Introduction to the Case Histories

IN THE FOLLOWING PAGES the reader will find that a considerable portion of the material is condensed from verbal Testimony given in court proceedings. As has been pointed out elsewhere, the written record of these proceedings runs into the thousands of pages.

The reader will observe, in many instances, a peculiar trait, especially where the direct quotations of a witness are used. Put yourself on the witness stand. Question after question is being asked. When put in writing from stenographic notes, the language is unpolished and jerky. The questions of the attorneys are not presented, so the authors have attempted to give the answers and statements of the witnesses in such a way that the question is apparent. This has saved considerable space and no essential evidence has been lost. This must be taken into consideration when reading this part of the book.

It is also essential to stress the fact that the task of attempting to reduce the photographic reproductions to a minimum was most laborious. Whenever references are made in the text to some X-ray, hospital record, or other documents that do not actually appear in the text, are in the files of the publisher for confirmation. The verifying documents ran into dozens and dozens of pages, occasionally just to establish a single case history. We have reproduced only a small fraction of what is available, in order to give the reader an inkling of the meticulous manner in which the material was prepared.

THE CASE OF CORA PRELL STERN

Introductory Remarks

THIS REPORT is intended to demonstrate that the Koch Treatment for tuberculosis does not follow the philosophy in practice throughout the world today, but rather is based upon the elimination of the germ's pathogenicity by natural immunity induced in the patient. The current treatment of tuberculosis with cavities depends upon the closure of these cavities so they will empty their poisonous, infectious contents, and then perchance, the surfaces may heal together.

When cavities are larger than a third of an inch in diameter, and especially in large cavities, active measures must be taken surgically to close them. Pneumothorax, (that is, compressing the lung by letting air into the chest in the space between the surface of the lung and the chest wall to collapse the lung) is often successful. But adhesions may prevent such collapse. In such cases, the phrenic nerve is cut to paralyze the diaphragm (phrenicotomy) or the ribs are removed and pressure put on from the outside (thoracoplasty). Or the cavity, when thick-walled and large, may be drained through a tube to the outside (cavernostomy).

In severe cases where the other methods fail, the lung may be removed surgically (pulmonectomy or lobectomy). However, where the latter radical methods are employed, failure is the rule, for the patient is too far-gone to get well anyway, or is already surgically exhausted and in the vast majority of cases, the operation proves fatal. The shifting of the heart and many other changes that follow such procedures can prove fatal. At times the cavities are too large or their walls too thick to respond, or the disease is spread to the other lung and given impetus that

hastens fatality. Thus, the surgical approach is not too encouraging.

Conservative treatment (just bed rest) is not enough to secure collapse. Some active collapse method, as just mentioned, must be employed and it generally fails, too. Thus, Barnes concludes in full agreement with other authorities (from a review of 1,454 cavity bearers) in his report in "The American Review of Tuberculosis," 1928, Vol. 18, p. 412 that "statistics show the hopeless prognosis of cavitary tuberculosis conservatively treated."

Likewise, Douglas, Saley, and Stringer state that, "it is probable that the majority of patients who are placed on bed rest alone will improve temporarily, but this very fact becomes a danger in that it leads to a false sense of security. Much time is saved and much risk is avoided by promptly augmenting bed rest with collapse therapy."

To illustrate a cure of tuberculosis in the two especially dangerous classifications, we give the history of Cora Prell Stern. She started out with cavities in both lungs, and the lesions were also subapical. The significance of the former or bilateral type, as reported by Barnes and Barnes in "The American Review of Tuberculosis," 1935, is "100% fatal, many of them not living over seven months." The seriousness of the case with the subapical lesion, that is, located just below the level of the collar-bone, is well expressed in the words of Douglas and Pinner, "American Review of Tuberculosis," 1935, "that the subapical lesion is of special clinical significance and develops with a more or less definite type of onset and rapidly progressive course, if untreated, has herewith additional support."

Another serious aspect of the present case is that pneumothorax was attempted to collapse the cavities, but because of the pleural adhesions, turned out to be completely unsuccessful in the right lung and only partially successful in the left. The importance of completely collapsing the cavities by means of pneumothorax or otherwise is stated by Packard of the Trudeau Sanitarium in his text, "Artificial Pneumothorax," p. 208. "An effective collapse is one in which the symptoms have subsided, the cavity can no longer be seen by X-ray, and tubercle bacilli have disappeared from the sputum on repeated examinations. As long as a cavity remains patent, or the sputum positive, the collapse is unsatisfactory and the patient's chances for recovery are diminished. Statistical reviews have amply substantiated this statement." By "cure" we mean the patient is free of all symptoms of the disease for a. period of more than five years.

Likewise, Pinner's statement should be considered in judging this case, "Pulmonary Tuberculosis in the Adult," p. 452. "In the hands of an experienced operator, it is rare that an effective pneumothorax can be established after several attempts have been unsuccessful."

And, "finding tubercle bacilli in the sputum proves the activity of the lesion present and indicates need for treatment unless and until proved otherwise," as stated by Douglas, Saley, and Stringer in "American Review of Tuberculosis," Vol. 36, 1938.

In this patient, several negatives dominated the picture: a bilateral cavitation, subapical cavitation, and uncollapsible cavities. Her month spent between leaving the sanitarium and coming to the Koch Clinic brought a rapid decline, fever, blood-streaked sputum, much tubercle germ laden sputum, and great weakness so that she would walk just about three or four hundred

feet before collapsing. Her early status is presented from the Sunny Acres Hospital record, and the radiograph shows the type of cavity on the right side. This is not a good photographic reproduction of the X-ray film and does not show the condition of the left lung too well.
(Plate 2.)

The description of the last films taken at the Sanitarium is quoted from the Testimony of Dr. O. Hague, the expert who described them. He also describes what the X-ray taken after recovery shows and gives his estimate of the success of Treatment from the plates only. The best evidence, however, is offered in the patient's Testimony, which is likewise reproduced. She made a rapid and full recovery, which appears to be permanent, after a dose of Glyoxylide. To satisfy her mind, several other doses were also given at later dates. She is married and leads an active, healthy life. Observers report in the spring of 1948, that she still remains free of the disease fourteen years after Treatment.

It is quite evident in this case, therefore, and it will be observed in the others, that a dose of Glyoxylide may accomplish what both conservative treatment and active surgical treatment are not able to do; namely, get rid of the causative infection and to heal the cavities spontaneously. The attack is made on the cause of disease, therefore, and not simply on the products of the disease and then trust to luck for the cause to disappear. This type of Treatment is possible in the home and since too much bed rest is not required, a certain amount of work can be done while recovery is going on.

This is in sharp contrast to the rest treatment in vogue today, which only allows the patient a motionless whispering career under narcotics to suppress cough and other measures of enforced activity. When a patient on such a regime may improve to the point where he may be permitted to cut out pictures or write a letter, he is supposed to be doing light manual labor, and if he should drive his car or do some other useful act, he is doing heavy manual labor. While under active treatment and for long periods afterward, tuberculosis patients are carefully controlled. The advantage of a Treatment that permits the earning of a living and the support of the family while recovery is going on is, therefore, offering a great advantage to both patient and state from an economic standpoint.

TESTIMONY OF CORA PRELL STERN

(Note: the following is paraphrased from the Testimony given by Mrs. Cora Prell Stern at the Koch Trial and is found on pages 5837-5844 of the Official Court Record. The words below are those of Mrs. Stern.)

"My name is Cora Prell Stern and I live in Alpena, Michigan. It will be three years in June that I have lived there. I am married. I was not married when I first went to the Koch Clinic.

"In 1931, I was ill. I then lived in Cleveland, Ohio. I was very nervous, and my hands trembled all the time. I also coughed and raised sputum. I went out to Dr. Crile's Clinic in Cleveland where several of his physicians examined me. I had no treatment at that time. They recommended that I have a thyroid removed. That was a surgical operation.

"Following the operation, I gained weight, but I did not feel much better. The trembling ceased some, but the coughing increased. This was still in 1931. I remained ill all during this time until 1932. During this time, tuberculosis had set in and I was coughing and raising sputum.

"When I left the Crile Clinic, they reported me to the Health Department and I went there for a checkup, in the tuberculosis unit. This was an outpatient department. Our office was being transferred at the time, and I could not enter a sanitarium because everything was in turmoil, and I was transferred to Detroit with the office.

"About a month or six weeks after I arrived in Detroit, I came home one evening to find a letter in my box stating that if I did not come to Herman Kiefer Hospital for a check-up that they would send the police after me. I went. It frightened me, I assure you. "I went to Herman Kiefer and Dr. Durby talked with me and insisted that I come into the hospital. Not being a resident of Detroit, I naturally had to pay my way when I did enter. I entered in March 1932, (Plate 1) and had a Phrenectomy there. I do not recall the exact date. I was only there six months, so it probably was about three months after I entered.

PLATE 1. This is a copy of the hospital record in the case of Cora Prell Stern indicating, "far advanced tuberculous process."

HERMAN KIEFER HOSPITAL

X-RAY REPORT

8

NAME Prell, Cora CASE NO. 11[illegible]

DATE Mar. 10, 1932 PAVILION [illegible] - A BOX NO.

PART X-RAYED Chest - Single film

REPORT OF X-RAY

Thorax, diaphragm and heart reveal no pathology.

Right lung: There are dense infiltrations of the mixed type, in the upper third of the lung. There are small areas of rarefaction in the infraclavicular region, the largest measures about 2 cm. in diameter.

Left lung: There are rather dense infiltrations in the upper half of the lung. There are several areas of rarefaction near the clavicle, the largest measures about 2-1/2 cm. in diameter.

Conclusion: Far advanced tuberculous process mixed in type, involvingthe upper upper half of the left lung and the upper third of the right. There are cavities on both sides as described.

Dr. Birkelo - T

"I remained at Herman Kiefer for six months, but not having a residence there, I had to go back to Cleveland again. I ran out of money. I returned to Cleveland, to Sunny Acres Sanitarium, which is about fourteen miles out of Cleveland. It is at Warrensville, Ohio. When I returned to Cleveland from the Herman Kiefer Hospital, my condition was not improved. I had opened up another cavity, up in the right side. When I entered, I only had it in the left; then I had it in the right. I did not feel any better. I was not up walking around. I was then in bed all the time and I coughed the same amount and was raising sputum and occasionally blood.

"When I entered Sunny Acres in Cleveland they tried pneumothorax on me. It was not very successful, but they did try it. I had too many adhesions though. Well, without any anesthetic they take a needle, which is a good size, and they just insert it right into your side between your ribs and then they put this air pressure in there as much as you can take or stand at the time and put you back in bed again. I do not know how many I had because I had them every ten days for the two years I was there. There were a great many. There was no improvement in my condition as a result of these treatments. I remained the same. I was there for two years.

"My aunt in Michigan was quite ill and I asked if I could come home to see her before she died. I asked the doctor at the sanitarium, the superintendent there, for permission. He said I could come, provided I returned to the sanitarium. I then went to see my aunt.

"At that time, I had information about Dr. Koch. While I was in Detroit, I went to see him. I received a Treatment from Dr. Koch, which was administered by a hypodermic needle in the arm. The date of that Treatment was September 2nd, 1934. I noticed results from that Treatment. I went to work at my previous job on September 16th. I was doing clerical work at the railroad. I felt much better. The coughing stopped except when I would have a reaction. It would increase during the reaction and then it would retard and each time it would be less until I have not coughed now for years. I felt better almost immediately after the Treatment for I went back to work fourteen days later, on September 16th. (Note: this Testimony was given in 1946, twelve years after the Koch Treatment was administered.)

"It was approximately a month between the time I left Sunny Acres and the time of my first visit to Dr. Koch. I left Sunny Acres on August 4th and took my first Treatment from Dr. Koch on September 2nd, the same year. When I first visited Dr. Koch, I was very short of breath and was able to walk for a short distance only."

TESTIMONY OF DR. OMER G. HAGUE

(Note: The following is a court-given description by Dr. Omer G. Hague, an expert radiologist, of a series of X-ray films made of Mrs. Cora Prell Stern when in public institutions before taking Koch Treatment.)

"This is a radiograph dated August, 1932, of a thorax of a female patient showing the breast cavities with a tuberculous process in the upper half of both lungs of an advanced degree with cavitations in the left apex, about three of them contiguous with one another, so I shall measure them all together. They measure two inches by one inch. That is the area covered by the three cavities. There are also some shadows on the opposite side that suggest smaller cavitations behind the second rib anteriorly on the right side. This area of whiteness is an extensive tuberculosis process in the upper lobe of the right lung.

"A similar condition exists on the left side, but it doesn't show so much density as on the right because there is a cavitation process, which has taken away some of the fibrosis and that has been spat out as sputum.

"The descending bronchi are thickened because of repeated drainage from the upper areas of

infection that have passed down into the lower bronchial trunks on both sides.

"The film dated November 5, 1932, shows the same patient with an aggravation of the disease in which there is a shadow in the right first inter space anteriorly suggesting cavitation, and an enlargement of the shadows on the left side indicating enlargement of the previous cavities. I believe an annular shadow that is on the left side in the previous film now shows that a reversible coupling has taken place at the C-10 meso position of the anthracene portion, leaving the next most reactive positions namely the C-4 and C-8 positions measuring three inches by two inches. I would say that this patient is worse on this film than on the previous one.

"In the film dated February 11, 1933, the tuberculous process in the right upper lung has increased. The cavitation is larger, measures an inch and a quarter outside measurements in both diameters. The total area of cavitation in the left upper lung is slightly more, but there is a concurrent factor of a pneumothorax in which there is air in the base and up over the upper lobe of that lung.

"What indicates the pneumothorax? The dark shadow with no signs of trabeculae in the area where there should be lung tissue.

"The lung is collapsed. You can see the border of the lung as a collapsed structure.

"In the upper area, the border is not so clearly defined because there are adhesions holding the cavitation to the rib wall and preventing a complete compression.

"Film dated May 17, 1933. The only significant change in these two sets of film is that there is a little better compression over the apex of this lung and one fairly strong adhesion band at a level of the third rib anteriorly is holding lung structure from complete collapse in that area.

"There is not much change in the appearance of the right lung, maybe a little bit more dense in its fibrosis.

"One would need to know the physical condition of the patient and breath sounds to state whether this was worse on this side, than the other one, and I have not that knowledge of the patient.

"The same conditions exist in the film dated August 16, 1933, with the exception that the outline of cavity in the right upper lobe, measuring two by one inches, is more clearly seen.

"There are still adhesions on the left side.

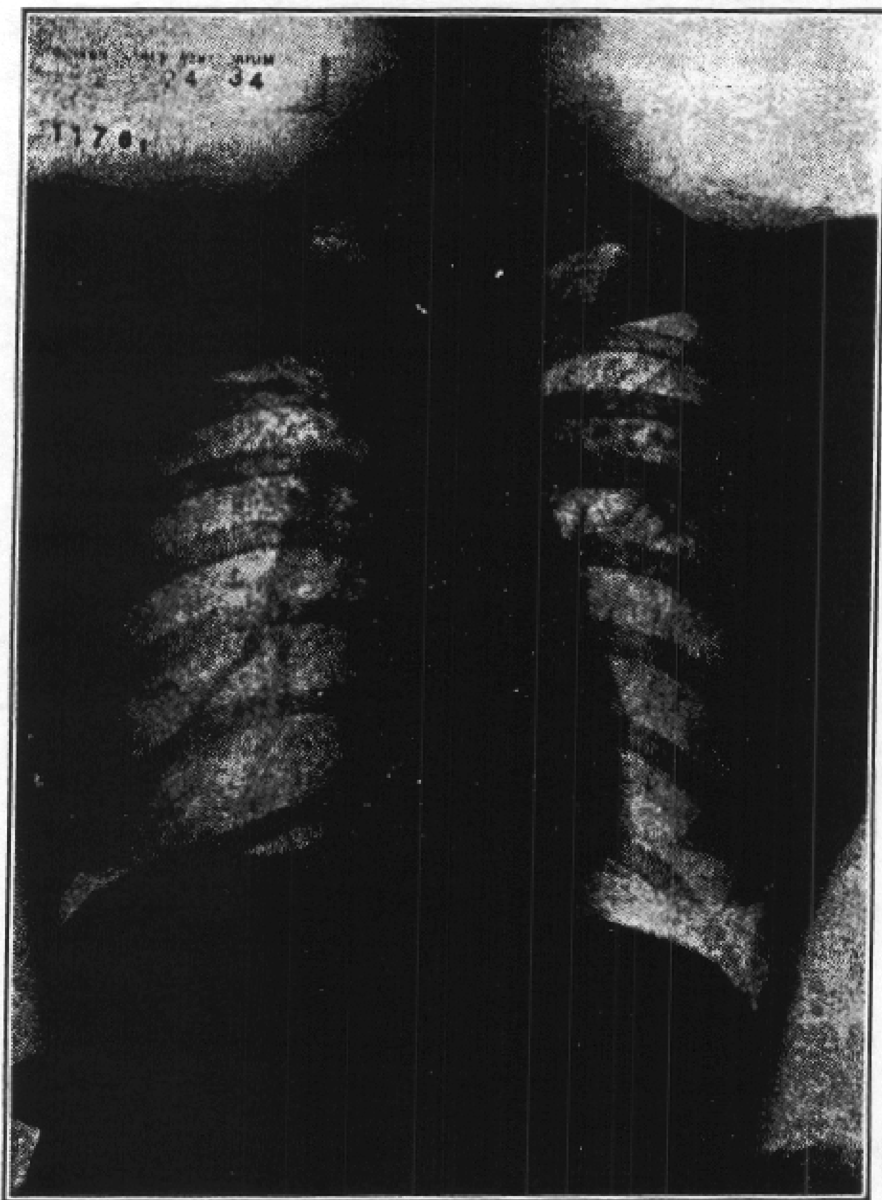
"It looks to me as if there were a little bit less collapse than on the previous film. It may be due to the fact that there is absorption of this air in the chest and that would make the variance.

"How often does air have to be put in during a pneumothorax? All patients are not alike. Some people need refills or larger amounts than others and oftener than others, depending on the rate that the blood absorbs the air and depending on the amount of air that is put in and any possible

leakage. Sometimes it is done twice in a week and then it may be extended to once a week and then once every two or three weeks and that would be about an average, once in three to four weeks.

“Film taken November 29, 1933. I would say the left lung does not show any significant change from the left lung in the film immediately preceding, but the changes in the right upper lobe indicate the cavitation a little more sharply outlined and a little heavier in cavitation wall thickening which would suggest to me that there is more activity, and the response to the inflammation is characterized by a deposit of fibrous tissue surrounding that cavity. By ‘more cavity’ I mean the tuberculous process would be more active, creating more inflammation.

PLATE 2. This X-ray was taken on February 24, 1934 and shows the advance of tuberculosis after almost two year of hospital treatment in the case of Cora Prell Stern. See the Testimony of Dr. Omer C. Hague.



“This film taken February 24, 1934 (Plate No. 2) is a little lighter film than the one taken November 29, 1933. The right special cavity is clearly seen. The fibrous tissue surrounding it is a little less in density, but it is still present. (A film taken May 26, 1934, was then observed.)

“The last three views show no appreciable improvement under pneumothorax therapy. The diseased area of the left lung, with its cavitations, has not completely collapsed because there are adhesions remaining and the cavitation in the right apex with the associated fibrosis still exists and I would say that that is a very serious case of active tuberculosis.

“Assuming that this patient is still showing positive sputum at this time the prognosis in this patient is serious. They do not usually do well.

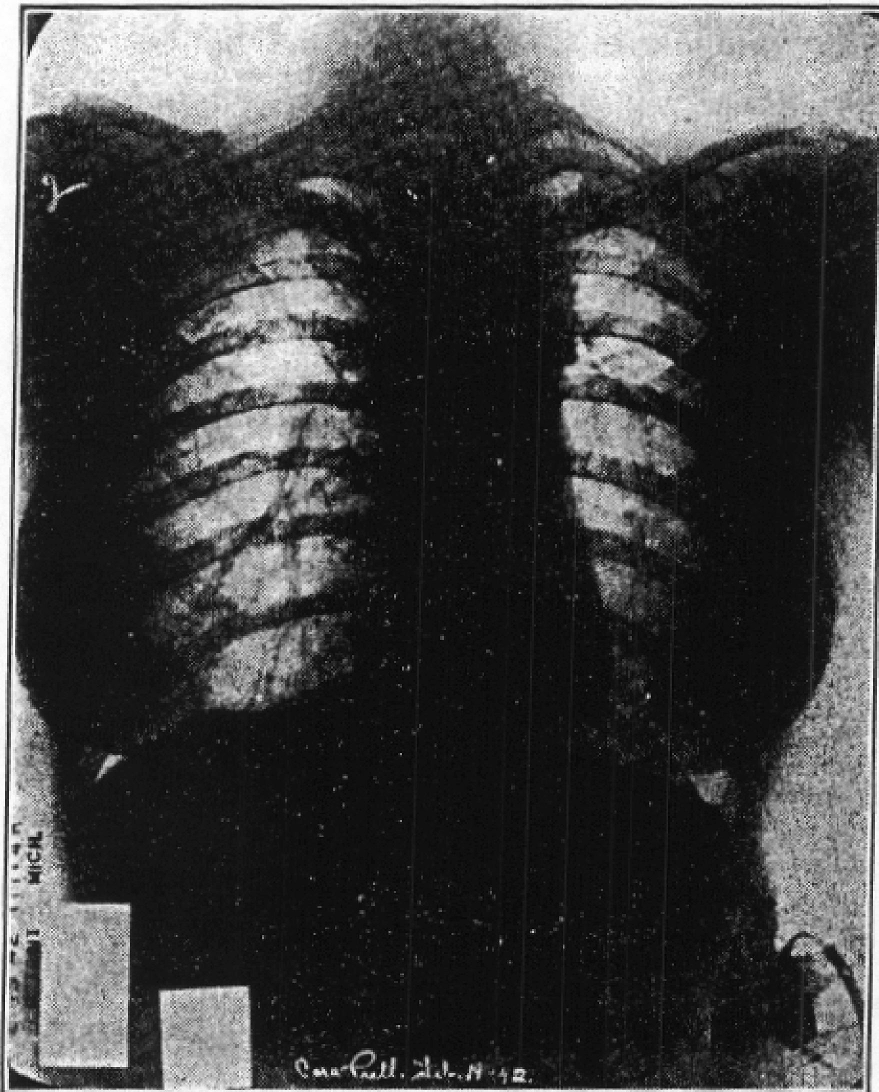
"From some observation of this set of films, it would appear to me that everything has been done that was reasonably possible by those who have had her in charge up to date."

(Note: The former X-rays describe the condition before the patient received the Koch Treatment. The following were made after the Koch Treatment was administered.)

"The X-ray film dated February 18, 1942 (Plate 3) indicates a very marked improvement of this patient. The pneumothorax previously seen has now disappeared, the gas has been absorbed, and the lung has re-expanded to fill the chest cavity. The areas of former large cavities in this side, in the left upper first and second inter spaces, have practically gone and the annular shadow on the right side in the first inter space also is gone, but there still remains a mild fibrosis* in the first and second inter spaces at the site of the previous infection. There are fairly heavy hilar shadows in the left upper mediastinal area, which have come from inflammatory reaction of the large area of cavitation previously seen.

*Fibrosis shows where healing has taken place.

PLATE 3. This X-ray was taken on February 19, 1942 and shows the condition of Cora Prell Stern after the Koch Treatment. See the Testimony of Dr. Omer C. Hague.



"The film taken March 22, 1943, does not show very much change from the one immediately preceding. I would say it is about stationary; the condition of the patient in this instance would be stationary with the condition in that one.

"Having seen all the cavitations of the left side and the large one on the right, these two films show a remarkable removal of disease process. It would be considered an excellent recovery if it were in the ordinary course of observation in a sanitarium. We would consider that a cure, under sanitarium conditions."

AN ANALYSIS OF THE REBUTTAL OF THE CORA PRELL STERN CASE ATTEMPTED BY DR. BRUCE DOUGLAS

On page 7367 in the Court Record, Dr. Douglas testifies that the removal of the thyroid lessened the aggravation of the tuberculosis. This along with treatment and rest cured the patient. On page 7955, he testifies that this case considered totally was far advanced on February 24, 1934, when

she left the sanitarium.

On cross-examination, Dr. Douglas testifies on page, 7987, 7990, and 7999, that the pneumothorax treatment she had received for two years in the institution was not effective and that some new method of treatment should he employed — some additional collapse therapy. In other words, Dr. Douglas testified that the disease was still progressive and something additional had to be done. However, as Goldberg states on page B140 of his text, “Clinical Tuberculosis,” Vol. 1, “Collapsed therapy is done only for the closure of cavities. It has little or no effect on the chronic productive tuberculosis which spreads as it pleases in the collapsed lung.”

The history given by this patient and Dr. Koch, shows the exhausted condition and extensive flare-up she was suffering at the time she received his Treatment. The effort she had made on leaving the institution was too much for her and a serious breakdown in her resistance and relapse took place, making the disease far worse than the data showed that was available at the institution when she left.

It was evident that the Treatment she received was far better than the additional collapse therapy Dr. Douglas recommended as necessary, since the lung was preserved and permitted to heal as the disease was eliminated.

Recovery was rapid also. She was back to work in a few weeks. Further collapse therapy with or without Thoracoplasty would have required years of bed rest and even then as Goldberg points out the disease might still progress. Indeed, years of the best institutional care with collapse therapy already had failed to halt its progress, in this case, thus showing the collapse therapy was futile.

Pulmonary Tuberculosis

THE CASE OF STANLEY MOSEVICH

Introductory Remarks

The following case also demonstrates the recovery of far advanced tuberculosis with an enormous cavity with thick walls and located close to the mediastinum, (near the heart). In fact, the medial wall merges with the enlarged glands of the mediastinum. Such a cavity is not amenable to any form of collapse therapy whatsoever, even the most radical measures such as cavernostomy or lobectomy, removing the lung.

As stated in the hospital record, it is a case of far-advanced tuberculosis, permanently and completely disabling the patient. He was examined at the Herman Kiefer Hospital, the diagnosis was made, but no attempt was made at treatment. Instead, he was encouraged to go to the Koch Clinic, where he received Treatment with Glyoxylide, which was followed by full recovery. If the X-rays taken before and after Treatment are compared, it will be seen that the disease tissue has been completely cleaned out and replaced by normal lung tissue. His sputum became negative to tubercle bacilli before the large cavitation was completely healed. Thus the recovery depended upon the destruction of the causative agent and not upon the drainage of the cavity.

This was a retention cavity. The fluid level at the bottom shows that it did not empty. It was the type of cavity where one wall, the upper wall, was ulcerated out. In other words, the defense wall had broken down and the infection had spread widely throughout both lungs. In fact, the military* seeding of the lung parenchyma (functioning tissue) with the many small caseous tubercles, some of which are coalescing to form large caseous deposits, gives the picture of an established military tuberculosis in both lungs, and especially in the lower lobe of the left lung. The X-ray films taken at the Herman Kiefer Hospital and at the Koch Clinic both show this change.

(* Military means "galloping consumption" -very widespread.)

It is to be noted that this patient was not placed on strict bed rest but was allowed to do as he pleased, taking a few hours' rest each afternoon, but he did his own cooking, shopping, and drove his car about sixty miles through the heavy traffic of the City of Detroit every two weeks to visit the Koch Clinic. This was, indeed, hard manual labor for a man in this condition.

One should contrast this type of Treatment with the enforced absolute bed rest required of tuberculosis patients who though having much less infection and lung destruction must practice perfect immobilization and learn to relax their muscles and keep them inactive, and not even speak above a whisper. Thus the recovery was secured after the Koch Therapy, while following entirely different procedure. The fundamental principle of raising the natural oxidative resistance to infection in the body so high that even under the unfavorable circumstances recognized by regular methods, recovery becomes possible, which was the goal.

Dr. Koch's Court Testimony, together with descriptions of the X-ray films given by the radiologists of the Herman Kiefer Hospital are followed by the report of Dr. Hague.

DR. KOCH'S COURT TESTIMONY

"Mr. Mosevich came to me on October 20th, 1938, with a history of a father who died of intestinal obstruction. His previous illnesses were pneumonia in 1935, pleurisy before the pneumonia set in, and the pleurisy was in the left chest.

"In September, 1938, he began feeling badly; he began coughing and arising; had night sweats.

"He went to the Herman Kiefer Hospital for X-ray pictures and the diagnosis of tuberculosis was made (far advanced, permanently disabled)

"We took his sputum and sent it into the Michigan State Board of Health for a report, and we ran our own tests too, and the sputum showed tuberculosis. We received the report from the Board of Health that it was positive and we confirmed it.

"We also made an X-ray picture of the chest which showed a huge cavity in the left lung located at the root of the lung, that is, at the hilar region.

“The bottom of the cavity shows a horizontal line straight across, which is a fluid level showing that this cavity contained fluid. It belongs to the class of cavities called retention cavities and that fact gives it a very important significance.

“Retention cavity is one that leads into a bronchus that is closed or stenosed — closed down so tightly that the contents cannot escape — that is, escape completely. Of course, some debris remaining in that cavity, which is always being absorbed, gets out. But, there is a certain amount of infection and tissue and poisoning the individual, and which is the source for spread of the infection through the rest of the system.

“That shows that the cavity is not the type which collapses readily. In order to collapse naturally, the contents of the cavity must be eliminated, squeezed out, whether it is air or pus or whatever the material may be. And a retention cavity does not close; it remains open, because of tension, the pressure on the inside is greater than the outside. The procedure for handling such cavities is to remove the lung or to cut a hole through the lung, through the cavity wall, to secure drainage and to help collapse it. However, with a thick wall, collapse is not possible in this position.

“I made a diagnosis of far-advanced tuberculosis of the lungs.

“I gave him a Treatment of Glyoxylide on October 24th, 1938, at which time his weight was 153½ pounds, his normal weight being 182 pounds.

“The hospital record contains the following letters:

“Dear Doctor:

“With reference to the above, named, I wish to advise that our X-ray examination of 9-16-38 revealed as follows:

“Diaphragm: The costophrenic angle on the left is obliterated. The heart is normal. Right lung: There is a small amount of fibrosis visible in the infra-clavicular region. No other abnormality is found. Left lung: There is considerable mottling throughout the lower 2/3 of the lung with a large excavation near the root, measuring about 7 cm. in diameter and showing a definite fluid level. Sputum examinations have been reported as positive for tubercle bacilli.

“Hospitalization has been recommended. If this meets with your approval kindly let us hear from you in order that the necessary arrangements can be made.

“Yours very truly,
“A. P. Derby, M. D.
“Director, Out-Patient Dept.”

“March 10, 1939.
“Chrysler Industrial Association,
“7900 Jos. Campau Avenue,
“Detroit, Michigan.

"Dear Dr. Mosevich:

"In re: Stanley Mosevich

"Stanley Mosevich was examined here on July 19th and I have procured the films from Dr. West for comparison.

"This man has a far advanced pulmonary tuberculosis and while there has been some clinical improvement since last September, still there is evidence of quite extensive disease of both lungs and sputum, tests run last month in the laboratory here showed the sputum to be strongly positive for tubercle bacilli. With a disease of this extent existing for this length of time, it would be my opinion that this man is totally and permanently disabled because of pulmonary tuberculosis.

"Yours very truly,
"Bruce H. Douglas, M. D.
"Tuberculosis Controller."

"Film No. 2 was taken July 8th, 1939. That is less than a year after Film No. 1 was made.

"In Film No. 2 you do not see the cavity as such anymore. However, the tubercular scattering through the lung, which is observed in Film No. 1, is observed in these little speckles throughout the field, and also in the right lung, there is some indication of the spread of myriads of small lesions of tuberculosis.

"They are very definite in the left lung. In fact, below the large cavity, there is an accumulation of tubercles, forming an agglomerate an inch in diameter, which looks as though they might break down to form another cavity, if they had time to do so. However, in Film No. 2, which was taken almost, a year after Film No. 1, the large cavity does not show and there are favorable changes going on in these scattered lesions of tuberculosis.

"The changes indicate improvement. This type of change we observe in our films quite frequently, in that the lesions become vascularized, and they show these soft densities. Moreover, the agglomerate of small tubercles, that formed a fairly large mass below the cavity, has lost its individuality. It is being absorbed and is disappearing as seen in the third film.

"In Film No. 3, one can easily see that the lung is clear; there is no sign of a cavity left. This film is dated June 18th, 1940."

During this time, he was doing what is considered hard manual labor for a tuberculosis patient. He went to the Dodge Motor Plant to work in 1942 and Dr. Ford, the factory radiologist, made X-ray films during the health examination for admission. These showed complete recovery and his ability to do hard manual labor, not only at regular hours but overtime as well. The Government did not ask Dr. Ford to testify, but the films were admitted and showed Mosevich was cured. He worked as a metal polisher for several years, and then in a brewery a number of

years, where he carried heavy casks of beer**.** He remains in perfect health and was so reported on June 4, 1946Another thing that is important, under ordinary treatment this man would be kept absolutely bedfast: he would not be allowed to turn in bed, hardly. Under the Koch Treatment, he was not restricted except being told to use common sense and not let himself get tired. And it was not very long afterwards that he was moving around as he pleased and was working within a couple of years (1942).

A matter of interest can be found in two Photostats in the publisher's files. They show that the Department of Health sent this hopeless Mosevich case to Dr. Koch and immediately notified the Police Division, Major Roehi, about it. This was to watch the patient come to an early death, as such cases regularly do in their experience. As soon as Mosevich should pass on, we suspect Koch was to be arrested on some sort of frame-up. However, Mosevich got well rapidly and stayed well.

COURT TESTIMONY OF DR. OMER GRENVILLE HAGUE DESCRIBING THE X-RAY FILMS ON THE STANLEY MOSEVICH CASE

"The radiograph of September 16, 1938, is that of a male chest with the bony cage and ribs and collarbones and heart shadow in the middle and diaphragm down here. There are some infiltration shadows in the parenchyma, or the active tion of the lung in these areas, in the fourth, fifth, sixth, and seventh, inter spaces anteriorly and a large cavitation shadow in the mid-lung zone. I am measuring the left lung. That cavity measures 2½ inches by 31% inches, a little better than 31/4 inches. The outside measurement of the capsule of the cavity.

"By a little better than 3 1/4 inches I mean about 1/2 an inch more. The reason I am not saying that with certitude is that the upper border of that cavity is very, very thin and very, very faint, but we can see the line that it follows and I would say it would be 3 1/4 inches at least. That is being very conservative.

"There is a small fluid level at the bottom of that cavity. There are, also, some heavy hilar shadows, and some thickening of the peribronchial trunks; that is, the lymphatics that follow the bronchi and smaller bronchioles. Those shadows indicate repeated infections that have resulted in inflammation and the inflammation has gone on scarring.

"The film dated July 8th, 1939, appears to he a film of the same chest; the ribs strip with the previous film. The lung tissues on both sides show soft infiltrated shadows throughout the lower two-thirds of both lungs.

"There is an interlobar line, indicating a thickening of the pleura between the middle and lower lobes, on the right side. There is a shadow in this area. It is smaller than the cavity on the left side previously referred to. It is in the same inter-space level, so that I conclude it is related to the previous cavity. It measures 1½ inches by 1 inch. The wall of this cavity is less distinct. That is why it is a little harder to see. The shadows in the lung are of a soft consistency, which would suggest an activity of disease in the lung structure itself.

"In the film dated September 16th, 1938, the linear markings are fairly well fibrosed, hard. In the

film dated July 8th, 1939, we see them softened and in an active state of inflammatory change. In the film dated June 18th, 1940, this inflammatory reaction has disappeared and the outline of the cavity is very, very faint, practically disappeared. It would be about one inch by an inch and a quarter. The general appearance of this chest is much better than in the films taken September 16th, 1938, and July 8th, 1939.

“Cavities almost of any size are a poor prognosis type of tuberculosis cases. The tendency usually is that individuals who have cavitation develop more cavitations rather than less. Cavities usually tend to get larger and unless they are treated successfully by a pneumothorax, or some other compression therapy, and are held down for a long time, they usually get worse and the patient’s outlook is serious.

“The cavity in the film dated September 16th, 1938, I think is about as large a one as I have ever seen and I would say that that patient’s condition would not be a good risk at all.

“The two succeeding pictures dated July 8th, 1939, and July 18th, 1940, show that there has been an extensive constitutional change taking place; that is, the soft tissue of the lung has undergone a remarkable exudative change; that is, there is a softening of the structure all through and in an instance like this that patient would have more cough and more sputum and it might be in the healing phase following this type of a chest. For instance, the tubercle from this cavity may have been coughed up and spread out throughout the whole lung and that might be a cause for the infection from here to become broad spread in that chest almost like a tuberculous pneumonic condition and then in this view, Film No. 3, this pneumonic process has disappeared and the shadows in the lung are back to what you would expect of an individual of this age and following conditions of a tuberculous recovery.

“The prognosis on the first film, dated September 16th, 1938, would indicate a very serious situation.

“The prognosis on the third film dated June 18th, 1940, without knowing anything about the other two, would be very good.”

THE TESTIMONY OF STANLEY MOSEVICH

(Note: The following is paraphrased from the Court Testimony of Stanley Mosevich, pages, 7516-7538.)

“My name is Stanley Mosevich, and I live in Detroit, Michigan. I am employed as a metal finisher in the Fisher Body Plant. In 1938 I went to see Dr. Podezwa in Hamtramack, Michigan. He sent me to the Herman Kiefer Hospital where a: diagnosis of far-advanced tuberculosis was made. No treatment was given me there since they decided my case was too far-advanced to get well. I, therefore, chose to go to the Koch Clinic and the doctors at the hospital thought it was a good idea.

“My symptoms were that I was sweating at night very profusely and I was coughing up blood and pus. I had become quite weak from all this and there was some pain in the left side and in the

back between the shoulder blades. This started in July 1938 and was very annoying by September. The Board of Health and Herman Kiefer Hospital found my sputum to contain the tubercle germs.

"I took Dr. Koch's Treatment. After that I had some reactions, times during which I felt feverish and coughed more than usual, but after each reaction, I improved and finally the reactions were so light, they were scarcely noticeable. This was at about October 1939, and after that there were no more reactions to be noticed. I had gained weight, going up from 153 to 204 pounds by this time, which was just a year after I received Dr. Koch's Treatment.

"My strength improved in the same way, too. In fact, I did not let myself get too weak by lying in bed too much. I did as Dr. Koch directed me; that is, not to get too tired, but to be up and about some, taking rest when I felt I needed it. So I got up early in the morning, about seven o'clock and stayed up until afternoon when I took a few hours rest in bed.

"Then I got up for supper and went to bed at nine in the evening or later, I also went about and did the shopping and the cooking and I drove to Dr. Koch's office through all the Detroit traffic every week or two and back to the country, a total distance of about sixty miles or perhaps more. I stayed in the country about two years and then returned to Detroit where I finished my recovery.

"In 1942, I took a job at the Dodge Auto Factory and worked overtime as a metal polisher for a long time. This is heavy work. I thrived on it, too. Recently, I have been working at carrying and piling up kegs of beer and more recently I have been carrying large heavy pieces of plate glass.

"My health is perfect and has been since about two years after taking the Koch Treatment. If I ever get tuberculosis again, I want Dr. Koch's Treatment."

(Note: This latter Testimony was given in the 1946 Trial.)

AN ANALYSIS OF THE REBUTTAL OF THE STANLEY MOSEVICH CASE ATTEMPTED BY DR. BRUCE DOUGLAS

The rebuttal was offered by Dr. Douglas who stated on direct examination for the Government on page 7869 and 7877, "The improvement was entirely compatible with what might be the course of a case of tuberculosis of this extent under a moderate rest program, while not working." Contrast with this statement required by the Government, the statement made by Dr. Douglas when Mosevich was examined by him and only a health problem was at stake, thus from page 14 of the hospital record we read: "This man is totally and permanently disabled because of pulmonary tuberculosis." Also contrast with it the statement made by Dr. Douglas on cross-examination appearing on page 8006 and 8049, that "pneumothorax for two years at a minimum which would have to be continued more or less indefinitely would be required on the treatment of this patient."

Even in this statement the ultimate prognosis of fatality is suggested. It is evident that the Koch Treatment which Mosevich received proved far superior to the treatment just suggested and

rescued Mosevich from the condition described in the hospital record as hopeless and permanent.

The enforced bed rest which is always required of such patients involving complete relaxation of the muscles, restriction of breathing to the most shallow that can be sustained, the prohibition of talking above a whisper, bedpan service, etc., and if the patient is permitted to do light manual labor, it is merely the writing of a short letter, intermittent periods of reading, or cutting out pictures while the patient is lying flat in bed, or the exercise of being wheeled in the chair to the bathroom and back, or the eating of a meal while sitting up, must be compared with the work which Mosevich carried on from the start of his Treatment which involved doing the chores about the house, cooking, going shopping, and driving his car some 30 miles each way across dense traffic of Detroit every week or two as he testified, in comparison, these acts are heavy manual labor and are sufficient to tire many healthy people who do not have tuberculosis. So, Dr. Douglas' Direct Testimony in rebuttal does not apply in this case as the facts reveal, but he is forced to admit on cross examination as reluctantly as he could, the truth of what he stated in 1939 when he first examined the patient — "This man is totally and permanently disabled because of Pulmonary Tuberculosis."

Pulmonary Tuberculosis

THE CASE OF STANLEY SANCHEZ

Introductory Remarks

The case of Stanley Sanchez is one in which modern tuberculosis surgery went the limit without success. For five years, from June 1929, to March 1934, he was under the most expert care that modern institutions can offer and yet with all the sacrifice and suffering nothing was gained. He steadily became worse. Strict bed rest and collapse therapy, including many pneumothorax attempts and complete left side thoracoplasty (removal of his ribs) done in three stages, could not close the cavitation. The sputum was copious, positive to the tubercle bacillus and occasional serious hemorrhages took place, plus a good deal of streaking in between. Finally, after five years of this, it was decided by the staff of the municipal tuberculosis hospitals of Detroit in conference on his case that further surgery was required. (Plate 4)

All that could be left for surgery to attempt would be a revision operation or a pulmonectomy, the removal of the lung surgically and that could not be done because of the great number of adhesions that had formed between the lung and chest wall and because of the already bad position of the heart and mediastinal structures. These attempts would be grasping at straws, indeed.

In order to make plain the position of the patient at this time, it would be well to review the statements of authoritative writers on the subject. Thus, Julius L. Wilson, M.D. Ulin. No. Amer. 29: 445 (March) 1945, Selected Writings, Ochsner Clinic, New Orleans, June 30, 1945, Vol. IV, P. 43 and 44, states:

"Pulmonary Resection—The second method of treating the tension cavity resisting other forms of therapy is pulmonary resection. Since lobectomy or even pneumonectomy of a non-adherent

lung is a simpler operation than a two or three-stage thoracoplasty, there is a temptation to substitute one of these radical methods of resection for the other measures of collapse therapy. However, pulmonary tuberculosis in the stages severe enough to require major surgical procedures is seldom confined to one lobe or even to one lung and, of course, the lesion here is only a manifestation of a generalized disease."

Pinner, p. 467, states:

"After unsuccessful thoracoplasty, revision operations have been attempted but are very dangerous. Many of these patients run the entire gamut of all possible collapse measures, ending usually with an unsuccessful thoracoplasty. At this point, patient and physician face the various modifications of 'revision' operations, such as anterior costectomy and resection of the regenerated ribs. These operations, particularly the latter, are technically difficult and their danger is potentiated because they are performed on 'surgically exhausted patients.' The rate of success of revision operations is small in most published series and probably still smaller in unpublished work. The operative mortality is relatively high."

In the Sanchez Case, the infection had gone beyond the chest confines, moreover, as Wilson explained above, and in this case, it had produced a rectal fistula, a branching abscess caused by the tubercle bacillus, which emptied into the rectum. It was operated on, but not successfully, and he still carried this infection when he was taken to Dr. Koch for Treatment, as Dr. Koch's Testimony showed. Up to this time, the only activity he had was to be wheeled to the bathroom and back to bed. Otherwise, he was on strict bed rest.

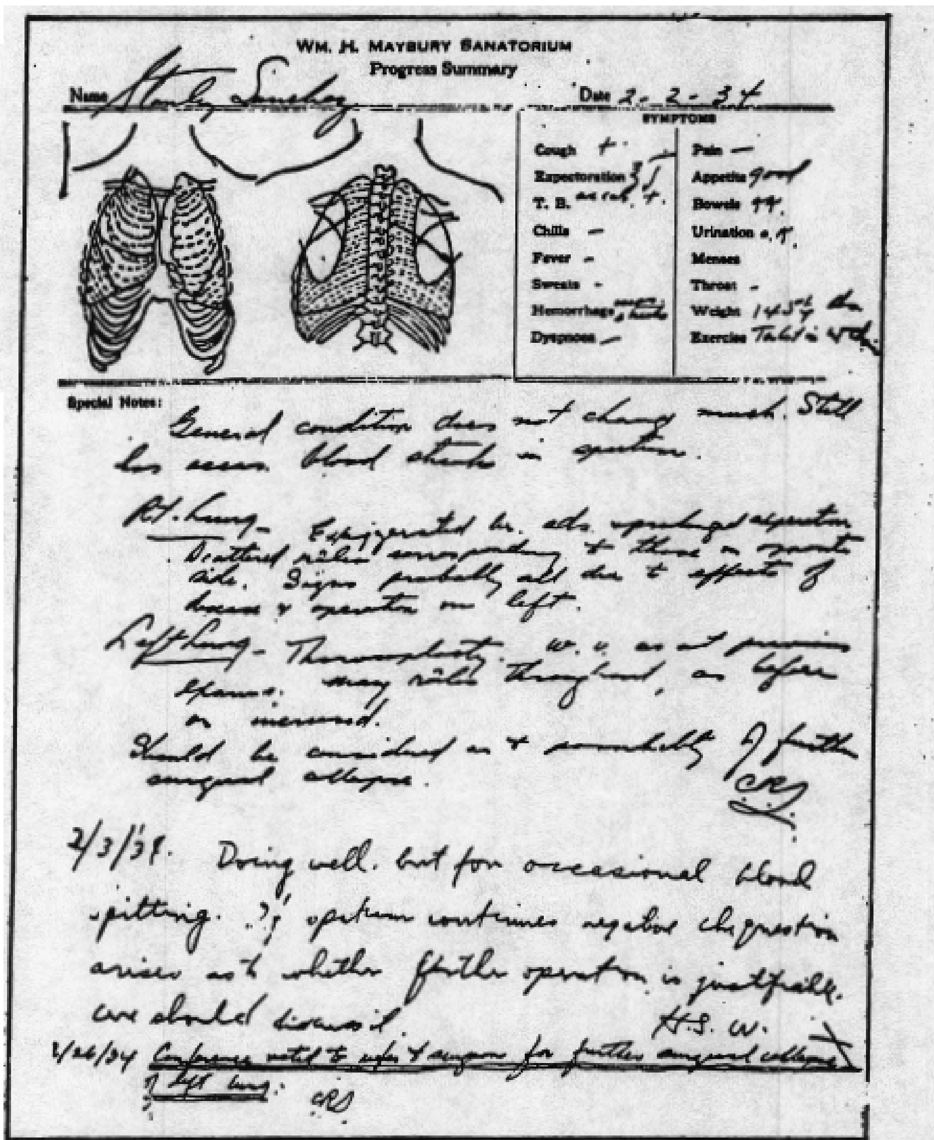
FROM DR. KOCH'S TESTIMONY WE TAKE THE FOLLOWING DATA

His color was sallow, very anemic, somewhat cyanosed and the heartbeat was very rapid and weak and the respirations were quick and labored. He was coughing a great deal and raising quantities of tubercle-laden sputum and appeared quite exhausted even in bed. He could not walk without help. On March 26th, 1934, his weight was 117 pounds, he claimed. His first injection of Glyoxylide was given on April 3rd. 1934. Other injections were made each year to insure the permanency of his recovery, whether needed or not.

The recovery was quite rapid in that the sputum became negative in about four months and except for the reaction periods there was very little or no sputum at all after that. At his fifteenth week reaction there was a copious hemorrhage. After that the recovery was more rapid. He was soon engaged in heavy manual labor at which he continues to date.

From the large hospital record a few pertinent statements are extracted and the final sheet is also reproduced where it states, "February 26th, 1934, — conference voted to refer to surgeon for further surgical collapse of left lung." This was just before he was taken to Dr. Koch and shows he was desperately in need of help. (Plate 4)

PLATE 4. This is one of the sanitarium records in the Case of Stanley Sanchez. Note particularly the last entry, "February 26, 1934, Conference voted to refer to surgeon for further surgical collapse of left lung."



WM. H. MAYBURY SANATORIUM
Progress Summary

Name [illegible] Date 2-2-34

SYMPTOMS

Cough	+	Pain	—
Expectoration	[illegible]	Appetite	good
T. B.	[illegible]	Bowels	[illegible]
Chills	—	Urination	[illegible]
Fever	—	Menses	
Sweats	—	Throat	—
Hemorrhage	[illegible]	Weight	[illegible]
Dyspnoea	—	Exercise	[illegible]

Special Notes: [illegible handwritten notes]

2/3/34. Doing well. but for occasional blood spitting. [illegible]

H.S.W.

2/26/34 [illegible]

From the hospital record of the Herman Kiefer Hospital, Tuberculosis Division, dated June 23rd, 1929, the following statements are taken.

The diagnosis: “Admission — pulmonary tuberculosis.”
Add the figures, “VII—B.”

Under date of November 4th, 1930, Case No. 8006, under the caption, “Interval History:” “Patient was transferred to Maybury on November 3rd, 1929. Artificial pneumothorax was instituted prior to his discharge from here. At Maybury, the patient had several small hemorrhages. Also developed effusion. Was transferred here for thoracoplasty.”

The operative procedure, August 29th, 1929: “One inch incision posterior border sternocleido; scalenus exposed by blunt dissection. Phrenic bound crossing the outer border of the scalenus. It

was injected, severed and 17 centimeters removed. Wound closed with two skin clips."

Second operation, November 7, 1930: Surgeon: D. O'Brien; Assistant: Dr. Brown; Assistant: Dr. Lullock; Surgical Nurse: Miss McCarty. Started the operation at 8:50 a. m.; finished it at 9:10 a.m. "Clinical diagnosis: Pulmonary tuberculosis. Left first lower stage thoracoplasty. "Operative Procedure: 10 inch incision paravertebral; thoracic cage exposed. Sections of the 8th, 9th, 10th, and 11th ribs removed subperiostally. About 10 centimeters of each removed. Posterior stumps removed with Sauerbruch. Wound closed without drainage. No complications.

This operation, November 28, 1930: Surgeon: O 'Brien; Assistant: Klein; Assistant: Lullock. Surgical Nurse: McCarty. The time of the operation, started at 9:00 a.m., finished, 9:21 a.m. "Clinical Diagnosis: Pulmonary tuberculosis. Left second stage thoracoplasty." "Operative Procedure: 10 inch incision paravertebral; thoracic cage exposed. It was necessary to make about 3 inch transverse incision at the middle of the wound. About 14 centimeters of the fourth, fifth, and sixth ribs, removed superiostally. Posterior stumps removed with Sauerbruch. Wound closed without drainage. No complications."

From the same hospital record: still another permission for operation, Estanislao Sanchez, third-stage thoracoplasty. And under date of December 19th, 1930, the same patient, Estanislao Sanchez, Case No. 8006, the same surgeon, O'Brien; Assistant, Brown; Assistant, Lullock; Surgical Nurse appears to be McCarty and Connor. Time that the operation started, 10:00 a.m., time finished 10:35 a.m. Clinical Diagnosis: Pulmonary Tuberculosis. Third upper stage thoracoplasty. "Operative Procedure: 12 inch incision paravertebral, thoracic cage exposed. 1.4 centimeters of the second and third ribs, and 8 centimeters of the first, removed superiostally. No complications. Wound closed without drainage."

From the same hospital record: still another permission for operation, signed by a member of the Sanchez family, the same Case No. 8006, under date of June 30th, 1931. This time the surgeon is Dr. Corbett. Assistant Doctor, Lullock. Clinical diagnosis is: Rectal fistula, probably tuberculous. Fistulectomy. "Operative Procedure: Two fistulous openings were found posterior and to the left of the external sphincter. These were found to communicate with a large undermined area external to the external sphincter. Fistulous tract was found to communicate with the rectum immediately about the internal sphincter. The entire fistulous tract was laid open and cauterized with the actual cautery. One iodoform was inserted." This shows that the disease had spread beyond the chest to other parts of the body, and was not under control.

THE TESTIMONY OF STANLEY SANCHEZ

"My name is Estanislao Sanchez. I am better known as Stanley. I live in Detroit, Michigan. I am a gasoline station attendant. I am a tune-up man. I overhaul generators, starters, distributors, anything about an automobile, such as brake checks, taking mufflers off and putting new ones on, greasing automobiles, selling gas, anything in the line of the automobile.

No internal stuff such as rings or valves; we do not do that as we do not have the time or space.

"I work under all kinds of conditions. We have no heating in this garage. It is damp and in the

wintertime it does get kind of chilly and in the summertime when we tune up an automobile, we use caseite, we make a lot of smoke and fumes and that is kind of bad.

“I was ill in 1928. I thought I had a severe cold. I had chills and a cough and I was feeling bad all around. I consulted medical advice and was examined and X-rayed and the doctor here said that I was sick, that I had a contagious disease or something; anyway, my dad, at the time took me down to Texas.

“Another doctor gave me some kind of shots to keep me going for a while. I was down in Texas several times on short visits. I was down there the first time about a month and then I was there about three different times. I cannot tell you exactly how long each time, but I was back in Detroit in June 1929.

“The state of my health then was bad. I was out playing baseball, and I had a bad hemorrhage from the lung. We called a doctor and I was told that I was supposed to go to Herman Kiefer Hospital.

“I went there and they started giving me some pneumothorax; they put a needle in between my ribs and pumped some gas, or something, into me to collapse the lung. I remained at Herman Kiefer Hospital at that time about three to four months.

“Just before I left Herman Kiefer they gave me a phrenectomy, an operation at the neck, and I do not know what they did; all I know is they were supposed to pull a nerve, or something, up to lift my lung up, and then they sent me to Northville, to the Maybury Sanitarium. That is about 30 miles from Detroit.

“I went directly there and my condition did not improve at Maybury Sanitarium. I went to the Maybury Sanitarium in October or November and stayed there just about a year.

“I received pneumothorax treatments there. My condition did not improve while I was there. I became weaker. I stayed at Maybury Sanitarium for about a year.

“They then sent me back to Herman Kiefer Hospital in Detroit. I received my first stage of thoracoplasty there, about a week or two after I had been back from Northville. This thoracoplasty was an operation on my back and naturally I cannot see on my back, but they operated on my back and they removed some ribs, so they said, anyway. When they finished with me, I was taped with adhesive tape underneath and then they had a binder over me. They kept me like that for several days and the worst part of it was about a week and it was rather a painful affair, as I believe anybody that has an operation where a bone is involved would testify. I was confined to my bed following that operation. I could not move around.

“They had me on the top of the side I was operated and I was supposed to lie on it with pillows under my back holding me without moving one way or the other.

“I did not have a chance to notice any result of that first thoracoplasty. Three weeks later they had me up again for another one. I had a second thoracoplasty just going right through the same

procedure as it did on the first one; everything went on the same; what I mean by that is, I was in bed, and I went through the same thing with my second as I did with my first.

“I did not notice any results from the second thoracoplasty. I was still in the same position when I got my third operation. I had a third thoracoplasty, the same thing as the other two.

“It was several months before they let me sit up in bed and I was rather thin, weak; did not gain much weight. I was still coughing, raising a very little. Right after the operation, I was not raising any blood. I started raising blood after a while. I would say after about three or four months I started streaking. When I was streaking, I would call that a little bit of blood on the sputum.

“I was in Herman Kiefer Hospital on that occasion, for the series of operations, for about eight months. I weighed about 117 pounds at that time.

“I was then sent back to Maybury Sanitarium at Northville. That would be in 1931. I was put in bed and kept right in bed until I left. I was still coughing. I certainly did hemorrhage. At that time I remained in Maybury Sanitarium about two years and seven months. Altogether, it was four years and nine months, during the stretch; Herman Kiefer, Northville, back and forth; but that last one was about two years and eight months, something like that at Maybury Sanitarium.

“At the end of that time at Maybury, I observed that I was getting nowhere. I was flat in bed. I was not gaining any weight; I was coughing, hemorrhaging. Every time I would raise sputum it would be clouded with blood. All in all, I was not getting any place. I was in bed, and I weighed 122 pounds.

“After I had been there for that time they were going to give me another operation under the apex or under the arm. I had already written a letter to Dr. Koch. I had heard about him, so I figured I would go home and take a chance with Dr. Koch’s Treatment rather than another operation.

“I went to see Dr. Koch and received a Treatment from him on April 2nd, 1934. I started feeling better. About five weeks after I received Dr. Koch’s Treatment, I was able to walk around a little, not too much, but I was able to walk around. I observed other results. On reaction weeks, I really felt bad. I had heard about reaction weeks. I did not experience it up to this, but I was feeling perfectly all right. In fact, I was feeling extra good. I started getting a headache and at the time I was home, so the next thing to do was to go back to bed because I had heard that it was supposed to be a reaction. Then I started getting a temperature. One minute I would feel hot and the next minute I would feel cold. I had about six blankets on me and a hot water bottle on my feet. This lasted for about two or three hours. One week it would affect me one way and the next it would be different. Sometimes it would affect me for two or three hours. I was weak and would have a temperature. It would go up to about 103 degrees and I would cough and raise a lot, but after the reaction, I would feel better than before I had gotten sick. During the reaction, there was evidence of blood in the raising of the phlegm or sputum.

“I would say I had my last hemorrhage after I had been with Dr. Koch for about a year, but I raised blood in the sputum for about a year and a half after I was with him.

“I had a second Koch Treatment during my fifteenth and sixteenth week. I could not tell you the exact date, but it was during the fifteenth and sixteenth week. I had a hemorrhage and the doctor thought it wise to administer another right there. That was administered at the nursing home.

“After this second Treatment, I felt much better. I was feeling better all the time, then I would get a setback. Now, by a “setback” I do not mean every three weeks, but our reaction week. It might have missed on the third and hit on the sixth; it might hit on the twelfth, or miss me on the fifteenth, or something like that, but during the reaction week, I would feel badly. In other words, I would not feel normal, like I did ordinarily, but after that reaction it seems to me that the severer the reaction was the better I felt afterwards and gradually my reactions disappeared and I felt better, more and more, oftener and oftener, and the first thing I knew I was feeling fine all the time.

“During this period my coughing decreased. My hemorrhaging stopped. I gained weight.

“I had a third Treatment about a year and a half later. I continued to improve.

“I do not recall exactly how many Koch Treatments I have had altogether, but I would say about eight or thereabouts. You see after my third Treatment I did not pay any attention whether I got one or not. I was feeling all right and if Dr. Koch gave me one, well, it was probably because it was his idea, not that I thought I needed it. These Treatments from Dr. Koch were given from about 1934 to March 1941 or 1942. I do not know exactly.

“After I left the Maybury Sanitarium and after I took the first Koch Treatment, I did not take any other treatments of any kind. I did not take any other therapy of any kind. Since the time of the first Koch Treatment, I have received no medical attention other than from Dr. Koch.

“I weigh 175 pounds now. I feel fine.

“My working hours vary. One day I work in the morning and the next day I work in the afternoon, but all in all I work about forty to forty-five hours a week.

“I do not cough now, I never raise blood. My appetite is fine. I do not tire easily. The general condition of my health is fine.”

Visitors to Stanley Sanchez’ gasoline station in 1950 report him still active and working hard every day.

ANALYSIS OF THE REBUTTAL OF THE STANLEY SANCHEZ CASE ATTEMPTED BY DR. BRUCE DOUGLAS

This case was classified by Dr. Douglas, on page 7959 on direct examination, as a far advanced case on admission in October 1930. On page 7491, he testified for the Government on direct examination that Mr. Sanchez had received his benefit from the treatment received in the five years under sanitarium care, plus the rest he received.

On cross-examination, however, he admitted that further treatment was necessary, removal of the lung or part of it or a revision operation of some kind. This was an admission that the patient was in most serious condition and that all of the previous sanitarium care including the thoracoplasty had failed to stop the progress of the disease and now the patient, in an exhausted condition, had to have an exceedingly dangerous operation as a last attempt to halt the infection.

The quotations from Wilson and Pinner given earlier show that little hope for benefit lay in that direction. He was surgically exhausted, the infection was not halted, mediastinal shift, and extensive adhesions made removal of the lung out of the question. The extensive fibrosis of the lung as revealed in the X-ray plate exhibits, removed any hope of collapsing such a lung so as to obliterate the cavities causing the hemorrhage and harboring the infection. But in addition, the infection had reached the intestine and progressed in spite of careful surgery. Surely this man needed something more than the attack against the injuries done by the disease. He needed his defense mechanism restored, and his chemistry repaired so he could no longer harbor disease-producing germs. Since recovery followed the Koch Treatment rapidly and steadily until good health was reestablished, we are forced to conclude that the Koch Treatment offers the correct method of attack, and should be made available to all sufferers from tuberculosis that desire it.

Pulmonary Tuberculosis

THE CASE OF MARIE BLANCHARD HALL

Introductory Remarks

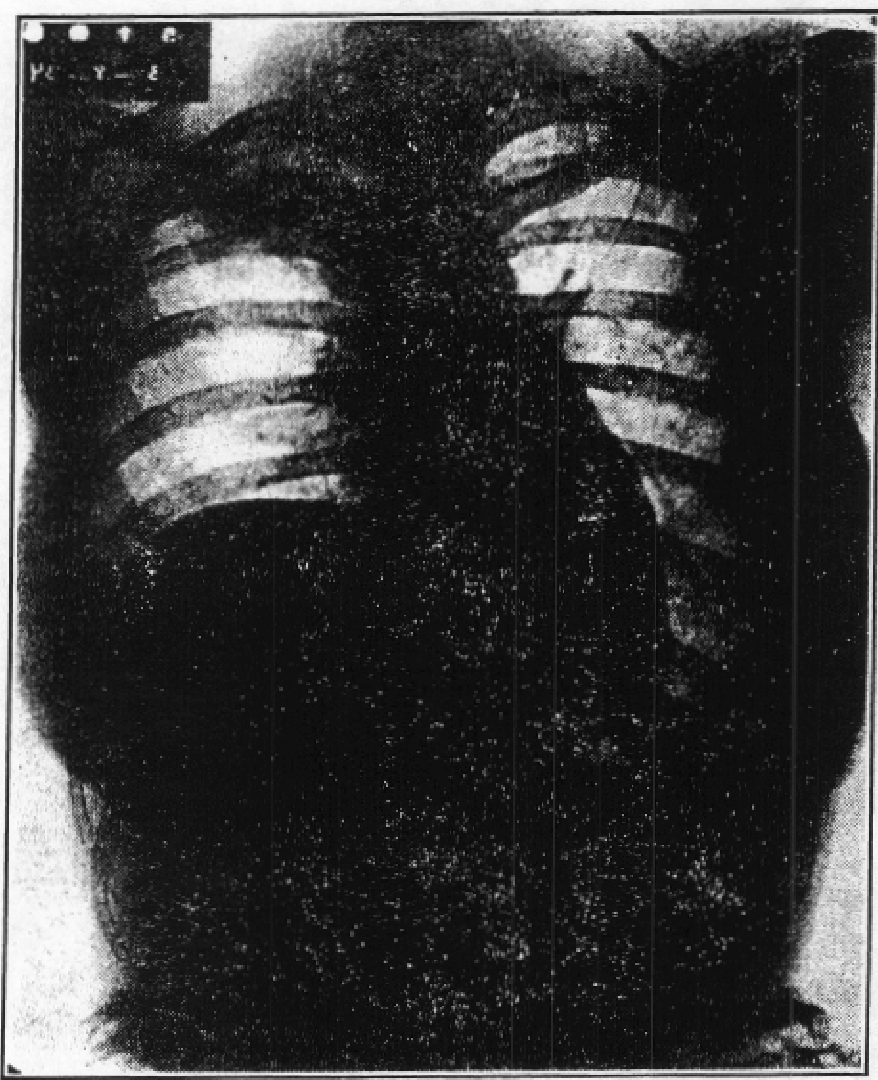
This is another case where cavity collapse was not accomplished during 3½ years of hospitalization. Phrenectomy was performed. That is, the phrenic nerve was partly removed to paralyze the diaphragm. This operation deprives the patient of the ability to cough out the germs and tissue debris that accumulate so rapidly in an advancing infection by the tubercle germ. The idea of the operation is to quiet the lung, but its value is now being doubted, and it is also recognized as harmful in many instances.

At the age of twenty-four, in August 1931, Mrs. Marie Blanchard Hall caught a severe "cold." Much coughing, fever, weakness, and raising of considerable sputum brought her to the Herman Kiefer Hospital (the City of Detroit Tuberculosis Hospital) where X-rays and sputum examination showed an advanced stage of tuberculosis. She entered this institution for their care and was also cared for at the Maybury Sanitarium, another municipal institution. The sputum stayed positive and the disease advanced.

To demonstrate the progress of the disease while at the Detroit tuberculosis hospitals, four X-ray films were presented. The first two showed the condition when she entered the Herman Kiefer Hospital in August 1931 and in April 1932. After resting there a while she was transferred to the Northville Tuberculosis Sanitarium, another municipal institution. These films show the major tubercular deposits in the apex of the right lung. The next Film, No. 3, showed the state of this deposit in January 1934. It is evident that a large cavity has formed at this place. The lung tissue rotted out, to speak plainly. The thick ring represents the wall of the cavity.

Film No, 4 (Plate 5) shows the condition of this same region on March 8th, 1934, just three weeks before she left the Maybury Municipal Tuberculosis Institution. It is evident from the changes in this film that the disease was advancing. Thus, the wall of the cavity has thickened and formed a nodular outgrowth that extended into the surrounding lung tissue. Moreover, the products of lung destruction have been piling up in the cavity leaving less emptiness. The films show these changes plainly. This nodular increase in the walls of a cavity is well recognized as a sign of uncontrolled progress of the disease. A smooth wall means, conversely, that the situation is improving.

PLATE 5. This X-ray was taken on March 8, 1934 in the Case of Marie Blanchard Hall, indicating that the tuberculosis was advancing**.**



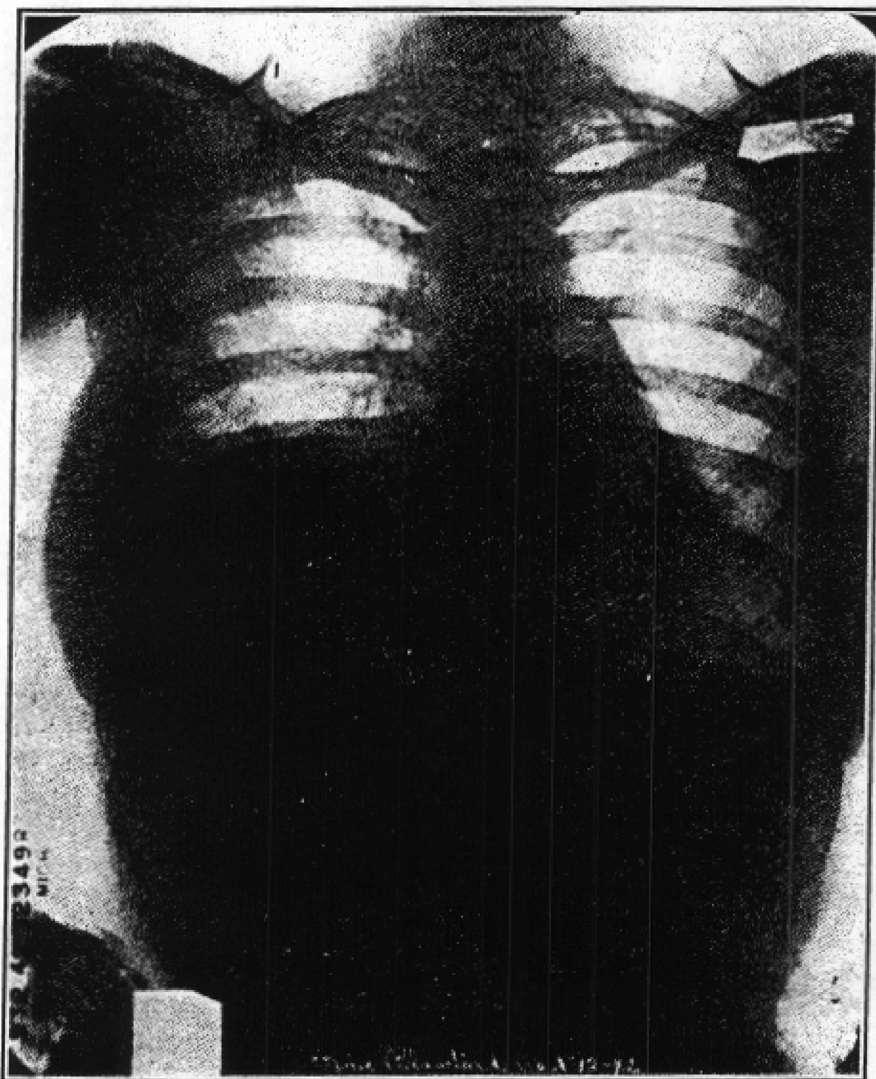
No film is accessible showing the condition when she left the institution, March 29th, 1934. For several weeks at this time the physicians there were trying to explain to her, as her Testimony shows, that she must have her ribs removed if she wanted to live; "thoracoplasty or death," she

reported to us, was their argument. She was running a fever that hovered about 104 degrees and "was a very sick girl" all this time, as she expressed it.

What the radiographs would have revealed at that time, had they been made, can only be conjectured from certain facts in addition to the condition revealed in Film No. 5 taken September 24th, 1934, six months after she left the institution and six months after she received her dose of Koch's Glyoxylide, April 2nd, 1934. This film must be interpreted in the light of the important fact that she was in good health, physically strong, in good nutrition, no cough, negative sputum, strong, steady pulse, easy breathing, and normally not fatigable. The cavity is clean with smooth walls and surrounded by healthy lung tissue. It, therefore, is healing and though not yet replaced by normal lung tissue and healthy fibrosis, it is on the way with a good start. The cause is removed and not further injuring her. Thus healing can progress. That this did progress to completion is demonstrated in Film No. 6 taken a few years later and showing that the recovery is permanent. (Plate 6)

We must conclude that though the cavity is larger in Film No. 5 than in Film No. 4, it represents a stage of transition from a worse condition at the time she left the sanitarium and when thoracoplasty was considered urgent, and she was carrying a fever of 104 degrees, with rapid thready pulse, rapid labored breathing, yet cyanotic though flushed from fever, and presenting the picture of an acute tubercular pneumonia of a rapidly fatal military tuberculosis (galloping consumption). This cavity in Film No. 5 may reasonably be considered to represent an area of marked lung destruction that had not healed as yet, but was already free of infectious activity.

PLATE 6. This X-ray was taken on September 12, 1942, in the Case of Marie Blanchard Hall, eight years after taking the Koch Treatment. It indicates that complete recovery from tuberculosis is still maintained.



These characteristics, demonstrated in the several films, show that the cure of tuberculosis following Glyoxylide takes place before the cavity has healed. The disease cause is disposed of first and the cavitary defects are cleaned out and healed afterward, not by collapse, but by replacement with normal tissues. This is the ideal mechanism and the natural way that recovery can take place after the germs causing the disease are killed. Tests showed that long before Film No. 5 was taken the sputum was free of tubercle bacilli.

After the germs are destroyed, the fibrotic cavity wall can be absorbed for, since it is produced to imprison the germs and limit their activity, it is no longer needed. It can, therefore, be absorbed and replaced by lung tissue as is seen in Film No. 6.

The details of this case are presented in the patient's own Testimony and extracts from the hospital records.

TESTIMONY OF MARIE BLANCHARD HALL DIRECT EXAMINATION

(Note: The following is paraphrased from the Testimony given by Mrs. Marie Blanchard Hall at the Koch Trial and which may be found on pages 6000-6010 of the Official Court Record. The words below are those of Mrs. Hall.)

"I was ill in August, 1931. I had a severe cold which I thought was a cold, and it was tuberculosis.

"I was sent by my doctor to have an X-ray taken and the report came that I had several spots on my lungs. After they took the X-ray, I entered Herman Kiefer Hospital. The doctor who sent me there was the one who took the X-ray. (Plate 7)

PLATE 7. This is a hospital record indicating the "far advanced" tuberculosis when Marie Blanchard Hall first entered Herman Kiefer Hospital in Detroit.

HERMAN KIEFER HOSPITAL

X-RAY REPORT

NAME Blanchard, Mary CASE NO. 11049

DATE Aug. 31, 1931 PAVILION 2 - A BOX NO

PART X-RAYED Chest - Single film

REPORT OF X-RAY

Thorax, diaphragm and heart reveal no pathology.

Right lung: There are scattered infiltrations of the mixed type, throughout the upper third of the lung. There are areas of rarefaction near the clavicle, the largest measures about 3 cm. in diameter and shows a small fluid level. The remainder of the lung is clear.

Left lung: There are exudative infiltrations visible at the 1st interspace. We see no cavities. There are less dense infiltrations in the apical region and at the 2nd interspace.

Conclusion: Far advanced tuberculous process of the mixed type, involving the upper third of both lungs. There is a large cavity on the right as described.

Dr. Birkelo - T

"I had bed rest after I entered there for about a month and a half and they suggested a phrenectomy, which I had. The phrenectomy was a pulling of the nerve and they cut it so as to make it permanent. They did not give me an anesthetic. They do not with the phrenectomy. It hurt very much. I will never forget. To my knowledge, I did not observe results from that operation.

"I remained at Herman Kiefer until May 12th, 1932. I did not feel any better after I left there than when I went in. I was coughing, and raising sputum. I was very weak. I went to Maybury Sanitarium at Northville, Michigan. I did not receive treatment there. I only had bed rest. My condition did not improve very much with bed rest.

“I remained at Maybury Sanitarium from May 12th, 1932 to March 31st, 1934. During this time I had nothing but bed rest as treatment. There was no change in my condition. I was still coughing and raising sputum. I had high temperatures off and on. I felt very weak.

“When I left in March of 1934, I asked Dr. Willis for permission to go home, which he did not want me to do. At that time I was raising a temperature up to 104 degrees. He refused but I said I could sign my release if I want to and he said, ‘all right, you are taking chances.’

“I did sign my release. I left right there. I came home and went to see Dr. Koch. That was March 31st, 1934. I received the Treatment on April 2nd.

“I noticed results from that Treatment after twenty-four hours. I woke up during the night with a sore chest and found it hard to breathe and almost thought I was dying. It was only a reaction, which I did not expect that was taking place and it lasted about one day, but I was very sick. I was not able to get out of bed, but after it lasted twenty-four hours, I was all right and I never had any severe reaction after that. I stayed at the nursing home six weeks after that first Treatment.

“I do not recall how long it was before I had a second reaction because it was so slight that I would not remember. It is twelve years ago, so I would not remember very much about it. I do remember the first one because it was so severe.

“After the reaction had passed I felt grand. I felt like I could live again.

“After I left the nursing home I went to live with friends in Berkley, Michigan, to get fresh air and rest, but I waited on myself and did all my work. I remained at Berkley from June to October, the same year, and after that I left there and came to live with my sister from October until the next May, which was 1935 and in May I went to work and I have been working ever since. I worked in a factory all the time and before I was married, I did housework. I worked during this last war; did war work and bench work and different jobs on the bench. That was right in the factory. The conditions in the factory were not so healthy. It was dusty because we were piling steel tubing.

“I had about three of Dr. Koch’s Treatments. I have not had any other treatments medically since I first took Dr. Koch’s Treatment.

“I do not have any cough at all and I do not raise sputum. I feel fine. I have felt well for twelve years. My appetite is very good. I weigh 134.”

(Note: Mrs. Hall has been observed in good health as late as June 1950. She is working daily and also maintains her home.)

AN ANALYSIS OF THE REBUTTAL OF THE MARIE BLANCHARD HALL CASE ATTEMPTED BY DR. BRUCE DOUGLAS

On Direct Examination, page 7469, Dr. Douglas testified for the Government that when this

patient left the Maybury Sanitarium in 1934, the chances of recovery were favorable and on page 7873 he testified that the Koch Treatment had no effect because the recovery, which took place in that case is that which would be fully expected from a case that had this rest in addition to the sanitarium period.

You will observe in the case history that this patient, both according to her own Testimony and that of Dr. Koch, was in a condition which is found after a serious breakdown and the disease is on the gallop, such as in a widespread tubercular pneumonia or acute military tuberculosis. She could not even be moved safely for X-ray examinations. Patients in this condition are dying from tuberculosis.

On page 8058 and 8066 Dr. Douglas testified the patient needed further treatment and thoracoplasty would be necessary. In other words, the favorable prognosis given on direct examination is reversed on cross-examination when the full situation was brought to Dr. Douglas' attention. The Testimony shows then that Marie Hall was drastically in need of help when she was given the Koch Treatment. Her recovery shows the help was real and efficient.

Acute Military Tuberculosis

WITH TUBERCULAR MENINGITIS AND SPONTANEOUS RUPTURE OF LUNG

Introductory Remarks

Another form of tuberculosis, the most rapidly fatal type, may develop on an infection previously established where the resistance is not good and a further breakdown permits widespread infection to develop through the blood stream; so that millions of new foci are set up all over the body, including the lung structure generally, the brain, bones, the spleen and kidneys. This event is made possible by the rupture of a tubercle into a blood vessel so that the infected caseous contents, with its billions of germs, are distributed to all the rest of the body.

THE CASE OF NORA ALDRICH RINEHART

A case of this type is reported here. She was a girl of 14 years when treated back in July 1922. She had been in the Detroit Tuberculosis Sanitarium about six months previously. (Plate 8) She tended to run high temperatures from 102 degrees to 104 degrees from the entrance into the hospital up to the time she left and thereafter. The radiographic findings at the time of entrance into the hospital on January 30, 1922, are available for study. They show the lesions to be of the rapidly disseminating type.

PLATE 8. This document indicates the official sanitarium diagnosis of "advanced parenchymal tuberculosis" in the Nora Aldrich Rinehart Case, six months before taking the Koch Treatment.

The Detroit Tuberculosis Sanatorium

X-RAY EXAMINATION

NAME Aldrich, Nora CASE NO. 3711

DATE January 30, 1922 X-RAY NO. 2004

Both diaphragm leaves are clear. The trachea shows no compression or deviation. The heart shadow is normally placed. Increased deposit at the hilum on both sides. Some accentuation of the linear markings throughout the right lung field. No definite evidence of a parenchymal lesion in the right lung field. There is extensive parenchymal infiltration throughout the left lung field, with the greatest changes in the upper half. Several small annular shadows at the apex and at the level of the first and second ribs anteriorly. We believe these represent small cavity formations.

DIAGNOSIS: Advanced parenchymal tuberculosis confined to the left lung field.

At the time of Dr. Koch’s first visit, she was emaciated, bedfast, in a stupor, comatose, had been vomiting projectively for three weeks, was cyanotic, with rapid weak respirations, very rapid, thready practically uncountable pulse, and with head drawn back stiffly, in a continuous spasm. The physical examination showed the heart to be drawn over into the right side of the chest; the left chest was empty so far as recognizable lung tissue was concerned. It contained fluid that could be heard to splash when her body was shaken. No breath sounds or signs of a lung could be found in the left chest. The lung had spontaneously ruptured. The right lung showed consolidations and cavities, an especially large one near the right axilla. The abdomen revealed a large tumor in the region of the spleen and left kidney. Whether it was a large tubercular spleen or large tubercular kidney could not be differentiated at that time. It could have been either or even both. At any rate she was dying. To better understand the seriousness of this condition a few authoritative statements are given, for comparison with the facts in this case.

(a) She was a young girl at the age when the disease develops most rapidly.
“The mortality rate is generally low between the ages of five and adolescence when there is an abrupt rise, reaching its peak in females in the early twenties and somewhat later in the males.” Cecil, “Textbook on Medicine,” page 315.

(b) She reacted with prolonged fever. All the time she was in and out of the hospital and when she was seen by Dr. Koch the fever was 105 degrees.

“Clinical symptoms measure in an approximate degree the patient’s reaction to the infection. Thus, a young girl who reacts with prolonged fever usually ‘does badly.’

“Young tuberculosis girls have notoriously unstable lesions and the mortality is relatively high; there is a similar trend, somewhat less striking, among young boys.” Cecil, page 341.

(c) She had a spontaneous rupture of the lung, which is so quickly fatal.
“Most of these patients die soon after accident (perforation). Of Sauerbruch’s, fifty-seven cases,

forty-three died within a week. In our series of twenty-one patients with permanent perforation, only two with open drainage are living, one and four years after the accident, and in each the fistula is still open." Packard, Hayes, Blanchet, "Pneumothorax," page 155.

(d) She had the generalized military form with the fatal meningitis.
"In the acute generalized military form, the lungs are quickly and uniformly seeded with small tubercles, which as a rule do not ulcerate because death intervenes." Cecil, page 324.

"Death occurs usually within six to eight weeks, occasionally with meningial involvement." Cecil, page 355.

The Glyoxylide Treatment was given in July 1922. The recovery was rather rapid. The vomiting ceased, the spasticity of the neck and opisthognathous disappeared. She was able to take nutrition again and she gradually recovered. The heart stayed on the right side for over a year longer, and the pulse was very rapid for about two years. But gradually the heart began to come back during the second and third years after Treatment and the pulse slowed down. This slow return of the heart to the left side shows that much more repair had to take place than the difficult job of healing a ruptured lung. The elasticity of the lung was greatly reduced by generalized tubercular invasion and fibrosis, and by the vascularization that temporarily replaces the lesions preceding the formation of functioning lung tissue. This necessary process kept the lung solid for a while and together with fluid kept the heart from going back in place. Steadily, however, she normalized and some years later, was married. She has two healthy twin children who are exceedingly resistant to infections and especially to the epidemic infections that affect the other school children. Thus, a hereditary resistance has been handed down. She has remained a picture of health all these years, very active and well. The radiographs show her lungs to be normal and also show signs of the extensive healing that was required to overcome the terrible destruction that once laid them waste. The large tubercular kidney (or spleen) absorbed completely and physical examination reveals no trace whatever.

AN ANALYSIS OF THE REBUTTAL OF THE NORA ALDRICH RINEHART CASE ATTEMPTED BY DR. BRUCE DOUGLAS

Dr. Douglas gave the "opinion" that this case did not present a true tubercular meningitis but rather an irritation of the meninges by the poisons present, a condition which he called meningismus. He also gave the "opinion" that the large mass described by Dr. Koch as possible tuberculosis of the kidney was rather an accumulation of pus in that region.

Regardless of these interpretations, the fatal state of the girl, presenting enormous lung destruction, spontaneous rupture, extreme toxicity, could not be denied and her recovery was equally phenomenal.

However, an advanced case of tuberculosis of this type presents an overwhelming infection by the tubercular bacillus, and any injury to different organs could not escape influence by this germ. Moreover, the most likely hard, irregular enlargement occurring in the region of the left kidney, in such a case, is either tuberculosis of the kidney or tuberculosis of the spleen. This, Dr. Douglas carefully avoided mentioning. This large tumor could have been tuberculosis of the

spleen and no alternative diagnosis given by an expert could properly escape mentioning this fact. To rule out ordinary pus infection, one must recall that such infections are not only highly fatal when so extensive, but they cause severe pain requiring large doses of opiates. An examination of the infected area by palpitation must cause excruciating pain. These were not present in this case, so Dr. Douglas' "opinion" was not in accord with the facts with which he was acquainted. Whether or not meningismus or meningitis was present, Douglas had no way of determining except that meningismus does not cause the projective vomiting, which was present in this case. So, it would have been more proper, in view of the facts, to leave the designation as tubercular meningitis, which is so often a complication of a terminal case such as this.

This was the most serious case of tuberculosis ever described that recovered, as far as we can determine. This recovery followed one administration of the Koch Treatment.

Tuberculosis of the Spine

Introductory Statement

Tuberculosis of the spine is one of the most hopeless and pitiful forms of the infection. Occurring in children so often, the little things start out on life with intense suffering and privation. Nothing is so pleasing to a human heart as to see a cure of this terrible disease by a truly scientific approach, so that the orthodox course of treatment, which is usually unsuccessful and very miserable, can be avoided.

The usual treatment depends upon absolute rest and immobilization of the affected bones. To secure this, the patient must always be lying down on his face or flat on his back. He is strapped in a shell or other contraption that fixes the spine absolutely and removes the weight and pressure from above the lesion. If he is to be turned, he is turned carefully in one piece, as it were, so that no motion will develop between the bones about the lesion. Otherwise, he is not allowed to turn or move from his position. He is so held two or three years as a rule.

Surgery may be performed, either the Albee splint operation or some other, the object of which is to transplant bone into spinous processes to fix the bones immovably. Even though this is performed, an additional year or more in bed is required with the patient flat on his back. The correction of the hump or deformity is not expected and does not take place either, except perhaps to a minor degree. Healing of the lesion with immobilization of the affected parts is all that is expected, but it only too often does not occur and the patient goes on through his torture to a miserable death. There is no satisfactory ambulatory method of treating tuberculosis of the spine known up to this demonstration of the value of the Koch Therapy.

It might be enlightening to quote some of the leading American authorities.

"Immobilization of the spine accomplished by the rest in bed, support on a firm frame, plaster shell, or brace until healing by bony consolidation of the diseased area is complete. Prolonged recumbency is necessary." Christopher, page 437-8, Saunders & Company, 1945.

The angulation, hump, or kyphosis deformity are not corrected by the orthodox method but are

encouraged to persist to keep the remaining parts of the crumpled bones together, so as to favor union.

Philip Lewin, Prof. of Bone and Joint Surgery, Northwestern University, Chicago, in his textbook, "Backache and Sciatic Neuritis," Lea Febiger and Company, 1934, 1944. Page 288-289, states:

"If a khyphos (hump) has developed, due to the collapse of vertebral bodies, it is not wise to try to correct the deformity by quickly forcing the collapsed vertebral apart. Prevention of the collapse is warranted and should be attempted but an empty space should not be produced 'in the anterior column healing by solid bony fusion in the diseased area requires a long period.'

"In children with tuberculosis of the lumbar spine, when the process apparently has started in the disc and has invaded contiguous areas of the vertebrae, solid bony fusion will often result in two or three years, without operative influence.

"Spontaneous fusion requires, on average, over six years. "Patients who have definite evidence of metastatic involvement have a mortality of almost 70% and no surgical treatment other than emergency measures to relieve pain or abscess should be attempted."

(The next case, the Aldrich boy, was a metastatic case as the evidence shows.)

"The best results are obtained when patients are carefully selected for operation, when spine fusion is employed during the period of healing of the disease and when such treatment is supplemented by conservative treatment for a prolonged period.

"No surgical treatment can be considered a substitute for conservative treatment."

Swett, Bennett, and Street, "Bone and Joint Surgery," Vol. 22, page 678, 9940, conclude:
"After an indefinite length of time the lesion may heal, but in a large number of cases healing fails to occur." "Even when healing does occur the time during which the process often remains unhealed is long. About one-third of the patients die within a few years. There is no advantage in the operative treatment over the non-operative."

THE FOLLOWING DATA IS PARAPHRASED FROM DR. KOCH'S TESTIMONY GIVEN ON THE JAMES ALDRICH CASE

The present patient was a child of three, when he was seen by Dr. Koch in August 1925. He had a definite hump in the lumbar spine. He wore a tight brace that made it possible to walk. He had been to the leading orthopedist, Dr. Laferte, Sr., before being brought in. This specialist fitted his brace and advised placing him on a frame for at least a year and possibly an Albee splint operation to immobilize the vertebrae that were attacked. There was much muscle spasticity about the diseased area. No radiographs were made at the time, since those taken by the orthopedist were available, however, these are not available now twenty-one years afterward and one must rely on what the healed spine shows to demonstrate the pathology that existed formerly.

"This radiograph taken for the Federal Trade Commission Hearings, absorbed in part and fused together to make the spine one vertebrae too short, however, there is no hump and the bodies of the vertebrae are in perfect alignment in all directions. Hence, there is no distortion, in one of the upper thoracic vertebral bodies an area of density exists the size of a large pen showing where another lesion had started and was healed before it could do injury. The very dense bone making up this repaired area shows the nature of the process of healing. (It also shows this to be a metastatic case, the type with 70% mortality rate according to Dr. Phillip Lewin.)

"The history of the case is that of pain starting at night when he relaxes in his sleep. Later he could not move without pain and if he fell down he could not get up. The condition was quite advanced when he was brought in and a different brace was fitted, which was worn for about six months. It was rather loose, but kept him from making gross changes in posture when sleeping. It did not relieve the diseased area of the weight of the body nor did it keep the diseased bones from moving, as is required by all accepted rules for care of these patients. It did not relieve the pain entirely either. Thus the brace, which was worn only six months, protected him while at play from serious fracture, and also limited his movements at night during sleep, and reduced the muscle spasm about the lesion.

"The Glyoxylide was injected immediately. This was done in August 1925. Recovery was quite rapid. In six months, he refused to wear the brace and could walk and play without it. The hump had disappeared and so had the spasm of the muscles of the region. The spine appeared definitely shorter, however, he grew up like other children, played their games, and has maintained good health ever since."

TESTIMONY OF JAMES ALDRICH BEFORE FEDERAL TRADE COMMISSION HEARING

"The first thing I remember in my life is when I was three years old. I went to my uncle's cottage that summer. It was shortly after that time I started having pains in my back. I remember my father taking me to the chiropractor and I remember my father said I had a dislocated spine. I was taken to several other doctors. I remember X-rays being taken. I remember Dr. Koch giving me a shot. I remember wearing a brace. It inhibited me, when I fell down I could not get up. I wore it all day for four or five months, then my mother finally consented to taking it off at night and not long after that I stopped wearing it altogether." (Tells incident of getting up and walking without the brace. About a week after that, he wore it no longer. No trouble with back after that.)

"I believe I was still wearing the brace when I started in Kindergarten. I was wearing it when Kindergarten opened and perhaps in September or October. I do not think any longer than that. As nearly as I can recall, I discarded it finally about the first part of November 1925. I think when I started to Kindergarten was when I was just wearing it days. My mother had taken it off that summer. I was particularly uncomfortable in hot weather and it was that summer she started removing it at night."

Here again is a demonstration that recovery is secured by getting rid of the cause of the disease, not by killing germs by a powerful germicide, but by a harmless process of restoration of the

natural immunity of the body. Thus, recovery took place and the dead bone debris was cleaned out as the result of getting rid of the infection. This gave Nature a chance to repair the damage in a masterly way. She absorbed whatever bone interfered with proper alignment so that no hump remained and the whole spine carried the body weight perpendicularly. This is an entirely different result than occurs after orthodox methods, or spontaneously so to speak, which leave the deformity, or even accentuate it. Even at that the patient is lucky to get out of the trouble in this deformed condition.

Since the X-rays in the hands of the Federal Trade Commission are not available to us at this time, we have others that are not so well made, and are not large enough to show the metastatic lesion in the thoracic vertebra, which is shown in the Federal Trade Commission films. Yet they show the bone absorption, the evening off, and the perfect union, where the lesion formerly was. They also show that the hump is no longer present. An incident occurred in giving the Testimony in this case; Dr. Koch did not have the history of this case with him, since this was taken about twenty years previously, and was misplaced. He therefore had to give the history from memory, and misstated the year in which Jimmy was treated as being in 1923, instead of 1925. Dr. Koch on returning home from Washington where the Testimony was given, found evidence that he made this error and asked the privilege of correcting it. However, the Federal Trade Commission attorney refused with the words, *"Not in your life will you correct it, except over my dead body."* Of course, the matter was too trivial for such an event, yet it shows how a truth-finding commission, as the Federal Trade Commission is supposed to be, hates the truth when certain interests are not favored by truth. It might be added that the Sur-rebuttal requested by Dr. Koch, to show up the errors and falsehoods of the Government's rebuttal, "opinion" expert witness, was denied him by the presiding judge. In matters of soapboxes and neckties, such refusal to get the truth, the whole truth, and nothing but the truth would not be so serious, but in matters of health, suffering, and life and death, a very serious situation exists. Here, the whole truth is important regardless of the consequences.

AUTHOR'S ANSWER TO THE REBUTTAL OF THE JIMMY ALDRICH CASE ATTEMPTED BY DR. BRUCE DOUGLAS

The Rebuttal in this case was that the brace, which Dr. Koch employed for a few months, actually brought about the recovery. It must be recalled that this brace was loose, that it did not keep the weight of the body off of the diseased bone and it did not prevent motion at that area. Please refer to the quotations from the authorities a few pages back. It is emphasized there that absolute immobility must be maintained, that if the patient is to be turned over it must be done as one piece and that the shell or cast which holds him absolutely rigid is made for that purpose. Then, it requires years of such immobilization to secure an occasional fixation of the parts, with the kyphosis (hunchback) deformity still present, or even emphasized.

Contrast with this the rapid healing while the child was running around and the absence of a kyphosis deformity; the spine actually straightened out with recovery. Thus, the recovery under the Koch Treatment was different in every respect from the best results obtained by immobilization.

Dr. Douglas' Rebuttal, therefore, does not conform with the facts nor with authoritative opinion.