P. O. A. CONVENTION

Program Will Consist Mainly of Methods Needed in Osteopathic Practice

President Martin and Program Committee Chairman Michell have prepared an interesting program that will delight the ears, restore the eyes, rejuvenate the body and thrill the marrow of every osteopathic physician. Many of these physicians will step out of barrow and come to Philadelphia on Friday and Saturday, June 1 and 2. After the banquet the program will be bound to get under way to a good start in the first inning.

Dr. Michell and Dr. Henry will address the audience.

K. Allen Dr. Margaret L. Callister's 1813 Spring Garden Street

Dal treatment away to a good start in the first inning Club and the K. Allen Dr. Margaret L. Callister's 1813 Spring Garden Street

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POSTGRADUATE COURSE

Dr. E. C. Upham, dean, in an address to the graduates of the College of Medicine of Philadelphia, delivered at the commencement exercises, June 27, 1934, stated that the College planned to open on July 1. He reviewed the history of the College since its founding by Dr. Glasgow Davis in 1852, and described the growth of the institution to its present position of leadership in medical education.

Dean Upham emphasized the importance of the College's role in the training of physicians and the need for continued excellence in education. He urged the graduates to maintain the high standards of the College in their future professional careers.

The following day, the College of Medicine of Philadelphia announced the opening of its postgraduate courses, which would include courses in internal medicine, surgery, obstetrics and gynecology, pediatrics, and dermatology.

OS O R T H O P E D I C G I S T

The Official Bulletin of the Philadelphia Academy of Osteopathy

8, with Dean Edgar D. Whitney, M.D., at the Hospital was held during the month of July for the benefit of our profession. This course was attended by over 200 osteopathic physicians from various parts of the United States and other countries.

The course, which was sponsored by the Philadelphia Academy of Osteopathy, was designed to provide a comprehensive review of the latest developments in the field of osteopathy. The program included lectures, seminars, and workshops on a wide range of topics, such as the musculoskeletal system, rehabilitation, and alternative medicine.

The course was well-received by the participants, who praised the faculty for their expertise and the quality of the presentations. Many participants commented on the opportunity to network with colleagues and to learn from each other.

The Philadelphia Academy of Osteopathy is committed to the continuing education of its members and to the advancement of the osteopathic profession. The Academy hosts a variety of educational programs throughout the year to further these goals.

WHO'S WHO

Dr. William S. Nicholl

Dr. Nicholl was born in Philadelphia, Pa., September 29, 1898. He was educated in the public schools of Philadelphia and graduated from Northeast High School. He then went on to study medicine at the University of Pennsylvania, where he received his degree in 1923. After completing his medical training, Dr. Nicholl returned to Philadelphia.

Dr. Nicholl has always been active in the American Osteopathic Association, serving as president of the Philadelphia County Society, president of the Pennsylvania Osteopathic Association, and vice-president of the American Osteopathic Association. He was also the first president of the New York Alumni Association and a 32nd degree Mason and a fraternity member in the Phi Delta Theta fraternity.

In addition to his work in medicine, Dr. Nicholl is an experienced photographer and has published several articles on the use of photography in medicine. He is also a lover of literature and has written several articles on the history of medicine and the role of the physician in society.

Dr. Nicholl is married and has two children. He is a member of the Philadelphia Osteopathic Association, the American Academy of Osteopathy, and the American Association of Osteopathic Physicians and Surgeons.

Annual Meeting

Pennsylvania Osteopathic Association

Banquet, 6:30 p.m., Friday, June 1

Bellevue-Straitford Hotel, Philadelphia, Pa.

Friday, June 1, and Saturday, June 2
Osteopathic Digest

Volume 6, No. 12

A personal osteopathic practice. This is a personal osteopathic practice. This is a personal osteopathic practice.

THE OSTEOGRAFM

VI

Frederick A. Long, D.O.

The charting of the lumbar lesion is an exact process, as demonstrated in the other areas with one difference. This is that the spinous process is oval in shape rather than circular. This more nearly approaches the outline of the lumbar spinous process and allows us to chart rotations and side-bendings by the use of the spinous process as a lateral segment. Flexion and extension are shown by the upward and downward movement of the spinous processes respectively.

Fig. 12. At the second lumbar is relatively normal, the third and fourth lumbar is shown a left side-bending rotation lesion. This lesion is combined left side-bending with right rotation. The right rotation being shown by the greater mass of the spinous processes on the right side of the mid-line.

Lesions of the sacro-iliac articulations are best charted by the use of the sacrum and ilium as the line of the articulation and crest of the ilium in their one position.

Fig. 15. A. A charted right in the mid-line, at a lower level, the spinous process shows a definite improved symbol on the sacrum at the right shows the charting in this is a lesion in a right anterior acetabulum.

B. A lateral view of the anterior ilium shows the lesion in the sacro-iliac articulation, a definite, straight line extending from the posterior sacrum to the anterior ilium. The sacro-iliac articulation shows a normal position.

Fig. 17. A case of drop foot in the right lower extremity. Notice the position of the first, fifth and sixth thoracic vertebrae in the area and also the almost complete absence of the posterior curve in the lumbar area.

Fig. 18. A case of double lesion. Rotation side-bending of the fourth thoracic, flexion of the seventh thoracic with muscular contraction from the third to the seventh thoracic on the right side.

OSTEOPATHIC LESIONS IN BRACHIAL NEURITIS.

J. Francis Smith, D.O.

The usual type of brachial neuritis are many, but the cases with the exception of traumatic neuritis are all common. The brachial neuritis is the one type that may directly just kill a relatively harm to others or other body of the body in the area is not concerned in this disease, is the subject of present osteopathic disease.

Alcohol blood stasis, toxins, etc., first affect the brachial plexus, followed by a motoric resistance has been lowered on account of osteopathic disease.

Where should we look for the lesion which produces following brachial neuritis? This depends in many instances upon what that part of the body to be affected. If the auxiliary serve to be involved, the symp- toms will be characterized by pain in the spines of the muscles, and in the skin over the region of the brachial plexus, and lesions should be looked for in the fourth, fifth, and sixth cervical vertebrae segments.

If the ulnar serve were involved the lesions will be referred to the hand brachial, brachioradialis and brachialis muscles and the skin over and back of the radial side and forearm.

Lesions should be looked for in the fourth, fifth, and sixth cervical vertebrae segments.

The if necessary to be involved the symptoms will be referred to all of the above named muscles and all of the muscles of the hand, excepting those which are served by the ulnar and ulnar flexor muscles to the flexor carpi ulnaris, to the flexor digitorum profundus, and ulnar flexor digitorum superficialis, to the hypothenar eminence, to the adductor pollicis brevis, opponens pollicis, to the adductor pollicis brevis and the two lateral hand muscles. If a neuritis were to occur in the region of these muscles the typical brachial neuritis symptoms would result. Lesions should be looked for in the seventh cervical and first dorsal vertebrae segments.

If the nerves were to be involved the symptoms will be referred to the following muscles; triceps brachii, brachialis and all of the extensor muscles, to the two lateral hand muscles and the four fingers. The skin area involved will be over the lateral side of the right upper arm, the outer lower half of the arm, the inner side of the arm, the posterior of the wrist and the thumb, index, middle, and radial side of the hand from the palm upwards to the tip of the fingers.

The typical derangement of the nerves in this area is known as "dropped wrist." The lesion should look for the fifth, sixth, seventh cervical and first dorsal vertebrae segments.

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