A Lifetime of Learning

I believe the College must do something more. First, I would humbly suggest that we join with sister colleges, such as the American College of Surgeons, in encouraging all medical schools to establish and maintain divisions of continuing education in the hope that each will have a broad concept of medical education as exemplified by the selection of its progeny whether in high school or in college, insisting upon a workable knowledge in the humanities, an adequate training for the M.D. degree and then will continue this student's training throughout his lifetime by bringing him back to the medical school at intervals for continuing training. The medical schools' responsibility for the individual will end only with senescence or death of its student. The challenge to the medical school is great. However, the dividends will be high. You may ask, why bother with lifetime continuing education? The first answer is one of compulsion, since if medicine, through the failure of its physicians, does not bring to people that which society demands, then the control of medical education will pass from the physician and the medical school into the hands of the bureaucrats and politicians. On the other hand, since physicians are dedicated to prevent disease, to cure when possible and to care for those who are ill, we would do less than meet our highest objective if we fail in any measure in a lifelong continuing medical education for all of the components of our medical society.


Myocardial Rupture

The total analysis of 204 cases of myocardial rupture which occurred in the Los Angeles County Hospital was reported. Myocardial rupture rarely occurs under the age of 50 years. Although the incidence of myocardial infarction invariably is reported to be higher among men than women, our material indicates that cardiac rupture is somewhat more likely to develop in women (110 women [53.9 percent], 94 men [46.1 percent]). Myocardial rupture is relatively rare in Negro patients.

In our material, reasonably good correlation was obtained between electrocardiographic indication of acute myocardial infarction and necropsy incidence of myocardial necrosis. As was anticipated, myocardial rupture occurred at or immediately adjacent to the site of necrosis. Ordinarily, myocardial ruptures occur in the left ventricle. In our series, the most frequent site of rupture was in the anterior wall, especially at the junction of the anterior wall and the septum.

Average survival time for 21 patients admitted to the hospital within six hours of the clinical onset of myocardial infarction was nine days, whereas average survival time for 21 patients hospitalized seven hours or longer after the myocardial infarction was only 2.6 days. The longer survival time for patients hospitalized within the first six hours may be due to greater restriction of their activity in the immediate postinfarction period. Death usually is immediate in ventricular rupture, whereas in the interventricular septal rupture, most of the patients survive a few days.

In the final eight years and three months of our survey, the incidence of rupture following myocardial infarction has undergone a sharp decrease at the Los Angeles County Hospital. This decrease is presumably due to better management of the acute episode of myocardial infarction and more particularly to the use of vasopressor drugs and anticoagulants. Anticoagulants did not increase the incidence of the rupture, but cardiac tamponade is relatively frequent in patients with myocardial rupture maintained on anticoagulants. The physician must be alert for signs of tamponade (i.e., pulsating neck veins, increase in cardiac dullness) because tamponade can be managed surgically. Except for the reduced incidence of myocardial rupture in the period of survey, the findings are in agreement with earlier reports from the same hospital.