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OFFICE OF THE SURGEON GENERAL'S OFFICE

Report of

Medical Department Activities

in

THE PERSIAN GULF COMMAND

by

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19th Field Hospital

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Interview with Abram J. Abeloff, Colonel, M.C.

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(Col. Abeloff graduated from Columbia University, College of Physicians and Surgeons in 1926. He entered on active duty 15 April 1942 and was sent to Fort Monmouth, New Jersey. He was with the surgical service at Fort Monmouth until 12 October 1942 when he went to Camp Butner, North Carolina, to form the Headquarters Detachment of the Persian Gulf Service Command. Overseas he was in command of the 256th Station Hospital, the 19th Field Hospital, and the 113th General Hospital.)

LOCAL CONDITIONS

In the desert the temperature in the shade, according to the thermometer we used, was between 110° to 120°. This thermometer was placed in a box because there were no trees to provide shade. The only trees near our area were at Khorramshar along the Gulf.

OPERATIONS

I departed for overseas with Headquarters for the Persian Gulf Command 1 November 1942 and arrived in Iran 11 December. After a few days of staging at Khorramshar we went to Teheran. I was made acting surgeon of the Command because the surgeon was down at Basra, another part of the Command.

At Teheran we set up a dispensary and also started to build a hospital for the 30th Station Hospital, which was coming there. The building to be converted into a hospital was one used by the Presbyterian Missions. Part of this building I used as a dispensary for illnesses that weren't too severe. This was done to avoid sending patients to the British hospitals.

I was at Teheran for only six weeks and then was sent to Ahwaz to a hospital which had been set up by the North Atlantic Division to treat civilians. The purpose of this hospital was to treat civilians who were building roads to set up a supply route to Russia. This hospital was designated the 256th Station Hospital. It was a 50-bed unit. The only personnel assigned to the unit were one Medical officer, one Dentist, one sergeant and myself as C.O. The other personnel we used were borrowed from other organizations.

I had a confusing situation in trying to organize the hospital. There wasn't a copy of AR 40-590 available but I managed to get along. I did know how to take care of patients but the making out of forms was something altogether different. The hospital at one time had about two hundred patients. We were able to handle this many patients because of our "moonlight" requisitioning of supplies and equipment. I was at this location about three months and then in April, 1943, moved eighty miles north of

Ahwaz to Andimeshk.

After arriving at Andimeshk I took command of the 19th Field Hospital. This was an interesting experience because it was located in the desert and the building of the new hospital was still in progress. We took over the huts that had been previously used by the British. These buildings were widely dispersed because the British were afraid of bombings. The huts would hold only twelve or fifteen patients. This made the treatment of patients difficult. There were only a few bedpans and it was amusing to see ambulances driving through the area with personnel to distribute them where needed.

Ward tents were finally used to house the patients because they were much cooler than the huts. Two tents were used with one placed about three feet above the other. This allowed for free circulation of air. The floor of the ward was six feet beneath the ground level of the desert. Twice a day a 1,500-gallon water truck sprayed the tent and patients. To amuse the patients we also sprayed the nurses. The spraying resulted in keeping the temperature down 10° lower than it was on the outside.

In July, 1943, our hospital moved into buildings which had been built by our Army. The patients and personnel of the unit were more comfortable than previously. I stayed at this hospital until 1 June 1944, when I was transferred to the 21st Station Hospital at Khorramshar. This was a 500-bed unit. I was there only three months and was transferred to Ahwaz to take over the 113th General Hospital.

The 113th General Hospital had originally come from the States as a 750-bed unit, but because of the difficulties in evacuating patients to Cairo to the 38th General Hospital the 113th was made a general hospital. The 113th General was expanded to 1,000 beds but the census never went over 750 or 770. In January it was dropped to a 750-bed hospital and later when the census in the Command dropped still further, the hospital was made a 500-bed unit. This unit still remained as a general hospital but the T/O was reduced accordingly.

The 113th General Hospital stayed at Ahwaz until 10 February 1945 when it was moved to Khorramshar. Ahwaz was closed as an installation and the whole Command was gradually being reduced, as our function of supply in Russia was finished. We moved into buildings formerly occupied by the 21st Station Hospital, which had been released from our Command and sent to Italy.

The unit departed for the States 5 May 1945 and I left 6 May. Many of the best trained men were left behind and I was a little bit upset about this. One hundred and five of the best trained technicians were left behind, plus some of the best officers, leaving me with only a skeleton of a hospital. This was necessary because the 19th Station Hospital in Teheran had been moved to Khorramshar. This was 250-bed hospital but the War Department had authorized them to operate as a general hospital,

even though it wasn't designated as such, so I had to leave my best personnel there in order to have it adequately staffed. The census of this hospital when I left was only 185.

A certain amount of our equipment was left, too, because our unit left on a T/O for a 500-bed station hospital. The laboratory had trained technicians to carry on the work.

MEDICAL SITUATION.

a. General

The outstanding cause of admission during the first year was diarrhea and malaria. During the second year it would be impossible to cite an outstanding cause for admission to the hospitals. The beds of the Command were never even fifty percent occupied.

When we arrived, the British had been having rates something like eighteen percent of their command being hospitalized. We set up on a ten percent basis and everyone anticipated much difficulty in caring for the number of patients we would receive. This was not true, because as soon as the men learned how to take care of their mess kits, kitchen utensils, etc., the diarrhea dropped. Venereal disease was always a problem but when we received penicillin, there was no hospital rate at all.

Four hundred cases of leishmaniasis were reported in 1943 and 1945 but very few of these cases were hospitalized. At first there were many cases of sandfly fever, but later the admissions dropped. The reason for the falling rate of this disease is unknown, except we may have been more accurate in our diagnostic procedures. Heat strokes were prevalent during 1943 but I don't remember a single one during 1944; at least we didn't have one at the 113th General Hospital.

b. Leishmaniasis.

Having been interested in surgery, I felt that a lot of these lesions could have been cleared up by cutting in ten days. The lesions were being treated with neostam and stilbamidine as The Surgeon General's Office wanted this information. Interesting results were obtained. One result was the discovery that it is a self-eliminating disease. The Persians say it takes a year to wear the disease out.

I excised several epithelioma in order to get material for slides so we could make studies and treat it as you would a malignancy. In performing the excision it is necessary to cut wide of the tumor in order to prevent the return. The pathologist can make this study to determine if you have removed the diseased tissue.

In the lesions of the face one would hesitate to perform surgery because of the damage that could be done. If surgery were done in

leishmaniasis cases, probably the patients would be cured in seven to ten days.

The disease is not incapacitating except in a few cases where cellulitis develops. Most of the patients with this disease were ambulatory and were not admitted to the hospital. They lost work hours coming to the clinic but were never carried as sick in quarters.

Our feeling is that the intermediary host in leishmaniasis is the kangaroo rat and then the disease is carried by the sandfly. During 1943 when there was much building and many natives were in the neighborhood, rats abounded in the area. Late in 1943, when the laboratory was well established, we tried to get some kangaroo rats to work with but there were none present. This project would have been interesting if carried out. Our theory is that the diminution in rats and sandflies gives a low rate of leishmaniasis.

I sent one of my officers to Palestine to consult with Dr. Adler, who has done more work on leishmaniasis than anyone else, except a few Russians, and the final opinion is that not too much is known about the disease. It is a relative innocuous thing except for the possible disfiguring and scarring of a woman. The only kind of leishmaniasis seen was of the dermatological type.

This disease is prevalent throughout the Middle East. It causes a noticeable scar when on the face. It is a tissue-paper scar, usually blotched all over.

The Russians have been experimenting with a form of immunization which produces a lesion of leishmaniasis. Just how successful this is I don't know.

c. Venereal Disease

The drive on venereal disease in Persia is terrific. Our VD rate was about 50 and I did not think it was high, but after comparing it with the rates of other units, which averaged 35, I realized that our rate was high.

The education program has been stressed to a high degree. This program has been reported in ETMD's from the Persian Gulf Command. Everything possible is being done to control the venereal disease rate. Telegraphic reports are submitted each Saturday morning on the V D rate and it reminds one of the stock market.

The education program was a terror campaign to control venereal disease but actually it doesn't work. As long as I can remember, and I suppose for thousands of years back, fear has been used in an attempt to control V.D. but with poor success. It is definitely impossible to make sexual intercourse unpopular but the attempt should be made to make prophylaxis popular.

At one of our locations there was a large field that had been used by the British Indians for trench mortar practice. The prostitutes gathered in this field at night and carried on their work. This information was given me by the men in the pro station. I talked this situation over with the provost marshal and I decided he should go see the Persian policeman. We thought that if we turned these women over to the Persian policeman, he might fine them. We suggested this and he was more than willing as the police are low paid and graft plays a big part in their wages. On a designated night we surrounded this area and took about fifty women into custody and turned them over to the Persian policeman. It took about three nights to get this area cleaned out and then business at the pro station dropped.

A little later one of the men from the pro station told me that the prostitutes were operating in a cemetery about six miles from us. How the soldiers get to these places is unknown but they find a way. We also raided this area and took the women in custody for the Persian policeman.

Gonorrhea was treated with penicillin and within eight hours we were through with the case except we made the patient return for a check as a matter of control. Formerly we had used sulfa drugs, but it took three or four days to clear up the discharge and then a few days to get the smears negative. This method usually kept the patient in the hospital about a week. Patients were sometimes sensitive to sulfa, whereas with penicillin we haven't had that trouble.

Penicillin was used in the treatment of syphillis for only two months before the hospital was closed. I can't give any data on this but with the few cases that we did have, penicillin cut down the hospital days considerably. Ordinarily, a patient could be released after seven or ten days' treatment at the most.

d. Nursing

The nurses were never overworked. There was an excellent chief nurse of the Command. The rotation system for the nurses was excellent and also promotions were given. This helped a lot in keeping up the morale. Their training was excellent but I do not know how they would have stood up in combat. A rest camp was established at Teheran and it was a very pleasant place. Nurses were put on 10-day special duty to go there. Palestine was designated as a leave area by the Command and every nurse had 10 days there.

SUPPLY AND EQUIPMENT

Medical supply was excellent. At first we did have trouble getting supplies but as the Command became better organized we got everything we needed. We needed a respirator one time and had no trouble at all getting it. Up until this time we had been using the British respirators but the British didn't take good care of them and often they wouldn't work.

ROTATION AND MORALE

The morale of Medical officers is a very difficult problem with which to deal. If they could only be kept busy, the problem would be solved.

There were too many beds allotted but this couldn't be helped. We had an unusually healthy command. These beds are necessary because the Army personnel is entitled to the best care possible. Under this condition there must be specialized personnel that are not too busy, because they are necessary for emergencies.

Rotation within the theater wasn't very successful because none of the hospital personnel ever worked themselves to death. We were just not busy all the time. Only occasionally did we have a peak load and that would last only a short time.

A rotation policy was established for personnel to return to the States but it took months and months before replacements arrived. Everyone felt that the life of the Command was limited and that the work was about completed. This did not help the morale of the Command at all.

It is my opinion that a reasonable length of time for anyone to stay in this Theater would be one year. If the individual knew he was going to be there for only a year he could carry on. It is definitely wrong to promise rotation and then for it not to operate.

PROMOTIONS

I feel that the most dangerous promotion in the Medical Department is from captain, MC, to major, MC. When a Medical officer is promoted from captain to major, it immediately gives him authority to be chief of a service. He then has a terrific amount of control as to how patients are to be treated. Promotions should not be made on the basis of protracted service alone but also on medical qualifications. I have talked with a great many people about this and find it a bit touchy. It is my feeling that personnel should be rewarded for their length of service but not by being advanced a grade when they are not capable. It happens very often that a man with little service and specialized training has to work under a chief who is not competent. This creates a problem because usually the T/O is filled and there is no chance for the younger officer to be promoted.

ETMD's

The first ETMD that I saw was at Teheran in the Surgeon's office and I asked him why he didn't send it down to me so I could look at it. After this all ETMD's were circulated throughout the hospitals in the Command. I thought these reports were excellent. In fact it was the first inkling at all that we had of what was going on in other theaters. It was difficult to read these reports when they were in the small form, but when they were changed to a larger size, they were excellent. It was our feeling that when we sent in an ETMD, someone in Washington was going to see it, and we would get a reply. It wasn't just going to be filed.

The ETMD's were used as a basis for staff conferences in the surgical and medical services. This was a good way of disseminating information.

The officers really enjoyed the material as they felt they were losing out on the real things that were happening in the combat areas.

PROPHYLACTIC STATIONS.

Second-rate men should not be placed in these units as so often is the case. If there are conscientious men in a pro station, it usually is a good one;if second raters are used the pro station is second rate too. If the corpsmen are interested in their work, they will report to the officers information that is valuable in controlling the VD rate.