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Asst. Security Officer, SSG)

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# HEALTH

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## MONTHLY PROGRESS REPORT

**CONFIDENTIAL**

DATA AS OF MAY 31, 1943

189

ARMY SERVICE FORCES, WAR DEPARTMENT

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**OFFICE OF THE SURGEON GENERAL  
HEADQUARTERS, ARMY SERVICE FORCES, WAR DEPARTMENT**



# HEALTH

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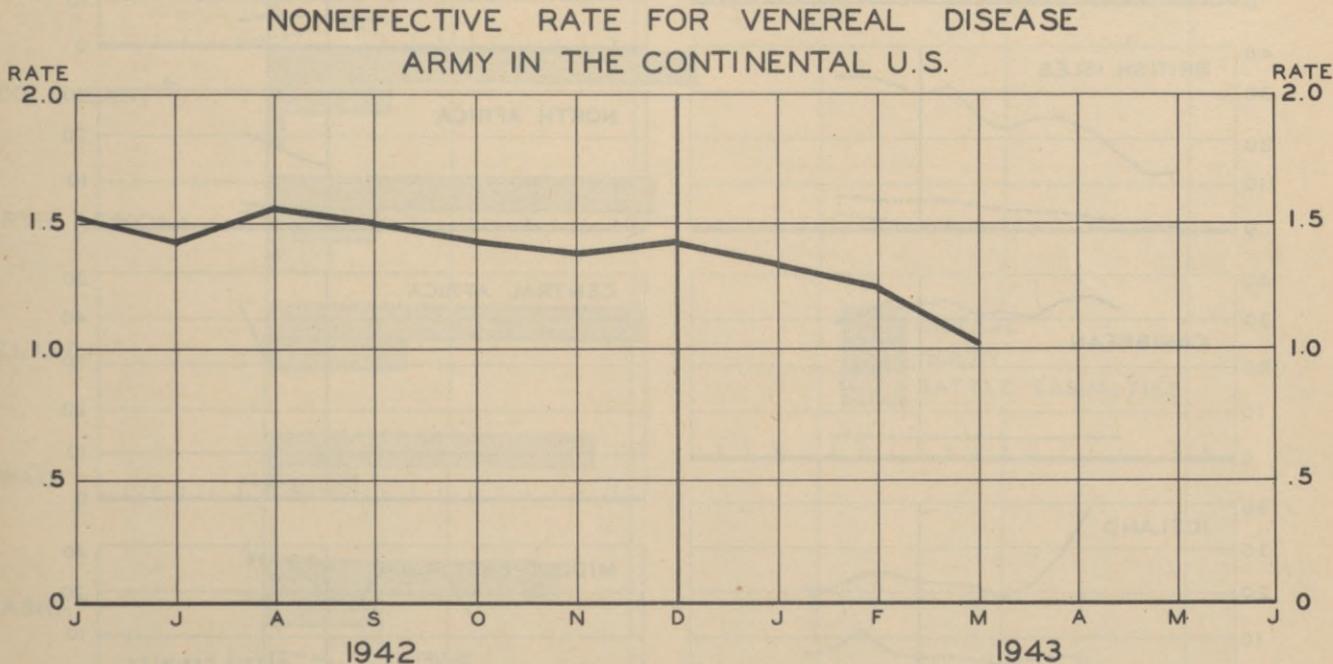
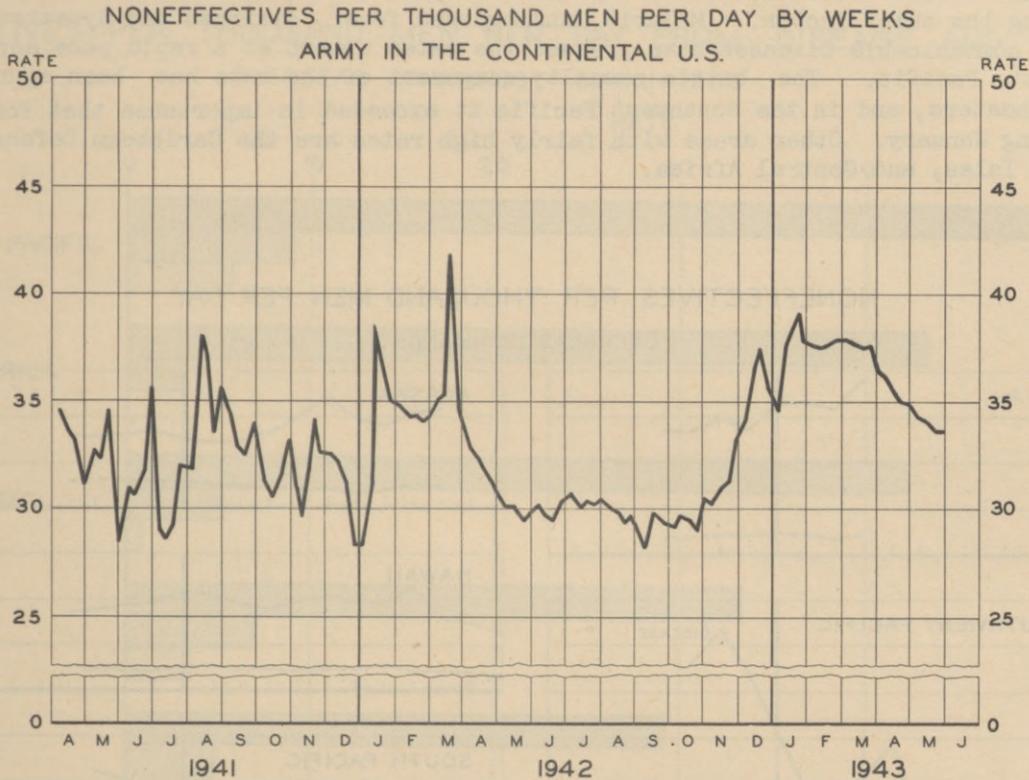


# DISEASE AND INJURY

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## NONEFFECTIVE RATES, CONTINENTAL U. S.

During May the average daily noneffective rate continued to decline for troops in the Continental U. S. From a level of 35 for the week ending April 24 it had fallen to 33.6 for the week ending May 29. The line graph below gives the average rate for the period April 1941, to date. The bottom chart traces the noneffective rate for venereal diseases during the ten months ending with March, 1943, a considerable diminution having occurred during this period. About 3 percent of the noneffective rate is attributable to venereal disease.



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# DISEASE AND INJURY

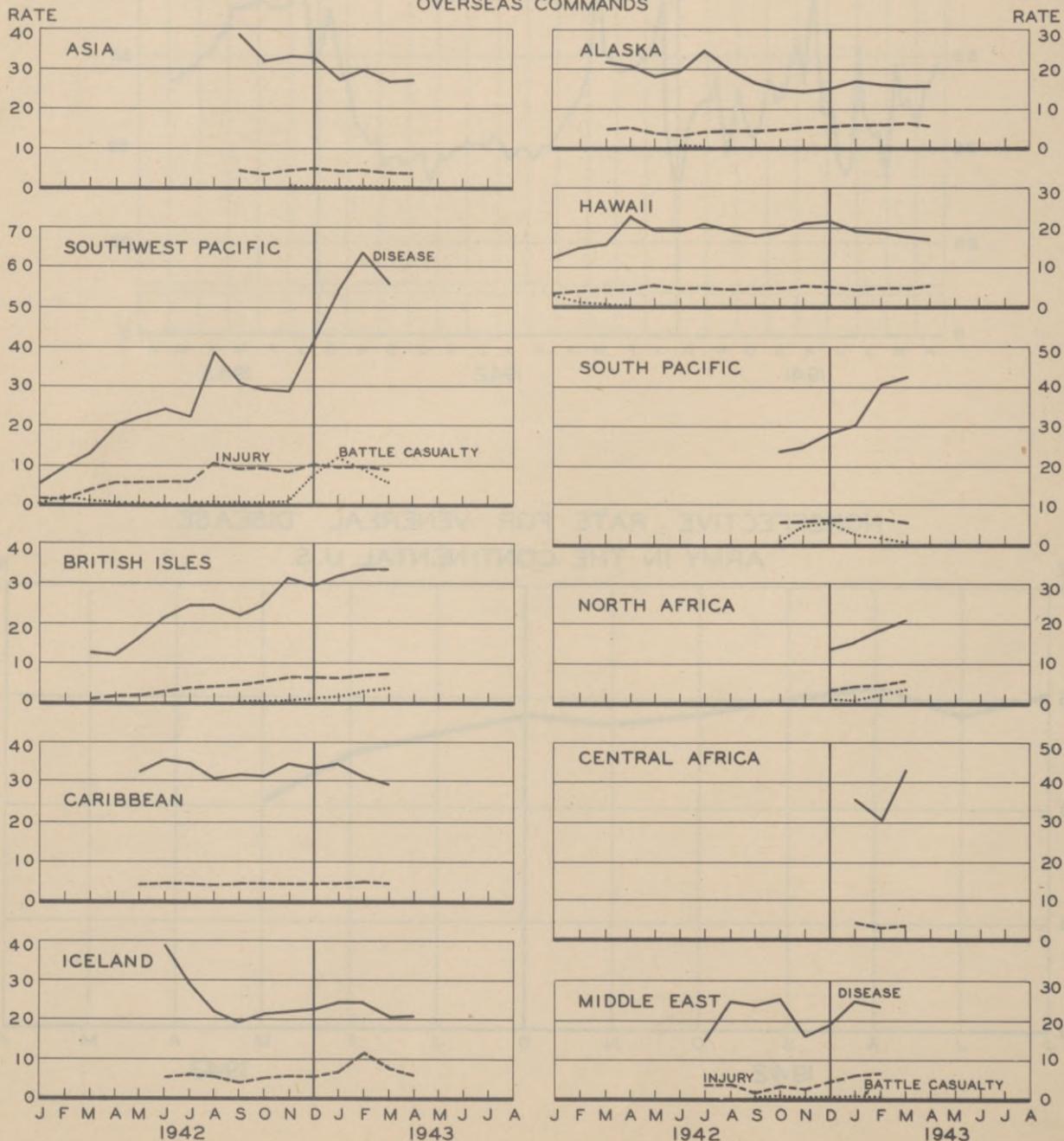
## NONEFFECTIVE RATES OVERSEAS

The average daily noneffective rate is perhaps the simplest and best index to the health of the Army, especially from the standpoint of military operations. The following charts give for various commands the trend of the chief components of the total noneffective rate, the parts attributable to disease, to nonbattle injury, and to battle injury. In each command shown below the disease component is the chief element of the rate, and only occasionally do battle casualties contribute materially to its average level. The rates shown for active theaters are especially reduced by the evacuation of patients to the U. S.

The recent rates for the South and Southwest Pacific have been remarkably high, disease being the chief factor. Malaria, undiagnosed fever, diarrhea and dysentery, dengue, and other communicable diseases have pressed the rates upward at a rapid pace especially in the Southwest Pacific. The battle casualty component of the rate has been appreciable in these two theaters, and in the Southwest Pacific it exceeded in importance that for nonbattle injury during January. Other areas with fairly high rates are the Caribbean Defense Command, the British Isles, and Central Africa.

### NONEFFECTIVES PER THOUSAND MEN PER DAY

#### OVERSEAS COMMANDS



DISEASE AND INJURY

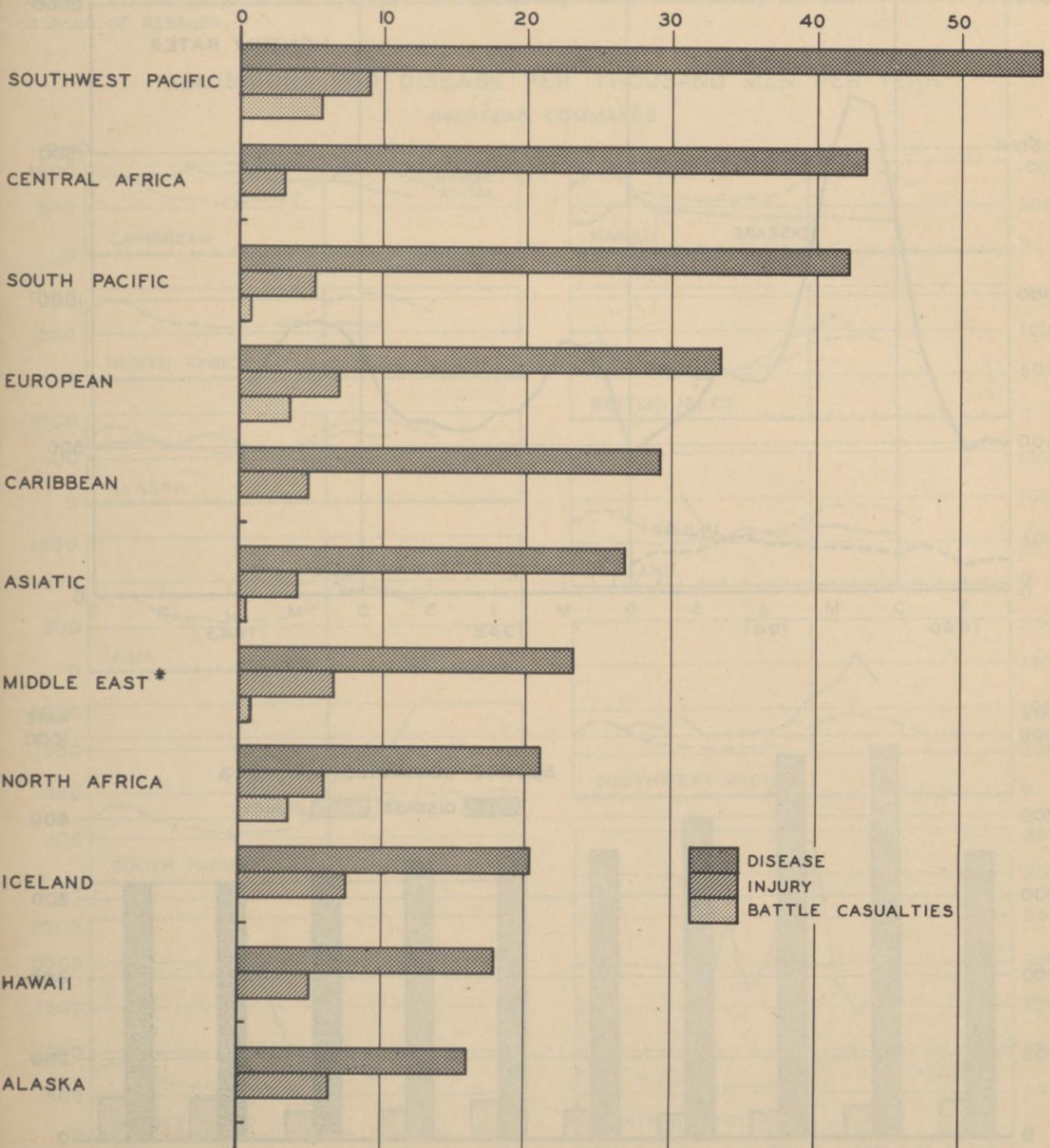
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NONEFFECTIVE RATES OVERSEAS (Continued)

Exceptionally favorable rates are reported from Hawaii, Alaska, and North Africa. The battle casualty portion of the rate for the British Isles may partly represent patients evacuated there from North Africa.

In order to permit more direct comparison of the various commands the bar chart below arranges them according to their noneffective rates for disease during the month of March 1943. The noneffective rates for nonbattle injury and battle casualties are also included for the sake of comparison among commands.

NONEFFECTIVES PER THOUSAND MEN PER DAY FROM DISEASE AND INJURY  
OVERSEAS COMMANDS MARCH 1943  
RATE



\* FEBRUARY

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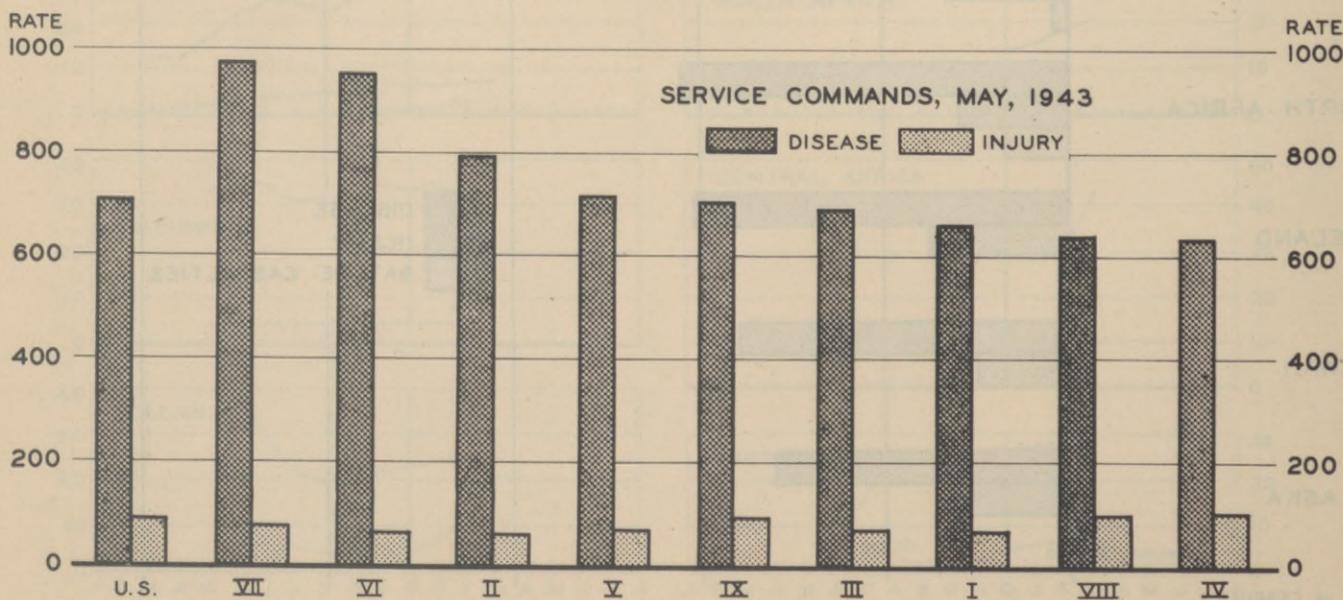
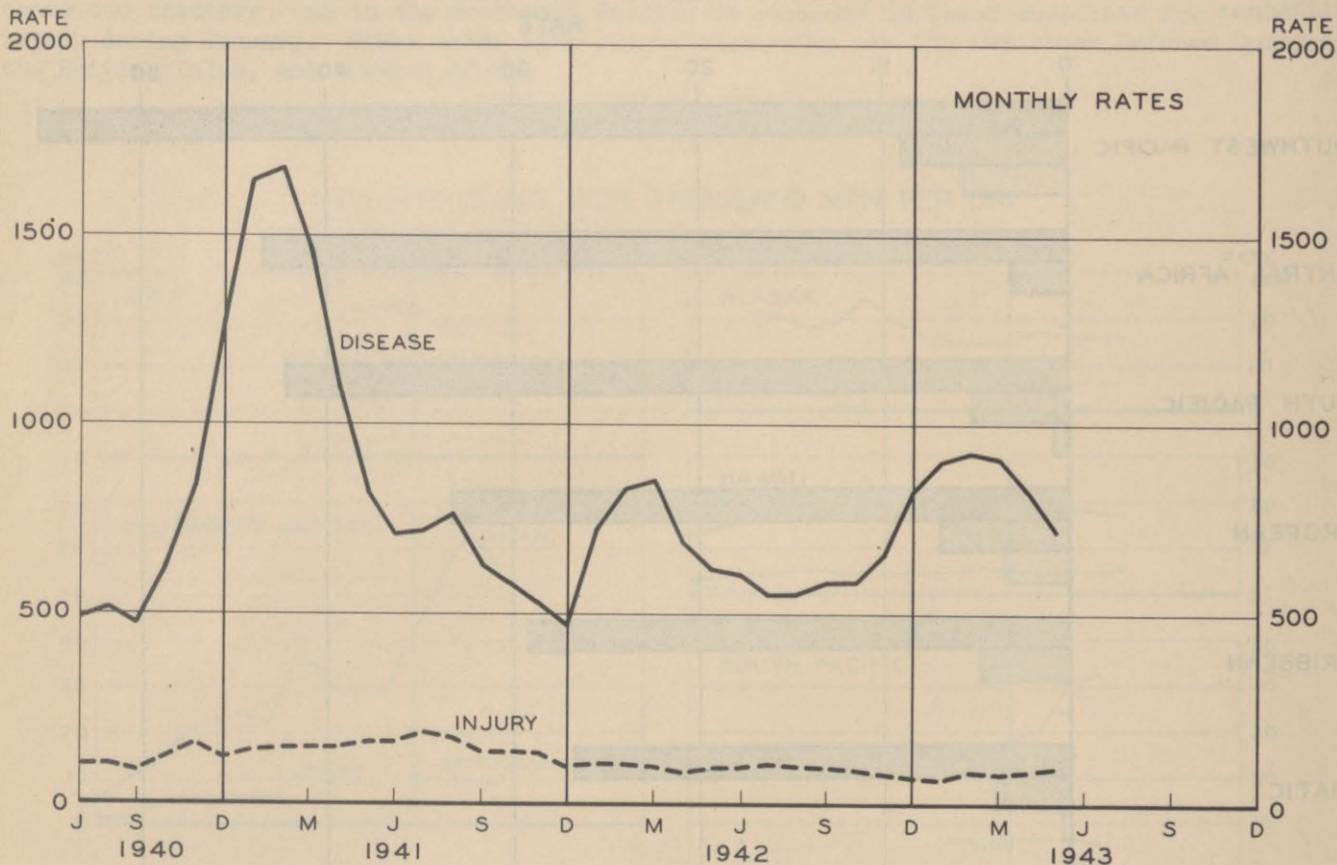
## DISEASE AND INJURY

### DISEASE AND INJURY, CONTINENTAL U. S.

The preliminary admission rate for all diseases declined from 819 admissions per 1,000 men per year for April to 710 for May. The admission rate for injuries was relatively unchanged at 85. The first chart below gives the rates from June, 1940, to date.

The bar chart at the bottom of the page compares the various service commands with respect to the preliminary rates for May. The taller bars represent admissions for disease, the shorter ones admissions for injury. The Sixth and Seventh Service Commands, which had the highest rates for all diseases, also had by far the highest rates for respiratory disease.

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



DISEASE AND INJURY

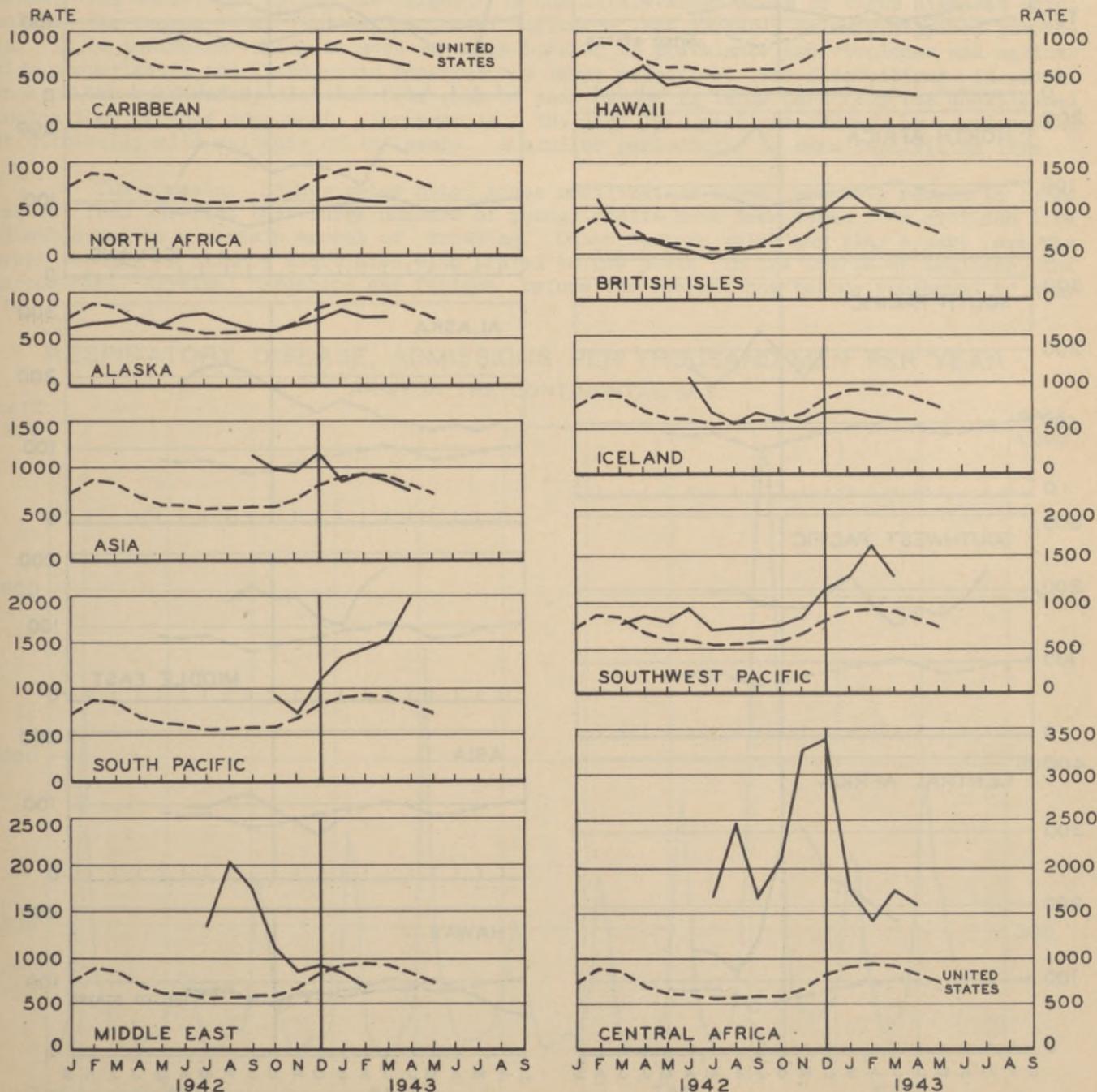
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ADMISSIONS FOR DISEASE, OVERSEAS

During the past winter, when the increase in respiratory disease raised the average rate of admission for disease in the U. S. to about 900 admissions per thousand strength per year, the rates for some overseas areas were lower. This was particularly true of Hawaii, but also obtained for North Africa, the Caribbean, Iceland, and Alaska. The experience of troops in the British Isles has followed a fairly close parallel to that of the Army in the Continental U. S., with a somewhat sharper winter peak.

The exposure of troops in the South and Southwest Pacific to malaria, dengue, diarrhea and dysentery, and other communicable diseases, despite the most modern methods of control, inevitably leads to high rates of admission followed by high noneffective rates. It is interesting to note that the higher rates of admission reported for the South Pacific area are accompanied by considerably lower noneffective rates for disease. In the Middle East and Central Africa malaria and diarrhea and dysentery have been among the causes of the high incidence of disease.

ADMISSIONS FOR DISEASE PER THOUSAND MEN PER YEAR  
OVERSEAS COMMANDS



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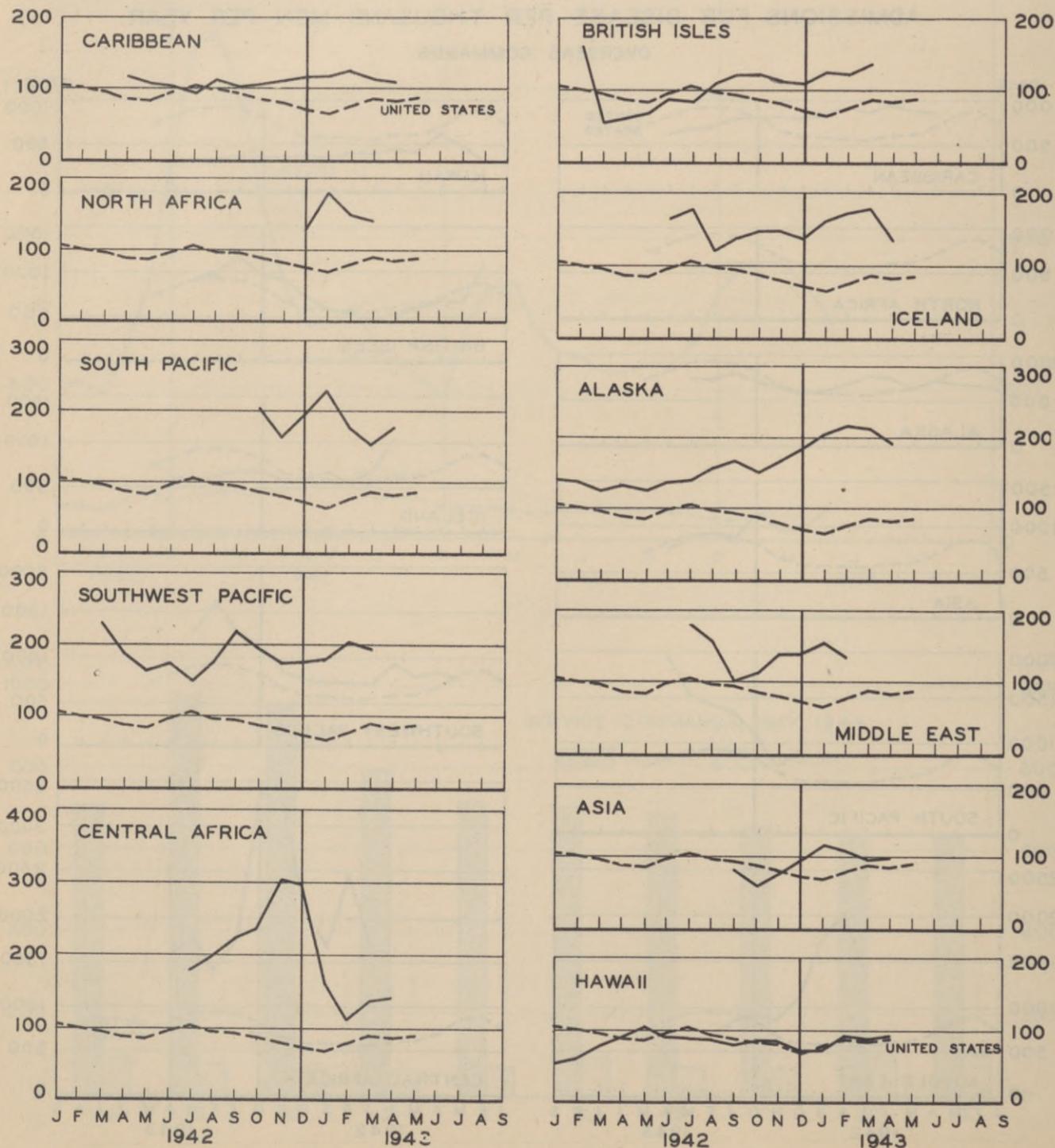
## DISEASE AND INJURY

### ADMISSIONS FOR NONBATTLE INJURY OVERSEAS

Troops stationed abroad have generally higher admission rates for nonbattle injury than have troops in this country, but there is great variation based on differences in type of duty, terrain, climate, composition of forces, and the like. On each of the charts below the average rate for the Continental U.S. is drawn for comparison.

The rates have been consistently high in the South and Southwest Pacific, Alaska, Iceland, and Central Africa. The strength of the latter command has been small. The experience of troops in Hawaii is almost identical with that of troops in the Continental U. S. The experience of troops in the Caribbean is also better than average for overseas forces.

ADMISSIONS FOR NONBATTLE INJURIES PER THOUSAND MEN PER YEAR  
OVERSEAS COMMANDS



## DISEASE AND INJURY

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## RESPIRATORY DISEASE - CONTINENTAL U.S.

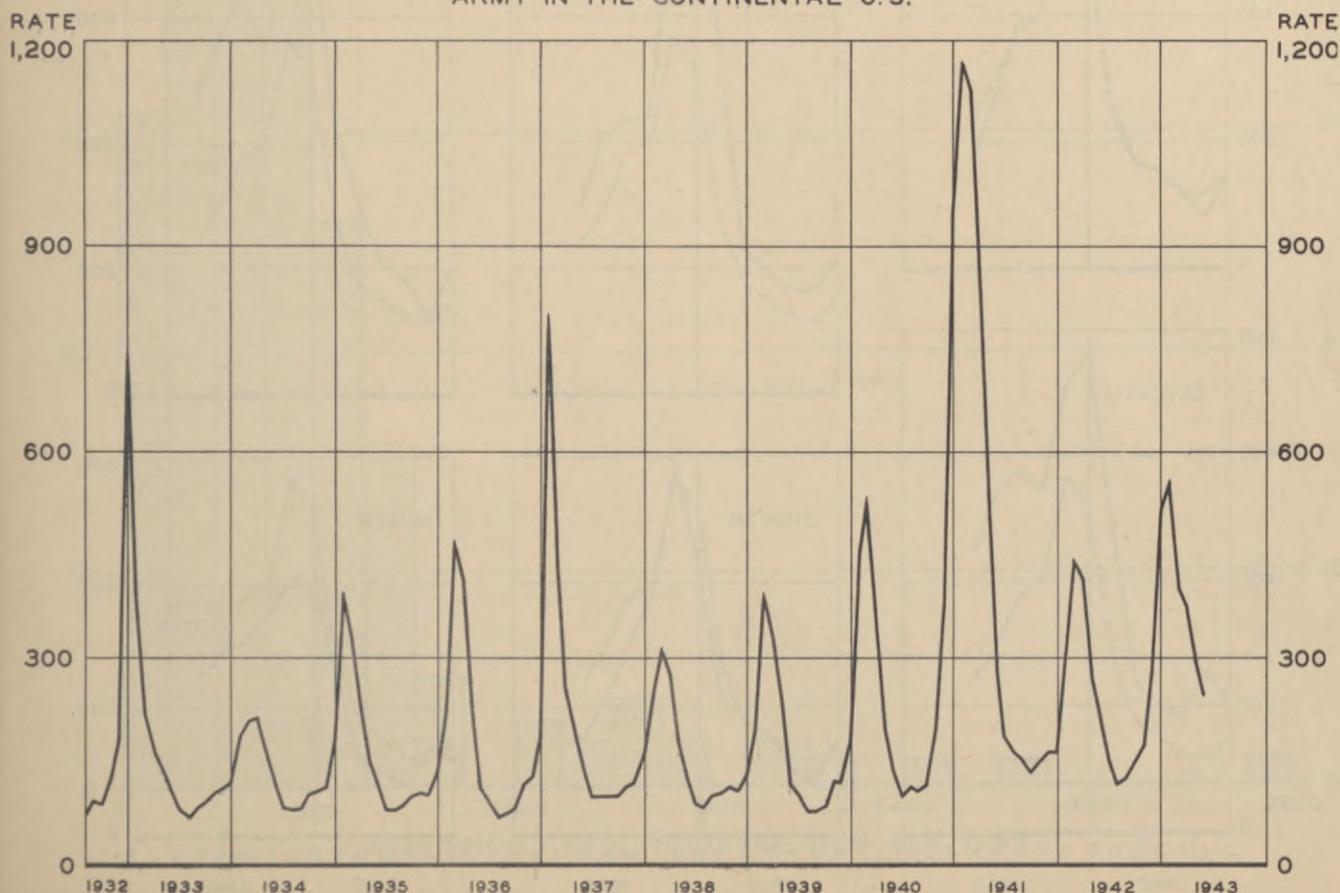
Admission rates for respiratory diseases (common respiratory diseases, pneumonia, and influenza) are shown by months over the past 12 years in the accompanying chart. In this period there have been 3 more or less epidemic years, with the highest rates in the winter of 1940-41. During the following winter the rates were fairly low; in the winter of 1942-43 they were somewhat higher but only about half those of 1940-41.

The seasonal pattern of respiratory disease incidence is most characteristic as shown in the chart. The winter peak is reached each year some time between December and March, most often in February. The rate then falls sharply to a summer low point which usually occurs in July. There is likely to be a slight elevation in the rate during the autumn, followed by the major winter rise. Until 1941 the summer low points had been strikingly uniform; since then they have been somewhat higher. On the average, during the ten-year period 1931-1940, the February rates have been slightly more than 3 times the July rates, but a glance at the chart will show the hazard of making predictions based on previous experience. While the pattern is predictable, the height of the winter peak is not.

There are two component types of infection which make up the respiratory disease group. One is bacterial infections of which the two commonest are pneumococcal and streptococcal. The other, and by far the larger, is the little-known group of virus diseases which includes the common cold, various strains of influenza, and probably primary atypical pneumonia. It is influenza which is most variable both as to prevalence and virulence and against which prophylactic and therapeutic measures are least effective. The fluctuations in prevalence of the respiratory diseases from year to year derive in large part from the unexplained fluctuations of this component. For example, the high 1941 peak was caused by a widespread but clinically mild epidemic of influenza. A similar periodicity is seen in civilian life.

The somewhat higher rates noted since mobilization began probably result in large measure from the fact that large numbers of young adults have been taken from civilian life and subjected to a certain amount of crowding. Other factors which may play a part are the abrupt changes in climate associated with travel to new posts in the course of training, and unaccustomed physical hardships and fatigue before the recruit has become toughened to Army life.

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



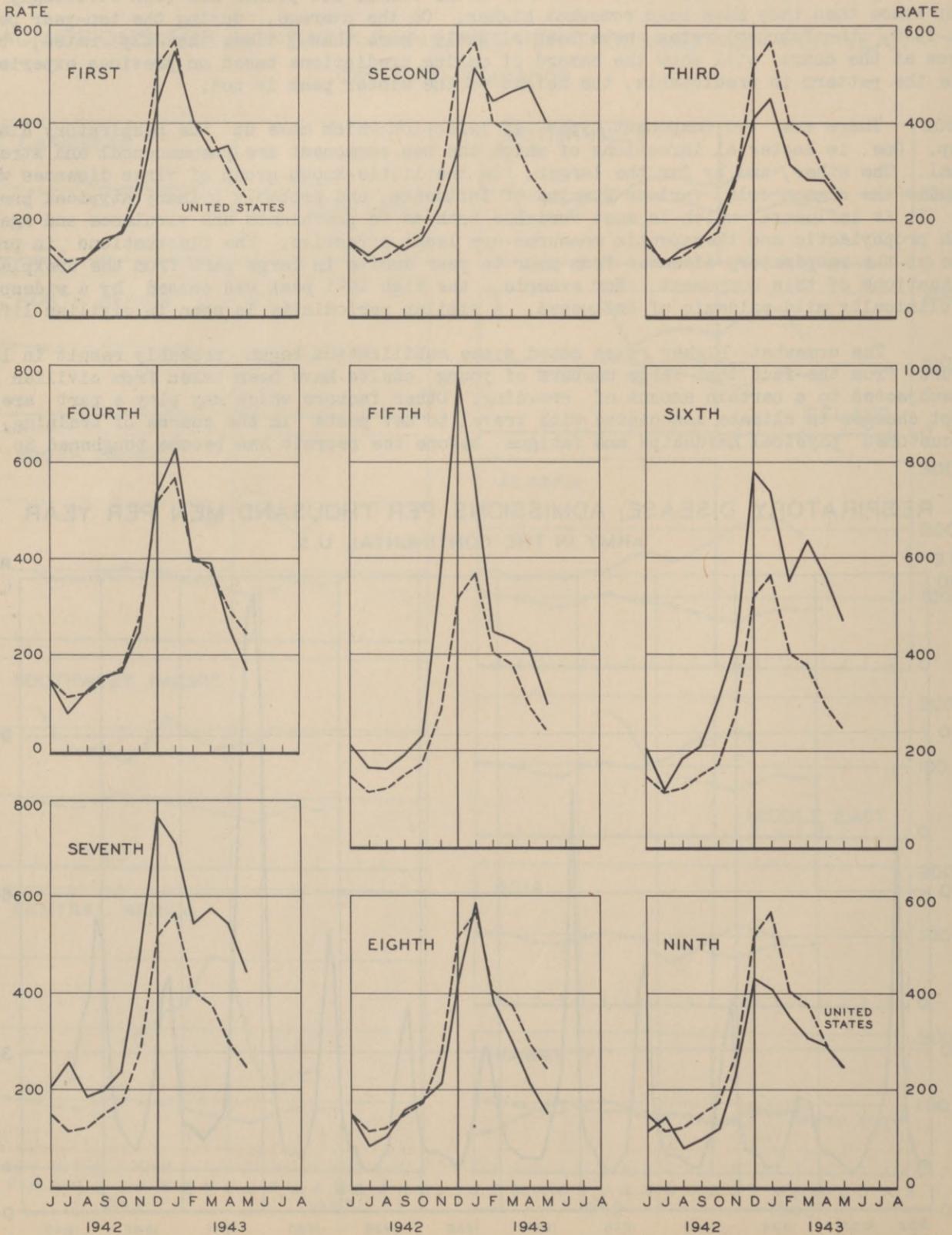
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**DISEASE AND INJURY**

RESPIRATORY DISEASE, CONTINENTAL U.S. (Continued)

Admissions for respiratory disease vary considerably among service commands. During the past winter the Fifth, Sixth, and Seventh Service Commands had rates well above average for the Continental U.S. as a whole, and the Third and Ninth had rates below the average for the country. The exceptionally high rate for the Fifth Service Command during December was largely determined by the unusual experience of two large camps

RESPIRATORY DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR  
SERVICE COMMANDS



DISEASE AND INJURY

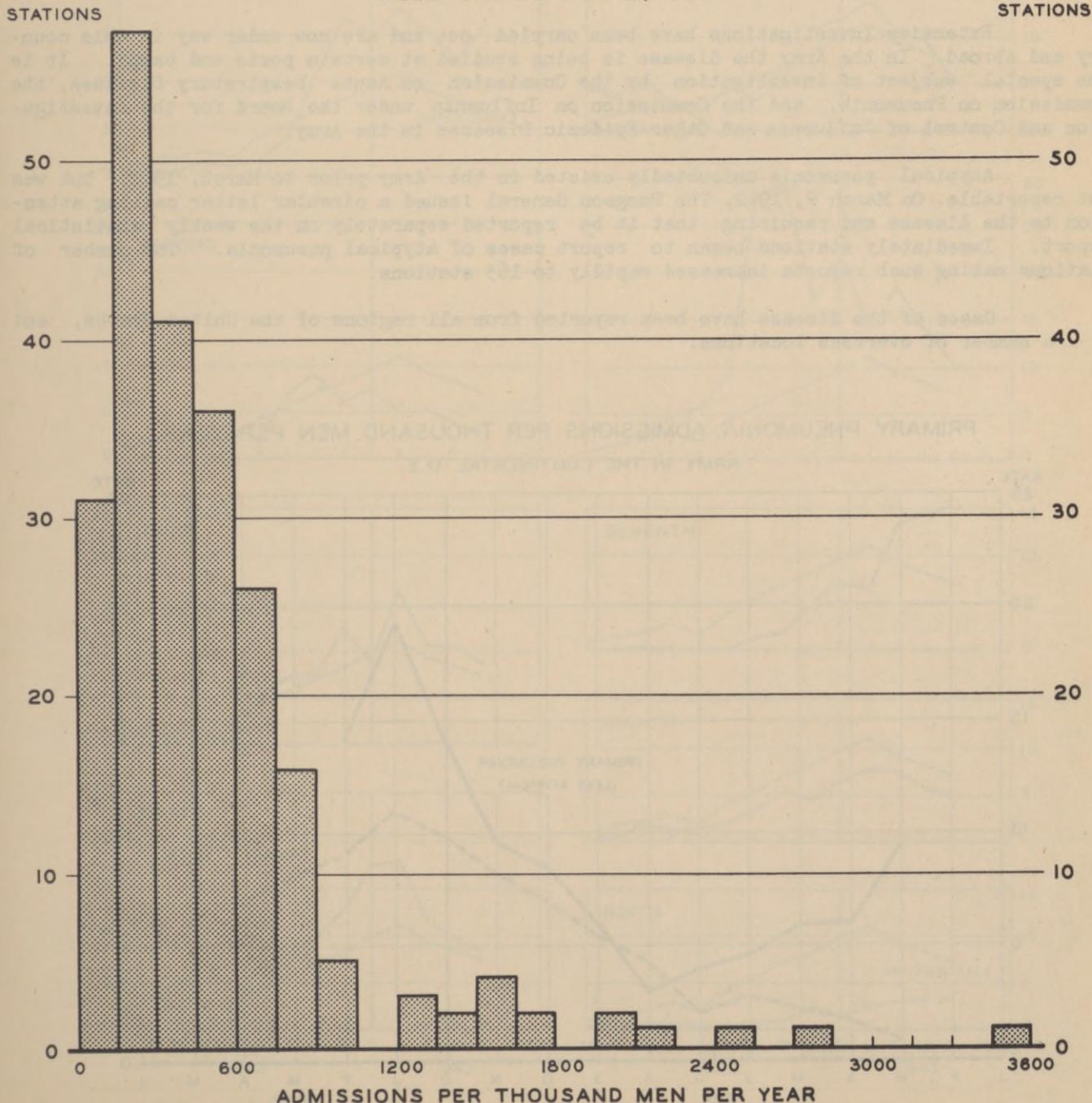
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RESPIRATORY DISEASE, CONTINENTAL U. S. (Continued)

There is even greater variation among stations from the standpoint of respiratory infection than there is among service commands. For the week of highest incidence during the past winter, stations of strength greater than 4,000 were tabulated and arrayed according to their rates of admission for all respiratory diseases. The resulting distribution is shown below.

It is noted that a number of the stations with the highest respiratory disease rates are basic training centers, replacement training centers, and air force technical training schools. Such stations receive men who have been in the Army for a brief time, and the turnover of troops is rapid, with consequent opportunities for introduction both of new infection and new susceptibles.

DISTRIBUTION OF STATIONS\*  
 BY RATE OF ADMISSION FOR ALL RESPIRATORY DISEASE  
 WEEK ENDING JAN. 16, 1943



\* Having a strength of 4,000 or more

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**DISEASE AND INJURY**

PRIMARY ATYPICAL PNEUMONIA

During the past eight years there have been reported numerous outbreaks of an acute pulmonary infection, called primary atypical pneumonia, occurring in the civilian population and among troops. During the past two years this type of pneumonia has constituted a large proportion of the total cases of pneumonia in this country. It appears to be definitely on the increase, although a considerable proportion of the cases now reported as atypical pneumonia may be referable to the relatively recent recognition of the condition.

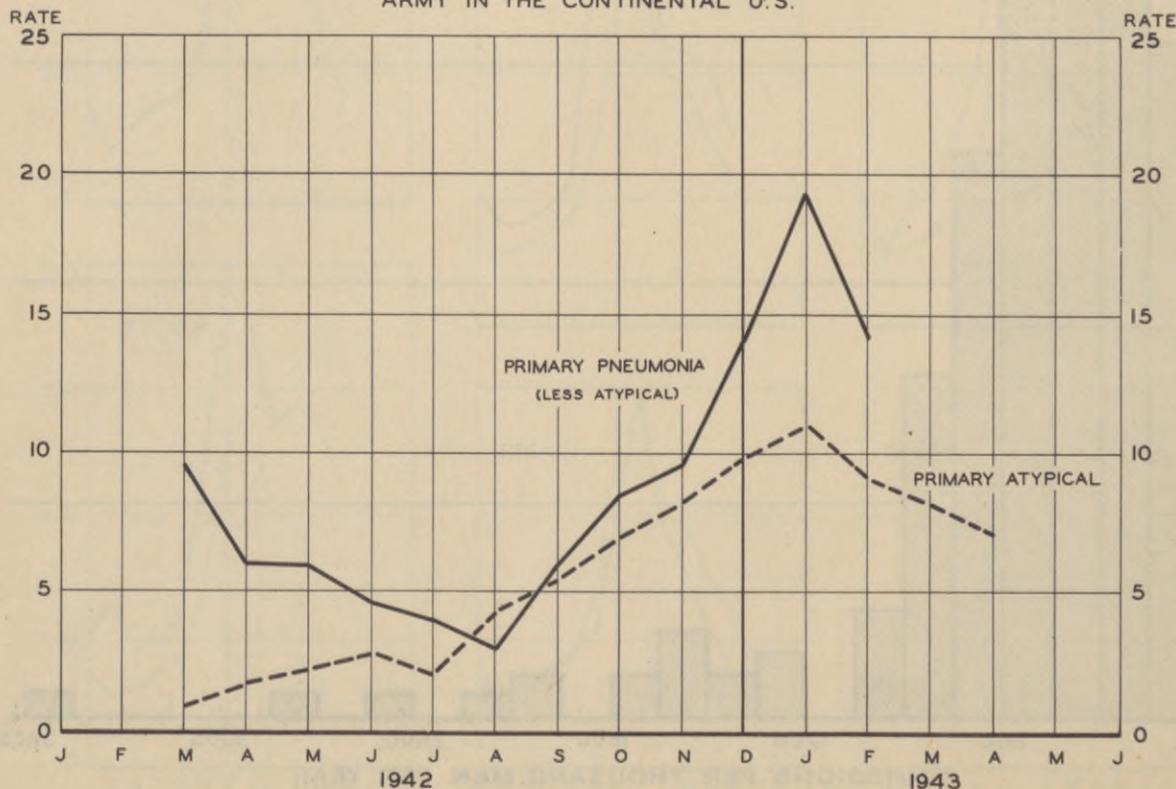
The disease is an infection of the respiratory tract, simulating moderately severe "grippe", with interstitial infiltrations of the lungs. The diagnosis is made almost exclusively by X-rays of the lungs. The illness lasts from a few days to several weeks. Complications are rare and the mortality from the disease is exceedingly low, probably less than 0.1 percent. It is, however, an important cause of temporary disability, resulting in loss of man-power hours and loss of days from training and other duties. The common disease-producing bacteria of the respiratory infection group (streptococci, pneumococci, influenza bacilli, etc.) apparently are not the cause of atypical pneumonia. The name "virus pneumonia" has been applied rather loosely to this group of cases, but proof that a virus causes the disease has not been substantiated. In fact the etiology of the disease is still unknown. It is possible that this so-called disease may be a group of similar pulmonary infections with several causes.

Extensive investigations have been carried out and are now under way in this country and abroad. In the Army the disease is being studied at certain posts and camps. It is the special subject of investigation by the Commission on Acute Respiratory Diseases, the Commission on Pneumonia, and the Commission on Influenza under the Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army.

Atypical pneumonia undoubtedly existed in the Army prior to March, 1942, but was not reportable. On March 2, 1942, The Surgeon General issued a circular letter calling attention to the disease and requiring that it be reported separately on the weekly statistical report. Immediately stations began to report cases of atypical pneumonia. The number of stations making such reports increased rapidly to 163 stations.

Cases of the disease have been reported from all regions of the United States, and a number of overseas locations.

PRIMARY PNEUMONIA, ADMISSIONS PER THOUSAND MEN PER YEAR  
ARMY IN THE CONTINENTAL U.S.



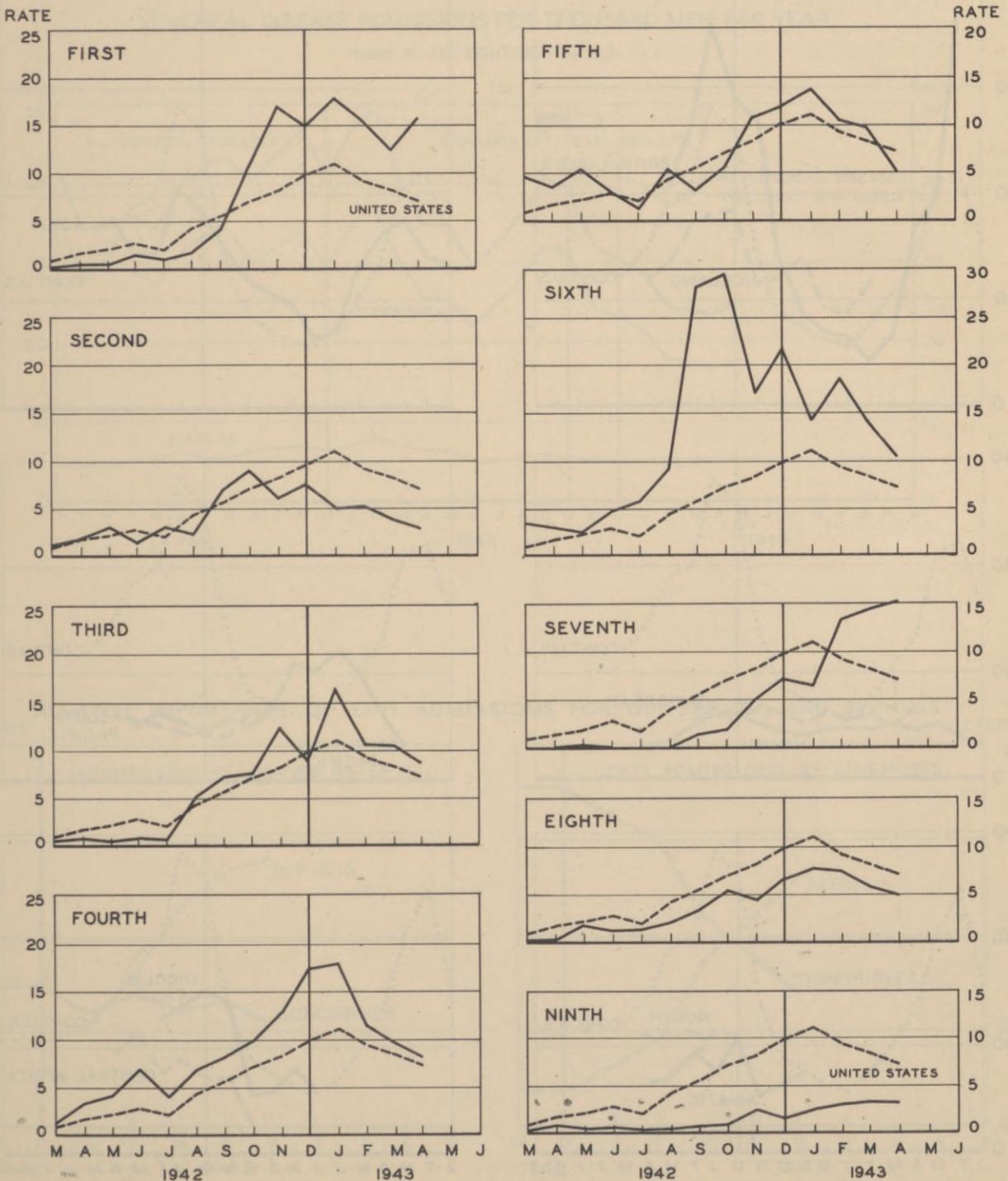
DISEASE AND INJURY

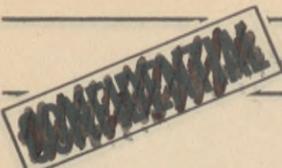
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PRIMARY ATYPICAL PNEUMONIA (Continued)

The total number of cases reported in troops in the continental limits of the United States from March to the end of December, 1942, was about 12,000. From January 1, to May 8, 1943, about 14,000 cases were reported. Because of rapidly changing conditions, including increasing recognition of the disease, it is inadvisable to attach too much significance to the precise rates computed on the basis of the admission figures. However, the monthly rates for the Continental U. S. and for the nine Service Commands are presented in the graphs on these pages. With a relatively low incidence in the spring and summer months of 1942 the incidence of atypical pneumonia rose in the winter and reached a peak in the week ending January 9, 1943, when 908 cases were reported for that week. Since then there has been a gradual decline to 620 cases reported for the week ending May 8, 1943.

PRIMARY ATYPICAL PNEUMONIA, ADMISSIONS PER THOUSAND MEN PER YEAR SERVICE COMMANDS



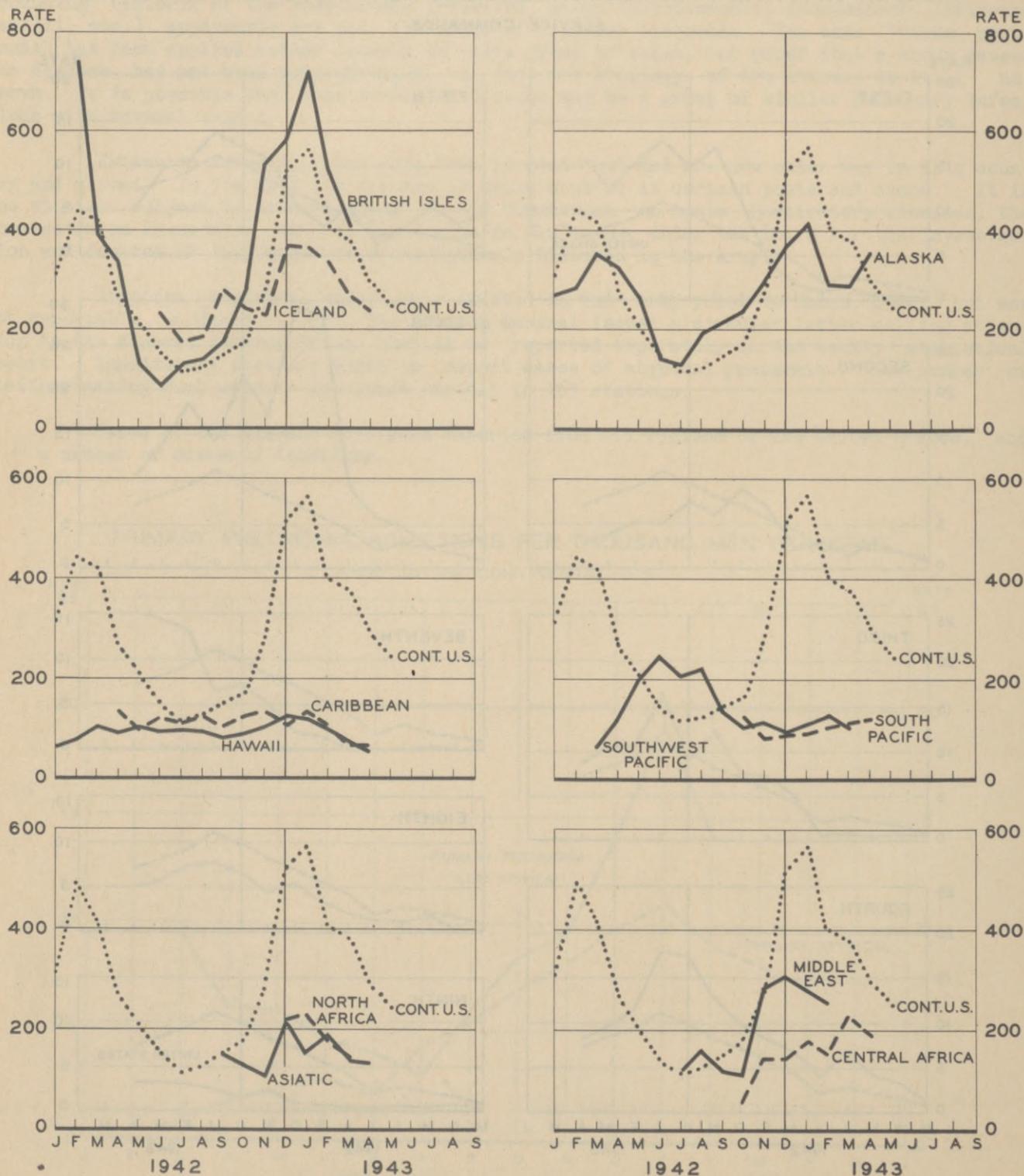


## DISEASE AND INJURY

### RESPIRATORY DISEASE OVERSEAS

During the past winter the troops in most areas overseas experienced much lower rates of admission for respiratory disease than did troops in the Continental U. S. The British Isles were an exception in this respect, however, for the rates there were consistently higher during the entire season. A peak of 719 admissions per thousand men per year occurred in January, when the rate for the U. S. was 566, about 20 percent lower. In the Southwest Pacific the reversal of seasons naturally produces peak rates in the middle of the year. The charts below give the experience of various theaters and lesser commands, the rates being for all respiratory diseases.

RESPIRATORY DISEASE PER THOUSAND MEN PER YEAR  
OVERSEAS COMMANDS



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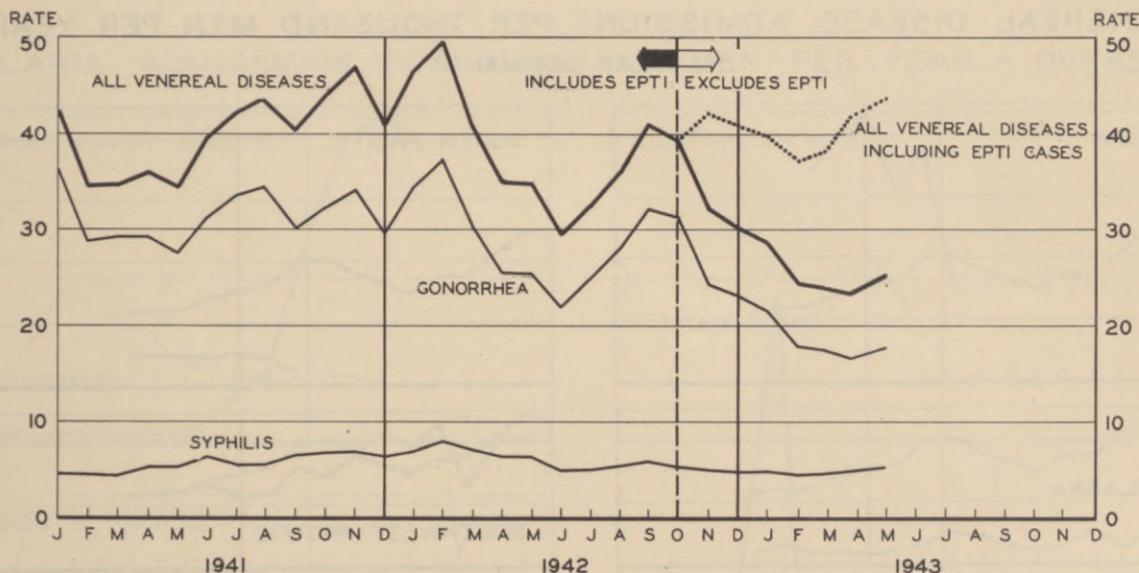
VENEREAL DISEASE, CONTINENTAL U. S.

With the induction of increasing numbers of infected men for treatment in the Army, the uncorrected admission rate (shown as a dotted extension of the top line of the chart below) continues at a high level. The preliminary rate for May is 44 admissions per thousand men per year. The corrected rates, which exclude EPTI cases (exposed prior to induction) are only 5.2 for syphilis, 17.7 for gonorrhea, and 25.1 for all diseases.

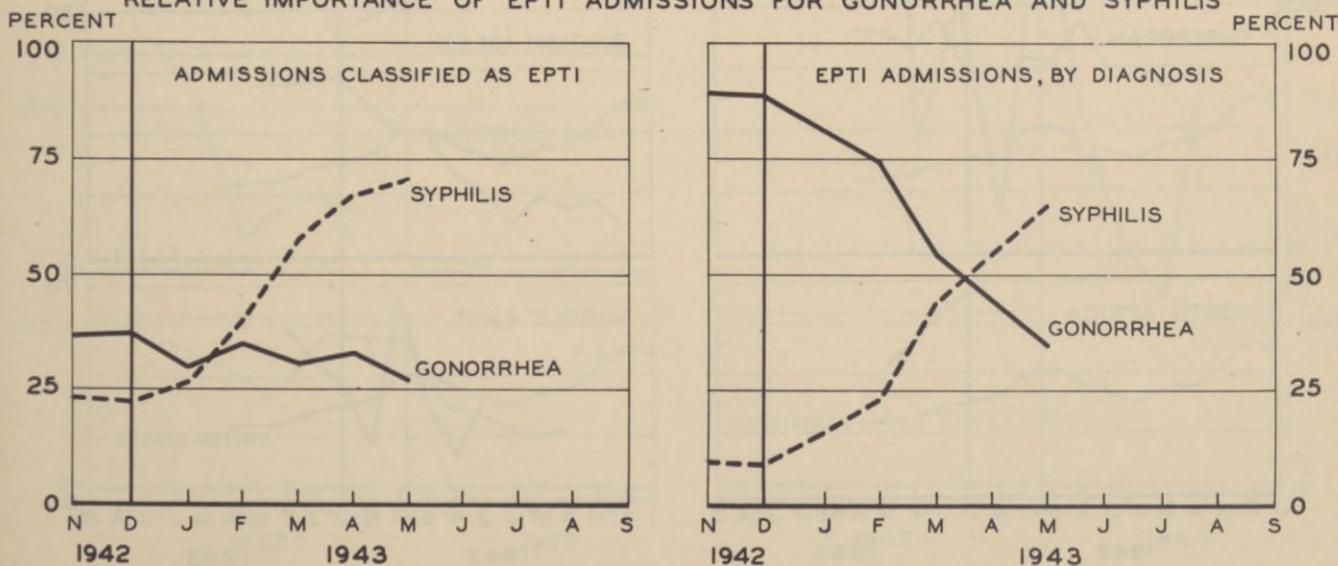
The chart at the bottom of the page reveals the relative importance of the EPTI cases, for both gonorrhea and syphilis. The percentage of gonorrhea admissions classified as EPTI has declined slowly from about 36 percent for November and December, 1942, to 26 percent for May. The initially lower percentage of syphilis admissions classified as EPTI rose rapidly in February and March, and reached 70 percent for May. With the induction of increasing numbers of men with syphilis, the proportion of EPTI admissions having syphilis now exceeds that for gonorrhea, as shown in the chart below and to the right.

VENEREAL DISEASE ADMISSIONS PER THOUSAND MEN PER YEAR

ARMY IN THE CONTINENTAL U.S.



RELATIVE IMPORTANCE OF EPTI ADMISSIONS FOR GONORRHEA AND SYPHILIS



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**DISEASE AND INJURY**

VENEREAL DISEASE OVERSEAS

The overseas theaters and bases vary greatly in their admission rates for venereal disease. The ratio of white to Negro troops, the prevalence of these diseases among civilians in the area of command, and differences in duty all contribute to the wide variation shown below in the charts for theaters and lesser commands.

Troops in Alaska, Hawaii, and the South Pacific have had proportionately fewer admissions than those stationed in the Continental U. S. The rates shown for the Continental U. S. exclude EPTI cases only after October, 1942, and for previous months are somewhat too high for that reason, there being no opportunity for EPTI cases to exaggerate rates for overseas commands. The Caribbean Defense Command continues to have an exceedingly high rate of incidence, the most recent figures being above 70 admissions per thousand men per year. High rates are also reported for the British Isles, the Asiatic Theater, North Africa, and the Middle East. The initially low rates for the British Isles climbed rapidly from July to December, 1942, and have remained fairly constant at about 55 for the past four months. Rates in the Asiatic Theater and in the Middle East have fluctuated considerably. The high rates for North Africa have declined precipitately since the end of the year; the rates for this theater are especially tentative.

**VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR**



DISEASE AND INJURY

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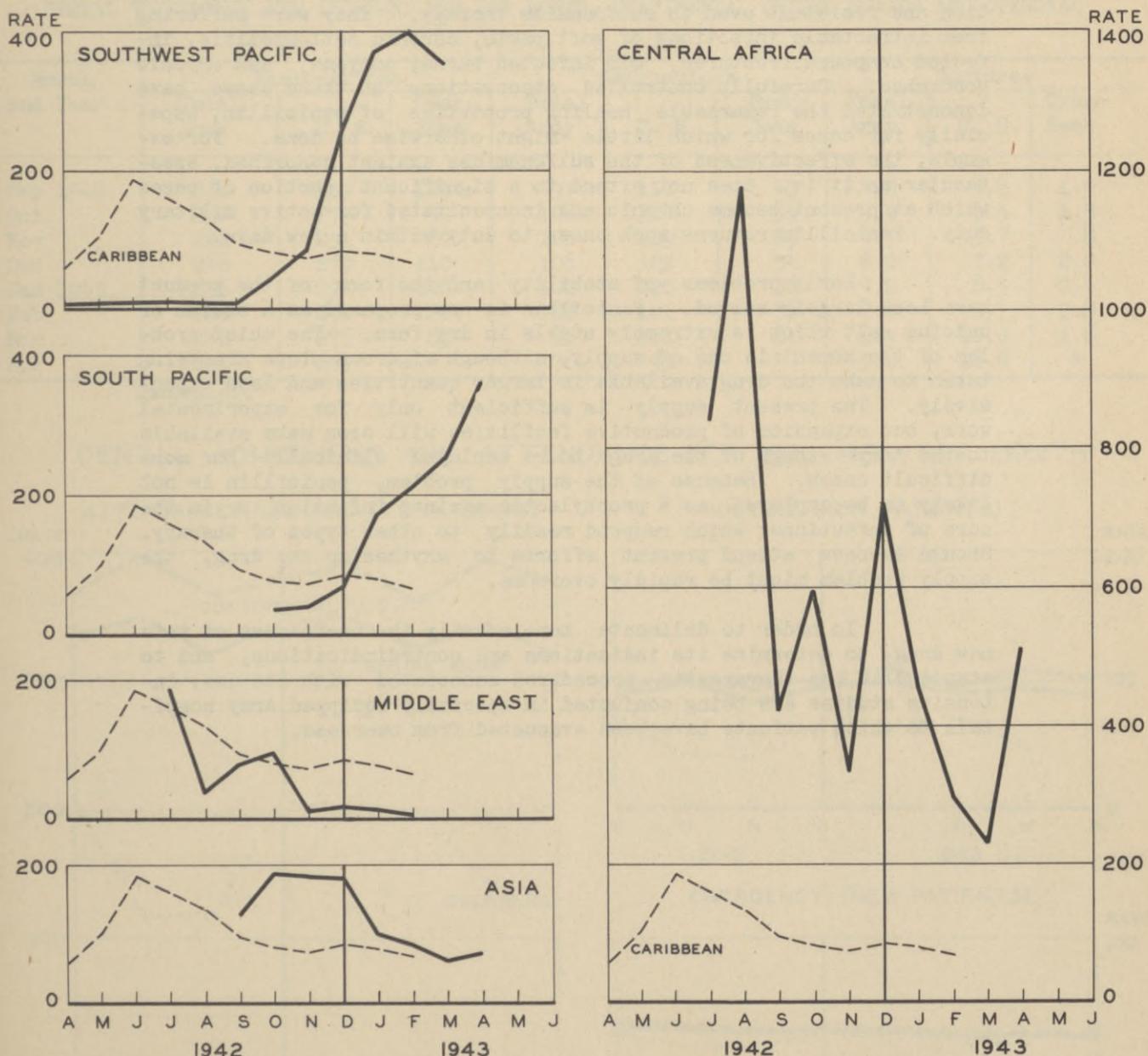
MALARIA OVERSEAS

Malaria has established itself as a serious menace to U. S. Army troops in several of the overseas theaters. In the charts which follow, the experience of troops of the Caribbean Defense Command has been used as a basis for comparison with that of troops in other overseas commands. After a steep climb in the latter part of 1942 and early 1943, the rates for Australia and New Guinea remained at a high level for the months of February, March, and April. Changes in the nature of the military operations in the malarious regions of this theater may account for some of the change in the character of the curve of malaria rates. The rates for the South Pacific theater have continued to increase steadily, a maximum of about 360 being reported for March.

The rates for the Middle East have shown a gratifying decline, some of which probably reflects the seasonal character of the disease in this area. The admission rates for the Asiatic Theater seem to have reached a trough after enjoying a steady decline since the beginning of the year. Seasonal and climatic factors may be influencing this curve to some extent.

The rates in Central Africa continue to be excessive and to fluctuate erratically. Much of the fluctuation can be attributed to the small size of the force in this area.

MALARIA ADMISSIONS PER THOUSAND MEN PER YEAR - OVERSEAS



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**DISEASE AND INJURY**

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NEW CURE FOR INFECTIONS

Since 1929, scientific investigators in England and in the U. S. have conducted experimental studies on a mould, penicillin, which promises unprecedented control over infection. Already this new drug has begun to save the lives and hasten the recovery of Army patients who might otherwise have died, been seriously crippled, or recovered only slowly.

Both clinical and laboratory experiments have demonstrated that penicillin is apparently non-toxic and highly effective in low concentrations against a wide variety of important pathogenic organisms, many of which resist the action of the sulfonamides. Unlike the sulfonamides, which operate by diminishing the rate of growth of bacteria, penicillin actually kills bacteria or stops their growth entirely. Its precise mechanism of action is not completely understood, but its discovery may make possible further important applications of a new principle. Among the bacteria which are not susceptible to penicillin are those which cause typhoid, paratyphoid, and dysentery.

Extensive clinical tests of the effectiveness of penicillin have been made on patients with serious infections of long duration and resistant even to sulfonamide therapy. They were suffering from intractable infections of soft parts, chronic osteomyelitis, infected compound fractures, old infected burns, empyema, and chronic gonorrhea. Carefully controlled observations on these cases have demonstrated the remarkable healing properties of penicillin, especially for cases for which little might otherwise be done. For example, the effectiveness of the sulfonamides against gonorrhea, spectacular as it is, does not extend to a significant portion of cases which at present become chronic and incapacitated for active military duty. Penicillin returns such cases to duty within a few days.

Early problems of stability and the form of the product have been largely solved. Penicillin is now prepared as a sodium or calcium salt which is extremely stable in dry form. The chief problem of the moment is one of supply, although vigorous steps are being taken to make the drug available in larger quantities and less expensively. The present supply is sufficient only for experimental work, but expansion of productive facilities will soon make available to the Army enough of the drug to be employed clinically for more difficult cases. Because of the supply problem, penicillin is not likely to be employed as a prophylactic against infection or in the cure of infections which respond readily to other types of therapy. Should success attend present efforts to synthesize the drug, the supply problem might be rapidly overcome.

In order to delineate more exactly the usefulness of this new drug, to determine its indications and contraindications, and to standardize the therapeutic procedures associated with its use, intensive studies are being conducted in specially equipped Army hospitals to which patients have been evacuated from overseas.

DISEASE AND INJURY

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DENTAL ADMISSIONS AND TREATMENTS

Rates of admission for routine and emergency care for troops in the Continental U. S. have remained fairly stable and at a high level for the past eight months, as shown in the charts below and to the right. Similarly, the rates of attendance (new and old patients) have been fairly well sustained at about 375 sittings per thousand men per month.

The overseas rates have been more variable and generally lower, especially for routine admissions, since a major portion of the dental work is accomplished before troops are sent overseas. The rates shown below are preliminary for March, and for earlier months they have been corrected on the basis of complete returns from overseas. Dental attendance overseas is appreciably lower not only because of the proportionately fewer patients but also because patients there require fewer sittings to complete the essential work.

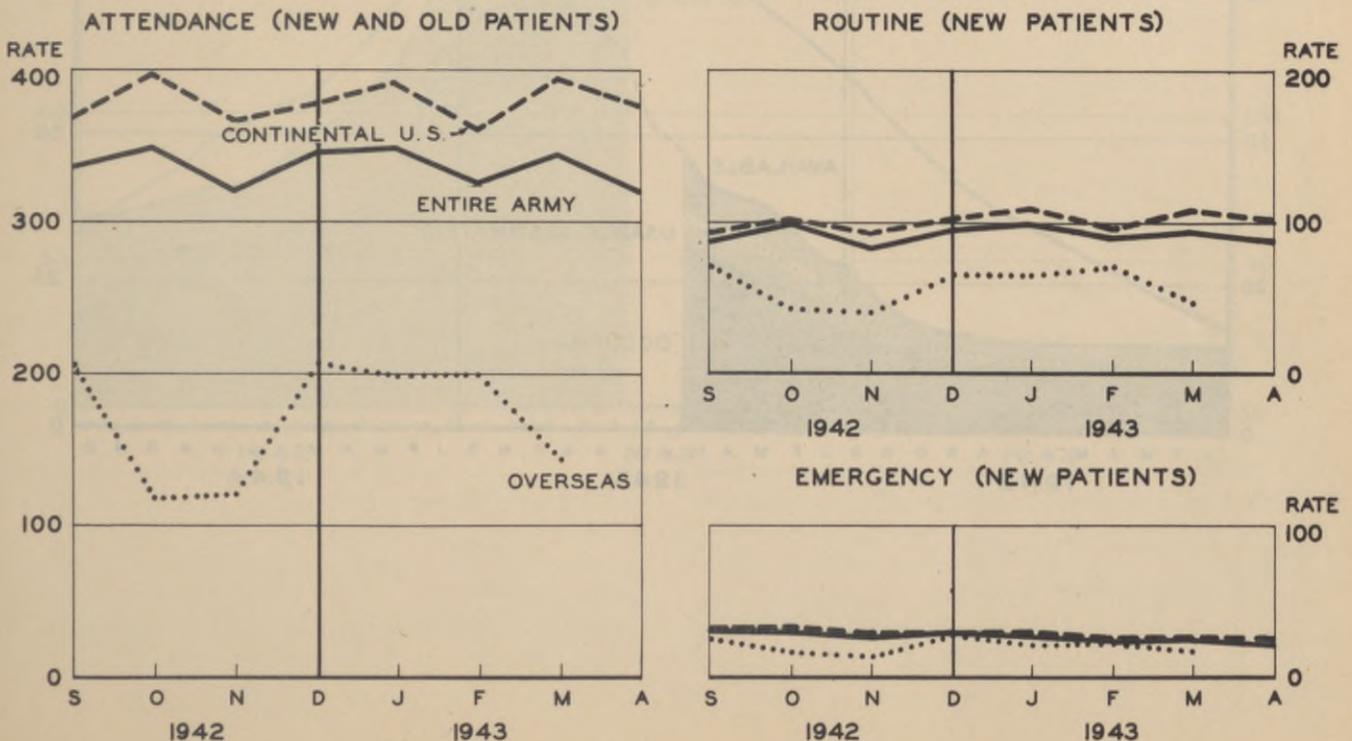
Restorations continue to be performed frequently, the latest ratios for the entire Army being about 240 per thousand men per month, as shown in the table below. The relative frequency of extraction has declined somewhat in recent months, especially for troops in the Continental U. S. The increasing provision of dentures is especially noteworthy. For the month of April, 18 dentures were constructed for each 1,000 men in the Army in the Continental U. S. The poor dental condition of many inductees has necessitated an extensive denture program in order that all men may be able to consume the Army ration. Only additional supplies and personnel could have permitted the increase, however.

DENTAL TREATMENTS PER THOUSAND MEN PER MONTH, CONTINENTAL UNITED STATES AND OVERSEAS

Month and Year	Restorations			Extractions			Dentures		
	Total Army	U. S.	Over-Seas	Total Army	U. S.	Over-Seas	Total Army	U. S.	Over-Seas
Sep 1942	232	259	123	97	111	41	4.2	4.8	1.9
Oct	250	275	99	108	124	39	4.9	5.5	1.5
Nov	221	251	89	101	119	23	4.7	5.7	.8
Dec	248	279	110	106	122	34	6.2	7.2	2.0
Jan 1943	256	294	120	102	120	36	7.0	8.3	2.4
Feb	226	254	120	88	101	36	7.4	8.7	2.8
Mar	241	276	85	91	101	21	8.4	10.0	1.8
Apr	244	299	*	78	93	*	9.0	18.0	*

\* Incomplete

DENTAL ADMISSIONS AND ATTENDANCE PER 1,000 MEN PER MONTH



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# HOSPITALIZATION

## UTILIZATION OF AND REQUIREMENTS FOR BEDS IN NAMED GENERAL HOSPITALS

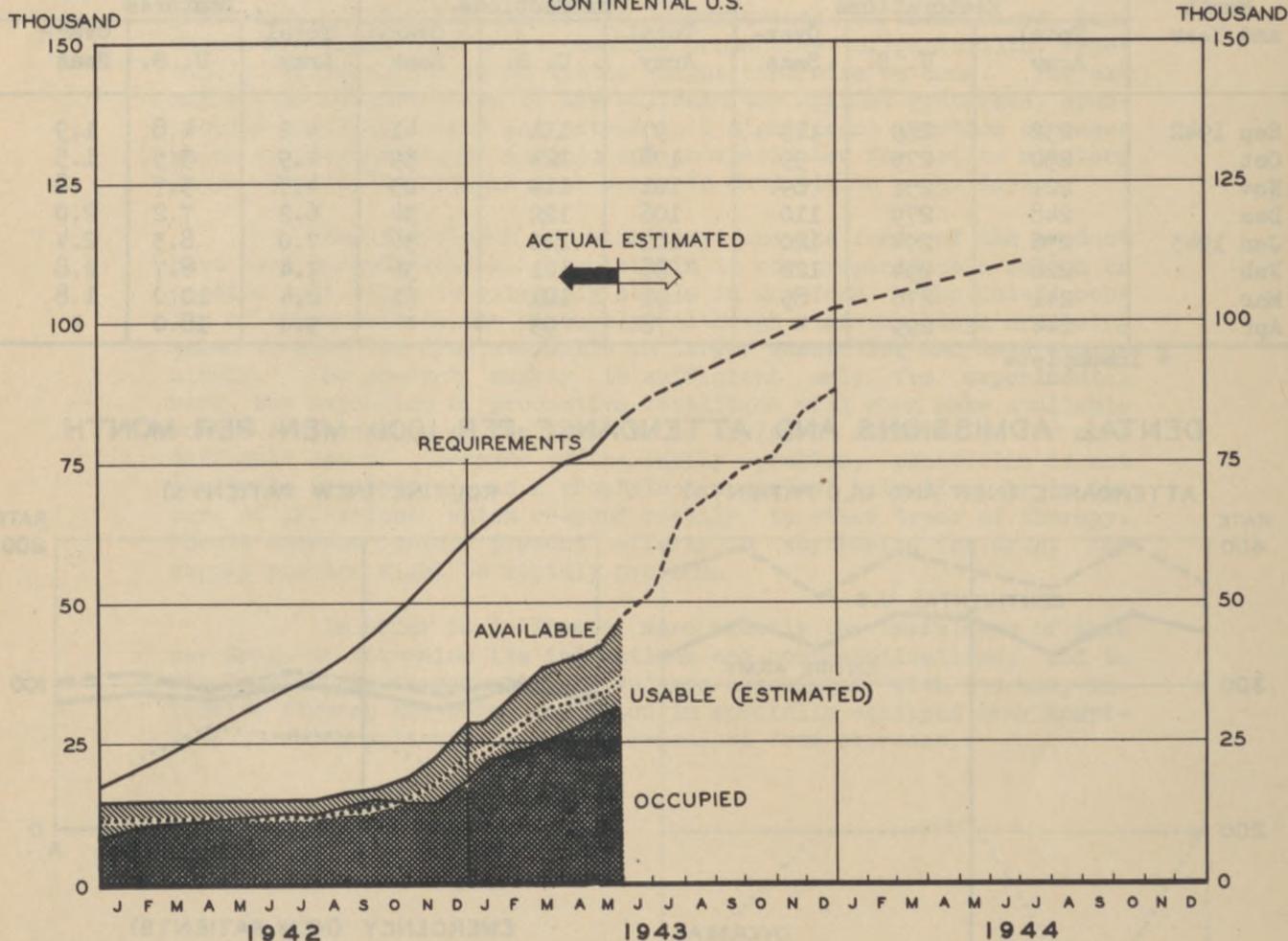
The requirements for beds in general hospitals are calculated at one percent of all troops in the Continental U. S. plus 1.7 percent of all troops overseas. The estimated needs for the period January, 1942, to June, 1944, are shown in the chart below. The line of projected availability reflects construction in progress, and will be revised as new sites are selected and construction begun. Attainment of the present schedule would provide 87,000 beds by the end of December, about 85 percent of the requirement for that date.

Since the Army enjoyed excellent health during 1942, and since overseas action requiring evacuation has become appreciable only recently, no penalty attached to the failure to meet the calculated requirements. The total number of occupied beds is shown by the bottom solid line. The broken line close to it represents the average limit of normal utilization without overcrowding, since at any one time about 20 percent of the available normal beds cannot be used because they are located in the "wrong" wards. When more than 80 percent of the normal beds are occupied, it indicates that in the average hospital emergency beds have been crowded into corridors and solaria, or that patients have been placed in expansion barracks.

The number of normal beds available in named general hospitals increased from 40,600 on April 24 to 45,600 on May 29. On the latter date about 69 percent of the normal beds were occupied, there having been no real change in this figure during the interval.

### REQUIRED AND AVAILABLE GENERAL HOSPITAL BEDS

CONTINENTAL U.S.



HOSPITALIZATION

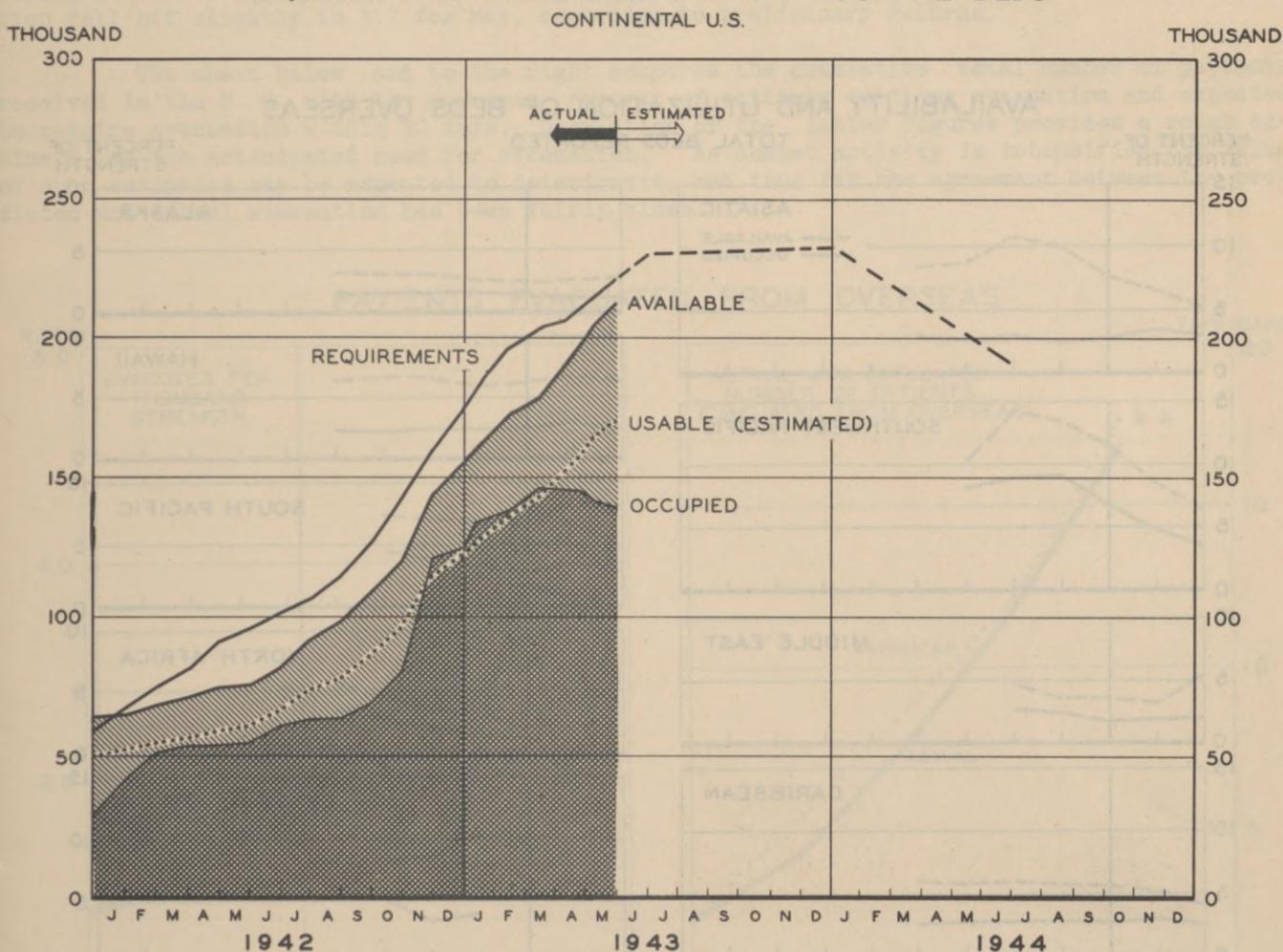
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UTILIZATION OF AND REQUIREMENTS FOR BEDS IN STATION HOSPITALS

The requirements for beds in station hospitals in the Continental U. S. are calculated on the basis of 4 percent of the strength of the troops to be stationed here. The uppermost line on the chart below gives the estimated need for beds in station hospitals from January, 1942, to June, 1944. The other lines show the total number of occupied beds, the number of available normal beds, and the estimated number of usable normal beds (80% of the number of available normal beds), to indicate average utilization without overcrowding.

The number of available normal beds continued its rapid increase from 179,400 on March 13 and 196,600 on April 24, to 211,800 on May 29, about 95 percent of the calculated requirement for that date. The percentage utilization at that time was 65, having declined appreciably from 74 for April 24.

REQUIRED AND AVAILABLE STATION HOSPITAL BEDS



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# HOSPITALIZATION

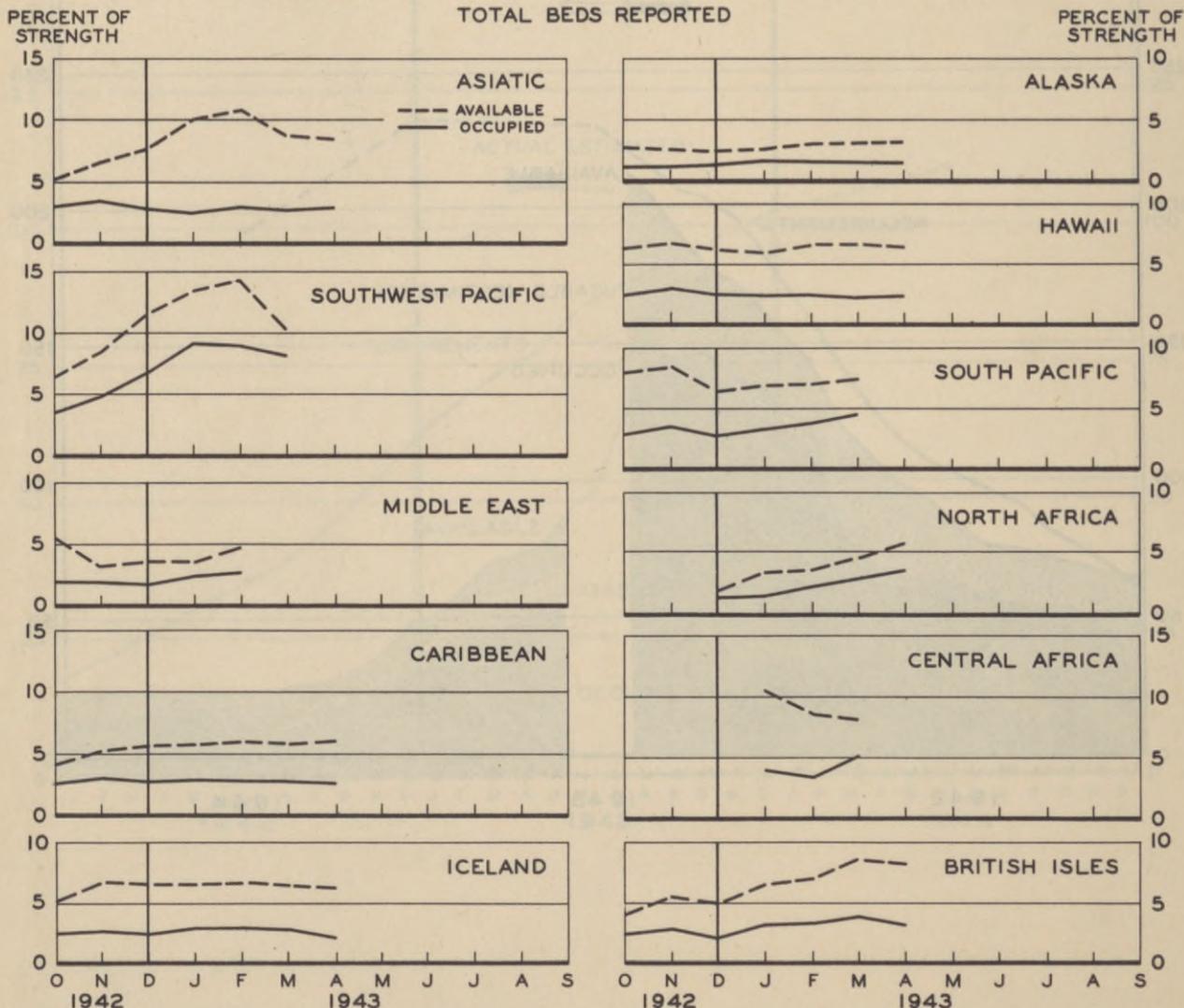
## AVAILABILITY AND UTILIZATION OF BEDS OVERSEAS

The need for beds in overseas theaters greatly exceeds that in the Continental U. S. In comparison with the 5 percent of strength now provided in the U. S. for station plus general hospitals, some overseas theaters need 10 percent or more in fixed hospitals alone (station, general, and field hospitals). However, the need is highly variable, depending chiefly upon the combat activity of the theater and the presence of special disease problems such as malaria.

The charts below show for various theaters and lesser commands the total number of beds reported on the weekly statistical report as set up and ready for occupancy in all types of hospital, fixed and mobile, and the total number of beds occupied, each being stated as a percentage of strength. The total number of available beds is something less than the number provided, some hospital facilities being shipped in anticipation of increases in strength or more extensive military operations.

The great increase in admissions and in the noneffective rate for the Southwest Pacific has raised bed occupancy to roughly 9 percent of strength, but the number of beds reported as available has been well in excess of this figure. In the South Pacific, on the other hand, the occupancy ratio has been only a little higher than that for troops in the British Isles. In North Africa the reported percentages of beds available and occupied have both been on the increase in recent months. The low occupancy rate for Alaska reflects not only a very favorable health picture but also an ability to evacuate patients readily to the U. S.

## AVAILABILITY AND UTILIZATION OF BEDS OVERSEAS



HOSPITALIZATION

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EVACUATION OF PATIENTS FROM OVERSEAS

During May roughly 5,000 patients were evacuated to the U. S. from overseas, according to preliminary reports to The Surgeon General. Although the number of patients received in New York was less than it was during April, the number arriving in San Francisco increased appreciably. The following table shows the monthly totals received, in both simple and cumulative form. The figures for May are preliminary.

NUMBER OF PATIENTS ARRIVING IN U. S. PORTS FROM OVERSEAS

Month 1942	Number	Cumulative Total
Aug.	515	515
Sep.	663	1,178
Oct.	1,019	2,197
Nov.	1,311	3,508
Dec.	2,253	5,761

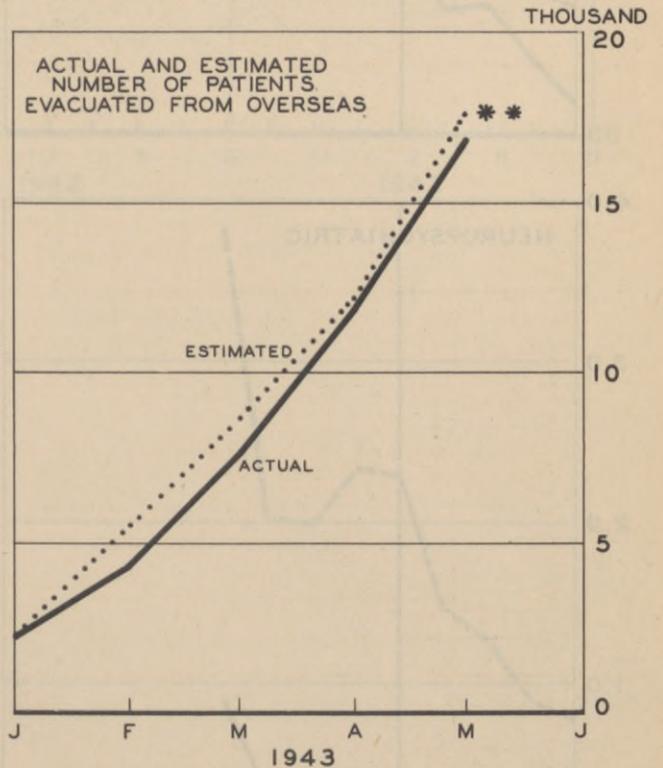
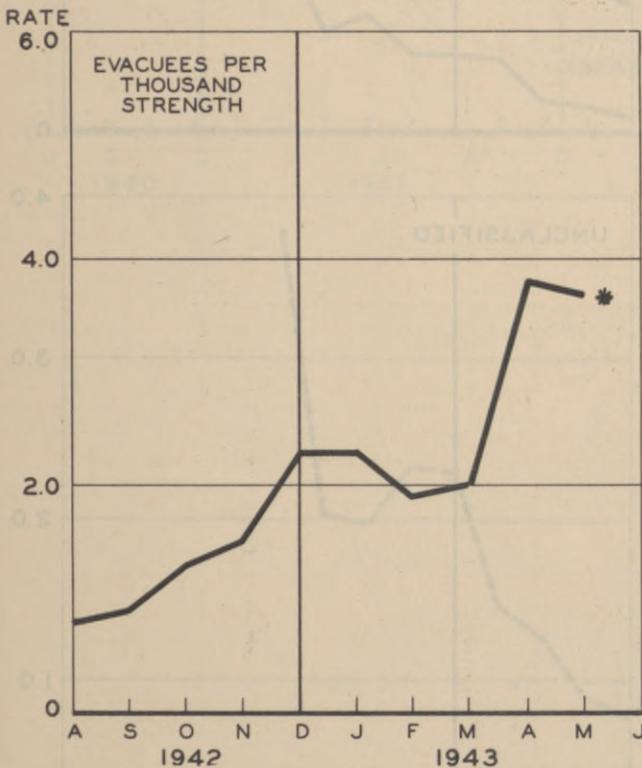
Month 1943	Number	Cumulative Total
Jan.	2,470	8,231
Feb.	2,208	10,439
Mar.	2,405	12,844
Apr.	4,819	17,663
May*	5,047	22,710

\* Preliminary only.

The chart below and to the left gives the number of evacuated patients per thousand strength overseas. After a sharp increase to 3.8 per thousand for April the rate of evacuation fell off slightly to 3.7 for May, according to preliminary returns.

The chart below and to the right compares the cumulative total number of patients received in the U. S. with the overseas reports of patients awaiting evacuation and expected to require evacuation within 30 days. Cumulation of the latter figures provides a rough estimate of the anticipated need for evacuation. As combat activity is intensified the value of such estimates may be expected to deteriorate, but thus far the agreement between the predicted and actual evacuation has been fairly close.

PATIENTS EVACUATED FROM OVERSEAS



\* Preliminary figure.

\*\* Patients awaiting evacuation plus those expected to be evacuated within 30 days.

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**HOSPITALIZATION**

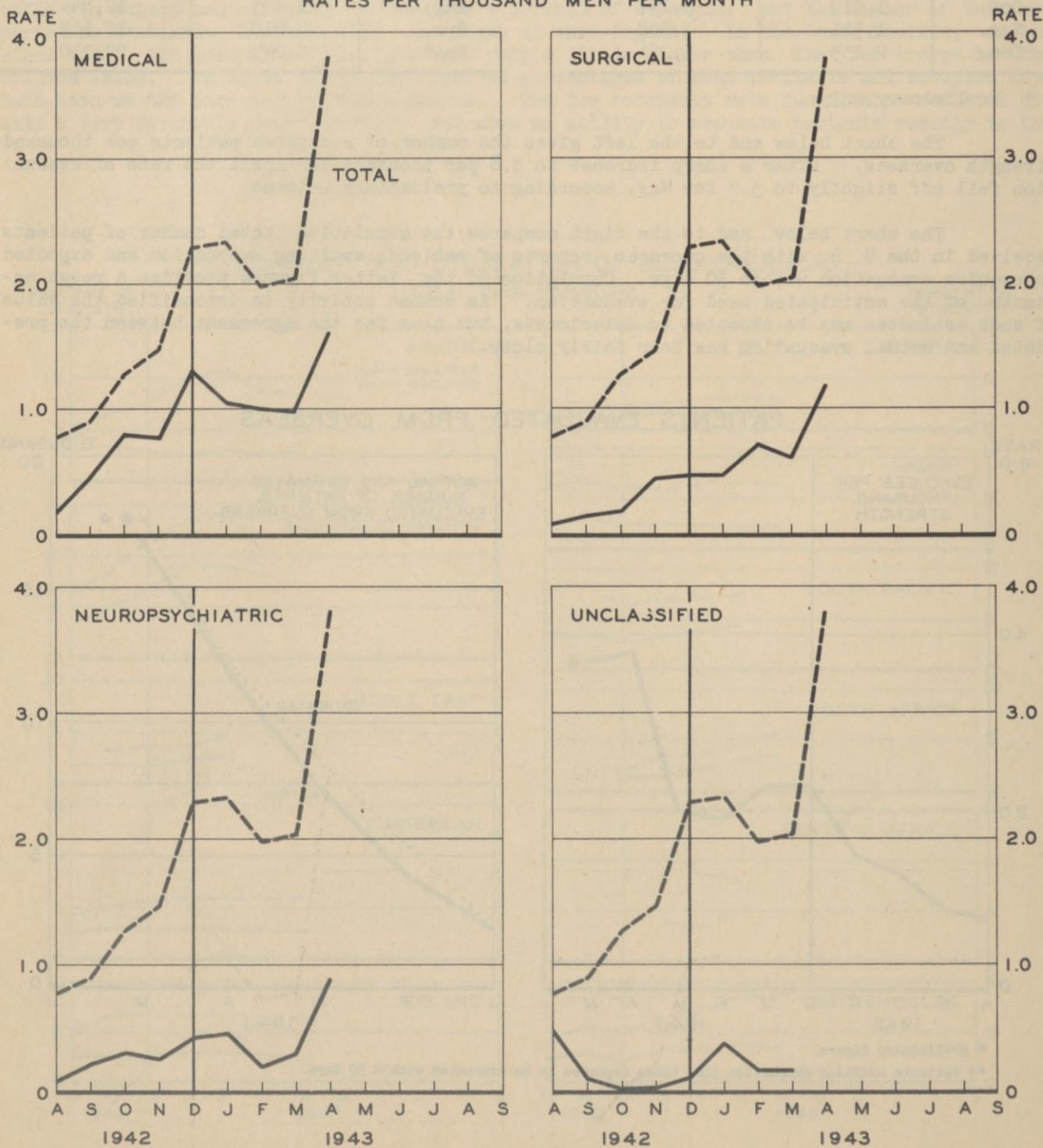
EVACUATION OF PATIENTS FROM OVERSEAS (Continued)

Reports of patients received in U. S. ports from overseas distinguish among medical, surgical, and neuropsychiatric patients. A small number is usually unclassified. The following charts give in rate form the number received in each category and permit ready comparison with the rate of evacuation for all types of patient.

Most patients have been medical in classification, but in April the rate of evacuation climbed most precipitately for surgical and neuropsychiatric patients. For that month the rates were 1.6, 1.2, and .88 for medical, surgical, and neuropsychiatric patients, the rate for all patients being 3.8 evacuees per thousand strength overseas.

**PATIENTS EVACUATED FROM OVERSEAS, BY TYPE**

RATES PER THOUSAND MEN PER MONTH



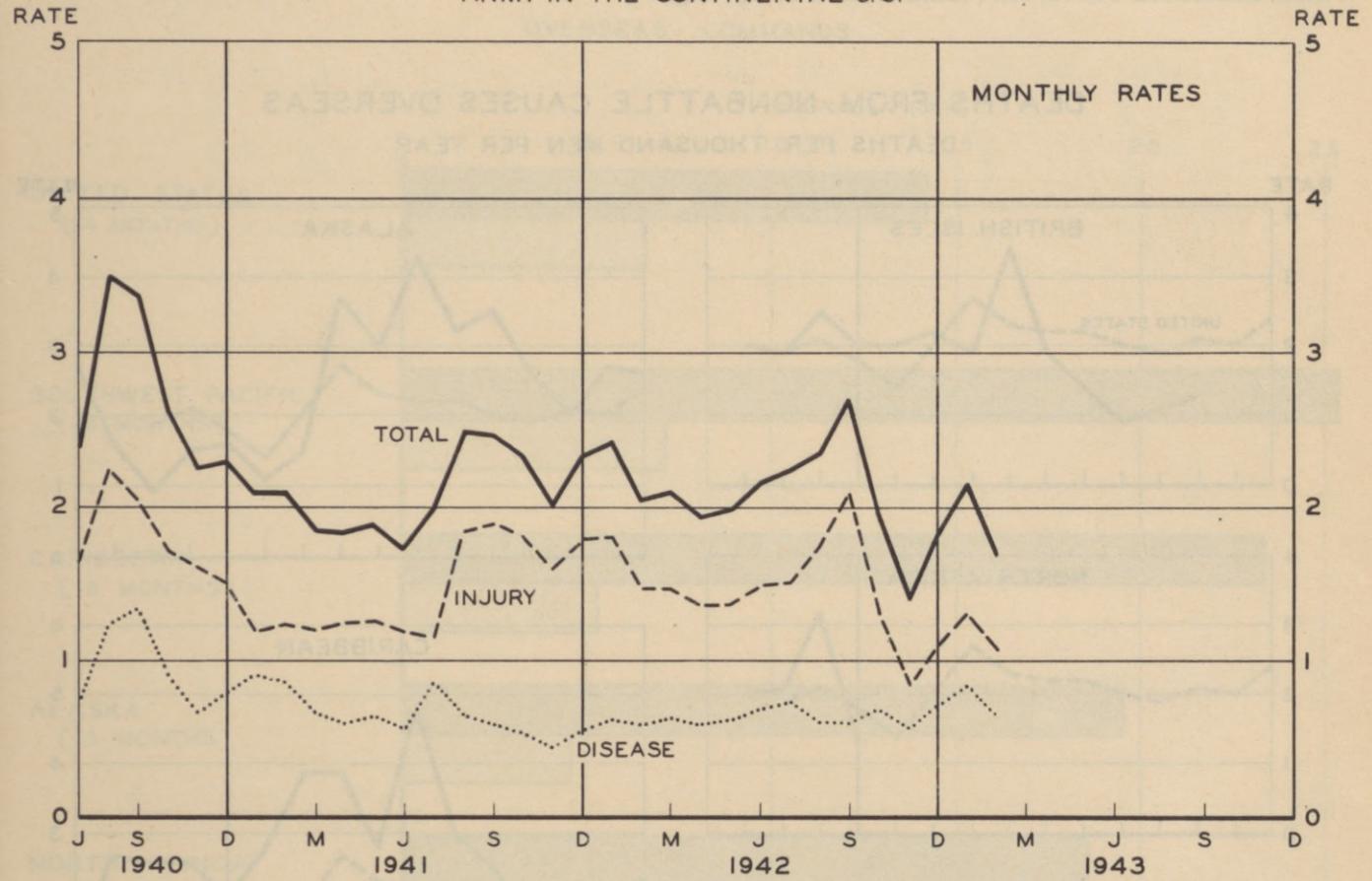
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DEATH RATES, CONTINENTAL U. S.

After a rise to 2.13 deaths per thousand strength during January, the death rate for troops in the Continental U. S. declined to 1.73 for February. The death rate for injury declined to 1.06, an exceedingly low rate, and that for disease fell to .67 deaths per thousand men per year. The chart below gives the rates for the period June, 1940, through February, 1943.

DEATHS PER THOUSAND MEN PER YEAR  
ARMY IN THE CONTINENTAL U.S.



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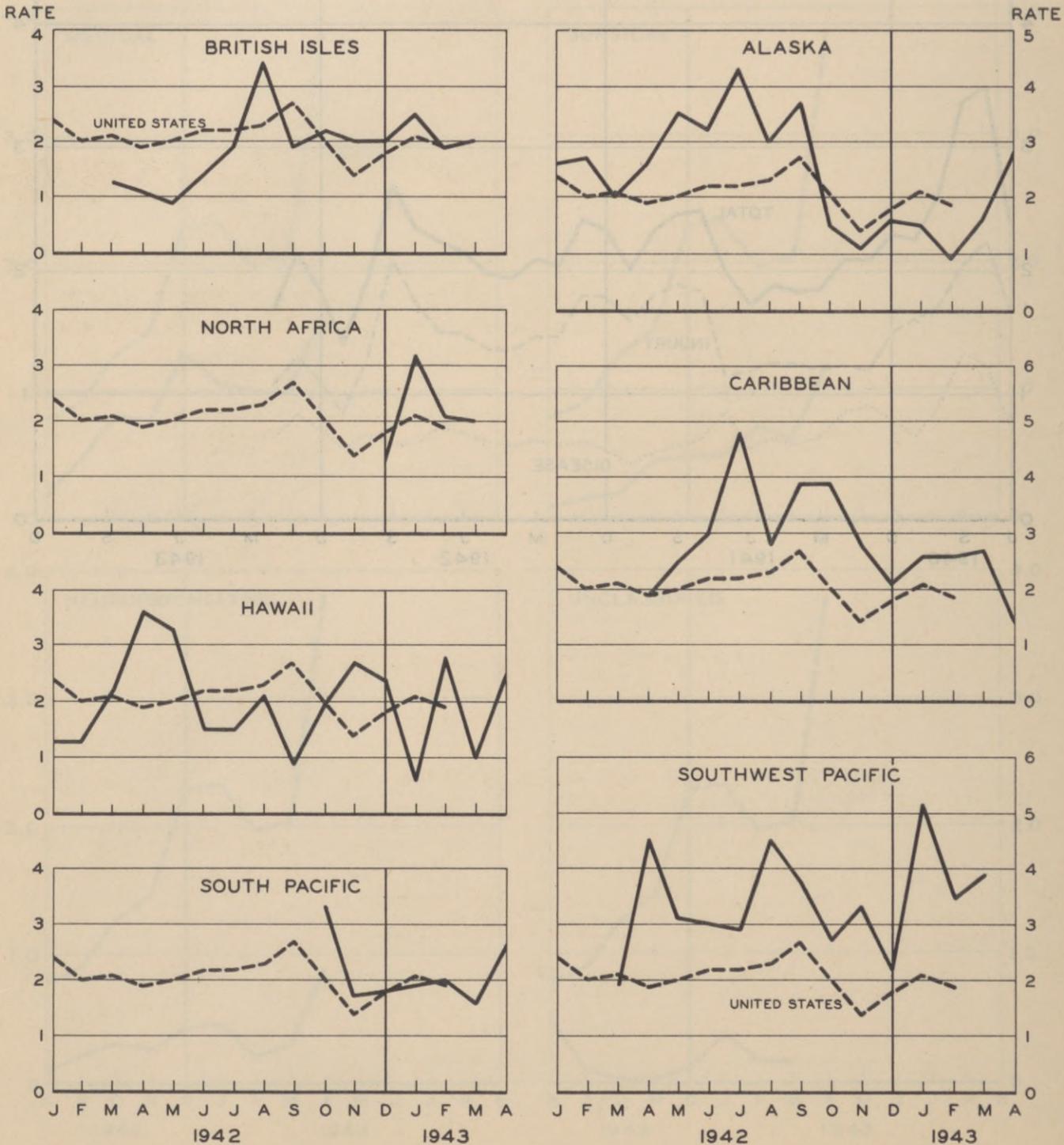
# MORTALITY

## DEATH RATES FROM NONBATTLE CAUSES OVERSEAS

Death rates for troops overseas tend to be somewhat higher than for troops stationed in the Continental U. S. even when battle casualties are excluded. The following charts compare various theaters and lesser commands with the Continental U. S. during 1942 and 1943. As in the U. S. death rates from nonbattle injuries are generally the chief component of the total death rate from nonbattle causes.

Because deaths are relatively few in comparison with admissions, the rates are not very stable, and many apparent differences are of a magnitude which chance alone might produce. Consistently high death rates are reported for the Caribbean and the Southwest Pacific. The high rates for Alaska during the summer of 1942 resulted chiefly from injuries, for which admission rates have also been fairly high.

DEATHS FROM NONBATTLE CAUSES OVERSEAS  
DEATHS PER THOUSAND MEN PER YEAR



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DEATH RATES FROM NONBATTLE CAUSES (Continued)

In order to facilitate comparison among the various areas shown on the previous page, and to provide a breakdown for disease and injury, the available death rates for 1942 and 1943 have been averaged to furnish a very rough index to the recent experience. The theaters and other commands are ranked by order of their death rates from disease, but comparison of rates from injury can be made readily. The variation shown in the chart is much greater than would be expected from chance, and presumably reflects the real differences in hazard which characterize the different areas.

DEATHS PER THOUSAND MEN PER YEAR, 1942 - 1943  
OVERSEAS COMMANDS

