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**HEALTH**

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**31 MARCH 1945**



# HEALTH

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## SUMMARY

COLD INJURY IN THE EUROPEAN THEATER About 45,000 cold injuries have been reported by the European Theater during the past winter. The problem of control is discussed on pages 2-6.

MEDICAL EXPERIENCE OF FIFTH ARMY The Fifth Army served somewhat as an experimental laboratory of military medicine and as a training ground in preparation of the Western Front offensive. Its problems and contributions are discussed on pages 7 to 11.

MALARIA PROBLEM The need for continued anti-mosquito work despite greatly improved malaria admission rates is stated on pages 12 and 13.

NONEFFECTIVE RATES The February noneffective rate for overseas troops was 60 per thousand, or six percent, below the 63 reported for January but higher than any rate reported for 1944. The total noneffective rate for the U. S. rose to 85 in March from 77 in February, but exclusion of patients evacuated from overseas lowers the March rate to 34. See pages 14 to 17.

ADMISSION RATES The admission rate for overseas troops declined in February, largely because fewer men were wounded and injured by cold in the European Theater. Comparison of 1943 and 1944 theater rates reveals some marked improvements in the morbidity picture during 1944. See pages 18 to 20.

DISPOSITION OF ADMISSIONS IN THE MEDITERRANEAN THEATER Admissions and dispositions by broad echelons of medical care are shown for 1944. See pages 22 and 23.

HOSPITALIZATION OVERSEAS Fixed bed occupancy in the European Theater declined to 87 percent of T/O fixed bed capacity and 5.8 percent of strength at the end of February, and to 5.3 percent at the end of March. In no other theater did fixed bed occupancy reach 70 percent of fixed T/O capacity at the end of February. See pages 24 to 27.

HOSPITALIZATION IN THE EUROPEAN THEATER The recent hospitalization experience of the European and Mediterranean Theaters is summarized and compared with that of the Southwest Pacific with an eye to the probable future needs of the Pacific and the occupation army in Europe. See pages 28 to 29.

TIME IN HOSPITAL PRIOR TO EVACUATION Recent evacuation statistics are presented on the rapidity with which evacuees are being embarked by the various overseas theaters. See pages 31 and 32.

EVACUATION FROM OVERSEAS Provisional transportation reports indicate that 43,000 Army patients were debarked in the Z/I during March, about 7,500 by air. Water debarkations from the European Theater were 27,000. An even higher lift is possible in the next few months. See pages 33 and 34.

HOSPITALIZATION IN THE Z/I At the end of March there were 107,000 beds occupied in general hospitals proper and 142,000 patients remaining. There were also 40,000 patients in convalescent hospitals, an increase of 15,000 during the month. Shortages of doctors and nurses were reduced during March. See page 35.

SEPARATIONS FOR PHYSICAL AND MENTAL REASONS Separations of enlisted men for physical and mental defects are summarized by cause for the war to date. See pages 40 to 43.

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# DISEASE AND INJURY

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## TRENCH FOOT AND FROST BITE IN THE EUROPEAN THEATER

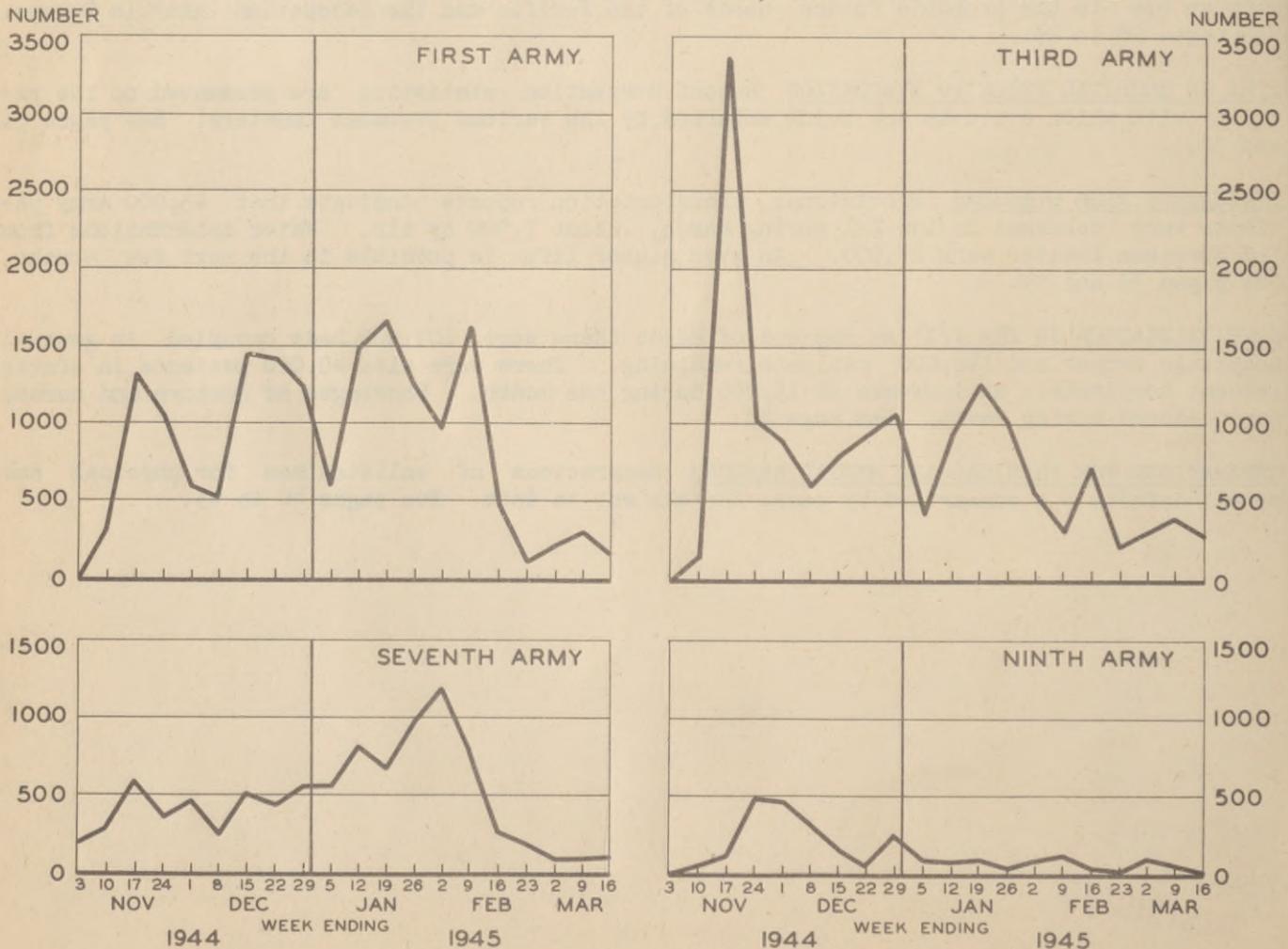
By the end of February about 45,000 men, predominantly front-line, combat troops, had suffered trench foot or frost bite in the European Theater. Provisional estimates suggest that perhaps up to 20 percent will be evacuated to the United States, while the remaining 80 percent will be returned to duty within the theater. A rough comparison can be made with the statistics for wounded, numbering about 160,000, during the same period (November through February). It is estimated that approximately 35 percent of the wounded will be disposed of by evacuation to the Z/I or will die, and 65 percent will be returned to duty. However, of all those wounded during this period, about 55 percent may return to actual combat duty. It is extremely doubtful that as many as 55 percent of the cold injury patients can be returned to combat duty even though it is estimated that 75 percent may be salvaged for some kind of duty within the theater. Because cold injuries are in considerable part preventable, losses of this magnitude lend particular significance to the lessons learned in Italy during the winter of 1943-1944 and in the European Theater during the winter of 1944-1945. It is important that commanders and supply officers from the lowest to the highest echelons profit from these lessons and provide adequate safeguards in their planning wherever cold weather operations are anticipated.

Definitive reports of the intensive studies made in the European Theater are not yet available, but the interim reports of medical investigations reaffirm the soundness of basic principles of control stated in HEALTH for June and November 1944, in WD Circular 312 published 22 July 1944, and in WD TB Med 81 dated August 1944. These principles are, in most general terms:

1. Instruction in and enforcement of adequate individual foot care;
2. Provision of suitable equipment; and
3. Avoidance of prolonged exposure.

Although the tragic experience on the Western Front this winter illustrates the great diffi-

## WEEKLY COLD INJURY ADMISSIONS, EUROPEAN THEATER



# DISEASE AND INJURY

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## TRENCH FOOT AND FROST BITE IN THE EUROPEAN THEATER (Continued)

culties attending the effective use of all these measures during periods of intense combat, the studies made by the European Theater have affirmed their effectiveness when adequately and vigorously enforced. Moreover, one cannot ignore the far greater success of the British in preventing cold injury despite no major difference in the type of footgear worn. During six weeks when at least one British division was engaged in battle on one flank of an American division, the British suffered only 66 cases in contrast to 846 among U. S. troops, a ratio of one to 13. Military necessity dictates the extent to which troops must operate under conditions conducive to the development of cold injuries. Any practical program of control must be one which envisages effective application under a variety of difficult tactical situations.

The equipment does not exist which alone will provide adequate protection under conditions such as those which have recently obtained in the European Theater, and if any single factor may be considered crucial, it is the trained ability and willingness of the individual to care for his own feet or even those of his comrade. Even the best of equipment, if not fitted properly and worn intelligently, will be of little avail. Despite the promulgation of directives and educational material prior to November 1944, neither the troops themselves, the line officers, nor the medical officers of most divisions were prepared for a problem of such magnitude as developed during the November offensive. In another month the general state of information and understanding had increased, but not sufficiently to achieve satisfactory control, and the enemy counter-offensive disrupted everything. Individual foot-care varies with the interest of company commanders and noncommissioned officers as well as with the intensity of combat. In even the best trained units foot discipline was observed to deteriorate in the face of maximum resistance. It is only natural that when death is the possible alternative, trenchfoot will be accepted as the lesser of two evils. It is under such conditions that a rotation scheme can be a most effective aid in preserving effective fighting strength. Regardless of how conscientious he may be, the combat soldier cannot be expected to do the impossible. In fact, extreme and selfless devotion to his immediate combat assignment may conflict with proper care of his feet. In some instances, however, the injury may be acquired in order to escape combat service, but there is no evidence available to indicate that this aspect of the problem is serious. In order to improve foot discipline, a plan issued on 30 January 1945 in the European Theater directed that company commanders appoint trench foot control noncommissioned officers with the following duties:

1. Personal investigation of the status of foot discipline, and encouragement of better discipline by means of personal instruction and force of example;
2. Determination of shortages in equipment and supplies essential to the prevention of cold injury; and
3. Institution of small-group discussions and demonstrations designed to acquaint all men with the details of measures to prevent cold injury and to keep effectively warm in winter weather.

The difficulties encountered in enforcing adequate care of the feet demonstrate that more time should be devoted to this subject in training. Consequently, The Surgeon General recently recommended that an additional hour be added to the schedule of training for the basic soldier in this subject. An educational program based on realistic studies of soldier opinion and attitudes also might well aid in improving the capacity of the average soldier to protect himself.

It is well known both in theory and in practice that footgear differs in its warmth-insulating and water-resistant properties. Special winter clothing for the rest of the body is also important in preventing cold injury of the feet by preserving body warmth. Experimental work and repeated field tests, one of them in Italy last winter, have shown that the shoe pac, a loose-fitting boot with a rubber foot, leather upper, and a replaceable felt innersole, properly fitted and supplemented with two pairs of heavy woolen socks, is the best standard Army equipment for cold, wet weather. However, unless it is fitted properly and supplemented by an adequate supply of dry socks and innersoles, with opportunities for change and the like, its special advantages are lost. The shoe pac is not claimed to be ideal, but improvements incorporated last August have met the principal objections previously made to its use under combat conditions and on long marches. Any further improvements will be adopted quickly. It is the preferred equipment in the Apennines fighting in Italy and is

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## DISEASE AND INJURY

TRENCH FOOT AND FROST BITE IN THE EUROPEAN THEATER (Continued)

credited with at least some of the responsibility for the favorable experience of the past winter. However, exposure was generally less severe than in 1943-1944 and the fighting more stable.

Whatever the reasons, it appears that the European Theater was inadequately supplied with the equipment considered most suitable for aiding in the prevention of trench foot when the November experience fell with full force. However, there were enough shoe pacs to equip the infantry regiments of the Seventh Army by the middle of November, by which time it had already suffered some 2,000 trench foot casualties. A considerable number of these were relapses on the part of men having trench foot in Italy during the previous winter, and many of the cases appeared throughout September and October prior to the November offensive when the First and Third Armies suffered so heavily. Trench foot is prone to recur under much less stringent circumstances than those precipitating the initial injury. By 15 January the Third Army had been issued enough shoe pacs for about 40 percent of its troops, and by 1 February the status of issues was roughly 35 percent for the First Army, 40 percent for the Third Army, and 20 percent for the Ninth Army. Troops not wearing shoe pacs wore either combat boots or service shoes with leggings, with or without overshoes. The theater had an ample supply of overshoes, and these had been issued in adequate numbers to the armies by 1 December. Until then, however, there apparently were shortages of overshoes in some of the armies. The exact type of overshoe issued in all instances has not been stated. Their value will differ with the type worn. The rubber overshoe is impervious, but the cloth type offers little or no additional protection under extremely wet conditions. Experiments made in the First Army also show that dubbin will not water-proof the combat shoe. Socks were more plentiful, but difficulty was encountered in improvising a sock-exchange service in the various armies. Combat shoes are generally considered to have been fitted too snugly to permit the use of adequate socks or sock combinations without constricting circulation.

Surveys of hospital patients arriving in Paris on 27 November, 21 December and 28 December elicited the testimony that 52, 28, and 36 percent of the patients had not been issued arctics or other type of overshoes, 28, 10, and 4 percent had received them only after trench foot developed, and 2, 12, and 15 percent had discarded them before combat. A recent radio report on the Third Army is paraphrased as follows:

"With the beginning of freezing weather on 22 December, all units, especially those on the offensive around Bastogne, had an increased incidence of cold injury. Many developed frostbitten feet for lack of overshoes. However, most of the cases occurred in men with adequate socks, boots, and overshoes. If wet the socks were frequently frozen. These troops did not have sufficient protective footwear to provide insulation from the cold despite individual daily care which, from interviews with the soldiers, seemed to have been usually well carried out.

"During the first week of January, shoepacs became available to all of the combat soldiers in every Third Army Division. It seems likely that this will reduce frostbite if the minimum care of the feet is maintained."

Further developmental work on cold-weather footgear continues, but it must be stressed again that superior equipment is merely a partial defense against cold injury and cannot be relied upon to the exclusion of the other elements of a control program. The fact that the Seventh Army was more adequately equipped at an earlier date, yet continued to have a fairly high incidence illustrates this point. The Seventh Army rates are insufficient to condemn the shoe pac, however, for there is no ready way of equalizing the relative exposure of the various armies to the hazard of cold injury. It also must be kept in mind that many of the Seventh Army troops were more prone to acquire trench foot having had it the previous winter in Italy. Too many factors are involved to make truly meaningful comparisons of the individual armies on the basis of information presently available to The Surgeon General.

Apart from weather and terrain the most significant factor determining exposure is tactical activity. It is the combat soldier, typically the infantry-man, who suffers cold injury, because his job exposes him to the cold and wet which damage the blood vessels of the extremities. Similarly, heightened tactical activity tends to deprive men of their accustomed shelter, to force them over unfavorable terrain, to occupy their minds with prior considerations, to immobilize them in exposed positions, to disrupt their supply, and the like. The relationship is thus a highly complex one for it is not tactical activity *per se* but its reflection in many other elements of the situation which directly causes cold injuries to mount. However, during the period when weather was unfavorable the gross relationship with tactical activity in the European Theater was unmistakable, as may be seen from the accompa-

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# DISEASE AND INJURY

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## TRENCH FOOT AND FROST BITE IN THE EUROPEAN THEATER (Continued)

nying chart of weekly cold injuries and wounded from November to March. The two series are shown in index form, each point being plotted as a percentage of the average for the period.

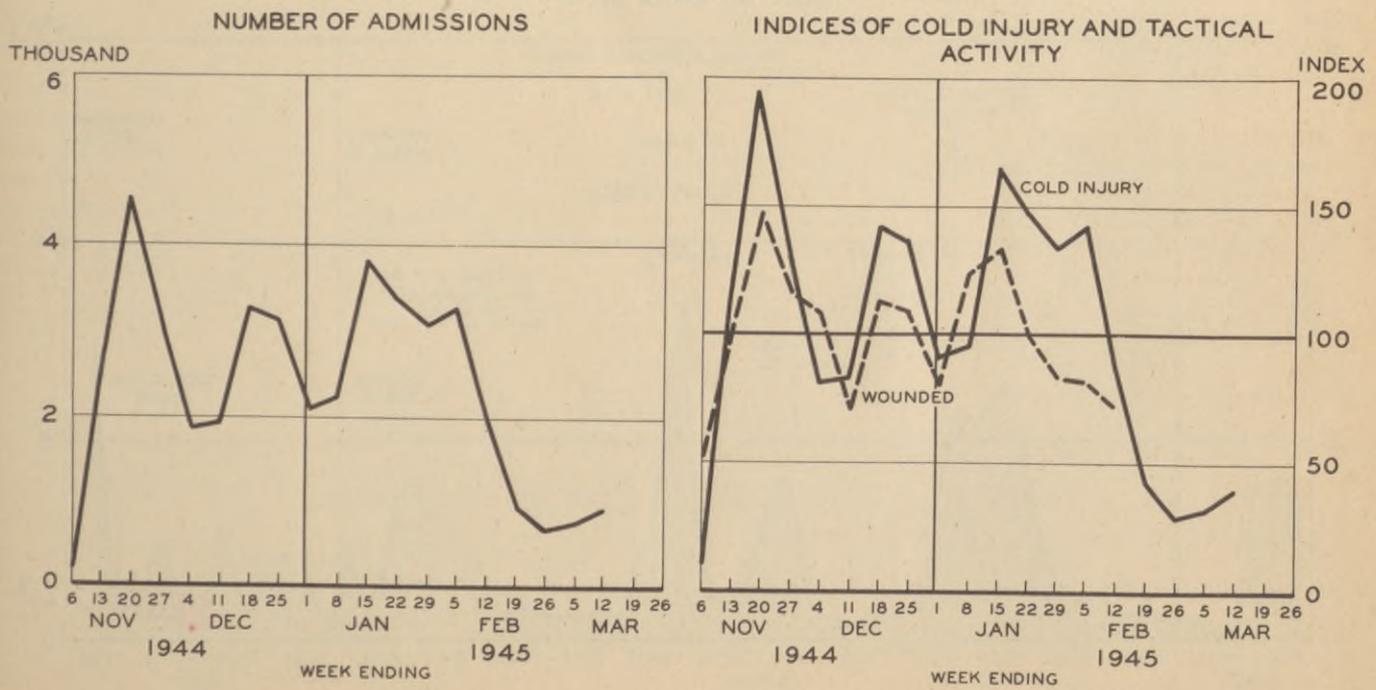
Review of the experience of individual divisions shows, almost without exception, a peak incidence of cold injury at a time of offensive activity. Regardless of equipment, troops get wet in negotiating swamps and rivers, or they may be forced to dig foxholes in poorly drained ground which becomes excessively muddy, or in open country where they are pinned down by enemy fire. Units thus exposed inevitably report many more cold injuries than sister units with less unfavorable assignments. It is obviously of the utmost importance that tactically unnecessary exposure be avoided, and that under such conditions unit commanders calculate their risks in terms of cold injuries as well as battle casualties. Moreover, it is essential that the soldier himself know how to minimize his exposure, to exercise the feet and legs so as to maintain adequate circulation and to avoid extreme exposure as much as possible within the limits of his military duty. Tactical conditions are rarely such that rotation at least by squads or platoons, cannot be practiced, and this policy has been found especially useful when it has been employed. A recent radiogram from the European Theater is paraphrased in part as follows:

"From discussions with division surgeons it seems evident that the only method of assuring that the feet are actually cared for once or twice a day when adequate equipment is at hand is to see that small groups are sent from the line daily to rear areas in order to warm feet and change socks. These areas need at times be only 300 yards behind the actual front. This method was used regularly by the 137th Regiment of the 35th Division from early November, with the result that only 57 cases occurred in the regiment during a month which was generally very bad."

As one feature of a formal program of control, part of which provides for the designation of suitable noncommissioned officers to instruct the men as described above, the European Theater required each army to provide a control team of two officers. Its duties were:

1. To determine the incidence of cold injury at the regimental level;
2. To assess the factors responsible for excessive numbers of cases in particular units;
3. To provide information on prevention to the noncommissioned trench foot control officers;

### COLD INJURY ADMISSIONS IN THE EUROPEAN THEATER AND THEIR RELATION TO TACTICAL ACTIVITY



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## DISEASE AND INJURY

~~SECRET~~TRENCH FOOT AND FROST BITE IN THE EUROPEAN THEATER (Continued)

4. To recommend to unit commanders necessary measures for improved control; and
5. To advise the army commander on the status of cold injury in the Army, on observed deficiencies, and on necessary remedial measures.

Information on the British experience does not yet permit the conclusion that any one measure is responsible for their far greater success. It may be that better adherence to all the measures prescribed explains the difference. A leather combat boot is standard issue, but Canadian divisions and some British troops are also equipped with a rubber boot which is worn in battle in preference to the leather boot. It is noteworthy that British winter clothing and equipment was issued prior to 15 November. Detailed control measures place emphasis upon daily change of socks, daily massage of feet, and daily foot inspection. A hexamine cooker is also standard issue, and may be of value in providing hot food to retain body warmth. In addition, the tactical employment of British troops is said to be such that battalions are forward on the attack for only two or three days without relief, after which they are placed in brigade reserve where proper foot hygiene is much easier. This may well be the most outstanding factor contributing to the British success in preventing cold injury. Differences similar to those reported on the Western Front this past winter were reported during the preceding winter in Italy, when the British X Corps had a negligible incidence in comparison with U. S. troops of the Fifth Army. (See HEALTH for June 1944).

There are too many variables operating in too complex a fashion to permit more than a preliminary estimate to be made of the control program in the European Theater in advance of definitive medical reports of the experience. It would be fallacious to conclude that cold injury of the extent reported was inevitable, given the basic tactical and environmental conditions, but also, it would be unwarranted to minimize the difficulties of enforcing the necessary control measures in the heat of combat. Apparently the situation would have been much worse had other control measures not been instituted, but they were not placed on a thoroughgoing basis soon enough to achieve maximum effect. The storm signals set by the Fifth Army experience during the winter of 1943-1944 in Italy were not fully heeded. Possibly the general feeling that the war in Europe would terminate early last fall played a part. The entire experience emphasizes the necessity for thorough, advance preparation whenever there is even a remote likelihood of combat under winter conditions. This should include the provision of specialized winter equipment well in advance and thorough instruction in the use of footgear. Certain aspects of the experience place new stress on the possibility of effective control. Of particular value are the demonstration that rotation is feasible and the development of a formal program which should serve as a model for future operations.

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FIFTH ARMY EXPERIENCE IN THE ITALIAN CAMPAIGN

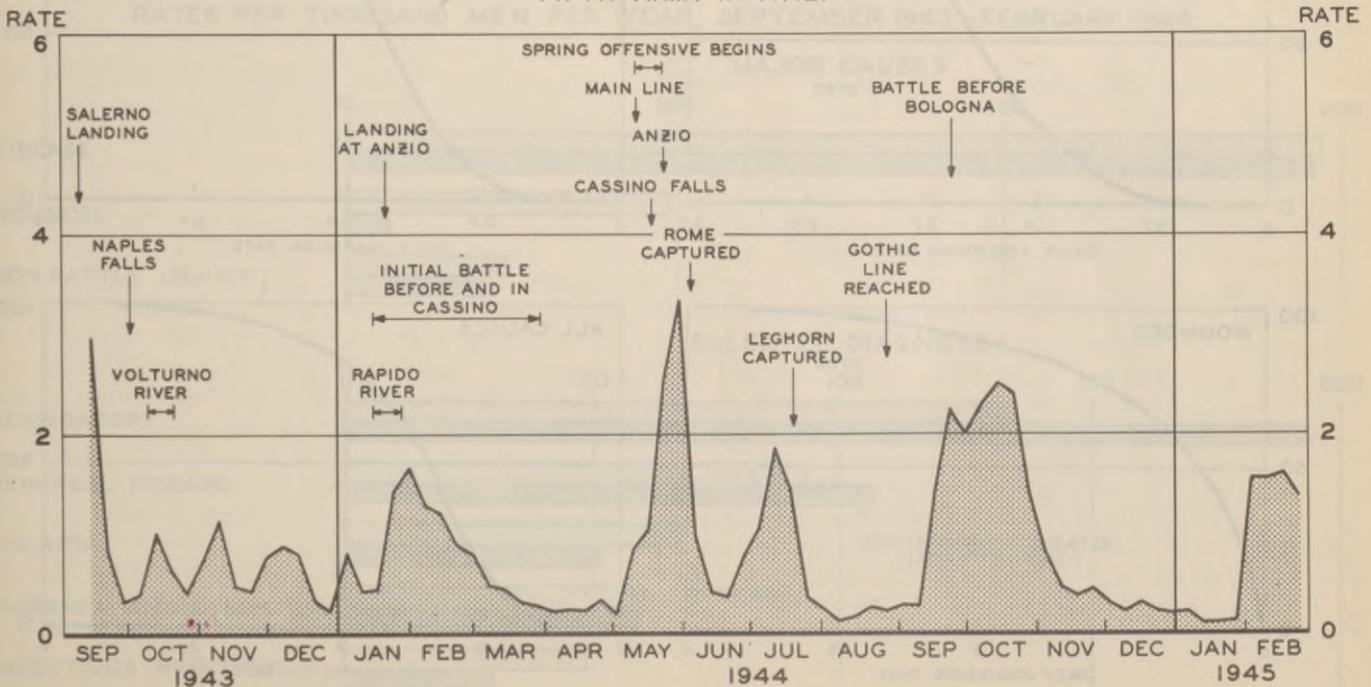
The experience of the Fifth Army in Italy is unique in that it is based on the longest active campaign in the present war for which adequate medical information is available. The medical lessons learned there prior to the invasion of Western Europe were of great benefit in the development of medical service in the European Theater. Under difficulties of climate and terrain at times extreme, the Fifth Army medical service has in a very real sense served both as an experimental laboratory and as a training ground in preparation for the offensive in Western Europe.

The extended drive up the Italian Peninsula proceeded throughout 1944 at an uneven pace marked by sporadic German resistance and retreat. Although the end of 1943 found troops attempting to pass Cassino for a drive on Rome, German resistance on the main line and around the perimeter of the attempted outflanking movement at Anzio was such that a stalemate resulted during the winter months. Not until the end of May after a short, but bitter battle, was German opposition broken, beachhead units joined with those moving northward from the main line, and the drive began which resulted in the capture of Rome on 4 June and the relatively unopposed northward pursuit of the retreating Germans for 150 miles to the Arno River, reached on 23 July. Deployed along the Gothic Line before Bologna, in some of the most rugged terrain in Italy, the Germans succeeded in forcing a relative stalemate by the middle of November. At that time it became apparent that further movement and, in particular, a breakthrough to the Po Valley would not readily materialize. The outlook at the end of the year was again one of difficult, mountainous warfare during the winter months.

For the first 14 months of combat in Italy the Fifth Army sustained wounded at the rate of 0.8 per thousand men per day, only about half of the rate for field forces in the European Theater during the first eight months after D-Day. However, the campaign in Italy has been punctuated by peaks of activity in which the rates have been as high as any but the most extreme reported for the Western Front. The chart below summarizes the casualty experience of the Fifth Army by weeks and shows the peak rate to have occurred during the spring offensive which opened at Cassino and on the Garigliano River. During this fierce battle, the army rate reached 2.39 wounded and .54 killed per thousand men per day. Lesser peaks occurred during the battles to cross the Volturno and Rapido Rivers, during the siege of Leghorn and in the battle before Bologna on the Gothic Line. The lower left-hand panel below gives the cumulative frequency distribution of daily hospital admission rates during the first 14 months in Italy. The other panels give comparable information for disease, non-battle injury, and all causes.

Confronted with a large and continuing volume of wounded, and with superb technical direction at the theater level, the Fifth Army built upon the experience of the II Corps in

WOUNDED IN ACTION, HOSPITAL ADMISSIONS PER THOUSAND MEN PER DAY  
FIFTH ARMY IN ITALY



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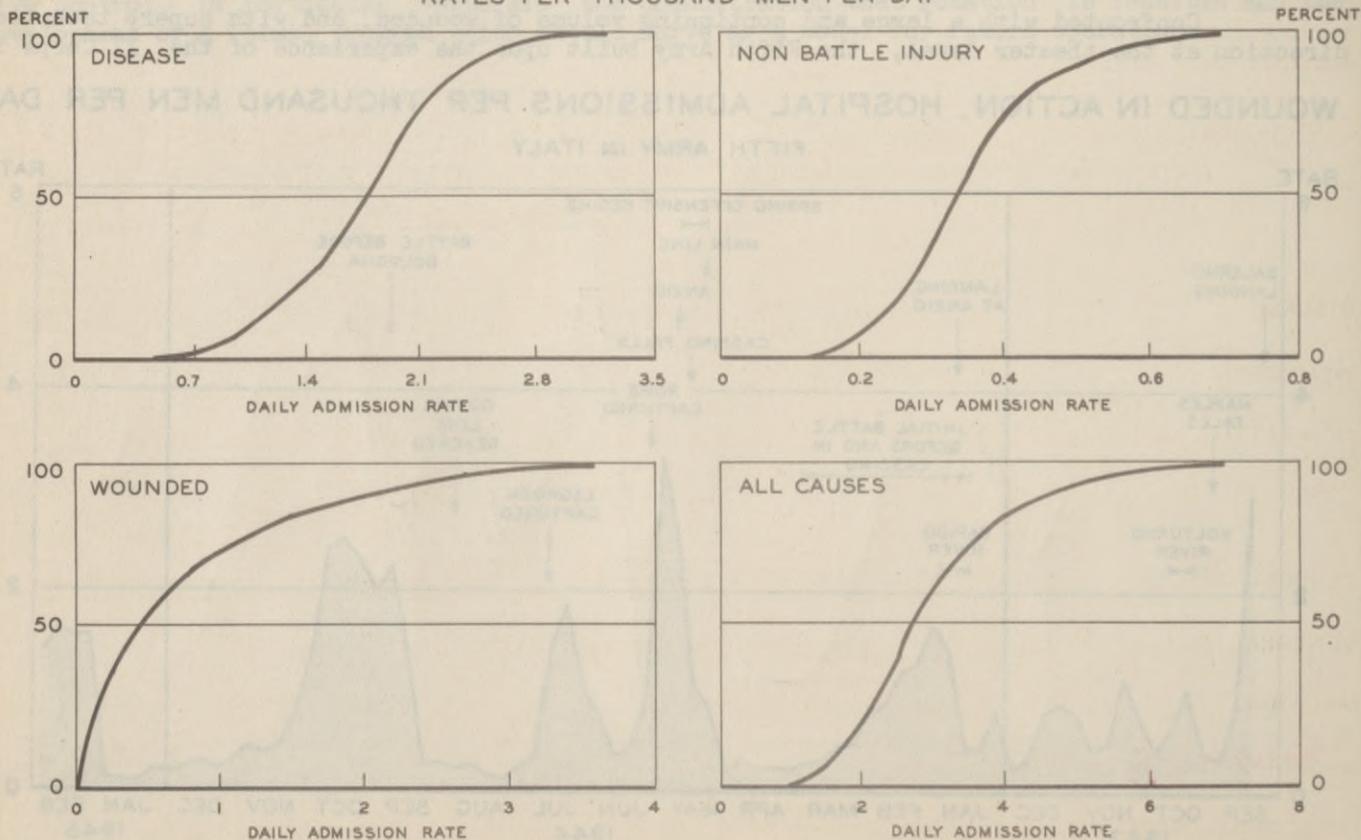
FIFTH ARMY EXPERIENCE IN THE ITALIAN CAMPAIGN (Continued)

Tunisia and the Seventh Army in Sicily and assisted in the development of the surgical care of the wounded to an extremely high professional level. In large part the scheme of hospitalization was geared to the surgical care of the wounded, every effort being made to shorten the length of time between wounding and initial surgical care. Pioneer work was done in the management of shock, and in demonstrating the need for whole blood in addition to plasma. The role of chemotherapy in the surgical management of wounds was defined, the sulfonamides and penicillin being found valuable as adjuvants to, but not substitutes for, good surgery. The increasing use of secondary closure of wounds in base hospitals, made possible by excellent initial surgery in the army area, has permitted earlier return to duty. Wound infection has been minimized by the constant emphasis placed by the theater and the army upon adequate initial surgery.

During 1944, admissions for nonbattle causes among Fifth Army troops averaged 1,045 per thousand men per year, a rate of 898 being attributable to disease. The experience of the Fifth Army with selected diseases for the period from September 1943 through February 1945 is shown in rate form against a background of the admission rates for the other troops in the theater on the following page.

In addition to providing a basis for working out the best system of wound management under the conditions of large-scale land warfare, the experience of the Fifth Army provided the first real means of comprehending the neuropsychiatric problem to be encountered in World War II by U. S. troops. From September 1943 to February 1945 there were 20,000 neuropsychiatric admissions, about one for every four wounded. It was shown conclusively for the first time in U. S. Army experience that neuropsychiatric symptoms were chiefly pressure symptoms induced primarily by the emotional stress of combat, and that the question of predicting neuropsychiatric breakdown resolved itself into one of determining when a man would break rather than who would break under the stress. As stated in HEALTH for July 1944, The Surgeon General concluded, on the basis of a study of Fifth Army experience, that the continued exposure of infantrymen to the rigors of combat, without providing a visible means of honorable exit after the completion of a fixed tour of combat duty, was exerting a deleterious effect upon morale and undermining the capacity of the men to withstand the emotional shock of continued, relentless combat exposure.

PERCENTAGE OF DAYS FOR WHICH ADMISSION RATE WAS LESS THAN GIVEN RATE  
FIFTH ARMY IN 420 DAYS OF ITALIAN CAMPAIGN  
RATES PER THOUSAND MEN PER DAY



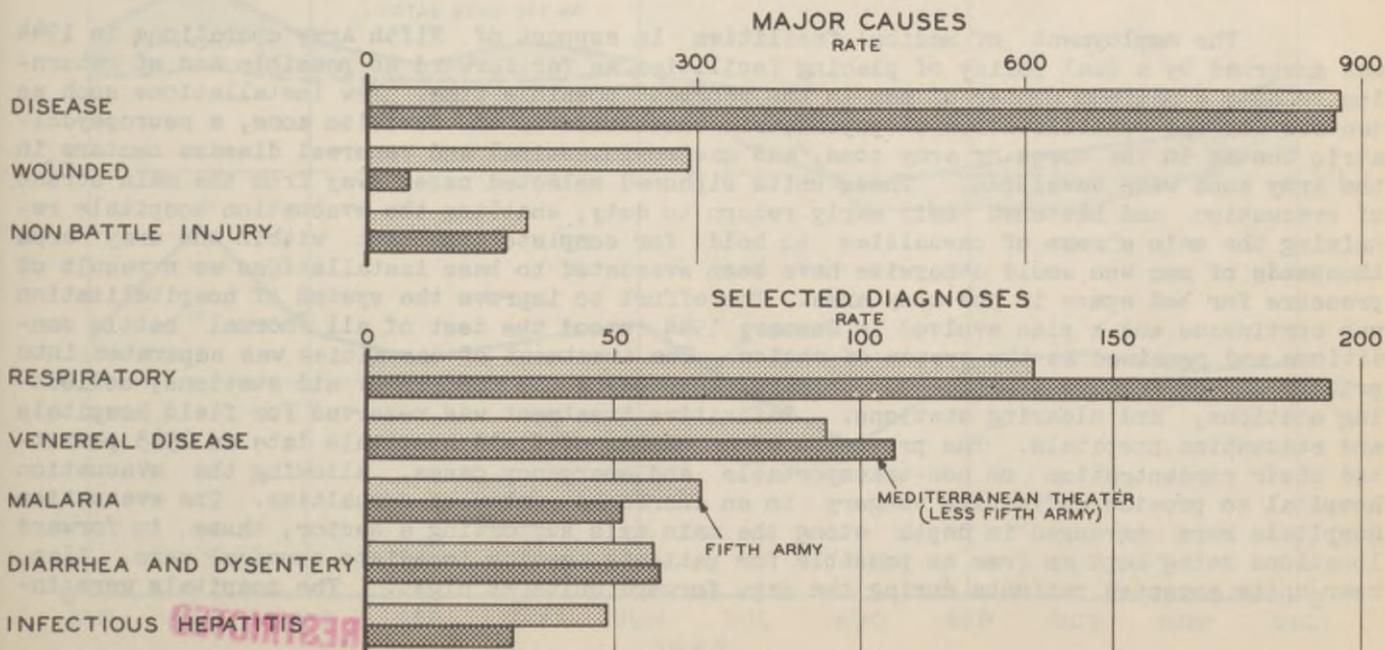
## DISEASE AND INJURY

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## FIFTH ARMY EXPERIENCE IN THE ITALIAN CAMPAIGN (Continued)

The great value of forward treatment of neuropsychiatric casualties was more conclusively demonstrated by the work of the Fifth Army than had been previously possible. Adherence to this cardinal principle of therapy led not only to the organization of a special neuropsychiatric hospital in the Army area, but also to the development of special Training and Rehabilitation Centers, as well as to emphasis on early treatment at battalion aid stations and clearing stations. The Fifth Army developed the function of the division psychiatrist assigned to prevent neuropsychiatric casualties and to institute means of returning the maximum possible number to duty within the divisional area. The Anzio experience led to the formation of the division Training and Rehabilitation Centers to receive patients after treatment at division clearing stations and to prepare them to return to duty after about two days of rehabilitation under highly skilled line and professional supervision. In some instances the function of the centers was broadened to include wounded and others for return to duty via a transition stage devoid of hospital atmosphere. It is reported that excellent results have been obtained through the use of these centers. The yield of all these measures is illustrated by a comparison between the 1943 and 1944 percentages of neuropsychiatric admissions returned to duty from Fifth Army installations. In 1943 only about 25 percent were returned to combat duty without evacuation from the army area, but by the end of 1944 it was customary for about 60 percent to be returned to combat duty and 80 percent or more to both combat and limited duty. The success of its program of returning neuropsychiatric casualties to duty also inspired pioneer Army work in the diagnosis of psychosomatic complaints, preventing many patients from being needlessly evacuated to the rear from which their return to army areas was inevitably slow and uncertain.

It is believed that no other large U. S. combat force has suffered from venereal disease as extensively and for so prolonged a period as the Fifth Army. From the standpoint of effective control of venereal disease, the economic chaos in Italy posed an exceptionally difficult problem. The difficulties of control of venereal disease in the Naples area were discussed in HEALTH for March 1944. In January 1944, when Naples was accessible to Fifth Army troops, venereal disease admissions reached the excessively high rate of 191 per thousand men per year. The commitment of large numbers of troops to the Anzio beachhead, the vigorous enforcement of legal controls, and an intensive educational program combined to produce a sharp drop in the venereal disease rate in March. With the gradual transfer of troops northward, incidence fluctuated in the general region of 75 to 85 admissions per thousand per year after April. In the last quarter of 1944, vigorous control over prostitution kept venereal contacts in Florence at only one-fifth of what they were in Naples during the winter campaign of 1943. Notable progress was made by the Army in the treatment of patients with venereal infection and in the management of their hospitalization so as to hasten their return to duty as discussed below.

COMPARISON OF ADMISSIONS, FIFTH ARMY AND BALANCE OF THEATER  
RATES PER THOUSAND MEN PER YEAR, SEPTEMBER 1943 - FEBRUARY 1944

## DISEASE AND INJURY

**CONFIDENTIAL**FIFTH ARMY EXPERIENCE IN THE ITALIAN CAMPAIGN (Continued)

The unfortunate malaria experience of the Seventh Army in Sicily during the summer of 1943 promised a parallel for the Fifth Army in 1944 unless vigorous mosquito control measures were undertaken and atabrine discipline rigidly enforced. By coincidence, just prior to the May offensive Fifth Army troops were deployed in regions which had the highest incidence of endemic malaria in all Italy. Enemy action had further aggravated the menace, particularly in the region of the Anzio beachhead, where continuous bombing and artillery fire had created new water basins and seepage pools. In order to improve their defensive positions the Germans had blown up the existing drainage systems on the main Fifth Army front as well as those for the Pontine Marshes at Anzio. Anticipation of the problem permitted the organization and execution of a detailed plan for the control of mosquitoes. Atabrine was administered by roster. Some malaria appeared but very little was contracted on the beachhead. The malaria control program of 1944 was quite comprehensive and well designed, including at the outset anti-malaria training schools. Much of the very real danger evident in the spring was obviated by the rapid advance northward from May to August out of the malarious areas. These facts coupled with fairly intensive use of suppressive atabrine, kept 1944 admissions at a fairly reasonable level in the light of the amount of transmission the year before. Moreover when Fifth Army troops were taken off suppressive atabrine toward the end of the year, there was no real increase in the rates, suggesting that new transmission during 1944 was probably not extensive.

At the outset of 1944, Fifth Army rates for diarrheal infections were of course considerably lower than they had been in North Africa during 1943. The highest rate of 1944 occurred in October when a sharp outbreak of diarrheal disease among combat troops pushed the admission rate from 76 to 160. It is believed that the fall rains and cold weather drove troops to seek shelter in poorly sanitized areas. As soon as the offensive against the Gothic Line bogged down and positions were stabilized, the level of field sanitation improved and the rate began to decline.

Infectious hepatitis was one of the principal diseases which sapped the fighting strength of the Fifth Army, particularly in the fall months. From a military standpoint it has ranked with trench foot as a devourer of manpower. On the basis of approximately 60 days lost per admission, it is estimated that infectious hepatitis was responsible for the loss of more than 400,000 man-days during 1944. The disease followed a seasonal trend in 1944 culminating in a rate of 161 per thousand men per year for December, more than 70 percent higher and occurring two months later than the peak of 94 per thousand in 1943.

In the winter of 1944-45, Fifth Army troops were better equipped and trained to prevent the occurrence of trench foot which created a serious problem in the winter of 1943-44. All combat troops were issued shoe pacs to be worn with two pairs of heavy woolen ski-socks and a pair of felt innersoles; sock exchange was well organized; and warming and drying stations were provided near the front lines. Maximum incidence was hardly one-third that of the previous season.

The employment of medical facilities in support of Fifth Army operations in 1944 was governed by a dual policy of placing facilities as far forward as possible and of returning to duty a maximum number of men in the shortest possible time. New installations such as centers for the rehabilitation of psychiatric casualties in the division zone, a neuropsychiatric center in the corps or army zone, and gastro-intestinal and venereal disease centers in the army zone were developed. These units siphoned selected cases away from the main stream of evacuation and hastened their early return to duty, enabling the evacuation hospitals receiving the main stream of casualties to hold for complete treatment within the army area thousands of men who would otherwise have been evacuated to base installations as a result of pressure for bed space in the army area. The effort to improve the system of hospitalization was continuous and a plan evolved in January 1944 stood the test of all "normal" battle conditions and remained as the system of choice. The treatment of casualties was separated into primary and definitive stages, the primary phase being the concern of aid stations, collecting stations, and clearing stations. Definitive treatment was reserved for field hospitals and evacuation hospitals. The provision of a number of field hospitals late in 1943 permitted their concentration on non-transportable and emergency cases, allowing the evacuation hospital to provide definitive surgery to an increased number of casualties. The evacuation hospitals were arranged in depth along the main axis supporting a sector, those in forward locations being kept as free as possible for patients needing immediate surgical care. Also, rear units accepted patients during the day, forward units at night. The hospitals were in-

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## DISEASE AND INJURY

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## FIFTH ARMY EXPERIENCE IN THE ITALIAN CAMPAIGN (Continued)

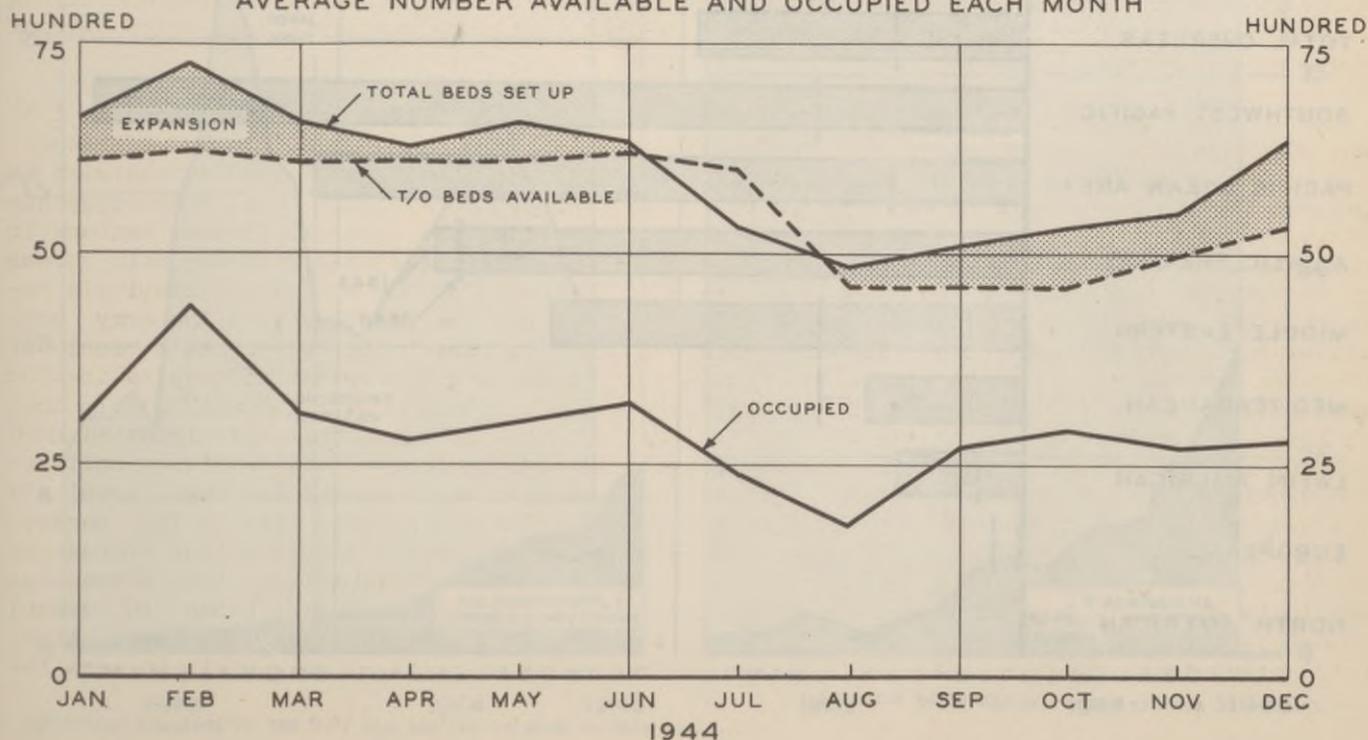
formed each day as to the number and type of casualties they would receive. These and other measures equalized the load and increased the effectiveness of the hospitals. The basic concept of conservation of manpower in the army area has been developed in an outstanding fashion by the Fifth Army, and constitutes a real contribution to military medicine. Perhaps the best example of a special army area hospital is the Neuropsychiatric Center instituted by the Fifth Army toward the end of 1943. Until December 1943, neuropsychiatric patients in the army area could be handled only in evacuation hospitals, where the urgent need for bed space for surgical cases often interrupted the treatment of neuropsychiatric patients and forced their evacuation to base hospitals. The special Neuropsychiatric Center was organized with a platoon of a clearing company and had a capacity of 250 beds. It was typically located well forward in either the army or corps area within sight and hearing distance of artillery in order to foster the notion that it was a modified rest center. Much of general value has been learned from the centralized and coordinated treatment of more serious neuropsychiatric casualties by virtue of the existence of the specialized hospital. Armies in the European Theater have made effective use of the innovations worked out by the Fifth Army.

The bed situation in Fifth Army hospitals during 1944 was such that expansion units were employed at all times except for a period in July and August when base section hospitals arriving in Rome were able to relieve forward installations. The chart below gives T/O bed capacity, expansion capacity, and occupancy during 1944. The decline in T/O beds during July resulted from the transfer of certain units to the Seventh Army for the landing in southern France. Bed occupancy is shown as an average for the month, which masks severe shortages at particular times and places, such as at Anzio.

The evacuation policy of the Fifth Army, like its hospitalization policy, was designed to conserve manpower in the army area. Of approximately 222,000 patients treated in Fifth Army hospitals during 1944, about 57 percent were evacuated to C/Z hospitals. Only 46 percent of disease patients and 64 percent of nonbattle injury patients were evacuated out of the army area in contrast to 80 percent of the wounded. Means of evacuation largely depended on whether base hospitals were distant or in close support of army hospitals. The difficult circumstances under which casualties were evacuated from the Anzio beachhead were discussed in HEALTH for October 1944. When the distances between army and base hospitals were sufficiently great to make air evacuation economical, this method was used as extensively as weather permitted. In October, during operations on the Gothic Line, a combination of circumstances whereby air-lift was available only when unfavorable flying weather existed, produced a critical overcrowding of hospitals in the Florence area.

## FIFTH ARMY MOBILE HOSPITAL BEDS

AVERAGE NUMBER AVAILABLE AND OCCUPIED EACH MONTH



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# DISEASE AND INJURY

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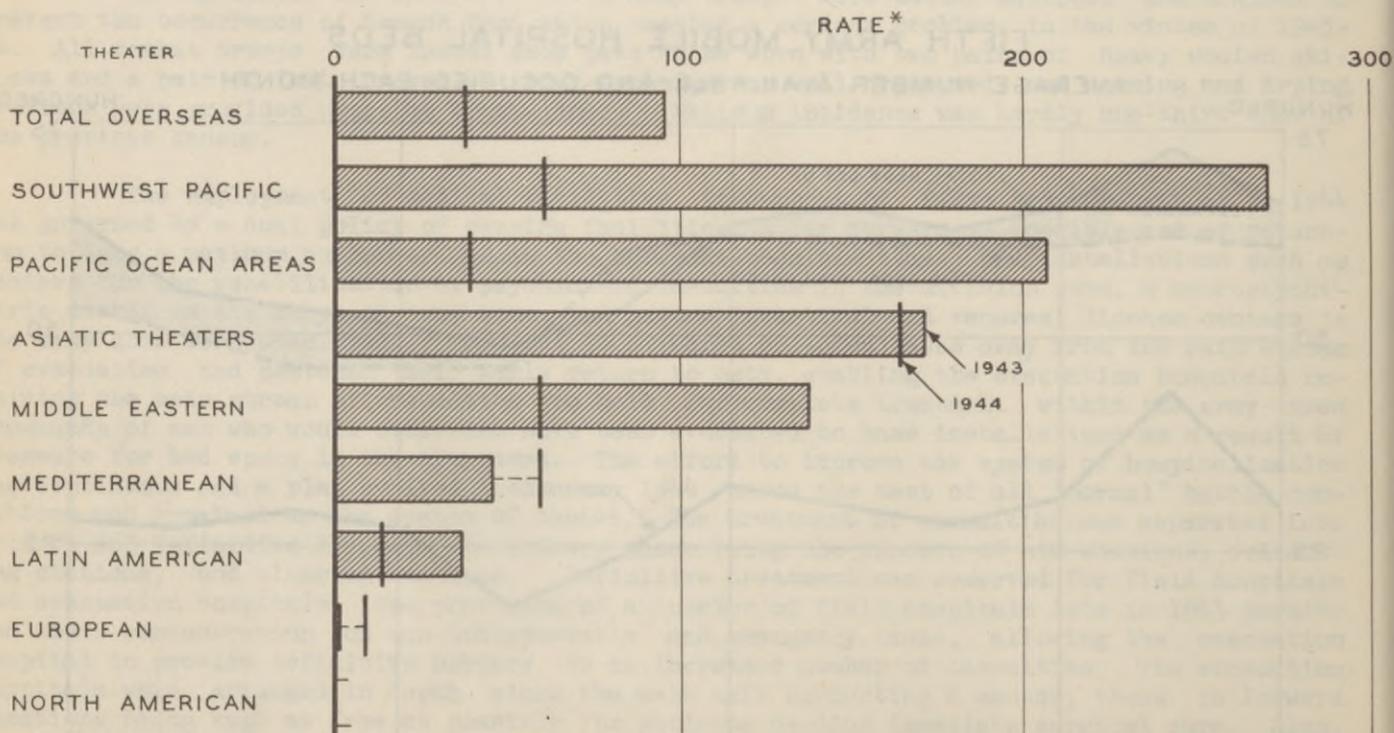
## CURRENT STATUS OF MALARIA PROBLEM

As the war in the Pacific quickens its pace it is more than ever essential that the military problem posed by malaria be understood. Many of the areas of potential operation are malarious, and the continued exposure of U. S. troops to malaria is a certainty. It is particularly disturbing, therefore, to note a growing misunderstanding of the meaning of the currently favorable malaria rates in most malarious theaters. The dramatic drop in incidence shown in the chart below should not be taken as evidence that basic anti-mosquito work is any less essential than before. The fight against the vectors of malaria must be unremitting in malarious areas.

The admission rates for malaria are as favorable as they appear for two reasons: (1) effective anti-mosquito work of all kinds and improved malaria discipline have greatly reduced the transmission of malaria; and (2) the increasingly successful enforcement of atabrine discipline operates to mask much of the malaria still being acquired, delaying its clinical appearance until after atabrine suppression has ceased. The use of drugs to suppress attacks of clinical malaria is absolutely necessary in operational areas where malaria threatens, but since its action is to prevent clinical symptoms of the disease without preventing the infection, it is literally true that the Army cannot know the extent to which malaria is being transmitted in most overseas theaters. That transmission continues is certain and that it would greatly increase were anti-mosquito work relaxed is even more certain.

The problem may be illustrated by reference to the present malaria experience in the Z/I. During February there were 6,000 admissions for malaria among U. S. troops in the Z/I, of which less than one percent represented infection acquired in the United States. In fact, in December, the latest date for which complete information is available, patients admitted in the United States whose infections were originally acquired overseas constituted 40 percent of all malaria admissions in the Army as a whole. The accompanying chart summarizes the Z/I malaria experience in this respect since January 1943. The current volume of malaria admissions in the United States barely suggests the magnitude of the hospitalization of the future. There has been no such mass evacuation of troops from endemic areas as will occur in the future, and the relapses now occurring are among men returned for furlough, rotation, or disability. When large numbers of troops return from the tropical theaters for demobilization, the extent of the facilities required to care for them may well be enormous.

**MALARIA ADMISSIONS PER THOUSAND MEN PER YEAR  
OVERSEAS THEATERS**



\* Average of monthly rates unweighted by strength

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# DISEASE AND INJURY

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## CURRENT STATUS OF MALARIA PROBLEM (Continued)

A volume of admissions ten times the current level is a conservative forecast. It is imperative that efforts be made to reduce this volume to the greatest extent possible. Unless a treatment is discovered which will completely cure vivax malaria, and none is in sight, the problem can be reduced only by preventing new infections in overseas theaters.

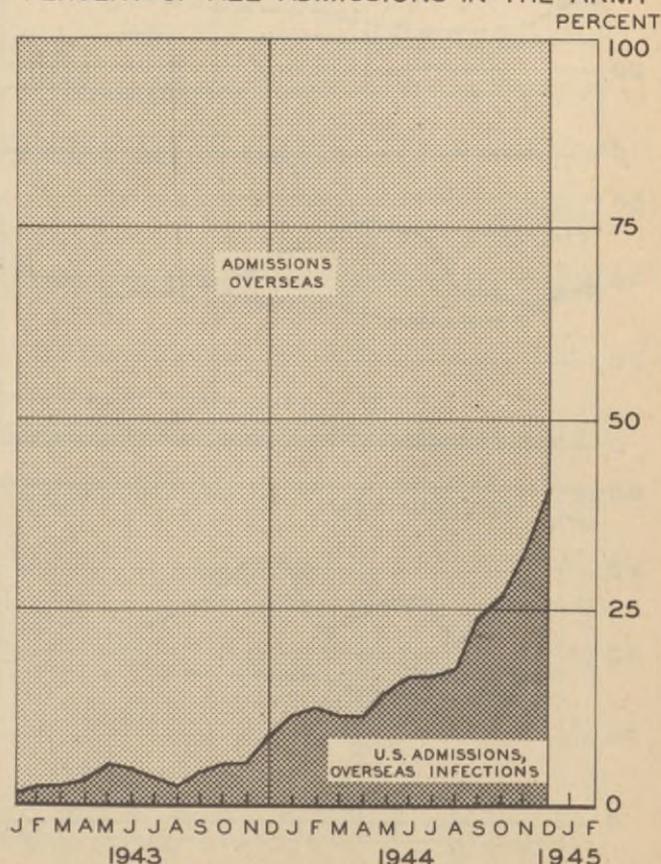
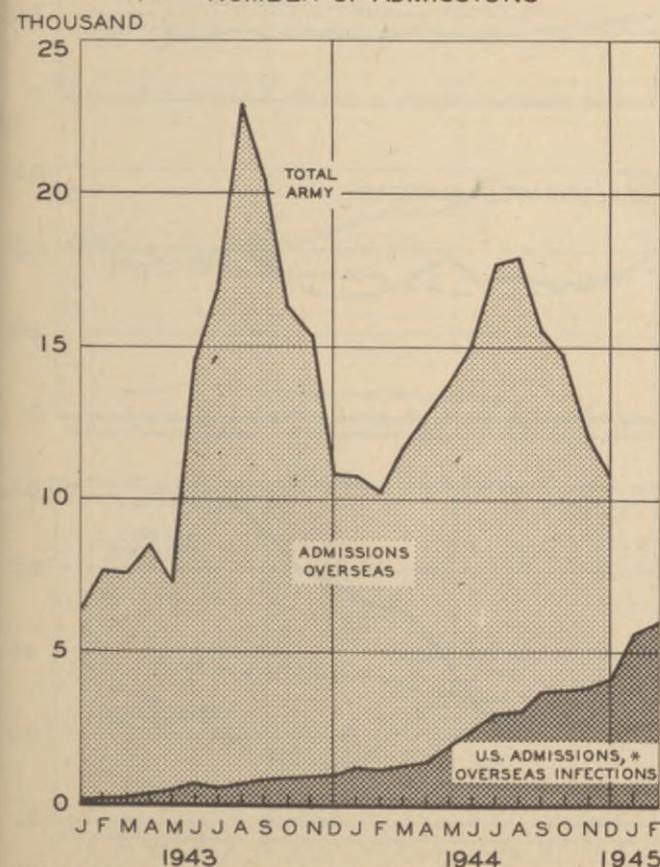
Atabrine in daily doses of 0.1 gram prevents the appearance of clinical symptoms of malaria as long as the drug is continued. However, no evidence has as yet been obtained that continued resort to atabrine in suppressive doses even for long periods will cure vivax malaria. After the drug is stopped, relapses usually occur within one or two months, but sometimes much later, and there is no evidence that the number of relapses expected after a long period of suppression differs materially from the number expected without suppression. Infections of falciparum malaria, on the other hand, are usually cured by the suppressive dose when it is continued for four weeks beyond the last exposure. Suppressives atabrine is the rule in the Southwest Pacific, except for Australia, and in certain areas of India-Burma. In the South Pacific suppressive treatment was common in 1943 but is now limited to units already heavily infected.

It is necessary that drug suppression of malaria continue to be used to reduce non-effectiveness in certain military situations, but it must be realized by all concerned that infection with vivax malaria is not prevented thereby, and that there is no substitute for control of actual transmission. This entails full use of malariologists and malaria control and survey units to determine the risk and to plan and execute programs of prevention. Mosquito control is effective in proportion to the skill and energy with which it is planned and applied. Improved materials in the form of repellents, insecticides, and dispensing methods are available in the field. Vigilance in supervision of the individual protective measures of proper clothing, use of bed nets and sprays, application of repellents, and avoidance of native habitations should never be relaxed in malarious areas.

## MALARIA ADMISSIONS, TOTAL ARMY AND IN THE UNITED STATES AMONG MEN INFECTED OVERSEAS

NUMBER OF ADMISSIONS

PERCENT OF ALL ADMISSIONS IN THE ARMY



\* Infections acquired in the U.S. are too few to show on this scale.

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# DISEASE AND INJURY

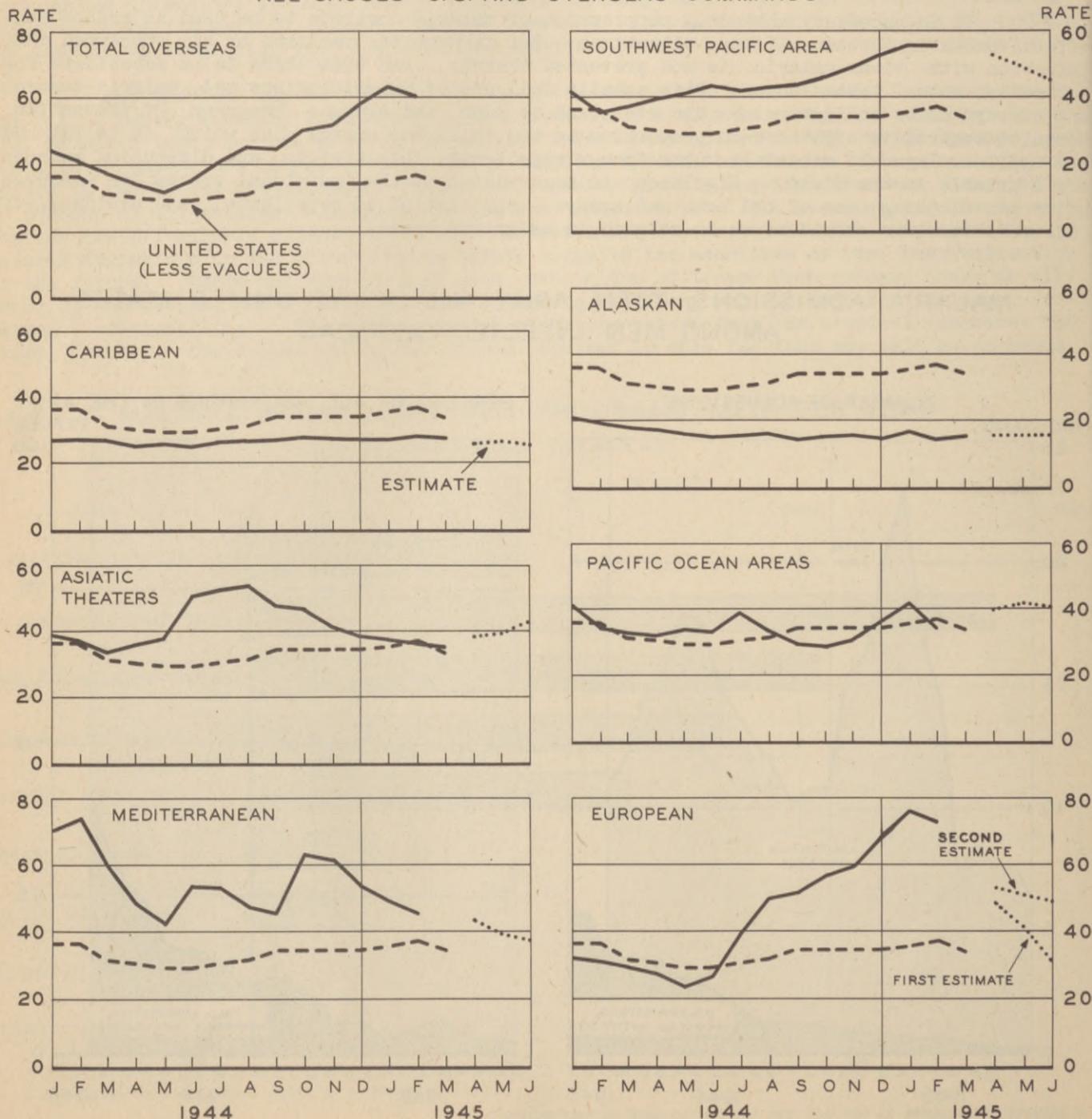
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## NONEFFECTIVE RATES

During February 1945 the total overseas noneffective rate declined for the first month since September 1944. This was mainly the result of a decrease in the total rate for the European Theater, the first since May 1944, as well as in those for Pacific Ocean Areas and the Mediterranean Theater. Improvement in the rate for the European Theater reflects the accelerated evacuation and a decline in the number wounded during February. Projections have been made on the basis of past experience coupled with the expectation of accelerated evacuation from the European area. Both estimates for the European Theater assume heavy evacuation during April, May, and June, but the first is predicated on radical declines in admissions for wounded and the second on a continuance of the average battle casualty experience of the winter months. Any projections of this kind must be regarded as extremely tentative.

The charts on the following page subdivide the total noneffective rates shown below into their disease, nonbattle injury, and wounded components. The rate for wounded continued

### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH ALL CAUSES - U.S. AND OVERSEAS COMMANDS



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# DISEASE AND INJURY

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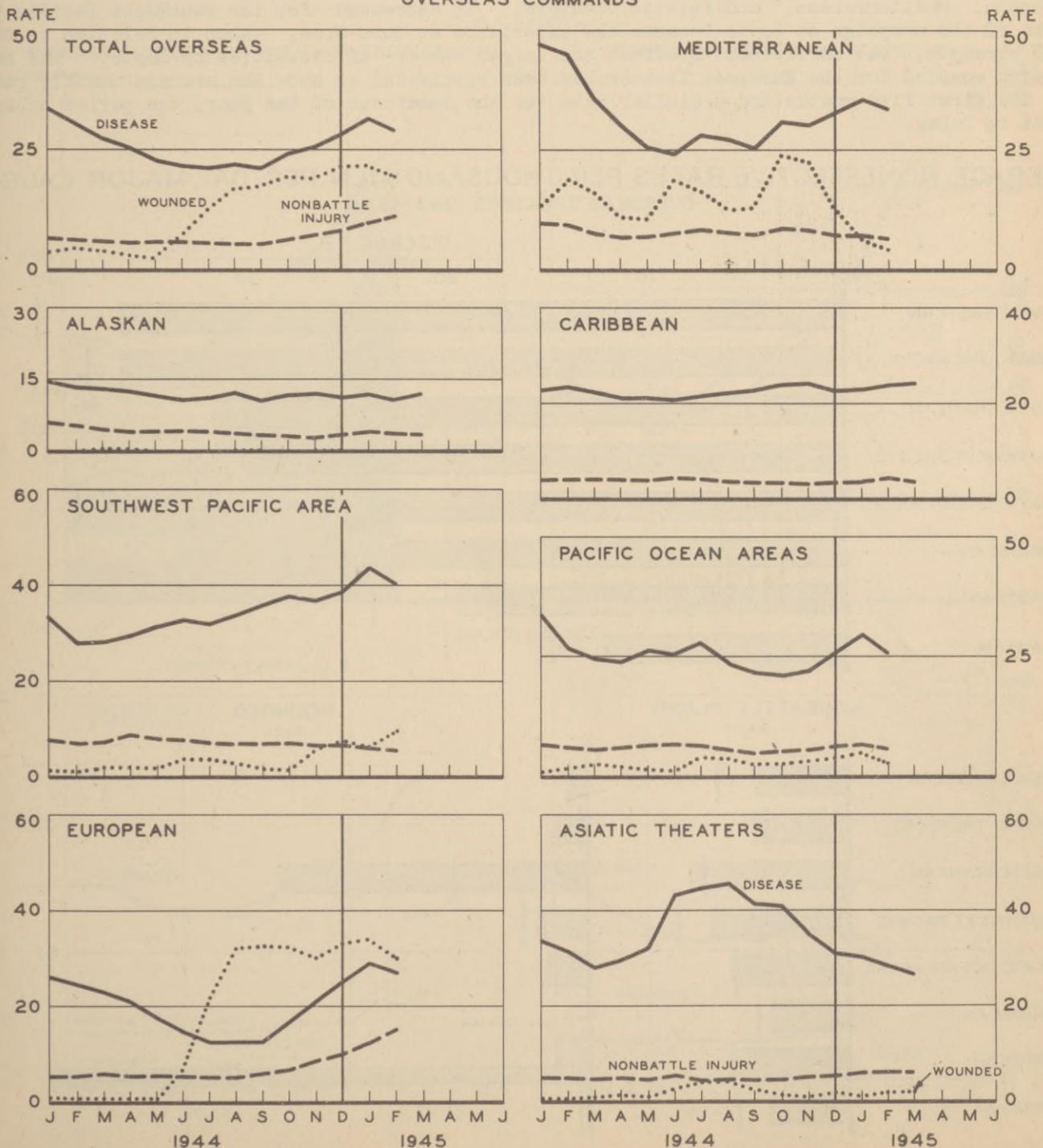
## NONEFFECTIVE RATES (Continued)

to increase in the Southwest Pacific during February as the Philippine Campaign produced a further increase in battle casualties. During February the Southwest Pacific noneffective rate for wounded was about 85 percent greater than the nonbattle injury rate, while the same percentage for the European Theater was about 95 despite the fact that noneffectiveness from nonbattle injury was three times as high in the European Theater as in the Southwest Pacific.

Noneffectiveness from disease decreased in all theaters during February, the decline in the Southwest Pacific rate being the first recorded since November 1944, and that in the European Theater the first since September 1944. After a steady increase since June 1944, during February noneffectiveness from disease in the Southwest Pacific was at about the level which obtained in August 1943. Noneffectiveness from disease in the Asiatic theaters during March matched the lowest rate in their experience, 26.8 per thousand strength reported for March 1943.

### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

#### OVERSEAS COMMANDS



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# DISEASE AND INJURY

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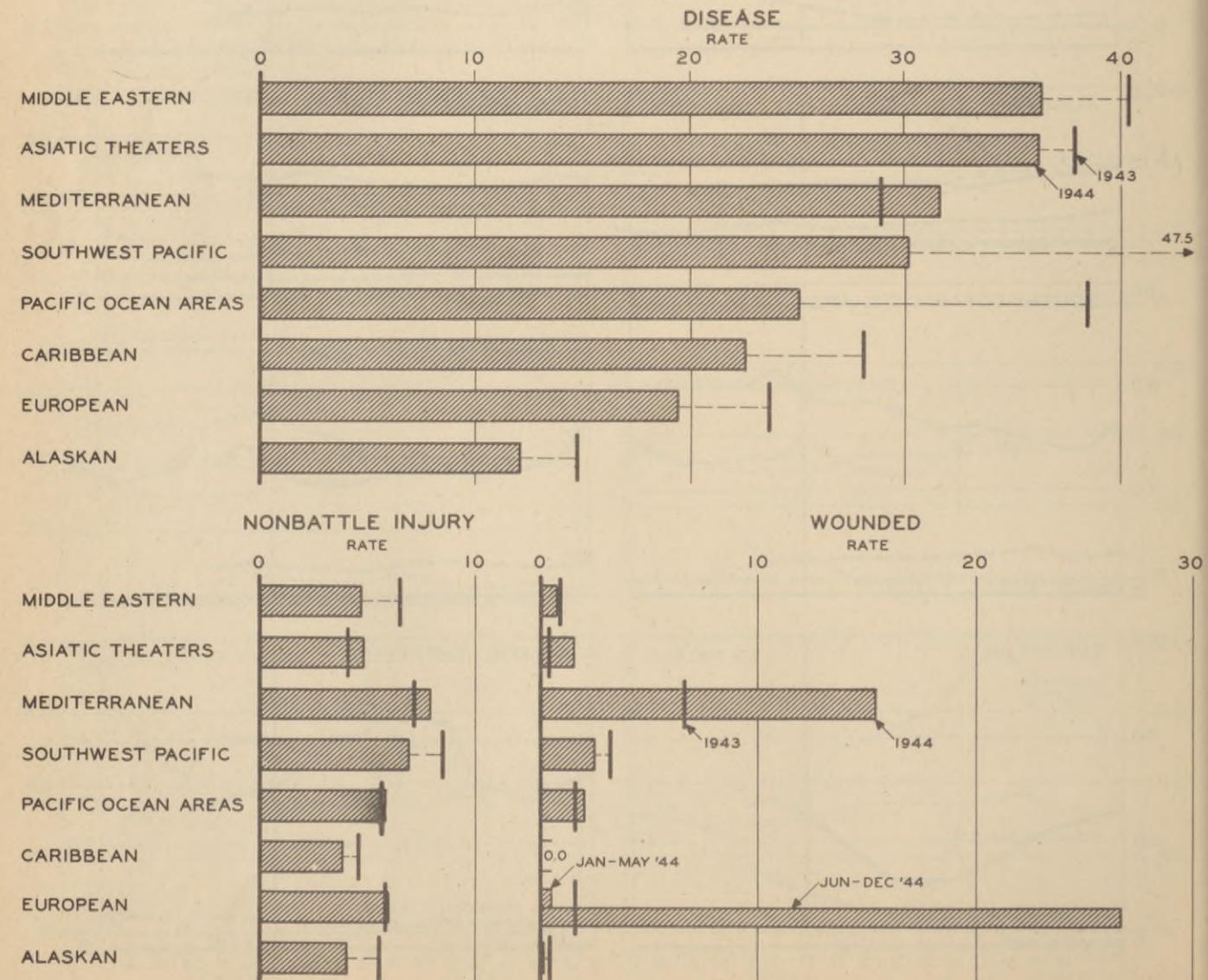
## AVERAGE NONEFFECTIVENESS OVERSEAS, 1943-1944

The receipt of complete reports from all overseas theaters makes possible a comparison of the average levels of noneffectiveness among theaters for 1943 and 1944. The panels of the charts below give the average monthly rates (unweighted by strength) for disease, non-battle injury, and wounded patients for all theaters for two years.

Average noneffectiveness from disease declined from 1943 to 1944 in all theaters except the Mediterranean, the decrease being greatest for the Southwest Pacific Area where the average rate fell from 48 to 30 per thousand strength. The improvements in this theater and in the Pacific Ocean Areas are mainly attributable to the better control and suppression of malaria, and to fewer admissions for diarrheal disease. The decreasing length of treatment required for malaria admissions in the Southwest Pacific also resulted in a decrease in noneffectiveness from this disease. In the Asiatic theaters, on the other hand, where the 1944 incidence of malaria was almost the same as that of 1943, the average noneffective rate for disease declined only four percent.

The average 1944 noneffective rate for wounded increased over that for 1943 in the European, Mediterranean, and Asiatic theaters. It decreased for the Southwest Pacific in spite of the campaign on Leyte because the experience at Buna-Gona, taken in relation to the 1943 strength, was sufficient to offset the larger number of casualties on Leyte. The bar showing wounded for the European Theater has been subdivided to show the average monthly rate for the first five months and a similar rate for the remainder of the year, the period subsequent to D-Day.

## AVERAGE NONEFFECTIVE RATES PER THOUSAND MEN PER DAY, MAJOR CAUSES OVERSEAS THEATERS, 1943-1944



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# DISEASE AND INJURY

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## Noneffective Rates, United States and Overseas

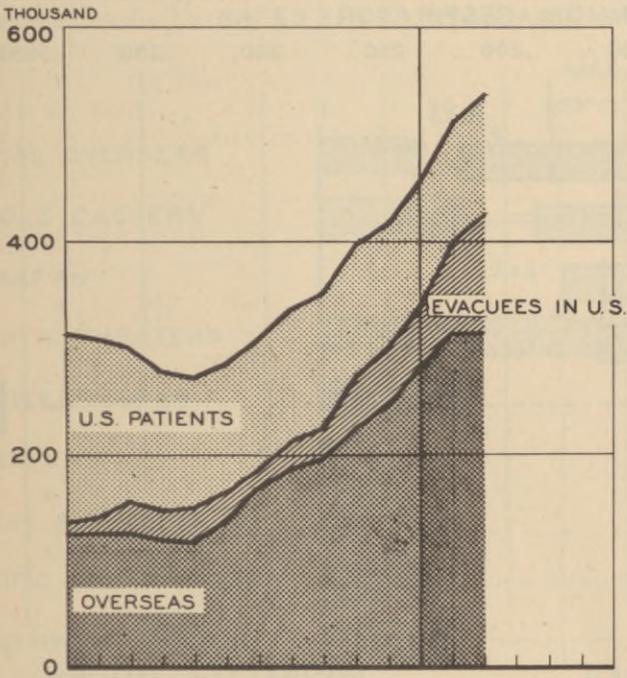
During February the overseas noneffective rate for all causes declined below the level of the previous month for the first time since September 1944, reaching 60 per thousand strength. The uncorrected U. S. rate continued to climb in both February and March, a rate of 85 being reported for March. Corrected to exclude patients evacuated to the Z/I from overseas, the U. S. rate was only 34 during March, slightly below the rate for February.

The accompanying charts state noneffectives in both absolute and rate form, showing that the high rate in the Z/I is partly an artifact of declining strength upon which has been imposed a population of overseas patients of growing size. On the average during February there were more than 530,000 men noneffective each day, 313,000 overseas alone. The lower two panels separate the total noneffective rates into their three main components. They indicate that the decline in the total overseas rate for February, for example, came from the fact that the rate for wounded fell below 20 for the first time in several months. Noneffectives from nonbattle injury continued to climb.

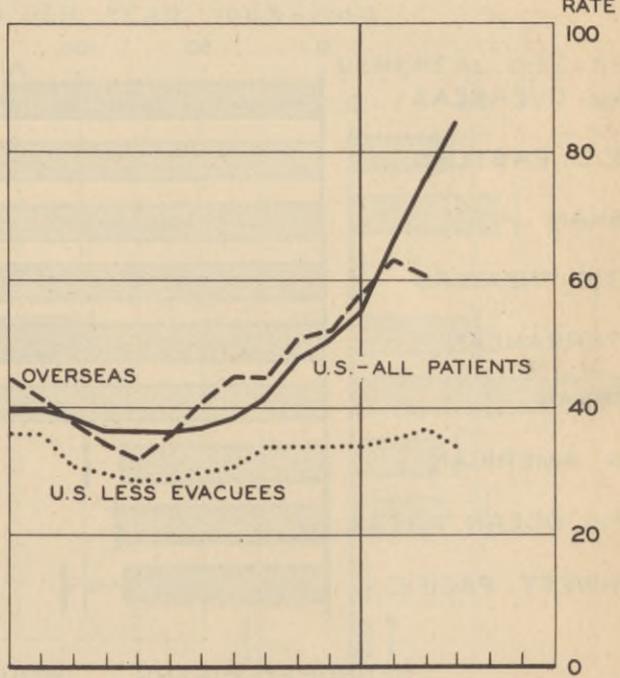
### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

#### ALL CAUSES

AVERAGE NUMBER OF PATIENTS EACH MONTH

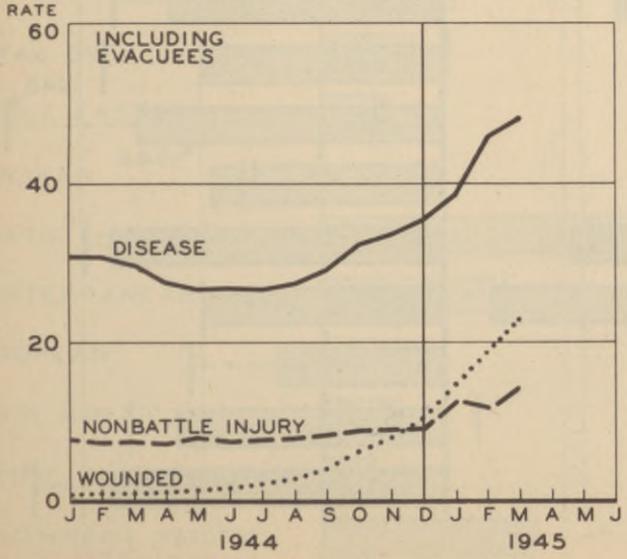


CONTINENTAL U.S. AND OVERSEAS

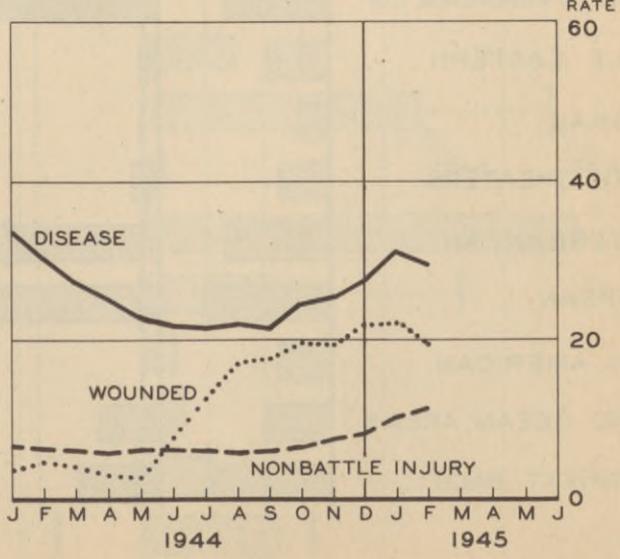


#### MAJOR CAUSES

CONTINENTAL U.S.



OVERSEAS



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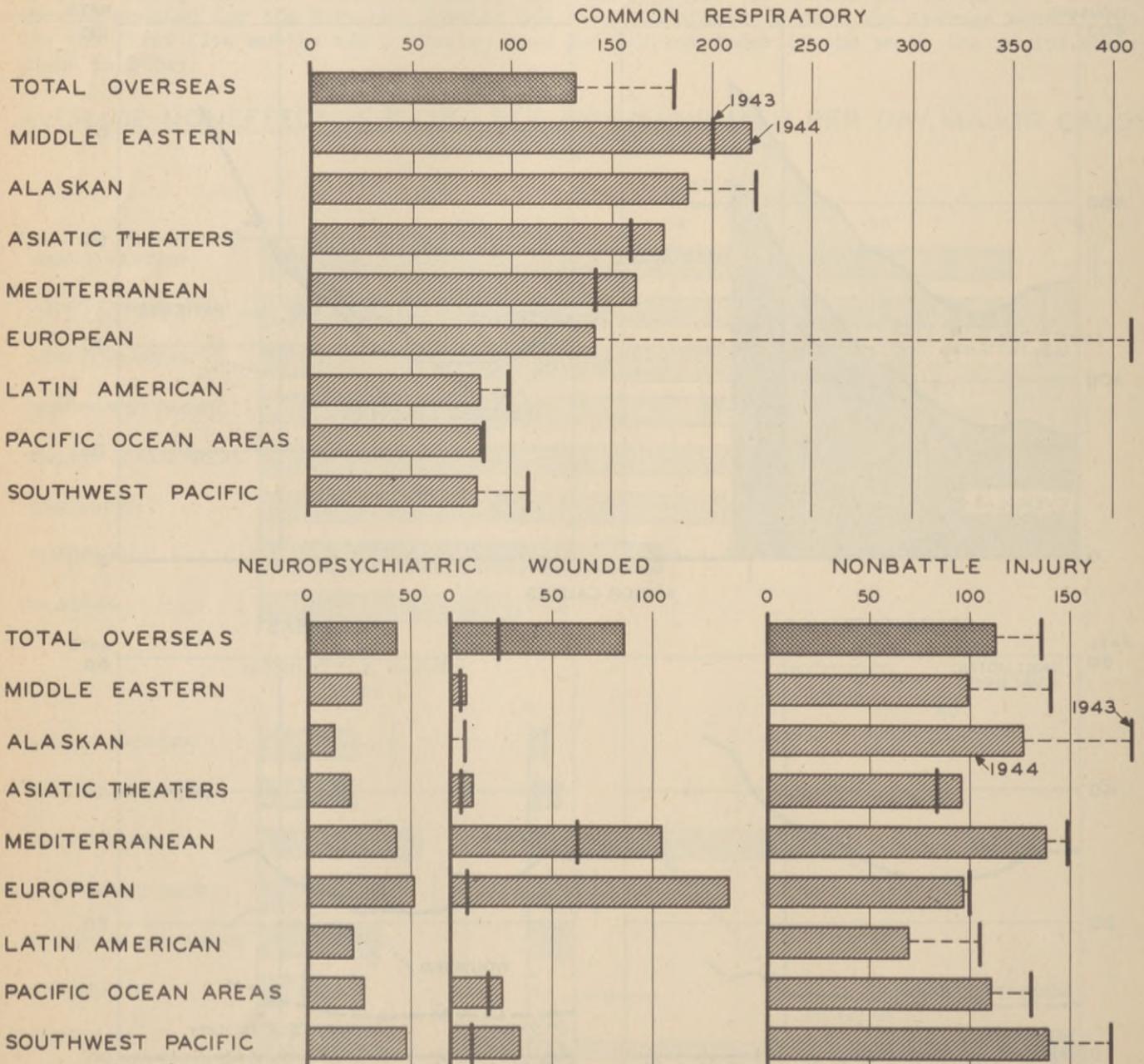
DISEASE AND INJURY

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ADMISSION RATES OVERSEAS, 1943-1944

The charts below and on the following page summarize the changes in average morbidity for selected causes overseas from 1943 to 1944. The comparison of admission rates for colds and influenza dominates the chart below because of the unusually high rate of 409 for the European Theater during 1943. Otherwise the experience of the two years is not too different. For 1944 the average overseas rate for colds and influenza was 132 admissions per 1,000 men per year. The panel for neuropsychiatric disease contains no 1943 data, as reliable rates for this period are not available. The rates for the European, Southwest Pacific, and Mediterranean Theaters are notably high, as discussed in HEALTH for February. The 1944 admission rates for wounded are in almost all instances considerably higher than the corresponding 1943 rates, but the average of 86 for the year falls short of that of 113 for nonbattle injury. Remarkable declines are apparent in the average rates for nonbattle injury in all instances except the Asiatic theaters, where the 1944 rate is higher, and the European Theater, where the improvement is small because of winter combat activity.

ADMISSIONS FOR SELECTED DIAGNOSES IN OVERSEAS THEATERS  
RATES PER THOUSAND MEN PER YEAR, 1943-1944



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# DISEASE AND INJURY

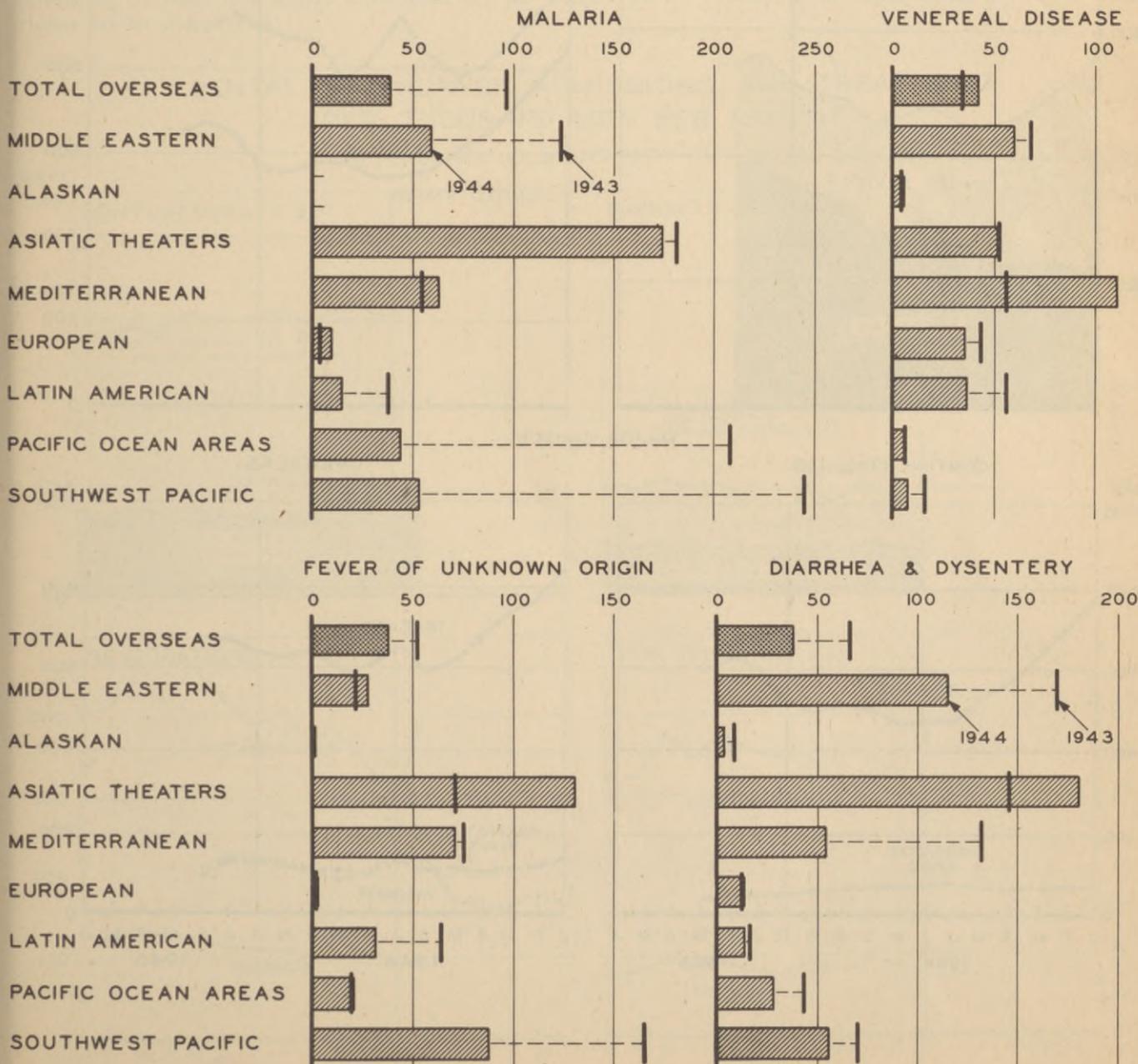
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## ADMISSION RATES OVERSEAS, 1943-1944 (Continued)

The most outstanding changes between the two years are those which occurred in the average rates for malaria, the significance of which is discussed on pages 12 and 13. The rates shown there are more appropriate for the comparison intended, and differ from those plotted below in being simple averages of the individual monthly rates, whereas the rates in the accompanying charts are derived in the customary fashion by weighting the individual rates by the corresponding strengths. For venereal disease, on the other hand, the improvement in incidence was not so general, and in the case of the Mediterranean Theater the 1944 rate is double that for 1943. Remarkable declines were, however, registered by the European, Latin American, and Southwest Pacific theaters. For the European and Southwest Pacific theaters higher rates may be forecast for 1945. Fever of undetermined origin is related to malaria in the main, many of the cases later being diagnosed as malaria. A decline of about 25 percent occurred in the average 1944 overseas rate for undiagnosed fever. In almost all theaters where the incidence of diarrheal disease was exceptionally high in 1943 there was marked improvement in 1944, and the average overseas rate for the year is 40 percent below that for 1943. The one exception is the Asiatic theaters where the rate advanced from 146 to 181 per 1,000 men per year.

## ADMISSIONS FOR SELECTED DIAGNOSES IN OVERSEAS THEATERS

RATES PER THOUSAND MEN PER YEAR, 1943-1944



# DISEASE AND INJURY

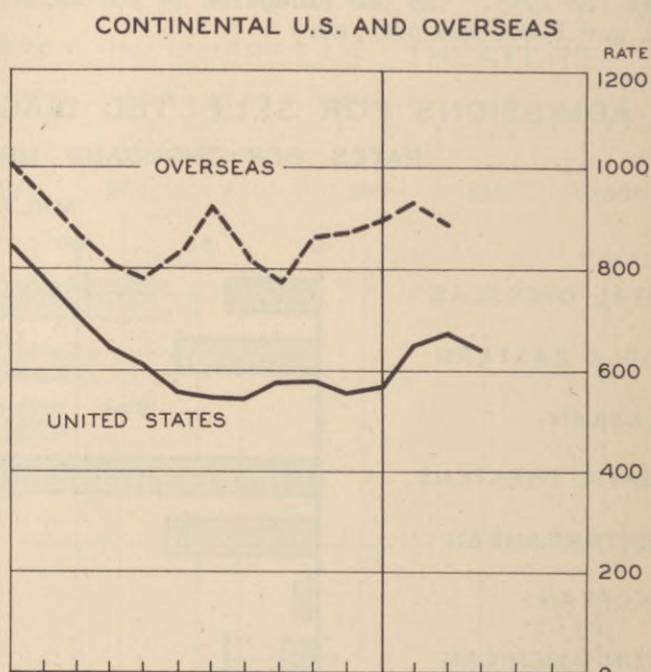
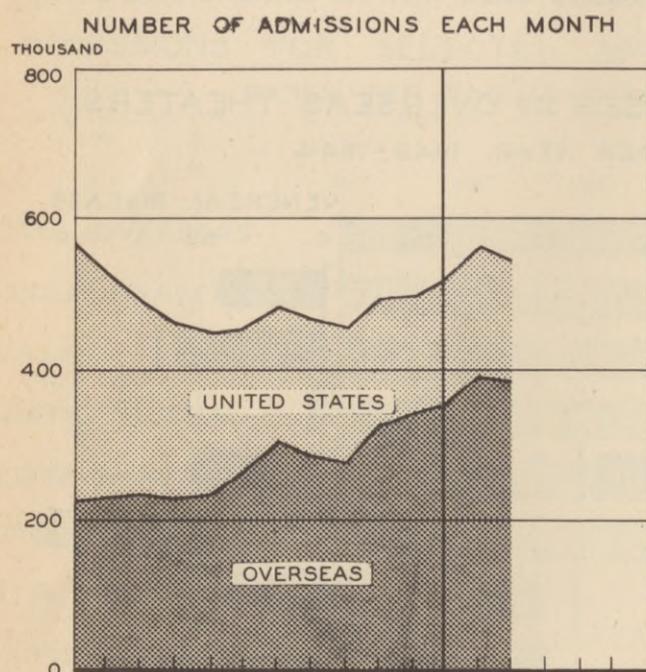
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## DISEASE, INJURY, AND BATTLE CASUALTY ADMISSIONS

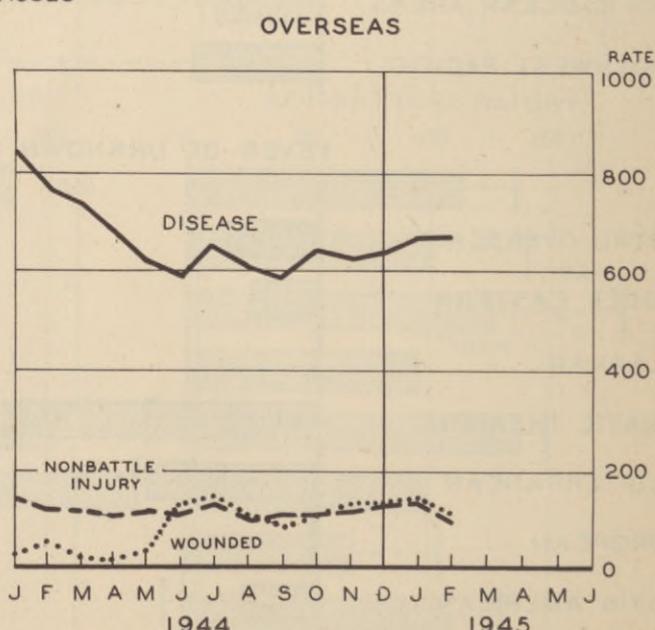
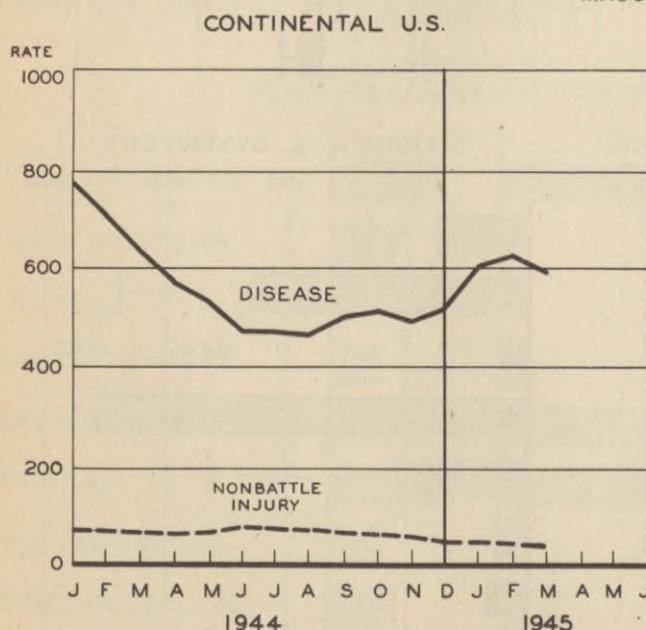
Reversing the upward trend in effect since September 1944, the overseas admission rate for all causes declined in February in response to a reduction in the number of wounded and in the number injured by cold in the European Theater. The overseas admission rate for disease remained at about the same level. The admission rate for all causes among troops in the United States was higher in February than in January, but fell appreciably during March. Current U. S. rates for nonbattle injury are the lowest of the war to date, about 50 admissions per 1,000 men per year, although this may be partly the result of a new method of classifying as disease admissions, patients readmitted to hospital with recurrences of old nonbattle injuries.

## DISEASE, INJURY, AND BATTLE CASUALTY, ADMISSIONS PER THOUSAND MEN PER YEAR

ALL CAUSES



MAJOR CAUSES



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# DISEASE AND INJURY

RESTRICTION

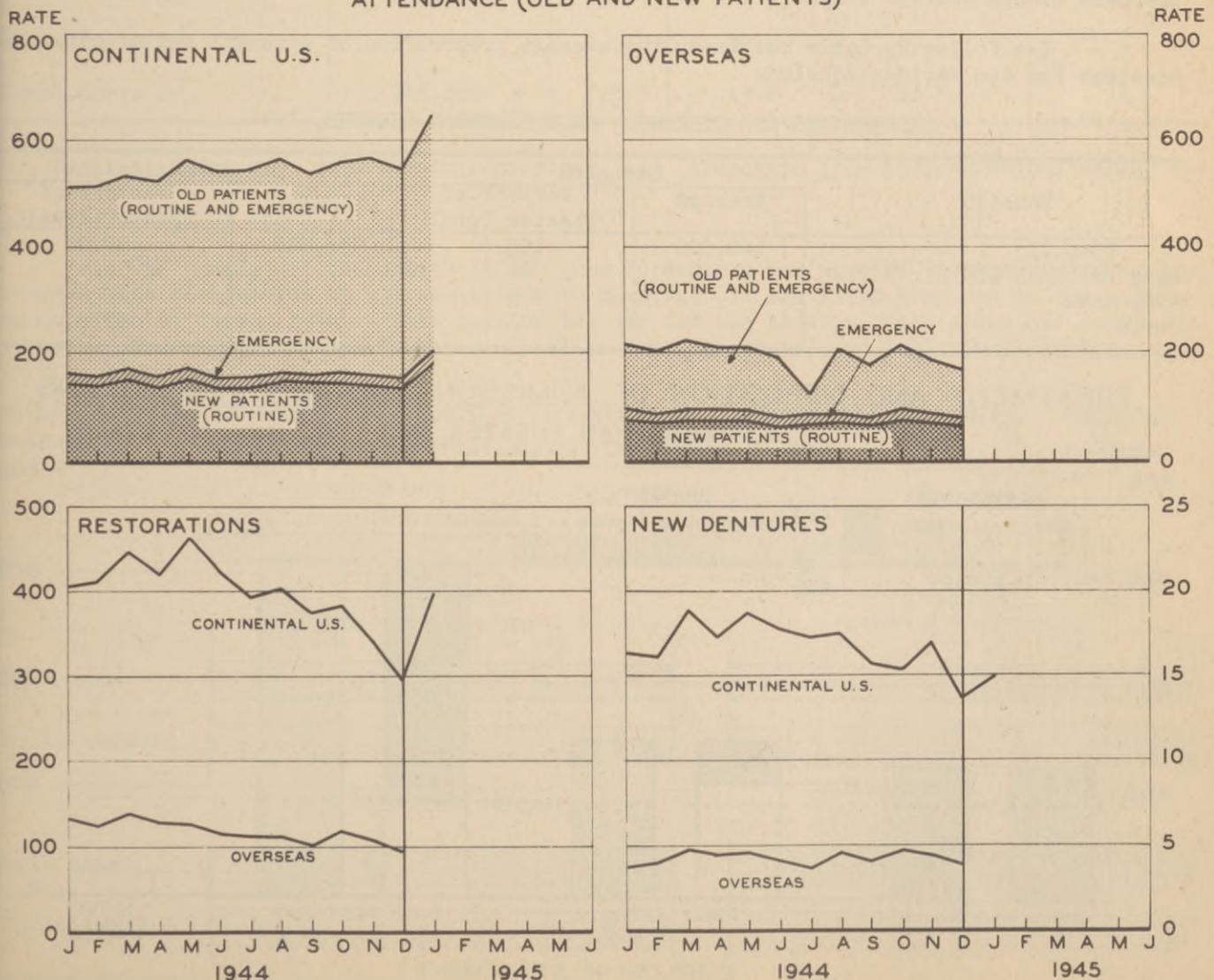
## DENTAL ADMISSIONS AND TREATMENTS

In the continental U. S. dental attendance on the part of both new and old patients was maintained at a satisfactory level throughout 1944. In January 1945 the rate advanced by about 20 percent to reach 646 admissions per 1,000 men per month, the highest rate yet attained. Overseas, on the other hand, dental attendance has continued its generally downward trend. In December the U. S. rate was about three times the overseas rate of 169. The sharp increase in U. S. admissions during January may have arisen from the continued movement of troops overseas, leaving a slightly higher proportion of dental officers to troops in the U.S., from the increasing build-up of patients in Z/I hospitals where dental facilities are more readily available than elsewhere, and from the many dental examinations made in dental clinics subsequent to the annual dental survey. There was no real change in emergency admissions.

Following a general decline from a peak of 462 restorations per 1,000 men in May 1944, the restoration rate among troops in the U. S. rose steeply from the low point of 297 restorations per 1,000 men per month in December to 396 in January. Overseas rates declined slightly throughout the year, and were about 100 at the end of the year.

For new denture construction the trend among troops in the U. S. has paralleled the trend for restorations. The January rate of 15 in the U. S. is about four times the current rate overseas. The U. S. rate was built up on the basis of a large backlog of untreated cases which have now about disappeared, so there is no occasion to expect the previous high rates to be sustained.

**DENTAL ATTENDANCE, ADMISSIONS, AND TREATMENT  
PER THOUSAND MEN PER MONTH**  
ATTENDANCE (OLD AND NEW PATIENTS)



HOSPITALIZATION

SECRET

DISPOSITION OF ADMISSIONS IN THE MEDITERRANEAN THEATER

The charts and tables on this and the following page detail the salient features of the process of admission and disposition of patients at the main echelons of medical care in the Mediterranean Theater during 1944. The data are approximate, being the best estimate which could be derived from available medical reports. The experience for corps is derived from statistics of the II Corps, the army material from reports of the Fifth Army, and the data for the base sections and air forces derived from the consolidated medical reports of the theater.

The chart below traces the flow of all patients through the various echelons of medical service. The experience of each echelon is depicted by the use of two adjacent bars. The first bar shows the source of the patients treated, whether they were admitted directly at that echelon or transferred from the next lower echelon. The second bar shows the disposition of the patients who were treated. This bar is broken to distinguish transfers to the next higher echelon from returns to duty, deaths, and patients remaining under treatment at the end of the year. The echelons shown are the corps (divisional medical services), the army area (exclusive of corps), and the base sections and air force (exclusive of army). These echelons are mutually exclusive with regard to direct admissions so that the sum of the direct admissions to the three echelons is the total number of admissions in the theater with the exception of a small number of patients on hand at the beginning of the period and included among those treated. The observations pertain to the year 1944.

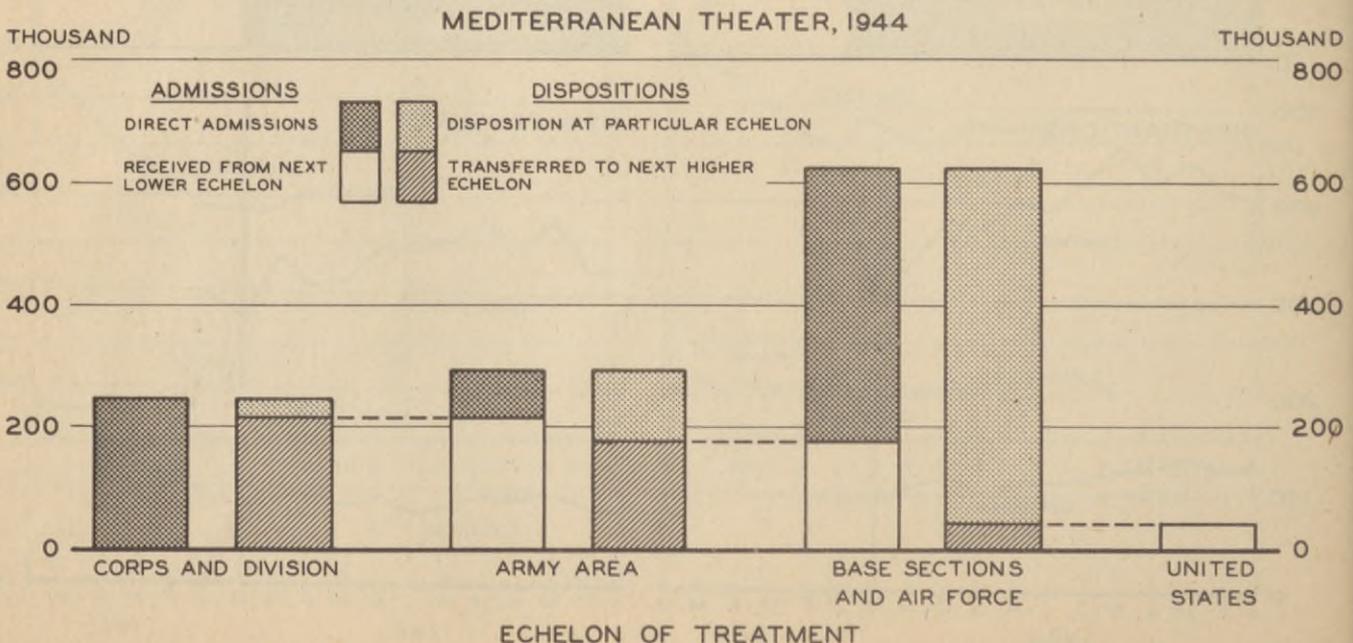
The patient load at the intermediate echelon, the army area, is mainly composed of patients transferred from the lower echelon. However, in the case of the base sections and the air force, the reverse is true, and the greater part of all patients treated represents direct admissions. The strength of the air force and base sections is sufficiently greater than that of the combat troops to counteract the lower admission rates which prevail among the base troops and air forces.

The following table compares the average proportions of strength and of direct admissions for the various echelons.

ADMISSIONS AND STRENGTH, MEDITERRANEAN THEATER, 1944

Echelon	Strength		Direct Admissions	
	Average	Percent of Theater Total	Number	Percent of Theater Total
THEATER	660,000	100.0	736,000	100.0
Base Sections and Air Forces	-	64.0	-	56.4
Army Area	-	9.6	-	10.2
Corps	-	26.4	-	33.4

TREATMENT AND DISPOSITION OF ADMISSIONS AT VARIOUS ECHELONS



DISEASE AND INJURY

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DISPOSITION OF ADMISSIONS IN THE MEDITERRANEAN THEATER (Continued)

The manner of disposition at each echelon bears a direct relationship to the medical facilities provided there. The data below show, as a percentage of the total number of cases treated at each echelon, the dispositions by death, return to duty, transfer or evacuation to the next higher echelon, and the number of patients remaining under treatment at the end of the year. The percentages returned to duty exclude some who do ultimately return to duty, and give only the proportion returned to duty prior to evacuation to the next higher echelon.

The percentages shown for deaths are probably somewhat understated, partly because of incomplete counts of those who died of wounds. The percentage for the army area is as high as it is because more battle deaths occurred in the Fifth Army at this echelon than at any lower, sixty percent of all men who died of their wounds having done so in evacuation hospitals.

DISPOSITION OF ALL ADMISSIONS IN THE MEDITERRANEAN THEATER DURING 1944

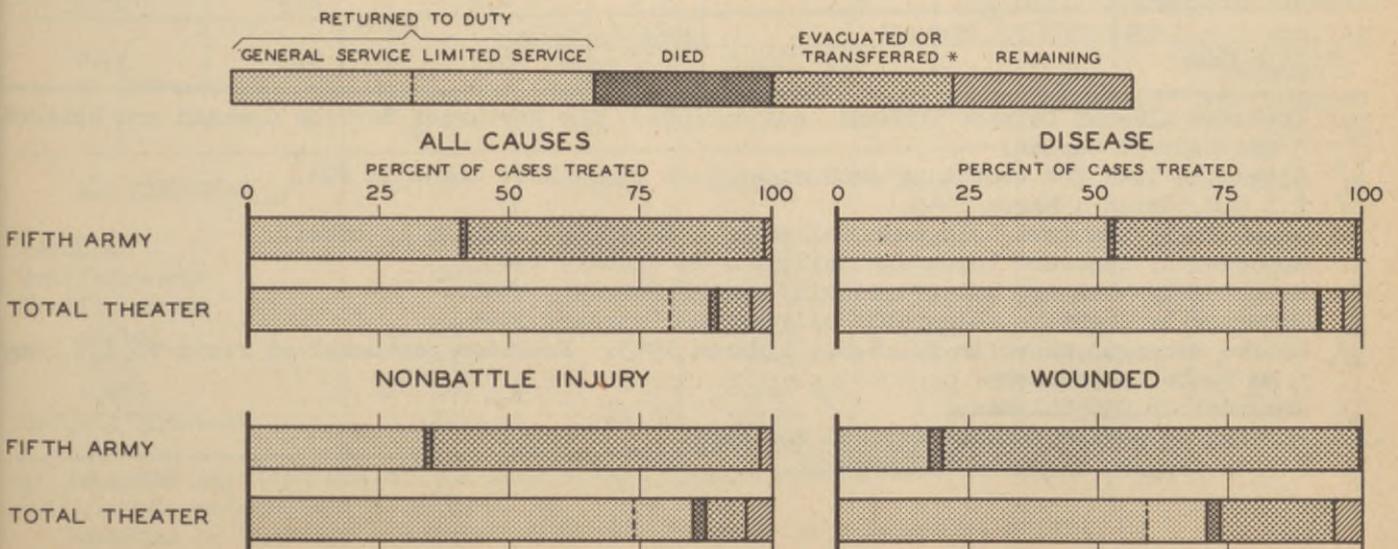
Echelon of Treatment	Total a/ Treated	Dispositions as Percent of Cases Treated			
		Died	Returned To Duty	Transferred	Remaining Year End
Total Theater	774,000	.6	91.2	5.1	3.1
Base Sections	626,000	.4	90.1	6.3	3.2
Total Armies b/	324,000	.7	43.7	54.3	1.2
Army Area	291,000	.5	37.7	60.5	1.3
Total Corps	246,000	.3	13.0	86.6	.1

a/ On hand 1 January plus direct admissions and transfers from lower echelons during the year.

b/ Army area plus corps.

The panels of the charts below show separately for disease, nonbattle injury and wounded, the disposition of all admissions to hospital in the Fifth Army and in the Mediterranean Theater during 1944. That part of the bar for the theater which shows the percentage returning to duty is divided to show initial returns to general and to limited service.

DISPOSITION OF HOSPITAL CASES TREATED IN THE MEDITERRANEAN THEATER  
FIFTH ARMY AND TOTAL THEATER, 1944



\* Transferred to base sections or evacuated to the United States.

## HOSPITALIZATION

SECRET

## HOSPITALIZATION OVERSEAS

The most notable change in the status of hospitalization overseas between 31 January and the end of February was the decline in the number of fixed beds occupied in the European Theater, an improvement which continued throughout March. As the result of the evacuation of about 30,000 patients to the Z/I during February, the establishment of special PW hospitals staffed by PW personnel, and a reduction in the number of men wounded, the number of beds occupied fell from 191,000 to 170,000 during the month.

The following tables summarize the bed situation in overseas theaters on 1 March

## FIXED BED UNITS AVAILABLE AND OCCUPIED

Number of Beds, 1 March 1945

Theater	W. D. Authorization	T/O Present <u>c/</u>		T/O <u>c/</u> Under Orders	Total Fixed Available <u>d/</u>	Total Occupied <u>d/</u>
		Number	Percent Authorization			
All Theaters	349,856	328,650	93.9	21,600		247,805
American <u>a/</u>	4,909	5,600	114.1	-	9,013	2,781
European	205,723	196,350	95.4	8,000	303,894 <u>e/</u>	169,892
Mediterranean	34,059	28,500	83.7	-	30,950	19,022
Pacific Areas						
Total	83,553 <u>b/</u>	78,100	93.5	13,050	84,312	45,506
POA	29,311 <u>b/</u>	28,750	98.1	5,050	30,766 <u>f/</u>	12,515
SWPA	54,242	49,350	91.0	8,000	53,546 <u>g/</u>	32,991 <u>g/</u>
Asiatic Theaters	19,105	16,800	87.9	550	18,428	9,296
Africa-Middle East	2,507	3,300	131.6	-	2,519	1,308

## Beds as Percent of Strength

Theater	Ration <u>h/</u> Strength (Thousands)	W. D. Authorization	T/O Present <u>c/</u>		Beds Occupied <u>d/</u>	
			Total	Usable <u>k/</u>	Percent of Strength	Percent of T/O Present
All Theaters	5,242	6.7	6.3	5.0	4.7	75.4
American <u>a/</u>	164	3.0	3.4	2.7	1.7	49.7
European	2,939	7.0	6.7	5.3	5.8	86.5
Mediterranean	516	6.6	5.5	4.4	3.7	66.7
Pacific Areas						
Total	1,263	6.6 <u>i/</u>	6.2	4.9	3.6	58.3
POA	421	6.0	6.8	5.5	3.0	43.5
SWPA	843	7.0	5.9	4.7	3.9	66.9
Asiatic Theaters	318 <u>i/</u>	6.0	5.3	4.2	2.9	55.3
Africa- Middle East	42	6.0	7.9	6.3	3.1	39.6

a/ Includes Alaskan Defense Command and excludes the Northwest Service Command and Eastern and Central Canada.

b/ Strengths used for computing authorized beds place XXIV Corps in POA.

c/ T.L.O.S. dated 1 March 1945.

d/ Reported by theaters telegraphically for 2 March 1945 except as noted.

e/ Reported by theaters telegraphically for 26 January 1945.

f/ Reported by theaters telegraphically for 16 February 1945.

g/ Reported by theaters telegraphically for 23 February 1945.

h/ Ration strength shown in T.L.O.S., 1 March 1945. Excludes personnel en route to Z/I, and en route to theaters.

i/ Includes 76,000 Chinese.

j/ Average of authorizations for POA and SWPA.

k/ Eighty percent of total T/O present.

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# HOSPITALIZATION

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## HOSPITALIZATION OVERSEAS (Continued)

1945, the latest date for which reasonably complete data are available. The counts of beds present and under orders are based upon the 1 March 1945 Troop List for Operations and Supply. The number of beds shown as present in each theater represents the capacity of units assigned to the commanding general of that area, except that units attached to other commands are included in the count of the theater to which they are attached. Three field hospitals, totaling 1,200 T/O fixed beds, assigned to Pacific Ocean Areas, but on Leyte on 1 March, are thus included in the count of fixed beds present in the Southwest Pacific. One hundred and fifty beds in six portable surgical hospitals attached to the Southwest Pacific from the Pacific Ocean Areas have been treated similarly. The strengths used are the U.S. Army ration strengths and include all personnel assigned to the commanding general of the particular theater as well as units under the Commanding General, Army Air Forces, and War Department Groups located within the geographical limits of that area and subsisted by the Army. The strengths shown for the Pacific Ocean Areas, therefore, exclude units attached to the Southwest Pacific Area for operational purposes. However, the strengths employed in computing the number of authorized beds exclude from the Southwest Pacific, and include in Pacific Ocean Areas, about 68,000 strength of the latter area then attached to the Southwest Pacific. It is possible that the data on bed occupancy for the Pacific Ocean and Southwest Pacific Areas include some duplication caused by the confusion over the reporting of the XXIV Corps. The strength of the Asiatic theaters includes 76,000 Chinese troops, the number reported as being in India-Burma at the end of January. The theater is authorized fixed hospitalization for Chinese units at 6 percent of their strength in India-Burma up to a total of 102,000 men. On 1 March control of the North Africa Service Command passed from the Mediterranean to the Africa-Middle East Theater. To care for the increase in troop strength of the latter command 425 beds in T/O units were transferred to the Africa-Middle East Theater.

For 29 December 1944, the Southwest Pacific Area has reported the operating status of 47,500 T/O beds present in the theater, 1,000 more than was reported in the Troop List for Operations and Supply as being present in the theater on 1 January 1945. According to this tabulation the theater dispersion for fixed bed units on the report date was about 32 percent. Only 68 percent of the fixed beds present in the theater were in operation, the remainder being in construction, staging, or under orders to move.

### STATUS OF BEDS PRESENT IN THE SOUTHWEST PACIFIC AREA 29 December 1944

	Fixed T/O		Non-Fixed T/O	
	Number Present	Percent Not Operating	Number Present	Percent Not Operating
TOTAL THEATER	47,500	31.6	10,025	55.9
Philippines	11,750	58.5	4,100	4.3
New Guinea and Islands	34,050	23.9	5,900	91.5
Australia	1,700	0	25	100.0

As of 2 March, 84,300 mobile and mobile convalescent beds were reported in overseas

### NON-FIXED BEDS AVAILABLE AND OCCUPIED

Theater	Number of Beds			Percent of Strength		Occupied as Percent of T/O Present
	T/O Present b/	Under Orders b/	Total Occupied c/	T/O Present	Total Occupied	
ALL THEATERS a/	84,300	2,825	28,091	1.6	0.5	33.3
European	55,800	2,800	17,828	1.9	0.6	31.9
Mediterranean	8,800	-	3,164	1.7	0.6	36.0
Pacific Areas						
Total	14,000	-	2,764	1.1	0.3	27.9
POA	3,900	-	448	0.9	0.1	11.4
SWPA	10,100	-	2,316 d/	1.2	0.4	34.3
Asiatic Theaters	5,700	25	3,191	1.8	1.0	56.0

a/ Includes American and Africa-Middle East Theaters which have no mobile beds.

b/ T.L.O.S. dated 1 March 1945.

c/ Reported by theaters telegraphically for 2 March 1945 except as noted.

d/ Reported by theaters telegraphically for 23 February 1945.

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## HOSPITALIZATION

~~SECRET~~HOSPITALIZATION OVERSEAS (Continued)

theaters according to the Troop List. The Pacific Areas continue to have a shortage of mobile units. On 23 February 34.3 percent of the mobile capacity present in the SWPA was occupied. The percentages for the European and Mediterranean Theaters are of the same order.

The need for hospitalizing prisoners and occasionally members of other U. S. armed forces, civilians, and neutral and Allied military personnel constitutes a drain on the available hospital beds in certain overseas theaters. The table below details the latest available percentage distributions of bed occupancy by type of patient in the various overseas theaters. The data for the European Theater are the same as those shown in HEALTH for February, no additional report having been received since that time, although substantial progress has been made in hospitalizing PW patients in non-T/O, PW-staffed units in that theater.

FIXED AND MOBILE BEDS OCCUPIED, OVERSEAS THEATERS  
By Type of Patient

Theater	Date	Total Beds Occupied	Percent of Total Beds				
			U. S.		Allies and Neutrals	POW	Civilians
			Army	Other			
All Theaters	-	278,516	90.4	0.4	2.9	5.5	0.8
North American	23 Feb '45	1,241	76.3	2.3	2.7	-	18.7
Latin American	23 Feb '45	1,900	96.4	0.4	0.2	-	3.1
European	12 Jan '45	200,323	91.4	0.1	0.9	7.3	0.2
Mediterranean	10 Mar '45	22,071	89.5	0.2	8.3	1.5	0.6
Pacific Ocean Areas	26 Jan '45	12,696	92.9	3.1	0.1	1.2	2.7
Southwest Pacific	29 Dec '44	27,642	95.4	0.9	0.4	0.4	2.9
Asiatic Theaters	a/	11,520	61.0	0.3	37.6	0.3	0.9
Africa-Middle East	b/	1,123	92.2	1.1	1.0	-	5.8

a/ 23 February for India-Burma and 26 January for China.

b/ 23 February for Africa-Middle East and 26 January for Persian Gulf Command, included with Africa-Middle East.

According to the 25th revision of the WD Six Months Troop Forecast, the theater requirements for fixed hospital units established by OPD will be fully met by the projections for May, July, and August. However, when the projected T/O capacity for each theater is related to the strength projections published in the Troop List for Operations and Supply for 1 March, the resulting percentages are below the WD authorized percentages for fixed bed units in certain theaters, notably the Mediterranean and Asiatic theaters. These projections do not take into account any shifts in strength or units which might be caused by redeployment. One notable change in the forecast is the lowering of the projected capacity of 8.3 percent for the Africa-Middle East Theater according to the 24th revision to 6.1 percent according to the 25th revision.

During the last week in March the War Department suspended shipment of six of the eight general hospital units (1,000 bed capacity) remaining on the troop basis for ETO.

# HOSPITALIZATION

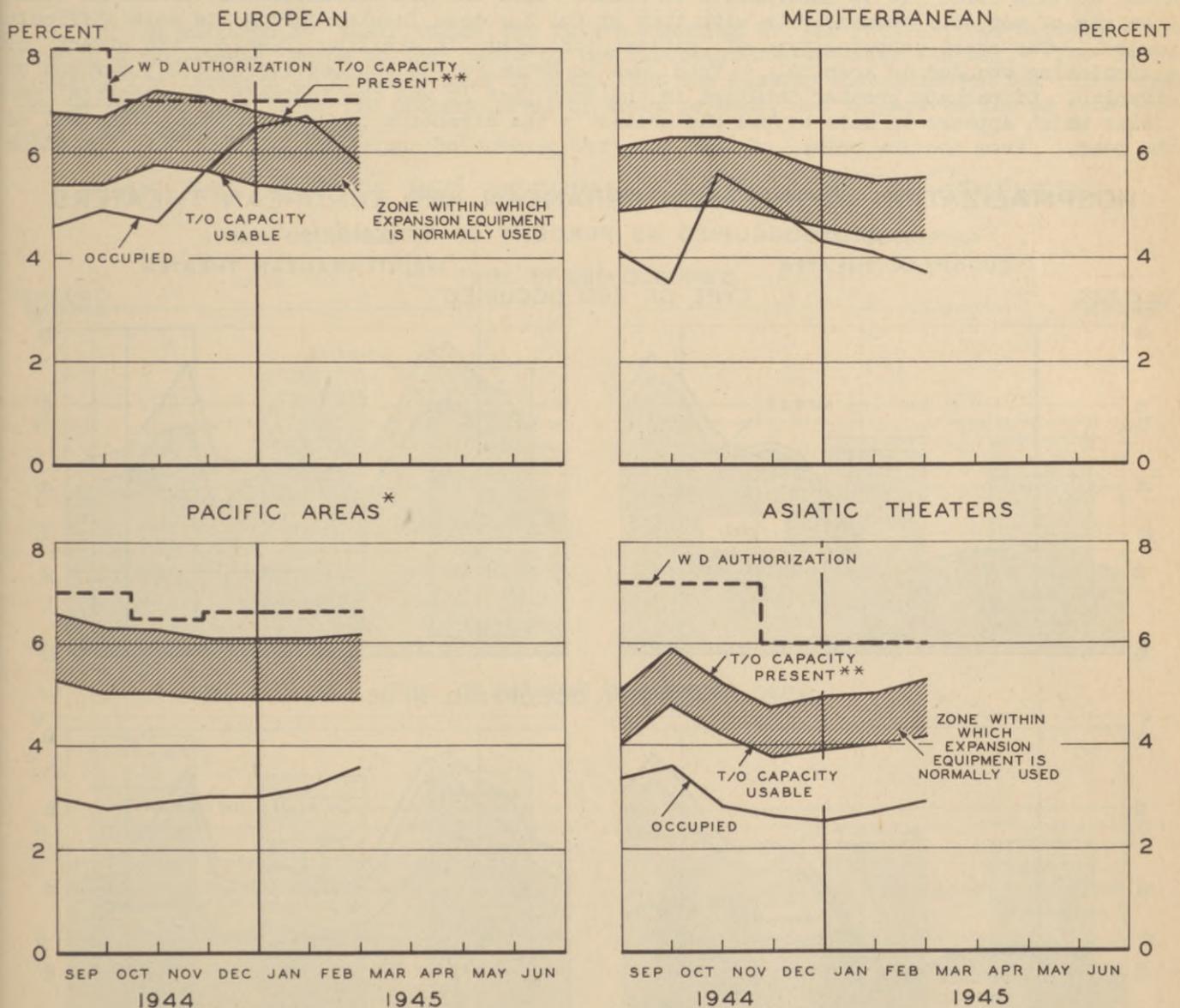
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## HOSPITALIZATION OVERSEAS (Continued)

The panels at the bottom of the page give the recent changes in the availability and occupancy of fixed beds in the more active theaters since the beginning of September 1944. The shaded band on each panel gives the range of occupancy within which the use of expansion equipment is usually necessary, so that an occupancy line in this area is evidence of pressure upon the theater supply of fixed beds. The pressure may be even greater than indicated, for in some instances a considerable number of units may not be operating, so that expansion facilities must often be used earlier than the charts show. In these instances, however, the personnel of units staging and under construction should be available for attachment to operating units expanded beyond T/O capacity. In the Southwest Pacific Area for example, on 29 December 51.6 percent of the beds present in the theater were occupied, but 75.4 percent of those operating were filled. In none of the theaters except the European is the fixed bed situation characterized by crowding, and even there the pressure has diminished somewhat since 31 January, occupancy having declined from 6.7 to 5.8 percent of strength on 2 March. A preliminary report indicates that by 30 March occupancy in fixed beds had declined even further to 5.3 percent of the theater strength.

### FIXED HOSPITALIZATION OVERSEAS THEATERS

BEDS AS PERCENT OF STRENGTH



\* Southwest Pacific and Pacific Ocean Areas.

\*\* Exceeds T/O capacity of units set up by capacity of units staging, etc..

# HOSPITALIZATION

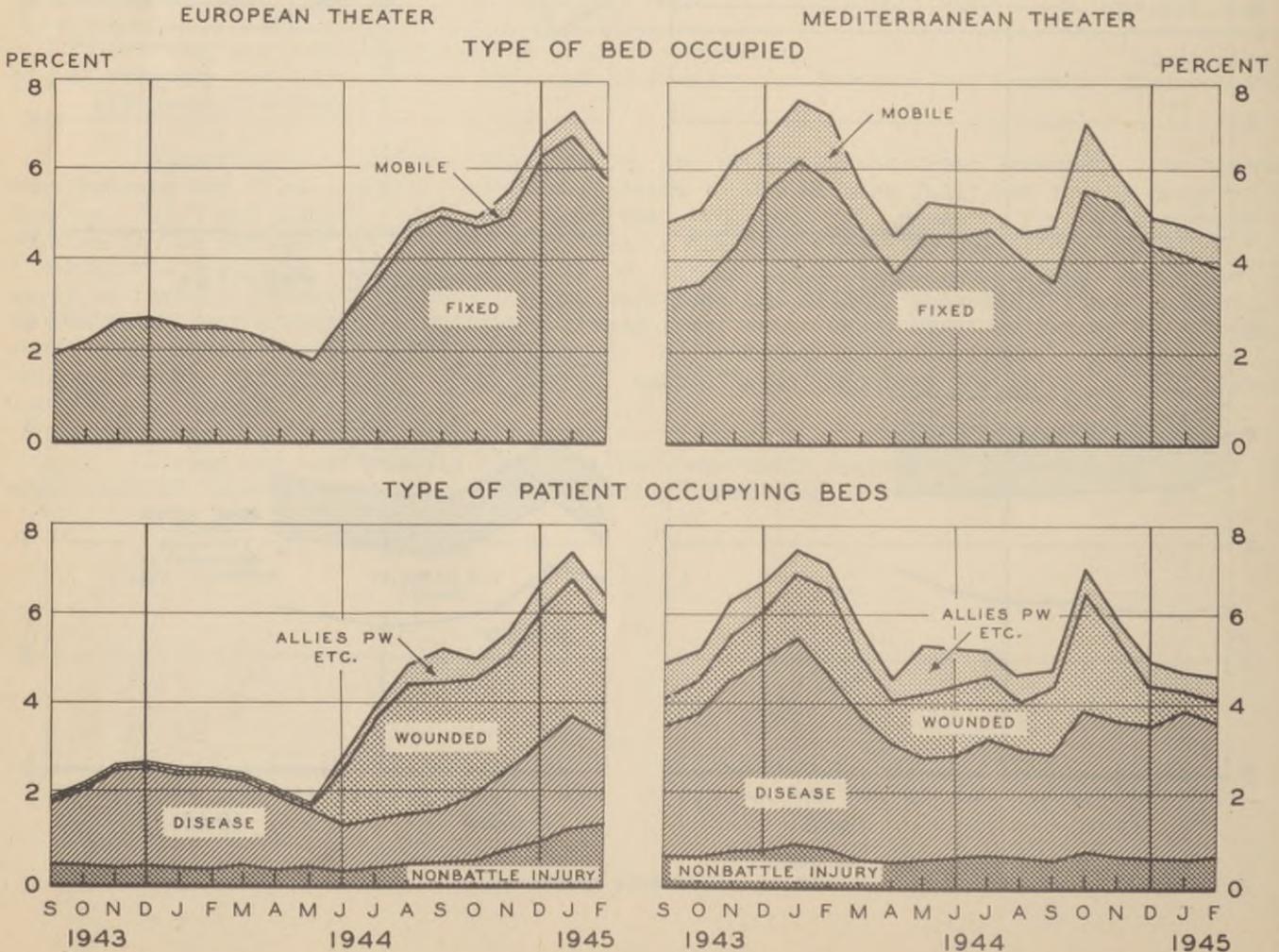
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## HOSPITALIZATION IN THE EUROPEAN THEATER

Prior to the invasion of France in June 1944, the ratio of beds occupied to strength had not exceeded 3.5 percent in the European Theater. Thereafter, however, it rose rapidly to reach a peak of 7.3 percent at the end of January 1945. In preparation for the invasion of the continent, the fixed bed capacity of the theater had been built up in the direction of the eight percent authorization then in effect. The experience of the first several months after D-Day suggested that the authorization could be reduced to seven percent with relative safety. However, as discussed in HEALTH for February, evacuation from the theater was slow in getting under way, a number of fixed hospitals were not set up in time, and too little capacity was located on the continent late in the year. In consequence, fixed hospitals became quite crowded at the end of the year and it became necessary to reduce the evacuation policy to 90 days in order to bring the hospital population to more reasonable levels.

The accompanying charts present the hospital experience of both the European and Mediterranean Theaters from the standpoint of beds occupied in fixed and mobile units on the one hand, and by type of patient on the other. Fixed bed units have borne a very heavy portion of the load, far heavier than in the Mediterranean where about 20 percent of beds occupied have been in mobile units during comparable periods. Whether this difference represents greater emphasis by the Fifth Army on holding and returning patients to duty in the army area or the more fluid tactical situation on the Western Front, or much of both, cannot be determined at this time. It is instructive to recall that the Mediterranean Theater had at times a volume of patients commensurate with that of the European Theater during its most difficult period. The chart showing type of patient indicates in striking fashion the effect of accumulating wounded in hospital. From June to February the wounded averaged 2.5 percent of strength. Of perhaps greater interest is the fact that it was the increase in nonbattle patients which appears to have tipped the scales in the direction of overcrowding at the end of the year. From the low point of less than two percent of strength in June, this component

## HOSPITALIZATION IN THE MEDITERRANEAN AND EUROPEAN THEATERS BEDS OCCUPIED AS PERCENT OF STRENGTH



# HOSPITALIZATION

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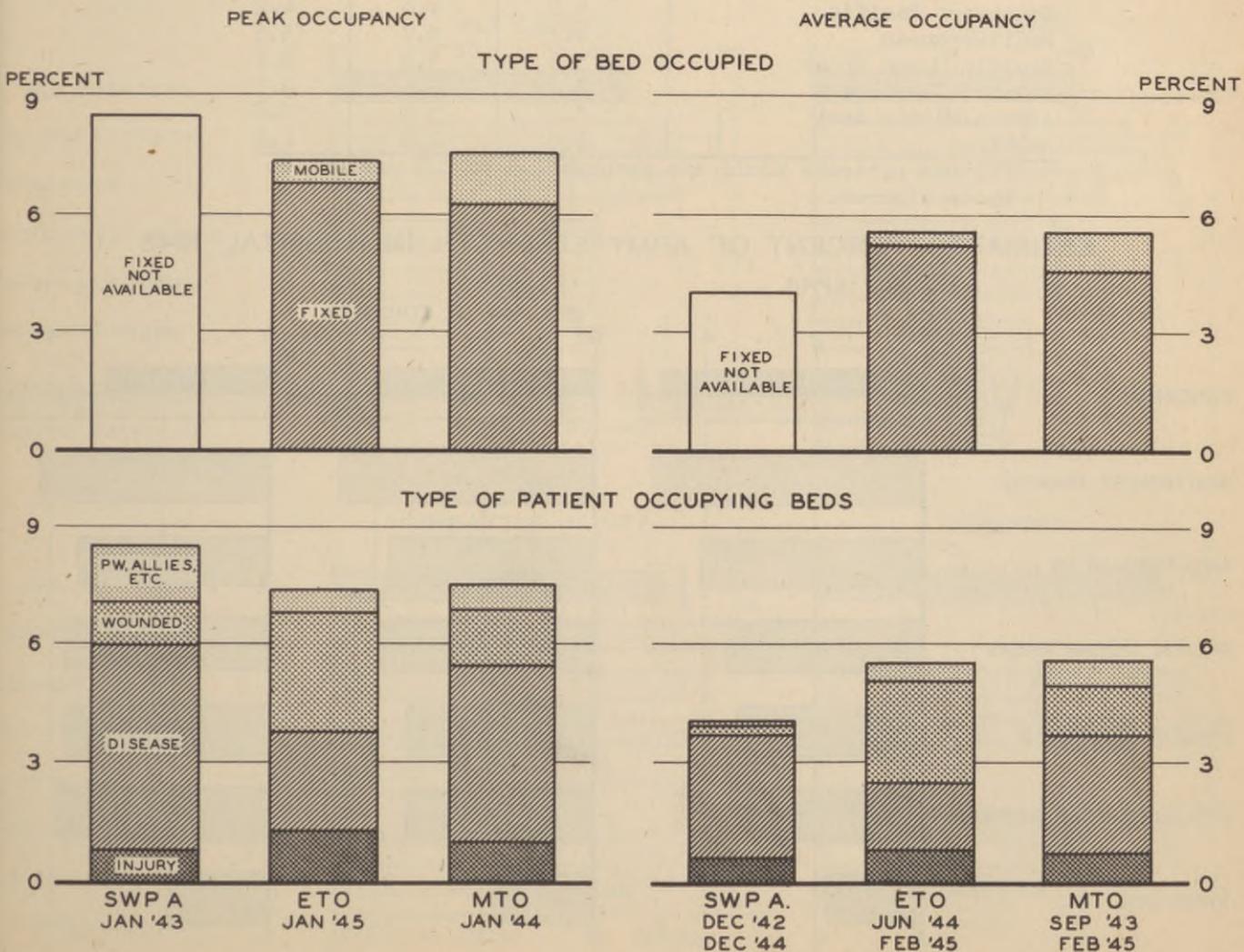
## HOSPITALIZATION IN THE EUROPEAN THEATER (Continued)

increased to 3.7 percent at the end of January. Cold injuries and traumatic psychoneuroses probably contributed in large measure to accentuate the usual winter trend. However, the January 1944 figure of 3.7 percent for nonbattle casualties is only 20 percent above the previous peak experience in February 1943, and thus within the expected range for the theater. During the fighting in Italy as high as 5.4 percent of theater strength were in hospital for nonbattle causes, but never more than 1.5 percent for wounded. Although the Mediterranean had at one time a hospital population equivalent to 7.5 percent of strength in comparison with the peak of 7.3 percent in the European Theater, its surgical load never attained the proportions observed in the European Theater and more of the patients were carried in mobile units. The peaks of occupancy in fixed beds are not as close, being 6.2 percent for the Mediterranean and 6.7 percent for the European Theater. The accompanying charts are arranged to permit ready comparison of the two theaters.

Although the winter of 1942-1943 saw disease and injury take as high a toll as 6.0 percent of strength in the Southwest Pacific, there is no reason to expect this high value to recur in future Pacific operations. On the other hand, in the face of an average of 3.7 percent in both the Southwest Pacific and the Mediterranean, it is plain that future Pacific planning for nonbattle patients must be based on values higher than those reported by the European Theater. With respect to battle casualties, on the other hand, the European experience may well provide a better guide than the Mediterranean.

In addition to their value for future planning in the Pacific, the European data provide a reasonable guide to the needs of the European Theater after V-E Day. The rates prior to the invasion of Normandy make it plain that the theater authorization for fixed beds can be reduced well below the present level of seven percent, and perhaps as low as four percent some time after V-E Day.

### PEAK AND AVERAGE BED OCCUPANCY AS PERCENT OF STRENGTH



HOSPITALIZATION

SECRET

FORECASTS OF ARMY PATIENTS IN HOSPITALS OVERSEAS

The Army hospital populations of the various theaters have been projected for several months on the basis of past experience as to admissions, average days lost, evacuation, and the like, coupled with information as to such changed conditions as increased lift for evacuation. In some instances, such as the Asiatic theaters, where there is a predictable seasonal trend with little combat, estimates of this kind are reasonably firm. In other cases, most notably the European Theater, they represent only an informed guess. It is believed, however, that such projections may be of value in visualizing some of the problems of redistributing personnel and medical resources once redeployment starts. The estimates assume no substantial redeployment until after 30 June 1945. The first series of estimates for the European Theater assumes that the number of wounded will fall to some such levels as 25,000 in April, 15,000 in May, and 5,000 to 10,000 in June. The second series of percentages for the European Theater assumes that the war will continue at the pace of March and earlier months, with 40,000 to 45,000 wounded each month. Only Army patients are included in the estimates, although in some areas substantial numbers of non-Army personnel will continue to require hospitalization. Also, the census of patients in the European Theater may be swelled somewhat by Allied prisoners of war released from enemy camps and needing medical attention.

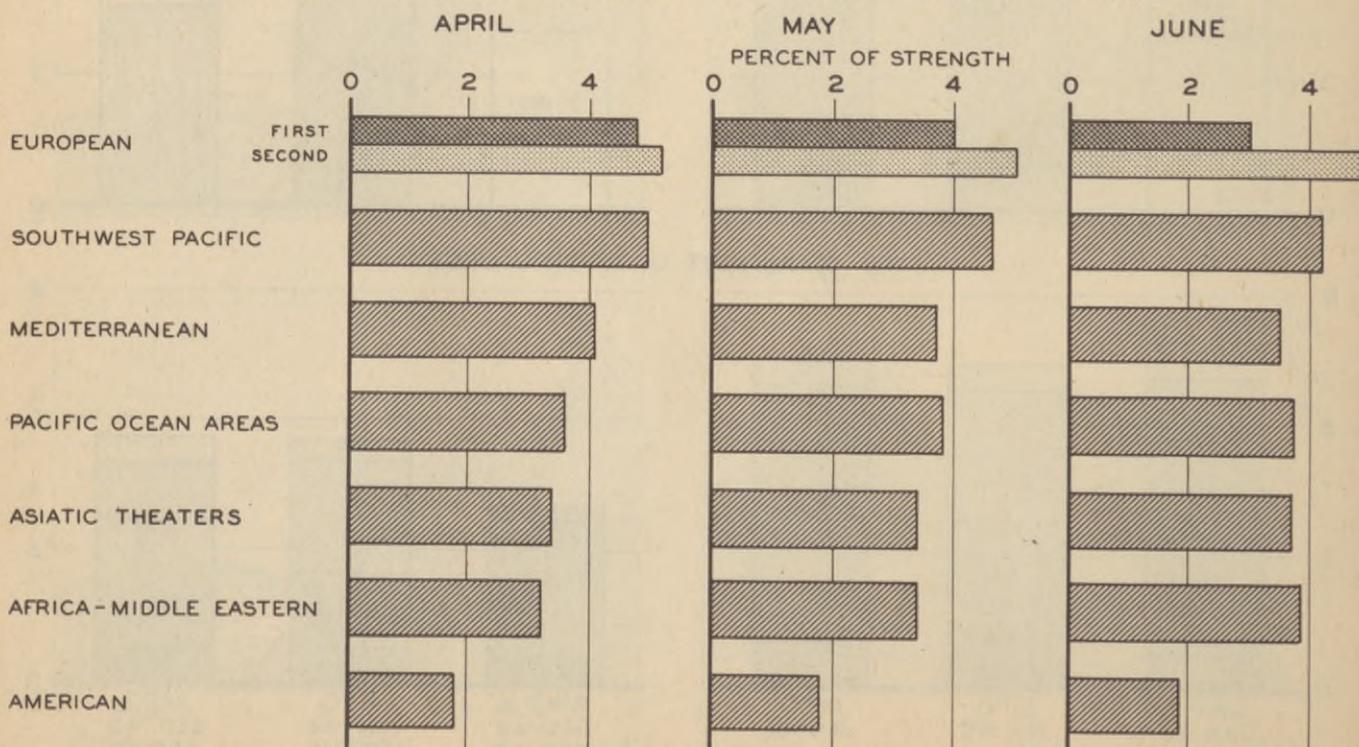
The forecasts shown below are all within the fixed authorizations of the various theaters, although the monthly averages shown there include some patients who may be expected to be in mobile beds. Readjustments in fixed bed authorizations will be necessary in both directions in the near future in recognition of the changing mission of the key theaters.

ESTIMATED PERCENTAGE OF ARMY STRENGTH IN HOSPITAL  
April, May, and June 1945

Theater	April	May	June
European (First Estimate)	4.8	4.0	3.0
European (Second Estimate)	5.2	5.0	4.8
Southwest Pacific	5.0	4.6	4.2
Mediterranean	4.1	3.7	3.5
Pacific Ocean Areas	3.6	3.8	3.7
Asiatic Theaters *	3.4	3.4	3.7
Africa-Middle East	3.2	3.4	3.8
American	1.8	1.8	1.8

\* Chinese patients would add perhaps 1.5 to 2.0 percent to these figures.

ESTIMATED PERCENT OF ARMY STRENGTH IN HOSPITAL, 1945



# HOSPITALIZATION

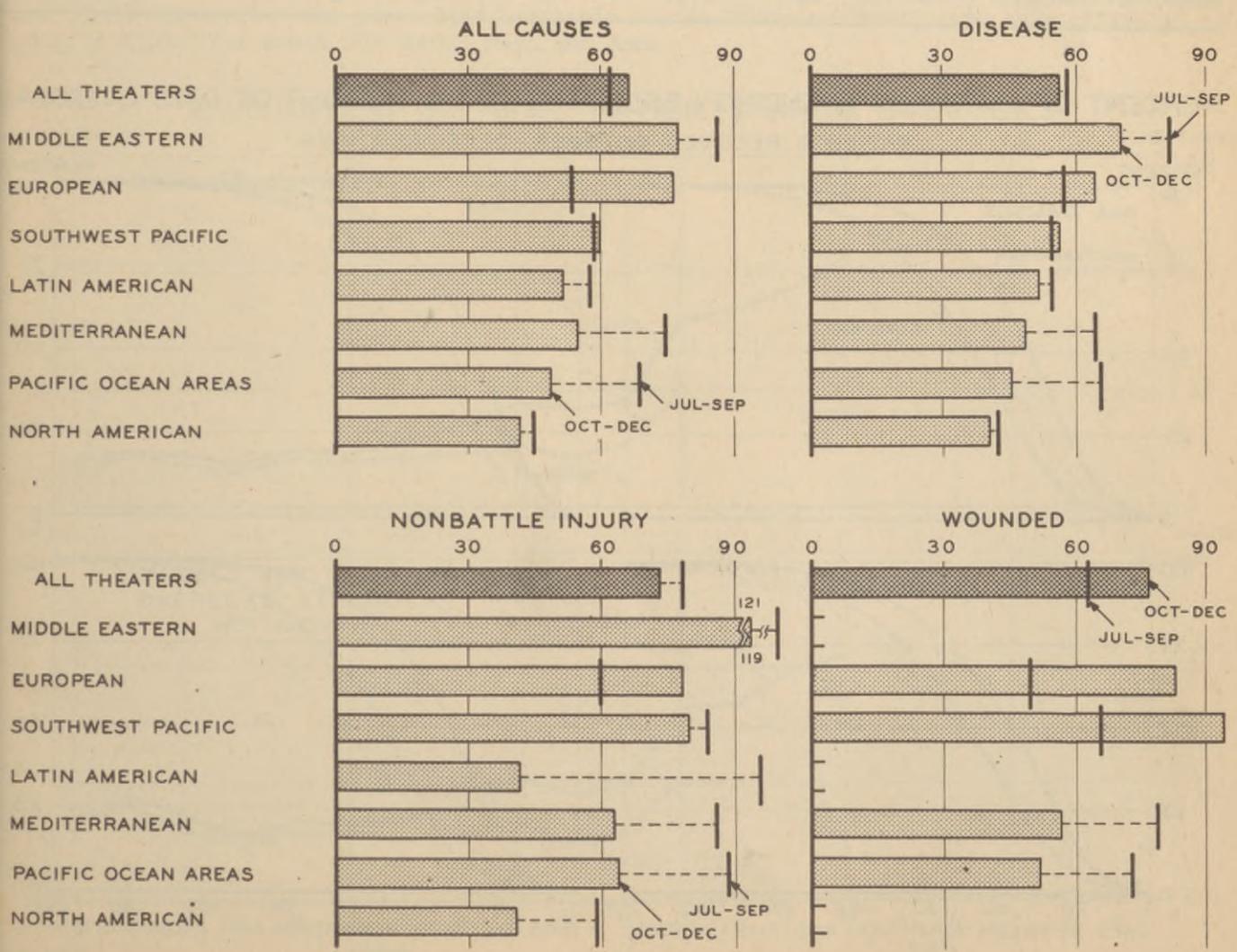
## LENGTH OF HOSPITALIZATION PRIOR TO EVACUATION

Length of hospitalization prior to evacuation has manifest significance for the efficient utilization of hospital facilities overseas, as discussed in HEALTH for December. There is ample evidence that the formal evacuation policies established for various theaters in order to implement hospitalization plans are not rigorously followed. In some instances departure from expected schedules of evacuation may not be important. In other instances, as in the European Theater, it may be serious. Where the success of a plan of hospitalization depends upon a certain evacuation policy it is important to exercise some surveillance over this aspect of evacuation. Data for this purpose are now becoming available.

All evacuees except wounded patients received during the last quarter of 1944 had spent less time in hospital overseas than patients received during the preceding quarter. The average days in hospital prior to embarkation declined from 59 to 57 for disease patients and from 79 to 74 for nonbattle injury patients, but increased from 63 to 77 days for the wounded. Only from the European Theater did all three classes of fourth-quarter evacuees (disease, injury, and wounded patients) have a longer hospitalization in the theater than patients received during the third quarter of 1944. However this was true of both disease and wounded evacuees from the Southwest Pacific. The longer hospitalization of evacuees from the European Theater in the face of a sharp increase in the rate of evacuation (see page 34) indicates that hospitals there were being cleared of patients under treatment for long periods of time. The panels below compare the various theaters with respect to the average length of time they had hospitalized evacuees who were debarked in the United States from October to December. The average duration of treatment is shown separately for disease, nonbattle injury, and wounded patients and compared with averages for patients debarked in the United States between July and September.

## AVERAGE TIME IN THEATER PRIOR TO EVACUATION

EVACUEES RECEIVED JULY-SEPTEMBER AND OCTOBER-DECEMBER 1944



# HOSPITALIZATION

**RESTRICTED**

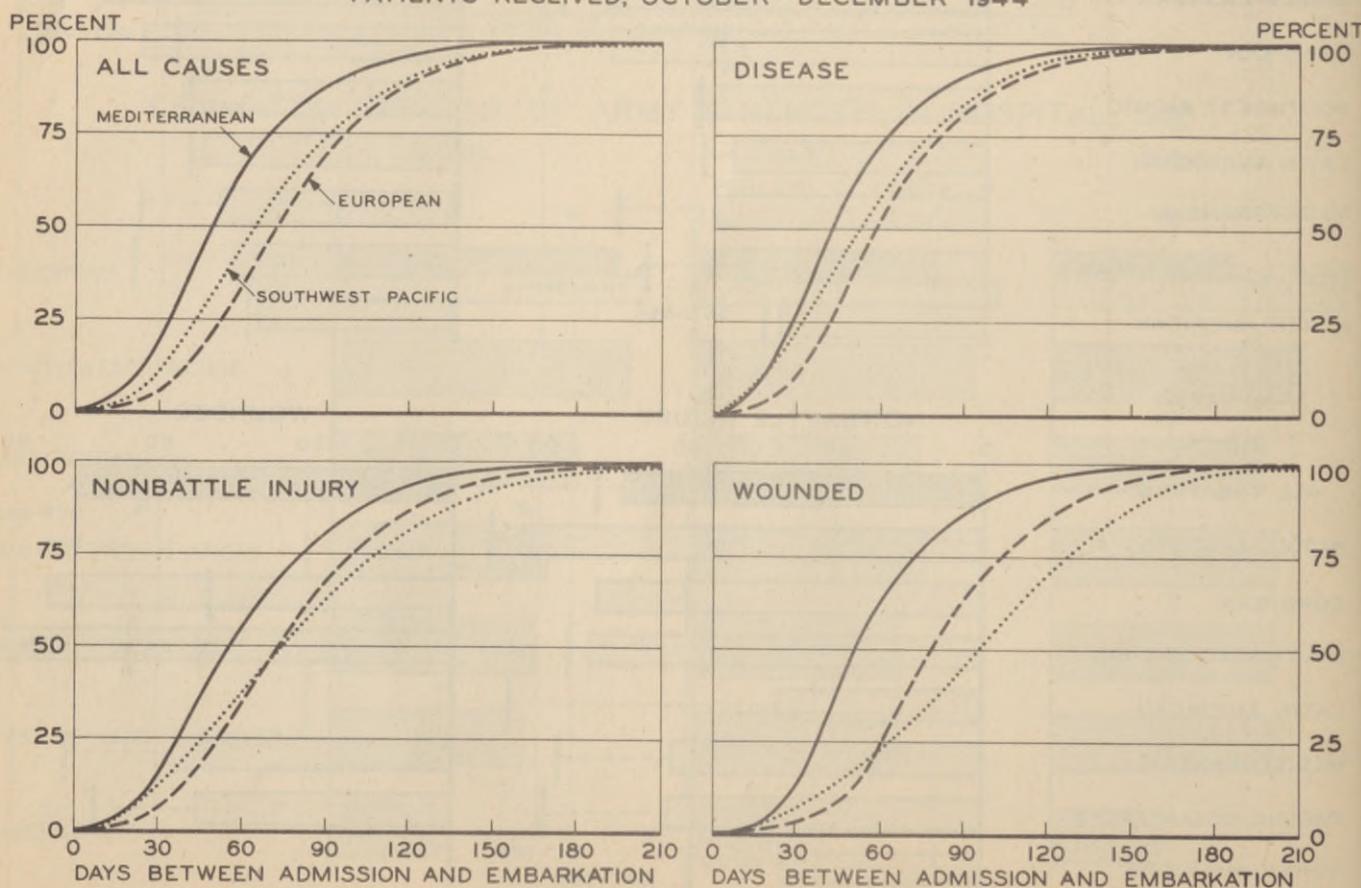
## LENGTH OF HOSPITALIZATION PRIOR TO EVACUATION (Continued)

The nature of evacuation is such that the average duration of treatment prior to evacuation needs to be supplemented by information about the proportion of patients remaining varying lengths of time prior to embarkation. For the three most active theaters the panels below give the proportion of disease, injury, and wounded patients received in the United States from October through December who had spent less than a given number of days in hospital overseas prior to embarkation. For all three broad groups the Mediterranean Theater displayed the greatest efficiency in evacuation as measured by the speed with which patients were evacuated. Whereas the Mediterranean Theater had embarked 50 percent of its disease patients after 43 days of treatment, and half of its injury and wounded patients after 55 and 50 days respectively, these figures are 59, 73, and 79 days for patients from the European Theater and 52, 76, and 95 days for patients from the Southwest Pacific. During the period when these particular patients were embarked all three theaters were technically observing a 120-day evacuation policy with the possible exception of the European Theater at the very outset of the period. However, their departure from the ideal schedule of evacuation was quite marked. As stated in HEALTH for December, under a 120-day policy it is highly desirable that all evacuees be embarked by 90 days after admission. The table below compares the several theaters with respect to the proportion of evacuees embarked after 90 and after 120 days of hospitalization.

PERCENTAGE OF EVACUEES WHO WERE EMBARKED AFTER 90 AND 120 DAYS OF TREATMENT  
Patients Received in United States October-December, 1944

Theater	Embarked after 90 Days				Embarked after 120 Days			
	All Causes	Disease	Nonbattle Injury	Wounded	All Causes	Disease	Nonbattle Injury	Wounded
Mediterranean	13	9	19	13	4	3	6	4
European	31	18	33	35	11	6	13	14
Southwest Pacific	26	16	37	54	10	5	18	32

PERCENT OF EVACUEES SPENDING LESS THAN GIVEN NUMBER OF DAYS OVERSEAS  
PATIENTS RECEIVED, OCTOBER - DECEMBER 1944



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# HOSPITALIZATION

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## TREND OF EVACUATION FROM OVERSEAS

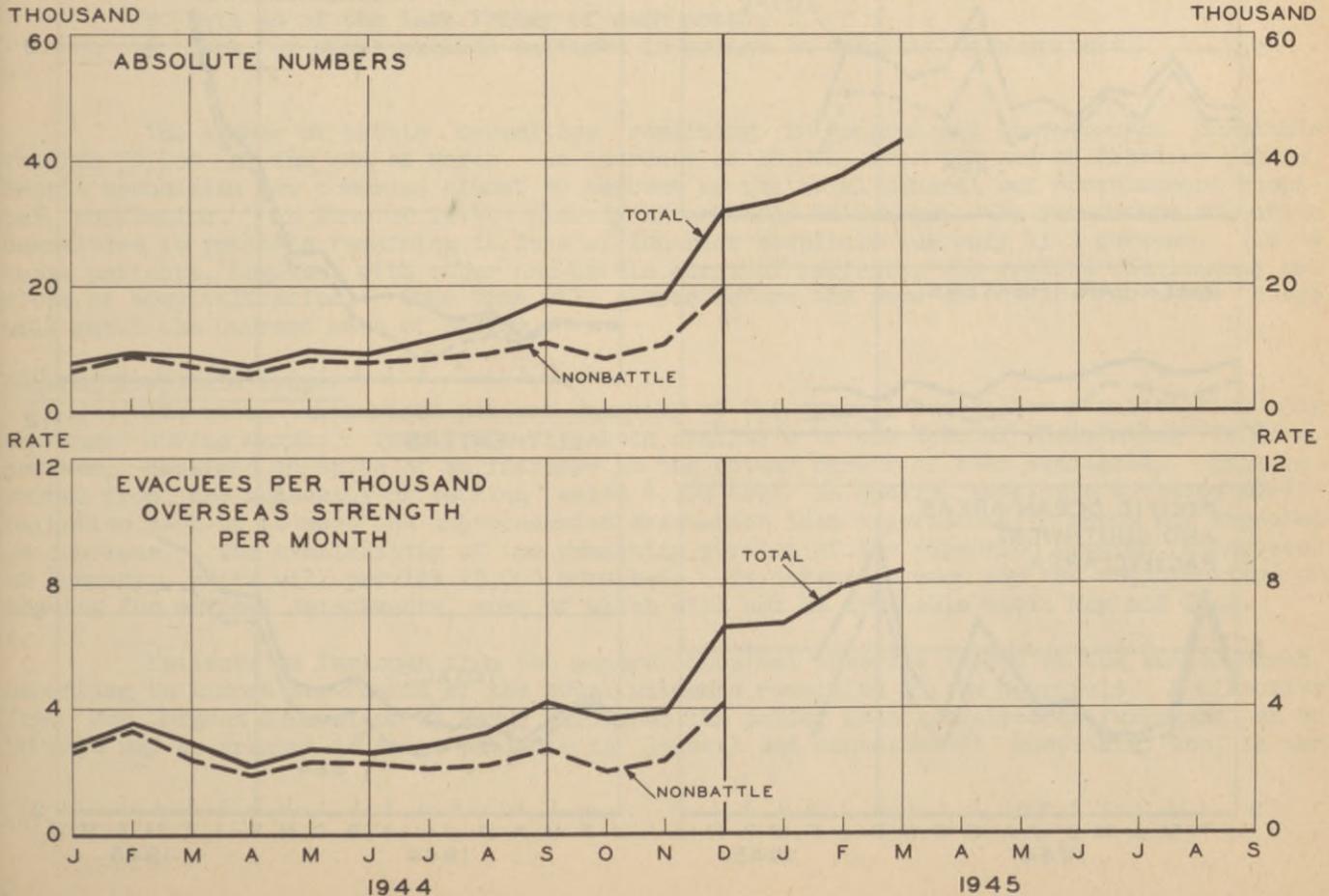
According to provisional transportation reports, the volume of Army patients debarked in U. S. ports rose to the unprecedented height of about 43,000 Army patients during March, an increase of nearly 6,000 over the final count of 37,100 for February. Air lift reached a new peak of about 7,500 patients, and there was an increase of almost 5,000 in the water lift from the Southwest Pacific. The accompanying table summarizes debarkations since the beginning of the war, by type of transportation.

ARMY PATIENTS DEBARKED

Year	Total	Air	Water
1942	6,700		6,700
1943	70,400	3,300	67,100
1944	159,800	30,700	129,100

The April volume may be expected to decline below the March level, since all theaters embarked only 30,300 in March by ship in comparison with 35,600 in February, and there is a lag of about two weeks in water transportation. A potential lift of 45,000 to 60,000 each month may be expected for the next few months, and the War Department has instructed the European Theater to make full utilization of all available evacuation capacity. The JCS forecasts originally prepared on the assumption of continued, full-scale hostilities in Europe through June, no longer provide a reasonable guide to the future volume of evacuation and have been dropped from the accompanying charts. For all theaters except the European, however, it seems reasonable to forecast a total of approximately 10,000 evacuees per month for April, May, and June. If the European Theater succeeds in evacuating 30,000 to 40,000 patients per month during this period, the total debarkation volume should run between 40,000 and 50,000 patients. The total lift available to the European Theater has been estimated at roughly 45,000 per month for April, May, and June.

## EVACUATION OF ARMY PATIENTS FROM OVERSEAS



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# HOSPITALIZATION

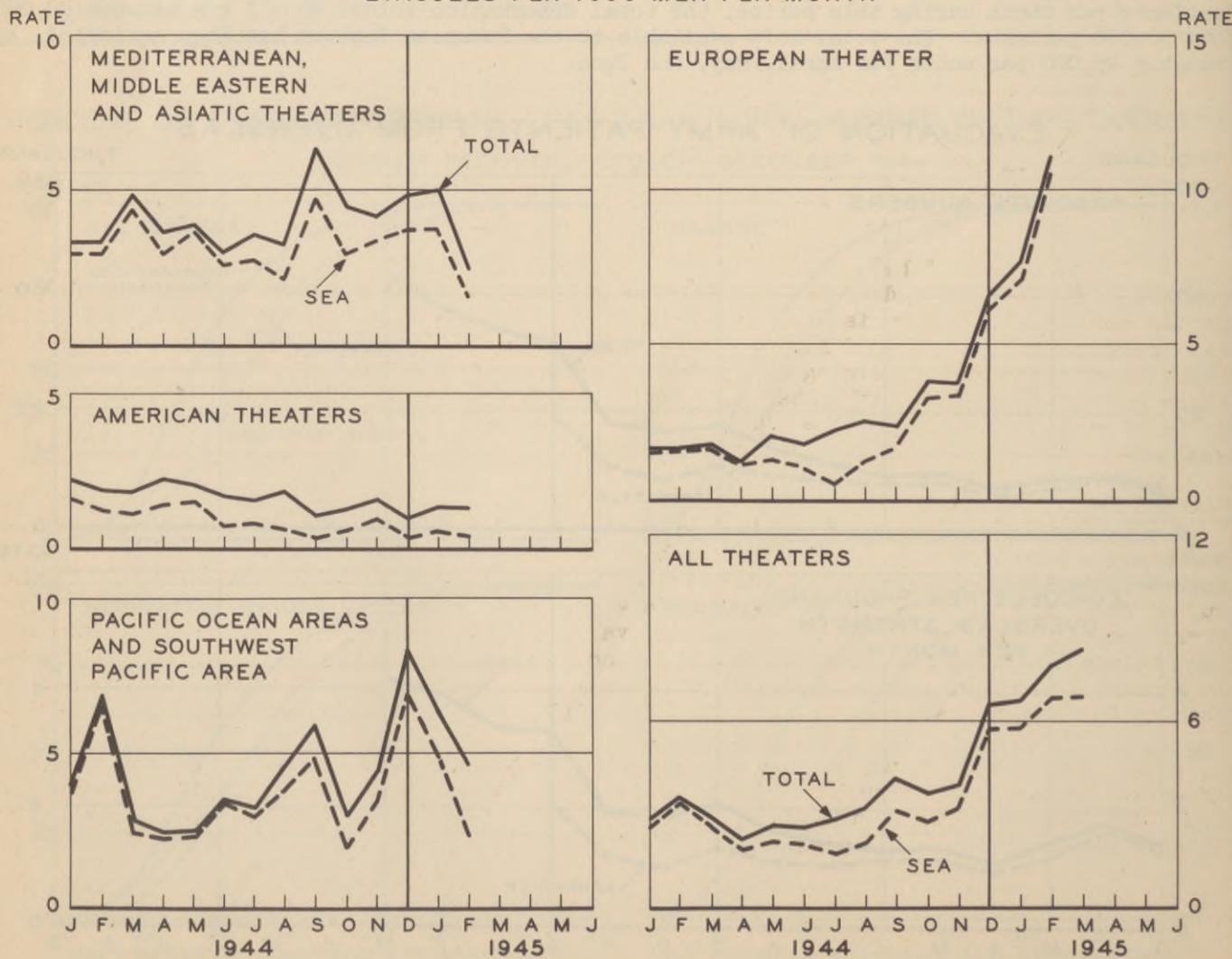
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## TREND OF EVACUATION FROM OVERSEAS (Continued)

In view of the necessity for combining the Southwest Pacific Area and the Pacific Ocean Areas in presenting their evacuation experience, it is no longer advantageous to provide theater data on the basis of embarkations in contrast to the data on debarications on the previous page. Hence the accompanying chart has been redrawn on the basis of transportation reports of Army patients debarked in the U. S. according to theater of origin.

The rate for the European Theater continued its precipitous rise in February, exceeding 11 evacuees per thousand theater strength per month. Elsewhere, except for the American theaters, there were sharp declines. However, it is known that the Southwest Pacific debarked 6,300 patients by water alone in March in contrast to 1,600 in February. The European Theater debarked about 27,000 Army patients by water in March, slightly less than the 28,000 reported for February. If account were taken of released PW's treated as patients upon their return to the Z/I, the counts would be almost the same for the two months. However, the water embarkation figures are 28,000 for February and 23,000 for March, suggesting a possible decline in April debarications from the European Theater unless embarkations are especially heavy during the first half of April. The theater is operating on a 90-day evacuation policy at the present time and may adopt a shorter policy before the collapse of Germany. It is doubtful if all transportation available to the European Theater can be used without further reduction in evacuation policy. There is every advantage in evacuating as much of the load as possible before Germany falls, while transportation is still plentiful, and with view to facilitating the redeployment of medical units needed elsewhere. On the other hand, if the number of wounded declines appreciably in April and May, the hospital population will be materially reduced even without any great increase in the volume of evacuation.

ARMY PATIENTS DEBARKED IN THE U. S. FROM OVERSEAS THEATERS  
EVACUEES PER 1000 MEN PER MONTH



# HOSPITALIZATION

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## HOSPITALIZATION IN THE ZONE OF INTERIOR

### Patient Trend

During the month of March, over 45,000 patients were evacuated from overseas theaters to the Zone of Interior, a new high in evacuation. This March figure represents an increase of 7,000 over February evacuations.

A direct reflection of this increase was the rise in the general and convalescent hospital population to a new peak of 181,700 (excluding patients in debarkation beds) at the end of March 1945. During a five-week period, from the end of February to the end of March, there was a net gain of 31,076 patients in the general-convalescent hospital system, or a rate of 6,200 patients per week. This rate of gain can be compared with the rate of 4,700 in February and 6,100 in January.

U. S. ARMY PATIENTS EVACUATED FROM OVERSEAS, TOTAL PATIENTS REMAINING  
AND BATTLE CASUALTIES REMAINING IN THE GENERAL  
AND CONVALESCENT HOSPITALS  
July 1944-March 1945

Month	Overseas Evacuees Received during Month*	Patients Remaining End of the Month**	
		All Patients	Battle Casualties
July 1944	10,566	61,954	8,926
August	13,970	69,367	12,061
September	16,630	79,315	17,138
October	17,437	87,282	24,158
November	17,852	95,068	28,765
December	31,350	108,640	37,335
January 1945	33,456	132,842	47,649
February	37,727	150,624	55,535
March	45,131	181,700#	70,555#

\* Based on patients processed through debarkation hospitals during the calendar month.

\*\* Data as of the last Friday of each month.

# Data for March exclude patients in triage in debarkation hospitals.

The number of battle casualties remaining in general and convalescent hospitals reached 70,555 at the end of March, an increase of 15,000 over the end of February figure. Battle casualties now comprise almost 40 percent of the total general and convalescent hospital population. In June of 1944, shortly after D-Day in Europe, the percentage of battle casualties to patients remaining in Zone of Interior hospitals was only 11.7 percent. It is these patients, together with other non-battle surgical patients, who require the longest periods of hospitalization. Some time will elapse before the rate of outflow for these cases will match the current rate of inflow.

### General Hospitals Proper

The total authorized patient capacity of the general hospitals remained virtually unchanged during March. Total effective beds available to the Medical Regulating Officer, however, declined in spite of an increase in the actual number of beds available. This resulted from the necessity of setting aside 4,100 beds in general hospitals to serve as debarkation back-up to meet the unprecedented evacuation load experienced in March and expected to continue. The availability of the remaining portion of the expansion program undertaken in January, which will provide 15,000 more beds, is dependent upon the new construction of housing for medical detachments, most of which will not be available until May and June.

Patients on furlough from the general hospital numbered 35,000 at the end of March, amounting to almost one-fourth of the total patients remaining in the hospitals. A directive from The Surgeon General on 23 March laid down the policy that convalescent furloughs up to 90 days may be granted to those patients in general and convalescent hospitals, who, in the

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**RESTRICTED****HOSPITALIZATION**HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

opinion of the commanding officer of the hospital, can convalesce as well or better at home than in the hospital. Included in this category are many types of patients such as those suffering from peripheral nerve injuries; having dermatological conditions; undergoing plastic operative procedures; etc. To facilitate the administrative paper work connected with the granting of furloughs, Circular 111, WD, 1945, was issued, revising AR 605-115 and AR 615-275 to allow commanding officers of general and convalescent hospitals (Z/I) to grant sick leaves and convalescent furloughs for periods not to exceed 90 days.

PATIENTS REMAINING IN GENERAL HOSPITALS PROPER  
End of March 1945

Command	Number of Hospitals	Authorized Patient Capacity*	Effective Beds**	Patients Remaining		Beds Occupied
				Number	Percent of Effective Beds	
Total	65	153,362	137,124	141,531	103.2	106,706
Service Commands						
First	3	9,000	7,200	6,152	85.4	4,980
Second	5	17,732	12,732	12,296	96.6	10,468
Third	5	10,375	9,093	10,287	113.1	7,578
Fourth	12	28,793	26,668	29,537	110.8	22,771
Fifth	8	14,397	14,397	16,192	112.5	9,860
Sixth	4	8,230	8,205	8,522	103.9	6,863
Seventh	5	13,434	13,434	12,720	94.7	10,141
Eighth	10	21,396	21,396	22,511	105.2	15,852
Ninth	12	27,005	20,999	20,310	96.7	15,885
The Surgeon General (Walter Reed)	1	3,000	3,000	3,004	100.1	2,308

\* Sub-authorized by Office of Surgeon General on basis of total authorization of 169,500 from G-4.

\*\* Authorized beds less 11,565 debarkation beds; 4,100 beds held for debarkation back-up purposes; and 573 beds not yet available for use by Medical Regulating Officer.

For the first time, total patients remaining in the general hospitals at the end of March exceeded total effective beds. This situation prevailed in all service commands except the First, Second, Seventh and Ninth Service Commands. The First Service Command had the lowest ratio of patients remaining to effective beds -- 85.4 -- and the Third Service Command the highest -- 113.1. The largest increase in number of patients was experienced by hospitals of the Fourth Service Command where patients remaining rose from 24,447 at the end of February to 29,537 at the end of March.

Convalescent Hospitals

The rapidly mounting patient load in the general hospitals has placed increasing emphasis upon the need for the speedy completion of the convalescent hospital expansion program. During the month of March, operating capacities of the convalescent hospitals, as used by the Medical Regulating Officer, increased from 33,750 to 40,750. The latter figure represents approximately 80 percent of the total planned capacity of the program. During the same period, there was a concomitant rise in the number of patients remaining in the convalescent hospitals: from 24,208 at the end of February to 40,169 at the end of March. These data by individual hospital are as follows:

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# HOSPITALIZATION

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HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

OPERATING CAPACITIES AND PATIENTS REMAINING IN CONVALESCENT HOSPITALS  
February and March 1945

Hospital	Operating Capacity		Patients Remaining		End of March	
	End of March	End of February	End of March	End of February	Percent Patients Remaining of Operating Capacity	Percent Beds Occupied of Operating Capacity
Total	40,750	33,750	40,169	24,208	98.6	54.0
Edwards	5,200	3,750	4,197	1,964	80.7	8.5
Upton	3,500	3,500	2,690	3,413	76.9	60.9
Pickett	4,000	2,000	4,027	303	100.7	15.8
Story	1,800	1,800	2,041	2,550	113.4	101.7
Butner	4,500	2,500	4,531	556	100.7	23.3
Welch	3,500	3,500	2,864	3,387	81.8	65.9
Wakeman	5,500	5,000	5,118	4,508	93.1	78.7
Percy Jones	5,500	5,000	4,751	2,903	86.4	66.1
Carson	3,700	3,000	5,810	2,075	157.0	76.3
Brooke	2,000	1,500	2,699	1,280	135.0	105.9
Mitchell	1,350	2,000	1,331	1,178	98.6	43.2
Old Farms	200	200	110	91	55.0	55.0

The above data indicate definite progress in increasing the patient holding capacity of convalescent hospitals. There was an increase of 7,000 operating capacity during March. Not all of this capacity has yet been converted to meet prevailing standards, although work is proceeding rapidly.

The conversion program for barracks, classrooms, and other facilities made it advisable to place many patients on furlough which together with a liberal furlough policy for all patients returned from overseas; explains the fact that at the end of March, 45 percent of the entire convalescent hospital patient load was on furlough. It is anticipated that as soon as the facilities are fully converted, the furlough rate will decrease.

The personnel situation improved noticeably during March, although shortages continue to exist in certain key categories, especially Medical Corps officers and trainer personnel. Service Commands are transferring wherever possible Medical Corps officers to overcome prevailing shortages and progress is likewise being made in overcoming the trainer shortage.

Shortages in equipment for both physiotherapy and occupational therapy continued in March. However, these shortages are being constantly reduced.

The rate of progress during March towards a complete and rounded convalescent hospital program exceeded that of any other month.

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**RESTRICTED****HOSPITALIZATION**HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)Station and Regional Hospitals

Authorized and effective beds in station and regional hospitals declined in March in line with reduction of troop strengths served. Total patients remaining amounted to 93.7 percent of total effective beds. For station hospitals, percent patients remaining of effective beds amounted to 88.2, in regional hospitals 106.6, and in hospitals under The Chief of Transportation 58.5. Examination of these ratios by service command indicates that generally effective utilization of available beds in the station and regional hospital system is being secured.

**BEDS AUTHORIZED AND PATIENTS REMAINING IN STATION AND REGIONAL HOSPITALS**  
End of March 1945

Command	Authorized Beds*	Effective Beds**	Patients Remaining		Beds Occupied ***
			Number	Percent of Effective Beds	
Army Service Forces - Total	74,005	53,524	50,169	93.7	49,038
Service Commands - Total	60,769	48,615	47,297	97.3	46,200
Station Hospitals	30,711	24,569	21,670	88.2	21,422
First	220	176	81	46.0	80
Second	1,659	1,327	916	69.0	903
Third	2,279	1,823	1,532	84.0	1,501
Fourth	4,725	3,780	3,895	103.0	3,870
Fifth	1,008	807	330	40.9	321
Sixth	1,146	917	1,087	118.5	1,009
Seventh	2,093	1,675	1,038	62.0	1,034
Eighth	12,543	10,034	8,970	89.4	8,935
Ninth	4,245	3,396	3,339	98.3	3,287
MDW	793	634	482	76.0	482
Regional Hospitals	30,058	24,046	25,627	106.6	24,778
First	550	440	510	115.9	472
Second	1,034	827	1,148	138.8	1,078
Third	2,850	2,280	2,604	114.2	2,503
Fourth	10,250	8,200	8,547	104.2	8,285
Fifth	1,574	1,259	1,693	134.5	1,682
Seventh	2,750	2,200	2,339	106.3	2,285
Eighth	7,200	5,760	5,161	89.6	4,978
Ninth	3,850	3,080	3,625	117.7	3,495
Chief of Transportation-Total	13,236	4,909	2,872	58.5	2,838

\* Authorized by Commanding Generals of Service Commands or by Chief of Transportation.

\*\* Authorized beds less an allowance of 20 percent for dispersion and 7,100 debarkation beds in Chief of Transportation hospitals.

\*\*\* Difference between number of patients remaining and corresponding number of beds occupied represents number of patients temporarily absent from hospital on sick leave, furlough or AWOL.

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# HOSPITALIZATION

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## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

### Personnel

The major trends in personnel during March can be summarized as follows:

- a. The change to Circular 209, WD, 1944, eliminating the conversion factor of three civilians for two enlisted men and establishing a principle of one for one conversion, represented a reduction in requirements in excess of 20,000 for the entire Zone of Interior hospital system. Specifically, it involved a reduction in requirements for the general hospitals alone of more than 15,000. With general hospitals operating at peak capacity, the revised personnel guides will probably prove inadequate from point of view of securing the most expeditious treatment and processing of patients.
- b. The Medical Corps shortages in station and regional hospitals all but disappeared during March as a result of a substantial reduction in the number of authorized station and regional hospital beds which reflected a declining requirement for such hospitalization.
- c. Shortages of Medical Corps officers have continued in the same magnitude at general and convalescent hospitals.
- d. Reflecting the very large increase in recruitment, the nurse shortage was more than halved.
- e. As far as total personnel is concerned, the hospital system is substantially in balance. However, it must be emphasized again that this balance is the direct result of the amendment to Circular 209, WD, 1944, without which the hospital system at this time would have a total shortage in excess of 20,000.

### Summary

- a. New peaks in evacuations and patients remaining in general hospitals have not strained existing facilities because of the existence of a liberal furlough policy.
- b. The convalescent hospital program made considerable progress in March, but it will not be in full operation until current work on facilities is completed, which will probably not occur until June or even later.
- c. A high utilization of beds continues to be the case at station and regional hospitals.
- d. Total personnel requirements have been cut by the revision of WD Circular 209 to a point of eliminating almost entirely the overall personnel shortage. The nurse shortage has been reduced as a result of improved recruiting. Shortages of Medical Corps officers continue to exist.

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR\*  
End of March 1945

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages***		
			Number	Percent of Effective Beds		MC	ANC	Total
	Authorized	Effective**						
Total	264,131	226,489	228,997	101.1	174,894	574	1,948	799
Station and Regional	60,769	48,615	47,297	97.3	46,200	25	845	-1,284
General	153,362	137,124	141,531	103.2	106,706	248	1,156	1,735
Convalescent	50,000	40,750	40,169	98.6	21,988	301	- 53	348

\* Excludes station hospitals under the Chief of Transportation.

\*\* Defined in two preceding tables.

\*\*\* Shortages make no allowance for availability of 3,090 protected personnel, consisting of approximately 402 Medical Corps officers and 2,688 corpsmen, since this personnel must be supervised by American medical officers, and, therefore, is not equivalent to corresponding categories of American personnel.

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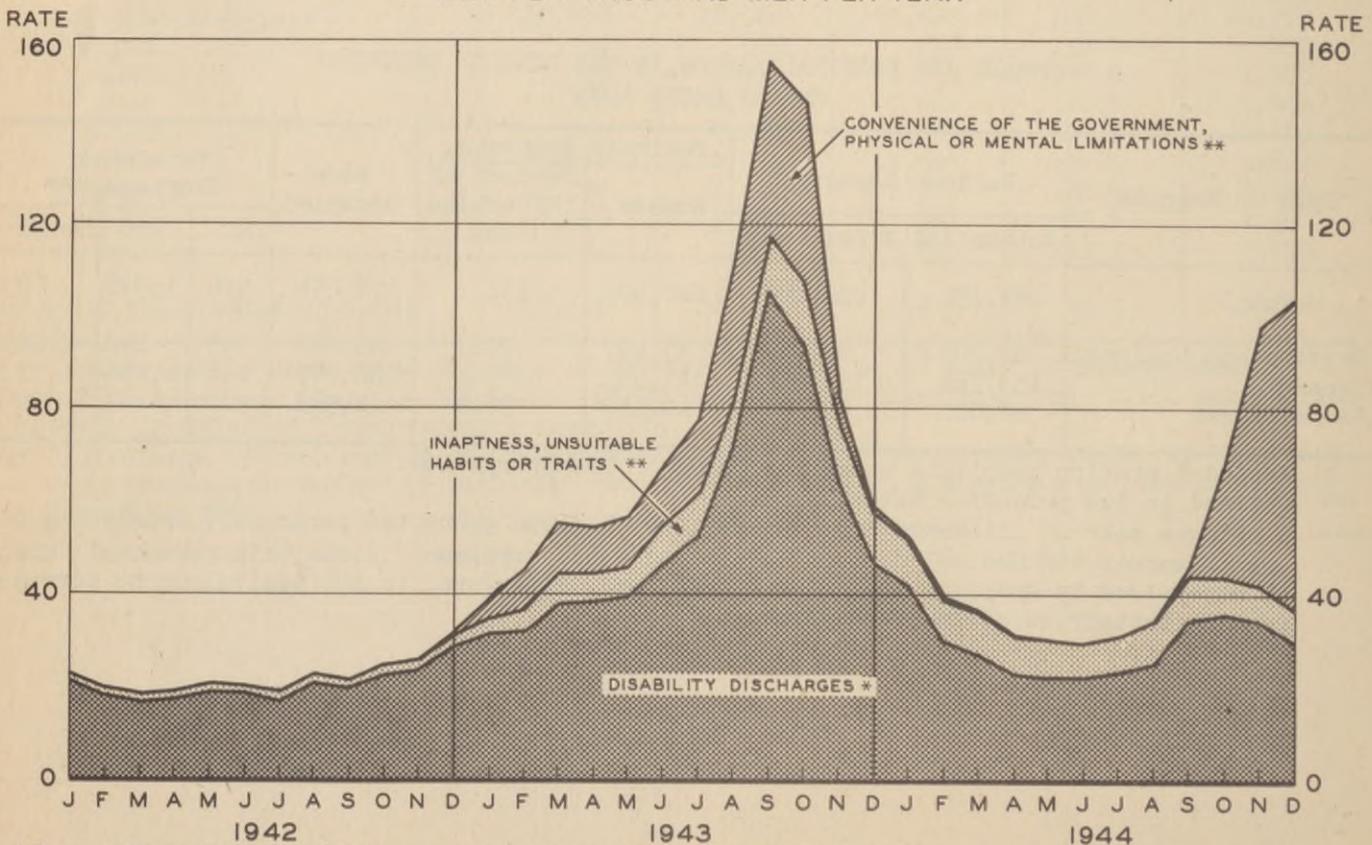
SEPARATIONS FROM THE ARMY FOR PHYSICAL AND MENTAL REASONS

From the beginning of the war through 1944 about 935,000 officers and men on active duty in the Army were discharged for reasons directly or indirectly attributable to physical and mental defects. This total is made up of about 625,000 discharges for disability, 85,000 for inaptness, 35,000 for undesirable habits or traits of character, and 190,000 for the convenience of the government because of physical or mental limitations affecting the performance of military duties. This loss of manpower, approximating in number about 60 divisions, is a matter of considerable importance, especially since a substantial portion of the total discharges reflect changes in administrative policies applicable to discharges, and abuse by command in effecting discharges through medical channels, rather than defects acquired by the men while in service or brought to light subsequent to induction.

The disability discharge experience among enlisted men during the three-year period 1942-1944 is presented below by major cause of discharge. The table shows for each year the number of cases, annual rates per 1,000 strength, and percentage distribution by cause.

In comparing the experience for the three years the major changes in administrative policy affecting disability discharges should be kept in mind. WD Circular 161 of July 1943 permitted discharge of men not able to meet current mental and physical standards for induction and is largely responsible for the sharp increase in the 1943 rate over that for 1942. In November 1943 WD Circular 293 reversed this policy and stressed the importance of keeping in service all men who could perform adequate service in any military assignment. A fairly strict policy as regards discharge was followed from that time until September 1944 when WD Circular 370 again permitted discharge of men unable to meet current induction standards with the added proviso that no appropriate position be available for the man in the major command or defense command in which he was then serving. This resulted in an immediate increase in the disability discharge rate, but a directive issued in the same month provided that ordinarily discharges were to be granted for the convenience of the government rather than for disability, since most defects would not be disabling to a degree sufficient to warrant discharge on a certificate of disability. A ruling issued at the end of January 1945 rescinded Circular 370.

SEPARATIONS OF ENLISTED MEN FOR PHYSICAL AND MENTAL REASONS, 1942-1944
RATES PER THOUSAND MEN PER YEAR



\* Based on forms 52 to Apr 1943 AGO separation cards thereafter by month of separation.
\*\* Based on data in AGO separation reports, by month of processing.

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SEPARATIONS FROM THE ARMY FOR PHYSICAL AND MENTAL REASONS (Continued)

The most important cause of disability discharge with respect to both number of cases and sensitivity to change in administrative policy has been psychoneurosis. During the three-year period 1942-1944 more than 177,000 men were granted disability discharges for this cause, which accounted for almost 68 percent of the disability discharges for all neuropsychiatric defects and about 29 percent of the total for all causes combined. The number of disability discharges for neuropsychiatric causes does not reveal the full importance of this group of defects as causes of discharge because a large majority of cases administratively discharged for inaptness and for undesirable habits and traits of character, and a certain proportion of those discharged for the convenience of the government because of mental or physical limitations, were also separated for defects which were neuropsychiatric in nature. Probably more cases of abuse of medical channels of separation have arisen in the neuropsychiatric defect group than in any other group.

The large increase in 1943 over 1942 in the rate of disability discharge for arthritis, eye, ear, feet, respiratory, cardiovascular and general musculo-skeletal defects is directly traceable to WD Circular 161 because considerable numbers of men who were borderline and substandard in these respects had been inducted during the earlier period of the war when emphasis was placed on the induction of every available man in the classes not otherwise deferred who could be reasonably expected to perform satisfactory military service.

It is interesting to note that the disability discharge rate for traumatism, which include battle casualties, did not reach a very substantial figure in 1944 although the trend is definitely upward. A long duration of treatment is usually required in the case of battle casualties and a substantial number of men who will ultimately receive disability discharges were still in the hospital at the end of 1944.

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## DISCHARGE FOR DISABILITY (Continued)

DISABILITY DISCHARGES FROM 7 DECEMBER 1941 THROUGH 31 DECEMBER 1944

Cause	Disability Discharges	
	Number	Percent
GRAND TOTAL	620,068	100.0
<u>Tuberculosis</u>	<u>10,863</u>	<u>1.8</u>
<u>Venereal</u>	<u>4,732</u>	<u>0.8</u>
Syphilis	4,061	0.7
Gonorrhoea	472	0.1
Other	199	0.0
<u>Other Infectious &amp; General Diseases</u>	<u>56,840</u>	<u>9.2</u>
Infectious & Parasitic	1,798	0.3
Cancer	1,043	0.2
Arthritis	33,510	5.4
Blood, Blood Forming Organs	1,096	0.2
Other	19,393	3.1
<u>Neuropsychiatric</u>	<u>263,856</u>	<u>42.3</u>
Neurological	15,121	2.4
Epilepsy	12,116	2.0
Psychoneurosis	178,149	28.6
Constitutional Psychopathic State	1,333	0.2
Mental Deficiency	4,773	0.8
Schizophrenia	28,183	4.5
Alcoholism	178	0.0
Neurocirculatory Asthenia	6,974	1.1
Other Neuropsychiatric	17,029	2.7
<u>Eye, Ear, Nose &amp; Throat</u>	<u>46,519</u>	<u>7.5</u>
Eye	20,379	3.3
Ear	20,921	3.4
Nose and Throat	5,219	0.8
<u>Respiratory</u>	<u>37,028</u>	<u>6.0</u>
<u>Cardiovascular</u>	<u>42,847</u>	<u>6.9</u>
Organic, Valvular Heart Disease	18,703	2.9
Hypertension	8,098	1.3
Varicose Veins	4,707	0.8
Hemorrhoids	1,070	0.2
Coronary Thrombosis, Embolism, Sclerosis	1,004	0.2
Other Cardiovascular	9,265	1.5
<u>Gastro-intestinal</u>	<u>44,459</u>	<u>7.2</u>
Teeth	234	0.0
Gastric, Duodenal Ulcer	37,457	6.1
Other	6,768	1.1
<u>Genito-urinary</u>	<u>11,549</u>	<u>1.9</u>
<u>Bones &amp; Organs of Locomotion</u>	<u>79,404</u>	<u>12.8</u>
Feet	26,116	4.2
Musculo-skeletal	45,460	7.4
Congenital Malformation	3,881	0.6
Hernia	3,947	0.6
<u>Traumatism, Results of</u>	<u>20,297</u>	<u>3.3</u>
Fracture	6,291	1.0
Amputation	2,993	0.5
Other Traumatisms of Musculo-Skeletal System	8,229	1.4
Traumatism, Internal	630	0.1
<u>Other</u>	<u>3,828</u>	<u>0.6</u>

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## DISCHARGE FOR DISABILITY (Continued)

Cause	Number of Discharges			Per Thousand Men Per Year			Percentage Distribution		
	1942	1943	1944	1942	1943	1944	1942	1943	1944
GRAND TOTAL	62,013	348,964	205,091	20.76	56.21	29.00	100.0	100.0	100.0
<u>Tuberculosis</u>	<u>2,403</u>	<u>4,643</u>	<u>3,513</u>	<u>0.80</u>	<u>0.75</u>	<u>0.50</u>	<u>3.9</u>	<u>1.3</u>	<u>1.7</u>
<u>Venereal</u>	<u>414</u>	<u>3,013</u>	<u>1,289</u>	<u>0.14</u>	<u>0.49</u>	<u>0.18</u>	<u>0.7</u>	<u>0.9</u>	<u>0.6</u>
<u>Syphilis</u>	<u>346</u>	<u>2,597</u>	<u>1,102</u>	<u>0.12</u>	<u>0.43</u>	<u>0.15</u>	<u>0.6</u>	<u>0.8</u>	<u>0.5</u>
<u>Gonorrhea</u>	<u>58</u>	<u>340</u>	<u>74</u>	<u>0.02</u>	<u>0.05</u>	<u>0.01</u>	<u>0.1</u>	<u>0.1</u>	<u>0.0</u>
<u>Other</u>	<u>10</u>	<u>76</u>	<u>113</u>	<u>0.00</u>	<u>0.01</u>	<u>0.02</u>	<u>0.0</u>	<u>0.0</u>	<u>0.1</u>
<u>Other Infectious and General Diseases</u>	<u>6,063</u>	<u>32,586</u>	<u>17,847</u>	<u>2.03</u>	<u>5.25</u>	<u>2.52</u>	<u>9.8</u>	<u>9.3</u>	<u>8.7</u>
<u>Infectious &amp; Parasitic</u>	<u>136</u>	<u>1,147</u>	<u>511</u>	<u>0.05</u>	<u>0.18</u>	<u>0.07</u>	<u>0.2</u>	<u>0.3</u>	<u>0.2</u>
<u>Cancer</u>	<u>160</u>	<u>492</u>	<u>383</u>	<u>0.05</u>	<u>0.08</u>	<u>0.05</u>	<u>0.3</u>	<u>0.1</u>	<u>0.2</u>
<u>Arthritis</u>	<u>3,024</u>	<u>19,800</u>	<u>10,558</u>	<u>1.01</u>	<u>3.19</u>	<u>1.49</u>	<u>4.8</u>	<u>5.7</u>	<u>5.2</u>
<u>Blood, Blood Form. Org.</u>	<u>174</u>	<u>500</u>	<u>414</u>	<u>0.06</u>	<u>0.08</u>	<u>0.06</u>	<u>0.3</u>	<u>0.1</u>	<u>0.2</u>
<u>Other</u>	<u>2,569</u>	<u>10,647</u>	<u>5,981</u>	<u>0.86</u>	<u>1.72</u>	<u>0.85</u>	<u>4.2</u>	<u>3.1</u>	<u>2.9</u>
<u>Neuropsychiatric</u>	<u>26,091</u>	<u>138,609</u>	<u>97,860</u>	<u>8.75</u>	<u>22.32</u>	<u>13.84</u>	<u>42.1</u>	<u>39.8</u>	<u>47.8</u>
<u>Neurological</u>	<u>2,222</u>	<u>8,291</u>	<u>4,488</u>	<u>0.74</u>	<u>1.34</u>	<u>0.63</u>	<u>3.6</u>	<u>2.4</u>	<u>2.2</u>
<u>Epilepsy</u>	<u>2,505</u>	<u>5,409</u>	<u>4,046</u>	<u>0.84</u>	<u>0.87</u>	<u>0.57</u>	<u>4.0</u>	<u>1.6</u>	<u>2.0</u>
<u>Psychoneurosis</u>	<u>12,899</u>	<u>98,611</u>	<u>66,127</u>	<u>4.32</u>	<u>15.87</u>	<u>9.36</u>	<u>20.9</u>	<u>28.3</u>	<u>32.3</u>
<u>Const. Psych. State</u>	<u>305</u>	<u>670</u>	<u>342</u>	<u>0.10</u>	<u>0.11</u>	<u>0.05</u>	<u>0.5</u>	<u>0.2</u>	<u>0.2</u>
<u>Mental Deficiency</u>	<u>645</u>	<u>2,611</u>	<u>1,501</u>	<u>0.22</u>	<u>0.42</u>	<u>0.21</u>	<u>1.0</u>	<u>0.7</u>	<u>0.7</u>
<u>Schizophrenia</u>	<u>4,916</u>	<u>10,464</u>	<u>12,463</u>	<u>1.65</u>	<u>1.69</u>	<u>1.76</u>	<u>7.9</u>	<u>3.0</u>	<u>6.1</u>
<u>Alcoholism</u>	<u>15</u>	<u>105</u>	<u>58</u>	<u>0.01</u>	<u>0.02</u>	<u>0.01</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
<u>Neurocirculatory Asthenia</u>	<u>610</u>	<u>5,116</u>	<u>1,220</u>	<u>0.20</u>	<u>0.82</u>	<u>0.17</u>	<u>1.0</u>	<u>1.5</u>	<u>0.6</u>
<u>Other Neuropsychiatric</u>	<u>1,974</u>	<u>7,332</u>	<u>7,615</u>	<u>0.67</u>	<u>1.18</u>	<u>1.08</u>	<u>3.2</u>	<u>2.1</u>	<u>3.7</u>
<u>Eye, Ear, Nose &amp; Throat</u>	<u>3,616</u>	<u>32,621</u>	<u>9,946</u>	<u>1.21</u>	<u>5.25</u>	<u>1.41</u>	<u>5.8</u>	<u>9.3</u>	<u>4.8</u>
<u>Eye</u>	<u>1,414</u>	<u>15,161</u>	<u>3,656</u>	<u>0.47</u>	<u>2.44</u>	<u>0.52</u>	<u>2.2</u>	<u>4.3</u>	<u>1.8</u>
<u>Ear</u>	<u>1,910</u>	<u>14,055</u>	<u>4,796</u>	<u>0.64</u>	<u>2.26</u>	<u>0.68</u>	<u>3.1</u>	<u>4.0</u>	<u>2.3</u>
<u>Nose and Throat</u>	<u>292</u>	<u>3,405</u>	<u>1,494</u>	<u>0.10</u>	<u>0.55</u>	<u>0.21</u>	<u>0.5</u>	<u>1.0</u>	<u>0.7</u>
<u>Respiratory</u>	<u>4,092</u>	<u>21,184</u>	<u>11,472</u>	<u>1.37</u>	<u>3.41</u>	<u>1.62</u>	<u>6.6</u>	<u>6.1</u>	<u>5.6</u>
<u>Cardiovascular</u>	<u>5,416</u>	<u>25,057</u>	<u>12,074</u>	<u>1.81</u>	<u>4.04</u>	<u>1.71</u>	<u>8.7</u>	<u>7.2</u>	<u>5.9</u>
<u>Organic; VHD</u>	<u>2,732</u>	<u>11,950</u>	<u>3,877</u>	<u>0.91</u>	<u>1.93</u>	<u>0.55</u>	<u>4.3</u>	<u>3.5</u>	<u>1.8</u>
<u>Hypertension</u>	<u>924</u>	<u>5,078</u>	<u>2,040</u>	<u>0.31</u>	<u>0.82</u>	<u>0.29</u>	<u>1.5</u>	<u>1.5</u>	<u>1.0</u>
<u>Varicose Veins</u>	<u>252</u>	<u>3,236</u>	<u>1,195</u>	<u>0.08</u>	<u>0.52</u>	<u>0.17</u>	<u>0.4</u>	<u>0.9</u>	<u>0.6</u>
<u>Hemorrhoids</u>	<u>23</u>	<u>661</u>	<u>382</u>	<u>0.01</u>	<u>0.11</u>	<u>0.05</u>	<u>0.0</u>	<u>0.2</u>	<u>0.2</u>
<u>Coronary Thrombosis, Embolism, Sclerosis</u>	<u>293</u>	<u>509</u>	<u>198</u>	<u>0.10</u>	<u>0.08</u>	<u>0.03</u>	<u>0.5</u>	<u>0.1</u>	<u>0.1</u>
<u>Other Cardiovascular</u>	<u>1,192</u>	<u>3,623</u>	<u>4,382</u>	<u>0.40</u>	<u>0.58</u>	<u>0.62</u>	<u>2.0</u>	<u>1.0</u>	<u>2.2</u>
<u>Gastro-Intestinal</u>	<u>5,835</u>	<u>20,664</u>	<u>17,684</u>	<u>1.95</u>	<u>3.33</u>	<u>2.50</u>	<u>9.4</u>	<u>5.9</u>	<u>8.6</u>
<u>Teeth</u>	<u>34</u>	<u>155</u>	<u>41</u>	<u>0.01</u>	<u>0.02</u>	<u>0.01</u>	<u>0.1</u>	<u>0.0</u>	<u>0.0</u>
<u>Gastric, Duodenal Ulcer</u>	<u>4,953</u>	<u>16,759</u>	<u>15,501</u>	<u>1.66</u>	<u>2.71</u>	<u>2.19</u>	<u>7.9</u>	<u>4.8</u>	<u>7.6</u>
<u>Other</u>	<u>848</u>	<u>3,750</u>	<u>2,142</u>	<u>0.28</u>	<u>0.60</u>	<u>0.30</u>	<u>1.4</u>	<u>1.1</u>	<u>1.0</u>
<u>Genito-Urinary</u>	<u>1,073</u>	<u>6,825</u>	<u>3,595</u>	<u>0.36</u>	<u>1.10</u>	<u>0.51</u>	<u>1.7</u>	<u>2.0</u>	<u>1.8</u>
<u>Bones &amp; Organs of Locomotion</u>	<u>5,764</u>	<u>57,619</u>	<u>15,341</u>	<u>1.93</u>	<u>9.28</u>	<u>2.17</u>	<u>9.3</u>	<u>16.5</u>	<u>7.5</u>
<u>Feet</u>	<u>1,112</u>	<u>21,749</u>	<u>3,095</u>	<u>0.37</u>	<u>3.50</u>	<u>0.44</u>	<u>1.8</u>	<u>6.2</u>	<u>1.5</u>
<u>Musculo-Skeletal</u>	<u>3,958</u>	<u>30,746</u>	<u>10,336</u>	<u>1.32</u>	<u>4.96</u>	<u>1.46</u>	<u>6.3</u>	<u>8.8</u>	<u>5.0</u>
<u>Congenital Malformation</u>	<u>408</u>	<u>2,072</u>	<u>1,345</u>	<u>0.14</u>	<u>0.33</u>	<u>0.19</u>	<u>0.7</u>	<u>0.6</u>	<u>0.7</u>
<u>Hernia</u>	<u>286</u>	<u>3,052</u>	<u>565</u>	<u>0.10</u>	<u>0.49</u>	<u>0.08</u>	<u>0.5</u>	<u>0.9</u>	<u>0.3</u>
<u>Traumatism, Results of</u>	<u>969</u>	<u>5,401</u>	<u>13,819</u>	<u>0.32</u>	<u>0.87</u>	<u>1.95</u>	<u>1.6</u>	<u>1.5</u>	<u>6.7</u>
<u>Fracture</u>	<u>436</u>	<u>1,996</u>	<u>3,815</u>	<u>0.14</u>	<u>0.32</u>	<u>0.54</u>	<u>0.8</u>	<u>0.6</u>	<u>1.9</u>
<u>Amputation</u>	<u>190</u>	<u>865</u>	<u>1,918</u>	<u>0.06</u>	<u>0.14</u>	<u>0.27</u>	<u>0.3</u>	<u>0.2</u>	<u>0.9</u>
<u>Other Traum. of Mus-Skel.</u>	<u>47</u>	<u>2,135</u>	<u>6,043</u>	<u>0.02</u>	<u>0.34</u>	<u>0.85</u>	<u>0.1</u>	<u>0.6</u>	<u>2.9</u>
<u>Traumatism-Internal</u>	<u>154</u>	<u>114</u>	<u>338</u>	<u>0.05</u>	<u>0.02</u>	<u>0.05</u>	<u>0.2</u>	<u>0.0</u>	<u>0.2</u>
<u>Other</u>	<u>419</u>	<u>1,033</u>	<u>2,356</u>	<u>0.14</u>	<u>0.17</u>	<u>0.33</u>	<u>0.6</u>	<u>0.3</u>	<u>1.1</u>

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## STATISTICAL TABLES

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The tables below and on the following pages present admission rates for selected causes in the overseas theaters. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from MD Forms 86ab (now AGO Form 8-122), both regular and telegraphic, submitted to The Surgeon General from each overseas theater or lesser command. Only the major overseas areas are shown separately, but the total overseas rates are based upon a complete consolidation. Except for wounded, the rates for each month are based upon the experience of four or five weeks depending upon the number of Fridays in a month. For wounded in action the rates pertain to calendar-month periods and are derived from The Adjutant General's report, Battle Casualties of the Army, which tabulates hospital admissions only. The rates are based upon all casualties incurred, including those of the Air Force. In addition, all casualties are tabulated according to the theater of assignment of the men involved. As a result casualties sustained by XXIV Corps in the Philippines, for example, are included with the experience of the Pacific Ocean Areas, rather than with that of the Southwest Pacific Area. Rates computed from incomplete reports are so noted, and those derived from the weekly telegraphic 86ab reports are distinguished from those obtained from the regular monthly report. Average rates for 1944 are shown for only those theaters which have submitted a complete set of regular 86ab reports for the year.

The malaria rates are for diagnosed malaria only, and include both primary attacks and recurrences insofar as these are reported as malaria, a variable amount, differing from theater to theater, being reported as fever of undetermined origin. The rates for the Army in the continental United States reflect only infections acquired in the United States. The venereal disease rates represent the data of the 86ab report rather than the Monthly Venereal Disease Statistical Report, which generally yields somewhat lower rates, and for the United States, exclude cases contracted prior to induction. The transfer of strength from the Mediterranean to the European Theater is believed to have caused some error in the reports from the former area for October and November, one which takes the form of too little strength for the admissions reported. Tentative neuropsychiatric admission rates are presented for 1944. Not systematically reported on the 86ab until late in 1943, these rates may not be as firm as those for communicable diseases. With respect to the table on fever of undetermined origin, many of the admissions initially reported as such are later given specific diagnoses, often malaria. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, a certain amount of dual reporting exists.

For those diagnoses which were shown in tabular form in HEALTH for January 1945, the theater experience prior to July 1945 has been summarized and separate monthly rates are shown only for July and subsequent months.

WOUNDED IN ACTION, AS REPORTED TO THE ADJUTANT GENERAL  
Hospital Admissions per Thousand Men per Year

Month and Year	OVERSEAS COMMAND								
	Total a/ Overseas	North American	Latin American	ETO b/	MTO	POA	SWPA	CBI	ME and PGC
1943 Average	23	6	0	7	62	18	9	4	4
1944 - Jan	30	-	-	4	115	8	11	0	4
Feb	39	0	-	6	144	35	6	1	0
Mar	24	-	-	4	65	37	29	10	1
Apr	13	-	-	6	38	5	12	12	17
May	42	-	-	5	182	1	25	8	23
Jun	116	-	-	192	101	56	45	42	11
Jul	142	-	-	268	94	41	25	24	12
Aug	100	-	-	189	72	20	10	8	-
Sep	112	-	-	174	167	37	5	3	0
Oct	95	0	-	116	173	32	62	3	-
Nov	132	-	-	231	36	18	57	4	-
Dec	118	-	-	190	30	13	65	8	-
1944 Average	86	0	-	138	104	25	33	10	6
1945 - Jan	124	-	-	199	14	2	77	11	-

a/ Including casualties among men en route overseas.

b/ Excluding Iceland. - is used to denote no admissions, 0 to denote a rate of less than 0.5.

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# STATISTICAL TABLES

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STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	OVERSEAS COMMANDS								
		Total	Alaska	Caribbean	ETOa/	MTO	POA	SWPA	Asiatic	ME and PGC
<b>ALL DISEASE</b>										
1942 Average	664	676	667	823	693	452	519	821	1,048	1,330
1943 Jan-Jun	807	873	737	690	887	723	1,008	1,289	957	1,023
Jul-Dec	675	899	533	649	822	1,065	942	921	1,004	1,177
1943 Average	739	889	624	670	837	943	971	1,046	991	1,107
1944 Jan-Jun	619	695	566	528	578	812	600	902	967	949
Jul	473	654	367	561	346	998	474 <sub>b/</sub>	877	1,535	1,073
Aug	472	609	377	555	329	845	500 <sub>b/</sub>	904	1,520	978
Sep	506	581	341	528	305	844	659 <sub>b/</sub>	816	1,228	896
Oct	511	644	341	532	467	930	545 <sub>b/</sub>	771	1,154	775
Nov	494	627	387	532	539	810	443 <sub>b/</sub>	729	897	729
Dec	513	629	298	512	564	862	449 <sub>b/</sub>	759	782	645
Jul-Dec	495	623	351	536	440	880	513 <sub>b/</sub>	804	1,152	842
1944 Average	563	654	478	531	492	846	561 <sub>b/</sub>	840	1,077	896
1945 Jan	603	c/	337	529	(619) <sub>b/</sub>	878	429	(917)	728	658
Feb	626	c/	363	587	(627) <sub>b/</sub>	790	(518)	(917) <sub>b/</sub>	(601)	(517)
Mar	591 <sub>b/</sub>	c/	(418) <sub>b/</sub>	(548)	c/	c/	c/	c/	(630)	(616) <sub>b/</sub>

## NONBATTLE INJURY

1942 Average	91	123	152	107	109	96	104	176	80	158
1943 Jan-Jun	80	150	193	115	130	154	135	191	103	144
Jul-Dec	81	129	173	93	91	145	128	160	77	136
1943 Average	80	136	182	105	100	149	131	171	84	140
1944 Jan-Jun	69	114	145	75	85	145	118	151	95	107
Jul	72	125	114	63	126	146	96 <sub>b/</sub>	141	86	105
Aug	71	105	103	65	88	125	86 <sub>b/</sub>	149	88	88
Sep	67	101	107	61	73	137	107 <sub>b/</sub>	144	81	95
Oct	66	108	95	60	87	135	116 <sub>b/</sub>	142	98	88
Nov	61	111	94	56	106	131	111 <sub>b/</sub>	117	115	81
Dec	55	121	84	59	136	107	101 <sub>b/</sub>	108	111	94
Jul-Dec	66	112	100	61	105	131	102 <sub>b/</sub>	132	97	92
1944 Average	67	113	127	68	97	138	111 <sub>b/</sub>	139	96	99
1945 Jan	55	c/	102	60	(149)	103	95	(121)	105	69
Feb	50	c/	94	67	(101)	88	(89)	(105) <sub>b/</sub>	(93)	(71)
Mar	49 <sub>b/</sub>	c/	(115) <sub>b/</sub>	(61)	c/	c/	c/	c/	(110)	(62) <sub>b/</sub>

- is used to denote no admissions, 0 to denote a rate of less than 0.5.

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

c/ Data not available

( ) Telegraphic Reports.

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**STATISTICAL TABLES**

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS  
Rates Per Thousand Men Per Year

Month and Year	United States	OVERSEAS COMMANDS								
		Total	Alaska	Carib-bean	EPOa/	MTO	POA	SWPA	Asiatic	ME and PGC
ALL VENEREAL DISEASE										
1942 Average	39	32	7	74	38	36	12	32	64	80
1943 Jan-Jun	25	31	4	67	50	41	6	21	58	64
Jul-Dec	27	36	2	43	41	65	5	12	50	71
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	35	38	7	34	22	117	4b/	7	50	50
Aug	36	36	6	31	21	121	4b/	7	47	50
Sep	37	44	6	30	35	125	5b/	6	53	55
Oct	38	56	7	37	57	140	5b/	5	50	62
Nov	39	47	7	42	48	115	3b/	4	43	79
Dec	39	47	8	29	50	134	5b/	5	53	72
Jul-Dec	37	45	7	33	40	125	4b/	6	50	62
1944 Average	33	42	5	33	35	111	5b/	7	51	60
1945 Jan	47	c/	6	29	c/	124	5	c/	54	80
Feb	43	c/	8	43	c/	105	c/	c/	c/	c/
Mar	43b/	c/	c/	c/	c/	c/	c/	c/	c/	c/

DIAGNOSED MALARIA

1942 Average	0.6	33	0	99	0	11	12	52	165	127
1943 Jan-Jun	0.2	86	0	50	0	12	164	330	116	90
Jul-Dec	0.3	101	0	23	3	77	241	201	205	150
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	0.2	50	-	20	17	81	21b/	59	265	121
Aug	0.2	47	-	15	12	91	14b/	48	310	71
Sep	0.2	37	-	11	6	74	15b/	42	240	51
Oct	0.2	33	-	13	6	61	10b/	37	255	40
Nov	0.1	23	-	8	5	38	9b/	32	165	23
Dec	0.1	18	-	6	6	25	6b/	32	112	15
Jul-Dec	0.2	34	-	12	8	63	13b/	41	216	52
1944 Average	0.2	38	-	14	9	62	43b/	53	174	59
1945 Jan	0.1	c/	0	7	c/	19	8	c/	74	11
Feb	0.2	c/	-	7	c/	16	c/	c/	c/	c/
Mar	c/	c/	c/	c/	c/	c/	c/	c/	c/	c/

- is used to denote no admissions, 0 to denote a rate of less than 0.5.

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

c/ Data not available.

# STATISTICAL TABLES

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STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	OVERSEAS COMMANDS								
		Total	Alaska	Carib- bean	ETOa/	MTO	POA	SWPA	Asiatic	ME and PGC
<b>COMMON RESPIRATORY AND INFLUENZA</b>										
1942 Average	243	159	244	113	287	151	89	146	150	197
1943 Jan-Jun	310	164	294	87	374	125	90	127	143	182
Jul-Dec	188	190	164	112	420	151	83	99	165	217
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	66	89	94	85	64	114	61b/	88	248	140
Aug	67	80	98	85	56	107	62b/	82	195	182
Sep	81	88	111	81	69	110	88b/	76	174	191
Oct	92	113	127	68	101	186	85b/	64	175	191
Nov	93	111	134	77	112	154	61b/	78	147	185
Dec	115	83	72	68	122	166	63b/	81	141	200
Jul-Dec	85	93	105	77	92	138	70b/	78	176	182
1944 Average	147	132	188	81	142	162	85b/	83	176	219
1945 Jan	167	c/	106	67	c/	190	c/	c/	c/	c/
Feb	192	c/	c/	c/	c/	c/	c/	c/	c/	c/
Mar	167b/	c/	c/	c/	c/	c/	c/	c/	c/	c/

## DIARRHEA AND DYSENTERY

1942 Average	8	28	5	19	17	33	34	57	120	185
1943 Jan-Jun	8	69	11	16	13	139	49	72	130	169
Jul-Dec	15	65	5	16	11	128	38	69	152	171
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	12	57	3	15	9	114	41b/	56	326	159
Aug	11	48	6	9	10	76	40b/	57	280	178
Sep	10	38	3	10	12	66	23b/	41	186	159
Oct	10	34	4	9	12	68	19b/	37	140	106
Nov	8	32	4	15	14	43	19b/	54	105	129
Dec	7	36	2	13	22	33	20b/	76	100	55
Jul-Dec	10	40	3	12	14	67	28b/	54	180	129
1944 Average	9	38	3	13	13	54	28b/	55	181	115
1945 Jan	8	c/	1	11	c/	20	18	c/	69	56
Feb	8	c/	2	14	c/	21	c/	c/	c/	c/
Mar	6b/	c/	c/	c/	c/	c/	c/	c/	c/	c/

- is used to denote no admissions, 0 to denote a rate of less than 0.5.

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

( ) Telegraphic Reports.

c/ Data not available.

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STATISTICAL TABLES

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STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS  
Rates Per Thousand Men Per Year

Month and Year	United States	OVERSEAS COMMANDS								
		Total	Alaska	Carib-bean	ETOa/	MTO	POA	SWPA	Asiatic	ME and PGC
FEVER OF UNDETERMINED ORIGIN										
1943 Jan-Jun	c/	45	0	74	1	16	17	244	54	17
Jul-Dec	c/	56	0	52	1	108	20	125	77	26
1943 Average	c/	52	0	64	1	75	19	166	71	21
1944 Jan	c/	32	0	41	1	51	18	179	46	16
Feb	c/	28	1	41	0	33	22	116	28	9
Mar	c/	34	1	34	2	58	34	102	36	6
Apr	c/	36	1	38	1	61	37	101	62	10
May	c/	34	1	34	1	52	30	96	87	24
Jun	c/	41	1	33	2	80	12	97	118	21
Jan-Jun	c/	35	1	37	1	57	26	102	69	16
Jul	c/	60	1	50	2	133	8b/	114	209	66
Aug	c/	57	0	50	5	122	31b/	95	247	52
Sep	c/	44	0	43	1	97	16b/	80	184	34
Oct	c/	34	-	14	1	66	8b/	60	213	30
Nov	c/	29	0	15	1	48	8b/	71	133	27
Dec	c/	24	0	13	4	38	5b/	69	97	21
Jul-Dec	c/	40	0	31	3	85	13b/	80	174	37
1944 Average	c/	38	1	34	2	71	20b/	88	131	27
1945 Jan	c/	c/	-	20	c/	39	5	c/	87	12
Feb	c/	c/	-	10	c/	43	c/	c/	c/	c/
Mar	c/	c/	c/	c/	c/	c/	c/	c/	c/	c/

NEUROLOGICAL AND PSYCHIATRIC DISORDERS

1944 Jan	27	30	12	23	36	22	29	44	29	30
Feb	27	29	10	24	25	36	25	44	29	28
Mar	27	27	12	22	19	33	29	45	23	27
Apr	26	24	11	21	18	26	25	43	19	23
May	32	29	9	16	20	48	22	52	16	30
Jun	33	35	8	19	29	50	26	53	24	27
Jan-Jun	29	29	11	21	24	37	26	48	23	27
Jul	32	59	10	16	84	52	27b/	58	16	31
Aug	36	50	12	18	76	28	25b/	48	17	21
Sep	46	41	13	25	40	50	32b/	53	16	15
Oct	48	56	13	23	65	82	32b/	39	21	21
Nov	47	60	13	27	85	47	28b/	41	23	16
Dec	47	56	12	22	72	39	29b/	53	20	26
Jul-Dec	45	53	12	22	69	50	29b/	49	19	22
1944 Average	36	43	12	21	52	43	27b/	48	20	25
1945 Jan	50	c/	14	25	c/	32	36	c/	19	20
Feb	49	c/	9	27	c/	31	c/	c/	c/	c/
Mar	c/	c/	c/	c/						

- is used to denote no admissions, 0 to denote a rate of less than 0.5.  
a/ Excluding Iceland. b/ Based on Incomplete Reports. c/ Data not available.