Medical Service In Combat

45th Evacuation Hospital

D + 10 to V-E Da

Medical Service In Combat

"Ready with Aid"

45th Evacuation Hospital

D + 10 to V-E Day

Edited and Published by

Irving Glucoft
and
Eric Fleischmann

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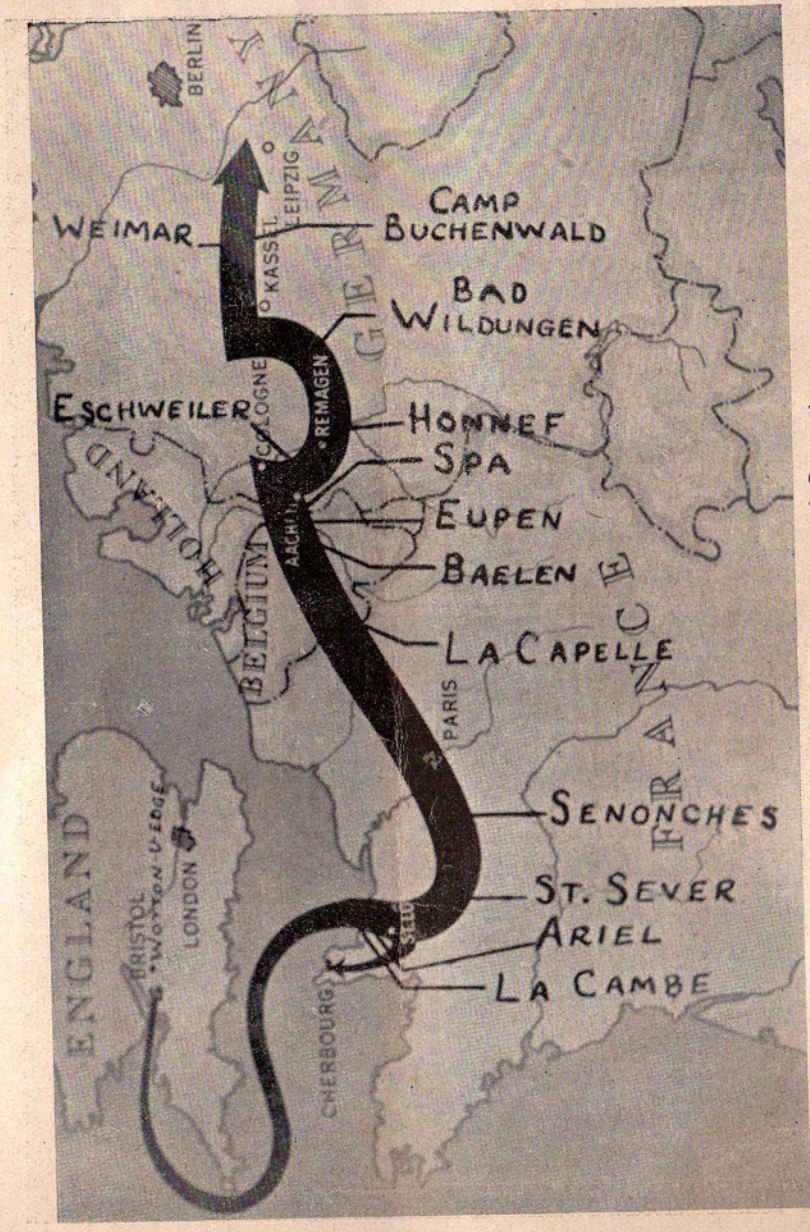
Contents . . .

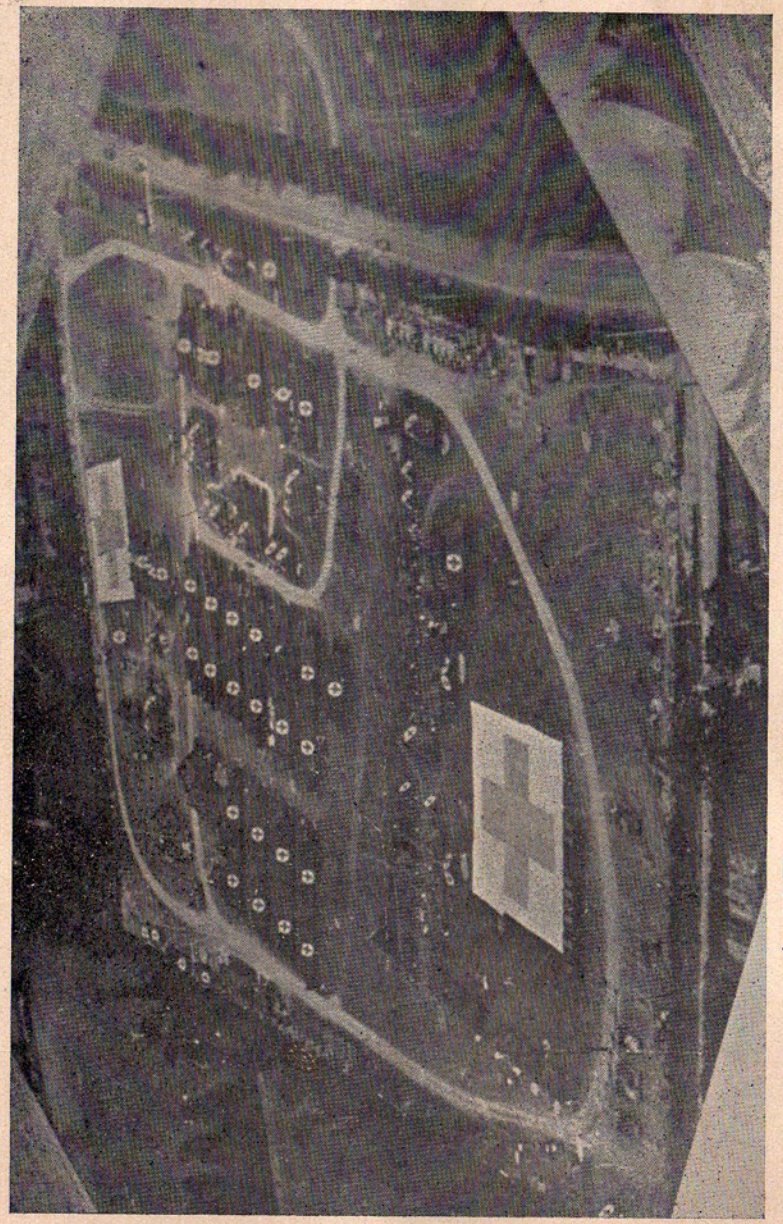
Foreword . . .

We were given the mission of caring for those who were wounded or became ill in combat. We accomplished it successfully. The award to the 45th Evacuation Hospital of the Meritorious Service Unit Plaque, as well as the many individual awards to our enlisted men, nurses and officers, are visible evidence of the success of our mission. Deep within each of us is the conviction and soul satisfying feeling that we have given everything of ourselves to our work, and rightfully can all of us say "Our job is well done". In no small part can our success be attributed to the close cooperation which existed between the various administrative and professional sections of the hospital. The efficient functioning of the ward section was my responsibility. Without the wholehearted effort of all of the ward personnel the road would have been much harder to travel. I can only express my sincere appreciation of your efforts by saying "Thank you and may God bless you". May the following pages, written immediately following each phase of our operations, serve to remind you in the future of some pleasant associations of the past.

Isidore A. Feder, Lt Col, MC
Chief of Medical Service



Map Showing Path of Hospital Operations



Aerial View of Hospital at La Cambe, Normandy, France

La Cambe, Normandy-France . . .

16 June — 14 July 1944

The general basic blueprint for the physical and functional set-up which had been planned at Camp Gordon, Georgia, and elaborated upon in Wotton-Under-Edge in England, had to be rapidly modified when we set up our hospital in the fields of France, near La Cambe. Our original ideas were based upon our own maneuver experience in Tennessee, in addition to the many practical suggestions offered to us by the various units which had already functioned in combat in the African and Sicilian campaigns. When we observed the difficulties encountered by other hospitals in France immediately after they set up, and realized that the situation here was an entirely different one than had confronted either them or us before, we modified our own plans immediately to meet the new situation. Double tents were erected side by side for receiving patients and for their distribution to the pre-operative and shock wards. Separate tents of 40 beds each were designated for:

(1) Early transportables
(2) Duty cases
(3) Non-transportables (head and extremity cases)
(4) Non-transportables (chest and abdominal cases)

Two tents of 40 beds each were designated as medical wards and four pyramidal tents were set up to hold contagious cases. In this manner, all patients who were brought to the hospital were always kept under cover; properly segregated in sufficiently large wards where they were triaged, prepared for operation, and following operation, properly distributed to particular post-operative wards, from which an efficient method of evacuation could be readily instituted. Following to the letter the directions of the Army to evacuate immediately those patients who could be safely transported, we were always able to have a sufficient number of beds available to take

care of the influx of new patients. Many of our ward officers had to be loaned out to the operating section to assist at operations or to give anesthesia. Such wards as shock, pre-operative, and non-transportable postoperative were in need of the largest number and the best qualified of our enlisted personnel. By shifting the assignments of all our officers and enlisted men as the occasion required, we were able to provide the best care to our patients that could possibly be given. In a similar manner, the proper assignment of nurses, and shifting them as the occasion required, supplied the best nursing facilities where they were needed most. One could readily see on a tour through the wards that the benefit of all modern scientific methods in medicine were afforded to our patients. To mention but a few of the procedures — transfusions of blood and plasma, infusions of glucose and electrolytes, Wangensteen gastric suction, the use of penicillin and sulfonamides, the constant laboratory check-ups to guide us in our therapy, constant redressing of wounds to keep patients clean and comfortable, and proper attention given to the patients' dietary needs — these and many other things were done according to the directions of the attending surgeons, and following the routine procedures as adopted in our S.O.P.

Despite the large number of battle casualties which were admitted, we treated a proportionately high percentage of medical cases. They constituted about 21 % of the total admissions. Approximately seventy different specific diagnoses were made, and a number of obscure conditions of the various systems remained undiagnosed, because of our inability to study these cases completely. The latter were evacuated to the United Kingdom for further study. Careful studies were made of all our patients, both clinically and in the laboratory. The results of our therapy were gratifying. The greater number of our patients were returned to duty or transferred to the Convalescent Hospital or to the Exhaustion Center, from where they could be sent to duty. These constituted sixty-three percent of the total number of medical cases. There was one death, a patient with acute leukemia, who expired a few hours after admission. The clinical diagnosis was confirmed at autopsy.

For the most part, only two ward officers were available to take care of the post-operative and medical cases. The last few days of this phase they were assisted by a third officer. Despite the difficult work and the long hours needed to observe

and care for our patients, special effort was made to keep accurate records, which will be of the greatest help in our future operations. Mistakes have been made, but they have been of a minor nature. We intend to benefit by them however, and make such improvements during our next phase that will improve the efficiency of our service.

Airel, Normandy-France . . .

25 July — 5 August 1944

After a long rest following the operations at La Cambe we were immediately greeted at Airel with a very large influx of patients. This continued without let up for almost the entire ten days during which we functioned at this area. It had been planned to erect a double holding tent beside the receiving ward. Here patients with minor wounds were to be held for complete examination and initiation of therapy until such time as they could be transferred, in the event that the backlog of non-transportable cases would make it difficult for us to reach these minor cases in a reasonable length of time. However, this had to be dispensed with, when we were ordered to turn in our excess tentage, and at the same time admit formally for definitive treatment every case which reached our receiving ward.

Enlarging the x-ray department by allowing them two tents hooked side by side so increased their efficiency that the greater number of patients were x-rayed, and had their dry plates with them, long before they were called to surgery.

Allowing three tents for the pre-operative and shock wards, hooking them on to the main surgeries, and building a surgical prep room in each of these two wards, greatly enhanced the efficiency of these wards, and eased the burden which their personnel labored under, until then. Especially did this make less burdensome the work of the litter bearers in these wards.

In view of the large number of patients admitted, it was necessary for us to dispense with Ward 2 as a ward in which we previously kept post-operative patients who could be returned to duty in 10 days. An analysis of this group of patients kept at La Cambe indicated that almost all of those who were not ambulatory shortly after operation eventually had to be evacuated. The policy was therefore instituted to

transfer all ambulatory duty cases, as soon as they reacted from anesthesia and were able to walk about, to the Convalescent Hospital. The remainder were automatically sent to Ward 1 and evacuated from there, as were all other early transportable cases. Wards 2, 5, and 6 were used as secondary preoperative wards. Whereas the most serious pre-op cases not in need of shock therapy were sent from receiving to the main pre-op ward, less seriously wounded patients were fed progressively into Wards 2, then 5, then 6. Here they were checked by a Ward Officer, therapy started, and x-rays ordered where indicated. All patients who were found to have more serious injuries were transferred either to the main pre-op or shock ward as indicated. A center section of about 30 cots in the main pre-op ward was used as a reserve for patients from Wards 2, 5, and 6, and from this section sent to surgery. In this manner all of the most serious cases were operated first, and subsequently the less serious cases were taken care of in such a way that those who came to the hospital early were operated on at the earliest feasible time. By this method we were able to have the majority of patients operated on in less than 20 hours after their admission to the hospital.

It had been intended to use Wards 8 and 9 for medical cases. However, in the early days of this phase Ward 9 had to be used for surgical patients. We attempted to segregate here patients who did not appear to be in need of surgical operation, e. g. bruises, sprains, blast concussions, etc. Both of these wards were well taken care of by our Medical Ward Officer. We were very fortunate during the latter days in having 8 officers from an inactive General Hospital assist us in the work of the Ward Section.

The laboratory was our chief concern when the Laboratory Officer was transferred out of the unit. Our internist took over, continued to supervise the excellent work which had already been done there, performed autopsies on all deaths, and kept our record perfect in that respect.

A few officers from the Ward Section were assigned to work in surgery as was the case during our set-up in La Cambe.

The large number of battle casualties made it necessary for us to concentrate all of the medical cases in Ward 8. On occassion these would overflow into Ward 9. As soon as a diagnosis was established, if the patient was transportable, he was either transferred to the Convalescent Hospital, the Gas Treatment Bn, sent back to duty, or evacuated as the case required. By this means the Medical Service handled 206 cases. These comprised 13 % of the total number of patients admitted. Malaria, Enteritis, and Nasopharyngitis headed the list of the definite diagnoses which were made.

The immediate discharge of all evacuable patients left us with sufficient empty beds to receive and care for all the incoming patients without any undue delay. The fact that we were able to receive such a proportionately larger group of patients during this phase attests to the increased efficiency, which our changes have effected. There are still changes to be made, changes which will further add to our efficiency. These will be instituted as soon as circumstances permit. We are cognizant of the hard work and long hours that our nurses, officers, and enlisted personnel have put into their work and are most appreciative of it. The result of their efforts can readily be seen on a tour through the wards of the hospital.

St. Sever Calvados, Normandy-France

9 August — 16 August 1944

When we finished the first phase of our operations at La Cambe, we felt that we had received a rather large number of patients, treated them amply, and evacuated them promptly. On completion of the second phase at Airel we had handled a proportionately higher daily admission rate than at LaCambe. We felt that our personnel and facilities had been greatly taxed and that nevertheless they were promptly treated and rapidly evacuated. Our opinions as to the previous burdens we had to bear were immediately revised when we began to receive patients at St. Sever Calvados. In a period of less than 18 hours we received approximately 400 patients. Despite this unusual influx they were all kept under cover in the receiving ward and in short order distributed to the proper wards. We feel that the triage of patients was even better supervised from the receiving ward and other wards than it was before. This increased efficiency can be ascribed to the fact that receiving was given three tents, set up side by side, which gave them more space for segregation of patients

and more time and opportunity to closely observe them before sending them on to the other wards. Another factor which aided in more quickly emptying the receiving ward was the switching of the main pre-op and shock wards in relation to receiving. This shortened the litter haul from receiving to pre-op, and because there are almost ten pre-op cases for every one of shock, more patients could more quickly be sent out of the receiving ward.

When Army decided to return to us some of the ward tents they had previously taken away, and directed us to slough off all less seriously injured patients, we erected a double ward tent (Ward 7) beside the receiving tent. It was used to segregate this group of cases. Here they were carefully examined by an officer, hydrated, started on penicillin and sulfonamides where necessary, and redressed to check the state of their wounds. Although we operated on many of these patients when our backlog was low, the policy will now be to send them back further for definitive therapy.

The excessive number of non-transportable chest, abdominal, head, spine and orthopedic cases made it necessary to use Ward 2 in addition to 3 and 4 for these patients. Apparently from now on these patients will comprise a rather high percentage of our total. We contemplate using these three wards for such cases in the future. Abdominal cases will be held in Ward 4, chest cases in Ward 3 and head, spine and orthopedic cases in Ward 2. The remainder of the set-up will be essentially the same.

The ward officers sent to us from the 56th General Hospital did excellent work in enabling us to continue to treat our large number of patients in the best way possible. Their pathologist was of invaluable help in maintaining a 100 % autopsy rate. There were two interesting pathological conferences at which some of the most instructive cases were discussed. During the last few days of this phase another ward officer was permanently assigned to our staff and helped to care for our post-operative non-transportable patients.

The Medicial Service, functioning under a policy of rapidly establishing a diagnosis in each case and quickly disposing of all transportable patients, cared for 177 cases which comprised 18 % of the total admissions. Medical admissions were practically all sent to Ward 8, leaving all other beds in the hospital available for combat casualties.

An improved system of record-keeping in the post-operative wards is going to help considerably in the follow-up of these patients. The new policy of the x-ray department in distributing all x-rays to the wards is a good one. Here they can be seen by the officer in charge. They then accompany the patient as he moves through the hospital, and are thus readily available for inspection by an interested officer. Plans have been made to revise the system of records for the shock ward. This will be put into operation during our next campaign.

Senonches, France . . .

22 August — 30 August 1944

We arrived at our new site on 21 August at 1900 hours after a long and tedious trip of about 160 miles from St. Sever de Calvados. Immediately after arrival we set to work erecting the hospital, and by 2200 had sufficient tentage up to receive patients that night, if we were so directed. In view of the fact that patients were not sent to us until noon on August 22, we were able to set up all of our wards and have them fully equipped to function at this time. The burden upon the enlisted men was made heavier, because we had lost 60 prisoners of war, who were of great help in assisting our personnel in erection of tentage.

Ward 7, a double tent, which was provided with 40 cots, was again set up beside the receiving tent. Here were segregated those not too seriously injured. They had been carefully examined by the receiving officers and found not to be in need of further therapy. Their records were completed by these officers and immediately processed through the Registrar's office and made ready for evacuation. In view of the fact that this group of patients comprised a rather large proportion of our total admissions, it is readily understandable how helpful this routine was. By giving this group priority in evacuation, we were able to get them on their way quickly for definitive therapy further back. Also it eased the strain on the few officers who manned the other wards.

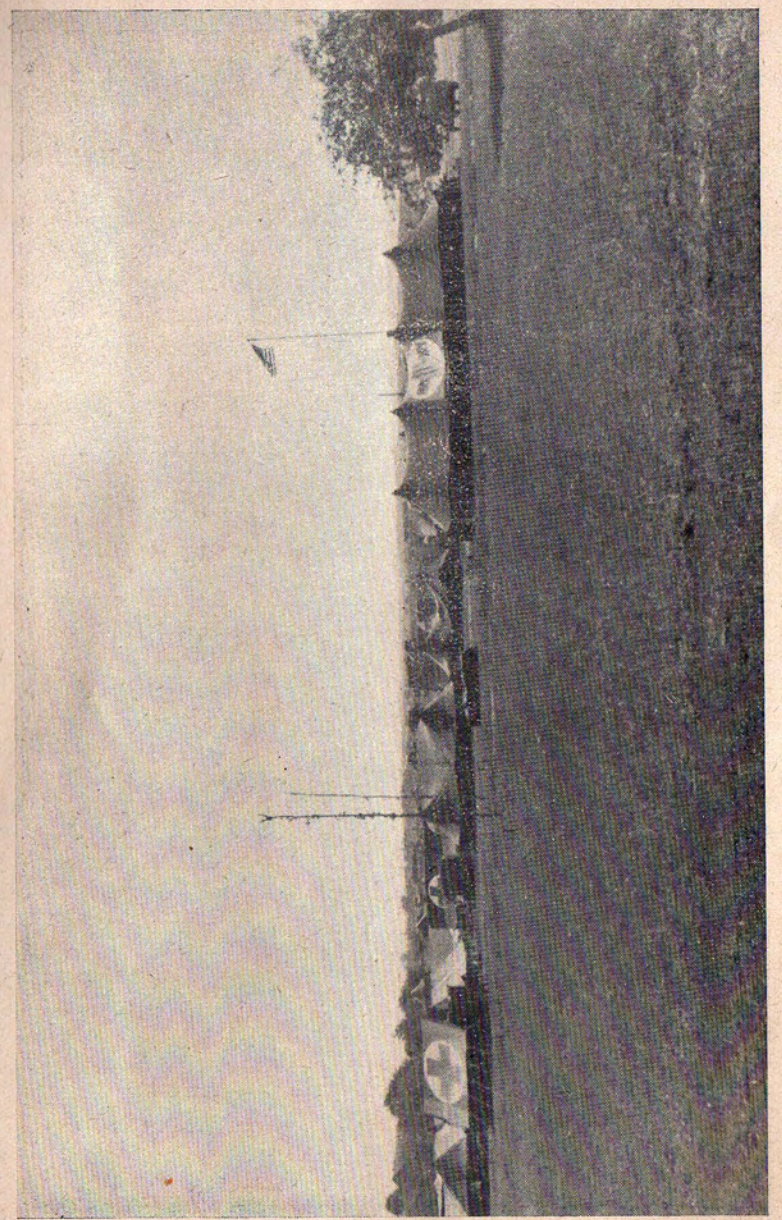
Maxillo-facial, head, and spine injuries were sent to the pre-operative ward where they were segregated in special sections assigned for these cases. Also sent here were all

patients with whom there was a question of non-transportability or who had to be hydrated, have chemotherapy instituted, dressings or splints changed before further transportation was advisable. After proper care, those of the latter group who could now be moved were directly evacuated; the remainder left to be operated upon, and then disposed of. The shock ward received all intrapleural, intra-abdominal and non-transportable orthopedic patients, as well as those with other wounds, who manifested evidence of shock. Ward 1 remained as an early transportable post-operative ward. Post-operative chest cases were sent to Ward 2; head, spine, and orthopedic cases to Ward 3; and abdominal cases to Ward 4. This was an improvement over our previous arrangement. It provided better segregation of different types of cases and made for more space and less confusion in treating them. Wards 5 and 6, which were kept in reserve, did not have to be utilized to any great extent. Ward 5 was occupied for a day by 20 post-operative cases, mistakenly sent to us by another Evacuation Hospital. One of these, a patient in extreme shock, who subsequently died, was retained for treatment at our hospital. The others were sent to the Evacuation Center.

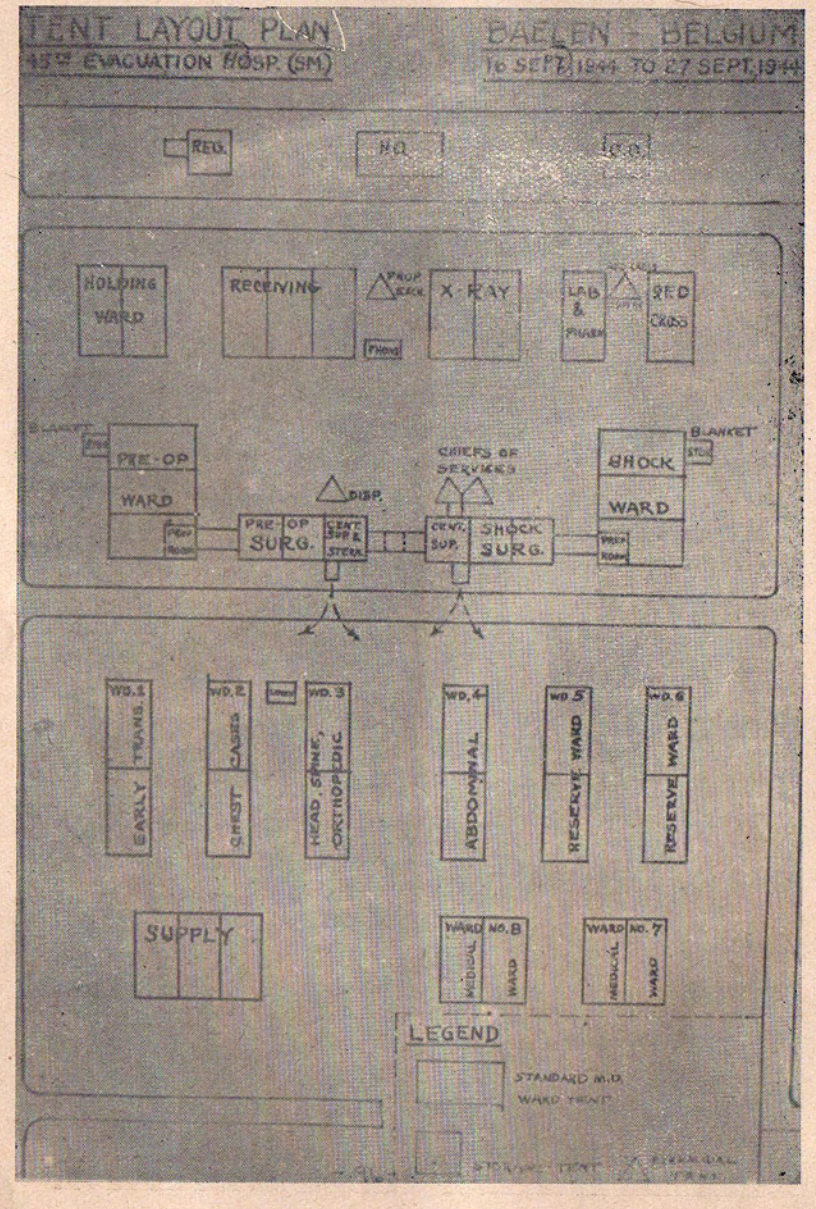
The rather high admission rate of medical cases made it necessary for us to utilize Wards 8 and 9 for this group. 299 such cases were admitted, constituting 20% of the total admissions.

Our policy of admitting all medical cases in whom the diagnosis has not yet been established has made it possible for us to have a most varied and interesting service. Although malaria, the diarrheal diseases, and respiratory infections still headed the list, other diseases, such as pernicious anemia, infectious mononucleosis, cerebral hemorrhage, etc., were encountered. Despite the high admission rate the medical cases never created a problem as far as bed space was concerned, because they were either evacuated or transferred as quickly as possible. There has been only one officer who has cared for our medical patients since we began to function. Credit must be given him for the efficient way he has already handled almost 1100 patients on the service. An interesting conference was held after we closed down, at which our hematologic cases were discussed.

The recent directive regarding "Utilization of Field Hospitals" to furnish hospitalization on the same basis as the



Side View of Hospital Set-up in Field at Senonches, France



Typical Tent Layout Plan of Hospital in the Field

Evacuation Hospitals makes us wonder about our future status, as far as the ward section is concerned. The proportion of non-ambulant post-operative patients who can return to full field duty in 10 days is almost negligible; the number of non-ambulatory medical cases able to return to duty in 10 days is small. Diphtheria and Meningitis have been rare. If the same directive remains in force during our next set-up, both the medical and surgical wards will in all probability be very inactive, in contrast to what they were in our previous operations.

Baelen, Belgium . . .

16 September — 26 September 1944

The rest period at La Capelle, after a rather hectic period of activity at Senonches, was a pleasant interlude before we set up to function again. The most important tents of the ward section were sent out in a limited number of trucks, together with other essential parts of the hospital, on the morning of September 14. In the evening we arrived at Ouffet in Belgium, where we were instructed to bivouac and move farther up on September 15. We arrived at our destination in an apparently excellent field in the town of Baelen, not far from the city of Eupen. The delay in the arrival of the remainder of the personnel from La Capelle imposed a difficult task upon the few enlisted men who came with the first group. They worked hard to set up their wards. We began to receive our first patients on the morning of September 16.

The directive regarding the "Utilization of Field Hospitals" apparently was not followed out. Our function here was in no way different at the start than it had been at our previous places. Patients were received directly from clearing stations. Non-transportable surgical and medical cases were taken care of. We held, for transfer or evacuation, those patients who could be transported farther back. However, due to the difficulty in evacuating them, many of the lesser wounded were also cared for. Many medical cases which we previously diverted had to be held. After a few days we ceased to function as an Evacuation Hospital and began to function as a holding hospital. Patients treated at other hospitals were transferred to us to be held until they could

be evacuated. Although our load of patients was markedly increased, we were not granted a sufficient number of extra tents or cots to take care of them. Every other available tent was appropriated for the ward section. Officers' recreation tents, Red Cross, Special Service and supply tents were made use of. An ample supply of litters was finally obtained and these substituted for cots. There was very little or no surgery done. Officers, nurses and enlisted personnel from the operating section were distributed through the wards to give the greatly increased number of patients the additional care which was required. Ample supplies of penicillin were not furnished to us. It was therefore reserved for the patients most in need of it. It is obvious that the same amount of professional care cannot be given to the large number of patients received, when an Evacuation Hospital serves as a holding hospital. Our system of keeping records had to be changed in order to get patients ready for evacuation as quickly as possible. This change of necessity made our records less reliable and accurate than it had always been our effort to make them. A turnover of over 600 patients a day in a hospital which normally cares for only 400, with limited personnel and equipment, makes more difficult the function of an Evacuation Hospital. We accomplished what we were required to do, but would prefer not to have to do it again. It is difficult to change the scope of an Evacuation Hospital without providing the material and manpower necessary to take care of the added load. In the long run the patient must suffer for it.

A total of 304 patients, 20 % of all admissions, were cared for on the medical service. Having to hold cases of combat exhaustion, we accumulated a rather large group of them. Except in a few instances, definitive therapy was not instituted until the patients were transferred to the Exhaustion Center. Neither the officers nor the wards were available where therapy could be given. Malaria, upper respiratory infections and diarrhea also showed a high incidence as in the previous phases. We saw our first case of immersion foot in a pilot who had wandered about in wet shoes for over a week. We saw a number of patients with the following symptoms: diarrhea of one or two days duration and fever followed by coryza and cough. A few of our own personnel were hospitalized with this syndrome. It appears highly contagious and it should be of interest to watch its future progress.

Bad weather interferes a great deal with the normal activity of a hospital in the field. Rain and mud, of which we had plenty, adds to the discomfort of the patients and the personnel. Litter bearers become bogged down. Cleanliness is difficult to maintain, with mud all over everyone. Stoves help the situation by warming the atmosphere and drying the ground within the wards. Working under cover in a building should do much to overcome the difficulties caused by bad weather.

Eupen, Belgium-I . . .

28 September — 18 October 1944

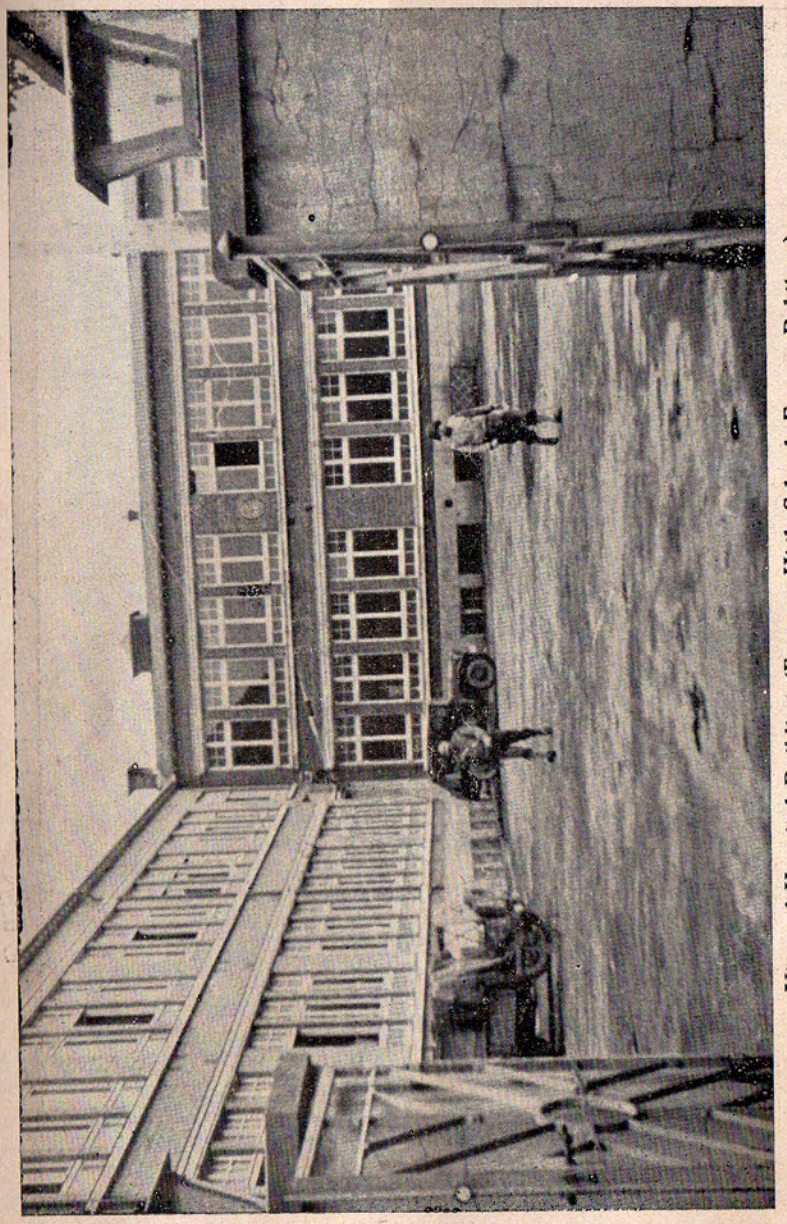
We were very fortunate in being able to set up our hospital in a building. The continuous rains would have markedly interfered with our smooth function, had it been necessary for us to remain in the field. There were some difficulties encountered in attempting to convert a high school into a hospital, but these were met and overcome. At first glance one would think by the size of the building that it would be very easy to make it accommodate the various sections of the hospital and all the equipment. Such is not the case. It isn't the height nor the number of rooms which are available. The important consideration is the floor space. The minimum area needed should be estimated and in the future this figure should be given the highest consideration before a building is selected. We were able to set up 400 beds by utilizing corridor space on all floors including the basement. The ward designations remained the same although the arrangement of the wards was changed in order to utilize the space available to the best advantage. The large auditorium served well for the shock and pre-operative wards and x-ray department. These were in close proximity to the operating rooms. The early transportable and non-transportable wards were also a short distance from the surgery which simplified the distribution of patients to these wards after operation. The large gymnasium with its adjoining room made an excellent combination of receiving and holding wards. All of these advantages far outweighed the disadvantages of a long litter haul from the receiving to the

shock and pre-operative wards. Reserve Wards 5 and 6 which overflowed into the corridors of the basement had a capacity of 100 beds.

After a few days, during which we received casualties for definitive treatment, we reverted to a holding unit. At times very large numbers of patients were received, but were quickly distributed to the proper wards. For the first time the medical cases outnumbered the surgical cases admitted. Wards 8 and 9 (expanded into the corridors on the second floor) had a capacity of 80 beds. Here were sent all patients in whom a diagnosis was not established; those who could not be transported further; and those who were to return to duty but still required bed treatment. All other medical cases were sent to the reserve wards in the basement, where their charts were rapidly processed and from where they could be rapidly evacuated. The holding ward was used for litter patients who were to be evacuated. When it overflowed, the pre-operative and shock wards were used to hold litter cases.

Of the total admissions, 54 % were medical. There were 1357 patients. The number of diagnoses totalled 136. A wide and most interesting variety of cases was seen. 121 patients with immersion foot were admitted. This condition was seen in all its stages from mere sensory changes to beginning gangrene. All such patients were carried as litter cases, given tetanus toxoid, started on penicillin and sulfadiazine; their feet were exposed, heels and toes padded; and they were evacuated from this theater. Upper respiratory infections, diarrheal diseases and malaria still were among the most frequently encountered diseases. Pneumonia, both the lobar and atypical types were seen. There were a number of benign and malignant neoplasms. Among the latter were a case of Hodgkin's disease and metastatic adeno carcinoma involving the lymph glands. For the first time since La Cambe we saw two cases of epidemic meningitis. There were no deaths during this phase.

The surgeons of the operating section were available for ward duty whenever they were needed. The outpatient department treated an unusally large number of patients, and saw many soldiers in consultation for the Division Surgeons. A roster of surgeons available for such consultations greatly expedited our work in this section.



View of Hospital Building (Former High School, Eupen, Belgium)

Courtyard of Hospital During Operation at Eupen, Belgium

Eupen, Belgium-II . . .

28 October — 25 December 1944

In point of time, we operated longer than we have during any one of our previous phases. Many more casualties than heretofore were processed through our wards. A total of 7707 medical and surgical patients were taken care of. The designation of various wards was changed in order to better accomodate the different types of cases received. Wards 5 and 6 in the basement were used solely for medical and non-operative surgical cases. The wards on the first and second floors were devoted entirely to the use of post-operative cases. Ward 1 remained the early transportable ward. Because there were many lesser wounded who were not evacuated as quickly as heretofore, this ward was enlarged by setting up an additional 20 beds immediately above it in the corridor of the second floor. One room of Ward 3 was converted into a third surgery. The other room was used exclusively for patients with vascular injuries. Wards 2 and 4 remained, as before, for the care of abdominal and chest injuries. Wards 7 and 8, on the second floor, previously used for medical patients, were converted into post-operative wards. One room was used solely for post-operative head and spine cases. The other three rooms were used for post-operative non-transportable orthopedics cases. The number of vascular and head cases was so unusually large that the segregation of these patients greatly facilitated their after-care, both by the officers and ward personnel. Again we were most fortunate to be able to work in a building. The inclement weather would have greatly handicapped us, were we set up in the field under tents. The burden placed upon the enlisted personnel was made greater by the fact that frequently the personnel of the collecting company, who were assisting us, were called out for duties elsewhere. By shifting men to wards where they were needed most, we managed as best we could under the circumstances.

The problem of providing suitable diets for the post-operative patients, especially those in the abdominal ward having gastro-intestinal injuries, became rather acute. Food was served to them, which either they could not eat, or if they did, might have upset them. This problem was discussed

with the mess officer. The need of choosing proper food and preparing it properly for these patients was pointed out. At the present time, the best is being made of the rations which are provided us. Menus of regular and soft and liquid diets are submitted one day in advance for criticism and copies are distributed to each ward where they can be checked against the food actually served to the patients.

The number of reactions from transfusions of bank blood on the wards was unusually large. There were several very serious hemolytic reactions. This problem has been taken up with the operating section. Reports on all reactions are being forwarded daily on a special mimeographed form by the ward nurses to the laboratory officer. Examinations of the blood are being made. By collecting the data obtained we hope to find and correct the reason for this serious difficulty.

Of the total admissions, 35 % were medical. There were 2172 cases. The number of diagnoses totalled 125. Trench foot headed the list. There were 739 cases, seen in various stages of the disease. The milder ones were sent to the Gas Treatment Battalion, from where we understand a large proportion was returned to duty. Many patients developed swollen, hot, painful feet when they were exposed to the warm air of our wards. If ice were available in which to pack such feet it might help prevent some of the more serious sequellae. The diarrheal diseases, upper respiratory infections, malaria and anxiety neurosis followed in this order. There were 16 cases of infectious hepatitis, 12 of atypical and 3 of lobar pneumonia. We saw our first cases of diphtheria. They responded well to antitoxin and penicillin. Our first meningitis death occurred in one case despite the use of penicillin intrathecally and intramuscularly in conjunction with sulfadiazine. This patient never became conscious; suffered a hemiplegia, a complication we have never seen before, and at post-mortem showed sub-pial hemorrhage over one temporal lobe.

Eight patients were admitted with a history of methyl alcohol ingestion; 3 died despite all treatment. The other 5 never had any symptoms. Two of these showed the presence of methyl alcohol in the urine. The urine of the other 3 was negative. Another patient was admitted dead on arrival. Post-mortem examination was essentially negative. Toxicological examination of the gastric contents indicated that this patient also died of methyl alcohol intoxication.

During the latter part of this phase one of our officers returned to the Z.I. because of the illness of his child. This added an additional burden to the few remaining officers. Two medical officers from the collecting company, one of whom took care of the out-patient clinic, and the other who worked in the wards, rendered valuable assistance in helping us give care to the greatly increased load of patients.

Spa, Belgium . . .

19 January — 8 February 1945

It appeared at first glance that difficulties would be encountered in setting up a smoothly functioning hospital in the buildings which were allotted to us. Access to the upper floors for litter patients would have been almost impossible because of the high, narrow, winding staircases. With the aid of the engineers however, we were able to utilize all the available space on the street level floors of our buildings. Litter haul was reduced to a minimum. Wheel litters were put to use and from that angle we fared better than in our previous set-ups. The shock and pre-operative wards were given ample space and were conveniently located in close proximity both to the x-ray department and to surgery. The post-operative wards were also well situated in relation to surgery. Although they were not as spacious as they previously were, we were able to manage quite well in view of the fact that as many patients were not admitted. A separate building was utilized as a medical pavilion. Two garages, close to the receiving ward, were converted into wards and were reserved solely for cases of trench foot. Lighting and heating of these spacious buildings posed a problem, but they were well taken care of. In general the physical and functional set-up of the hospital turned out to be as good, if not better, than that at Eupen. Many visitors commented favorably upon the appearance and arrangement of the hospital wards.

Criticism had previously been made that post-operative patients from our hospital had reached general hospitals with decubitus ulcers. A check of our records did not bear this criticism out. Favorable comment had always been made relative to the excellent nursing care which our patients received. Therefore we kept close watch over this angle and

made detailed records of our observations. There were no instances of decubitus ulceration, and in only one case was an abrasion of the sacrum noted, and this in an incontinent patient who could not be kept off his back for the first few days postoperatively. The nurses and corpsmen are to be commended for the constant and meticulous attention which they gave to our patients.

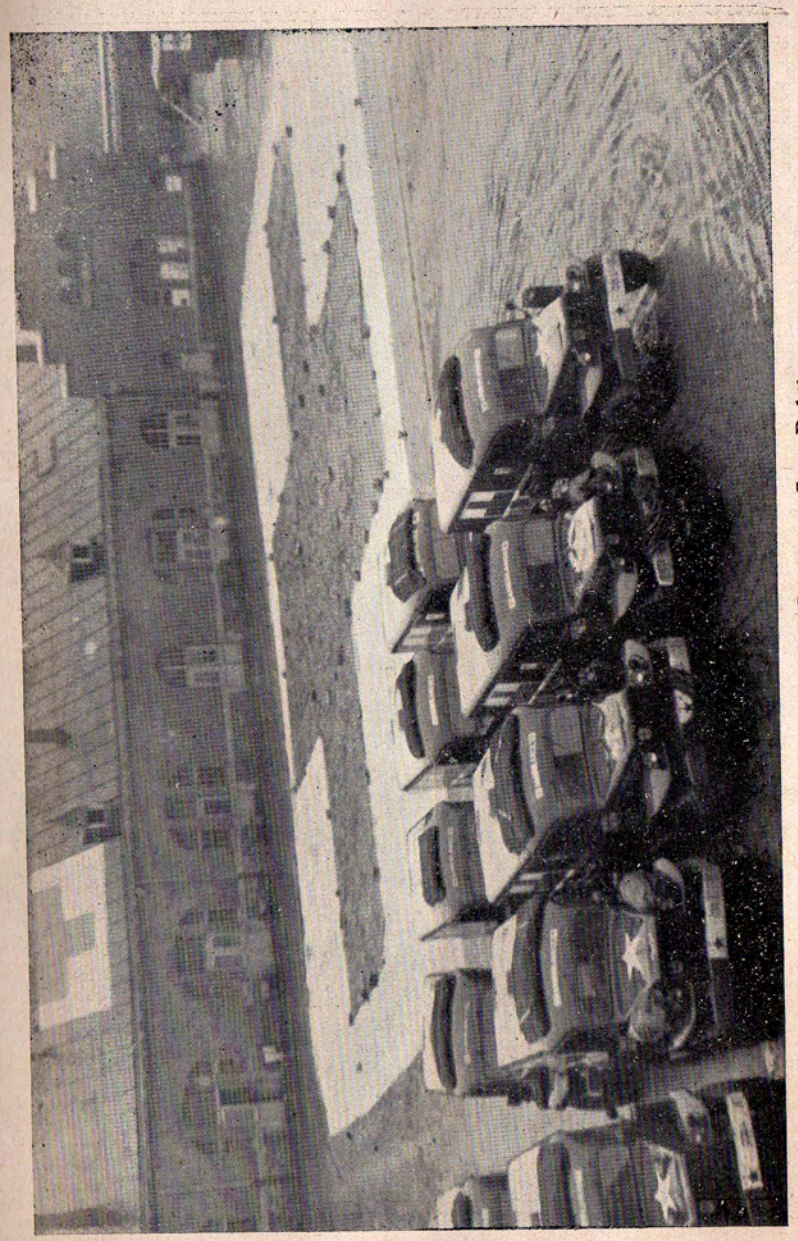
Segregation of the medical patients in one large ward facilitated the work of the Internist. 56% of the total admissions were medical cases. They totalled 1432. The respiratory infections were again frequently encountered. Both atypical and lobar pneumonia showed an increased incidence. Atypical pneumonia and severe diphtheria with laryngeal involvement coexisted in the same patient, who made an excellent recovery with 200,000 units of diphtheria antitoxin in combination with penicillin. We have instituted a study of the effect of penicillin in atypical pneumonia by treating alternate cases with the drug. An insufficient number of cases have been treated to make it possible for us to draw definite conclusions, but our impression is that penicillin lessens the severity and shortens the course of the disease. Diarrheal diseases were still encounterd in large numbers. Almost as many cases of bacillary dysentery were seen in this phase as in all our previous operations combined. Infectious hepatitis was more frequently seen. Trench foot still headed the list of medical admissions and frost-bite was frequently encountered.

The problem of officer personnel in the wards was solved by the return of our officers from the division and the addition of another officer to our ranks. We also were assisted in great measure by three officers from an attached collecting company.

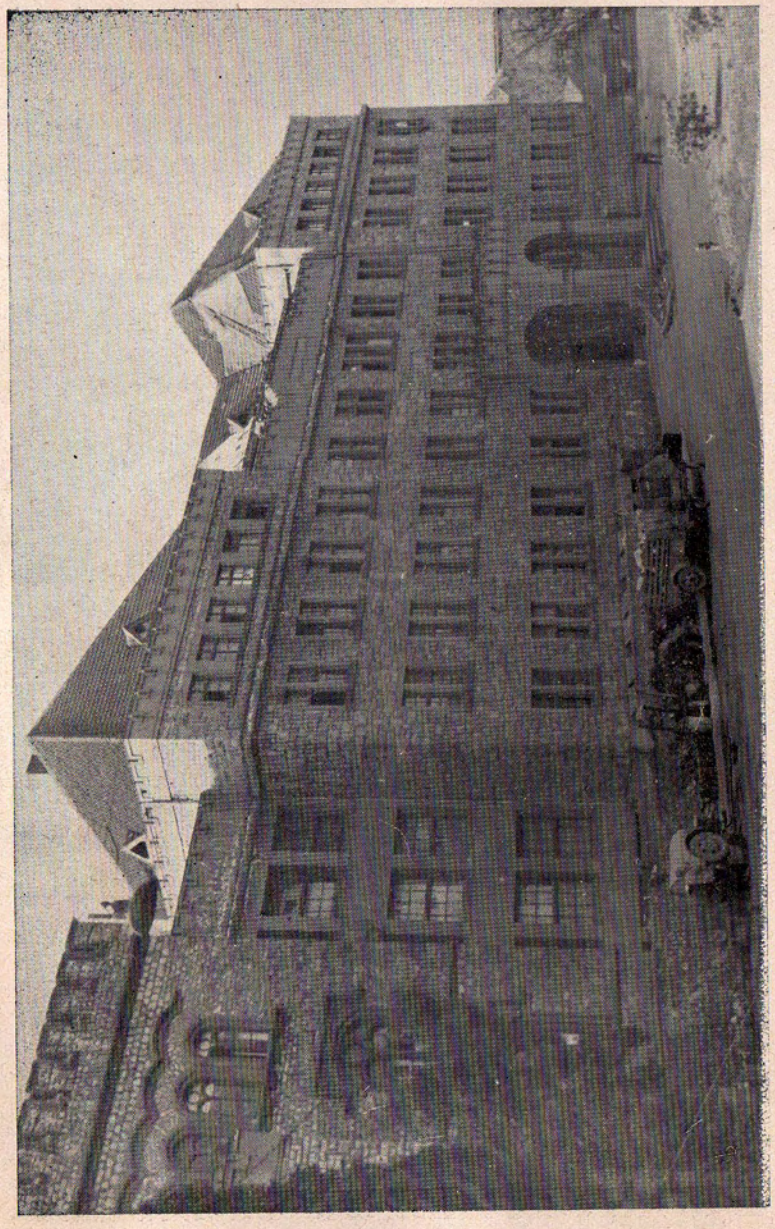
Eschweiler, Germany . . .

5 March — 22 March 1945

Our first move into Germany was expectantly awaited by everyone. Shuttling of equipment to the new area from Spa for a number of days prior to the time we left, greatly facilitated the move. The rubble and trash within and outside of the new building added a back-breaking job to the



Partial View of Hospital Set-up at Spa, Belgium



Civilian Hospital Used by Unit at Esdhweiler, Germany

already difficult work of actually setting up the hospital and ward equipment. The shattered windows and bombed-out parts posed a problem, especially as regards blackout, but with the aid of civilian workmen, repairs were made which made it possible to amply light, ventilate and blackout the essential wards. The long litter haul from receiving to the preoperative and shock wards, as well as from the latter to the x-ray department, could not be avoided in view of the layout of the building. However a triple ward tent, erected beside the receiving ward, and connected to it by an enclosed corridor, was most helpful in disposing hastily of our by-pass cases. An advantageous feature of the new site was the segregation of the various wards in isolated wings of the building. Although most of the rooms were small, there were a number of sufficiently large rooms in each wing to accommodate the bulk of the patients.

A number of seriously wounded non-transportable patients remained when the 53rd Field Hospital moved out and a number of others were admitted from the 51st Field Hospital. Most of these suffered from chest and abdominal injuries. There was a large incidence of complications in both groups, especially the chest cases, and because many of them were running elevated temperatures, they had to be kept here for a long time past the usual day of evacuation.

In the 8 days during which we functioned as an evacuation hospital, comparatively few patients were admitted, and of these only a small proportion were seriously wounded. Due to the lack of litter bearers however, the ward men were burdened with this duty in addition to their regular ward chores. Reinforcement of our detachment by enlisted personnel of the 115th Evacuation Hospital greatly lightened their tasks. We were fortunate in finding many wheel litters at the new area, which were put to good use.

The medical admissions also fell off perceptibly. They totalled 160. 26 cases of trench foot and frost-bite still placed those conditions at the head of the list. They were mild in comparison to what we had previously seen. The incidence of infective hepatitis showed a marked rise. There were 9 cases, 2 in enlisted men of our own unit. There were 7 cases of atypical pneumonia, and 2 of lobar pneumonia, a large percentage of the total admissions. The diarrheal diseases were encountered frequently as heretofore. There were 5 cases of true dysentery, 3 due to s. paradysentereae flexner, from one

unit. An effort was made to contact this unit and advise them of the precautionary measures to be taken to prevent widespread dissemination of the disease. Upper respiratory infections showed their usual incidence. 2 cases of diphtheria were seen, one of whom had paralysis of the soft palate.

When we began to function as a convalescent hospital on March 13, the hospital was reorganized to meet the new problems which arose in connection with the function of such an organization. Surgery was reduced to a minimum, leaving sufficient equipment to take care of emergency procedures. All the officers of the surgical service were assigned to convalescent medical or surgical wards. The dispensary and dental departments were enlarged. An officer was placed in charge of Special Services and a large room was released to Red Cross, in order to provide sufficient diversion for the patients who were ambulatory and ready to be returned to duty within a few days. We found it feasible to erect an evacuation tent to which all patients who were to be discharged were sent on the day before their discharge. Here they were clothed just prior to being transported to their respective units. The professional and ward care to be given such patients is no problem whatsoever. In contrast to the type of work done while functioning as an evacuation hospital, convalescent work afforded the entire unit a period of rest and quiet. In the 5 days during which we functioned in this manner, 188 patients were received on the medical service; all but a few of whom were returned to duty in a period of from 1 to 4 days.

Honnef, Germany . . .

25 March — 1 April 1945

Days of back-breaking work were expended in cleaning out the building, and almost completely setting up our hospital at Bad Neuenahr. When word arrived for us to repack and reload our equipment to move farther on, a note of disappointment was evident among the enlisted men who had been working so hard for so many days. But their enthusiasm suddenly spurted when it was made known that we were to cross the Rhine for our next location. Crossing the river in itself was a milestone all of us were looking forward

to. But to be the first Evacuation Hospital in our armies to accomplish this feat made the event so much more welcome and exciting. The men worked fervently all that day and night to keep the trucks moving constantly. We shall never forget our first view of the Rhine; the pontoon bridge which we crossed; and the collapsed bridge at Remagen, which during the 10 days it stood, enabled so many of our troops to cross over and appreciably shorten the course of the war.

A Field Hospital was still in operation at Honnef when we moved in. Added to the task of cleaning out the remainder of the building, was the work of taking over all the non-transportable cases and assigning personnel to care for them. And all this went on while the Field Hospital received new cases and operated upon them. It appears that there is always some new problem which presents itself when we arrive at a new site. But as has happened on every occasion before, the new difficulties were quickly overcome. Everyone seems to work to the maximum he or she is capable of, and in quick time the hospital is ready to function. The building was large and lent itself well for an Evacuation Hospital set-up. All the essential wards were large and this materially helped in getting the most out of our limited personnel. We did not receive as many patients as we had expected. The casualty rate was low. The rapid movement of our troops made it neccessary for us to close down after less than 3 days of work and seek a new site for the hospital. This was the shortest period during which our hospital worked at any one particular place. It makes one wonder whether it is worth while expending so much energy in cleaning buildings, as we do, for the short period we are to function in them.

The large number of post-operative, non-transportable chest and abdominal cases transferred to us by the Field Hospital made these wards the most active. 4 nurses and 6 enlisted men were assigned to each of these wards for each shift. A fairly large number of these cases, especially POW's, were received by us directly. The remainder of the wards were not too busy.

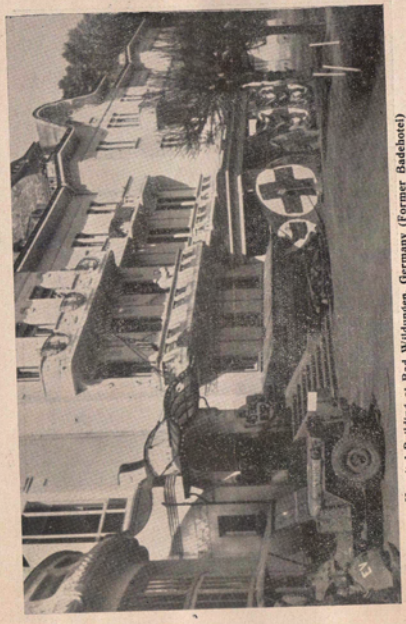
There were 67 cases on the medical service, 16 % of the total admissions. The upper respiratory infections and diarrheal diseases again headed the list. 4 cases of atypical pneumonia were seen. The variety of other cases was the same as that experienced before.

Bad Wildungen, Germany . . .

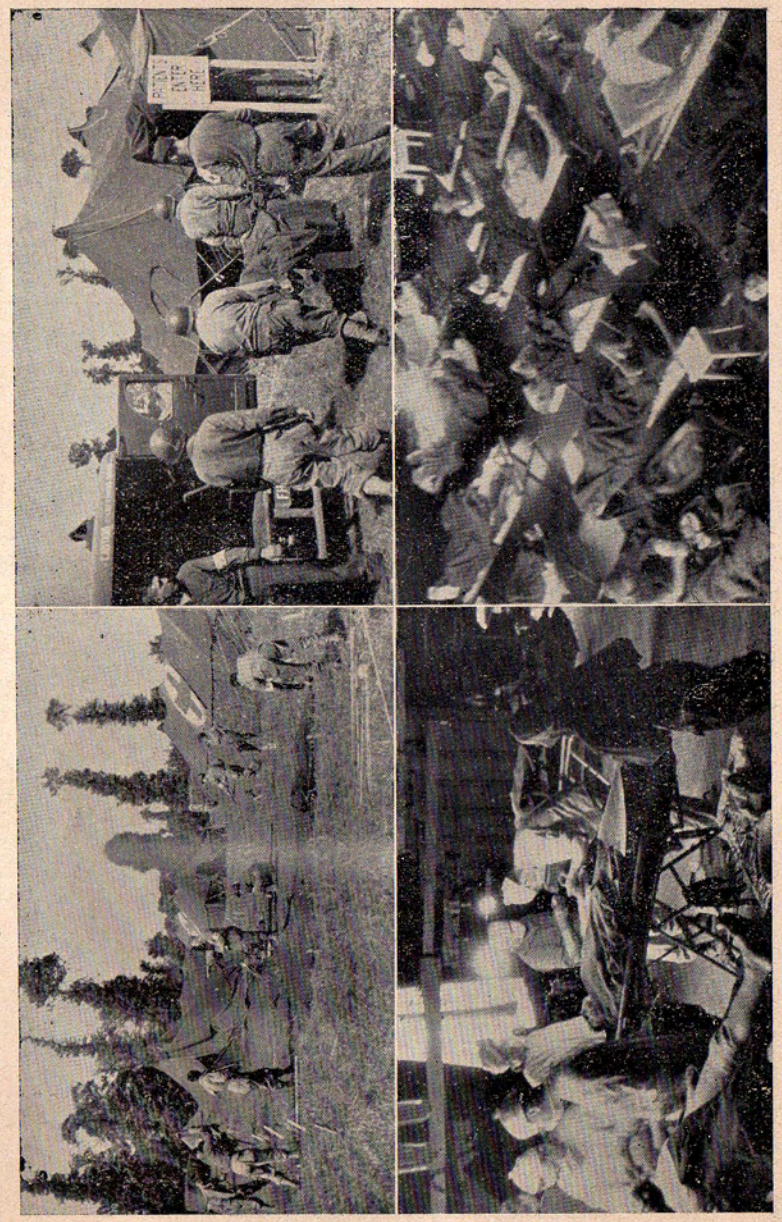
3 April — 19 April 1945

The hospital set-up in the hotel at Bad Wildungen was probably the best that we have had thus far in buildings, both from the esthetic and functional viewpoints. We were able to accommodate the entire hospital and staff under one roof, a situation which always adds to the efficiency of both the professional and administrative departments. The essential wards, such as pre-operative, shock, and post-operative non-transportable, had ample room to accommodate our markedly increased load without too much crowding and with sufficient natural light and air to add to the comfort of the patients. The operating rooms were on the second floor, one floor above pre-op and shock, but because of the easy approach to the former by wide staircases, this did not appreciably interfere with our routine. Although the receiving ward was broken up into a number of small rooms, utilization of the wide corridor space for litter patients overcame this difficulty. The large holding ward adjacent to receiving saved us many a headache, in that it was able to hold as many as 100 patients at a time, and we were thus able to avoid holding slough-off patients in wards which were designated for other special purposes. The new policy of retaining hand cases for 5 days, and the large number of such cases, were well handled by designating a special ward for them adjacent to the vascular ward. With the aid of additional enlisted personnel the nurse in charge of the vascular ward was able to care for her own cases as well as those in the hand ward. The medical cases were segregated in one wing of the second floor and at times there were as many as 125 patients taken care of by this service. Separate exits from the holding, early transportable and medical wards simplified and hastened the evacuation of these patients. The landscaped area surrounding the building and the wooded hills in the vicinity added a hospital air to the set-up, something, we have not enjoyed heretofore.

Being the closest Evacuation Hospital to the front, and with other hospitals far behind us, it was inevitable that we would receive the bulk of the casualties; and we did. We were as busy here as we were during some of the most



Hospital Building at Bad Wildungen, Germany (Former Badehotel)



Composite View of 45th Evacuation Hospital in Operation

active fighting in Normandy. The cooperation of the officers, nurses and enlisted men, together with the efficient functional organization of the hospital, enabled us to handle the large load of patients quickly and without a hitch. At one time 435 beds were occupied by patients.

The Medical Service was unusually busy. 715 patients, 31% of the total admissions, were processed through this department. Although the upper respiratory infections and diarrheal diseases were still at the top of the list, infective hepatitis with 34 cases, and atypical pneumonia with 16, showed a marked increase in incidence. A soldier of our own command, ill with jaundice, was finally diagnosed as a case of subacute yellow atrophy of the liver and was evacuated. Because an installation was not set up during the first few days to which we could transfer patients with contagious diseases, our statistics show a larger number of these, than have been recorded since our early days in Normandy. There were 16 cases of parotitis, 3 of them complicated by orchitis. There were no deaths on the Medical Service.

Our laboratory was burdened with an increased number of examinations because of our heavy census but with the aid of a civilian technician, and longer hours of work, the personnel managed very well. Temporarily the laboratory officer was transferred to the Surgical Service in exchange for one of the surgeons.

Many expected that the war would end before we finished this phase of our work and were looking forward to a period of rest and relaxation in this resort and country like atmosphere. But such was not to be the case. Although we are always enthused about moving forward, some were disappointed in having to leave such a beautiful site and the comforts it provided during off-duty hours.

Nohra, Germany . . .

22 April — 28 April 1945

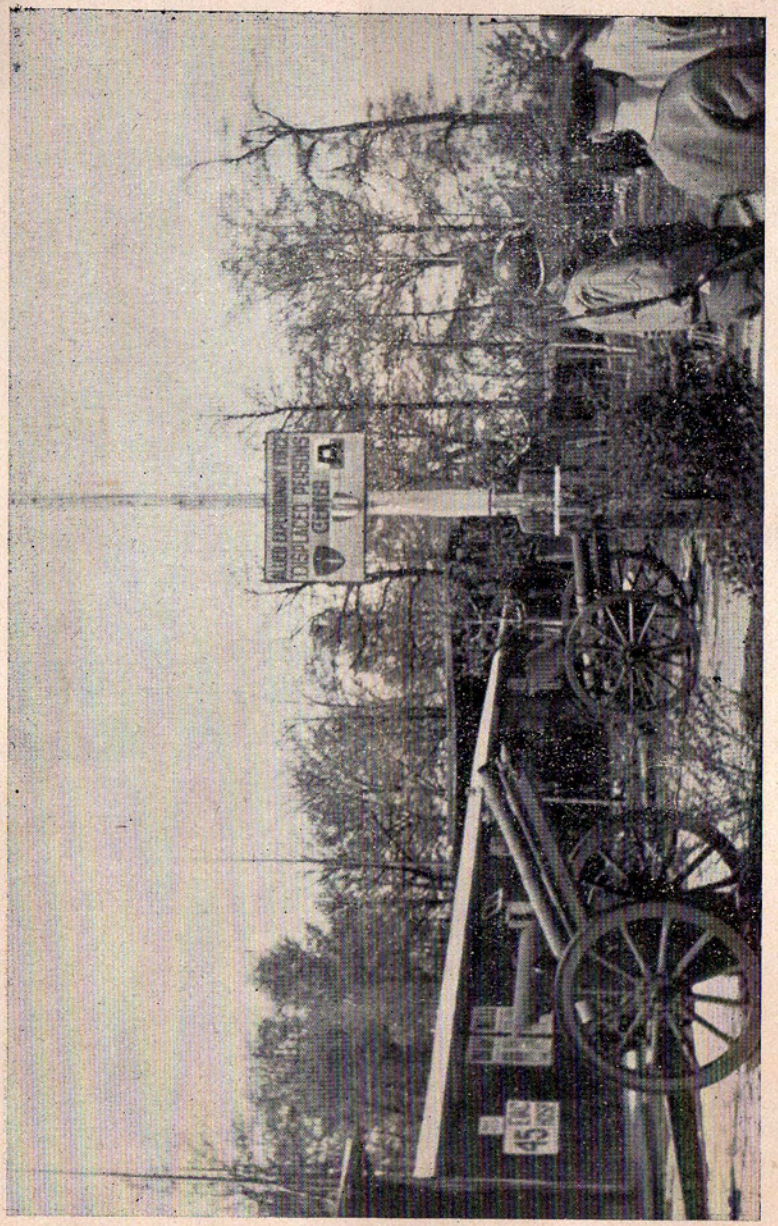
The trip from Bad Wildungen to Nohra, 4 miles west of Weimar, was through country as picturesque and beautiful as we have ever seen. It was most puzzling for all of us to comprehend why the Germans have constantly been crying for more "lebensraum". A number of buildings were

available in a wooded area a short distance from an air strip. We selected the largest one for the hospital, the others to house the personnel. Although the buildings themselves were well constructed, the condition of the interior was worse than we had seen heretofore. Fortunately we were able to obtain a sufficient number of civilians to supplement our own men in cleaning up the filth and rubble. The general plan of the wards and operating rooms was rather similar to that used at Wildungen. The rooms were not as large here, but with a little more crowding, we were able to set up 400 cots. The marked diminution of active fighting as well as the long distance from the front, practically eliminated our admission of combat casualties. The surgical admissions consisted almost entirely of accidentally incurred injuries. Although the medical cases were more numerous, this service too was slower than it ever had been. There were 141 cases, 59 % of the total admissions. Infectious hepatitis and atypical pneumonia again comprised a high proportion of the cases treated. At one time we were advised that we would receive 400 extremely malnourished released American prisoners of war. The hospital set-up was immediately organized to handle this large influx of patients. The professional staff was reorganized to meet the new situation of all medicine and no surgery. But though we planned and waited, the admission of these patients never materialized.

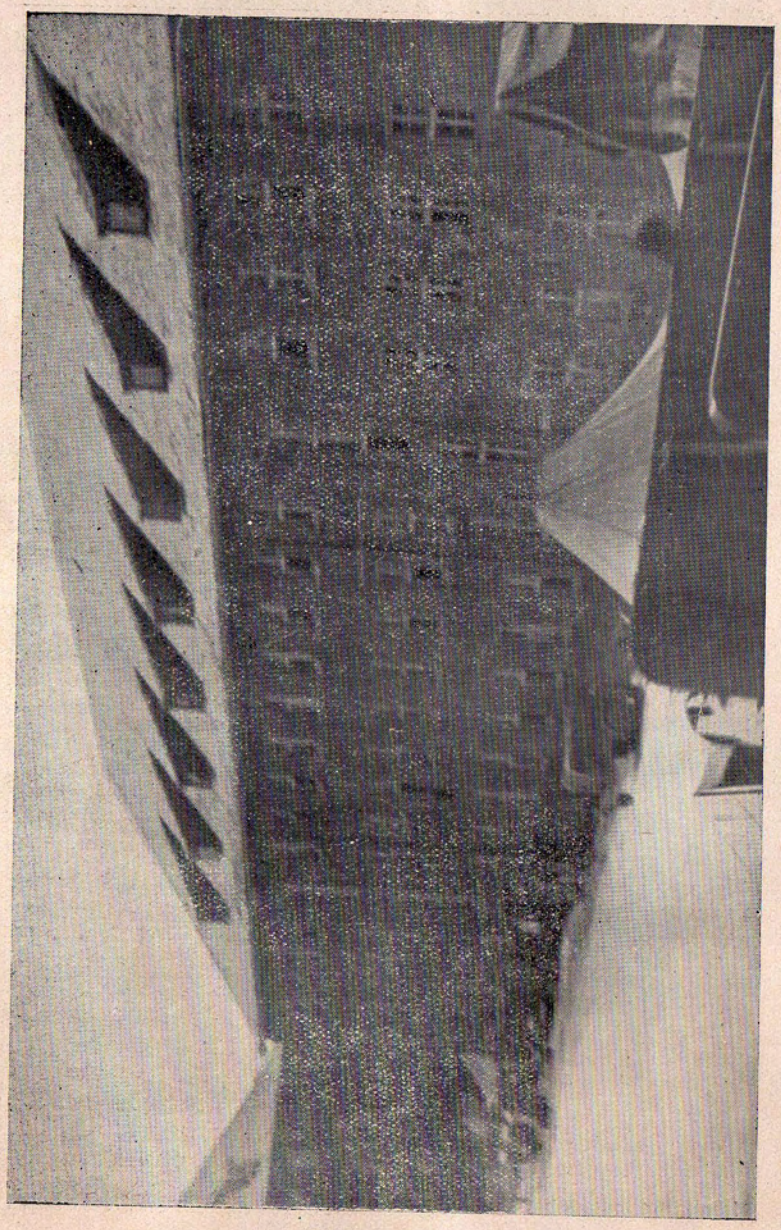
Weimar, Germany (Buchenwald) . . .

28 April — 12 May 1945

After only 5 days at Nohra we were ordered to set up our hospital in the notorious concentration camp at Buchenwald. We must admit that hardly any of us were too enthusiastic about it. Nevertheless, as in every one of our operations in the past, the officers and men continued to exert their every effort to the full accomplishment of our mission. However, for the first time, our nurses did not accompany us; we functioned without them. The burden thus placed on the enlisted personnel was a much heavier one. Much time and effort had been expended in setting up at Nohra and now at Buchenwald Camp an even more difficult task was



Hospital Headquarters Building at Buchenwald Concentration Camp



Hospital Site at Buchenwald (Former SS Barracks)

assigned to us. The function assigned to the hospital *per se* was that of processing all proven and suspected cases of tuberculosis for subsequent evacuation to more permanent quarters at Blankenhain. The critical condition of most of these patients made it necessary for us to select a site on the camp grounds as closely as possible to the prison compound in order to shorten the ambulance haul. The atmosphere of the area was a most depressing one. The state of the available buildings was so deplorable that at first glance it seemed that one could not be made suitable as a hospital dwelling. We sought a site to set up our tents but there was nowhere sufficient open space to accomodate them. We were therefore compelled to select two buildings which were previously used as SS barracks. These had been rendered almost unusable by the guards before they left and had been fouled by the liberated prisoners who swarmed into the buildings after their release. Here again, as before, our men energetically undertook their task of cleaning the buildings and before long they were made suitable for use. One housed the hospital, the other the personnel. The problem here being essentially a medical one, only a two-table operating room was set up. The ground floor was utilized for administrative offices, receiving, x-ray, laboratory, pharmacy and surgery. Our procedure in processing patients after admission was altered. Most of the patients had not been bathed in months and many of them were infested with lice. Typhus was prevalent and means had to be taken to prevent its spread. We arranged to space our admissions over the entire day and receive from 10 to 15 every hour. After their records were made out, the group was taken to the bath room. Their clothes were discarded and burned. Each patient was bathed, sprayed with DDT powder and clothed with clean pajamas. They were then taken to x-ray where a chest plate was taken on each patient. From here they were assigned to the ward. By this method only clean, deloused patients entered the wards and subsequent movement of patients for diagnostic procedures was eliminated. Examinations of blood, sputum and urine were routinely done on all patients. Sedimentation rates were done where patients were afebrile. Laryngeal and bronchoscopic examinations were done where indicated.

Five wards of 40 beds each were set up on the second floor, and a similar number on the third floor. An officer

was assigned to each ward. Each ward had 4 enlisted men during the day and 3 during the night. (The nurses did not work with us during this phase.) All were instructed in detail as to the precautionary measures to be used. Gowns, masks, and antiseptic solutions were made available for each ward. Patients were provided with individual masks and instructed to cover their mouths with them, when they coughed, were being examined, or attended. All details were meticulously followed out, and it is a credit to the personnel and officers that such an excellent sanatorium-like atmosphere was maintained. Matresses or sufficient thicknesses of blankets to supply adequate padding were provided for each cot. Although linens were scarce we managed to obtain a sufficient number for all cots. Arrangements were made with the mess officer to provide three high-caloric, high-vitamin meals daily, and that in addition three in-between-meal feedings of chocolate milk, malted milk and eggnog be served. Multivitamin pills and candy bars further supplemented the diet.

It is difficult to describe the reaction of the patients to their new found freedom and the solicitous care which they received at our hospital. The physicians who cared for them before we took over, former prisoners themselves, were strong in their praise of the attention which the patients received.

Never before had we seen patients in such a deplorable physical state. The ravages of their illnesses and long state of severe malnutrition induced by starvation, combined to form a clinical picture which is rarely if ever seen in our own country. Under the conditions which the prison physicians worked it was inevitable that many cases should have been mistakenly diagnosed. Of the 600 patients admitted, 433 were found to be ill with tuberculosis. Many had pulmonary pathology which was non-tuberculous. There were 10 cases of atypical pneumonia, 4 of lobar pneumonia, 2 of lung abscesses, 1 neoplasm, 1 thoracic empyema, 1 atelectasis of a lung resulting from an aneurysm of the aorta. In many the lungs were clear but some other systemic disease was present to account for the symptoms. Malnutrition in some degree was present in all. In 223 it was unusally severe and in 22 there was clinical evidence of marked vitamin deficiencies such as pellagra, scurvy etc. Most of those with tuberculosis had widespread involvement of both lungs, with exudative lesions and cavitation predominating in the x-ray findings. 37 patients had unexplained temperatures. They were discharged

as cases of fever-of-undetermined-origin and returned to the compound hospital for further study. Our mission being solely to screen out cases of tuberculosis we had insufficient time to devote for more thorough study of these cases.

63 patients had pneumothoraxes artificially induced before they were sent to us. In certain instances too much air was introduced, in others not enough. In some the procedure was a failure because adhesions prevented collapse of the lung and closure of a cavity. But considering the circumstances under which the procedure was done, the home-made apparatus which was devised and lack of x-ray facilities under which the inmate physicians labored, the work which they did can be considered truly remarkable.

One patient died. Post-mortem examination revealed extensive tuberculous involvement with cavitation of both lungs and ulceration of the terminal ileum. The ultimate prognoses in most of these cases is extremely poor. The large majority will succumb to tuberculosis in a shorter or longer period. A few may still be rehabilitated. By removing them as a source of infection to the other malnourished prisoners of the camp and making them comfortable we will have accomplished our mission. The relief which these patients showed after their long period of torture and filth in the concentration camp, was ample reward to all of us for the difficulties we encountered during this unusual phase of our operations.

"Processing of Tuberculous Patients from Buchenwald Concentration Camp by the 45th Evacuation Hospital."

Letter by Colonel Esmond H. Long, Chief Consultant on Tuberculosis to the Surgeon General:

"1. Assignment of task to 45th Evacuation Hospital:

When the Buchenwald Camp was liberated a problem immediately apparent was the care and disposition of several hundred tuberculous patients under treatment in the camp. It was recognized that these were a source of dissemination of the disease, and from the point of view of medical care represented a long range problem. The processing and evacuation of these patients to a hospital appropriate for their continued care was assigned to the 45th Evacuation Hospital.

2. Background of Tuberculosis problem at Buchenwald:

a. The conditions under which prisoners lived at Buchenwald were conducive in every way to the development and spread of tuberculosis. The malnutrition, from which every inmate suffered, together with heavy labor and harsh treatment, inevitably led to the progression of tuberculous lesions in men previously infected, whether these were originally of serious or minor character, and the intense crowding and lack of any sanitary precautions led to dissemination of infection throughout the barracks. "Block physicians", themselves prisoners, appointed by the Prison Administration, constantly discovered cases and sent them to hospitals established within the camp, since distinguished as the "old", the "little" and the "great". The "old" hospital, an indescribably crowded and filthy place, in which patients lay on dirty shelves in a long series of triple-decked compartments, five feet long by two feet high, six patients to a compartment, was in no remote sense a place for treatment, and in effect simply a breeding ground for the disease. In the others, thanks to the interest and intelligence of prisoner doctors, standard treatment was carried out insofar as it was possible under the desperate circumstances prevailing, with little food available, and that of the worst quality, and no relief in sight. In all of these hospitals the mortality from tuberculosis was tremendous. No accurate estimate can be made, but it is probable that many thousands of the 50,000 known to have died in the camp succumbed to tuberculosis.

b. Following the liberation a medical organization was promptly put into effect by Dr. Horn, an eminent Czech surgeon, who had been a hostage in the camp, arrested originally as a supporter of Dr. Benes. He was at the camp six years. His distinguished position was recognized by the Germans, and after November 1943 he did a large proportion of all the operative work. His capacity was universally recognized by the physicians of various national groups in the camp. Under Dr. Horn the following physicians were appointed as tuberculosis consultants:

Dr. Josef Szmeja, a Polish tuberculosis specialist, Chief Consultant

Dr. Stanislaw Machotka, a Jugoslav, who had been superintendent of a tuberculosis sanatorium in Jugoslavia, Second Consultant

Dr. ——, a Russian, who had specialized in tuberculosis.

In addition, three physicians with experience in the treatment of tuberculosis, were retained in direct charge of the "great" and "little" tuberculosis hospitals (the "old" hospital having been closed with liberation of the camp):

Dr. Gerhard Arnstein, an Austrian, in charge of the treatment ward in the "great" hospital

Dr. Edmund Adams, a German political prisoner of English descent, in charge of the far advanced cases in the "great" hospital

Dr. Heller, a Czech, in charge of bilateral cases not suitable for specific therapy, but not hopelessly advanced, in the "little" hospital.

c. The treatment ward of the "great" hospital, with 116 cases, almost all of them under pneumothorax treatment by Dr. Arnstein, was a crowded, malodorous place in which patients slept in double-decker beds. Discipline was maintained, and patients received three times as much food as before the liberation, but no substantial improvement could be expected in such surroundings. Dr. Arnstein was conscientiously doing everything possible under the circumstances. The ward for advanced cases was simply a death room. There were thirty-two cases where there had been seventy a few days before. The "little" hospital, containing ninety-six patients, was a former stable, which had been improved by the patients themselves by the construction of windows. It was a highly crowded place filled with ambulant patients who used three-decker beds at night. There was a total lack of discipline in spite of Dr. Heller's best efforts. Three to four patients a week died here. The most that could be said for it was that it served for the isolation of ambulant patients with infectious sputum.

d. The three hospital groups just cited, made up of 244 patients, did not account for all the known cases of tuberculosis. The different national groups into which the prisoners had gathered immediately after liberation had retained some cases. Altogether it was believed that 100—150 tuberculous patients could be located in the various groups.

3. Evacuation Procedures:

a. The above outline indicates what had been accomplished, thanks to the intelligent action of a few liberated physicians, in the short period preceding the assignment of

the 45th Evacuation Hospital to the evacuation problem. The principal accomplishment of these physicians was discovery, isolation and classification of patients, which enormously facilitated the procedure of evacuation. The institution of pneumothorax on the scale established was heroic, but much success in treatment, under the circumstances, was not to be expected.

b. A priority system, based on the emergency care required, the advisability of removal for early continuation of care elsewhere and other considerations, was set up, whereby patients already in the Buchenwald Camp hospitals were to be delivered to the 45th Evacuation Hospital at the rate of ten an hour during the working day, commencing on 28 April 1945. On the 29th the system was found to be functioning smoothly in spite of mechanical difficulties in the water line and concomitant cleaning of the hospital. Under the direction of the commanding officer, Colonel Zehm, a remarkably rapid and effective job had been done in taking over a terribly dirty building, fouled by unrestrained, suddenly freed prisoners, with no hygienic standards, who had swarmed into the building on their release. Dead bodies were in the corridors and excrement all over the floors on arrival of the staff. Two days later, when evacuation operations commenced, the place was clean and normal operation was in progress.

c. A dispensary organization has been set up by Dr. Horn in Buchenwald Camp for diagnoses of new cases from suspects sent in by physicians in the barracks, which still housed some 15,000 exprisoners. The selection is based entirely on symptoms. In the opinion of the undersigned the number of cases would run far beyond the expected 150 cases if a more careful method of selection including x-ray examination were possible. In view of the tremendous exposure to which the group has been subjected, cases will inevitably arise in considerable number for years to come. At present only the method indicated is practical. The dispensary will hold 35 patients for observation at one time, and it is expected that by the time the present 240—250 patients have been evacuated the dispensary can conclude the retaining task in a few days.

4. Organization of the 45th Evacuation Hospital:

a. The staff consists of the Commanding Officer and 20 medical officers. Lt. Col. Feder, Chief of the Medical Service, has instituted an organization which admirably combines

simplicity and efficient operation. Ten 40-bed wards, each in charge of a medical officer, have been set up. In addition to these there is a receiving officer, general internist, an x-ray chief, a laboratory chief and a specialist in ear, nose and throat work. The rest of the staff of 20, composed of members of the surgical team, are at present on other duties in the area.

b. On arrival at the hospital, patients are taken to the receiving wards (one for ambulant and one for litter patients) and their records are initiated by the receiving officer. By arrangement with the doctors at Buchenwald Camp, their previous medical records are sent with them. EMT's are made out, and a simple medical record devised by the 45th Evacuation Hospital, entirely suitable for the purpose, is started. After this, patients move across the hall, where their clothes are taken away from them to be destroyed and they bathe in hot showers, and are dried and sprayed with DDT. Then they receive clean pajamas and are sent to the x-ray room, where a roentgenogram is made of each man, with a Picker field unit, the subject holding the cassette in his arms. The pictures made are remarkably good, with all the required detail and excellent contrast. Much credit is due to the technician in the dark room, for the condition of the electrical line requires relatively long, fixed exposure and fixed kilovoltage so that careful individual processing in the development tanks is necessary. After the x-ray film is made each patient is sent to his ward. Shortly afterwards, clinical histories are taken through an interpreter, and specimens are obtained for laboratory examination, sputum, blood and urine being examined routinely. Blood sedimentation rates are determined in cases where tuberculosis is diagnosed but the patient is afebrile. The whole procedure is handled quietly and expeditiously.

c. Special mention should be made of the work of the enlisted men. Good technical work is done in the x-ray department and laboratory as well as the bath department, and the care given by the litter bearers, as observed by the undersigned, was superb. Very sick, suffering patients were transferred from litters to cots with infinite gentleness, which, in the light of the bestial brutality which had been the lot of the patients in Buchenwald Camp prior to their liberation, was extraordinarily impressive.

5. Assessment of the Evacuation Procedures:

a. The work done by the 45th Evacuation Hospital in processing tuberculous patients is excellent. Dr. Horn, who had observed the care of tuberculous patients at Buchenwald for years, was strong in his tribute to the spirit and standards of the Medical Department of the U. S. Army. No words can describe the relief and joy of the patients. After their long misery in the filth and torture at Buchenwald, the clean sheets and blankets and personal solicitous attention of the 45th Evacuation Hospital were incredible luxuries.

b. The medical processing meets its purpose in every way. The objective of the hospital is to effect machinery for suitable transfer of patients to permanent quarters. Status as ambulant and litter patients is being established in a sound manner. A certain number of cases misdiagnosed as tuberculous are being discovered, and will be returned for such medical care as they require. Some patients will be found who are too sick to move further under any circumstances, and terminal care is being provided. Treatment is quite properly by rest and good food, which is enormously appreciated by the patients. Pneumothorax treatment is not being given and does not appear indicated in the expected short period of retention of the Evacuation Hospital. It is believed that refills, if necessary, in any cases, can be given, by special arrangement, by the camp physicians who initiated the procedure . . . . . "

. . . — V . . . —

Activity Under Fire . . .

An Evacuation Hospital is protected by the articles of the Geneva Convention, and by its safe establishment considerably to the rear of possible harrassment by enemy ground action. An installation of the size requiring movement by seventy $2\frac{1}{2}$-ton trucks must have at least 24 hours to ensure disposition of remaining casualties and rearward or forward displacement as necessary. Ample time was always available.

Under these circumstances in most instances our unit was free of the more rigorous "trial by fire." Considerable air activity occurred over the Omaha beach as our personnel and equipment awaited debarkation, and at night over the La Cambe area. The greatest risk to personnel was ack ack fragments, unexploded AA shells, and low level firing of .50 caliber machine guns. The intense noise of this activity caused more apprehension than the falling fragments, which fortunately caused no casualties among personnel or patients.

The only individual protective measure taken was the wearing of the helmet, and on the wards or in surgery even this was not feasible. Personnel were not required to dig slit trenches near their quarters since in any event all personnel went to their duty posts during emergencies. All enlisted men's areas were usually placed in the vicinity of a ditch which could furnish some cover.

In the Airel operation the hospital moved somewhat in advance of the divisional clearing stations in that area, and in the bombing preliminary to the St. Lo offensive a stick of bombs fell sufficiently close to our installation to send fragments through several tents. Two of the operating room personnel had the extraordinary experience of having their clothes ripped by these fragments but the only casualty was a prisoner of war who suffered a superficial wound of the forearm.

After the St. Lo breakthrough on 25 July 1944, evidence of enemy activity was negligible. Even though our vehicles were no longer protected by the Red Cross (by Army directive),

we made our movements in convoy without apprehension, a method we discontinued during subsequent movements in the vicinity of the German border.

Meticulous care was always given to maintaining a guard detail among our own enlisted personnel, armed with carbines. In friendly territory the inhabitants were given to wandering around the installation, usually out of curiosity or good will, but sometimes with mischievous intent. Prisoners of war, used for labor, were guarded by our own personnel. When we established ourselves in Eupen an alert guard around the area was necessary since we were among German speaking and indoctrinated civilians.

Occasional flying bombs fell in the Eupen area but very few casualties were sustained by military personnel. The billet of our Commanding Officer suffered serious damage from one such incident. Not until the start of the German counter offensive did the unit find itself under fire of enemy air and ground elements. With news of this offensive our prisoners of war were evacuated and all personnel restricted to the hospital area. At 0530 hours, 16 December 1944 the town of Eupen came under intense enemy artillery fire, presumably from 88 mm weapons. One shell burst about 10 yards from the building which housed our shock and pre-operative wards. An intervening stone wall fortunately caught most of the blast and fragments. No damage resulted to the hospital. At 2330, 17 December 1944 a gasoline dump to our immediate east was hit by a stick of "fire" bombs falling from 150 to 180 yards of our hospital. High explosive bombs then fell within 60 yards of the northwest corner of the hospital. The concussion was severe. All windows were blown out, the lighting system disrupted, and corridors, ward floors, and beds were littered with debris.

According to our previous S.O.P. personnel not on duty were in the basement and shelters during the bombardment, and those on duty stayed with their patients. All personnel assisted with immediate evacuation of the 166 patients to the basement and shelters. An emergency surgery was promptly set up in one of the basement shelters. The conduct of all personnel was exemplary and determined primarily by needs of the patients. There were no casualties and no undue excitement whatever among personnel and patients, an astonishing fact in view of the extensive damage which was evident the following morning.

Bomb fragments and blast caused most damage to the north side of the hospital. The walls of the wards on that side, the Registrar's office, Laboratory and Pharmacy showed evidence of splinter damage and cannon fire. The ceiling of the nurses' quarters, shock and preoperative wards showed evidence of machine-gun fire. The entire hospital was filled with miscellaneous rubbish; plaster, glass, screens. An incendiary container, type ABB 500, was found in front of the mess hall; unexploded candle flares in the storeroom; and an unexploded 50 kg phosphorus bomb in the street facing the hospital.

Two precautionary measures, as well as extreme good fortune, seemed to have prevented injury to patients. Blankets had been used as black-out screens and barred or arrested the flight of some fragments; at the beginning of the attack beds were pushed to the center of the wards.

The day following, 18 December, all patients were evacuated and repairs started. Enemy air activity continued but was almost always in the form of observation and occasional strafing of road junctions. On 19 December the Surgeon's office directed us to dismantle the hospital and prepare all equipment for loading. During the night, flares, but no bombs were dropped. On 20 December at 1000 hours a retrograde movement to our new area in Huy, Belgium was begun. Forty-five 2 1/2-ton trucks had been dispatched by infiltration and many had already arrived at Huy, when First Army ordered all vehicles to return to Eupen, unload, and proceed immediately to Malmedy, Belgium, to assist in evacuation of the First Army Medical Depot and the 44th and 67th Evacuation Hospitals. Four Medical and two Medical Administrative Corps officers were also requested by Corps; they left at 2000 hours.

The following morning, 21 December, the officer dispatched to Malmedy with a detail of 42 enlisted men returned to report three of his men missing. All were subsequently accounted for, two having been evacuated for wounds caused by enemy machine-gun fire. Only one vehicle was seriously damaged by gun fire.

We again prepared to receive patients. The excitement had abated and only our own batteries of heavy artillery about 1 1/2 miles from the hospital were active. On 22 December we admitted 218 patients and remained open to patients until Christmas day. Our motor officer on detached

service with the Infantry was reported as wounded in action although not seriously. On Christmas day an egg-nog party and an excellent supper were not in the least disturbed by occasional enemy aircraft. Bombing and strafing occurred intermittently, but at considerable distance from the hospital.

The 30th and 31st of December were spent in moving from Eupen to Jodoigne, Belgium. The precaution of transporting the nurses by ambulance was taken since enemy air activity continued. The movement on the whole was uneventful.

After eleven months operation the hospital organization, and our personnel as individuals, proved able to function when necessary in the midst of the confusion and clamor of combat. The unit has been "blooded" and emerged as veterans. This intense participation has added to our feeling of comradery with the troops we serve.

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Medical Service Personnel . . .

OFFICERS:

Lt. Col. Isidore A. Feder	Brooklyn, N.Y.
Maj. Benjamin A. Gross	Wilmington, Del.
Maj. Philip S. Wagner	Fresno, Calif.
Capt. Henry A. Boswell	Troy, N.Y.
Capt. Alfred L. Chicote	Quincy, Pa.
Capt. Louis Fratello	New York, N.Y.
Capt. Harold C. Hodges	Mesquite, Texas
Capt. Frank D. Jacobs	Peoria, Ill.
Capt. Bernard J. Moore	Morgentown, W.Va.
Capt. Marden, G. Platt	Baringtown, R.I.
Capt. Ernest Sachs Jr.	St. Louis, Mo.
Capt. James E. Scott Jr.	McClellanville, S.C.
Capt. Ivins S. Tanner	Staten Island, N.Y.
Capt. Stoughton F. White	Kansas City, Mo.

NURSES:

Mary O. Biskup	Waynesboro, Tenn.
Edith E. Brooks	Mooresboro, N.C.
Lula L. Churchwell	Leakville, Miss.

Medical Service Personnel (continued) . . .

Evelyn T. Crary	Winnetka, Ill.
Margaret D. Crim	McMinnville, Tenn.
Margaret V. Cunningham	Sag Harbor, N.Y.
Madeline H. Fazenbaker	Cumberland, Md.
Nancy S. Grubbs	Seneca, S.C.
Anne L. Howe	Weymouth, Mass.
Lorene E. Johnson	Scottsboro, Ala.
Jane M. Kreitz	Baltimore, Md.
Margaret W. Little	Roanoke, Va.
Elon E. Martin	Roanoke, Va.
Agnes P. McGrath	Washington, D.C.
Theresa R. Neill	Shamokin, Pa.
Gertrude A. Nolan	Cold Spring, N.Y.
Sabina H. Orlinski	Holyoke, Mass.
Julia D. Ramaccotti	Hagerstown, Md.
Evelyn W. Riley	Roanoke, Va.
Gladys M. Rush	Alexandria, La.
Helen G. Shirley	Philadelphia, Pa.
Margaret M. Strong	Memphis, Tenn.
Marion Sebring	Oil City, Pa.
Elizabeth Thompson	Peaver Falls, Pa.
Zora A. Wilson	Roanoke, Va.

ENLISTED MEN:

Harold E. Allen	Hawthorne, Calif.
John B. Altmann	Washington, D.C.
Carl F. Anderson	Parlin, N.J.
George A. Ayres	Atlantic City, N.J.
Lester Barbier	New York, N.Y.
Anthony Bonanno	Bloomfield, N.J.
Denver M. Christman	Edon, Ohio
Bruce J. Clark	Detroit, Mich.
Daniel P. Clifford	Minneapolis, Minn.
Sterling Cowan	Arlington, Mass.
John E. Craig	Marysville, Ohio
Walter J. Cycak	Brooklyn, N.Y.
Joseph S. Daley	Batavia, N.Y.
Sterling A. Dalton	Attleboro, Mass.
Charles Danish	Brooklyn, N.Y.
Chester J. Darlak	Buffalo, N.Y.

Medical Service Personnel (continued) . . .

Lawrence E. Davis	Covington, Ky.
Guy E. Dimichele	Poultney, Vt.
Lyle M. Domine	Iowa City, Iowa
Frank W. Drzewiecki	Buffalo, N.Y.
Michael Dzialoski	Buffalo, N.Y.
Harold F. Eggleston	Cicero, N.Y.
George Fedick	Hoonell, N.Y.
Joseph A. Fenicle	Duncannon, Pa.
Eric L. Fleischmann	Philadelphia, Pa.
Richard Fox	Bronx, N.Y.
Henry J. Frazier	Stanley, Ky.
Thomas F. Frerichs	Waterloo, Iowa
Walter J. Gartner	Arago, Minn.
Howard J. Glass	Brooklyn, N.Y.
Irving L. Glucoft	Bloomfield, N.J.
Joseph N. Goglia	Ozne Park, N.Y.
Sidney M. Goldman	Brooklyn, N.Y.
Joseph A. Gordon	Beaver Meadows, Pa.
James M. Greelish	St. Paul, Minn.
Melvin A. Guenther	Cleveland, Ohio
Ben M. Hawes	Bluefield, W.Va.
David Hochstat	Minneapolis, Minn.
Robert L. Hoen	Maplewood, N.J.
Vencil A. Honc	Yoakum, Texas
Vincent P. Horan	Jersey City, N.J.
Ralph E. Hudspeth, Jr.	Kansas City, Mo.
Homer M. Huggins	Austin, Texas
Kenneth J. Hynous	Berwyn, Ill.
Joseph H. Jessop	Previdence, R.I.
James M. Johnson	Somerville, N.J.
Harry Kaminsky	Brooklyn, N.Y.
Andrew Kiniry	May's Landing, N.J.
Cyril F. Kleyn	Detroit, Mich.
Walter S. Kucharski	Bayonne, N.J.
Stanley J. Kusic	South Amboy, N.J.
Theodore G. Lemberg	Port Washington, N.Y.
William H. Linzer	Irvington, N.J.
Steve Madura	Farrel, Pa.
Gordon H. Malsbury	Imlaystown, N.J.
Anthony C. Mangano	Fulton, N.Y.
William E. McCarter	Memphis, Tenn.

Medical Service Personnel (continued) . . .

Dana M. Messenger	Montpelier, Idaho
Leonard A. Mott	Durhamville, N.Y.
Robert C. Nicolicchia	Brooklyn, N.Y.
John J. O'Connell	New York, N.Y.
Dominick Petrozola	Brooklyn, N.Y.
Hubert E. Powell	Smithfield, N.C.
William Przygocki	Jersey City, N.J.
Alfred M. Quintal	Fall River, Mass.
Robert Roberts	Wilmington, Del.
Bennie H. Romary	Rocky Ford, Colo.
Louis A. Rose	Irvington, N.J.
Robert E. Rutherford	Fresno, Calif.
Frank J. Scarano	Saratoga Springs, N.Y.
Jack Schrager	New York, N.Y.
Tommy Scott	West Palm Beach, Fla.
Paul H. Seeber	Niagra Falls, N.Y.
Gregory J. Segreti	Washington, D.C.
James J. Shannon	Jersey City, N.J.
Stephen Skarzynski	South Amboy, N.J.
Calvin S. Stan	Fairview, N.J.
Edward C. Steinberg	Irvington, N.J.
Thaddeus M. Stepniak	Newark, N.J.
Timothy P. Sullivan	Brooklyn, N.Y.
Gaylord F. Tuskind	Davenport, N.Dak.
Lewis A. Wallace, Jr.	Okmulgee, Okla.
Andrew M. Walko	Jersey City, N.J.
Alden F. Wiegert	Shawano, Wis.
George G. Windell	Columbia, Mo.
Edward R. Ywasek	Paw Paw, Mich.
Louis W. Zywicki	Milwaukee, Wis.

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Important "45th" Dates . . .

U.S.A.:

Left Camp Gordon, Georgia, 1000 hrs, 7 Nov 43
Arrived Camp Kilmer, New Jersey, 1000 hrs, 8 Nov 43
Left Camp Kilmer, New Jersey, 1900 hrs, 16 Nov 43
Boarded ferry to Pier 86 at 46th St.
Boarded "Acquitania", 2030 hrs, 16 Nov 43
Left New York, 1100 hrs, 17 Nov 43

U.K.:

Arrived Greenoch, Scotland, 0400 hrs, 24 Nov 43
Debarked at 1400 hrs, 24 Nov 43
Boarded train for Wotton-Under-Edge, Glos.
Arrived at Wotton, 0730 hrs, 25 Nov 43
Left Wotton-Under-Edge, 0700 hrs, 13 June 44, by train
Arrived Hursley, Hants, 1315 hrs, 13 June 44
Left Hursley (Marshaling Area), 15 June 44
Arrived Southampton, 1400 hrs
Boarded "HMS Glenearn", 1720 hrs

France:

Arrived at Omaha beach, 1500 hrs, 16 June 44
LaCambe — 16 June 44
Airel — 25 July 44
St. Sever, Calvados — 9 August 44
Senonches — 22 August 44
La Capelle — 5 September 44 (bivouac)

Belgium:

Baelen — 16 September 44
Eupen — 28 September 44
Jodoigne — 31 December 44 (non-operative)
Spa — 19 January 45

Germany:

Eschweiler — 5 March 45
Honnef — 25 March 45
Bad Wildungen — 3 April 45
Nohra — 22 April 45
Buchenwald Camp — 28 April 45
Nohra — 11 May 45 (bivouac)
St. Wendel — 4 June 45
Schwabisch Hall — 14 July 45 (bivouac)
Bretten — 22 July 45

U.S.A.:

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Addendum . . .

45th Evacuation Hospital Personnel

(D + 10 to V-E Day)

OFFICERS

Lee H. Battle, Jr.
William G. Birch
Henry A. Boswell
Bert Bradford, Jr.
Alfred A. Chicote
George W. Cleveland, III
James J. Coats
John K. Crawford
Edward Dierolf
Edwin B. Egli
Isidore A. Feder
Louis Fratello
Wallace E. Godwin
Harry W. Goswick, Jr.
Benjamin A. Gross
William R. Hardy
Frank R. Hill
Harold C. Hodges
Paul G. Hogan
Bernard Isaacson
Frank D. Jacobs
Richard P. Johnson
Raymond E. Karnes
Hyman Lebson
Philip A. Lief
John N. McEachren
Harry Meyer
Austin W. Miller
Robert J. Miller
Bernard J. Moore
Maurice J. Moore, Jr.
Howard S. Oberleder
Samuel S. Pasachoff
Marden G. Platt
Ernest Sachs, Jr.
James G. Sawyer
James E. Scott, Jr.
Billy V. Smith
Morris Swartz
Ivins S. Tanner
Philip S. Wagner
Jerome J. Weintraub
James M. Weldon
Staughton F. White
Abner Zehm
George W. Zinz, Jr.

NURSES

Mary O. Biskup
Edith E. Brooks
Margaret Bruchnechter
Mary Ann Brugger
Lula L. Churchwell
Evelyn T. Crary
Margaret D. Crim
Margaret Cunningham
Madeline H. Fazenbaker
Mary S. Ferebee
Anna B. Gasparovic
Nancy S. Grubbs
Virginia J. Hall
Dorothy D. Henry
Anne L. Howe
Frances A. Johnson
Lorene E. Johnson
Harriet M. J. Kreitz
Margaret E. Lechner
Margaret W. Little
Virginia H. Lloyd
Barbara Mallett
Elon E. Martin
Myrtle D. Massie
Alice J. Matthews
Eva H. McLin
Agnes P. McGrath
Theresa R. Neill
Gertrude A. Nolan
Alva G. North
Sabina H. Orlinski
Julia D. Ramaciotti
Evelyn E. W. Riley
Nancy H. Rogo
Gladys M. Rush
Marion R. Sebring
Susanne F. Sheldon
Helen G. Shirley
Hazel G. C. Skinnell
Margaret M. Strong
Inez E. Terrini
Elizabeth Thompson
Zora A. Wilson

ENLISTED MEN

Charles J. Adamski
Herbert C. Alder
Harold E. Allen
John B. Altmann
Carl F. Anderson
George Auche
George A. Ayres
Alfonso J. Baccaro
William Balogh
Lester Barbier
Arthur O. Bein
Joseph C. Berger
Anthony Bonanno
Joseph Bonanno
Henry F. Brodbeck
Philip J. Bulone
Charles M. Burda
Salvatore Calabufalo
Andrew F. Campbell
Joseph F. Campbell
Consiglio J. Caravello
Frank J. Carpellotti
Richard Carugatti
Arnold G. Chadwick
Odea J. Charest
Peter Cherkos, Jr.
Denver M. Christman
Frederick Cohen
Bruce J. Clark
Daniel P. Clifford
William H. Coleman
Francis X. Collins
John B. Conlon
William Connaughton
Charles A. Corandan
Sterling B. Cowan
John E. Craig
Richard J. Cramer
Donald E. Cushman
Walter J. Cycak
Joseph Czubowicz
Joseph S. Daley
Sterling A. Dalton
Charles Danish
Chester J. Darlak
Lawrence E. Davis
Kenneth J. Davitt
Charles E. Dew
Lester S. Diehl
Guy E. Dimichele
Lyle M. Domini
Joseph F. Dorocak
Fred G. Drinkwater
Frank W. Drzewiecki
Michael Dzialoski

Addendum (continued) . . .

Harold E. Eggleston
William S. Elder
Samuel M. Ellowitch
William G. Ench
Steven J. Fallon
George Fedick
Joseph A. Fenicle
Paul W. Ferguson
Michael A. Fezza
Sidney Fleischman
Eric L. Fleischmann
Richard Fox
Joseph E. Frock
James E. Fulcher
Richard U. Furlong
Pierce B. Gardiner
Walter J. Gartner
Stephan Gido
Stanley A. Given
Howard J. Glass
Durward A. Glessner
Irving L. Glucoft
John P. Godowsky
William H. Gogan
Joseph N. Goglia
Sidney M. Goldman
Joseph A. Gordon
John Gornik
Louis S Grazier
James M. Greelish
Leon Guervitz
Melvin A. Guenther
Victor D. Gwinn
Joseph E. Haczynski
Clarence Harootunian
George M. Hartley
Ben M. Hawes
Milton O. Hemness
Francis J Hill
John H. Hiltner
David Hochstat
Robert L. Hoen
Donald C. Holland
Vencil A. Honc
Vincent P. Horan
Ralph Hudspeth, Jr.
Homer M. Huggins
Kenneth J Hynous
Joseph H. Jessop
Michael J. Jessup
James M. Johnson
Kent O. Johnson
George Joseph, Jr
Harry Kaminsky
Robert L. Kehoe
Stanley W Kenczka
Joseph A. Kennedy
Doran L. Kernodle
Andrew Kiniry, Jr.
Cyril F. Kleyn
Joseph Kowalskie
Walter S. Kucharski
Stanley J. Kusic
Michael J. Laccietelli
George W. Lamm
Lester L Lang
Edmond D. Laperriere
Victor P. LaPoma, Jr.
Michael Laraia
Ralph M. Laserson
Theodore G. Lemberg
Patrick J. Lennon
Raymond F. Lennon
William H Linzer
Charles J. Lord
Steve Madura
Anthony C. Mangano
Edward J. Mankowski
Marcel Marauda
Gordon H. Malsbury
Eddie Marshall
Joseph Mauro
Peter O. McCallum
William E. McCarter
Daniel F. McGrath
Harold W. McLaughlin
Edward McManus
Francis A. Meissner
Dana M. Messenger
Herman A. Miller
Raymond E. Morgan
Leonard A. Mott
Walter J. Mullen
Julius W. Nelson
William Nezgodowitz
Robert C. Nicolicchia
Michael Nicoletti
Frank H. Nilsen
Elmer A. Niswonger
Steven M. Oblack
John J. O'Connell
Maurice C. O'Connor
Theodore F. Orebaugh
Michael J Parichuk
John H. Patton
Willard P. Parriott
John W Peters
Dominick Petrozola
Anthony J. Pierro
Hubert E. Powell
Bernard A. Prakopcyk
William P. Pryzgocki
Alfred M. Quintal
William E. Rafferty
Nicholas Ramminger
James L. Regan
Harry J. Reimer
Lester J. Riffle
Salvatore Riggio
Robert Roberts
Bennie H Romary
Leonard Roppolo, Jr.
Louis A. Rose
Francis Russell
James W. Russell
Robert E. Rutherford
Joseph P. Sanfilippo
Frank J. Scarano
Jack Schrager
Tommy Scott
Paul H. Seeber
Gregory J. Segreti
Roland D. Seawright
James J. Shannon
Stephen L. Skarzynski
Calvin S. Stan
Edward C. Steinberg
Thaddeus M. Stepniak
Charles B. Sturm
Timothy Sullivan, Jr.
George R. Truett
George M. Turnbull
Waine R. Turner
Gaylord F. Tuskind
Robert F. Van Alstine
Carson H. Van Horn
Emilio Villanova
Lewis A. Wallace, Jr.
Andrew M. Watkins
John A. Watson, Jr.
Harold A. Weinberg
Stanley Whitehead
Alden F Wiegert
Robert H. Wilks
Oscar Willerman
Kent J. Wilson, Jr.
Everett S. Winchenbach
George G. Windell
George A. Wingfield
John P. Yourkavitch
Edward R. Ywasek
Louis W. Zywicki