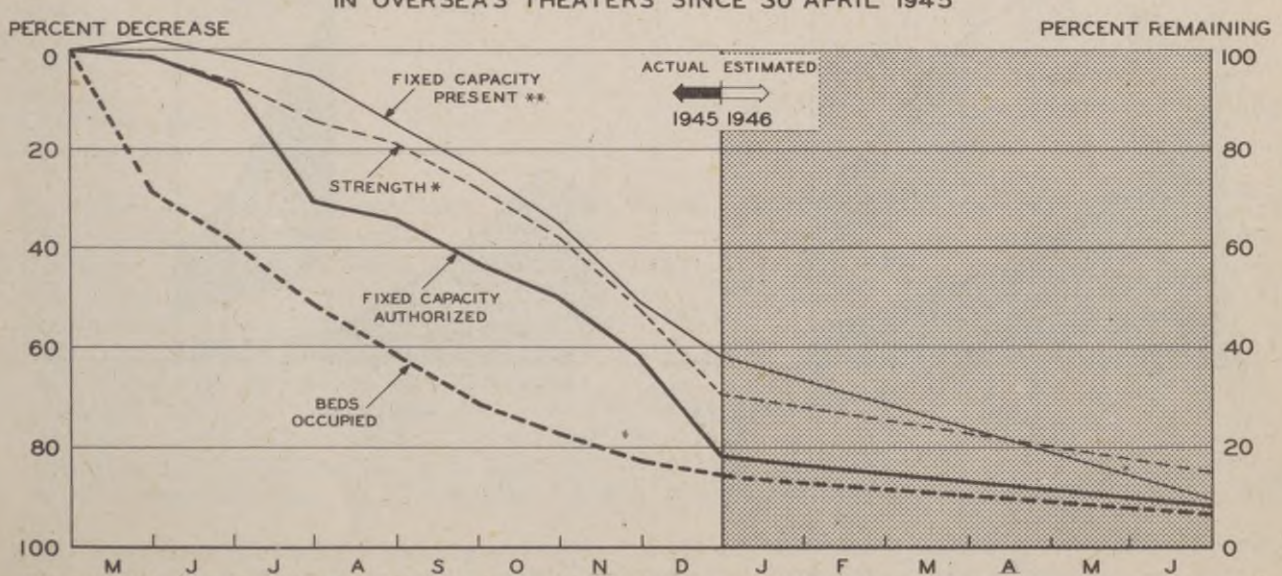
HOSPITALIZATION OVERSEAS

As a result of marked reductions in percentage authorizations for bed capacity in overseas theaters, discussed in HEALTH for December, the average bed authorization for all theaters fell from 5.5 percent of strength on 30 November to 3.9 percent on 31 December. As a consequence of this reduction of 29 percent, and of the decline of 34 percent in the strength for which hospitalization was authorized, the number of beds authorized on 31 December was only 66,071, 53 percent fewer than at the end of November.

The T/O capacity of units present in the overseas theaters does not yet provide an adequate or reliable guide to medical personnel present because so many units are entirely out of operation or have only skeleton strengths remaining. This will continue to be true throughout the period of demobilization and until the overseas forces stabilize at occupation levels at the middle of 1946 according to present estimates. As a result, data on the capacity and occupancy of overseas hospitals during this transition period are less meaningful than formerly when theater strengths were more stable and the pressure was in the direction of speedy, functional employment of units.

The chart below shows the progress which has been made in adjusting bed authorizations and bed capacity in all overseas theaters to the decreased requirements consonant with declining strength and the lessened bed requirements of troops under more nearly garrison conditions. Strengths and numbers of beds authorized, occupied, and present have been expressed as percentages of the comparable values for 30 April 1945. All the series have been estimated for 30 June 1946 which is the date when troop and unit deployment will again be relatively stable. Between 30 April and the end of 1945 the greatest decline in any of these series occurred in beds occupied which fell by about 85 percent. The number of beds authorized declined by 82 percent. Except in July and December, when theater authorizations for fixed beds were revised downward, the number of beds authorized has decreased at about the same rate as strength. However, the net decline in strength is only 69 percent. The two upper panels on the next page compare the decreases in some of these elements and in the number of Medical Corps officers in the two major overseas theaters since the approximate dates of cessation of hostilities in the respective areas. In Europe bed occupancy has declined by 92 percent since 30 April, while T/O capacity has fallen by 73 percent and the number of Medical Corps officers by 77 percent in the last eight months of the year. In the Pacific the declines have not been as great but the rate of decline does compare favorably. Between 31 August and 31 December T/O capacity fell by 55 percent, bed occupancy by 68 percent, and the number of Medical Corps officers by 44 percent. In a similar four-month period after 30 April these percentage declines were 26, 79, and 36 in the European Theater for T/O capacity, bed occupancy, and Medical Corps officers respectively. The counts of Medical Corps officers are those which appear in The Adjutant General's report STRENGTH OF THE ARMY and include all personnel assigned to the theaters. Inasmuch as doctors enroute to the Z/I are included as assigned until debarked in the United States these percentages are higher than those which give only personnel actually in the theaters.

DECREASE IN STRENGTH AND BEDS PRESENT, AUTHORIZED AND OCCUPIED
IN OVERSEAS THEATERS SINCE 30 APRIL 1945



* Strength subject to authorization. ** Includes operating nonfixed capacity after 30 November 1945.

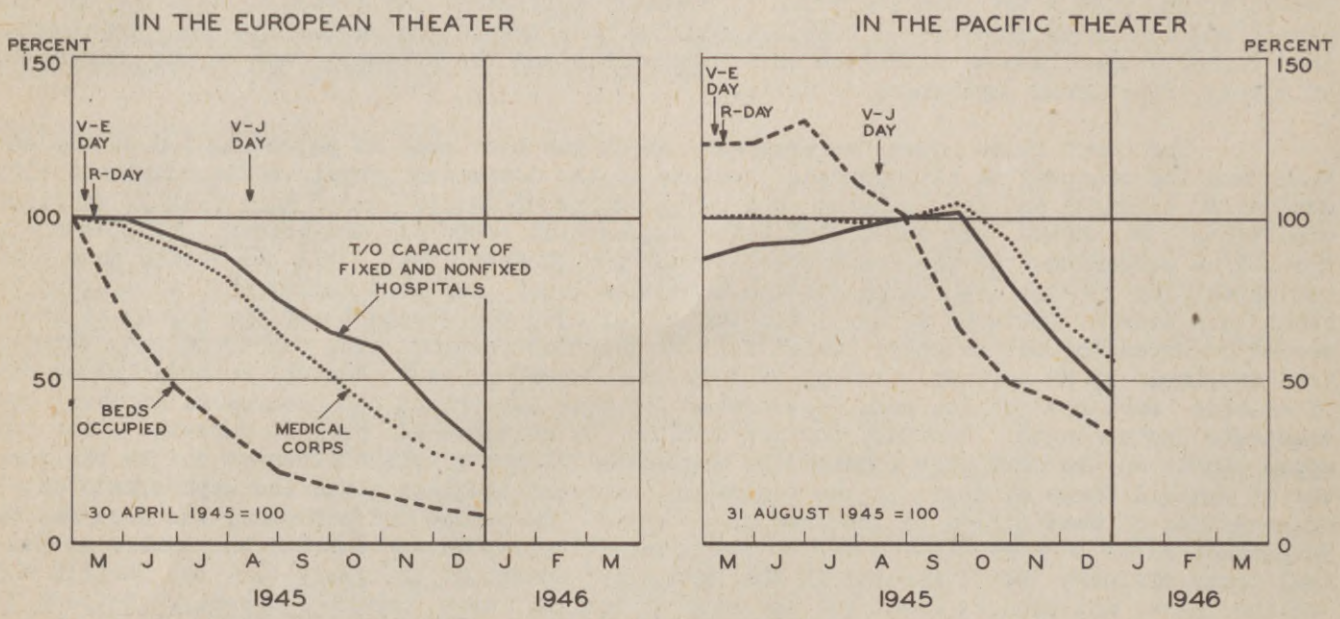
HOSPITALIZATION OVERSEAS (Continued)

Another measure of the speed of demobilization of personnel and facilities is shown in the panels at the bottom of the page. There the absolute number of beds in fixed and nonfixed hospital units remaining in the theaters is shown with a distinction between those actually operating and those not operating, and together with the number occupied at the end of each month.

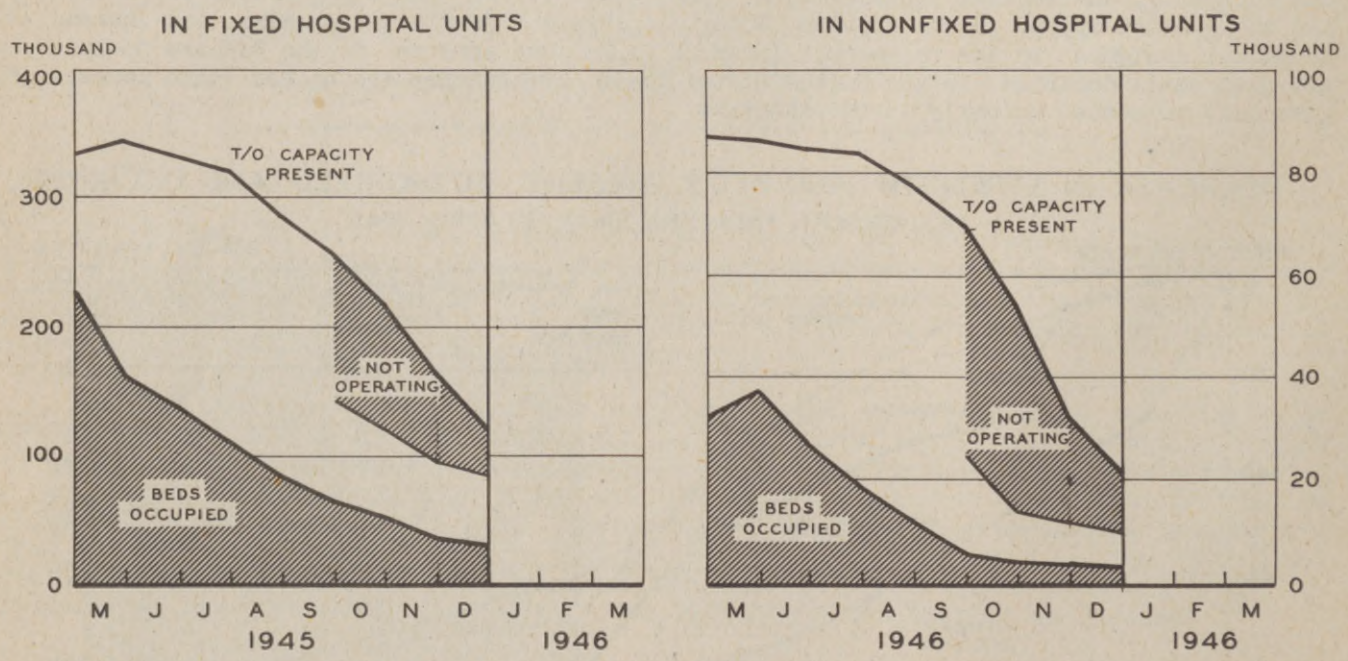
Of the 247,000 beds in field, station, general, and convalescent hospitals in

DECLINE IN MEDICAL STRENGTH AND HOSPITAL CAPACITY AND OCCUPANCY

DOCTORS, PATIENTS AND BEDS AS PERCENT OF NUMBER OVERSEAS ON BASE DATE



HOSPITAL CAPACITY AND PATIENTS REMAINING IN ALL OVERSEAS THEATERS



HOSPITALIZATION OVERSEAS (Continued)

Europe, the Mediterranean,, and the Africa-Middle East on 30 April 1945, 65 percent had been returned to the Z/I by 10 February 1946, an additional 14 percent had been or were to be inactivated in the theater, and somewhat less than one percent were under directive to return. In contradistinction to the large proportion of units returned to the Z/I from these areas, the equivalent of 64 percent of the 118,000 beds which were in the Pacific and Asiatic theaters on 31 August had been or were to be inactivated overseas, only one percent were under directive to be returned to the Z/I, and five percent had been returned to the Z/I and inactivated here by 10 February. By this date the War Department had received notice from the Pacific that 66 percent of the beds in units scheduled for inactivation in the theater had been so disposed of, and from the European theaters that 83 percent of their beds in this category had been deactivated.

Certain items in the table below have been included more to preserve the continuity of the series reported in previous issues than for their relevance to the current picture. The abrupt fall in strength and the presence of many incompletely staffed hospitals in pro-

BEDS AVAILABLE AND OCCUPIED a/
Number of Beds, 31 December 1945

Theater	W. D. Authorization	T/O Fixed and Operating Nonfixed Present c/	Operating		Occupied d/
			Number d/	Percent of Beds Present	
ALL THEATERS	66,071	128,925	94,801	73.5	33,011
American b/	1,882	3,475	3,980	114.5	823
European	26,683	59,825 e/	35,161 e/	58.8	12,775 g/
Mediterranean	2,177	3,800	3,400	89.5	1,200
Pacific	32,191	56,125 f/	47,550 f/	84.7	16,989 h/
Asiatic	2,638	5,150	3,650	70.9	1,099
Africa-Middle East	500	550	1,060	192.7	125

Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) j/	W.D. Authorization (Percent)	Bed Capacity		Beds Occupied as		
			Number Present	Operating	Percent of Strength	Percent of Number Present	Percent of Operating
ALL THEATERS	1,687	3.9	7.6	5.6	2.0	25.6	34.8
American b/	63	3.0	5.5	6.3	1.3	23.7	20.7
European	667	4.0	9.0	5.3	1.9	21.4	36.3
Mediterranean	54	4.0	7.0	6.2	2.2	31.6	35.3
Pacific	805	4.0	7.0	5.9	2.1	30.3	35.7
Asiatic	85	3.1 i/	6.1	4.3	1.3	21.3	30.1
Africa-Middle East	13	4.0	4.4	8.5	1.0	22.7	11.8

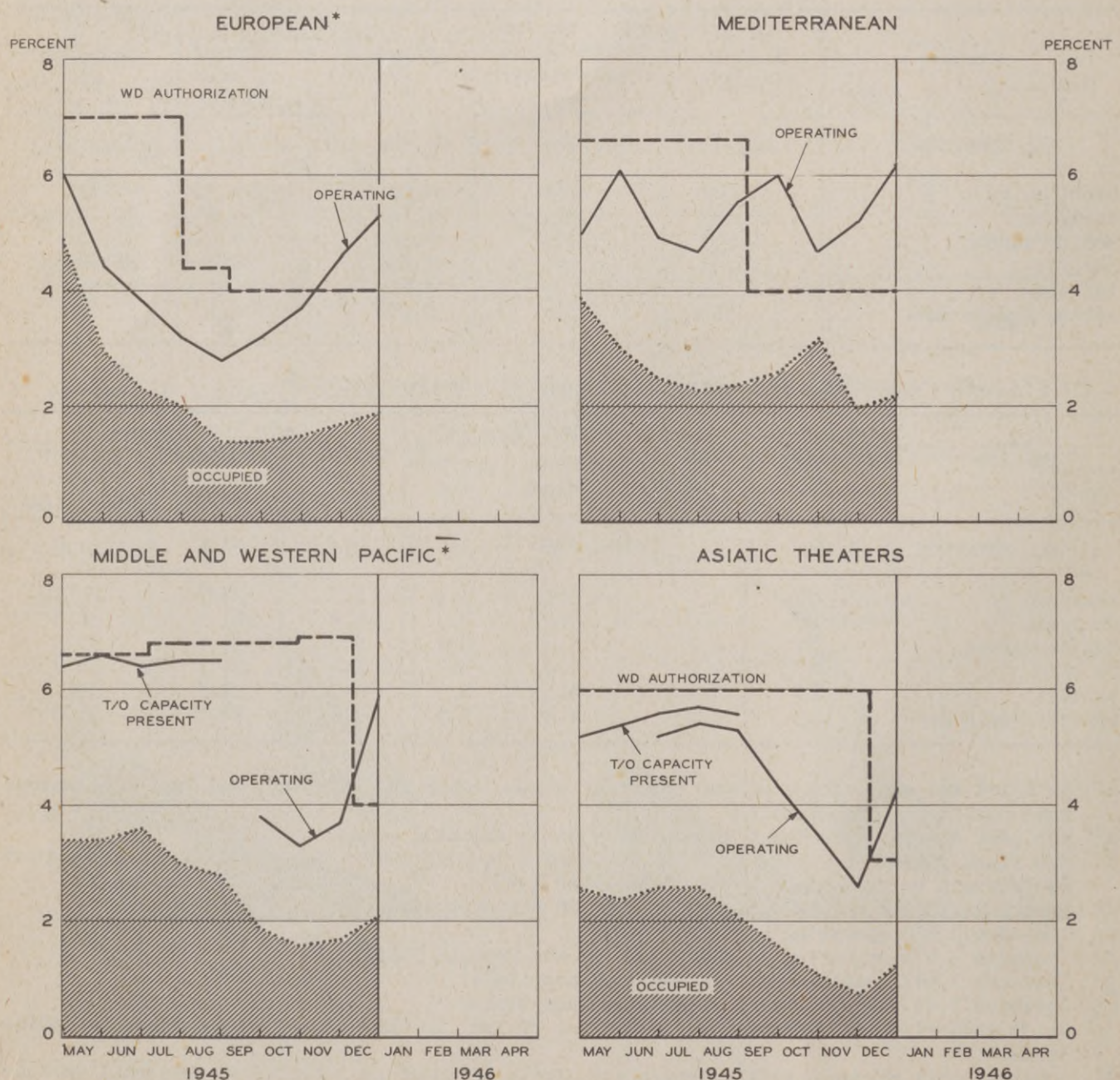
a/ In fixed and operating nonfixed hospital units. Only the European and Pacific theaters have nonfixed hospital units.
b/ Includes Alaskan Department and excludes North Atlantic bases.
c/ T/O fixed present reported by T.L.O.S. dated 1 January 1946. Operating nonfixed reported by theaters telegraphically for 28 December 1945.
d/ Reported by theaters telegraphically for 28 December 1945.
e/ Includes 5,625 operating nonfixed beds.
f/ Includes 3,675 operating nonfixed beds in the Western Pacific.
g/ Includes 1,647 beds occupied in nonfixed hospitals.
h/ Includes 1,237 beds occupied in nonfixed hospitals.
i/ Joint authorization. Percentage is 4.0 for troops in China, and 3.0 for those in India-Burma.
j/ Includes only strength within geographic limits of theaters. Excludes personnel enroute to or from the theaters. No allowance is made for Philippine Army strength.

HOSPITALIZATION OVERSEAS (Continued)

cess of shutting down combine to produce a possibly misleading picture. For the European and Pacific theaters, the only commands having nonfixed hospitals, operating nonfixed beds have been added to the fixed in the table since the authorizations for beds now cover all fixed units and the professionally staffed nonfixed units. Of the 128,925 beds present overseas on 31 December, all but 9,300 were in fixed-type units, and only 74 percent of the total number were operating. In addition, 35 percent of the operating beds were occupied. In the two major theaters, the European and Pacific, occupied beds represented only 36 percent of operating capacity on 31 December in comparison with the 30 November figures of 37 percent for Europe and 45 for the Pacific. In the Asiatic theaters all measures based upon strength increased during December because of the cancellation of the authorization for the support of Chinese troops in India-Burma. In the following panels, the recent changes in bed authorizations, operating bed capacity, and beds occupied are shown for the major theaters. In each panel the line for total T/O capacity present has been removed after V-E or V-J Day, whichever is appropriate.

FIXED HOSPITALIZATION IN OVERSEAS THEATERS

BEDS AS PERCENT OF STRENGTH



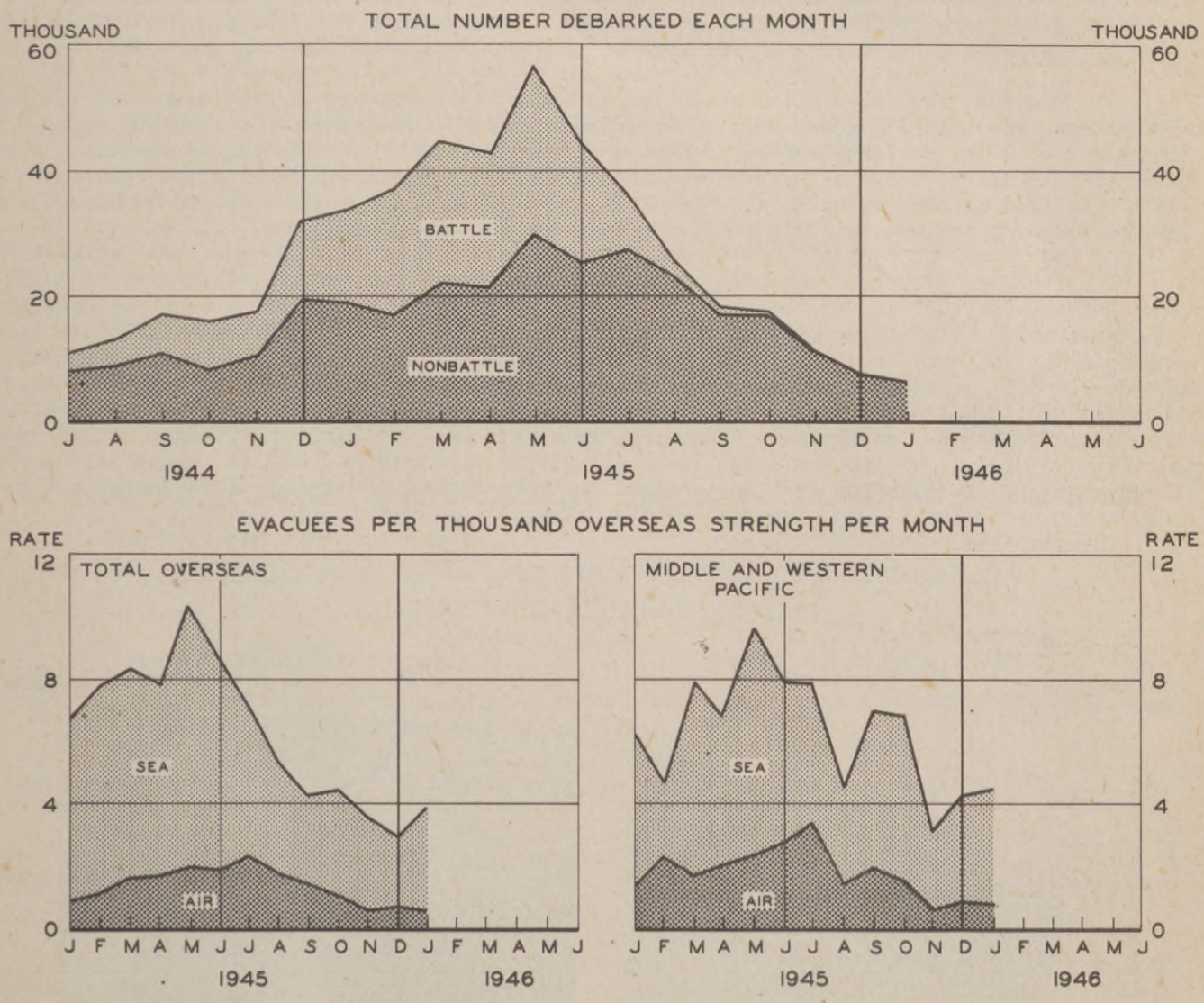
* Professionally staffed nonfixed hospitals included in European beginning 30 November and in Middle and Western Pacific beginning 31 December.

TREND OF EVACUATION FROM OVERSEAS

Continued decline characterizes the trend of evacuation from overseas, the provisional total for January being 6,500, lower than any total since July 1943. However, there was some increase in patients from the European Theater, about 2,100 being debarked in January in comparison with only 800 in December when the lift was exceptionally small. About 3,600 patients were received from the Pacific. About 15 percent of the patients arrived by air, rather lower than in previous months. The total of about 1,000 is lower than any air lift since April 1944.

Strengths are declining so rapidly in overseas theaters as to introduce extraneous variation into evacuation rates per 1,000 strength. Since the troop strength overseas declined more rapidly than patients during January, the evacuation rate rose from 3.0 to 3.8 per 1,000 per month. For the European Theater the provisional rate is 3.2 while for the Pacific it is 4.5.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS



HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR

During the month of January the patient load in the convalescent hospitals remained almost constant at 11,500, while patient load in the general hospitals decreased by slightly more than 6,000 to 105,500.

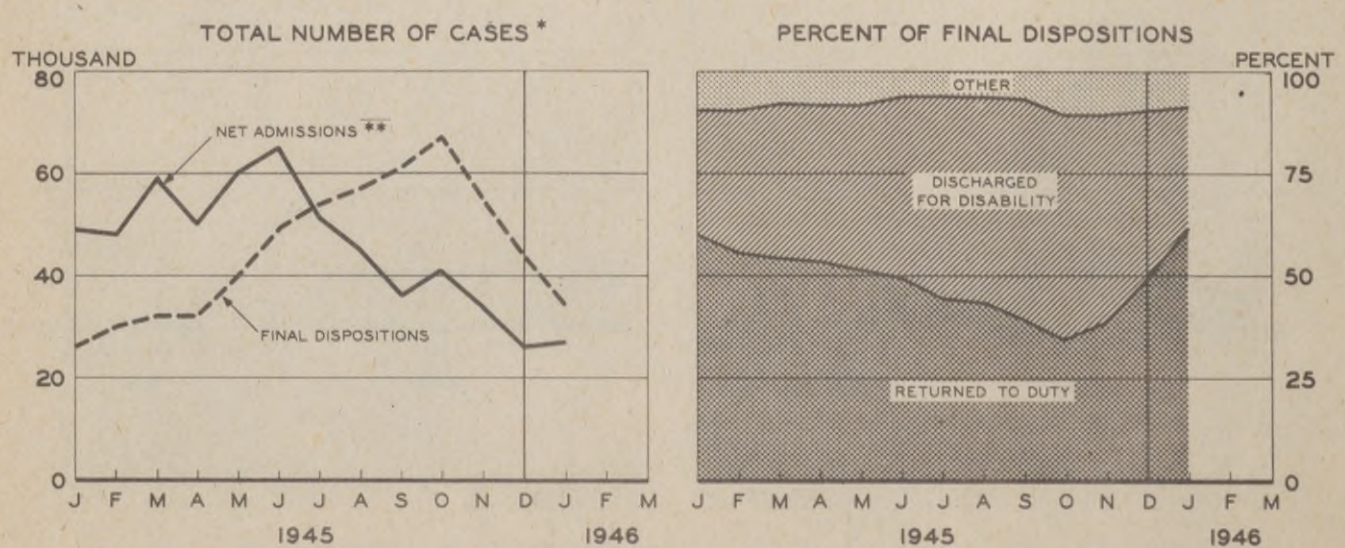
This small reduction in patient load in the general hospital system should be viewed in relation to the very large reduction in the number of active operating beds available to the Medical Regulating Officer. As of 1 January, more than 34,500 general hospital beds and almost 4,000 convalescent beds were blocked for the receipt of new patients. With the retardation in the rate of dispositions occasioned by the Christmas holidays, the entire reduction in patient load in the general hospitals took place in the blocked hospitals since the few vacant beds that arose in the active hospitals were needed to accommodate patients arriving from overseas. By the end of the month it had not yet been possible to initiate the transfer of long-time patients from the closing hospitals to installations which are remaining active beyond 31 March.

The net reduction of approximately 6000 in patient load is largely accounted for by a decrease of less than 7,000 in overseas patients, and an offsetting increase of 400 in Veterans" Administration beneficiaries. Since there were approximately 6600 patient evacuees processed through the debarkation hospitals during the month, there were only 13,500 overseas patients disposed of from the general hospital system. The sharp increase in the ratio of the number of patients returned to duty over the number disposed of by CDD from the general hospital system reflects the decrease in the number of overseas patients disposed of and the heavy predominance of Z/I over overseas type of patient dispositions during the month.

Despite the substantial reduction in troop strength served, the number of Z/I patients remaining in the general hospital system remained almost constant. The stability of this portion of the patient load is accounted for by two factors: the higher seasonal incidence of admissions; and the substantial increase in the number of tuberculous patients in the specialized centers owing to the inability of the Veterans' Administration to accept the transfer of such patients at this time.

The number of Veterans' Administration beneficiaries hospitalized in Army installations increased by 400 during the month of January. Although the number of such patients has been constantly increasing since August 1945, when there were 665 Veterans' Administration beneficiaries in Army hospitals, last month's increase was by far the sharpest and presages more substantial increases in the future. The War Department has agreed as a temporary emergency measure to make available 10,000 bed credits requested by the Veterans' Administration in three installments of approximately 3,300 beds each by 1 March, 1 July, and 1 October respectively, subject to the availability of qualified personnel. Detailed negotiations for the arrangement of these bed credits, as well as the necessary personnel adjustments, are now under way between The Surgeon General and the Veterans' Administration.

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)

Personnel stringencies resulting from the demobilization of Medical Department personnel at the fastest possible rate compatible with the remaining medical mission limit the number of Veterans' Administration beneficiaries that can be accommodated in Army-staffed hospitals. However, unstaffed facilities are being made available to the Veterans' Administration as soon as they become surplus to the needs of the Army and at a faster rate than they can be absorbed by the Veterans' Administration. To date, the Veterans' Administration has expressed interest in approximately 20 general hospitals; it is already operating 3; and it is definitely committed to the acceptance of 5 additional hospitals by 31 March. Three of these hospitals - McGuire, Vaughan, and Birmingham - are paraplegia centers where Army patients have been concentrated, special facilities for the treatment and care of paraplegics established, and personnel trained. To achieve continuity of operations and the retention of the bulk of civilian personnel on their jobs, plans have been prepared for teams of key Veterans' Administration personnel to enter these hospitals approximately one month before the official dates of transfer.

In the station and regional hospitals, beds authorized were reduced by approximately 3,000 during the month while patients remaining actually increased by 1000. Separate comparisons for the regional and station hospitals are not very meaningful at this time, since eight regional hospitals were reduced to station hospital status under the provisions of Section II, Circular 22, WD, dated 23 January 1946, amended by Section IV, Circular 40, WD, 8 February 1946. It is noteworthy, however, that if the station hospitals under the jurisdiction of the Chief of Transportation were excluded from the data, the percent constituted by patients remaining in station hospitals relative to effective beds would be almost 100, eliminating thereby any excess authorization in bed capacity.

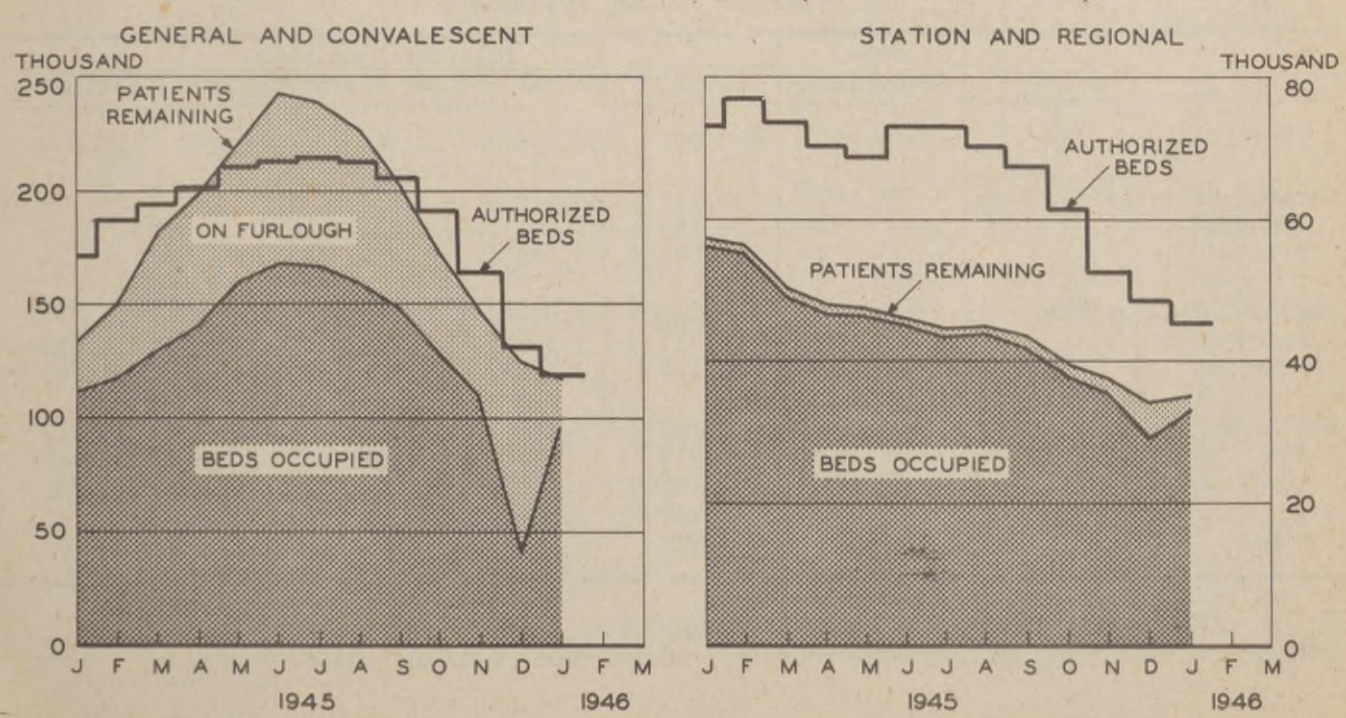
Reductions in operating personnel assigned to the hospitals kept pace with reductions in requirements. As in December, excesses of assigned personnel over requirements exist, concentrated largely in the station and regional hospitals. The revised separation criteria that became effective on 1 February combined with an expanded surplus provision should materially reduce these excesses. Shipments of rotational personnel overseas now being planned will also contribute to the elimination of these surpluses.

Summary:

a. The retardation of dispositions during the Christmas holiday season has resulted in a tight bed situation.

b. The second phase of the contraction of the general hospital system got under way with the blocking of fifteen general hospitals and four convalescent hospitals. However, the transfer of long term patients to hospitals remaining open could not be initiated.

HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITALS, 1945-1946



HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

c. Reductions in bed authorizations more than kept pace with reductions in patient load in the general and convalescent hospitals. In the station and regional hospitals, authorized bed capacities were reduced while patient load increased.

d. Reductions in assigned personnel kept pace with reduction in requirements. Excess personnel are now being eliminated by the application of the new separation criteria and the broadened surplus provision.

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR
End of January 1946

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages c/		
	Authorized	Effective a/	Number b/	Percent of Effective Beds		MC	ANC	Total
Total	165,316	150,443	152,297	101.2	128,078	-1,110	-1,349	-10,340
General	107,586	103,321	105,459	102.1	85,636	-519	-753	-2,491
Not Blocked	81,989	77,724	78,678	101.2	62,860	-410	-338	1,301
Blocked d/	25,597	25,597	26,781	104.6	22,776	-109	-415	-3,792
Convalescent	11,890	11,890	11,602	97.6	9,308	8	-8	-1,298
Not Blocked	9,690	9,690	9,614	99.2	7,726	-3	-15	-297
Blocked d/	2,200	2,200	1,988	90.4	1,582	11	7	-1,001
Regional	16,883	13,506	16,199	119.9	14,734	-214	-316	-1,946
Station e/	28,957	21,726	19,037	87.6	18,400	-385	-272	-4,605

a/ Less debarkation beds and 20 percent dispersion in regional and station hospitals.
b/ Data exclude patients in triage at debarkation hospitals.
c/ Overages are indicated by a minus sign (-).
d/ Hospitals blocked for receipt of new patients; England scheduled for closure by 30 June; Deshon by 30 April; all others by 30 March 1946.
e/ Includes eight (8) hospitals reduced from regional status in January, which reported 4041 beds authorized, 3393 patients remaining, and 2817 beds occupied; also hospitals under Chief of Transportation.

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS
BY TYPE OF CARE AND TYPE OF HOSPITAL a/
End of January 1946

	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station b/
Total	159,251	152,297	105,459	11,602	16,199	19,037
General-Convalescent Care	94,149	96,113	84,775	11,338	-	-
Evacuees	-	81,683	71,097	10,586	-	-
Z/I	-	14,430	13,678	752	-	-
Regional-Station Care	55,733	48,024	16,870	236	15,100	15,818
Regional	9,353	8,875	3,589	-	4,253	1,033 c/
Station	46,380	39,149	13,281	236	10,847	14,785
Non-Army	9,369	8,160	3,814	28	1,099	3,219
POW	4,727	3,873	875	14	536	2,448
Civilians	2,273	2,309	1,258	14	385	652
Veterans Administration	2,020	1,496	1,334	-	141	21
Other	349	482	347	-	37	98

a/ Excludes debarkation beds and patients.
b/ Includes hospitals under the Chief of Transportation.
c/ Patients remaining in hospitals recently reduced from regional status.

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 from 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/	Neuro-psychiatric	All Causes	Wounded a/	Neuro-psychiatric 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	93.9	27.2	23.8
Nov c/	33,730	8,850	7,800	80.2	21.0	18.5
Dec c/	25,260	6,240	4,850	73.0	18.0	14.0
1945 Total c/	357,927	74,117	119,923	53.3	11.0	17.9
1946 Jan c/	15,900	3,800	3,560	58.6 d/	14.0 d/	13.1 d/

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	Caribbean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
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	674	587	539
Oct	443	508	268	467	482	768	347	571	385	434
Nov	474	(511)	274	424	555	941	257		365	364
Dec	506		245	442	664	1,055	285			352
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	62	78	40	50	55	72	86	55	35
Oct	31	63	77	43	54	62	62	77	42	41
Nov	30	(59)	75	39	52	64	58		46	34
Dec	29		75	40	55	69	81			36

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	Caribbean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
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	110	7	18	154	213	4	68	40	77
Oct	56	115	9	20	168	287	3	71	42	76
Nov	60		10	38	208	456	2		55	86
Dec	50		10	35	224	417	5			81
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	1	12	6	24	4	46	33	14
Aug	0.1	12	-	8	3	15	2	29	31	13
Sep	0.1	11	-	9	1	8	3	25	29	12
Oct	0.1	10	-	9	1	3	1	24	21	11
Nov	0.1		-	7	0	2	1		18	7
Dec	0.1		-	10	0	1	1			3

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	MIDPAC	WESPAC	Asiatic	AME
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	182
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	87	68	117	63	66	60	123	123	116
Oct	79	84	47	140	72	74	51	105	84	97
Nov	101		53	131	69	61	24		62	64
Dec	160		44	128	105	90	19			102
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	27	1	10	9	15	13	51	79	87
Oct	4	20	0	7	5	11	11	38	46	58
Nov	4		-	10	4	10	4		42	44
Dec	4		-	20	4	7	1			34

a/ Excluding Iceland.

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS
Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Caribbean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
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/	12	-	8	3	41	3	10	76	49
Oct	c/	9	-	10	2	28	4	8	52	27
Nov	c/		-	16	2	25	1		45	25
Dec	c/		-	22	3	20	1			15
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
Jun	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	14	10	15	7	12	30	24	18	7
Oct	23	11	8	11	6	12	19	15	17	11
Nov	23		8	10	5	10	16		11	8
Dec	21		12	11	5	14	10			11

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.

[redacted]

1 [redacted] Officer
23-24 Plans & Operations 24 - Gen Bliss
13 Training Division
5 Supply Service
10-11 Med. Statistics Div.
Nursing Div.
Enlisted Strength
6 Mil. Pers. Div.
21 Veterinary Div.
12 Dental Division
15-19 Prev. Med. Service
2-3 Control Division
4 Fiscal Division
7-8 Hospital Division
14 Professional Service
22 Office of Tech. Inf.

9 Research
20 Dist
25 Edit
26 Med Corps.
27 Surg
28 Neuro.
29 Record.