

HEALTH



ARMY
MEDICAL
APR 25 1946
LIBRARY

RESTRICTED

31 MARCH 1946

HEALTH

**THIS DOCUMENT CONTAINS
INFORMATION AFFECTING THE
NATIONAL DEFENSE OF THE
UNITED STATES WITHIN THE
MEANING OF THE ESPIONAGE
ACT, 50 U. S. C., 31 AND 32, AS
AMENDED. ITS TRANSMISSION
OR THE REVELATION OF ITS
CONTENTS IN ANY MANNER
TO AN UNAUTHORIZED PERSON
IS PROHIBITED BY LAW.**

OFFICE OF THE SURGEON GENERAL

HEADQUARTERS, ARMY SERVICE FORCES, WAR DEPARTMENT

DISTRIBUTION *

SECRETARY OF WAR
Army Industrial College

CHIEF OF STAFF

Deputy Chief of Staff
Secretary, General Staff
Statistics Branch
Strength Accounting and Statistics Office
A. C. of S., G-1
A. C. of S., G-2
A. C. of S., G-4
Executive Officer, WAC
Budget Division
Civil Affairs Division
The Inspector General
War Department Manpower Board
Information & Education Division
Bureau of Public Relations

ARMY AIR FORCES

Chief of Air Staff
Management Control
A.C. of A.S., Operations, Commitments, and Requirements
Organization Division
A.C. of A.S., Personnel
Military Personnel Division
The Air Surgeon
Chief of Flying Safety Branch
Air Transport Command
AAF School of Applied Tactics
Aviation School of Medicine

ARMY GROUND FORCES

ARMY SERVICE FORCES

Commanding General
Chief of Staff
Deputy Chief of Staff for Service Commands
Service Commands
Deputy Chief of Staff (Control)
Director of Plans and Policies
Director of Military Training
Director of Personnel
Military Personnel Division
Director of Supply
Supply Control Branch
Director of Procurement
Director of Services
Chief of Chaplains
Provost Marshal General
Adjutant General
Chief of Finance
Chief of Engineers
Chief of Ordnance
Chief Signal Officer
Quartermaster General
Chief of Chemical Warfare Service
Surgeon General
Chief of Transportation
Director Army Medical Library
Field Installations
Command and General Staff School

NAVY DEPARTMENT

OVERSEAS

Commanding General, USAF - European Theater
Commanding General, Iceland Base Command
Commanding General, USAF - Mediterranean Theater
Commanding General, USAF - Africa
Commander-In-Chief, USAF - Pacific
Commanding General, USAF - Western Pacific
Commanding General, USAF - Middle Pacific
Commanding General, USAF - India-Burma
Commanding General, USF - China
Commanding General, Alaskan Department
Commanding General, Caribbean Defense Command

OTHER AGENCIES

Army and Navy Staff College
British Joint Staff Mission
Bureau of the Budget
Federal Board of Hospitalization
Office of Strategic Services
Veterans Administration

* MPR distribution is governed by ASF Manual M 703-8

CONTENTS

	Page
SUMMARY	1
DISEASE AND INJURY	
Disease Hazards at Basic Training Centers	2
Measles, Mumps, and Scarlet Fever	6
Meninococcal Meningitis	7
Noneffective Rates	
U. S. and Total Overseas	8
Major Theaters	9
Admission Rates	
Hospital Admissions, U. S. and Overseas	10
Disease by Theater	11
Respiratory Disease in the U. S.	12
Venereal Disease	
In the U. S.	16
Overseas	17
Health Briefs	18
HOSPITALIZATION AND EVACUATION	
Hospitalization Overseas	20
Evacuation from Overseas	22
Hospitalization in the Z/I	23
STATISTICAL TABLES	
Discharges of Enlisted Men for Disability	26
Disease and Nonbattle Injury	27
Venereal Disease and Malaria	28
Respiratory Disease and Diarrheal Disease	29
Fever of Undetermined Origin and Neurological and Psychiatric Disorders	30

SUMMARY

DISEASE HAZARDS IN BASIC TRAINING CENTERS The basic training centers of all three components characteristically have morbidity rates far in excess of those for other posts in the U. S. The differential is especially large at the present time. New recruits were diverted from Crowder and Belvoir in March in recognition of the special problems at these centers. Further study is needed of environmental controls, of the feasibility of curtailing the flow of recruits during the epidemic season of winter and spring, and of methods of training raw recruits which will lessen their exposure to infectious agents. (See pages 2 to 5)

SCARLET FEVER Because of the sharp outbreaks at a number of training centers current admission rates for scarlet fever are higher than at any time since World War I. This departure from trend is not evident in Navy or civilian rates. (See page 6)

DISEASE AND INJURY During February both admission and noneffective rates overseas and in the U. S. were relatively unchanged. Apart from the large evacuee population in the U. S. noneffective rates are especially favorable. Admission rates in many areas are being sustained in part by phenomenal venereal disease rates. (See pages 8 to 11)

RESPIRATORY DISEASE IN THE UNITED STATES Correction of Army respiratory disease rates for the absence of personnel on pass or furlough during the December influenza epidemic in the U. S. leaves unchanged the conclusion presented in HEALTH for December that the epidemic of mild influenza B touched the Army only very lightly because of the protection afforded by vaccination. The higher level of Army rates in February and March is attributed to the prevalence of streptococcal types of respiratory disease in certain camps, notably basic training centers. (See pages 12 to 15)

VENEREAL DISEASE The venereal diseases continue to constitute a pressing problem. More vigorous command action will be needed to bring rates down to reasonable levels. Upward trends are marked in Japan and in the United States. (See pages 16 to 17)

HOSPITALIZATION OVERSEAS Demobilization of hospital facilities overseas progressed further during February. By 28 February ninety percent or more of the reduction necessary to bring April 1945 totals down to the estimated levels for 30 June 1946 had been accomplished for beds authorized, for beds present, and for patient-census. The T/O capacity of fixed units in operation and the capacity of operating nonfixed hospitals totaled 57,000 beds on 28 February. The number of beds set up for use was even lower. Only 24,000 beds were occupied. (See pages 20 to 21)

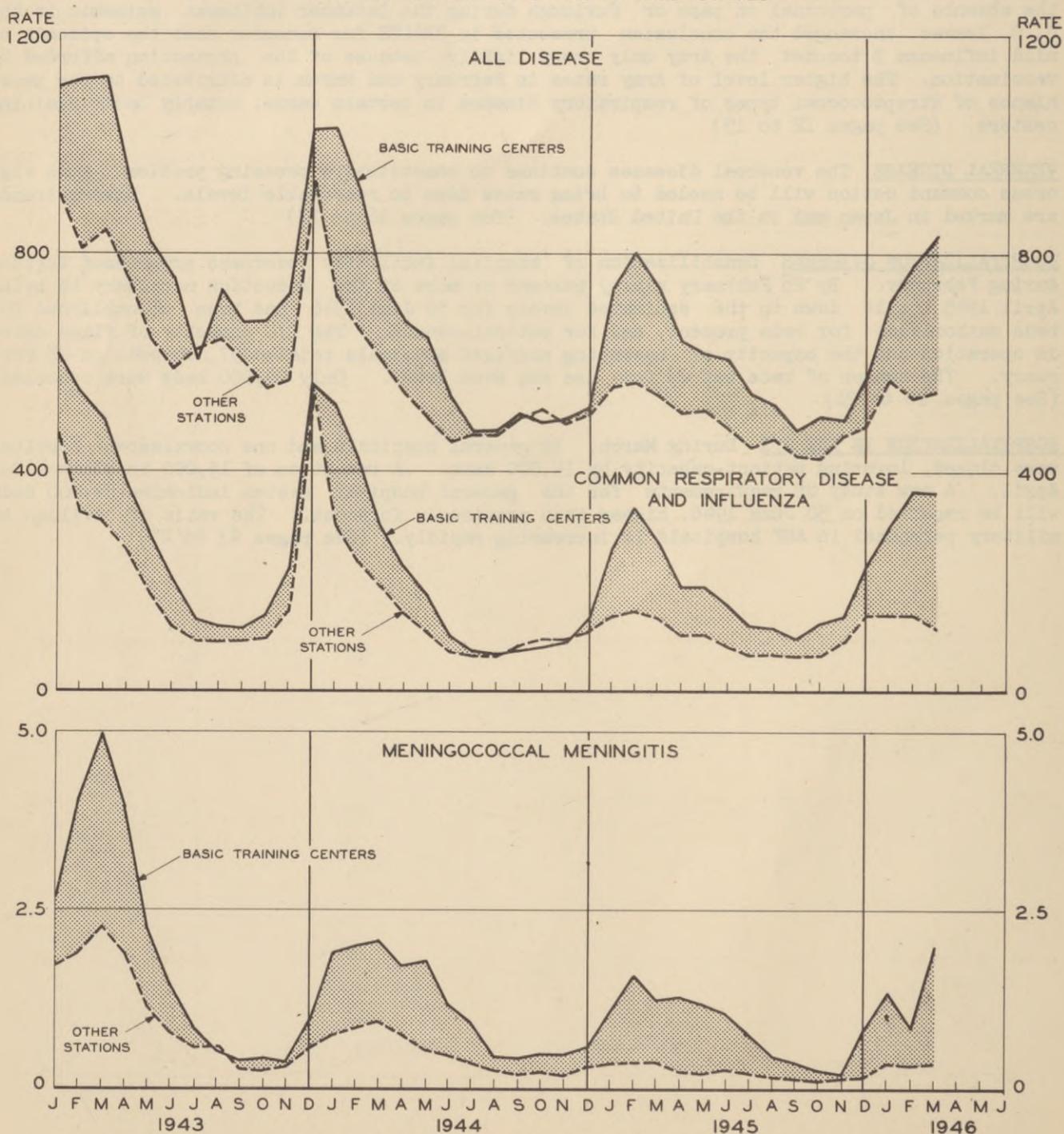
HOSPITALIZATION IN THE Z/I During March, 12 general hospitals and one convalescent hospital were closed, lowering patient-capacity by 14,000 beds. A reduction of 15,000 is planned for April. A new study of requirements for the general hospital system indicates 54,000 beds will be required on 30 June 1946, higher than previously forecast. The ratio of civilian to military personnel in ASF hospitals is increasing rapidly. (See pages 23 to 25)

DISEASE AND INJURY

SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS

The problem of high morbidity rates in basic training centers was stated in *HEALTH* for February with reference to admission rates for that month, and special emphasis was placed upon the prevalence of disease at Aberdeen Proving Ground, Fort Belvoir, and Camp Crowder. It is now possible to show how large was the differential in disease rates at basic training centers and all other stations during the greater part of the war period, and to report on efforts to control the incidence of disease in these problem camps. It should be made clear, however, that at times, especially during 1943, the basic training centers included perhaps as little as 50 percent of the men inducted in the previous three months, for a great deal of basic training was received in units to which many men proceeded directly from the reception centers. The data on the training centers are also somewhat less complete in the early part of the period studied here. It should also be borne in mind that other activities may have predominated even at a post designated as a basic training center.

**DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR
ARMY IN THE CONTINENTAL UNITED STATES**



DISEASE AND INJURY

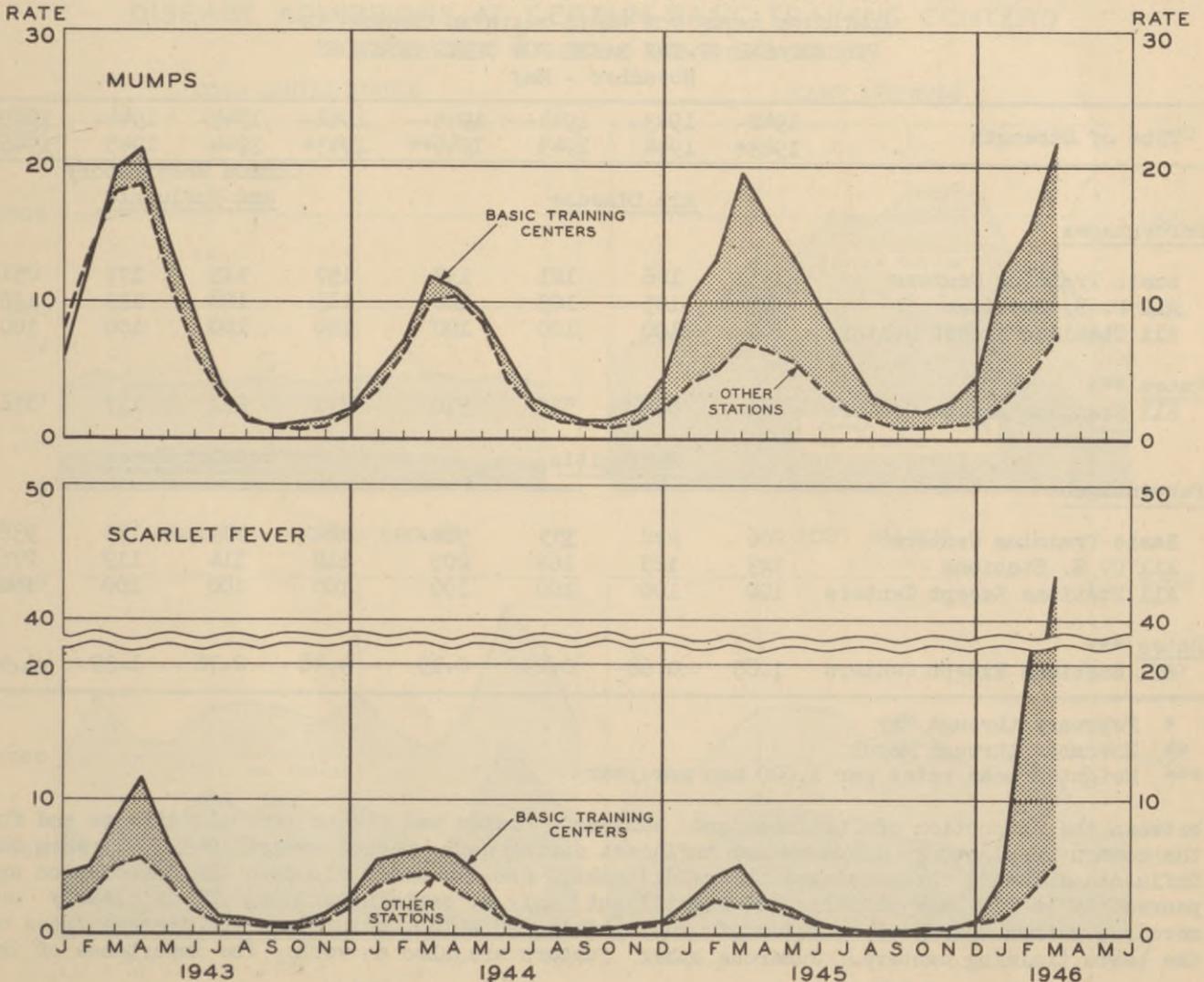
SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS (Continued)

Were it possible to isolate all the basic trainee strength the differentials shown here would be even larger. Ultimately it should be possible to derive morbidity rates for men of varying lengths of service and to measure more precisely such differentials as are described here.

The accompanying charts give the monthly rates for basic training centers in comparison with those for all other stations in the United States. The top panel below presents the data for all disease and for the common respiratory diseases plus influenza. The area of differences, which is shaded, shows how large is the margin between the two series. Almost negligible during summer months, it usually ranges from 20 to 40 percent for all disease during the winter months, and from 50 to 100 percent for the common respiratory disease and influenza. During March 1946 the differential is proportionately greater than in any previous month of the period, 50 percent for all disease and 220 percent for common respiratory disease and influenza. It is noteworthy that, during the one frank influenza epidemic within the interval, namely that of December 1943, there was virtually no difference between the two rates. This is in accord with the known fact that influenza attacks seasoned as well as unseasoned troops without distinction. Conversely, the margin which exists at other times between the two respiratory rates probably does not represent influenza.

The diseases are legion for which raw recruits tend to be more susceptible than seasoned troops. Among those which are outstanding are measles, mumps, scarlet fever, and meningococcal meningitis. Although the existence of the differential is common knowledge, it is not generally realized how large it is even for such mixed groups as obtain when one com-

**DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR
ARMY IN THE CONTINENTAL UNITED STATES**



DISEASE AND INJURY

SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS (Continued)

compares basic training centers with other stations. The bottom panel on page 2 gives the data for meningococcal meningitis. Despite their only partial coverage of the basic trainee population, the basic training centers had rates often more than twice those for all other stations. In March 1946 the ratio was about six to one.

The charts on page 3 present the series for mumps and for scarlet fever. It is not known why the differential was so slight in the case of mumps in 1943 and 1944, as it became quite large in the two later seasons. Of course the coverage of trainee strength is more complete in the last two epidemic periods. In March 1946 the ratio was almost three to one. The 1946 rates for scarlet fever are so high as to require a break in the scale if the variation of the earlier seasons is not to be minimized. The panel also shows how slight has been the recent rise in admissions for scarlet fever in stations other than basic training centers.

The following table provides a summary of the data for the epidemic period from November through May each season, except that the 1942-43 season is restricted to the months February through May 1943, and the 1945-46 season to the months November through March. Disease rates in the basic training centers average 21 to 37 percent above the rates for all other stations, and the U. S. average was increased five to eight percent by the higher rates at the basic training centers. Among the different diagnoses the percentages are consistently highest for meningococcal meningitis, the excesses being over 100 percent each season for the basic training centers, and 25 percent or more for all U. S. troops.

For each epidemic period the basic training centers were studied to ascertain the extent to which the variation in their morbidity rates appeared to reflect variation in the percentage of post strength classified as basic trainees. Although a moderate association

ADMISSION RATES FOR BASIC TRAINING CENTERS AS
PERCENTAGES OF THE RATES FOR OTHER STATIONS
November - May

Type of Strength	1942-	1943-	1944-	1945-	1942-	1943-	1944-	1945-
	1943*	1944	1945	1946**	1943*	1944	1945	1946**
	<u>All Disease</u>				<u>Common Respiratory and Influenza</u>			
<u>Percentages</u>								
Basic Training Centers	133	126	121	137	157	143	177	251
All U. S. Stations	107	105	105	108	113	108	119	132
All Stations Except Centers	100	100	100	100	100	100	100	100
<u>Rates ***</u>								
All Stations Except Centers	760	663	530	510	271	251	117	116
	<u>Meningitis</u>				<u>Scarlet Fever</u>			
<u>Percentages</u>								
Basic Training Centers	206	232	355	584	184	173	175	938
All U. S. Stations	123	125	162	205	118	114	119	276
All Stations Except Centers	100	100	100	100	100	100	100	100
<u>Rates ***</u>								
All Stations Except Centers	1.85	0.68	0.29	0.19	4.48	2.78	1.39	1.41

* February through May

** November through March

*** Weighted mean rates per 1,000 men per year

between the proportion of trainees and admission rates was found for all disease and for the common respiratory diseases and influenza during each period except 1943-1944, when the influenza epidemic overshadowed the relationship, for the other diseases the association appeared to be far less reliable and significant only at certain periods. It is clearly not merely a matter of the proportion of susceptible men which determines the disease rates of the basic training centers. Numerous other factors are also at work. The importance of the

DISEASE AND INJURY

SPECIAL DISEASE HAZARDS IN BASIC TRAINING CENTERS (Continued)

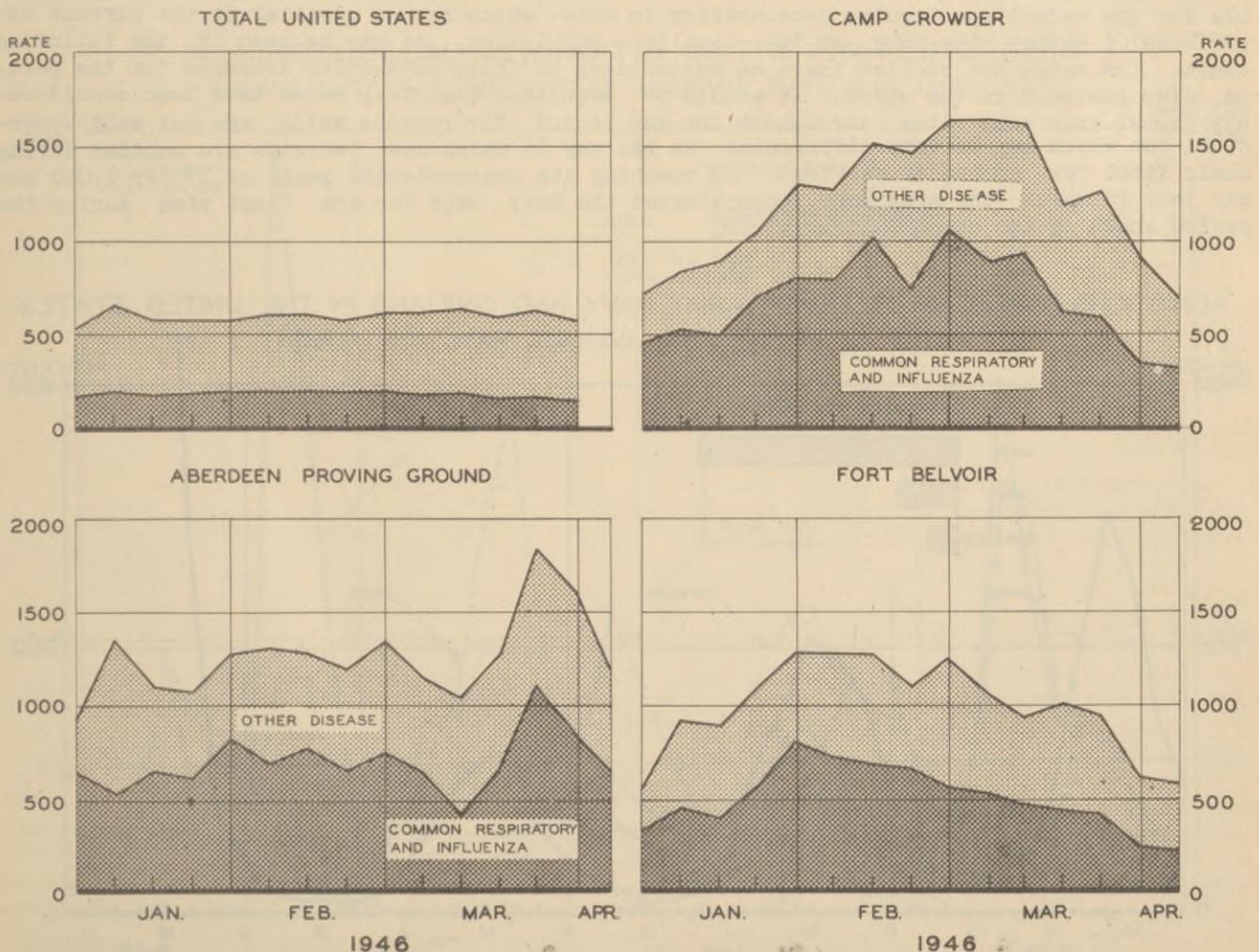
trainee strength lies, first, in providing a ready soil in which chance infections will spread, and, second, in effecting so rapid a turnover of personnel as to increase the chance of infection being introduced into the camp where it will subsequently spread.

The three posts with extreme rates, Crowder, Belvoir, and Aberdeen, made considerable improvement in late March and early April. The accompanying chart gives their admission rates for all disease in comparison with those for the entire U. S. from February through the first of April. Special preventive measures have been taken in these three extreme instances. Most significant is the fact that the flow of new recruits into Camp Crowder and Fort Belvoir was stopped late in March. Other measures include the application of oil to floors and blankets for dust control. The specific effect of the special control measures cannot be determined, especially since a seasonal downswing is expected at this time of the year.

It is believed that amelioration of conditions in basic training centers can be effected by such measures as the following: (1) further study of the efficacy of practicable environmental controls, such as changes in barrack construction, oiling of floors and blankets, and methods for disinfection of air in barracks and gathering places; (2) extending the length of the training cycle to reduce the rapid turnover of troops at training camps; (3) curtailing if possible the rapid influx of recruits into large training centers in the winter and spring; (4) making provision for temporarily diverting the flow of unseasoned troops to other posts during periods when epidemic conditions prevail at particular training centers; and (5) study of ways to develop a more satisfactory method of training recruits so as to reduce the hazards of the present system of uncontrolled exposure of new personnel to infectious agents against which they have not acquired immunity.

DISEASE ADMISSIONS AT CERTAIN BASIC TRAINING CENTERS

RATES PER THOUSAND MEN PER YEAR



DISEASE AND INJURY

MEASLES, MUMPS, AND SCARLET FEVER

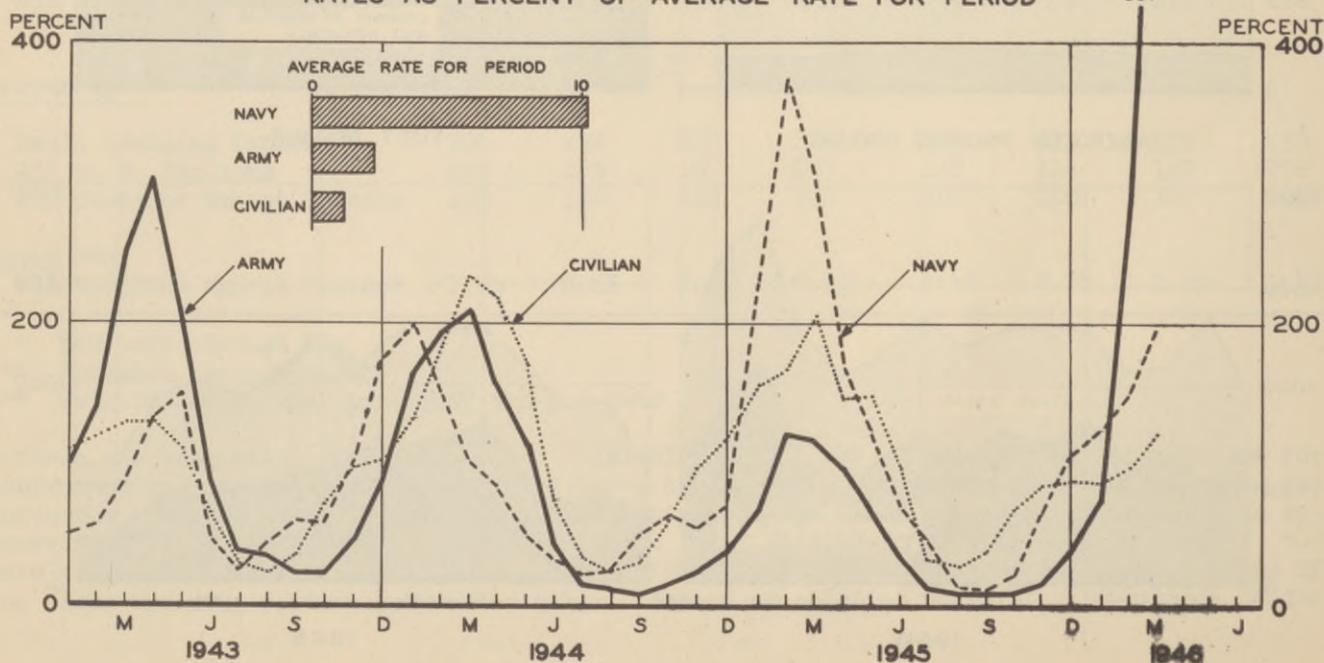
Admissions for measles, mumps, and scarlet fever characteristically increase during the winter months to reach their maximum levels early in the spring. Although their incidence is not usually high enough to make them seem very important, they have some additional significance as precursors of certain serious complications. Rheumatic fever, for example, is occasionally a sequel to scarlet fever and other streptococcal infections. The table below compares average admission rates for February and March this year with those for the same months in previous years.

Z/I ADMISSIONS PER THOUSAND MEN PER YEAR
FOR MEASLES, MUMPS, AND SCARLET FEVER

Year	Average Rates for February and March		
	Measles	Mumps	Scarlet Fever
1946	11.4	9.1	10.4
1945	2.9	8.7	2.7
1944	8.2	8.6	4.6
1943	26.4	16.2	4.5
1942	16.4	17.2	2.6
1941	55.5	13.7	8.8
1925-1940	8.6	11.4	1.9

Although admission rates for mumps are reasonably satisfactory, the rate for measles shows a sharp increase over the 1945 level. Comparison with the trend of measles in the civilian population shows, however, that the Army incidence is merely following the general pattern of civilian incidence, now higher than at any point since 1943. Army admission rates for scarlet fever are markedly higher than they have been at any time since World War I. It is probable that unusual environmental factors at certain camps are chiefly responsible for the recent spectacular acceleration in rate which has no parallel in the current experience of either the Navy or the civilian population, as may be seen in the following chart. The rates are plotted there as percentages of their respective averages for the period, also included in the chart. It should be mentioned that Navy rates have been considerably higher than Army rates throughout the war period for reasons which are not well understood but which may reflect differences in the way in which new recruits are handled during their first few months of service. In reaching its unprecedented peak of 15 per 1,000 men per year in March the Army rate approximated the Navy rate for the first time during the period shown in the chart.

ADMISSIONS FOR SCARLET FEVER, ARMY, NAVY, AND CIVILIANS IN THE UNITED STATES
RATES AS PERCENT OF AVERAGE RATE FOR PERIOD



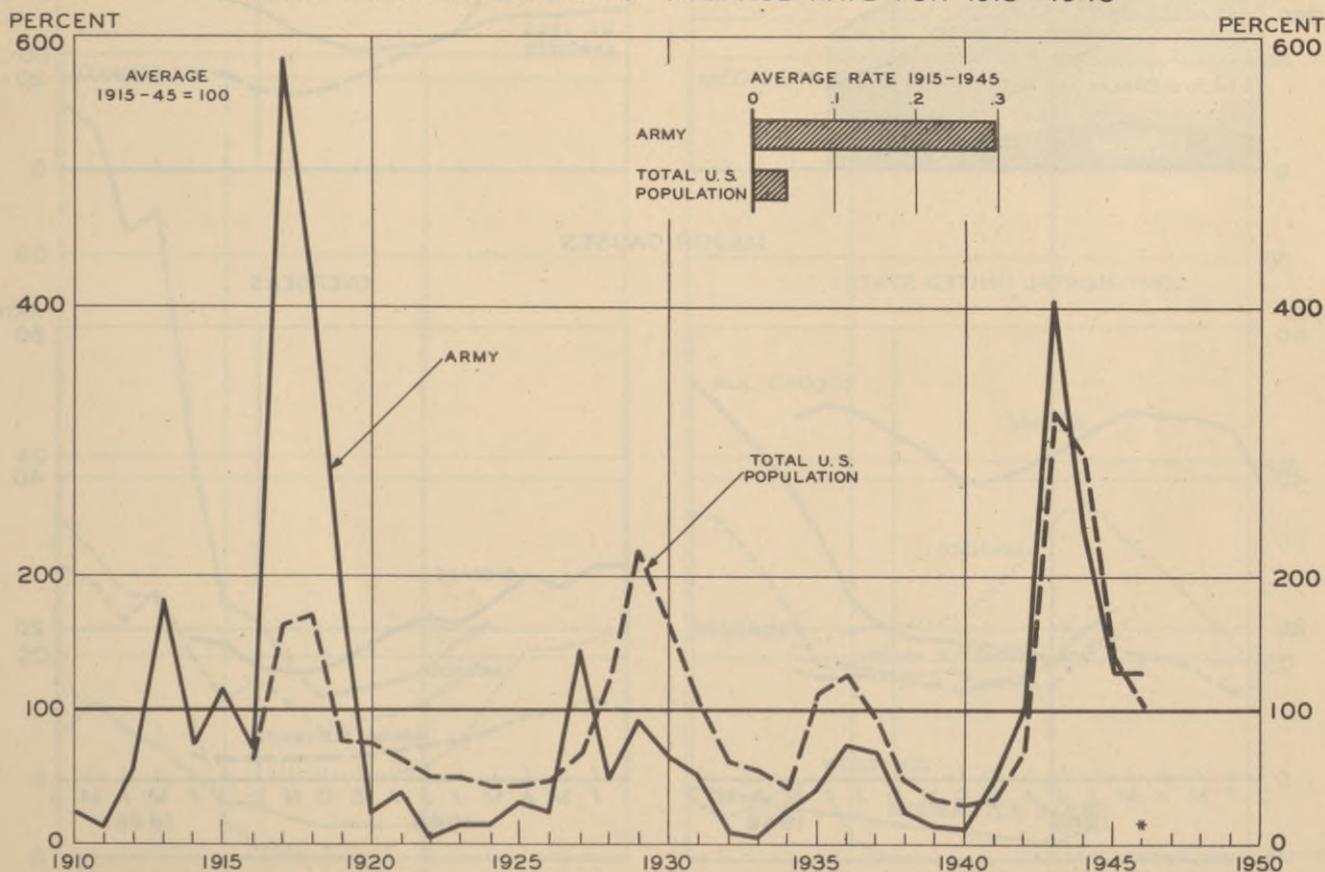
DISEASE AND INJURY

MENINGOCOCCAL MENINGITIS

Meningococcal meningitis in the civilian population has been recorded with increasing accuracy and completeness during the past several decades. Since 1910 there have been five well-defined epidemic cycles, the most recent of which is now in its declining phase. The cycles are of uneven lengths and of variable height. The accompanying chart gives both total U. S. and Army rates, which have followed a generally similar pattern. The U. S. totals include cases occurring in both the Army and the civilian population. Because the rates for the Army, with its greater proportion of men of susceptible age, are so much higher than those for the civilian population, the cyclic variation is shown better by plotting the rates as percentages of the respective averages. However, the averages also appear on the chart. The peaks and troughs of the cycles have occurred at approximately the same time for the Army and for the population as a whole, but the amplitude of the fluctuation has been far greater in the case of the Army rates.

During World War I, when mobilization rapidly introduced large numbers of unseasoned recruits into the Army, admission rates for Army troops rose proportionately more than did those for the population as a whole. A marked rise also occurred during World War II, but the proportionate increases were about the same in the Army and in the entire population. Both rates rose above those for the two previous peaks. Late in 1943, experimentation at several camps having indicated its value, sulfadiazine began to be given in prophylactic doses to all men entering the Army during the winter months as well as to all personnel at posts where meningitis outbreaks were occurring. In the following year routine administration was discontinued, the incidence of the disease having fallen, but the authorization of sulfadiazine prophylaxis under epidemic conditions continued in effect. The subsequent decline in Army incidence appears to be a response to the basic factors governing civilian incidence and it is impossible to determine what, if any, contribution sulfadiazine made to the total decline. There is no doubt, however, of its effectiveness in the control of specific outbreaks. The current rates are following a long-established, general pattern of cyclic variation. Rates for 1946, which have been estimated from the admissions of the first quarter, when incidence is highest, continue the roughly parallel trends in rates for both the Army and the entire U. S. population.

MENINGOCOCCAL MENINGITIS IN THE UNITED STATES
ANNUAL RATES AS PERCENT OF AVERAGE RATE FOR 1915 - 1945



* Estimated.

DISEASE AND INJURY

NONEFFECTIVES IN HOSPITAL AND QUARTERS

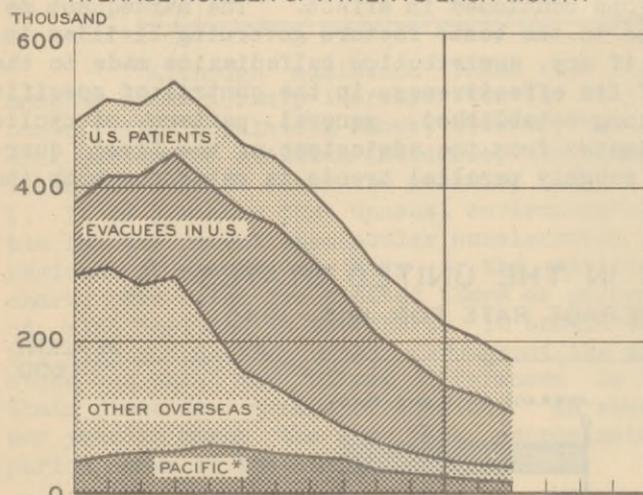
The noneffective population continued to shrink both overseas during February and in the U. S. during February and March. On the average there were 173,000 Army patients in hospital and quarters during February as contrasted with 202,000 during January. Relative to declining strengths, however, there was little change in the noneffective population either overseas or in the United States. A slightly downward trend does, however, characterize U.S. noneffective rates for February and March when evacuees from overseas are included. On the other hand the rate for U. S. troops less evacuees increased slightly during February and March. Of the entire noneffective population of the Army during February, 69,000, or 40 per cent, were patients evacuated from overseas to U. S. hospitals.

In this period of rapidly falling strength it is important to distinguish between admission rates and noneffective rates as indices of health. The former represent the initial impact of disease incidence and are therefore relatively independent of strength fluctuations. Noneffective rates include patients remaining from a time when strengths may have differed, an important factor at the present time. For example there were 24,000 wounded remaining in Z/I hospitals at the end of March, and during the month the wounded accounted

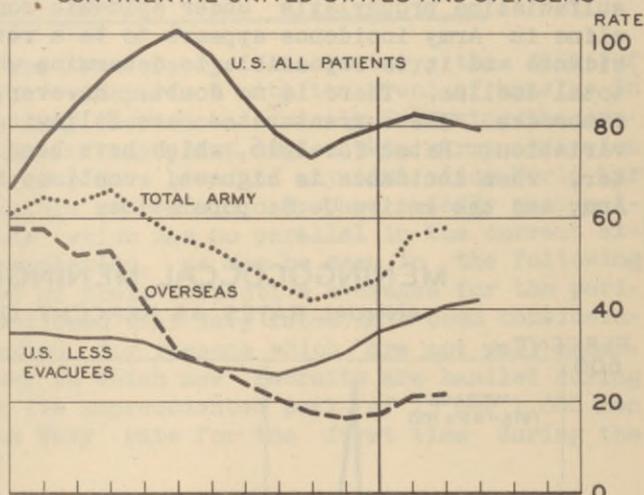
AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES

AVERAGE NUMBER OF PATIENTS EACH MONTH

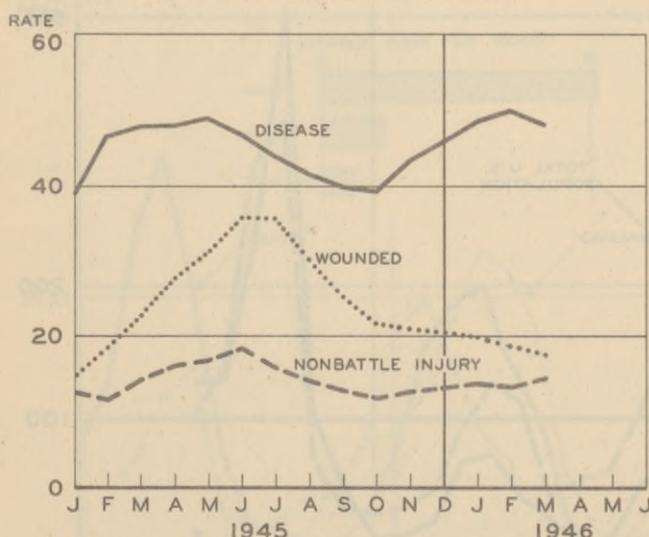


CONTINENTAL UNITED STATES AND OVERSEAS

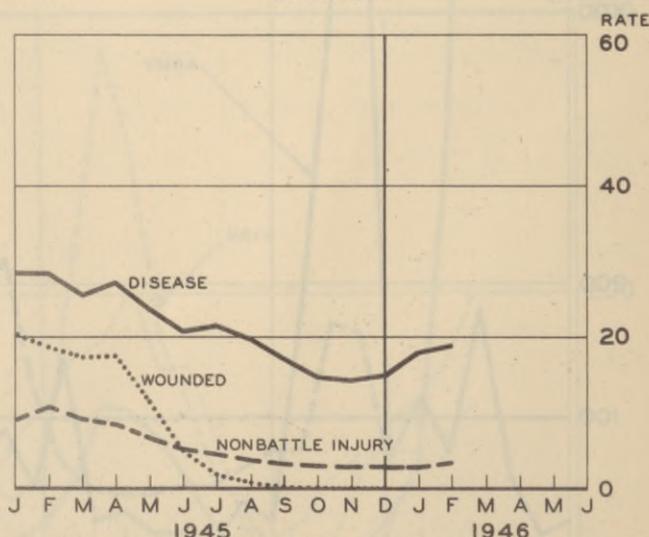


MAJOR CAUSES

CONTINENTAL UNITED STATES



OVERSEAS



* Middle and Western Pacific

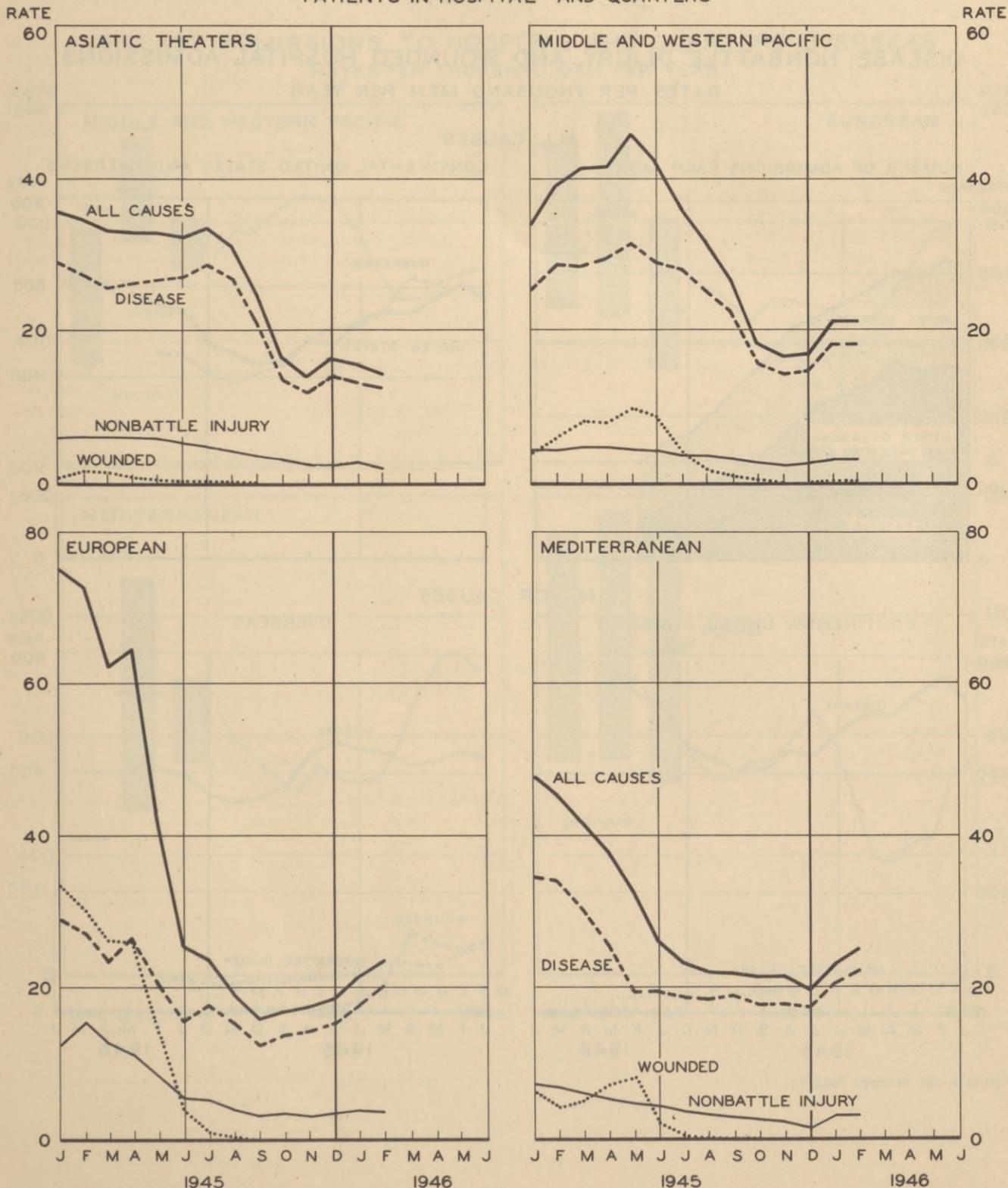
DISEASE AND INJURY

NONEFFECTIVES IN HOSPITAL AND QUARTERS (Continued)

for 22 percent of the total Z/I noneffective rate of 79 per thousand strength. The admission rates provide a better index of health conditions among troops, and the noneffective rates a better measure of the need for medical care.

Noneffective rates in the individual overseas theaters were relatively unchanged during February. A slight upward trend in noneffectiveness from disease in the European and Mediterranean Theater was continued, but in all theaters current rates are very favorable.

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



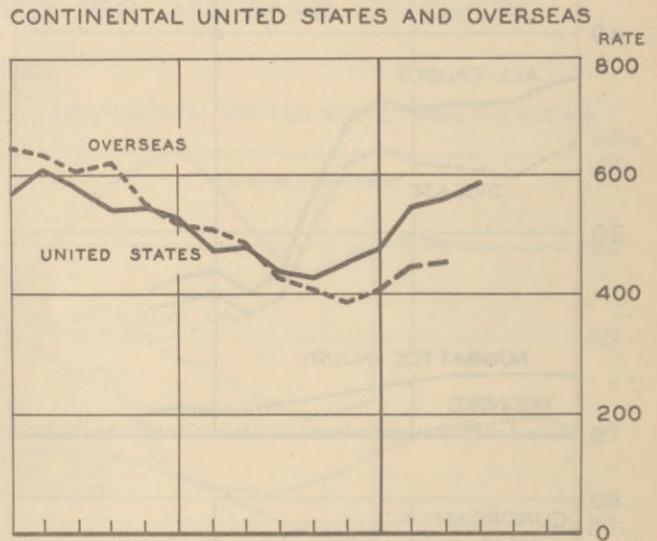
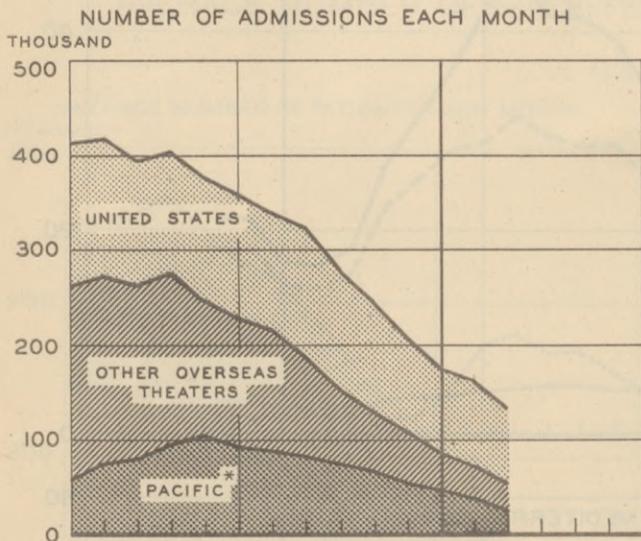
DISEASE AND INJURY

TREND OF HOSPITAL ADMISSIONS IN THE UNITED STATES AND OVERSEAS

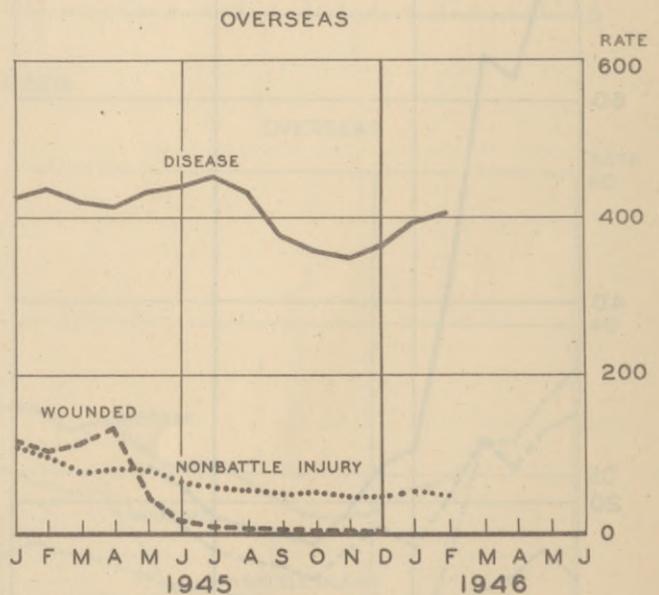
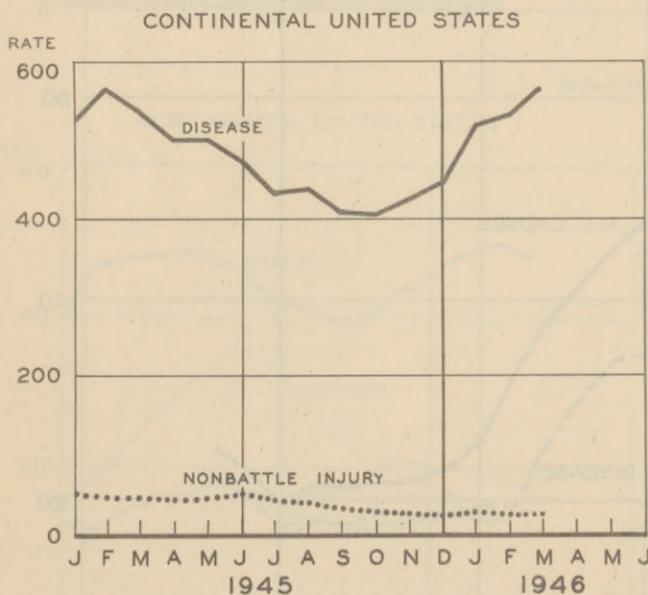
The recent rates for morbidity both in the U. S. and overseas are rising. In the Z/I the hospital admission rates have increased for the past five months, mainly as the result of increasing respiratory diseases. The preliminary March rate for disease is 565 in comparison with the revised rate of 532 for February. The admission rate for nonbattle injuries is essentially stable at about 28. Overseas also, the rates have been increasing although they remain lower than those in the United States. The most recent data, those for February, yield a preliminary rate of 403 admissions per thousand men per year for disease. The increasing rates for overseas result from the greater prevalence of the respiratory and venereal diseases. The incidence of nonbattle injuries is also stable overseas, but at a level about twice that for the United States, the February rate being 47.

DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS RATES PER THOUSAND MEN PER YEAR

ALL CAUSES



MAJOR CAUSES



* Middle and Western Pacific.

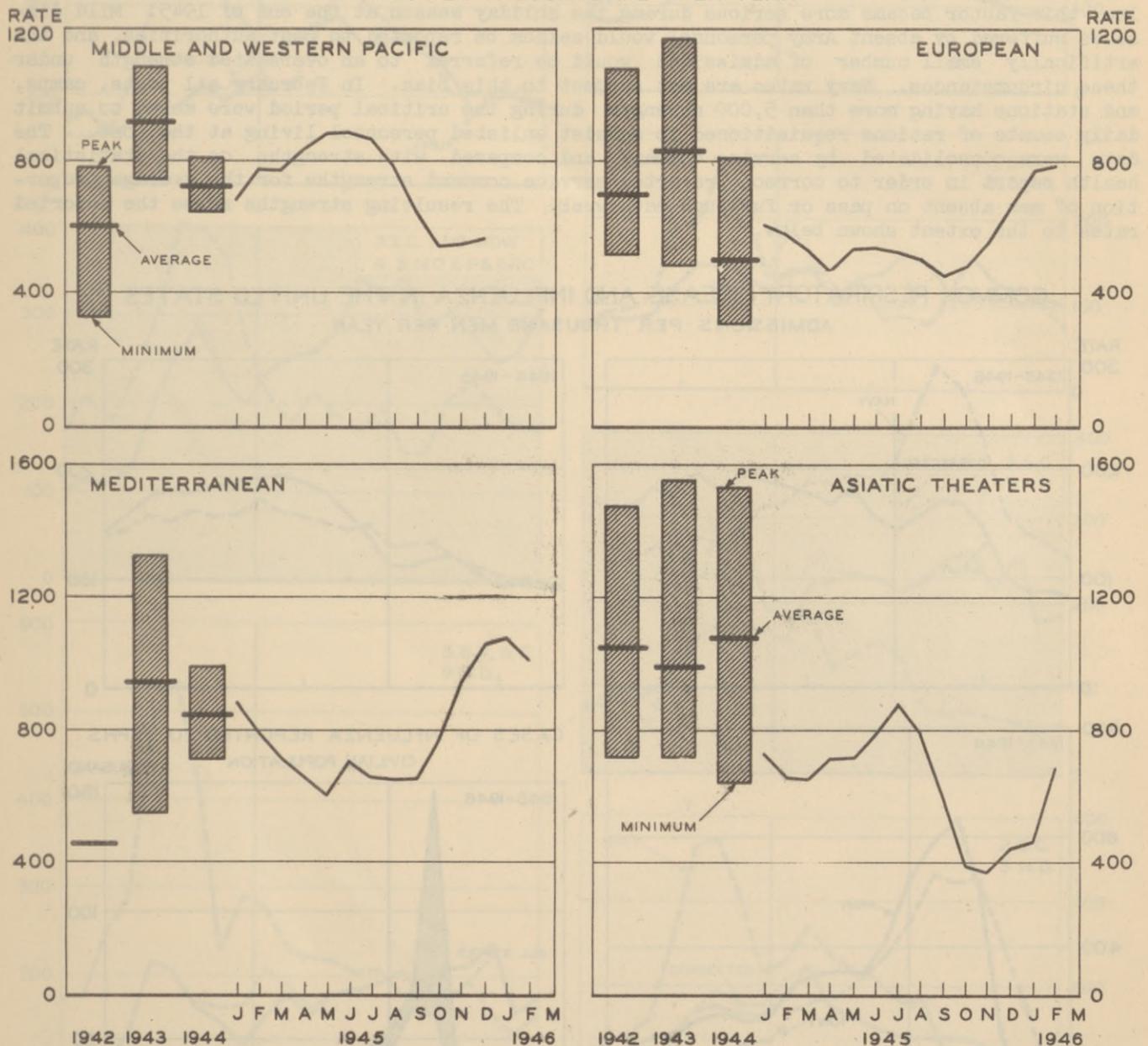
DISEASE AND INJURY

DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS

During February overseas admission rates for all diseases were relatively unchanged in the major theaters. However, the very small force in China reported a large increase in admissions from 843 per 1,000 per year in January to 1,952 in February, sending the rate for the Asiatic theaters up about 50 percent. Although there was an increase in respiratory admissions it accounts for only a small part of the rise which remains unexplained at this writing.

February admission rates for lesser areas not shown in the charts below are: 314 for Alaska; 401 for Latin America; and 323 for Africa-Middle East. The comparable U. S. rate is 596.

DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS RATES PER THOUSAND MEN PER YEAR



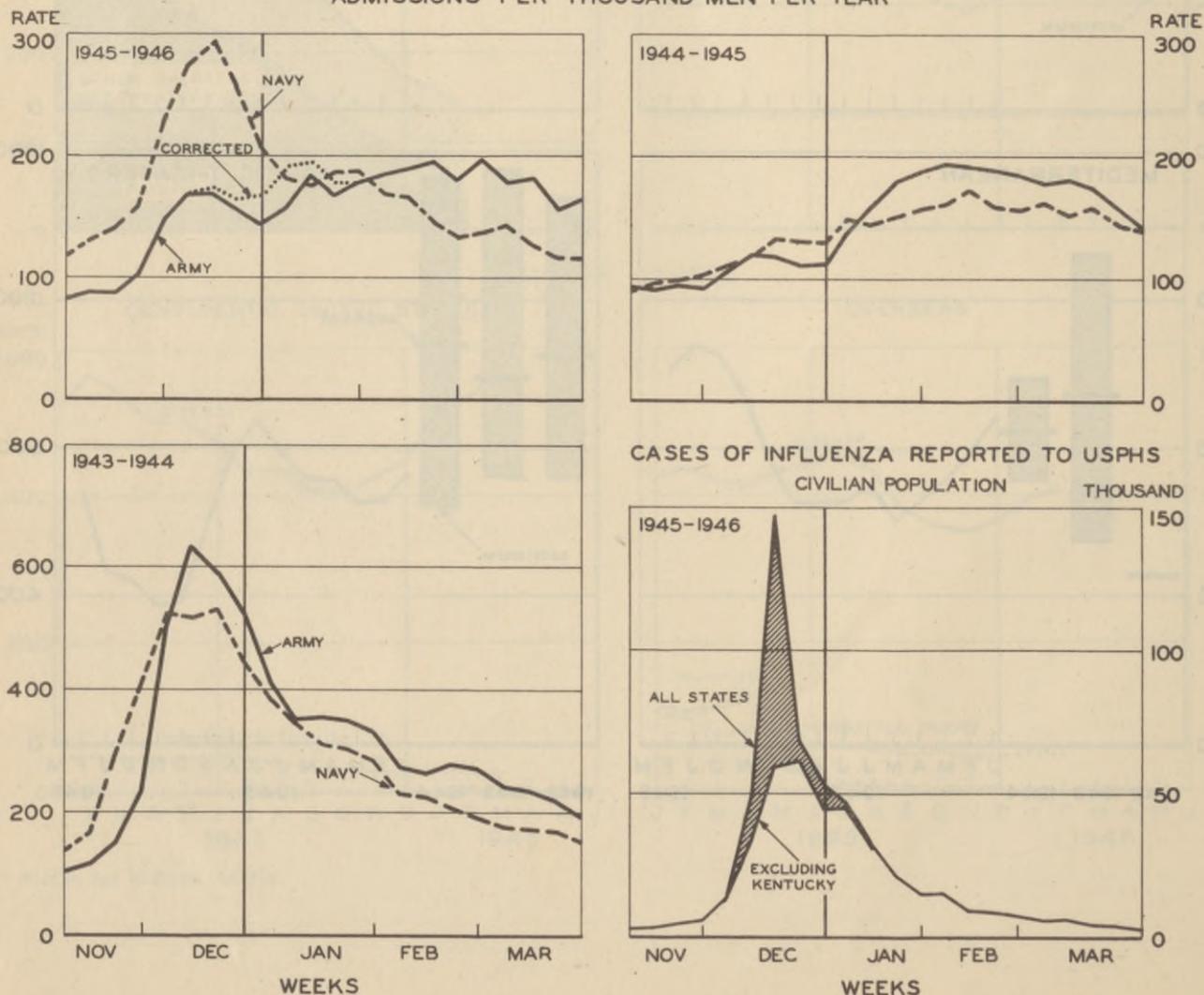
DISEASE AND INJURY

RESPIRATORY DISEASE IN THE UNITED STATES

In HEALTH for December 1945 it was reported that the mild epidemic of influenza B which occurred in the civilian population in December had no real counterpart in the Army, probably because of the recent immunization of Army troops. Comparison of the Army experience with Navy morbidity rates supported this contention. As mentioned there, it was difficult to state precisely how much of the failure of Army rates to rise to anticipated epidemic levels resulted from the unprecedented scale on which personnel were absent from their posts on pass or furlough, especially during the holiday season. As may be seen from the upper left-hand panel below, adjustment of the reported series for this deficiency does not increase the rate sufficiently to prejudice the conclusion that the Army rate failed to respond in expected fashion to the epidemic then in progress. The other panels give both Army and Navy rates in the two previous seasons and the civilian experience of the 1945-1946 season.

Correction of the Army series is necessary because the reporting system makes no allowance for strength which is temporarily absent from the post. Ordinarily a minor problem, this factor became more serious during the holiday season at the end of 1945. Mild diseases suffered by absent Army personnel would seldom be reported to post authorities, and the artificially small number of admissions would be referred to an overstated strength under these circumstances. Navy rates are not subject to this bias. In February all posts, camps, and stations having more than 5,000 strength during the critical period were asked to submit daily counts of rations requisitioned to subsist enlisted personnel living at the post. The data were consolidated by service command and compared with strengths on the statistical health report in order to correct reported service command strengths for the average proportion of men absent on pass or furlough each week. The resulting strengths raise the reported rates to the extent shown below.

COMMON RESPIRATORY DISEASE AND INFLUENZA IN THE UNITED STATES
ADMISSIONS PER THOUSAND MEN PER YEAR

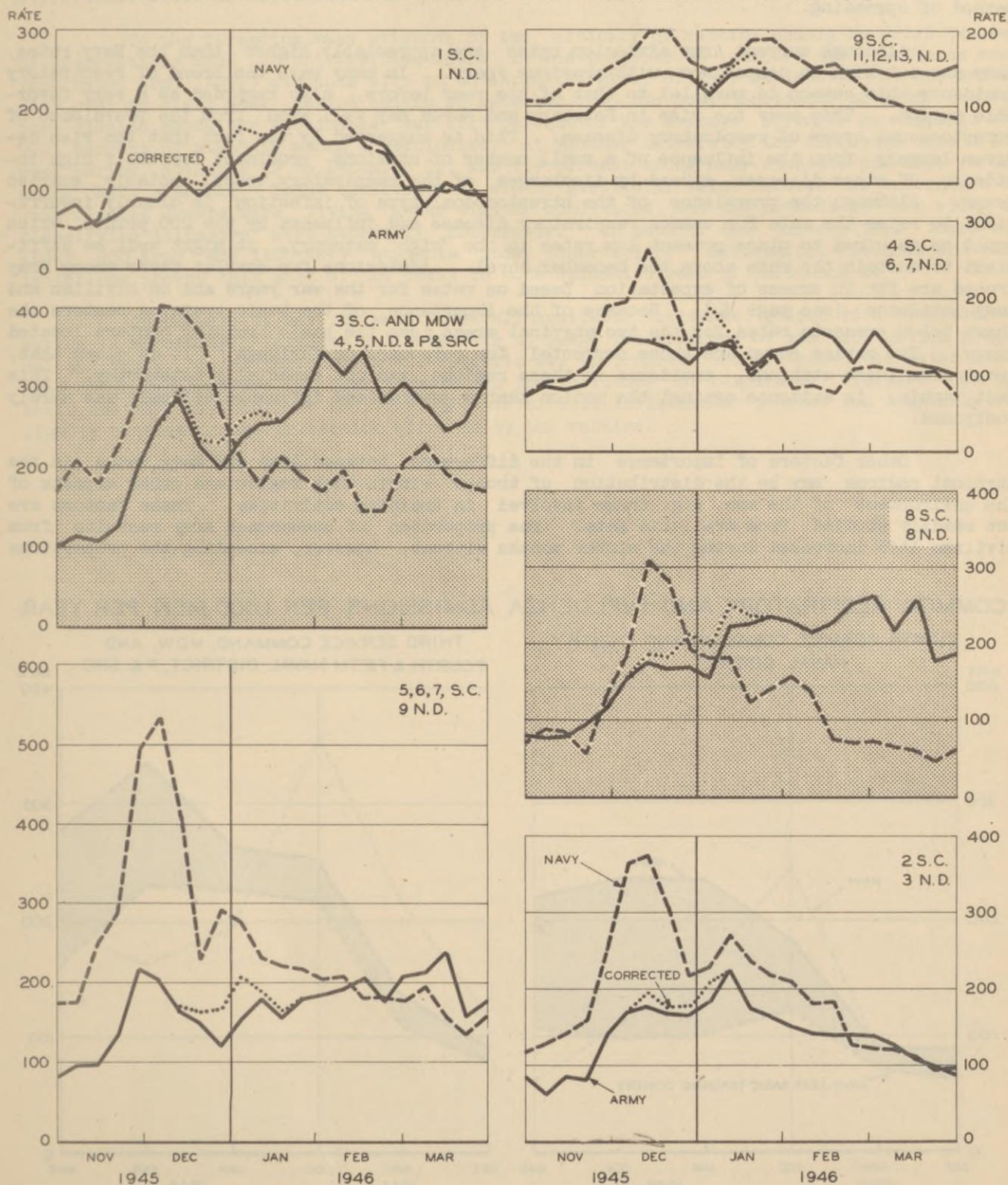


DISEASE AND INJURY

RESPIRATORY DISEASE IN THE UNITED STATES (Continued)

Although correction of the Army series shows fairly conclusively that the Army escaped the full impact of the mild influenza B epidemic in December, after the influenza epidemic had subsided Army rates not only rose to higher levels than before but exceeded the rapidly falling Navy rates by a considerable margin. It might be contended that the vaccination program merely postponed the epidemic for Army personnel and spread it over a longer period by imparting a short-lived immunity. The most important evidence against this view

**COMMON RESPIRATORY AND INFLUENZA ADMISSIONS PER THOUSAND MEN PER YEAR
ARMY AND NAVY BY SERVICE COMMAND AND NAVAL DISTRICT IN THE U. S.**



DISEASE AND INJURY

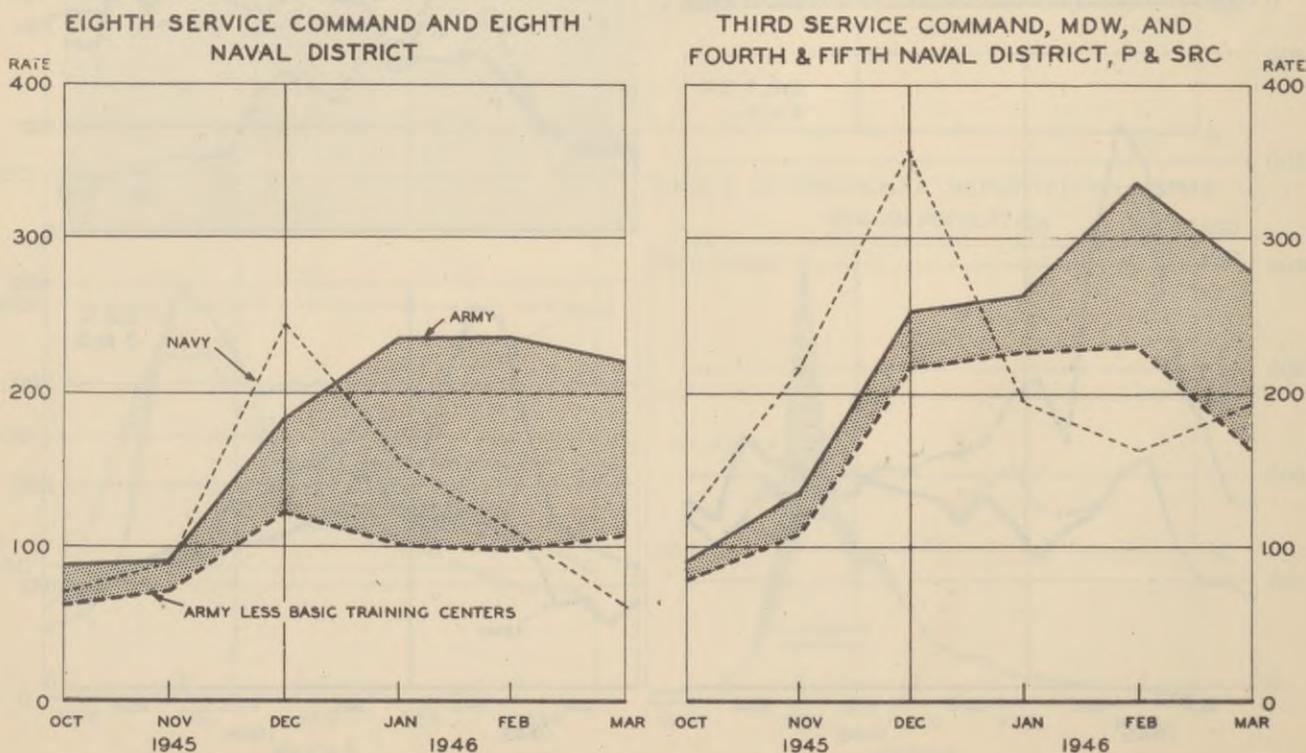
RESPIRATORY DISEASE IN THE UNITED STATES (Continued)

consists in the fact that the Army and Navy series are reasonably close in the post-epidemic period in all areas except the Eighth Service Command and the Third Service Command plus the Military District of Washington. The accompanying chart makes these regional comparisons graphically. The adjustments for Army strength on pass or furlough during the period of the influenza epidemic are also shown. Within the two broad regions which contribute the bulk of the cases making up the differential between Army and Navy rates, a few stations, chiefly basic training centers, are primarily responsible for the high rates during February and March (see pages 2 to 5). Laboratory and clinical investigations have uncovered no evidence that influenza epidemics were in progress at these or any stations in the U. S., and such a focal concentration of influenza in epidemic form would be contrary to its usual method of spreading.

Although current Army admission rates are appreciably higher than the Navy rates, they are not high in comparison with previous years. In many ways the trend of respiratory incidence this season is parallel to that of the year before, also regarded as a very favorable period. This year the rise in February and March may well stem from the prevalence of streptococcal types of respiratory disease. This is suggested by the fact that the rise derives largely from the influence of a small number of stations prominent for their high incidence of other diseases spread by discharges of the respiratory tract, notably scarlet fever. Although the prevalence of the streptococcal type of infection is clearly insufficient to raise the rate for common respiratory disease and influenza by the 200 points which would be required to place present low rates in the "high" category, it might well be sufficient to sustain the rate above the December level. Admissions for scarlet fever among Army troops are far in excess of expectation based on rates for the war years and on civilian and Navy incidence (see page 6). Because of the importance of the basic training centers the chart below presents rates for the two atypical areas less the basic training centers located there. The series shown are those corrected for personnel on furlough. It is clear that, apart from these stations, incidence in these regions was not especially noteworthy. This fact, again, is evidence against the notion that a generalized influenza epidemic was merely postponed.

Other factors of importance in the difference between Army and Navy rates in the atypical regions may be the distribution of troops within each region and other aspects of the environment of the men, e.g. those involved in training activities. These factors are not readily studied from available data. The proportion of unseasoned Army recruits from civilian life increased during the winter months without, however, exceeding the proportions

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



DISEASE AND INJURY

RESPIRATORY DISEASE IN THE U. S. (Continued)

which obtained during the war years. It is higher than the proportion for Navy personnel, but not remarkably so. If the present season is atypical, therefore, it is not obviously a matter of the mere number or proportion of raw recruits. Shortening of the training cycle or other factors governing the rate of contact in the training centers may be more important. Finally, although there is a remarkable correspondence between the Army and Navy respiratory disease incidence during the 1943 influenza epidemic, the agreement is not so close at other times in 1943, 1944, and 1945, especially when measles, mumps, and scarlet fever were most prevalent. It is known that slight differences exist between the Army and Navy systems of classifying, for reporting purposes, diseases spread by respiratory tract discharges. Any differences would be least noticeable during influenza epidemics.

To the foregoing mass evidence of the efficacy of vaccine should be added two sets of observations made at universities where it was possible to compare the incidence among vaccinated Army (ASTP) students with an unvaccinated group of Navy students. At one university over an eight-week period ending 22 December 1945 the total incidence of acute respiratory disease among the vaccinated was 1.15 percent of the average strength as compared with 9.91 percent of strength among unvaccinated. At another university the incidence over a six-week period, November 12 to December 22, was 1.9 percent among Army students and 16.9 percent among Navy students. These observations are of particular value because the vaccinated and unvaccinated groups were living under similar conditions and the methods of recording and classifying illnesses were generally comparable. In each of the universities there were about 600 Army and 1100 Navy students under observation. Serological studies and virus isolations proved that most of the cases in both epidemics were of influenza B.

In summary it may be said that all available evidence points to a considerable saving in morbidity. It seems entirely fair to judge the efficacy of the vaccination program on the basis of the period when the epidemic was in progress and to ignore the later months when other factors were at work to maintain the incidence of respiratory disease. On this basis one can only conclude that the epidemic of mild influenza B touched the Army only very lightly because of the protection afforded by the vaccine.

DISEASE AND INJURY

VENEREAL DISEASE IN THE UNITED STATES

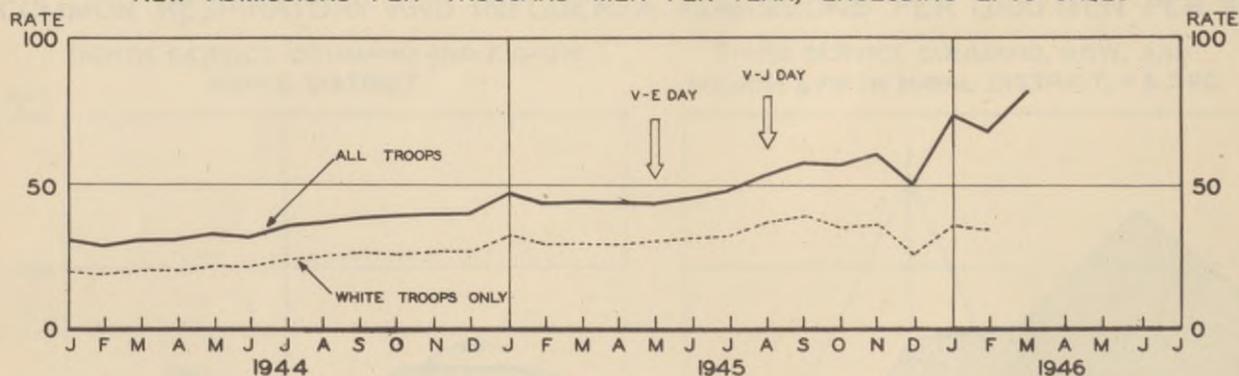
In March the admission rate for venereal disease among Z/I troops rose to 81 per 1,000 men per year, the highest it has been since about 1920 and more than twice the average 1944 level. From the beginning of 1944 to the end of 1945 the rate has increased steadily at an average rate of 10 percent per quarter, but during the first quarter of 1946 the rate of increase has been further accelerated. Moreover, analysis of the March rate discloses that the weekly rates increased progressively during the month, ending with a rate of 92 for the last week, contrary to the usual pattern of a peak rate in the third week of a five-week month. The changes which have occurred since January 1944 are shown in the first panel below.

Analysis of the rates by color reveals that the relative incidence among Negro troops was seven times that for white troops, on the average, throughout 1944 and the first half of 1945. Thus, during this interval, rates for both white and Negro troops were increasing at about the same pace, 10 percent per quarter. During the second half of 1945 and the first quarter of 1946, however, the admission rate for Negro troops advanced at the more rapid pace of about 30 percent per quarter, while the rate among white troops has shown no tendency to rise above the peak rate of 38 in September 1945. Thus the recent spectacular increase in the venereal disease rate for all troops in the U. S. reflects primarily the influence of the high rate for Negro troops. The rate for Negro troops in February was 437, while that for whites was 35, a ratio of more than 12 to one.

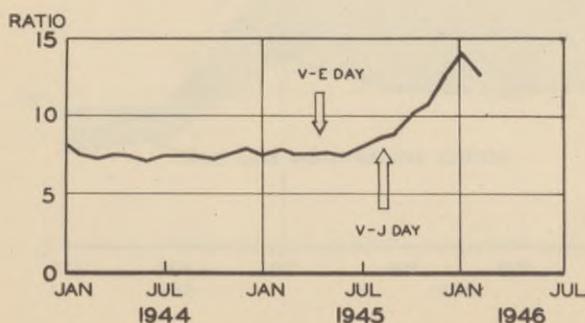
The situation in the Z/I has its counterpart overseas, and also exists in the Canadian Army. The bottom right-hand panel compares recently reported Canadian Army rates for troops in Canada with those for U. S. troops in the Z/I. Although the U. S. rate rose proportionately more from 1944 to 1945 than did the Canadian rate, both series reflect a similar pattern of decline in the early years of the war followed by a reversal of trend and an advance to higher levels. Accompanying the Canadian data is a comment attributing the increase to "the increased number of personnel returned from overseas who acquire venereal disease while on disembarkation leave".

The incidence of venereal infection has increased to the point where it has become a critical problem, particularly among Negro troops. Without greatly intensified efforts by command to control venereal disease incidence the problem is likely to continue to be a pressing one.

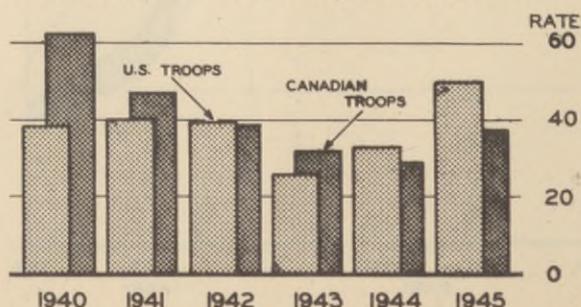
VENEREAL DISEASE AMONG TROOPS IN THE CONTINENTAL UNITED STATES
NEW ADMISSIONS PER THOUSAND MEN PER YEAR, EXCLUDING EPTS CASES



RATIO OF NEGRO TO WHITE RATE



ANNUAL ADMISSION RATES FOR U.S. AND CANADIAN TROOPS, U.S. & CANADA



DISEASE AND INJURY

VENEREAL DISEASE OVERSEAS

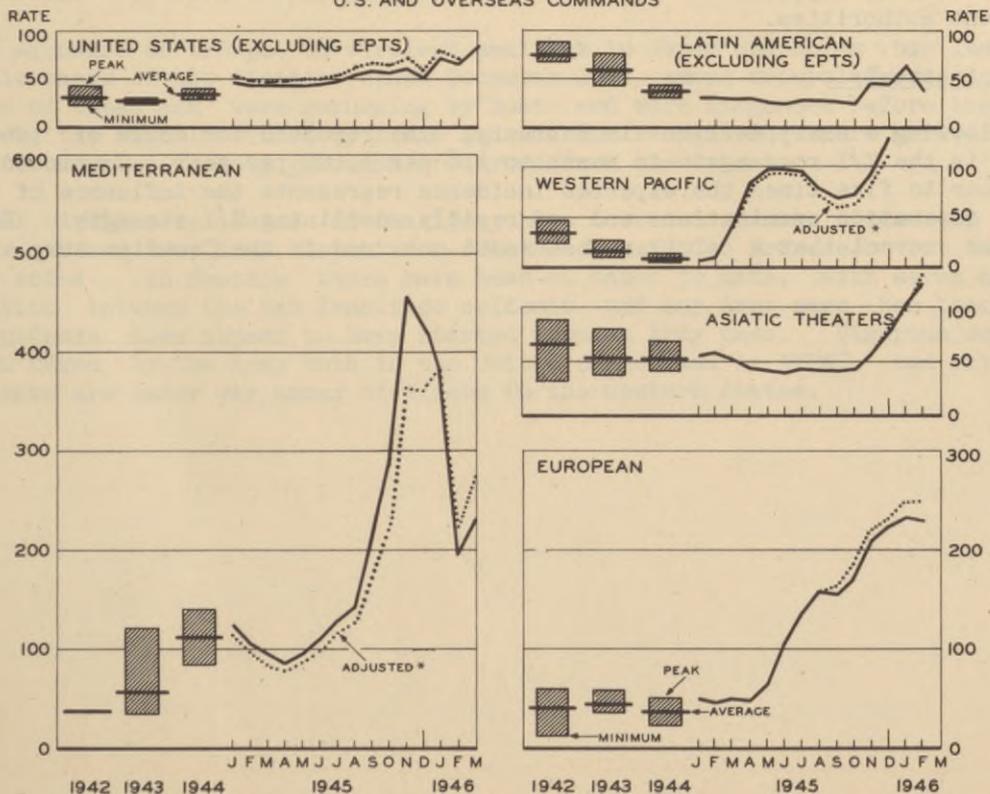
The most important facts about the incidence of venereal disease overseas are the continued advance in the rate for troops in Japan and the truly spectacular decline in the rate for the Mediterranean. From 117 in November the admission rate for venereal disease in Japan rose to about 180 in December and to 227 in January. It approximates current rates in the European Theater. In Korea, however, the situation is both stable and very favorable, according to advance reports. At 22 per 1,000 men per year the January rate for the XXIV Corps is but one-tenth that for troops in Japan. In the Mediterranean the January rate of 382 was halved in February, only partly because of a decline in the proportion of Negro strength. However in March the rate rose again to 225.

Trends in other areas, and in the entire Western Pacific Area through December, are shown in the accompanying chart. The adjusted line for any theater shows what the rates would be if it had the average color composition of all overseas forces during 1944.

The dismal state of venereal disease control overseas stems from three main sources: (1) failure of command to check the growing apathy with which officers and men view venereal disease; (2) lack of trained venereal disease control officers; and (3) greater leisure and opportunity for sexual contact on the part of troops stationed in areas where the civilian populations suffer extreme deprivations. Specific factors are: scarcity of food for civilians; inadequate centralization and control of housing for troops; poor officer leadership and conduct; insufficient supervision of enlisted men; inadequate recreation facilities; insufficient trained police; and insufficient orientation of replacement troops.

In order to stimulate command interest and to facilitate the correction of such deficiencies as those listed above, the Chief Surgeon, USFET, has recommended the establishment of Venereal Disease Control Boards in all major commands. The European Theater is also placing great stress on improved methods of tracing contacts so as to bring infected women under treatment. Army Nurse Corps personnel are used to excellent advantage in this work, according to theater reports. The most productive method of finding infected contacts is reported to be the after-curfew sweep by military and civilian police, but under optimum conditions as high as 60 percent of the infections of a unit have been successfully traced from the sex-contact history. The Bremen Port Command is reported to have a force of 300 military police and shore patrol troops who, dressed as GI's and sailors, use themselves as decoys and place under arrest women who consent to sexual intercourse.

VENEREAL DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR
U.S. AND OVERSEAS COMMANDS



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

DISEASE AND INJURY

HEALTH BRIEFS

Military Government in Germany

Latest Military Government reports indicate that satisfactory resumption by German authorities of the direction and operation of health facilities has been delayed by inadequacies in facilities for communication and transportation, by difficulties in obtaining replacement personnel with requisite public health training and experience, and by shortages in both medical supplies and specialized hospital facilities. Medical care and sanitation in DP centers, some of which are under the direction of UNRRA medical personnel supplemented in certain instances by German medical personnel, are reported to be satisfactory.

Hospital bed capacity has increased to the point where, for the first time during the occupation, a sufficient coverage is in prospect. Although the available capacity of 1.1 percent of the population on 1 February was still below the target of 1.5 percent, the patient census declined slightly during January. The transfer of PW patients to civilian authorities was directed in January, and provision was made for transfer of adequate personnel and hospital facilities for the purpose. The PW patient population numbered 56,000 on 1 February. An equipment reserve of 80,000 beds destined for disposal as surplus was placed under Military Government control in January. These reserve stocks are to be released for disposal as surplus property on or before 1 May if no epidemic intervenes to make their use mandatory.

The reporting of communicable diseases at the lower echelons has been placed under civilian control. After an initial delay it is now reasonably up-to-date. Reported trends in incidence are largely favorable in direction, although a high toll is still exacted by certain diseases, notably diphtheria, venereal disease, and the typhoid group. An active immunization program is being continued, especially against diphtheria, smallpox, typhoid, and scarlet fever.

The caloric value of the official ration in the U. S. Zone increased during January but remains below the recommended levels for all except infants. Most age-groups were receiving an official ration from 70 to 85 percent of their calculated requirement. However, nutrition surveys indicated that consumers were able to increase their average caloric intake appreciably on the basis of non-rationed foods.

In February it was reported that civilian medical service was more handicapped by depleted or reduced stocks of medical supplies than at any time since the occupation. German production of medical supplies was reported to be lagging and in need of stimulation by Military Government authorities.

Tuberculosis in the Z/I

Following a sharp decline in February, the reported incidence of tuberculosis in U. S. troops in the Z/I rose again in March to 4.8 per 1,000 per year. Continued maintenance of a level four to five times the expected incidence represents the influence of case-finding incident to separation examinations and of rapidly declining Z/I strength. Recently published figures reveal that a similar phenomenon occurred in the Canadian Army at the end of 1945.

DISEASE AND INJURY

HEALTH BRIEFS (Continued)

Hepatitis in the Z/I

Infectious hepatitis was relatively uncommon among Z/I troops until the spring of 1945, when an upward trend began. Cases were diagnosed largely in general hospitals and in ports of embarkation or their supporting installations. The rise may well have been associated with the arrival of large numbers of evacuees and was sustained by the influx of troops being returned to the Z/I from areas and organizations in which hepatitis was prevalent. The incubation period is so long that appreciable numbers of men who are exposed overseas may become ill after their arrival in the Z/I. Although the proportion of Z/I strength in general and convalescent hospitals declined sharply from July through September 1945, and has been relatively constant since that time, the incidence of infectious hepatitis has mounted fairly steadily from 3.2 in June 1945 to about 4.5 in February and March 1946. Nearly half of the cases are still being reported by general hospitals, ports, and staging areas. In February, with only eight percent of the total U. S. strength, general hospitals reported 28 percent of the hepatitis cases; for ports and staging areas the percentages are five for strength and 18 for hepatitis. In the great majority of instances these infections were probably contracted overseas. There has also been an increase in the number of cases reported from other types of installations, but many of these could likewise have arisen among recent returnees. Returnees are so dispersed throughout U. S. camps that even a tabulation excluding general hospitals, ports, staging areas, and personnel centers reveals a significant amount of malaria acquired overseas and a substantial amount of scabies, also likely to have been contracted overseas. It cannot be stated definitely, however, whether there has actually been any increase in the level of "indigenous" hepatitis among troops who have not been overseas.

Diphtheria in Europe

Admissions for diphtheria among Army troops in the European Theater continued to rise in February, reaching 6.0 per 1,000 per year, or one-third higher than the January rate. The immunization program continued to make progress in February but it was still restricted to troops considered to be most exposed to infection from civilian sources. A directive has now been issued to accomplish the immunization of replacements and civilian dependents under the age of 35 who embark for Europe at U. S. ports. Current rates are also high for troops in the Mediterranean Theater. Preliminary reports suggest a further increase in the incidence in the European Theater during March.

Smallpox

The exposure of troops to virulent smallpox in Japan and Korea has led to the occurrence of six cases of the disease since December 1945 among troops enroute to the United States. Five of these men were returning by boat and were diagnosed before they reached a West Coast port; the sixth returned by plane and was not recognized before arrival. Several cases have also occurred in Navy personnel returned from the Orient.

Small civilian epidemics of smallpox have occurred in the cities of Seattle and San Francisco. There have been seven non-fatal cases in San Francisco but this outbreak seems to have ended. In Seattle there have been 40 cases to date, with seven deaths. No direct connection between the San Francisco epidemic and any Army case has been proven but the Seattle epidemic does appear to have started from an Army case. Vigorous control measures have been taken by the Army both in the United States and in AFPAC, and extensive vaccination programs are under way among civilians in the western states.

HOSPITALIZATION

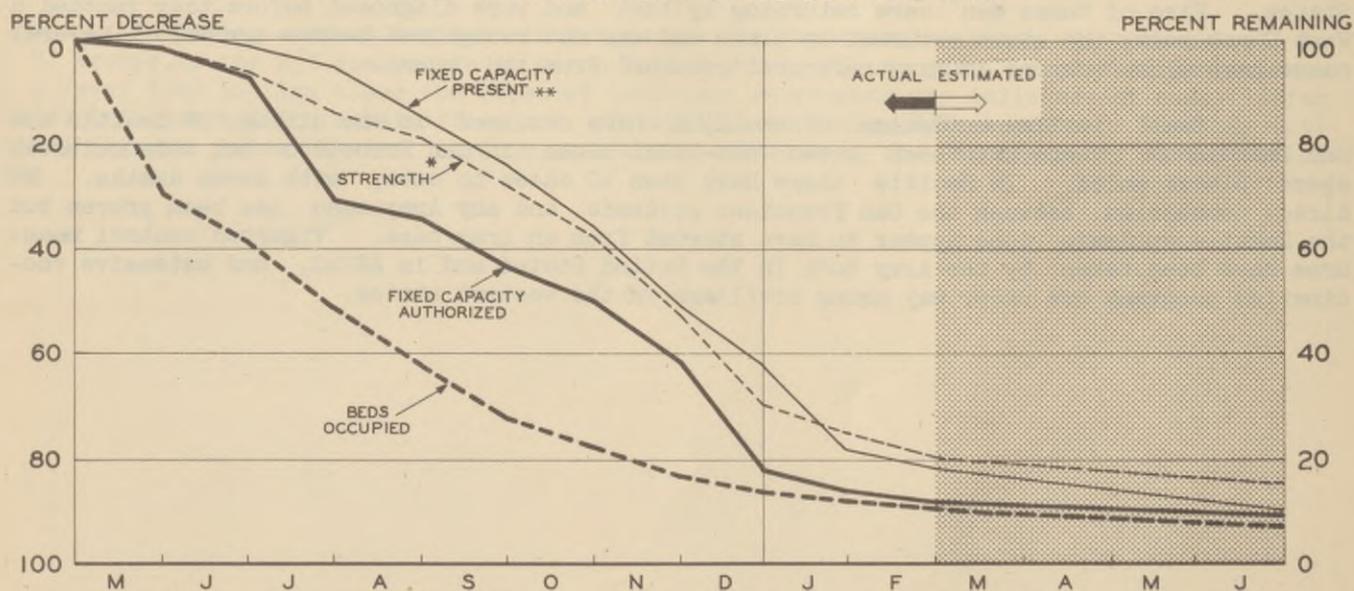
RESTRICTED

HOSPITALIZATION OVERSEAS

Demobilization of hospital facilities overseas progressed further during February. By the end of the month the remaining fixed hospitals and operating hospitals of the non-fixed type had an aggregate T/O capacity of 63,000 beds. The number of operating beds had fallen to 57,000 and 24,000 beds were occupied. The chart below gives a graphic picture of the reduction which has occurred in the overseas hospital structure since 30 April 1945. The left-hand scale gives the percentage decrease since that base date, and the right-hand scale the percent of strength, bed capacity, authorization, and occupancy on 30 April 1945 which was remaining on any subsequent date. The points after 28 February 1946 are forecasts. In comparison with reductions of 82 percent of the base level in fixed hospital capacity present and 88 percent in fixed capacity authorized, 81 percent of the Medical Corps officers overseas on 30 April 1945 had been returned to the Z/I by the end of February 1946. In relation to the same base date, 94 percent of the reduction in strength required to meet the projection for 30 June 1946 had been accomplished by 28 February. The reduction already achieved is 97 percent for authorized beds, 90 percent for bed capacity present, and 96 percent for beds occupied.

The table at the bottom of the next page continues the series previously shown in HEALTH although factors associated with the continuing demobilization tend to reduce the pertinence of some of the items. Particularly inefficient as a measure of either plant capacity or trained personnel available are the counts of T/O fixed plus operating nonfixed beds present. Since units are dropped from the Troop List upon publication of inactivation orders, the time-lag between promulgation of the War Department authorization and actual inactivation by the theater results in theater reports of 71,000 beds present overseas in comparison with a Troop List total of 63,000. Since an appreciable number of units included in theater reports are actually staging for inactivation, the best measure of available capacity presently obtainable is the T/O capacity of the units actually in operation. On 28 February operating T/O capacity totaled 57,000 beds for all overseas theaters, or 132 percent of the number authorized. Even this series, however, is not entirely adequate as a measure of bed capacity actually in use, for not all units in operation are so staffed as to have a full complement of beds in use. For example, in the Western Pacific Area use is made of a count of "established" beds in order to obviate the bias implicit in the assumption that all operating units have their full T/O count of beds set up for use. The distinction is important not only in comparing available and authorized capacity but also in measuring bed occupancy. Although the bed-occupancy ratio on 28 February amounts to only 42 percent when based on T/O operating capacity, it would be significantly larger if it could be related to the beds adequately staffed and set up for use.

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



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

RESTRICTED

HOSPITALIZATION

RESTRICTED

HOSPITALIZATION OVERSEAS (Continued)

As in the United States, credits in Army hospitals have been authorized by the War Department for the use of the Veterans Administration in Puerto Rico, Alaska, Hawaii, and the Philippines. At the present time these credits amount to only 425 beds, but negotiations are under way which may eventually increase this total to about 1,500 beds.

Of the 247,000 beds in field, station, and general hospitals and in convalescent centers and camps in Europe, the Mediterranean, and Africa on 30 April 1945, 66 percent had been returned to the Z/I by 10 April 1946, and an additional 17 percent had been or were to be inactivated overseas. In the Pacific and Asiatic Theaters 60 percent of the beds present on 31 August 1945 had been inactivated overseas by 10 April, 10 percent were scheduled for inactivation on this date, and only six percent had been disposed of by return to the Z/I for inactivation.

BEDS AVAILABLE AND OCCUPIED IN OVERSEAS THEATERS a/
Number of Beds, 28 February 1946

Theater	W. D. Author-ization	T/O Fixed and Operating Nonfixed Present b/	Operating		Occupied c/
			Number c/	Percent of Beds Authorized	
ALL THEATERS	43,184	62,602	57,208	132.5	23,918
American	1,420	3,100	3,270	230.3	672
European	19,953	23,577 d/	20,833	104.4	10,395 f/
Mediterranean	1,769	3,800	3,400	192.2	1,324
Pacific	18,145	29,275 e/	28,175	155.3	10,969 g/
Asiatic Theaters	1,610	2,550	1,080	67.2	522
Africa	287	300	450	156.8	36

Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) h/	W. D. Author-ization	Bed Capacity		Beds Occupied as	
			Number Present	Operat-ing	Percent of Strength	Percent of Operating
ALL THEATERS	1,102	3.9	5.7	5.2	2.2	41.8
American	47	3.0	6.6	6.9	1.4	20.6
European	499	4.0	4.7	4.2	2.1	49.9
Mediterranean	44	4.0	8.6	7.7	3.0	38.9
Pacific	454 i/	4.0	6.5	6.2	2.4	38.9
Asiatic Theaters	51	3.2 j/	5.0	2.1	1.0	48.3
Africa	7	4.0	4.2	6.3	0.5	10.3

- a/ In fixed and in operating hospitals of the nonfixed type.
- b/ T/O fixed present reported in W. D. Troop List dated 1 March 1946. Operating nonfixed reported by theaters.
- c/ Reported by theaters telegraphically for 1 March 1946.
- d/ Includes 3,177 operating beds in hospitals of nonfixed type.
- e/ Includes 1,200 operating beds in nonfixed type hospitals in the Western Pacific Area.
- f/ Includes 1,128 beds occupied in nonfixed type hospitals.
- g/ Includes 590 beds occupied in nonfixed type hospitals in the Western Pacific Area.
- h/ Includes only strength within geographic limits of theaters. Personnel enroute to or from the theaters are excluded.
- i/ Includes 6,414 Philippine Scouts.
- j/ Joint authorization for China and India-Burma theaters.

RESTRICTED

HOSPITALIZATION

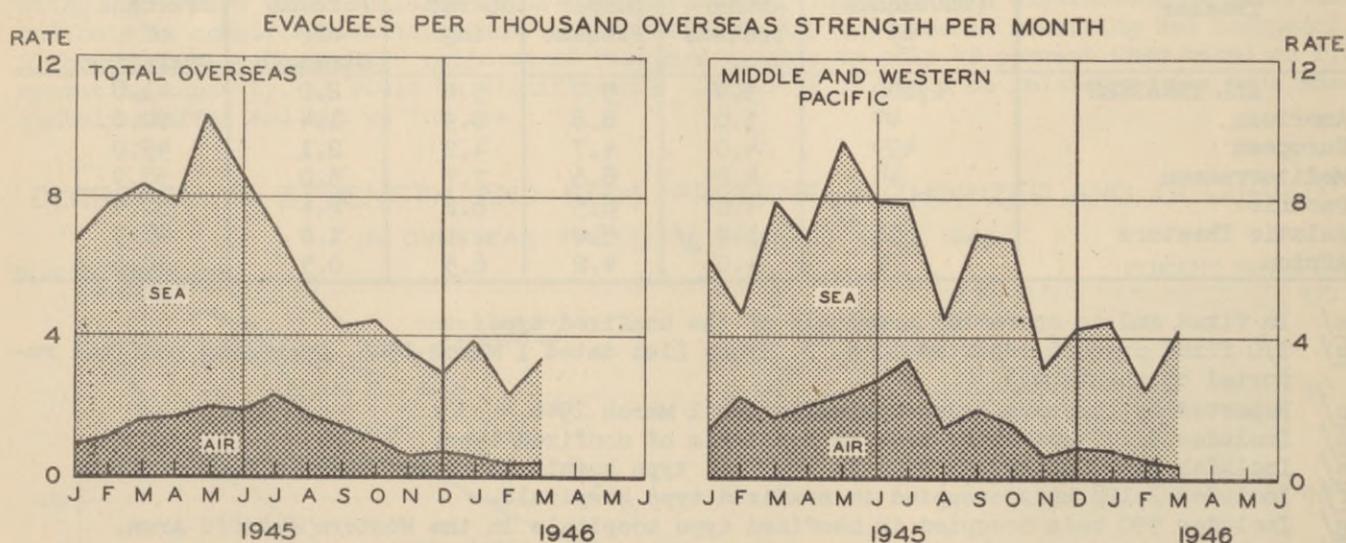
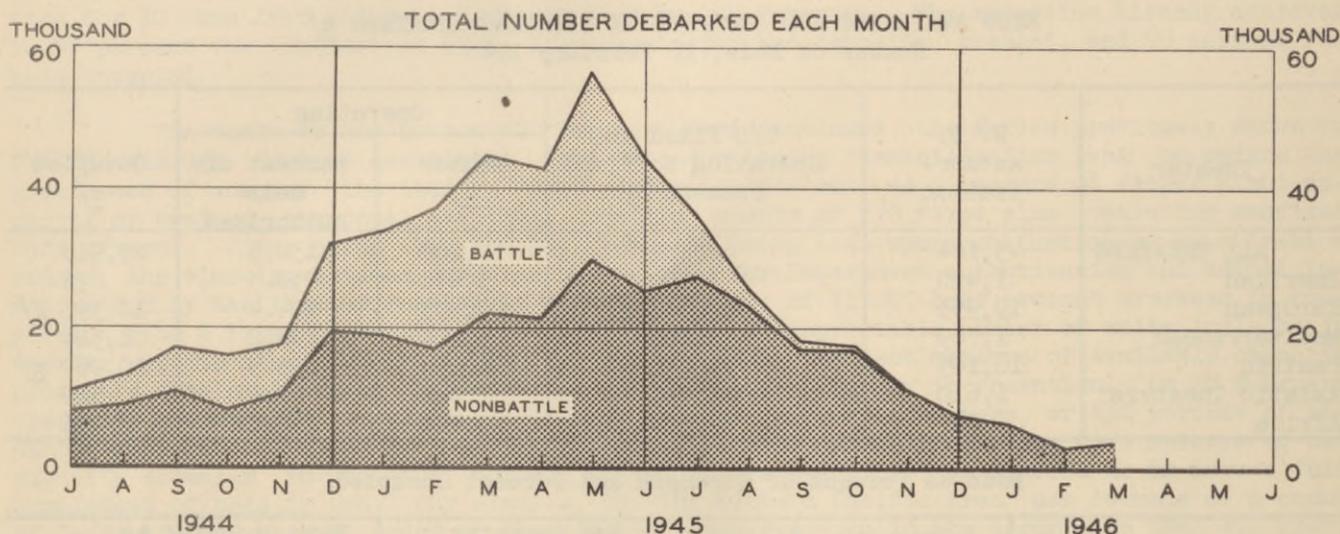
RESTRICTED

TREND OF EVACUATION FROM OVERSEAS

There was a slight increase in the number of overseas patients debarked in the Z/I during March. In contrast to February totals of 2,400 arrivals by water and 600 by air there were 3,300 by water and an estimated 400 by air during March. About 1,900 originated in the Pacific.

Strengths are still declining so rapidly in overseas theaters as to introduce extraneous variation into evacuation rates per 1,000 strength per month. A decline in strength combined with an increase in number of patients evacuated to increase evacuation rates to a point well above the February level but still low according to war-time experience.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS



RESTRICTED

HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR

The number of patients remaining in general and convalescent hospitals dropped to 78,000 by the end of March, a net reduction of 18,000 for the month. More than 15,000 of this decrease represented net dispositions of overseas patients. Patient capacity was reduced by 14,000 beds during the month. A further reduction of approximately 15,000 in patient capacity is scheduled for April.

The second phase of the contraction of the general-convalescent hospital system was completed in March. Twelve general hospitals and one convalescent hospital were closed during the month, bringing the total for the quarter to thirteen general hospitals and four convalescent hospitals closed. The closed hospitals represent a patient capacity of over 33,000. An additional saving of approximately 8,000 beds was achieved by reducing the authorized capacities in several of the other hospitals. The next phase of the contraction was initiated during this quarter by the blocking of Deshon, Lovell, and England General Hospitals for receipt of new patients.

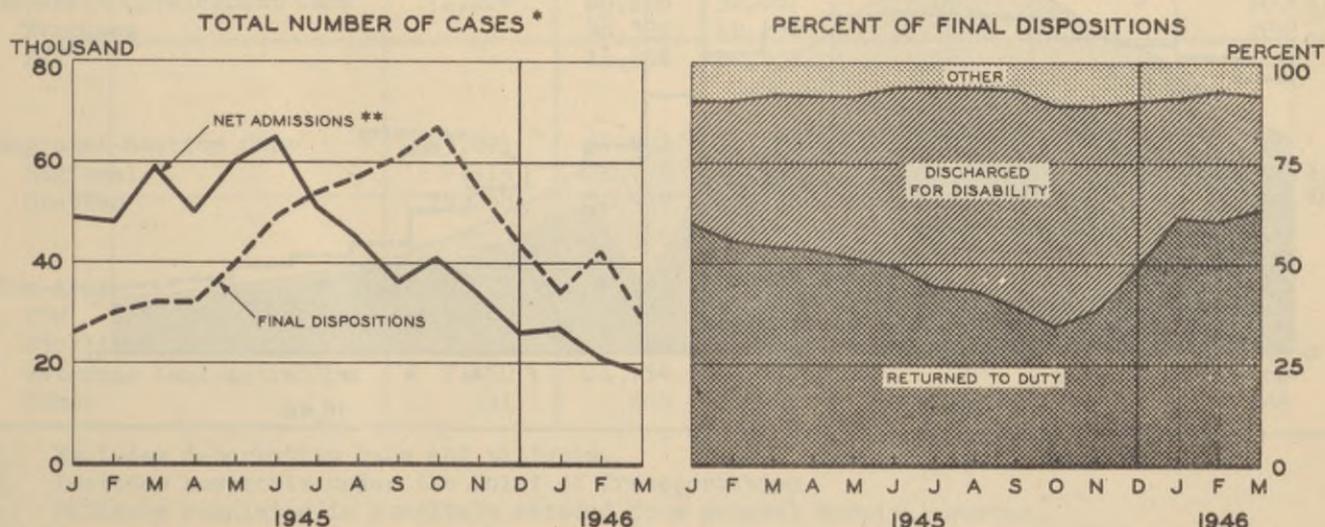
A review of the plans for future reductions of the patient capacity of the general-convalescent hospital system in light of recent developments has been completed. Bed requirements for 30 June 1946 are slightly higher than presented in the November issue of HEALTH, page 28. The principal reasons for this increase are:

- a. The firming of bed requirements for Veterans Administration beneficiaries in Army hospitals.
- b. The continuing accumulation of backlog of tuberculous patients due to the inability of the Veterans Administration to accept these patients.
- c. The contemplated closure of regional hospitals and the consequent transfer of serious cases to the general hospitals.

The study indicates a requirement for approximately 54,000 patient capacity at the end of June. The preliminary estimate for the end of September is 40,000 beds. As a result of these findings, it is planned to close 13 general hospitals with a patient capacity of 28,000 beds and two convalescent hospitals with a patient capacity of 3,000 beds during the second quarter of 1946. Reductions in authorized patient capacities of hospitals remaining open after 30 June will also be effected. In line with recent developments, the following revisions in the cutback of general hospitals prepared last December are indicated:

- a. Retention of Halloran and Mason General Hospitals beyond 30 June 1946 to meet requirements of the Veterans Administration for beds in the New York area.
- b. The postponement of the closing of Mayo General Hospital and the closing of Ashford General Hospital by 30 June in order to provide a better geographic distribution of patient capacity.

ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



* Adjusted to four-week months.

** Total admissions less dispositions by transfer.

HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

c. Postponement of the closure of the Daniel Field Annex of Oliver General Hospital in order to permit the expansion of facilities for tuberculous patients at Moore General Hospital. Other patients requiring specialized treatment will be transferred from Moore to Oliver General Hospital.

d. The designation of Pasadena and Coral Gables as general hospitals.

e. The closure of Dante Annex of Letterman General Hospital by 30 June 1946.

The Surgeon General has recommended the formal inactivation of all convalescent hospitals as of 30 June, with the exception of the special installation at Avon for blind patients, which is scheduled for closure by 31 October 1946. Upton and Welch Convalescent Hospitals are scheduled for closure by 30 June, and the remaining convalescent hospitals--Madigan, Brooke, and Percy Jones--will be operated as convalescent facilities of the corresponding general hospitals.

Both patient load and beds authorized in the station and regional hospitals decreased by 4,700 during March. However, more than half of the decrease in authorized beds was in station hospitals under the jurisdiction of the Chief of Transportation. Excluding Chief of Transportation hospitals, the patient load in station and regional hospitals decreased by over 4,400 while authorized beds decreased by only 2,100.

Personnel assigned to ASF hospitals declined from 105,000 at the end of February to 92,500 at the end of March. This represented a decrease of approximately 3,000 officers, 7,000 enlisted personnel, and 2,000 civilians. The number of civilians in other than blocked hospitals increased during the month despite the drop in beds authorized. At the end of March, the number of civilians in ASF hospitals outnumbered enlisted personnel three to two. In general and convalescent hospitals, the ratio was two to one.

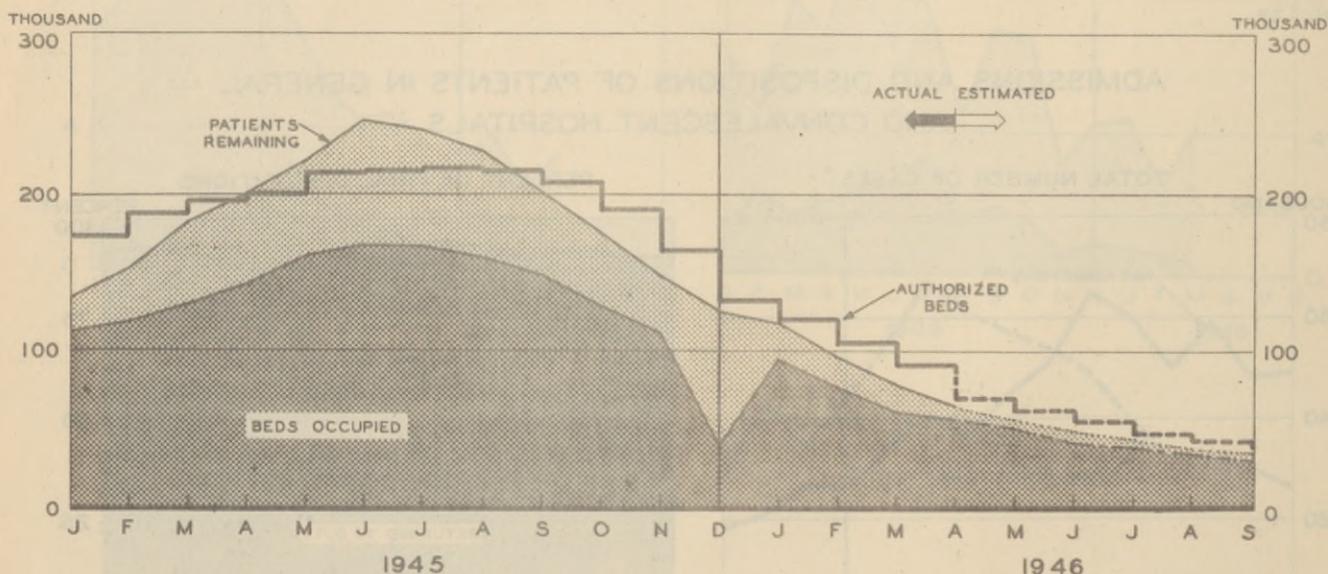
Summary:

a. Thirteen general and four convalescent hospitals were closed during the first quarter of 1946.

b. A re-estimate of bed requirements for the end of June 1946 indicates a slightly slower rate of contraction during the second quarter of the year than previously planned.

c. The Surgeon General has recommended the formal inactivation of all convalescent hospitals as of 30 June, except for Old Farms scheduled to close 31 October 1946. Facilities

HOSPITAL CAPACITY AND PATIENT LOAD IN THE GENERAL - CONVALESCENT HOSPITAL SYSTEM IN THE UNITED STATES.



HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

at Madigan, Brooke, and Percy Jones will be operated as convalescent facilities of the general hospital after 30 June.

d. The ratio of civilians to military personnel in ASF hospitals is increasing at a rapid rate. At the end of March, more than three civilians were employed to every two enlisted personnel assigned.

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

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages ^{c/}		
	Authorized	Effective ^{a/}	Number ^{b/}	Percent of Effective Beds		MC	ANC	Total
Total	127,432	116,856	104,292	89.2	85,073	-768	-1,001	-7,885
General	82,562	80,222	70,352	87.7	55,379	-274	-440	-3,568
Not Blocked	77,512	75,172	64,723	86.1	50,894	-147	-143	934
Blocked ^{d/}	5,050	5,050	5,629	111.5	4,485	-127	-297	-4,502
Convalescent	7,690	7,690	7,290	94.8	5,055	12	- 19	-389
Regional	16,959	13,567	14,632	107.8	13,228	-163	-188	-656
Station ^{e/}	20,221	15,377	12,018	78.2	11,411	-343	-354	-3,272

^{a/} Less debarkation beds and 20 percent dispersion in regional and station hospitals.

^{b/} Data exclude patients in triage at debarkation hospitals.

^{c/} Overages are indicated by a minus sign (-)

^{d/} Hospitals blocked for receipt of new patients; Deshon scheduled for closure by 30 April, Lovell by 31 May; England by 30 June 1946.

^{e/} Three general hospitals and one regional hospital reverted to station hospital status during March. Data include hospitals under Chief of Transportation.

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS BY TYPE OF CARE AND TYPE OF HOSPITAL ^{a/} End of March 1946

	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station ^{b/}
Total	124,092	104,292	70,352	7,290	14,632	12,018
General-Convalescent Care	72,224	60,278	52,887	7,091	-	300 ^{c/}
Evacuees		48,322	42,130	5,908	-	284
Z/I		11,956	10,757	1,183	-	16
Regional-Station Care	43,671	37,691	14,194	176	13,542	9,779
Regional	7,413	6,772	3,458	-	3,239	75 ^{d/}
Station	36,258	30,919	10,736	176	10,303	9,704
Non-Army	8,197	6,323	3,271	23	1,090	1,939
POW	3,150	2,182	496	15	413	1,258
Civilians	2,256	2,098	1,057	7	483	551
Veterans Administration	2,450	1,754	1,518	1	173	62
Other	341	289	200	-	21	68

^{a/} Excludes debarkation beds and patients.

^{b/} Includes hospitals under the Chief of Transportation.

^{c/} Patients remaining in hospitals reduced from general hospital status.

^{d/} Patients remaining in hospitals recently reduced from regional status.

STATISTICAL TABLES

STATISTICAL TABLES

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

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

DISCHARGES OF ENLISTED MEN FOR DISABILITY

Year and Month	Number of Men Discharged			Discharges Per 1000 Enlisted Men Per Year		
	All Causes	Wounded a/	Neuro-psychiatric	All Causes	Wounded a/	Neuro-psychiatric
1942	62,013	30	26,091	20.8	0.0	8.8
1943	348,964	b/	138,609	56.2	b/	22.3
1944	205,091	b/	97,860	29.0	b/	13.8
1945						
Jan-Jun	122,819	15,363	55,631	33.9	4.2	15.4
Jul	34,312	6,660	10,534	55.1	10.7	16.9
Aug	37,915	7,947	12,311	61.9	13.0	20.1
Sep	40,346	10,676	12,640	71.1	18.8	22.3
Oct	45,047	12,460	12,983	86.0	23.8	24.8
Nov c/	35,060	8,990	8,260	83.4	21.4	19.6
Dec c/	24,180	5,840	4,730	69.8	16.9	13.7
Total	339,679	67,936	117,089	50.6	10.1	17.4
1946						
Jan c/	14,770	3,450	3,370	54.4	12.7	12.4
Feb c/	14,830	4,400	3,020	b/	b/	b/
Mar						
Total to Date	985,347	b/	386,039	b/	b/	b/

a/ Discharge diagnosis b/ Not available.

c/ Estimated from AGO Form 8-122 and adjusted to calendar months.

STATISTICAL TABLES

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command*								
		Total	Alaska	Caribbean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
ALL DISEASE										
1942 Average	669	679	668	823	700	451	494	832	1,046	1,356
1943 Average	739	860	624	670	837	943	813	1,046	991	1,107
1944 Average	564	654	478	531	492	846	561	840	1,077	896
1945 Jan-Jun	569	631	426	562	538	726	448	1,006	707	587
Aug	478	621	346	531	501	645	466	891	796	620
Sep	442	538	288	465	456	649	465	674	587	544
Oct	443	507	268	467	482	750	347	571	385	434
Nov	474	542	274	424	555	911	257	581	365	364
Dec	506	608	245	442	664	1,055	285	611	440	332
Jul-Dec	467		311	493	520	724	448	717	607	521
Average	517	611	379	531	530	720	442	843	661	558
1946 Jan	600		320	519	773	1,072	293		462	404
Feb	593		314	393	789	1,004	421		689	323
Mar	621 ^{b/}									
Apr										
May										
Jun										

NONBATTLE INJURY

1942 Average	91	125	152	107	110	96	104	178	81	162
1943 Average	80	133	182	105	100	149	114	171	84	140
1944 Average	67	113	127	68	97	138	111	139	96	99
1945 Jan-Jun	51	108	97	61	115	93	90	114	98	66
Aug	44	73	90	50	56	62	83	107	68	71
Sep	36	62	78	40	50	55	72	86	55	35
Oct	31	62	77	43	54	62	62	77	42	41
Nov	30	62	75	39	52	64	58	77	46	34
Dec	29	65	75	40	55	69	81	76	48	34
Jul-Dec	37		82	45	58	65	82	88	58	49
Average	44	92	91	54	94	85	86	99	80	59
1946 Jan	30		69	34	60	71	75		40	44
Feb	29		79	41	57	63	48		38	35
Mar	30 ^{b/}									
Apr										
May										
Jun										

a/ Excluding Iceland

b/ Based on Incomplete Reports.

STATISTICAL TABLES

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Caribbean	ETO a/	MTO	MIDPAC	WESPAC	Asiatic	AME
ALL VENEREAL DISEASE										
1942 Average	39	32	7	74	38	35	11	33	64	86
1943 Average	26	34	3	56	43	56	5	15	53	69
1944 Average	33	42	5	33	35	111	5	7	51	60
1945 Jan-Jun	44	57	9	26	60	102	3	57	47	74
Aug	53	111	8	17	155	142	4	77	40	73
Sep	57	110	7	18	154	212	4	68	41	77
Oct	56	117	9	20	168	287	3	71	41	77
Nov	60	142	10	38	208	456	2	91	55	83
Dec	50	163	10	35	224	416	5	128	81	76
Jul-Dec	54		8	23	166	213	4	86	46	78
Average	49	83	8	25	99	132	4	73	46	75
1946 Jan	71		17	58	233	382	7		101	93
Feb	67		10	30	227	193	10		118	61
Mar	81 ^{b/}									
Apr										
May										
Jun										

DIAGNOSED MALARIA

1942 Average		34	0	99	0	11	12	52	165	136
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan-Jun	0.1	19	0	9	8	23	5	58	37	11
Aug	0.1	12	-	8	3	15	2	29	31	13
Sep	0.1	11	-	9	1	8	3	25	29	12
Oct	0.1	11	-	8	1	3	1	24	21	11
Nov	0.1	16	-	7	0	2	2	35	18	8
Dec	0.1	22	-	10	0	1	2	50	22	8
Jul-Dec	0.1		0	9	2	13	3	33	27	11
Average	0.1	17	0	9	6	21	4	44	32	11
1946 Jan	0.1		-	8	0	0	2		21	2
Feb	0.1		-	5	0	0	2		12	2
Mar	0.2									
Apr										
May										
Jun										

a/ Excluding Iceland.

b/ Based on incomplete reports.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

STATISTICAL TABLES

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Carib-bean	ETO <u>a/</u>	MTO	MIDPAC	WESPAC	Asiatic	AME
COMMON RESPIRATORY AND INFLUENZA										
1942 Average	243	163	244	113	291	152	90	149	150	202
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Average	147	132	188	81	142	162	85	83	176	219
1945 Jan-Jun	145	115	177	95	112	132	65	128	139	132
Jul	77	93	89	150	57	62	98	180	182	109
Aug	79	96	86	105	66	69	92	152	157	116
Sep	72	86	68	117	63	66	60	122	123	116
Oct	79	84	47	140	72	76	51	105	84	97
Nov	101	80	53	131	69	61	33	100	62	65
Dec	160	101	44	128	105	90	44	109	72	96
Jul-Dec	90		69	127	68	68	73	127	121	104
Average	116	105	131	109	96	114	68		131	120
1946 Jan	172		61	178	135	154	87		87	50
Feb	191		46	58	153	208	242		126	102
Mar	176 ^{b/}									
Apr										
May										
Jun										

DIARRHEA AND DYSENTERY

1942 Average	8	30	5	19	17	34	34	59	123	196
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Average	9	38	3	13	13	54	28	55	181	115
1945 Jan-Jun	7	35	2	15	16	22	22	104	98	73
Jul	6	45	1	15	20	30	24	106	151	120
Aug	8	38	1	11	17	25	12	75	122	106
Sep	7	27	1	10	9	15	13	51	79	87
Oct	4	20	0	7	5	11	11	38	46	58
Nov	4	16	-	10	4	10	7	25	42	44
Dec	4	14	-	20	4	7	6	21	50	32
Jul-Dec	6		1	12	12	21	14	51	89	87
Average	6	33	1	14	14	22	19	74	93	79
1946 Jan	4		1	10	3	6	16		54	64
Feb	3		1	7	4	3	2		51	44
Mar	3 ^{b/}									
Apr										
May										
Jun										

^{a/} Excluding Iceland.

STATISTICAL TABLES

STATISTICAL TABLES (Continued)

ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Command								
		Total	Alaska	Carib- bean	ETO <u>a/</u>	MTO	MIDPAC	WESPAC	Asiatic	AME
FEVER OF UNDETERMINED ORIGIN										
1943 Average	<u>c/</u>	52	0	64	1	75	19	166	71	21
1944 Average	<u>c/</u>	38	1	34	2	71	20	88	131	27
1945 Jan-Jun	<u>c/</u>	28	0	12	6	42	7	100	70	28
Jul	<u>c/</u>	30	1	7	5	57	10	86	102	50
Aug	<u>c/</u>	22	0	6	5	58	5	13	91	59
Sep	<u>c/</u>	12	-	8	3	41	3	10	76	49
Oct	<u>c/</u>	9	-	10	2	28	4	8	52	27
Nov	<u>c/</u>	7	-	16	2	25	2	6	45	25
Dec	<u>c/</u>	8	-	22	3	20	3	7	50	14
Jul-Dec	<u>c/</u>		0	10	4	47	6	24	73	44
Average	<u>c/</u>	23	0	11	5	43	7	57	72	34
1946 Jan	<u>c/</u>		-	21	3	14	3		52	17
Feb	<u>c/</u>		-	9	3	36	3		62	20
Mar	<u>c/</u>									
Apr										
May										
Jun										

NEUROLOGICAL AND PSYCHIATRIC DISORDERS

1944 Average	36	43	11	21	52	43	27	48	20	25
1945 Jan-Jun	48	33	12	24	30	27	26	60	22	15
Jul	39	18	11	22	10	12	24	38	25	10
Aug	37	18	16	18	8	13	21	34	22	12
Sep	26	15	10	15	7	12	29	24	18	7
Oct	23	11	8	11	6	12	19	16	17	11
Nov	23	10	8	10	5	10	16	14	11	8
Dec	21	8	12	11	5	14	10	10	13	11
Jul-Dec	29		11	15	7	13	22	22	19	10
Average	38	25	12	20	22	23	24	39	21	13
1946 Jan	24		16	6	6	14	13		11	3
Feb	20		7	6	6	16	7		6	5
Mar										
Apr										
May										
Jun										

a/ Excluding Iceland.

b/ Based on incomplete reports.

c/ Not available.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.